A COMPETENCY FRAMEWORK

For Fetal Alcohol Spectrum Disorder Assessment & Diagnostic Clinics

Disclaimer:

This Competency Framework, previously titled, "Best Practice Guide for Fetal Alcohol Spectrum Disorder Assessment and Diagnostic Clinics" (2016, 2018) is intended for informational and instructional purposes. The competencies, practices, and procedures described in this framework are not conditions of any employment or mandated policies for organizations. This guide has been revised with additional competencies and appendices. Future revisions to this document are expected and will be ongoing, based on emerging best practices, responses from clinics across jurisdictions, and key stakeholders in the field.

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Acknowledgements

We wish to thank the following individuals for their feedback, review, and oversight on the editing and production of this guide:

- Dr. Hasmukhlal (Hasu) Rajani, FRPCP, Pediatrician
- Dr. Sabrina Eliason, MD, FRCPC, Developmental Pediatrician
- Lynette Taal, Program Manager, Lethbridge Family Services
- Monty Nelson, Ph. D., Registered Psychologist
- Brent Symes, Ph. D., Registered Psychologis
- Kelly D. Harding, Ph.D., Canada FASD Research Network
- Colleen Burns, Lakeland Centre for FASD
- Amber Bell, Alexander First Nations FASD Clinic

Courtney R. Green, Ph.D., is acknowledged for previous version of the guide (2016 and 2018).

This project was supported by the Government of Alberta.

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Introduction

The Competency Framework for Fetal Alcohol Spectrum Disorder (FASD) Assessment and Diagnostic Clinics comprises evidence-informed practices that describe high-priority areas for diagnostic clinics that are central to quality and safety. The practices outlined in this framework should be considered as part of an adaptive learning process, rather than a fixed set of rules or guidelines.

Goals of the Framework

The overarching goals of this framework are to:

- **(1)** Provide a framework for which diagnostic clinics can measure their strengths and areas for improvement to provide the most effective diagnostic services and is based on a set of standards that are important for all clinics.

- **(2)** Offer guidance to clinicians, coordinators, and other FASD clinic team members on providing the most effective and consistent service delivery for clients undergoing assessment for FASD.

- **(3)** To highlight that assessment and diagnostics service should always be client driven, not agency-need driven.

- **(4)** To assist in the planning, implementing, evaluating, and adapting clinic services according to a set of standardized recommendations that were described in the revised Fetal alcohol spectrum disorder: a guideline for diagnosis across the lifespan[(1)].
    - (a) Using a standardized framework will lead to increased consistency in diagnostic outcomes amongst clinics, and higher quality services to clients.

Core Competencies

The core competencies outlined in this framework represent important considerations and practices that can help to guide safe and effective FASD assessment and diagnostic practices.

This guide is not intended to say what clinics must do, but rather to offer a broad guide to the scope of services that FASD diagnostic clinics may provide. This framework is not intended to replace competencies or standards of practice directed by professional colleges or associations.

19 Core Competencies

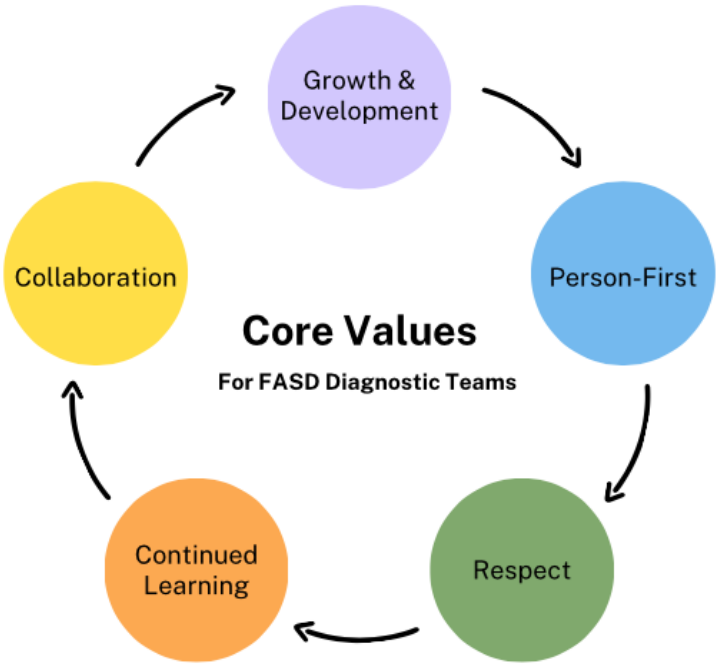
The Competency Framework is divided into 19 Core Competencies that outline specific practices, activities, and expectations that the FASD diagnostic clinics can review prior to the commencement of services as well as ongoingly as they operate and provide service.

The activities and practices included may need to be implemented quickly for safety and quality of service, and other can be seen as longer-term considerations for quality improvement that require significant time to be fully developed or may be long-term and in need of consistent improvements across time.

