

**FETAL ALCOHOL SPECTRUM DISORDER (FASD)
AND THE CRIMINAL JUSTICE SYSTEM:
AN EXPLORATORY LOOK AT CURRENT
TREATMENT PRACTICES**

by

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ABSTRACT

Fetal Alcohol Spectrum Disorder (FASD) is widespread amongst inmates within the Canadian correctional system. Although research suggests that up to half of the prison population is plagued by an alcohol-related birth defect, little has been done within corrections to address this problem. Diagnosis is rare and treatment is ineffective. Research pertaining to the treatment of FASD-impacted adult offenders is limited; however, interventions can be derived from work done with children and youth affected by FASD. To date, Canada only has one community residential facility (CRF) working with FASD-impacted male offenders on parole. Although an innovative project, it has been faced with many challenges. In order to assist with the successful reintegration of FASD offenders, many changes need to take place within our correctional system.

Keywords: Fetal Alcohol Spectrum Disorder (FASD); Corrections – Canada, Corrections Service Canada, Offenders with mental illness; Community residential facility (CRF)

Subject Terms: Fetal Alcohol Spectrum Disorder (FASD); Community residential and reintegration program for adult male offenders with mental disabilities; Corrections Service Canada; Children of prenatal abuse

DEDICATION

To my parents, Marge and Bill, for pushing me to finish.

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INTRODUCTION

Fetal Alcohol Spectrum Disorder (FASD) is an alcohol-related birth defect which negatively affects all aspects of one's life, including the lives of friends and family. FASD is an entirely preventable brain disorder; however, every year thousands of children are born with this disability because of prenatal alcohol exposure. Babies born with FASD are initially affected with primary disabilities such as central nervous system damage. As they develop, they are further plagued with secondary disabilities such as depression. FASD is not a "drunk" baby or a baby born physically dependent or addicted to alcohol (Stratton, Howe, & Battalia, 1996, p.2). Unlike children born addicted to narcotics, these infants are born with alcohol-related birth defects for which there is no cure. In 2003, Health Canada estimated that nine in every thousand Canadian babies are affected with an alcohol-related birth defect (p.8). It is further estimated that the cost of care over a lifetime for a person with FASD is 1.5 million dollars (p.8). In fact, FAS-related mental retardation accounts for higher residential costs than does either Cerebral Palsy or Down syndrome, and may account for one-fifth of costs of all institutionalized mentally challenged patients in the United States (Boland, Burrill, Duwyn, & Karp, 1998, p.30).

As a result of their alcohol-related birth defects, many persons with FASD come into contact with our legal system at an early age, often initiating a pattern that

will follow them throughout their lives. Arguably, the Canadian Criminal Justice System does not have an accurate method for identifying persons with FASD, nor are our treatment programs adequately designed to rehabilitate these persons. The reality is that offenders suffering from FASD are rarely able to recognize high-risk situations, are easily victimized and manipulated by others (Lutke, 2004, p.38). As a result, criminal involvement is often a consequence of their primary disability, often making institutions their second home. Sadly, many persons working with FASD offenders have noted that those with “FASD thrive in the federal prison system because of the daily structure that it provides” (Miller, 2005, p.12).

This paper is intended to introduce the reader to FASD; to gain an understanding of its causes, effects, and ways in which the severity of the disorder can be reduced. The primary focus is on FASD in the Criminal Justice System and the role it plays in correctional treatment and ways in which we can better aid persons with alcohol-related birth defects. To better understand current correctional treatment, a close look will be taken at the only community program working with FASD-impacted adult offenders. It will be compared to what we know “works” with persons affected by FASD. Finally, although FASD has no cure; a brief discussion will be given regarding the many preventative measures which can be implemented to reduce the number of children born with FASD.

Understanding FASD

Diagnosis and Description

Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term used to describe a range of birth defect disorders caused by the consumption of alcohol during pregnancy. Drinking while pregnant may cause a variety of syndromes; however, the primary and most damaging consequence is brain damage (Page, 2002). The severity of the disorder is dependent upon the amount of alcohol consumed, in addition to the developmental stage of the fetus.

For centuries, people have recognized physical and intellectual differences in babies born to mothers who have abused alcohol while pregnant. However, it was not until 1968 that Fetal Alcohol Syndrome (FAS) was first described in the medical literature (Stratton et al., 1996, p.17). Numerous studies preceded Lemoine's 1968 study of birth related defects, but the term "FAS" was coined in 1973 by two dysmorphologists from the University of Washington (Minister of Health, 1997, p.17). Kenneth Lyons Jones and David W. Smith documented a pattern of physical features and behaviour deficits found in infants and children of mothers who consumed alcohol during pregnancy, and began using the term Fetal Alcohol Syndrome (Boland et al., 1998, p.13). By 1978, 245 cases of FAS had been formally recognized by medical researchers, thus making FAS the most frequent known cause of mental retardation (Page, 2002, p.2).

For heuristic purposes, the term FASD is used to encapsulate all alcohol-related birth defects; however, FASD itself is not a medical diagnosis. Rather, five diagnostic categories fall under the umbrella term, each having its own medical diagnostic criteria (Chudley et al., 2005, p.54). There are currently several standards for diagnosing FASD disorders; however, the most prominent mode of diagnosis is that of the American Institute of Medicine (Verbrugge, 2001, p.1)¹. In order to receive a medical diagnosis of FASD, an extensive list of criteria must be met. This list is beyond the scope of this paper; rather, a brief discussion will be given regarding the five categories of FASD, with a concise overview of the diagnosis criteria. Both the first and second alcohol-related disorders under the umbrella are known as Fetal Alcohol Syndrome (FAS). A diagnosis of FAS requires either confirmed maternal alcohol exposure or unconfirmed exposure; it is this confirmation which will determine the diagnostic label. Additionally, this diagnostic label refers to the presence of growth abnormalities, all characteristic facial features, and the presence of significant brain dysfunction (Antrobus, 2007a, p.2).

The third subtype is known as Partial FAS (pFAS) with confirmed maternal alcohol exposure. A person affected with pFAS often displays some characteristic facial features, and significant brain dysfunction (p.2). Fourth, are Alcohol-related birth defects (ARBD) with confirmed maternal alcohol exposure. Children categorized as having ARBD typically have “congenital anomalies

¹ Canada has recently implemented its own set of diagnostic criteria. These guidelines are similar to those of the American Institute of Medicine. See Chudley et al., 2004 for more information.

related to the heart, skeleton, kidneys, eyes, and ears” (Verbrugge, 2004, p.1). The final category under the umbrella is known as an Alcohol-related Neurodevelopmental disorder (ARND) with confirmed maternal alcohol exposure. ARND has often been referred to as the “invisible disorder” since there are no apparent physical features (Antrobus, 2007a, p.2). Rather, these persons are afflicted with central nervous system development abnormalities, or with other cognitive and behavioural irregularities (Verbrugge, 2004, p.1). It is important to note that no one diagnosis is more or less disabling than another; in fact, there is almost equal brain damage across the board (Lutke, 2004, p.9).

Individuals affected with FASD display an array of symptoms and disturbances; however, to receive a conclusive diagnosis, four factors must be present (Verbrugge, 2004, p.1). The first requirement is documentation of maternal consumption of alcohol. Second, children born with alcohol-related defects often have visible facial anomalies such as a short upturned nose, a malformed mouth, a small lower jaw, or having ears which are significantly too big or small (Lutke, 2004, p.11). Although these features are often visible in early childhood they are often less distinct in older children and adults (p.12). Given that facial features change dramatically with age, childhood photographs are often critical for the diagnosis of adults (p.12).

In addition to facial deformities, children subjected to prenatal alcohol exposure frequently experience growth retardation. This third feature can often be

identified at birth, given that FASD babies are frequently born with lower than average birth weights. Furthermore, childhood growth rates tend to be delayed and these children are often considered “skinny” for their age (p.13). Along with the visible characteristics of FASD, the fourth diagnostic requirement is significant central nervous system damage. Some of these cognitive abnormalities may consist of impaired motor skills, poor eye-hand coordination, and learning difficulties (p.14). If all four conditions have been met, the individual receives a diagnosis of Fetal Alcohol Syndrome with confirmed maternal alcohol exposure. However, it is often the case that one or more of the requirements cannot be satisfied; as a result one of the other three diagnostic labels would be applied. Each diagnosis under the FASD umbrella has its own set of requirements, which are composed of one or all of the above mentioned criteria.

