FETAL ALCOHOL DISORDER, DISABILITY AND THE CRIMINAL JUSTICE SYSTEM

by Clare Townsend, Janet Hammill and Paul White

INTRODUCTION

Fetal Alcohol Syndrome ('FAS') is an incurable brain based defect resulting from prenatal alcohol exposure. It is one of a continuum of diagnoses included under the rubric Fetal Alcohol Spectrum Disorder ('FASD'). Data for Australian prevalence rates are extremely limited and focused on Aboriginal and Torres Strait Islander populations.[1] People with FASD experience intractable and permanent disability. Specific characteristics include complex behavioural, cognitive, physical and psychological problems.[2] Symptoms of FASD, including impaired impulse control; poor social judgement; low tolerance; anger and aggression can increase the risk of criminal activity.[3]

The disease and social burden of FASD is high for individuals, their families and society. The few existing studies measuring the economic impact of FASD undertaken in Canada and the USA highlight the huge direct and indirect monetary costs of FASD.[4] In 2014 a report by the Michigan Department of Community Health estimated the cost of FASD was $6 billion per annum and $2 million per individual with FAS.[5] In 2011 an Australian Government inquiry into FASD highlighted the lack of FASD awareness and prevalence data, the myriad of challenges faced by people with FASD and their families, and the need for a nationally agreed diagnostic and screening tool.[6] Despite this, Australian government strategies to comprehensively address the problem have yet to be enacted. Societal responses to FASD have thus often included the Criminal Justice system ('CJS').

PREVENTION & EARLY INTERVENTION

FAS and related conditions are the most common preventable form of developmental disability and birth defect.[7] Cessation of alcohol use during pregnancy prevents FASD.[8] Population education has the potential to raise public awareness of FASD, and to identify the teratogenic properties of alcohol.[9] There is evidence of benefit from programs which target at-risk groups who consume high amounts of alcohol by using brief interventions[10] and motivational interviewing.[11] Where FASD does present, early intervention is a protective factor.[12] This includes screening of 'at-risk' newborns. Supplementation of the newborns diet with choline may ameliorate some of the sequelae in children with Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure ('ND-PAE').[13]

ASSESSMENT, DIAGNOSIS AND TREATMENT

People with FASD have been largely undiagnosed in Australia despite 40 years of work in North America and the development of at least five major diagnostic approaches for children. Adult diagnostic and assessment services for FASD are relatively rare worldwide and are based on child assessments. There is a need for common assessment frameworks specific to adults, which are culturally appropriate, acceptable to diverse populations within a range of settings. The framework needs to be operationalised by clinicians who are adept at obtaining patients' historical information and identifying physical characteristics of neurodevelopmental disorders.[14]

DECLARING FASD A DISABILITY

FASD is not officially recognised as a disability in Australia.[15] This precludes sufferers from automatic disability supports and benefits. This challenges Article 25 (b) of the *Convention on the Rights of Persons with Disability*[16] ratified by Australian in 2008. Declaring FASD a disability will enable appropriate disability policy, service development and reform in accordance with the Convention. This also has implications for how people with FASD will be treated in the criminal justice system including assessing responsibility, guilt and moral culpability.

WITHIN THE CRIMINAL JUSTICE SYSTEM

Recognising FASD as a disability has significant implications for the justice system and the way its services are delivered. At all points in the criminal justice process, disability services with expertise in FASD should fulfil a key collaborative function. This should include timely assessment of FASD and the implementation of long-term post-diversion support services.

IDENTIFICATION

Many legal professionals lack an adequate understanding of disabilities[17] and have been found to have limited understanding

of FASD.[18] Lawyers need to accurately assess and present the nature and level of disability/impairment to the court. They also need to be able to communicate effectively with a person with FASD.[19] Expert witnesses with FASD experience could have a valuable role in the provision of information about diagnosis and appropriate responses to FASD.[20]

DIVERSION

For people with FASD, involvement in the court and prison system can begin a trajectory of criminal activity leading to repeat offending and life-long episodes of imprisonment.[21] Diversionary programs aim to divert the offender away from the criminal justice system. Innovative sentencing mechanisms with some evidence of benefit include circle sentencing, Aboriginal and drug courts, children's Koori courts. Outcomes can differ markedly depending on the attitudes of court personnel and officials toward people with disabilities and their willingness to use discretionary processes where available.[22] Barriers to diversion for FASD offenders, particularly Aboriginal and Torres Strait Islander offenders, include the likelihood they have multiple charges and previous convictions; present with substance misuse coexisting with mental health problems; often do not recognise their guilt; and are more likely to have been convicted of a serious crime.[23] The problem is exacerbated in rural and remote areas.

