FASD Justice Resource Outline

Introduction

> *"They see the world through a different window." (*New Zealand Grandparent of an adult grandson with FASD. Personal correspondence 2018*).*

FASD is a severe and pervasive neurodisability resulting from the brain being exposed to alcohol in its formation. It is an invisible disability that is expressed through behaviour, learning, social and emotional problems that are not intentional but the direct result of brain damage. In our society where drinking is the predominant culture and normalised, it is no individual's fault that many pregnancies are alcohol exposed and many children go on to be compromised in their development as a result.

Although first evident in childhood the brain damage and the limitations prenatal alcohol exposure (PAE) places on daily function remain lifelong, reducing capacity to live typically productive and independent lives throughout the lifespan. The capacity of the brain to judge situations, moderate actions and fit in around the wishes and rights of others is impaired and this causes problems for the child, adolescent and then adult and their loved ones who support them, as well as the community.

The Ministry of Health estimates that fifty percent of pregnancies in New Zealand are alcohol exposed. Most of this occurs before the mother recognises the pregnancy at which point the majority abstain (FASD Working Group, 2016). However, around a quarter of pregnant women report continued drinking and twelve percent do so at levels that are hazardous to human health, thus placing the unborn child at greater risk of FASD (Mallard et al, 2014).

Many women receive little, poor or no professional advice about the risk posed by alcohol and it is still not common knowledge that drinking in pregnancy may cause lifelong brain damage in the baby born. FASD is a societal problem with large numbers of individuals with FASD falling through the cracks in systems and services to not reach their true potential. Due to unmet disability needs those with FASD are at increased risk of being harmed and causing harm. This brings large numbers of children, young people and adults with FASD into the legal system both as victims and as offenders.

Individuals with FASD tend to be immature, trusting, gullible and lacking in common sense. If the environment is suitably adapted to the disability, they can thrive and live productive lives. However, this requires the provision of structure, supports and supervision and most have missed out on this. Currently FASD is not recognised in New Zealand as a funded disability and it is only those with an extremely low level of intellectual ability who are eligible for disability supports. Each has a strength which is unlikely to be in an academic area but more likely in practical areas such as sports, music, art, gardening or a love of animals. When strengths are optimised and life can progress simply without stress, there is no need for those with FASD to come to the attention of the law. However, when disability supports are not in place the risk of offending and being victimised is extremely high.

The child with FASD will struggle at school unless the FASD disability is recognised and suitable supports are put in place. They may not be able to focus, learn, retain, follow instructions, inhibit their actions and realise how their behaviour impacts on others, thus tending to break rules. The young person may have experienced considerable failure at school, will readily follow and not fully comprehend the consequences of things that they and others do. The adult with FASD if unsupported will not be able to manoeuvre life's obstacles to become responsible for themselves and others.

In Canada it has been shown that individuals with FASD are 19 times more likely to be incarcerated (Popova et al 2011). Estimate range from 11% to 24% (Conry & Fast, 2000; McPherson & Chudley 2011). A recent study of mostly aboriginal youth sentenced to detention in West Australia found high rates of neurodisability and a rate of 36% with diagnosed FASD (Bower, Watkins & Mutch et al 2017). An earlier study in America found that 60% of individuals who had been diagnosed with FASD ran into trouble with the law (Streissguth et al, 1996). In the absence of any New Zealand studies we can assume that the situation is no better, due to the relatively high incidence of drinking in pregnancy.

What is FASD?

Alcohol is recognised as a teratogen, a substance or agent capable of crossing the placenta via the mother's bloodstream to reach the developing embryo or fetus and alter the course of normal development. Alcohol is the most damaging of neurotoxins commonly ingested and the mechanisms by which it damages brain development and other function are multifaceted, (Jamesz et al, 2017).

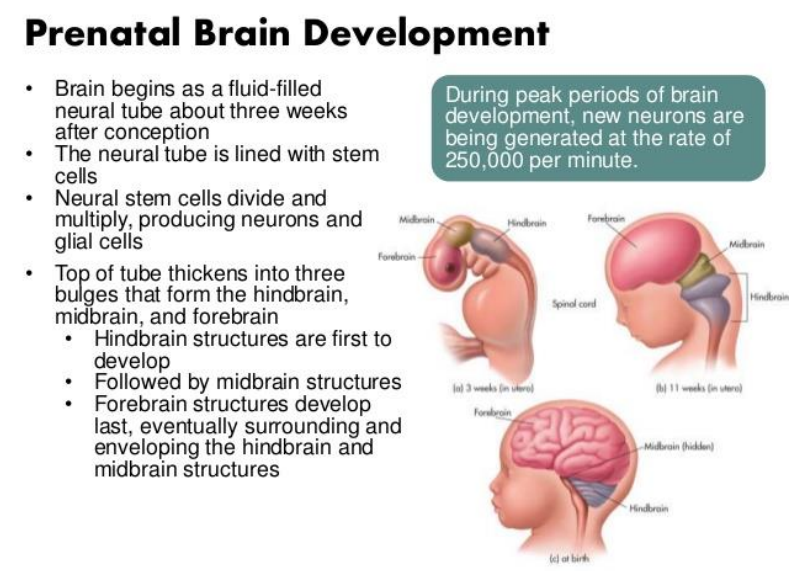
Variability is due to dose, timing, pattern of drinking, maternal health factors and the genetics interplay of the fetus, the parents and other prenatal risk factors. Some may be exposed to relatively large amounts of alcohol and be largely unscathed, whereas others may be less heavily exposed and more severely affected. There is no way to predict who is more at risk. However generally speaking, the higher the blood alcohol concentration per occasion, the greater the risk to whatever is developing at that time. The sooner during pregnancy drinking stops, the better the outcome for the child.

