Fetal Alcohol Spectrum Disorder: An Informational Resource Manual and Presentation for Correctional Services of Canada Parole Officers

by

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The information in this staff manual is meant to be used by agency staff, as part of the broader services they provide, or under supervision of agency staff.
ABSTRACT

The correctional system within Canada encounters a number of offenders with Fetal Alcohol Spectrum Disorder (FASD), a recently identified disorder among the offender population. These offenders, like many others, may encounter difficulties adhering to parole conditions once released from prison, thus, jeopardizing their successful reintegration into the community. Parole officers seek to help offenders back into the community with as little difficulty and as much support as possible. A manual and presentation were created for parole officers to increase their awareness on FASD. Research shows that having a better understanding of offenders with FASD and identifying ways to help them cope while on parole could contribute to success within the community.

The manual and presentation provided background information about FASD, etiology and symptoms, common obstacles, relative coping mechanisms and interventions, and further resources in the community of the particular parole office. The participants of the presentation were parole officers employed within Correctional Services of Canada. Three parole officers attended the presentation and evaluated the presentation using a feedback form administered at the end of the presentation by the student facilitator. The feedback form sought to evaluate the performance of the presentation using ten statements to be rated using a Likert scale from one (strongly disagree) to five (strongly agree). The results from the feedback forms indicated that the presentation was overall effective in increasing FASD awareness. The total number of fives received on the feedback forms was twenty-nine out of a total of thirty statements, yielding a successful average of 96.6 %. The total number of fours received on the feedback forms was one out of a total of thirty statements, yielding an average of 0.03 %. Based on the responses to the feedback form, the research findings were consistent with this hypothesis. Parole officers who participated found that their understanding of FASD had improved after the presentation. The parole officers also agreed that the presentation was relevant to their career and that they would recommend the presentation to other parole officers. Further research should examine the continued usefulness of the FASD manual by parole officers.
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Chapter I: Introduction

Correctional Services of Canada (CSC) comes into contact with a plethora of different types of offenders. Although some offenders are easier to work with than others, CSC employees take on cases of many kinds and work with offenders ranging in a variety of domains. CSC parole officers attempt to successfully reintegrate offenders back into the community with as few problems and as much support as possible. Parole officers monitor, assess, and provide supportive services on different levels of supervision to offenders, based on their risks and needs, and their community contacts.

Not all offenders are managed in the same way, as no one offender is exactly the same. Parole officers work with federal offenders, many of whom have intellectual or developmental disabilities, mental health issues, and a range of other biological, psychological, and behavioural deficits.

A recently identified disorder among the offender population is Fetal Alcohol Spectrum Disorder (FASD). Although there is no reliable data to determine how many offenders in Canada have FASD (Canadian Centre of Substance Abuse, 2012), it is important to examine this cohort, given that parole officers do come into contact with offenders with FASD or FASD-like symptoms. These offenders are likely to be ones with high needs.

Since many offenders with FASD are undiagnosed or misdiagnosed, it would be beneficial for parole officers to have some understanding about the disorder. Many parole officers are unfamiliar with the specifics of FASD. Physical characteristics, behavioural patterns, neurocognitive functioning, and other symptoms may be ignored or misinterpreted without a reasonable understanding of the disorder. It is important that parole officers are able to identify these symptoms as early as possible to introduce appropriate assistance. Proper services and supports can be distributed to offenders diagnosed with FASD or with FASD-like symptoms, possibly strengthening their reintegration back into the community following incarceration.

For the present project, this information included an explanation of FASD, its symptoms, the deficits that are most common in the FASD population, and the way in which to address the deficits. Information that highlights these areas was given to parole officers in the form of a manual and an accompanying PowerPoint presentation. The manual provided background information about FASD, etiology and symptoms, common obstacles with FASD, relative coping mechanisms and interventions, and further resources in the community of this particular parole office. The PowerPoint presentation explained the manual to staff members and was also offered to a number of different CSC and other related agencies in the community. Following the presentation, copies of the manual and the presentation were given to each agency for future use and reference.

Increasing FASD awareness with CSC parole officers will better equip them to deliver appropriate services and supports to offenders in the target population. Thus, offenders diagnosed with FASD or showing signs of FASD may receive more tailored assistance from their parole officers. Working to target common FASD deficits might strengthen the offender’s
successful reintegration into the community. The information in the FASD manual and presentation is hypothesized to better strengthen the understanding of FASD with parole officers.

A presentation for parole officers is an informative and efficient way to communicate information, share strategies, activities, and teaching methods on the topic of FASD. A PowerPoint presentation and hard copy of a manual can be used multiple times and within a group format. Resources provided at the time of the presentation are important for parole officers to keep in their offices for future reference. These resources include the FASD manual and a layout of the PowerPoint presentation.

Topics examined in this thesis include information about FASD, common impairments in individuals with FASD, treatment methods, FASD in correctional settings, and delivery methods of information regarding FASD. The method for creation of the manual and presentation is described and includes a brief description of the participants, design, and procedure. The FASD manual and PowerPoint presentation are included in the appendices, along with the presentation feedback form and feedback form results. Lastly, a thesis summary is presented and includes strengths and limitations, multilevel challenged to service implementation, contribution to the Behavioural Psychology field, and recommendations for future research.
Chapter II: Literature Review

FASD History and Terminology

FASD is viewed as the most preventable source of a neurobehavioral abnormality (Nash et al., 2006) and is the result of alcohol exposure to an unborn child by means of maternal alcohol consumption (Fast & Conry, 2009). Fetal alcohol exposure can cause permanent damage to one’s cognitive, behavioural, physical, and neurological structuring. FASD is a relatively new diagnosis; first identified by Jones and Smith in 1973. They characterized numerous deficits that were found in children whose mothers consumed alcohol during pregnancy. Its relatively recent recognition has made it difficult to obtain qualitative information on the long-term effects of treatment. According to Fast and Conry (2009), individuals with fetal alcohol syndrome (FAS) exhibit defects in growth, characteristic facial features, and the central nervous system. Individuals displaying only some of the FAS defects were previously referred to as having fetal alcohol effects (FAE) (Clarren & Smith, 1978). The term FASD was later coined to include the full spectrum of prenatal alcohol exposure effects. FASD now includes partial FAS, alcohol-related neurodevelopmental disorder, and alcohol-related birth defects (Stratton, Howe, & Battaglia, 1996).

Characteristics of FASD

Alcohol exposure to the embryo and fetus during pregnancy has a teratogenic influence, which means that development is hindered in an embryo or fetus, resulting in evident impairments following birth (Davis, Desrocher, & Moore, 2011). Children with FASD often have a specific set of facial malformations, including “microcephaly, short palpebral fissures, a smooth philtrum, a thin upper lip”, (Davis et al., 2011, p. 146) “epicanthal folds, [a] low nasal bridge, and [minor] ear abnormalities” (Riley & McGee, 2005, p. 358) (Appendix A). The facial abnormalities associated with prenatal alcohol exposure are not seen across the FASD scale but rather are only seen in a small number of individuals diagnosed with FAS (Davis et al., 2011). Larkby and Day (1997) have also found that children with FASD are smaller in weight, height, and head circumference than other children their age. Larkby and Day recognized that many of these physical malformations remain present throughout adulthood but become less noticeable after the onset of puberty.

Statistics of FASD in Canada

According to Davis, Desrocher, and Moore (2011), FASD statistics are more difficult to obtain that those of FAS, because children who lack the typical facial features of FAS may remain undiagnosed. Neurological, psychological, and behavioural deficits in individuals with FASD may be misattributed to other factors if the obvious physical characteristics are not present. Hutson (2006) estimated that about 3000 births in Canada yield children with FASD on an annual basis. More intensive research is necessary to map out the rates of FASD within the Canadian population. According to the Public Health Agency of Canada (2011), reliable prevalence rates of FASD are nonexistent and are not closely monitored; therefore no true profile of individuals with FASD in Canada is available.
Diagnosing FASD

Diagnosing FASD is another obstacle faced in this domain. Resources exist for diagnosing children who are suspected of having FASD but similar tools do not yet exist for diagnosing adults with FASD (Burd & Martsolf, 1989; Public Health Agency of Canada, 2011). Thus, much FASD research for children is generalized to the adult population. FASD is deemed as a costly disability to manage and as a result, many Canadian provinces are involved in FASD prevention, recognition, and intervention plans. The Public Health Agency of Canada believes that recognition and intervention of FASD in children have opened doors for similar services needed for many adults showing signs and symptoms of FASD.

