Yukon FASD Diagnosis and Case Management in Adult Corrections Population

FINAL REPORT

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For Public Health Agency of Canada

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Name of Organization:	Yukon Government – Health and Social Services (HSS)
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EXECUTIVE SUMMARY

Yukon has a long history of action on Fetal Alcohol Spectrum Disorder (FASD). However, providing a range of coordinated services and supports in a small rural jurisdiction has its challenges. FASD funding from the Public Health Agency of Canada (PHAC) provided an opportunity to increase Yukon capacity to identify, assess and provide services to adults with FASD.

Yukon received funding from PHAC from 2011 to 2015 to carry out a project to improve outcomes for adults with FASD who are involved in the criminal justice system. There were two components to the project:

1. Prevalence Study (led by Department of Justice)
2. Diagnosis, Case Management (led by Department of Health and Social Services)

The PHAC funding was essential in providing Yukon with the capacity to:

- Research best practices on FASD diagnosis of adults and collaborative case management;
- Provide case management training to front-line workers;
- Train, recruit and establish a Yukon-based team to assess and diagnose adults with FASD;
- Carry out a Prevalence Study in the adult corrections population;
- Develop a Strategic Framework for collaboration on FASD;
- Develop a protocol agreement between the Departments of Health and Social Services and Justice on collaborative case management; and
- Other outcomes set out in this report.

Like many projects of this scope, challenges arose along the way and timelines and plans needed to be adjusted. A group of dedicated individuals who believed in the projects gave generously of their time and expertise. Despite setbacks, the team prevailed and new solutions were found. As well, the multi-year funding commitment from PHAC and the flexibility to adjust timelines also contributed to the success of the project. We thank PHAC and the many individuals who have helped bring this project to fruition.

We hope that other small jurisdictions in Canada can benefit from our experiences in setting up an adult diagnostic clinic and undertaking a prevalence study.

BACKGROUND

Yukon action on FASD

Yukon is the ninth largest province/territory in Canada and is home to over 37,000 people. About 21 per cent of the Yukon population is reported to be First Nation. Eleven of the 14 First Nations in Yukon have land claims agreements and are self-governing.

Yukon has a long history of action on Fetal Alcohol Spectrum Disorder (FASD) resulting in many activities, services and initiatives related to FASD prevention, assessment/diagnosis, supports for individuals and families, training and education, and research and evaluation. These initiatives are delivered by a variety of agencies and organizations including Yukon government, First Nation governments, non-profit groups, and Yukon College.

The FASD Project funded by Public Health Agency of Canada (PHAC) allowed Yukon to take these initiatives to the next level.

There is a fairly high awareness of FASD amongst the general population at all levels and Yukon has provided leadership on FASD in various forums in Canada. In 2008 the Yukon Government's Department of Justice hosted a national conference on Access to Justice for Individuals with Fetal Alcohol Spectrum Disorder. The Department of Justice has continued to play a lead role in federal/provincial/ territorial discussions on FASD. As well, Yukon Health and Social Services has been a member of the Canada Northwest FASD Partnership since 1999 and has hosted regional conferences and collaborated with other jurisdictions on various initiatives related to FASD.

On assessment and diagnosis, Yukon developed a local diagnostic team to assess pre-school children with FASD in 2004. In 2006, capacity was increased to assess school-aged children. The Child Development Centre (CDC) is funded by Yukon Health and Social Services to coordinate assessments for the two teams. CDC provides a psychologist and therapists for assessment of pre-school children and the Department of Education provides psychologists and therapists for assessment of school-aged children. The two teams assess approximately 10 pre-school and 10 school-age children per year.

For adult diagnosis of FASD, starting in 2004, assessment teams from Alberta were brought to Yukon once a year to assess approximately 10 adults. Health and Social Services provided

funding to Fetal Alcohol Syndrome Society of Yukon (FASSY) to coordinate these assessments until 2014. Justice also provided funding for FASD assessments of some clients each year.

The long-term vision in Yukon has always been to develop a local assessment/diagnostic clinic for adults to complement the services available for children.

The PHAC project allowed Yukon to further develop local capacity to identify, assess and effectively support adults with FASD. In sharing the results and lessons learned from this work, we hope to be able to assist others in their efforts to improve outcomes for people affected by FASD.

FASD

Fetal Alcohol Spectrum Disorder (FASD) refers to a spectrum of difficulties in learning, behavioural and emotional regulation and adaptive functioning. These difficulties result from brain damage due to prenatal alcohol exposure (PAE). Many adults with FASD also experience mental health problems.

Adults with FASD also experience "secondary disability" or adverse life outcomes as a result of the disability. These secondary disabilities may include unstable housing, lack of employment, difficulties with social relationships, alcohol and drug problems, victimization and trouble with the law.

Estimates of the prevalence of FASD vary from 1 to 9 per 1000 live births are affected by FASD if all the diagnostic categories are included (Sampson et al, 1997). The variability in rates is, in part, due to the lack of consistency in the diagnostic criteria used in clinics and research settings.

In Canada, the lifetime cost per person with FASD is estimated to be $1.8 million, not including loss of productivity and caregiver burden (Thanh & Jonsson, Institute of Health Economics, Alberta, 2009). Costs include use of health services, special education services, social services, and corrections.

It is clear that preventing FASD and providing effective services to those affected by FASD is a compassionate and cost-effective response.

PROJECT OVERVIEW

The original impetus for the Yukon project came out of a national conference on *FASD and Access to Justice* co-hosted in Whitehorse by the Yukon Department of Justice. Recommendations flowing from the conference identified the need for research on the prevalence of FASD in the criminal justice system and the development of more effective case management. Department of Justice was interested in conducting a prevalence study to determine the number of adults affected by FASD in the justice system. And both Departments of Justice and Health and Social Services were interested in identifying and implementing ways to improve case management for adults moving from the justice system into the community.

The overall goal of the project was to improve outcomes for adults with FASD who are involved in the criminal justice system.

Specifically, the project had two streams:

1. Prevalence Study (Department of Justice lead)

Objectives:

- Determine the prevalence of FASD and alcohol-related neurocognitive impairment among offenders in the Yukon justice system.
- Identify the rates of mental health and substance abuse problems among offenders in the Yukon justice system.
- Test FASD screening tools in the context of the Yukon justice system.
- Ensure the adaptability of the research methodology and project models for other jurisdictions.

2. Diagnosis, case management (Health and Social Services lead)

Objectives:

- Increase capacity within Yukon to assess and diagnose adults with FASD.
- Strengthen collaboration between service providers and improve case coordination for adults with FASD who are moving from the justice system into the community.
- Develop a FASD framework for coordinating programs and services.
- Improve awareness of FASD and understanding of supports.

Assumptions and Guiding Principles

The project was guided by the following assumptions and principles, based on research and practice-informed knowledge:

- Individuals with FASD are over-represented in the justice system.
- Recidivism can be reduced if individuals with FASD receive appropriate supports to live in the community.
- "Assessment must assist intervention"; assessment and diagnosis do not on their own lead to improved outcomes for the adult being assessed. Assessments must focus on the individual's functional strengths and needs and provide practical recommendations and strategies that the adult and their support people can use to help them live a good life.
- Coordination and collaboration between services providers and support people helps to build a cohesive and consistent network of supports for the adult.
- Building more Yukon capacity for assessment/diagnosis and case management will improve services for individuals with FASD in Yukon.
- Deepening and broadening knowledge of FASD amongst Yukon service providers and clinicians ripples out to the broader community. Local expertise on FASD is key to ongoing knowledge exchange and service improvement.

Timelines and Resources

The project was originally funded to start in January 2011 and finish on March 31, 2012. Additional funding was provided to extend the project to March 31, 2014. A further time extension was provided to March 31, 2015 and approval was granted to carry over funding from 2013/14 to finish the project. Total funding received from PHAC was $507,300 over four fiscal years.

In addition to the contribution from PHAC, Yukon government contributed multi-year funding of over $643,000 to the Prevalence Study plus significant in-kind resources. (An additional $251,000 has been allocated by Yukon Department of Justice to conclude the study in 2015/16.) Justice Canada and Yukon College also contributed to Phase 1 funding for the Prevalence Study. (See the Evaluation and Sustainability section of this report for more detail on other financial and in-kind contributions to the project.)

Health and Social Services also provided in-kind staff resources to the project, including a Clinical Coordinator for the Adult Assessment Clinic who started on a full-time basis in November 2014. Other Yukon and national agencies contributed in-kind resources to support aspects of the project (e.g. training), including Fetal Alcohol Syndrome Society of Yukon, Council of Yukon First Nations, Northern Institute of Social Justice and Yukon College.

Both streams of this project are still underway. A final report on the Prevalence Study is expected to be completed in 2015/16. The first referrals for assessment through the Yukon Adult Assessment Clinic were accepted in May 2015.

PROJECT ACTIVITIES

Activities for the entire project are summarized below by project phases for the two project streams – Prevalence Study, and Diagnosis and Case Management. Activities completed in fiscal year 2014-15 are noted below.

1. Prevalence Study (Department of Justice lead)

Planning and Development Phase

- Established governance structures to oversee the prevalence study.
- Consulted with project partners (in Yukon and in other parts of Canada).
- Identified a principal investigator and developed a research methodology, consents, data collection, adapted screening tool, determined test battery for assessment, diagnostic criteria.
- Secured resources for project phases.

Implementation Phase

- Yukon's Information and Privacy Commissioner reviewed research protocols for compliance with *Access to Information and Protection of Privacy Act.*
- Hired and trained staff and contract personnel to coordinate and conduct assessments (Principal Investigator, Prevalence Study Manager, Supervising Neuropsychologist, Administrative/Research Assistant, Psychologist, Physician). (Completed during 2014/15).
- Reached agreement with the University of British Columbia to provide data analysis.
- Provided ongoing training and consultation, and mentoring and supervision for clinicians conducting assessments to ensure quality, consistency and reliability of research findings (2014/15).
- Undertook assessments starting in 2014/15:
    - Recruited volunteers from the corrections and probation populations, obtained consents.

- Screened participants using the adapted Asante tool.
- Collected relevant information for assessment, including evidence of Prenatal Alcohol Exposure.
- Conducted assessments, provided client reports and offered follow-up services to clients.

- Obtained ethics approval for research and necessary research licenses (February 2014).
- Secured *Scientists and Explorers Act* license (September 2014).
- Posted summary of research methodology on Department of Justice website (2014/15).
- Data collection period extended into 2015/16. Final report estimated to be available in 2016.

2. Diagnosis, Case Management (Health and Social Services lead)

Planning and Development Phase

- Gathered information on diagnostic best practices from literature, field experts and clinics in Canada and Alaska.
- Reviewed literature on case management models.
- Developed relationships with agencies and individuals in Yukon and across Canada and shared information on FASD with contacts in Yukon.
- Carried out planning for training on case management in partnership with local agencies and Yukon College.
- Gathered information on Yukon services related to FASD.
- Developed a model for a local adult assessment/diagnostic team and secured necessary resources to implement.

Implementation Phase

- Provided two offerings of a certificate-level training on FASD and case management in collaboration with Fetal Alcohol Syndrome Society of Yukon (FASSY), Council of Yukon First Nations (CYFN), Yukon Justice and Northern Institute of Social Justice (NISJ) and

additional financial support from Yukon Government's Community Development Fund. The Child Welfare Institute of Canada provided the 11-day training program to staff from Health and Social Services (HSS), Justice, federal government, First Nations and non-governmental organizations:

  - 2013: 25 trained
  - 2014: 30 trained
  - In addition to the staff trained in the case management course, 60 people took the first 2 days of the certificate training as an introduction to FASD and case management.
  - Both training offerings were evaluated by Child Welfare Institute via participant survey.
  - FASSY is following up with graduates of certificate program.

- Hired a local adult assessment/diagnostic coordinator (November 2014) and developed clinic policies, procedures, forms, logic model and performance measurement framework (March 2015).

- Developed an Advisory Committee to provide advice on the development of a local assessment clinic (November 2014).
- Trained a pool of local psychologists and physicians in adult assessment of FASD, which included the University of Washington on-line training on the 4-Digit Code and 2-days of in-person training provided by Alberta clinicians (January 2015).
- Recruited physicians and psychologists to the adult assessment/diagnostic team and planned further training and mentoring to support the development of skills required for the psychological assessments (February 2015).
- Developed a protocol agreement between Health and Social Services and Justice on case collaboration of common clients with complex needs including those with FASD (March 2015).
- Developed Terms of Reference for a Yukon Government interdepartmental committee on FASD (March 2015).
- Drafted a FASD Framework to guide planning and coordination by the interdepartmental committee (March 2015).
- First referrals for assessment were accepted in May 2015. Training/mentoring plan for psychologists and for new team will be carried out over the first year of assessments.

LESSONS LEARNED

While the Yukon project has experienced a number of challenges along the way, it is important to start with factors that contributed to the project's success.

SUCCESS FACTORS

1. Generosity and dedication of many

Within both project streams, a dedicated group of committed individuals who believed in the projects adopted a "let's make it work" attitude to solving problems and moving the projects forward. Support came from within Yukon Government (Departments of Health and Social Services and Justice), the federal government and national agencies (Public Health Agency of Canada, Correctional Services Canada, Department of Justice Canada, Canadian Centre on Substance Abuse, Child Welfare Institute of Canada), Yukon non-governmental organizations (Fetal Alcohol Syndrome Society of Yukon, Council of Yukon First Nations – Health and Social Development, Child Development Centre, Northern Institute of Social Justice, Yukon College) and other individuals and institutions (Principal Investigator Dr. Kaitlyn McLachlan– UBC, Dr. Gail Andrew – Glenrose Clinic, Dr. Jacquie Pei – Neuropsychologist, Bernie Mallon – Social Worker/Clinic Coordinator) and various clinics and experts in FASD within Canada and the U.S.

Many clinics have freely shared their experiences and lessons learned in assessing adults with FASD. The Glenrose Adult Clinic and Lakeland Centre for FASD shared many resources including training materials, clinic procedures and clinic forms. This provided a solid starting point for Yukon to adapt materials, rather than start from scratch.

Within Yukon, various organizations partnered to achieve common aims. For example, the First Nations Health and Social Directors (Health Commission) and Fetal Alcohol Syndrome Society of Yukon (FASSY) were part of the advisory committee struck for the Prevalence Study. As well, FASSY, CYFN, Northern Institute of Social Justice, Department of Justice and Health and Social Services worked together to offer two 11-day certificate training programs in collaboration with the Child Welfare Institute of Canada. And individuals from some of the same organizations plus the Child Development Centre (CDC) gave freely of their time and knowledge on the Advisory Committee established to assist with the start-up of the local adult assessment clinic.

Individual clinicians also rose to the task of applying their knowledge and developing new competencies. Specifically, Yukon psychologist Allison McNeil and physician Dr. Sally MacDonald developed the necessary skills and knowledge by

mentoring with Dr. Jacquie Pei and Dr. Gail Andrew for the Prevalence Study.

Without the support and generosity of many individuals and organizations, the projects would not have achieved the successes set out in this report. The community of FASD experts in Canada is connected, collaborative and very willing to share knowledge and help build capacity and knowledge on FASD. This project relied heavily on advice and subject matter expertise from outside Yukon. This expertise, coupled with the knowledge and wisdom of Yukon people ensured that projects were based on best practices and grounded in Yukon realities.

2. Multi-year commitment

Both Yukon project streams were complex and required significant front-end planning and development. The Yukon project could not have been carried out without a multi-year commitment to funding. Project sponsors were willing to extend timelines in order to accommodate delays. PHAC provided additional funding to the project and granted two time extensions in response to unforeseen process delays. These accommodations were key to maintaining momentum for the project and in leveraging resources from within Yukon Government and other sources to continue the project.

3. Ability to leverage resources

Funding from PHAC and other sponsors allowed the Yukon project to leverage resources from other sources. For example, in 2013/14 the PHAC project contributed $40K to the first round of FASD case management training. In 2014, FASSY received $90K from the Yukon Government's Community Development Fund (Economic Development) for the second round of training.

The two project streams also worked collaboratively to leverage human resources and expertise.

Training: Members of the Justice Prevalence Study assessment team were recruited and undertook training in September, 2013, and later throughout 2014 as team members changed. They also participated in the training held in January 2015 as part of the development of the Adult Assessment Clinic and were able to share their knowledge and experience with others.

Shared mentors: The two projects share the same Yukon physician diagnostic team member who has received training and mentoring through the Justice Prevalence Study. Dr. Gail Andrew from Glenrose Hospital is the supporting/mentor physician for both the Prevalence Study and the Adult Assessment Clinic. Some of the psychology resources are also shared – the supervising neuropsychologist, Dr. Jacquie Pei, supports the primary psychologist performing assessments with the Justice Prevalence Study and will also support the psychologists conducting assessments for the Adult Assessment Clinic.

Shared resources: A psychologist who is currently conducting some psychological tests for the Justice Prevalence Study will receive additional training and support to conduct assessments for the Adult Assessment Clinic. This training and hands-on experience will benefit both projects.

The two project streams have worked together to build on each other's work in order to enhance Yukon capacity and ensure success of the projects. To assist in building a core competency in adult assessments and diagnosis, the Adult Assessment Clinic decided to start with the same battery of psychological tests being used by the Justice Prevalence Study. This battery may expand and/or change over time, but provides a solid starting point for building local capacity to conduct clinical assessments of FASD.

CHALLENGES

1. Front-end work takes time

Planning, obtaining approvals and staffing always takes time and this project was no exception. Recruitment of a Principal Investigator, development of a research methodology, and development of a research agreement with the University of British Columbia to hold and analyze data all took time. Obtaining ethics approval and a research license meant that the research project did not get underway until 2014. Similarly for the adult diagnostic clinic, research, planning, obtaining approvals, and staffing took more time than anticipated. As noted above, the ability to adjust timeframes for the project was critical to ensuring that the project could continue to fruition. Front end/planning is time consuming but crucially important.

2. Need to position FASD

In Yukon, FASD is only one of many disabilities. Assessment capability in Yukon is thin (in particular, neuropsychological assessment capacity) and many adults could benefit from a multidisciplinary, comprehensive assessment, regardless of whether their cognitive disability is a result of FASD, traumatic brain injury, or a genetic or developmental intellectual disability. In discussing the FASD diagnostic clinic, Health and Social Services grappled with issues of equity and fairness to all clients. In the end, the clinic was established within this context:

- Our long-term goal is to develop more Yukon capacity to provide functional assessments for all adults with cognitive disabilities, regardless of the origin of their disability. This vision is reflected in the name of the clinic – "Adult Assessment Clinic".
- Functional assessments will provide the individual adult and service/support providers with practical information about the strengths and needs of the adult, which can then inform strategies to help the adult. These assessments are an important component of individualized planning for adults with disabilities.
- We have an opportunity through the PHAC project to develop a local team to assess and diagnose adults with FASD. This is a good starting point for developing greater capacity to perform functional assessments in Yukon. In time, the adult clinic may evolve in much the same way as the children's FASD clinic evolved. (The pre-school FASD children's clinic expanded their assessments to Complex Needs and Autism Spectrum Disorder in 2014).

3. Many interdependencies

The FASD project required the alignment of many factors including:

- obtaining approvals and resources,
- recruiting staff, clinicians, and participants, and dealing with staff turnover,
- developing and undertaking training of individual clinicians using resources from Yukon and outside Yukon.

As noted above, undertaking the planning and obtaining approvals for the project streams took a significant amount of time and effort. Because project timelines were extended, additional resources had to be secured. Staff turn-over also threatened the continuity of the project. Creative solutions and pulling people in with previous history with the project allowed the project streams to move forward with limited disruption. As indicated above, those involved in the project were committed to making the project work and found solutions to problems as they arose.

4. Building local capacity step by step

Recruiting clinicians and training individuals to perform the FASD assessments was challenging. At the time of this project, there were only two neuropsychologists living in Yukon – both employed full-time by Yukon government. Generally, neuropsychological assessments for Yukon people with disabilities were being performed by visiting neuropsychologists. At the time of recruitment, there were no neuropsychologists available to perform FASD assessments for the Prevalence Study or the Adult Assessment Clinic.

The Prevalence Study required a full-time psychologist as of summer 2013. After an unsuccessful attempt to recruit a psychologist from the private sector, an arrangement was made with Department of Education to have an Educational Psychologist trained to perform assessments for the Prevalence Study. The Educational Psychologist began in September 2013. Department of Education agreed to extend this temporary arrangement in April 2015 in order to ensure the continuation of the Prevalence Study, even though school psychologists were in short supply. Once again, the spirit of cooperation and generosity prevailed.

The Adult Assessment Clinic recruited clinicians in January 2015. The private psychologists that responded to the Request for Proposals had limited experience assessing/diagnosing adults with FASD. Health and Social Services (HSS) had anticipated this situation and put together a training plan.

As a first step, HSS offered local psychologists the opportunity to take the 20-hour University of Washington on-line course on the FASD 4-digit code at no charge. HSS also paid a pool of psychologists and physicians to attend in-person training (provided by Dr. Gail Andrew, Dr. Jacquie Pei and Bernie Mallon) on January 26-28, 2015.

Once psychologists were chosen for the Adult Assessment Clinic, a more detailed training plan was developed. Because one of the chosen psychologists was performing some tests for the Prevalence Study, the Adult Assessment team, as advised by Dr. Jacquie Pei, decided to start with the same battery of psychological tests, in order to build competency on a core set of common tests.

Dr. Reagan Gale, a neuropsychologist employed with HSS (Continuing Care), had been advising the HSS team on recruitment of psychologists. She then began to assist with the training, offering to provide

training during evenings and weekends, including some pro bono hours. A schedule of classroom and practice sessions was set up for the three psychologists who were successful in obtaining a Standing Offer Agreement with HSS for performing assessments. The training plan set out:

- classroom training on each of the psychological test (with psychologists coming prepared by reading test manuals and protocols)
- classroom training on scoring and interpretation of results
- intense hands-on training during assessments of the first adult assessment undertaken by the Adult Assessment Clinic
- ongoing consultation and supervision in assessment, scoring, and writing reports
- support during multidisciplinary diagnostic team meetings

Roles were clarified to ensure ethical and legal accountability. Because the psychologist performing the assessments is provisionally registered, arrangements were made to have Dr. Pei listed as a co-supervisor for the FASD assessments.

The training plan is currently being rolled out. Training needs will be assessed as the training unfolds and the training plan will be adapted accordingly. Ensuring that psychologists are competent to perform the FASD assessments requires significant training resources and support from outside resources.

Training for the physician resource was provided by Dr. Gail Andrew through the Prevalence Study. The Adult Assessment Clinic will use the same local physician, building on the capacity established by the Prevalence Study.

5. Evolving best practices

At the time of this project, there was no consistent standard for assessing and diagnosing adults with FASD. Clinics across Canada were using different criteria and different diagnostic labels. In 2013/14 work across Canada was undertaken to update the 2005 Canadian Guidelines for Diagnosis. These updated Guidelines, due to be published in 2015, will provide further clarity on best practices for diagnosing adults with FASD. However, because the new Guidelines had not been published as of March 2015, the Yukon Adult Assessment had to make an interim decision on the diagnostic criteria and language that would be used by the Clinic. Once the new Guidelines are published, the children and adult clinics will arrange for training and then incorporate changes into practices and clinic forms/processes.

Because of the evolving nature of practice in this area, it is clear that ongoing training and professional development will be required to maintain and expand competencies.

EVALUATION AND SUSTAINABILITY

The Yukon FASD Project Logic Model (Appendix A) sets out inputs, activities, outputs, and outcomes. As indicated by the Project Activities set out in this report, most of the activities have been completed. Shifting timelines for this project have made evaluation of medium and longer-term outcomes premature. A final report on the Prevalence Study will be complete in 2015/16. The Adult Assessment Clinic began to accept referrals in May 2015. A protocol agreement on collaborative case management between Health and Social Services and Justice (Corrections) was signed in April 2015.

Some project components were evaluated during the course of the project, namely the case management certificate training provided to front-line workers in Yukon by the Child Welfare Institute of Canada. These evaluation reports can be found in Appendix C.

To ensure that continuous learning is incorporated into the ongoing components of this project, a performance measurement framework has been developed for the Adult Assessment Clinic. A logic model and performance measurement framework is set out in Appendix F. This framework will be embedded into the operation of the clinic so that data collected and lessons learned from the operation of the clinic inform program planning for the clinic and for support services provided by Health and Social Services. The Clinic Coordinator is responsible for implementing the performance measurement framework.

As a result of the PHAC project, a new position within HSS has been created – the Adult Assessment Coordinator, hired in November 2014.

In addition to the clinic coordinator role, this position is also responsible for providing leadership on FASD within HSS, coordinating the interdepartmental committee on FASD, developing protocols with other departments/agencies as needed and acting as a resource on FASD to adults, caregivers and community agencies on the assessment process.

This new position provides a focal point for all work on FASD within HSS. For many years, individuals within Yukon Government have identified a need for an interdepartmental committee to coordinate activities related to FASD. This new position creates capacity to move forward with this objective. The position will also provide a designated point for liaison on FASD with community agencies and First Nations.

In the Prevalence Study stream, Department of Justice has secured the necessary resources to complete the study in 2015/16.

Other sources of funding and in-kind resources contributed to the success of this project. In addition to the contribution from PHAC, Yukon Government contributed multi-year funding of over $643,000 (plus $251,000 in 2015/16) to the Prevalence Study as well as significant in-kind resources. Justice Canada and Yukon College also contributed to Phase 1 funding for the Prevalence Study.

Yukon Department of Economic Development (Community Development Fund) contributed $20,000 in 2013/14 and $90,000 in 2014/15 for the FASD Collaborative Case Management Training provided under contract by Child Welfare Institute of Canada.

Both Justice and Health and Social Services contributed significant in-kind resources to the project including staff time, office space, office equipment, etc. For both streams of the project, management structures were developed to provide oversight and direction to the projects. Staff involved included program directors, Deputy Ministers, Assistant Deputy Ministers, policy personnel, communications staff, and financial and administrative staff.

Yukon agencies also contributed in-kind resources to support aspects of the project (e.g. training), including Fetal Alcohol Syndrome Society of Yukon, Council of Yukon First Nations, Northern Institute of Social Justice and Yukon College.

Funding provided by Yukon Government will enable these two projects to continue. The Adult Assessment Clinic will continue indefinitely and will benefit from the performance measurement framework established by the PHAC project.

As a result of the PHAC project, staff within the Departments of Justice, Education and HSS have developed skills in project management, research methodology, case management and FASD assessment. The two project streams have also involved key community stakeholders and resulted in some joint initiatives (e.g. training). This created a venue for dialogue and information-sharing which has strengthened relationships between all parties.

PHAC CONTRIBUTION

As noted previously in this report, the financial support provided by PHAC and the flexibility on timelines allowed this project to be successful. Although some aspects of the project are still being implemented, the work is well underway and there is a commitment to continue the work. A performance measurement framework has been put in place to ensure that the Adult Assessment Clinic evolves through a process of continuous improvement.

PHAC staff were very responsive to questions and provided guidance on completing financial deliverables and other reports. Staff understood the challenges faced by the project at different stages and facilitated accommodations within PHAC. In summary, the PHAC staff were a pleasure to work with.

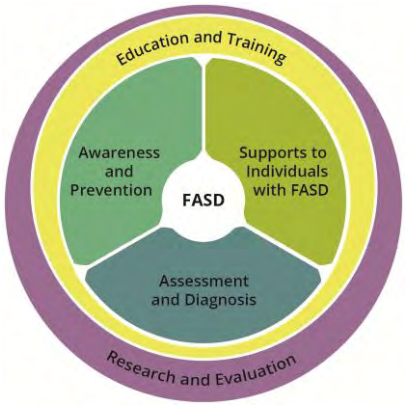
FINANCIAL REPORTING

The financial reports for 2014/15 have been submitted separately. Some funds were transferred between budget categories, but the global amount of funding ($105,328) did not change.

CONCLUSION

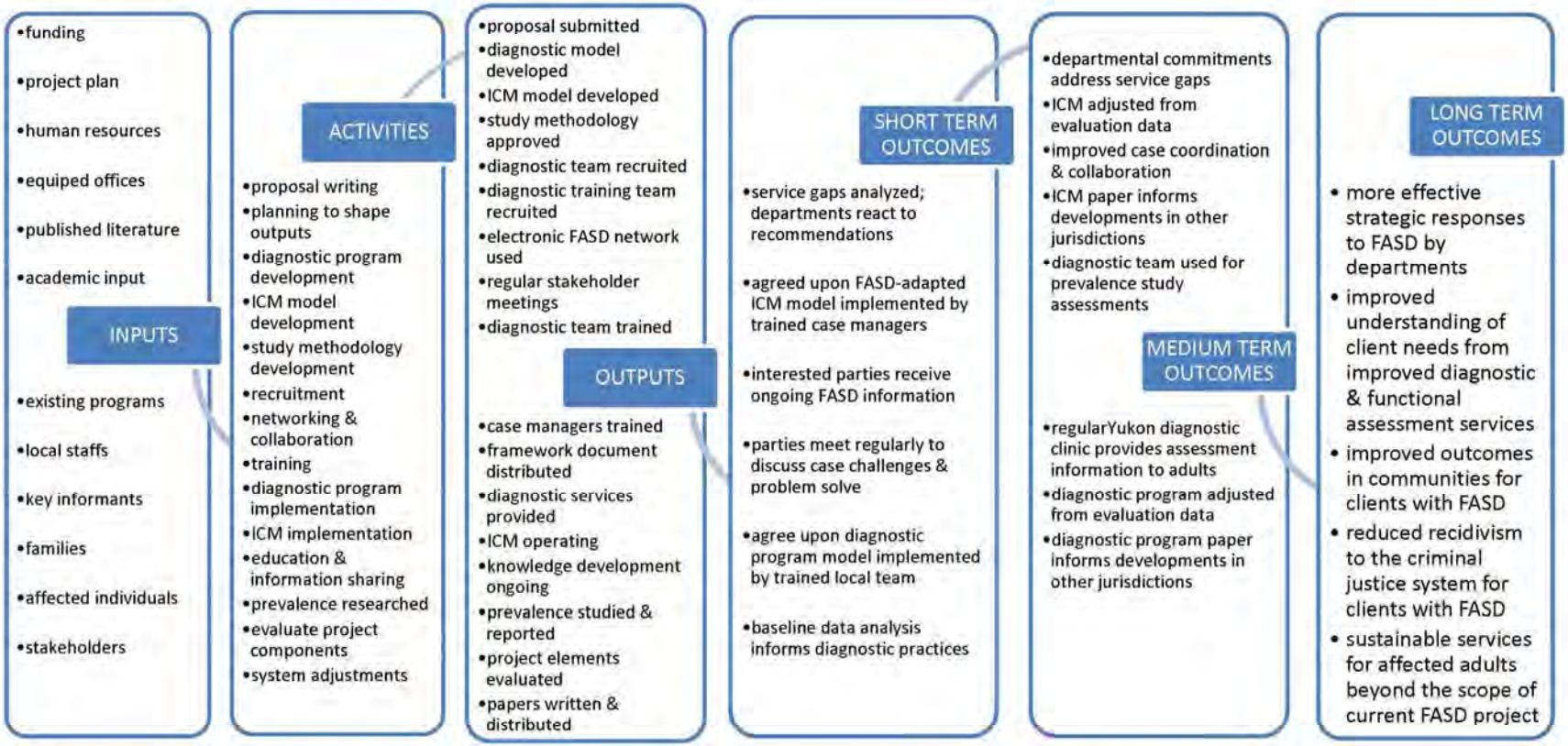
This multi-year FASD project has been very successful in providing Yukon with capacity to undertake a Prevalence Study, develop an Adult Assessment Clinic, undertake training and set processes in place to promote collaboration between governments and agencies working to provide services and supports to adults with FASD in the correction system.

The funding allowed Yukon to leverage other resources to sustain activity in this area. We will continue to work together to improve outcomes for people with FASD.



APPENDIX A

YUKON FASD PROJECT LOGIC MODEL (August 2012)



NOTE:
ICM = Integrated Case Management defined as a collaborative, team decision-making approach to support client service coordination for individuals with complex long-term needs.
Diagnostic program refers to a multi-layered assessment process to determine if a FASD diagnosis is appropriate, an individual's functional capabilities and their service needs.

FASD Diagnosis and Functional Assessment: Discussion Paper

Purpose

This paper summarizes the information on FASD assessment and diagnostic best practices for adults. It will be used to inform the development of the Yukon assessment clinic.

Background

Identifying the prevalence of FASD and supporting persons with FASD in Yukon is a government priority. The government platform outlines a commitment to "use a multi-agency approach, including other governments and NGOs, to develop individualized plans for and provide appropriate supports to people with FASD to assist them in participating fully in society." Improving FASD diagnostic and functional assessment practices will further emphasize FASD prevalence and demonstrate the scope of support services needed in Yukon and improve outcome for persons with FASD. Diagnosis represents the starting point for specific treatment planning in collaborative case management, intervention and prevention.

This paper will examine FASD diagnostic and functional assessment program models for adults.

FASD Diagnosis

Fetal Alcohol Syndrome (FAS) is a permanent birth defect syndrome caused by maternal consumption of alcohol during pregnancy (Astley, 2011, p.3). FAS is the leading known preventable cause of intellectual disabilities in the Western World (Abel & Sokol, 1987, p.51) Because the physical, cognitive, and behavioral deficits observed among individuals with prenatal alcohol exposure are not dichotomous, an accurate diagnosis of FASD is critical for prevention and intervention. FASD diagnosis provides general information on where an individual falls on the FASD spectrum. Fetal Alcohol Spectrum Disorder is a term used to support individuals who have been diagnosed with a "spectrum" of effects related to prenatal alcohol exposure such as:

- **Fetal Alcohol Syndrome (FAS)**: which refers to a person who has slowed growth, certain facial features and brain abnormalities.
- **Partial FAS (pFAS)**: which refers to individuals who have some but not all of the FAS characteristics this was previously referred to as fetal alcohol effects (FAE).
- **Alcohol Related Neurobehavioral Disorder (ARND)**: which encompasses a range of Central Nervous System (CNS) dysfunctions associated with in utero exposure to alcohol.

4-Digit Diagnostic Code

In western Canada, not excluding Yukon, the 4-Digit Diagnostic Code (Appendix 1) is used in most clinics to provide a diagnosis of FASD. The four digits in the code reflect the magnitude of expression/ severity of the four key diagnostic features of FAS:

1. Growth deficiency,
2. The FAS facial features,
3. Central nervous system (CNS) damage/dysfunction,
4. Fetal alcohol exposure.

The magnitude of expression/ severity of each feature is ranked independently on a 4-point Likert scale. 1 refers to the complete absence of the FAS and 4 to severe presentation of the feature or definite evidence of brain damage.

An individual's 4-Digit Diagnostic Code diagnosis is derived after a thorough evaluation by an interdisciplinary team of professionals such as social workers, psychologists, speech language pathologists, occupational therapists, and physicians (Andrew, 2011, p.133-134).

The Canadian Guidelines for Diagnosis

The Canadian Guidelines for Diagnosis have six additional steps that must be taken before implementing the 4-Digit Diagnostic Code. The guidelines have been organized into 7 categories:

1. screening and referral;
2. physical examination and differential diagnosis;
3. neurobehavioural assessment;
4. treatment and follow-up;
5. maternal alcohol history in pregnancy;
6. diagnostic criteria for fetal alcohol syndrome (FAS), partial FAS and alcohol-related neurodevelopmental disorder;
7. harmonization of Institute of Medicine and 4-Digit Diagnostic Code approaches.

The diagnosis requires a comprehensive history and physical and neurobehavioural assessments; a multidisciplinary approach is necessary. (Chudley, Conry, Cook, Loock, Rosales, LeBlanc, 2005, p. 1).

Unlike the 4-Digit Code the Canadian Guidelines require confirmation of maternal alcohol history in pregnancy before the team can begin the final 4-Digit Diagnostic Code assessment. Categories 1-6 may be interpreted differently by professionals involved in the diagnostic process, which may cause discrepancies leading up to category 7.

Most Canadian diagnostic clinics use a combination of the 4-Digit code and the Canadian Guidelines, for example the findings of the multidisciplinary diagnostic team are

numerically organized according to the 4-digit code and a diagnosis is made using the terminology in the Canadian Guidelines (Conry, 2010).

The Canadian Guidelines are the overarching guidelines used in the assessment and diagnosis of FASD. Criteria for diagnosis, as outlined in these guidelines, must be met in order for a diagnosis on the Fetal Alcohol Spectrum to be given. Only the diagnoses referenced in the Canadian Guidelines are used. In cases of discrepancy between the Canadian Guidelines and the 4-Digit Code Guidelines, the Canadian Guidelines will prevail.

The 4-Digit diagnostic code is an integral component of the diagnostic process; coding is used for growth, face, brain structure and function, alcohol exposure and pre/postnatal factors. 4-Digit coding is completed for each assessment, during the diagnostic team discussions, and is compared against the criteria outlined in the Canadian Guidelines.

Challenges with the Diagnostic Process

Diagnostic codes are a medical diagnosis model, which are rigorous, reliable and valid. Service providers rely on accurate diagnoses and systems respond to prevalence with relevant support.

Although there are many diagnostic models (Appendix 2) it is essential that we move towards a standard diagnostic model to ensure that all diagnosis and assessments can be interpreted equally from one professional to the next leaving no room for error and misinterpretation of diagnostic results.

It is essential that all diagnostic services in Yukon (Department of Education, Department of Health and Social Services, Child Development Centre) follow the same diagnostic model to ensure that all professionals involved in the effected clients' lives are passing on consistent, informative and therefore transformative knowledge.

It is difficult in some cases to obtain accurate maternal drinking histories for the following reasons. First, there is an overwhelming stigma attached to women who drink during pregnancy and therefore many mothers do not feel comfortable revealing maternal drinking histories. In some cases adult clients do not have access to their birth family to obtain drinking histories; effected adults may not have grown up with birth parents, which makes it difficult to obtain drinking history. Finally, privacy legislation such as ATIPP limits the ability to obtain maternal drinking history records without the individual's consent. Typically third party information is redacted, which often removes maternal drinking history.

In addition to sound diagnostic practices there is a great need for improved support services during and after diagnosis and assessment. Current thinking in adult diagnostic clinics across Canada is that assessments should lead to improved supports for clients.

FASD Functional Assessment

Best practice suggests that diagnosis and functional assessment should go hand in hand. Diagnosis provides needed information on where an individual falls on the FASD spectrum (FAS, pFAS, and ARND), but FASD functional assessment provides practical information on effected individuals' brain function in the ten brain domains:

1. Motor (ability to coordinate large and small muscles);
2. Sensory and Soft Neuro (ability to process sensory information)
3. Cognition (IQ);
4. Communication: Receptive/Expressive Language;
5. Academic Achievement;
6. Attention;
7. Memory (Short term/long term/ working/visual/auditory;
8. Executive Function and Abstract Reasoning;
9. Adaptive Behaviour;
10. Social Skills and Social Communication;
11. Other: Comorbidities, Secondary Issues, other stressors, etc.

Best practice in the diagnosis of FASD requires input from a multidisciplinary team, in order to accurately determine the functional abilities of effected individuals within the eight brain domains. This in turn provides practical information to service providers and allows for the appropriate delivery of services according to the unique abilities of each individual.

Adult Diagnosis

Reliable literature on best practices for adult diagnosis is minimal, as is the depth of literature on delivery of services or development of community-based programs in support of adults with FASD living in rural areas. Lakeland Centre for Fetal Alcohol Spectrum Disorder is one of the few clinics available to adults in rural remote regions. Lakeland started as a children's diagnostic clinic, but quickly realized that adults who have been prenatally exposed to alcohol were in desperate need of an accurate diagnosis and support; there are few diagnostic clinics that serve adults, and many adults with fetal alcohol spectrum disorder (FASD) have received treatment for symptoms and not the diagnosis, which has led to substantial maladaptations to life (McFarlane & Rajani, 2007, p. 26).

Diagnosis of adults creates special challenges in all aspects of diagnosis. Physical features may change over time, there may be catch-up growth, and cumulative environmental influences may distort the evaluation of brain function the adult's history may include additional traumatic head injury, alcohol and drug abuse and mental health problems. Clinicians working with the adult FASD population find that the general diagnostic tests are not sensitive to real life issues. Therefore it is essential that a functional assessment be completed, which would highlight adaptive functioning skills

such as literacy, numeracy, employability, quality of life. Finally, clinicians should not rely solely on the self-report of individuals with FASD as the history and abilities of the individual must be verified by a reliable source (Chudley, Conry, Cook, Loock, Rosales, LeBlanc, 2005, p14).

Importance of Diagnosis and Functional Assessment

Recognition and diagnosis of FASD is important because it can lead to a better understanding of the individual and his or her needs; access to additional supports in the community; and more effective interventions and services tailored specifically to the individual's strengths and weaknesses. Without a diagnosis of FASD many get labeled with secondary disabilities only and the treatment is ineffective.

Current Diagnostic Practices in Yukon

Medigene Services Inc. is a diagnostic clinic from Alberta, which comes to Yukon annually. It provides annual diagnostic and assessment services to adults with known or suspected prenatal exposure to alcohol through the Fetal Alcohol Syndrome Society Yukon (FASSY). Services include: follow-up evaluations, case conferencing with key stakeholders in the individual's life, and information necessary in accessing services and supports.

From October, 2009 to March 2010 FASSY undertook the process of identifying, assessing and diagnosing individuals for FASD. As highlighted in their final report it became very apparent that a Yukon based diagnostic program was needed. The current practice of contracting non-Yukon based agencies such as Medigene to provide diagnostics is costly and does not allow for the recognition and understanding of local supports available to individuals undergoing assessment. Medigene had a very limited understanding of the local services and supports. They relied heavily on FASSY to assist them with providing local recommendations to clients that were appropriate to Yukon.

FASSY suggests that a community based model much like the Lakeland Centre for FASD based in Alberta would be more appropriate for Yukon (McFarlane & Rajani, 2007). McFarlane and Rajani suggest that the most effective process for the diagnosis of FASD in rural regions of Canada is a multidisciplinary diagnostic team. The multidisciplinary approach allows for the inclusion of a variety of professionals. Each team member brings their own professional expertise to the team allowing them to provide comprehensive assessments unique to the client undergoing assessments, including the necessary recommendations to support that individual in the full spectrum of identified disabilities (2007).

The proposed adult diagnostic clinic should offer 10 assessments per year based on the services currently provided to children and youth in Yukon. The Child Development Centre offers 10 assessments per year to children and the Department of Education offers 10 assessments per year for youth. If the proposed adult diagnostic clinic provided 10

assessments there would be a total of 30 assessments offered annually to children, youth and adults in Yukon.

Based on adult diagnostic data from 2004-2013 (Appendix 3) there was a total of 63 assessments done on adults in Yukon, which is approximately 8 assessments per year (no clinic was held in 2011/2012.) Out of the 63 assessments completed 45 of the 63 assessed were on the spectrum meaning approximately 71 percent of those assessed were on the FASD spectrum.

The Child Development Centre and the Department of Education do not have an evaluation framework in place; the proposed adult diagnostic program will have an evaluation framework in place. Evaluative framework will allow the clinic to track data, which will increase effectiveness and therefore encourage diagnosis.

A Yukon based adult diagnostic team with ongoing FASD assessments throughout the year would allow for a greater number of diagnoses, as well as continual learning for team members. The following highlights best practices implemented in other jurisdictions, which provides the foundation for the Yukon-based diagnostic program recommendations.

Cost analysis of Current Yukon Diagnostic Services for Adults

FASSY Contract with the Department of Health and Social Services for Adult Diagnosis

- FASSY receives around $80,000.00-$85,000.00 per year from the Department of Health and Social Services to hold a diagnostic clinic.
- FASSY contracts Medigene out of Alberta.
- Medigene completes around 7 assessments at $5,500.00 equaling $38,500.00.
- There is one .5 FTE clinic coordinator @ $35,000.00.
- $10,000.00 community travel budget.

FASSY's Recommendations for a Yukon-based Adult Diagnostic Program

The following are recommendations that came out of the FASSY final report (2010) as they relate to a Yukon based diagnostic program:

- Develop a Yukon-based diagnostic team using a community collaboration model
- The diagnostic team should include both core staff members as well as secondary community members
- Core staffing of the team should include: medical professional, psychologist, Occupational Therapist, Social Worker, Diagnostic Coordinator.

- Community Team members should include but not be limited to: Justice, Health and Social Services, First Nations Governments, NGOs (FASSY, L-DAY, YCOD, Etc.)
- It would be unethical to provide diagnosis without follow-up support therefore a support worker must be identified to work with the client to implement recommendations made by the team.

Moving Towards Best Practices

Best practices suggest that both a clinical diagnosis using the Canadian Guidelines and a functional assessment (assessing the 10 brain domains) preformed by a multidisciplinary team are essential. The following highlights diverging clinical and delivery models based on best practices.

Clinical Models

Hospital Based:

Hospital based models draw on the support staff within the hospital to create a specialized service for those requiring FASD diagnosis and assessment. The assessment team includes a Coordinator, a Neuropsychologist, a Registered Nurse, and a Social Worker. The following highlights a FASD Adult clinic model based out of Alberta called Glenrose FASD Adult Clinic.

Glenrose FASD Adult Clinic

The Adult FASD Assessment Clinic is for individuals (18 – 40 years) from the Edmonton area, who are experiencing difficulties that are suspected to be the result of prenatal alcohol exposure.

Mentors or advocates that are from an agency or service associated with the Edmonton Fetal Alcohol Network (EFAN) can refer their clients for an assessment. The mentors or advocates will serve as the primary contact. They must be able to support their clients throughout the assessment process and be able to provide follow-up.

The assessment team includes a Coordinator/Social Worker, a Neuropsychologist, and a Registered Nurse. During the assessment process the team works with clients, their mentors or advocates, and any other support people that they involve in their assessment. This could include family members, close personal friends, and any professionals or service providers they may be working with.

The assessment team accesses birth, health, and education records as well as other relevant documents such as adoption, mental health, and social service records. It may take up to three months (or longer) for the records to be received. When all of the records

and required documentation are received, the mentors or advocates are contacted to schedule an appointment. The assessment consists of at least three sessions.

Clients and their family members or caregivers are interviewed and asked to fill out some questionnaires. Clients complete about six hours of testing to look at their thinking skills. The assessment also include a brief health screening, and the nurse takes pictures to look at facial features that are sometimes seen in individuals with prenatal alcohol exposure. The nurse also consults with family physicians whenever possible to assess for any past or current medical concerns that could impact the assessment.

Clients may or may not receive an FASD diagnosis; however, the results of the assessment will be shared with them, their mentors or advocates and anyone else they choose to include. Clients (and their support people) will have an opportunity to learn about their strengths and areas of difficulty. A management plan to address their current needs is developed and includes linkages to services and supports. The mentors and advocates help with the management plan.

