

APPENDIX I: HANDOUTS

HANDOUT #1

LEARNING OUTCOMES

The caregiver can:

- describe some of the effects of prenatal exposure to alcohol and describe some of the characteristics of children with Fetal Alcohol Syndrome.
- describe some of the consequences in the neonate of maternal drug and alcohol abuse (NAS).
- explain the value of having a diagnosis of Fetal Alcohol Syndrome and indicate why diagnosis of this condition is difficult.
- indicate how many children are likely to be affected by FAS and explain why this knowledge is important to caregivers.
- describe some of the later life problems that may affect children with FAS.
- describe effective parenting approaches for responding to the particular needs of children with FAS.
- describe the particular demands on caregivers of children with FAS, and ways of providing support for themselves.
- identify community and other resources that may be of assistance to families caring for children with FAS.

HANDOUT #3

THE NATURE OF FETAL ALCOHOL SYNDROME

What is Fetal Alcohol Syndrome?

- the result of prenatal exposure to alcohol
- results in physical abnormalities, such as in the features of the face and reduced size of the newborn
- leads to problems of behaviour and cognition
- found in all economic and racial groups
- not genetic or inherited.

What is the impact of alcohol on fetal development?

- Alcohol is a teratogen - it disrupts normal prenatal development and can lead to birth defects.
- Differences in the developing brain can lead to later behavioral effects such as: attention deficits, learning disabilities, mental disabilities, and many other behavioral problems.
- The specific effects of alcohol on the development of a particular child depends on a number of factors, including:
 - the dosage, timing and pattern of prenatal alcohol exposure.
 - the mother's nutrition and health, and the child's genetic factors.
 - other health hazards, such as poly-drug use.
- Because each child may have different levels or elements of these contributing factors, there are large individual variations in the manifestations of the effects of prenatal alcohol exposure.

Some characteristics of young children with FAS

There are individual variations in the characteristics of children with FAS. Each child may have a particular set of characteristics. The following is a list of frequently mentioned behavioural characteristics of preschool children with FAS.

- hypersensitivity to touch
- Attention Deficit Disorder (ADD)
- hyperactivity (“always on the go,” “never sits still,” “never seems to listen”)
- impulsiveness
- accident prone (possibly a combination of hyperactivity and poor coordination)
- extreme mood changes (laughs or cries too readily)
- heightened anxiety
- constantly demands attention
- low threshold for frustration
- unusual aggressiveness
- frequent temper tantrums over trivial problems
- disobedient in response to requests from parents

-
- unable to adapt easily to changes in routine activities
 - requires more direct supervision than other children
 - difficulty forming friendships with other children
 - overly friendly and social toward adults
 - does not distinguish friends from strangers; has no fear of strangers
 - overly talkative; little meaningful content to speech
 - talks at inappropriate times
 - sleep problems
 - lack of coordination
- (From: Abel, 1988)

Parents of children with FAS have described their children in the following way:

- over-reacts
- chats, no content
- [talks about] unusual topics
- demands attention
- seems unaware of consequences
- does not complete tasks
- likes to talk
- interrupts
- likes to be center of attention
- touches others frequently
- can't play on a team
- can't take a hint
- has sleeping problems
- is over-stimulated

(Note: Based on a selection of descriptions by Streissguth et al, 1998)

HANDOUT #4

NEONATAL ABSTINENCE SYNDROME (NAS)

Prenatal drug use by an expectant mother can lead to a passive drug addiction in the developing child. At birth the infant is deprived of the drug and then may experience drug withdrawal symptoms.

Drugs that can induce such effects include:

- heroin
- cocaine
- amphetamines
- alcohol
- other drugs.

Depending on the type of drug used, symptoms in the neonate may include:

- irritability
- excessive crying
- hypersensitivity
- feeding problems.

As well there may be tremors, seizures, and sleep disturbances.

Initial treatment of withdrawal symptoms needs to be managed in a medical setting, and may need to be followed by specialized care by a knowledgeable caregiver with advanced training.

Longer term effects in the preschool years are variable, but may include:

- delayed motor development
- lowered cognitive development
- distractibility
- hyperactivity.

