Prince George Youth Custody Center Report
Training Needs and Capacity Related to Fetal Alcohol Spectrum Disorder

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Preamble

Overview of Findings

Fetal Alcohol Spectrum Disorder (FASD) could affect more than 50% of the youth at Prince George Youth Custody Center according to the anecdotal information provided by staff. The work of Conry, Fast and Loock (1997) supports this conservative estimate. FASD is brain damage and as such an invisible disability that requires specialized services due to differential needs. Our correctional system is one based on the premise that offenders understand the nature and consequences of their acts and that punishment is appropriate to connect their actions to consequences. This system has not been designed with any understanding of this disability and is not equipped to look at alternatives to meet the goals of public safety and protection.

However, the management and staff in Youth Custody Centers are recognizing the need for best practices to work with this disability. At Prince George Youth Custody Center, the staff and management have clearly identified core areas to address in working with Fetal Alcohol Spectrum Disorder (FASD); the need for specific case management roles to co-ordinate the identification, assessment and implementation of specialized services for FASD youth as well as strategic intervention planning and communication of this to all staff; the inadequacy of current training to respond to this specialized need and the ineffectiveness of the phase or point system as a behavior management tool to deal with FASD affected youth.

Introduction

On behalf of the Prince George FAS Network, our agency Northern Family Health Society, was asked to conduct a review of current training needs at the Prince George Youth Containment Center. We were asked to review training that would be relevant to Youth Custody Staff and Management as well as to recommend what training would improve performance, outline a potential training model, distinguish training needs from organizational problems and link job performance with organizational goals.

One aspect of this assessment was to determine the best practice for working with FASD affected youth and the supports and barriers in the institution that could affect practice.

Needs Assessment Methods and Tools:

A combination of the following information collection methods and tools were used in gathering information for this report:

A review of the relevant literature includes a contextual perspective of what is happening nationally, provincially and locally in the area of training as well as regarding Fetal Alcohol Spectrum Disorder. The literature review provides a broader perspective of the key issue of FASD and criminal justice responses to this problem.

Consultation with key individuals included interviews with 10 individuals from the following groups: contractors, management, health, line staff and support services, directly or indirectly associated with the Prince George Youth Containment Center.

A Best Practices survey was conducted of all staff at the center with approximately 70 surveys sent via e-mail (See Appendix A). 33 surveys were returned. This constitutes approximately 50% return of surveys.

Staff questionnaires were used to determine self-reported levels of knowledge, skills and training needs. Thirty-three of the questionnaires were returned by staff members. The results suggest a spread of knowledge and skills to address FASD but a definite majority of staff who feel that their knowledge and skill levels are less than or inadequate to create a responsive environment for FASD affected youth at PGYCC.

Focus groups were conducted with Senior Corrections Officer's (SCO's), Line staff, Bowron House staff and School staff (See Appendix B)

Direct observation was used to gather information pertaining to the day- to-day operations on site.

The Standing Orders were reviewed for organizational information that could assist in determining

institutional supports, barriers and areas for further examination.

Background and Literature Review

Prevalence of Fetal Alcohol Spectrum Disorder

As there are no established incidence rates for Northern British Columbia in the general population, we must rely on estimates of prevalence or anecdotal information that is outdated (Asante and Nelms-Matzke, 1985). The generally accepted incidence rates of Fetal Alcohol Spectrum Disorder (FASD) are 1 to 3 out of every 1,000 live births with Fetal Alcohol Syndrome and 5 to 15 out of every 1000 live births with Fetal Alcohol Effects (Stratton, Howe and Battaglia, 1996). A more recent summary of prevalence by Dr. May and Gossage found a prevalence rate of 0.5% to 2 cases per 1,000 births in the United States (May and Gossage, 2000).

One recent report by Corrections Canada reports Canadian incidence rates at 2 per 1,000 births with Fetal Alcohol Syndrome and 8 per 1,000 births with Fetal Alcohol Effects. In Northern Yukon and B.C. however those numbers are estimated to be 10.9 per 1,000 with as high as 190 per 1,000 on one B.C. reserve alone (Corrections Canada, 1999). One physician in Faro Yukon states a full 50% of people in some communities have been affected by alcohol before birth (CBC News, 2001)

Within the prison systems it is estimated that prison inmates with intellectual disabilities are at least twice as high as in the general population. In the only published study of FASD youth in the criminal justice system, Dr. Julie Conry found that 23.3% of youth remanded to the forensic psychiatric inpatient assessment unit were diagnosed with Fetal Alcohol Syndrome. A further 50% were thought to be possible FASD affected. Dr. Christine Loock, estimates that at least one in every four inmates in federal institutions are behind bars because of FAS and while Corrections Canada researchers dispute these numbers, studies are only just underway to determine how many people with mental disorders are behind bars (CTV National News, June 11, 2001). Of those children 12 and over with FASD, there is a 60% risk of their being charged or convicted of a crime. (Streissguth, 1998).