Community Based:

Community based models draw on the expertise of professionals within the greater community who come together to form a multidisciplinary team for designed diagnosis and assessment days (once a week/ once a month depending on assessed need.) Each team has a team coordinator who completes intakes, assesses eligibility and provides appropriate referrals and support for clients. In addition to the coordinator each team has a physician, neuropsychologist, mental health therapist, legal representative, persons with developmental disabilities (PDD) coordinator, Aboriginal liaison worker, and addictions counsellor. The following highlights two FASD Adult community based models that based out of rural Alberta and Alaska.

Lakeland Centre for Fetal Alcohol Spectrum Disorder (LCFASD)

The Lakeland Centre provides services to people in northwestern Alberta. It has a clinic in cold lake along with a mobile clinic, which services more rural communities in the areas. All together Lakeland Centre serves 1 small city, 25 small towns, 7 First Nation communities, 4 metis settlements, and 1 military base. The total combined population is 80,000.

Lakeland's diagnostic team consists of a physician, neuropsychologist, mental health therapist, legal representative, persons with developmental disabilities (PDD) coordinator, Aboriginal liaison worker, addictions counsellor and team coordinator. There assessment model includes a pre-clinic phase where the team coordinator completes the initial intake form and uses this information to determine eligibility for a full assessment. Services also include training and prevention programs and follow-up support after diagnosis such as emotional support and outreach support. A counsellor works with the diagnosed adult after diagnosis to provide ongoing emotional support and a community navigator or liaison provided ongoing outreach support.

There are six phases to the diagnosis process at Lakeland. The following provides a brief description of each phase:

- Phase 0 Pre Clinic**:**

Referrals are received by the team coordinator, who determines eligibility (i.e., residence in the service area, and confirmation prenatal drinking). An advocate (e.g., community worker, public health nurse, women's shelter, parent, spouse) is identified to assist the patient in completing the application and consent forms.

On receiving the application package, the team coordinator reviews all information and collects any missing documentation. When the file is complete,a clinic date is selected, with an average wait of 3 months. The cultural liaison or the team coordinator may assist the patient and members of the support system in understanding the process of clinic day.

- Phase 1 Clinic Days:

Most patients like the in-clinic process to occur in one day; clients may have difficulty waiting for results or may have problems returning for a second clinic day. The neuropsychologist completes a handful of tests depending on what assessments have been completed in the past.

The team is provided with a history of the patient. Information gaps are identified and questions generated for the clinical interviews. The interviews provide valuable information about the current situation, functional difficulties, areas of strengths and any heretofore undocumented information. Clinical interviews are followed by examination by the physician, which includes facial measurements, head circumference, height and weight, and a soft neurologic assessment.

- Phase 2 Diagnosis and Recommendations:

The team meets to review all of the gathered information and to make a determination of diagnosis and recommendations. Consensus must be reach in all areas of the 4-Digit Code and the Canadian Guidelines.

Then the team formulates the recommendations, which are given to the client, family, and support workers that day. During this phase, the postdiagnostic outreach worker will meet with the patient and members of the support system to inform them about what will happen during the next phase, the case conference, and to tell them that they will meet in 1 or 2 weeks to begin working on the recommendations.

- Phase 3 Case Conference:

A case conference held the same day with the patient and members of the support system provides the diagnostic information and recommendations. A simply, written copy of the

diagnosis and recommendations is provided, which helps the client remember what was discussed and begin to address the recommendations. Questions are answered from the clients and or support workers by the team.

- Phase 4 Emotional Support:

The mental health therapist meets with the client privately to review diagnostic and recommendation information and to emotionally debrief. The psychiatrist will meet privately with the people supporting the client for the same purpose.

- Phase 5 Team Debriefing:

Many community-based team members are not accustomed to the process of diagnosis and may have to emotionally debrief particularly difficult client histories. This helps to keep team members healthy and allow them to continue their work.

- Phase 6 Outreach Support:

The LCFASD believes that every family requires some form of additional support following a diagnosis. The centre employs postdiagnostic outreach workers to connect the client to the local community supports and assist the client with following through on recommendations. The outreach worker will remain involved with the patient as long as is required (McFarlane & Rajani, 2007, p.27-28).

This particular community based model has a fee-for-service arrangement with the neurophysiologist and physician. Additional costs include physician compensation for costs associated with being away from the office and billing for one patient through the diagnostic clinic. The clinic conducts all assessments, interviews, collaboration of information, diagnostic determination, recommendations and report writing on clinic days.

The Juneau FASD Diagnostic Clinic

The Juneau FASD Diagnostic Clinic meets once a month at SEARHC Behavioral Health to diagnose individuals for FASD. The clinic's interdisciplinary team consists of physicians, psychologists, parent navigators, speech and language specialists, a nurse, physical therapist and a clinic coordinator. Clients can be referred by a professional or can self-refer, which creates more flexibility and allows for a greater reach.

The physicians, psychologists, speech and language specialists, a nurse, physical therapist are "loners" from other clinics and agencies therefore no new money is added to the overall cost of the clinic. Permanent personal costs include salary for the clinic coordinator and navigator. The space is loaned to the diagnostic team by the SEARHC Behavioral Health.

Non-Targeted Program:

This model works by training staff within a walk-in clinic to diagnose and assess for FASD along with providing primary care services. This reduces stigma attached to a "fixed" or "intenerate" FASD specific clinic model. Clients can go in to address primary care issue they maybe having and can inquire and may be screened in for FASD diagnosis, which may increase overall diagnosis. A possible home for this model would be a referred care clinic.

Delivery Models

Stationary/Fixed Service:

A stationary service provides a multidisciplinary diagnosis and functional assessment services in a fixed location. The benefits to this model are that community members know where to access services and make referrals and all services and referrals supports are located in one place. Stationary models can have multiple assessments days per year, which creates more flexibility for those accessing services. The drawbacks to having a stationary service are community stigma may develop and rural remote persons must travel to access services and once assessed clients may not have access to appropriate support services within their community. Professionals at the stationary service may not be aware of support services available within their rural clients community. It is generally more difficult to support clients in rural community post diagnosis with the stationary service model.

Itinerant/ Mobile Service:

An itinerant service provides rural communities with a multidisciplinary diagnosis and functional assessment team through a mobile service. The benefits to this service include increased accessibility for rural community members. The drawbacks to this service include increased stigma for clients accessing services on assessment day, and limited supports services after diagnosis. Mobile clinics would only be able to visit individual community once or twice a year to perform assessments. Due to the nature of clients with FASD's disability it may be difficult for them to meet the rigid assessment day schedules.

Assessment Days:

Assessment days are often open for anyone and everyone to attend. Assessment days happen at the same time each week/month/year depending on the community size.

Assessment by professional referral or self-referral:

Professionals (physicians, social workers, teachers, councellors, etc.) refer clients to a clinic where they can be appropriately assessed by a diagnostic team. Some clinic models allow clients to self-refer such as the Surrey Place Centre for assessment or treatment services.

Multidisciplinary Team:

A multidisciplinary team consists of professionals from different backgrounds who all play a unique and critical role in the diagnosis and assessment process. The range of team members include:

- *Medical Professional:* Reviews the medical and other records provided by the coordinator. At appointment, obtains history and concerns of family/caregiver about the client. Conducts medical exam including head circumference measurement. Facial photos- front, and lateral views to assess eyes, midface, philtrum, and upper lip.
- *Psychologist:* Reviews records provided by coordinator. Observes behavior in testing setting. Conducts testing for cognitive memory, & neuropsychological function.
- *Occupational Therapist:* Evaluates and assists with: fine motor skills, cognition, visual perception, self-help, sensory integration.
- *Speech Pathologist:* Evaluates receptive and expressive language skills, language processing skills, pragmatic language skills, articulation and sensory based feeding issues.
- *Social Worker/ Counsellor/ Navigator:* Provides referral, provides assistance with document collection, assists with follow-up support and outreach. In addition, this role provides emotional support before, during and after medical evaluations. Discovers appropriate resources and services designed to enhance the life of individual. Assists the individual in identifying and prioritizing their needs.
- *Diagnostic coordinator:* Completes the initial intake form and uses this information to determine eligibility for a full assessment

Follow up supports:

Many clinics offer follow up supports. A support worker may work closely with the client post assessment to implement recommendations made by assessment team.

Culturally safe and Inclusive Environment:

It is important that the diagnostic and functional assessment models are accessible to everyone. An inclusive environment is one that encourages cultural diversity along with encouraging clients to bring supports with them such as family/community members. People should not feel stigmatized or excluded.

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APPENDIX 1: 4-Digit Diagnostic Code

4-Digit Diagnostic Code ™

One Example of FAS

Growth Deficiency	FAS Facial Features	CNS Damage		Growth (3)	Face (4)	CNS (4)	Alcohol (4)		Prenatal Alcohol
significant	significant	definite	4		X	X	X	4	high risk
moderate	moderate	probable	3	X				3	some risk
mild	mild	possible	2					2	unknown
none	none	unlikely	1					1	no risk

APPENDIX 2: Comparison of Diagnostic Criteria

Table 1. FAS diagnostic criteria: Comparison across the five most current FAS/D diagnostic guidelines (Astley, 2011, p. 5).

	4-Digit Code	CDC	Canadian	Hoyme	IOM
Growth	Prenatal and/or postnatal height or weight < 10th percentile (Growth Ranks 2-4)	Prenatal and/or postnatal height or weight < 10th percentile (Growth Ranks 2-4)	At least 1 of the following: □ Prenatal and/or postnatal height or weight < 10th percentile □ Weight-to-height ratio (<10th percentile) (Growth Ranks 2-4)	Prenatal and/or postnatal height or weight < 10th percentile (Growth Ranks 2-4)	At least 1 of the following: □ Low birth weight □ Low weight for height □ Decelerating weight (Growth Ranks 1-4)
Face	All 3 of the following at any age: □ PFL < 3rd percentile □ Smooth philtrum Rank 4 or 5 □ Thin upper lip Rank 4 or 5 (Face Rank 4)	All 3 of the following: □ PFL < 10th percentile □ Smooth philtrum Rank 4 or 5 □ Thin upper lip Rank 4 or 5 (Face Ranks 3-4)	All 3 of the following at any age: □ PFL < 3rd percentile □ Smooth philtrum Rank 4 or 5 □ Thin upper lip Rank 4 or 5 (Face Rank 4)	2 or more of the following: □ PFL < 10th percentile □ Smooth philtrum Rank 4 or 5 □ Thin upper lip Rank 4 or 5 (Face Ranks 2-4)	Characteristic pattern that includes features such as short PFL, flat upper lip, flattened philtrum, and flat midface. (Face Ranks 1-4)
CNS	At least 1 of the following: □ Structural/Neurological: (e.g., OFC < 3rd percentile, abnormal structure, seizure disorder, hard signs) □ Severe Dysfunction: (3 or more domains[a] of function with impairment 2 or more SDs below the mean) (CNS Rank 3 and/or 4)	At least 1 of the following: □ Structural/Neurological: (e.g., OFC < 10th percentile, abnormal structure, seizure disorder, hard/soft signs) □ Dysfunction[b]: o 3 or more domains of function with impairment 1 or more SDs below the mean o Global deficit (2 or more SDs below the mean) (CNS Ranks 2-4)	At least 3 of the following Structure/Neurological/ Functional domains with impairment[c]: □ Hard/soft signs, structure, cognition, communication, academic achievement, memory, executive functioning, abstract reasoning, ADD, adaptive behavior, social skills, or communication (CNS Ranks 3 and/or 4)	At least 1 of the following: □ Structural o OFC < 10th percentile o Abnormal structure (CNS Rank 1 or 4)	At least 1 of the following: □ Structural/Neurological: o Decreased cranial size at birth o Abnormal structure (e.g., microcephaly, partial/complete agenesis of the corpus callosum, cerebellar hypoplasia) o Neurological hard/soft signs (CNS Rank 4?)
Alcohol	Confirmed or Unknown (Alcohol Ranks 2,3 or 4)	Confirmed or Unknown (Alcohol Ranks 2,3 or 4)	Confirmed or Unknown (Alcohol Ranks 2,3 or 4)	Confirmed-excessive or Unknown (Alcohol Ranks 2 or 4)	Confirmed-excessive or Unknown (Alcohol Ranks 2 or 4)

a. 4-Digit Code: Domains may include, but are not limited to: executive function, memory, cognition, social/adaptive skills, academic achievement, language, motor, attention, or activity level.

b. CDC: Performance substantially below that expected for an individual's age, schooling, or circumstances, as evidenced by: 1. Global cognitive or intellectual deficits representing multiple domains of deficit (or significant developmental delay in younger children) with performance below the 3rd percentile (2 standard deviations below the mean for standardized testing) or 2. Functional deficits below the 16th percentile (1 standard deviation below the mean for standardized testing) in at least three of the following domains: a) cognitive or developmental deficits or discrepancies b) executive functioning deficits c) motor functioning delays d) problems with attention or hyperactivity e) social skills f) other, such as sensory problems, pragmatic language problems, memory deficits, etc.

c. Canadian: Impairment indicates scores > 2 SDs below the mean, discrepancies of 1.5-2 SDs among subtests, or > 1 SD discrepancy between subdomains.

The equivalent 4-Digit Ranks for Growth, Face, CNS and Alcohol are inserted in red font to facilitate comparison across the guidelines.

APPENDIX 3: FASD Diagnosis and Assessment Results for Adults in Yukon

	NUMBER REFERRALS	SOURCE					NUMBER ASSESSED	RESULTS							ASSESSMENT TEAM
		JUS	HSS	FASSY	FAMILY OR CAREGIVER	OTHER		FAS	pFAS	SE-AE	SPF-NBD-AE	NBD-AE	NBD-UAE	SE-NAE	* Codes below
2012/13	11	4	6	1	0	0	9	0	2	3	1	1	1	1	MediGene, Calgary
2011/12	No clinic held														
		JUS	**HSS**	**FASSY**	**FAMILY CAREGIVER**	**OTHER**		**FAS**		**pFAS**		**ARND**		**Other**	
2010/11	8	3	0	2	0	3 self	5	No report[1]							MediGene, Calgary
2009/10	9	2	0	3	2	2 self	8	No report[2]							Lakeland Centre for FASD, Cold Lake
2008/09	15	5	1	4	0	5 self	13	2		11					14 by MediGene 13 reported?
2007/08	No data on file														10 by MediGene
2004 - 2007							28	6 1[3]		19		1		1[4]	22 by MediGene in 2006

[1] Breakdown of diagnoses not provided in final report.
[2] Individual results not provided in final report. Report states, "All individuals assessed were found to have a diagnosis on the FASD spectrum."
[3] Individual diagnosed with a FASD, prenatal alcohol not confirmed.
[4] Global mental disability, not FASD

APPENDIX C-1

FINAL REPORT ~ EVALUATION FINDINGS FOR YUKON

Fetal Alcohol Spectrum Disorder (FASD)
2-Day Training & 12-Day Certificate Program

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Date: **October 2013 v5**

FINAL REPORT ~ EVALUATION FINDINGS FOR YUKON

Fetal Alcohol Spectrum Disorder (FASD)

2-Day Training & 12-Day Certificate Program

1.0 Background

In late Fall 2012, a partnership was formed between the *Yukon Government (YG), Yukon College – Northern Institute of Social Justice, Council of Yukon First Nations,* and the *Fetal Alcohol Syndrome Society Yukon (Fassy).* The goal of the collaboration was to arrange for training to be provided to Yukon human service professionals in a key service area that crossed many sectors: fetal alcohol spectrum disorder (FASD).

The partners reviewed training delivery options and contracted with the Child Welfare Institute (CWI) at Children's Aid Society of Toronto, a leader in this training area. CWI organized both the training and the evaluation of the training. CWI's FASD training curriculum for the Yukon included two types of FASD training: the 2-day Core training and a 12-day Certificate Program training that included consultation sessions and follow up. The trainer for both types is a known Canadian expert in the area of FASD, Donna Debolt.

Yukon's FASD training commenced in February 2013 and ended in May 2013. It was delivered in four training blocks. A total of 28 participants attended the 2-day Core training and 32 completed the 12-day Certificate Program training. The first two days of training included all 60 trainees, then the 32 Certificate trainees continued on to complete their more extensive training and certification.

1.1 2-Day vs. 12-Day FASD Training

The 2-Day Core training ~ is aimed at front-line workers, supervisors and caregivers who have had little to no prior training in FASD. The 2-day curriculum reviews current theories and literature. As well, it highlights evidence-informed strategies for families, caregivers and communities aimed to increase long-term placement stability. The training also underscores how to recognize FASD, including developmental trajectories and secondary disabilities. This training flags how FASD is a cradle to grave societal issue of significance for the children, adult and seniors involved with social services, health, education and justice.

The 12-Day Certificate training ~ is designed for service providers working in a case management capacity with adults and youth with FASD. In addition to the learning relayed in the 2-day training, this training uses real life examples from participants' caseloads and the class leverages the learning to develop and implement appropriate, comprehensive case plans. Given the intensity and commitment required, selection of participants into the training was based on each applicant's written application. Criteria for participant selection included:

- Those working in Justice, Health, or Social programs for YG, a Yukon First Nation, or non-government agency serving clients with FASD;
- Those involved in case management, case planning, coordination, and/or service provision for individuals affected by FASD;
- Those willing and able to attend the full 12-day Certificate training program;
- Those recommended and supported by the employer to attend the program;
- Those interested in learning and applying FASD-informed approaches in their work with clients;
- Those willing to engage in a "community of practice" both during and after the training to sharing information, problem solving, and networking to improve outcomes for individuals with FASD.

1.2 Training Objectives

There were two key objectives for this training:

Objective 1) For participants to gain a greater understanding of the nature and consequences of FASD for the individual, their family and the community; and

Objective 2) For participants to use real life case examples that will guide them in developing and implementing appropriate, comprehensive case plans.

1.3 Key Learning Goals

The organizing partners' learning goals for the trainings were:

- For trainees' to be able to recognize the presentation of FASD including issues for Justice, Education, Mental Health and Addiction Services;
- For trainees' to know how individuals with FASD interact with the community and the need for long term placement stability;
- For trainees' to be able to identify women at risk to have children with this disability as they present in the community and the trainee's role in prevention; and
- For trainees' to know how to assist caregivers to help develop strengths based strategies to manage behaviors and how to build community capacity for care.

Participants were to also learn how to develop and evaluate case plans within a framework of FASD "best practice" so that the case plans post-training were:

- ❖ Realistic
- ❖ Focused on secondary disability prevention
- ❖ Focused on finding permanent placements and creating placement stability
- ❖ Reflective of the need for family connections (including previous placements)
- ❖ Creating meaningful futures
- ❖ Framed to deal with case plan setbacks

1.4 Anticipated Outcomes from the *FASD Training*:

- ✓ To build on trainee's existing capacity to work more effectively with individuals, families and communities affected by FASD;
- ✓ To promote knowledge exchange and skill development within and across Teams, Agencies and Sectors;
- ✓ To strengthen community FASD networks and advance partnerships to both improve & ensure sustainability of best practices.



2.0 Evaluation Methodology

2.1 Evaluation Tools

All trainees were asked to complete the evaluation tools. To separate the 2-day (n=28) from the 12-day (n=32), the tools were printed in different colours. Identifying information, such as the trainee's name was not collected but trainees were asked to provide the name of their agency. Standardized pre-test and post-test questionnaires were administered to all participants. A non-identifying confidentiality code was used to match the pre-test to the post-test. At the pre-test point trainees' were asked if they would provide consent and contact information that would allow evaluators to conduct a follow up, standardized phone interview approximately three to six months after the training; evaluators asked about the impact of the training on practice and challenges to implementing the training. These consents were on a tear-a-way section so they could be separated from the pre-test tool.

The pre-test questionnaire collected information on three areas:

- Demographics (e.g., *age, gender, current field, years of experience, level of position, role in the field, amount of previous training in FASD*)
- Pre-training knowledge test on FASD (*10-question knowledge quiz on FASD*)
- Workshop goals

The post-test questionnaire collected information on:

- Post-test knowledge test on FASD
- Attainment of workshop goals
- Satisfaction and outcomes with training

A combination of closed, Likert-scale, check-box questions as well as open-ended, narrative-based questions were used. The former were used to collect demographic data and data on pre-test and post-test knowledge and satisfaction. The latter allowed trainees to use their own words to describe their workshop goals, they could write about the challenges they faced in implementing the training, and they could relay their recommendations to improve the training.

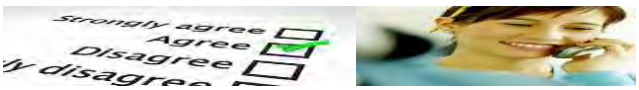
2.2 Data Analysis

All quantitative data were inputted and analyzed using the statistical software called *Statistical Package for Social Sciences* (SPSS) Version 20.0. Data were analyzed for frequency, distribution, and significance (set at $p<.05$). All qualitative data were inputted into Microsoft Word 2007 and each question was examined for content which informed the thematic analysis.

2.3 Sample

A total of 28 of the 2-day training participants provided pre/post-test data, of which 15 had matched pre and post-test data (54%); 32 of the 12-day trainees completed the evaluation tool, of which 24 gave matched pre and post-test data (75%). A total of 18 follow up phone interviews were completed.

Table 1: Sample by Training Type	2- day Training		12-Day Training		TOTAL	Matched
	N	*Matched*	N	*Matched*		
Pre/Post Test	28	*15 (54%)*	32	*24 (75%)*	60	39 (65%)
Follow Up Interview	7		11		18	



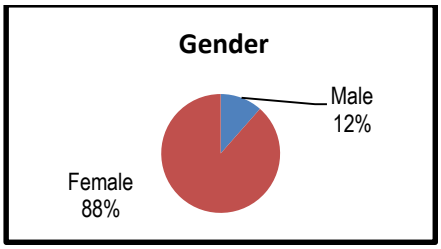
3.0 Findings

3.1 Trainee Demographics

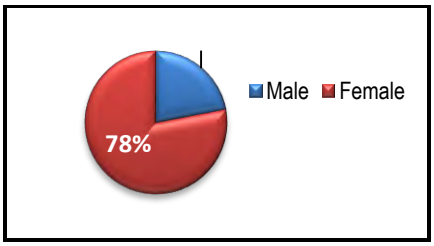
As Darwin aptly noted, the first order of science is to describe. Thus, all trainees were asked a number of demographic questions – their gender, age group, years of work experience, type of work and their role in that work, and the amount of prior training they had taken in FASD. First, are the results by the two training types (2-day vs. 12-day) and then an independent t-test analysis examines if there are differences of significance ($p<.05$) across the training types.

3.1.1 Gender

2-Day: 26 of 28 trainees provided data of which 26 (88%) identified as female and 3 (12%) as male.



12-Day: 27 of 32 trainees provided data of which 21 (78%) identified as female and 6 (22%) as male.



3.1.2 Age

2-Day: The mean age of these 28 trainees was 42.78 years. Nearly half were under age 40 (47%) and a little more than half were over age 40 (53%); approximately two-thirds (64%) were over age 30.

Ages *20-29 = 36%*
Ages 30-49 = 39%
Ages 50-59 = 25%
Total = 100%

12-Day: The mean age of these 32 trainees is slightly older at 44.07 years. Since these trainees were to be the most experienced staff the added weight of their experience is noted in this being a somewhat older cohort. About one-third were under age 40 (37%) with two-thirds over age 40 (63%), and 90% over age 30.

Ages 20-29 = 10%
Ages 30-39 = 50%
Ages 50-59 = 40%
Total = 100%

3.1.3 Level of Position

2-Day: While the largest portion came from direct service (67%), one-in-seven were management, and one-in-five (19%) indicated they were a caregiver of someone with FASD.

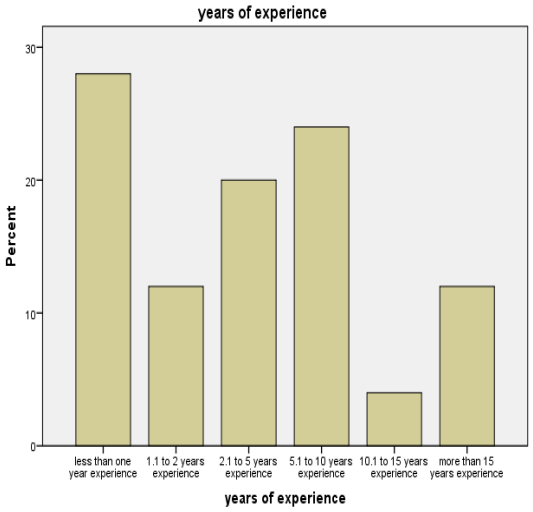
Direct Service= 67%
Management = 14%
Caregiver= 19%

12-Day: Most of the 32 trainees identified as a front-line/direct service worker (74%), nearly one-in-four said they were a manager, with less than five percent being a caregiver.

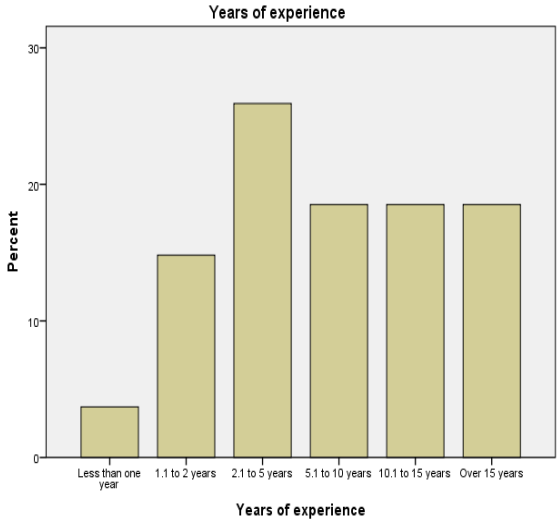
Direct Service= 74%
Management = 22%
Caregiver= 04%

3.1.4 Years of Experience

2-Day: For these 28 trainees, the years of experience data is related to the previous data on age. The overall results suggest a somewhat younger workforce: 60% have less than 5 years of experience; one-quarter have 5-10 years of experience and 16% bring more than 10 years of work experience. The largest group - those with less than one year of experience in their field (28%). See graph below.



12-Day: Again, correlated with age, this cohort brings much more workforce experience to the training. The largest group are those with 2 to 5 year's work experience (26%), those with 5 years or more experience are over half of the trainees (55%), whereas those with less than one year experience only make up 4% of these trainees and one-in-seven (15%) bring 1-2 years of experience. See graph below.



3.1.5 Field of Work

2-Day: 23 of 28 trainees provided data. The preponderance of attendees were from the Aboriginal communities (48%) and "other" (18%) with some representation from other areas such as children's mental health, criminal justice, health, residential care and child care. "Other" included: parent and taxi driver.

Field of Work: 2-day Training	#	%
Aboriginal/First Nations/Metis/Inuit	11	48
Children's Mental Health	1	4
Criminal Justice System Youth	1	4
Health Services	3	13
Residential Care Provider	2	9
Child Care (day care)	1	4
Other	4	18
TOTAL	**23**	**100%**

12-Day: 27 of 28 trainees gave data. Findings suggest better diversity across work fields vs. 2-day training, with strong representation from the Aboriginal communities and the Justice System. "Other" included: open custody staff, parent, recreation, social assistance worker, diagnosis, and outreach.

Field of Work: 12-day Training	#	%
Aboriginal/First Nations/Metis/Inuit	6	22
Child Welfare	2	7
Criminal Justice System Youth	1	4
Criminal Justice System Adult	6	22
Health Services	1	4
Residential Care Provider	1	4
School Boards/Educators	1	4
Other	9	33
TOTAL	**27**	**100%**

3.1.6 *Position & Role*

2-Day: On the topic of position, 21 trainees gave data. Two-thirds (67%) are front-line, one-in-seven (14%) management, and one-in-four (19%) are caregivers. Regarding "role", 22 provided data with the largest portion (58%) identifying themselves as "other"; examples included: support worker, open custody caregiver; health care worker, and recreation director.

Role: 2-day Training	#	%
Child & Youth Worker	1	5
Education	1	5
Child Care /ECE	1	5
Social Work	4	18
Psychology	2	9
Other	13	58
TOTAL	**22**	**100**

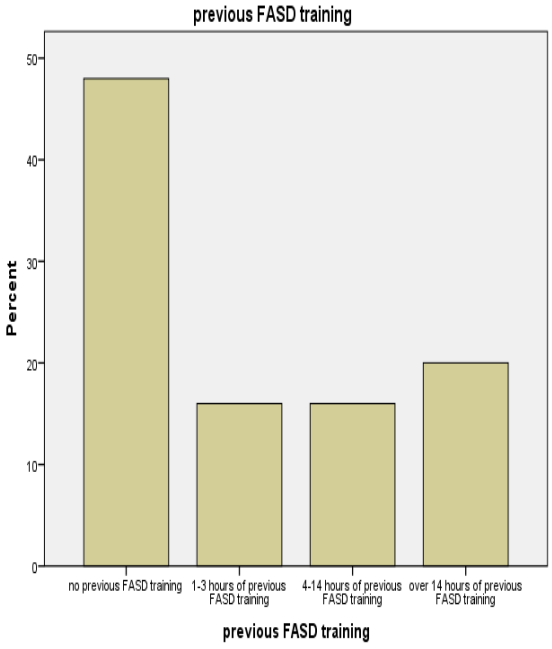
12-Day: On the topic of position, 27 trainees noted their position. Three-quarters (74%) are front-line, one-in-four (22%) management, and very few caregivers (4%). Regarding "role", 23 of 28 trainees provided data with the largest portion (48%) also identifying themselves as "other"; examples included: advocate, adult worker, job coach, outreach worker, and case manager.

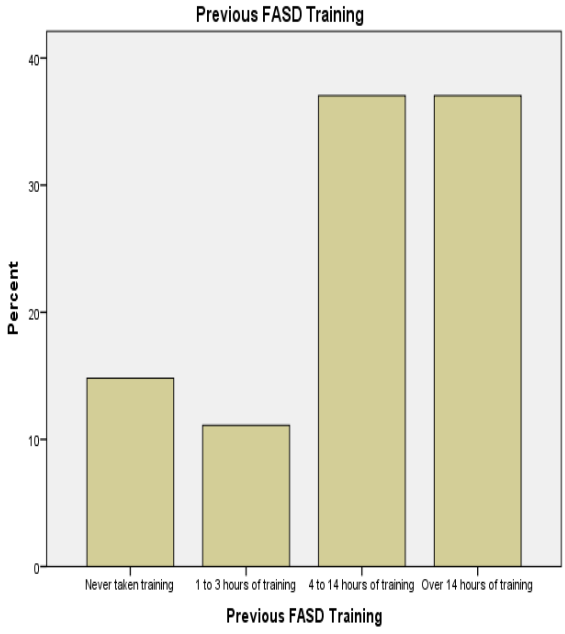
Role: 12-day Training	#	%
Child & Youth Worker	2	9
Education	2	9
Legal	2	9
Social Work	5	22
Therapist/Counselor	1	3
Other	11	48
TOTAL	**23**	**100**

3.1.7 *Previous Training in FASD*

2-Day: Half (48%) of the 25 trainees in the 2-day training had no prior training in FASD. One-in-six (16%) had 1 to 3 hours, and slightly more than one-third (36%) had four hours or more (4-14 hours (16%), 14 hours + (20%).

12-Day: 15% had no previous training in FASD prior to this training, three-quarters (74%) had more than 4 hours of prior training in FASD, although the intensity varied (1 to 3 hours (11%), 4-14 hours (37%), and 14 hours+ (37%).





3.18 Comparison of Trainee Demographics: 2-Day vs. 12-Day Training

Comparison of the different elements of the trainees' demographics across the two training types finds:

- No Significant Differences (ns = >.05) such as *gender, age,* and *position*.
- Significant Differences (** = <.05) such as *years of experience* and *previous training in FASD.*

2-day Training n=28	DEMOGRAPHICS	12-day Training n =32
Female=88% vs. Male =12%	**GENDER (ns)**	**Female =78% vs.** Male=22%
< 39 years =47% **> 40 years = 53%** *20-29 = 36%* ***30-49 = 39%*** *50-59 = 25%* *MEAN AGE: 42.78*	**AGE (ns)**	< 39 = 37% **> 40 = 63%** *20-29 = 10%* ***30-49 = 50%*** *50-59 = 40%* *MEAN AGE = 44.07*
Direct Service= 67% Management = 14% Caregiver= 19%	**POSITION (ns)**	**Direct Service= 74%** Management = 22% Caregiver= 04%
< 1 year= 28% **1-5 years = 32%** 5-10 years = 24% 10+ years = 16%	**YEARS OF EXPERIENCE** (p=.048)**	< 1 year= 4% **1-5 years = 41%** 5-10 years = 19% 10+ years = 36%
No training = 48% 1-3 hours= 16% 4-14 hours = 16% 14 + hours= 20%	**PREVIOUS FASD TRAINING** (p=.003)**	No training = 15% 1-3 hours= 11% **4-14 hours = 37%** **14 + hours= 37%**


3.2 FASD Knowledge Test

The FASD knowledge quiz consisted of 10 multiple choice questions with one bonus question. The purpose was to determine if gains in FASD knowledge occurred for trainees from Time 1 (pre-test/pre-training) to Time 2 (post-test/post-training). Analysis finds knowledge gains of significance ($p<.05$) did occur for both training types. A matched-pair t-test was used (only participants with matched data at Time 1 and Time 2); respondents with only Time 1 or only Time 2 data are not included in this analysis.

2-Day: Of the 28 trainees, 15 had matched pre-test/post-test scores. Analysis of the matched pair T-Test finds a significant learning shift did occur for the 2-day trainees, with 5 as the average number correct at Time 1 and by Time 2 that had risen to about 7 correct answers ($p=.003$).

Pre-Test Correct Score:	5.07
Post-Test Correct Score:	6.53
Significant Difference:	Yes; p= .003

12-Day: Of the 32 trainees, 25 had matched data. Analysis shows a significant learning shift did occur for the 12-day trainees, with 5 as the average number correct at Time 1 and by Time 2 the number correct rose to 6 ($p=.009$). *Note, these trainees had a much longer span of time between the Time 1 test and Time 2 re-test.*

Pre-Test Correct Score:	4.96
Post-Test Correct Score:	5.88
Significant Difference:	Yes; p=.009

3.3 Stated Training Goals (Pre-Test) vs. Goals Achieved (Post-Test)

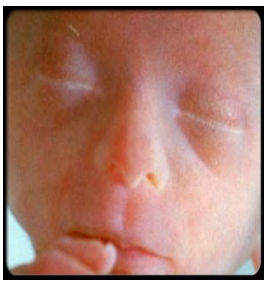
Each training group was asked what their stated training goals were at the Pre-test point, to identify three (3) and to rank them highest to lowest. At the Post-test they were then asked to note those training goals and whether they were: *a) Fully Met, b) Partially Met,* or *c) Not Met At All*. The chart below summarizes the results, for at least nine-in-ten of the trainees assessed this FASD training to have *met* or *partially* met their learning and training objectives. This held for both types of training although the 12-day trainees had a much higher rate of "met" compared to the 2-day trainees.

	PRE-TEST GOALS	POST-TEST GOALS		
	STATED GOALS	Met	Partially	TOTAL Met/Partial
2-DAY TRAINING				
TOP GOAL	To increase understanding of FASD (68%)	62%	27%	**89%**
SECOND TOP GOAL	To learn how to better help/support/assist clients (36%)	22%	67%	**89%**
THIRD TOP GOAL	To learn how to recognize /assess symptoms (18%)	38%	50%	**88%**
12-DAY TRAINING				
TOP GOAL	To increase understanding of FASD (52%)	83%	17%	**100%**
SECOND TOP GOAL	To learn how to better help/support /assist clients (19%)	80%	20%	**100%**
THIRD TOP GOAL	To increase case management skills (11%)	94%	6%	**100%**

3.3.1 Anticipated Challenges in Implementing the Training

At the pre-test and post-test trainees were asked to identify what they thought the greatest challenges would be to implementing the learning from the training. The chart below provides a summary of the analysis of their responses by training types, noting both similarity and differences.

Anticipated Challenges in Implementing the FASD Training		
Same or Differs	**2- Day Training**	**12-Day Training**
Same	➢ Applying it properly ➢ Dealing with emotions ➢ Agencies working together ➢ Addressing confidentiality	➢ Using new techniques ➢ Hostility ➢ Commitment of agencies-find a way to work together ➢ Confidentiality policies
Differs	○ Getting others trained ○ Integrating strength-based approach ○ Making a difference ○ Changing ways of thinking	❑ Lack of community support networks & understanding; bringing supports, peers, teams on board; educating others; ❑ A disjointed approach ❑ Acceptance in using the tools ❑ Application to local conditions ❑ Being effective... learn how to approach people and talk to them confidently
	SUMMARY OF KEY THEMES ~ CHALLENGES [Pre-Test] 1. Application of tools & knowledge 2. Collaborating with Agencies/Individuals 3. Lack of Resources and Raising Awareness **SUMMARY OF KEY THEMES ~ CHALLENGES [Post-Test]** 1. Systemic Barriers 2. Client Support	




3.4 Trainees' Satisfaction with Training: Post-Test

Both training groups (2-day and 12-day) were asked at the end of the training to rate their satisfaction with the training in six areas. The table below summarizes the respective responses by training type noting the percentage agreement related to "strongly agree/agree". The overall satisfaction scores are all over the minimum acceptable level of 70% and do not differ radically by training type (e.g. Q1 2-day (86%) vs. 12-day (96%) or Q5- 2-day (93%) vs. 12-day (100%), with the exception of one question: 2-day training Q2 "Curriculum content was clear"; there is significant difference between the 2-day (64%) and the 12-day (96%) to this question. One possibility is that because there was an adaptation to the training curriculum where the 2-day and 12-day trainees were together for the first two-days of training, that this caused confusion for the 2-day trainees regarding what was their curriculum.

Satisfaction Questions	2-DAY TRAINING			12-DAY TRAINING		
	Strongly Agree	Agree	Total	Strongly Agree	Agree	TOTAL
Q1- I learned more about FASD than I previously knew	64%	22%	**86%**	69%	27%	**96%**
Q2- The curriculum content was clear	21%	43%	**64%**	61%	35%	**96%**
Q3- The trainers were well organized	43%	43%	**86%**	62%	38%	**100%**
Q4- The handouts/training materials were helpful	29%	64%	**93%**	63%	37%	**100%**
Q5-Training will assist me in the performance of my job	64%	29%	**93%**	85%	15%	**100%**
Q6- I would recommend this training to my colleagues	79%	7%	**86%**	89%	11%	**100%**

3.4.1 Percentage of New Training: Post-Test

Participants were asked what percentage of the training was new to them.

2-Day: Of the 28 trainees, 14 provided data on their perception of the level of new data they received through the training. Analysis suggests that one-in-five (21%) said less than 20% was new knowledge for them, while eight-in-ten (79%) said the FASD training was new knowledge. More specifically, over forty percent (43%) of these 2-day trainees said 80% or more of the training was new knowledge.

Less than 20% new knowledge	= 21%
About 40% of new knowledge	= 21%
About 60% of new knowledge	= 15%
About 80% of new knowledge	**= 36%**
100% knowledge is new	= 07%
TOTAL	**= 100%**

12-Day: Of the 32 trainees, 25 rated their level of new knowledge. It was expected that since these trainees had much more prior training in FASD that would impact the degree of new knowledge gained and this was the case, as only one-quarter said 80% or more was new. Overall, one-in-six (16%) said less than 20% of the training was new, meaning 84% said 40% or more was new knowledge for them.

Less than 20% new knowledge	= 16%
About 40% of new knowledge	**= 32%**
About 60% of new knowledge	= 28%
About 80% of new knowledge	= 20%
100% knowledge is new	= 04%
TOTAL	**= 100%**

3.4.2 Overall Satisfaction with Training

All trainees were asked to rate the training using a 5-point likert scale: "*poor*", "*fair*", "*average*", "*good*", or "*excellent*". Of the 2-day training, 14 of 28 trainees provided a response: 7% rated it "*good*" and 93% rated it "*excellent*". The 12-day training had 26 responses: 1% said "*average*", 19% said "*good*", and 77% said "*excellent*". Across the 40 respondents from both training types, **82.5% said it was *"excellent".***

3.4.3 *Helpfulness of Training ~ Trainee Comments*

Trainees (T) were asked to comment on what was most helpful about the training. Their quotes only identify their group (2-day vs. 12-day) and their assigned research code number.

Gaining General and Specific FASD Knowledge

2-day T4 *"Learning more about identification of FASD"*
12-day T5 *"Learning more general information on FASD"*
12-day T22 *"A better understanding of FASD"*
12-day T25 *"Increase my overall knowledge of FASD"*

2-day T16 *"To learn more of the effects"*
12-day T4 *"Understand the primary and secondary characteristics"*
12-day T6 *"Learn more about FASD indicators and assessment"*
12-day T10 *"Knowledge regarding cause and effect of FASD"*

Learning Useful Techniques and Practical Strategies re FASD

2-day T9 "To troubleshoot and foresee and understand FASD clients"
12-day T2 "Learning how to talk and approach clients"
12-day T17 "Learning case management strategies for working with people with FASD"

Learning to Work Together

2-day T27 *"Why do we continue to work in silos - it has not been effective"*
12-day T19 *"Passing the knowledge on to key players"*
12-day T8 *"Teaching what is learned to co-workers"*

Focus on Clients

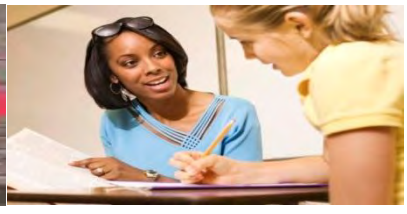
2-day T2 *"Learning more about how to assist people with FASD"*
2-day T13 *"To learn skills to support families affected by FASD"*
2-day T27 *"Become more aware and empathetic of people with FASD"*
12-day T5 *"Have knowledge about how to provide the best service for people with FASD"*
12-day T27 *"Be able to assist the FASD affected people I work with better"*
12-day T12 *"Better understanding of FASD to assist women at workplace"*
12-day T23 *"Learning what's new and different in the field to assist"*
12-day T26 *"Being provided with more information to adjust my techniques with clients"*

3.4.3 *Best Feature of the FASD Training & Recommendations for Improving Training*

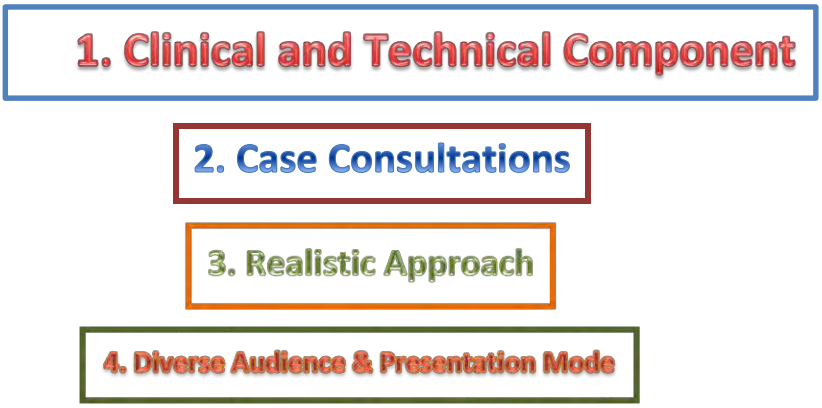
At the end of the training, each participant was asked two questions.

- Question 1: What was the **best feature** of the FASD training?
- Question 2: What do you **recommend to improve** the training?





QUESTION 1: BEST FEATURE….Analysis of the data from the 2-Day training found two-thirds (62%) of participants identified one theme: 1) *The Trainer*. Review of the responses from the 12-Day training identified four key themes. In order of identified importance they are:



THEME 1: Clinical and Technical Component

The preponderance of the 12-day trainees stated the "best feature" was the quality of the knowledge transferred. This included basic information as well as the clinical and technical information. Trainees felt that it would help them assist their clients. They found the information useful, it gave them insight and a new perspective of how to advance FASD in the workplace. A few participants noted the repetition of the important points or basics about FASD was helpful.

T1 "Always remembering "the organic brain disorder"
T2 "Very good information. Love how the important stuff was drilled over and over again"

THEME 2: Case Consultations

Participants were clear that the case consultations were a great feature and benefit of the training. For some, putting the written information into practice was a concern due to perceived confidentiality issues. Trainees found the case consultations an excellent way to infuse the learning and practice what was being taught in the FASD training.

T15 "Case consultations were great learning tools"
T21 "Putting information into practice with case conferences"

THEME 3: Realistic Approach

The way in which the training was delivered was positive which speaks to the skills and abilities of the presenter, Donna Debolt. Trainees appreciated that the information and case consultations were presented in a realistic manner; they found the presenter's shared, honest real life experiences enhanced their understanding and knowledge of the information being taught; and trainees recognized the helpfulness of the consistency of the language used were also positive aspects of the FASD training.

T12 "Donna had great useful information followed by strong examples"
T22 "Donna not being wishy washy…giving us practical info/ways to think about the disability"

THEME 4: Diverse Audience and Presentation Mode

A few participants found the best feature to be the ability of the agencies to come together, to collaborate, to learn from each other, to learn the same information. Participants appreciated the comfortable and interactive atmosphere which enabled positive training sessions.

T32 "The representation of other agencies/organizations"

QUESTION 2: IMPROVEMENT TO TRAINING …Trainees (T) were asked to give their recommendations to improve the training. While less than half responded, four themes emerged from the analysis.

1. Ongoing Structured Curriculum
2. Practical Component
3. Participation and Resource Development
4. 'Nothing'

THEME 1: Ongoing Structured Curriculum

While only half the trainees responded to this question, this theme emerged as the dominant theme. Specifically, participants identified a few items that fit in this theme. Many wanted an ongoing, structured FASD curriculum with more training sessions throughout the year. Some noted they would have preferred the training sessions to have been closer together, rather than stretched over three to four months. And finally, a few participants wanted a more structured syllabus, a glossary, and more information on the use of language along with a slower pace and more time for the in-class sessions.

THEME 2: Practical Component

Although case consultations were one of the *best features* of the training there were some recommendations noted regarding suggested improvements to this component. Firstly, participants wanted more case consultations. Secondly, some wanted more child based consults along with participation from other teams (e.g., Justice Department, Regional SW Team and FCS). Finally, a few thought more group work and self-directed case consultations would enhance the practical learning.

THEME 3: Participation and Resource Development

There was general interest from a group of participants to have more collaboration and participation from across the different teams, departments and agencies, whether it be for case consultation or just to communicate information and best practices. A number of trainees recommended a greater focus on resource development in the training.

THEME 4: "Nothing"

A very few trainees said "nothing is needed to be changed about the training". The felt the training was well done and were give the "tools" during this training so that they could put them into practice.