While the timeline for achieving the activities and practices outlined below will be dependent on clinic resources, funding, and infrastructure requirements, clinics are encouraged to meet as many of the competencies as possible prior to becoming an operational FASD diagnostic clinic. However, if you are already operational, this framework can provide an opportunity to reflect on current practices, strengths, and areas for future improvement.

Diagnostic Clinics: Core Values

The following core values are important to the growth, development, support, and activities of assessment and diagnostic clinics. Considering your organizations core values and how they align with these values and the goals of the clinic can help to ensure services are safe, effective, respectful, and client centred.



Growth and Development: Engage in growth by evaluating clinic practices, processes, and policies regularly to maintain high clinical standards. Continue development by reviewing research findings to improve delivery of assessment and diagnostic services.

Person-First: Prioritize clients by maintaining confidentiality, providing client-centred services and supports, and ensure that all clinic work is culturally safe and sensitive.

Respect: Hold respect by providing case-specific approaches, create personalized management plans, and appreciate the uniqueness of the FASD population.

Continued Learning: Sustained education and training to maintain competence within the scope of practice for each team member. Continue professional development in the areas of assessment and diagnosis and implement evidence-based learning opportunities.

Collaboration: Between a multidisciplinary team with high quality, safe and coordinated services.

How to Use the Competency Framework

The following framework is meant to be a self-assessment tool for diagnostic clinics to understand their strengths and areas of improvement. This is a working document that can be completed year after year to measure progress and reflect on completed strengths and improvements, as well as needed areas of change and implementation.

The Documentation Information section allows you to record when and by whom the framework was completed. We encourage you to save this document and review it annually with your team, and to complete a new self-assessment every few years.

Following this section, competencies are organized under headings and include a personal rating score to understand and record where the organization is at with that particular competency.

The self-assessment includes:

1. **Achieved:** the clinic has undertaken or met this competency.
2. **In Progress:** the clinic is working toward meeting this competency.
3. **Ongoing:** the clinic is working on this competency, and it will be an ongoing activity for the clinic, or the competency is continually being improved/developed/learned about.
4. **Barrier/Challenge:** there is a barrier or challenge in obtaining this competency.

The “notes” section is provided to allow for the addition of comments about progress on each competency.

The following questions are suggested to consider when writing notes:

1. If “In Progress”, what progress has been made? What is the goal and the timeline to achieve this?
2. If “Ongoing”, how is this competency being continually developed?
3. If “Barrier/Challenge”, what is the barrier and what is stopping progress? What is the solution?

Documentation Information

Name:	
Name of additional person:	
Name of additional person:	
Year of self-assessment:	
Notes:	

Competency 1: Clinic Development

Multiple factors need to be considered when developing a new FASD clinic and team. These competencies are relevant for all emerging teams, while recognizing their unique abilities and strengths (see Appendix A).

(1) Understand the needs and readiness of the communities in service regions, and their ability to accept and implement FASD diagnostic clinic services, taking unique community needs and factors into account.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(2) Engage with stakeholders and seek community input during clinic development.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(3) Have a concrete mission, goal, and organizational structure in place.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(4) Have procedures in place to adapt processes, identify barriers, as well as emerging needs.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(5) Create a culture of excellence to deliver high-quality services by adapting to change and adjusting to reach this.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(6) Understand the diverse needs of children/youth and adult clients, their families, and service providers.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(7) Be able to describe community resources to support providers and the families they serve both pre- and post- diagnostic clinic.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 2: Initiation of Referral and Referral Process

(1) Referral procedures have been implemented to ensure clients', mother, and caregivers' wellbeing.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(2) Prior to accepting referrals, client/legal guardian is fully aware of the purpose of the referral and consents are signed and received by the clinic.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(3) Procedure in place for client/caregiver/legal guardian to be informed of timelines and referral process and has contact information of a staff member who can answer questions.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(4) Clinic staff are trained and knowledgeable to review and have a process in place to update intake forms when needed.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(5) If a referral is not accepted, an explanation of the reason(s) for not accepting the referral is given to the legal guardian or adult client. Referrals to appropriate services are provided.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(6) Referral criteria have been communicated to health, social services, education, and other relevant agencies and organizations.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(7) Support is available for clients and legal guardians needing additional help when completing referral package.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 3: Consents for Collecting and Disclosing Information

(1) Have policies around consents for accessing and disclosing personal and health information to inform a diagnosis.

Consent forms will identify the authority for collecting of information that is reported on any online reporting or other data system. When clinics collect, use, or share information about an individual, they need appropriate authority through program and/or privacy legislation to do so.

