ASANTE CENTRE

YOUTH PROBATION OFFICERS' GUIDE TO FASD SCREENING AND REFERRAL

Julianne Conry, PhD

Kwadwo Ohene Asante, MBChB, FRCPC

Funded by the Department of Justice Canada

Supported by the Ministry of Children and Family Development

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Funded by the Department of Justice
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A free PDF version of this resource is available at www.asantecentre.org

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The Asante Centre offers diagnostic, assessment and family support services, based on the multi-disciplinary team approach, for children, youth and adults living with Fetal Alcohol Spectrum Disorder.

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The Youth Justice FASD Program, in partnership with PLEA Community Services and British Columbia's Ministry of Children and Family Development (MCFD), has for the past six years provided the impetus and vision of developing a screening tool to help youth probation officers recognize individuals with possible FASD. The result of this objective is the Youth Probation Officers' Guide to FASD Screening and Referral, designed to help increase capacity and develop the confidence of probation officers across Canada to identify youth requiring a full FASD assessment.

The Asante Centre is grateful for the financial contribution of the **Department of Justice Canada** towards the creation of this guidebook, as well as for the continued support and participation of the **Ministry of Children and Family Development**.

The Guide together with the FASD Screening and Referral Tool for Youth Probation Officers have been selected by the Taskforce for the Development of FASD Screening Tools to be included in a user-friendly toolkit that will be available to communities and professionals for use across Canada. This unique initiative was established by a committee of FASD Experts through the **Canadian Association of Pediatric Health Centres (CAPHC)** and funded by the **Public Health Agency of Canada**. The Centre would like to thank the Canadian Association of Pediatric Health Centres for their continued support and contribution to the Guide. The National Screening Toolkit will be available for download online at www.caphc.org. A PDF of the Guide and a full-sized version of the FASD Screening and Referral Tool for Youth Probation Officers is also available for download on the Asante Centre for Fetal Alcohol Syndrome website at www.asantecentre.org.

The Centre would like to take the opportunity to express gratitude to the probation officers, youth justice consultants and managers from across Canada who have taken the time to review and provide feedback regarding the development and use of the Youth Probation Officers' Guide to FASD Screening and Referral. Acknowledgement and appreciation goes to the probation officers who have referred youth to the Youth Justice FASD Program, who have used the FASD Screening and Referral Tool for Youth Probation Officers, and

who continue to work daily with young people who have FASD.

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It is the hope of the Asante Centre that the Youth Probation Officers' Guide to FASD Screening and Referral becomes a valuable resource for probation officers throughout Canada.

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Executive Director
Fetal Alcohol Spectrum Disorder (FASD) Society for British Columbia
Governing Body for:
The Asante Centre for Fetal Alcohol Syndrome

Contents

FASD and the Youth Justice System

In 1981, Fetal Alcohol Syndrome (FAS) first came to the attention of British Columbia's Judge Cunliffe Barnett. As told in "A Judicial Perspective on FAS" (Barnett, 1997), soon after attending a workshop by Dr. David F. Smith, he became aware of individuals with FAS coming before his court. They were often first seen in child protection hearings as children of alcoholic parents, and later as defendants in serious criminal cases. Their cognitive limitations, lack of insight, impulsivity, seeming inability to learn from consequences, vulnerability to the influence of peers, and their own substance abuse problems appeared to increase the likelihood that they would be victimized by others or end up in conflict with the law as offenders.

With the increasing awareness of Fetal Alcohol Spectrum Disorder (FASD), the impression was that a disproportionate number of individuals with FASD were coming into conflict with the law. In a one year study of youth remanded to a forensic psychiatric inpatient assessment unit, 23.3% were diagnosed with FASD (Conry et al., 1997). Similar rates of confirmed (10%) and possible (18%) FASD in a Canadian adult prison have been found (MacPherson and Chudley, 2007).

When a longitudinal follow-up was done among individuals diagnosed with FASD, approximately 60% had had some contact with the law (Streissguth et al., 2004). The overall prevalence rates of FASD in the population are estimated at 2-5% (May et al, 2009). Therefore, people with FASD are clearly disproportionately represented in the justice system. Their fair treatment can be jeopardized at all stages of the legal process from the commitment of the crime, to interrogation by police, to appearance at court, and finally to the disposition by the court.

The Youth Criminal Justice Act (YCJA) stipulates that special considerations need to be made for young offenders with special needs, including FASD, with the goal of rehabilitation and preventing or reducing recidivism in the future. Yet, at age 12, their mental age may be that of a 6-8 year old, and at chronological age 18 the cognitive and adaptive skills of those with FASD may be at age 10 or younger. Consequently, many of the YCJA provisions that are based on chronological age are inherently harmful and detrimental to these youths' fair treatment. However, in order for special considerations to be given,

the special needs must be identified.

In both Canada and the U.S. there has been increasing interest in developing screening tools for FASD in the youth justice population. Through its Youth Justice FASD Program and research initiatives, the Asante Centre for Fetal Alcohol Syndrome has developed a screening tool and referral process for use by probation officers that has been found to be effective in identifying youth who are likely to receive an FASD diagnosis, when assessed.

While individuals with FASD can present as witnesses, victims and defendants in criminal actions, this tool focuses on screening for FASD in young offenders.

In a one year study of youth remanded to a forensic psychiatric inpatient assessment unit, 23.3% were diagnosed with FASD (Conry et al., 1997)

What is Fetal Alcohol Spectrum Disorder (FASD)?

Fetal Alcohol Spectrum Disorder (FASD) is not a diagnosis, but an umbrella term that describes the range of effects that can be caused by prenatal exposure to alcohol. These effects include both the physical and "invisible" manifestations. Alcohol exposure during the early weeks of pregnancy can result in a characteristic pattern of facial features (called facial anomalies) and exposure later in pregnancy can result in growth deficiency (height and/or weight). Exposure at any time during the pregnancy can cause life-long damage to the developing brain.

Fetal Alcohol Syndrome was first discovered because of a small group of children who appeared similar because of the unusual physical features and developmental delay, and who shared the common denominator that their mothers had abused alcohol during the pregnancy (Jones et al., 1973; Jones and Smith, 1973). It was many years later that Streissguth, et al. (1996), Mattson and Riley (1998), and Mattson et al. (1997, 1998) published studies showing cases where there had been significant prenatal alcohol exposure but the individuals displayed an absence of the facial features and growth delay that characterized the original FAS group. The brain dysfunction of these individuals demonstrated similar levels of severity to those with the characteristic physical features. These findings meant that while growth and facial features may be markers for fetal alcohol exposure, in the absence of these markers, there can still be the "invisible" disability of significant brain damage caused by prenatal alcohol exposure.

Alcohol can affect the whole brain, including its structure and function. How the brain is affected by the alcohol is related to the amount of alcohol consumed, the pattern of alcohol use, the timing of the alcohol use, and the general health of the mother including her nutrition and genetics, as well as other prenatal factors that have not yet been well defined.

While recognizing the important role of prenatal alcohol exposure, we need to be cautious in attributing any and all learning and behaviour problems to alcohol. Other *prenatal* factors that can affect development and outcome include other exposures (e.g., tobacco, cocaine, and some prescription drugs), other chromosomal conditions (e.g., Down syndrome) and genetics (family

histories of learning problems, ADHD, and mental health disorders) and possibly maternal stress during the pregnancy.

Postnatal factors are important to ascertain as contributing to the child's developmental outcome as well. History of early childhood abuse, neglect, and placement in multiple homes can affect behaviour and development. When assessing older youth and adults, the role of the past environment becomes increasingly important. Accessing records from throughout their lifespan can be useful to establish patterns of cognition, achievement, and behaviour. An older youth may have his or her own history of postnatal traumatic brain injury, mental health issues, and/or suffer the effects of his or her own substance misuse. Thus, if the FASD diagnosis is being made for the first time during adolescence parsing out these factors can be particularly challenging. Ultimately, the actual diagnosis of FASD is only one part of the picture. To help this youth, all of the prenatal and postnatal factors contributing to the diagnosis need to be considered.

Making the Diagnosis

In Canada, the recommended approach for the assessment and diagnosis of FASD is laid out in *Fetal Alcohol Spectrum Disorder: Canadian Guidelines for Diagnosis* (Chudley et al, 2005). FASD is a medical diagnosis best made by a multidisciplinary team consisting of (1) pediatrician (or other specialist experienced in dysmorphology, genetic conditions and developmental disabilities), (2) psychologist, (3) speech and language pathologist, and (4) other health professionals who can interpret the assessment findings from their respective disciplines. Evaluation of social, educational, and medical histories, medical examination, and neurobehavioural assessments comprise the assessment in the areas of:

- Prenatal Alcohol Exposure
- Physical Growth
- Facial Features
- Brain Function

Prenatal Alcohol Exposure

To make an alcohol-related diagnosis the presence of significant alcohol use during the pregnancy must be confirmed! Especially when an older youth or an adult is being assessed for FASD, an alcohol exposure history may not be readily available because:

- the birth mother may not be available, e.g., child/youth was adopted or in foster care, or indeed, the mother may be deceased;
- the birth family members may not have been present or in contact with the mother during the pregnancy; or may deny a known alcohol history;
- complete prenatal records of the gestation and delivery are absent.