HANDOUT #5 (a)

DIAGNOSIS OF FAS

A diagnosis is important for the following reasons.

- It provides directions and guidance for intervention. Many of the problems of FAS have a good chance of being improved with appropriate interventions.
- It will provide opportunities for assistance and support for caregivers.
- In general, the earlier the determination and interventions for FAS, the greater the likelihood for the reduction of associated symptoms.
- It provides a reason for caregivers to become more knowledgeable about FAS and to learn how to assist the child more effectively in her development.
- It provides the basis for an explanation of the child's behaviors.
- It can lead to more realistic expectations about what the child may achieve.

Abbreviations:

FAS – Fetal Alcohol Syndrome

FARC – Fetal Alcohol Related Conditions

ARBD – Alcohol Related Birth Defects

ARND – Alcohol Related Neurodevelopmental Disorder

Other Terms: (Older Terms – usage diminishing)

FAE – Fetal Alcohol Effects

PFAE – Possible Fetal Alcohol Effects

Difficulties with diagnoses:

- Some of the central nervous system impairments can be subtle and difficult to measure.
- Some of the child's problem behaviours may be due to abuse and neglect while growing up in the home of alcoholic and abusing parents.
- Absence of diagnosis should not deter caregivers from learning to respond effectively to the needs of the child.

HANDOUT #5 (b)

**DIAGNOSTIC CRITERIA FOR FETAL ALCOHOL SYNDROME (FAS)
AND ALCOHOL-RELATED EFFECTS**

Diagnostic criteria for Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Related Conditions (FARC), from the Institute of Medicine, 1996. For further details see Stratton, Howe and Battaglia (1996).

Fetal Alcohol Syndrome

1. FAS with confirmed maternal alcohol exposure *
 - A. Confirmed maternal alcohol exposure *
 - B. Evidence of a characteristic pattern of facial anomalies that includes features such as short palpebral fissures and abnormalities in the premaxillary zone (e.g. flat upper lip, flattened philtrum, and flat midface)
 - C. Evidence of growth retardation, as in at least one of the following:
 - low birth weight for gestational age
 - decelerating weight over time not due to nutrition
 - disproportional low weight to height
 - D. Evidence of CNS neurodevelopmental abnormalities, as in at least one of the following:
 - decrease cranial size at birth
 - structural brain abnormalities (e.g., microcephaly, partial or complete agenesis of the corpus callosum, cerebellar hypoplasia)
 - neurological hard or soft signs (as age appropriate), such as impaired fine motor skills, neurosensory hearing loss, poor tandem gait, poor eye-hand coordination
2. FAS without confirmed maternal alcohol exposure
B, C, and D as above
3. Partial FAS with confirmed maternal alcohol exposure
 - A. Confirmed maternal alcohol exposure *
 - B. Evidence of some components of the pattern of characteristic facial anomalies

Either C or D or E

- C. Evidence of growth retardation, as in at least one of the following:
 - low birth weight for gestational age
 - decelerating weight over time not due to nutrition
 - disproportional low weight to height

-
- D. Evidence of CNS neurodevelopmental abnormalities, as in:
 - decreased cranial size at birth
 - structural brain abnormalities (e.g., microcephaly, partial or complete agenesis of the corpus callosum, cerebellar hypoplasia)
 - neurological hard or soft signs (as age appropriate) such as impaired fine motor skills, neurosensory hearing loss, poor tandem gait, poor eye-hand coordination
 - E. Evidence of a complex pattern of behavior or cognitive abnormalities that are inconsistent with developmental level and cannot be explained by familial background or environment alone, such as learning difficulties; deficits in school performance; poor impulse control; problems in social perception; deficits in higher level receptive and expressive language; poor capacity for abstraction or metacognition; specific deficits in mathematical skills; or problems in memory, attention, or judgment.

