ALCOHOL-AFFECTED OFFENDERS: ALASKA'S CRIME CONUNDRUM

By
Maureen F. Harwood

RECOMMENDED:

[Signatures]

Advisory Committee Chair

Department Head

APPROVED:

[Signatures]

Dean, College of Liberal Arts

Dean of Graduate School

Date
ALCOHOL-AFFECTED OFFENDERS: ALASKA'S CRIME CONUNDRUM

A

THESIS

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of the University of Alaska Fairbanks
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By

Maureen Frances Harwood, B.S.

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ABSTRACT

Offenders with Fetal Alcohol Syndrome (FAS) are being inadequately identified and addressed in Alaska’s criminal justice system. Without recognition of the problems associated with FAS (e.g., slow cognitive pacing, language impairments, impaired ability to deal with abstract concepts such as time) the alcohol-affected individual’s ability to understand and effectively participate in the criminal justice process is compromised. This thesis examines the challenges that people with FAS and other prenatal alcohol exposure conditions present for Alaska’s criminal justice system. Ways of protecting people prenatally exposed to alcohol against poor life outcomes, like trouble with the law, are explained. Additionally, I present effective steps that criminal justice system entities utilize to assist people with disabilities who commit crimes and discuss their adaptation to the problems of people with FAS.
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ACKNOWLEDGEMENTS

For the past 19 years, people with FAS have been an integral part of my life. I undertook this study because our State needs to do a better job assisting alcohol-affected individuals. Justice, in this instance, does not need to be blind.

I wish to thank Dr. Judith Kleinfeld for giving me the opportunity to explore this topic, and for believing in and supporting me; my advisory committee members, Dr. David Blurton, Dr. Teresa Bunsen, and Dr. Sandra Bond for their advice and insight; Marilyn Tony, Ardyce Turner, Betty Taaffe, Jan Lutke, and Mary Lou Canney, "mom heroes" who live with FAS everyday and still take time to listen to me; Quida Peters, Vickie Horodyski, and Loraine Philips, more "mom heroes" who agreed to share their particular insight on this topic; Sarah Williams, Jim Orr, Kathi Trawvers, and Heidi Brocious for time and technical support; my mother, father, and sisters who always believe in me; Pat Weiss, who is always there for me, and most especially, my husband, Chris, who willingly disrupted our life so that I could do this, then read it, he is a gift from God.

And finally, this thesis is for Eddie and Christopher, both alcohol-affected. Tragically, Chris died at 16 because he failed to understand hope. Thankfully, Eddie is filled with hope and has a future replete with possibilities. They both have taught me much about life and love.
CHAPTER 1
INTRODUCTION

The Problem

Offenders with Fetal Alcohol Syndrome (FAS) are being inadequately identified and addressed in Alaska’s criminal justice system. Without recognition of the problems associated with FAS (e.g., slow cognitive pacing, language impairments, impaired ability to deal with abstract concepts such as time), the alcohol-affected individual’s ability to understand and effectively participate in the criminal justice process is questionable. Additionally, an inability to follow through on tasks in the timely or reasonable fashion expected by criminal justice personnel places people with FAS at risk for frequent rule violations and high recidivism rates. The result is injustice for both the alcohol-affected offender and the society that requires protection from individuals who commit criminal offenses.

Alaska has a high incidence of people born adversely affected by alcohol. Because the state is in the earliest stages of understanding and addressing the life span needs of people with FAS, little research has gone into determining how many people with FAS are in Alaska’s criminal justice system. Limited training and information about effective strategies for addressing the organic-based language and cognitive processing problems of people with FAS have reached the criminal justice system. Inadequately addressing the needs of this special population of offenders costs the state continued resources, frustrates people
working in the criminal justice system, and denies of people with disabilities the right to fair and humane treatment.

The Purpose

The purpose of this thesis is to discuss the problems associated with identifying and programming for offenders with FAS in Alaska’s criminal justice system and to suggest valuable strategies for tackling the issue. Why currently accepted criminal justice methods of discussing legal rights, interrogating suspects, representing clients at trial, and providing probation or incarceration programming are unsuccessful and at times counterproductive with alcohol-affected offenders will be examined. Effective interventions being carried out in Alaska and New Jersey to support alcohol-affected offenders and people with similar disabilities will be described. This thesis offers an opportunity to scrutinize this topic and suggest effective strategies that Alaska could use to address the issue.