The Asante Centre often receives referrals for an FASD assessment where the background information includes notations of a mother's life style that is highly suspicious of alcohol use: a documented history of alcohol abuse shortly before or after the pregnancy with this youth, other drug use, living "on the streets," and diagnoses of FASD in siblings of the youth being referred. However, if these *risk* factors were used to *establish* the history of prenatal alcohol exposure they would not "stand up in court" especially if new contrary information became available and pregnancy alcohol use was denied. Prenatal alcohol history and therefore the alcohol-related diagnosis have at times been challenged, making it crucial for the assessment team be able to defend the clinical findings and diagnosis in court. There are times when an individual does not receive an FASD diagnosis because the evidence for the alcohol history is too weak or unreliable. It is etiologically incorrect, wrong or "unethical" to make such a diagnosis of FASD when the level of certainty is not sufficient.

This does not mean that *only* information taken directly from the mother can be used to make an FASD diagnosis. Confirmation can be based on reliable clinical observation, reports by reliable sources, or reliable medical records *(See Section on Social Factors). At the present time, hair sample studies and meconium tests at birth are rudimentary but may hold promise in the future.*

Physical Growth

Significant prenatal or postnatal growth deficiency is defined as height and/or weight below the 10th percentile on standard growth charts, or disproportionately low weight to height ratio. The interpretation of the growth parameters takes into consideration genetic factors (parental heights, cultural differences), illness, gestational diabetes, and other medical factors.

Facial Features

The three facial features that have been found to best differentiate those with FAS from other conditions or syndromes are:

- Palpebral fissure lengths (eye openings)
- Philtrum (groove between the nose and upper lip)
- Upper lip

Norms have been developed to assess the palpebral fissure length (Clarren, 2010) and a pictorial scale has been developed to evaluate the philtrum and upper lip (Astley, 2004). Characteristic facial features of FAS include palpebral fissure lengths below the 3rd percentile, a smooth philtrum and a smooth upper lip.

Paediatrician Dr. Heather Kee demonstrates philtrum and palpebral fissure measurements.

The pediatrician/physician needs to consider and rule out other possible dysmorphic syndromes, which may require genetic investigation and follow-up.

Brain Function

The purpose of the assessment of brain function is to determine if there is evidence of brain damage that could be attributed to prenatal alcohol exposure. At present, there is no known cognitive profile identified that is specific to prenatal alcohol exposure. The recommended approach is to complete a comprehensive assessment of multiple domains of brain function and judge whether the individual's performance is broadly *normal*, shows "*mild to moderate*" impairment or shows "*significant*" impairment. At least *three* functional brain domains need to show *significant* impairment to consider an alcohol-related diagnosis. Therefore, the definition of brain dysfunction is as follows:

Brain Dysfunction

Substantial deficiencies or discrepancies across multiple areas of brain performance likely due to underlying brain structure or function rather than to adverse post-natal environmental experiences.

Listed below are the specific domains of brain function that are assessed. They are grouped in two categories, those described as (1) *organic* and indicate definite brain damage on neurological assessment and those described as (2) *functional*, assessed with standardized psychological tests and which indirectly indicate brain dysfunction.

Domains for the Assessment of Brain Function

Organic:

_____ Head circumference

_____ Brain abnormalities as evidenced through imaging (e.g., CT scan/MRI)

_____ Neurologic conditions, such as seizures

Functional:

_____ Soft neurological signs: fine and gross motor; sensory

_____ Cognition: IQ

_____ Communication

_____ Academic achievement

_____ Memory: spatial/visual/verbal

_____ Executive functioning/abstract reasoning/problem solving

_____ Attention and/or activity level

_____ Adaptive behaviour /social skills/social communication

The findings of the multidisciplinary team using the physical and neurobehavioural measures are then numerically organized according to the 4-Digit Diagnostic Code (Astley, 2004) and a diagnosis is made using the terminology in the Canadian guidelines.

Speech and Language Pathologist Jaime Hack demonstrates language assessment.

The terminology for alcohol-related effects can be confusing because the terms for the diagnostic conditions are quite similar and the meaning of the terms has changed over time. The current, specific alcohol-related diagnoses under the FASD umbrella include: Fetal Alcohol Syndrome (FAS), Partial Fetal Alcohol Syndrome (pFAS) and Alcohol-Related Neurodevelopmental Disorder (ARND). Previously, the term Fetal Alcohol Effects (FAE) was also used to

describe the effects of prenatal alcohol exposure. These diagnoses are now differentiated on the extent to which physical features and growth deficiency are present.

All three diagnoses require confirmation of prenatal exposure to significant amounts of alcohol. All three require evidence of significant brain dysfunction in at least three domains. The criteria for brain dysfunction are the same for all three, *"The Brain's the Same."* Other terms, such as Neurodevelopmental Disorder and Neurobehavioural Disorder, are used to indicate that the youth has learning and behaviour problems but these cannot be confirmed to be alcohol-related. Neonatal Abstinence Syndrome (NAS) is not an alcohol-related diagnosis but refers to the symptoms of a child who was born withdrawing from other substances.

Criteria for Alcohol-Related Diagnoses: "The Brain's the Same"

Diagnosis	Criteria
Alcohol-Related Neurodevelopmental Disorder (ARND)	Confirmation of significant prenatal alcohol exposure + brain dysfunction in three domains
Partial Fetal Alcohol Syndrome (pFAS)	Confirmation of significant prenatal alcohol exposure + brain dysfunction in three domains + two facial features
Fetal Alcohol Syndrome (FAS)	Confirmation of significant prenatal alcohol exposure[a] + brain dysfunction in three domains + three facial features + growth deficiency

[a] *In some cases a diagnosis of Fetal Alcohol Syndrome can be made in the absence of confirmed prenatal alcohol history if all the other defining criteria are present. This circumstance is rare and has not occurred in any Asante Centre assessment.*

In our review of 37 youth justice clients who received an FASD diagnosis, (Conry and Lane, 2009) only 2 had moderate or severe growth deficiency, and all had mild or no FAS facial features. Therefore, all had a diagnosis of ARND. We have found that ARND has a significantly higher prevalence rate than that of individuals with FAS or pFAS.

The Importance of Screening for FASD

Screening vs. Diagnosis

The purpose of screening is to identify individuals who are likely to have a particular condition so that a comprehensive, diagnostic assessment can follow. Since it is now apparent that youth with FASD are disproportionately represented in the youth criminal justice system, there has been increasing interest in developing screening tools for FASD in the youth justice population. To be practical, a screening tool needs to be "user friendly" and not time consuming to administer, yet able to efficiently identify the appropriate individuals who should receive a full, diagnostic assessment. *"Specificity"* refers to how well the instrument identifies only the individuals of interest and *"Sensitivity"* refers to how many individuals of interest would be missed using the tool (that is, those who would have received an FASD diagnosis if they had been assessed). If too many individuals are captured by the screening, even if all those with the condition (FASD) are included, then the resources for a diagnostic assessment are not being used efficiently because too many individuals are being seen unnecessarily. However, if the screening is too narrow, individuals who should receive the diagnostic assessment may be denied the service. The screening tool should balance specificity and sensitivity.

Screening for FASD cannot be used as a substitute for a complete, diagnostic assessment, because the screening tools are not perfect. We know that in some places, results from screening tools have been used in lieu of a proper diagnosis with the argument "since this individual will likely never get a diagnostic assessment, we will use this instead and treat him as though he does have FASD"!

In fact, most of the screening tools or checklists being used have not been found to accurately distinguish those with FASD from those with other developmental or behavioural problems. In some cases, individuals have argued with the doctor who did not make an FASD diagnosis saying the checklist said he did have FASD or have argued for an FASD diagnosis because of the presence of some FASD characteristics! Using screening tools for diagnosis is dangerous. To make, or assume a diagnosis that would turn out to be incorrect can be more harmful than not making a diagnosis at all. In our experience we have assessed

individuals who, for all their lives, were assumed to have and been told that they have FASD and who did not turn out to have FASD. Some were later diagnosed with a different syndrome. In other cases, the data did not warrant an FASD diagnosis.

Screening should not be done if there is no follow-up with a full diagnostic assessment.