Alcohol-Related Effects

Clinical conditions in which there is a history of maternal alcohol exposure, and where clinical or animal research has linked maternal alcohol ingestion to an observed outcome. * **

There are two categories, which may co-occur. If both diagnoses are present, then both diagnoses should be rendered:

- 4. Alcohol-related birth defects (ARBD) List of congenital anomalies, including malformations and dysplasias

Cardiac	Atrial septal defects Ventricular septal defects	Aberrant great vessels Tetralogy of Fallot
Skeletal	Hypoplastic nails Shortened fifth digits Radioulnar synostosis Flexion contractures Camptodactyly	Clinodactyly Pectus excavatum and carinatum Klippel-Feil syndrome Hemivertebrae Scoliosis
Renal	Aplastic, dysplastic, hypoplastic kidneys Horseshoe kidneys	Ureteral duplications Hydronephrosis
Ocular	Strabismus Retinal vascular anomalies	Refractive problems secondary to small globes
Auditory	Conductive hearing loss	Neurosensory hearing loss
Other	Virtually every malformation has been described in some patient with FAS. The etiologic specificity of most of these anomalies to alcohol teratogenesis remains uncertain.	
- 5. Alcohol-related neurodevelopmental disorder (ARND)

Presence of:

- A. Evidence of CNS neurodevelopmental abnormalities, as in any one of the following:
- decreased cranial size at birth
 - structural brain abnormalities (e.g., microcephaly, partial or complete agenesis of the corpus callosum, cerebellar hypoplasia)
 - neurological hard or soft signs (as age appropriate), such as impaired fine motor skills, neurosensory hearing loss, poor tandem gait, poor eye-hand coordination

and/or:

- B. Evidence of a complex pattern of behavior or cognitive abnormalities that are inconsistent with developmental level and cannot be explained by familial background or environment alone, such as learning difficulties; deficits in school performance; poor impulse control; problems in social perception; deficits in higher level receptive and expressive language; poor capacity for abstraction or metacognition; specific deficits in mathematical skills; or problems in memory, attention, or judgment.

* A pattern of excessive intake characterized by substantial, regular intake or heavy episodic drinking. Evidence of this pattern may include frequent episodes of intoxication, development of tolerance or withdrawal, social problems related to drinking, legal problems related to drinking, engaging in physically hazardous behavior while drinking, or alcohol-related medical problems such as hepatic disease.

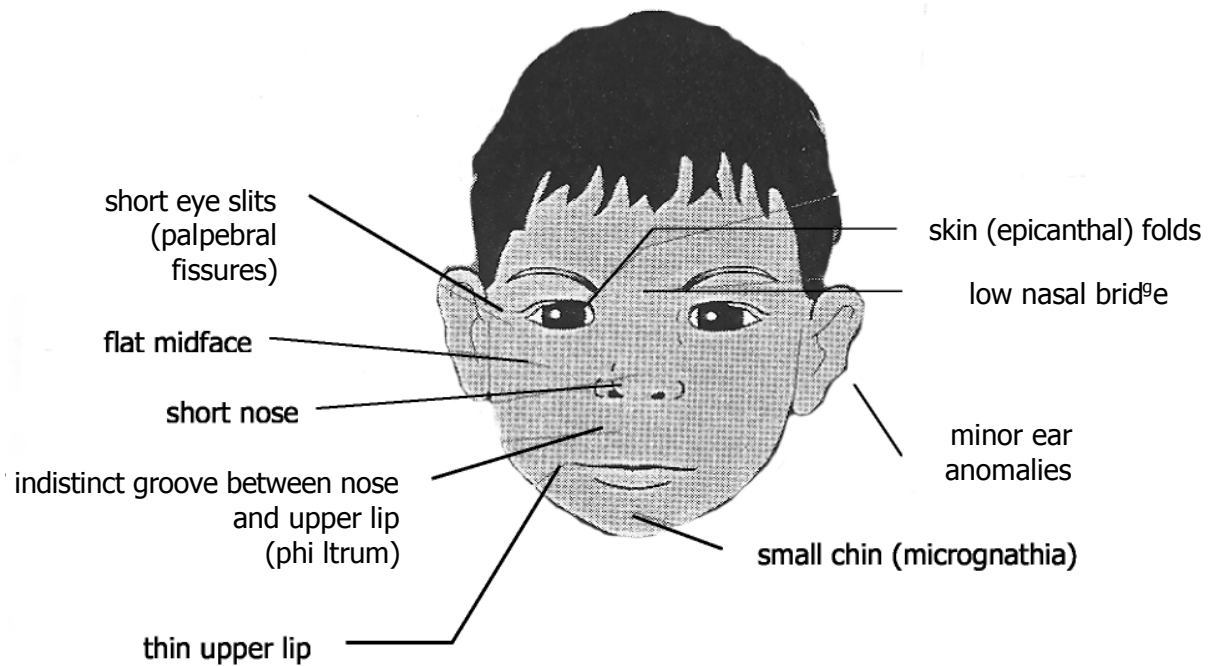
** As further research is completed and as, or if, lower quantities or variable patterns of alcohol use are associated with ARBD or ARND, these patterns of alcohol use should be incorporated into the diagnostic criteria.