3.5 3 to 6 Month Follow Up with Trainees

At the pre-test survey, all trainees were asked if they would consent to being contacted 3 to 6 months after the training by evaluators. The purpose was to follow up with the trainees to better understand if and how the training was impacting practice and what the challenges were to implementation. A total of 28 of the 60 trainees provided consent. In August 2013 these 28 trainees were contacted by the evaluators.

2-Day 10 of the 28 trainees (36%) provided consent; 3 could not be contacted or were on vacation; a total of 7 (28%) completed the standardized phone interview (see questions below). Respondents were from youth justice, health, education, social work or were a care provider.

12-Day 18 of the 32 (56%) trainees gave consent to be contacted; 5 could not be reached and 2 were no longer employees at the agency; a total of 11 (34%) were contacted and interviewed. Respondents were from youth justice, adult justice, child worker, outreach, or adult care.

3.5.1. Standardized Interview Questions

A total of 18 of 60 trainees (30%) were interviewed over the phone during August 2013. All were asked the following standardized questions:

Q1.	How much exposure do you have to FASD at your workplace?
Q2.	Do you feel that your knowledge of FASD increased as a result of the training you attended?
Q3.	Since the FASD training, have you noticed any changes in your practice in any way? For example, have your case plans or organizational supports been impacted?
Q4.	Now that you have received FASD training, have you encountered any challenges in practicing what you have learned?
Q5.	Are there barriers to making any changes in your workplace? If yes –what?
Q6.	Is there anything that you think we should have asked before or after the training that we did not ask?

3.5.2 *Findings From Follow Up Interview*

The qualitative data were analyzed for content and themes. Analysis was first done question by question by training type. It is presented in summary format by question by training type in the following table.

Follow Up Questions	2-Day Training n =7	12-Day Training n=11
Q1. How much exposure do you have to FASD at your workplace?	FASD ranges from being a major element of their work to a limited issue.	FASD is a prominent issue in their workplace.
Q2. Do you feel that your knowledge of FASD increased as a result of the training you attended?	Yes ~ 86% (6 of 7) said general, practical knowledge increased & would like more training	Yes ~ 91% (10 of 11) said general, practical knowledge increased
Q3. Since the FASD training, have you noticed any changes in your practice in any way?	<u>Yes ~at Individual Level:</u> Trainees are educating others; they bring a better attitude about FASD; they are thinking differently about FASD; they approach clients differently and are more empathetic; they know when to incorporate knowledge learned into case planning. <u>Yes ~ at Organizational Level:</u> Trainee's state because of their training the agency has more awareness of FASD.	<u>Yes ~ at Individual Level:</u> Trainees are sharing knowledge with others; they are doing "mini" FASD sessions; they approach clients differently; they have changed the way the office is set up; they are making services fit with clients better; they are advocating more for clients; they are adjusting their expectations of clients. <u>Yes ~ at Organizational level:</u> wasn't recognizing FASD before at agency and now beginning acceptance

Q4. Now that you have received FASD training, have you encountered any challenges in practicing what you have learned?	No challenges …things appear to be going smoothly.	Yes ~ Systemic challenges: The confidential policy remains an issue; still no organizational sharing of info; still no collaboration amongst agencies; still each agency has a different approach. Yes ~ "Change" challenges: It is hard, takes time to adjust to "new" thinking; as people, as organizations, we are challenged by the "old" thinking

Follow Up Questions	2-Day Training n =7	12-Day Training n=11
Q5. Are there barriers to making any changes in your workplace?	Yes. There are challenges related to: ➢ Current policies ➢ Lack of collaboration across agencies, department, sectors ➢ Lack of awareness regarding FASD	Yes. There are challenges related to: ❖ Ineffectual policies *Still no organizational sharing of information* ❖ Ineffectual practices *Practice is to NOT work together* *No support from upper management* ❖ Lack of knowledge/ resources about FASD Not all colleagues are trained Not all sectors were at training
Q6. Is there anything that you think we should have asked before or after the training that we did not ask?	No. …training was thorough …interested in more training though.	Yes. The biggest support needed in the region is the need to explore how to apply training to local conditions.

Summary

Trainees indicated they were eager to infuse the learning from the training into practice. They gave many examples of how in little and big ways, the training is positively impacting practices. That said, the challenges identified at the start and end of training have not abated. Personal, agency and systemic barriers adversely impact the trainee's ability to effect the changes needed. They clearly identify the need for senior management to "be on board", to be trained in FASD, to be supportive of the need for change. Without that support, the ability of the front line to effect change and implement the learning from the training is limited.

4.0 Summary: Were Training Goals Achieved?

Were the goals of the training met? Upon what evidence is drawn upon to support the finding?

FASD Training Goals	Achieved	Evidence
To build on trainee's existing capacity to work more effectively with individuals, families and communities affected by FASD;	✓ **YES**	Post-test Follow up interview
To promote knowledge exchange and skill development within and across Teams, Agencies and Sectors;	✓ **YES**	Post-test Follow up interview
To strengthen community FASD networks and advance partnerships to both improve & ensure sustainability of best practices	✓ **yes**	Follow up interview

Goal 1 ~ Achieved? YES

This evaluation very clearly found that trainees' knowledge of FASD increased due to the training. Due to the knowledge exchange and sharing of information, trainees improved their use of a common language regarding FASD, their honed their conceptual understanding of the issues surrounding FASD, and they developed their skill base in creating evidence-informed, realistic case plans. Together these gains contribute to improved capacity for best practices with individuals, families and communities affected by FASD.

Goal 2 ~ Achieved? YES

Important gains were made in this area. Trainees spoke and wrote about the importance and benefit of having the multiple sectors, different agencies and range of departments together at the FASD training. The ability to join together in learning sets down possibilities for collaborating and partnering in improved ways going forward. The gains will recede if the changes are not sustainable or not supported by the various agencies.

Goal 3 ~ Achieved? yes

Initial groundwork for strengthening current collaborations, including new ones, was laid through the successful planning, implementation and conclusion of this FASD training initiative. However, sustained system change and cultural shifts in practices take time, often a long time. For improvements in knowledge, practice, policy and research to occur at the front-line level it will take strong senior leadership and management support.

The final comments come directly from the trainees'. These are their words about what is different, what is better, what has improved for clients because of the FASD training (taken during the Sept 2013 follow up consultation/presentation, Whitehorse, Yukon):

"BEFORE THE TRAINING I WOULD HAVE BEEN TOO POLITE AND WOULD NOT HAVE CHALLENGED THE LAWYERS"

"I FEEL MORE CONFIDENT ABOUT MY KNOWLEDGE TO DO WHAT IS BEST PRACTICE. I ASK BETTER QUESTIONS THAT ELICIT BETTER BRAIN ENGAGEMENT"

"I FEEL MORE COMPETENT ON MY FEET"

"I FEEL MORE PREPARED TO CHALLENGE THE MYTHS AND BAD PRACTICE"

"I RESIST MAKING INAPPROPRIATE REFERRALS"

"I FOCUS ON TEACHING NEW STAFF AND LESS FOCUS ON OLD GUARD"

"I SPEND LESS TIME ON DOING THINGS THAT WON'T WORK, LIKE BAIL CONDITIONS THAT SET UP PEOPLE WITH FASD TO FAIL"

"I AM NOT LEADING THE CONVERSATIONS WHEN TALKING WITH THOSE WITH DISABILITIES"

5.0 Recommended Next Steps

- To continue to provide ongoing FASD training to human service professionals (front-line, management, senior management, decision makers) and others (e.g. caregivers, parents);
- To include practical training, such as case consultations, as a large component of the training sessions;
- To encourage more professionals from a variety of fields and sectors to attend these FASD trainings;
- To stimulate and secure senior leadership support for the FASD training across the various sectors;
- To maintain continuity of trainer where possible;
- To advocate FASD be core training for Yukon human service professionals and caregivers;
- To foster the development and use of Yukon resources in the provision of that training.

Yukon's Training In



Fetal Alcohol Spectrum Disorder

FASD Training & Capacity Building Evaluation (2014)

The 12-Day Core Training, The 12-Day Certificate Training, & The 20-Day Facilitator Certificate Training Programs, Whitehorse, Yukon

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Date: February 8, 2015

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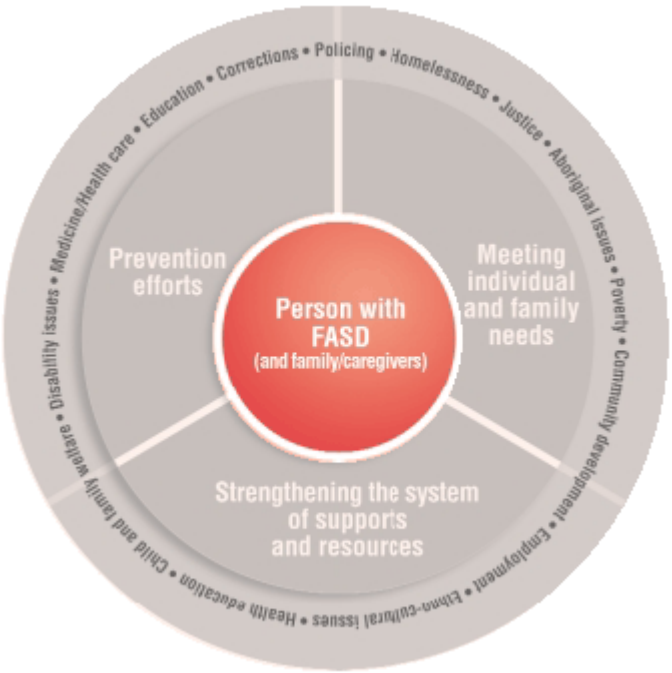


1.0 Introduction

1.1 Background

In 2012, a number of organizations formed a partnership in order to arrange for Fetal Alcohol Spectrum Disorder (FASD) training to be delivered to a range of Yukon human service professionals. These collaborating organizations were: Health & Social Services, Yukon Justice, Northern Institute of Social Justice, Yukon College, Council of Yukon First Nations, and the Fetal Alcohol Syndrome Society Yukon (fassy). Known for its leadership and excellence in research, evaluation, and FASD training, the Child Welfare Institute (CWI) of the Children's Aid Society of Toronto (CAST) was invited into the partnership by the above organizations to provide the trainer and conduct the evaluation. CWI organized two types of training, ***2-Day Core training*** and ***12-Day FASD Certificate Program*** training that took place between February and May of 2013. The training was funded through a Public Health Agency of Canada Grant and the Yukon Community Development Fund. In addition, CWI delivered a program evaluation report in November 2013 and provided a number of on-site presentations to the partner organizations.

In 2014, the lead Yukon organizations received another year of FASD training delivery and evaluation funding. The focus of this evaluation report is to present the findings from the second year of capacity building training and implementation that occurred throughout Fall 2014.

1.2 Training Description

Three types of training took place between September and December of 2014:

1. *Core Training ("**2-Day**");*
2. *FASD Certificate Training Program ("**12-Day**"); and*
3. *Facilitator Certificate Training Program ("**Facilitator-Certificate**").*

Following the 2013 training model, the ***2-Day*** and the ***12-Day*** trainees completed the first two days of training together, after which the ***12-Day*** trainees continued and completed the additional 10 days of the curriculum. The 2014 training program replicated the 2013 one but introduced a new element into the training program, the ***Facilitator-Certificate***. See below for a description of the three training types.

1.2.1 Core Training (2-Day)

The ***2-Day*** training was aimed at front-line workers, supervisors and caregivers who have had *little* to *no prior* training in FASD. The 2-day curriculum is delivered in one block:

- **Block 1:** *2-Day Intensive Workshop on FASD and Impact on Practice**.*** This training reviews current theories on FASD and the FASD literature, highlighting evidence-informed strategies aimed to increase long-term placement stability. This training underscores how to recognize FASD, including developmental trajectories and secondary disabilities. This training flags how FASD is a *cradle to grave* societal issue of significance for the children, adult and seniors involved with social services, health, education and justice.

1.2.2 FASD Certificate Training (12-Day)

The ***12-Day*** training was designed for service providers working in a case management capacity with adults and youth with FASD; this specialized curriculum is delivered in four training blocks. In addition to the learning noted in the ***2-Day*** training (**Block 1**), the 12-day curriculum includes three more blocks:

- **Block 2:** 3-Day Workshop on the Principles of Case Consultation and Assessments and Diagnosis and Introduction to Case Consultation
- **Block 3:** 4-Day Intensive Workshop on FASD and Impact on Practice
- **Block 4:** 3-Day Workshop on Case Management and Awarding of Certificates

12-Day training uses real life examples from participants' caseloads and the class leverages the learning to develop and implement appropriate, comprehensive case plans. Given the intensity and commitment required, selection of participants into the training was based on each applicant's written application.

1.2.3 Facilitator Certificate Training Program (20-Day)

The ***Facilitator-Certificate*** training was designed specifically for the 2013 ***12-Day*** training completers. The purpose of this training was to develop mentors who would assist the 2014 course leader in delivering the ***12-Day*** training as well as to develop more advanced case consultation and facilitation skills. In addition to the four training blocks described above, ***Facilitator-Certificate*** trainees attended two more training days per block, adding up to a total of 20 days of training. Specifically, these trainees met with the course leader one day prior to the course where they had the chance to prepare and assign roles as well as one day following the course where they had the chance to debrief and review. ***Facilitator- Certificate*** trainees had the following learning objectives in each training block:

- **Block 1:** To increase their knowledge of FASD and strengthen presentation skills;
- **Block 2:** To increase their knowledge of collaborative case consultation;
- **Block 3:** To practice the leading of an FASD Case Conference for the Course Participants;
- **Block 4:** Facilitator Course Participants lead the 3-days and demonstrate a sound understanding of case management principles plus an ability to provide constructive feedback and direction.

1.3 Course Leader

Michele Palk, MSW, RSW, M.Psy. was CWI's FASD lead trainer for all three 2014 training types. She has over 10 years of front-line experience in providing assessment, intervention, training and case consultation services to vulnerable children, adolescents, families and groups. Her social work career focused on providing frontline child protection services at a First Nations child welfare organization and a large urban CAS. Assessment expertise includes doing court ordered custody, access plus trauma assessments. and has been a guest lecturer at two faculties of social work in Ontario. After working on a specialized FASD child protection team, Ms. Palk obtained her Fetal Alcohol Spectrum Disorder Trainer certificate in 2010. She has since provided training, case consultation, and interventions to families and organizations working with individuals suspected of having, or diagnosed with, FASD.

1.4 Key Anticipated Outcomes

- **Outcome 1:** Increase Trainee Understanding of FASD
- **Outcome 2:** Strengthen Trainee, Mentor and Community/Agency Collaborative Networks
- **Outcome 3:** Develop and hone FASD Mentorship Program
- **Outcome 4:** Improve & Standardize Evidence-Informed Service Practices to those with FASD
- **Outcome 5:** Advance Yukon FASD Training Capacity and Expertise via Mentorship Development

2.0 Evaluation Methodology

2.1 Sample

A mixed-method approach was used. The sample included training participants, mentors, and the course leader who completed the evaluation tools and/or follow-up interviews:

- ✓ A total of 33 of 33 of the ***2-Day*** training participants completed the evaluation tools, of which 10 participated in a follow-up telephone interview;
- ✓ 31 of 31 of the ***12-Day*** trainees completed the evaluation tools, of which 10 consented to a follow-up telephone interview;
- ✓ Three of three participants completed the ***Facilitator-Certificate*** and provided follow up telephone interviews.
- ✓ The course leader was interviewed via telephone.

2.2 Procedures

As mentioned previously, participants of both the ***2-Day*** and the ***12-Day*** training (N=64) completed the first two days of training together. Following these two days of training, only ***12-Day*** trainees (n=31) continued for additional 10 days of curriculum. Both ***2-Day*** and ***12-Day*** trainees were asked to complete paper questionnaires before training ("*pre-test*") and after training ("*post-test*"). Although the questionnaires used in the two training types were identical, the post-test survey completed by ***12-Day*** trainees was split between two time points: (1) the first part containing a knowledge test was completed after two days of training (**Block 1)** and (2) the second part containing outcome and satisfaction related questions was completed at the end of training **(Block 4**).

To increase accuracy while maintaining confidentiality, the evaluation questionnaires were printed in two different colours to separate the ***2-Day*** trainees from the ***12-Day*** trainees. In addition, a non-identifying confidentiality code was used to match all the questionnaires completed by each participant. Participants in both trainings were asked in the body of the questionnaires to voluntarily provide their contact information for a follow-up interview. Ten ***2-Day*** trainees and ten ***12-Day*** trainees were randomly selected from those who consented. These 20 former trainees were contacted and interviewed via telephone in January 2015.

Facilitator-Certificate trainees (n=3) and the course leader (n=1) were contacted and interviewed via telephone in January 2015. Please see Table 1 for a complete summary of sample by training type.

Table 1. *Sample by training type*

Training Type / Data	2-Day		12-Day		TOTAL		Facilitator-Certificate
	N	Matched	N	Matched	N	Matched	
Pre/Post Test	33	27 (82%)	31	25 (81%)	**64**	**52 (81%)**	
Follow Up Interview	8		7		**15**		3

The evaluation utilized a mixed methods research design, using a combination of quantitative and qualitative questions. Specifically, the types of questions used included Likert-scale, check-box, multiple choice, open-ended, and narrative-based. Quantitative questions were most effective to collect demographic data and FASD knowledge information. Qualitative questions allowed trainees to use their own words to describe their workshop goals, anticipated implementation challenges, best features of the training, and recommendations. The next section describes the measures used in greater detail.

2.3 Measures

Demographic information. At pre-test, ***2-Day*** and ***12-Day*** trainees were asked for their *year of birth, gender, level of position, years of experience, current field of work, role*, and *name of their organization* in order to establish an overall profile of trainees. In addition, trainees were asked about the *extent of their prior training in FASD.*

FASD Knowledge test. At pre-test, ***2-Day*** and ***12-Day*** trainees were asked *ten multiple choice questions* to assess their baseline knowledge of FASD. At post-test, the same ten questions were asked to assess the knowledge gain by trainees. In order to encourage trainees to demonstrate their knowledge rather than guess the answers, "*Unsure*" was one of the multiple choice answer options. It should be noted that both ***2-Day*** and ***12-Day*** trainees completed the post-test knowledge test following **Block 1** of training; for ***2-Day*** trainees this was the end of their training while for ***12-Day*** trainees this was the end of **Block 1** of **4**.

Workshop goals. At the pre-test, the ***2-Day*** and ***12-Day*** trainees were asked to list *their top three goals* and *what they were hoping to achieve during their training*, and what they thought their *greatest challenges would be in implementing their learning into practice*. At post-test, both trainee groups were asked to revisit the goals they set out at the pre-test and indicate whether they were "*Fully Met*", "*Partially Met*", or "*Not Met*". Trainees were once again asked what they thought their greatest challenges would be in implementing their learning into practice. It should be noted that ***2-Day*** and ***12-Day*** trainees completed the post-test workshop goals section at the end of their training; for ***2-Day*** trainees this was following **Block 1** of training, but for ***12-Day*** trainees this was following **Block 4**.

Satisfaction with training. At post-test, the ***2-Day*** and ***12-Day*** trainees were asked to rate *six satisfaction statements* on a 5-point Likert scale ranging from "*Strongly Disagree*" to "*Strongly Agree*". Trainees were also asked to indicate what percentage of the information presented was new to them as well as give the training an overall rating on a 5-point scale ranging from "*Poor*" to "*Excellent*". Finally, participants were asked to respond in their own words to two open ended questions: *What was the best feature of the training?* and *What are your recommendations for improvements?* This post-test was completed by trainees at the end of their respective trainings.

Follow-up phone interview. A standardized follow-up phone interview was conducted with consenting former ***2-Day*** and ***12-Day*** trainees, within one to three months after the completion of training. The researcher asked six questions pertaining to the impact of the training on practice we well as any implementation challenges. Follow up phone interview were also conducted with the three peer-mentors, who completed the ***Facilitator-Certificate.*** This five-question interview focused on which aspects of the training were successful and which required improvement. Finally, the course facilitator was contacted for a follow-up interview regarding the implementation of the ***2-Day***, ***12-Day***, and ***Facilitator-Certificate*** training.

2.4 Data Analysis

All quantitative data were inputted and analyzed using the statistical software called Statistical Package for Social Sciences (SPSS) Version 20.0. Data were analyzed for frequency, distribution, and significance (set at $p<.05$). All qualitative data were inputted into Microsoft Word 2007 and each question was examined for content which informed the thematic analysis.

3.0 Results: 2-Day & 12-Day Training

3.1 Demographics

All trainees were asked a number of questions pertaining to themselves, their place of work, and their previous FASD training experience. The replies have been analyzed, separated by training type (***2-Day*** vs. ***12-Day*** training), and are presented next. The final portion of this section will explore any potential statistical differences in group demographics between the two training types.

3.1.1 Gender

2-Day (N=33): A total of 29 trainees provided data, of which 24 (83%) identified as female and 5 (17%) as male.

12-Day (N=31): Of 30 trainees who provided responses, 22 (73%) identified as female and 8 (27%) as male.

Figure 1. *Gender for 2-Day*

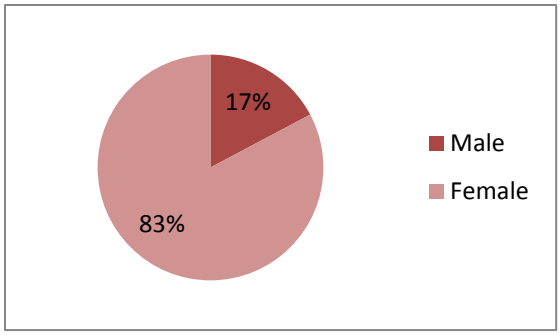
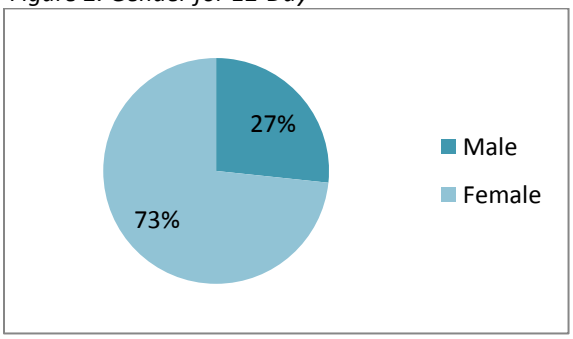


Figure 2. Gender for 12-Day



3.1.2 Age

2-Day (N=33): A total of 30 trainees provided their year of birth. The mean age was 43.10 years. Please see a breakdown by age group below.

Table 2*. Age groups for 2-Day Training*

Age Group	#	%	
20-29	4	13%	**Min** = 23
30-39	**11**	**37%**	**Max** = 73
40-49	7	23%	**Mean** = 43.10
50-59	5	17%	**SD** = 12.212
60-69	2	7%	
70-79	1	3%	
TOTAL	**30**	**100%**	

12-Day (N=31): All participants provided their year of birth. The resulting mean age of 44.32 years was slightly older than in the 2-Day training. Breakdown by age group is below.

Table 3. *Age groups for 12-Day*

Age Group	#	%	
20-29	4	13%	**Min** = 26
30-39	**9**	**29%**	**Max** = 68
40-49	7	23%	**Mean** = 44.32
50-59	6	19%	**SD** = 12.073
60-69	5	16%	
TOTAL	**31**	**100%**	

"If we knew what it was we were doing, it would not be called research, would it?" ALBERT EINSTEIN

3.1.3 Level of Position

2-Day (N=33): The largest portion of the 29 trainees who responded to this question identified as front-line employees (n=19; 66%). The remaining 34% of responding trainees were evenly divided between management and caregiver positions (see Table 4).

12-Day (N=31): Of the 28 trainees who responded, 27 (96%) identified as front-line employees. The remaining one trainee held a management position. There were no ***12-Day*** trainees who identified as caregivers at this time.

Table 4. *Level of position for 2-Day Training*

Level of Position	#	%
Front-line – direct service	**19**	**66%**
Management - supervising	5	17%
Caregiver - caring	5	17%
TOTAL	**29**	**100%**

Table 5. *Level of position for 12-Day*

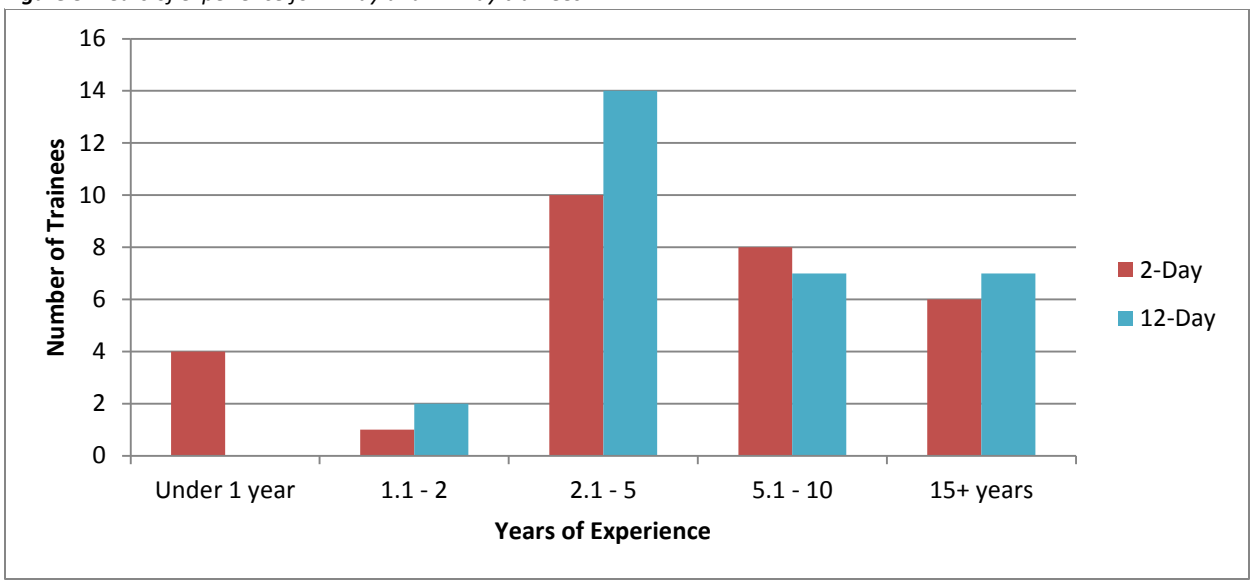
Level of Position	#	%
Front-line – direct service	**27**	**96%**
Management - supervising	1	4%
Caregiver – caring	0	0
TOTAL	**28**	**100%**

3.1.4 Years of Experience

2-Day (N=33): Of the responding 29 trainees, just over half (52%) had less than 5 years of experience, where one in four had less than one year in their line of work. See Figure 3 below for more detail.

12-Day (N=31): These 30 respondents demonstrate a little more work experience than their ***2-Day*** training counterparts. With that being said, a comparable portion of respondents (54%) indicated less than 5 years of experience. See Figure 3 below for more detail.

Figure 3. *Years of experience for 2-Day and 12-Day trainees*



3.1.5 Field of Work

2-Day (N=33): Of the 29 responding trainees, the field of work of 10 (35%) was with the Aboriginal communities. Although "other" was the second largest category (28%), no descriptors were provided.

12-Day (N=31): Findings from 28 trainees who provided data are summarized in Table 7. It is evident that half (50%) of the trainees identified working with Aboriginal communities while the second most common reply (18%) was Adult Criminal Justice System.

Table 6. *Field of work for 2-Day Training*

Field	#	%
Aboriginal Communities	**10**	**35%**
Children's Mental Health	~	~
Child Welfare	3	10%
Criminal Justice System - Youth	1	3%
Criminal Justice System - Adult	2	7%
Health Services	1	3%
Residential Care Provider	4	14%
Other	8	28%
TOTAL	**29**	**100%**

Table 7. *Field of work for 12-Day*

Field	#	%
Aboriginal Communities	**14**	**50%**
Children's Mental Health	1	4%
Child Welfare	2	7%
Criminal Justice System - Youth	3	11%
Criminal Justice System - Adult	5	18%
Health Services	1	4%
Residential Care Provider	1	4%
Other	1	4%
TOTAL	**28**	**100%**

3.1.6 Role

2-Day (N=33): Nearly half of the 27 trainees indicated "other" (e.g. job coach, support worker, admin, board member). Of the remaining categories, nearly one-third (30%) were associated with Education (15%) and Social Work (15%).

12-Day (N=31): The largest portion of the ***12-Day*** training, 42% of the 26 responding trainees also indicated "other" (e.g. employment counsellor, family support, outreach worker, case manager). Of the remaining categories, Social Work was the most prevalent (31%).

Table 8. *Role for 2-Day Training*

Role	#	%
Child & Youth Worker	2	7%
Education	4	15%
Legal	1	4%
Parent/Caregiver/Care provider	2	7%
Social Work	4	15%
Therapist/Counsellor	2	7%
Other	**12**	**45%**
TOTAL	**27**	**100%**

Table 9. *Role for 12-Day*

Role	#	%
Child & Youth Worker	1	4%
Education	2	8%
Legal	1	4%
Social Work	8	31%
Therapist/Counsellor	3	11%
Other	**11**	**42%**
TOTAL	**26**	**100%**

"I have loved the stars too fondly to be fearful of the night."

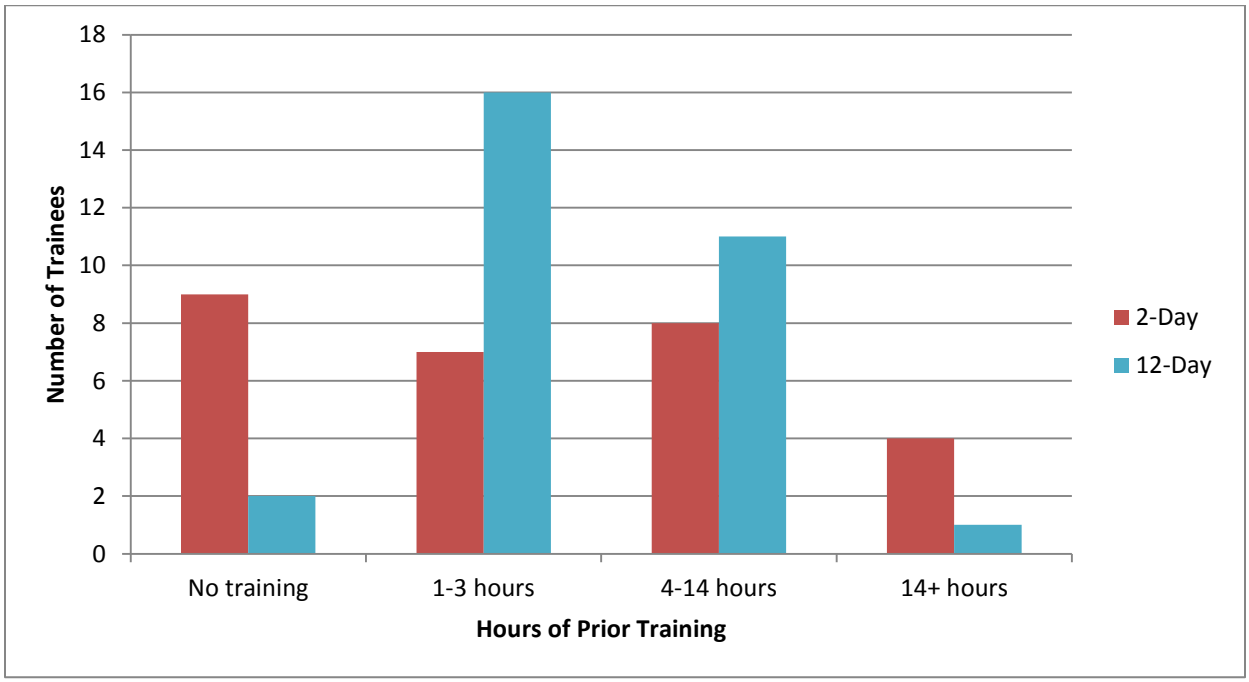
GALILEO

3.1.7 Previous Training in FASD

2-Day (N=33): As demonstrated in Figure 4, one-third of the 28 trainees who responded to the question had *no previous training in FASD* while half (54%) had 1-14 hours of prior FASD training

12-Day (N=31): Only 7% of these 30 responding trainees had *no previous FASD training;* having *1-3 hours of prior FASD training* was the most common response (16 of 31).

Figure 4. *Previous training in FASD for 2-Day and 12-Day trainees*



3.1.8 Summary and Comparison of Demographic Data

Table 10 provides a summary of the demographic data that were displayed in this section. In addition, a comparison between the participants in the two training groups was performed using either using a *t-test* (comparison of the mean scores) or a *Chi-Square* test (goodness of fit test between the observed and expected values).

- **No significant difference** was found in the distribution of ***gender, age***, and ***years of experience*** between the two training groups. This finding about years of experience is somewhat surprising as the ***12-Day*** training targets trainees appeared to have more experience in the field.
- **No statistical comparison was made** in the ***field*** and ***role of work*** between participants in the two trainings; given the low number of trainees in the majority of categories, such comparison would be inaccurate as well as minimally important for the purposes on this evaluation.
- **Significant statistical difference found** between the two training groups on two variables:
    - ***Level of position:*** it appears that ***12-Day*** training group was made up almost exclusively of front-line workers, while ***2-Day*** training group had presence of managers/supervisors and caregivers. The lack of caregivers in the ***12-Day*** stream might reflect the target audience of the program, which are mainly professionals. The lack of management presence in the ***12-***

Day stream could be a reflection of the lengthy time commitment required. Interestingly, in last year's report, management encompassed 22% of ***12-Day*** trainees.

- ***Previous FASD training:*** the ***2-Day*** participants were more likely to have *no previous training in FASD* compared to the ***12-Day*** training group. Given the more advanced level of the ***12-Day*** program in comparison to the ***2-Day*** training, a higher level of previous training within this group was to be expected.

Table 10. *Summary and comparison of demographic data*

2-Day Training (n=33)	Demographics & Statistics	12-Day Training (n=31)
Female = 83%	**Gender**	**Female = 73%**
Male = 17%	NO significant difference	Male = 27%
20-29 = 13%	**Age**	20-29 = 13%
30-39 = 37%	NO significant difference	**30-39 = 29%**
40-49 = 23%		40-49 = 23%
50-59 = 17%		50-59 = 19%
60-69 = 7%		60-69 = 16%
70-79 = 3%		70-79 = 0%
Mean age = 43.10		**Mean age = 44.32**
Front Line = 66%	**Level of Position**	**Front Line = 96%**
Management = 17%	$X^2(2, N=57) = 9.04$, $p=.011$*	Management = 4%
Caregiver = 17%	YES significant difference	Caregiver = 0%
<1 year = 14%	**Years of Experience**	<1 year = 0%
1-5 years = 38%	NO significant difference	**1-5 years = 54%**
5-10 years = 27%		5-10 years = 23%
>15+ years = 21%		>15+ years = 23%
Aboriginal = 35%	**Field of Work**	**Aboriginal = 50%**
Other = 28%	No significant comparison could be made due to the low number of trainees in the majority of fields	Adult Justice = 18%
Residential = 14%		Youth Justice = 11%
Child Welfare = 10%		Child Welfare = 7%
Adult Justice = 7%		Other = 4%
Youth Justice = 3%		Residential = 4%
Health Services = 3%		Health Services = 3%
Children's MH = 0%		Children's MH = 3%
Other = 45%	**Role at Work**	**Other = 42%**
Education = 15%	No significant comparison could be made due to the low number of trainees in the majority of roles	Education = 8%
Social Work = 15%		Social Work = 31%
CYW = 7%		CYW = 4%
Counsellor = 7%		Counsellor = 11%
Caregiver = 7%		Caregiver = 0%
Legal = 4%		Legal = 4%
No Training = 32%	**Previous FASD Training**	No Training = 7%
1-3 hours = 25%	$X^2(3, N=58) = 10.19$, $p=.017$*	**1-3 hours = 53%**
4-14 hours = 29%	YES significant difference	4-14 hours = 37%
14+ hours = 14%		14+ hours = 3%

* Indicates statistically significant *Chi-Square* test where $p < .05$. **Please note that this result should be interpreted with caution as not all necessary numerical conditions for the test were satisfied.**

3.2 FASD Knowledge Test

The FASD knowledge quiz consisted of 10 multiple choice questions on FASD. The quiz was administered to all trainees prior to training (pre-test) to establish a baseline of their FASD knowledge. The same quiz was administered once again after 2 days of training (post-test) to determine if gains in FASD knowledge occurred for trainees. A paired-sample t-test analysis found statistically significant knowledge gain for trainees in both training types.

Table 11. *Pre-post knowledge test for 2-Day Training*

	Mean	t-test
Pre-test Correct	4.52	t(26) = -4.37, *p*<.000
Post-test Correct	6.26	

A total of 27 of 33 ***2-Day*** trainees provided matched pre-test and post-test knowledge test data. As seen in Table 11, the average number of correct answers increased from about four to six. This is a statistically significant result with the odds of it occurring by chance alone being less than 1%.

Table 12. *Pre-post knowledge test for 12-Day Training*

	Mean	t-test
Pre-test Correct	4.68	t(24) = -4.62, *p*<.000
Post-test Correct	6.36	

A total of 25 of 31 ***12-Day*** trainees provided matched pre-test and post-test knowledge test data. The average number of correct answers increased from about four to six. This is a statistically significant result with the odds of it occurring by chance alone being less than 1% (Table 12).

3.3 Training Goals

All trainees were asked to identify their top three training goals at pre-test. The three goals provided by trainees added up to a total of 63 goals in the ***2-Day*** group and 65 goals in ***12-Day*** group. The goals were then analyzed for content themes and the emerging three top goals are presented in Table 13.

Table 13. *Goals of 2-Day and 12-Day trainees*

Pre-Test Goals		Post-Test Goals			
2-Day Training (n=63)		**n**	**Met**	**Partially**	**TOTAL**
Goal 1	More **understanding/knowledge** of FASD and of the **living experience** of people with FASD (n=28; 44%)	27	67%	26%	**93%**
Goal 2	To **enhance practice** through learning **skills** or acquiring **tools/resources** and **help/support** people with FASD (n=23; 37%)	21	48%	43%	**91%**
Goal 3	Professional **Networking** (n= 5; 8%) **Community** awareness (n=5; 8%)	16	69%	19%	**88%**
FASD Certificate (n=65)		**n**	**Met**	**Partially**	**TOTAL**
Goal 1	To **enhance practice** through learning **skills** or acquiring **tools/resources** and **help/support** people with FASD (n=28; 43%)	24	67%	29%	**96%**
Goal 2	More **understanding/knowledge** of FASD and of the **living experience** of people with FASD (n=26; 40%)	23	70%	26%	**96%**
Goal 3	Increase **communication** and enhance **relationship** with **community** and **partners** for improve prevention/intervention practices (n= 9; 14%)	21	71%	24%	**95%**

It appears that the most common goal among ***2-Day*** trainees was to increase their knowledge of FASD as well as improve their understanding of FASD itself and the perspectives/challenges of people living with FASD. This goal was common among ***12-Day*** trainees as well, but for this group the more commonly expressed goal was to enhance their own practice-related competencies in order to benefit their FASD clients.

At the completion of training (post-test), trainees were asked to revisit their three goals and identify whether they were "*Fully Met*", "*Partially Met*", or "*Not Met*". Table 13 summarizes these results. As evident in the table, over 85% of all trainees who responded to this question indicated that their pre-training goals were either fully or partially met.

3.4 Anticipated Implementation Challenges

Trainees in both groups were asked to identify what they thought the greatest challenges would be in implementing the learning from the training into practice. This question appeared in the pre-test and post-test. Table 14 below provides a summary of the anticipated challenges by training type.

Table 14. *Anticipated Challenges of 2-Day and 12-Day Trainees*

2-Day Training		12-Day Training	
Pre-test (n=17)	**Post-Test (n=20)**	**Pre-test (n=18)**	**Post-test (n=18)**
Proper application of the learning (n=10) ▪ Retaining and recalling the information ▪ Being effective and helpful ▪ Flexible application	**Systemic barriers** (n=12) ▪ Resources/supports ▪ Lack of knowledge or agreement within the community ▪ Funding	**Successful professional growth** (n=9) ▪ Retention ▪ Specific caseload challenges ▪ Practice ▪ Consideration	**Successful professional growth** (n=9) ▪ Keeping momentum ▪ Specific caseload challenges ▪ Case consultations
Systemic barriers (n=7) ▪ Resources ▪ Red tape	**Individual barriers** (n=8) ▪ Time constrains ▪ Opportunity to practice ▪ Transfer of learning to others ▪ Using the learning	**Systemic barriers** (n=9) ▪ Working with untrained community ▪ Changing old patterns/habits ▪ Resources ▪ Agency mandates	**Systemic barriers** (n=9) ▪ Lack of buy in internally and/or externally ▪ Policy, agency mandates, and values

"Go confidently in the direction of your dreams. Live the life you have imagined."

HENRY DAVID THOREAU

3.5 Satisfaction with Training

3.5.1 Overall Satisfaction

Both ***2-Day*** and ***12-Day*** training groups were asked to rate their satisfaction with the training at the time of completion. Table 15 summarizes the responses by noting the percentage of agreement with six satisfaction statements.

Table 15. *Trainee satisfaction*

Satisfaction Questions	2-Day Training (n=30)			12-Day Training (n=28)		
	Strongly Agree	Agree	TOTAL	Strongly Agree	Agree	TOTAL
1. I learned more about FASD than I previously knew	27%	50%	**77%**	54%	39%	**93%**
2. The curriculum content was clear	13%	67%	**80%**	46%	46%	**92%**
3. The trainers were well organized	17%	50%	**67%**	54%	36%	**90%**
4. The handouts/training materials were helpful	20%	63%	**83%**	54%	29%	**83%**
5. Training will assist me in the performance of my job	23%	60%	**83%**	50%	36%	**86%**
6. I would recommend this training to my colleagues	23%	67%	**90%**	61%	25%	**86%**

The overall satisfaction scores were all over the minimum acceptable level of 70%, with the exception of responses to statement three, *"the trainers were well organized"*; the agreement score of ***2-Day*** trainees to this statement was 67%. It might be important to note that only 3% of trainees disagreed with this statement while the remaining 30% were neutral. Given that ***12-Day*** trainees, who attended the first two days of training jointly with ***2-Day*** trainees, had 90% agreement this statement, it is reasonable to assume that the perceived trainer organization drastically improved.

3.5.2 Percentage of New Information

2-Day (N=33): Of the 30 responding trainees, one-in-four (27%) believed that they gained less than 20% of new knowledge. One-in-five (20%) indicated 60% was "new knowledge" and one-quarter (26%) said 80% or more was "new knowledge"

12-Day (N=31): Of the 28 responding trainees, one-in-five (18%) indicated that they gained less than 20% of new knowledge, while the remaining 82% gained at least 40% new knowledge. Of importance, over one-third (36%) said 80% or more was "new knowledge" results, which is particularly encouraging as this trainee group had more prior training in FASD.

Table 16. *New knowledge 2-Day trainees gained*

2-Day	#	%
Less than 20% new knowledge	**8**	**27%**
40% new knowledge	**8**	**27%**
60% new knowledge	6	20%
80% new knowledge	6	20%
100% new knowledge	2	6%
TOTAL	**30**	**100%**

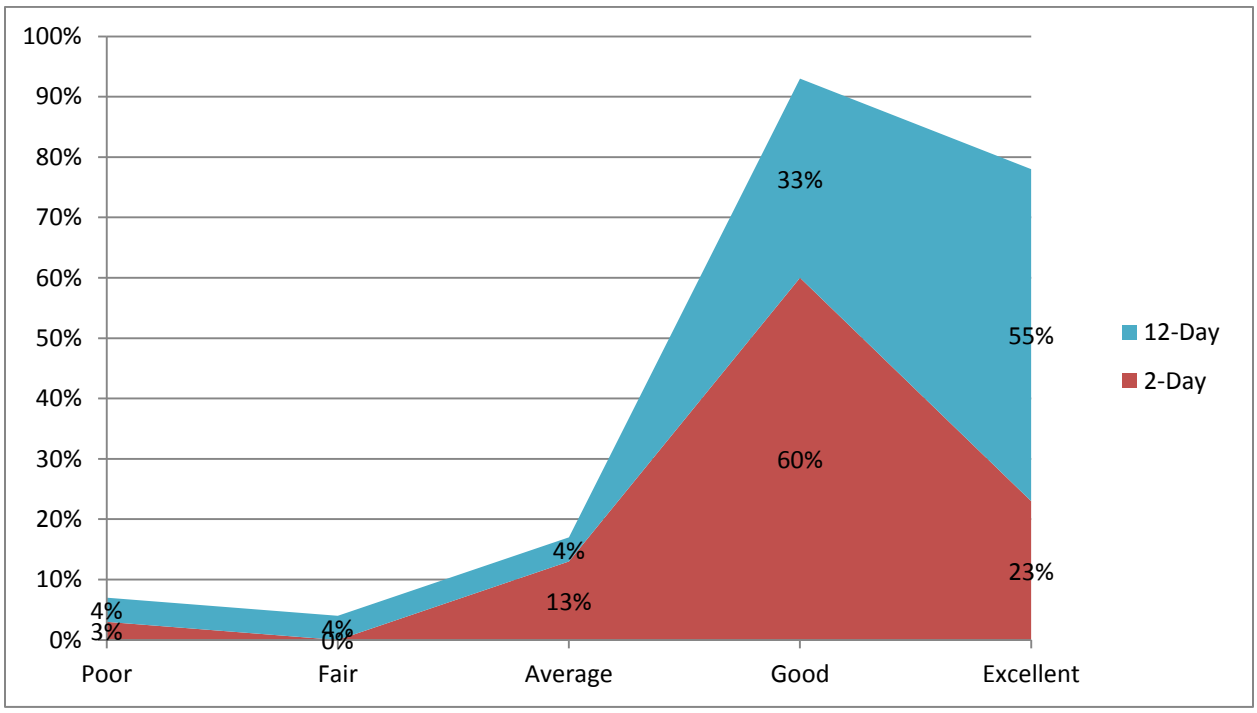
Table 17. *New knowledge 12-Day trainees gained*

12-Day	#	%
Less than 20% new knowledge	**5**	**18%**
40% new knowledge	**9**	**32%**
60% new knowledge	4	14%
80% new knowledge	7	25%
100% new knowledge	3	11%
TOTAL	**28**	**100%**

3.5.3 Overall Rating

All trainees were asked to rate the training using a 5-point Likert scale, ranging from "*Poor*" to "*Excellent*". Table 18 portrays the responses for ***2-Day*** trainees (n=30) and ***12-Day*** trainees (n=27). As portrayed in Figure 5, 83% of ***2-Day*** trainees gave the training above average rating (either "*Good*" or "*Excellent*") while 88% of ***12-Day*** trainees rated their training as above average. An *"Excellent"* rating was more common for ***12-Day*** rather than ***2-Day*** trainees.