In developing a screening tool it is necessary to consider who will be using the measure: the identification and interpretation of specific indicators (especially behavioural) may not be appropriate if used by front-line workers without training about FASD. In response to a Canada-wide survey of probation officer training, we found that most probation officers have received some education about FASD (see Appendix A). Previously, we found that probation officers reported "knowing the youth well" for 73.5% (n = 132) of at-risk youth on their caseloads (Munro et al, 2005). Thus, we are confident that with their basic knowledge about FASD and experience with the youth on their caseloads, probation officers using this tool can effectively identify youth who would most benefit from having an evaluation for FASD.

The probation officers who have referred youth for an FASD assessment have described the positive outcomes arising from the assessment and the diagnosis. For example, when asked what had been learned from the assessment, one probation officer answered, "A caring, more compassionate and understanding approach was used. It gave better insight as to why [he] had got involved in the criminal justice system, and made questionable choices of associates. It explained much of his actions, and how to more effectively support and supervise [him]." The recommendations that were generated by the clinical team, along with those who were supporting this youth, were found to be helpful. In another case the feedback said, "[His] low IQ became more evident while working with him and showed a real need for ongoing life long supports; and the need for [him] to be provided with reminders .The diagnosis allowed [the probation officer] to change the way of supervising and dealing with [him.] Consideration was given to his inabilities, and this was passed onto the Court when returned there" (Conry and Lane, 2009).

Identifying the risk factors associated with the likelihood of an FASD diagnosis among youth in trouble with the law

Significant behaviour problems have come to be the *sine qua non* of FASD. Many of the screening checklists that have previously been developed have focused on behavioural indicators. We now know that children and youth are often referred for an FASD assessment *because* they are presenting with significant and long-standing behaviour problems that have been difficult to manage. This is perhaps missing a number of individuals with FASD who are not referred for an assessment because of a lack of noticeable problem behaviours. These adaptive behavior problems are assessed as one of the domains used to make an FASD diagnosis.

Our understanding of the condition (FASD) can become biased due to the non-random selection of individuals to be assessed as they may not represent the range of characteristics of the larger (but non-referred) group of people with prenatal alcohol exposure. This is called a *bias of ascertainment.* Research studies can compare clinical groups who are self-selected and come for an assessment with research groups. Using longitudinal data Coles (2009) found that the clinic (referred) group showed more behavior and attention problems, social problems and depression on the Child Behavior Checklist than the experimental or research group being following longitudinally. Adaptive behaviour scores were also lower in the clinic group.

The group of youth who are in trouble with the law is yet again a select group. More or less by definition, they would likely be found to have behavior, attention, and social problems. Getting in trouble with the law is already a marker of a "high risk" group. If we want to screen for FASD, are there specific behaviours or markers that will distinguish a group with a potential diagnosis of FASD from other youth in trouble with the law?

The FASD Screening Tool and Referral Form for Youth Probation Officers was developed to be used as part of a referral process for an FASD diagnostic assessment in the Youth Justice FASD Program at the Asante Centre. As such, the rating scores are not on a continuous scale with cutoff points representing a greater or lesser probability of the youth having FASD. It is a *screening* and *referral* form for a more formal assessment.

Items for the initial screening tool were selected based on a review of the research and anecdotal reporting of the behavioural characteristics of youth with FASD, on the findings in an earlier study of youth in trouble with the law (Conry at al, 1997), and consideration of the FASD diagnostic criteria. The following notes were made:

- The screening tool items should be based on information that is generally available to the probation officer
- Gathering the information should not be time-consuming for the probation officer
- The information requested should be fairly general, and not require special expertise on the part of the probation officer (e.g., interpreting previous assessments)
- The information in the items should be linked to specific criteria for making an FASD diagnosis

The selected items were grouped in two categories, Social (environmental) Factors and Personal Factors (for ease of understanding, these are the revised items):

A. Social Factors are those that may identify a youth at-risk for FASD. That is, these factors may increase the probability that the youth could have FASD. Included in this category are:

- Youth is adopted
- Youth currently, or previously, was in foster care or involved with child protection services
- Youth has a sibling with a documented diagnosis of FASD
- There is documentation (from a professional) that the youth is suspected of having FASD
- Youth's mother has a known history of alcoholism or prenatal alcohol use

B. Personal Factors are those that have been associated with (but not necessarily unique to) FASD. Included in this category are:

- Developmental Delay in early childhood—youth received speech/language therapy, occupational therapy, infant development or child development services prior to school entry
- Learning difficulties—required learning assistance, a modified program, or experienced school failure or drop-out
- Growth deficiency—appears short compared to peers, or of a low weight for age
- Diagnosis of Attention Deficit Hyperactivity Disorder
- Mental health diagnosis—such as anxiety, depression, Oppositional Defiant Disorder, Conduct Disorder

The youth could be referred for assessment if he/she had:

- 1 social factor PLUS at least 2 personal factors, **OR**
- No social factors PLUS at least 3 personal factors

During the period April 1, 2003 through March 31, 2005, twenty-one youth met the screening criteria, the caregiver gave consent for the assessment, and the client's background information was further screened in order to establish a strong likelihood of a significant prenatal alcohol exposure history. Seventeen of the twenty-one (81%) received an alcohol-related diagnosis through the Asante Centre clinical team. While this statistic is impressive it did not tell us which component or components of the screening process were most important in predicting the ARND diagnosis.

A web-based "snapshot" survey conducted in October 2004 (Munro et al, 2005) provided further support for the specificity of this group of items and informed a slight revision of the tool that has been used subsequently.

The surveys were completed by 41 probation officers in British Columbia on 484 youth who were on adjudicated probation orders on their caseloads on a given day. The average caseload was 15.5 youth, with a range of 3 to 29 youth. Using the *a priori* combinations of social and environmental risk factors and personal risk factors of the original screening tool, 27.3% were determined to be "at risk" for FASD and 72.7% were not determined to be at risk. However, additional questions suggested that, without the screening tool information, 60% of these youth would have been missed if referrals were made on casual information alone, either because of misunderstandings about FASD or because concurrent mental health diagnoses were thought to be the primary problem.

This was not a true validation study because the researchers were not able to follow-up with FASD assessments on youth in both the "at-risk" and not "at-risk groups". While we can not know whether the 27.3% actually had FASD, this percentage is similar to the prevalence of FASD (23.3%) in the Conry et al (1997) study. The data does show that the at-risk and not at-risk groups were significantly different on key environmental/social variables:

Environmental Risk Factor	**Percent of at risk youth (n=132)**	**Percent of *not* at risk youth (n=352)**
Involvement with child protection services	68.9	16.8
Known prenatal alcohol exposure or maternal alcoholism	31.8	6.0
Child protection and alcohol history	20.5	0.4
NONE	18.2	79.3

The data also showed significant differences on key personal youth factors:

Personal Risk Factor	**Percent of at risk youth (n=132)**	**Percent of *not* at risk youth (n=352)**
Developmental delay in early childhood	19.7	0.6
Learning difficulties	93.2	33.0
Growth abnormalities	24.2	1.1
Diagnosis of ADD or ADHD	57.6	2.7
Other mental health diagnosis	72.7	8.8
NONE		60.2

Striking differences were found when combinations of personal risk factors were compared:

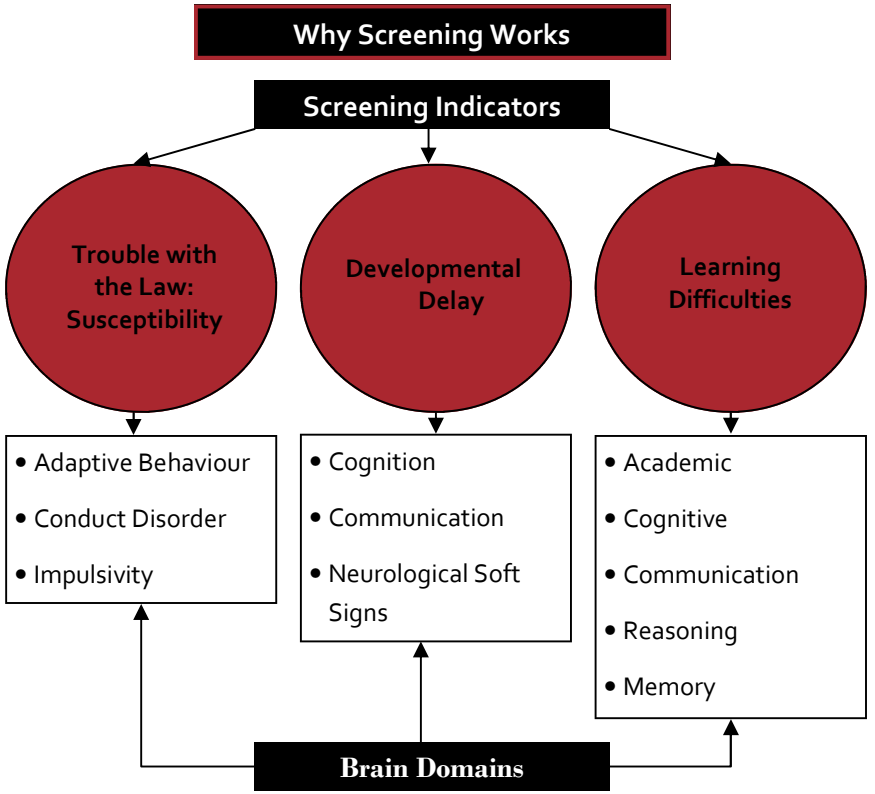
Personal Factors	**Percent of at-risk youth (n=132)**	**Percent of *not* at-risk youth (n=352)**
Learning and Mental Health	65.9	4.0
Learning and ADHD	50.3	2.3
Learning and Growth	24.2	0.6
Learning and Developmental Delay	18.9	0.6

These findings lent support to the use of multiple, broad-based indicators based on multiple sources as an effective way of providing the initial screening for FASD among the youth justice population.