Screening for FASD

According to the Public Health Agency of Canada, adults who have been outside of the FASD spotlight are coming forward seeking a diagnosis and programs because of their FASD-like characteristics. Novick-Brown, Connor, and Adler (2012) advised that a regular FASD screening process is important in order to receive appropriate services early. A screening process (Burd, Cotsonas-Hassler, Martsolf, & Kerbeshian, 2003) could be applied to the correctional setting, whether during incarceration or on parole.

Unfortunately, as stated by Novick-Brown et al. (2012), only one functional screening device exists for identifying FASD behaviours: the Fetal Alcohol Behaviour Scale (FABS). Streissguth, Bookstein, Barr, Press, and Sampson (1998) created the FABS, which is comprised of 36 FASD related behaviours. Seven domains that differentiate individuals with and without FASD make up the FABS. The domains consist of “communication, personal manner, emotions, motor skills, social skills, academic functioning, and physiological functioning” (Streissguth et al., 1998). According to Novick-Brown et al., the tool can be administered in approximately 15 minutes but needs the knowledge of someone close to the individual who is aware of his or her functioning levels (e.g., parole officers or relatives). They also stated that a FABS result of 14 or higher indicates that the tested individual is likely to have FASD. Novick-Brown et al. mentioned that an informal checklist including items from the FABS is an effective preliminary screening tool for individuals suspected of having FASD. This informal checklist is known as the FASD Experts Forensic Screening Checklist and includes empirically validated elements identified with FASD. Novick-Brown et al. state that there is no particular quantity of factors on the checklist that confirm FASD. However, if the screening process results in significant evidence of possible FASD with a large number of factors identified, the individual should then be further examined and thoroughly assessed by a physician for a possible diagnosis. A diagnosis of FASD includes a physical and a functional screening component. The diagnostic standard for physical features includes both facial deformations and a deficit in height and/or weight. The third diagnostic feature includes atypical central nervous system structure and/or function, which could be determined with a neurological and physical examination.

Deficits in Individuals with FASD

According to the Public Health Agency of Canada (2012), common neurological impairments in FASD include the following: a prolonged duration of developmental delays,
attention impairment, cognitive, learning, and/or intellectual impairments, memory impairment, and motor control impairment. The agency also stated that persons with FASD usually encounter numerous neurobehavioural dilemmas, which may lead to information processing difficulties in their connection to their environment. A person with FASD experiences difficulties in controlling impulses and recognizing the connection between cause and effect. Individuals with FASD encounter trouble when generalizing information from one context to another. These individuals also experience difficulties when grasping abstract concepts and thoughts, such as metaphors or hypothetical scenarios. Short-term memory and translations of auditory information are also impaired in an individual with FASD. An example of this type of auditory deficit may include an individual not being able to recognize slight differences between the sounds of different words. Conry and Fast, (as cited in Fast & Conry, 2009, p. 252) described five significant areas of impairment in the functioning of individuals with FASD: “adaptive functioning, language, attention, reasoning, and memory”.

Davis, Desrocher, and Moore (2011) summarized that a number of domains are affected by fetal alcohol exposure and have long-term outcomes. They explained that overall intelligence is one area in which people with FASD have shown decreased intellectual functioning due to alcohol related brain damage. Mattson, Riley, Delis, Stern, and Jones (1997) confirmed this with IQ testing, in which the individuals with FASD showed generally lower IQ results than those without FASD. Mattson et al. found that intellectual functioning was impaired in individuals diagnosed with FASD, even when physical signs of the disorder were not present or were less visible. Riley and McGee (2005) recorded that the size of the brain in individuals with FASD was also smaller than in individuals without FASD.

Leaning and memory have also shown impairment in individuals with FASD. Mattson, Riley, Delis, Stern, and Jones (1996) found that children exposed to alcohol prenatally had difficulty in learning lists of words and remembering them after a brief delay period. Prenatal alcohol exposure yields a smaller sized hippocampus, the area that is used to create long-term memories from short-term memories (Davis, Desrocher, & Moore, 2011; Mattson, Schonfeld, & Riley, 2001). The smaller hippocampus size helps to explain why many individuals with FASD have trouble learning from past experiences and applying previous knowledge to future events. Problems with learning and memory can also negatively affect a number of cognitive and behavioural domains.

Although only a limited number of studies have addressed the long-term effects of prenatal alcohol exposure, adults with FASD struggle in a number of areas. The physical facial features of FASD, in most cases, tend to diminish after the onset of puberty (Streissguth & LaDue, 1987; Streissguth et al., 1991). Cognition and behaviour, on the other hand, continue to show significant impairment. According to Phelps and Grabowski (1992), a deficiency in intellectual functioning persists into adolescence and adulthood. As might be expected, academic functioning is also an area of impairment. Phelps and Grabowski (1992) examined studies in which the subjects showed difficulties in completing undemanding mathematical problems. They stated that such subjects are in need of special educational services.

Behavioural anomalies appear to be quite problematic and hold a variety of challenges for adults with FASD. Agitation, hyperactivity, poor judgment, inattentiveness, and trouble
recognizing social cues are common FASD characteristics that persist into adulthood (Driscoll, Streissguth, & Riley, 1990; Streissguth, Clarren, & Jones, 1985; Streissguth et al., 1991). Other FASD characteristics include trouble in communicating, socializing, making resolutions, attaining goals, and being self-reliant (Streissguth & LaDue, 1987; Streissguth et al., 1991). It is important to note that many or all of these issues can be identified in some individuals who have not had prenatal alcohol exposure.

Secondary Disabilities of FASD

Many people with FASD also experience secondary disabilities as a result of the direct effects of FASD, which are possibly preventable through proper understanding and addressing of the issues accordingly (Burd, Fast, Conry, & Williams, 2010). Streissguth, Barr, Kogan and Bookstein (1996) found that the most common secondary disabilities are in mental health, education, law, confinement, sexual behaviour, and substance use. Individuals with FASD are more susceptible than individuals without FASD to develop psychological disorders, struggle in academics, and disobey the law. These individuals are also more likely to engage in inappropriate sexual behaviour, consume high levels of alcohol, and misuse addictive drugs such as opiates. The Public Health Agency of Canada (2012) also recognized a number of secondary disabilities in the FASD population. These included issues in mental health, education, the legal system, sexual behaviour, use of alcohol and/or drugs, dependent functioning, and employment. Individuals with FASD are also more likely than individuals without FASD to depend on others for day-to-day functioning, such as keeping track of finances or communicating with others. They also show difficulties in employment; individuals with FASD tend to have more trouble seeking out employment, attaining it, and maintaining it due to a combination of the deficits resulting from FASD.

The effects of FASD, both primary and secondary, can impede an offender’s successful reintegration into the community. According to Burd et al. (2010), it is important for correctional parole officers to receive training to better recognize and create proper management plans for offenders with FASD. Burd et al. suggested that recognizing the behaviour of an offender with FASD as an organic, neurological disorder, rather than a deliberate misconduct, can yield more supportive supervision and more positive correctional outcomes. Fast and Conry (2009) also stated that individuals with FASD who are in the correctional system need to be accommodated, as are individuals with any other disability. They mentioned that continuous education and training must be provided to correctional professionals to better develop their skills when interacting with individuals with FASD.

FASD in the Correctional System

Bekmuradov, Lange, Mihic, Popova, and Rehm (2011) estimated that individuals with FASD in Canada are 19 times more at risk to be incarcerated than individuals without FASD. They also stated that with proper diagnosis, intervention, and long-term support, individuals with FASD would have a stronger chance to avoid problems with the law. Bekmuradov et al. estimated that the Canadian correctional system had over 3,500 adults with FASD in 2008 or 2009. According to Streissguth et al. (1996), a combination of problems with the law, issues at school, attention deficits, poor social influences, or alcohol and drug misuse could lead to
significant matters within the legal system. Burd et al. (2010) stated that systematic screening for FASD of all individuals entering the correctional system should take place and that the results of such screening could lead to proper diagnostics, interventions, and supports. According to Burd et al., it is expected that adults keep jobs, handle household and financial responsibilities, attain their hygiene and well being, and take pleasure in social and intimate relationships. On the other hand, individuals on parole who have FASD experience a difficult time returning to community life after incarceration without long-term support, thus less likely to achieve the normal expectations of other adults.

Interventions for FASD

Although there is limited research in relation to adults with FASD, a few notable studies show positive results in intervention for individuals with FASD. Those outcomes could be applied in the correctional setting with offenders suspected of or diagnosed with FASD.