Maternal Risk Factors

A mother’s use of alcohol during pregnancy may cause a range of mental and physical defects to her unborn child. According to Health Canada (2005b),

the impact of alcohol varies with the amount, timing and frequency of alcohol consumed, and depends on a number of other factors including the genetics of the fetus and mother, and the overall state of health of the mother as well as other social, economic, physical and environmental factors (p.8).

Although alcohol is the cause of FASD, many mothers smoke during pregnancy, use other harmful substances (e.g. narcotics), maintain a poor diet, receive limited prenatal care, and are often in adverse psychosocial circumstances (Burd, Marlsof, & Juelson, 2004, p.2). It is often the case, that women who

consume alcohol during pregnancy are susceptible to many other shortcomings throughout their lives. In fact, research conducted by Boland and colleagues (1998) showed that women with drinking problems are often in situations of low social integration, including significant periods of unemployment (p.57). In turn, these women are often of low socioeconomic status. Furthermore, they found that these women had a history of spontaneous abortions, or low pregnancy weight. Enquiry into their past relationships revealed a high percentage of divorce and separation. Additionally, it was found that women who were susceptible to alcohol consumption during pregnancy often had a partner with a drinking problem, or were in close contact with men who were heavy drinkers. It is important to note that the risk of FASD increases by 75-80 percent in future pregnancies (Burd et al., 2004). For this reason, it is vital that we provide birth mothers with effective support in order to help reduce the number of children born with alcohol-related birth defects.

Protective Factors

Secondary disabilities are often detrimental for those afflicted with FASD. These disabilities are not apart of the diagnosis criteria, rather they are a result of being undiagnosed and/or having a poor understanding of the disorder (Silden, 2004, p.11). Although secondary disorders often accompany primary disorders, there are numerous protective factors which can eliminate or reduce the likelihood of the development of these secondary disorders. Researchers have outlined five principal protective factors associated with the reduction of secondary disabilities

(Boland et al., 1998; Burd et al., 2004; Streissguth, Barr, Kogan, & Bookstein, 1997). First and foremost, living in a stable and nurturing home of “good quality” is crucial for children affected with FASD. In essence, this requires that the child’s home environment be serene, structured and supportive. Secondly, residential stability is important for children with alcohol-related birth defects. However, this is often unachievable considering that the majority of children suffering from FASD do not reside with their biological parents (Boland et al., 1998, p.47). Rather, it has been estimated that approximately 77 percent of FASD children live with relatives, have been adopted, or reside in foster care, group homes or institutions (p.47). Boland (1998) adds that children who remain with their biological parents tend to experience high anxiety, frequent abuse and pervasive neglect; therefore, it is often in their best interest not to live with their natural parents (p.47). Research by Burd and colleagues (2004) suggests that a child remain in each living situation for a minimum of 2.8 years. Frequent changes in living arrangements are not ideal for any child; however, children with FASD are often harmed more severely. Ongoing familial structure and support play a significant role in the reduction of secondary disabilities.

The third factor contributing to the reduction of secondary disabilities is not being a victim of violence. Experiencing violence, such as physical abuse from a guardian or sexual assault, will likely contribute to the development of secondary disabilities. Although this is an apparent preventative factor for all children, victimization often plays a dramatic role in the lives of FASD children (Boland et

al., 1998, p.47). Some estimates suggest that 73 percent of youth with FAS/FAE have experienced some form of abuse (e.g. physical, emotional, and sexual) (Fast & Conry, 2004, p.162). The fourth protective factor is receiving a medical diagnosis before the age of six (e.g. FAS, pFAS). Finally, obtaining support from a developmental disabilities service significantly reduces the potential development of secondary disorders. Ideally, these services should be first accessed while the child is young (i.e. under the age of six). Immediate acknowledgement and acceptance of the disorder, along with treatment, will likely reduce future harm.

There is no cure for alcohol-related birth defects; however, that does not mean that these individuals are doomed to failure. Infants born with FASD will be faced with a variety of challenges throughout their lives, and early intervention is ideal in order to eliminate secondary disabilities and reduce the impact of primary disorders. With intervention, it is reasonable to assume that FASD individuals have the ability to lead a successful life to the best of their abilities.

Secondary Disabilities

Aside from the primary disabilities associated with FASD, there are many secondary disabilities that are a direct result of having an alcohol-related birth defect. Although secondary disabilities often accompany primary disabilities, it is assumed that they can be prevented, reduced or eliminated with proper intervention (Boland et al., 1998, p.42). Unlike primary disabilities, they are not a result of central nervous system damage, rather secondary disabilities develop

because the child has difficulties adapting to his/her environment. Individuals living with FASD are faced with a variety of challenges, some more detrimental than others. Typically, persons with FASD “have difficulty communicating their needs, being self-sufficient, maintaining their own hygiene, relating to their age mates appropriately, and applying for and receiving social services” (Boland et al., 1998, p.49). These routine secondary disorders are problematic in themselves yet there are numerous disabilities which may develop as a result of having FASD.

Research suggests six principal secondary disabilities associated with Fetal Alcohol Spectrum Disorder. First, mental health problems are frequently seen as a co-morbid diagnosis. It has been estimated that 94 percent of all adults with FASD will experience a mental illness at some point in their lives (Lutke, 2004, p.41). Depression, suicide threats and attempts, panic attacks, psychosis, and attention deficit hyperactivity disorder (ADHD) are fairly common among persons with FASD (p.41). Although considered a secondary disability, recent research has begun to suggest that mental health issues are so “prevalent and pervasive among those living with FASD that they are considered to be primary to the disability” (Antrobus, 2007a, p.4). In addition to mental health problems, a large percentage of youth have disrupted school experiences (e.g. being suspended and/or expelled) (Streissguth et.al., 1997, p.34). Furthermore, approximately half of all persons with FASD will experience some conflict with the law and will be

faced with mandatory confinement (e.g. inpatient treatment or incarceration) (p.34).

The fifth secondary disability commonly associated with FASD is inappropriate sexual behaviour (ISB). ISB is defined as “any compulsive and problematic sexual behaviour or any behaviour that results in sentencing of an individual for sexual offender treatment” (Novick, 1997, p.162). Although it is commonplace for many FASD adolescents and adults to display inappropriate sexual behaviour, it is often the result of their brain damage. They are unable to understand social rules, cause and effect, and lack evaluative processing (Lutke, 2004, p.36).

Finally, it is estimated that 35 percent of those above the age of 12 with have problems with drugs and alcohol (p.45). There does not appear to be a significant gender difference concerning the level of drug use with FASD individuals; however, on average, males significantly abuse more alcohol than females (Boland et al., 1998, p.49). Unfortunately, the reality is that secondary disabilities do not only affect the individual, but they have the potential to devastate the lives of friends and family.

As a result of their birth defects the majority of FASD adults are unable to live independently. In fact, it is estimated that roughly 80 percent of individuals with prenatal alcohol exposure are unable to successfully care for themselves (Lutke, 2004, p.43). They have difficulties managing money, accessing medical services,

using public transportation, and completing simple everyday tasks such as grocery shopping and meal preparation (p.43). As previously stated, persons with FASD have difficulty maintaining stable employment, approximately 80 percent of adults over 21 are unable to obtain or retain employment, regardless of their IQ (p.43). Problems arise because they are easily frustrated; have poor task comprehension, anger management issues, and are unreliable (p.44). Unfortunately, their brain disorder makes it appear as though they are lazy, unmotivated workers. Consequently, they are incapable of maintaining employment for significant periods of time.