- Understand which privacy legislation (if any or multiple) applies to information collected from other service providers for informing diagnoses.
- Understand which privacy legislation (if any or multiple) applies to information disclosed to other service providers or agencies during the referral process.
- Understand which privacy legislation (if any or multiple) applies to information submitted to any online reporting system or data collection program.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(2) Clinics need to determine the structure and tools required to share collected information, and policy on managing any risks associated when sharing information.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(3) Information sharing policy includes clear release instructions when sharing any reports to third party organizations. This is only permitted with written permission is given from the client, or the individual/agency legally authorized to represent the client.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(4) Release instructions should detail which information is to be disclosed, to whom, and in what time frame.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(5) Consent and/or assent processes must be completed without duress, pressure, or other conflicts of interest.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(6) On each consent form, there is contact information of someone in the organization/clinic who can answer questions about the information collected and its use.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(7) There are resources, education, and training for staff regarding information sharing and consent/assent processes.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 4: Record and Information Management

(1) Have information management controls in place to support and address the requirements, issues, and risks associated with privacy, confidentiality, and security.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(2) Staff are aware of and follow the requirements for record keeping specified by their organization and licensing jurisdiction. **Requirements may include:** • Type of data collected. • How information is recorded. • With whom and under what circumstances information may be exchanged. • Processes for amending client records. • The length of time records are retained. • Plans for appropriate disposal of records.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(3) Case files are only accessible to clinic staff who are identified by the agency/organization to have access, to ensure that unauthorized individuals do not overhear any discussion of confidential information. Documents containing confidential information are not left in the open or inadvertently shared without permission of the client/guardian.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(4) Case management documents should reflect the following elements: • Client's identifying information. • Dates, times, and description of contact with the client, family system, and other service providers or organizations. • Initial and subsequent neurodevelopmental and other assessments • Service plans and procedures for monitoring. • Services provided and other information about plan implementation. • Outcomes of service provision. • Referral to or from providers. • Organizations or resources, including rationale for referrals, and other collaboration on behalf of the client. • If consultation was sought or provided to enhance case management services. • Rationale for referrals and transfer or termination of services.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(5) All case management activities are recorded in the appropriate client record in a timely manner.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 5: Information Collection

(1) The diagnostic process should include compiling a comprehensive history including: • Past and current medical history, including medication and mental health history. • Family and social history. • Education history. • Prenatal alcohol exposure (PAE) related to the index pregnancy. • Pre- and post-natal exposures and risk factors.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(2) Procedures in place to request all prior completed assessments by physician, psychologist, speech-language pathologist, and occupational therapist.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(3) Clinic has implemented use of collection tools for required information, such as standardized forms, checklists, and screening instruments.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(4) Individuals providing background and other information receive support as needed. *Note: Supports and personal contact may lead to more accurate and detailed information needed for comprehensive assessment.*			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 6: Prenatal Alcohol Exposure (PAE) Confirmation

Confirmation of PAE is an essential part of the assessment process once a referral is received at a FASD diagnostic clinic. A decision must be made based on the collected information as to whether it is probable that the patient/client was exposed to a significant amount of alcohol in utero.

<table>
<tr><td colspan="4">(1) Obtaining PAE information is done in a sensitive, non-judgmental, and tactful manner and the team members tasked with this role have received appropriate training to obtain consent, interview, and support the birth mother.</td></tr>
<tr><td>☐ Achieved</td><td>☐ In Progress</td><td>☐ Ongoing</td><td>☐ Barrier/Challenge</td></tr>
<tr><td colspan="4">Notes:</td></tr>
<tr><td colspan="4">(2) Developed criteria for determining reliable, accurate PAE information that includes:
Reliable clinical observation.
Self-report by biological mother.
Reports by a reliable source.
Medical records documenting disclosed alcohol use during pregnancy.
Information about pre-pregnancy drinking patterns, and PAE prior to birth-parent aware of pregnancy are documented and confirmed.
Note: Other information may be collected including:
Pre-pregnancy alcohol consumption patterns.
Intended versus unintended pregnancy.
Alcohol treatment or other social legal, or medical problems related to drinking during the pregnancy, in addition to pre-pregnancy behaviours.</td></tr>
<tr><td>☐ Achieved</td><td>☐ In Progress</td><td>☐ Ongoing</td><td>☐ Barrier/Challenge</td></tr>
<tr><td colspan="4">Notes:</td></tr>
<tr><td colspan="4">(3) Referrals to support and counselling services are available for birth mothers who disclose continued difficulties related to alcohol use.</td></tr>
<tr><td>☐ Achieved</td><td>☐ In Progress</td><td>☐ Ongoing</td><td>☐ Barrier/Challenge</td></tr>
</table>

Notes:

(4) PAE information is not being confirmed by inaccurate recollection, biases, and the use of indirect evidence that is not confirmed by reliable sources.
Although the following may provide context around maternal alcohol use, this list is not a proxy for PAE, nor does it provide reliable and accurate confirmation of PAE in the index pregnancy for a referred client[(2)]:

- Alcohol exposure in another pregnancy.
- Alcohol use before or after this pregnancy.
- Confirmed exposure to other street drugs, but no alcohol exposure recorded.
- Potential risk factors such as being unhoused or being in high-risk situations.
- A general statement about PAE that can't be traced to the source, as is sometimes made by individuals who were not involved at the time of the pregnancy with the mother.
- Alcohol exposure that is described as 'probable' or 'likely'.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(5) Whenever possible, when appropriate and with consent, and taking individual circumstances into account, the birth mother is contacted and interviewed even if she is not the primary care provider.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

Competency 7: Diagnostic Guidelines

(1) Clinicians completing assessments understand and are able to apply diagnostic recommendations into the clinical setting.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(2) The clinical team has adopted the diagnostic and designation criterion as outlined in the CMAJ 2016 publication of the Canadian Diagnostic Guideline[1]. • FASD with sentinel facial features. • FASD without sentinel facial features. • At Risk for Neurodevelopmental Disorder and FASD, Associated with Prenatal Alcohol Exposure (this is not a diagnosis, but is a designation). • No FASD.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(3) The use of the designation "At Risk for Neurodevelopmental Disorder and FASD, Associated with Prenatal Alcohol Exposure" has been incorporated into the clinic program such that appropriate resources and referrals are made to support individuals in this category, and that the individual will be tracked for subsequent clinic referral process.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(4) Other associated features (e.g., sleep problems; sensory sensitivities, physical findings/other congenital anomalies; growth; attachment; and proprioception) as detailed in the current diagnostic guidelines for FASD should be assessed and documented.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(5) Clinician with specific training measures the 3 sentinel facial features (SFF) associated with FASD. Measurements follow the University of Washington lip-philtrum guide[3] and the University of Washington facial analysis software[4] program or manual measurement of the palpebral fissure length. *Note: All 3 SFF must be present simultaneously to consider FASD with SFF as a diagnosis.*			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(6) Facial features should be assessed in all age groups, with an understanding of some challenges in measurements as the individual ages. (i.e., facial hair, facial injuries, cleft lip, or palate).			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(7) Clinic teams use the term FASD as a diagnosis in all communications. Medical documentation should use FASD as a diagnostic term when communicating with other clinical colleagues.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(8) Clinicians measure and document associated features (abnormalities such as mid-faced hypoplasia, micrognathia, abnormal position or formation of the ears, high arched or cleft palate, epicanthic folds, limb abnormalities, palmar crease abnormalities, short-upturned nose, cardiac defects etc.).			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 8: The Multidisciplinary Team

(1) The multidisciplinary team consists of professionals with qualifications, training, expertise, experience, and knowledge in the field of FASD (i.e., has received training in FASD assessment and diagnosis). The multidisciplinary diagnostic team is composed of the Core Team Members (see Appendix B) as outlined in the revised Canadian Diagnostic Guideline[1] and based on the scope of practice set out for the clinic. The team includes member(s) who have appropriate education and background to administer and interpret neurodevelopmental test.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(2) The clinic team members have access to additional clinicians and support personnel such as addiction counsellors, childcare workers, cultural interpreters, mental health professionals, parents or caregivers, advocates, mentors, probation officers, psychiatrists, teachers, vocational counselors, nurses, clinical geneticists or dysmorphologists, neuropsychologists, social workers, nurse practitioners and family therapists, and other professionals if needed.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(3) Relationship building among team members is emphasized to support candid and open sharing of values and questions when discussing assessment and diagnostic results and recommendations.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 9: Professional Development and Training

(1) All team members have completed training and are familiar with the current FASD assessment and diagnostic guidelines.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(2) Clinic staff members have access to ongoing training opportunities that reflect current research, evidence, and expertise as well as professional development opportunities including attending conferences and other events that allow for the maintenance of knowledge in emerging practice and research.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(3) Training is provided for all staff and those involved in the assessment and diagnostic process that specifically provides information about violence, trauma, and re-traumatization.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 10: Virtual Clinic Process

(1) Proper consent is obtained by the child's legal guardian or informed consent by an adult referral, ensuring they understand the process and are willing to use a virtual platform for assessment and diagnosis. Legal guardians, caregivers and client are provided with contact information for any questions about virtual clinic processes and there are no negative consequences if someone chooses not to participate in a virtual clinic.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(2) The client will receive the same assessment, diagnostic and assessment reports, and recommendations for interventions and follow-up as with in-person service delivery.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(3) The setup for virtual connection will use interactive video technology that links the clinician and the child/youth/adult. The clinician can see, hear, and communicate with client and support person during the entire assessment.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:			
(4) A trained support person is present with the client throughout their assessment and will be instructed by the clinician completing the assessments.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(5) Staff and assessment team feel confident in using virtual processes and have access to support when needed.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(6) Ensure the patient and clinic team member is in a private, safe, and secure place to ensure the best confidentiality possible during any interviews or meetings.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(7) Virtual appointments use technology that is properly secured. Platforms that are not secure or are not compliant with clinician standards of practice or approval should not be used (i.e., FaceTime, texting, email, free versions of software like Zoom).			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