HANDOUT #6

**THE FACE OF FETAL ALCOHOL SYNDROME
IN THE YOUNG CHILD**

**Discriminating
Features**

**Associated
Features**



Note: These facial features change beyond puberty and are typically no longer recognizable in adulthood.

HANDOUT #6**HOW MANY CHILDREN ARE AFFECTED BY FAS?**

The number of children with FAS has been difficult to determine. The following are some estimates:

- up to 3 births per 1000 (Institute of Medicine, 1996)
- about 1 per 100 births in Seattle region (Sampson et al, 1997)
- an Alberta Family and Social Services Survey (1997) of children in care estimated 4% with confirmed diagnosis for FAS/FAE; 11.5% suspected; this data shows that children in care have a significantly higher rate of fetal alcohol syndrome than those in the general population.

Implication for caregivers: there is a significant likelihood that a child in your care may have the effects of fetal alcohol syndrome.

HANDOUT #7

LATER LIFE ISSUES

In a survey of individuals with Fetal Alcohol Syndrome, Streissguth, 1997 found many had later life issues:

- mental health problems (90% of sample)
- disrupted school experiences (suspended, expelled, or dropped out of school, 60% of sample)
- trouble with law (charged or convicted, 60% of sample)
- confined for treatment or jail (50% of sample)
- inappropriate sexual behaviour (reported or sentenced, 50% of sample)
- alcohol/drug problems (having or having been treated, 30% of sample)
- dependent living (i.e., not living independently, 80% of sample over 21 years of age).
- problems with employment for those 21 years of age or older (80% of sample).

She also found that the likelihood of these problems was reduced with the presence of these “protective factors”:

1. living in a stable and nurturing home
2. being diagnosed before the age of six
3. never having experienced violence against oneself
4. staying in each living situation for an average of more than 2.8 years
5. experiencing a good quality home from ages 8 to 12 years
6. having applied for and been found eligible for special needs services
7. having basic needs met.

HANDOUT #8

CARING EFFECTIVELY FOR A CHILD WITH FAS

Caregivers:

- will need to seek the support of professionals, such as physicians, therapists and teachers.
- will need to supervise, monitor, teach, plan, structure, reward, guide and protect the child more than a typical parent.
- may have to readjust their expectations for the child's future.

Guidelines for caregiving:

- First seek to understand the child - the child's condition, strengths and limitations, and point of view.
- Be understood by the child - state expectations in a clear, direct and courteous manner; confirm that the child has understood you; repetition of instruction is important.
- Be proactive - anticipate events and plan the setting and your role in the event.
- Begin with an end in mind; consider the goals you seek for the child to achieve. The goal may be as specific as solving a homework problem or a larger goal such as successfully completing a week of school. Such consideration may aid in the development of a “map” or a strategy on how to achieve the goal.
- Consider yourself the “advocate” for the child; providing care for a child with the effects of prenatal alcohol exposure likely will bring the caregiver in contact with a number of professionals (teachers, therapists, physicians, etc.), all of whom may provide advice, or intervention for an aspect of the child's functioning. Being with the child continuously places the caregiver in a position to understand what may be in the overall best interest of the child.
- Be guided by experience and evidence. There is no handbook that could cover all possible events a caregiver may encounter. To be guided by experience and evidence means:
 - a) acknowledging that you do not know all you need to know about providing care to a child with FAS.
 - b) seeking further knowledge about FAS - this may include seeking advice from professionals, reading materials on FAS and consulting with others who provide care to children with FAS.
 - c) trying out an approach based on experience and acquired knowledge, and then evaluating the outcome. If the approach was not successful, further knowledge seeking and revisions may be necessary. Keeping good records (see the Module “Caring for Children: Observing, Recording and Reporting”) aids in this process.