According to Burd et al. (2010), the ways in which to approach treatment programs and interventions should be considered when dealing with offenders with FASD. They mentioned that a number of factors could help contribute to successful community integration. Increasing treatment or intervention duration to strengthen learned concepts is important. These concepts should be as concrete as possible and can be explained using picture guides or stories. Burd et al. also state that allowing more focus in smaller groups of people would be beneficial towards positive treatment outcomes. They believe that avoiding the escalation of anxiety and targeting anxious thoughts immediately can also lead to better treatment outcomes for individuals with FASD. When interacting with individuals with FASD, Burd et al. believe that allowing for one problem and one solution at a time can help the individual to stay focused and better comprehend his or her situations. The authors advocate that one should adapt or cater to FASD deficits in order to decrease the negative effects of the deficits. This means altering the environment around the individual with FASD to enhance their pro-social skills. Promoting long-term generalization is vital in successful intervention, as are short and simple directions. Burd et al. also stress the appropriate treatment of mental health issues. If need be, this can be achieved through counselling, behavioural programs, or with psychotropic medications for the treatment of mental health issues. These factors can be applied with offenders in an individualized manner. The factors should be considered and implemented, as they are supports that could benefit the offender.

Kalberg and Buckley (2007) also agreed that appropriate structure, such as using visuals, environmental aids, and teaching methods could result in better outcomes for individuals with FASD because of their beneficial environmental properties. Providing offenders with FASD with visual aids creates a simple and anticipated learning experience. The structure assists the individual to become more organized. One of the most widely used forms of visual structuring is in the form of a schedule, which can be personalized to meet the needs of the individual’s learning style. Integrating a form of a schedule for offenders with FASD will help to organize their lifestyle, serving as a reminder of what is important and the timeframes. According to Kalberg and Buckley, the use of schedules helps to decrease anxiety and increase motivation in individuals with FASD. Schedules can be created using words, symbols, pictures, and stories and can easily be adapted to meet the needs of an individual with FASD.
Kalberg and Buckley (2007) also examined the effects of environmental structuring on individuals with FASD. They found that by adjusting the environment, for example by providing a space free of multiple distractions, an individual with FASD may be better equipped to tackle challenging academic tasks. Similarly, structuring tasks is also beneficial. Re-structuring can give an individual clarification, expectations, sequence, and order.

According to Paley and O’Connor (2011), behavioural consultation is one way to address the issues of FASD with individuals and their close contacts, for example, family, significant others, and/or children. Behavioural consultation is implemented to increase self-efficacy and positive treatment outcomes by providing clients with support and step-by-step instructions for using numerous behavioural strategies. This could take place with a parole officer, the individual with FASD, and a significant other to the individual. This type of guidance and support can be ongoing and can be beneficial to those in the lives of individuals with FASD. Behavioural consultation could help to educate others about the disorder and to make clear that most problems are likely a result of prenatal alcohol exposure, not simply attitude or temper.

Individuals with FASD often have trouble managing time, which affects certain conditions and expectations on parole. Difficulties in recognizing and understanding the concept of time could be the result of difficulties with mathematics. Burny, Valcke, and Desoete (2011) examined individuals who had difficulties in math and therefore, in telling time. They explained that reading a digital clock, as opposed to an analog clock, was an easier task and resulted in higher time-telling performance. This study relates to offenders with FASD who have trouble managing appointments, curfews, and schedules.

According to Loomes, Rasmussen, Pei, Manji, and Andrew (2008), a significant deficit in individuals with FASD is working memory. They studied the effects of verbal rehearsal on working memory and found that it was an effective strategy to use with individuals with FASD. Verbal rehearsal entails repeating a list vocabulary, either aloud or to oneself, over and over again until one can recite the list by recall. Verbal rehearsal can be applied to teaching offenders with FASD because hearing words or phrases more frequently makes them more likely to be remembered.

Effective Informational Methods

Burd et al. (2010) described that an integration of a manual and a video was ranked as a first choice amongst correctional systems employees as a means to learn about FASD. This choice was followed by the option of attending an FASD workshop in the correctional setting. Burd et al. recommended that the following domains should be addressed and incorporated into staff training in the corrections systems: FASD information, screening, coping strategies, effects on daily living, effects on parole, and a set of outside community resources. Fast and Conry (2009) stated that it is of significant importance that all correctional employees receive information and training to better understand FASD within the offender population. It is important to note that the informative methods suggested are rather general and can be applied to any offender showing one or many of the described deficits, regardless of their cause. Parole officers are likely to become aware of offenders with FASD if they are diagnosed. However, if parole officers recognize any of the characteristic features of FASD in an undiagnosed offender,
or if the offender shares that their mother consumed alcohol during her pregnancy with him or her, the parole officer would then have evidence to further discuss the case with a psychologist or health care team.
Chapter III: Method

Participants

The audience consisted of a small group of parole officers with a maximum of 20 individuals per presentation. Four parole officers attended the presentation and three were available to provide feedback. The presentation was not open to the public and was only provided through the parole office. Parole officers who attended the presentation consisted of females hired by Correctional Services Canada.

Setting

The presentation setting was on site at a Correctional Services of Canada parole office. The presentation was held in a boardroom, large enough to seat 20 audience members. The presentation was made available regular during office hours of 9:00 am to 4:00 pm.

Description of the Facilitator

The presentation facilitator was a fourth year student of Behavioural Psychology attending St. Lawrence College. She was placed at a Correctional Services of Canada parole office for her 16-week thesis placement. The agencies head supervisor and her college supervisor oversaw the facilitator during the duration of the placement. The facilitator’s duties at the parole office were varied and included shadowing parole officers, conducting assessments, accompanying the psychologist during appointments, and assisting with administrative tasks. The facilitator created the manual and the PowerPoint presentation and independently exhibited both to the participants.

Apparatus

Presentation equipment consisted of the FASD manual, a laptop running the PowerPoint presentation, a television screen connected to the laptop for a larger display, a paper outline of the presentation for participants, copies of the presentation feedback form, and writing utensils. An FASD manual was given to each of the attending participants and later distributed to all other parole officers at the agency.

Measures

The feedback form (Appendix B) consisted of 10 general statements regarding the performance of the presentation. A Likert-type rating scale, ranging from one (strongly disagree) to five (strongly agree), was used to evaluate the presentation. The form included a section for written feedback from the parole officers to the facilitator. The form would require less than ten minutes to complete. Parole officers were encouraged to ask the facilitator for clarification on the feedback form if necessary.
Procedure

A user-friendly manual (Appendix B), which described FASD, was developed for the agency parole officers. The purpose of the manual was to help parole officers better understand FASD and FASD coping strategies, relative to their offender population. A manual was given to each parole officer at the presentation and extra copies were kept on reserve at the agency. The presentation component was an interactive means of presenting the manual’s information in a group setting, open to discussion.

The presentation itself was approximately forty-five minutes in length and reviewed the FASD manual using a PowerPoint presentation and included an open discussion. For an outline of the PowerPoint presentation, see Appendix C. The presentation allowed time for questions, comments, or concerns at the end. Following the presentation, a feedback form is given to all audience members to complete before departure. The participants were allotted up to ten minutes to complete the form. Further requests for agency services and supports will be forwarded to direct staff members.

Confidentiality and Informed Consent

No formal document for obtaining consent was provided to parole officers at the time of the presentation or distribution of the manual due to the nature of the agency’s policies. The parole office had guidelines and policies that outline factors such as confidentiality already in place and in accordance with Correctional Services of Canada. The facilitator explained to the participants of the presentation that presentation feedback would remain confidential and only be used for the facilitator’s academic purposes. The student facilitator and the college supervisor were the only individuals to review the completed feedback forms.
Chapter IV: Results

During the student facilitator’s placement, one FASD presentation was held. Due to time and location constraints, only three feedback forms were completed after the presentation. From the three forms, all of the ratings were at a level 5 – strongly agree, with one exception. One form had a score of four (agree) for item number four. Item number four reflected the use of sufficient examples, visual aids, and materials in support of the presentation. One participant filled out the comments section with the following: “Good job – an insightful presentation.” The total number of fives received on the feedback forms was twenty-nine out of a total of thirty statements, yielding an average of 96.6 %. The total number of fours received on the feedback forms was one out of a total of thirty statements, yielding an average of 0.03 %. The total number of scores less than four received on the feedback forms was zero. Appendix D shows a table of the data from the presentation feedback forms.
Chapter V: Discussion

Thesis Summary

This thesis strives to increase FASD awareness in CSC parole officers. An FASD resource manual and presentation were provided to parole officers to increase their understanding of FASD, more specifically, within the offender population. Based on the feedback provided following the presentation, the research finding is consistent with the hypothesis of increasing FASD awareness in parole officers. Parole officers who completed the feedback form found that their understanding of FASD had improved after the presentation. The parole officers also agreed that the presentation was relevant to their career and that they would recommend the presentation to other parole offices. The FASD manual and presentation were appreciated by the parole officers due to the lack of similar resources available at that time.