Competency 11: The Neurodevelopmental Assessment

(1) Diagnostic team clinicians must have clinical expertise, training, and background to evaluate the 10 neurodevelopmental domains, using the criteria for severe impairment in 3 or more domains (as per the Canadian Diagnostic Guideline[1]), as an indication of pervasive brain dysfunction. • The most recent and updated assessment measures and tools should be used as they are published, and their validity and effectiveness are confirmed. • Neurodevelopmental functioning should be interpreted by a team member with expertise in that brain domain/area.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(2) The diagnostic clinic has adopted the criteria for severe impairment as defined by a global score or a major subdomain score on a standardized neurodevelopmental measure that is 2 or more standard deviations (SD) below the mean with appropriate allowance for test error (see the Canadian Diagnostic Guideline[1]).			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(3) The use of direct standardized measures should be used to assess brain domains whenever possible and is recommended for the majority of evidence for brain dysfunction. When direct measures are not possible, indirect assessment methods such as ratings,			

clinical interview, or historical assessment through file review may be used (see the Canadian Diagnostic Guideline[1]). *Note: For indirect methods, multiple sources rather than a single informant rating multiple domains of function is required.*			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(4) If historical assessment, clinical interview, or file reviews are used for indirect assessment (e.g., assessing adaptive behaviour) deficits should be considered by the team to be at a severity level equal to the clinical cut- off, which is defined as 2 standard deviations below the mean (see the Canadian Diagnostic Guideline[1]).			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(5) Additional assessment tools are completed by a Registered Psychologist with clinical expertise, even when a Psychological-Educational Assessment has been completed. This is to ensure that all brain domains, in addition to educationally- related tests, are included in the testing battery for an FASD diagnosis.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(6) The clinic team is aware that screening tools are not diagnostic and no one screening method is more valid than another. Individual completing screening tool needs education and training on its use.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

Competency 12: Final Medical Summary Report

(1) The medical diagnosis should be communicated to clients and their families by the clinic physician. This includes explaining any essential medical referrals (e.g., for mental or physical health). • Clinic physician and/or other supporting team members should assume responsibility for interpreting the report findings and relaying this information to the client and legal guardians.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(2) The medical summary report should identify individual's strengths and abilities, in addition to challenges and deficits, and include recommendations for appropriate interventions and referrals to services.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(3) Any medical, family history, PAE details, birth record history will be redacted when the medical summary report is shared (with consent) to outside agencies, schools or 3rd party individuals who don't have need for this confidential information.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(4) Ensure timely completion of final medical summary reports and disclosure of reports to families, according to the policy and process determined by the clinic[5].			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(5) Information is recorded in a clear, accurate and professional manner that is non-judgemental or stigmatizing using the FASD Language Guide[6].			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 13: Cultural Knowledge and Safety Practices

Cultural competency refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, language, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each[7].

(1) The Clinic has developed policy and training for clinic team to deliver culturally safe practices, which recognize, respect and nurture cultural identity. All staff have received training on cultural competency ad safety policy and process.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(2) All levels of management, staff and clinic supports understand that cultural competence is a lifelong learning progression and is incorporated into clinic staff supervision and direction.

- Understand unconscious bias and how it can impact care.
- Discuss racialized experiences of care through a colonial lens.
- Recognize how reflective practice can deepen empathy and improve patient experiences.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(3) Clinics have policies and practices that promote respect for differences, and advocate for follow up, intervention services that recognize and demonstrate culturally competent practices.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(4) The clinic process has culturally safe and aware practices in place for the following:

- Intake and referral.
- Information gathering, including interviews with biological parents, family, agencies.
- Assessments, including informing the client, caregiver, legal guardian about the assessment process, purpose, scheduling, and logistics of attending (in person or virtually).
- Diagnostic clinic process, including venue location, time.
- Supports provided to client and family/caregivers on day of the clinic.
- Diagnostic formulation and recommendations by team.
- Debrief with client/caregiver/family/legal guardian.
- Post-clinic follow up supports and treatment.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(5) Indigenous world views and perspectives are integrated into considerations of health as well as the goals, mission and values of the assessment and diagnostic clinic and agency housing the services[8].			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(6) Strategies are formulated for identifying areas of adapting clinic processes, improvement and identified measurable goals and timelines for the plans.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(7) Processes are in place to identify ongoing professional development and training needs in cultural safety and competence.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 14: Trauma-Informed Practice

"Trauma-informed practice is not a counselling technique, but rather a relational approach to service delivery that considers the experiences and enduring effects of early and later life

trauma. It is based on principles of creating safety, promoting agency and collaboration, and building skills in self-regulation"[13].