With regards to intelligence and IQ, people with FASD typically have an IQ within the normal range. Interestingly, research reveals that FASD individuals with the highest IQs often have the greatest trouble with life adjustment and frequently have the most psychosocial problems (Boland et al., 1998, p.50). Streissguth and Randels (1988) found that many of the higher functioning patients in their study were painfully aware of their deficits, to the point of understanding that they were caused by their mother's drinking during pregnancy (Boland et al., 1998, p.50). This knowledge could lead to additional secondary disorders, such as depression, suicide attempts, and excessive alcohol/drug use (p.50).

FASD and the Criminal Justice System

One of the most detrimental effects of Fetal Alcohol Spectrum Disorder is early involvement with the law. The cognitive, social, and behavioural problems faced

by persons with FASD are believed to lead them into trouble with the law, and create further problems for them during incarceration (Boland et al., 1998, p.53). As previously discussed, approximately 60 percent of young persons with FASD have been in trouble with the law and 50 percent have been incarcerated (Boland et al., 1998; Silden, 2004, Streissguth et al., 1997). Although these statistics may appear high, they do not reveal how many youth end up in an adult correctional facility. Even though we lack definitive results pertaining to the number of offenders affected by FASD in our correctional system, reports suggest that FASD is far more common in corrections than within the general population (Burd et al., 2004, p.2).

In 1999, Fast and fellow researchers published the first study on the prevalence of FAS/FAE youth in the criminal justice system (p.371). They found that the percentage of youth with an alcohol-related birth defect was ten to forty times higher than the accepted worldwide incidence (p.371). Although this study was conducted in a forensic psychiatric unit, the findings are nonetheless surprising. In fact, some estimates suggest that half the Canadian prison population is plagued by prenatal alcohol exposure (Lutke, 2004, 6). Unfortunately, once a person with FASD enters the criminal justice system he/she will likely continue to cycle through for curfew violations, association with the wrong people, drug and alcohol consumption, shoplifting, or minor sexual offences (Page, 2002, p.14).

Despite the large percentage of FASD adolescents and adults becoming involved in criminal activity, it appears that their involvement is impulsive and unpremeditated (Boland et al., 1998, p.46). In 1997, Streissguth studied FASD adolescent offenders and found that their maladaptive behaviour and cognitive defects contributed to their conflict with the law (Boland et al., 1998, p.46). Some of the defects included impulsivity, attention deficit, and trouble understanding the consequences of one's actions. Additionally, it was found that these young persons have an excess amount of free time, likely caused by unemployment or school-leaving. This surplus of time inevitably leads to unstructured days; often with poor family supervision and association with negative peers which impels FASD individuals into criminal activity.

In 1992, LaDue and colleagues looked at secondary disorders and their role in the lives of young persons suffering from FASD. Their research revealed that 46 percent of youth were defiant to authority, 53 percent had truancy problems, 35 percent were involved in theft, 28 percent for petty larceny, 27 percent for destruction of property, 23 percent had been charged with drunk driving, and 57 percent had a problem with lying (Boland et al., 1998, p.45). They further noted that socially inappropriate behaviour often led to legal problems among individuals suffering from FAS (p.45). Approximately 13 percent of their sample was involved in sexually inappropriate behaviour which lead to a variety of charges (p.45). A similar study found that approximately 50 percent of the

sample had demonstrated inappropriate sexual behaviour (Burd et al., 2004, p.2).

Benefits of Diagnosis

Diagnosis of an illness can be disadvantageous or beneficial, simply dependent upon the label. In the case of Fetal Alcohol Spectrum Disorder it seems as though a diagnosis would reap only positive rewards (e.g. appropriate treatment), especially within the correctional system. There are certainly negative effects of being labelled (e.g. being identified as different from one's peers); however, in this case it appears that the benefits outweigh the costs. When FASD is "unrecognized, the needs of this population are not considered in sentencing and subsequent treatment" (Fast et al., 1999, p.370). However, one concern associated with attempting to diagnosis adolescents or adults with FASD is that it is often mistaken for a multitude of other disorders. Persons affected with FASD often display similar symptoms as people with attachment disorder, ADHD, autism, oppositional deficit disorder, or sensory integration dysfunction (Silden, 2004, p.9). For this reason it is essential that an appropriate means of diagnosis is developed. In corrections, a standardized approach should be introduced to correctly identify inmates with FASD.

As stated, there are many benefits of early diagnosis for FASD offenders initially entering the criminal justice system. Streissguth (1997) has outlined four such benefits (Boland et al., 1998, p.59). First, she states that diagnosis creates visibility, thus making people aware of the behaviours exhibited by individuals

impacted with FASD. This visibility encourages the correctional system to acknowledge these individuals and their disabilities, permitting people to recognize that these behaviours are not completely out of the ordinary; rather they are a result of a birth defect. Secondly, a diagnosis aids people in understanding the cause and effects of the disorder. People want to know why an individual is acting or reacting in a particular manner. A diagnosis or label aids people in understanding, thus encouraging them to respond appropriately and set realistic expectations. Therefore, it would appear as though a diagnosis would only strengthen the relationship between the offender and his/her parole/probation officer. Ideally, a medical diagnosis would aid with community supervision by encouraging the parole/probation officer to set appropriate rules and expectations. Furthermore, a diagnosis is imperative within an institution where offenders are required to attend correctional programming. Individuals affected by prenatal alcohol exposure do not benefit from correctional programming in the same manner as other offenders and certain adjustments need to be made to benefit persons with FASD.

A diagnosis of one of the disorders under the FASD umbrella helps identify the cause(s) for inappropriate behaviour, thus motivating the development of appropriate treatments and interventions (p. 60). If an individual is identified as having special needs early on, it will ensure that the most suitable treatment be provided. Finally, Streissguth notes that diagnostic records can aid in further research on needs-assessment, program evaluation, and recidivism (p.60).

Maintaining accurate, up-to-date records of individuals with FASD would help to ensure that appropriate social, educational, psychological, and medical interventions are made (p.60).

Although diagnosis and identification of FASD offenders would certainly produce successful results, our current system does not have a standardized method of diagnosing adults with FASD. This is not simply a downfall of the correctional system; rather the entire diagnosis scheme for adults with FASD is unstructured. To date there does not appear to be a universal diagnosis strategy in place, unfortunately this creates a situation where people with FASD are not receiving the care and treatment they desperately need. It is important to note that there are agencies providing assessment and diagnostic services for persons suspected of having FASD (e.g. Asante Centre).² However, in order to receive an assessment, a referral and fee is required. The diagnosis of persons suspected of having FASD is a complicated process, requiring a team of experts (i.e. a neuropsychologist, pediatrician, physical therapist, occupational therapist, speech-language pathologist, and a social worker) (Mitten, 2004, p.21). Presently, our correctional system does not have dependable means for identifying persons suspected of having FASD, nor does it have the resources to diagnose these persons if recognized.

² The Asante Centre is the leading FASD diagnosis centre in British Columbia. Presently, the Ministry for Children and Family Development is funding a program to work with suspect FASD youth who are in conflict with the law. Refer to www.asantecentre.org for more information.

TREATING PERSONS WITH FASD

Correctional Programming

According to the Canadian Criminal Code (section 718), one of the fundamental purposes of sentencing is to assist in rehabilitating the offender (Fast & Conry, 2004, p.164). Correctional Services Canada (CSC) does attempt to do so by requiring offenders to participate in a multitude of programs; such as education and employment programs, family violence, sexual offender programs, substance abuse, violence prevention, and living skills (CSC, n.d.). Although a wide variety of programs exist, the majority are based on behavioural modification, with the success rate being dependent upon self awareness, self motivation, impulse control, people skills, mood management, and behavioural change (Lutke, 2004, p.40). Unfortunately, these are not skills that can be taught or should be expected from persons with FASD. Rather, it has been suggested that the “most effective sentence for people with FASD may be one that aims to change their living or social situation, rather than their behaviour” (Fast & Conry, 2004, p.164). For that reason, it would seem beneficial to identify individuals with FASD within the correctional system because their “disorder represents a substantial barrier to learning and would impact the affected person’s ability to master essential programs” (Burd, Selfridge, Klug, & Juelson, 2003, p.6). Moreover, even if the skills were “learned” persons with FASD would have

significant difficulties generalizing the skills learned in an institution to a non-institutionalized community setting (p.6).

