FROM PREVALENCE TO PREVENTION—A COMMUNITY BASED APPROACH IN A CANADIAN ABORIGINAL COMMUNITY

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LEARNING OBJECTIVES:

1. To increase understanding and to review Canadian prevalence data on FASD in aboriginal communities in relation to other populations in Canada, North-America and internationally
2. To increase understanding of the socio-economic risk factors for FASD also associated with cultural erosion and historical trauma
3. To increase understanding of an effective community and culturally based approach to FASD service delivery
4. To explore the differences in focus between this community based model of FASD prevention and the current PHAC prevention model

SUMMARY: FASD is a significant health problem in some aboriginal communities and a remnant of years of economic oppression and social trauma. This presentation will explore prevalence rates in a Canadian aboriginal community at two points in time. In 2000 there was FAS prevalence in the community of over 5%. In 2014 there was 0% FAS in the community. Rates of other FASD’s have also been significantly lowered. It will also discuss the development of community and culturally based approaches that have worked to significantly lower FASD prevalence.

Children conceived in indigenous communities deserve the same opportunities as children in the general population. Canada has an ethical responsibility to provide resources, support and expertise at a community level. This includes resources to determine the extent of the FASD problem as well as the development of community and culturally based tools, programs and approaches to deal with FASD health service delivery. This work is an attempt to move in that direction.

RESEARCH OBJECTIVES: While we do know that FASD affects people of all races and ethnicity there is evidence that there are FASD prevalence rates in some aboriginal communities as high as 20%. This data is not generalizable to the whole indigenous population but it is indicative of a serious health gap. FASD is a significant health problem and in aboriginal communities likely a remnant of years of economic oppression and social trauma. This presentation will explore prevalence rates in a Canadian aboriginal community at two points in time. It will discuss the development of community and culturally based programs and approaches implemented after high FASD prevalence was established. Was the community approach effective? Are FASD prevalence rates lower now than they were in 1999-2000?

RESEARCH METHODS: This research is based on two school-based FASD prevalence studies and on following the first cohort of 53 youth with confirmed PAE, Prenatal Exposure to Alcohol, who were also referred for diagnosis and school interventions based on diagnostic team recommendations
The study population of school age children attending a FN Band operated elementary school were assessed for FASD at two points in time- 15 years apart. FASD screening, assessment and intervention tool place in the context of a community based multi-disciplinary approach to support youth and families with high level of needs to help them succeed in school and out. The first group cohort was followed longitudinally for 15 years after diagnosis and screened for select secondary disabilities including: trouble with school, trouble with law, trouble with addictions. Data was collected through multiple sources including teacher surveys, parent interviews, health and educational records. Data was entered into Excel and SPSS

PROCEDURE: Review the findings from the original FASD school prevalence study.
In 1999-2000 a needs assessment was undertaken in a FN community school. Approximately 24% of the children in the school population were found to have been PAE, prenatally alcohol exposed, and 20 % of the children were
subsequently diagnosed with an FASD. Local physicians at the time were advising women in the community that drinking moderately during pregnancy would not affect their babies.

Review the diagnostic, prevention and intervention services and tools developed as well as the community based 4 level model of FASD prevention

Over the last decade an FASD service delivery prevention model was developed in the community that included development of culturally based screening and diagnostic tools, access to community based diagnostic team, implementation of school interventions and an FASD mentoring and outreach program for pregnant and high risk women. This community based model of FASD prevention is a 4 level prevention model developed with the input of community elders, parents and service providers during a series of community focus groups and meetings. It is similar to Leavell and Clark’s 1965 3 level prevention model rather than the present PHAC model of FASD prevention

Establish the present prevalence of FASD’s in the community school

RESULTS: In 1999-2000 there was FAS prevalence in the community of over 5%. In 2014-15 there was 0% FAS in the community. Rates of other FASD’s have also been significantly lowered. Overall FASD prevalence rates have dropped from approximately 20% % to 12.5%.

CONCLUSION: The rate of FAS in the community is now 0% but the prevalence rate of other FASDs continues to be higher than in the general population. Through a public awareness campaign women in the community now understand alcohol harm when pregnant and most report stopping as soon as they find out they are pregnant but there is continuing lack of resources to provide adequate FASD prevention services as suggested in the prevention model. There is still a gap in health status in relation to FASD and prevalence rates in the community are 12.5% compared to 1-5% in the general population. This may also be associated with broader socio-economic issues and risk factors for FASD such as poor nutrition. Community based interventions have been effective but more programs are needed to provide culturally based support for young women and young mothers with addiction issues as well as diagnosis and support for individuals affected with FASD through the life-span. The present PHAC prevention model may be too narrow to support the levels of prevention services that are needed for effective community based FASD service delivery.

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