Social Services needs of adults with FASD in the Correctional System

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Social Services & Corrections

Evidence

Themes

Recommendations

Argument

Social services need to be an essential support both within the correctional system and immediately upon release

FASD and the Correctional System
The Size of the Challenge

- **The birth defects caused by FASD associated with incarceration (Boland et al 2002, Public Health Agency of Canada 2008, Streissguth et al 2004, Malbin 2004)**
- **FASD is underrecognized, current rates at 2 to 5% for North America and Western Europe (Malbin 2004, May et al 2009, Fast and Conroy 2004)**
- **FASD 95 % under-diagnosed and 40 times over-represented in juvenile justice system; therefore FASD is also likely a problem in the adult system because FASD does not improve over time and some impairments may intensify over time (Moore and Green 2004, National Science Council 2007)**

FASD and the Correctional System

The literature indicates an estimated 10 times greater incidence of FASD in correctional population than the general population (MacPherson and Chudley 2007), therefore based on the statistics cited by May et al (2009) of an estimated 2 to 5% incidence approximately 20% of incarcerated people may have FASD

1. Costs of FASD

- Current estimates of cost of correctional programs in Canada at $21.5 Million (2009)
- Official calculations of costs associated with people with FASD does not include incarceration, thus costs are likely underestimated (Thanh and Jonsson 2009)
- In order to better estimate cost need to follow people with FASD through the system (National Round Table 2007)

1. Costs of FASD

- Literature acknowledges that FASD is associated with recidivism; by addressing the problems in matching the abilities of people with FASD with release requirements can reduce the costs of recidivism associated with FASD (AB solicitor general AR 2007-8, Every et al 2000, CSC #208 2009, Nat'l Roundtable FASD 2007)

2. FASD and Social Determinants of Health

- The conditions in which people are born, work and live, or the social determinants of health, cause differences in health status (WHO)
- Need to improve daily living conditions in key areas: Housing, Employment, Social protection, Health (WHO 2009)
- People with FASD are often born into society with low social determinants of health which further contributes to the declining health status and disabilities associated with FASD

3. Legal rights of individuals with disabilities requires different approach

- Recent correctional policy shift from a strictly punishment model to one that incorporates rehabilitation (Ward and Marshall 2007, McFarlane 2006, Criminal Code of Canada section 718)
- Once incarcerated people with FASD are often victimized and become scapegoats for other offenders (Fast and Conry 2004, Miller 2005)

3. Legal rights of individuals with disabilities requires different approach

- The legal rights of people with disabilities in corrections facilities must be legally protected, from both harm and discrimination (Fast and Conroy 2004, Cox 2005, PHAC 2008, Green 2006)
- Behavior associated with FASD is linked to the cognitive disability and for interventions to be effective specific environmental adaptations for the disability must be addressed (Malbin 2004)
- Literature recognizes the ineffectiveness of traditional services for people with FASD (Debolt 2009)

4. Co-morbid mental illness in adults with FASD

- Mental health and substance abuse problems are significant co-morbid diagnoses in people with FASD (Famy et al 1998, Sneed et al 2006, Cox 2005, Chapman 2008, Debolt 2009, Incarceration can worsen psychiatric conditions (Sneed et al 2006)
- Call for integrated programs to be accessible and relevant to people with disabilities (Mittler 2005, Roskes and Feldman 1999, Clark et al 2008)
- Call for supported employment for offenders with mental illnesses (Sneed et al 2006) and FASD (Debolt, 2009)

5. Coordinated programs for people with FASD and mental illnesses

- Benefit of effective community programs in partnerships with corrections facilities upon release (National Framework on Harm Reduction 2005)
- Mental illnesses effects individuals abilities, need integrated programs post-release and more coordination between programs for offenders with mental illnesses (Hartwell and Orr 1999, CIHI 2009)
- Barriers between mental health system and correctional system has a negative impact on the care of people on parole (Roskes and Feldman 1999)

5. Improve skills of people with FASD while in custody

- Respond to the needs of people with FASD while in custody, corrections environment can be an opportunity (Streissguth et al 1998, Chapman 2008)
- Developing the necessary tools and competencies to avoid offending requires access to alternative ways of living, social supports and opportunities (Ward and Marshall 2007, Ward 2002)
- Individuals with cognitive impairments require external structures to compensate for the lack of executive/moderating function (Ward 2002, Ward and Brown 2004, Boulding 2007, Kellerman 2003)

6. Need integrated programs for adults with FASD in the Correctional system

- Need interdisciplinary teams delivering programs in prisons (Evans and Brewis 2008, Egger et al 2009, Eggers et al 2006)
- Due to changes in functional abilities traditional treatment programs not effective for offenders with FASD – programs need to address their abilities (Chapman 2008, Debolt 2009, AHS 2009, SAMHSA 2007,Ward and Marshall 2007)
- Need for social support in integrated programs, there is little access to such programs for most affected people and a negative impact of a lack of access to formal paid support (Clark et al 2008, SAMHSA 2007)