Why the Screening Tool Works

While the indicators in the screening items are quite general, they are linked to the specific criteria for making an FASD diagnosis:

Screening Indicators and Brain Domains



The above diagram shows the relationship between the brain domains that comprise the FASD diagnostic assessment (shown in the bullets) and the broader indicators on the FASD Screening Tool and Referral Form for Youth

Probation Officers (shown in the circles). If problems have been documented in the broader indicators, the likelihood is increased that the underlying brain domains have been affected. The statistics mentioned below can be found in Conry and Lane, 2009.

Underlying the fact that the youth is in trouble with the law are likely problems with adaptive behaviour. This could include behaviours such as being easily led by others, unable to think about the possible consequences of actions, poor understanding of personal boundaries, and unable to anticipate and avoid potentially dangerous social situations. In our youth diagnosed with FASD at the Asante Centre, the indicator "Makes poor decisions" applied to 100%, "Attention deficit/hyperactivity disorder (ADHD)" was identified in 70%, "impulsivity" in 93 % and "disinhibited" in 33%. Not all of the youth in trouble with the law meet the psychiatric criteria for conduct disorder, but "anger control" problems were found in 60%. Streissguth et al. (1996) had found concurrent mental health problems in 90% of those with FASD.

Streissguth et al. (1996) found concurrent mental health problems in 90% of those with FASD.

Underlying a history of developmental delay are these early indicators of problems: cognition, communication, and neurological soft signs. Where data were available, indications of learning and behaviour problems were already apparent in early childhood for most of the youth. Delay in motor skill development, language, social skills, and high activity level had brought them to the attention of a pediatrician or early childhood program suggesting that the predisposition to these difficulties existed from birth. The same frequencies, or even greater frequencies, of these problems were carried over into adolescence.

Underlying a history of learning difficulties can be deficits singly or in combinations of cognition, academics, reasoning, memory, and communication. When assessed for FASD, the results of the psychology and speech and language assessments will profile the individual's abilities in these areas. In the sample group at the Asante Centre, over 70% had problems with cognition, memory, achievement, and reasoning. The school histories may show failing or repeated grades, learning assistance or special education services, and the need for Individual Education Plans (IEPs).

Completing the FASD Screening and Referral Tool for Youth Probation Officers

The form should be completed using direct information, either from earlier records or by interview with a reliable informant. Information provided by the youth himself can be useful but if it is not corroborated by another source, cannot be depended upon to be reliable. If the youth is well known to his or her probation officer, this form should take about 15 minutes to complete.

Background Information

Basic demographic information is recorded on the screening and referral form: identifying information for the probation officer making the referral, the youth, his guardians/caregivers and place of residence.

Note that on the form for referral, the guardian consent to assessment must be received before the referral can be processed (indicated in the top box). It is important for the clinical team to know that the family has been approached and is aware of the purpose of the assessment. A large number of medical and school records and social service information will need to be gathered for the time of assessment, including prenatal alcohol history, requiring both youth and guardian consent. Guardians, and the youth must have the nature and purpose of the assessment explained to them in order to give informed consent.

Please indicate if the youth has previously received specialized assessments. This information assists the clinical team in gathering records to ensure they are complete, as well as determining that the youth has not had any recent assessments that would invalidate new testing.

Screening

Social Factors is the first screening category. Being in foster care or having been involved with child protection services raises the probability that the youth may have FASD. The circumstances that resulted in the child being removed, or being placed for adoption, often involve parental substance misuse, and subsequent neglect of the child, risk factors for FASD. In First Nations communities, it is common for a child to live with relatives from time to time

during his/her childhood, and this is not considered "foster care." However, if the child is living with relatives due to an unstable home environment that has included substance misuse, this factor should be checked. This family history is usually known to the probation officer. Medical or psychological reports that have been prepared for the court or information obtained from the youth's social worker will typically provide a social history that includes earlier and present living circumstances and may mention that siblings have been diagnosed with FASD or that a pediatrician has previously *suspected* the possibility that the youth has FASD.

The last question in this section asks if the mother has a history of alcoholism or prenatal alcohol use. Again, the social history of the youth and previous reports may mention the mother's history of alcohol problems at some point in the past prior to the pregnancy with this youth or subsequent to this pregnancy. It should be recognized that confirmed alcohol use in another pregnancy or at another time does not necessarily imply alcohol use during the pregnancy with this youth, but it does raise the risk-level and should be recorded when available. Known use of other substances may also raise the risk that alcohol is involved, but an alcohol-related diagnosis cannot be made based on lifestyle.

The probation officer's duties should not necessarily include obtaining a history of prenatal alcohol exposure. However, previously recorded sources of prenatal alcohol history may need to be evaluated by the probation officer as an important part of the client referral process. By way of requesting the guardian's consent for the assessment (if the guardian is the biological mother), the explanation for the assessment would need to include the question of whether there are prenatal factors that have affected this youth's development and behaviour, one of those factors being prenatal alcohol exposure. This raises the question whether or not an assessment for FASD should go ahead if the youth meets the rest of the screening criteria without establishing the prenatal alcohol exposure at the outset. If during the referral and diagnostic process the prenatal alcohol history cannot be established, the result may be a diagnosis of "Neurodevelopmental Disorder-Alcohol Exposure *Unknown*".

We have been asked why a confirmed history of prenatal alcohol exposure on the screening and referral form is not required. The simple answer is that the exposure history may not be given in written records and the probation officer may be unable to ascertain a positive exposure history from the mother.

Family and Community Support Coordinator Allison Pooley demonstrates interviewing format.

Families, and especially the biological mothers, who have had a long history of involvement with social services or child protection services may not admit to drinking during the pregnancy for fear of being "shamed and blamed". Some may have an adversarial relationship with social services, the youth criminal justice system and probation services, because of their own histories with the legal system and may not be cooperative. In our experience very few families have refused to grant permission for the assessment, and indeed, many families have a positive relationship with their youth's probation officer. Yet, the issue of obtaining the alcohol history can be a very sensitive one. A mother may deny the alcohol history if questioned by the probation officer but may be more forthcoming with the nurse or doctor at the time of the assessment. Questioning the mother is best left to someone who has specific expertise in this area and in an optimal place and circumstance.

Recall the statistics that showed that 81% of the youth who completed an FASD diagnostic assessment at the Asante Centre were given an alcohol-related diagnosis. During that period, after the youth had met the basic screening criteria, a second phase of screening was done by the nurse clinician. The nurse clinician spent time directly with the family to gather background information, to explain the assessment and how the findings could help the youth, and was able to ascertain a confirmed alcohol history before the youth was finally accepted for the assessment. More recently, we have accepted youth for assessment when the prenatal alcohol history was highly suggestive, but not directly confirmed prior to the assessment. The result was nearly equal numbers of diagnoses of "Alcohol-Related Neurodevelopmental Disorder" and "Neurodevelopmental Disorder", with either "alcohol-exposure unknown" or "no exposure." With "exposure unknown", there can be no alcohol-related diagnosis. There are occasional surprises when it comes to the actual assessment, and in planning an FASD youth justice program there will need to

be discussions around this issue. The information gleaned from the assessment, both medical and psychological is valuable to the probation officer, the youth, and his family even if the result is not an alcohol-related diagnosis. This emanates from the comprehensive management discussions after the assessment.

Where there is a probability that a client's problems may be related to prenatal alcohol exposure (FASD), the probation officer should endeavor to gather confirmatory information from the client's past medical (prenatal maternal and delivery) records and from other sources, before directly interviewing the birth mother for a gestational alcohol history.