JUSTICE REINVESTMENT

FASD prevalence rates within the criminal justice system are unknown. Rates are thought to be high due to the social and behavioural problems experienced by people with FASD. Justice reinvestment recognises that the removal of people from communities reduces social capital and does not reduce offending. It seeks to address this problem by re-allocating funds from the prison system and invests these resources in programs and services that are aimed to address the underlying causes of crime and to build and strengthen communities.[24] In doing so it seeks to meet the needs of the community to be safe; as well as supporting people not to offend in the first place and reducing recidivism.[25]

BAIL

People with FASD are at risk of prolonged remand due to unstable housing, poor decision-making and impulsive behaviour. Reduced social integration increases their chance of coming into contact with negative role models and the likelihood of cyclic criminality and anti-social behaviour.[26] Long-term remand is costly with estimates of the average cost of 5 months in remand at $39 000.[27] While bail is a method of diverting an individual, it requires a capacity to meet bail conditions including regular reporting which is extremely challenging for many people with FASD.

CONFERENCING AND FASD CASE MANAGEMENT

Conferencing confronts young people with their behaviour and provides avenues for direct reparation and restitution of victims. It may be used as a mechanism for diverting the individual from the criminal justice system or a vehicle for directing cases into an alternative process of community based justice.[28] While people with FASD may appear able to negotiate the court system, it is likely they will need a competent support person to assist them throughout the criminal justice process. They may need a collaborative approach between a range of stakeholders when participating in the court process. FASD court liaison officers with an understanding of FASD, neurocognitive disability and the legal system may assist.[29]

SENTENCING

A diagnosis of FASD should be a crucial consideration in sentencing and should inform judgments that weigh up the ever present reality of the risk of reoffending with the needs and human rights of the offender with FASD.[30] Where probation is considered, the court will need to take into account that the person with FASD may not understand the conditions of a suspended sentence, and may need the support of people within the justice and disability sectors in order to comply with probation conditions. Opportunities for re-offending and problematic associations may be reduced or eliminated by the introduction of strict routines and supervision. Existing models designed specifically for Indigenous young people, including diversionary programmes with appropriate links to community controlled health services and programmes that support families in the re-integration of offenders, may provide useful templates.[31]

RELEASE

Research into the management of at risk young offenders demonstrates that systematic and developmentally informed risk assessments, selectively assigning intensive intervention to the highest risk offenders, using proven interventions and treatment strategies, and applying rigor in implementation and follow-up may reduce re-offending.[32] People with FASD who are assessed as having a higher probability of re-offending are often excluded from treatment services that target criminogenic needs.[33] The structured environment of prison, which may assist people with FASD to manage their behaviour is frequently unavailable on release.

CASE EXAMPLE: TROY[34]

Troy is a 27-year-old Indigenous man whose early childhood experiences included the suicide of his alcoholic father, uncles and an aunt, and the suicide of peers throughout his adolescence and adulthood. Troy was diagnosed with FASD in 2002 by a child development specialist who stated:

> [Troy] appears to have little insight into his own predicament. His capacity for planning is limited and he lives in a perpetual present. His behaviour is often impulsive … he had little sense of long term future direction. His background has been highly prejudicial. There is a mixture of sniffing, alcohol, abuse, neglect, inconsistency and a variety of other factors all known to be causal for the problems he is currently experiencing … If [Troy] were a Caucasian child presenting with the same spectrum of problems we would classify him as extremely disabled.

Troy's poor executive functioning, deficits in impulse control and inability to relate behaviour to outcomes compounds his poor insight and judgement. He suffers ongoing addictions to inhaled and injected substances, mental health issues, inability to manage money and illiteracy. He has minimal chances of employment. These recognised secondary disabilities were compounded by a lack of meaningful early intervention. From the age of eleven, Troy has been involved with the legal system with frequent incarceration totalling more than ten years, including months in solitary confinement. He has been the victim of sexual abuse in care and in custody.

This case study demonstrates that the absence of recognised and customised interventions for people with FASD results in secondary disabilities including mental health problems; disrupted school experience and learning; criminality; inappropriate sexual behaviour and drug and alcohol addictions.[35]

CONCLUSION

FASD is a public health problem of epidemic proportions affecting Indigenous and non-Indigenous Australians. FASD is a disabling condition characterised by complex behavioural, cognitive, physical and psychological problems including early onset chronic disease and poor mental health and the heightened risk of criminality.