Unpublished incidence rates in recent Saskatchewan study revel nearly 50% of young offenders had been born with Fetal Alcohol Syndrome (Alcohol Related Birth Injury Resource Site)

The relationship between Fetal Alcohol Spectrum Disorder and Attention Deficit Disorder with Hyperactivity is addressed in the literature. Research from the University of Washington indicates that 85% of kids diagnosed with FAS also have ADHD (Warren and Foudin 2001). It is important to note however that the type of ADHD for FAS affected children is different and "theoretically distinct" from other types of ADHD. There are 6 subtypes of ADHD. Dr. C. Cole in her article *Fetal Alcohol Exposure and Attention: Moving Beyond ADHD* (1998) calls into question the assumption that behavior seen in children with FAS results from the same neurocognitive deficits as those seen in children diagnosed with ADHD. The two groups do have unique attentional profiles with little similarity in their pattern of responses and behavioral problems that differ according to this study.

Impact of Fetal Alcohol Spectrum Disorder

The cost of punishing juvenile offenders in Canada is $450-500 million per year (Kellerman, 1998).

Individuals affected by Fetal Alcohol Spectrum Disorder are highly susceptible and suggestible for criminal behavior (Conry, 1999). As such they require differential treatment within the criminal justice system due to their brain damage. "Community protection is not served by temporary warehousing of FAS children in secure custodial facilities because…in all likelihood they will return to the community

in worse condition" (Turpel-La Fond, 1999). Inmates who have intellectual disabilities are at serious harm in the prison system due to their "susceptibility to abuse, exploitation, manipulation and misunderstanding of what is expected of them and inability to benefit from most habilitative programs" (Endicott, 1991). Many individuals with FASD have diminished capacity due to their inability to predict the consequences of their actions. Teresa Kellerman with the FAS Community Resource Center identifies 14 factors for consideration for FASD affected in the Court System. These include accountability, arrested social development, delayed emotional development, communication skill deficits, co-occuring psychiatric and medical conditions, attention deficits, sensory integration disorder, need for medications, presence of pregnancy and paternity, sexuality issues, money mismanagement, behavioral issues, information processing deficits and the lack of ability for independence.

Recent research into the physiological affects of FASD conclude that people pre-natally exposed to alcohol demonstrate impaired performance on test assessing both cognitive-based and emotional-based executive functioning. Executive functioning refers to cognitive functions involving planning and guiding behavior in order to achieve a goal in an efficient manner. (Kodituwakku, Kalberg and May, 2002). As well, newer studies indicate problems with processing visual information less effectively than auditory (Coles, 2001) and slower information processing and motor response times (Simmons, 2001).

Implication for Practice

There is a move towards changing the way we think about FASD. The need for specialized training is becoming more recognized. Governments managers such as Bob Sinclair, Solicitor General of Correctional Services Alberta agrees that we need to begin to acknowledge that "to work effectively with FASD affected youth we need to be aware of each individual's abilities and disabilities and to adjust our expectations and behavior management strategies" (Jordon, 2002). Correction prison guards such as British Columbia's Bob Steeves support changes to our system, changes that stress education not incarceration.

A Correctional Services of Canada report recommends the early identification of FAS/FAE, the appointment of internal advocates for FAS/FAE inmates and identification of specific learning disabilities, attention problems and behavioral attributes. It also recommends design of an FAS/E Awareness Manual and implementation of in-service training at all level in order to educate and raise awareness of this condition (Boland, Burrill, Duwyn and Karp, 1998).

Current training initiatives in Canada include the investigation of training options for probation officers working with Adult Offenders in Alaska, a Train the Trainer FAS workshops in Alberta, ½ day training initiatives for RCMP in Manitoba and FAS training incorporated into correctional services training in both Yukon and the Northwest Territories. Initiatives in B.C. include a one-day training on FAS for youth custody and youth probation officers delivered through the Justice Institute of B.C. (Interjuristdictional Youth and Adult FAS Justice Committee, 2002) with plans to develop a post-hire training course as the Branch embarks on a new training plan.