Figure 5. *Overall rating of training*



3.5.4 Best Feature of the Training

All ***2-Day*** and ***12-Day*** trainees were asked at the end of the training to use their own words to write the best features of the training they just experienced. Analysis of the responses identified main themes for each training group.

2-Day (N=33): A total of 28 responses were received. Analysis of the data found that approximately one third of respondents (37%) identified Networking and connecting with others as valuable, while 43% of respondents identified the Structure of the training and the activities as key.

12-Day (N=31): Review of the 25 responses identified four key themes:

THEME 1: Case Consultations

The majority of the certificate program respondents indicated that they found the case consultations as the most helpful, that they found it enjoyable and that it was a good use of their time (60%; n=15).

T34 "*Doing the case consultations with people at training was fun*"
T42 "*The amount of time allotted to practicing case consultations*"

THEME 2: Realistic Life Examples
Respondents appreciated the use of real life examples in the training, allowing them to practice on real life cases and integrate into their understanding of FASD (24%; N=6).

T46 "*Multiple hands-on examples*"
T52 "*The chance to practice case consultations in a realistic manner*"

THEME 3: Networking and Collaborating
Respondents found the opportunity to network and collaborate with other professionals as a very important part of the training. The opportunity to connect with other agencies was mentioned as being helpful (24%; N=6).

T48 "*Working together with other agencies*"
T54 "*Collaborative, networking, and multiple voices*"

THEME 4: Knowledge Acquisition
A subset of the respondents found that the knowledge that they acquired on FASD to be an important part of the training. Learning about other services and knowing what to do with individuals who have FASD was identified as a key part of the training (19%; N=5).

T37 "*Making sure that people know what FASD is. Best practices, cases, functions, environment*"

3.5.5 Recommendations for Improvement

2-Day (N=33): Trainees were asked to give their recommendations to improve the training. Just over two thirds of the trainees responded, some with suggestions for improvement (N=23). Three themes emerged during data analysis:

THEME 1: More Group Work
The dominant theme that emerged from the responses of the 2-day trainees was that they wanted more group work (35%; N=8). They indicated that the wanted more interaction with other members of the group, more group discussion and they missed teambuilding/icebreakers.

T3 "*Start with teambuilding/icebreakers*"
T7 "*Less talking, more group work*"

THEME 2: No Improvements Needed
Almost one third of the respondents thought that the training didn't need improvement (31%; N=7).

THEME 3: Handouts
A small but vocal portion of the trainees found that the handouts provided by the program were not satisfactory. The major complaint was that PowerPoint presentations did not match the handouts, while one respondent noted that a page was missing from the handout (17%; N=4).

T28 "*The handouts need to match the PowerPoint. Content was disjointed + disorganized. Page #5 needed on handout*"

12-Day (N=31): A total of 22 participants responded to the question of what needed improvement with the certificate program. While a significant group of respondents found that there was no needed improvement (23%; N=5), it was clear from other respondents that there was still a great deal of work to be done. Four key themes emerged during data analysis.

THEME 1: Structure of Training

Almost one third of the respondents found that the structure of the training needed improvement. Respondents found that there was too much repetition, that there needed to be more directions for groups, that the agenda needed to be followed more closely, and that there needed to be more group work (32%; N=7).

T55 "*More speaking from the heart not the head*"
T56 "*Curriculum content wasn't followed, direction of the group would have been helpful*"

THEME 2: Attendance Issues

A small but important portion of the respondents found that attendance was an issue with the program, indicating that people should only miss the training for an emergency (18%; N=4).

T30 "*Have a more stable of a group. People coming and not coming changes group dynamics*"
T45 "*Fewer days might improve attendance*"

THEME 3: Better Representation from Community

A smaller theme around representation emerged from data analysis (18%; N=4). Respondents indicated that they would have appreciated someone who had FASD speaking to the group as well as other sectors in social services represented.

T27 "*To have an actual person who has FASD come and speak about how they function on a daily basis would have been interesting*"
T52 "*More participation in case consults by people 'outside' of the course who may be more resistant*"

THEME 4: Handouts

As with the ***2-Day*** trainees, a small but significant group found that the handouts needed improvement (18%; N=4). The respondents wanted copies of the upcoming case plans and wanted handouts to match the Power-Points.

T53 "*Handout to everyone of upcoming case plan*"
T55 "*Match the handouts to the PowerPoint*"

3.6 Follow-up Interviews

A total of 17 of the 33- ***2-Day*** trainees and 19 of the 31- ***12-Day*** trainees agreed to be contacted for a follow up phone interview. In January 2015, 10 participants from each training group were randomly selected and contacted by phone. If the interviewer was unsuccessful in contacting the participant four times, the participant was crossed off the list and another trainee was selected. Using this method, the number of interviews completed for the ***2-Day*** trainees was eight (n=8) and for the ***12-Day*** trainees a total of seven (n=7) was interviewed. The interviews were performed by a CWI MSW student. The data obtained were summarized in Table 18.

Table 18. *Follow-up interviews with trainees*

Questions	2-Day Training (n=8)	12-Day Training (n=7)
Q1. *How much exposure do you have to FASD at your workplace?*	FASD ranges from being a major element of their work to a limited issue.	FASD ranges from being 10% of their caseload to being 100%.
Q2. *Do you feel that your knowledge of FASD increased as a result of the training you attended?*	Yes ~ 25% (2 out of 8) replied that their knowledge did not increase, 25% said that their knowledge increased somewhat and 50% (4 out of 8) said that their knowledge of FASD definitely increased. Examples where knowledge increased included: when pregnant women were most at risk for having a child with FASD and how FASD affected the brain.	Yes ~ 100% said general, practical knowledge increased; some found it "*extremely helpful*" and helped them to understand the stereotypes around it.
Q3. *Since the FASD training, have you noticed any changes in your practice in any way?*	**Yes ~at Individual Level:** Respondents are taking FASD into consideration when dealing with clients, understanding client needs better, how to serve families, and have an increased awareness of the signs and symptoms of FASD. **No ~ Expecting more:** Everyone is not on the same page, there is too much disparity in the knowledge that everyone has around FASD. There needs to be formal training so that everyone has the same understanding of FASD.	**Yes ~ at Individual Level:** Respondents found that they collaborated more with other workers, they were more conscientious about how they approached clients with FASD, were more aware of their needs and requirements and their knowledge base of FASD increased. **Yes ~ at Community level:** Respondents have noticed a community-wide change in the awareness of FASD, they are better able to educate the public about FASD, and that they were able to connect better with other agencies and resources for their clients with FASD.

Q4. *Now that you have received FASD training, have you encountered any challenges in practicing what you have learned?*	**No challenges** For the majority of the respondents, things were going smoothly. However, there were some challenges for a few: ▪ Supervisors didn't necessarily have knowledge of FASD ▪ Red tape	**Yes ~ Systemic challenges:** There is disconnect between the needs of the community and the needs of the client: ▪ *"I am expected to hold those with criminal charges culpable yet they do not have the cognitive ability to understand or remember what they did was wrong".* ▪ *"Workers and the community have trouble separating behavior from individuals, especially those that commit crimes and may have cognitive disabilities… This means that people may not get the help that they need, because everything else is overshadowed by the label of criminal offender. Affects public funding and everything else that may be attached to it."* **Yes ~ "Change" challenges:** There were some challenges in connecting with other workers and aren't on board with supporting clients. People are still in denial that there are so many people who have FASD. **No ~ "Change" challenges** 3 respondents indicated that there were no challenges in implementing the learning they received.
Q5. *Are there barriers to making any changes in your workplace?*	**Yes. There are challenges related to:** ▪ Current policies ▪ Relationship building with clients with FASD ▪ Not having the time or supports available to properly support clients ▪ Lack of awareness regarding FASD ▪ Funding	**Yes. There are challenges related to:** ▪ **Ineffectual practices** ○ Practice is to NOT work together ○ No support from upper management ▪ **Legislation and policies have not changed** ○ Clients with FASD may not understand what they have done is wrong or be able to remember not to do it again. ○ Policies dictate how we help clients and do not consider clients with FASD. ○ Still a great deal of red tape.

		• **Lack of FASD knowledge/resources** ○ Not all colleagues are trained ○ Not all sectors were at training ○ Lack of Funding
Q6. *Is there anything that you think we should have asked before or after the training that we did not ask?*	One respondent felt that issues around confidentiality should have been addressed before the training as there were also family members present and it would have been disrespectful to share information while they were there. Another respondent felt that it would have been useful to discuss the amount of exposure that trainees had to FASD at the beginning of the training.	One respondent felt that there should have been a prerequisite before taking the full certificate program, as there were attendance issues and not everyone had the same foundation of knowledge. Some respondents felt that there needed to be an overview of FASD services or programs to offer participants.

3.6.1 Trainee Interviews Summary

The majority of the respondents found that the training greatly increased their FASD knowledge and their ability to deal with clients who had FASD. They felt that their ability to educate their communities increased and that they were better prepared to make changes with their own practice, their agency, and their communities. Respondents mentioned that there were several systemic barriers that prevented them from implementing some of the changes that they would like. These barriers included legislation and organizational policies, red tape, lack of funding, and lack of FASD knowledge in other workers and supervisors. Even with the identified barriers, it was clear that respondents were passionate in their commitment to help clients with FASD.

4.0 Results: Facilitator-Certificate

The ***Facilitator-Certificate*** recipients were contacted in January 2015 for a follow-up interview. All three participants completed the interview. Please see below for a summary of their responses.

Table 19. *Follow-up interview with peer mentors*

Questions	Peer Mentors (n=3)
Q1. *This time around, what do you know now regarding what is key in effective work with those with FASD?*	Peer mentors indicated that they had a firmer grasp on the knowledge in the FASD training this time around. One of the important messages was that the difference between case conferencing and case consulting had not been clear in the original training and that additional exposure to the concepts allowed for better understanding. Mentors indicated that they were more comfortable with the information and concepts that were presented, including neurology of the disease and the implications for clients.
Q2. *What could be improved with the training? For the trainees? For the Peer Mentors?*	There were several issues identified with the training by the peer mentors: ▪ **Class size** – the first two days of training had 50 people and the remainder of the training had 30; this did not allow for much interaction in the first two days and not everyone got to lead a case consultation in the certificate program. ▪ Peer Mentors felt they did **not have sufficient time or training to prepare for presentations**. They were not sure of their roles and would have felt more comfortable with the material if they were allowed to prepare their own presentations. ▪ There was **not enough education around residential school syndrome, Aboriginal culture, and intervention and prevention of FASD.** ▪ Should be a focus on **intergenerational trauma** (parenting issues, alcoholism, shame in being aboriginal) and the need for **aboriginal healing** (pride in being aboriginal, pride in language and culture, pride in being an aboriginal woman). ▪ Needs to be **several sectors targeted for FASD training** in order to make sure that there was a common understanding of FASD: Health, Education, Government, Justice, Social services, Housing
Q3. *What worked? What made the training successful? What were the factors that will help leverage change in their community?*	▪ Peer Mentors identified **the trainer** as one of the key factors that made the training effective; they described her as passionate, knowledgeable and capable; the trainer never left them with unanswered questions, she helped them to build confidence in their abilities, and she used the medicine wheel to give focus to the training. ▪ The mentors also identified **the consultations** as successful, allowing people to develop confidence and skill in helping clients with FASD.
Q4. *What were the barriers? What did not work with the training? What were the factors that will be a barrier to leveraging change in their community?*	Peer mentors acknowledged **confidentiality** as one of the barriers to the training, noting that people were reluctant to bring cases forward and that it resulted in fake cases. This impacted the quality of the learning for the trainees. There were several barriers to implementing change in the community: ▪ Clients **need a diagnosis of FASD in order** to access [certain] services, yet many clients are unwilling to be diagnosed due to issues such as stigma. ▪ Many clients come from **smaller communities** that don't have many

	services available. Leaving their community re-traumatizes clients and reminds them of the way they were forced to go to residential schools. ▪ Lack of education around the residential school syndrome and the need for better legislation and policies that recognizes the **impact of trauma**. ▪ **Lack of organizational support**, which is the result of lack of FASD education. ▪ **Lack of funding for FASD services**, such as meals, cleaning homes, budgeting.
Q5. *What is the Number 1 barrier to establishing a FASD Community of Practice in the Yukon?*	The peer mentors identified several barriers: ▪ **Buy-in from other agencies**. ▪ **People are already overwhelmed**; it's hard to take on more work. ▪ There **needs to be enough support** for the work itself. ▪ **"Silo-ism"…**everyone is isolated in their own areas of interest, as well as community.

5.0 Results: Trainer Interview

The course trainer participated in a follow-up telephone interview. The successful elements of the training, the barriers, and recommendation she identified are summarized in Table 20 below.

Table 20. *Follow-up interview with the course trainer*

Questions	Course trainer (n=1)
Q1. *What worked? What made the training successful? What were the factors that will help leverage change in their community?*	▪ Key factors in training success was having a variety of people from different service sectors who practiced case consultations and worked together. Case consultations were a significant part of training success; ▪ Another key factor was the peer mentors; they had been through the training previously and knew the needs of their communities.
Q2. *What were the barriers? What did not work with the training? What will be a barrier for leveraging change in their community?*	▪ More time to prepare for the Peer Mentors was needed ▪ With so many of the trainees there wasn't an opportunity for all of them to facilitate case consultations and it impacted their learning. ▪ People did not want to bring actual cases to consultations.
Q3. *What could be improved with the training? For the trainees? For the Peer Mentors? For the trainer?*	▪ Better screening for the introductory training as there were people who had previous FASD training and it made the program not suitable for their learning needs. ▪ Peer mentors would have benefited from training on how to train people.
Q4. *What is your perspective on establishing a FASD Community of Practice in the Yukon?*	▪ If people received support from their organizations to work within an understanding of FASD, then they could successfully form a community of practice. Frontline staff shared that they don't feel supported in doing the work differently. Organizations need to be willing to practice differently, practice within a neuro-disability lens and deliver services from that understanding. ▪ People need to be committed to working together, develop a clear plan for what a community of practice IS and what they hope to achieve.
Q5. *Any final suggestions or recommendations?*	▪ People in the Yukon that work with people with FASD have a lot of experience and are doing good work, so ensuring that a common understanding and language about FASD exists amongst professionals will support the work that people are already doing as well as the clients

6.0 Summary

Table 21 provide an overall summary of the ***2-Day***, ***12-Day***, and ***Facilitator-Certificate*** trainings that took place between September and December of 2014.

Table 21. *Were anticipated training outcomes achieved?*

Anticipated Training Outcomes	Status	Evidence
O1: Increase Trainee Understanding of FASD	☑ Done	▪ A statistically significant increase in FASD knowledge quiz scores between pre-test and post-test. This was true for both ***2-Day*** and ***12-Day*** trainees. ▪ Over 87% of ***2-Day*** trainees and over 94% of ***12-Day*** trainees felt that all their training goals were met. ▪ 77% of ***2-Day*** trainees and 93% of ***12-Day*** trainees agreed with "*I learned more about FASD than I previously knew*". ▪ 73% of ***2-Day*** trainees and 82% of ***12-Day*** trainees indicated that 40% or more of the course material was new to them. ▪ 75% of ***2-Day*** trainees and 100% of ***12-Day*** trainees indicated FASD knowledge increase during the follow-up interview.
O2: Strengthen Trainee, Mentor and Community/Agency Collaborative Networks	In progress	▪ Over one-third (37%) of ***2-Day*** trainees identified networking and collaborating as the best feature of the training. For ***12-Day*** trainees, networking and collaborating emerged as the third main theme, touched upon by 24% of respondents. ▪ In their follow-up phone interviews, ***2-Day*** trainees indicated lack of community awareness and attention to FASD. However, ***12-Day*** trainees indicated increased FASD-related community collaboration and awareness at follow-up. ▪ Additional comments during follow-up interviews from both ***2-Day*** and ***12-Day*** trainees indicated lack of knowledge and resistance in the community, which negatively impacts collaboration and networking.
O3: Develop and hone FASD Mentorship Program	In progress	▪ Mentorship program was developed with three participants successfully graduated with ***Facilitator-Certificate***. ▪ Both peer mentors and training leader indicated that there was no opportunity for mentors to develop sufficient proficiency in the course material. ▪ Further training for peer mentors was recommended.
O4: Improve & Standardize Evidence-Informed Service Practices to those with FASD	In progress	▪ Knowledge gain and practice change has been mentioned by both ***2-Day*** and ***12-Day*** participants, but lack of buy-in within the larger community was also mentioned by participants. ▪ Lack of representation of all relevant sectors in the training was mentioned (i.e. government). ▪ Specific important elements of Aboriginal cultural practices were missing from the training.
O5: Advance Yukon FASD Training Capacity and Expertise via Mentorship Development	In progress	▪ Three peer mentors graduated and indicated a higher level of knowledge of FASD-related materials at this time. ▪ Peer mentors indicated satisfaction with ***Facilitator Certificate*** training and with the course instructor.

7.0 Next Steps

- ✓ Increase the level of training of Yukon professionals in a variety of sectors
- ✓ Increase community awareness of FASD
- ✓ Continue to strengthen collaboration and networking within the community
- ✓ Further develop the ***Facilitator-Certificate*** to increase the number of graduates and address the gaps in training

Others…

"The obstacles of your past can become the gateways that lead to new beginnings."

RALPH BLUM

Yukon
Health and Social Services

ADULT ASSESSMENT TEAM – FASD DIAGNOSTIC CLINIC
Services to Persons with Disabilities
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FASD CLINIC: ADULT ASSESSMENT FOR INTERVENTION

January 26-28, 2015

Westmark Whitehorse – Conference Room #5

Gail Andrew, MDCM, FRCPC, Alberta Health Services
Jacqueline Pei, Ph.D., R. Psych, University of Alberta;
Bernadene Mallon, MSW, RSW, Edmonton Fetal Alcohol Network Society

Day One

9am -10:30 - Session One

I. FASD Diagnosis, Interventions and Preventions

- History of FASD
- Research – where are we at?
- Opportunities for prevention

10:30 -10:45 Break

10:45-12:00 - Session One cont.

- Diagnostic models / guidelines
- Assessment of adults
    - Implications / Challenges
- Assessment for Intervention
- Review of case examples

12:00-1:00 Lunch

1:00 – 2:30 – Session Two

II. ***FASD Diagnosis: 4-Digit Code / Canadian Guidelines***:

- Diagnostic model
- Assessment process
- Role of the multidisciplinary team

2:30-2:45 Break

2:45-4:30 – Session Two cont.

- Application to adult assessment
    - Implications / Challenges
- Review of case examples

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Day Two

8:30-10:30 - Session One

I. Neuropsychological & Mental Health Assessment of Adults

- Overview of domains assessed
- Mental Health Screening / Assessment
- Assessment for Intervention

10:30-10:45 Break

10:45-12:00 – Session Two

II. FASD Assessment: Breakout Session

Physicians and Allied Health Professionals – Room 167
Coordinators – Conference Room #4
Psychologists – remain in Conference Room #5

- 4-Digit Code / Canadian Guidelines
- Discipline specific roles
- Methods & tools
- Application to adult assessment
- Assessing for intervention

12:00-1:00 Lunch

1:00- 3:15 Session Two Breakout Sessions Cont.

3:15-3:30 Break

3:30-4:30

III. FASD Diagnosis: Practical Application

- Group exercise - Deriving a diagnosis using an adult case scenario

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Day Three

9:00-10:45

I. Concurrent sessions

i. Community Stakeholders

- FASD Overview - History / Current Research
  - Where are we at now?
- Diagnostic Service Model
- Contributions / Role of the Representative
- Adult Assessment
  - Implications / Challenges / Intervention

ii. Psychologist Breakout Session (Cont. from Day 2) – Room 167

10:45-11:00 Break

11:00-12:00

II. Interventions / Management planning

- Assessment for Intervention / Not Simply for Diagnosis
- Practical Application to Management Planning for Adults
- Case Scenario
- Summary

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ADULT FASD DIAGNOSTIC CLINIC

Fetal Alcohol Spectrum Disorder (FASD) is a term that includes all of the diagnoses/difficulties that individuals may have if they were exposed to alcohol prenatally (in the womb). These difficulties may include problems with thinking, behaviour, and social and emotional functioning.

The Whitehorse-based Adult Assessment Team for FASD Diagnosis was developed in 2014. The team is coordinated by Yukon Government's Services to Persons with Disabilities program, and provides FASD assessments that are administered by local medical and psychological professionals, with the assistance of a Clinic Coordinator.

Who will the clinic serve?

The Adult FASD Diagnostic Clinic is for adults (19 years of age and older) from Yukon who are experiencing difficulties that are suspected to result from prenatal alcohol exposure. These individuals may have difficulty with education, employment, social relationships, and independent living and may struggle with addictions or criminal justice involvement.

Confirmation of prenatal alcohol exposure is not a requirement for the assessment to proceed. However, if prenatal alcohol exposure cannot be confirmed, this will affect the diagnosis that can be given, and the assessment will be considered functional in nature.

How can individuals access the clinic? Who can refer an individual?

A referral is required to access the clinic. The clinic provides voluntary assessment only; court-ordered assessments will not be accepted at this time.

An individual may self-refer, or be referred by anyone who believes the assessment would be helpful for the individual. The person making the referral will be asked to complete a referral form with information about the individual. Referrals will be screened for eligibility for the assessment.

Who is involved in the assessment process?

Yukon's FASD Diagnostic Team consists of a physician, a psychologist and the Clinic Coordinator. During the assessment process, the team will work closely with clients and their support person(s). Clients may choose to involve trusted friends, family, or professionals in the process, at the appropriate times.

The client will be required to have a specific support person who can commit to help them through the entire assessment process. This person will be expected to provide information (with the client's consent), help explain the process to the client, and provide general support, including ensuring that the client attends appointments, eats well and gets enough sleep before assessments. The support person will also help the client to implement the recommendations that result from the assessment.

How long does the assessment take to complete?

The Assessment Team will need to access relevant records about the client, with the client's consent. It may take several months to receive the documents. When all of the records and required documentation are received, the support person will be contacted to schedule an appointment.

The client will meet with the Clinic Coordinator for information gathering. The assessment itself will consist of at least three appointments. The client will meet with the Clinic physician at least once, and will have meetings with the psychologist to complete a number of tests and assessments. These appointments will take about 10 hours in total.

What happens in the assessment process?

- We will take photographs of the client's face to look for features that are sometimes seen in individuals with prenatal alcohol exposure.
- Clients and their family members or support people will be interviewed and asked to complete some questionnaires.
- The Clinic Coordinator will compile records about the client's history and search for documentation of prenatal alcohol exposure.
- Clients will complete about six hours of testing to look at their thinking skills.
- Client will have a brief health screen done by the clinic's physician.
- Once the testing is completed, a meeting will be held with the client and support person to share the results.
- Follow-up and clinic evaluations will be offered.

How will the results of the assessment be provided?

Clients may or may not receive a diagnosis of FASD; however, the results of either a diagnostic or functional assessment can be very valuable because they highlight strengths and areas where clients need support. Recommendations to address the client's current needs will be developed and will include linkages to services and supports that could be helpful. The support person will assist the client with the implementation of the recommendations. With the client's permission, the final report will be forwarded to his/her family doctor and other identified support people and agencies.

The Clinic Coordinator will be available for follow-up meetings around case planning, or to answer any questions the client may have about his/her diagnosis, and to provide ideas, strategies, or access to resources that might be helpful to the client and his/her supports. .

The Clinic Coordinator will also be available to family members or those close to the client, who may wonder what this means for their loved one, or who may be dealing with grief and loss issues resulting from the diagnosis.

For additional information, please contact the Clinic Coordinator, Lise May, directly at 867-667-3626.

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CLINIC REFERRAL PROCESS

Basic Eligibility

- 19 years or older
- Yukon resident
- Has valid YHCIP
- Voluntary participant in assessment
- Has functional, behavioural and/or developmental concerns believed to be related to prenatal alcohol exposure (PAE)
- Support Person identified (ideal)
- Not court-ordered/Justice Referred
- Legal guardian consent, if applicable

Referrals to Clinic may be made by completing the *Referral For Assessment* form. These can be handwritten, or completed on computer and forwarded by mail, drop-off, or by internet. Referrals can also be made by calling the Clinic Coordinator Lise May directly at 667-3626.

Any referrals must be made with the client's consent, or the consent of the legal guardian.

Referrals will ideally contain detailed information about the concerns regarding the client's functioning, and may cover areas such as behaviours, emotional stability, developmental concerns, as well as information about housing and education issues, social and family relationship concerns, parenting issues, including contact with F&CS, daily functioning (i.e. money management, time management, maintaining a household). If you are aware of any significant head injuries or medical issues, these would also be important to describe. This may seem like a lot of information to provide, but will help inform a well-rounded assessment of the client's functioning.

We also want to know what is hoped for as a result of the assessment – does the client want specific services, does the client and his/her family want to better understand his/her needs and strengths?

The client will require a support person who will assist them throughout the assessment process. This may include assisting with transportation, ensuring the client has a good sleep and meal before the assessments, and providing emotional support to the client throughout the process.

If a FN client from the communities wishes to have an assessment, funding can be made available to assist them to travel to Whitehorse for the appointments with the physician and psychologist. Most of the preliminary work will be done by phone, email, or telehealth, to reduce the amount of time the client has to be away from home. These arrangements must be made and approved in advance, through the Clinic Coordinator.

ASSESSMENT FOR INTERVENTION

The main purpose of assessment is intervention. A FASD diagnosis may or may not result from assessment, but it will yield valuable information that can be used to help others better understand the needs and strengths of the client, and to have realistic expectations about what they can do. Clients who have undiagnosed FASD are often labeled as "trouble-makers" or "unmotivated", and often think of themselves as "stupid". A good assessment can help us shift the way we view people with challenges related to PAE, and how they view themselves, from "bad" to "hurt".

Interventions that we know can help

- Enriched environments, particularly for babies with FASD
- Exercise - cardio in particular
- Motor training - strength exercises, stretching, yoga etc
- Dietary interventions, good nutrition – again, especially for babies
- Money management – break down cheques to weekly; use gift cards/vouchers for groceries, pay rent directly to landlord etc.
- education on sexual and reproductive health – the best way to prevent another generation of children with FASD is reliable birth control for women who drink;
- education on alcohol use – some people who come from alcoholic parents may not know that their risk of alcoholism is higher as a result; support pregnant mothers to not drink
- supported housing - with family, OFI, approved home etc
- support and respite for caregivers to prevent burnout
- snow-ploughing – think about what challenges a client may face, then "get out in front and clear the way"
- considering "developmental age" rather than chronological age – someone may be 25, but functions like a 12 year old, so use respectful strategies that would work with that age range
- building relationship by building competencies – find something the client is good at and work towards a trusting relationship based on building that skill/talent
- be as concrete as possible
- Shift thinking from "they won't" to "they can't"
- rhythmic activities like drumming, listening to rap music, or rocking seem to be calming to neural pathways
- "facilitated wandering" – a client may visit a number of supportive people throughout the day, getting a bit of direction and emotional support from each. Each support person plants the seed for next steps "Oh, are you going to see Jack now? That's great, he'll be happy to see you".

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REFERRAL FOR ASSESSMENT

On behalf of _____ (the Client), please accept this referral for assessment. The Client is ☐ aware of this referral.

Please note: If the Client is not aware of, and consenting to this referral, please do not complete this form. Please obtain consent from the Client before proceeding with the referral.

Client Name: _____

NAME: _____ DOB: _____ (YYYY-MM-DD) Age: _____

Address: _____ Phone: _____

_____ Cell: _____

First Nation? _____

REFERRAL AGENT NAME:

Please check: ☐ Mentor ☐ Advocate ☐ Caregiver ☐ Medical Professional ☐ Other: _____

Phone: _____ Agency: _____

Relationship: _____

Address: _____

_____

Phone: _____ Cell: _____ Fax: _____

The personal information contained in this form is being collected under the authority of Yukon's *Health Act* and s.29(c) of the *Access to Information and Privacy Protection Act* for the purpose of assessment for FASD. Non-identifying information resulting from this diagnostic assessment may be used to inform future program development. For questions regarding this collection of information, contact the Adult Assessment Coordinator – FASD Diagnostic Clinic, at the contact information noted above.

Please describe, in detail, any concerns you have regarding this Client's functioning, behaviour, and emotional state, and what causes you to suspect that this behaviour is caused by prenatal exposure to alcohol?)

☐ Referral Letter Attached or

☐ See below for details

Please add additional sheets as necessary.

What is hoped for as a result of this assessment?

SUPPORTS AVAILABLE FOR THE PRE, MID, AND POST ASSESSMENT PROCESS.

Confirmed: ☐ Yes ☐ No ☐ Maybe

Name and contact information: _____

_____

POTENTIAL:

Name: _____

Contact information: _____

_____

CONTACTS FOR CONFIRMATION OF PRENATAL ALCOHOL EXPOSURE (PAE):

Name and contact information (relationship): _____

_____

_____

Are they aware they may be called: ☐ Yes ☐ No ☐ Maybe

_____ _____

Referral Agent's Name and Signature Date (YYYY-MM-DD)

YUKON FASD ADULT ASSESSMENT CLINIC

LOGIC MODEL

Program Goal: To build Yukon's capacity to comprehensively assess adults suspected of FASD in order to more effectively assist them to access supports they require, based on a full understanding of each individual's condition, functional strengths and needs.

Program Objectives:
1) Provide Yukon-based multi-disciplinary diagnosis and functional assessments for adults suspected of being affected by FASD.
2) Provide an assessment service that is respectful, collaborative, strengths-based, and responsive to individual needs.
3) Work with adults suspected of having a FASD and their support people to incorporate assessment results into the adult's life in order to build on the client's strengths and effectively support him or her to reach his or her potential.

Inputs	Activities	Outputs	Outcomes/Impact		
			Short Term 1-2 years	**Medium Term 2-5 years**	**Long Term 5-10 years**
People - Assessment team members - Coordinator, physician and psychologist - Trainers (Yukon and outside) Training/mentoring - For assessment team Partnerships - Advisory Committee for clinic - NGOs (FASSY, CDC, etc.) - Justice, Education	**1. Develop and maintain competencies** of diagnostic team and other Yukon professionals - Recruit, train and contract diagnostic team members as needed	- Contracts with trainers - Training and mentoring for physicians, psychologists - Contracts with assessment team members - Annual Performance Measurement report	Clinic Operations/Services: - Assessment team members able to start assessments in 2015 with ongoing training/mentoring - Core Yukon assessment team members have acquired competencies required to conduct assessments and diagnose FASD	Clinic Operations/Services: - Increased number of Yukon physicians and psychologists able to conduct assessments - Decreased reliance on outside expertise to provide training/mentoring	Clinic Operations/Services: - Increased capacity in Yukon to conduct comprehensive assessments for adults suspected of FASD and other adults with cognitive disabilities
	2. Develop or strengthen communication and partnerships with referral sources, support services and other stakeholders: - Maintain Advisory Committee for at least Year 1 of clinic operations - Share information with other clinics and agencies - Establish Interdepartmental FASD Committee to coordinate YG planning and activities	- Advisory Committee: TOR, meetings and resulting decisions and activities - Interdepartmental/Interagency FASD Committee: TOR, committee established, regular meetings, and resulting decisions and activities	Community: - Good level of engagement at committee meetings – members feel heard and valued - Community partners[1] are satisfied with service provided by assessment clinic - Interdepartmental Committee develops into an Interagency Committee within 1 year of inception	Community: - Increased awareness of the FASD assessment process, services and supports amongst community members - Increased coordination of services to assess and support adults with FASD	Community: - Stronger collaborative working relations between health and social services partners throughout Yukon

[1] "Community partners" in this context refers to health care and social workers in various organizations including government, First Nations, NGOs and private providers.

Inputs	Activities	Outputs	Outcomes/Impact		
			Short Term 1-2 years	**Medium Term 2-5 years**	**Long Term 5-10 years**
- First Nations/CYFN - Referring professionals/agencies - Interdepartmental Committee on FASD - Within HSS (e.g. Insured Health, Continuing Care) Funding - Yukon HSS (Social Services, Insured Health) - Federal gov't Infrastructure - Physical space: clinic - Equipment/materials - Diagnostic tools and standards	- Communicate and coordinate with referral and support services in process of conducting assessments	- Communications with other clinics and FASD experts in and outside Yukon - Information on assessment services provided to referral sources	- Committee has a common understanding of goals of collaborative work on FASD		
	3. **Undertake other Clinic Operations** activities (other than #1 & 2) to support Activities #4 and #5 - Data/information collection, analysis and management for use within HSS and potentially for research studies - Develop/modify processes and procedures and clinic standards - Be a resource for those seeking information for FASD-related assessments and support	- Standardized clinic practices/procedures - Data spreadsheets	Clinic Operations/Services - Clinic practices are understood and followed by referring agencies and clinic team members	Clinic Operations/Services - Increased standardization of clinic practices, policies and procedures in alignment with evolving Canadian guidelines - Increased understanding of distribution and nature of FASD and functional needs as a result of data collected in the clinical database - Clinic processes result in timely, efficient assessments	Clinic Operations/Services - Information from clinic operations informs program development within Yukon and may contribute to FASD research
	4. Conduct Assessments: - Referral - Screening - Access and review records - Determine evidence of prenatal exposure to alcohol (PAE) - Review file information - Conduct medical and psychological assessments - Undertake team diagnosis	- Referral forms received - Pre-assessment reports and consent forms completed for each client - Client information summaries - Assessment reports - Team diagnostic meetings - Diagnostic report and recommendations	Clinic Operations/Services: - Accurate assessment results - Practical/useful recommendations - Assessment team is satisfied with its assessment recommendations	Clinic Operations/Services: - A well-functioning assessment team that is collaborative, supportive, respectful and compassionate - Stable team membership	Clinic Operations/Services - Assessments are high quality - Assessments reflect best practices

Inputs	Activities	Outputs	Outcomes/Impact		
			Short Term 1-2 years	**Medium Term 2-5 years**	**Long Term 5-10 years**
	5. Carry out follow-up activities: - Meet with client and support person to present assessment report and recommendations - Develop follow-up plan for each client assessed - Discuss follow-up plan with client, support person, and case manager - Obtain feedback on clinic operations and assessment process from each client and support person - Conduct 6 month follow up with each client	- Assessment result meetings with client and support person - Follow-up plans for each client - Client and support person (satisfaction) feedback forms	Clients: - Clients are supported throughout the assessment process by a support person - Clients are satisfied with the assessment process and how they were treated by the assessment team - Clients are able, to the best of their ability, to understand: o their strengths, and challenges o recommendations o how supports could help them o next steps for implementing their follow-up plan - Clients are connected with the appropriate supports and services Support people/services: - Support people are satisfied with the assessment process and how they and the client were treated - Support people/workers understand how to integrate the client's assessment results and follow-up plan into strategies and supports for the client	Clients: - Clients have improved self-esteem, self-confidence, sense of hope - Increased client use of appropriate supports Support people/services: - Assessment findings are integrated into strategies used by support people and agencies to support individual clients - Increased awareness among Yukon service providers of effective strategies for building on strengths and supporting adults with FASD	Clients: - Clients have improved health and well-being and increased participation in community life/work - Clients have reduced adverse life outcomes, trauma, abuse and involvement in crime Support people/services: - Support services are effective and based on a shared understanding of an individual's strengths/needs and effective strategies to promote the client's well-being

ADULT ASSESSMENT CLINIC – FASD DIAGNOSTIC CLINIC

PERFORMANCE MEASUREMENT MATRIX

Program Goal: To build Yukon's capacity to comprehensively assess adults suspected of FASD in order to more effectively assist them to access supports they require, based on a full understanding of each individual's condition, functional strengths and needs.

Program Objectives:
1) Provide Yukon-based multi-disciplinary diagnosis and functional assessments for adults suspected of being affected by FASD.
2) Provide an assessment service that is respectful, collaborative, strengths-based, and responsive to individual needs.
3) Work with adults suspected of having a FASD and their support people to incorporate assessment results into the adult's life in order to build on the client's strengths and effectively support him or her to reach his or her potential.

OUTCOME TERM / OBJECTIVE	SHORT TERM (1-2 Years)	PERFORMANCE MEASURE	MEDIUM TERM (2-5 Years)	PERFORMANCE MEASURE	LONG TERM (5-10 Years)	PERFORMANCE MEASURE
Clinic Development and Maintenance	Assessment team members able to start assessments in 2015 with ongoing training/mentoring	• 2015 start from clinic records	Increased number of Yukon physicians and psychologists able to conduct assessments	• # of physicians and psychologists trained and able to conduct assessments	Increased capacity in Yukon to conduct comprehensive assessments for adults suspected of FASD and other adults with cognitive disabilities	• # of physicians and psychologists trained and able to conduct assessments
	Core Yukon assessment team members have acquired competencies required to conduct assessments and diagnose FASD	• Core team completes basic training on diagnostic processes, FASD assessment Battery	Decreased reliance on outside expertise to provide training/mentoring	• # of hours/total expense for OOT consulting		
Communication and Relationships with Community	Good level of engagement at Advisory and Interdepartmental (ID) committee meetings – members feel heard and valued	• Representation from each Department and Agency invited – from clinic records • Quorum representation at meetings – from clinic records	Increased awareness of the FASD assessment process, services and supports amongst community members	• # of referral sources and subjective evaluation of whether it is representative of various service areas	Stronger collaborative working relations between health and social services partners throughout Yukon	• For future formal evaluation

ADULT ASSESSMENT CLINIC – FASD DIAGNOSTIC CLINIC

OUTCOME TERM / OBJECTIVE	SHORT TERM (1-2 Years)	PERFORMANCE MEASURE	MEDIUM TERM (2-5 Years)	PERFORMANCE MEASURE	LONG TERM (5-10 Years)	PERFORMANCE MEASURE
		• Annual Review of TOR and qualitative review of comments – from clinic records				
	Community partners[1] are satisfied with service provided by assessment clinic	• Record informal feedback about clinic	Increased coordination of services to assess and support adults with FASD	• Qualitative review of TOR – what is working and what could be improved?		
	Interdepartmental Committee develops into an Interagency (IA) Committee within one year of inception	• Accomplished?				
	ID/IA Committee has common understanding of goals of collaborative work on FASD initiatives	• Framework or plan of action created				
Clinic Process and Assessment Results	Clinic practices are understood and followed by referring agencies and clinic team members	• Record number of follow-ups by Coordinator when policy not followed • Team debrief after each assessment	Increased standardization of clinic practices, policies and procedures in alignment with evolving Canadian guidelines	• # of revisions to Policy and Procedures; clinic operations	Information from clinic operations informs program development within Yukon and may contribute to FASD research	• # of new programs • Program expenditures on FASD programs or initiatives
	Accurate assessment results	• Clinicians provided with appropriate training and supervised until expert in field considers them	Increased understanding of distribution and nature of FASD and functional needs as a result of data collected in the clinical database	• Identify trends resulting from assessments and report these to management	Assessments are high quality	• Provision of relevant ongoing training

[1] "Community partners" in this context refers to health care and social workers in various organizations including government, First Nations, NGOs and private providers.

OUTCOME TERM / OBJECTIVE	SHORT TERM (1-2 Years)	PERFORMANCE MEASURE	MEDIUM TERM (2-5 Years)	PERFORMANCE MEASURE	LONG TERM (5-10 Years)	PERFORMANCE MEASURE
		competent to work independently				
	Practical/useful recommendations	• Client and Support Person Evaluation questionnaires • Anecdotal evidence recorded	Clinic processes result in timely, efficient assessments	• Statistics on waitlists, length of assessment process, length of time from request to receipt of records • Team debrief to identify barriers	Assessments reflect best practices	• Commission sample file review by expert in field
	Assessment team is satisfied with its assessment recommendations	• Team debrief post assessment	A well-functioning assessment team that is collaborative, supportive, respectful and compassionate.	• Team debriefs post Assessment		
			Stable team membership	• # of changes in clinical staff per reporting period		
Client Experience	Clients are supported throughout the assessment process by a support person	• Number of clients able to provide own support person	Clients have improved self-esteem, self-confidence, sense of hope	• For future formal evaluation	Clients have improved health and well-being and increased participation in community life/work.	• For future formal evaluation
	Clients are satisfied with the assessment process and how they were treated by the assessment team	• Client Evaluations • Anecdotal evidence recorded	Increased client use of appropriate supports	• For future formal evaluation For future formal evaluation	Clients have reduced adverse life outcomes, trauma, abuse and involvement in crime	• For future formal evaluation
	Clients are able, to the best of their ability, to understand: o their strengths, and challenges	• Client evaluations • Client Follow-up meetings • Anecdotal evidence				

OUTCOME TERM / OBJECTIVE	SHORT TERM (1-2 Years)	PERFORMANCE MEASURE	MEDIUM TERM (2-5 Years)	PERFORMANCE MEASURE	LONG TERM (5-10 Years)	PERFORMANCE MEASURE
	○ recommendations ○ how supports could help them ○ who can help them in implementing their follow-up plan					
	Clients are connected with the appropriate supports and services	• Client and Support Person Evaluations				
Support Person Experience	Support people are satisfied with the assessment process and how they and the client were treated	• Support Person Evaluations • Anecdotal Evidence	Assessment findings are integrated into strategies used by support people and agencies to support individual clients	• For future formal evaluation	Support services are effective and based on a shared understanding of an individual's strengths/needs and effective strategies to promote the client's well-being	• For future formal evaluation
	Support people/workers understand how to integrate the client's assessment results and follow-up plan into strategies and supports for the client	• Support Person Evaluations • Record of follow-up contacts with Coordinator • # of items implemented from Recommendations for Follow-up document	Increased awareness among Yukon service providers of effective strategies for building on strengths and supporting adults with FASD	• For future formal evaluation		

Fetal Alcohol Spectrum Disorder in the Yukon Corrections Population: Measuring the Prevalence of FASD, Mental Health, and Substance Use Problems

Project Background

Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term that describes permanent brain damage associated with prenatal exposure to alcohol. Individuals with FASD are thought to be overrepresented in the Canadian justice system. Identifying individuals with FASD in corrections is important for a number of reasons. Persons with FASD often experience brain-based difficulties like decision-making and problem solving, mental health problems, or problems with drugs and alcohol abuse. The Department of Justice is trying to learn more about how many offenders have these types of problems, to better inform how to meet their needs in the future.

The need to better understand how many people are affected by FASD in Yukon's correctional population was first raised at the *Access to Justice for Individuals with FASD Conference* in 2008, hosted by Yukon Department of Justice and Justice Canada. One of the conference recommendations was the need for research to determine the prevalence of FASD in the adult Yukon correctional population.

This study will be one of few Canadian projects examining the prevalence of FASD in the adult correctional system. Several specific research questions will be investigated:

1. What is the prevalence of FASD and alcohol-related neurocognitive impairment among adult offenders in the Yukon justice system?
2. What are the rates of mental health and substance abuse problems among offenders in the Yukon justice system?
3. What is the reliability and validity of FASD screening tools in the context of the Yukon justice system?

Information gathered over the course of this study will be used to help inform service delivery for this population. Overall, there is a strong need to improve the understanding of, and responses to, FASD within Yukon among individuals and organizations.

Who is Responsible for this Research?

Dr. Kaitlyn McLachlan is conducting this study through the University of British Columbia (UBC), under the supervision of Dr. Tim Oberlander and in collaboration with Yukon Department of Justice. A Prevalence Partnership Board has overseen all aspects of study development, including Yukon government Departments of Justice and Health and Social Services; Yukon

College Northern Institute of Social Justice and Yukon Research Centre; Fetal Alcohol Syndrome Society of Yukon; Yukon First Nations Health and Social Development Commission; Department of Justice Canada; Correctional Service Canada and Canadian Centre on Substance Abuse. A Prevalence Study Manager is coordinating the project in Whitehorse. This person will organize the day-to-day tasks of the project and liaise with the principal investigator.

How is this Project Funded?

The Government of Yukon has committed the resources, including funding, staffing, and internal support required for the successful completion of the study. The University of British Columbia is also contributing in kind resources necessary to secure the data collected from this research in an ethical manner.

What Does this Study Involve?

This project seeks to recruit approximately 150 adult offenders, including both men and women ages 18 through 50under the supervision of Yukon Corrections during the research timeframe. An estimate of the total prevalence of FASD in corrections will be made based on this sample.

To participate, individuals must:

- Live in Yukon Territory;
- Be willing to undergo all aspects of the assessment, including diagnostic interviews and testing, as well as sharing contact information and records to investigate the presence of prenatal exposure to alcohol; and
- Be serving a probation order or be supervised by a probation officer, serving a community or custodial territorial sentence (two years less one day), or remanded to the Whitehorse Correctional Centre for at least 30 days.

Recruitment will take place in both Whitehorse and at the Whitehorse Correctional Centre. Throughout recruitment, every effort will be made to protect the identity of those who are participating. Participation is completely voluntary and will in no way impact supervision by Yukon justice.

Each participant will be required to attend four study visits, requiring approximately a 10 to 12 hour time commitment:

- *Visit #1: Meet with the Research and Administrative Assistant*
- *Visit #2: Meet with Physician*
- *Visit #3: Meet with Psychologist*
- *Visit #4: Feedback Meeting with Assessment Team*

During Study visits participants will complete an informed consent process, a medical history interview, have three pictures of their faces taken, be asked to give consent to access

information from records and collateral informants, including birth mothers, complete psychological tests and screening tools, and undergo a brief medical exam.

Participants are free to discontinue their involvement in the study at any time without penalty.

Diagnostic Procedures

Diagnostic procedures used in this study will follow leading National and International guidelines including the Canadian Guidelines for Diagnosing FASD (Chudley et al., 2005). The clinical team will be made up of a physician, psychologist, and a research and administrative assistant. The Washington FAS DPN Four-Digit Diagnostic Code (Astley, 2004) will also be used. A feedback session with the clinical team will be coordinated for each participant so that he or she may hear assessment findings from the research team and ask any questions. A report summarizing each participant's functioning, any diagnoses, and specific strengths and weaknesses will be developed and shared with following each assessment. Participants can then share this information with whomever they decide (e.g. family members, case managers, probation officers), but may also choose to keep this information confidential. All participants will be provided with appropriate contact information for local resources that may be appropriate for their needs. Participants will also be given the option to meet with a post-study coordinator who will help them connect with appropriate community supports and take the time to help them understand their study results and/or any diagnosis stemming from the assessment (e.g., FASD).

Canadian Ethical Guidelines

Ethical approval for this study was given on February 18, 2014 by University of British Columbia / Children's and Women's Health Centre of British Columbia Research Ethics Board (UBC C&W REB). Approval and monitoring from this Research Ethics Board will ensure that Canadian ethical standards for research will be followed throughout the study.

Cultural Considerations

It is important to consider the impact that this study could have on Yukon First Nations people and communities. Research has long established the overrepresentation of Aboriginal Peoples in correctional settings across Canada (Royal Commission on Aboriginal Peoples, 1993, 1996; Tait, 2000, 2003; Waldram, Herring, & Kue Young, 1995).