Strengths and Limitations

A significant strength of this thesis is that it relates directly to the field of corrections in Canada. Information on FASD within the correctional system needed attention and elaboration at the time of this thesis. Its relevancy and usefulness is adaptive in the correctional field. This thesis is also supported by empirical, peer-reviewed research related to corrections and FASD.

A noteworthy limitation of this thesis is the time constraints that accompanied the student facilitator while on placement. Had more time for presentations been granted, more feedback could have been obtained. The presentation was held at only one parole office and, unfortunately, on a day when most parole officers were unavailable due to holiday events at the correctional agency. Another limitation found by the student is the lack of recent research in the area of FASD within corrections. As FASD is still a relevantly new diagnosis, it was difficult to obtain reliable resources and treatments for adults with FASD.

Multilevel Challenges to Service Implementation

A number of challenges exist when focusing on providing Correctional Service of Canada’s parole officers with new information. This thesis delivered an informational FASD manual and PowerPoint presentation to parole officers. The goal was to increase their awareness on FASD within the offender population. Whether parole officers will use the information is unknown and could therefore pose a number of difficulties in service implementation on various levels.

**Client level.** Ultimately, one would expect parole officers to utilize the provided information with their offenders with FASD. Realistically, parole officers are busy individuals and often have large caseloads and responsibilities. They meet with clients back to back and have little time to investigate research for a specific population of offenders. Some parole officers have an overall general understanding of FASD and may therefore choose to disregard the manual and presentation information. Other parole officers simply might not prefer to spend their spare time figuring out how to specifically help an offender with significant deficits. Thus, the information in the FASD manual and presentation could be disregarded or forgotten.
Program level. It is challenging applying learned knowledge to different cases. A parole officer might have a number of offenders with FASD but they are all unique and could behave differently from one another and struggle in different areas. Applying one learned method to a number of different individuals and expecting the same outcome could pose a problem. This is why behaviourists focus on treating symptoms rather than diagnoses. If parole officers choose to disregard the information presented on FASD, their offenders with FASD or with potential FASD are therefore affected. Without the proper service delivery on behalf of parole officers, these offenders could continue to display the same problem behaviours over the course of their parole, such as misunderstanding and breaking parole conditions.

Agency level. The best outcomes for offenders with FASD would include tailored support from their parole officers. Although parole officers might attempt to utilize the FASD information when working with their offenders, the agency might have different priorities in mind and might not allow extra time for specific individualized support. The parole office that the student facilitator attended for 4 months did not have a large population of offenders with diagnosed FASD. The office also did not have any particular known groups, treatments, or supports in place for individuals with FASD. This general lack of resources and time spent on FASD within the offender population is certainly a challenge.

Societal level. One societal challenge is the way that the general community perceives federal offenders. The negative stigma attached to being an offender out in the community is notable. Many individuals in the community simply might not give offenders a chance with employment or any other contributing responsibility. This challenge becomes greater when the offender has a psychological disorder. Society often views individuals with disorders or disabilities as incapable of being productive members of a community. These offenders are at risk for discrimination and rejection. Therefore it is important to teach offenders with FASD prosocial skills for coping in the community in a way that they will understand and retain.

Contribution to the Behavioural Psychology Field

The field of Behavioural Psychology seeks to encourage, create, and maintain adaptive behaviour in a wide variety of clients. It relies on valid and accurate research to facilitate successful outcomes for all clients. Behavioural Psychology is directly related to the correctional field and many correctional services for offenders with mental health needs are based on the treatment findings of Behavioural Psychology. This thesis contributes to the field of Behavioural Psychology in that it acts as a research-based resource for individuals to utilize, generalize, adapt, and further develop when necessary. This thesis summarizes relevant and informative research on FASD in corrections and provided resources to an agency in which little information was available. This thesis can act as a stepping-stone for future students to obtain additional information and expand the current results.

Recommendations for Future Research

A recommendation for further steps with the created manual and presentation is to present the material to more parole officers in a number of different settings. One would also value the importance of feedback from parole officers after frequent use of the created materials.
Thus, providing parole officers with a feedback form identifying whether or not they found the manual useful and relevant would be an important further step. One would also recommend seeking a number of concrete needs of offenders with FASD to direct the manual towards. Interviewing parole officers who regularly interact with offenders with FASD would be a positive step in this direction. Furthermore, one could directly interview offenders with FASD to assess their direct needs while on parole.

Future research could benefit from more focus on treatments for adults with FASD. Most of the literature in the field of FASD focuses on treatments for children and youth and does not elaborate on generalization and maintenance into adulthood. Future research could examine the outcome of various treatments in targeting the deficits of FASD in adults.
References


*Literature review word count: 3,172*
Appendix A: FASD Manual

Understanding & Coping with Fetal Alcohol Spectrum Disorder

An Informational Resource Manual for Correctional Services of Canada Parole Officers
Understanding and Coping with Fetal Alcohol Spectrum Disorder: An Informational Resource Manual for Correctional Services of Canada Parole Officers

Created by Angela Kanlic

College Supervisor – Lana Di Fazio
This resource manual was created for Correctional Services of Canada Parole Officers to help better understand fetal alcohol spectrum disorder and to utilize coping strategies that research suggests possibly beneficial to individuals showing signs of the disability.

A student created this manual in her 4th year of Behavioural Psychology at St. Lawrence College as part of her academic portion of placement. During the time of the manuals creation, the student worked at the Hamilton Parole Office for fourteen consecutive weeks.

Created by Angela Kanlic
December 2012
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1.0 Introduction

1.1 About Fetal Alcohol Spectrum Disorder

Fetal alcohol spectrum disorder (FASD) is a diagnosis used to describe individuals who have been prenatally exposed to alcohol and encompass a wide range of distinguishing characteristics as a result. These abnormal characteristics vary and differ with age. FASD is considered an umbrella term, encompassing three central nervous system disabilities that all result from prenatal alcohol exposure. These disabilities include fetal alcohol syndrome (FAS), partial FAS, and alcohol-related neurodevelopmental disorder (ARND).

The central nervous system of an unborn child is damaged when alcohol meets the placenta during a pregnancy. This causes the undeveloped embryo or fetus damage at the cellular and structural level, thus impairing functioning. Research shows that the central nervous system is damaged when consuming alcohol at any point during the pregnancy – especially from the second to eighth week because cortical and subcortical components of the brain are developing at this point.
The above figure shows the different stages of a pregnancy and when teratogens, such as alcohol, can severely impact a child’s development.

FASD is still a relatively new diagnosis and thus, is very limited in research. The research that is available on the topic is mostly geared towards young children and adolescents with FASD. Few studies have looked at FASD in adults and a limited number of interventions have been specifically designed for adults with FASD. Much of what is being done with adults has been generalized from interventions, coping strategies, and therapies that have been successful with children with FASD or with other similar disabilities. A number of interventions for individuals with FASD have also been generalized from interventions designed for individuals with ADHD or autism.
There is no cure or permanent treatment for FASD, seeing as the alcohol damage is irreversible. There are, however, strategies that can be put into place to help individuals with FASD better cope with their disability.
2.0 Signs and Symptoms

A number of abnormal features in an individual can be contributed to the effects of prenatal alcohol exposure. Individuals with FASD may look different than others. They might act in unusual ways, displaying behaviors that are not a part of the societal norm. These individuals might also have different patterns of thinking than the norm.

2.1 Physical Characteristics

Children with FASD often have a specific set of facial malformations, including microcephaly, short palpebral fissures, a smooth philtrum, a thin upper lip, epicanthal folds, a low nasal bridge, minor ear abnormalities, and micrognathia. The facial abnormalities associated with prenatal alcohol exposure are not seen across the FASD scale, but are rather usually seen in a small number of individuals diagnosed with FAS. Research has also found that children with FASD are smaller in weight, height, and head circumference than other children their age. Professionals recognize that many of these physical malformations remain present throughout adulthood, but that they are less noticeable after the onset of puberty.
The above figure exhibits the most common facial abnormalities seen in children with FASD. Most of these characteristics are present throughout adulthood, but are less noticeable after the onset of puberty.