A review of behavior management programs in the correctional system has found that the vast majorities rely on such programs to manage behaviors and ensure safety (Endicott, 1991). At the same time, we know that the prison system, though providing some stability and routine for FASD affected, is the least productive context for habilitation of persons with disabilities. Some correctional services are moving towards use of rehabilitation programs based on life skills training and supportive advocacy, however little material from institutions are available to ascertain the full impact of this move. However a meta-analysis of mostly community-based programs found that effective programs contained 4 elements that resulted in 10%-20% effectiveness in reducing subsequent delinquencies. These were 1) concentration on changing behavior and improving pro-social skills 2) focus on

problem solving with juveniles and their families 3) have multiple modes of intervention and are highly structured and intensive (Lipsey, 1992) and 4) Attempts are being made to teach the concepts of "victim impact" and "victim empathy" despite being the most difficult to teach. What is often seen as lack of remorse or guilt for FASD affected is in fact not maliciousness but these youths inability to make the connection between their actions and the effects or consequences of those actions on others (Ministry of Children and Family Development, 2001). Teaching empathy is being explored as a means of teaching accountability for these youth.

Communities need to develop resources to provide adequate supervision and rehabilitation as an alternative to incarceration because sentencing to jails and detention centers often is making the problems worse. Until we are able to develop this more humane response to this disability, we must ensure that our practices within institutions are congruent with the differential developmental and needs of FASD affected youth.

Reason for the Report

In 1996 the recommendations of the Federal-Provincial-Territorial joint Task Force on Youth Justice called for protocols to be established for the delivery of services to young offenders with FAS/FAE. These have not been created.

In 1998, a report to Corrections Canada titled *FAS: Implications for Corrections Canada* recommended that the criminal justice system consider the design of a FAS/E Awareness Manual and in-service training for education and awareness of FAS, at all levels of the corrections system. To date, 2002, no comprehensive in-service training in FAS exists. Though some isolated training opportunities are available in each province (Interjuristdictional Youth and Adult FAS Justice Committee: Initiative, 2002), there is no overall training developed to meet the differential needs of FASD affected individuals in the criminal justice system.

This report included recommendations to consider the development of "a practical screening instrument for identifying suspected cases of FAS/FAE early in the incarceration process." To date no such screening instrument has been implemented.

In her study of Youth Custody populations, Julie Conry (2000) recommended "ongoing training about FAS/FAE for probation officers and custodial personnel", yet British Columbia has only one such training program accessible through the Justice Institute in the south of the province.

The need for ongoing training for personnel, practical screening instruments, FASD Awareness Manuals and protocols for service delivery to FASD affected youth still exists. Our failure to address these vital issues means everyday we miss the opportunity of having provided our best practices in working with disabled youth and in ensuring that their return to the community is the most positive it can be.

Achieving best practices in working with FASD youth will require integration of knowledge from research and our day to day practice. It is this balanced combination that will inform both decision-making and action regarding work with FASD youth in the criminal justice system.

As we have been asked to identify training needs within the institution, we have concentrated on the in house training and organizational needs. It is not in the scope of this assessment to evaluate release planning and after-care support for the FASD affected however some recommendations will certainly impact these areas.

Findings: Staff Survey Results:

Knowledge and Skills

18% of staff reported a good to adequate knowledge and skill level to create a responsive environment for FASD affected youth.

25% of staff reported an adequate knowledge and skill level.

45% of staff reported a less than adequate knowledge level and skill level however 2 staff reported less than adequate knowledge level but adequate skill level due to developing their own responses to FASD affected youth.

12% of staff report inadequate knowledge and skill level to create a responsive environment.

These results suggest that though there are some staff who are self-reported as working at a satisfactory level with this disability;

56% of staff reported the need for further training in FASD and strategies for intervention.

Barriers

The question asked in the survey regarding barriers to best practice was: What barriers exist in the organization for you to do your best work with FASD affected youth?

The most commonly **identified barriers** to doing their best work were related to knowledge acquisition, time and behavior management tools. They were further identified as:

- **lack of 'expert' information, both about FASD in general and about youth affected at YCC inparticular;**
- **formal training**
- **resistant or unknowledgeable staff members.**
- **lack of time to deal effectively with these youth**
- **the phase system**

Supports:

The question asked in the staff survey regarding organizational supports that assisted best practice was:

What supports are there in the organization that are particularly helpful for you to do your best work with FASD affected youth?