There is no known safe amount of alcohol to drink in pregnancy and even low amounts have been shown to increase the risk of conduct disorders in children (Larkby et al 2011; Disney et al, 2008). With heavier drinking early in pregnancy the face may form differently and the three characteristic facial features can be a marker of FASD in about 5% of cases. These are small eye lengths (palpebral fissures), a thin upper lip and a flat philtrum (groove running from top lip to nose). However, by and large the people with FASD look no different and it is only through neuropsychological testing of brain processes that the extent and nature of the problems experienced as a result of PAE can be accurately pinpointed.

There are wide ranging behavioural, emotional, physical intellectual, cognitive, social and interpersonal consequences of prenatal alcohol exposure that may predispose those affected to behave inappropriately in the community. When the condition is misunderstood these actions may seem intentional and wilful when in fact the individual may be responding to a situation or set of circumstances that has become too complex or stressful for them to manage due to their functional brain limitations. As well as damaging the brain, other organs and systems of the body can be affected by prenatal alcohol exposure, influencing physical and mental health (O'Leary et al 2013; Jones et al 2010; DeRoo et al 2008; Wyper & Pei 2016).

"[Jackson] had smashed our windows because I wouldn't give him money to buy weed... we had been quite terrified because he was on a rampage. The Police came and everything calmed down. Later that night the Policeman phoned to check that we were OK. He said "[Catherine], I have been doing this a very long time and I can tell you that your son is not a criminal. I can see that he just makes some really poor decisions sometimes, but that does not make him a criminal".. The relief that came with those words was immense. It helped me believe we could still get through this. Having the support and understanding of our local Police has been invaluable."

(Personal correspondence with mother of a 16 year old son with FASD 2018) (Name changed to protect identity).



The Stages of Brain Development in which alcohol can cause damage

Image: (Meyer 2014).

Identifying FASD through Diagnosis

FASD is on a spectrum rather than a continuum. There is no mild case of FASD. In order to be diagnosed with FASD each child, young person or adult is required to be severely affected, but the effects vary. FASD is not diagnosed when there are merely weaknesses. A diagnosis requires convincing evidence of brain damage measured on standardised testing and an investigation of all contributing factors to determine that alcohol was the predominant cause of observed problems (Cook et al 2015).

To reach the criteria for an FASD diagnosis, a minimum of three areas of brain function will be impaired when tested and be 2 standard deviations or more below the mean for age. More often than not, six or seven brain domains may show this level of impairment. That means that the individual being assessed has performed lower than 97% of others of the same age in these brain processes. This stringent cut off rules out other post-natal sources of delay or disadvantage that may be ameliorated with an enriched learning environment.

The brain domains that may be impaired are:

- Motor Skills: fine or gross motor skills, tremor, motor in-co-ordination or planning
- Neuroanatomy/neurophysiology: microcephaly, seizures, abnormal structure
- Cognition: level of intellectual function may be about 70 or below
- Language: expressive/ receptive skills, vocabulary, verbal reasoning, comprehension
- Academic achievement: reading, reading comprehension, spelling and maths
- Memory: visual/verbal encoding, retaining and retrieving of learning

- Attention: sustained, divided, switching focus and distractibility
- Executive Function: planning, reasoning, problem solving, inhibiting, fabricating, being flexible, understanding other perspectives, learning from consequences.
- Affect Regulation: depression/ anxiety/ extremes of emotions and reactions
- Adaptive behaviour, social skills, or social communication: ability to be independent and responsible in everyday life (Cook et al, 2015)

When considering FASD within a Court or forensic setting it will be important that the international guidelines for diagnosis have been rigorously applied and a report has been provided by a suitably qualified and FASD trained health professional. FASD expert opinion will provide an analysis of how a particular individual has been affected and will describe the nexus between brain impairment and offending behaviour so that degree of culpability can be considered and an effective response can be formulated. When there is a diagnosis of FASD, safeguards will be required to ensure that the disabled offender is protected from harm if placed in custody and is enabled to participate adequately in their legal process.

Implications of FASD on Behaviour

"FAS is not an excuse for bad behavior, but rather a guidepost for how best to evaluate and produce more adaptive behavior" (Streissguth et al, 1996).

When the brain is damaged in its formation, the foundation building blocks of learning and skills development are disrupted. Typically, when the brain is damaged at a later age through injury or insult, many foundation functions remain resilient or at least recover. FASD is the earliest form of brain damage where nothing has yet been established and for that reason the resulting problems are proportionally greater and more pervasive than other forms of brain injury. Children with FASD can certainly learn and develop but not at a normal rate or following a typical developmental course.

Whether a brain; damaged or not, develops optimally also relies greatly on the environment and learning experiences it is exposed to. Many children with FASD are born into homes and families with substance abuse and their needs may not be adequately met. They are more likely to be victimised, to have experienced trauma and been witness to violence (Streissguth et al 2004).

In addition, their behaviours will be challenging from a young age placing stress on those caring for them, especially when the FASD goes undiagnosed for many years. The problem is often intergenerational. There are many situations where parents with undiagnosed FASD are raising children also affected. It is difficult for parents with FASD to put their own needs aside to understand and focus on what is best for the child. Parenting courses that may help the 'neurotypical' parent will be unsuitable for the parent with FASD who requires practical hands on help. Often it seems that the advice is not being followed when it was the wrong advice for an individual with brain damage. Situations may become unsafe when both mother or father and child are poorly regulated and poorly organised. The mother with FASD and her children may become vulnerable to victimisation when there is not a protective circle of care placed around them. Unrecognised, these become intergenerational cycles of dysfunction perpetuating across successive generations.

School failure and exclusion, family breakdown, early substance use and mental health problems are common experiences for those growing up with FASD and their caregivers. For these reasons many children with FASD come into state care and are raised by whanau or non-kin caregivers. It can be

difficult and a stigmatising experience for the most well-equipped caregiver to ask for help or to know the best way to go about it.