Terminology

Certain terms used throughout this thesis are specific to the criminal justice, social service, and disability research fields and are defined in various manners. For clarification of how these terms are applied in this thesis, definitions are supplied on Table 1. [Additional definitions are included in Appendix B.]
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<th>Term</th>
<th>Field</th>
<th>Definition</th>
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<tr>
<td>Alcohol-affected individual</td>
<td>Disability research</td>
<td>Any person with permanent brain damage caused by prenatal alcohol exposure. This person may be described as having Fetal Alcohol Syndrome (FAS), Fetal Alcohol Effects (FAE), Fetal Alcohol Spectrum Disorder (FASD), etc. All of these terms will be explained in detail in Chapter 2.</td>
</tr>
<tr>
<td>Primary disability</td>
<td>Disability research</td>
<td>Permanent debilitating conditions associated with prenatal alcohol exposure. These include, but are not limited to, problems sustaining attention (attentional deficits), impaired thinking skills, language processing problems, etc.</td>
</tr>
<tr>
<td>Secondary disability</td>
<td>Disability research</td>
<td>Conditions or situations that afflict an alcohol-affected individual after birth that could have been avoided had primary disabling conditions associated with their disorder been addressed properly.</td>
</tr>
<tr>
<td>Services</td>
<td>Social Services</td>
<td>Any one of a number of support activities (provided by a social service or mental health agency) that are designed to assist a person in coping with the demands of their immediate environment. This can include an individualized educational plan (IEP), case management services, home-helpers, respite care, job training, etc.</td>
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Table 1. Definitions of terms (cont.)

<table>
<thead>
<tr>
<th>Term</th>
<th>Field</th>
<th>Definition</th>
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<td>Guilty mind</td>
<td>Criminal justice</td>
<td>A legal construct that establishes that moral blameworthiness is demonstrated only if a person acts with awareness that the conduct was wrong (Dix &amp; Sharlot, 1999, p. 65). This is a broad term for a legal concept that deals with “state of mind” or ability to form intent, required for the crime charged.</td>
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**Background**

In an important study of the long-term impacts of prenatal alcohol exposure for the individual, Streissguth, Barr, Kogan, and Bookstein (1996) describe “secondary disabilities” that evolve if primary disabilities associated with having FAS are not addressed appropriately. When primary disabilities, typically manifested as compromised intelligence and difficulties with adaptive living skills, are undiagnosed or inadequately treated, people with FAS frequently develop secondary problems such as disrupted school experiences, inappropriate sexual behavior, mental health issues, alcohol and drug problems, and trouble with the law (Streissguth et al., 1996, p. 4).

“Trouble with the law” is defined in the Streissguth et al. study as, “those clients who ever were in trouble with the police or authorities, or were ever arrested for, charged with, or convicted of any of seven types of crime” (p. 42). Types of crime include crimes against property or person (i.e., theft, burglary, assault, and murder), possession or selling of illegal goods, sexual assault,
status offenses, vehicular offenses, and others. Of the 412 participants in the study, 60% of the adolescents and adults and 14% of the 6 to 11-year olds had trouble with the law (p. 109). Shoplifting/theft was the first type of crime reported (Streissguth et al., 1996, p. 109).

While the Streissguth et al. study suggests that alcohol-affected individuals are very likely to come in contact with the criminal justice system, no accurate figures on how many offenders with FAS exist for the Alaska, or any state. One Canadian study by Conry, Fast, and Loock (1999), however, provides suggestive information. In their study, 23.3% of youths remanded to a forensic psychiatric inpatient unit in Canada met the diagnostic criterion for FAS (p. 372). These data are supportive of the contention that alcohol-affected individuals are “disproportionately represented in the juvenile justice system” (Conry, Fast, & Loock, 1997, p. 17; Roberts & Waters, 1998). Only three of 87 individuals identified during the study had previously been diagnosed with an alcohol-related birth defect (p. 17).