The supports identified as helpful to doing their best work were predominantly people in the organization.

- Youth Forensic Services, Nurses,
- Case Management, Managers,
- SCO's, team members

Resistance to labeling

While there is mixed reaction to the idea of labeling, the majority of staff felt it important to ensure proper identification of FASD affected youth. Those who were resistant to the idea, were concerned that the label would provide an excuse for their behavior, give staff no extra skills to deal with the issue, be seen by staff as a reason to ignore or write-off youth or the youth may themselves be picked on for this disability.

Labels denote status. In our society, an individual's status and success is determined primarily by their neurological functioning. It is no wonder then that FASD affected individuals find themselves marginalized, criminalized and ostracized, with or without the label.

Labeling is not an excuse, it is an explanation as to why an individual has acted and reacted they way that they do. The advantage of a label for FASD youth is that a diagnosis or label serves as a starting point to develop new expectations and accept a reality of how thing are going to be. It allows staff to appropriately address behaviors and deficits within the context of the youth's abilities instead of from unrealistic expectations. Once we accept that this youth will not respond the same as other youth then we have an opportunity to take steps to develop a new plan for not only behavior management but for learning skills that will prevent that individuals recidivism.

As long as we maintain an attitude of indifference and unawareness, we will continue to disregard the very areas were solutions can be found.

Attention Deficit Disorder with Hyperactivity was an area that was to also be addressed in this report. ADHD was not discussed in the same depth as FASD by staff. Because this report will address the broader area of specialized needs of which ADHD falls under, this area will be addressed in the proposed protocol and organizational changes. Training for this topic will be on request.

Limitations and Capacity

Limitations:

1. Resource Issues:

- Use of Case Management Position
- Screening and Diagnosis
- Staff feeling overwhelmed

2. Organizational Issues:

- Discrepancy in Viewpoints
- Lack of Information
- Limited Communication of Information
- Discrepancy in application of Phase system and disagreement as to its effectiveness.

3. Training Issues:

- Lack of Awareness of FASD
- Concerns regarding "fairness" of differential treatment
- Need for further training

Capacity/ Strengths

- Supportive Management
- Effective Intervention Skills
- Alternative Programs
- Youth Focused Staff and Support Services

Limitations

To preface any discussion of limitations within the current organization, we must first be aware of a fundamental value held by the institution and how this dominant ideology impacts the work done by staff and management. This relates to the assumption that youth in the criminal justice system are capable of understanding the repercussions of their behavior.

In the Provincial Standing Orders Manual: Mission Statement, Section A, Youth Custody Values states:

"In carrying out our mandate we believe:
that youth can understand the repercussions of their behavior and should be held accountable for their behavior in a manner that is consistent with their age and social development".

According to Dr. Julie Conry (1999), there are a number of susceptibility factors particular for youth with FASD. These youth are unable to integrate all the information from cause and effect situations and so are unable to look at the "whole picture". They do not anticipate consequences and lack good judgment or common sense. They are often **not capable of understanding the repercussions of their behavior**. As well, FASD affected youth have delayed or non-existent social-emotional development that is inconsistent with their age.

1. Resource Issues

a. Use of Case Management position

Though individual case managers are assigned to working with youth it has been stated that more active case management is needed, as this position is not effective. There is also some concern that Individual Care Plans are not consistently implemented. Court orders psychiatric assessments, which could identify FASD, are completed on less that ½ the population.

Designated Case Management could be used more proactively in addressing the differential needs of FASD youth.

b. Screening and Diagnosis

There are conflicting views about the label of FASD and how much it is needed. Staff wants to know the specifics of what special needs these youth have but do not necessarily want a label that tells them nothing.

There is a sense that a label does not provide information to get to know the youth.

At the same time there is acknowledgment that understanding strategies for best practice might change people's minds about what would be helpful for these youth.

Standing Orders and Operations Manual content are clear as to the need for assessment of specialized needs yet the reality is that the current assessment forms and intake process do not accommodate an accurate assessment of specialized needs or a differential response to those needs.

Though there is resistance to labeling, the necessity of identifying potential problems for youth is a part of ensuring the need for specialized services that is promised in the Standing Orders and Operations Manuals.

Standing Orders, Section G 1.05 - states, "specialized services shall be available to sentenced youth based on the **individual assessment of need** and the related case management plan."