7. Intensive client-specific programs and reducing recidivism

- Need a determination of each offenders ability to make sound and accurate judgments, what is worthwhile and how to act (Ward and Marshall 2007)
- Important therapeutic task is aligning treatment interventions with cherished offender goals (Ward and Marshall 2007)
- Lack of adequate community services after release can exacerbate mental illnesses and contribute to recidivism (Sneed et al 2006)

7. Intensive client-specific programs and reducing recidivism

- High rates of recidivism related to a lack of community living skills (Eggers et al 2006)
- Intensive client-specific treatment programs needed to help reduce recidivism (CSC 1996)
- Higher rates of recidivism in Aboriginal offenders (CSC 2001) and high rates of Aboriginal offenders in correctional system (Daubney 2002, CSC 2001, Miller 2005)

8. Need to identify offenders with FASD

- People with FASD are vulnerable and the disabilities contribute to trouble with the law (Moore and Green 2004)
- FASD under-recognized and under-diagnosed in children, youth and adults; FASD diagnosis leads to more effective interventions (Malbin 2004)
- Not enough being done in Canadian corrections to meet the needs of this population (Chapman 2008, Miller 2005, Boland et al 2002, Boland et al 1998)

9. Need for screening adults in the Correctional System

- Need for screening process for FASD at intake into corrections system (Chapman 2008, Burd et al 2004, Boland et al 1998 & 2002, Chudley et al 2005, Astley 2004, Clarren and Sebaldt 2009)
- Diagnosis increases the services that can be provided to people with FASD within correction system and through access to programs and helps in community integration (Chapman 2008)

10. Develop FASD unit in adult correctional systems

- Need FASD unit in correctional system in Canada (Boland et al 1998, Bell et al 2004)
- Widespread ignorance of FASD in criminal justice system (Moore and Green 2004, Miller 2005, Chapman 2008, Boland et al 2002)
- School research suggests a structured environment, with integrated programs heavily oriented around order and routine is beneficial for people with FASD (Chapman 2008, Bell et al 2004)
- Brain injury and dementia program illuminate strategies for community living applicable to the needs of people with FASD (Ashley, Persel & Clark, 2001)

10. Develop FASD unit in adult correctional systems

- Limited access to social services for adults with FASD in the community (Chapman 2008, Pedlar et al 2008)
- Develop parole orders clearly for people with FASD so they can adhere to the guidelines and not reoffend (Fast and Conroy 2004)
- Don’t release people without adequate discharge planning (Debolt 2009)

10. Develop FASD unit in adult correctional systems

- Rehabilitation guidelines for adult men and women need to reflect the differing socialization of the genders in pragmatic ways (Gieger and Fischer 2005)
- Men with FASD are at a higher risk of getting into trouble with the law than are women (Streissguth et al 2004)
- Need a special environment in corrections (Mitten 2003); management of people with FASD is exacerbated if social and legal issues are disregarded

Findings Lead Where?

- In Corrections the size and costs of FASD-affected population demand the attention of the social sector as preparation for release
- Social sector supports can help to offset the impact and consequences of FASD on behavior and community living
- Health and social management of offenders with FASD must start on first offence to have better outcomes

Recommendations

Within Justice system:

1. Screening and assessment process for FASD necessary of individual adult offenders
2. Assess functionality of individuals across life skills
3. Adapt Correctional environments to respond to the organic origins of FASD as persons with a disability and to protect them from exploitation and abuse
4. Integration of Health and Social services required for the complex needs of this population

Recommendations

5. Pre-release and post-release programs for individuals need to be established before the individual departs the correctional system.
6. Focus on integrated programs targeted at individuals addressing key issues, creating a seamless link between correctional system and community.
   - Housing (transitional, emergency, permanent)
   - Transportation (to and from programs and employment)
   - Employment (productivity) and skills development
   - Trustees and guardians
   - Transitional Relationship building
   - Assertive community outreach

Recommendations

7. Evaluate programs for people with FASD based on adequate interventions in:
    - social support,
    - quality of life provisions (AISH, PDD), and
    - ability to tap individual's internal references (values and interests)

Recommendations

8. The requirements of residents who live in rural areas are different from those who live in urban areas
   - Need comprehensive knowledge of provincial community supports and resources
   - Need fast-tracking of applications for services
   - Address lack of professional capacity in rural areas

Recommendations

9. Develop a FASD unit in corrections system to address functional needs of the adult population with (or suspected) FASD
10. Develop training and education for Justice System and Correctional professionals on the management of FASD within the adult offender population

Recommendations

11. Formal community support through case manager / community navigator to provide:
    - Advocacy and outreach needed to reflect the link between health and access to social services
    - Access to continued assertive treatment for mental illness and substance abuse
    - Integrated case management that monitors and involves all participants providing health and social services to individuals
    - Health literacy education at level appropriate for people with FASD

Recommendations

12. Human resources in Corrections and Community social services need to be increased and well informed about FASD

Argument

Social services need to be an essential support both within the correctional system and immediately upon release and **continuing into the community**

Note: The factors that can reduce recidivism rates and sustain longer community tenure are primarily in the social domain

Corrections and Connections to the Community 3C

References