"Trauma-informed practice means integrating an understanding of trauma into all levels of care, system engagement, workforce development, agency policy and interagency work"[14].

(1) FASD Clinics will incorporate trauma-informed practice in their services to create programs and services that are sensitive and create physical and emotional safety.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(2) Embed trauma-informed approaches into all aspects of policy and practice to ensure a systemic shift within the organization.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(3) Practices will safeguard against traumatization and re-traumatization, regardless of knowledge of past history of clients accessing assessment and diagnostic services.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(4) Awareness of how re-traumatization can occur, such as interviewing clients and requiring them to re-tell accounts of violence, abuse and other traumas when accessing services from many agencies, organizations, other service providers.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 15: Wait Times and Wait Lists

The term, “wait times” refers to the entire time an appropriate clinic referral waits for comprehensive services that result in a scheduled FASD assessment and diagnostic clinic. Wait time start with an initial referral and ends with the assessment and diagnostic process completed by a multi-disciplinary clinic team. The term, “wait list” refers to the number or list of individuals waiting for services[5].

(1) Provide timely, consistent, client-centered, comprehensive services.

- Those who prioritize client referrals, the length of time they are on a wait list, and any care provided while waiting for assessment and diagnostic services will have the training, competency, and qualifications to make decisions, and have discussed wait time standards or policies with team clinicians.
- Clinics depend on the leadership role within the team to manage referrals. Regular review by managers/supervisors is completed to be aware of wait times and wait lists, and to ensure policies and standards set by clinic are being met.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(2) Client-centered services and care reflect wait list and wait time management strategies.

- Clear communication with clients/caregivers/legal guardians about wait times for appointments and subsequent services.
- Acknowledgement of Receipt of Referral be communicated with the client/referral source within a reasonable length of time after clinics receive a referral for service.
- Regularly communicate wait lists and wait times with clinic team so they are aware of wait times and plans for continuity of services and subsequent referrals.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(3) Assign reasonable timelines for Assessment and Diagnostic clinic services:

- Referral packages; acceptance of referral; acknowledgements to legal guardian; scheduling assessments and clinic date; final report completed; follow up.
- Time frame for confirming PAE should be 0-6 months.
    - Should occur prior to adding referral to an indefinite or unreasonable wait time, while waiting for PAE confirmation.
    - Ensure appropriate supports or referrals are in place during these wait times.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(4) Improvement systems in place to review efficiencies and challenges; understand processes and apply knowledge to make any changes and adjustments that could impact wait times and wait lists.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

Competency 16: Research

(1) Use evidence and research to inform policies, programs and practice (see Appendix D). Considerations for clinics when undertaking or participating in research projects:

- Does my organization have policies for participating in research?
- How does the research benefit the clinic, clients, and the broader system?
- Is there an ethics approval process attached to the research?
- Is our clinic able to manage the work and resources required to meet the research goals? Is there a clear description of what this participation involves?
- What does it mean if we do NOT participate?

• Are projects discussed with the clinic team prior to accepting participation?			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(2) Ensure Ownership, Control, Access, and Protection (OCAP) principles are followed when participating or leading research involving Indigenous individuals or communities[9]. *Note: The First Nations principles of OCAP establish how First Nations' data and information will be collected, protected, used, or shared. OCAP® is a registered trademark of the First Nations Information Governance Centre (FNIGC).*			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			
(3) Understand and describe the ethical issues involved when dealing with vulnerable populations and the need for additional safeguards[10].			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 17: Accessibility & Availability

Accessibility can be understood as "the availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them"[11].

(1) Policy and strategic plans in place for rural, remote communities to deal with significant barriers in accessing timely, and available services.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(2) Assessment and Diagnostic services are equitable and accessible for residents in the service region: • Varied clinic models are used to meet the diverse needs of populations served (i.e., virtual, satellite, mobile, face-face). • Interpreter services are offered for those whose first language is not English.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(3) Communication is accessible and available in different modes that are understandable and reduce barriers and options[12]: • Provide text alternatives for non-text content. • Provide captions and other alternatives for multimedia. • Create content that can be presented in different ways, including by assistive technologies, without losing meaning. • Make it easier for users to see and hear content.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 18: Evaluation Process

(1) The Clinic performs regular evaluation at set times during the year (annually; bi-annually) to obtain outcomes measures pertaining to program management, ; impact and deliverables.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(2) The following should be regularly evaluated by the agency providing services, to ensure the services delivered are of highest standard, relevant and effective: • Clinic processes, meetings, training. • Communication with all team members, stakeholders, external agencies, clients, and families. • Budgets.			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Competency 19: Organization & Senior Management

The following competencies speak to organizational management of clinics. This can be used as a tool to reflect and to provide feedback to management and supervised on what may be working or areas where further support and work is needed.