Section G 7.01 states; **Specialized services respond to the distinct needs of a particular youth or categories of young offenders** and Section G 7.02 states that **specialized services "will be determined by the Youth Needs assessment of person's qualified to provide the service"**.

Despite this policy, the Youth Needs Assessment does not have a designated Case Needs Area that would reflect the possibility of FASD. Case managers describe the ability of this document to adequately reflect the reality of the individual's situation as "poor". This becomes problematic when access to specialized care can only be determined by documents that are meant to capture the information that FASD is of concern.

"Disordered Offender Programs to address the specific needs of youth related to fetal alcohol syndrome/effects" (Section G; 7.05 - 4) can only be accessed if specialized services are identified. These can only be identified if youth needs assessment designates it and with limited information about the possibility of FASD and the need for diagnosis coming from the medical staff or case managers, how will the actual needs be addressed?

Standing Orders, Section F 1.05 - 3 states "Programs and services should respond to the needs of youth, particularly those needs and factors associated with criminal behavior". FASD is a disability that has definite differential needs that directly relate to the disabilities susceptibility to criminal behavior yet no specialized programming exists to address this.

Research fully supports the presence of Fetal Alcohol Spectrum Disorder in the system. As a specialized need, youth affected by this disability constitute a category with a distinct need that is currently not being addressed in the Youth Custody setting.

c. Feeling overwhelmed to deal with the many different needs of youth.

The loss of staff at YCC and extra pressure on existing staff to perform duties up to or beyond standards is being felt at the line level.

2. Organizational Issues

a. There is a discrepancy in viewpoints between enforcement vs. rehabilitation and thus divergent value systems and application of practice.

b. Lack of information coming from the intake procedure to the front line prevents appropriate responses to these youth.

The standing orders are not clear in defining FASD as a medical issue, behavioral issue or a

psychological issue. As such, neither the medical personnel nor Forensic personnel are necessarily identifying possible FASD affected youth. A pediatrician or physician and a psychologist can only achieve definitive diagnosis of FASD however, screening and assessments will need to be followed up by designated staff. As a result of limited information regarding specialized needs being available, no further information is forth coming to the line that could assist them in determining the necessary behavioral interventions.

It has been reported that Initial Case Management Plans are determined based on background information from previous placements, Medical reports and the Youth Needs and Risk Assessments, which again do not address the possibility of a disability, and resulting specialized needs. The Case Management plan may state queries under the area of "Concerns" however this query is not necessarily addressed, as there is no recourse for obtaining a diagnosis so this query is simply left and specialized needs are not assessed.

This lack of adequate identification results in staff's frustration over behavior problems and the youth's loss of appropriate interventions.

c. Communication of Information

Both medical information and educational information are seen to be restricted. Though it was acknowledged that this is due to confidentiality issues, at the same time stated it was stated that this works to a disadvantage for delivery of appropriate services to the youth.

d. There are discrepancies in the application of the behavioral management program and disagreement as to the effectiveness of the phase system as applied to FASD/ADDH affected youth.

The phase system used at YCC is a motivationally based behavior management program, however FASD is not a motivational deficit.

Motivation only enables us to do what we are already capable of doing. FASD affected individuals capabilities in specific areas are limited.

The implementation of a motivationally based program to a disability which is not motivationally based, results in the loss of opportunities to acquire the very skills the youth are being "consequenced" for not having. Where access to community resources or opportunities for social interaction will assist youth with learning skill sets and development of a sense of belonging and self, the denial of access based on points they fail to earn means they being deprived of their need for learning new ways of behaving and interacting.

The irony of depriving FASD youth of the social opportunities and supports that could help them learn better skills is not lost on most staff.

Instead of creating an environment based on responsibility, a sense of belonging and generosity, values we hold dear, we are creating an environment that not only does not reflect the reality of the world but is based on external control, compliance and subjectively applied judgment. VanderVen (2000) establishes a very strong argument for the transformation of point and level systems within the custody setting. She contends that these systems interfere with the healthy overall development of youth by depriving them of the normative needs such as privacy, relationship development, decision making and group participation which can teach them the skills they need to develop. These findings have special application to FASD as these youth have developmental ages much younger than their actual chronological ages and therefore developmentally appropriate practice is especially relevant.

While not everyone was in agreement about the point system, some staff felt very strong about its use with youth in general.

The majority of non-line staff felt the point system was ineffective:

Others, though definitely the minority, felt equally as strong about the need to retain the point system:

3. Training Issues

a. There is a current lack of awareness among the vast majority of staff about the differential needs of FASD/ADDH affected.