-
- Consider the child as an individual. Each child with FAS will have unique and particular characteristics. For some, problems can range up to severe levels such that they will need constant care. All of them will have some learning difficulties and behaviour problems. Because of such wide variations it is important to focus on the particular needs of the child rather than trying to apply some general approach.
 - Assess the child's progress. In order to determine the value and effectiveness of an intervention or caregiving procedure, there needs to be ongoing observation and assessment of the child's behaviour with appropriate adjustments if necessary. When assessing the child's behaviour, consider the following:
 - a) knowledge of disability; at times the child may behave in a particular way or may misbehave because of the limitations produced by the FAS conditions. For example, what may appear to be dishonesty may be due to memory loss or lack of understanding of the circumstances involved.
 - b) goals; expectations for the attainment of goals by the child may at times have to be adjusted. The child's learning difficulties may interfere with the acquisition of social, academic, and other skills. Consequently caregivers may need to set more realistic goals for the child's development.
 - Recognize the child's strengths. Many children with FAS are happy, friendly, and talkative. For each child it is important to identify particular strengths and to build on these when developing interventions. In order to create positive self-esteem caregivers should find activities and create opportunities for the child to succeed. Successful completion of a task leads to a sense of fulfillment and raises self-esteem.

Specific suggestions for caregiving include the following.

- a) **Environment:** Commonly observed problems are learning difficulties, limitations in planning skills and anticipating the consequences of one's behaviour. Because of these limitations it is important to structure the environment of the child to improve learning. For example:
 - if there is too much noise and too many objects or people for the child to concentrate, the intensity of this stimulation needs to be reduced.
 - if the child is easily distracted and engages in off-task behaviours, a high level of monitoring and supervision may be required to maintain on-task behaviour.
- b) **Consistency:** Many caregivers have found it important to maintain familiar routines and consistency in the environment of the child. A structured environment familiar routines leads to predictability and a sense of security for the child.

Examples are:

- establishing predictable and consistent patterns for morning and bed-time routines.
- keeping routines similar at mealtime and for homework activities.

c) **Learning:** Children with FAS may require more focused and deliberate efforts to develop skills and acquire knowledge. Important elements of teaching strategies are:

- Distraction-free environment
- Rewards: On completion of an appropriate task, provide immediate rewards, such as praise and attention. Praise and attention should be specific for the behaviour to be promoted. For example:
 - when the child has picked up the phone and answered appropriately, before speaking to the caller say: “Tommy, you answered the phone politely, thank-you.”
- Consequences: Make consequences for inappropriate behaviours also immediate, natural, and logical. For example: if the child has thrown some food, ask the child to help clean it up.
- Repetition: Children with FAS may require many repetitions to learn a skill. Close supervision and assessment will determine the need for re-teaching. Reminders and other cues to prompt the appropriate behaviours are useful. For example: a list of steps and tasks (written or pictorial) posted in the child's room may guide the child's morning routine. Such posted lists are useful for many tasks and in many settings.
- Task analysis: If a task is initially too difficult for the child to master, break it down into component steps and work on each component in turn.
- Show-by-doing: Modeling and other concrete demonstrations may help the child to understand the skill to be acquired.
- Generalization. The child may require learning to occur in different settings in order to be able to apply it in different settings. For example: When teaching a child to “take turns” in play, the child may need repeated instructions in a variety of settings such as at home, playground, school.

d) **Transitions:** As many children with FAS need stability and consistency, new tasks, settings or routines require prior preparations. Examples of such prior preparations are:

- advance notice and discussion with the child for an impending change.
- breaking up a major change into smaller steps and working through each one in turn.