We recommend the following as possibly the most reliable sources:

1. Birth Mother. When she is available, she should be approached with tact, sensitivity and in a non-judgmental fashion, realizing the hiatus of several years since the pregnancy. Affirmative alcohol use information by the mother is obviously useful and confirmatory. Denial of alcohol, or other substance use, may be genuine or, frequently, may result from either maternal feelings of guilt or due to a genuine lack of memory regarding events during the index pregnancy. Obviously, reliable information from the mother is deemed to be "confirmed". Note that the amount of alcohol exposure may be minimized in phrases, e.g., "social drinking", "I quit as soon as I found out I was pregnant", "the occasional drink", etc, reacting to the risk that the mother may experience stigmatization and blame when she acknowledges alcohol use in the pregnancy. A more detailed pattern of use history is, perhaps, best reserved for the physician/pediatrician.

2. Physician's/Midwife's Prenatal and Birth Records. When available, recorded substance use information during the gestation has been very useful in confirming a suspected history of exposure. It is, however, noted that many at-risk mothers do not avail themselves of regular prenatal care, or deny alcohol use when specifically questioned.

3. Maternal Grandparents/Aunts. These relatives may provide useful information when they have knowledge and specific recollection of the pregnancy. This source of information tends to be reliable since family was often involved in a supportive role during the mother's pregnancy.

4. Social Workers' Records. Information is useful when incidents during the pregnancy are specifically recorded, e.g., need for supports for siblings, spousal conflicts, police reports, (regarding neglect, fights with partners/ spouses), etc. This information may be found in the Family Service File as well as the Child Service File.

5. Father's or Mother's Partners. Pregnancy information from this source may be reliable but many partners, unless they admitted to drinking and using substances together, were often not present during a major portion of the pregnancy. Moreover, partners' reports may not be deemed objective because of social conflicts, e.g., separation, child custody issues, spousal abuse, etc. Some partners either deny or may exaggerate the mother's alcohol use. The father may also feel responsible for the lifestyle with his partner and experience guilt. Paternal information is, consequently, at best, suspect unless confirmed by another source.

This information on the documentation of maternal alcohol use in pregnancy provides a broad summary of what is obviously crucial information for a diagnosis of Fetal Alcohol Spectrum Disorder (FASD). Ultimately, the significance of the exposure, i.e., the frequency, timing, and dose of alcohol, will need to be interpreted from the above information by the clinicians during the assessment and diagnostic process.

Personal Factors is the second screening category. This information can be obtained from a variety of sources including family members, social workers, previous reports and school records.

Caregivers' recollections of early developmental milestones may not be accurate, but involvement with an infant development program or child development centre and early developmental assessments may indicate Developmental Delay, especially if there is a record that the youth required speech and language therapy, physical therapy, or occupational therapy as a preschool-aged child.

The youth likely had Learning Difficulties if he/she received learning assistance or required an adapted or modified program in school. The youth may remember receiving "extra help" for some subjects and may say he was in a "special class" or had to "repeat a grade." If he had "testing in school" with a

special teacher or school psychologist, it is likely there were concerns about his academic progress. If asked, the youth may say that he had lots of trouble with math (the most often found learning problem in those with FASD). The youth's self-report may not be accurate. The school records may say he was on an "IEP", that is, an individual education plan or program. Even this can be misleading as some IEPs are for behavior problems more than learning problems. Often, by the time they are adolescents, these youth are attending an alternate program, or they may have been suspended or expelled from school or dropped out; again this could be the result of a history of behaviour problems, not learning problems. The absence of apparent learning difficulties does not mean that the youth does not have FASD or that learning disabilities will not be discovered when the testing is done.

Growth abnormalities or growth deficiency is rarely found, but if identified it is one of the "sentinel physical findings" that could be associated with FASD. Growth deficiency refers to short height or low weight at birth or throughout life.

Diagnosis of Attention Deficit Hyperactivity Disorder (ADD or ADHD) is common among youth with FASD. Many people have ADHD without prenatal alcohol exposure as there can be a genetic link or another cause, but because ADHD is common in FASD it is another important marker. If there has been a diagnosis of ADHD at some earlier time, this will be mentioned in medical reports or commented upon in a school psychoeducational assessment report and it is likely that the youth may have taken a medication, such as Methylphenidate (Ritalin), Concerta or Strattera.

Mental health diagnoses, other than ADHD, could include anxiety, depression, Oppositional Defiant Disorder, Conduct Disorder, Attachment Disorder, Substance Misuse Disorder, or another psychiatric diagnosis. If the youth has received a psychiatric assessment in the past or as part of a pre-sentence report, a mental health diagnosis may have been made. These mental health diagnoses are not part of the FASD diagnosis but it is now known that prenatal alcohol exposure can predispose the individual to these issues. If the youth has not had a psychiatric assessment, confirmation of mental health diagnoses may not be available to the probation officer.

After completing the checklist for social factors and personal factors, determine if the youth meets the criteria of:

- 1 social factor plus at least 2 personal factors OR
- No social factors plus at least 3 personal factors

Documentation of Previous FASD Diagnosis

The form asks if there is documentation that the youth already has a diagnosis of FASD. If the youth received a diagnosis when he was younger, the diagnosis may not have been made using the more specific Canadian Diagnostic Guidelines (2005) and the diagnosis should be reviewed. New information may have come available that would change the diagnosis. For example, there may be new confirmation of prenatal alcohol exposure. Also, the diagnosis may change if an updated assessment confirms significant brain dysfunction in areas that were not assessed when he/she was younger.

Case Management

The remainder of the information compiled on this form is for tracking, statistics, as well as for case management and planning. Screening and diagnosis are of little benefit if the findings do not translate into better case management.

Offences

The referral form lists possible current and past offences and asks if the youth has spent time in custody. The study by Conry et al (1997) found that those with FASD did not commit more serious crimes than those without FASD, and in the FASD group there was a large range in the number of offences committed. Also, the youth with FASD was not necessarily more likely to commit the offence as part of a group versus on his/her own. Sometimes it is clear that they have been easily led by their peers into committing the offence. In the general corrections population, offences are often committed while under the influence of drugs and alcohol or in order to access drugs and alcohol and this seems to be true of the youth with FASD as well. Managing "breaches"/"failure to comply" seems to be the most aggravating issue for these youth. By including the date(s)

of offences, it may be possible to establish whether the youth with FASD is progressing from petty crime to more serious crimes. A number of risk-assessment tools are in use across the country by probation officers and corrections officials. The detailed information that is compiled for the risk assessment can also be helpful in completing this screening tool. Patterns of breaches can help the probation officer develop probation conditions that may be more effective in managing the behaviours and diverting the youth from the justice system. The probation officer may wish to include offences for which the youth has been convicted and indicate others they know about. School attendance, alcohol and drug treatment and counseling are all important for case planning. Other factors such as a stable home environment and a strong circle of support are crucial for the individual with FASD.

Behaviour Checklist

Based on the Youth Court Services Study (Conry et al, 1997) and responses to the probation officers survey (Munro et al, 2005), a behaviour checklist was developed to describe common characteristics of youth with FASD in trouble with the law. Highlighting these maladaptive behaviours can be helpful in better understanding the disabilities associated with FASD for this youth, in making appropriate referral for mental health and other services, and for case planning.

Referral

Screening for FASD is of little value and can be harmful (because an FASD diagnosis may be assumed), without a referral for a comprehensive FASD assessment. For tracking purposes, indicate if a referral for an FASD assessment is now being made and to which agency.

"In the field of criminal justice, it is vital to understand the individual offender. Nowhere can this be more important than in the situation in which the offender is a person with a disability."

-Mr. Justice David H. Vickers, B.C. Supreme Court [Quoted from Conry, J and Fast, D (2002)]

References

Astley, S. J. (2004). Diagnostic guide for fetal alcohol spectrum disorders: the 4-digit diagnostic code, 3rd ed. Seattle WA: University of Washington.

Barnett, C.C. (1997). "A judicial perspective on FAS: Memories of the making of Nanook of the North" in Streissguth, A and Kanter, J (Eds). The challenge of fetal alcohol syndrome. Overcoming secondary disabilities. Seattle WA, the University of Washington Press, pgs 134-145.

Chudley, A.E., Conry, J., Cook, et al. (2005). Fetal alcohol spectrum disorder: Canadian guidelines for diagnosis. Can Med Assoc J 172:S1-S21.

Clarren, S.K., Chudley, A., Wong, L., Friesen, J., and Brant, R. (2010). Normal Distribution of Palpebral Fissure Lengths in Canadian School Age Children. Can J Clin Pharmacol, 17 (1), e67-e78.

Coles, C. (2009). Characteristics of clinical and exposure samples that affect behavior. Presentation to the meeting of the Interagency Coordinating Committee on Fetal Alcohol Spectrum Disorders (ICCFASD), May 7, 2009, (personal communication).