> A number of staff expressed the lack of understanding as to why FASD affected youth are unable to change their behavior even when there are strong rewards and punishments attached to the behavior.
>
> It is this same lack of awareness of FASD as a brain damage that causes developmental and behavioral disturbances, which appears to account for staff's unrealistic expectations. Staff believe that these youth should be able to "get it" just like anyone else. They are unaware that by holding the same expectations for the disabled as the abled, it creates a further disability for FASD affected youth.

b. There are concerns regarding the "fairness" of differential treatment for FASD affected youth.

> **The need for differential treatment for FASD affected is necessary for fair application of services (Vickers, 1999).**
>
> The definition of fairness is not that everyone gets the same thing but that everyone gets what he or she needs, thus differential treatment is fair. Not giving children what they need is unfair and by definition giving children and youth what they do need is fair treatment.
>
> This concept of fairness seems to be deeply felt by a number of staff however their definition is not one of access to what is needed but one of trying to ensure equally applied treatment. This is proving problematic for staff; as such an equality of application is not possible. Instead perhaps emphasis should be placed on the role of case management, which is to provide for individualized need, and thus individualized treatment.
>
> Internal control is known to be a major factor contributing to a youth's psychological health and it is one of the main attributes we strive to help FASD youth obtain. The point system however teaches compliance and external control.

c. Further Training is required

> Further training about FASD and the strategies to address it were seen as a means to benefit staff's best practice.
>
> Another area that was insightfully suggested was the training of the youth themselves in understanding disabilities. It was felt that this would not only assist youth in understanding difference and tolerance but that it would also building a more empathic and social responsible youth. A local example of this is the F.O.R.C.E. program for FAS affected adult recently run through the Native Friendship Center. This program taught life skills and job

placement skill to assist the FAS adult with more normalized living. A large part of this program was in helping the individuals understand their disabilities and work with them. Their presence in the agency required a learning curve for many of the staff and other adults working with them. This however was seen as an extremely positive experience.

CAPACITY/ STRENGTHS

Supportive Management

Every organization has its strength upon which to build the necessary environment for change. At Prince George Youth Custody Center the support from management was viewed as an important capacity that exists for staff to continue doing effective work.

Effective Intervention Skills

It was noted that this Custody Center deals with high-risk youth very effectively in terms of containment and safety issues.

Alternative Programs

The presence of programs like Bowron House, where youth can begin to work towards community placement, allows for opportunities for youth to succeed. This program is able to adjust their leveling system and work around the specific needs of youth. This is a definite strength when looking at alternative programming for youth.

As well, the skill based programming such as forestry also provides youth with real life skill to transition into the community. Concrete, hands on skills are something that FASD youth can learn to work with well, once their behavioral needs are addressed.

Youth Focused Staff and Support Services

The apparent eagerness for training displayed by staff is a capacity that cannot be undervalued. Their commitment to their best practices for working with youth is evident in their willingness to discuss training needs and in being honest about their level of competency. Many staff expressed positive sentiments about this assessment.

Another important strength is the willingness of the various support services to ensure their best practices in working with FASD. Forensic services initiated a meeting to discuss our goals in this training initiative and are also interested in obtaining more concrete skills for working with FASD youth. It is this kind of support that will ensure that the initiative is effective and timely.

RECOMMENDATIONS

As indicated by the literature review, diagnosis of FASD is recommended to best address the reduction of criminal behavior in FASD youth. However, the ability to access diagnosis is not always available and PGYCC staff do not all agree that it is necessary to doing good work.

Though YCC may be unable to ensure the diagnostic confirmation that a certain youth is affected, this

institution can address the assessment of the level of maladaptive behaviors and the secondary disabilities of youth, in order to achieve the highest possible level of functioning while in Custody. This would include screening and assessment for specific learning disabilities, attention problems and behavioral attributes that could signify specialized needs.

The following recommendations are made with the intent of ensuring best practices response for working with FASD youth at Prince George Youth Custody Center.

Overview of Recommendations:

Generally, the staff and management at YCC appear to be very satisfied with their work and display a strong commitment to ensuring their best practice in dealing with youth. However, there is a strong realization that their current practice does not incorporate enough knowledge or skills around FASD or other specialized needs.

There is also a paradigm disparity, which is apparent at both the management and line level. A paradigm is a belief system or way of viewing the world that direct your behaviors and determines the way you will approach your work. There is ongoing debate about the effectiveness of rehabilitation versus enforcement paradigm.