> *"I had been told for a few years by child, adolescent mental health services that if my son was violent then I should call the police. I didn't for a long time as I was worried that they would laugh at me because of his age (he was about 7 years old). In July 2014 things came to a head (he was 10) and I called the police fully expecting them to tell me not to waste their time."* (Personal correspondence with a kin caregiver, 2018).

It has been estimated in Canada that 30-50 percent of children in foster care have FASD (Institute of Health Economics 2014). In many cases in New Zealand this may not have been diagnosed. Without sufficient supports provided, placements break down and many children growing up with FASD experience considerable post-natal adversity and lack of stability, magnifying the problems that are already brain-based. This overlay of postnatal disadvantage is termed secondary disability and much can be done to prevent or at least lessen the extent to which this impacts a child, teenager and adult with FASD. However, once the criminal justice system is entered, unless FASD is recognised and accommodated many with FASD spend their adult lives revolving through Courts and prisons. This is at great financial and human cost to society, the individual and their loved ones (Brown et al 2015).

Immaturity is a primary characteristic of individuals with FASD who seem and behave as if they are many years younger than their age despite looking their age physically. As a 15 or 16 year old, a youth offender with FASD may be functioning in their communication, social understanding and reasoning at a 6 to 8 year old level. Likewise, an adult may also be at a child's level of understanding, without realising this and thinking that they understand when they do not. About 80 percent of those with FASD also have an ADHD like presentation as part of their brain dysfunction (Streissguth et al, 2004). This can mean that they miss things, rush and impulsively make errors; behaviour not easily inhibited.

They may also grasp something said, miss the next, grasp another part, misinterpreting what has been said or what happened. Individuals with FASD tend to be gullible and suggestible and may be easily led both by peers but also by police interviewing them. Some may confabulate as part of their brain damage; that is, make up things to fill in memory gaps or to please others by saying what seems to be expected. This raises the risk that statements and confessions cannot be relied on to be accurate. At school and at home, things a child with FASD may say and believe to be true should be taken with 'a grain of salt' and be checked with a reliable source. Likewise, for adults with FASD who are alleged to have offended, things they say need to be matched against the known facts of the case rather than be taken at face value.

There are many potential pitfalls for both the alleged offender with FASD and the participants in the legal process that may even lead to a miscarriage of justice without the opinion of an FASD expert available. FASD is an issue that requires health and legal professionals to work in collaboration to give the Court the information needed to consider the impact of the FASD disability for that individual's case.

Why is it important for Justice Professionals to know about it?

> *"The person with FASD can be misunderstood in court, victimized in jails, and mismanaged in the transition back to the community,* ***unless*** *those working with the individual are aware of FASD and its implications"* (Fast & Conry 2004)

There are safeguards in the law to ensure that defendants can adequately comprehend legal process and participate actively in their own defence. It is not sufficient for a defendant to be a mere bystander while their Counsel acts on their behalf. To be determined unfit to stand trial the defendant must, due to mental impairment, be unable to plead, understand the nature or purpose or possible consequences of the proceedings or communicate adequately with Counsel for the purposes of conducting a defence. FASD has been established as a mental impairment that can compromise capacity to stand trial. For the defendant with FASD capacity to stand trial will depend on the number, complexity and severity of the charge, the amount and types of evidence and a range of other factors such as the contributing roles of differing individuals in the alleged events.

When considering the necessary tasks to adequate and active participation, those with FASD-related brain damage may fall short in many ways. They may have inadequate communication and concentration skills to enter into a reasoned dialogue with Counsel and may agree with and acquiesce to their advice without truly comprehending the implications. This can be masked by a facade of confidence and comprehension. Without a neurodevelopmental diagnosis, Counsel may miss that their client does not adequately understand.

It is not often that they admit to 'not understanding' and they often think that they do, when they do not. It is common for alleged offenders with FASD to waive their rights to silence and to legal representation at police interview and they may wrongly confess to crimes, often just to get away from an immediate or prolonged stressful situation. False confessions are not uncommon in situation where an individual with FASD is undergoing police interrogation, especially where suggestive techniques or inducements have been used.

A defendant with FASD may appear to lack remorse and not be taking responsibility for their actions and the harm that they have caused to victims. This tends to reflect badly on them when sanctions are being applied, unless the disability has been explained to the Court. FASD brain damage limits the extent to which an individual can take the perspective of others; with sufferers lacking the capacity to normally realise the consequences of their actions. Due to this limitation to their reasoning they may make excuses or blame others.

Egocentricity is a common feature of the condition and it is very difficult for children and adults with FASD to wait or to not get what they want, seeming to disregard the wishes and rights of others. This is a feature of the brain damage not intentional callousness. These symptoms of FASD place the legal process in a quandary when admitting wrongdoing, showing remorse and making amends are the concepts that underpin our moral code.

The Family Group Conference process in the Youth Court allows for the youth and their supporters to meet with the victim in a restorative process. The young person with FASD cannot often adequately participate in such higher order thinking tasks due to their brain-based limitations. Unless the nature of the disability is presented to the Court, they may be unduly disadvantaged rather than gaining the benefits that this process can provide.

Our criminal justice system is based on the assumption that when citizens have been judged to have done wrong, a sanction will be applied so that they will learn not to do this again; a specific deterrent to that person and a general deterrence to others. It is assumed that everyone in society

knows right from wrong and has the free will to choose right from wrong. However, with FASD, the very disability impairing ability to reason, think of consequences and make rational decisions impairs the ability to choose right from wrong. Moreover, extreme impulsivity and an ease to anger and lash out due to flushes of cortisol, a biological response that is elevated in FASD, the cognitive impairments of persons with FASD call the fundamental premises of our legal system into question.

When FASD is not brought to the attention of the Court the degree of culpability and mitigating factors cannot be considered fairly. For those with FASD it is not a matter of getting tough on crime but rather becoming more effective. Consequences that cannot change behaviours due to brain damage are doomed to fail. However, providing suitable structure, supports and supervision will enable the person with FASD to function better in society and reduce the risk of reoffending. In this way the community is protected, as well as the person with FASD.