Conry, J. and Fast, D.K. (2000). Fetal alcohol syndrome and the criminal justice system. Vancouver, B.C., British Columbia Fetal Alcohol Syndrome Resource Society.

Conry, J.L., Fast, D.K., Loock, C.A. (1997). Youth in the criminal justice system: identifying FAS and other developmental disabilities. Vancouver, B.C.: Final Report to the Ministry of the Attorney General.

Conry, J.L. and Lane, K. (2009). Characteristics of youth on adjudicated probation orders with FASD. Maple Ridge, B.C.: Final Report to the Department of Justice Canada, Youth Justice Policy and British Columbia Ministry of Children and Family Development.

Jones, K.L. and Smith, D.W. (1973). Recognition of the fetal alcohol syndrome in early infancy. Lancet, 2, 999-1001.

Jones, K.L., Smith, D.W., Ulleland, C.N., and Streissguth, A.P. (1973). Pattern of malformation in offspring of chronic alcoholic mothers. Lancet, 1, 1267-1271.

MacPherson, P. and Chudley, A.E. (2007). FASD: Screening and estimating incidence in an adult correctional population. Presented at the 2nd International Conference on Fetal Alcohol Spectrum Disorder, Victoria, B.C. March 7-10.

Mattson, S.N. and Riley, E.P. (1998). A review of the neurobehavioral deficits in children with fetal alcohol syndrome or prenatal exposure to alcohol. Alcohol Clin Exp Res, 22, 279-294.

Mattson, S.N., Riley, E.P., Gramling, L.J. et al (1997). Heavy prenatal alcohol exposure with or without physical features of fetal alcohol syndrome leads to IQ deficits. J. Pediastr, 131, 718-721.

Mattson, S.M., Riley, E.P., Gramling, L.J. et al. (1998). Neuropsychological comparison of alcohol-exposed children with or without physical features of fetal alcohol syndrome. Neuropsychology, 12, 146-153.

May, P.A., Gossage, J. P., Kalberg, W.O., et al. (2009). Prevalence and epidemiologic characteristics of FASD from various research methods with an emphasis on recent in-school studies. Dev Dis Res Rev, 15, 176-192.

Munro, P., Conry, J., and Lane, K. (2005). Fetal alcohol spectrum disorder among youth on adjudicated probation orders: A three year research study. Report to the Department of Justice Canada, Youth Justice Policy and British Columbia Ministry of Children and and Family Development.

Gruman, N. (2005). Expert panel on FASD screening in the juvenile courts (personal communication).

Streissguth, A.P., Barr, H.M., Kogan, J. et al. (1996). Understanding the occurrence of secondary disabilities in clients with fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE), Final Report to the Centers for Disease Control and Prevention (CDC). Seattle: University of Washington, Fetal Alcohol and Drug Unit, Tech. Rep. No. 96-06

Streissguth, A.P., Bookstein, F.L., Barr, H.M. et al (2004). Risk factors for adverse life outcomes in fetal alcohol syndrome and fetal alcohol effects. J. Dev. Behav. Pediatri. 25:228-238.

Appendix A: Survey of Youth Probation Officer Training Results

The purpose of the survey was to determine the level of general knowledge among youth probation officers in Canada about FASD and the availability of training in order to ensure the transferability of the User's Guide to regions across Canada. The survey was completed in September 2009, with eight responses received representing Yukon Territory, British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Prince Edward Island and Newfoundland.

Responses were prepared by:

- Yukon Territory—Whitehorse Youth Probation, Yukon Territorial Government
- British Columbia – Ministry of Children and Family Development
- Alberta – Alberta Correctional Services Division - Young Offenders Branch
- Saskatchewan – Corrections and Public Safety – Young Offenders Program Saskatchewan
- Manitoba – Manitoba Youth Probation Services
- Ontario – Youth Justice Services Division, Ministry of Children and Youth Services
- Prince Edward Island – Community and Correctional Services
- Newfoundland – Department of Health and Community Services

1. <u>What is the educational background of individuals applying to take training to become a Youth Probation Officer?</u>

YT: Minimum BA, preferably Social Work, Criminology, Psychology, Child and Youth

BC: University degree in related discipline (criminology, social work, psychology, etc)

AB: The supervision of youth varies depending on the geographical location in which they live with some having dual caseloads (youth and adults). All probation officers have post secondary education through a variety of programs including criminology, law enforcement, criminal justice, etc. Probation officers with the City of Calgary are all registered social workers.

SK: Required education to become Community Youth Worker/Probation Officer: BSW, BISW, BHJ

MB: Social sciences degree is preferred

ON: All applicants applying for employment in Ontario as a Probation Officer in Youth Justice are required to have at minimum a Bachelor of Arts degree in the Social Sciences or in a related discipline

PE: Masters degree in criminology or social work and two years experience in human services, OR a bachelor degree in social sciences and five years experience in human services, directly related to youth and corrections

NL: Bachelor of Social Work degree or equivalent

2. <u>Where do new Probation Officers receive their training?</u>

YT: On site as part of their orientation and training to reach full Youth Worker delegation

BC: Training is delivered through the Justice Institute of BC through a combination of online and in-person courses

AB: Correctional Services Division staff received training through our departmental staff college

SK: On the job training is provided by the Ministry's Program Development and Therapeutic Services Unit

MB: Some online – orientation, MB Justice Policies (11 days – [Client Offender Management System], court report writing, facilitation skills, Static 99)

ON: Basic training is completed at the Ontario Correctional Services College (OCSC) of the Ministry of Community Safety and Correctional Services in Hamilton, Ontario. The College provides staff training and development for Probation Officers, through agreement with the Ministry of Children and Youth Services. OCSC is guided by the academic policy established by the Ministry of Community Safety and Correctional Services states all training will provide "…updated, effective correctional programs and improved service delivery to enhance rehabilitation and reduce recidivism"

PE: Limited in-service training is offered after hiring through a Divisional training calendar

NL: Internal orientation on a regional basis

3. How long is the training program?

YT: 1—6 months depending on previous experience

BC: Training will normally be completed in between 3 and 6 months

AB: The training is delivered in two phases and is supplemented with on site and specialized training as needed

SK: Training received after hiring takes place within the months following hiring

MB: 2 days mental health and first aid, 5 days domestic violence, 10 days sex offender (2 parts)

ON: Basic Training that is provided to Youth Justice Probation Officers through the Ontario Correctional Services College is six weeks in duration and encompasses a variety of areas, inclusive of FASD

PE: There is no specialized training program

NL: 3 – 4 days

4. Does the program provide additional training opportunities after the entry-level training?

YT: Nothing structured, however Yukon Territorial Government does provide [some training]

BC: Yes

AB: Yes

SK: After hiring, training includes: Mastery of administration of risk assessment, community safety training, core correctional practice, introduction to public service, orientation, and training in the legislation. Additional opportunities include workshops on suicide intervention, ad hoc training opportunities related to social work practice, cognitive behavioural interventions, etc

MB: Domestic violence, sex offender and mental health training is offered yearly, not entry level; FASD training yearly

ON: Additional training opportunities subsequent to Basic Training are provided to Probation Officers across Ontario, through regionally and provincially supported training initiatives. Additionally, a professional association for Probation Officers in Ontario (POAO) plans an annual symposium that is considered a professional opportunity that contains many diverse workshops related to the field

PE: N/A

NL: Yes

If so, are these training opportunities optional or mandatory?

BC: Both

AB: This depends on the content of the training

SK: Mandatory training includes: risk assessment mastery, community safety planning, core correctional practice, suicide intervention training

MB: Mandatory [except FASD training]

ON: The designation of training as being "required" or optional tends to vary, depending on the topic and direction specified

PE: A variety of Divisional in-service training courses are core for youth probation officers and therefore mandatory

NL: Mandatory

5. Does the initial training program provide information about people with disabilities (such as intellectual disabilities or mental health issues)?

BC: Yes

AB: Yes

SK: Yes

MB: No

ON: Yes, the Basic Training course for Probation Officers is inclusive of providing information and training to staff in relation to working with youth who have intellectual disabilities or a mental health diagnosis. Training also addresses responsivity factors that may impede in some way a client's ability to progress (i.e. learning disabilities such as FASD, ADD/ADHD, Conduct Disorders) or meet the goals that have been set out for them by the Youth Probation Officer

PE: N/A

NL: Yes

If so, what disabilities are discussed?