-
- e) **Communication:** To facilitate understanding, instructions to the child should be clear and simplified. Instructions should be short, explicit and concrete. If possible, demonstrate and model how something is to be done, rather than simply describing it. Phrase directions in a positive way (rather than telling the child what not to do). Accompanying visual cues, such as exaggerated facial and body language, and hand signals, may also facilitate communication.

Note: There are many additional parenting suggestions in Parenting children affected by fetal alcohol syndrome: A guide for daily living, edited by Graefe (1998).

- f) **Sensory hypersensitivity:** Children with FAS may over-react because of their inability to manage an 'overload' of sensory stimulation. Reducing the amount or intensity of stimulation will allow the child to calm down and focus on what to do. Examples of such sensory reductions are:
- reducing noise level
 - reducing glare by using sunglasses
 - avoiding crowded situations.

HANDOUT #9

PARADIGM SHIFTS AND FAS/FAE

As our understanding of the meaning of 'organic brain differences' is integrated into everyday life, at home and in the community, parents and caregivers undergo a personal and professional paradigm shift in how they understand and feel about children with FAS/FAE. The shift includes moving from:

From Seeing Child As:

To Understanding Child As:

Won't	Can't
Bad	Frustrated, defended, challenged
Lazy	Tries hard
Lies	Confabulates/fills in
Doesn't try	Exhausted or can't start
Mean	Defensive, hurt, abused
Doesn't care, shut down.....	Can't show feelings
Refuses to sit still	Over-stimulated
Fussy, demanding	Oversensitive
Resisting	Doesn't 'get it' Can't
Trying to make me mad	remember
Trying to get attention	Needing contact, support
Acting younger	Being younger
Thief	Doesn't understand ownership
Doesn't try	Tired of always failing
Inappropriate	May not understand proprieties
Not trying to get the obvious.....	Needing many re-teachings

Source: Diane Malbin

HANDOUT #10

SUPPORT FOR CAREGIVERS

Caregivers can minimize the stress by:

- anticipating stressful events; identifying upcoming stressful events and planning how best to cope prevents simply reacting to events and feeling powerless and out of control.
- beginning with an end in mind (while ensuring that goals are realistic and do-able). This allows for a broader focus and makes it less likely to become distracted by minor instances of inappropriate behaviors.
- coping with stressful events:
 - delay your response; rather than reacting in a possibly emotional or angry manner to the child's behavior, delay your response to allow for a more considered reaction.
 - practice relaxation.
- practicing personal renewal:
 - take a short break from caregiving (respite) or take a weekend off. This should be discussed with the child's worker to determine what is possible.
 - seek support from friends, relatives (e.g., engage with others in recreational activities).
 - review Module 3 – “Effects of Caregiving” for further suggestions on personal renewal.
- becoming an advocate for the child with FAS:
 - become knowledgeable about FAS.
 - seek the support of the child's physician, therapists, worker, school staff, to help promote and guide the child's personal, educational and social development.
 - provide opportunities for the child to establish relationships with peers and others in the community. A sense of ‘connection’ and ‘belonging’ is important for the child's self-development. The well-being of other children need to be part of the consideration of developing such relationships.
 - become active in parent support groups and develop common strategies for increasing community support for children with FAS.
 - ask your child's worker if she knows of any specific FAS activities in your community.

HANDOUT #11

NEED FOR FURTHER TRAINING

To knowingly accept into care a child with FAS caregivers need to become more knowledgeable in the following areas:

- further understanding of altered neurological function due to prenatal alcohol exposure, and the typical behavior patterns that are likely to occur, particularly in the areas of abstract thinking, memory, and attention.
- further details on providing care, with specific reference to the unique demands of children with FAS, age differences, and further insight into the management of daily behaviors
- caring for infants who have experienced drug withdrawal symptoms
- suggestions on how to promote self-regulation skills to guide children's behaviour
- an understanding of attachment problems that may be the result of prenatal exposure to alcohol or may have arisen from the consequences of having been raised in a home with alcohol misusing parents (included would be suggestions for responding to attachment problems)
- suggestions for providing early educational support to a child who likely will experience difficulties in school;
- suggestions for physical care, in areas such as sleeping, eating, pain, and medical problems
- consideration of possible later problems at school, peer relationship difficulties, problems in mental health and with the justice system, and consideration of how to begin early to prevent or reduce these risks
- support for caregivers.