Research involving Métis, First Nation, and Inuit Peoples in Canada is governed by Chapter Nine of the Tri-Council Policy Statement (TCPS) for Ethical Conduct for Research Involving Humans (2010). These Guidelines provide a framework for the ethical conduct of research involving Métis, First Nation, and Inuit persons. In particular, emphasis is placed on the development of respectful relationships, collaboration, and engagement between researchers, participants, and communities. The present research methodology has been developed following the recommendations and spirit of the TCPS. Our prevalence partnership included the

Yukon First Nations Health and Social Development Commission (YFNHSDC). This community engagement, from the inception of this research and methodological development has helped to ensure that all aspects of the research methodology are culturally informed, and sensitive to the needs and values of participants, their families, and communities. Importantly, the YFNHSDC wanted to ensure that study participants and their families are protected and receive appropriate support during and after involvement in this research. The First Nations Principles of OCAP (ownership, control, access, and possession) must also be taken into consideration when planning research that impact First Nation individuals and communities. Together with YFNHSDC the following methodology was crafted to ensure as many principles as appropriate and relevant were respected in planning this research.

Findings from the study will be reviewed with the YFNHSDC. We will follow their internal process for ensuring that study results will be communicated in a way that is respectful, rooted in history and context, and useful for current and future generations of knowledge users from impacted families and communities.

Conclusion

This research project does **not** target individuals who are suspected of having FASD. Similarly, this research does **not** target First Nations persons in the justice system. Instead, this study invites anyone in the correctional population to participate. Persons from all walks of life, who may or may not be experiencing difficulties, will be included. This is necessary to provide an accurate assessment of the prevalence of FASD in the corrections population.

Ultimately, the Department of Justice is trying to learn more about the extent of the issue of FASD in the justice system to better inform how to meet these people's needs in the future. The results of the study will help inform and improve service delivery, case coordination, and outcomes for these clients.

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Adult Assessment Clinic Advisory Committee
Terms of Reference

Purpose

The purpose of the **Adult Assessment Clinic Advisory Committee** (the Committee) is to provide expertise and guidance to the Manager, Services to Persons with Disabilities (HSS), on the development, implementation, and evaluation of the adult diagnostic clinic. This clinic will initially assess adults suspected of being affected by Fetal Alcohol Spectrum Disorder.

The Committee is advisory in nature and will not have any formal decision-making authority.

The role of the Committee includes, but is not limited to:

- Providing professional and clinical expertise and guidance during clinic start-up;
- Providing advice regarding training for diagnostic clinic team members;
- Providing advice regarding evaluation of the diagnostic clinic; and
- Providing advice regarding the ongoing operation of the clinic and operational challenges that may arise.

Membership

Membership of the Committee will be drawn from health professionals and non-government organizations that have expertise related to conducting medical or functional assessments, or providing direct services and supports to adults with disabilities. Representatives from each of the following organizations will be invited to name a representative to the Committee:

Child Development Centre
Fetal Alcohol Spectrum Society of Yukon
Disability Programs Advisory Committee
Neuropsychologist (HSS)
Council of Yukon First Nations
Department of Education
Department of Justice

Consistent representation and attendance at Committee meetings is encouraged. If, however, a representative is occasionally not able to attend a meeting, they may send an alternate.

The Committee will be chaired by the Manager of Services to Persons with Disabilities (HSS) who reports to the Director of Adult Services Branch (HSS). Secretariat functions will be provided by the Adult Assessment Coordinator (HSS). Other individuals from government or agencies may be invited to attend particular meetings as needed.

In order to avoid a conflict of interest, members of the Committee cannot in any way be remunerated to provide direct service to the Adult Assessment Clinic.

Meetings
The Committee will meet monthly until the clinic is established, and thereafter quarterly or as needed. The Committee will evaluate the frequency of meetings after one full year of clinic operations.

Meetings will be scheduled and coordinated by the Adult Assessment Coordinator.

Documentation and Communication
The Adult Assessment Coordinator will be responsible for recording and distributing all meeting minutes. Minutes will include documentation of advice provided by the Committee. The Adult Assessment Coordinator will provide an update on the status of the clinic during each meeting, and raise any issues requiring advice from the Committee for discussion.

Any personal client information that members may obtain through their participation in the Committee must be treated as confidential and shall not be shared with anyone outside of the Committee.

All public information provided to the media about the Committee and the diagnostic clinic will be handled by Department of Health and Social Services, as represented by either the Director, Adult Services Branch or Director, Communications (HSS).

Review
The Terms of Reference for this committee will be reviewed by the members after one year of operation. The Director of Adult Services Branch may amend the Terms of Reference as a result of this review or from time to time.

PROTOCOL AGREEMENT

BETWEEN

YUKON GOVERNMENT DEPARTMENTS OF

Justice (Corrections Branch)

AND

Health and Social Services (Adult Services Branch)

REGARDING

Collaboration on Adults with Complex Needs

1.0 PURPOSE

This protocol agreement sets out the process for collaborative planning and coordinated transition of clients with complex needs from the corrections system to voluntary community-based social services.

Adults with complex needs may have a variety of functional impairments that affect their ability to succeed in life. Understanding the functional strengths and deficits of each individual can help the adult, their support people and service providers design strategies and interventions that are tailored to their needs. A collaborative approach to planning places the adult at the center and harnesses the knowledge and creativity of people who know the adult. It results in consistency and stability for the client as they transition from the corrections system to the community.

Research indicates that individuals with complex needs who are well supported have improved health and well-being, increased participation in community life and work, and reduced trauma, abuse and involvement in crime.

2.0 SCOPE

This agreement applies to Department of Justice (Justice)

- Whitehorse Correctional Centre(WCC), Corrections Branch
- Offender Supervision and Services (OSS), Corrections Branch

and

Department of Health and Social Services (HSS)

- Services to Persons with Disabilities Unit (SPD), Adult Services Branch

The process set out in this agreement applies to offenders identified as having Complex Needs through the *Complex Needs Case Management Standing Order* and to other offenders identified as having complex needs who reside in Whitehorse.

This agreement does not apply to adults referred to the Yukon Review Board.

DEFINITIONS

Case Management: is a process that involves working with the client to develop and implement a plan based on the individual's risks, goals, strengths and needs.

Case Manager: the individual assigned to take the lead on development, implementation and periodic review of the Case Management plan.

Complex Needs: arise due to the severity or nature of the adult's impairments, resulting in significant functional limitations and the need for multiple services or supports. Complex needs may present in a variety of domains including:

- Behaviour
- Physical/motor
- Mental health
- Cognition and learning
- Memory, attention and executive functioning
- Social skills and communication
- Self-help and adaptive functioning skills

Complex needs often arise from cognitive impairments and mental health problems.

Community support services: are services provided by HSS, another government (e.g. First Nations), a community agency or an informal support network that are available to the client.

Services to Persons with Disabilities (SPD): is a program within the Adult Services Branch of Health and Social Services. Services provided to eligible clients may include case management, employment supports, day programs, residential services, Supported Independent Living and respite.

3.0 ROLES

The primary case manager for adults charged with offences or under periods of correctional supervision will be the WCC case manager and/or the OSS probation officer (Correctional Services case manager).

The Correctional Services case manager will ensure that consent is obtained from the client prior to making referrals or sharing any information about the client with HSS.

HSS will ensure that consent is obtained from the client for any release of information back to Justice or other agencies

HSS and Justice will ensure that clients are aware of the legal, ethical and professional obligations to share information as it pertains to any breaches of court orders, child protection or threats of harm or self-harm.

4.0 GENERAL COLLABORATION

In order to support a consistent approach with clients and develop capacity amongst staff, HSS and Justice will share relevant assessment tools (e.g. risk assessment), intervention strategies, and program resources. Staff may exchange information and arrange for joint meetings or in-service training sessions in order to share knowledge and skills.

5.0 PROCESS FOR COLLABORATIVE CASE MANAGEMENT

5.1 When a Complex Needs offender has been identified by WCC or OSS, and it is expected that the individual will require support services in Whitehorse (upon release from WCC or while on probation), the Correctional Services case manager will obtain consent from the client to contact the Manager of SPD to share information and discuss appropriate referrals and involvement in case planning.

5.2 Where the client with complex needs appears to meet eligibility criteria for SDP services, a case worker from SPD will be assigned to work collaboratively with the Correctional Services case manager on planning for community-based support services. Decisions regarding services that may be offered to the client by SPD will be made within program parameters and resources.

5.3 Where the client with complex needs does not appear to meet eligibility criteria for SPD services, the SPD Manager will provide information on appropriate community-based services that may be available from other governments or community agencies.

5.4 As part of the case management process, HSS and Justice will share relevant information (with consent), including assessment results that may shed light on the adult's strengths and inform strategies and interventions.

5.5 Once the client is no longer under correctional supervision, the primary case manager responsibility will transfer to the appropriate HSS case manager (where the client meets eligibility requirements). Justice and HSS case managers will ensure that the transition from one case manager to another is planned and coordinated.

6.0 DISPUTES

Operational discrepancies or professional conflicts that arise in the course of collaborating on clients with complex needs will be resolved at the lowest level possible. If issues cannot be resolved at the case manager level, they will be taken to managers, and thereafter to the Director or ADM level for discussion and resolution.

This protocol may be reviewed and revised upon request of either party.

T. Râtel

Tricia Râtel, Director
Community & Correctional Services
Department of Justice

April 22, 2015
Date

Michele McDonnell, Director
Adult Services
Health and Social Services

April 28, 2015
Date

Terms of Reference
Yukon Government Interdepartmental Committee on FASD

Mandate

The purpose of the Interdepartmental Committee on FASD is to facilitate ongoing interdepartmental coordination and collaboration on FASD in Yukon Government within the following areas:

1. Awareness and Prevention
2. Assessment and Diagnosis
3. Supports to Individuals with FASD
4. Education and Training
5. Research and Evaluation

The committee will carry out their responsibilities by:

- Sharing expertise, resource materials, best practices and information on FASD
- Reviewing and revising the draft Strategic Framework on FASD so that it becomes a living document that guides action on FASD within YG
- Identifying YG activities and opportunities within the 5 areas above
- Collaborating on prevention initiatives to ensure common messaging
- Identifying opportunities to work collaboratively across departments
- Sharing information on potential research projects and assessing Yukon capacity and interest in participating
- Coordinating the development of Yukon Government positions on national initiatives related to FASD
- Developing and implementing an interagency committee to facilitate coordination and collaboration on FASD that includes Yukon stakeholders from other governments and non-governmental organizations

Membership

Membership on the committee will include at least one consistent representative from each of the Departments of:

- Education
- Justice

- Health and Social Services
- Women's Directorate
- Yukon Liquor Corporation
- Yukon Housing Corporation

Departments will name one or more representatives to the committee. The number of individuals named to participate in the committee should reflect the breadth of the department's mandate for FASD in relation to the five areas covering the mandate of the Committee.

Departments should name representatives who have knowledge of FASD, knowledge of the department's activities and services regarding FASD and have an ability to facilitate decisions within their respective department. Consistent representation and attendance at Committee meetings is encouraged.

Members are responsible for actively participating in the meetings of the Committee, for representing the interests of their respective departments and for sharing information from the Committee and seeking out relevant information from within their departments.

In addition to members of the Committee, other individuals from member Departments or from other Departments may be invited to attend one or more meetings to discuss relevant topics as needed.

Chair, Reporting Structure, Secretariat

The Committee will choose a Chair from the membership of the committee. This designation will be reviewed on an annual basis.

The Chair will call and chair meetings. The Chair is responsible for ensuring that a joint-report summarizing activities of the Committee is prepared on an annual basis. Members are responsible for reporting to managers within their own department. Issues requiring interdepartmental direction may be taken to managers, ADMs or DMs from the affected departments as needed.

Secretariat functions will be provided by Health and Social Services, Adult Assessment Coordinator (Adult Services Branch). In coordination with the Chair, the Coordinator will arrange meetings, prepare an agenda and provide a summary of action items from each meeting. The Coordinator will also assist the Chair and the Committee with the preparation of an annual report.

Working groups may be established as necessary to address specific issues/topics. These groups report back to the Committee.

Timelines

The Interdepartmental Committee on FASD will be established as a standing committee. The Committee will establish regular meetings (e.g. once every two months). Frequency of meetings will be determined by the Chair and Committee members depending on the work to be carried out.

Decision-Making

The Committee is advisory in nature and does not have any formal decision-making authority. Representatives may, however, provide advice and recommendations to their respective departments.

The Committee will attempt to reach consensus on any recommendations made by the Committee. In the event that consensus cannot be reached, the Chair may facilitate further interdepartmental discussion and decision-making with managers in order to resolve the issue.

The Committee, through the members, will seek appropriate direction from managers, senior managers, Deputy Ministers, Ministers, Cabinet and Management Board when required.

Yukon FASD Strategic Framework

INTRODUCTION

In Canada, prenatal exposure to alcohol is a leading cause of preventable brain damage and birth defects, and one of the top three reasons for developmental delays in children. Public Health Agency of Canada estimates that 9 out of every 1000 babies are born with Fetal Alcohol Spectrum Disorder (FASD). While studies have not calculated all the costs of FASD, some studies have estimated that the direct costs associated with individuals with FASD over a lifetime are about $1.8M per person. The social and economic costs of FASD are high. It is clear that preventing FASD and providing effective services to those affected by FASD is a compassionate and cost-effective response.

Yukon has a long history of action on FASD resulting in many activities, services and initiatives related to this disability. These initiatives are delivered by a variety of agencies and organizations including Yukon government, First Nation governments, non-profit groups, and Yukon College. Services and supports range from public awareness campaigns on the risks of drinking while pregnant, to assessment and diagnosis for children and adults, to supportive housing and other services for children and adults with disabilities.

Yukon is also recognized as a leader on FASD within Canada. In 2008 the Yukon Department of Justice hosted a national conference on Access to Justice for Individuals with Fetal Alcohol Spectrum Disorder. Yukon Justice has continued to play a lead role in federal/provincial/ territorial discussions on FASD in the justice sector. Yukon Health and Social Services has been a member of the Canada Northwest FASD Partnership since 1999 and has hosted regional conferences and collaborated with other jurisdictions on various initiatives related to FASD.

FRAMEWORK FOR COLLABORATION

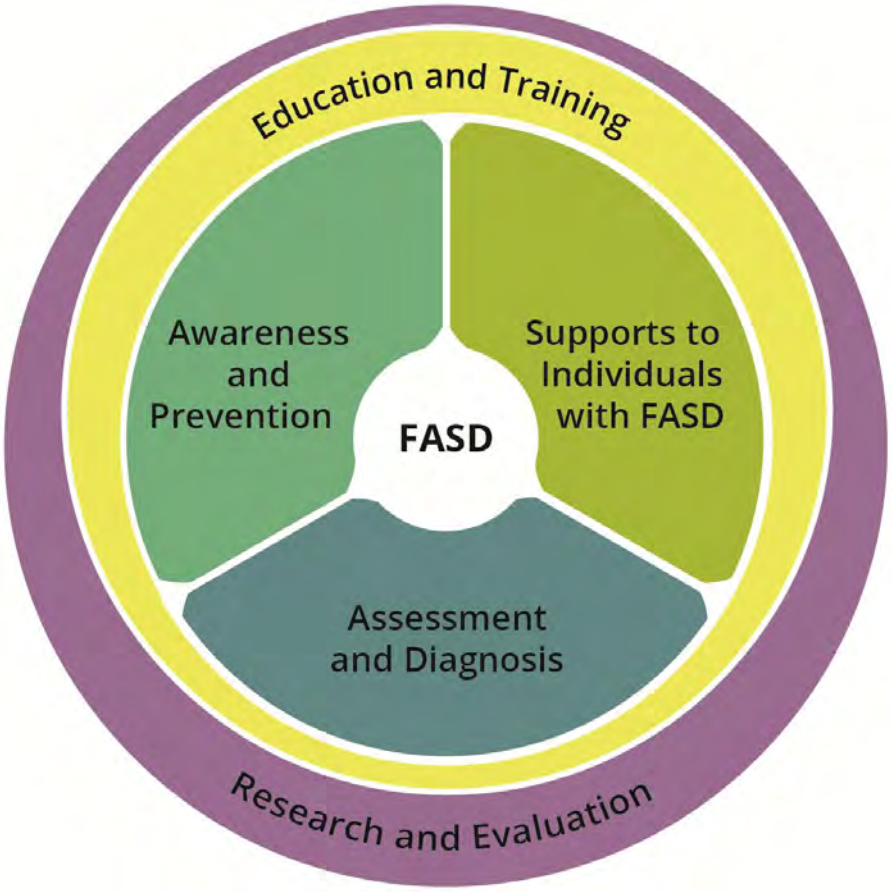
Yukon's activities on FASD can be grouped into five broad categories:

1. Awareness and Prevention
2. Assessment and Diagnosis
3. Supports to Individuals with FASD
4. Education and Training
5. Research and Evaluation

This draft Framework provides a structure for identifying goals and priorities for action. It provides a framework for planning and coordinating activities on FASD.

The draft Framework will serve as the basis for coordinating Yukon Government action on FASD. The Framework will be reviewed, validated and updated as necessary by the Yukon Government Interdepartmental Committee on FASD.

Yukon FASD Strategic Framework (DRAFT)



Vision:

Children are born healthy and free from the effects of prenatal alcohol exposure and people living with FASD are supported to reach their full potential in healthy and safe communities.

Goals:

- Increase community awareness of FASD and prevent prenatal exposure to alcohol.
- Improve local capacity to provide functional strengths-based assessments and diagnoses to individuals with FASD.
- Support people with FASD to achieve their full potential.
- Expand common approaches, competencies and use of best practices amongst service providers.
- Contribute to research on FASD prevalence, prevention and best practices.

Yukon Action on FASD:

Awareness and Prevention

- Public awareness campaigns, social marketing
- Targeted education, school curriculum
- Alcohol and drug detox, treatment, healing camps
- Sexual health counselling, access to contraception
- Maternal health services, pre-natal programs
- Family support programs, parenting programs

Assessment and Diagnosis

- Assessment and diagnosis of pre-school and school-aged children
- Assessment and diagnosis of adults
- Strategies and support plans based on functional assessment
- Screening of children and adults suspected of having a FASD

Supports to Individuals with FASD

- Interventions/therapies for pre-school children
- Child care services for children with special needs
- Special educational programming K-12
- Supports and interventions for children with disabilities and their families
- Income supports for adults with disabilities
- Supported housing
- Employment supports
- Supports for daily living
- Corrections programming for youth and adults
- Wellness Court, youth diversion

Education and Training

- Core competency courses
- Ad hoc staff training
- Conferences, webinars
- Ongoing training on assessment, diagnosis
- Exchange of information
- Periodic training on screening for high risk
- Curriculum development

Research and Evaluation

- Canada Northwest FASD Partnership and Research Network
- Justice Prevalence Study
- Other research opportunities

Overall Strategies for Action:

- Integrate prevention into all services – see every interaction as an opportunity for prevention.
- Use available evidence on what works to inform priority-setting, planning and activities on FASD.
- Develop common understandings among Yukon service providers on FASD, evidence-based prevention strategies and effective ways to support people with FASD.
- Coordinate and collaborate with others to maximize the impact of efforts.
- Promote a holistic and compassionate approach to work on FASD that recognizes the importance of social, family, community, cultural, legal and economic factors.
- Encourage leadership on FASD amongst all people at all levels.
- Develop mechanisms for measuring progress and continuous learning.

Yukon Legislative Assembly

Number 150	1st Session	33rd Legislature

HANSARD

Wednesday, April 30, 2014 — 1:00 p.m.

Speaker: The Honourable David Laxton

YUKON LEGISLATIVE ASSEMBLY

SPEAKER — Hon. David Laxton, MLA, Porter Creek Centre
DEPUTY SPEAKER — Patti McLeod, MLA, Watson Lake

CABINET MINISTERS

NAME	CONSTITUENCY	PORTFOLIO
Hon. Darrell Pasloski	**Mountainview**	**Premier** Minister responsible for Finance; Executive Council Office
Hon. Elaine Taylor	Whitehorse West	Deputy Premier Minister responsible for Education; Women's Directorate; French Language Services Directorate
Hon. Brad Cathers	Lake Laberge	Minister responsible for Community Services; Yukon Housing Corporation; Yukon Liquor Corporation; Yukon Lottery Commission Government House Leader
Hon. Doug Graham	Porter Creek North	Minister responsible for Health and Social Services; Yukon Workers' Compensation Health and Safety Board
Hon. Scott Kent	Riverdale North	Minister responsible for Energy, Mines and Resources; Yukon Energy Corporation; Yukon Development Corporation
Hon. Currie Dixon	Copperbelt North	Minister responsible for Economic Development; Environment; Public Service Commission
Hon. Wade Istchenko	Kluane	Minister responsible for Highways and Public Works
Hon. Mike Nixon	Porter Creek South	Minister responsible for Justice; Tourism and Culture

GOVERNMENT PRIVATE MEMBERS

Yukon Party

Darius Elias	Vuntut Gwitchin
Stacey Hassard	Pelly-Nisutlin
Hon. David Laxton	Porter Creek Centre
Patti McLeod	Watson Lake

OPPOSITION MEMBERS

New Democratic Party

Elizabeth Hanson	Leader of the Official Opposition Whitehorse Centre
Jan Stick	Official Opposition House Leader Riverdale South
Kevin Barr	Mount Lorne-Southern Lakes
Lois Moorcroft	Copperbelt South
Jim Tredger	Mayo-Tatchun
Kate White	Takhini-Kopper King

Liberal Party

Sandy Silver	Leader of the Third Party Klondike

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Published under the authority of the Speaker of the Yukon Legislative Assembly

Yukon Legislative Assembly
Whitehorse, Yukon
Wednesday, April 30, 2014 — 1:00 p.m.

Speaker: I will now call the House to order. We will proceed at this time with prayers.

Prayers

DAILY ROUTINE

Speaker: We will proceed with the Order Paper.

Tributes.

TRIBUTES

In recognition of National Immunization Awareness Week

Hon. Mr. Graham: On behalf of all members of the Legislature, it's my pleasure today to tribute National Immunization Awareness Week, which was from April 26 and will continue through to May 3.

Mr. Speaker, 100 years ago, infectious diseases were the leading cause of death worldwide. Today in Canada, they cause fewer than five percent of all deaths. The drastic decrease in deaths is thanks mostly to immunization. Immunization protects individuals and communities by preventing the spread of disease. As more people are immunized, the disease risk for everyone is reduced. Immunization has probably saved more lives in Canada in the last 50 years than any other health intervention.

Immunization Week this year is from April 26 to May 3, as I mentioned, and "Vaccination: Your Best Shot" is the theme. A week is set aside every year to raise awareness about the importance of immunizing ourselves and our children and making sure our immunizations are up to date. The reason we have to promote awareness of this important topic is that too many Canadians do not immunize their children or immunize themselves fully.

Earlier this month, the Public Health Agency of Canada issued a warning that there has been a higher than usual number of measles cases in Canada since the beginning of the year. Since measles is a preventable disease, it is a little disheartening to see these outbreaks.

We can understand why polio makes a resurgence in war-torn countries like Syria, where public health is stressed for obvious reasons, but measles should be as rare in Canada as the bubonic plague. Instead, there have been recent outbreaks in British Columbia, Alberta, Saskatchewan, Manitoba and Ontario.

As the Yukon is a land of travellers, we have been extremely fortunate to escape measles so far. The Public Health Agency of Canada states clearly that measles can cause a rash, high fever, cough, runny nose and watery eyes that could last one to two weeks, but those are just the mild symptoms. Measles can also cause pneumonia, convulsions, deafness, brain damage and even death. These complications are rare, admittedly, but with enough cases of measles we will see them again. Why take that chance when vaccines are available to prevent our children from catching it or, at the very least, to ease the symptoms if they do contact measles?

I am old enough, Mr. Speaker, to remember when childhood illnesses like measles and mumps swept through our neighbourhoods here in the territory. I also remember the devastation of polio. A young fellow who I grew up with was afflicted with polio at a very young age here in the territory.

We have people in our communities today who are still dealing with the effects of polio, and that is not something that we would wish on anybody and especially not on a child.

These are only two of the diseases that are still around and that can be prevented by immunization.

I understand parental fears — I really do — but I urge parents to base their decisions on sound scientific evidence rather than on emotionally charged and often baseless arguments. Working with the Yukon chief medical officer of health and Health and Social Services vaccine program manager, the department has set up a website that provides scientifically accurate information on immunization, including links where Yukoners can obtain more information if they so desire. I encourage anyone with questions to visit www.yukonimmunization.ca and learn for themselves.

In recognition of Yukon College's mobile trades training trailer

Mr. Silver: I rise on behalf of the Liberal Party and the Official Opposition to pay tribute to the students participating in the first round of mobile trades trailer pre-apprenticeship certification in Dawson City.

According to the Yukon College's website the Centre for Northern Innovation in Mining's trades training trailer allows Yukon College to deliver trades courses in smaller communities across the territory as well as in operating mine sites. The state-of-the-art facility is just this week completing the examination process for its first round of participants for classes in welding up in Dawson City. I had the pleasure of being asked to say a few words at the ceremony at the Tr'ondëk Hwëch'in community hall for students last Friday and I wouldn't have missed that opportunity for the world.

Not only does the college do an amazing job of promoting this programming to the population at large, but there were students of my age from Dawson who participated and used this facility and received their pre-apprenticeship certification. Not only did the college more forward on dual credit courses, partnering with Robert Service School, but they also provided programming options for some of our more marginalized students. For that, I cannot thank them enough.

In my speech last Friday at the ceremony, I asked these students to reflect on why it was this particular program that worked. Everyone who started, finished this program. Was it because of the instructor, Ed Bergeron, and his ability to inspire? Was it the state-of-the-art facility itself? Was it the overwhelming support from the Tr'ondëk Hwëch'in education department or the amazing efforts of Chief Taylor to ensure that Dawson was the first to host this mobile trades trailer? Whether it was any or none of these things, I encouraged the students to believe that the success is theirs to own — it

comes from inside — and to use this confidence to continue down that road toward successfully developing their skills and also toward defining themselves as extremely valuable contributors to our community by filling important jobs in our territory and economy.

I spoke with Chief Taylor this morning and he wanted me to mention that this is the first time that a welding course was ever offered in the Klondike Valley and he looks forward to more opportunities with the College for us to continue to run our own economy in the Klondike Valley. He wanted me to mention that it is the leadership of Yukon College President Karen Barnes that helps to build these partnerships in the communities — that shows a lot of leadership. During the ceremony, a lot of the Yukon College folks were mentioning how happy they were with Chief Taylor's advocacy, so it is good to see that he is also giving that back to the college as well — a true partnership.

I would like to congratulate the inaugural class of the pre-apprenticeship graduates. Jayme Favron — who is a local celebrity and is appearing on history channels *Yukon Gold* with Karl Knutson's crew — also, Jake Duncan, Marvin Frost Junior, Jay Gagnon, Aaron Mendelsohn, Waylin Nagano, Jesus Panaligan, Andrew Taylor, and, jack of all trades, Spencer Wallace.

In recognition of Vision Health Month

Hon. Mr. Graham: On behalf of all Members of the Legislature, I would like to rise in tribute to Vision Health Month. Tomorrow — May 1 — marks the beginning of Vision Health Month, and I would like to invite my colleagues in this House to join me in recognizing the importance of eye health and the importance of getting the message out about sight loss.

It originally began as a collaborative public awareness campaign between the Canadian National Institute for the Blind and the Canadian Association of Optometrists. For the first time, the month is being recognized at the federal level, with the Canadian Senate declaring May as national Vision Health Month.

In Yukon, there are approximately 950 people living with blindness or partial sight and as a one-eyed referee I can sympathize with every single one of those people. These Yukoners face other risks, though — serious health risks associated with vision loss. They are three times more likely to suffer from clinical depression, twice as likely to fall and four times as likely to suffer a hip fracture. Seniors living with vision loss tend to be admitted into nursing homes three years earlier than their sighted peers. Vision loss can happen to anyone at any age. In fact, one in seven Canadians will develop a serious eye disease in their lifetime.

Thankfully, 75 percent of vision loss is avoidable through prevention and treatment. Prevention measures and early detection of eye disease through a comprehensive eye exam significantly lower one's risk of vision loss. Many serious eye diseases have no symptoms and can only be detected through an eye exam. Even someone who has 20/20 vision may be at risk. After age 40, the number of cases of blindness or partial sight doubles. In fact, at age 75, it triples.

The Department of Health and Social Services continues to financially support the work of CNIB here in the territory, and also through the support we provide to other non-governmental organizations that provide a broader community service that includes those who are vision-impaired.

As a government, we promote good health. We tell people to make healthy school lunches for their children and themselves. We encourage them to be physically active and to see a health care professional regularly. We offer assistance to help them quit smoking. We also need to encourage them to take care of their vision, keep their eyes healthy and prevent loss of vision or blindness. This is a first step in preventing further deterioration of vision in the territory.

In recognition of the Northern Adult Basic Education Symposium

Hon. Ms. Taylor: I would like to rise in the Legislature today to pay tribute to a very important symposium that is currently underway at Yukon College. That is the very first inaugural Northern Adult Basic Education Symposium, which is currently running from April 28 to May 1.

This symposium is the first of its kind and it has gathered together some 200-plus educators, management experts and stakeholders from Yukon College, Aurora College and Nunavut Arctic College, as well as partner organizations, to discuss adult learning and literacy in the northern context.

Our government encourages students of all ages to continue to pursue new learning experiences and training throughout their lives to help them reach their full potential and in turn to help contribute to the ongoing success of our territory.

Supporting lifelong learning and success for each learner for all Yukon students — including adult learners — is our number one objective. Adult education programs enable Yukoners to continue to build upon their skillsets and to be able to more fully participate in and contribute to our workplaces and communities.

This symposium provides an invaluable forum for the front-line professionals and management in this field to network and share their knowledge, best practices, lessons learned and new initiatives. Over the course of the three days, participants will be attending round table discussions, focus groups, storytelling workshops, experiential learning sessions about improving the cultural competencies of programs, integrating technology and distributed learning options and building partnerships with industries and students.

The ideas and the discussion arising from this event will help those working in adult education to deliver better programming to northern, rural, First Nations, Métis and Inuit adult learners. Our adult students rely on these programs to be able to continue to pursue their education and access skill development and vocational training and in turn contribute to the overall success of our north.

I would like to recognize the fantastic work being done by all adult educators and the many educational organizations throughout the territory and throughout the north and to thank them for supporting adult literacy and learning through the many services to our communities.

I want to also thank Nunavut Arctic College, Aurora College, Yukon College, and the Northern Adult Basic Education organizers for putting this huge event — and a very important event at that — together. Of course, last but not least, to our own Yukon College for hosting this inaugural event. I would also like to thank the Government of Canada which announced back in February of 2012 an investment of over $27 million over five years for the Northern Adult Basic Education program to be delivered by the respective territorial colleges across the northern territories.

I would like to also extend our heartfelt thanks to all of the delegates and a safe, successful and productive stay here in the territory this week. I understand there is a great trip to Kluane National Park and Reserve this afternoon.

Mr. Speaker, I also have the liberty and privilege of being able to extend a warm welcome to two of my northern colleagues — counterparts who I have had the opportunity to work with over the last number of months in my capacity as Minister of Education, Public Schools, Advanced Education and on the immigration file as well — starting with Hon. Jackson Lafferty, who is Deputy Premier for Northwest Territories, Minister of Education, Culture and Employment and also minister responsible for the Worker's Safety and Compensation Commission.

Accompanying him is Andy Bevan, who is the assistant deputy minister for — I believe it's the Labour and Income Security branch of the department. Forgive me if I got that wrong.

I also want to extend a warm welcome to Hon. Paul Quassa, who I would say is the "new kid on the block" in terms of being the newly appointed Minister of Education for the Government of Nunavut and also minister responsible for the Nunavut Arctic College, and his executive assistant who has also joined him as well. I just want to thank my colleagues for their ongoing leadership and certainly we'll look forward to our meetings next week in Yellowknife. I'm looking forward to collaborating on a multitude of different files of interest and importance to all northerners. I extend a warm welcome on our behalf to our counterparts.

Applause

Speaker: Introduction of visitors.

INTRODUCTION OF VISITORS

Ms. Hanson: I was just going to have the MLA for Vuntut Gwitchin introduce Agnes Mills, an elder from Vuntut Gwitchin, and welcome her to the Legislative Assembly today.

We also have Mike McCann, Executive Director of the Fetal Alcohol Syndrome Society Yukon and Gwenda Bradley and Jolene Waugh from the Human Rights Commission.

Applause

Speaker: Are there any returns or documents for tabling?

TABLING RETURNS AND DOCUMENTS

Ms. Hanson: I have for tabling a consensus statement from the Institute of Health Economics, a consensus statement on legal issues of fetal alcohol spectrum disorder, dated September 2013. The electronic link will be provided for all members of the Legislative Assembly.

Hon. Mr. Istchenko: Today I have for tabling in this House the *Fleet Vehicle Agency 2014-2015 Business Plan*, Yukon Highways and Public Works.

Hon. Mr. Nixon: I have for tabling today the *Yukon Law Foundation Annual Report — November 1, 2012, to October 31, 2013*.

I also have for tabling today the *Workers' Advocate Office 2013 Annual Report*.

Speaker: Are there any other returns or documents for tabling?

Are there any reports of committees?

Are there any petitions to be presented?

Are there any bills to be introduced?

INTRODUCTION OF BILLS

Hon. Mr. Graham: Pursuant to Standing Order 14.3, notwithstanding the provisions of Standing Order 74, I request the unanimous consent of the House to move that Bill No. 74, entitled *Act to Amend the Vital Statistics Act*, be now introduced and read a first time.

Unanimous consent re introduction and first reading of Bill No. 74, *Act to Amend the Vital Statistics Act*

Speaker: The Minister of Health and Social Services has requested the unanimous consent of the House, pursuant to Standing Order 14.3, notwithstanding the provisions of Standing Order 74, to move that Bill No. 74, entitled *Act to Amend the Vital Statistics Act*, be now introduced and read a first time.

Is there unanimous consent?

All Hon. Members: Agreed.

Speaker: There is unanimous consent. The minister may now move the motion.

Bill No. 74: *Act to Amend the Vital Statistics Act* — Introduction and First Reading

Hon. Mr. Graham: I move that Bill No. 74, entitled *Act to Amend the Vital Statistics Act*, be now introduced and read a first time.

Speaker: It has been moved by the Minister of Health and Social Services that Bill No. 74, entitled *Act to Amend the Vital Statistics Act*, be now introduced and read a first time.

Motion for introduction and first reading of Bill No. 74 agreed to

Speaker: Are there any other bills to be introduced?

Are there any notices of motions?

NOTICES OF MOTIONS

Ms. McLeod: I rise to give notice of the following motion:

THAT this House urges the Government of Yukon, in recognition of the Yukon Party's platform commitments to promote Yukon's tourism economy, to continue to study the technical and economic business case of further capital upgrades, including paving the runway at the Dawson City Airport, as part of the Government of Yukon's work with Air North, Yukon's airline, and Holland America to promote tourism to Yukon and the Klondike region through the use of tourism cooperative marketing agreements and strategic marketing campaigns.

I also give notice of the following motion:

THAT this House urges the Government of Yukon to host a website that answers common questions and provides statistics, news and information about immunizations, including the Yukon immunization schedule for children.

Mr. Hassard: I rise to give notice of the following motion:

THAT this House urges the Government of Yukon to consult with stakeholders including, but not limited to, the agriculture industry, livestock owners and veterinarians in the development of regulations pursuant to the *Animal Health Act*.

I also give notice of the following motion:

THAT this House urges the Government of Yukon to make changes to the permitting process under the *Environment Act* by:

(1) eliminating the nominal fees associated with permits;

(2) increasing the maximum duration of permits; and

(3) formalizing the collection of review fees.

Mr. Elias: I rise to give notice of the following motion:

THAT this House urges the Government of Yukon to partner with the Canadian Centre for Child Protection to launch a campaign to promote safe and responsible use of communication technologies among youth.

I also give notice of the following motion:

THAT this House urges the Government of Yukon to implement the 2013 *Management Plan for Yukon Amphibians*, which includes:

(1) improving the knowledge of the distribution and abundance of amphibians;

(2) identifying and maintaining key amphibian habitats;

(3) assessing and mitigating threats to amphibian populations; and

(4) increasing public appreciation of amphibians and their habitats.

I also give notice of the following motion:

THAT this House urges the Government of Yukon to continue to explore opportunities to replace on-grid diesel electricity generation with lower carbon technology to fulfill that commitment of the *Climate Change Action Plan*.

Speaker: Is there a statement by a minister?

This then brings us to Question Period.

QUESTION PERIOD

Question re: Seasonal auxiliary employee layoffs

Ms. Hanson: Auxiliary-on-call employees provide a great service to the Yukon government. For example, they help departments meet short-term staffing needs and they provide opportunities for professional development. But not all auxiliary-on-call employees are being employed in this manner. Everyone knows an employee who works for the government and has been working as an auxiliary on call for years without the benefits and security of a more permanent status.

Will the minister tell this House how many Yukon government employees are employed on an auxiliary-on-call basis?

Hon. Mr. Dixon: As the minister responsible for the Public Service Commission, I am pleased to rise and respond to this particular question. Auxiliary-on-call employees are an important and valued segment of our Yukon government workforce. AOCs are called into work as and when required to replace other employees who are sick or on leave to provide coverage for peak periods or for special projects. They help us fulfill our public service obligations when departments determine there is an operational justification for regular employment hire.

People work as AOCs for a variety of reasons. Some choose it as a lifestyle choice because it affords employment flexibility and variety, while others prefer full-time employment. AOC work can be a stepping stone to a full-time job as well.

AOCs are covered by the collective agreement and we jointly monitor AOC use with the union. There has been only one grievance related to the use of AOCs in the last 11 or so years. My understanding is that, in total, there were over 700 AOC employees across all government departments as of the end of the calendar year last year.

Ms. Hanson: It is true that there are over 700 men and women working on an auxiliary-on-call basis with this government.

The hiring and staffing practices of this government were found to be lacking, according to an audit that was released by the Yukon Government Audit Services in February 2013.

The audit found that over 60 percent of the 1,900 staffing actions fell into the category of direct-hire exemptions and temporary and acting assignments. There was no regime to monitor the quality of these staffing actions.

When I raised my concerns about the lack of a monitoring regime and the fact that non-competitive hires outnumber

competitive hires, the minister assured me that he was working on it and taking it very seriously.

Can the minister tell us what he has done to address the concerns raised by the government audit on staffing branch services?

Hon. Mr. Dixon: We continue to work throughout our government departments to address this particular issue. I would note that auxiliary-on-call terms and conditions of employment are very important here. It is important to recognize that AOCs receive the same rate of pay as regular employees in the same classification. They generally have no set hours of work and are called on as needed. When they are called in to replace an employee, they work the scheduled hours of the employee being replaced.

They do receive overtime pay when they have worked more than the daily or weekly hours of work, as a regular employee with the same qualification, and when they worked for two consecutive shifts. As well, they receive overtime pay when they have worked more than the normal hours of work for their classification in a pay period. They receive vacation pay ranging from eight to 14 percent of regular pay. They are entitled to the Yukon bonus, paid based on hours worked, and they are entitled to leave without pay for illness and maternity parental needs. They do not get leave with pay for sick, special or annual leave, court leave or parental leave top-up.

Mr. Speaker, I would note that we continue to address the needs set out in the audit committee's report and the audit on this particular issue, and we take that particular report very seriously and are working across the department to address the suggestions and recommendations made therein.

Ms. Hanson: Fifteen months later, we're still taking it seriously. The fact of the matter, with respect to auxiliaries on call, is that not all auxiliaries on call are short term. Many people work them year after year, and being employed in an auxiliary-on-call position can be tough. There is no guarantee of work, meaning there is no guarantee of income. These individuals face the risk of losing their positions if they refuse work more than three times. So, auxiliary-on-call employees do receive financial compensation for benefits, but that comes twice a year in a flat sum. As the minister said — he is correct — they don't receive sick pay, and vacation pay is added to each paycheque, meaning that the employees don't receive pay while they are on leave. All of these factors contribute to a stressful situation for auxiliary-on-call employees. It is hard for them to settle into a community and invest.

Does the minister think it is appropriate for auxiliary-on-call employees to work full-time on an ongoing basis without the same employee benefits as other government employees?

Hon. Mr. Dixon: As I indicated previously, we value the contribution of auxiliary-on-call employees. They are an important and valued segment of our government workforce. I would note that individuals who work as auxiliaries on call do so for a variety of reasons. In some cases, some choose it as a lifestyle choice because it affords employment flexibility and variety, while for others who prefer full-time employment, AOC work can be a stepping stone to a full-time job.

AOCs are covered by the collective agreement, as I noted, and we jointly monitor AOC use with the Yukon Employees Union. There has been only one grievance related to the use of AOCs in the last 11 or so years but, as I noted, we have conducted the internal audit, as suggested by the member opposite. We continue to take the recommendations and aspects of that particular audit very seriously and are working across our government departments to ensure that we respect AOCs and use them when needed and ensure that AOCs remain an important and valued segment of our government workforce.

Question re: Burwash Landing policing

Ms. Moorcroft: Last week my colleague from Mayo-Tatchun asked a question about the lack of an RCMP presence in Burwash Landing. The minister informed this House that he thinks the lack of policing service in Burwash is just fine. The people of Burwash don't think it is just fine, and neither do I.

Having a community's first responder stationed nearly 200 kilometres away is completely unacceptable. Why doesn't the minister think the people of Burwash Landing deserve the same level of safety and police protection as other rural communities?

Hon. Mr. Nixon: In addressing the member opposite, we continue to work with the community of Burwash through the Department of Justice along with the RCMP and the First Nations to address community policing needs.

I will correct the member opposite. It is about 120 kilometres from the detachment in Haines Junction. Members responding to calls in the Burwash area — it could take them up to about an hour to get there. However, we do have reservists who are hired in the summer months who pay special attention to the Burwash area in busier times. The RCMP and the Department of Justice feel that the coverage is sufficient for that community.

I noted not too long ago — and we have members here from other territories — that other areas have fly-in communities that are unstaffed by RCMP members. We do believe that Burwash gets sufficient coverage through the RCMP. I would like to thank the RCMP for their good work in all Yukon communities.

Ms. Moorcroft: Mr. Speaker, doing the 120 kilometres that the minister has said the distance is between Haines Junction and Burwash in an hour or less would certainly be speeding, particularly with the condition of the road.

The Minister of Justice has spoken at length about the benefits that the part-time summer officer brings to the community. The minister's lack of coherence on this issue is startling. Does the community suddenly lose all need for the police to prevent crime and undesirable behaviour in Burwash when the weather starts cooling off? Perhaps the minister has determined that the only pressing need the people of Burwash have for police services is to enforce summer highway traffic. If the summer policing program is so needed and successful for the community, it stands to reason that the benefits of an RCMP station would be felt in the winter too.

Why does the minister think that Burwash benefits from policing service in the summer, but as soon as winter rolls around, they no longer need it?

Hon. Mr. Nixon: Clearly, the member from the NDP is not paying attention to what we are saying on the floor of this Legislature. The Department of Justice continues to work with the RCMP and the community of Burwash, including the Kluane First Nation, to ensure that there are sufficient policing services in the community of Burwash, as well as working with the RCMP through the Department of Justice to ensure that the policing needs of all communities are sufficient.

Again, I would like to thank the RCMP for their work with the Department of Justice and with all communities throughout the territory to ensure ample policing is covered. They have certainly come a long way, I believe. They have a very professional approach and I know that the leadership of the RCMP at M Division — it is very important to him to stay connected to Yukon communities to ensure that policing is sufficient. Thanks to the RCMP.

Ms. Moorcroft: The simple fact is that the community of Burwash is not getting the police services that it needs or deserves. People in Burwash are not calling the RCMP because they are worried that they will not come on time, if they come at all. In the best case, police response takes over an hour. In the worst case, it takes days, if not weeks.

The First Nation has requested a permanent police presence and has even offered to provide office space and housing. Several citizens have raised safety concerns due to the absence of police presence for most of the year in that community. It is the minister's job to agree to the number and location of detachments in Yukon. He has the power and the responsibility to respond to the community's needs.

Will this government do the right thing and commit to working with the RCMP to establish a police department in Burwash Landing?

Hon. Mr. Nixon: As I mentioned previously, the Department of Justice continues to work with the RCMP and Kluane First Nation and it was, in fact, through those discussions that they arrived at the solution, based on the community's policing needs, including an assessment of when calls for service are at their peak. In fact, community members reported that the presence of the RCMP resulted in a reduction in speeding on the highway and less drinking and driving for community events. They also reported that this police presence was a deterrent to crime and undesirable behaviour.

As I mentioned earlier, many small communities across Canada do not have a permanent police presence and they receive policing services through a hub detachment similar to the RCMP detachment in Haines Junction. The RCMP and the Department of Justice will continue to assess the needs of all Yukon communities to determine how the RCMP respond to those individual areas.

Question re: Mining regulatory uncertainty

Mr. Silver: I have a question for the Premier. During the 2011 election campaign, the Yukon Party committed to, and I quote, "…work with industry, the federal government, and First Nation governments to establish greater certainty for access to resources, water licenses and permits by creating a clear permitting regime …" During the first two and a half years of its mandate, the government has in fact gone in the opposite direction and, according to a recent Fraser report, actually increased the level of uncertainty by its actions and inactions.

During the Geoscience Forum held last fall in Whitehorse, the Premier told delegates, "Our government has also submitted proposed amendments to the Yukon Environmental Socio-economic Assessment Act or YESAA to the federal government."

Can the Premier tell Yukoners who developed these amendments and explain why they have not been made public yet?

Hon. Mr. Kent: When it comes to ensuring that we have a competitive permitting and licensing regime, that's something that I take very seriously as Minister of Energy, Mines and Resources, and all members of the Yukon Party caucus take seriously as well.

Members will remember last week we introduced adequacy timelines for quartz mining water licences, which were received very positively by industry. As mentioned by the member opposite, we have introduced suggested amendments to the YESAA legislation. Some were done as part of the five-year review. There were additional ones that were also introduced. As Minister of Energy, Mines and Resources, I also funded the Yukon Mineral Advisory Board to come up with suggestions to the government on how we can improve the licensing and permitting regime to make it competitive. This is something that I am very pleased that the Mineral Advisory Board took up on our behalf, and I look forward to receiving their annual report here in the next couple of weeks and tabling it in the Legislature.

Mr. Silver: Last fall, the government was heavily criticized by both First Nation governments and the mining industry alike when it unilaterally went forward on changes to the *Quartz Mining Act*. Instead of changing the way it does business, the government is continuing with its unilateral approach by developing these new YESAA amendments in a silo and not sharing them with anyone else in the development process. The Liberal caucus supports establishing greater regulatory certainty and has been asking questions about this for the last two years. Those changes must involve all of the players and should not be developed in secret by the Conservatives in Ottawa and the Yukon Party here in Whitehorse.