Why is offending such a problem for individuals with FASD?

Not everyone with FASD offends but the risk is greatly increased, especially when circumstances such as family criminality or being excluded from school puts them within an antisocial peer group. Children and adults with FASD are very impressionable and tend to mimic what they see around them. If their role models are offending, using substances and involved in gangs, so will they. Likewise, if they are exposed to positive cultural and spiritual role models this will be a good influence on them. FASD prevents the person from being able to learn normally from their mistakes which they may repeat over and over even when they seem to have the best of intentions not to. If they go back into the same situation, they will be at risk of doing the same thing unless appropriately accommodated.

Each person with FASD has a unique set of strengths and impairments and all will not show all of the characteristic neurobehavioral symptoms that increase risk to rule break. However, there are similarities such as wanting to participate fully in social and community life, and to not fully understand the complexities of social communication. They can miss social cues and may respond wrongly in social situations leading to being excluded from friendship groups. This can cause them to gravitate to those willing to accept their difference; often others with FASD or those getting into trouble. Being immature and easily led means that they are at risk of acting on the instructions of others who may be involved in criminal activities. The level of inhibition that may prevent others of their age from doing the wrong thing is weakened due to brain damage.

Individuals with FASD tend to be generous and will give away everything they have wit little appreciation of value. They may also take things due to a poor understanding of belonging. If a mobile phone is beside a person then they will know it belongs to them but if it is sitting on a teacher's desk with no-one around, they may just pick it up, and due to poor reasoning capacity say they just found it denythey stole it or blame others even when caught red-handed. They may also admit to things that they did not do. Inconsistency and contradiction will often be a feature of their communication. This is not intentional and differs from lying. It stems from an inability to link their report to actual events.

"You can't convince people with fetal alcohol that their thinking is off… because their thinking is off. Thinking is their disability. Save your energy for interventions not lectures." (Noble & Soucie 2012: P. 12).

What to do in response to FASD and Offending

FASD is not an excuse to offend but it is a reason. The Courts in New Zealand have accepted FASD as a mitigating factor when considering applying suitable sanctions for law breaking. A sanction that provides longer periods of monitoring will be more effective than other forms of punishment. Individuals with FASD are seriously limited in what they can do independently so some forms of sanctions, such as community work will require a mentor directly helping by working alongside. It can be twice as hard to achieve half as much so expectations need to be realistic to the disability.

It is estimated that only 20% of adults with FASD can live independently or work outside of disability services, so any fines or reparation have to be paid by family members who are already struggling to keep their loved one with FASD safe from harm. Imprisonment will serve to protect the public for some time but will not be effective tat teaching the offender with FASD not to offend. In fact, it will place them in situations where they are likely to be victimised and mimic the criminal behaviours of others, making the situation worse.

Often offenders with FASD face increasing sanctions due to not following Court imposed conditions which are beyond their capacity to abide by. Poor comprehension of timeframes, impulsivity and mood dysregulation need to be factored into responses to breaches. Conditions should be simple and achievable with a support system built in to help follow them.

Courts can be flexible in sanctioning and in the Youth Court plans that place the young person with FASD into prosocial activities and direct them away from antisocial options have been successful. Therapeutic jurisprudence, where a Judge provides oversight and directly encourages the offender with FASD are most effective. Longer term monitoring will be more effective than a short sharp punishment.

A correctly formulated diagnosis provides access to FASD knowledge established internationally over decades, to guide how best to change trajectories from negative to positive. It is not applying consequences that makes a difference but rather establishing circles of care and creating an environment that provides structure, support and supervision that is vital; and the sooner the better. Disposing of FASD cases in a way that will encourage access to disability supports will be most effective to prevent the revolving door of justice for many offenders with FASD.

Why is being victimised so likely for individuals with FASD?

The developmental immaturity and gullibility of persons with FASD, even when adults, can be quickly recognised by predators who are more than willing to take advantage of their vulnerabilities. Those with FASD also take situations at face value and cannot recognise the underlying intentions of others. If someone is friendly they will be friendly back, without realising that there might be an ulterior motive and that they are at risk. From a young age, a child with FASD may be overly trusting, lacking an age appropriate level of caution. They may appear quite forward due to a lack of inhibitory control but be unaware of how they differ, often thinking themselves to be sophisticated and mature beyond their age level. Insight into limitations is limited and therefore, they see no reason why they need to be protected and supervised, remaining oblivious to the risks that a physical environment or a social situation may present. This leaves them at risk of harm in many forms and is why they need to be supervised as if much younger than their years.

They can are very easily tricked and then may acquiesce to pressure placed on them, putting them at risk of sexual exploitation both as children and as adults. When perpetrators of sexual abuse tell them that they are to blame or threatens them, it is more difficult for a person with FASD to realise that they

are being manipulated into keeping silent. They may even seem willingly to return to situations with their abuser, not recognising the danger this places them in. Once a young person with FASD is informed about and begins to understand how they are affected by FASD, they can become more willing to accept help and guidance. The younger this starts, the better for their safety.

There are provisions in the law to protect disabled people, including those with FASD, from sexual exploitation despite being over the age of consent. This requires proving in Court that the disability significantly impairs the complainant's capacity to understand, make decisions about or communicate decisions about sexual conduct. It also requires establishing that the perpetrator knew of the disability and exploited it. Nevertheless, there has been precedence set in cases where victims with FASD were sexually exploited.

In terms of being subjected to violence, disabled persons are afforded the same protection as others. There are issues within a legal process when the giving of evidence of victims with FASD is required. In such cases, it will be important that a neuropsychological report is available to the Court establishing the nature of the complainant's disability, especially any features of confabulation and suggestibility to ensure that the complainant has the capacity to give true testimony. Without this documented assessment of brain function it may be that questions asked are not suitable to enable the person with FASD to express themselves adequately. Responding inconsistently or contradicting themselves, can mean they are confused or unable to comprehend.