Parents and care providers of people with FAS/FAE cite fear of involvement with the criminal justice system as a pressing concern in caring for their children (Jones, 2000; J. Lutke, personnel communication, August, 2001). Many parents report that alcohol-affected adolescents are impulsive, have low self-esteem, and can be easily convinced by peers to engage in criminal behavior without understanding the consequences. Families believe that a lack of understanding of the disorder makes communication with criminal justice
personnel difficult. Parents report that extreme suggestibility can lead to unjust consequences during interrogation, arrest, and incarceration.

Literature review.

The literature available on how a person diagnosed with an alcohol-related birth defect fares in the criminal justice system is scant. Much of the literature on people with disabilities and the criminal justice system focuses on the needs and rights of people with mental retardation and learning disabilities (Conley, Luckasson, & Bouthilet, 1992; Luckasson, 2001; Petersilia, 1997; Petersilia, Foote, & Crowell, 2001). While this literature is useful for background information, it lacks insight into unique needs and impact of people with FAS who commit crimes.

The most significant work on the topic is by researchers Conry & Fast (2000). Their book, Fetal Alcohol Syndrome and the Criminal Justice System, details for the Canadian legal community how potential clients with FAS/FAE might act in the police station, courtroom, jail, probation office, and community correction center. The authors offer creative sentencing and communication strategies that have been applied in Canadian cases that adequately address the needs of alcohol-affected offenders. Conry and Fast state, “people with FAS have a huge impact on the criminal justice system” (p. 105). Their work suggests that this impact would be minimized by early diagnosis and intervention. Until improved early diagnostic and intervention services are in practice, the authors
conclude that it behooves the criminal justice system to increase its awareness of how best to work with people with FAS (p. 105).

Additional information on people with FAS and interactions with the criminal justice system is found in Streissguth and Kanter's (1997) The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilities. Noteworthy are: 1) Dagher-Margosian's "Representing the FAS client in a criminal case," 2) LaDute and Dunne's "Legal issues and FAS," and 3) Barnett's "A judicial perspective on FAS." All are instructive overviews of issues that clients, lawyers, and psychologists confront in cases where the accused has FAS. The chapters provide descriptions of procedural concerns, legal and psychological definitions, and moral implications that practitioners should be aware of when the accused is alcohol-affected.

Particularly important in the discussion of FAS and crime are Dagher-Margosian's (1997) points about intent and deterrence. She notes that aspects of the disorder itself negate the guilty mind (intent) requirement essential to establishing legal culpability. Using case law examples, Dagher-Margosian questions the effectiveness of prison as a deterrent with people with FAS (p. 125). Barnett (1997) addresses issues of creative sentencing in some detail in his chapter and what sentences are proportionate and productive for alcohol-affected defendants (p. 138). Barnett insists that in sentencing a person with FAS the goal should not be to deter the crimes of others but to help the accused. He writes, "It is, I believe, simply obscene to suggest that a court can properly warn
other potential offenders by inflicting a form of punishment upon a handicapped person who has, indeed, committed an offense for which a sanction must follow. That is not justice. That is unthinkable retribution" (p. 137).

The work by LaDue & Dunn (1997) reviews why the diagnosis of FAS raises numerous questions about the fairness of proceedings when the accused has FAS. The authors suggest that expert testimony from a mental health professional experienced in FAS is essential. Experts on FAS can explain the characteristics of the disorder and assist legal personnel in making informed decisions about the need for further assessments regarding competency, diminished capacity, remand determinations, probation recommendations, and appropriateness for parole. The authors make the vital point:

Although the presence of a mental disorder is NOT part of the criteria for diagnosing FAS, secondary psychiatric disabilities frequently occur...Little knowledge of the demonstrated organic damage and deficits associated with FAS has made it into the legal system. However, the organic brain damage caused by prenatal alcohol exposure often does limit a person's ability to form intent and understand behavioral consequences (p. 149-150).

In Kleinfeld, Morse, and Wescott's (2000) Fantastic Antone Grows Up: Adolescents and Adults with FAS, Jones' chapter, "Trouble with the law," offers insight into procedural problems involved in dealing with the criminal justice system from a family's perspective. The author suggests helpful measures like having the affected individual carry a specialized ID card that explains their disability and need for an advocate to be present before being interviewed.
Additionally, in the book's summary Kleinfeld reiterates the need for trained advocates and suggests that existing court services to assist mentally ill defendants might be useful for offenders with FAS (see p. 341-343).