Why were the Government of Yukon-proposed amendments to YESAA not shared with the Yukon First Nations before they were submitted to Ottawa?

Hon. Mr. Kent: Just to correct the member opposite with some of his opening remarks, the changes that we made to the *Quartz Mining Act* last year came out of a Court of Appeal process. There were two declarations, and they were to deal with the class 1 notification. That's why we made the

changes to the *Quartz Mining Act*. Those weren't done unilaterally. They were court-ordered.

I know the members opposite don't take court orders very seriously, but we have to and we do. That is why those changes to the *Quartz Mining Act* and the *Placer Mining Act* were made at that time.

As I mentioned, we recently introduced changes to the water licensing process, as well as changes to the YESAA process, many of which emerged from the five-year review that was conducted by the three parties — First Nations, Yukon government and Canada.

The Government of Canada has suggested that they are looking to make further amendments and we have responded to those. The Yukon Minerals Advisory Board, which has representatives of the Chamber of Mines and the placer mining industry as well as a number of executives who are engaged in the industry, has also made recommendations to us to assist in ensuring that our licensing and permitting regime remains competitive, which is something that is incredibly important to me as minister and our Yukon Party caucus.

Mr. Silver: It is clear by the actions of this government that the only group that it is prepared to work on regulatory certainty with is the Conservatives in Ottawa. I asked the Premier to make these amendments public during the mineral Roundup and he refused. I have asked again today, and it seems that the same answer from the Minister of Energy, Mines and Resources is no. The government wants to change YESAA; that much is clear. They want to keep it secret and that is clear as well.

Why has the Government of Yukon decided to go it alone, instead of working with the Yukon First Nation governments to come up with a united position to present to Ottawa?

Hon. Mr. Pasloski: In response to the Leader of the Liberal Party, quite frankly, he's just wrong. Certainly, we have seen this many, many times with the Liberal leader. When he is talking to miners, of course he is supporting the mining industry; when he is talking to the conservationists, of course he is opposed to mining. We are certainly clear on what his position is on such areas as the Peel. It is an area that is as large as the Province of New Brunswick and larger than Nova Scotia and Prince Edward Island combined.

We are doing exactly what we said we would do during the election, which was that we would be seeking improvements to our regulatory and our permitting regime. We said that in our platform during the last election. We are showing again that we are doing what we said we would do and we will continue to do that. We are continuing to work together on changes to the YESAA legislation and regulations. First Nations have also been consulted and the YESA Board provided input. The industry has provided input as well. Certainly this is federal legislation. We know that the Leader of the Liberal Party doesn't like the answer so he'll continue to talk over top of it. What we are doing is exactly what we said we would do. This process is a federal process. We look forward to the completion of their consultation and moving forward with these legislative amendments.

Question re: Oil tank inspections

Ms. White: There are three main components to oil heating systems: the oil tank, the appliance that fires and the chimney. Last week, my colleague for Copperbelt South asked about oil tanks and all she got in return were answers about oil-fired appliances.

For clarity's sake, all of the following questions are about oil tanks, so I'm looking for answers about oil tanks. In his previous response, the Minister of Highways and Public Works said that whether it's the appliance, the fuel tank or the fuel lines, they are constantly inspected and have annual servicing.

Mr. Speaker, can the minister assure this House that during the constant inspections and annual servicing, all Yukon government oil tanks, whether owned or leased, are compliant and meet required codes? Do all of the oil tanks used by government meet required codes?

Hon. Mr. Cathers: First of all, I would point out to the member that the inspection that is conducted on installation is actually conducted by staff of Community Services, and then the ongoing maintenance is done by the competent staff of the Department of Highways and Public Works. Unlike the NDP, my colleagues and I have confidence in the staff and confidence in their competence to do their jobs and ensure the safety of employees and of the public.

Ms. White: It was hard to understand if that was a yes or a no.

For an oil tank to be compliant — but more importantly, to be safe — you have to know exactly how much oil is in the tank at all times. This can be accomplished through a number of components: spill whistles, visual gauges, dipsticks and dip charts. These safety features allow the people using, working on and filling oil tanks to know exactly how much oil is in the tanks, thereby avoiding spills that could be detrimental to the environment, to property and to public health. Will the minister confirm that every single oil tank owned or leased by the Yukon government has at least one of these fill-safety components?

Hon. Mr. Cathers: Again, as I noted to the member, in fact it is the Department of Community Services staff who conduct the inspections on installation for the permitting of oil-fired appliances and other parts of that system. They also issue the permits in areas including occupancy permits for private homes and for public facilities owned by private citizens.

What I would note to the member is that the equipment requirements, including equipment on the tanks, are decisions that are made at an operational level. The inspections are done by our competent staff, and the maintenance is done by the competent staff of Highways and Public Works. Once again, we see very clearly that the NDP does not have confidence in the staff, but I and my colleagues have confidence in the competence of our government staff in both Community Services and Highways and Public Works to fulfill their responsibilities in this important area.

Ms. White: I know that the members opposite think that ministerial responsibility is a strange thing, but it is actually

their job. They are the only ones who are speaking about government employees and they continue to hide behind them.

Mr. Speaker, it says a lot when a question that could be answered with a simple yes or no gets everything but a yes or a no as an answer. We have the utmost confidence in the government employees and the work that they do, but Yukoners have little confidence that this government takes the safety of oil-fired appliances and heating installations as seriously as they claim.

Within the last year, there have been two serious oil spills at both Macaulay Lodge and the Carcross Community School.

Can the minister assure Yukoners that those spills were not a result of oil tanks that are not in compliance with existing codes?

Hon. Mr. Cathers: First of all, I would point out to the member that her assertion that ministers should personally be out dealing with determining whether it is a dipstick or a whistle that is the appropriate way to test the level in a tank — that is a level of detail that would, quite frankly, be ridiculous for a minister to get into. We leave it to staff.

Some Hon. Member: (inaudible)

Hon. Mr. Cathers: Again we hear the constant heckling from the NDP, but I would remind the members that the standards are in place. Staff at Community Services do the inspection to issue the permit in the first place, and the competent staff of Highways and Public Works are responsible for the maintenance of those facilities.

The level of details — dipsticks and whistles on tanks. Ministers do not go out personally and run the dipstick down the tank, or check the whistle.

Again, we see that the NDP clearly doesn't appreciate the importance of this matter. Clearly we see again, from the Member for Copperbelt South, the clear demonstration of the lack of confidence in our competent government staff and, from the Member for Takhini-Kopper King, the lack of respect and lack of confidence in our very competent government staff.

Question re: Yukon Liquor Corporation social responsibility

Mr. Barr: Alcoholism is a worldwide disease that knows no boundaries. It affects all races, classes and ages of people. Alcohol is the number one date-rape drug and the highest contributor to trauma. We see the impact of alcohol in the emergency department, in the jails and in the incidents of violence. Alcoholism is recognized by the medical community as a family disease.

When will the Yukon Party government take their role as a distributor of alcohol seriously and start implementing a social responsibility strategy?

Hon. Mr. Cathers: Indeed, social responsibility programs are part of what the Yukon Liquor Corporation does. Certainly if the member has specific constructive suggestions of ways it could be improved, we take them under consideration. I do point out that our staff at Yukon Liquor Corporation liaise with all other Canadian jurisdictions and take into account what they are doing in terms of social responsibility programs and consider what best to implement within a Yukon context.

Mr. Barr: The per capita consumption of alcohol in Yukon is the highest in the country. Liquor sales are the third-highest source of self-generated revenue for this government. The Yukon Liquor Corporation has had a static number of employees for several years. Each year the same number of hard-working employees is selling more and more alcohol. Having the same amount of staff resources processing more and more sales has led to the social responsibility role of the Yukon Liquor Corporation taking a back seat.

For instance, I visited the liquor store this morning, and the vast majority of the merchandise does not have fetal alcohol syndrome warning stickers applied.

Does the minister believe that preventing FASD is an important part of the social responsibility mandate of Yukon Liquor Corporation and, if so, will he ensure there are adequate resources applied to that mandate?

Hon. Mr. Cathers: It's interesting to hear again from the NDP. We hear the Member for Takhini-Kopper King expecting ministers to run out and run dipsticks down tanks or ensure that there are whistles in place on all tanks. Apparently now the Member for Mount Lorne-Southern Lakes would like the minister responsible for the Yukon Liquor Corporation to go out and personally put stickers on all of the liquor bottles.

Again, in this case, I would point out that, contrary to the member's assertions, there have been increases in recent years in the staffing complement of the Yukon Liquor Corporation. Those decisions, in terms of both the staffing complement required and the roles and responsibilities of each position, are personnel matters. They are operational decisions made by the president of the Yukon Liquor Corporation, not by me. I have confidence that she and her staff are continuing to do an excellent job in that area. They are continuing to liaise with other Canadian jurisdictions to determine best practices, including in areas of social responsibility programs.

I would remind the member that in areas such as support for Fetal Alcohol Syndrome Society Yukon and other valuable Yukon organizations dealing with the downstream effects of the misuse of alcohol, this government has put far more investment into supporting these valuable programs than any previous government, including the NDP and the Member for Copperbelt South —

Speaker: Order please. The member's time has elapsed.

Mr. Barr: Maybe the minister's attempt at jokes seems interesting to him but I'm sure people who have suffered from date rape do not find this a joke. Social responsibility is very important to those of us in the Yukon.

The Yukon Party boasts that they are leaders in diagnosis support for persons with fetal alcohol spectrum disorder but, with limited diagnostic capacity for children and next to none for adults, it is a hollow boast. FASD is 100-percent preventable. We want this government to show real leadership in FASD — eliminate FASD by preventing it. The stickers are but one baby step toward the goal. They do not touch the root

causes of drinking — the history of trauma, poverty and housing.

It is time the Yukon Liquor Corporation took their obligation to social responsibility seriously. It needs a designated position with a Yukon-specific program —

Speaker: Order please. The member's time has elapsed.

Hon. Mr. Cathers: I'm very disappointed by the member's attitude toward the work of our staff. I'm disappointed with the fact that the member thinks that he knows better than senior staff of the Liquor Corporation — what the staffing allocation is. I'm disappointed that the member fails to recognize the work that this government has done on our five-step FASD action plan, the significant investments — including the significantly increased investments to Fetal Alcohol Syndrome Society Yukon that occurred during my time as Minister of Health and Social Services — and the investments we've put into areas such as the Options for Independence and the recent opening of the Options for Independence building.

We've made significant investments in supporting our front-line staff. Through the early identification program, we have put in significant resources. Through the Child Development Centre — this is another area where we've significantly increased resources. I could go on.

Clearly, the NDP has no interest in the facts and has no respect for the good work that is done by our competent staff or the significant investments that government has made in supporting FASD programming, providing additional supports for those who have it and working with our valuable NGOs in these areas. We will continue to do more in supporting those valuable staff and those NGOs doing that good work.

Speaker: The time for Question Period has elapsed.

Speaker's statement

Speaker: It has now come time for me to make a comment on the heckling. Over the last couple of weeks or so, I've noticed, not necessarily the amount of heckling, but the tone and loudness of the heckling is getting to a point where I'm having a difficult time listening to either side. I would ask that, if you insist on heckling, you keep it down a little bit lower. I know you are impassioned about your statements.

Also within your heckling, I would caution you — because I can hear you quite clearly at times — to watch the language that you are using such as "lying", "liars" or implying that somebody is in fact doing something intentionally to misrepresent the facts.

We will now proceed to Orders of the Day.

ORDERS OF THE DAY

OPPOSITION PRIVATE MEMBERS' BUSINESS

MOTIONS OTHER THAN GOVERNMENT MOTIONS

Motion No. 638 — adjourned debate

Deputy Clerk: Motion No. 638, standing in the name of Ms. Hanson; adjourned debate, Ms. Hanson.

Ms. Hanson: I will carry on from where I left off, which was on April 16. At that time, we were talking about a motion that the Official Opposition had brought forward:

THAT this House urges the Government of Yukon to demonstrate its support for Bill C-583, *An Act to amend the Criminal Code* (fetal alcohol spectrum disorder) by:

(1) urging the Government of Canada to support Bill C-583;

(2) urging the Government of Canada to schedule full committee hearings, including the testimony of expert witnesses, respecting Bill C-583;

(3) collaborating with the Government of the Northwest Territories and the Government of Nunavut to express pan-northern support for Bill C-583; and

(4) introducing to this House amendments to the Yukon's *Corrections Act* in order to better meet the needs of individuals with FASD, and to accommodate FASD as a disability in Yukon's corrections system;

Further, THAT this House directs the Speaker of the Yukon Legislative Assembly to convey the consensus of this House in support of Bill C-583 to the Speaker of the House of Commons of Canada, the Speaker of the Legislative Assembly of the Northwest Territories and the Speaker of the Legislative Assembly of Nunavut.

When I started to address this motion on April 16, I said that I was honoured and a bit daunted by the challenge of speaking to this motion. Today, that feeling remains.

As I indicated then, a lot has changed since my early career as a social worker, a time when there was not a lot of real information or understanding about fetal alcohol spectrum disorder. Preparing for this discussion, it is apparent that today we have significantly more information but we are still woefully short on understanding.

It bears repeating that the motion today provides all members of this Legislative Assembly with an opportunity to work together as representatives of all Yukon citizens to support an initiative that has the potential to change lives, not only in Yukon, but across Canada and, by our example, elsewhere in the world.

As the Leader of the Official Opposition, I stand here again to urge this House to set aside our partisan differences, to support the initiative of our Yukon MP Ryan Leef, who brought forward a private member's bill, Bill No. C-583, *An Act to amend the Criminal Code* (fetal alcohol spectrum disorder), and to commit to making amendments to the Yukon *Corrections Act* in order to better accommodate fetal alcohol spectrum disorder as a disability in the Yukon corrections system.

This motion is an ambitious one because it asks us to not only demonstrate our support for the necessary changes to our criminal justice and corrections systems and to recognize that fetal alcohol spectrum disorder is a permanent brain injury acquired before birth — a brain injury that sets in motion a broad spectrum of disability — but we are also being challenged to stand by our convictions, to work with our colleagues — and I was so pleased to see that there were some

colleagues from our sister territories, the Northwest Territories and Nunavut, here today. It's kind of special to be able to ask them to take this message back to their colleagues and ask them to join us in a pan-northern demonstration of support of these important changes to how we treat people born with fetal alcohol spectrum disorder.

I remind you that Bill C-583 received first reading on March 31, 2014. The bill would amend the *Criminal Code* to add a definition of fetal alcohol spectrum disorder and establish a procedure for assessing individuals who are involved in the criminal justice system and who are suspected of suffering from fetal alcohol spectrum disorder. It requires the court to consider — as a mitigating factor in sentencing — a determination that the accused suffers from fetal alcohol spectrum disorder and manifests certain symptoms. The act itself — or the amendment — does lay those out.

Bill C-583 is scheduled to go before a Parliamentary committee in early June. I think we all know that most private members' bills rarely get beyond the starting gate. To succeed, we can demonstrate clear unanimous support for the bill. We in this Assembly have an opportunity to clearly show that the Yukon Legislative Assembly believes that, although not perfect, Bill C-583 is important and that through a full committee hearing with the advice of expert witnesses, it deserves to be passed by Parliament. Our united voice can help our Yukon Member of Parliament make much-needed and widely supported positive changes to our criminal justice system.

The NDP Official Opposition in Ottawa has indicated their support for Bill No. C-583, as has — I am told — the federal Liberal Party. However, our job today is not simply to say: "Yes, we support changes to the federal *Criminal Code*." We must heed the call of the many experts from across many disciplines who point out the need to also make sure that the laws that fall within our control as Yukon legislators reflect the reality of fetal alcohol spectrum disorder.

The past president of the Canadian Bar Association, Rod Snow, in his speech at the National Biennial Conference on Adolescents and Adults with Fetal Alcohol Spectrum Disorder identified the need to ensure that one consistent principle guides both judges and jailers. The question posed by Mr. Snow was critically important. He said that if a judge decides to treat fetal alcohol spectrum disorder as a mitigating factor because she understands that the offender's disability is responsible for their behaviour, will our corrections system accommodate that person's disability when they arrive in jail, or will Corrections expect the offender to meet standards of behaviour that their disability prevents them from meeting? He said that we cannot be guided by one principle of justice, fairness and ethics in the courts and by a different principle of justice, fairness and ethics in our corrections system. Our judges and our jailers must be guided by one consistent set of principles applied both outside and inside our jails.

This is why this motion is so important. We are being challenged to apply the same principles of justice and fairness to the laws and policies over which the Yukon Legislative Assembly has control, as we ask the federal government to apply laws and policies within its own jurisdiction. We have to walk the walk.

As Mr. Snow said, it is neither ethical nor just for the law to punish individuals for failure to meet a standard of behaviour that their disability prevents them from meeting. Yet that is what the law and our justice system institutions do when they fail to accommodate fetal alcohol spectrum disorder. In this way, our society criminalizes individuals with fetal alcohol spectrum disorder because of their disability.

He went on to say, "I believe that when a law is unjust, we have an obligation to change it." According to Mr. Snow, Ryan Leef's Bill C-583 will change the *Criminal Code* to allow judges to accommodate fetal alcohol spectrum disorder offenders where there is evidence that their disability contributed to their conduct. Judges will do this by treating fetal alcohol spectrum disorder as a mitigating factor in sentencing. They will understand that it is not ethical, fair or just to punish an individual for failure because of their disability to meet a standard they cannot meet. We do not do that for other disabilities and we should not do it for fetal alcohol spectrum disorder. That is why I believe we must support Bill C-583.

In his speech, Mr. Snow also said that Bill C-583 is guided by a single principle that explicitly accommodates fetal alcohol spectrum disorder as a disability in the *Criminal Code*. That same principle demands that we explicitly accommodate fetal alcohol spectrum disorder as a disability in the *Corrections Act*. Just as Bill C-583 gives judges the tool to deliver smart and effective justice to individuals with FASD or fetal alcohol spectrum disorder within the courtroom, we must give our Corrections staff the tools they need to be smart and effective when dealing with fetal alcohol spectrum disorder individuals inside the jails. That is our challenge and our opportunity here today, Mr. Speaker.

We do this, confident that Yukon is again leading the way in deepening our understanding, not just of the impact of fetal alcohol spectrum disorder, but also our obligation to address this serious legal, social, economic and moral challenges that this disorder presents to us all.

It has taken a long time for these challenges to be recognized. Today there is an abundance of research on the issue of fetal alcohol spectrum disorder, but it did not spring out of nowhere. It was, and is, a difficult struggle to sort out the complexities of fetal alcohol spectrum disorder. Today we have a name for it. In the not so distant past, it was not like that.

One of the medical pioneers in this field was Dr. Kwadwo Asante. Initially based out of Prince George, his expertise helped several generations of parents, advocates and helping professionals, including those within the justice system, understand the complexity of fetal alcohol spectrum disorder. The Asante Centre is now a renowned centre of expertise on matters related to fetal alcohol spectrum disorder.

We also owe a huge debt of gratitude to the persistence and the love that drove the families, often adoptive parents, to understand what it was that made their child different and to struggle to have those differences not only recognized but

addressed. Their stories were and often are heartbreaking. I think of Judy Pakozdy or Lesley Carberry and Ray Marnoch or Jenny Jackson, who captured the experience of both caregiver and a person with FASD through her book, *Silent No More!*, which combined poetry with simple interpretations of the daily living routines that we take for granted and that confound those with fetal alcohol spectrum disorder.

As well, I think of the hard work of groups like Fetal Alcohol Syndrome Society Yukon — FASSY — who have doggedly brought about greater awareness and an appreciation of the scope of the work still to be done. We have come a long way. When Dr. Asante first spoke in Yukon and elsewhere about fetal alcohol spectrum disorder, the reality that this is brain damage caused by alcohol use during pregnancy and it is wholly preventable — well, I can tell you that the reaction was negative. It was essentially denial, fear and shame. We are not there yet. We can only hope that the fear of stigma slowly erodes as we focus more on dealing with reducing the incidence of fetal alcohol spectrum disorder and understanding its prevalence in our communities.

What has changed is the amount and scope of research that has been carried out in the past 40 years or so on fetal alcohol spectrum disorder. Despite the knowledge we have accumulated about the causes of fetal alcohol spectrum disorder and the implications of this permanent brain damage on the day-to-day lives of those who have fetal alcohol spectrum disorder, we have been slow to change our interactions and expectations of people who often do not look very different from you or me.

Spreading understanding of fetal alcohol spectrum disorder for the Canadian justice system is due in no small part to the dedicated efforts of Yukon's own legal community.

I would like to recognize Fia Jampolsky, who is here today with the Yukon chapter of the Canadian Bar Association. I also see Lisa Rawlings Bird from YCOD — Yukon Council on DisABILITY — and Heather MacFadgen who is the current president of the Yukon Bar association and also the executive director of the Human Rights Commission — people who have all had an instrumental part in creating a better understanding of the issues related to the justice system and fetal alcohol spectrum disorder.

As you know, in 2010, the Canadian Bar Association decided to elect — for the first time ever — a president from one of Canada's three northern territories, Rod Snow. Being chosen to lead a voluntary professional association representing more than 37,000 lawyers, judges, notaries, law teachers and law students from across Canada is a significant recognition. When the Canadian Bar Association elected a president from the north for the first time, he brought with him a challenge from the northern branches of the Canadian Bar Association — that is, to make fetal alcohol spectrum disorder a priority in their advocacy work. When Mr. Snow assumed his role as president of the Canadian Bar Association, he met with ministers, politicians and policy-makers across Canada. As he says quite proudly, he was lobbying to effect change in the justice system.

His commitment to working to get others to recognize that the time has come for the justice system to face up to fetal alcohol spectrum disorder and to understand that our legal system is failing those who live with the disorder was as evident then as it is now. When the Canadian Bar Association considered why so many people with fetal alcohol spectrum disorder were coming into the justice system time after time, they realized that the legal system has a fundamental problem when it comes to dealing with people with fetal alcohol spectrum disorder.

That problem is that criminal law is based on certain assumptions. It assumes that individuals make informed choices, that they decide to commit crimes and that they learn from their own behaviour and the behaviour of others. Another assumption is that people can be rehabilitated. However, each of these assumptions is frequently invalid for people with fetal alcohol spectrum disorder. Because of their permanent organic brain injury, people with fetal alcohol spectrum disorder often lack impulse control.

Words like permanent organic brain damage are clinically correct; however, sometimes we need graphic imagery to get the full picture.

I was reading a number of articles, and I came across one by a B.C. lawyer named David Boulding, who put it this way in a 2007 article. He said, "Briefly, alcohol in the womb acts as a solvent on the baby's developing brain, much like the effects paint stripper has on old furniture: alcohol dissolves brain cells — bubbles them away. As a result, brain functions are missing." Fetal alcohol spectrum disorder, he said in this graphic, if not clinically worded, description, "…is a physical disability because like an amputee, individuals with FASD are missing body parts called brain cells." So even if they know that something is wrong, a person with fetal alcohol spectrum disorder may be unable to resist the impulse to do it again. Therefore, a jail sentence often doesn't work. It does not deter and it does not rehabilitate, and it certainly does not keep people from re-offending.

This leads to a disconnect with the legal system; a disconnect captured by a candid statement by a prominent judge, who summed it up this way: What a judge sees is a defiance of court orders; what a judge sees is absence of remorse; what judges see is a criminal record of incorrigibility, calling of course for stiffer penalties in the cause of deterrence. What is missed is the cause of the apparent incorrigibility and, with it, the change to fashion a disposition that is responsive to the special needs of the defendant.

Lawyers who have worked with clients who have fetal alcohol spectrum disorder are often frustrated by the behaviours they see. In an article published by the Asante Centre, one lawyer talked about the mistakes he had made with his fetal alcohol syndrome clients.

He said his intention was not just to confess his mistakes, but to show that we can change how lawyers, judges, police, probation officers, prison guards and family members can work with people who have fetal alcohol spectrum disorder.

Reading his list of mistakes as a lawyer, one gains an appreciation of the challenges. Some of the examples he gave include — he said, "I assumed that my fetal alcohol spectrum disorder clients could tell the judge what happened in a way that made sense. I assumed that my fetal alcohol spectrum disorder clients would be able to demonstrate remorse to the sentencing judge. I assumed that after my clients were caught for the third or fourth time for the same offence and in the same set of circumstances that at least they would learn not to get caught for either another offence, wear gloves, or at least not be surprised when they were caught. I assumed that my fetal alcohol spectrum disorder clients understood the notion of consequences: if you steal from cars and are caught, you will go to jail. I assumed that my fetal alcohol spectrum disorder clients understood the notion of time — three days in jail is not the same as three months in jail. I assumed," he said, "that my … clients could be helped by using standard terms of probation orders in the provincial court."

None of these assumptions held for his fetal alcohol spectrum disorder clients. He went on to set out how his assumptions then led him to fail his clients who had fetal alcohol spectrum disorder. He said, "I was always puzzled and failed to understand that there is a good reason why, in pre-sentencing reports of probation officers, my clients seemed to shoot themselves in the foot. My clients participated completely and without guile in their pre-sentence reports."

He said, "I failed to understand that the reason they were so candid, up front, and straight with Probation Officers was that …" his clients "… were impressionable, suggestible and easily misled and misunderstood." They were simply "…eager to please." He went on to say that "I failed to see that… To most judges, police officers, probation people… my clients did not present themselves as really bad people." They tended to present themselves as first-time offenders who had made some silly one-time "mistakes." The problem was they actually had long Criminal Records for those same "mistakes."

He said, "I failed to notice that when my clients were telling their story, there were blanks in their memories or parts of the story were just not available. My clients did not remember important facts…I failed to see that jail had no effect on my clients' behavior … I failed to see that often within the aboriginal community, aunts distantly related to my FAS clients understood there was a problem and instinctively took care of my clients for various periods of their lives. It was during those periods of intense supervision that my FAS clients were crime-free. However, as soon as that supervision went away, leaving my clients alone, it was predictable that they would return to familiar criminal behavior." They have no impulse control. They were not competent thieves. They did not plan. They were opportunistic and impulsive. He used as an example one client who spent 10 minutes breaking into a car while being observed by the police.

So what does this mean? It means and leads us to understand that a permanent brain injury is not like a mental illness. A mental illness can be treated, but there is no cure for a permanent organic brain injury. Even though treatment outcomes can sometimes improve it, you can't cure it.

Sending a person to jail will give them structure. It will often allow them to function better for a time, but it won't rehabilitate them and it won't cure them of fetal alcohol spectrum disorder. As the stories that I've just related reveal, if there's no structure when they're released from jail, they are at high risk of reoffending. Unfortunately, in Canada, the justice system works in what Rod Snow — and I believe Rod has joined us. Rod is the former president of the Canadian Bar Association and he shared with me a fair amount of information.

He described that the Canadian justice system worked in what he called a binary fashion. You are either criminally responsible or not criminally responsible — there is no in-between. The binary nature of the legal system makes for clarity, but some issues just don't fit neatly into yes-or-no categories.

Fetal alcohol spectrum disorder is one such issue. The question he asked is: Could there be another option? A suite of alternatives? A third option? To that end, the Yukon chapter of the Canadian Bar Association developed a resolution that, as I said previously, was unanimously adopted by the Canadian Bar Association. The resolution has three key points.

It's important to point out that this resolution was actually introduced at the national level twice. It was introduced in 2010, unanimously approved, and again in 2013, receiving unanimous sanction, because in the intervening period, despite the promises made post-2010, there were some delays in progress. The Canadian Bar Association felt it was important to bring it forward again.

That resolution — Canadian Bar Association Resolution 13-12-A — reads as follows: "WHEREAS a person whose mother consumed alcohol during a critical development period in her pregnancy may be born with a permanent organic brain injury which results in a cognitive disorder known as Fetal Alcohol Spectrum Disorder (FASD), a range of neurological and behavioral challenges that may affect an individual;

"WHEREAS disabilities of FASD reflect the underlying brain and central nervous system damage, including impaired mental functioning, poor executive functioning, memory problems, impaired judgment, inability to control impulse behavior, inability to understand the consequences of their actions, and inability to internally modify behavior control;

"WHEREAS the nature of behavior resulting from these disabilities means that persons with FASD frequently come into conflict with the law;

"WHEREAS in 2010 the Canadian Bar Association: supported the initiative of federal, provincial and territorial Ministers responsible for Justice with respect to access for justice for people with FASD; urged all levels of government to allocate additional resources for alternatives to the current practice of criminalizing individuals with FASD and develop policies designed to assist and enhance the lives of those with FASD and to prevent their persistent overrepresentation in the

criminal justice system; and urged the federal government to amend criminal sentencing laws to accommodate the disability of those with FASD;

"WHEREAS at the 2010 Canadian Bar Association annual meeting the federal Minister of Justice said that FASD is a 'huge problem' in the Canadian justice system and promised to put it on the agenda for the next Federal/Provincial/Territorial (FPT) Justice Ministers meeting … and invited the CBA to engage in a dialogue with them on this issue;

"WHEREAS at the 2012 CBA Annual Meeting, the federal Minister of Justice reaffirmed his commitment to address the issue of FASD in the Canadian legal system;

"BE IT RESOLVED THAT the Canadian Bar Association urge the federal government to amend the *Criminal Code* and other legislation based on the following principles …"

The first principle is that the legal definition of FASD "should define FASD by reference to generally accepted medical guidelines and protocols except that any requirements for evidence of maternal consumption of alcohol may be waived by the Court if there is a good reason why this evidence is not available, such as when the birth mother has died or cannot be identified or found."

"Power to Order Assessments — Based on the precedent of section 34 of the *Youth Criminal Justice Act* which allows a judge to order an assessment of an accused youth, the *Criminal Code* should be amended to allow a judge to order an FASD assessment of an accused adult who is suspected of having FASD.

"Mitigating Factor — If an accused is found to have FASD, this should be a mitigating factor in sentencing the accused.

"External Support Order — A judge should be authorized to make an order approving an external support plan recommended by an FASD person's probation officer that could be in effect after probation expires.

"Duty to Accommodate — The *Corrections and Conditional Release Act* should be amended to expressly require the Correctional Service of Canada to accommodate FASD as a disability when providing correctional services to inmates who have or likely have FASD."

The CBA resolution was a call for action that was heard far and wide.

I referenced in the recitation of the resolution that was put forward in 2013 that the then Minister of Justice had put that on an agenda for a meeting of federal-provincial-territorial justice ministers from across the country. That joint CBA and federal-provincial-territorial coordinating working committee of senior officials made a number of recommendations and they are helpful in giving us a sense of the scope of the work to be done if we are serious about addressing fetal alcohol spectrum disorder.

One of the recommendations was allocating new resources or reallocating existing resources, as appropriate, for effective programs that avoid the unnecessary criminalization of fetal alcohol spectrum disordered individuals, including community alternatives, supportive housing and social services. It is interesting to note that Yukon has recognized and supported community-driven initiatives like FASSY, options for independent living, and other NGOs that work with people with fetal alcohol spectrum disorder.

We have a good base to build on and a huge knowledge base of people, primarily from the non-government sector, who have built this up over the years.

A second recommendation was to explore and develop alternative measures and diversion programs that deal with individuals with fetal alcohol spectrum disorder who come into conflict with the law in a timely, effective manner that holds individuals accountable, consistent with their degree of responsibility.

Again, Yukon has been quite creative in this area. Going back to what I call the judicial activism of people like Heino Lilles and Barry Stuart — we have a good base to build upon. The Community Wellness Court was developed based on experience here in the Yukon, along with practices elsewhere.

A third recommendation of that CBA and federal-provincial-territorial working group was to educate justice system professionals, including RCMP, police services and probation officers, judges, Crown defence, courtworkers, corrections and victim services workers about fetal alcohol spectrum disorder and the implication for service provision.

The development of fetal alcohol spectrum disorder-specific training through the northern justice institute provided to front-line staff in the government is a good start. As we shall see, there is a need to ensure that the training is offered systemically on an ongoing basis.

The fourth recommendation was to amend the legislative framework within the *Criminal Code* to more effectively address the unique challenges that fetal alcohol spectrum disorder presents to the criminal justice system, which is where Yukon's Member of Parliament's Bill C-583 comes in. His amendments to the *Criminal Code* deal with some, but not all, of the issues identified by the Canadian Bar Association.

When I was reviewing this, it was interesting that, in a number of the documents, including the recommendations from this working group that met several years ago, as well as the consensus statement on the legal issues respecting fetal alcohol spectrum disorder, there was a recognition that the *Youth Criminal Justice Act* provides a legislative framework that could be applied to offenders with special needs, such as those with fetal alcohol spectrum disorder.

Some of the sections of that legislation offer special protection to youth under the *Youth Criminal Justice Act* that could be added to the *Criminal Code* to accommodate the unique challenges that individuals with fetal alcohol spectrum disorder present to the criminal justice system. This goes back and it links to the amendments that were being proposed by the CBA, including ordering assessments and the ability under the *Youth Criminal Justice Act* to have a right to counsel. Ensuring counsel is present in encounters with the criminal justice system is critical for people with diminished cognitive ability, such as with fetal alcohol spectrum disorder.

Another recommendation was to address the problems of people affected by fetal alcohol spectrum disorder through an interdisciplinary, multi-sectoral approach. Some jurisdictions effectively use collaborative or interministerial approaches between government ministries to share information and coordinate and integrate services. Yukon has made progress on this through efforts to have a multiagency approach, including other government departments and NGOs, and to start to work on developing individual plans and appropriate supports for people with FASD. The question here is whether there are adequate or any current resources available to complete diagnostic assessments in the Yukon.

The federal-provincial group also recommended that we create legislative authority to allow courts to obtain an accurate assessment of an individual's neurocognitive abilities. The youth criminal justice system has been used effectively to order assessments for fetal alcohol spectrum disorder. They suggested that the same provisions should be added to the *Criminal Code* for adults affected by fetal alcohol spectrum disorder. Currently the courts cannot order assessments for adults accused who, they believe, may have a cognitive deficit unless the accused is considered unfit to stand trial or not criminal responsible by reason of a mental disorder.

That provision of the *Criminal Code* dealing with mental disorder is generally not applicable to or appropriate for individuals with fetal alcohol spectrum disorder.

Bill C-583 addresses and amends the *Criminal Code* to provide for assessment in order to more effectively ensure access to justice for individuals with fetal alcohol spectrum disorder. Courts should be able to order an assessment at any stage in the proceedings, and as early as possible in the judicial process, to ensure that any diagnosis is properly considered through the individual's involvement with the court justice system.

They also stated that fetal alcohol spectrum disorder should be recognized as a lifelong disability distinguishable from mental illness. The distinction between permanent brain damage and a condition that may change with treatment is critical when considering the appropriate criminal justice system response, including in specialty courts and in sentencing dispositions.

Fetal alcohol spectrum disorder must be considered the primary underlying issue and any mental illness then be considered in the context of fetal alcohol spectrum disorder. It must be recognized that fetal alcohol spectrum disorder is not an illness but a permanent disability that requires appropriate legal and social accommodation.

We have heard much about changes to sentencing and sentencing laws and rules in this country, and the recommendation is that there is need to allow for all sentencing options to be available to judges to allow them to devise just and appropriate dispositions for people affected by fetal alcohol spectrum disorder.

It is important, they said, to remove barriers that constrain the exercise of judicial discretion including mandatory minimum sentences.

The final recommendation of this group was to minimize the possibilities for people with fetal alcohol spectrum disorder to accumulate unnecessary administration of justice breaches. They said that all justice officials should limit unnecessary conditions, bail conditions, terms of probation and sentencing conditions to accommodate the cognitive ability of individuals with fetal alcohol spectrum disorder and avoid the unnecessary accumulation of administration of justice breaches.

In Yukon, 28.6 percent of court cases in 2010-11, involved an administration of justice breach as the most serious offence. As we have heard, a leading characteristic of people with fetal alcohol spectrum disorder is an inability to organize their lives, meet deadlines, keep appointments, learn from experience and understand the consequences of the failure to do any of these things. These administration of justice breaches in effect criminalize those with fetal alcohol spectrum disorder by setting the person up for further charges — the revolving door.

This is a perfect example of the need for education and the types of policies and directives that can be established by our justice agencies for working with individuals with fetal alcohol spectrum disorder.

Mr. Speaker, the success of any program for dealing with fetal alcohol spectrum disorder offenders will depend on judges and lawyers being more aware of fetal alcohol spectrum disorder. I think that the interest in efforts to address the serious challenges posed by the motion we are debating today continues to grow with ever more focus and precision, building on the work that was in so many ways pioneered by community groups and individuals in Yukon — championed by the Yukon Bar association — and now Yukon's Member of Parliament.

In September 2013, an important consensus statement on the legal issues of fetal alcohol spectrum disorder, which I tabled earlier today, was developed as part of an Institute of Health Economics consensus development conference. The Hon. Ian Binnie, former Justice of the Supreme Court of Canada, led a 14-person jury that heard 20 presentations of evidence and scientific findings regarding the legal issues related to fetal alcohol spectrum disorder. They developed 62 recommendations that provide thoughtful, comprehensive guidance for parliament, for provincial and territorial governments, courts, lawyers and social workers — in short, the spectrum of people who come into contact and work with or on behalf of people with fetal alcohol spectrum disorder. I commend the report to all interested in this issue.

Just as ongoing training on fetal alcohol spectrum disorder must be incorporated into legal education and police curricula, we also need to define, develop and implement those third options that Rod Snow mentioned, as I mentioned earlier. Without an alternative to incarceration on the one hand, and unconditional, unstructured release from custody on the other, the criminal justice system may be tough, but it will not be effective and we will have failed in our duty to deliver public safety and justice for people with fetal alcohol spectrum disorder.

The reality is that there are currently no confirmed statistics on the number of people who have fetal alcohol spectrum disorder in Canada. The most commonly cited estimate is 9.1 per 1,000 live births, or roughly one percent of the population. It has also been estimated that here in Canada today there are some 200,000 undiagnosed cases of fetal alcohol spectrum disorder.

It has been suggested that fetal alcohol spectrum disorder may be the most common birth defect in Canada, affecting, as I said, about one percent of the population. Sadly, we do know that they are over-represented in the criminal justice system.

Based on the currently accepted prevalence rate of one percent, the annual cost of fetal alcohol spectrum disorder in Canada has been estimated at approximately $7.6 billion a year, so we do need more insightful data. To get beyond anecdotes and individual cases, we need to better understand the prevalence. I would like to take a moment to acknowledge the work being led by the Minister of Justice in his effort to undertake an offender prevalence study at the Whitehorse Correctional Centre that will give us the hard numbers for that slice of our community — those who are sentenced to the correctional facility. It is a start to understanding the key question: How big is this challenge?

The *Consensus Statement on Legal Issues of Fetal Alcohol Spectrum Disorder (FASD)* offered a recommendation that would help address both the prevalence within the correctional system as well as provided a tool for people working within that system. They recommended, "… admission procedures in correctional centres (either on remand or on sentence) should include screening for possible FASD to ensure that prisoners are dealt with appropriately by staff trained in the problems associated with FASD. Again, the FASD diagnosis should not be used against the prisoner but should be used to help better accommodate and manage such persons within the correctional system."

The consensus statement observed: "Offenders with intellectual impairments or neurodevelopmental disorders such as FASD who are serving their sentences in custody are particularly vulnerable to exploitation and manipulation by other inmates."

If corrections officials know that an inmate has FASD, there are measures that can be taken to house the inmate in a secure area or a secure range. In addition, knowing that an offender has FASD could help corrections officers understand the inmate's behaviour in prison and could result in fewer disciplinary charges for the inmate. They went on to say, "Knowledge of an offender's FASD status is also critically important in developing an effective correctional plan. This is true for offenders who are serving their sentences in custody as well as offenders who are serving their sentence in the community. It makes little sense to have a correctional plan that involves a treatment modality that relies heavily on neurodevelopmental reasoning for an offender who has reduced executive functioning. Even more important, however, is developing an evidenced-based approach to effective correctional programming for offenders with FASD."

The jury — the 14 people I mentioned who produced this consensus statement — noted they had heard about a recent study that "found that 9- to 10-percent of 91 participants/inmates at Stony Mountain Penitentiary were identified with FASD, while another 16- to 18- percent were possibly affected by FASD." These data suggest that not enough is done to diagnose and provide treatment for FASD in prisons.

As one judge noted, if more residential facilities were available for people with FASD, "Fewer of these offenders would be incarcerated in jail; those who were incarcerated would not be incarcerated for as long, and, in the end, there is a very real likelihood that the revolving door of offending, often with increasing severity, would slow or be closed altogether for the individual fetal alcohol spectrum disorder offender."

These observations reinforce the need to ensure that we, as legislators, are open to reviewing the Yukon *Corrections Act, 2009* and related systems as well as the federal *Criminal Code*.

It has been noted that people with fetal alcohol spectrum disorder need an external brain. That external brain can be a parent, an auntie or an authority figure. We know that, in the right circumstances, people with fetal alcohol spectrum disorder can be happy and productive if they are given that external brain in the form of family or community support.

When looking at options in the justice system, we need to examine ways the community can provide support and be supported. Lawyers and judges will need the help of experts in fetal alcohol spectrum disorder to fashion appropriate third-option solutions. People on the front lines — lawyers, judges, health workers, parents, social workers and probation officers — all agree that our approach isn't working. Our justice system is not making society any safer, and we are not making a difference in the lives of individuals with fetal alcohol spectrum disorder.

Rod Snow — whom I quoted earlier — said that in Canada when something is not working and we think we can do better, we bring people together and we say that we have a problem. How can we do this better?

Passing this motion, working toward a full parliamentary committee hearing, and passage of Bill C-583 and amendments to our own *Corrections Act, 2009* does not mean that the going would be easy or quick, but we must all — members of this Legislative Assembly, justice ministers, judges and the legal profession, and community agencies — stay the course.

Why? Because there is no justice in labelling someone as a criminal simply because their disability makes them incapable of meeting the standard of behaviour required by the law. With the right resources and a sustained, collective effort, we can make the justice system more responsive to the needs of all Canadians, but especially to the needs of people with fetal alcohol spectrum disorder, both offenders and victims.

The Canadian Bar Association and others have begun the process of educating lawyers and judges. They have begun

looking for ways to make the criminal justice system more responsive to the needs of people with fetal alcohol spectrum disorder. Things are happening. In the Yukon and in jurisdictions elsewhere, judges are designing probation and sentences with fetal alcohol spectrum disorder in mind. Awareness is growing.

As I said, the former president of the Yukon chapter of the CBA told me that, when they thought their CBA resolution in 2010 would only serve to encourage those public servants within the federal Department of Justice who they knew were toiling away somewhere, deep in the bowels of official Ottawa, they were surprised by the amount of attention received by the Yukon chapter of the Canadian Bar Association and the Canadian Bar Association resolution on fetal alcohol spectrum disorder.

This should give us heart, because it tells us that people are ready to listen, that they are ready to act to ensure that people with fetal alcohol spectrum disorder are treated more fairly by the justice system. Our unanimous support for this motion today is another step in making this happen.

Hon. Mr. Nixon: I thank the member opposite for tabling this motion and bringing it back to the House today. This motion outlines and asks:

THAT this House urges the Government of Yukon to demonstrate its support for Bill C-583, *An Act to amend the Criminal Code* (fetal alcohol spectrum disorder) by:

(1) urging the Government of Canada to support Bill C-583;

(2) urging the Government of Canada to schedule full committee hearings, including the testimony of expert witnesses, respecting Bill C-583;

(3) collaborating with the Government of the Northwest Territories and the Government of Nunavut to express pan-northern support for Bill C-583; and

(4) introducing to this House amendments to Yukon's *Corrections Act* in order better meet the needs of individuals with FASD, and to accommodate FASD as a disability in Yukon's corrections system;

Further, THAT this House directs the Speaker of the Yukon Legislative Assembly to convey the consensus of this House in support of Bill C-583 to the Speaker of the House of Commons of Canada, the Speaker of the Legislative Assembly of the Northwest Territories and the Speaker of the Legislative Assembly in Nunavut.

I will be speaking to this motion in some detail. As I prepared for today's debate, I realized that we really do need to put on the record some facts and then have an informed discussion about FASD and the role of FASD in the correctional system.

To give you a road map for today's debate, I would like to begin by offering an overview of Yukon's work to date on the FASD file. I would then like to talk about the contents of Bill C-583, especially the parts around the definition of FASD, the ability of the court to assess FASD and the ability of a court to consider FASD in sentencing. I would then like to point out the response of the government and the courts to FASD, as I really think that we need to correct the record, especially with respect to the fourth element of this motion that speaks to amending the Yukon's *Corrections Act, 2009*.

With that said, the Yukon Party has recognized that FASD is a serious affliction here in our territory. It was something that we committed to address in our 2002 platform. When the Yukon Party campaigned for office in 2002, one of the areas highlighted in our platform was the need to address substance abuse in Yukon. Part of that included the need to address FASD.

The five-step FASD action plan was set out in the 2002 Yukon Party election platform. The five steps are as follows: promote prevention programs to eliminate alcohol consumption of high-risk parents in order to foster the birth of healthy babies; early diagnosis of FASD before the age of six; supporting people and families with FASD through a wide range of services, such as professional counselling and foster homes in order to provide a stable, nurturing home environment; enhance supported living arrangements for adults with FASD; and form a diagnostic team of professionals trained in personal counselling and social work or health to provide services to Yukon schools in order to provide support for students with FASD and their families.

In June of 2005, the government of the day held a substance abuse summit. This summit resulted in the recognition that the old ways of dealing with substance abuse were not as effective as they could have been. The summit eventually led to the *Substance Abuse Action Plan*. Along the way, we've had FASSY at our side. Yukon has financially supported FASSY and we are so very grateful for their contribution, not only to our community, but to our territory.

Yukon funded two diagnostic teams. An adult diagnosis is performed in conjunction with the Fetal Alcohol Syndrome Society Yukon — FASSY. Yukon has education and awareness campaigns. The youth FASD diagnostic and support teams provide support for public school children based on identified need. Our platform indicated the Yukon Party's determination to address the issue of FASD. The administration of the day committed to address the need to deal with the Yukon's serious alcohol and drug problems as a matter of top priority. This included addressing the drug and alcohol rehabilitation package, including counselling offered to offenders. The government developed the *Substance Abuse Action Plan* as a way of addressing Yukon's substance abuse issues. The government of the day also committed to continue to implement the *Substance Abuse Action Plan* in 2006.

Madam Chair, I want to acknowledge the work of Yukoners in bringing this issue to the national agenda. It is in fact people like Rod Snow who used his capacity as president of the 37,000-member Canadian Bar Association, or CBA, to advocate for this issue.

One of the issues he flagged when talking about this leadership role was that, based on his experience of 17 years in the north and more than 25 years as a partner in a national law firm, he knew we can do more to improve access to justice for individuals with fetal alcohol spectrum disorder.