Witnesses with FASD may become emotionally over reactive when overloaded by complex legal language so using simple words, one step at a time and allowing them to explain in their own words will help them give testimony. Often a disabled witness, similar to a child witness, will be able to give their evidence via video-link to the Court so as not to put them in a distressing situation that will provoke high levels of anxiety. Communication assistants who are usually speech language therapists, can greatly help victims with FASD understand and respond to questioning in a legal process. Victims with FASD tend to be suggestible and may agree with leading questions which should be avoided.

How does FASD impact on legal process?

What follows are practical considerations when engaging individuals with or thought to have FASD in various stages of the justice process

1. At arrest

Individuals with FASD can get easily stressed and behave unpredictably when confronted over something they may have done wrong. Once in a heightened state, they cannot think or be reasoned with and their response will escalate unless everyone stays calm and quiet. Once escalated, they may behave aggressively or even violently or they may try to get away from the stressful situation. All of these factors may mean that they are considered the troublemaker and be the one apprehended while others who are smarter escaped or implicated the person with FASD. It is common for a person with FASD to get additional charges as a result of their distressed state, such as resisting arrest, not stopping for the flashing lights or even assaulting police depending on how police respond to them at arrest.

When being arrested, an accused with FASD may deny all wrongdoing or admit to things they didn't do so as to reduce the stresses. Things they say and do may not seem logical because of their impaired reasoning. Due to becoming un-cooperative and aggressive in the face of an authoritarian approach,

charges may be laid more severely than if an accused remained polite and did not argue at arrest. It is usual for the person with FASD not to tell the police about their disability. However, in situations where an individual is behaving markedly stressed and unpredictable, FASD should be considered likely and enquired about. Once stressed a person with FASD will deteriorate in their emotional regulation if they have thinking demands placed on them, such as needing to respond to questions or explain themselves. There is much that a police officer can do to help the situation such as remaining quiet and reassuring, delaying questioning until the situation has calmed and focusing on simply explaining one or two things that are going to happening.

2. At police questioning

An accused with FASD will have difficulty understanding and enacting their Bill of Rights. They may understand the words and will usually say that they do understand, without actually appreciating the need for heeding the caution they are being given. Usually, an ability to repeat back or mimic others is deceptively strong but this does not replace comprehension. Due to levels of inhibition it can be almost impossible for an individual with FASD to remain silent. They tend to blurt out things that may or may not be true without being able to consider the possible repercussions. For example, a young person with FASD have been told they have a right to a lawyer to then say "no it's alright I already have a lawyer" without realising that they need their lawyer there and then.

There are limitations to being able to think through to how things they are saying might be used as evidence against them at trial. Thinking is usually about the present and getting out of the situation they are in right now. Thinking to the future is not pertinent to those with FASD who lack normal capacity to consider consequences in a multitude of situations, including at Police interview. It has been shown that young people with FASD overestimate their level of understanding of psycho-legal matters (including their rights) while having much less understanding of legal matters than others of their age (Brown et al, 2015). This leaves them thinking they understand sufficiently when they do not.

Being highly suggestible and at increased risk of agreeing to leading or closed ended questions, individuals with FASD may confabulate and say things that are not in fact true even though they may believe it to be so. This may be due to filling in the gaps when they have forgotten details but also can be in situations where certain facts have been suggested to them and they will take them on and distort what may have happened to better match what others are telling them. They do not like to look dumb in situations so may say something that seems expected, even when it is completely fabricated or false. They are poor historians and have difficulty with time frames. A person with FASD may report something that he or she saw on TV as actually happening to them. They have been known to confess to crimes in the face of incentives.

Communication, attention and memory impairments mean that the individual may only grasp some of what has been said or asked of them and may put pieces of information together in fragments, misunderstand the meaning of words or questions and respond using the interviewer's words rather than their own. It is important for officers to look for red flags of FASD when interviewing suspects to ensure that they are not being lead into saying things that may amount to a false confession. Inconsistencies and changing responses depending on how a question has been worded should be looked out for. An accused with FASD may look as if they are lying due to inconsistent reporting or seeming to be evasive but often they do not comprehend and are trying to respond the best they can. We advise that things a person with FASD say cannot be relied on and need to be checked out with the available hard evidence. A case resting on the confessions of an individual with FASD may very well lead to a miscarriage of justice, as was the case with Mr Teina Pora.

"The combination of Pora's frequently contradictory and often implausible confessions and the recent diagnosis of his FASD leads to only one possible conclusion and that is that reliance on his confessions gives rise to a risk of a miscarriage of justice. On that account, his convictions must be quashed." (decision of Privy Council on Pora V Queen delivered by Lord Kerr on 03/03/15)

3. When meeting with Counsel

It is the responsibility of Counsel to raise a possible neurodisability in legal process and to ensure that suitable medical evidence is sought to ensure a fair trial. This is especially important in the case of FASD where the disability may not be visible or even previously diagnosed until the legal process. Questioning by Counsel about family of origin drinking patterns, childhood development and behaviour, schooling history and employment record may all raise red flags for a possible FASD. If the individual was ever in state care as a child this is a very high-risk group for FASD (30 to 50% IHE ....). There may also be a history of the individual seeming to repeat the same mistakes, not abiding by routinely applied Court conditions and not benefitting from consequences commonly expected to reduce offending. Most markedly when interacting with a client with FASD they may seem very immature, naive and not able to appreciate common sense in discussion. They may seem to be full of excuses and lack remorse and not appreciate the severity if the situation they are in. All of these should raise a concern about FASD in a defendant that may require further investigation by a suitably qualified and experienced health professional.