CSC programs have shown success with various offender populations (see CSC, 1996); however, this type of programming does not benefit those affected with FASD in the same manner. Cognitive behavioural programs are intended to change thinking patterns, yet people with FASD have brain damage which prevents them from understanding consequences, thinking ahead, or learning from their mistakes. The reality is that these offenders have brain damage; therefore, targeting thinking patterns is not the best rehabilitative choice (Silden, 2004, p.61). Consequently, FASD persons in conflict with the law do not appear to benefit from treatment. Similar to their inability to maintain employment, they appear lazy and unmotivated, thus giving the program facilitator the impression that they are uninterested in change.

It is important to note that the content of CSC's core programs is appropriate for FASD offenders; however, adjustments need to be made in order for them to fully absorb the material. Furthermore, there is a consensus among experts that programming for persons with FASD should "focus on functional skills for independent living (e.g. problem solving, arithmetic, social interacting and decision-making)" (Roberts & Nanson, 2000, p.15). It is important to develop realistic expectations of the FASD person and to promote independent adaptive living, social and communication skills, and role playing to teach logical

consequences and appropriate behaviour (p.15). Programs need to be simplified, made incredibly concrete and more redundant with frequent review of core terms and principles (Boland et al., 1998, p.81). It is important that the pace of program delivery be reduced significantly; offenders should be given plenty of time for practice and repetition (p.81). Unlike typical day long sessions, it has been suggested that shorter daily sessions be the format for FASD offenders (p.81). Individuals with FASD have difficulties focusing for lengthy periods of time, as we have seen with their inability to maintain a job and with the high rates of high school drop out. Ideally, daily programming should be short in length, contain less information, and key concepts should be repeated on a daily basis. Moreover, improvements are seen when FASD offenders are placed in small groups or receive one-on-one counselling (Silden, 2004, p.57).

Treatment that “works”

Although there are many treatment paradigms and programs designed to work with FASD clients of all ages, traditional group or milieu therapy has been found disorienting and upsetting to patients with FASD (Novick & Streissguth, 1996, p.20). This is due to their difficulty with boundaries, emotional control, and suggestibility. Novick and Streissguth (1996) have identified three factors associated with successful inpatient treatment (p.20). First, individual therapy is seen as most beneficial when working with persons with permanent brain damage. FASD clients “often respond more successfully to a mentoring, one-on-

one type of treatment where they feel a special bond with a staff member who serves as their advocate and point of contact” (p.20).

The Restorative Circles Initiative in Saskatoon is a prime example of a community based mentoring program working with persons suffering from prenatal alcohol exposure. The mentors have become part of an integral support team that has been found to be extremely effective in working with troubled youth (Miller, 2005, p.15). Washington has a similar mentoring program but mentors serve as external brains (this concept discussed in more detail below) for FASD mothers who have difficulty staying clean and sober (see Grant et al., 2004). The goal of the Parent-child assistance program (P-CAP) is “to help mothers build and maintain healthy independent family lives, to ensure that children are in safe and stable homes, and to prevent future births of alcohol and drug-affected babies” (Page, 2002, p.21). Mentoring programs can successfully work in institutional or community-based settings. It appears that these “cognitive-behavioural approaches work best, because they can be specifically tailored to accommodate the judgment and organizational problems of the patient” (Novick & Streissguth, 1996, p.20).

Second, family therapy has been found to be particularly effective with this population. For a person with FASD to “sustain progress made in treatment once he/she is discharged depends heavily on the amount of support available in the home environment” (p.21). This holds particularly true with youth; however, as

previously discussed, many adults with FASD cannot properly care for themselves. Although research suggests that family support is an important asset for treatment, it is often the case that offenders with FASD do not have any positive, pro-social familial support. It is this lack of community support which often contributes to their antisocial behaviour.

Since many persons with FASD do not have adequate family support, they often need intensive case management. Professional aftercare support is the final factor associated with successful inpatient treatment, and this in itself is a complex task. Attempting to “coordinate the many services that the patient may need; such as ongoing individual therapy, vocational support, job coaching, housing, transportation, and financial assistance” is extremely time consuming and laborious (p.21).

Learning from children and youth with FASD

Few agencies work with FASD-impacted adults, especially those engrossed in the criminal justice system. New Beginnings is the presently the first and only community residential facility working with federally sentenced males in Canada. Regrettably, adults suffering from an alcohol-related birth defect have limited access to help within the community and are often ineligible for mental health services.

One consequence of having few organizations working with adults is that limited empirical evidence is produced supporting “what works” with FASD-impacted adults. However, this does not mean that there is no research pertaining to what works with this population. In North America, numerous organizations and programs are committed to working with children and youth suffering from prenatal alcohol exposure (see for example Vancouver YWCA Crabtree Corner, Epiphany Centre in San Francisco, Shared Family Care program, or Alternative Response Services). Many of these agencies have shown great success, and the knowledge gained from working with children and youth can be pertinent to the successful treatment of FASD-impacted adults.

Early childhood education is one area that has shown great success with FASD-impacted children. There has been extensive research conducted pertaining to the schooling experience of young persons, with the primary focus being on individualized learning plans, learning tools/methods, and the school environment (Davis, 1994; Ministry of Education, 2002; Page, 2002). It may appear as though early childhood education has little to do with FASD-impacted offenders; however, information gathered from schools can be applied to correctional programming. To aid with rehabilitation, offenders are often required to participate in designated programs which in essence requires them to attend school. As previously discussed, current correctional programming does not benefit FASD persons; therefore, it seems plausible to apply learning techniques used in schools in order to maximize the benefits of CSC programming.

Research suggests that the optimum school environment is one with structure, order, and routine (Davis, 1994, p.38). Persons with FASD are easily distracted and frustrated; as a result, their surroundings must maintain as constant as possible. The environment in which an FASD person is surrounded contributes immensely towards their positive or negative behaviour. One's environment "includes the physical setting and the attitudes, beliefs and actions of those caring for and providing services to the individual" (Antrobus, 2007b, p.3). Research recommends that the physical setting of a classroom be free of all extraneous materials and that the noise levels be monitored in order to reduce student distractions (Plant, 2003). The students' (or offenders') school work should be kept in one binder, as opposed to several small notebooks. Learning techniques should be creative and simple, students should be asked to paraphrase the learned material in order to ensure comprehension, strengths should always be rewarded and excessive homework and/or long assignments should be avoided. It further suggests that pictorial cues be used; such as bulletin boards and soft colours. Organization and structure are essential when trying to teach persons with FASD new skills and behaviours. Fundamentally, the environment should be as calming and relaxing as possible which will help reduce stress levels and distractions often experienced by persons affected with FASD. Furthermore, research suggests that all classrooms have a quiet area where the child knows he/she can go if they feel distracted and overwhelmed (Plant, 2003).

Information pertaining to early childhood education has found that the following arrangements can benefit youth suffering from FASD:

... separation from distraction, greater flexibility around punishment, seating close to the teacher, permission to move when needed - to special, self-contained classes with few students and greater therapeutic/behavioural emphasis, always with an eye toward encouragement and teaching rather than pointless punishment and deprivation (Page, 2002, p.16)

Although intended for classroom use, this can be easily applied to correctional programming or the CRF. As stated, individualized learning plans are used with FASD children. Although more detailed, these plans are similar to an offender's correctional plan. It is suggested that CSC review the model used for FASD-impacted children, and apply it with diagnosed or suspected FASD offenders. Having a comprehensive correctional plan will clearly delineate the steps needed in order to ensure successful reintegration of the FASD parolee. This newly-reformulated plan should also include detailed information pertaining to aftercare, his support network, and community services.

While the majority of this discussion has focussed on correctional programming, knowledge gained from school settings could also be applied to employment. Persons affected by an alcohol-related brain disorder have difficulties maintaining employment, but this does not mean that they are unable to work. Employers need to be educated in order to comprehend the limitations of their FASD-impacted employee. Information gathered from schools offers many suggestions that will aid these persons in sustaining employment for extended periods of

time. A “job coach, instructions either written out or illustrated in pictures, built-in stress relief such as a quiet refuge or someone to vent to, repetition of instructions, and forgiveness for mistakes and forgetfulness” (p.17) are tools which will assist the FASD-impacted offender in leading a successful, pro-social life.