HANDOUT #12

SUGGESTED RESOURCES

The following is a beginning selection of resources that may be of interest to caregivers. A number of the organizations and internet sites listed provide access to more extensive resource lists.

Books/Guides:

FAS/E Support Network of B.C. (1995). A layman's guide to fetal alcohol syndrome and possible fetal alcohol effects. Vancouver, B.C.: FAS/E Support Network of B.C. Contact: 604-589-1854. This organization has also published: Assessment tools (for six different age groups), FAS/E and education: The art of making a difference, and other resources.

Graefe, S. (Ed.) (1998). Parenting children affected by fetal alcohol syndrome: A guide for daily living. Vancouver, B.C.: The Society of Special Needs Adoptive Parents (SNAP). Contact SNAP: 604-687-3114

Kleinfeld, J., and Wescott, S. (Eds.) (1993). Fantastica Antone succeeds: experiences in educating children with fetal alcohol syndrome. Fairbanks: University of Alaska Press. Contact: B.C. FAS/E Support Network, 604-589-1854.

McCreight, B. (1997). Recognizing and managing children with fetal alcohol syndrome/fetal alcohol effects: A guidebook. Washington, D.C.: CWLA Press.

Normand, C., and Rutman, D. (1996). Caring for children with fetal alcohol syndrome. Victoria, B.C.: School of Social Work, University of Victoria. Available through: Child, Family and Community Research Program, School of Social Work, Box 1700, University of Victoria, Victoria, B.C., V8W 2Y2 (e-mail cfcpr@hsd.uvic.ca)

Streissguth, A., and Kanter, J. (Eds.) (1997). The challenge of fetal alcohol syndrome: overcoming secondary disabilities. Seattle: University of Washington Press. Available through: UBC Press, Vancouver; phone 604-822-5959.

Streissguth, A. (1997). Fetal alcohol syndrome: A guide for families and communities. Toronto: Brooks Publishing.

Turpin, J., and Schmidt, G. (Eds.) (1999). Fetal alcohol syndrome/effect: developing a community response. Halifax: Fernwood Publishing. Available through: Mosquito Books - 1-800-451-6495.

Suggested Resources (cont'd)

Videos:

David with FAS (1996). Kanata Productions in cooperation with the National Film Board of Canada and CBC Newsworld.
Available through: NFB, 1-800-267-7710

Fetal alcohol syndrome and effects: Stories of help and hope. (1994)
Available through: Hazelden, 15251 Pleasant Valley Road,
Box 176, Center City, MN, 55012-1176.

Helping families - helping children (1997). Yellowknife Films.
Available through: Yellowknife Association for Community Living,
P.O. Box 981, Yellowknife, NT, X1A 2N7
Phone: 403-920-2644.

Living and learning with FAS (1991). LENA Productions for the British Columbia FAS Resource Group.
Available through: B.C. Learning Connections.
Phone: 604-324-7752.

Newsletters:

About FAS/E
FAS/E Support Network of B.C.
Phone: 604-507-6675, [e-mail: fasnet@istar.ca](mailto:fasnet@istar.ca)

Society of Special Needs Adoptive Parents Newsletter
SNAP, 205-409 Granville Street, Vancouver, B.C. V6C 1T2,
Phone: 604-687-3114, [e-mail: info@snap.bc.ca](mailto:info@snap.bc.ca)

Iceberg
P.O. Box 95597, Seattle, W.A. 98036, U.S., Phone: 206-827-1773.
An educational newsletter about FAS.