An FASD assessment may be ordered by the Court as part of a process of determination of fitness to stand trial or by the defence as evidence at trial or for sentencing purposes. When a person with FASD has allegedly committed a crime then it needs to be established that this was done with intent and the nexus between the individual's brain damage and the target actions are important for the Court to consider. If Counsel is not well versed with FASD disability they may overlook ordering a medical report that may shed light on the events in question and the degree of culpability of their client as well as sentences that may be most effective if guilt is proven or admitted.

Everyone in society wants the risk of reoffending reduced to make the community safer. Yet without recognising FASD disability the cycle of offending is more likely to continue unabated at increasing cost. When FASD has been recognised then Counsel can simplify the way they talk, repeat things over and involve family or other advocates that may not usually be included in discussions with an adult defendant. Listening to family member who know the individual with FASD will help improve communication and understanding or the issues at hand.

Lawyers with clients with FASD can be in a difficult situation of acting without being able to gain adequate instructions. The client may go along with advice offered without being able to evaluate it and choose for themselves how to plea, what case to run in their own defence and whether to give evidence. They may not be able to follow the language used in the Court room or challenge evidence as it is presented in Court in real time. Although an individual may pass the low threshold of fitness to stand trial, their understanding of legal process, the role of their own counsel and their own role may be seriously limited, restricting the degree to which they can participate. Counsel may need to give considerably more time to explaining and repeating concepts than may be normally required and even then comprehension may be far from adequate. If this becomes the case then fitness can be revisited at any stage of proceedings to ensure that the process is fair. The emotional volatility of persons with FASD may also impact on both meetings with Counsel and participation in the Court room. They may

become angry due to their brain based increased emotionality and this may reflect badly on them unless evidence about the nature of the disability is provided to inform the Judge or jury

4. In the Courtroom

There is no onus on the prosecution to simplify language or question in an adapted way to a defendant or witness with FASD, but it would be advised and helpful. Court is inherently stressful so taking an enquiring rather than adversarial approach will be more effective in enabling the defendant or complainant with FASD to participate to the best of their ability. All Court participants speaking in a kindly manner, as if talking with a child will help the situation remain calm and reduce confusion. Asking a witness with FASD to explain in their own words will be more likely to find the truth, still keeping in mind that suggestibility and confabulation may still be factors. It will be essential especially in serious matters that expert evidence is available to explain the exact nature of the brain damage so that the behaviour and testimony of an individual with FASD can be understood. This assessment will advise on how to pitch communication and adapt legal process to better suit a defendant with FASD. A communication assistant who can simplify, repeat and ensure comprehension can be invaluable. Proceedings will need to progress more slowly with regular breaks, as would be the case with other forms of neuro disability such as traumatic brain injury. If the defendant of complainant becomes overwhelmed or falls asleep then a break will need to be scheduled. Other regular breaks may be required for Counsel to explain and take instructions as a defendant with FASD will not be able to manage this in the Courtroom as the case progresses.

5. At sentencing

When a defendant with FASD has been found guilty or has entered a guilty plea then the Judge is responsible for applying a fair sanction taking into consideration the degree of culpability. If an FASD neurodisability has not been raised as a factor to take into consideration at sentencing, then the defendant may be unduly harshly punished. This may come about due to an apparent failure to show remorse and take responsibility for actions that have caused harm to others. The individual for brain-based reasons thinks from their own perspective and may seem to fail to acknowledge guilt, blaming others or even the victim for their actions. Factors such as admitting guilt, showing remorse and taking actions to make amends such as undergoing treatment or paying reparation are all seen as positive steps by the Court to err towards a less restrictive sanction. However, these actions may be impossible for the FASD affected offender to do independently. Purposeful things are more likely to reduce risk of reoffending than Court applied punishments. Incarceration may protect the public for a period of time but an offender with FASD is likely to have a higher rather than lower level of risk after release due to the contamination effect of mixing with criminal, being induced into gangs while incarcerated and then gravitating to these new friends on release.

6. When following Court conditions

When bailed in the community with conditions to follow such as curfews or not associating with co-offenders, those with FASD are commonly breached for failure to follow these Court imposed conditions. In fact, many enter a cycle of remaining within the justice system, not because of the initial offence or intent, but due to noncompliance to the rules that other offenders can abide by. Telling the time and keeping track of time can be a deficit in many with FASD.

Case examples: A young person used nightfall as his way to abide by his curfew. However, the daylight hours got longer but he insisted he did not need to be home until nightfall. One night he realised he had

missed the bus home, so he stole a car to ensure he was home in time for his curfew. This is the type of illogical thinking that can accompany FASD.

Another young person on home detention was able to remain in the area of containment for several weeks. However, during the Court process he was informed of his FASD diagnosis. Being unable to wait, he needed to talk to his girlfriend about it that night. He cut off his bracelet and left the address to find her. Although he knew that this would lead him back to prison this knowledge did not stop him acting impulsively due to his distress. The Judge took his FASD into account and released him back to his sentence of home detention, despite his actions. He continued to abide by his conditions after this with support from his caregiver and mentor.

When a sentence of supervision has been made, the probation officer will also need to apply some flexibility to reporting. Many probationers with FASD will not have access to transport and will have impaired organisational skills to get themselves to appointments on time. They may forget the day and date and need constant reminding. Keeping in touch by txt can help jog the memory and in some cases, it may require the probation officer to report to the person with FASD rather than vice versa. Breaching for minor discretions will not be helpful overall. Rather than expecting a person with FASD to be able to access services themselves such as WINZ and finding employment, a disability agency will need to be enlisted to help.

The expectation of gaining and maintaining unsupported employment is generally unrealistic and this is not a personal failing of the individual with FASD. Connecting in with cultural services or NGO organisations will help with establishing networks of support. Every individual with FASD needs to find a mentor or support worker who can help them negotiate systems, including justice more effectively. Often there may be a family member who has expertise in FASD and who can provide guidance to services in how best to accommodate the FASD needs for their loved one. They have usually gained this expertise through the school of hard knocks and they will know what works and what doesn't. The individual with FASD may not be the best person to ask about what they need to help them due to the common lack of insight that is part of the condition.