Mr. Snow used his time on the CBA executive to advance this file, and I believe his efforts were timely and very effective. Indeed, I note that MP Leef, in his introductory comments in Parliament, also acknowledged the contribution of Mr. Snow. One of the contributions he made was his September 20, 2010, letter to the then Minister of Justice and Attorney General of Canada, the Hon. Rob Nicholson, regarding fetal alcohol spectrum disorder and the criminal justice system.

Mr. Snow's letter acknowledged that fetal alcohol spectrum disorder is a big problem in the criminal justice system. He noted that the search for solutions will not be easy and may not be popular, but he was confident that, together, we can do better. Mr. Snow's letter expressed support for the initiative of the FPT Justice ministers on fetal alcohol spectrum disorder to date and urged governments to dedicate resources and develop programs and policies to assist and enhance the lives of people with FASD.

The CBA resolution called upon the government to amend the criminal sentencing laws to accommodate the disability of those with FASD. Madam Speaker, I want to acknowledge the work of the CBA in general, and Mr. Snow in particular, on this file.

As members of this House are already aware, our government has been a leader, both locally and nationally, in working to address the challenges that FASD presents to the criminal justice system.

Our government was very pleased to see the private members' Bill C-583, which was put forward by our very own Member of Parliament, Mr. Ryan Leef. We are very much in favour of working to improve the criminal justice system so that it responds more appropriately to those with FASD. We are supportive in principle of Bill C-583 and we encourage the federal government to support this bill so that it may move into Committee for a more fulsome review and analysis, not only by the officials at Justice Canada and the provinces and territories, but also provide the opportunity for input from the experts that work in this field on a daily basis. We believe this bill is a good starting point to generate this discussion. However, we have concerns with some of the provisions of the bill in its current form.

For example, I'm sure that my counterparts across this country would echo Yukon's concern with the inclusion of a provision that would allow courts to order assessments. This is not a simple fix. We must be clear on what we hope to accomplish by adding such a provision and ensure that any provision like this would achieve the intended outcome.

While we understand that knowing what we are dealing with is important when it comes to individuals who are involved in the criminal justice system, the real fact is that most jurisdictions in the country do not have the capacity to deliver adult diagnostic services. Yukon, as you are aware, has been working to address this issue locally through our prevalence study and capacity development project.

The inclusion of such a provision in the *Criminal Code*, in our opinion, must be accompanied by a commitment from the federal government to provide the necessary funding that would allow the provinces and territories to develop and deliver such services on a consistent and timely basis. This bill is a good starting point. As a government, we encourage the federal government to move this bill forward so that it can receive a more fulsome review.

Mr. Speaker, one of the areas identified was the need for a more skilled workforce in the area of substance abuse, especially with respect to FASD. This led to the government developing the Northern Institute of Social Justice, because it would assist by providing more skill development and training opportunities for Yukoners. Yukon is working hard to address FASD at the national level. We have raised this issue as a matter of great concern. Yukon hosted The Path to Justice: Access to Justice for Individuals with Fetal Alcohol Spectrum Disorder (FASD) Conference, a conference of 130 government and non-government stakeholders. This investment of $139,000 helped us find ways to address the reality that people with FASD who are engaged in the justice system as victims, offenders and witnesses have special and unique needs. Although that conference was in 2008, it set in motion initiatives and work that is ongoing today, including the FASD prevalence study that I will come back to in a few minutes.

Let me summarize again the five-step FASD action plan: we want to promote prevention; make diagnosis early in the child's life; provide support for families with children who have FASD; provide supportive housing for adults who have FASD; and support schools for students who have FASD.

These areas all require Yukoners with skills and training. Think about how the Northern Institute of Social Justice could support these activities.

As a government, we are committed to creating safer Yukon communities and to dealing with substance abuse in our communities. To do that, we are changing the way that we do corrections in Yukon. The previous administration consulted extensively on changing the approach to corrections. The feedback that was received indicated that public safety and holding offenders accountable were key principles that needed to be promoted. As a result of that consultation on corrections, the government changed our philosophy of corrections, developed a new act and built a new Correctional Centre. Clearly, one of the issues is that we have people in our corrections system who have FASD. My concern is that processing people who have FASD the same way we process other offenders may not be all that effective. The previous administration was successful in having FASD placed on the national agenda at both the justice and the health ministers' meetings. Yukon has been — and continues to be — the co-lead with Canada on the file of FASD.

One of the accomplishments of MP Leef's bill is that it defines what fetal alcohol spectrum disorder means.

I think many of us have a general idea of what FASD is, but I heard one of our staff who is retiring reflect on the changes she has seen in Yukon from when she started to when she retired. This file was one of the ones that she had commented on. She indicated that, early on, kids with FASD were diagnosed as FLKs, and that was short for funny-looking

kids. I would like to mention some of the background work that has been undertaken on advancing how society responds to FASD by talking about the Canada FASD Research Network. CanFASD is a collaborative interdisciplinary research network with collaborators, researchers and partners across the nation. It is Canada's first comprehensive national fetal alcohol spectrum disorder research network.

It started as an alliance of seven jurisdictions and operated for seven years as the Canada Northwest FASD Research Network. CanFASD's unique partnership brings together many scientific viewpoints to address the complexities of FASD with a focus on ensuring that research knowledge is translated to community and policy action. Their mission is "to produce and maintain national, collaborative research design for sharing with all Canadians, leading to prevention strategies and improved support services for people affected by Fetal Alcohol Spectrum Disorder."

In March 1998, the governments of Alberta, Manitoba and Saskatchewan formed the prairie province partnership on FAS. In November 1999, the partnership was expanded to include the Northwest Territories, Nunavut and Yukon. In 2001, the partnership expanded to include British Columbia and, in February 2003, the partnership's name changed to the Canada Northwest Fetal Alcohol Spectrum Disorder Partnership or CNFASDP.

CNFASDP conferences were held in 1999, 2000, 2001 and 2002 in Whitehorse, and 2003 and 2008. Symposia were also held annually for a number of years. Yukon hosted a symposium in Dawson City in 2005 and the most recent symposium was held in Manitoba in 2008.

In the fall of 2002, the Canada Northwest FASD Research Network was established. The partnership contracted with the provincial health services authority of B.C. to implement phase 1 of the network and appointed a 15-member board of directors. In 2005 and 2006, consultations on the research agenda and structure of the research network was undertaken. Network action items were established at that time. In 2007 and 2008, there was implementation of that research network.

At the Access to Justice for Individuals with Fetal Alcohol Spectrum Disorder (FASD) Conference held here in Whitehorse in September of 2008, Kent Roach and Andrea Bailey noted in their work that physical facial features are present in only some people with FASD. Roach and Bailey shared that fetal alcohol spectrum disorder is a non-clinical umbrella term that refers to a range of cognitive deficits associated with disabilities incurred when a mother uses alcohol during her pregnancy. Such disabilities are permanent and can result in a range of symptoms, including poor memory, impulsiveness, inability to appreciate fully the consequences of one's actions; being easily influenced and even perhaps abused by others.

In only some cases will FASD produce physical facial features, such as thin upper lips, short eye slits and the slightly recessed jaw that have been associated with fetal alcohol syndrome. Falling within the FASD diagnosis of fetal alcohol effects, or FAE, are also partial fetal alcohol syndrome, alcohol-related neurodevelopmental disorder and alcohol-related birth defects. It is a significant accomplishment that MP Leef's bill looks to define what FASD is.

According to his bill, fetal alcohol spectrum disorder, or FASD, refers to any neurodevelopmental disorder that is associated with prenatal alcohol exposure and that is characterized by permanent organic brain injury and central nervous system damage that result in a pattern of permanent birth defects, the symptoms of which may include: impaired mental functioning; poor executive functioning; memory problems; impaired judgment; inability to control impulsive behavior; impaired ability to understand the consequences of one's actions; and impaired ability to internally modify behavioral control.

The MP's bill states that, "A court may, at any stage of proceedings against an accused, by order require that the accused be assessed by a qualified person, alone or with the input of other qualified persons, to determine whether the accused suffers from FASD and, if so, to indicate the relative severity of the disorder. The assessment may be ordered (a) with the consent of the accused and the prosecutor; or (b) by the court on its own motion or on application of the accused or the prosecutor, if the court believes a medical, psychological or psychiatric assessment in respect of the accused is necessary for a purpose mentioned in paragraphs (4)(a) to (d) and the court has reasonable grounds to believe that the accused may be suffering from FASD or a similar mental disorder or disability."

I would also like to note that Roach and Bailey reflected on obtaining assessments for FASD before sentencing. On pages 40 and 41 of their study, they observe that, "An FASD diagnosis is clearly very relevant to a court's consideration of the circumstances of a particular offender. Nevertheless, getting this information before the court is problematic. There are no provisions in the Criminal Code that would allow a judge to order an FASD assessment for sentencing purposes, and the question of who pays for such an assessment is often hotly contested."

One of the challenges that has often been noted in addressing FASD is the challenge of obtaining a diagnosis of FASD. I want to share a couple of definitions for diagnosis that I found. FASD is usually diagnosed by a multidisciplinary team consisting of a speech language pathologist, a psychologist, occupational therapist and a medical doctor.

The diagnosis is based on four areas. Each of the four areas is given a level of severity ranging from one to four — one being complete absence of the feature and four being strong classical presentation of the feature. The areas are: (1) maternal use of alcohol during pregnancy. If alcohol exposure histories are not documented or confirmation of use cannot be obtained from the mother, children cannot receive a diagnosis of FASD; (2) growth deficiency, which would be based on weight and height measurements; (3) facial features would be based on three key factors: small eye openings, flattened vertical columns in the upper lip and a thin upper lip; and (4) brain damage, which is based on three different areas: structural changes as seen in an MRI or a CAT scan — and I

should note that most individuals do not show abnormalities; neurological dysfunction — for example, seizures, muscle weakness, coordination deficits — and I should note that some, but not all, individuals show neurological dysfunction. Brain functioning is assessed by a multidisciplinary team, so that is the occupational therapist, a psychologist and/or a speech and language pathologist using standardized tests.

Mr. Speaker, I also consulted the Centres for Disease Control and Prevention and here is what they report. Health care professionals look for the following signs and symptoms when diagnosing FASD.

Abnormal facial features — so the person with FASD has three distinct facial features: smooth ridge between the nose and upper lip. Another feature is a thin upper lip and short distance between the inner and outer corner of the eyes, giving the eyes a wide-spaced appearance.

Growth problems — children with FAS have height, weight or both that are lower than normal, at or below the tenth percentile. These growth issues might occur even before birth. For some children with FAS, growth problems resolve themselves early in life.

Central nervous system problems — the central nervous system is made up of the brain and spinal cord. It controls all of the workings of the body. When something goes wrong with a part of the nervous system, a person can have trouble moving. They can have trouble speaking or learning. He or she can also have problems with memory, senses, or social skills.

There are three categories of central nervous system problems. The first is structural. FASD can cause differences in the structure of the brain. Signs of structural differences are smaller-than-normal head size for the person's overall weight and height, at or below the tenth percentile, and significant changes to the structure of the brain is seen on brain scans such as MRIs or CT scans.

There are also neurological problems — problems with the nervous system that cannot be linked to another cause. Examples include poor coordination, poor muscle control and problems with sucking as a baby. There are also functional issues, so the person's ability to function is well below what is expected for his or her age.

To be diagnosed with FAS, a person must have cognitive deficits — so a low IQ or a significant developmental delay in children who are too young for an IQ assessment, or problems in at least three of the following areas: a cognitive deficit or developmental delays. Examples would include specific learning disabilities — especially math — poor grades in school, performance differences between verbal and non-verbal skills, and slowed movements or reactions. Also, executive functioning deficits — these deficits involve the thinking process that help a person manage life tasks. Such deficits include poor organization and planning, lack of inhibition, difficulty grasping cause and effect, difficulty following multi-step directions, difficulty doing things in a new way or thinking of things in a new way, poor judgment and inability to apply knowledge to new situations.

There are also motor functioning delays. These delays affect how a person controls his or her muscles, and examples would include delay in walking, gross motor skills, and here would be difficulty in writing or drawing, fine motor skills, clumsiness, balance problems, tremors, difficulty coordinating hands and fingers — so dexterity — and, as I mentioned earlier, poor sucking in babies.

Attention problems or hyperactivity is also noted. A child with these problems might be described as busy, overactive, inattentive, easily distracted or having difficulty calming down, completing tasks or moving from one activity to the next. Parents might report that their child's attention changes from day to day — so there are on days and off days.

Also noted are problems with social skills. A child with social skill problems might lack a fear of strangers. They might be easily taken advantage of, and they might prefer younger friends, be immature, show inappropriate sexual behaviours and have trouble understanding how others feel.

Other problems that might be associated can include sensitivity to taste or touch, difficulty reading facial expressions, and difficulty responding appropriately to common parenting practices. An example of that would be not understanding cause-and-effect discipline.

Pertaining to a mother's alcohol use during pregnancy, confirmed alcohol use during pregnancy can strengthen the case for an FASD diagnosis. Confirmed absence of alcohol exposure would rule out the FASD diagnosis. It's helpful to know whether or not the person's mother drank alcohol during pregnancy but confirmed alcohol use during pregnancy is not needed if the child meets the other criteria. As you can see in one definition, maternal consumption of alcohol is a fairly important factor in determining a diagnosis of FASD. The MP's bill addresses this by stating — and this is in section 672.02 (3): "If the court is satisfied that there is good reason the evidence of alcohol consumption by an individual's mother while she was pregnant with the individual is not available, such as in circumstances in which the mother has died or cannot be identified or found, the cause of the FASD may be presumed to be the maternal consumption of alcohol."

I would now like to talk about what this means for the correctional system. The motion before us wrongly assumes that Yukon would have to amend our *Corrections Act, 2009* as it was drafted with offenders with issues like FASD in mind and, unfortunately, the members opposite do not seem to be acquainted with our legislation.

I would like to talk about the scope of the challenge before us. We are working to determine how many offenders have FASD. Yukon's Department of Justice implemented an FASD prevalence study in two phases. Overall, the study will determine the prevalence of FASD and identified mental health and substance abuse problems in Yukon's adult correctional population. Phase 1 completed the research methodology and the project plan. The study in its current phase, phase 2, includes obtaining formal ethics approval, recruiting adult Yukon offenders to participate in the study, assessments and diagnosis of the participants, data analysis and a final report outlining results and conclusions.

The University of British Columbia completed its ethical approval of the project in February of this year. Participant recruitment can now begin. The process for assessing adults for FASD requires a team of clinical professionals to administer medical exams, neuropsychological tests and multiple interviews. The study's research team has been assembled and trained. There is a principal investigator, a study manager, a psychologist, a physician, a research assistant, a supervising neuropsychologist and post-study coordinator. The next step is to launch a pilot assessment study with three to five participants to be run at the Whitehorse Correctional Centre.

How will the study help adult offenders with FASD here in our territory? The Department of Justice is trying to learn more about how many offenders have FASD to better meet their needs in the future.

FASD is not actually a diagnosis, but rather it's an umbrella word that describes permanent brain damage that is associated with prenatal exposure to alcohol. Persons with FASD experience difficulties, such as decision-making, problem solving, mental health problems or drug and alcohol abuse. There is very little data on the prevalence of FASD in the criminal justice system. The participants in the study will have an assessment of their specific needs and strengths, which may or may not include a finding of FASD. This report can help to inform service providers of where intervention should focus for that individual. This research does not actually target individuals who are suspected of having FASD or prenatal exposure to alcohol; rather, it will recruit a wide range of individuals with and without behavioural and health challenges to accurately determine the prevalence of FASD among the correctional population in Whitehorse and in Yukon.

Mr. Speaker, you may now be asking yourself: Just what are the costs of the FASD prevalence study? The Yukon Party government committed $643,000 for the next three fiscal years for phase 2 implementation of the study — funds for this program, that I might add, all members opposite voted against. The funds will cover the costs of personnel to administer the tests, the purchase of neurological tests, clinical training for the local research team, administrative costs and knowledge translation. Justice Canada, the Northern Institute of Social Justice and Yukon College funded development of the research methodology in 2013 and 2014.

Funding from the Public Health Agency of Canada financed the study manager and the training of the clinical team until March 31 of this year. The need to better understand how many people are affected by FASD in Yukon's correctional population was first raised at the Access to Justice for Individuals with Fetal Alcohol Spectrum Disorder (FASD) conference in 2008 that was hosted by the Yukon Department of Justice and Justice Canada.

The Department of Justice recognizes that a number of people in the adult correctional population have cognitive impairments, along with mental health and substance abuse issues. The FASD prevalence study will be conducted over an 18-month period and approximately 150 offenders will be assessed. All male and female offenders who are between the ages of 18 and 40 years old, who are serving territorial sentences or on probation, will be invited to participate. I might add that participation in this research study is completely voluntary.

The study is being conducted under the supervision of a principal investigator from the University of British Columbia. A 2013 research agreement between the University of British Columbia and the Government of Yukon outlines the university's role in the study, data ownership, data storage, data analysis, deliverables and overall research support. The University of British Columbia/Children's and Women's Health Centre of British Columbia Research Ethics Board approved this study methodology on February 18, 2014. Ethics approval from this respected source is crucial to the standards and procedures of the study. Colleagues across Canada in both justice and health and social services fields are looking forward to the results of Yukon's FASD prevalence study.

The FASD prevalence study is being conducted in collaboration with Health and Social Services. Justice leads the research study stream, while Health and Social Services leads the local capacity development and case management stream.

The prevalence project partners' board oversees the study. It includes Yukon Justice, Yukon Health and Social Services, Correctional Service Canada, Justice Canada, the Canadian Centre for Substance Abuse, the Northern Institute of Social Justice, Yukon College, Fetal Alcohol Syndrome Society of Yukon and First Nations Health and Social Development Commission.

Yukon's leadership role in this area began with the national conference that Yukon hosted with Justice Canada in September 2008, entitled The Path to Justice: Access to Justice for Individuals with Fetal Alcohol Spectrum Disorder (FASD) Conference. Officials from the department have been continually working on how we will address FASD and the challenges that it presents from a policy and program perspective, both internally and collaboratively.

This past November at our annual Minister of Justice meeting in Whitehorse, my colleagues and I discussed this very important topic and directed officials that this issue was to remain a priority item and to continue their work with respect to increasing access to justice for individuals with FASD. Yukon will continue to bring forward FASD as an access-to-justice issue to the federal-provincial-territorial ministers' and deputy ministers' levels and other agencies that have an interest in this issue, to ensure that work on this issue continues at a national level.

The Department of Justice has been working very hard on the development and implementation of a prevalence study of FASD and mental health and substance abuse issues in the Yukon adult corrections population. Our government had committed over $600,000 to fund this important work so that we can have a full understanding of how FASD affects the correctional system.

This study is a significant undertaking and I am pleased to report that this project is moving forward and we look forward to the results. I was very pleased that the Canadian Bar Association once again recognized the importance of our efforts to improve access to justice for people with FASD at their recent meeting.

It is our belief that, in order move forward in properly addressing this issue, due diligence is required to define this complex issue, which is why we have approved the work currently being done by the FPT officials. I can also assure you that we look forward to the opportunity to further dialogue with organizations such as the Canadian Bar Association and other justice system professionals to address this issue and develop appropriate solutions.

As I mentioned earlier, $643,000 was committed by Yukon government for three fiscal years to implement the FASD prevalence study: $228,000 in 2013-14 that the members opposite voted against; $367,000 in the 2014-15 budget that the members opposite have indicated that they will vote against; and an additional $45,000 in the 2015-16 budget that the members opposite will very likely not support. However, this study is only one piece of the larger access-to-justice initiative.

$68,000 from the 2008-09 and 2009-2010 fiscal years was committed to the costs associated with developing and delivering curriculum on FASD for justice professionals through the Northern Institute of Social Justice.

The department has supported Justice staff who deal with clients who have FASD to attend a 12-day FASD certificate program. This 12-day program was designated for service providers working in a case management capacity with adults and youth with FASD. During the course, participants will gain a greater understanding of the nature and consequences of FASD for the individual, for their family and for their community. Participants will learn the skills and techniques necessary to effectively develop a community case plan for a person with FASD. The department will continue to commit resources to train staff who deal with individuals who have or may have FASD to ensure that they are well-equipped to work with these individuals in the most effective way possible.

I should note that the Department of Justice with partners — Yukon Health and Social Services, Justice Canada, Yukon College's Northern Institute of Social Justice and the Yukon Research Centre, the Canadian Centre on Substance Abuse, Correctional Service Canada, FASSY, and the First Nations Health and Social Development Commission — developed a research methodology to research the prevalence of FASD and mental health and substance abuse issues among Yukon's adult correctional population. The goal of this prevalence study is to determine the extent and the degree that FASD and other issues affect the Yukon correctional population.

The research methodology was developed in a way to conduct a study to provide functional and clinically meaningful feedback to participants while executing a methodology's sound, efficient and feasible research design. Justice Canada provided $60,000 to carry out the methodology and project plan from 2009 to the 2013 fiscal years, and the Northern Institute of Social Justice provided $25,000 to develop the research methodology in 2012 and 2013.

Yukon Justice will oversee approximately 150 FASD assessments and will examine the rates of mental health and substance abuse problems reported in the Yukon corrections population. I should also note that there are a number of jurisdictions participating in the CCSO steering committee on FASD and access to justice. They are Yukon, Northwest Territories, Quebec, Justice Canada, British Columbia, Alberta, Manitoba, Saskatchewan, Ontario, Newfoundland and Labrador. Yukon, in partnership with Justice Canada, has been the lead in bringing the issue of FASD as an access-to-justice issue forward to the deputy ministers' and ministers' national agendas since the 2008 Path to Justice: Access to Justice for Individuals with Fetal Alcohol Spectrum Disorder (FASD) Conference in Whitehorse, which both governments co-hosted.

In 2009, federal, provincial and territorial ministers responsible for justice approved an initial FASD workplan prepared by CCSO criminal officials. FPT deputy ministers approved a second framework for a plan at their June 2013 meeting. This framework builds upon the initial workplan and remains focused on the same three theme areas of education, information sharing, and identification.

FPT ministers responsible for justice have continued to indicate support for this issue and have frequently identified it as a priority issue, including at the November 2013 justice ministers meetings held here in Whitehorse. There have also been external initiatives that have raised the profile of FASD as an access-to-justice issue recently. These include, in 2010, the Canadian Bar Association passing their resolution respecting the application of notions of criminal liability for those with FASD and the development of policies and solutions regarding FASD as an access-to-justice issue. In March 2011, the CBA met with representatives from the FPT FASD steering committee and identified a total of 10 measures that would increase access to justice for individuals with FASD.

In August 2013, the Canadian Bar Association passed another resolution on FASD and the justice system. This resolution was passed unanimously and urged the federal government to make several amendments to the *Criminal Code*. The September 2013 consensus conference on FASD and legal issues echoed many of the same recommendations as the CBA regarding changes to the *Criminal Code*, including provision for the ability of judges to order assessments and the inclusion of an escape clause to allow for judicial discretion in sentencing where mandatory minimum sentences exist, among other recommendations.

FASD is mostly talked about as a health or medical issue, but the conversation has started to shift to also think about FASD as a justice-related issue.

FASD impacts many Government of Yukon departments, other sectors and many countries. It is one of the most common disabilities in the world and is 100-percent preventable.

In 2009, the Institute of Health Economics reported that an annual economic cost of FASD in Alberta alone is estimated to be between $130 million to $400 million per year. These costs include educational costs, medical costs, addiction and drug treatments, additional costs to families, social services, supportive housing, loss of productivity and other justice system costs.

Unfortunately, there are not concrete numbers telling us how many people have FASD in Canada. Even less is known about the prevalence of FASD among Canadians in the criminal justice system. This is true for Yukon and it is true for other jurisdictions as well.

In 2008, our department put the wheels in motion to understand more about FASD as a justice-related issue. Yukon's Department of Justice, together with Justice Canada, hosted the Access to Justice for Individuals with Fetal Alcohol Spectrum Disorder (FASD) Conference. One of the recommendations from the conference was the need for research to determine the prevalence of FASD in the adult correctional population. The need for the development of adult diagnostic capacity was also identified.

Following the conference, the Yukon departments of Justice and Health and Social Services launched a collaborative FASD project to better understand and determine the prevalence of this specific disability. The FASD project is divided into two streams: Justice leads the prevalence study and Health and Social Services leads the adult diagnostic capacity development as well as the case management stream.

Both of our departments recognize that a number of people in the adult correctional population have cognitive impairments, along with mental health and substance abuse issues, that may be hindering their ability to benefit from treatment as well as programs. We also recognize that clients often access the same type of services in Health and Social Services and Justice.

I would like to take this opportunity to thank both the minister and the staff of the Department of Health and Social Services for their important collaboration on the FASD project. Health and Social Services has taken on the critical task of increasing Yukon's capacity in adult diagnostics, improving case management and case coordination.

Our front line employees understand that individuals who have FASD sometimes fall through the cracks. This is in part because individuals with FASD have brain-based disabilities that cause difficulties with decision making as well as problem solving. They also often have secondary mental health issues or problems with drug and alcohol abuse.

Simply put, FASD is a permanent brain disability. Societies and governments recognizing this disability and exploring a means to respond to it — it is issues like this that made me decide to get involved in government.

Many Yukoners have shared with me the challenges that they have experienced with respect to issues they, or a loved one face because of intellectual disabilities, including FASD. Those same people also indicated that the same challenges decreased during this nearly 12 years under a Yukon Party government.

As someone who has well over 10 years of experience in the social sector — not to mention that I have a child with a disability — I can verify this. There were challenges regarding access to tests, treatment and therapies. There were challenges with accessing initiatives to make adaptations to their home or to accommodate a family with a physical disability.

As many of the members in this House are already aware, my youngest son Jack has autism and as a parent, I know first-hand the challenges that we face and I know that helpless feeling that a parent with a child with a disability can have. I have to say thank you to this Yukon Party government. Our family is very fortunate to have had the supports that we have had over the years. My drive as a father and always ensuring the best for my child — along with the support of the previous Yukon Party governments — our son and our family have put together an incredible team of professionals who have helped in more ways than can be described.

Just last week here in this Legislature, we were paying tribute to Principal Marj Hlady from Christ the King Elementary School. I have to extend my sincere thanks to her and the staff from Christ the King Elementary School for their dedication and support to children who have intellectual disabilities, including FASD. They have made an incredible difference in many people's lives.

I know of other programs that Yukon government has incorporated for people with intellectual disabilities, including FASD and autism, just to name a couple. The healthy families program is a voluntary program that provides support to families prenatally or at birth, and continues until the child is school age. It has been offered in Whitehorse since 1999.

I have had parents share with me how helpful they find this program. In fact, one foster mom of a child with FASD explained that, with her child, she didn't know what to expect; she didn't know if her child's development was on track or not. It was comforting to have someone knowledgeable she could talk to about her baby's development.

The healthy families program — which is free of charge, I might add — will explore what's important to various families. It will explore what you want for your child. It will support you to build a safe and healthy environment, and it will provide interesting information and fun activities to strengthen your child's growth and development. I know first-hand how early assessment and early intervention can make a world of difference in a child's life.

Once a family finds out that their child has a disability, the support they receive from the government is through the family supports for children with disabilities program. Parents can make a referral to the program, or they can give their permission for someone working with their child, such as a doctor or a teacher, to do so.

This very important program provides support to Yukon families to care for their child with a disability, including children with FASD. It supports early intervention to increase the child's lifelong learning potential. It provides coordinated access to supports and interventions. It promotes inclusion of

children with disabilities in community life, but perhaps it can be expanded to do more.

My comments thus far have been focused on the supports that are available. As a parent of a child with special needs, I can tell you that finding out that your child has complex medical issues can be very, very challenging for families. I've spoken previously about the impact that it had on my family and on myself. It's important for me to share the comparison from my experience being a parent of a child with autism, as it pertains to potential resources to those being diagnosed with FASD.

I can think of parents I know who are raising children with extraordinary needs, including a diagnosis of FASD, and taking care of them is a full-time job. In fact, it's more than a full-time job, because most full-time jobs end after 40 hours a week and you get two weeks of vacation every year. Adult children with disabilities who stay at home are not uncommon. In fact, adult children who are of an age of more than 40 years old and still living with a parent are not uncommon. These incredible parents also need increased supports for their families and their adult children living at home.

I can give you a brief overview of what it might be like to be such a parent — and I've shared this in the Assembly before but I think in the context of resourcing issues pertaining to FASD, it's important to reiterate, because parents and caregivers are on call and available for work 24 hours a day, seven days a week, 365 days a year, without holidays and without pay.

It can take hours and hours of planning to attend a simple 15-minute appointment or just to go to the grocery store. What about buying that new outfit you have been wanting? Not likely — your funds have been overextended to provide for your adult child with a disability or with FASD. That nice, peaceful glass of wine at the end of the day while sitting on the front porch watching the sunset is replaced by sitting outside the bedroom of your adult child while they tantrum for hours because they aren't able to communicate their needs or how they are feeling.

Mr. Speaker, you know that my son doesn't really speak and, when he does, it is difficult to understand his communication because it only has to do with what he wants in that moment of time. Don't get me wrong, we feel very fortunate to have that, but before Jack could communicate verbally or through the iPod touch that he uses now — or an iPad — he would frequently have five-hour tantrums because he couldn't communicate his needs. This is common with people with a wide variety of disabilities, including FASD. As an assisted device, we incorporated the iPod touch that has an app that Jack can use to flip through pictures to identify his wants and needs. Jack does not know — nor have we found — a way to help him tell us how he feels. We don't know if he is happy or if he is sad, tired or stressed unless we look at the obvious physical attributes.

Another area of concern for me as a father is that my son would literally walk in front of a bus without understanding or being able to comprehend the consequences of such an action. Consequences are often something that individuals with FASD can't fully grasp.

On the subject of FASD as it pertains to me as a parent of a child with a disability, it's important to note where we came from. When my son, Jack, was diagnosed at age two, there were very few services available for him, let alone for other children with autism or other disabilities. Because of my background in health, I knew that early intervention was the key, as it is with a diagnosis of FASD. I remember in the early days sitting around a table with just two other families that were in the same boat as us. Their children were older than Jack. I even recall another family refusing to meet with us because they had attempted to obtain services for their child through the previous Liberal and NDP governments. They were met with closed doors. As a result, their child received very few supports.

This is relevant because the history is similar with providing services to people with FASD and making amendments to our legislation during the time of the Yukon Party being in government. I'm glad that I'm a bit stubborn and I know that there are a few people in the department that will attest to that, especially when it comes to my child and working on something that I believe in.

For the record, it was indeed this Yukon Party government that initiated support services for my son and other children with autism, Asperger's, with Rett's, FASD and other developmental disabilities. This Yukon Party government's decision to provide ABA therapy to people like Jack and others has had a profound impact on their lives. The Health and Social Services minister and the Premier, in 2002, truly stepped up to the plate and made a very bold move and should forever be commended for their work. We were also quite fortunate when the Health and Social Services portfolio was handed to our current Minister of Community Services on December 12, 2005 — fittingly two days after Jack's birthday.

To focus more specifically on the FASD prevalence study, I would like to outline three main goals for the justice stream of this particular project. First, the research team is going to determine the prevalence of FASD and other neurocognitive disorders in Yukon's adult correctional population. Second, the team is going to identify mental health and substance use problems in that very same population. Third, the team will test and assess certain FASD screening tools for use in the adult corrections population.

The study is being conducted under the supervision of a principal investigator from the University of British Columbia. A research agreement between the University of British Columbia and the Government of Yukon —

Some Hon. Member: (inaudible)

Point of order

Speaker: Member for Copperbelt South, on a point of order.

Ms. Moorcroft: On a point of order, I believe that the member opposite is reading into the record the same information related to the prevalence study at the Whitehorse Correctional Centre that he read into the record just a few

moments ago. I am sure that I heard him reading that previously, and I would point to Standing Order 19 regarding the unnecessary repetition in the course of a speech. I would like to ask the minister to refrain from reading into record material he has already spoken and to move on to some new ground that is relevant to the motion that we are debating.

Hon. Mr. Cathers: I believe that the minister was simply reading in comments that he believes are relevant to the subject matter at hand and I don't think that is any different from what other members have done, including the member herself.

Speaker's ruling

Speaker: There is no point of order. The member may continue.

Hon. Mr. Nixon: The University of British Columbia's Children's and Women's Health Centre British Columbia research ethics board approved this study methodology in February, which is crucial to the standards and procedures of this particular study. We are currently in phase 2, which includes obtaining formal ethics approval, recruiting adult corrections client volunteers to participate in the study, assessing and diagnosing participants, analyzing data and finally, reporting the results in the conclusions.

I should point out that the study does not target individuals — and I need to point this out again — that the study does not target individuals who are suspected of having FASD or prenatal exposure to alcohol. Rather, it will recruit a wide range of individuals with or without behavioural and health challenges to accurately determine the prevalence of FASD among the adult correctional population here in our territory.

Helping guide this study is a prevalence project partners' board, whose members represent Yukon departments of Justice and Health and Social Services, Correctional Service Canada, Justice Canada, Canadian Centre on Substance Abuse, Northern Institute of Social Justice, Yukon College, FASSY and the Yukon First Nations Health and Social Development Commission.

Again, I would like to take this opportunity to thank our partners. A project of this size does not happen on its own. The department is very, very grateful to have the guidance and direction from the prevalence project partners' board. The study research team consists of the principal investigator, the manager, the psychologist, the physician, the research assistant, a supervising neuropsychologist and a post-study coordinator. I can't thank them enough for their work.

As I have mentioned before, all participation from adult correction clients is 100-percent voluntary. After the FASD assessments are completed, participants in the study will receive a report outlining their results from the assessments. These results include a profile of their strengths and limitations, any diagnoses and recommendations regarding the program or any potential referrals. Study team members will meet with each participant and help him or her understand the results.

Following the end of an assessment, Justice will make available the services of a post-study coordinator to connect and navigate participants to services here in our territory. The cost of this prevalent study is approximately $640,000 over the three fiscal years.

The current model for assessing and diagnosing adult corrections clients and other referrals in the territory is to contract a local organization to organize the assessments on an annual basis. In turn, they hire a team capable of conducting these types of assessment. Under this model, an assessment team travels to Yukon once a year to conduct assessments.

The estimated cost of assessing one adult corrections client is approximately $5,000 to $6000 per adult. Assessing and potentially diagnosing a person with FASD can be expensive. This is because assessing adults for FASD requires a team of clinical professionals to retrieve personal records, conduct multiple interviews and administer neuropsychological and medical exams. The study's budget has to cover the costs of the clinical professionals, plus the cost of the neurological tests, dedicated management of the project logistics, travel for team members who are not based in our territory, administration and finally knowledge translation costs.

We already know that people who have FASD may require many supports and services from different sectors and different government departments. These supports and services often include, but are not limited to, housing, life skills, extra help in school, neuropsychological assessments, drug and alcohol counselling, social assistance, medical attention, mental health services, navigation through the justice system and community outreach. This is in part why other Canadian jurisdictions estimate that FASD costs between $130 million and $400 million a year.

A person's quality of life, safety, success and happiness obviously can't be fully measured in dollar amounts. However, we need to be aware of the costs of FASD as we move forward. The benefits to finding answers to deal appropriately with persons with FASD stem from both an economic and a social justice perspective. In a project of this scale, the complexities, research protocols and different understandings of FASD can bring challenges to timelines and goals.

I would like to highlight some of these challenges now and illustrate how the Department of Justice is addressing them. First, during meetings with our stakeholders, partners and service agencies, we consistently heard that FASD assessments must go beyond a clinical diagnosis and include a strength-based functional assessment. This is because functional assessments provide more potential benefits for individuals, their caregivers and their caseworkers. We listened to these requests and responded. As I mentioned earlier, after participants are assessed, they will receive a functional assessment outlining their results, including a profile of strengths and limitations, any diagnosis, and recommendations regarding programs or referrals.

Second, the department understands the importance of both protecting personal information and providing better

service. In the study protocols, any FASD diagnosis or other information gathered about an offender will only be known to the research team. The decision to share diagnostic information will be made by the study participants. The team will point out the benefits of sharing a diagnosis with persons such as a caseworker in order to improve service delivery. However, the decision to share information is solely up to the participant. The team will assist any participant who wishes to share their diagnosis information by helping them communicate that particular information.

Third, our stakeholders and our partners often stress how important it is to be mindful of the stigmas related to an FASD diagnosis. The department has responded and built these messages into employee training and study presentations. FASD is neither a First Nation issue nor just an issue in northern Canada. FASD affects people around the world and from many different socio-economic levels. In an attempt to break through these FASD stigmas, department staff will be holding awareness sessions for participants and corrections staff.

The final challenge I would like to discuss today is that improved diagnostic and assessment services must consider post-diagnosis service provisions. As I mentioned earlier, a post-study coordinator will be available to meet with participants following the end of assessments. This person will connect and help guide study participants to our services in Yukon and will facilitate referrals and recommendations from the research team.

I want to stress how important it is to first understand the extent of FASD in the justice system. The Department of Justice wants to gather good, strong evidence that will contribute to improved decision-making now and in the future. We intend to keep FASD and its challenges at the forefront of our priorities.

By doing so, the department leaders and service workers can continue to work toward providing the necessary responses to FASD in the justice system. I am very proud of the work that department staff has accomplished, both locally and nationally, to address the complex challenges that FASD presents. I am truly inspired by their commitment.

I need to talk about how Yukon is responding. First, we've developed the Community Wellness Court. This court was implemented as a pilot project in June 2007 in response to the call for the creation of a therapeutic court in Yukon in the *Yukon Substance Abuse Action Plan*. In March 2009, the pilot project was extended for three years to allow for an evaluation of the project and to further develop that court. In 2011, the Canadian Research Institute for Law and the Family, which is a non-profit, independent research institute in Calgary, evaluated the court and provided comments to support a further three years of pilot project funding. This report is available on the Yukon court's website.

In February 2012, the project was extended again until the end of the 2014-15 year to allow further assessment of the achievement of the court's objectives. The Community Wellness Court is currently being evaluated by Dr. Joe Hornick. This evaluation will be completed this year. Since implementation, over 2,000 charges and 208 offenders have been referred to the Community Wellness Court, 104 offenders were accepted into the program, and 80 offenders have graduated from the program, receiving either full or partial credit for their participation. Currently there are 24 active clients.

Following several assessments, an in-depth wellness plan is tailored to the needs of that individual client. The wellness journey can take up to 18 months before sentencing and may include things like individual or group therapeutic counselling and treatment, assistance with employment, housing and other basic needs. It may include medical assistance including psychiatric services; it may include assistance from agencies such as Fetal Alcohol Syndrome Society of Yukon and Many Rivers Counselling and Support Services, or intensive supervision and support by a probation officer working closely with that particular individual; and it may include assistance with building family and community supports.

Community Wellness Court participants are given priority placement for risk assessment in offender programming. In February 2012, Management Board approved $459,000 in operation and maintenance funding until the end of the 2014-15 year to allow for further assessment of the Community Wellness Court in the achievement of its objectives.

I also want to talk about the *Corrections Act, 2009* for a few minutes, as the members opposite seem to think we should amend it. The *Corrections Act, 2009* represents one of the pillars that have come out of the original corrections consultation initiated by the Yukon Party government in its first mandate of 2002 to 2006. The government continued to make Yukon communities safer by dealing with Yukon's serious alcohol and drug problems as a matter of top priority. The government committed to offer a drug and alcohol rehabilitation package to offenders who opted to seek that treatment. We delivered on those commitments.

In 2006, the Yukon Party committed to Yukoners to implement the corrections action plan that included measures to address the construction of a new correctional facility or facilities. I am pleased to report that, as all members of this Legislative Assembly know, we have delivered on that commitment.

The Yukon Party also committed as part of our clear vision for a bright future to look at governance issues, including new legislation. New legislation passed in 2009. That is one more commitment that we have completed. In looking over this work, I'm impressed by its quality. I think this is in large part due to the time the government took to consult Yukoners.

In terms of working together, in 2004 the government of the day began an exhaustive consultation that canvassed Yukoners on what they thought the future of corrections should look like. Clearly the old approach needed to change. Flowing out of that consultation is the *Corrections Act, 2009*.

Work began immediately on the new *Corrections Act, 2009* and public consultation began in late 2007, finally finishing in January 2009. Due to the good work of all the

participants in the consultation, we have a modern, sophisticated, robust and useful tool to address our correctional system. Their input was very important in creating that final product.

I want to note the comments in the *What We Heard* document that was generated in response to the consultation on corrections. The document stated that the Whitehorse Correctional Centre is not the best place for those with FASD. There should be perhaps another facility or at least a separate place within Whitehorse Correctional Centre for offenders with FASD. Inmates with FASD have a range of needs that must be identified and addressed while they are in the Correctional Centre. After they are released, they will need follow-up support and a range of other programs and services. Front-line staff need training to better understand clients who have FASD.

I also want to mention some other comments that we received that were made by Yukoners. The document also stated that more doctors are required to deal with medical and mental health issues. Inmates need to be treated by people who know the situation. We must accept responsibility for creating support for those who suffer from FASD and work toward breaking that FASD cycle.

I can appreciate the NDP's misunderstanding of what is in the *Corrections Act, 2009*. I went back and reread the debate from April 2009 when this bill was debated here in the Legislature.

What struck me as incredible was the complete disinterest by the Opposition in debating it. The NDP critic didn't want to discuss it and I see that they are noticeably absent from the debate on this bill. In fact, I notice that when it came time to vote, no one from the NDP showed up to vote.

Some Hon. Member: (inaudible)

Point of order

Speaker: Leader of the Official Opposition, on a point of order.

Ms. Hanson: There is a rule in this House, I believe, about not making — I don't know the reference but making reference to absences during votes. If he will look at the record, he will find out that the person was very ill — terminally ill.

Some Hon. Member: (inaudible)

Speaker: Are we done?

Some Hon. Member: (inaudible)

Unparliamentary language

Speaker: The debate across the floor is interfering with my ability to actually give a ruling here. I ask the member to retract the statement, apologize profusely and immediately and refrain from referring to anybody's absence or presence in this House or at a vote.

Withdrawal of remark

Hon. Mr. Nixon: Mr. Speaker, I retract the statement and I apologize. I misinterpreted the rule as being a current legislative sitting, so I do apologize for making those comments.

Speaker's statement

Speaker: I will add that it is still inappropriate, whether it is this sitting or any other sitting, now or in the future, to mention the presence or absence of anybody, particularly in the case of a vote.

Minister of Justice, please carry on.

Hon. Mr. Nixon: Thank you, Mr. Speaker. The *Corrections Act, 2009* and the companion regulations represent a new way of doing corrections. This section, entitled "Principles of corrections", clearly expresses this new approach. The paramount consideration is in the protection of society. I spoke about our commitment to work together. High on this list is collaboration with First Nations, who make up a majority of inmates held at the Correctional Centre or on probation. There is an onus on government to provide programming that is culturally relevant for Yukon First Nations. In addition, there are objectives calling for specialized programming for women.

We have changed the way we deal with complaints at the facility. The principles section gives the policy direction for the rest of the act and regulations, and it sets the tone for the whole regulatory framework. Our new program integration section puts Yukon at the leading edge of corrections legislation in our country. The focus of our legislation is on protecting Yukoners and on helping those in the correctional system get the help they require, especially in the area of drugs and alcohol.

Amendment proposed

Hon. Mr. Nixon: I move:

THAT Motion No. 638 be amended by deleting clause (4).

The amended motion would then read:

THAT this House urges the Government of Yukon to demonstrate its support for Bill C-583, *An Act to amend the Criminal Code* (fetal alcohol spectrum disorder) by:

(1) urging the Government of Canada to support Bill C-583;

(2) urging the Government of Canada to schedule full committee hearings, including the testimony of expert witnesses, respecting Bill C-583; and

(3) collaborating with the Government of the Northwest Territories and the Government of Nunavut to express pan-northern support for Bill No. C-583.

Further, THAT this House directs the Speaker of the Yukon Legislative Assembly to convey the consensus of this House in support of Bill No. C-583 to the Speaker of the House of Commons of Canada, the Speaker of the Legislative Assembly of the Northwest Territories and the Speaker of the Legislative Assembly of Nunavut.

Speaker: Order please. The amendment is in order.

It has been moved by the Minister of Justice:

THAT Motion No. 638 be amended by deleting clause (4).

Minister of Justice, you have 20 minutes on the amendment please.

Hon. Mr. Nixon: I don't need to go on at great length about the amendment. I think it clearly is self-explanatory and it should be clear to all members but, in conclusion, I've spoken to this motion in some detail and I've put on record some facts and have informed this House on the decision about FASD and the role of FASD in the correctional system. I've provided you with a road map for today's debate and I've given you an overview of Yukon's work to date on the FASD file.

I've taken some time to talk about the contents of Bill C-583, especially the parts around the definition of FASD, the ability for a court to assess FASD and the ability for a court to consider FASD in sentencing. Following that, speaking to the amendment, I've pointed out the response of the government and the courts to FASD and have corrected the record, especially with respect to the fourth element of this motion, which speaks specifically to amending Yukon's *Corrections Act, 2009*.

Ms. Hanson: On the amendment, I will be very brief. I just want to say that I've rarely been as disappointed as I have been this afternoon at a missed opportunity. When I introduced this motion, my very first comments were to the effect that it was an opportunity for us to rise above — "set aside" were the words I used — our partisan differences and to support the initiative of our Yukon Member of Parliament. I made every attempt to acknowledge and accolade the Yukon government for the work that they have done, pointing out that there is — and it's blind to suggest that there is not work still to be done.

I will only point out that, when I quoted the past president of the Canadian Bar Association, he said that there is the need to ensure there is one consistent principle that guides both judges and jailers. We cannot be guided by one principle of justice, fairness and ethics in the courts and by a different principle of justice, fairness and ethics in our corrections system. Our judges and our jailers must be guided by one consistent set of principles applied outside and inside our jails.

Unfortunately, what we have heard this afternoon and what we have just seen demonstrated as the road-map — as the minister refers to it — is the same as we have had repeatedly tossed across this way: it is our way or the highway. That is unfortunate. We had an opportunity here to actually talk to each other, as opposed to having a series of multiple attacks and multiple repetitions of the same material.

I think if people go back and check the Blues, that is what they are going to find tomorrow. It is very unfortunate and very disappointing, but we will not be supporting this amendment.

Mr. Silver: I just want to voice my concern here with the amendment. I will absolutely not be supporting the amendment. I want to give credit to our MP Ryan Leef for bucking the trend to begin with. What we are seeing here today is just not something that I can support. I would like to also commend the NDP for bringing forth the motion to begin with.

I will not be supporting this amendment.

Ms. Moorcroft: On the amendment, I prepared my remarks this afternoon with great hope that we in this Assembly would express unanimous agreement on this motion to accommodate the needs of people with fetal alcohol spectrum disorder and other alcohol-related neurodevelopment disorders in the correctional systems in Yukon and in Canada.