BC: There is one course module on "Mental Health and Suicide Awareness," and another module on "FASD"

AB: Information on select groups is provided and phase II training includes a section dedicated to FASD

SK: Community Safety Planning includes tailoring services to meet the client's learning needs (e.g. cognitive disabilities). The training includes information on case planning and treatment for these persons but is not comprehensive related to all disabilities. CPSP works with other organizations and Health to deliver treatment to address this – Health provides training on an ongoing basis which Ministry staff access. They also provide education and information sharing with youth workers on case by case basis regarding treatment and integrated case planning for persons with learning or mental disabilities

MB: Mental health and first aid offered yearly. FASD is yearly but not mandatory

ON: Participants who attend Basic Training do receive instruction that addresses a broad range of issues as they relate directly and indirectly to mental heath. Training components include topics such as substance use, sexual offending behaviours, adolescent suicide, domestic violence, child maltreatment and cognitive behaviourism

PE: N/A

NL: FASD, Mental Health diagnosis, ADHD

6. How much time is devoted to disabilities (a full course or number of teaching hours within a course)?

BC: Each of the modules noted take approximately 7 hours to complete

AB: A half day is dedicated to FASD during training at the staff college. On-site training is also provided at probation offices across the province identifying case management techniques and providing resource information. A general day long course on FASD is offered to staff within Correctional Services Division to keep them current.

SK: Each worker has access to 3 – 4 days training in FASD/ARND

MB: 1 – 6 hour day (optional training offered yearly)

ON: The Basic Training program devotes approximately four to five days of training in relation to working with the above-referenced clients. Training that is a half-day in duration is devoted to each of the following components: Substance Abuse, Sexual Offending, Adolescent Suicide, FASD, Child Maltreatment, Cognitive Behaviourism and a Mental Health "overview." An entire day is committed to Domestic Violence

PE: None

NL: Approximately 1 day

7. Is information provided about Fetal Alcohol Spectrum Disorder (FASD)?

BC: Yes

AB: Yes

SK: Yes

MB: Yes

ON: Yes, the Basic Training program does provide training regarding Fetal Alcohol Spectrum Disorder: an awareness of FASD, being able to recognize and understand the neurological and behavioural characteristics of FASD and being able to improve the effectiveness of interventions with young people with FASD

PE: No

If so, how much time is devoted to this topic?

BC: Approximately 7 hours

AB: A half day is dedicated to FASD during training at the staff college

SK: The workshops provide specific information about FASD, intervention options and system awareness of the disorder

MB: 1 – 6 hour day (optional training offered yearly)

ON: The Ontario Correctional Services College devotes four hours of training for Youth Probation Officers in relation to Fetal Alcohol Spectrum Disorder

PE: N/A

NL: 3 – 4 hours

8. Outside of this initial training program, do new and experienced Probation Officers receive any education about FASD?

BC: Yes

AB: Yes

SK: The training is offered to new and existing staff

MB: [Optional training offered yearly]

ON: Within the province of Ontario, training in the area of FASD has been made available to Youth Justice Probation Officers

PE: Occasionally there are opportunities for Officers to attend training related to FASD

NL: No

If so, how is this provided?

BC: This will vary by region, but staff will have opportunities to attend regional and provincial level workshops, conferences, etc

AB: As above

SK: Training is provided in module form generally by the Ministry of Health

MB: Also those POs with youth who have been diagnosed work very closely with FASD Youth Justice Program

ON: Training that has been provided to Youth Justice Probation Officers encompasses two separate sessions of which one is two days in duration followed at a later date by a session that is one day in length. The first two days of training focus specifically on the Disorder and speaks to the 'primary' and 'secondary' disabilities exhibited by individuals with FASD, the impact it has on communities and the justice system, working collaboratively with other service partners, guidelines to interventions with families and creating a support system.

The third day of training is only available to those Probation Officers who have completed the above-referenced two-day training. The focus of this training is to provide Probation Officers with the skills necessary to effectively case manage youth with FASD and how to proficiently plan for their care

PE: External training opportunities through Justice partners, e.g. Health, addictions

NL: N/A

Is attendance optional or mandatory?

BC: Optional

AB: Attendance is encouraged

SK: Training is optional

MB: Optional

ON: Such training is not considered to be mandatory in Ontario and remains optional

PE: Optional

NL: N/A

9. For how long has education about FASD been available to Probation Officers in your jurisdiction?

BC: Approximately 15 years

AB: Alberta has been involved in FASD initiatives since the late 1990s. Solicitor General and Public Security is a member of the FASD – Cross Ministry Committee that is responsible for a large range of initiatives

SK: 8 – 10 years

MB: 2002

ON: Such education and training have been made available to Youth Justice Probation Officers in Ontario since December of 2004

PE: A number of years

NL: Several years

10. Approximately what percentage of the Probation Officers in your area do you think are knowledgeable about FASD?

BC: 100% (Levels of knowledge may vary depending upon when staff were hired/trained and what subsequent workshops/conferences they have attended, but all staff will have some knowledge/awareness for FASD)

AB: 90 – 100% have an awareness of FASD

SK: 75%

MB: 30%

ON: An accurate measurement regarding the percentage of Probation Officers that may or may not be knowledgeable in the area of FASD cannot be presumed. It would be difficult to speculate regarding such an estimate and subsequently it would not be fair or accurate approximation of such information

PE: All officers have a basic knowledge

NL: 90%

11. Do the Probation Officers make referrals for FASD diagnosis?

BC: Yes

AB: Probation officers can and do make referrals or request for assessment and/or diagnosis to any of the provincial clinics; however, the majority are generally done through the courts

SK: Youth workers make recommendations through pre-sentence reports for court to order a court-ordered assessment; additionally, where symptoms are evident, referrals are made to child and youth services to complete a screening and if required formal referral to a Medical Doctor specializing in FASD diagnosis

MB: Yes

ON: In Ontario, Probation Officers, when assigned the responsibility of supervising a young person by the court, become dedicated case managers for the young person throughout the young person's history within the youth justice system. As part of the case management model the case manager conducts a comprehensive assessment based on the Risk Needs Assessment (RNA) inventory that clearly identifies a young person's criminogenic risk, need and responsivity factors. A case management plan is developed to respond to the assessed risk, needs

and responsivity factors and the probation officer acts as a broker and advocate for community service referrals made to manage the young person's issues. The RNA assesses for intellectual/cognitive deficits but does not target factors specific to FASD.

PE: Not often

NL: Yes

12. Where would youth be assessed for FASD in your area?

BC: In the Lower Mainland, referrals would normally be made to the Asante Centre. In other areas, referrals may be made to the Regional Health Authority; as well, Youth Forensic Psychiatric Services has completed some FASD diagnoses

AB: Most assessments are completed through Alberta Health Services – Forensic Psychiatry Program or independent service providers.

SK: Regina and Saskatoon

MB: At Manitoba Youth Centre – FASD Youth Justice Program if involved with the justice system. At FASD Centre (formerly CADEC) if not involved with justice

ON: [Clinics in Toronto, Cornwall, Durham Region, Kingston, Peel Region, Sioux Lookout District Thunder Bay]

PE: IWK Health Centre, Halifax, NS

NL: Diagnostic teams are in place at the provincial children's health centre, and in Labrador

Summary of Findings

Results of this survey indicate that youth probation officers across Canada are very well trained, receiving post-secondary training and degrees. All but one province provides education on mental health issues and FASD. Most provinces have course outlines or power point modules available. Outside of the initial probation officer training that includes modules on disabilities, there are opportunities for further training around FASD. FASD training has been provided for a number of years. In most provinces, the majority or even all of the probation officers have some background knowledge about FASD. Most make referrals for FASD assessments and there are agencies in all of the provinces to provide these assessments.

Appendix B: FASD Screening and Referral Tool for Youth Probation Officers

The FASD Screening and Referral Tool for Youth Probation Officers is also available for download in printable format at www.asantecentre.org

Name of Probation Officer: _____ Date: _____

Phone #: _____ Fax #: _____

Address: _____

Email: _____

O Received mandatory guardian consent to refer youth for an FASD assessment

Background Information

Name of Youth: _____

Date of birth: _____ Age_____ oMale oFemale

Ethnicity: O Caucasian O Aboriginal O Asian
O South Asian O Black O Other

Has the youth been assessed at any of the following?

	Name of agency	Date of Assessment
Psychoeducational assessment	_____	_____
Hospital/private psychiatric assessment	_____	_____
Youth Forensic psychiatric assessment	_____	_____
Mental health assessment	_____	_____
Other specialized facility	_____	_____

Legal Guardian:

O Birth Parent(s) O Adoptive Parent(s) O Social Worker O Other

Name: _____

Address: _____

Phone #:_____ Fax #:_____

Youth currently resides with:

O Birth Mother O Birth Father O Adoptive Parent(s) O Foster Parent

O Group Home O Custody Centre O Other_____

Name of caregiver: _____

Address: _____

Phone #:_____

Screening Checklist

Please check all boxes in sections A and B that apply to this youth.