Individuals with FASD cannot benefit from reasoning-based interventions that are commonly delivered to offenders in the attempt to change criminal thinking and lifestyle. Cognitive Behaviour Therapy is commonly part of offender treatment programmes in prisons or delivered in the community but is counter indicated in those with FASD. Participants with FASD will try to do their best while not comprehending the programmes or how to make changes in their lives. They will learn to say the right thing and will have every intention to not reoffend but may lack the capacity to carry through to actions. They can participate in simple directive skills-based programmes with FASD informed counsellors. However, when it is brain damage being dealt with, it will not be possible to change the limited thinking that may lead them into trouble.

It is the environment that needs to change and without FASD informed supports around them risk of reoffending will remain high. A failure to engage in CBT or other reasoning-based treatments may be interpreted as the individual lacking in motivation or being unwilling to change, when it is the treatment approach that has failed. Substance abuse and sex offender treatment programme will also need to be adapted to suit a person with FASD. An abstinence rather than harm reduction model is better suited to alcohol and other drug treatment. Any treatment that requires an offender to accept responsibility, appreciate harm caused to victims, make amends and change their life so that it never happens again, will be of limited or no use. These resources would be better allocated to teaching skills directly and providing community supports.

7. When in custody

Many offenders with FASD adapt well to the routines and low requirements to make decisions that prison provides. They can become quickly institutionalised. The problem with using prison as a punishment for offending where FASD is a factor, is that it is ineffective at reducing reoffending, the primary purpose that such a sentence is imposed. Another factor, where imprisoning the disabled for behaviours that result from brain damage and unmet disability needs, is their high risk of victimisation making imprisonment a harsher punishment. Their vulnerability is usually evidence and can be exploited by other prisoners. They may gravitate towards those who seemingly befriend them and may be manipulated to do as instructed. Whereas they may not have been mixing in criminal circles prior to incarceration, they are more likely to once released.

Individuals with FASD who are confined to a correctional setting may be perceived as lazy, manipulative, irritating and self-defeating, when their underlying neurodisability is not recognised within the legal process. The possibility of FASD should be considered when a prisoner is showing impaired comprehension, learning, memory, and social skills deficits, as well as behavioral and emotional problems.

Prisoners with FASD may not follow rules or understand the need for them and may over react to limits imposed. When told harshly to do something they may become oppositional, while if asked nicely they may be very obliging. Building relationships with prisoners is critical to their best management and they are best managed in a segregated setting away from violent or gang associated inmates.

Common histories of many incarcerated individuals with FASD is previous involvement in foster care, special education programs, family history of alcohol misuse, inability to manage money, vocational problems [get a job but unable to keep it], frequent contact with the criminal justice system. They may present as impulsive with impaired ability to manage conflict and stress all of which can be highly problematic within correctional settings. Case management and treatment plans will need to accommodate FASD in order to be successful.

With up to 25% of prisoners in correctional facilities in the US and Canada suffering FASD, it is estimated that New Zealand also has a large number of at risk incarcerated individuals with FASD, some of whom may be innocent. With the lack of suitable support and services in childhood, prison is becoming the residential setting most likely to be caring for adults with FASD. This is placing corrections officers in a caregiving role for which they are not trained for.

8. When released

New Zealand, unlike Canada, currently does not have services tailored specifically to FASD. Often other justice-related services are not FASD informed to ensure the person with FASD receives interventions that are appropriate for their permanent brain-based disability when released from prison. To reduce the risk of recidivism, a collective, collaborative and agreed way forward from multiple sectors involved with justice is required. The principles of providing the person with ongoing, support, supervision and structure in a low risk environment as set out in this guidelines appears to be the best way to achieve this for this vulnerable population in our midst.

"If The Police had not believed me and not responded in the supportive way they did then I think that I would be either dead or in and out of hospital/doctors for all manner of injuries and 'Carl' would be back in the care of Oranga Tamariki although they did tell me during all the time I was having trouble

with him that they did not have anyone trained to look after someone who had his behaviours." (Personal correspondence from a caregiver of an adolescent with FASD, 2018).

Resources

A helpful resource to understanding the effect of alcohol on the developing brain and subsequent function and emotional responses can be viewed at http://professionalswithoutparachutes.com/video-resources/

The New Zealand Ministry for Children's Oranga Tamariki Practice Centre provide comprehensive and practical information on FASD for children in Care and Protection including videod case examples https://practice.mvcot.govt.nz/knowledge-base-practice-frameworks/fetal-alcohol-spectrum-disorder/index.html

Canadian Fetal Alcohol Spectrum Disorder: A Guideline for Diagnosis Across the Lifespan http://www.cmaj.ca/content/early/2015/12/14/cmaj.141593

Canadian FASD and Justice resource can be found @ http://fasdjustice.ca

References

Andrews G.(2011). Diagnosis of FASD: An overview. *Fetal Alcohol Spectrum Disorder: Management and Policy Perspectives of FASD*. Eds Edward P. Riley, Sterling Clarren, Joanne Weinberg, Egon Jonsson pg 127 Publisher Wiley-VCH 2011.

Bower C, Watkins R, Mutch R et al (2017). Fetal Alcohol Spectrum Disorder and youth justice: a prevalence study amongst young people sentenced to detention in Western Australia. *BMJ Open* 2018;8:e019605. doi:10.1136/ bmjopen-2017-019605.