(1) Organizations and managers foster a culture of collaborative and positive relationships within their clinic staff and external stakeholders (government, agencies, partners).			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

(2) Management ensures that clinic coordinators and others responsible for assessment and diagnostic clinic processes have the necessary competencies and skill set to carry out the highest standards of services and operations.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(3) Management recognizes how the various functions of the organization depend on one another, and how changes in any one part affect all the others.

Recognizing these relationships and perceiving the significant elements in any situation, the Senior Manager should then be able to act in a way that advances the overall welfare of the total organization.

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(4) Organizations and management display competencies related to 'dealing with people; other organizations/stakeholders; self-management (see Appendix C)

☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge

Notes:

(5) Understand and implement planning, budgets, and resources to increase clinic capacity and efficiencies, all of which impact wait times and wait lists.

- Explore and make use of funding sources to support assessment and diagnostic costs (i.e., Jordan's Principal funding; regional and local funding; School Division and other agency cost sharing agreements, in kind- health services from health authorities and other stakeholder agencies).
- Clinics have information regarding average costs for contracted clinicians, to guide

budgets, assessment costs/client and make optimum use of assessment and diagnostic clinic funds[5].			
☐ Achieved	☐ In Progress	☐ Ongoing	☐ Barrier/Challenge
Notes:			

Resources

Fetal alcohol spectrum disorder: a guideline for diagnosis across the lifespan

- The most recent Canadian FASD guideline was published as a supplement to the Canadian Medical Association Journal (CMAJ) in 2015. This revision to previous Canadian guidelines for FASD diagnosis was due to new evidence and recommendations.

Rajani Diagnostic Clinic Training Services

- Since 2002, Lakeland Centre for FASD (LCFASD) has trained and supported FASD diagnostic and assessment teams across Canada by providing comprehensive FASD training services. The Rajani Clinic Training Service provides FASD Assessment and Diagnostic training on the revised Canadian FASD Diagnostic guideline and support teams through a mentorship model to increase the confidence level of teams.

Multidisciplinary Team Training for Diagnosis of FASD: An online curriculum

- This online FASD curriculum is developed to assist professionals in learning the processes, procedures, and in developing the skillset needed to be effective members of a multidisciplinary diagnostic team.
- For additional trainings see: CanFASD Online Learners

FASD Diagnostic Clinic Cards

- These cards provide answers to frequently asked questions about FASD diagnosis and FASD clinic contact information for each province and territory which provides FASD assessment and diagnostic services.

CanFASD Common Messages Guide

- This document is to assist those writing and talking about FASD – and the issues related to the disability.

Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working with Children, Youth and Families

- This guide is concerned with advancing understanding and action about trauma-informed approaches that support program and service delivery for/with children, youth and families.

Trauma Informed Practice (TIP) Resources

- Trauma-Informed Practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma. It emphasises physical, psychological, and emotional safety for everyone, and creates opportunities for survivors to rebuild a sense of control and empowerment. The guide will coach you on how you can use a trauma-informed approach to support children, youth and families, in your teams and/or personal life.

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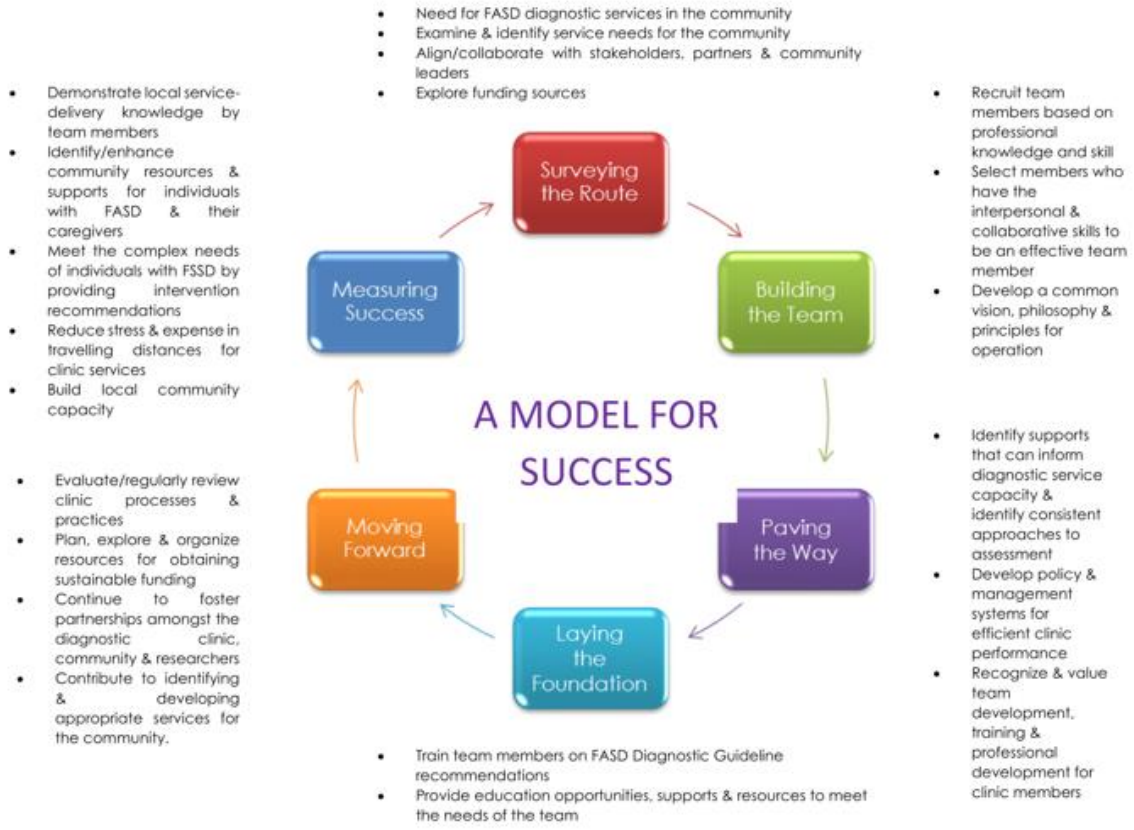
Appendices