Just to briefly speak about the needs in the correctional system for accommodating people with FASD, those needs need to be accommodated. Many things happen in the correctional system, including internal disciplinary charges and proceedings. We have the deep concern that there is no accommodation of that disability once people are in a correctional service if they cannot meet the behavioural code that is established in the jail.

When doing programming of any kind, it is very important that those programs are adapted to the needs of the population that it serves. FASD is one of the disabilities that needs to be accommodated at Whitehorse Correctional Centre and across Canada.

The government will use its majority to pass that amendment, so I won't be able to speak to it further, but I was going to urge the Minister of Justice to consider the need to accommodate people with FASD in the correctional system because — in 2013 — a woman with mental illness reached a landmark settlement with Correctional Services Ontario because it discriminated against her by failing to accommodate her mental health-related needs. Christina Jahn alleged she had been placed in segregation for 210 days at the Ottawa-Carleton Detention Centre because of her mental health disabilities.

So the government will not introduce amendments to the Yukon *Corrections Act, 2009* to accommodate FASD as a disability. We in the Opposition will continue to advocate that the government direct the correctional services to accommodate people with FASD in the corrections system, using the *Human Rights Act* and other statutes as the basis for that.

To close, I do not support the amendment.

Speaker: Does any other member wish to be heard on the amendment?

Are you prepared for the question?

Some Hon. Members: Division.

Division

Speaker: Division has been called.

Bells

Speaker: Madam Deputy Clerk, please poll the House.

Hon. Mr. Pasloski: Agree.
Hon. Mr. Cathers: Agree.
Hon. Ms. Taylor: Agree.
Hon. Mr. Graham: Agree.
Hon. Mr. Nixon: Agree.
Ms. McLeod: Agree.
Hon. Mr. Istchenko: Agree.
Hon. Mr. Dixon: Agree.
Mr. Hassard: Agree.
Mr. Elias: Agree.
Ms. Hanson: Disagree.
Ms. Stick: Disagree.
Ms. Moorcroft: Disagree.
Ms. White: Disagree.
Mr. Tredger: Disagree.
Mr. Barr: Disagree.
Mr. Silver: Disagree.

Deputy Clerk: Mr. Speaker, the results are 10 yea, seven nay.

Speaker: The yeas have it. I declare the amendment carried.

Amendment to Motion No. 638 agreed to

Speaker: Is there any further debate on the motion, as amended?

Hon. Mr. Graham: On the motion, as amended: I was quite interested to listen to the debate, but I was also interested in listening to the Member for Mount Lorne-Southern Lakes in his righteous indignation during Question Period stating that there was virtually no — and I think I wrote down his quote quite accurately — that there was no diagnostic program available for adults in the territory. I just think that when people make those kinds of statements without actually understanding or knowing the true facts, they should be made aware of those facts.

FASD diagnostic clinics for school-age and preschool-age children have been delivered by trained in the Child Development Centre and the Department of Education for a number of years. We have trained teams that can diagnose up to 10 children per year — each team. We also have a contract with the Fetal Alcohol Syndrome Society of Yukon every year, for a number of years now, to provide that same diagnostic services to adults in the territory.

When the member for Mount Lorne-Southern Lakes talked about the difficulty of diagnostics for adults in the territory, it's simply not accurate. We've had that contract for a number of years. We've provided that service. As part of the program, the prevalent study that is going on — we're expanding that service. We're attempting to enhance Yukon's capacity to provide additional diagnostic services for adults across the territory. We're working on that. We're improving the service, but it has been available for a number of years.

He also mentioned prevention. He went on at great length about the lack of prevention and what we are doing as a government, so I thought I'll tell you. The Alcohol and Drug Services prevention unit develops and delivers universal FASD prevention. We first of all do a broad-scope approach, intended to anticipate and prevent substance abuse. This approach involves promoting awareness and influencing healthy behaviours and activities.

They include: FASD education and awareness presentation; program developments; and consultations in communities and schools. We work with the Department of Education to build FASD prevention information into the school curriculum for children around the territory.

We've also worked with other territories in the development of a pan-territorial FASD prevention media campaign about the importance of supporting women to have alcohol-free pregnancies. We also developed a public awareness campaign about Canada's new low-risk drinking guidelines, entitled "What's YOUR Normal?", promoting a culture of moderation.

That was only last year. We also distributed women and alcohol booklets that explained how alcohol affects women differently than it does men. The prevention unit also develops and delivers selected FASD prevention focused on populations at risk of alcohol-related disabilities — retrain and —

Some Hon. Member: (inaudible)

Hon. Mr. Graham: Mr. Speaker, obviously the Leader of the Official Opposition knows everything that is going on in the department and still chooses to criticize what is going on. Unfortunately, they obviously are unaware of what is going on within the department.

Speaker's statement

Speaker: Order please. I would ask the minister to speak to the motion and not to the harassment coming from the other side of the House.

Some Hon. Member: (inaudible)

Point of order

Speaker: Member for Takhini-Kopper King, on a point of order.

Ms. White: On a point of order. Standing Order 19(b)(i) speaks to matters than the question under discussion.

The minister right now is responding to the perceived comments from the Member for Mount Lorne-Southern Lakes and is not speaking to the amended motion.

Speaker's ruling

Speaker: It's difficult for the Chair to know where and how the member is going to tie the comments to the question at debate until such time as it is done. I would caution the member to make an effort at this point to try to indicate to the House how this ties to the motion at hand please.

Hon. Mr. Graham: Immediately, Mr. Speaker — in fact, I probably would have summed up by now if it wasn't for the interruption opposite.

What I'm trying to point out here is that there's a great deal of activity in the ADS division supporting FASD clients here in the territory. We're making that effort but we think more effort is needed. We believe that the motion being put forward by our Member of Parliament is a good motion, and I think it can be improved. I hope this is accepted by the members opposite as a friendly amendment, because that's what it's intended to be.

Amendment proposed

Hon. Mr. Graham: I move:

THAT Motion No. 638, as amended, be further amended in clause (1) by adding after the phrase "Bill C-583" the phrase: "by providing the provinces and territories with increased funds to fully cover all additional costs to implement the legislation;"

Speaker: It has been moved by the Minister of Health and Social Services:

THAT Motion No. 638, as amended, be further amended in clause (1) by adding after the phrase "Bill C-583" the phrase: "by providing the provinces and territories with increased funds to fully cover all additional costs to implement the legislation;"

Minister of Health and Social Services, you have 15 minutes and two seconds on your amendment.

Hon. Mr. Graham: It will only take a moment. We know the costs of providing services such as OSFI and we know the cost of providing housing for these individuals with FASD. We suspect that if they are being diverted from the correctional institute and from the justice system, we would like to be able to provide them with the appropriate accommodation and supervision that is needed in order for them to live — what we would term — very difficult lives. Consequently, we believe that it is in everyone's best interest if the federal government is able to provide these funds for provinces and territories across the country.

Ms. Hanson: The Official Opposition will essentially remain agnostic on this one. If we are talking about a government acting as a mature government, one would assume that in a mature federal-provincial-territorial relationship, the matters of costing and how that is dealt with would come out in that forum.

We are talking about the fundamental issues of amendments to the *Criminal Code* here. Unfortunately, we have a government that acts like an immature government that wants to go cap-in-hand all the time. I think if you are talking from a position of strength and you are supporting this motion, you would be supporting going as an equal to that table and not having to go as a supplicant.

So we will be agnostic. If you want to put that in there, go for it.

Speaker: Does any other member wish to be heard on the amendment?

Amendment to Motion No. 638, as amended, agreed to

Speaker: Member for Copperbelt South, on the motion, as amended.

Ms. Moorcroft: Mr. Speaker, notwithstanding the events preceding — having an opportunity to speak to the motion and the amendment, I do still hope that we in the Assembly today will reach unanimous agreement on the motion to accommodate the needs of people with fetal alcohol spectrum disorder and other alcohol-related neurodevelopment disorders in the correctional system in Yukon and in Canada.

This motion is being brought forward today because we know that people with fetal alcohol spectrum disorder, without criminal intent, often end up in conflict with the law. Both in society and across the criminal justice system, generally people do not understand the disorder. People with FASD are locked up in jails or other institutions and correctional systems and social programs fail to meet their needs.

I will speak today about this disability, about how leaders and all members of society can address the problems contributing to FASD, and about how actors in the criminal justice system can respond. I will make the case for legislative changes to the *Criminal Code* of Canada and, closer to home, the need to amend Yukon's *Corrections Act, 2009*, which could help support people struggling with FASD and prevent the over-incarceration of people with fetal alcohol spectrum disorder — a cognitive, organic brain disorder.

I want to acknowledge the initiative of the Canadian Bar Association and past president Rod Snow of Whitehorse, who is present in the gallery, for a lead role working with the federal Minister of Justice and the federal, provincial and territorial ministers responsible for justice with regard to the need to provide access to justice for people with FASD.

People with FASD need access to justice at all points of the criminal justice system — being taken into custody, being held in remand custody before a bail hearing, at various court appearances, and during the time they may be held in correctional facilities. I will also speak to better approaches and the need to find new ways to support stable living standards and conditions that could divert people with FASD away from jails.

What is FASD? Fetal alcohol spectrum disorder denotes a range of neurological and behavioural challenges that may affect an individual. The underlying brain and central nervous system damage may include impaired mental functioning, impaired judgment, inability to control impulse behaviour, inability to understand the consequences of their actions and the inability to internally modify behaviour control. All of these behaviours contribute to the criminalization of people with FASD.

We know that FASD is a preventable disease. A person whose mother consumed alcohol during the critical development period in her pregnancy may be born with fetal alcohol spectrum disorder. We know that substance abuse is a

deeply rooted social problem that affects everyone regardless of race, sex, class or age.

Alcoholism is recognized by the medical community as a family disease. It's a worldwide disease that knows no boundaries. FASD is something anyone can get, and I want to emphasize at the outset that it is counterproductive to shame and blame women for drinking. Families and communities must recognize and address underlying problems of substance abuse, such as poverty, lack of housing, violence, abuse or trauma and cultural dislocation by supporting women and by ensuring women do have their basic needs met and by helping women who are pregnant — educating them on the potential consequences of drinking alcohol during their pregnancies.

We need to understand the problem is not one that affects aboriginal populations exclusively, but that affects everyone. I have a big concern that governments and institutions do not stigmatize people with FASD, or their mothers.

We do know that nationally and in the northern territories, aboriginal people and people with FASD are over-represented in the criminal justice system. According to the Office of the Correctional Investigator, while aboriginal people make up four percent of the Canadian population, as of February 2013, 23.2 percent of the federal inmate population is aboriginal. In the Yukon, 70 to 90 percent of the correctional population is aboriginal, and Northwest Territories and Nunavut have very large numbers of aboriginal people in their correctional systems too.

Speaking about the institutionalization of persons with FASD and mental health problems, I need to emphasize the correctional system is a bad place for those with mental health illnesses and far too many people with FASD and mental health problems end up in jails. The federal Office of the Correctional Investigator has reported that, between 1997 and 2010, symptoms of serious mental illness reported by federal offenders at admission increased by 61 percent for males and 71 percent for females. That information comes from a 2010 report by Sorenson. I'm certain that at the federal level where MP Ryan Leef is attempting to make some limited changes to the *Criminal Code* of Canada, parliamentarians will take into account the full picture, the prison population, the numerous reports that have been done for and about the Correctional Service Canada and people with FASD and mental health disabilities in that system.

Michelle Mann's report, *Good Intentions, Disappointing Results*, states that the offending circumstances of aboriginal offenders are often related to substance abuse, intergenerational abuse and residential schools, low levels of education, employment and income, and substandard housing and health care, among other factors. Aboriginal offenders tend to be younger and to have more mental health problems, including fetal alcohol spectrum disorder and mental health issues. We know this is something we are dealing with in our correctional system.

While in recent years Yukon began to recognize the challenges of dealing with fetal alcohol spectrum disorder, we must be mindful of colonial practices that dislocated Yukon First Nation families and communities. As I have learned from Yukon elders, being told by priests that your spiritual practices are heathen, by the Indian agents and the courts that your ceremonies and cultural practices are against the law, by missionaries that your home and your children are unclean, by social workers that you are an unfit mother, by police that your children are being lawfully taken to "residential school" and that you will go to jail if you don't hand over your children are all practices that have caused deep pain.

This deep sense of loss reaches to generations of today. These injustices are a root cause of alcohol abuse and we cannot begin to right those wrongs until we understand that history.

I would like to thank many elders who have shared with me their thoughts about what is needed today to respond to these problems. I have been told that what government can do is to meet with — and listen to — Yukon First Nation elders and leaders to spend time to truly understand and respect their cultures.

In the past, the settler community and governments tried to take the Indian out of the child and to destroy aboriginal cultures and practices, but First Nations are strong — they resisted those attempts and their culture thrives today. Land-based treatment and healing programs that are directed by First Nations and supported by the Yukon government are a significant way to respond to the social problems that contribute to FASD. People with FASD may be found in group homes, foster care, the youth justice system and the correctional system, and there is a lack of programming for people with this disability.

The Leader of the Official Opposition spoke today about early efforts in Yukon to diagnose FASD, and the Minister of Health and Social Services seemed quite indignant when he put on the record that there are supports, both in the Department of Health and Social Services and contracts to the Fetal Alcohol Syndrome Society Yukon to provide diagnostic services for children and results.

I would like to know for the record how many of those diagnoses have occurred for children and for adults on an annual basis over the past dozen years that this government has been in office, and over the last year and the current year.

Mr. Speaker, members of the Yukon judiciary have long recognized the problem of FASD and have addressed it in their sentencing decisions and encouraged government to act. More recently, Canadian Bar Association resolutions to address FASD in the criminal justice system resulted in the federal Minister of Justice and federal, provincial and territorial ministers making it a priority to deal with FASD in the correctional system.

I am going to acknowledge the work here in the Yukon on the prevalence study on the incidence of FASD, mental health and substance abuse problems that will most likely reveal what we already know: that many people who are held at Whitehorse Correctional Centre do have FASD and need accommodation. I want to urge the government to work with Yukon First Nations and to also consult with and work with experts and consultants in the communities, such as the Yukon Council on DisABILITY, the Yukon Association for

Community Living and FASSY, which work with people with FASD. I would like to thank the representatives of those organizations who have been here today.

Prisons are dangerous and damaging places for mentally ill people. Canadian statistics will show, as I've read into the record previously, that there is a rising population of people with mental illnesses in the correctional systems.

A 2003 Human Rights Watch report states that there are three times as many men and women with mental illnesses in U.S. prisons as in mental health hospitals. They make the following comment as well: "Prison staff often punish mentally ill offenders for symptoms of their illness — such as being noisy or refusing orders, or even self-mutilation and attempted suicide. Mentally ill prisoners are more likely than others to end up housed in especially harsh conditions, such as isolation or separate confinement, that can push them over the edge into acute psychosis… Woefully deficient mental health services in many prisons leave prisoners undertreated — or not treated at all."

Our Member of Parliament's proposed amendments to the *Criminal Code* of Canada would establish a procedure for assessing people in the criminal justice system who it suspects suffer from FASD. It requires the courts to consider, as a mitigating factor in sentencing, a determination that the accused suffers from FASD and manifests certain symptoms.

The resolution also speaks to the need for judges to have the power to order assessments as is currently provided for in section 34 of the *Youth Criminal Justice Act*.

The CBA resolution calls for an external support order that a judge should be authorized to make an order approving an external support plan recommended by a FASD person's probation officer that could be in effect after probation expires.

The resolution speaks to the duty to accommodate. The *Corrections and Conditional Release Act* should be amended to expressly require Correctional Service Canada to accommodate FASD as a disability when providing correctional services to inmates who have or likely have FASD.

I do hope that all members in this House will support the motion before us. People with FASD need to have their disabilities accommodated in the correctional system. A more comprehensive approach to the mental health and criminal justice system would address prevention, diversion, treatment and rehabilitation needs of people with mental illnesses. For Yukon residents and communities, taking a comprehensive approach would mean the full direction and participation of Yukon First Nations in developing and delivering program models for healing, for after-care supports and for supportive housing.

Before I close, I want to comment to the members opposite and in particular to the Minister of Justice, that the overrepresentation of people with FASD in the correctional system and the overuse of separate confinement does a grave disservice to the population held at Whitehorse Correctional Centre and to the staff there and to the family members and community members of those who are incarcerated.

I think that this government needs to acknowledge the requirements in the Yukon *Human Rights Act* for accommodating people with disabilities, and that includes mental health and people with FASD.

Before I close, I want to say that I support the motion's procedural direction that in the event of support from all members for the bill, that this House directs the Speaker to convey the consensus of this House in support of Bill No. C-583 to the Speaker of the House of Commons of Canada, the Speaker of the Legislative Assembly of the Northwest Territories and the Speaker of the Legislative Assembly of Nunavut.

Mr. Speaker, I trust that you will reflect in your communication of the consensus some of the arguments that I have made today in support of this motion and some of the important matters that we are dealing with here today.

Mr. Silver: I rise to speak to this motion as amended. I do believe that the intent of the original motion coming forth from the NDP is still intact and I congratulate them for standing up for this important issue today.

It is of huge significance to all Yukoners. It is also admirable for the Yukon's Member of Parliament Ryan Leef to buck the trend and table legislation that actually looks to help people in the Canadian justice system, rather than handcuffing them with a mandatory minimum sentence.

In speaking also to former MP Larry Bagnell, I know that this was something he was also working on prior to leaving office in 2011. I'm glad to see our MPs, despite being from different parties, have common goals when it comes to issues that face Yukoners.

I would like to read from a consensus statement found in our Member for Parliament's act to amend the *Criminal Code* of Canada in respect to fetal alcohol spectrum disorder, FASD — and I quote: "The failure to have a full diagnosis of FASD should not be an excuse for ignoring relevant neurological impairments that may be associated with FASD. The imprisonment of an innocent man or woman, because of misunderstandings created by a condition over which an accused has no control, should shock the conscience of society."

There is still much research that needs to be done on FASD. The Canadian FASD research network notes that no two cases are identical and that the effects that alcohol has on brain development can vary widely. There are no statistics on how many people in Canada have FASD, but research indicates that in some other western countries it may be as high as five percent of live births.

I would like to take this opportunity to echo some of the other MLAs today thanking FASSY, the Fetal Alcohol Syndrome Society Yukon, for the hard work that they do to create an accepting and educated community in the Yukon for those whose cases have been identified, as well as the work that they do to prevent FASD. I know from my many years teaching that children born with fetal alcohol spectrum disorder do require special attention and the Yukon government did publish an education strategy on this in 2006.

It stands to reason that if a government is acknowledging FASD as an issue in the education system, then they should also be doing that in the judicial system. FASD is a complex issue that requires compassion. My office has been in contact with our federal Liberal counterparts and is encouraging them to support Bill C-583 should the private member bill ever make it to the floor of the House of Commons. I will be supporting this motion today. Once again, I would like to thank the members of the NDP for bringing it forward today.

Ms. White: Speaking to this motion today, I'm not going to go through studies and I'm not going to go through clinical diagnosis. What I'm going to talk about are two people that I'm really lucky to know quite well.

Back when I owned a coffee shop, there was a young man who would come by, probably three or four times a week and ask me if he could get a job. I told him, "When you turn 14 and you come back, I will give you a job."

This young man was exceptional in a lot of ways and it didn't take very long for me to realize that some of his exceptional qualities were ones that I was really going to have to learn to work with. When he started working with me, it was — he and I worked together because of some of those difficulties that he was going to have — not that he was going to have them, it just turned out that he had them when he came to work. When he came to work, I needed to learn how to ask him to do things in a way that he could understand. I couldn't expect him to understand things in a way that the other teenagers would. I needed to figure out how I needed to communicate, and the communication was different.

There are examples. I almost paid my rent at the Canada Games Centre in cookies — $1 cookies — and those $1 cookies had to get wrapped. But when we were wrapping cookies, we would wrap hundreds of cookies at a time — and it was a process — and it was a production line. Well, he got frustrated with the cookie-wrapping because there was a clear start, but there was never a clear end. He always had to leave the shop before we were finished, so he never got to see the task completed. I learned that cookie-wrapping was not something that he could do.

What I learned is that scrubbing the sink and making it shine like I had never seen before was something he could do — or cleaning the refrigerator was something he could do. What I also learned was that there was no cause and consequence. So every time that he would make a mistake and we would correct it, I had to learn that when he came back — even the next day — there was no recognition that that mistake was a mistake and couldn't be done. There was no cause and consequence. It never clued in for the next day.

I learned things like there was no caffeine when he worked. I learned that we wouldn't have sugared drinks. These are all things that I had to learn about him so that he could be successful, and he was successful because I gave him the opportunity and because I also listened to what his needs were. I didn't expect him to behave like other people because he didn't behave like other people. The thing is I worried about him always, because one of his traits is that he is a people-pleaser. He wants to be liked and he wants to be normal — whatever normal is. He would go to great lengths to be accepted by people.

I always worried about him being victimized when he got older because — when I met him— his family had hired a caregiver, and 100-percent of that caregiver's concentration was on the one son — and they had three sons. I always worried about what would happen when he got to an age where the caregiver wasn't going to be able to keep up. There are examples. He loved remote-controlled cars but he was unable to stop himself from clipping the wires in the remote-controlled cars. That would make the radio antenna not work.

So it didn't matter that every time he clipped the wire on a car, the car wouldn't work, and he was always sadly disappointed that it wouldn't work again, but he couldn't stop himself from that compulsion. That all had to do with his disability.

In 2009, when I got my job in corrections, I said to my boss shortly after I got there that I worried that one day he would come in — that I worried that, after he turned 18, he was going to be doing something to try to please people, and he was going to get arrested. That actually happened when I was there. He was brought into the correctional facility. He is a bit smaller than men his age — he is a man now.

The correctional facility inadequately dealt with his needs. At the beginning, they were able to keep him out of general population because they recognized that he was small and he would be victimized. He would be the one with the bad behaviour; he would be the one to be encouraged to do those things. They kept him apart at the beginning, but they couldn't do that forever, so when he moved into the general population, he learned all sorts of skills that he never had when he went in — and they are not skills that we should be congratulating him on having. He developed behaviours that he didn't have before, because he was a constant people-pleaser — and when he left corrections, he came back in.

The second example when I was in corrections, in the two years I was there, there was only one single person who went through the diagnosis process for FASD. It took eight months for the manager of my unit and the woman's sister to convince her to go through that process. Part of the reason why it was so long is because she didn't want to have the title. She did not want the stigma that was associated with that.

So in the two years that I was there, I only saw one person go through the process of that and it was not an easy process. It took eight months of convincing before she actually started that.

We talk about the prevalence study and we talk about trying to identify people. This will not be easy, but just because it's not easy — I think we still need to go forward with it. There is so much still attached to it — so much stigma is still attached to the title — that we have to be really aware that this is not an easy process. We need to make sure that people have all the supports. When we talk about changing and what Bill C-583 is suggesting, it's actually about putting the human face behind those actions and behind those mistakes.

I hope that the Government of Canada does what I consider is the right thing and I hope we follow suit.

Mr. Tredger: Mr. Speaker, I rise in support of this motion. I was full of hope when we entered the afternoon and I'm still hopeful, but I also want to scream. It's high time that we as legislators, as members of our communities, have this conversation. This is a first step in a long and challenging journey. I want to thank the Member for Whitehorse Centre and our Member of Parliament Ryan Leef for bringing this to the fore — for bringing this long-awaited discussion to the light of day.

I want to congratulate and thank the members of the Canadian Bar Association. I am proud of them and the work they are doing, for recognizing that there was a problem — that there is a problem — and continuing to do the same thing would not work. They have become champions for justice for people — not just in the justice system, but for people in all of our communities — Whitehorse, rural, and across Canada.

We do have a problem. Dealing with FASD is a serious problem. It is challenging. The consequences of not dealing with it far outweigh the challenges of dealing with it. Front-line workers in the justice system, in the education system, in the health and social services system have known this. Community members, parents, friends and family have known this. They've been struggling; they've been bewildered; they've been frustrated.

I can remember first becoming aware of FASD. Teachers would come to me crying, angry, not knowing what to do. Parents would come to me at their wits' end. They were embarrassed. They couldn't manage their children. Courtworkers would come to me, saying, "What can we do?" We were fortunate to have been introduced to a book called *The Broken Cord* by Michael Dorris that put words to some of our frustrations that brought ideas to us. Further along, Dr. Asante gave us hope and inspiration and helped us as we worked together.

We know we can't do this alone. We know we have a problem. We know that the cost of diagnostics and appropriate supports are minuscule compared to the costs of ignoring the situation. The cost of family, the cost of community, the cost of friends and parents, the cost to our front-line workers and the monetary costs are huge if we don't deal with this.

I will keep my comments briefer than I had intended because I think it is important that we get this to a vote. When I look at all the legislators in here, I will say to each and every one of you that we don't need gate keepers. We need leaders. We need risk takers.

We need people to work together with people throughout our territory. We need compassion. We need hope. We need to build on the inspiration from this debate. The courtworkers, the judges, the teachers, the parents and the community members are counting on us.

Our Member of Parliament and the CBA are champions. We need to all be champions. We need to follow their lead. We need to realize that what we're doing now is not working. We need to put our heads together and come up with creative solutions. We need to recognize our responsibility. If we recognize that jails are not the place for people with FASD, then we must also recognize that it is our duty not to pass on that responsibility, but to accept that responsibility to ensure that they have appropriate supports in place.

In conclusion, I thank everyone for their contributions to the debate. I thank our Member of Parliament, I thank the Member for Whitehorse Centre and I thank the Canadian Bar Association for having the courage to show us the way. I ask each and every one of us in this Legislature to take their lead and follow.

Speaker: If the member now speaks, she will close debate. Does any other member wish to be heard?

Ms. Hanson: When we came into the Assembly this afternoon, I think we all came in — certainly I did — I came in with a good heart and hoped that collectively we would find a way to set aside our partisan political consideration and basically show support for Bill C-583, a private member's bill introduced by our Yukon federal Member of Parliament and, at the same time, the humility to recognize, as I said earlier when I was quoting Rod Snow, the notion that we can't be guided by one principle of justice, fairness and ethics in the court and a different principle of justice, fairness and ethics in our correctional systems. I firmly believe that our judges and our jailers must be guided by one consistent set of principles applied both outside and inside our jails.

There is a lot of work to be done on that front. There's nothing in the many, many words that I heard this afternoon that has dissuaded me of that. I do believe that the motion that was brought forward by the Official Opposition today recognizes, as the past president of the CBA said, that it's neither ethical nor just for the law to punish individuals for failure to meet a standard of behaviour that their disability prevents them from meeting, and that is what the law and our justice system's institutions do when they fail to accommodate fetal alcohol spectrum disorder. In this way, our society criminalizes individuals with fetal alcohol spectrum disorder because of their disability.

I firmly believe and concur with him. He said that when a law is unjust, we have an obligation to change it. I believe that by passing this motion today — at least for those who are not present today to actually witness the proceedings — they will only view the outcome, which I am hopeful is the support of Bill C-583 — the support, if not the difficult and often unpleasant discourse. We will at least have done our small part to encourage the federal government to take seriously the initiative that is Bill C-583.

As I said at the outset, the federal New Democratic Party Official Opposition and the federal Liberals will support this. I have made personal calls to the Northwest Territories, but not yet to Nunavut — to members of the Legislature there — to seek their support. We now look to you, Mr. Speaker, presuming — and I suppose one should not presume the will of the House, but I'm hopeful — that you will take the news of the passage of this motion, which urges the federal

government to amend the *Criminal Code* with respect to fetal alcohol spectrum disorder, to your federal and territorial counterparts.

I commend this motion to the House.

Speaker: Are you prepared for the question?

Some Hon. Members: Division.

Division

Speaker: Division has been called.

Bells

Speaker: Madam Deputy Clerk, please poll the House.

Hon. Mr. Pasloski: Agree.
Hon. Mr. Cathers: Agree.
Hon. Ms. Taylor: Agree.
Hon. Mr. Graham: Agree.
Hon. Mr. Kent: Agree.
Hon. Mr. Nixon: Agree.
Ms. McLeod: Agree.
Hon. Mr. Istchenko: Agree.
Hon. Mr. Dixon: Agree.
Mr. Hassard: Agree.
Mr. Elias: Agree.
Ms. Hanson: Agree.
Ms. Stick: Agree.
Ms. Moorcroft: Agree.
Ms. White: Agree.
Mr. Tredger: Agree.
Mr. Barr: Agree.
Mr. Silver: Agree.

Deputy Clerk: Mr. Speaker, the results are 18 yea, nil nay.

Speaker: The yeas have it. I declare the motion, as amended, carried.

Motion No. 638, as amended, agreed to

Motion No. 659

Deputy Clerk: Motion No. 659, standing in the name of Mr. Silver.

Speaker: It has been moved by the Leader of the Third Party:

THAT this House urges the Government of Yukon to meet with all stakeholders following the 2014 tourism season to ensure the Dawson City airport is adequately serving the needs of all users.

Mr. Silver: Last year it was announced that Holland America would be partnering with Air North to provide a direct flight between Dawson City and Fairbanks, Alaska. Since then, we have seen ups and downs in whether these new flights would actually happen. The flights present new opportunities, clearly, for Dawson's tourism economy and I am excited to hear what the Klondike Visitors Association will have to say after the end of the tourism season here in October about theses impacts. It will also be interesting to see what the Klondike Development Organization has to say.

There are a number of stakeholders for whom this year will be make-or-break and this could have long-term ramifications for the Yukon tourism economy and the City of Dawson.

I rise today to speak to the following motion:

THAT this House urges the Government of Yukon to meet with all stakeholders following the 2014 tourism season to ensure that the Dawson City airport is adequately serving the needs of all users.

There are innumerable stakeholders these flights will effect, but specifically I would encourage the Government of Yukon to meet with the City of Dawson, the Klondike Visitors Association, the Dawson City Chamber of Commerce, the Klondike Development Organization, Wildland Fire Management, the Klondike Valley Fire Department, and of course Air North and Holland America.

The timeline of events have been filled with uncertainty since the announcement that Air North and Holland America would be partnering on this endeavour. In early November it was made public that U.S. Customs would not be accommodating new flights and that the manpower from the Top of the World border crossing would not be moved. A few weeks later, thanks to pressures from the industry and from Alaskan Senator Lisa Murkowski, the U.S. Customs reversed its decision and the flights were able to go ahead.

We also heard that there were delays with the Customs office construction. The original purposed customs structure was a wall tent, which neither the Canadian Border Services nor United States Customs and Border Protection saw as an adequate building for international security screenings. We are now days away from the first flights leaving, and although construction appeared to have started since I was in Dawson on Saturday, the Customs building is not quite ready as of yet.

During the budget speech, the Premier was proud to announce that the budget would include Yukon's largest transportation budget ever, providing $85.264 million overall for airports, highways and bridges. We know that there will be a shortfall already in this, seeing as how the Nisutlin River bridge would not be moving forth this summer, but within this was the $16.316 million that was earmarked for airports.

Nothing major for the Dawson Airport was in that, despite it seeing the largest increase in traffic this summer. Even the Customs building was not properly allocated for, and my understanding is that the structure being used for the 2014 season will once again be a temporary building, a temporary solution.

As well, the 737s cannot land and take off with full capacities because of the gravel runway. As the minister himself said to the *Yukon News* on Monday, flights can only take off with 60 passengers and land with 80.

On Monday, the Minister of Highways and Public Works reminded the House of the needs assessment that had been completed on the airport. The document was published in October yet no activity was taken in this budget.

Mr. Speaker, with so much hinging on the Dawson City Airport this summer, it leaves us to wonder why this was not budgeted as a major capital project. When this summer is over, it will be incredibly important that all of the tourism operators and stakeholders are brought to the table to dissect how the summer went. The obvious stakeholders to be at the table will be Holland America, Air North and the City of Dawson. They can provide us with the successes, the shortfalls, and if the summer indicates the long-term potential for flights between Dawson and Fairbanks.

I also encourage the Klondike Visitors Association, the Klondike Development Organization and Dawson City Chamber of Commerce to also be included at this table. As the associations that represent businesses in Dawson, they will be the ones who can best tell us whether the hotels, restaurants and small businesses saw an increase in business.

Finally, Wildland Fire Management and the Klondike Valley Fire Department should also be included in this round table. An issue that I raised on April 15 of this sitting was the state of readiness for local firefighters due to the increased traffic to come as a result of Holland America's decision to fly passengers through the Dawson City Airport. Last fall, the minister said: "Don't worry — Wildland Fire Management has a station right at the airport." As I've previously stated, the firefighters in Dawson I have spoken to weren't too excited with that response, to say the least. Wildland firefighters are not trained to handle airport fires or airplane fires, for that matter — also, for that matter, neither is the Klondike Valley Fire Department. With these flights only weeks away, why has no training taken place to ensure that there is adequate fire protection at the ready?

In response to my question, the Minister of Community Services informed the House that — and I quote: "… we don't take anything that comes out of the mouth of the Leader of the Liberal Party at face value." I can see that the member over there agrees with himself again — imagine that. But the fact remains — and this is the fact — that proper training has not been facilitated in Dawson for firefighters who have to meet and deal with incidents at the airport. Once again, we will be encouraging the members opposite to look into this serious issue and maybe get serious about fire protection at the Dawson City Airport.

The final point that I would like to make is about my concerns regarding the Kluane region. Last spring, I asked the minister about the impacts of the changes to the Kluane region as a result of Holland America rerouting away from the Alaska Highway. As the Member for Klondike, I am naturally happy to see more business being shuttled into Dawson this summer. However, I don't want to see the growth at the expense of another region. What steps has this government taken to ensure that impacts of this change are minimalized? I am hoping we can have that conversation today.

It is good to see that the department is going to be visiting Haines Junction on Friday, but it is too late to mitigate any negative impacts in that region with the summer tourism season kicking off within the next three weeks. Kluane has seen a lot of businesses turn over in the last couple of years. Holland America not providing tours in the region can only hurt those attempting to provide new life to the tourism sector.

Earlier this week, the Minister of Tourism and Culture stood up and presented this motion:

THAT this House urges the Government of Yukon, in recognition of the Yukon Party's platform commitments to promote Yukon's tourism economy, to continue to study the technical and economic business case of further capital upgrades, including paving the runway at the Dawson City airport, as part of the Government of Yukon's work with Air North, Yukon's airline, and Holland America to promote tourism to Yukon and the Klondike region through the use of tourism cooperative marketing agreements and strategic marketing campaigns.

I am happy that the minister is committed to capital upgrades at the Dawson City Airport but we have many questions. For example: What is the status of the study for the technical and economic cases? When will this paving happen? I hope the minister will be sharing some of his timelines with the House today or very soon.

Mr. Speaker, the NDP Member for Copperbelt South asked the Minister of Tourism and Culture and the Minister of Highways and Public Works about the airport on Monday as well. The Minister of Tourism and Culture presented his motion on the topic. It seems to me that we have support for the success of the Dawson City Airport across all party lines but, once again, the intent of the motion on the floor today is: What are the next steps?

I do urge the government to sit down in the fall with the City of Dawson, the Klondike Visitors Association, the Klondike Development Organization, Dawson City Chamber of Commerce, the Klondike Valley Fire Department, Wildland Fire Management, Holland America, Air North and all other stakeholders to ensure that the Dawson City Airport is meeting the needs for the tourism industry. This motion was written so that it was pretty straightforward. I think it needs support. It doesn't necessarily need amendments, but we'll see what happens on that front.

I don't think there's a member in this House who doesn't think that tourism is an extremely important industry and, in the spirit of cooperation and in the spirit of actually getting this debate to continue — I mean, I could sit here and talk for another five minutes and therefore have my turn continue later on, but I'm not going to do that. I'm intentionally going to sit down and allow somebody else to have the floor. This will be brought up again when we have our turn at the end of the session and I hope to continue the debate there.

Once again, I'm just putting it to the floor. I would like to thank everybody for listening to my comments and I hope that we get unanimous consent to this extremely important motion for my district.

Hon. Mr. Nixon: In my comments today, I want to talk for a few minutes about how we're working with stakeholders in Dawson City and the Klondike region to address and promote tourism. I would then like to talk about the changing market and how that influences travel options,

including the Dawson City Airport. Then I would like to talk about the importance of Air North, Yukon's airline, in responding to the changing market demands for transporting tourists to and within our territory.

I want to acknowledge the key role that Air North, Yukon's airline, contributes to the Yukon's social and economic development. As members know, the issue of tourism in the Klondike region is one that I care about very deeply. Members may recall that, when Parks Canada implemented some significant changes to the way their sites were made available to the public, my colleagues and I stepped up and worked with our MP to address that issue. I'll come back to that in a bit.

In response to this motion, I can say that the Government of Yukon is very proactive in actively communicating and working with the tourism industry stakeholders. Together, the tourism industry and the Department of Tourism and Culture continue to make notable and significant progress in raising global awareness of Yukon as a year-round travel destination. This progress is being made despite the competitive market challenges that Canada's tourism sector is seeing as a whole. Visitor and economic data demonstrates the success of this partnership.

Data from the Yukon visitor tracking program, from the border crossing statistics and from the 2013 Yukon business survey all confirm that tourism in Yukon is enjoying a period of growth. In fact, according to the visitor tracking program, visitation to Yukon is up 26 percent since 2004. Visitor expenditures are up 31 percent and average spending per party is up 95 percent. Canadian visitation increased by 127 percent and the overseas market increased by 79 percent. For reporting on an annual basis, border crossing statistics continue to be a consistent and reliable indicator of visitation numbers. 2013 saw an all-time record with more than 345,000 people crossing Yukon's borders, which was an eight-percent increase over 2012. This includes 17-percent more Canadian visitors and seven percent more U.S. citizens in 2013 over 2012.

Growth in tourism has also been confirmed in the recently released 2013 Yukon business survey, which is produced by the Yukon Bureau of Statistics. This survey shows that the private sector revenue attributable to tourism is an estimated $250 million, up from $197 million reported in 2009. Similarly, tourism's contribution to the GDP was $113.8 million in 2012, which was up from $92.5 million in 2009.

Speaker: The time being 5:30 p.m., this House now stands adjourned until 1:00 p.m. tomorrow.

Debate on Motion No. 659 accordingly adjourned

The House adjourned at 5:30 p.m.

The following Sessional Paper was tabled April 30, 2014:

33-1-117

Yukon Law Foundation Annual Report - November 1, 2012 to October 31, 2013 (Nixon)

The following documents were filed April 30, 2014:

33-1-81

Fleet Vehicle Agency 2014-2015 Business Plan (Istchenko)

33-1-82

Workers' Advocate Office 2013 Annual Report (Nixon)

FOR RELEASE
August 2, 2013

APPENDIX M-1

Yukon government implements study to determine the prevalence of FASD in corrections population

WHITEHORSE—The Yukon government is committing $643,000 towards a new study to determine the prevalence of Fetal Alcohol Spectrum Disorder (FASD) and other cognitive impairments among Yukon's adult corrections population Justice Minister Mike Nixon announced today.

"This initiative is critical if we are to improve outcomes for people with FASD, cognitive or mental health disorders and/or substance use issues who are involved with the corrections system," Nixon said.

The departments of Justice and Health and Social Services are collaborating with other partners, including the Public Health Agency of Canada (PHAC), to implement the three-year study.

The need to better understand the number of individuals with FASD involved in Canada's corrections system was first raised at the Access to Justice for Individuals with FASD conference in 2008, hosted jointly by the Yukon Department of Justice and Justice Canada.

Since then, Justice has been leading the research study stream and Health and Social Services has been developing an FASD framework for the territory as well as a local adult diagnostic team.

Over the past two years, the Yukon government has held stakeholder consultations and worked to establish relationships with both government agencies and non-governmental organizations involved with individuals with FASD.

A prevalence partners' board is guiding the project, through representation from the Yukon government, Justice Canada, Correctional Services Canada, the Canadian Centre on Substance Abuse, Fetal Alcohol Syndrome Society of Yukon, Yukon College and the First Nations Health and Social Development Commission.

More information on the project is available at www.justice.gov.yk.ca.

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News release #13-198

FOR RELEASE
May 14, 2014

Yukon leads the country with the start of FASD prevalence study

WHITEHORSE—In partnership with the Child & Family Research Institute at BC Children's Hospital and the University of British Columbia (UBC), the Department of Justice has begun a study evaluating the prevalence of fetal alcohol spectrum disorder (FASD) in individuals who are incarcerated or on probation in Yukon. The purpose of this research is to better understand how many people in the corrections system face challenges linked to FASD, mental-health disorders and substance-use problems.

The study was recently granted ethics approval by the UBC Children's and Women's Health Centre of British Columbia Research Ethics Board. Throughout the study, Department of Justice staff will conduct interviews, assessments, and screenings. The data collected will then be analyzed by the university.

"The Yukon government is working with partners to improve services and outcomes for adults with FASD, cognitive or mental health disorders, or substance-use issues involved with the corrections system," Minister of Justice Mike Nixon said. "The findings from this study will be helpful in guiding our next steps."

To provide an accurate picture of the prevalence of the disorder, 150 volunteers between the ages of 18 and 40 (both men and women) with and without FASD will participate in the study.

"We are grateful for the participation of the volunteers," FASD Prevalence Study Manager Kailey LeMoel said. "Our hope is that the results of the study will contribute to, and improve, Yukon service delivery."

The FASD study is part of a larger collaborative FASD initiative between the Yukon departments of Justice and Health and Social Services, who are tasked with developing a local FASD diagnostic team to identify and improve gaps in service and case management.

"The information gained from this ground-breaking study will not only help Yukoners afflicted with FASD who are involved with the justice system, it will also provide an important resource for all Canadians," Nixon added.

Learn more:
Read about the study online at www.justice.gov.yk.ca/FASDStudy.html

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See background below.

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Background

The current Government of Yukon FASD initiative comes from the recommendations of the 2008 national conference on Access to Justice for Individuals with Fetal Alcohol Spectrum Disorder (FASD), hosted by Yukon Justice and Justice Canada.

There are two streams to the government initiative: the research stream with the University of British Columbia (UBC) managed by the Department of Justice; and the framework/capacity development stream managed by the Department of Health and Social Services.

In 2013 the Government of Yukon signed a three-year research agreement with UBC which outlines how the study will be conducted. This includes the financial arrangement for data analysis and reporting, storage, ethical procedures, deliverables, and the roles of members of the research team, such as the principal investigator.

The project aims to determine the prevalence of FASD and other mental health and substance use problems in the corrections population, to test the validity of several FASD screening tools; and ensure the adaptability of the research approach and project models to other jurisdictions in Canada.

The principal investigator who is leading the research is Dr. Kaitlyn McLachlan who also developed a research methodology and submitted it for ethics review. Dr. McLachlan is a postdoctoral fellow with the University of Alberta at the Child & Family Research Institute (CFRI) at BC Children's Hospital, working in collaboration with Dr. Tim Oberlander, developmental pediatrician with BC Children's Hospital, and a professor at UBC.

The goals of the framework/capacity development stream of the Government of Yukon FASD initiative are to increase adult FASD diagnostic and assessment capacity within Yukon, to improve case coordination for individuals, access to services and support for offenders with FASD, and improve awareness and understanding of FASD in the territory.

A Prevalence Project Partners Board helps guide the study and it includes: Yukon Department of Justice; Yukon Department of Health and Social Services; Correctional Services Canada; Justice Canada; Canadian Centre for Substance Abuse; Northern Institute of Social Justice; Yukon College; Fetal Alcohol Syndrome Society Yukon; and First Nations Health and Social Development Commission.

Yukon is co-chair of the Federal/Territorial/Provincial Coordinating Committee of Senior Officials' Steering Committee on FASD.

News release #14-126

FOR RELEASE
January 14, 2015

Adult FASD diagnostic team to be established in Yukon

WHITEHORSE—Training will begin this month for professionals who will make up the diagnostic team for adults suspected of having Fetal Alcohol Spectrum Disorder (FASD). This team will complement the early childhood and youth diagnostic teams already in place.

"This is an exciting time in Yukon with so many good things happening locally that can impact the lives of individuals with FASD and their families," Minister of Health and Social Services Doug Graham said.

A pool of local physicians and psychologists will be trained to build capacity among service providers in Yukon. Focus will be on functional assessments to identify an adult's strengths and needs. Assessment results will help in the development of supportive strategies for those individuals.

Previously, the government funded the Fetal Alcohol Syndrome Society of Yukon (FASSY) to bring in an assessment team from outside Yukon. Between 2004 and 2013 an average of six adults were assessed yearly. With a team located in Yukon, more assessments can be completed per year.

"This is just one initiative that will better support individuals with FASD," Graham added. "We recently completed an analysis to identify gaps and duplications in the prevention services we offer in Yukon. The report identified a number of recommendations, many of which we are now acting upon."

In addition to the new local diagnostic team, the Yukon government is addressing identified gaps in FASD prevention by:

- funding a new sexual health clinic in Whitehorse that provides accessible information and services related to sexual health, including the risks of drinking while pregnant;
- partnering with community agencies to develop awareness campaigns and integrate information into school curriculum about the risks of alcohol; and
- creating an interdepartmental committee to improve coordination for collaborative action on FASD. This committee will be responsible for coordinating FASD-related activities occurring within

- government including: screening and assessment; provision of support services; education and training; research and evaluation; as well as awareness and prevention. This new committee, once established, will create a more seamless response.

View: Gaps analysis

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News release #15-012

APPENDIX N

Dissemination Plan – Yukon FASD Project Final Report

General

- French and English copies of the Final Report will be made available electronically
- Hard copies will be made available upon request
- Appendices will be made available upon request
- Distribution method will primarily be via email. The document will also be posted to the HSS website.

Distribution

PHAC – Health Promotion and Chronic Disease Prevention Branch

Health Canada – Regional Office (Pam Schmidt)

Dr. Jacquie Pei (Alberta)

Dr. Gail Andrew (Alberta)

Dr. Bernie Mallon (Alberta)

CanFASD Research Network (Dr. Amy Salmon)

Canada Northwest FASD Partnership Steering Committee (NWT, BC, AB, Man, Sask)

Prevalence Partners and affiliated organizations:

- Fia Jampolsky – Yukon Canadian Bar Association
- Charlotte Fraser – Justice Canada
- Joanne Lewis – Northern Institute of Social Justice
- Lori Duncan – First Nations Health and Social Development Commission
- Wenda Bradley – FASSY
- Lisha Di Gioacchino – Canadian Centre for Substance Abuse
- John Weekes – Correctional Services Canada
- Dr. Kaitlyn McLachlan, Principal Investigator of the prevalence study

Dr. Reagan Gale (HSS)

Senior Managers (HSS and Justice)

Child Development Centre (Alayne Squair, Brooke McKenzie)

YG Interdepartmental Committee on FASD (YLC, Ed, YHC, HSS, Justice)