FAS and FASD should be considered within a human rights and disability framework.[36] A holistic and multidisciplinary approach would include prevention and reduction of the incidence of FASD, improved quality of life of people with FASD, and reduced involvement in the justice system. Where this is not achieved, provision of a suitably structured justice system should ensure timely diversion from and innovative alternatives to long-term and repeated incarceration.

We argue that these solutions will in part reside in the recognition of FASD as a disability, prevention and early intervention strategies, the establishment of an evidence base and the adoption of a disability approach to FASD within the criminal justice system.

Clare Townsend is the Manager of Research and Development for Synapse Queensland; and an Associate Professor (Adjunct) in the School of Public Health, Tropical Medicine & Rehabilitation Sciences at James Cook University, Australia. Clare undertakes research in Indigenous neurocognitive disability in Far North Queensland. She has published in the area of development and implementation of strategic research agendas which address the needs of people with neurocognitive and other complex disabilities.

Janet Hammill is the Coordinator of the Collaboration for Alcohol Related Developmental Disorders at the University of Queensland's Centre for Clinical Research and Senior Researcher at Synapse. Janet's research focus includes the neurobiology of stress, teratogenic exposures especially of alcohol and the transgenerational implications for children.

Paul White is the Clinical Director and Senior Staff Psychiatrist in the Specialist Disability Services Assessment and Outreach Team for Disability Services, Queensland. He specialises in the care of people with complex neurocognitive disabilities and his research priority is marginalized and stigmatized groups in society and their psychosocial wellbeing.

1 Fitzpatrick et al, 'Prevalence of Fetal Alcohol Syndrome in a Population-based Sample of Children Living in Remote Australia: The Lililwan Project' (2015) 51(4) *Journal of Paediatrics and Child Health.*

2 Kieran D O'Malley (ed), *ADHD and Fetal Alcohol Spectrum Disorders* (Nova Science Publishers, 2011) 1-24.

3 Green et el, *FASD and the Criminal Justice System*, Canada FASD Research Network < http://www.canfasd.ca/wp-content/uploads/2014/11/FASD-and-Justice-Nov-16.pdf>; Anne Streissguth, *Fetal Alcohol Syndrome; a Guide for Families and Communities* (University of Washington, 1997); Diane K Fast, Julianne Conroy and Christine A Loock, 'Identifying Fetal Alcohol Syndrome Among Youth in the Criminal Justice System' (1999) 20(5) *Developmental and Behavioural Pediatrics* 370.

4 S Popova et al, 'What Do We Know about the Economic Impact of Fetal Alcohol Spectrum Disorder? A Systematic Literature Review' (2011) 46(4) *Alcohol and Alcoholism* 490.

5 Rick Snyder and James K Haveman, *Report on Efforts to Prevent and Combat Fetal Alcohol Syndrome As Well As Deficiencies in Efforts to Reduce the Incidence of Fetal Alcohol Syndrome (FY2014 Appropriation Bill - Public Act 59 of 2013)* (April 1 2013), Michigan Department of Community Health < http://www.michigan.gov/documents/mdch/502_04_01_14_Revised_453763_7.pdf>.

6 House of Representatives Standing Committee on Social Policy and Legal Affairs, Parliament of Australia, *FASD: The Hidden Harm Inquiry into the Prevention, Diagnosis and Management of Fetal Alcohol Spectrum Disorders* (2012).

7 Margaret E Clarke and W Benton Gibbard, 'Overview of Fetal Alcohol Spectrum Disorders for Mental Health Professionals' (2003) 12(3) *Canadian Child and Adolescent Psychiatry Review* 57.

8 O'Malley, above n 2.

9 Kieran D O'Malley and Susan D Rich, 'Clinical Implications of a Link

Between Fetal Alcohol Spectrum Disorders (FASD) and Autism or Asperger's Disorder – A Neurodevelopmental Frame for Helping Understanding and Management' in Michael Fitzgerald (ed) *Recent Advances in Autism Spectrum Disorders – Volume 1* (InTechOpen, 6 March 2013).

10 R L Floyd et al, 'Preventing Alcohol-exposed Pregnancies: a Randomized Controlled Trial' (2007) 32(4) *American Journal of Preventive Medicine* 360.

11 S D Ceperich and K S Ingersoll, 'Motivational Interviewing + Feedback Intervention to Reduce Alcohol-exposed Pregnancy Risk Among College Binge Drinkers: Determinants and Patterns of Response' (2011) 34(5) *Journal of Behavioral Medicine 381; J D Hanson et al, '*Prevention of Alcohol-exposed Pregnancies Among Nonpregnant American Indian Women' (2013) *American Journal of Health Promotion* 27(3) S66; H Hutton et al, 'Novel Integration Effort to Reduce Risk for Alcohol-exposed Pregnancy Among Women Attending Urban STD Clinics' (2014) 129(1) *Public Health Reports* 56.