RISK MANAGEMENT AND AFTERCARE

New Beginnings' FASD Program

One of the disheartening side effects of Fetal Alcohol Spectrum Disorder is that many adults are unable to effectively care for themselves. In spite of institutional release, FASD offenders require an extensive amount of aftercare in order to successfully reintegrate back into the community. While on conditional release these persons necessitate a substantial amount of support and careful monitoring (Boland et al., 1998, p.83). Even upon sentence completion aftercare is required in order to reduce the likelihood of future offending. Without proper support it is likely that individuals born with alcohol-related birth defects will once again enter the correctional system. In 1998, Boland and colleagues made several recommendations for the risk management and aftercare of FASD offenders.

Because of their permanent neurological deficits and the many secondary problems these deficits generate, FASD inmates require extensive planning for their release. Safe and appropriate housing that allows them to establish structure and routine, job training that allows them to work within their abilities, continued social and life skills training that allows them to improve their adaptive functioning, a long term relapse prevention and maintenance program for those with substance abuse needs, and close and supportive monitoring would all help ensure that a stable and successful transition to community life would be made. As with institutional programs, evaluation should be ongoing in order to ensure further refinement to what works with this difficult population (p.85).

One organization has made attempts to adhere to the majority of these recommendations and work one-on-one with federally sentenced FASD-impacted offenders. In 2000, the New Beginnings Group was established.³ Its mission is to “promote the physical, emotional, and spiritual well-being of adults affected by social marginalization due to such factors as substance misuse, Fetal Alcohol Spectrum Disorder, Aboriginal status, mental health issues, homelessness, and involvement in the criminal justice system” (N/A, 2003, p.1). Once established, the New Beginnings Group opened New Beginnings, a 20-bed Community Residential Facility (CRF) and program centre in the Lower Mainland of British Columbia. New Beginnings is under contract with CSC and “strives to support high-need adult male offenders on conditional release to develop pro-social living skills and behaviours that will help them reintegrate successfully into the community” (p.1). New Beginnings is currently the first and only CRF in Canada working directly with adult offenders affected by FASD, and is founded on the principle that traditional approaches do not necessarily work with this specific clientele (p.4).

The aim of New Beginnings is to work with offenders during and after their residency. Intensive therapeutic casework is tailored to meet the needs of each offender, focusing on their social skill development, life skills, employment readiness and job search, substance use, health care, and the development of community support networks (New Beginnings, 2006, p.1). New Beginnings uses

³ For purposes of confidentiality, the actual name has not been used; rather, a fictional name has been used throughout this paper.

an intensive therapeutic case management system that is focused on individualized approaches and that allow for more intensive supervision and monitoring of residents (New Beginnings, 2005b, p.4). The ultimate goal of this model is to reinforce accountability to their Parole Officer, support group, and the community at large (p.6).

It is apparent that New Beginnings staff want to follow many of Boland's (1998) risk management recommendations. However, once New Beginnings began working with FASD offenders it became apparent that their needs exceeded staff resources. In order to address the need, volunteers became a fundamental component of the program. The FASD volunteer program was modelled on Vancouver's faith community's "Circles of Support and Accountability" (COSA) program (p.4). CSC defines a "Circle of Support and Accountability" as a "group of 4-7 primarily faith-based community volunteers, who are committed to enhancing public safety by supporting community re-entry through: covenanting, meeting and walking daily in friendship with a person who has been detained to the end of his sentence because of a sexual offence history" (CSC, 2003). COSA was originally designed for high-risk sex offenders who had reached warrant expiry; however, many communities have used the COSA model with other offender populations. New Beginnings is a prime example of an organization that has utilized the circle of support and accountability model.

FASD Volunteer Program (FVP)

The FASD volunteer program (shortened to FVP) is sponsored through Health Canada and is a fundamental component of the FASD program. The FVP's objective is to provide individualized support for FASD impacted clients to reduce problematic substance use and criminal recidivism (New Beginnings, N/D).

To effectively work with individuals diagnosed with an alcohol-related birth defect, volunteers receive specialized training to more fully comprehend the primary and secondary disabilities associated with the disorder (New Beginnings, 2006, p.1). It is expected that volunteers meet with the Core Member (e.g. CRF resident) approximately once a week to engage in outings and activities that meet the needs of the Case Management Team (p.1). Activities are based on a needs assessment created by the counsellor. The needs assessment is originally derived from the *Intake Questionnaire* and *Assessment of Social Support Questionnaire*, which are completed within the first forty-eight hours of the resident's arrival. The *Intake Questionnaire* consists of a variety of basic questions pertaining to the offender's background, and inquires into their immediate goals and how the CRF can help them achieve their goals. In addition, the *Assessment of Social Support Questionnaire* is intended to determine the level of support the resident has within the community. This assessment should be reviewed every three months, in order to monitor changes in the client's perceived level of support (New Beginnings, 2005a, p.12) It is important to note that volunteers are not simply there to "entertain" the FASD-impacted offender; rather, the purpose is to create a trust relationship whereby the offender can

begin relying on them for leadership and guidance (New Beginnings, 2006, p.3). Once a relationship is built on trust and respect, it is expected that the FASD client will be willing to ask for help and/or advice.

External Brain Model

The FASD program at New Beginnings is based on the concept mentioned earlier of the “external brain,” a term coined by Dr. Sterling Clarren (Kellerman, 2003, p.1). An external brain refers to the “presence of another responsible person who can mentor, assist, guide, supervise, and/or support the affected person to maximize success” (p.2). The difficulty with this model is that the FASD-impacted offender is usually unaware of his disability; therefore, does not believe that he needs help. Furthermore, most persons affected with FASD do not want to be perceived as “different,” they want to fit in and be treated like their peers. Thus, the challenge is often getting the client to accept the need for an external brain (p.3). Persons with alcohol-related birth defects may need assistance with simple tasks such as keeping track of time, budgeting or decision making. Although assistance is needed, these individuals often refuse help because they believe they can do it on their own. It is only after a bond has been formed that the FASD client will feel comfortable asking for help. It is essential that the client trust his mentor or “external brain,” thus making him or her feel as though it is acceptable to ask for help.

Breaking down the FASD program at New Beginnings

It is often the case that an immense amount of time, planning, and research has gone into the development of a new program, yet for a variety of reasons the program is never fully realized. Regardless of the type of program, there is always a program ideal, an ultimate goal. However, new programs are often faced with many obstacles and challenges and New Beginnings is no exception. New Beginnings has had many successes as the first Canadian CRF working with FASD impacted offenders, and no one can deny that they have spent a great deal of time and resources working with these persons. Although there have been many positive efforts, it is important to acknowledge that there is a significant amount of room for improvement. The following discussion is meant to be a constructive addition to ongoing work concerning FASD treatment and I acknowledge that there are inherent limitations to the discussion, given that I was placed in an agency setting for a relatively short period of time vis-à-vis other people working in this field.

While New Beginnings has accomplished a great deal in a short period of time, there are several areas in which it can improve in my opinion. One of the major drawbacks of the FASD program at New Beginnings is the limited number of FASD-impacted residents. Unfortunately, due to the difficulties in obtaining accurate medical assessments and diagnoses of FASD, referrals have been admitted to the program based on developed screening criteria which identifies “characteristics consistent with FASD” (N/A, 2003, p.5). The general profile of an

FASD resident at New Beginnings is as follows; he is typically between the ages of 20 and 35, he will reside at the CRF for approximately 6-18 months, he usually has multiple convictions often as a result of his impulsive behaviour (Pierce, 2007, p.1). He often presents as immature and unsophisticated and may lack inhibition when sharing personal information. The FASD parolee is often defensive towards authority figures, has limited vocational and/or education skills, has limited community support, and is often plagued with a substance abuse problem (p.1).