Brown, J, Mitchell M, Wartnik A and Russell A (2015) Fetal Alcohol Spectrum Disorder and the Courts: An introduction for Legal Professionals. Behavioural Health Vol 3(1*). Journal of Forensic Behavioural Health*. http://www.jghcs.info (ISSN: 2331-7582 ONLINE)

Burns S and Legge L (2013). FASD and Justice: Summary of Activity in Ontario 2013 Survey, Report Phase One. FASD Ontario Network of Expertise. http://www.fasdontario.ca/cms/wp-content/uploads/2014/05/FASD-and-Justice-Survey-Report.pdf

Cook, J, Green C, Lilley C, Anderson S, Baldwin M E, Chudley A E, Conry J, LeBlanc N, Loock C, Lutke J, Mallon B, McFarlane A, Temple V, Rosales T and for the Canada Fetal Alcohol Spectrum Disorder Research Network (2015). *Fetal alcohol spectrum disorder: a guideline for diagnosis across the lifespan* Canadian Medical Association Journal. cmaj.141593; DOI: https://doi.org/10.1503/cmaj.141593.

Disney E, Iacona W, McGue M, Tully E & Legrand L (2008). Strengthening the case: Prenatal Alcohol Exposure is Associated with Increased Risk of Conduct Disorder. *Pediatrics, 122(6)* e1225-e1230.

FASD Working Group (2016). *Taking Action on Fetal Alcohol Spectrum Disorder: 2016-2019: An Action Plan*: Wellington: Ministry of Health).

Conry, J., and D.K. Fast. 2000. *Fetal alcohol spectrum disorder and the criminal justice system*. Maple Ridge, BC: British Columbia Fetal Alcohol Syndrome Resource Society Vancouver & Law Foundation of British Columbia.

DeRoo LA, Wilcox AJ, Drevon CA, Lie RT. First-trimester maternal alcohol consumption and the risk of infant oral clefts in Norway: a population-based case-control study. *Am J Epidemiol*. 2008;168(6):638-46.

Egon J, Dennett L and Littlejohn G; Editors (2009). Fetal Alcohol Spectrum Disorder (FASD): Across the Lifespan. Proceedings from an IHE Consensus Development Conference. *Institute of Health Economics.* Edmonton Canada. www.ihe.ca

Fast, D.K., and J. Conry. 2004. The challenge of Fetal Alcohol Syndrome in the criminal legal system. *Addiction Biology* 9: 161–166.

IHE Consensus Development Conference. Institute of Health Economics. Edmonton Canada. www.ihe.ca

Jarmasz J, Basalah D, Chudley A, Del Bigio R (2017). **Human Brain Abnormalities Associated With Prenatal Alcohol Exposure and Fetal Alcohol Spectrum Disorder.** *Journal of Neuropathology & Experimental Neurology*, Volume 76,(9:1). https://doi.org/10.1093/jnen/nlx064

Jones KL, Hoyme HE, Robinson LK, Del CM, Manning MA, Prewitt LM, et al.Fetal alcohol spectrum disorders: Extending the range of structural defects. *AmJ Med GenetA*. 2010;152A(11):2731-5.

Lange S, Shield K, Rehm J & Popova S (2013). Prevalence of Fetal Alcohol Spectrum Disorder in child care settings: A meta-analysis. *Pediatrics, 132(4),* e980-e995.

Larkby C, Goldschmidt L, Hanusa B & Day N (2011). Prenatal Alcohol Exposure is Associated with Conduct Disorder in Adolescence: Findings from a Birth Cohort. *Journal of the American Academy of Child Adolescent Psychiatry*, 50(3) e262-e271.

MacPherson, P, Chudley, A & Grant, B (2011). *Fetal Alcohol Spectrum Disorder (FASD) in a correctional population: Prevalence, screening and characteristics,* Research Report R-247. Ottawa (Ontario), Correctional Service Canada.

Malbin D (2002) *Fetal Alcohol Spectrum Disorders: Trying Differently rather than Harder. Second Edition*. Tectrice Inc. Portland Oregon.

Mallard S, Connor J and Houghton L (2013). Maternal factors associated with heavy periconceptional alcohol intake and drinking following pregnancy recognition: A post-partum survey of New Zealand women. *Drug and Alcohol Review*, DOI: 10.1111/dar.12024.

Meyer G (2014). *Lifespan Development Chapter 9.* In Psychology Sixth Edition. Trinity University. Published by Hockenbury & Hockenbury. https://www.slideshare.net/drellen/chapter09-39111311

Noble J and Soucie T (2012) FASD Soundbites and Sanity Savers. www.fasdforever.com

Noble J and Soucie T (2012) Making Sense of the Madness: An FASD Survival Guide. www.fasdforever.com

O'Leary CM, Elliott EJ, Nassar N, Bower C. Exploring the potential to use data linkage for investigating the relationship between birth defects and prenatal alcohol exposure. *Birth Defects Research Part A: Clinical & Molecular Teratology*. 2013;97(7):497-504.

Popova S, Lange S, Bekmuradov D, Mihic A & Rhem J (2011). Fetal Alcohol Spectrum Disorder Prevalence Estimates in Correctional Systems: A Systematic Review. *Canadian Journal of Public Health,* Vol 2(5) 336-340.

Steinberg, L. 2008. A social neuroscience perspective on adolescent risk-taking. *Developmental Review* 28: 78–106.

Streissguth A, Barr H, Kogan J and Bookstein F (1996). *Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE).* Final Report. University of Washington School of Medicine Department of Psychiatry and Behavioural Sciences.

Streissguth A, Bookstein F, Barr H et al (2004). Risk Factors for Adverse Life Outcomes in Fetal Alcohol Syndrome and Fetal Alcohol Effects. *Developmental and Behavioral Pediatrics*, Vol. 25, No. 4.

Wyper, K, and Pei, J. (2016). Neurocognitive difficulties underlying high risk and criminal behaviour in FASD: Clinical implications. In M. Nelson & M. Trussler (Eds.), *Fetal alcohol spectrum disorders in adults: Ethical and legal Perspectives* (pp. 101–120). Cham: Springer International Publishing.