12 Clarke and Gibbard, above n 7.

13 D Brauser, *Extreme Rate of Prenatal Alcohol Disorders in Poor* (10 March 2015), Medscape <http://www.medscape.com/viewarticle/841168>.

14 Ibid.

15 House of Representatives Standing Committee on Social Policy and Legal Affairs, above n 6.

16 *United Nations Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 61st sess, 76 plen mtg, Agenda Item 67, UN Doc A/Res/61.106 (13 December 2006).

17 K Diesfeld et al, 'Literature Review: Unmet Legal Needs of People with Disabilites in the Auckland Region' (Report 1 to Legal Services Agency, 2006).

18 Heather Douglas et al, 'The Importance of Foetal Alcohol Spectrum Disorder for Criminal Law in Practice: Views of Queensland Lawyers' 32 *Queensland Lawyer* 153; Heather Douglas et al, 'Judicial Views of Foetal Alcohol Sprectrum Disorder in Queensland's Criminal Justice System' 21(3) *Journal of Judicial Administration* 178.

19 Mindy Sortiri and Jim Simpson, 'Indigenous People and Cognitive Disability: an Introduction to Issues in Police Stations' (2004) 17(3) *Indigenous people and cognitive disability* 432.

20 Heather Douglas, 'The Sentencing Response to Defendants with Foetal Alcohol Spectrum Disorder' (2010) 34 *Criminal Law Journal* 221.

21 Green et el, *FASD and the Criminal Justice System*, Canada FASD Research Network <http://www.canfasd.ca/wp-content/uploads/2014/11/FASD-and-Justice-Nov-16.pdf>.

22 Australian Human Commission, 'Access to Justice in the Criminal Justice System for People with Disability' (Issues Paper, April 2013) 11.

23 Sarah Krasnostein, 'Too Much Individualisation, Not Enough Justice: Bugmy v The Queen' (2014) 39 *Alternative Law Journal* 12.

24 Law Society of South Australia, 'Justice Reinvestment' (2013) 35(10) *Bulletin (Law Society of South Australia)* 10.

25 Mick Gooda, 'Justice Reinvestment: a New Solution to the Problem of Indigenous Over-representation in the Criminal Justice System' (Paper presented at ANTAR NSW Seminar: Juvenile Justice Strategy: A Better Way, Sydney Mechanics School of Arts NSW, 20 March 2010).

26 Phillip French, *Disabled Justice: The Barriers to Justice for Persons with Disability in Queensland* (May 2007), The Criminal Justice Project <http://www.cjn.org.au/docs/disabled_justice__the_barriers_to_justice_for_persons_with_disability_in_queensland.pdf>; Suzanne Brown and Glen Kelly, 'Issues and Inequalities Facing People with Acquired Brain Injury in the Criminal Justice System' (Report for the Victorian Coalition of ABI Service Providers Inc. (VCASP), September 2012).

27 Australian Institute of Health and Welfare, 'Youth Justice in Australia 2012-13' (Bulletin No. 120, April 2014).

28 Sortiri and Simpson, above n 19.

29 Ibid.

30 Heather Douglas, Submission No. 112 to the Senate Select Committee on Regional and Remote Indigenous Communities, 2008.

31 Intellectual Disability Rights Service Inc, 'Diversion of Alleged Offenders with an Intellectual Disability from the New South Wales Local Courts System: A Review of the Practical Operation of s32 of the Mental Health (Criminal Procedure) Act 1990' (Research Report, 2006).

32 Randy Borum, 'Managing At-Risk Young Offenders in the Community' (2002) 19(1) *Journal of Contemporary Criminal Justice*, 114.

33 Sotiri and Simpson, above n 19.

34 Name has been changed to protect the individual's identity.

35 Larry Burd, 'Fetal Alcohol Syndrome in the Canadian Corrections System' (2003) 1(e14) *Journal of FAS International*; Diane K Fast, Julianne Conroy (2004) 'The Challenge of Fetal Alcohol Syndrome in the Criminal Legal System' 9(2) *Addiction Biology* 161.

36 Jim Simpson, Meredith Martin and Jenny Green, 'The Framework Report: Appropriate Community Services in NSW for Offenders with Intellectual Disabilities and Those at Risk of Offending' (Report commissioned by the Intellectual Disability Rights Service and the NSW Council for Intellectual Disability, July 2001).