Few residents have been medically diagnosed with FASD; in fact, it would appear as though there was only one resident with a medical diagnosis of FASD during a three month period. This is not problematic in itself; however, there are not enough referrals being made. At most, there were four residents impacted with “characteristics consistent with FASD” living in the CRF during the same time period. On average, there are typically twenty conditionally released federal offenders residing at New Beginnings. In the writer’s opinion, four FASD-impacted residents out of twenty is not adequate for a community residential facility intended to work with primarily FASD-impacted offenders.

One explanation for the small number of FASD residents at New Beginnings is that the municipality will not permit the CRF to accept sex offenders. It is an unfortunate situation since there are several diagnosed and suspected FASD-impacted sex offenders in British Columbia. As previously mentioned, a common

attribute of individuals affected with alcohol-related birth defects is that they are sexually inappropriate, which may contribute to the relatively high number of FASD offenders being incarcerated for a sex crime. Regrettably, there is no easy solution for increasing the number of residents affected with FASD. However, it is imperative that a program designed to assist FASD offenders have FASD persons to work with. It is quite probable that a program evaluation will reap many positive benefits from New Beginnings' FASD program; however, results will most likely be based on a very small, homogeneous sample.

FASD Volunteer Program (FVP)

The FASD volunteer program (FVP) has the potential to be a great success, and with minor improvements it will be. At the present time, the FVP has approximately 40 trained volunteers at its disposal. The volunteers are diverse in background and qualifications, with a large percentage of volunteers being Criminology students. There is also a noteworthy amount of recovering substance abusers, and former offenders. Each volunteer brings something unique to the table, and is an invaluable asset to the FASD volunteer program.

New Beginnings is doing a tremendous job of training its staff and volunteers. Training is provided on an ongoing basis for all staff and volunteers, and is intended to “dispel certain myths about FASD, and to teach that punishment is not necessarily an appropriate or adequate response to the problem” (N/A, 2003, p.5). Staff and volunteers “are taught to engage in a trust relationship with the clients, to look past their immediate behaviour to see the disability, and to focus

on long-term realistic goals” (p.5). A variety of training sessions have been offered to expand the knowledge of staff and volunteers who work not only with FASD impacted offenders, but with all residents in the CRF. The following six training sessions were provided between January and April 2007: Correctional Service of Canada volunteer and FVP orientation, Understanding FASD, a Parole Officer awareness training entitled “Management strategies for the FASD client”, a Substance Abuse awareness training session, a Nonviolent Crisis Intervention training, and a two-day workshop on Motivational Interviewing.

The ultimate goal of the volunteer program is that when a suitable offender is referred to New Beginnings, a group of volunteers is selected to form a circle of support, known as a support group (New Beginnings, 2006, p.3). It is expected that FVP groups are formed in advance of the Core Member’s arrival and that the group remain intact for at least six months or until the Core Member has moved out of the CRF (p.3). It does appear as though support groups are being formed while the offender is still incarcerated, with approximately 3-4 volunteers per Core Member. However, one difficulty has been the limited number of male volunteers at New Beginnings. Ideally, each Core Member would have at least one male volunteer in their circle of support, yet this is often not possible. One could easily assume that Core Members might feel more comfortable sharing particular information with other males. Many offenders at New Beginnings do not have a strong male presence in their life; therefore, it would be ideal for FASD-impacted offenders – who are almost invariably boys or men - to have a

male role model in their lives for which they can learn to model appropriate behaviour. Furthermore, although the groups are formed in advance it does not appear as though they have the opportunity to meet one another and discuss their future Core Member. It seems as though in the majority of cases volunteers are working on their own, not as a group.

As stated in the *Support group volunteer manual (2006)*, it is preferable that each support group hold a minimum of three meetings throughout the six month duration (p.33). It is expected that the counsellor, FVP coordinator, the volunteers, and Core Member are present at each meeting (p.33). Furthermore, it is expected that each volunteer "... be prepared to focus on a specific area with the Core Member (e.g. job search, leisure), and must stay focused on that particular need until it has been successfully accomplished" (p.33). Within the support group one could assume that each member is focusing on a different component, thus providing support in all aspects of the Core Member's life. As previously stated, it is assumed that each volunteer target a specific area based on the initial needs assessment. However, this does not appear to be taking place. It would seem as though FVP volunteers are focusing on the same areas with their Core Member (e.g. leisure, or attending AA/NA meetings). It is important that the Core Member partake in a variety of activities with a variety of people, not the same one or two activities with a variety of people. Although it is important that the client attend AA meetings or participate in his Aboriginal

culture, it is also important that he address other areas such as employment, volunteering, or learning new skills.

While it would be beneficial for the Core Member to attend the support group meetings, it is my experience that FASD-impacted individuals work best one-on-one. Consequently, it may not be in their best interest to attend the meetings. Perhaps once a trust relationship is built with all members of the group, it would be ideal for the Core Member to attend, enabling him to work on his social skills and group interactions. However, it is typical for persons with FASD to feel as though the group is “ganging up” on him, thus producing a negative effect. Regardless of the Core Member’s presence, it is the writer’s opinion that the volunteers should be meeting on a regular basis to discuss their client, and their role within the support group.

The CRF Environment

While research indicates that the environment contributes to the overall behaviour of persons with FASD, the very nature of a CRF is ever-changing thus limiting the amount of stability. It has been recommended that new places, people and concepts be introduced gradually and ideally one at a time (Plant, 2003). In fairness, this ideal model is not possible in a community residential facility. However, New Beginnings does “maintain a high-intensity, highly-structured, supervised environment” (N/A, 2003, p.2). The residents are in constant contact with staff and all residents are expected to follow their correctional plan and house rules. Substance abuse and criminal activity of any

sort are not permitted, nor is any violent or threatening behaviour (p.2). The CRF attempts to create a stable, stress-free environment for all of its residents. New Beginnings maintains a high level of structure, hence benefitting to the well-being of the FASD residents.

During the developmental phase of the FASD program, New Beginnings made certain that they were educated in all areas pertaining to persons' affected by alcohol-related birth defects. Attempts were made to follow FASD guidelines and one area was paid particular attention. FASD-impacted persons are susceptible to a range of distractions, which often contributes to sensory overload. For this reason, a desensitization or quiet room was constructed on the third floor of the CRF. The room was built on contemporary FASD recommended specifications, and contains a large aquarium and bean bag chair (New Beginnings, 2005b, p.10). When the room was first established it was decided that New Beginnings CRF staff would encourage residents to use the desensitization room on a regular basis (p.10). Although, the construction of the quiet room had good intentions, it is underutilized. It does not appear as though staff encourage residents to use the space, nor does it seem as though FASD residents are aware of the room. It may be possible to persuade FASD residents to read a book or take a time out after stressful events; however, it is far more likely that they will do so in the comfort and privacy of their room. It is my opinion that the primary drawback of the quiet room is that it is located on the third floor of the

CRF, whereas most FASD-impacted offenders reside on the first floor of the CRF.

In continuing with the ambience of the halfway house, it is my view that the physical setting and decor be altered slightly to further the residents' wellbeing. However, it is difficult to determine which aspects of the CRF might be changed, since FASD-impacted persons do not want to be seen as "different" from their peers. Conversely, if there were more residents affected with FASD it may be possible to place all FASD residents on the same floor of the CRF, which could present itself differently (e.g. paint colour, pictorial cues on the walls and washroom, a bulletin board containing each resident's daily schedule).

In addition to the physical environment of the CRF, persons affected by alcohol-related birth defects have been described as "moral chameleons;" imitating the behaviours of persons in their environment (N/A, 2003, p.7). Consequently, it may not be in their best interest to reside in a facility with other maximum-security offenders (p.7). The reality is that living in a general population CRF or institution may be detrimental to their success. However, this is not something that New Beginnings has control over. The most they can do is monitor which residents they room together, which the CRF does in fact do. They make attempts to pair the FASD affected residents together or with another resident who may act as a positive role model.