2.2 Behavioural Characteristics

Individuals with FASD can display a wide range of abnormal or maladaptive behaviours. Some of these behaviours include the following:

- Noncompliance
- Making the same mistakes over and over again
- Being late on a regular basis
• Fidgeting and having difficulties remaining still
• Asking questions about the same things over and over
• Exhibiting aggression
• Displaying socially inappropriate actions (i.e. shouting in a quiet space)

2.3 Cognitive Characteristics

Individuals with FASD may also exhibit a number of the following cognitive impairments:
• Forgetting
• Trouble connecting consequences to actions
• Deficits in attention regulation
• Difficulty planning
• Trouble organizing
• Deficits in problem solving
• Distorted perceptions
• Impairment in learning and understanding
• Impaired academic functioning (especially in mathematics)
• Poor judgment
• Trouble recognizing social cues
• Difficulty attaining goals
2.4 Secondary Disabilities

The direct effects of prenatal alcohol syndrome can affect other aspects of an individual with FASD. This, in turn, may cause secondary disabilities. Secondary disabilities might consist of some of the following:

- Impairment in mental health
- Educational set backs
- Trouble with the legal system
- Inappropriate sexual behaviour
- Substance abuse
- Dependent functioning
- Trouble attaining and keeping employment

2.5 Misinterpretations

It is often difficult to recognize if someone has FASD or any other developmental disability, especially if the associated facial features are not strong. Thus, when displaying the common signs and symptoms of FASD, an individual might be mistaken as being noncompliant, deviant, or as an attention seeker. It is important to take the time and extra measures to get a better understanding of these signs, for they could lead to a better quality of life for the individual. Recognizing that an individual might have FASD early on could lead to quicker screening, diagnosing, and interventions.
3.0 Screening and Diagnosing

3.1 Screening Methods and Tools

When an individual first displays signs or symptoms of a possible alcohol-related disability, attention should be shifted towards setting up a professional referral. By doing so, a multidisciplinary team of experts can perform specific screening measures and diagnose, if need be. Early recognition of FASD is vital, as it brings quicker appropriate services and supports to the individual. If an individual does not meet the criteria for a diagnosis, professionals can continue to keep an eye on the individual and recommend various treatments and interventions for maladaptive behaviours and cognitive functioning.

What to look for in an individual suspected of having FASD:

- Deficits in height and weight
- Ears sticking out
- Flat midface or cheeks
- Flat or low nasal bridge
- Little or no groove between the lip and nose
- Thin upper lip
- Drooping eyelids
- Skin folds in corners of inner eye
- Short, wide neck
- Scoliosis (curved spine)
• Limited joint mobility in arms and hands
• Smaller fingers, pinky especially
• Poor finger motor movements
• Sunken chest
• History of heart murmurs or any other cardiovascular defects
• Raised red birthmarks
• Mild to moderate mental retardation
• Deficits in speech and language
• Impaired sight
• Impaired hearing
• Hyperactivity

Refer to Appendix A for an example of a screening tool with more detailed information. The screening tool in the appendix is one that the Public Health Agency of Canada created to screen for FASD. It is organized into regional categories and each symptom has a corresponding numerical value. If the screening form yields a score of 20 or higher, referral to a professional is recommended.

3.2 Diagnosing and its Difficulties

A multidisciplinary team of professionals with substantial knowledge on FASD typically consists of an occupational therapist, a social worker, a physician, a speech language pathologist, a neuropsychologist, and a family support worker. Ultimately, a physician assigns the diagnosis to an
individual with FASD, but each member of the team screens and assesses valuable factors needed for a diagnosis.

An example of a diagnostic checklist for FASD created by the Public Health Agency of Canada is displayed in Appendix B. Physicians, when attempting to diagnose an individual with FASD, use this sort of a checklist as a guideline to practice. It sheds light on what physicians look for and measure when diagnosing. The current Canadian guidelines for diagnosing require the following for an FASD diagnosis, as noted by the Canadian Medical Association Journal:

- Growth deficit in at least one of the following:
  a) Birth weight or birth height at or short of the 10th percentile for the developing age
  b) Weight or height at or short of the 10th percentile for chronological age
  c) Weight to height ratio is disproportionately low
- Displaying all three of the following facial abnormalities at the same time at any given age:
  a) Short palpebral fissure length
  b) Smooth or flattened philtrum
  c) Thin upper lip (score of 4 or 5 on the lip-philtrum measure; see figure to the right)
- Impairment in at least 3 of the following central nervous system domains: hard and soft neurologic signs; brain structure; cognition; communication; academic achievement; memory;
executive functioning and abstract reasoning; attention
deficit/hyperactivity; adaptive behaviour, social skills, social
communication.

- Confirmed or unconfirmed maternal alcohol exposure during pregnancy

Difficulties exist in properly diagnosing FASD, especially in suspected adults. This is in part by their often-diminished defining facial features following puberty. At this point, suspected individuals may have suffered from accidents resulting in brain injury, abused substances, or developed other cognitive or physical disorders. Many of the associated signs and symptoms of FASD overlap with other disorders and disabilities. In this case, individuals with FASD might have been wrongfully diagnosed.
4.0 Obstacles of Fetal Alcohol Spectrum Disorder

4.1 Effects in Daily Living

Individuals with FASD, like almost all individuals, have daily tasks, activities, and responsibilities that they need to look after. Some of the earlier mentioned characteristics of FASD appear to often hinder the individual’s daily living. The following daily living components can be disrupted for an individual with FASD:

- Transportation
- Cooking and/or buying food
- Taking care of finances – paying bills, keeping records, shopping, saving money
- Telling time – being on time for meetings and appointments, scheduling
- Finding a job and keeping it
- Appropriately interacting with others – creating and maintaining friendships and relationships
- Staying out of trouble – understanding that his/her actions have corresponding consequences
- Remembering
4.2 Effects on Parole

Whilst in the correctional system, specifically on parole, an individual with FASD will most likely encounter difficulties. Although the individual might not comply with the rules and regulations of the correctional system, their intent might not be to do so. For example, if an offender with FASD on parole continuously breaches his curfew, it might be because he does not remember his curfew, is unable to tell time, is distracted by something else, or does not understand that the curfew is always the same.

Issues on parole could have negative impacts on the individuals record and might yield incarceration. The parole officers, along with other correctional staff, are recommended to receive training on FASD to better recognize and create proper management plans for offenders with FASD. It is important to offer offenders with FASD the appropriate services and supports to help them succeed whilst on parole and afterwards, in the community. Recognizing the behaviour of an offender with FASD as an organic, neurological disorder, rather than deliberate misconduct, can yield more supportive supervision and more positive correctional outcomes.
5.0 Coping Mechanisms for Individuals with FASD

The following six domains are often exposed to difficulties with individuals with FASD. Although there may not be many concrete interventions or treatment strategies for adults yet, the following coping mechanisms can be of use for the individual with FASD to practice.

5.1 Managing Effective Communication

- Be sure to understand what someone else is saying before responding
- Ask for clarification when necessary
- Make eye contact
- Do not speak too quietly or too loudly
- Keep in touch with important individuals (i.e. parole officers)
- Listen to what someone has to say before interrupting them
- Ask questions or make comments when the other person stops talking

5.2 Managing Finances

- Keep important receipts together in one place
- Keep track of payments made (e.g. date, amount, utility) in a designated notebook
- Carry a small amount of money when leaving the house
- Make note of bill payment due dates on a large calendar
- Seek assistance from bank employees to decrease a credit limit or open a savings account
- Create a weekly and monthly budget
• Allow someone trustworthy to help manage financing
• Spend money on necessities first, then on leisurely items

5.3 Managing Time

• Wear a watch – digital is easier to read than analog
• Set alarms for important dates and times
• Use a calendar to schedule important events or appointments
• Cross off calendar days and events as they are completed
• Use a weekly planner or agenda to manage time within a day – write out a sequence of events and their corresponding times
• Hang digital clocks beside face clocks to compare the different clocks and learn to tell time on both
• Use visual cues – a timer or hour glass can be helpful in counting down
• Keep routine times consistent, if possible (i.e. wake up at 8:00, go to work at 9:00, eat lunch at 12:00, etc.)