Divergent paradigm when left unaddressed can create enormous conflict and tension.

Some line staff and management work to ensure that behaviors are controlled and safety is maintained and that is the extent of their work. Yet others work from a rehabilitative focus and believe that while safety is still important, intervention towards addressing more than control of behaviors is also required. For these staff, creating supportive relationships that ensure success for the youth and appropriate intervention are seen to be an important part of their best practice.

There is a need for an identification process for assessing the presence of FASD in youth and ensuring an appropriate assessment/diagnosis is done. The case managers can play a more active information collection and advocacy based role for the youth. They could also ensure the proper communication of this information and strategies for intervention to the line workers who, when trained, will then be able to implement better strategies for behavior management and for rehabilitation. There are two key areas to address when looking at best practices: protocols and training.

First, a case management protocol must be put in place that addresses an adequate assessment of the specialized needs of the youth which would in turn better inform the line staff as to alternative behavior management strategies and fair expectations of the youth s abilities.

The training is a second part of the overall strategy for best practice and should include initial training in what FASD is as well as strategies for working with FASD affected youth. Depending on the resources available, the preference should be to train all staff. Perhaps the more important part of the implementation of best practice in FASD and other specialized needs is the follow-up work to ensure that the strategies that are being developed and implemented are found to be effective in their application. This evaluation process could ensure best practices and help to shift staff behavior and attitudes towards the necessity for differential work with FASD youth.

Specific Recommendations

1. Differing Paradigms

The overarching paradigm disparity must be addressed if there is to be accord between the enforcement vs. rehabilitation debate.

Consider the use of social marketing tools as well as training to directly address an attitude change in the institution. The use of marketing can change behavioral patterns through communication and dissemination of educational messages.

2. Case Management

It would seem that the benefits of Integrated Case Management are not being realized in the area of FASD and other specialized needs.

Integrated Case Management proposes that cases must be assessed medically as well as for needs and risk and then managed according to the individual's need and level of functioning. However, the role of case management is being under utilized in achieving an accurate assessment of specialized needs.

Standing Orders, Section F 1.05-1 states that "Each youth is the subject of a **comprehensive assessment with respect to their associated risks and needs**" yet a full assessment of the presence of FASD, risk potential, differential needs and medical implications are not being done from an informed perspective. Assessment at the community level, and youth custody probation level are not providing the information needed to "effect change in the criminal behavior of these youth" and information at the medical and educational levels are considered confidential and inaccessible.

Develop a case management response that directly addresses an assessment of a youths needs as well as their risk.

3. Development of protocols

Develop a protocol about the sharing of information relevant to the well-being and appropriate case management of the youth.

Standing Orders Section G1.03 - 6 states, "Programs should be delivered in a way that meets the distinct learning styles, experience of …..disordered offenders. Programs for these groups should be developed in conjunction with those who have **appropriate experience and expertise**."

There is a need for the designation of a specific position to become institutional advocates for all FASD youth flagged in the intake process. This position is well suited to the role of the Social Worker in the institution.

The "Youth Needs Advocate" could develop a portfolio that:

- Understands the full nature of FASD.
- Works actively to ensure a full specialized needs assessment is available for youth screened "at risk".
- Is aware of the individual youths strengths and weaknesses as determined by appropriate

assessment.

- Works directly with the youth to help them function most effectively.
- Works with Case Managers, SCO's and line staff to ensure appropriate behavioral, medical and educational interventions.
- Helps them with close interpersonal interactions where they have difficulty.
- Works to ensure proper monitoring that addresses situations that can aggravate disruptive behavior.
- Advocates within the system and related services for the specialized needs of this youth.

Another benefit of utilizing the position of the Social Worker would be to assist with release planning for the youth and family follow-up.

4. Screening

Currently, youth with specialized needs are not being adequately identified in the present system of intake.

Use of either the FASNet screening tool or the Symptoms checklist devised by Strethguss, La Due and Randals could provide a comprehensive non-medical way to assess the possibility of FASD. This could be done by medical, social work and/or Forensic staff.

Use of appropriate screening tools could indicate that a diagnostic assessment is warranted and could be facilitated by the case "advocate" or staff with an expertise in screening. Alternatively, an assessment of the youth's specific learning disabilities, attention problems and behavioral attributes (Spohr and Steinhauser, 1987) could give case managers and social workers sufficient information by which to ensure the provision of responsive and appropriate interventions. This would require co-operation by a number of systems; management, education, medical and forensic.