Appendix A: Developing a community based FASD assessment and diagnostic clinic.

This figure illustrates the various steps to consider when establishing an FASD diagnostic clinic. The figure reflects that each step needs to be evaluated or re-evaluated routinely to identify new challenges and emerging needs. This model for success is intended to be a guide when establishing successful FASD diagnostic clinics[1].



[1] Adapted from 7th International Conference on FASD, Vancouver BC. Poster Presentation, Burns C., McFarlane A., 2017

Appendix B: Core Team Members Across the Lifespan

For infants (< 18 months)

- Pediatrician/physician
- Child development specialist who has the skill set to conduct physical and functional assessments (e.g., speech-language pathologist, physiotherapist, occupational therapist, clinical psychologist)

For preschoolers (18 months–5 years)

- Pediatrician/physician
- Occupational therapist
- Speech-language pathologist
- Psychologist

For school-aged children (6 years–age of majority)

- Pediatrician/physician with expertise in FASD and differential diagnosis
- Occupational therapist
- Speech-language pathologist
- Psychologist

For adults

- Physician
- Psychologist
- Speech-language pathologist/psychologist with expertise in language assessment

Appendix C: List of competencies as defined by Cripe and colleagues (2001)

Competencies with People	Competencies with Business	Competencies with Self-Management
• Establishing Focus • Providing Motivational Support • Fostering Teamwork • Empowering Others • Managing Change • Developing Others • Managing Performance • Attention to Communication • Oral Communication • Written Communication • Persuasive Communication • Interpersonal Awareness • Building Collaborative Relationships • Customer Orientation	• Diagnostic Information Gathering • Analytical Thinking • Forward Thinking • Conceptual Thinking • Strategic Thinking • Technical Expertise • Initiative • Entrepreneurial Orientation • Fostering Innovation • Results Orientation • Thoroughness • Decisiveness	• Self Confidence • Stress management • Personal Credibility • Flexibility

Appendix D: Information on the Canada FASD Research Network

Canada is a world leader in the field of FASD and promotes increased capacity for prevention, intervention, and diagnostic initiatives. Many of the programs, services and resources are directly informed by the outcomes of research projects focused on improving our understanding of FASD and the many factors that influence and contribute to this issue. Specifically, research programs are critical to improving consistency across diagnostic clinics and the delivery of management strategies.

The Canada FASD Research Network is a collaborative, interdisciplinary research network with collaborators, researchers, and partners across the nation. It is Canada's first comprehensive national FASD research network. Canadian diagnostic clinics have the unique opportunity to contribute to the evolving research landscape by sharing clinical data through various projects underway (such as the Universal data form project). Not only can the data benefit individual clinics, but also provide a comprehensive picture of FASD prevalence across the country. Data is critically important for creating change at the policy and practice level and influencing future funding opportunities.

Whenever possible, FASD diagnostic clinics are encouraged to contribute to the growing body of knowledge related to this field. By participating in research and data sharing, clinics can receive direct feedback on their performance and this information can be used to make improvements to their diagnostic assessment model and to provide the best management recommendations based on evidence. Data can also be used to highlight areas where additional training and/or expertise are needed.

While not all clinics have the resources and capacity to participate in research activities, it is important to be aware of the programs underway and where to find current information (see https://canfasd.ca for up-to-date research, opportunities, and literature). CanFASD's unique partnership brings together many scientific viewpoints to address complexities of FASD, with a focus of ensuring that research knowledge is translated to community and policy action. CanFASD researchers are currently leading many major projects related to FASD prevention, intervention, and diagnostics: connecting researchers, graduate students and practitioners from communities and institutions across Canada and internationally.