5.4 Managing Aggression

• When feeling tense, upset, or anxious, remain still with your eyes closed and slowly count to ten
• Be careful not to raise your voice where an indoor voice is required
• Talk to someone about an issue before getting really upset
• Go to a soothing, calm, and quiet area with little stimulation to cool down
• Stop and think of the reasons why you are feeling aggressive – think of alternative ways to feel and act that are more appropriate

5.5 Connecting Behaviours to their Consequences

• Ask yourself what happened right before a consequence occurred
• Stop and think about what you are about to do – ask yourself what will happen afterwards? Will it be good? Will it be bad? Will I get hurt? Will I hurt someone?
• Keep track of behaviours and consequences for small durations of time for practice – write down the event (behaviour) and beside it write down what happens right after the event (consequence)
• Use short stories as a way to learn about behaviours and consequences (these can be made specifically for one behaviour and its corresponding consequence at a time)

5.6 Remembering

• Use a calendar
• Use an alarm clock and a watch
• Stick notes on a desk or wall with reminders written on them
• Write out important events and times and leave them somewhere you will see often (i.e. on the fridge door)
• Keep a journal of important events as a reference if you forget
• Keep lists for daily tasks (i.e. grocery list, to-do list, chores list)
• Practice to put things where they belong to avoid losing them
6.0 Important Considerations

The following is a compilation of ways to interact with an individual with FASD. Keep in mind that not all individuals are the same and not all individuals will respond appropriately with the right help.

- Be mindful of an individual’s deficits and work with them
- If you sense that the individual with FASD does not comprehend what you are saying, speak slowly to them and maintain eye contact
- Be straightforward, avoiding elaborate descriptions
- Tell a simple story that is easy to visualize and generalize to what you are trying to convey
- Draw pictures or use symbols to help understand
- Offer direct and simple cues for the individual to pick up on, whether verbal or gestural
- Repeat something if need be – do not assume that the individual heard you or understood you the first time
- Assist them with keeping track of their finances, if need be
- For appointment times, try drawing a clock with the hands pointing to the scheduled time adjacent to the written time
- Be patient and allow longer times for responses
- Use as many visual cues as possible
- Reward the individual with praise or a head nod when they are on the right track and respond accordingly
7.0 Further Resources

http://www.faslink.org
http://www.fasdontario.ca/cms/resources/support-groups

fasWorld Fetal Alcohol Support Group of Niagara
Location: St. Catherines
Contact: Indigomaman@aol.com
website: www.fasworldfassupportgroupofniagara.weebly.com

Hamilton FASD Support Group
Location: Hamilton
Contact: bstanley@cogeco.net

Anishnawbe Health Toronto
225 Queen Street East, Toronto, ON, M5A 1S4
Tel: (416) 360-0486 x234
Contact: Joanne Anderson

Mothercraft (Breaking the Cycle) FASD Diagnostic Clinic
761 Queen St. West, Ste. 107, Toronto ON, M6J 1G1
Tel: 416-364-7373 / Fax: 416-364-8008
Website: www.mothercraft.ca
Hamilton FASD Community Initiative
Hamilton www.fasdhamilton.ca
Contact jbrooks@cfshw.com
905-527-3823 Ext. 267

St. Michael's Hospital Fetal Alcohol Spectrum Disorder Diagnostic Clinic
61 Queen Street, 2nd Floor, Pediatric Clinic, Toronto, ON, M5C 2T2
Tel: 416-867-3655 / Fax: 416-867-3736
Email: stadeb@smh.ca

Surrey Place Centre FASD Adult Diagnostic Clinic
2 Surrey Place Toronto, ON M5S 2C2
Tel: Adult Intake (416) 925-5141 / Fax: (416) 923-8476
Contact: Valerie Temple
Website: www.surreyplace.on.ca

Toronto FASD Coordinating Network Toronto
SRichards@TorontoCAS.ca
### Appendices

**Appendix A: FASD Screening Checklist**

Source: Burd, Cox, Fjelstad, & McCalloch, 1999 as presented in Burd et al. (2003, p. 687)

Name __________________ DOB ___/___/____ Age ___ Sex (circle one) F M

Date of Exam ___/___/____

Child’s Race (circle one) 1) white 2) NA 3) other

Height ______________ inches <5% Y ___ N ___ 10

Weight ______________ pounds <5% Y ___ N ___ 10

Head Cir. ______________ cm <5% Y ___ N ___ 10

<table>
<thead>
<tr>
<th>Head and face</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ears stick out (protruding auricles)</td>
<td>Y N 4</td>
</tr>
<tr>
<td>Skin folds near inner eye (epicanthal folds)</td>
<td>Y N 5</td>
</tr>
<tr>
<td>Drooping of eyelids (ptosis)</td>
<td>Y N 4</td>
</tr>
<tr>
<td>Crossed eyes – one or both eyes (strabismus)</td>
<td>Y N 3</td>
</tr>
<tr>
<td>Flat midface/cheeks (hypoplastic macula)</td>
<td>Y N 7</td>
</tr>
<tr>
<td>Flat/low nose between eyes (low nasal bridge)</td>
<td>Y N 2</td>
</tr>
<tr>
<td>Upturned nose</td>
<td>Y N 5</td>
</tr>
<tr>
<td>Groove between lip and nose absent or shallow (flat philtrum)</td>
<td>Y N 5</td>
</tr>
<tr>
<td>Thin upper lip</td>
<td>Y N 4</td>
</tr>
<tr>
<td>Cleft lip or cleft of roof of mouth (present or repaired)</td>
<td>Y N 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neck and back</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Short, broad neck</td>
<td>Y N 4</td>
</tr>
<tr>
<td>Curvature of the spine (scoliosis)</td>
<td>Y N 1</td>
</tr>
<tr>
<td>Spina bifida (history of neural tube defect)</td>
<td>Y N ___</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Arms and hands</td>
<td>Fingers, elbows (limited joint mobility)</td>
</tr>
<tr>
<td></td>
<td>Permanently curved, small fingers, especially pinkies (clinomicrodactyly)</td>
</tr>
<tr>
<td></td>
<td>Deep or accentuated palmar crease</td>
</tr>
<tr>
<td></td>
<td>Small nails/nail beds (hypoplastic nails)</td>
</tr>
<tr>
<td></td>
<td>Tremulous, poor finger agility (fine motor dysfunction)</td>
</tr>
<tr>
<td>Chest</td>
<td>Sunken chest (pectus excavatum)</td>
</tr>
<tr>
<td></td>
<td>Chest sticks out (pectus carinatum)</td>
</tr>
<tr>
<td></td>
<td>History of heart murmur or any heart defect</td>
</tr>
<tr>
<td>Skin</td>
<td>Raised red birthmarks (capillary hemangiomas)</td>
</tr>
<tr>
<td></td>
<td>Greater than normal body hair, hair also on forehead and back (hirsutism)</td>
</tr>
<tr>
<td>Development</td>
<td>Mild to moderate mental retardation (&lt; 70)</td>
</tr>
<tr>
<td></td>
<td>Speech and language delays</td>
</tr>
<tr>
<td></td>
<td>Hearing problems</td>
</tr>
<tr>
<td></td>
<td>Vision problems</td>
</tr>
<tr>
<td></td>
<td>Attention concentration problems</td>
</tr>
<tr>
<td></td>
<td>Hyperactivity</td>
</tr>
</tbody>
</table>

Comments: Score total _______

Refer if 20 or above
### Appendix B: FASD Diagnostic Checklist

Source: Burd & Martsolf (1989, p. 40)