5. Forms

Initiate a review of current case management forms and the development of a category for both Initial Case Management Plan and Youth Needs Assessment forms that captures the necessary information to ensure appropriate assessment and provision of differential practice.

The Youth Needs Assessment (Youth Case Plan); RNA (96/08/30), Initial Case Management Plan or the Health Information form (HS 005) do not capture the information that could identify the specialized needs of Fetal Alcohol Spectrum Disorder or other disabilities in the youth being assessed. Failure to identified individual needs will result in youth not receiving the specialized services they require. The inclusion of a category "Specialized Needs" would not only require that further information would be sought but would also ensure that this information is sent with the youth in their move or discharge.

Areas for questioning could relate to delayed social, sexual and emotional development, communication skills deficits, co-occurring psychiatric or physiological conditions, sensory integration disorders, information processing deficits, inability for abstract thought, dependence and the need for continual supervision as well as behavioral issues.

6. Phase System

Development of a more appropriate behavioral management system that does not further penalize the youth for their disability should be investigated.

There is a definite question as to whether or not this behavioral management tool, implemented to target the maladaptive behavior of residents, is delivered in a consistent format. There is also some question about its suitability for FASD youth or even whether these youth are capable of benefiting from this type of system. In the absence of FASD related research that could answer this question we must rely on the research that raises questions about the point system for youth overall and the feedback of front line staff. Enough question exist within YCC and within the service delivery system itself to warrant a closer examination of alternatives for behavior management.

Bowron House staff are have been adapting their leveled system and are currently revisiting this tool using an informed approach to evaluating its effectiveness. As well, the new female unit at PGYCC will be utilizing different approaches to their behavior management and should be encouraged and supported in an evaluation of this for examination of more useful tools in the Center.

7. Training

YCC should implement practices that are responsive to the specialized needs of FASD affected youth based on what is known about how they develop and what practices promote this development. This will require specialized training.

The general opinion of the majority of staff was that training would be a benefit to their ability to do their jobs. While they requested information about FASD their greatest need was for information that would give them hands-on concrete strategies for intervention with FASD youth. Given the shift nature of this institution and the number of staff (>70), it is recommended that training concurrent to the changes in case management delivery and that it dependant on resources, it be initiated with staff whom have most impact on these youth.

8. Additional Training Considerations:

Consider the implementation of FASD awareness training within the Custody Center population of youth in general, giving youth a better understanding of diversity and tolerance.

Awareness of FASD for the youth themselves was seen as a positive step towards building skills and knowledge for youth to understand and respect diversity, develop tolerance and empathy for others.

9. Additional Recommendations:

Increased access to concrete skill based programs i.e. forestry, based on ability to perform and risk factors. Such programs give opportunity to build success and competencies at the same time as developing relationships and social skills.

The creation of an on-site resource library to increase staff access to more resources and information regarding disabilities and other related areas was suggested as an important source for self-directed learning.

The information and training tools available in the resource area would be prevention and intervention oriented with resources geared towards staff but also for the youth themselves, about the prevention of FASD. The creation of a resource area could be linked with local FASD resources such as the Family Resource Center, which has active involvement of parents of FASD affected children and youth. The establishment of a useful resource library would convey a clear message regarding management's expectations for on-going self and educational development.

Summary

Prince George Youth Custody Center is known for its ability to deal with very difficult youth offenders. The staff speaks very highly of management and their commitment to ensuring the best work environment for dealing with youth offenders during trying fiscal and philosophical times. Workers feel over committed and do not need additional responsibilities in their work yet many are willing to address specialized needs in the best interest of the youth.

What we are proposing with these recommendations is not more work for staff and management but the opportunity to learn to work differently with a population of youth that constitute over 50% of their population. The majority of staff and management are supportive of this move and believe that case management reorganization and new training initiatives are a positive step.

The foresight and innovation that management has shown in initiating this review is worth mentioning. As indicated in the literature review, few if any institutions are addressing the presence of this disability in their populations. It requires a forward thinking team to move into an unfamiliar area. Our sincere hope is that the work of the PGYCC will set a benchmark for other Centers to follow in the humanization of our penal systems. Policy changes in women's prisons and in the youth custody area are promising. The shift towards more empowerment focus in corrections work demonstrates a willingness to examine viable penal reform strategies, hopefully reform that will address the specialized needs of the disability of Fetal Alcohol Spectrum Disorder.

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