A. SOCIAL FACTORS

O Youth is adopted

O Youth has been in foster care or involved with child protection services

O Youth has a sibling with a documented diagnosis of FAS/pFAS/ARND

O There is documentation that youth is *suspected* of having FAS/pFAS/ARND

O Youth's mother has a history of alcoholism or known prenatal alcohol use

B. PERSONAL FACTORS

O Developmental delay in early childhood (e.g., required speech/language therapy, occupational therapy or child development services prior to school entry)

O School learning difficulties (e.g., required learning assistance, modified or special program, school failure or drop-out for academic reasons

O Growth deficiency (i.e., short height or low weight)

O Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD or ADD)

O Other mental health diagnosis

oAnxiety oPost Traumatic Stress Disorder

oDepression oOppositional Defiant Disorder

oConduct Disorder oSubstance Misuse Disorder

oAttachment Disorder oUnknown

oOther _____

Using the information in A and B previous, refer for an FASD assessment if youth meets the following criteria:

O One Social Factor (Section A) PLUS at least Two Personal Factors (Section B)

OR

O No Social Factors (Section A) PLUS at least Three Personal Factors (Section B)

Is there documentation in medical, social service, and or court records that the youth already has a diagnosis of FAS/pFAS/ARND or FAE.

O Yes O No

If yes, who made the diagnosis: _____

Date of diagnosis: _____

Location: _____

Case Management

Has youth been in custody: O Yes O No

Date of next court appearance: _____

Probation expiry date: _____

What offences has the youth committed (Please check all that apply and date):

O Break and enter
O Theft under $5000
O Robbery
O Theft over $5000
O Assault
O Murder/manslaughter
O Possession/use of a weapon
O Possession of stolen property
O Dangerous driving offence
O Solicitation/prostitution
O Sexual offence
O Mischief to property
O Arson
O Public mischief
O Fraud
O Drug charges
O Kidnapping
O Breach/failure to comply
O Obstruction of justice
O Theft of a vehicle
O Assault causing bodily harm/aggravated assault
O Possession of break-in instruments
O Uttering threats to cause death/bodily harm
O Other:_____

Does youth have an Intensive Support and Supervision Program (ISSP) worker or other one-to-one worker: O Yes O No

Name of worker: _____

Agency: _____ Phone #: _____

Does youth have a non-guardian social worker: O Yes O No

Name of social worker _____ Phone #_____

Is youth currently attending school: O Yes O No

If yes, does the youth attend:

O Regular School O Alternate School O Home School

Has youth received alcohol and drug treatment O Yes O No

Has youth received mental health counseling O Yes O No

Is youth currently taking medications: O Yes O No

If yes, please list: _____

Behaviour Checklist:

Which of the following behaviours characterize this youth (Please check all that apply):

O Attention seeking, demanding, loud
O Impulsive
O Misuse of alcohol and other drugs
O Anger control problem
O Easily manipulated and led by others
O Socially inept/immature
O Has a high need for acceptance
O Concrete and literal thinker
O Poor understanding of personal boundaries
O Chronically misses appointments
O Disinhibited about sharing personal information
O Has trouble following rules or requirements
O Poor decision maker, poor problem solver, lacks insight
O Does not understand effects of his/her actions on others
O Requires supervision and management of time and money

Referral for an FASD assessment

Agency: _____

Contact_____

Date referral was sent: _____

Name of Person Completing Form (If different from Youth Probation Officer):

_____ Date: _____

Phone #: _____ Fax #: _____

Address: _____

Appendix C: Case Study: Using the FASD Screening and Referral Tool for Youth Probation

This case study description is based on a composite of typical patterns of histories found among young offenders with FASD

Darren had a history of shoplifting, stealing from the family, and sneaking away from home at night since the age of 12. Darren was first charged when he was 15 years old for stealing the family's car and dangerous driving. He is now 16 years old. He has been engaged in property offences, stealing, and threatening. Recently, he and another youth confronted a man on the street and demanded his cell phone. Darren asserts this was not stealing because the man gave it to him. He is currently on probation and has breached his probation on several occasions in the past.

Darren was born to a mother whose prenatal records indicated she used cocaine, tobacco, and alcohol during her pregnancy with Darren. She was single and suffered from mental health problems. Darren was born 4 weeks early and weighed 6 lbs. He experienced some jitteriness and feeding problems at birth and was cared for in the special care nursery. When Darren was discharged from hospital he went to live with his mother and grandmother until he was 9 months old. At that time he was apprehended by the Ministry and placed in foster care due to his mother's inability to parent and her continued drug and alcohol use.

At 4 years of age Darren was sexually molested and there was a tremendous change in his behaviours. He was noted to lack emotional involvement with others and exhibited severe behaviour problems. He was kicked out of day care. Darren's kindergarten teacher was unable to cope with his behaviours and he was expelled from school for the first time at age 5. After that, he attended six different schools.

This year, a school psychoeducational assessment found that his Verbal Comprehension IQ was average (90) and his Perceptual Reasoning IQ was in the borderline range (71). His Processing Speed was very slow (1st percentile) and his Working Memory was weak (1st percentile). He can read quite well (average range) but his math skills are that of a grade 3 student and he has required a modified program and learning assistance since the early grades. During the assessment, Darren talked very rapidly and constantly used language

inappropriate to the setting. He made derogatory comments about women and minorities. Darren has average vocabulary skills and he likes to talk but he is unable to understand or explain abstract ideas. There have been several attempts to enroll him in an alternate school setting but these have lasted only a few weeks, at best. He is not currently attending school but his probation order requires him to attend and he has expressed interest in going back to school. Previous school reports said he was very distractible and impulsive. He had taken Ritalin for his ADHD when he was younger and this was found to be effective. He was also diagnosed with Oppositional Defiant Disorder (ODD). Now, he refuses to take the medication, saying he "doesn't want to take drugs."

Currently, he admits to using alcohol, marijuana, and cocaine and has had several "blackouts" where he has ended up in the hospital emergency. Other than the support of his social worker, no other services are in place. When programs or activities have been set up for him, he was "too busy" to go. His mother died two years ago and his father's whereabouts are unknown. He has occasional contact with his maternal grandmother. Since age 4, he has resided in 12 different foster homes. Mostly, the placements would break down because his behaviour was becoming aggressive and unmanageable. He has done dangerous things, risking the safety of the family, such as lighting an aerosol can emission to create a "torch" effect in his bedroom.

Socially, he has difficulty interacting appropriately with peers but wants to win their approval. He claims to belong to a gang. He confronts people who are bigger than he is and makes inappropriate remarks. He does not seem to understand the effect of his behaviour on others. He has a high pain threshold, receiving deep cuts and bad bruises, but refusing treatment. He doesn't always know where he got the injuries. He is also manipulated by peers; he steals for them when offered a smoke in exchange, or on a dare. He trades away or loses his good clothes. Darren can tell time, but he has no sense of time. For example, first thing in the morning he leaves the house saying, "I gotta go" even though his only appointment is with his probation officer and isn't until the afternoon. He, then, often misses the afternoon appointment because he gets distracted. He constantly misses curfews, often to go visit his girlfriend and thinks this doesn't count. He does not think about the possible consequences for his behaviour and actions.

Darren's ability to avoid contact with the justice system and live independently

in the near future as a young adult is in question unless he receives a great deal of support from his family and community.

Screening Checklist for Darren

Please check all boxes in sections A and B that apply to this youth.

A. SOCIAL FACTORS

O Youth is adopted

X Youth has been in foster care or involved with child protection services

O Youth has a sibling with a documented diagnosis of FAS/pFAS/ARND

O There is documentation that youth is *suspected* of having FAS/pFAS/ARND

X Youth's mother has a history of alcoholism or known prenatal alcohol use

B. PERSONAL FACTORS

O Developmental delay in early childhood (e.g., required speech/language therapy, occupational therapy or child development services prior to school entry)

X School learning difficulties (e.g., required learning assistance, modified or special program, school failure or drop-out for academic reasons

O Growth deficiency (i.e., short height or low weight)

X Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD or ADD)

X Other mental health diagnosis

oAnxiety	oPost Traumatic Stress Disorder
oDepression	**X**Oppositional Defiant Disorder
oConduct Disorder	oSubstance Misuse Disorder
oAttachment Disorder	oUnknown

oOther _____

Using the information in A and B previous, refer for an FASD assessment if youth meets the following criteria:

X One Social Factor (Section A) PLUS at least Two Personal Factors (Section B)

OR

O No Social Factors (Section A) PLUS at least Three Personal Factors (Section B)

Is there documentation in medical, social service, and or court records that the youth already has a diagnosis of FAS/pFAS/ARND or FAE.

O Yes **X** No

If yes, who made the diagnosis: _____

Date of diagnosis: _____

Location: _____

A SANTE CENTRE

THE ASANTE CENTRE
for fetal alcohol syndrome

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Maple Ridge, B.C. V2X 3C1
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