#### Severity score for FAS and related disorders

<table>
<thead>
<tr>
<th>Category</th>
<th>Scoring Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Growth</strong></td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td>10 – height percentile</td>
</tr>
<tr>
<td>Weight</td>
<td>10 – weight percentile</td>
</tr>
<tr>
<td>Head circumference</td>
<td>10 – head circumference percentile</td>
</tr>
<tr>
<td><strong>2. Facial Features</strong></td>
<td></td>
</tr>
<tr>
<td>Number of facial features</td>
<td>1 point for each</td>
</tr>
<tr>
<td>Number of anomalies</td>
<td>1 point for each</td>
</tr>
<tr>
<td><strong>3. Neuropsychological</strong></td>
<td></td>
</tr>
<tr>
<td>Comorbid neuropsychiatric</td>
<td>2 points for each</td>
</tr>
<tr>
<td>conditions</td>
<td></td>
</tr>
<tr>
<td>IQ</td>
<td>&lt;85 = 4 points</td>
</tr>
<tr>
<td></td>
<td>&lt;70 = 8 points</td>
</tr>
<tr>
<td></td>
<td>&lt;50 = 10 points</td>
</tr>
<tr>
<td><strong>4. Neurobehavioural</strong></td>
<td></td>
</tr>
<tr>
<td>Sleep (consecutive hours, select only one)</td>
<td>&lt;6 = 1 point</td>
</tr>
<tr>
<td></td>
<td>&lt;4 = 5 points</td>
</tr>
<tr>
<td></td>
<td>&lt;2 = 10 points</td>
</tr>
<tr>
<td>5. Vineland scores</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>10 – communication score</td>
<td>+ 10</td>
</tr>
<tr>
<td>10 – daily living score</td>
<td>+ 10</td>
</tr>
<tr>
<td>10 – socialization score</td>
<td>+ 10</td>
</tr>
<tr>
<td>10 – motor skills score</td>
<td>+ 10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster care placement</td>
<td>3 points each</td>
</tr>
<tr>
<td>Inpatient hospital care</td>
<td>1 point each</td>
</tr>
<tr>
<td>Criminal justice</td>
<td>1 point each month probation/ incarceration</td>
</tr>
<tr>
<td>Special education</td>
<td>1 point each hour of service per day</td>
</tr>
<tr>
<td>Residential care</td>
<td>1 point each month in the last year</td>
</tr>
</tbody>
</table>

| FAS Phenotype Score                                     | 1 + 2 + 3 |
| FAE Phenotype Score                                     | 3 + 4 + 5 + 6 |
| Total Score                                             |   |
Appendix B: Presentation Feedback Form

Fetal Alcohol Spectrum Disorder Presentation Feedback Survey

Dear participant,

Your feedback helps to improve future presentations, provides data, and allows the presenter to be seen through your eyes. Please fill out the following survey and return it to the speaker. Your participation is greatly appreciated.

Date of presentation: Thursday, December 13, 2012

<table>
<thead>
<tr>
<th>(1) Strongly disagree (2) Disagree (3) Neutral (4) Agree (5) Strongly Agree</th>
</tr>
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<tr>
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Additional Comments or Feedback

__________________________________________________________________________
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45
Appendix C: FASD PowerPoint Presentation

UNDERSTANDING AND COPING WITH FETAL ALCOHOL SPECTRUM DISORDER:
AN INFORMATIONAL RESOURCE MANUAL FOR CORRECTIONAL SERVICES OF CANADA PAROLE OFFICERS

CREATED BY ANGELA KANLIC

AGENCY SUPERVISOR – BILL GREEN
COLLEGE SUPERVISOR – LANA DI FAZIO

This resource manual was created for Correctional Services of Canada Parole Officers to help better understand fetal alcohol spectrum disorder and to utilize coping strategies that research suggests are possibly beneficial to individuals showing signs of the disability.
CONTENTS

• Introduction to Fetal Alcohol Spectrum Disorder (FASD)
• Signs & Symptoms
• Screening & Diagnosing
• Obstacles of FASD
• Coping Mechanisms for Individuals with FASD
• Important Considerations
• Further Resources

INTRODUCTION

Fetal alcohol spectrum disorder (FASD)

• Diagnosis used to describe individuals who have been prenatally exposed to alcohol and encompass a wide range of distinguishing characteristics as a result
• Characteristics vary and differ with age
• FASD = umbrella term
• Encompasses three central nervous system disabilities:
  - fetal alcohol syndrome (FAS)
  - partial FAS
  - alcohol-related neurodevelopmental disorder (ARND)
INTRODUCTION

• The central nervous system of an unborn child is damaged when alcohol meets the placenta during a pregnancy
• This causes the undeveloped embryo or fetus damage at the cellular and structural level, thus impairing functioning
• Research shows that the central nervous system is damaged when consuming alcohol at any point during the pregnancy – especially from the second to eighth week
• Cortical and subcortical components of the brain are developing at this point.

The above figure shows the different stages of a pregnancy and when teratogens, such as alcohol, can severely impact a child's development.
INTRODUCTION

• Relatively new diagnosis
• Very limited in research
• Research that is available is mostly geared towards young children and adolescents with FASD
• Few studies have looked at FASD in adults and a limited number of interventions have been specifically designed for adults with FASD
• Much of what is being done with adults has been generalized from interventions, coping strategies, and therapies that have been successful with children with FASD
• Interventions for individuals with FASD have also been generalized from interventions designed for individuals with ADHD or autism

INTRODUCTION

• No cure or permanent treatment for FASD
• The alcohol damage is irreversible
• Permanent defects in the central nervous system
• Strategies can be put into place to help individuals with FASD better cope with the disability
SIGNS & SYMPTOMS

- Abnormal features in an individual can be contributed to the effects of prenatal alcohol exposure
- Individuals with FASD may look different than others
- They might act in unusual ways
- Displaying behaviours that are not a part of the societal norm
- Different patterns of thinking

PHYSICAL CHARACTERISTICS

<table>
<thead>
<tr>
<th>Discriminating Features</th>
<th>Associated Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short palpebral fissures</td>
<td>Epicanthal folds</td>
</tr>
<tr>
<td>Flat midface</td>
<td>Low nasal bridge</td>
</tr>
<tr>
<td>Short nose</td>
<td>Minor ear anomalies</td>
</tr>
<tr>
<td>Indistinct philtrum</td>
<td>Micrognathia</td>
</tr>
<tr>
<td>Thin upper lip</td>
<td></td>
</tr>
</tbody>
</table>
PHYSICAL CHARACTERISTICS

- Facial abnormalities associated with prenatal alcohol exposure are not seen across the FASD scale
- Usually seen in a small number of individuals diagnosed with FAS
- Research has also found that individuals with FASD are smaller in weight, height, and head circumference than others their age
- Many of these physical malformations remain present throughout adulthood, but that they are less noticeable after the onset of puberty

BEHAVIOURAL CHARACTERISTICS

- Noncompliance
- Making the same mistakes over and over again
- Being late on a regular basis
- Fidgeting and having difficulties remaining still
- Asking questions about the same things over and over
- Exhibiting aggression
- Displaying socially inappropriate actions (i.e. shouting in a quiet space)
COGNITIVE CHARACTERISTICS

- Forgetting
- Trouble connecting consequences to actions
- Deficits in attention regulation
- Difficulty planning
- Trouble organizing
- Deficits in problem solving
- Distorted perceptions
- Impairment in learning and understanding
- Impaired academic functioning (especially in mathematics)

- Poor judgment
- Trouble recognizing social cues
- Difficulty attaining goals

SECONDARY DISABILITIES

- Impairment in mental health
- Educational set backs
- Trouble with the legal system
- Inappropriate sexual behaviour
- Substance abuse
- Dependent functioning
- Trouble attaining and keeping employment
MISINTERPRETATIONS

• Often difficult to recognize if someone has FASD or any other developmental disability, especially if the associated facial features are not strong
• When displaying the common signs and symptoms of FASD, an individual might be mistaken as being noncompliant, deviant, or as an attention seeker
• Take the time and extra measures to get a better understanding of these signs, for they could lead to a better quality of life for the individual
• Recognizing that an individual might have FASD early on could lead to quicker screening, diagnosing, and interventions.

SCREENING

• Deficits in height and weight
• Ears sticking out
• Flat midface or cheeks
• Flat or low nasal bridge
• Little or no groove between the lip and nose
• Thin upper lip
• Drooping eyelids
• Skin folds in corners of inner eye
• Short, wide neck
• Scoliosis (curved spine)
• Limited joint mobility in arms and hands
• Smaller fingers, pinky especially
• Poor finger motor movements
• Sunken chest
• History of heart murmurs or any other cardiovascular defects
• Raised red birthmarks
• Mild to moderate mental retardation
• Deficits in speech and language
• Impaired sight
• Impaired hearing
• Hyperactivity
SCREENING

This screening tool is organized into regional categories and each symptom has a corresponding numerical value. If the screening form yields a score of 20 or higher, referral to a professional is recommended.

DIAGNOSING

- A multidisciplinary team of professionals with substantial knowledge on FASD typically consists of
  - an occupational therapist
  - a social worker
  - a physician
  - a speech language pathologist
  - a neuropsychologist
  - a family support worker

- Ultimately, a physician assigns the diagnosis to an individual with FASD, but each member of the team screens and assesses valuable factors needed for a diagnosis.
DIAGNOSING

The current Canadian guidelines for diagnosing require the following for an FASD diagnosis:

Confirmed or unconfirmed maternal alcohol exposure.