The In-House Counsellor

New Beginnings is fortunate enough to have a full-time in-house counsellor at its disposal. However, problems arise because she is the primary caseworker for all residents at New Beginnings. Although, there are a limited number of residents affected with FASD they are an extremely demanding group of individuals. Their level of need is immense and the reality is that each FASD resident is faced with what he deems a “crisis” on a daily basis. The role of the counsellor is to work with these offenders and assist them through their moments of need, to create a case plan for each resident and update it on a monthly basis (e.g. Correctional Plan), to aid with the FVP program (e.g. create a needs assessment), to meet with the resident on a daily basis in order to discuss their plan of action for the day and for the remainder of the week, to meet with the resident and his Parole Officer on a regular basis, and to Case Conference with the supervising Parole Officer on a regular basis. It is important to note that these are simply some of the primary tasks associated with working with FASD offenders; there are many additional undertakings that occur on a daily basis. When working with individuals affected with alcohol-related birth defects it is essential to remember that they will be faced with a multitude of crises; therefore, it is necessary for one to be proactive and plan ahead. It is the counsellor’s role to interpret potential dangerous situations and plan in advance.

Although the in-house counsellor is an invaluable asset to New Beginnings Group, her caseload has made it unfeasible to work effectively with all the FASD-impacted offenders. It is imperative that New Beginnings have two counsellors,

one of whom would be designated to work specifically with the diagnosed and suspected FASD parolees. While working with persons affected by FASD is a team approach, one that requires the assistance of all CRF employees, it is the counsellor who plays a momentous role in the lives of these persons. One could assume that with daily contact, the FASD offender may begin to view the counsellor as someone he can trust and confide in, perhaps even viewing her as an "external brain."

Parole Officer and Non-Compliance Issues

As indicated in the *Supervision strategy for residents impacted by Fetal Alcohol Spectrum Disorder* (2005b), ideally one designated Parole Officer would work with all of the CRF's FASD-impacted residents. For the most part, this takes place at New Beginnings. The principal Parole Officer has specialized experience working with FASD-impacted offenders (p.8), and spent many years working with persons suffering from mental health issues before becoming a Parole Officer. Having only one Parole Officer working with the FASD residents, creates a unique relationship among the Case Management Team. This relationship greatly enhances the ability to be consistent and to work cooperatively and collaboratively in supporting the needs of the residents (p.8). In addition, "it affords the opportunity to work together creatively on issues of non-compliance and allows the required flexibility to implement individualized support structures" (p.9).

The very nature of a Community Residential Facility requires structure, rules, and regulations. In turn, this often results in non-compliance issues. New Beginnings has a meal program, whereby all residents are guaranteed three meals a day plus snacks. In addition to a balanced diet, meal times are also “a crucial time for making contact with residents in an informal but nevertheless supportive manner” (p.9). This contact helps build rapport between residents and staff, which is essential considering the negative attitudes of residents towards most authority figures. The very design of the meal program (e.g. set times for meals) provides structure and routine, which is essential for FASD residents (p.9). If residents are unable to be present during designated times, they are able to “save” meals, or may receive a “bagged lunch” if employed. Non-compliance issues come into play when residents sign up for a meal for which they do not eat.

In addition to the meal program, there are numerous areas where non-compliance becomes an issue. FASD residents often have difficulties adequately completing their chore(s); they often fail to contact the CRF during the designated call in periods, and continuously have difficulties meeting their curfew. Regardless of whether the resident inadvertently failed to meet CRF requirements, it is considered a non-compliance issue which must be dealt with accordingly. One major difficulty is that the CRF is often unable to distinguish between a non-compliance issue and a non-competence issue (New Beginnings, 2004, p.24). New Beginnings Group is under contract with CSC; therefore, they are required to meet all standards and guidelines expected of a CRF. One of the

requirements is that all residents are treated equally and reprimanded for not following house rules and regulations.

In general, it is acceptable for a resident to receive three related non-compliance warnings before he is faced with a consequence. One of the difficulties in working with offenders impacted with alcohol-related birth defects is that the inherent nature of their disability contributes to their failure to conform to rules and regulations. Unfortunately, these persons incur a great deal of sanctions because of their failure to conform and follow direction. However, as previously stated, persons with FASD are generally unable to learn from their mistakes. They are unable to distinguish between cause and effect. This creates many difficulties when attempting to manage an FASD-impacted offender in the community. Parole Officers are required to follow CSC's guidelines while supervising offenders in the community, which often leads to the frequent re-incarceration of FASD parolees.

One challenge that New Beginnings faces is knowing that traditional behavioural interventions are inappropriate and do not work with persons affected with FASD, yet having to abide by CSC parameters. For example, understanding traditional consequences (e.g. institutional charges, increased curfew), predicting that similar consequences may occur in a whole new experience, inferring consequences that they have not directly experienced (e.g. "if I do not attend program, I will not be granted day parole"), and accepting delayed consequences

for actions done previously (e.g. increased supervision because of past history) are not skills that these individuals possess (New Beginnings , 2004, p.9). The challenge becomes apparent when one attempts to “punish” or place an adverse consequence on the offender for failing to abide by particular rules and regulations.

It is important that the consequence relate to the offence and is immediate. Otherwise, the FASD resident is not be able to link the consequence with their behaviour; consequently not understanding why he is being “punished.” For example, if a resident arrives late for curfew, he may receive a two hour reduction in curfew for the remainder of the week. Although this may seem logical, a person with FASD is unable to link the two. In his mind, he is wondering why he has to be home at 9:00 P.M. as opposed to 11:00 P.M.. It is probable that he will feel as though he is being treated unfairly, which may further result in his dislike toward authority figures. It is for this reason that alternative sanctions need to be created in order to successfully deal with FASD offenders. These alternatives should be designed to aid with the offender’s positive reintegration, thus allowing him to remain in the community regardless of minor infractions.

Although alternatives measures may seem to be the solution, there are many challenges in creating appropriate sanctions. CSC has its own set of sanctions and procedures in which the Parole Officer must follow; therefore, it is often inevitable that an FASD offender will be re-incarcerated. Since there is only one

Parole Officer working with the FASD clients, there is some promise in working collaboratively with New Beginnings staff to create suitable alternatives. However, the Parole Officer is limited in what she can do; it is her responsibility to manage the offender in the community and to ensure that he is doing what is expected of him. Regrettably, this new approach to working with offenders affected with FASD is often seen as being too "soft on crime" and going against the traditional principle of "maximum security/punishment for maximum offenders" (N/A, 2003, p.7). Education and training is required to convey the message that traditional correctional practices do not necessarily have the desired effect on FASD individuals and may in fact be counterproductive (p.9).

Final words on New Beginnings

New Beginnings Group has recently secured two new facilities which will be renovated into one large aftercare centre. Although I am unaware of the specifics of the new housing project, it appears as though the new facility will house the homeless, mentally ill, and potential aftercare clients. It is my recommendation that physical environment of the house be designed according to FASD recommended standards, hence making the environment "user friendly." If the entire facility is built according to FASD standards, all residents will feel as though they are being treated in the same manner. Additionally, persons with mental health issues will also benefit significantly from an atmosphere with minimal stimuli and disturbances.

I would like to note that the FASD Volunteer Program is currently being modified and is in the process of obtaining a new volunteer coordinator. It is apparent that the Executive Director of the New Beginnings Group acknowledges the need for improvements and is making the appropriate changes. The FASD program continues to be in the developmental stages, thus change is inevitable. Without change, adjustments and improvements cannot be made. New Beginnings is an innovative new project which will continue to amend itself until it finds the perfect fit.

New Beginnings' FASD program is original in its attempts to work long term with offenders impacted by FASD. New Beginnings has acknowledged that the "focus must be taken away from conventional behaviour modification principles and techniques which depend upon the individual for change," instead it uses the Disability Model (New Beginnings, 2004, p.15). The Disability Model seeks to modify the elements of the environment for positive change, rather than try to change the person with FASD (p.15). It additionally accepts that difficult and problematic behaviours and issues of non-compliance are chronic in nature and usually arise as a direct result of organic brain damage and disability in the individual; they are not always a consequence of actual non-compliance, manipulation, or true criminality (p.15). This is a unique approach that has not been attempted before in corrections. New Beginnings understands that we

cannot expect total behaviour modification; rather we can only expect the FASD person to learn behaviour management skills.