FAS Times: Fetal Alcohol Syndrome/Family Resource Institute Newsletter.
FAS/FAE, P.O. Box 2525, Lynnwood, WA, 98036, U.S.

Growing with FAS
7802 S.E.. Taylor, Portland, OR, 97215, U.S.
Information for parents and professionals.

Notes from NOFAS
National Organization on Fetal Alcohol Syndrome,
418 C Street North East, Washington, D.C. 20002, U.S.,
Phone: 202-785-4585, [e-mail: information@nofas.org](mailto:information@nofas.org).

Suggested Resources (cont'd)

Organizations:

• Provincial FAS/E Prevention Coordinator

Ministry of Children and Family Development
Community Services and Program Supports
3rd. Floor
737 Courtney Street
Victoria, B.C.
V8W 9S1

Phone: 250-952-6056, Fax: 250-953-4556

The coordinator provides information and referral services for the public and professionals on how to access information resources, expertise and services related to FAS; also provides technical support to groups and organizations that are initiating activities at a community level to address FAS issues.

• FAS/E Support Network of B.C.

13279 72nd Ave.
Surrey, B.C.
V3W 2N5

Phone: 604-507-6675, Fax: 604-507-6685

[e-mail: fasnet@istar.ca](mailto:fasnet@istar.ca) www.fetalalcohol.com

The FAS/E Support Network, a provincial organization funded by the Ministry of Children and Family Development, provide information, support, consultations and advocacy services for individuals, families and professionals and the broader community around prevention, intervention and treatment issues pertaining to alcohol related birth defects (FAS/E) caused by alcohol used during pregnancy. It operates a 24 hours a day 'Warm Line'.

-
- Society of Special Needs Adoptive Parents (SNAP)
205-409 Granville Street
Vancouver, B.C.
V6C 1T2
Phone: 604-687-3114; Toll free; 1-800-663-7627; FAX: 604-687-3364 [e-mail: snap@ibm.net](mailto:snap@ibm.net)
SNAP is a provincial organization dedicated to assisting special needs adoptive families through mutual support, information sharing and advocacy. SNAP provides support groups and one-on-one contact resources parents throughout B.C. The society provides a newsletter as well as other resources.
 - B.C. Aboriginal Network on Disability Society
1179 Kosapsum Crescent
Victoria, B.C.
V9A 7K7
Phone: 250-381-7303, Fax:: 250-381-7312
 - YWCA Crabtree Corner FAS/NAS Prevention Project
101 East Cordova Street
Vancouver, B.C.
V6A 1K7
Phone: 604-689-2808, FAX 604-689-5463
www.ywca.van.org
The YWCA Project provides FAS/INAS educational workshops, a resource lending library, a peer support group for mothers with children with FAS/NAS, and information and crisis counselling.
 - FAS/FAE Information Service
Canadian Centre on Substance Abuse
75 Albert Street, Suite 300
Ottawa, Ontario
K1P 5E7
Phone: 1-800-559-4514 or 613-235-4048, ext. 223
FAX 613-235-8101
[e-mail: tas@ccsa.ca](mailto:tas@ccsa.ca)
internet: [http: / /www.ccsa.ca/fasgen.htm](http://www.ccsa.ca/fasgen.htm)

Note: A complete listing of FAS activities in B.C. is available from the Provincial FAS/E Prevention Co-ordinator. Another source of information is "Moving Forward": FAS Activities in B.C., published by the Ministry of Children and Families (also now on the Internet).

Internet Sites:

- B.C. Ministry of Children and Families Library Resource Center for FAS/FAE. http://www.mcf.gov.bc.ca/library/subjects/sub01_1b.html
 - Canadian Center on Substance Abuse, provides directories, resources. <http://www.ccsa.ca/fasgen.htm>
 - FAS Link List Serve, provides resources, teaching guide. [www.acbr.com/fas/faslink2 .htm](http://www.acbr.com/fas/faslink2.htm)
 - NOFAS, a US organization providing training and resources <http://www.nofas.org/>
- There are many other internet sites that can be accessed by typing in 'fetal alcohol syndrome' or 'FAS' using any of the search engines such as Altavista or Yahoo.