Growth deficit in at least one of the following:
- Birth weight or birth height at or short of the 10th percentile for the developing age
- Weight or height at or short of the 10th percentile for chronological age
- Weight to height ratio is disproportionately low

DIAGNOSING

Displaying all three of the following facial abnormalities at the same time at any given age:
- Short palpebral fissure length
- Smooth or flattened philtrum
- Thin upper lip (score of 4 or 5 on the lip-philtrum measure)
DIAGNOSING

Impairment in at least 3 of the following central nervous system domains:

- Hard and soft neurologic signs
- Brain structure
- Cognition;
- Communication;
- Academic achievement
- Memory;
- Executive functioning and abstract reasoning
- Attention deficit/hyperactivity
- Adaptive behaviour
- Social skills
- Social communication.

DIAGNOSING

- Difficulties exist in properly diagnosing FASD, especially in suspected adults
- Often-diminished defining facial features following puberty
- Suspected individuals may have suffered from accidents resulting in brain injury, abused substances, or developed other cognitive or physical disorders
- Many of the associated signs and symptoms of FASD overlap with other disorders and disabilities
- Individuals with FASD might be wrongfully diagnosed
OBSTACLES OF FASD

Effects on daily living:

• Transportation
• Cooking and/or buying food
• Taking care of finances – paying bills, keeping records, shopping, saving money
• Telling time – being on time for meetings and appointments, scheduling
• Finding a job and keeping it
• Appropriately interacting with others – creating and maintaining friendships and relationships
• Staying out of trouble – understanding that his/her actions have corresponding consequences
• Remembering

OBSTACLES OF FASD

Effects on parole:

• Whilst in the correctional system, specifically on parole, an individual with FASD will most likely encounter difficulties
• Although the individual might not comply with the rules and regulations of the correctional system, their intent might not be to do so
• For example, if an offender with FASD on parole continuously breaches his curfew, it might be because he does not remember his curfew, is unable to tell time, is distracted by something else, or does not understand that the curfew is always the same
OBSTACLES OF FASD

- It is important to offer offenders with FASD the appropriate services and supports to help them succeed whilst on parole and afterwards, in the community
- Recognizing the behaviour of an offender with FASD as an organic, neurological disorder, rather than deliberate misconduct, can yield more supportive supervision and more positive correctional outcomes

COPING MECHANISMS FOR INDIVIDUALS WITH FASD

The following six domains are often exposed to difficulties in individuals with FASD. Although there may not be many concrete interventions or treatment strategies for adults yet, the following coping mechanisms can be of use for the individual with FASD to practice.
COPING MECHANISMS FOR INDIVIDUALS WITH FASD

Managing Effective Communication

- Be sure to understand what someone else is saying before responding
- Ask for clarification when necessary
- Make eye contact
- Do not speak too quietly or too loudly
- Keep in touch with important individuals (i.e. parole officers)
- Listen to what someone has to say before interrupting them
- Ask questions or make comments when the other person stops talking

COPING MECHANISMS FOR INDIVIDUALS WITH FASD

Managing Finances

- Keep important receipts together in one place
- Keep track of payments made (e.g. date, amount, utility) in a designated notebook
- Carry a small amount of money when leaving the house
- Make note of bill payment due dates on a large calendar
- Seek assistance from bank employees to decrease a credit limit or open a savings account
- Create a weekly and monthly budget
- Allow someone trustworthy to help manage financing
- Spend money on necessities first, then on leisurely items
COPING MECHANISMS FOR INDIVIDUALS WITH FASD

Managing Time

• Wear a watch – digital is easier to read than analog
• Set alarms for important dates and times
• Use a calendar to schedule important events or appointments
• Cross off calendar days and events as they are completed
• Use a weekly planner or agenda to manage time within a day – write out a sequence of events and their corresponding times
• Hang digital clocks beside face clocks to compare the different clocks and learn to tell time on both
• Use visual cues – a timer or hour glass can be helpful in counting down
• Keep routine times consistent, if possible (i.e. wake up at 8:00, go to work at 9:00, eat lunch at 12:00, etc.)

COPING MECHANISMS FOR INDIVIDUALS WITH FASD

Managing Aggression

• When feeling tense, upset, or anxious, remain still with your eyes closed and slowly count to ten
• Be careful not to raise your voice where an indoor voice is required
• Talk to someone about an issue before getting really upset
• Go to a soothing, calm, and quiet area with little stimulation to cool down
• Stop and think of the reasons why you are feeling aggressive – think of alternative ways to feel and act that are more appropriate
COPING MECHANISMS FOR INDIVIDUALS WITH FASD

Connecting Behaviours to their Consequences

- Ask yourself what happened right before a consequence occurred
- Stop and think about what you are about to do – ask yourself what will happen afterwards? Will it be good? Will it be bad? Will I get hurt? Will I hurt someone?
- Keep track of behaviours and consequences for small durations of time for practice – write down the event (behaviour) and beside it write down what happens right after the event (consequence)
- Use short stories as a way to learn about behaviours and consequences (these can be made specifically for one behaviour and its corresponding consequence at a time)

COPING MECHANISMS FOR INDIVIDUALS WITH FASD

Remembering

- Use a calendar
- Use an alarm clock and a watch
- Stick notes on a desk or wall with reminders written on them
- Write out important events and times and leave them somewhere you will see often (i.e. on the fridge door)
- Keep a journal of important events as a reference if you forget
- Keep lists for daily tasks (i.e. grocery list, to-do list, chores list)
- Practice to put things where they belong to avoid losing them
IMPORTANT CONSIDERATIONS

The following is a compilation of ways to interact with an individual with FASD. Keep in mind that not all individuals are the same and not all individuals will respond appropriately with the right help.

IMPORTANT CONSIDERATIONS

- Be mindful of an individuals deficits and work with them
- If you sense that the individual with FASD does not comprehend what you are saying, speak slowly to them and maintain eye contact
- Be straightforward, avoiding elaborate descriptions
- Tell a simple story that is easy to visualize and generalize to what you are trying to convey
- Draw pictures or use symbols to help understand
- Offer direct and simple cues for the individual to pick up on, whether verbal or gestural
IMPORTANT CONSIDERATIONS

• Repeat something if need be – do not assume that the individual heard you or understood you the first time
• Assist them with keeping track of their finances, if need be
• For appointment times, try drawing a clock with the hands pointing to the scheduled time adjacent to the written time
• Be patient and allow longer times for responses
• Use as many visual cues as possible
• Reward the individual with praise or a head nod when they are on the right track and respond accordingly

Questions?

Comments?
FURTHER RESOURCES

- http://www.fasdonario.ca/cms/resources/support-groups

- fasWorld Fetal Alcohol Support Group of Niagara
  Location: St. Catharines
  Contact: lensigomaman@aol.com
  Website: www.fasworldfassupportgroupofniagara.worldy.com

- Hamilton FASD Support Group
  Location: Hamilton
  Contact: bstanley@cogeco.net

- Anishnaswe Health Toronto
  235 Queen Street East, Toronto, ON, M5A 1S4
  Tel: (416) 360-0486 x254
  Contact: Joanne Anderson

- Mothercraft (Breaking the Cycle) FASD Diagnostic Clinic
  763 Queen St. West, Ste. 107, Toronto ON, M6J 1G1
  Tel: 416-364-7373 / Fax: 416-364-8008
  Website: www.mothercraft.ca

- Hamilton FASD Community Initiative
  Hamilton
  www.fasdhamilton.ca
  Contact: jbrooks@cshw.com
  905-327-3823 Ext. 267

- St. Michael’s Hospital Fetal Alcohol Spectrum Disorder Diagnostic Clinic
  61 Queen Street, 2nd Floor, Pediatric Clinic, Toronto, ON, M5C 2T2
  Tel: 416-867-3655 / Fax: 416-867-3736
  Email: stadebs@msh.ca

- Surrey Place Centre FASD Adult Diagnostic Clinic
  2 Surrey Place Toronto, ON M5S 2C2
  Tel: Adult Intake (416) 925-3143 / Fax: (416) 923-8476
  Contact: Valerie Temple
  Website: www.surreyplace.on.ca

- Toronto FASD Coordinating Network
  Toronto
  SRichards@TorontoCAS.ca

- http://www.faslink.org

PLEASE TAKE 10 MINUTES TO COMPLETE THE FEEDBACK SURVEY

THANK YOU
## Appendix D: Results of the Presentation Feedback Form

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<thead>
<tr>
<th>Statement</th>
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<tr>
<td></td>
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**Average Frequencies**

|                      | 0 %      | 0 %      | 0 %      | 0.03 %   | 96.6%   |