Raymond and Belanger (2000) examined three literacy-based community treatments provided to young adults with FASD. They looked at circles of support, lists, memory and organizational aids (e.g. calendars, tracker systems), homework books, goal setting and planning tools. Their study focused on many of the tools New Beginnings has begun to implement with their FASD clients. Raymond and Belanger found potential uses for these devices, and stated that depending on the time commitment and the skills of the volunteer mentors who attempted to implement them there could be great success with FASD clients. Therefore, it is important to recognize the potential behind the FASD program at New Beginnings. With certain modifications, New Beginnings has the ability to truly help those offenders suffering from an alcohol-related birth defect, and possibly create a positive change in their life, thus ensuring that they do not re-enter our correctional system.

Unfortunately, this is CSC's only pilot project concerning FASD offenders. New Beginnings is only one CRF and can only house so many individuals, it is necessary that more programs are established throughout Canada. Although this CRF is recognized as accepting and working with FASD residents they are continuously faced with difficulties diagnosing FASD adults. Presently our Canadian corrections system does not have a way to track rates of FASD. In

2003, there were only 13 listed cases of FASD out of 169,169 inmates in our provincial and federal prisons (Lutke, 2004, p.42). This figure is unrealistic considering that if we assume only one percent of the prison population has alcohol-related birth defects, only 1,539 offenders would fit under the FASD umbrella (p.42). As previously stated, estimates of FASD within the prison system have been around 50 percent; for this reason it is unlikely to assume that there were only 13 cases of FASD-impacted offenders within corrections.

LOOKING AHEAD

Prevention

Three levels of prevention can be taken to reduce the number of infants born with FASD. All three preventative methods target at-risk women who engage in the consumption of alcoholic beverages during pregnancy. At the initial level there are primary preventative measures. According to Health Canada, primary prevention activities “are undertaken with a healthy population to maintain or enhance physical and emotional health” (Roberts & Nanson, 2000, p.13).

Typically these are measures which attempt to educate the public about the effects of alcohol. There are a variety of methods that would fall within the primary prevention model, such as alcohol control measures and public awareness campaigns. These approaches have had some success in creating awareness surrounding the dangers of alcohol. Furthermore, there has been some “evidence to support warning labels and posters as a means of increasing awareness and effecting short-term behaviour change among low-risk women” (p.87). In essence, primary prevention methods are used to reduce the number of children born with FASD.

The goal of secondary prevention methods are to identify and address a problem before it becomes severe or persistent (p.19). When addressing pregnant women who consume alcohol, the aim is educate by reaching out, intervening, and

referring them to services (p.19). In order for secondary preventative methods to take action, a pregnancy must be identified. Therefore, it is not always the case that alcohol-related birth defects will be prevented; however, it is likely that the symptoms may be reduced and that the potential risk for future pregnancies is eliminated. Reliable evidence has emerged stating that brief interventions in prenatal settings are effective low-cost means of helping pregnant women with early-stage alcohol problems to reduce or eliminate alcohol use during pregnancy (p.88).

Finally, there are tertiary preventative methods for addressing persons with FASD. Tertiary methods involve intensive multi-component activities, such as substance abuse treatment, education surrounding birth control, and parenting programs (p.28). Typically, these preventative methods are used for women who have previously given birth to an FASD child, and who have a high-risk for future pregnancies (p.28). Canada has several programs designed to work with substance abusing at-risk women; Sheway in Vancouver and Breaking the Cycle in Toronto are two examples (Clarke & Tough, 2004, p.11). According to Health Canada, there is strong evidence that intensive case management or coordination services that advocate for women are effective in promoting family planning, providing connections to community services, offering substance abuse treatment and are able to keep women involved in treatment, thus reducing alcohol consumption for high-risk pregnant women (Roberts et al., 2000, p.88). It has further been suggested that in the United States, the cost of providing

effective pre-pregnancy prevention programs for mothers who have already given birth to an FAS child would be thirty times less than the cost of raising another child with FAS (see Health Canada, 2005a, p.7).

Although these preventative methods are essential, they do not completely eliminate the number to children born with FASD. While preventative methods are crucial for at-risk mothers, the reality is that many Canadian women do not have access to the full range of services and programs offered in the treatment continuum (p.20). Moreover, it is necessary that we develop more programs addressing youth and adults with FASD, primarily those involved in the criminal justice system. It is fundamental that we address the disorder as soon as possible, thus limiting the possible effects of FASD as well as reducing the expected secondary disabilities.

Potential Screening Tools

The development of systematic screening tools for persons entering the corrections system would be helpful in identifying those persons who are assumed to need specialized interventions throughout their incarceration, and once released back into the community (Burd et al., 2003, p.6). Boland and associates (2002) have recommended that screening take place during the *Offender Intake Assessment* in order for the information to be used to “help meet the needs of the offender during incarceration and when planning reintegration strategies in the community” (p.4). However, further research would need to be done in order to determine whether identification of FASD is possible at this

stage. There have been several developments of new tools to screen potential persons with FASD; however, none of these tools has yielded extensive praise or acceptance.

New Beginnings currently uses an *FASD program screening tool* to aid in the identification of FASD-impacted offenders while incarcerated. Their screening tool has been adapted from the more comprehensive FASNET screening tool, which is used with adults over the age of 19. Although not a diagnostic tool, it assists in determining characteristics found to be consistent with FASD; thus helping to identify “suspected” individuals. While not a standardized tool, it aids in identifying suitable candidates for New Beginnings’ FASD program.

Screening tools and referrals should occur early on, when contact with the correctional system first occurs. It is estimated that only 4-5 percent of persons with FASD commit their first crime after the age of twenty (Lutke, 2004, p.41). If this statistic is correct then approximately 95 percent of all FASD offenders will come into contact with the justice system at some point during their adolescence. Burd (2004) has suggested four possible screening strategies, the first starting off with minimal cost and time commitments (p.3). As the suggestions increase so do the cost and time requirements. The aim of this paper is not to discuss potential screening strategies; rather the reader is referred to the article (Burd et al., 2004, p.3). However it is important to note that progress is being made. CSC and researchers have begun to acknowledge that FASD individuals are

commonplace in the federal and provincial system; therefore, it is imperative that we address this problem and make attempts to correct it.

POLICY AND FASD

To date, there is no policy in place to effectively deal with FASD individuals within Canadian corrections. A lack of policy can be seen in either a positive or negative light. Pessimistically, "a lack of policy could be seen as an unwillingness to recognize the problem or of an inability to deal with it" (Silden, 2004, p.25). I do not believe this is the case with FASD. Although the phenomenon of FASD is not new, the concept is, thus time and research are required to adequately address the issue. It is essential that we become more familiar with the disorder, the symptoms and effects. We are currently aware that FASD and criminal involvement are strongly correlated; therefore, it is time to step in and react in a proactive manner.

In my opinion, CSC needs to contract out several more pilot projects similar to New Beginnings. A lack of policy means that there is considerable room for new initiatives and ideas. It is only with this type of applied research that we will begin to further understand those affected with FASD and develop successful interventions.

CONCLUSION

Fetal Alcohol Spectrum Disorder affects thousands of persons every year. It is an incurable brain disorder resulting from prenatal alcohol exposure. As discussed, there are a variety of primary disorders associated with FASD; however, it is a disability that leads to many secondary disabilities. The bulk of this paper has focused on the impacts of FASD in our correctional system. Criminal involvement is seen as a secondary disorder, something that results from impulsivity, lack of reasoning, and victimization.

Presently, our system is ill-equipped when it comes to offenders with FASD. Our current practices (e.g. programming) are not meeting the needs of this population. Our institutions have become a revolving door for these persons, and without proper intervention it is likely that they will once again be face to face with our justice system. Further research and pilot projects such as New Beginnings are needed to fully investigate the detrimental effects of this alcohol-related birth disorder. There is promise for change; however, it is imperative that we react to the problem sooner than later.

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