Other notable articles on the topic are available in corrections, law, and social science journals. Many of these articles are introductions to the disorder and the problems it presents in legal and correctional settings. Two that go beyond rudiment discussion of the disorder are: 1) Golden's (1999), "An argument that goes back to the womb: The demedicalization of Fetal Alcohol Syndrome, 1973-1992," and 2) Capron's "Fetal Alcohol and Felony." Golden offers a historical review of how the diagnosis of FAS evolved from a medical diagnosis to a social issue as well as a review of court cases where the diagnosis has been a factor. Capron explores weighty issues of a) whether people with FAS can form intent, and b) if this disorder may require a reexamination of current understanding of how the insanity defense applies in cases where the defendant is disabled.

In summary, information on the specific manifestations of brain damage caused by alcohol exposure in utero is continually emerging. A plethora of information is currently available on many of the life span needs of people with FAS. Resources on how people with FAS behave in criminal justice settings and how to address their needs are emerging, each improving awareness of this crucial issue. Unfortunately, no literature on alcohol-affected individuals and their impact on Alaska's criminal justice system is currently available.
Methods: Overview

To present a clearer picture of the challenges people with FAS present to Alaska's criminal justice system and treatments that might be helpful, I will provide information from:

1) a survey of how Alaskan probation officers view the issue of FAS and working with affected offenders,

2) exploratory interviews with service providers and families of people with FAS and other disabilities who have had trouble with the law, and

3) materials and interviews on useful techniques for working with people with disabilities who commit crimes utilized by the projects I visited as part of this study.

Survey of probation officers

Participants

Eighty-two Alaskan adult community corrections, six adult institutional, and 24 Division of Juvenile Justice (DJJ) probation officers were given the opportunity to complete a survey on their attitudes towards, knowledge about, and accommodations for people with FAS they may encounter. This number represents all of the adult community corrections probation officers employed by the Alaska Department of Corrections (ADOC) as of August 2001, DJJ probation officers employed in the Northern region, and the ADOC Institutional probation officers working in the Fairbanks, Alaska area. The response rate was 40 % for
the adult community corrections officers and 100% for both the institutional and DJJ participants. The overall survey response rate was 56%.

Survey Design

An 18-question survey was designed and field-tested. The purpose of the survey was to gain insight into FAS and criminal justice issues from probation officers’ perspective. The survey was designed using Dillman's (1978) *Mail and Telephone Surveys: The Total Design Method*. Permission was obtained from the Department of Corrections (DOC) and DJJ to contact the probation officers. A field test of several steps was conducted to detect construction defects in the survey (Dillman, 1978, p. 155). First, the chief probation officers at the adult and juvenile probation level in Fairbanks were given the survey to complete and comment upon. Several DOC and DJJ employees were asked to participate in the field test. They offered suggestions on vocabulary and content. Afterwards, DOC, the State Office of FAS, and University of Alaska Fairbanks officials were given the opportunity to review, comment upon, and revise the survey questions. An audio-conference was held to discuss and finalize the survey content.

The survey includes 15 closed-ended with ordered response questions and two open-ended questions. [A copy of the Institutional Review Board’s approval letter and the survey are included in Appendix A.]

Procedure

A list of currently employed probation officers was obtained from the Department of Corrections. Participants were either mailed the survey or it was
delivered to them if they were employed in the DJJ northern region or Fairbanks, Alaska area. Each survey was mailed with a letter of introduction that stated the purpose of the investigation and how the information would be used. Participants were asked to complete the survey and return in the stamped envelope provided. [A copy of the introduction letter is included in Appendix A.]

**Exploratory interviews**

Three parents, three adult-field probation officers, one DJJ probation officer, and three community members were interviewed to provide perspective and offer insight on the issue of people with FAS and the criminal justice system. Participants to be interviewed were chosen as a result of personal requests, referrals, or after the completing survey.

All interviews were conducted in person, by phone, or by e-mail. Participants were asked to sign an informed consent. In-person interviewees were given the option of being audiotaped. When taping was not done, written notes were used. A semi-structured interview format was used.

**Site visits**

In an effort to offer possible ideas for addressing people with FAS who commit crimes, effective actions that are being taken in Alaska and other states were investigated. An on-site visit was conducted at the Developmentally Disabled Offenders Program in North Brunswick, New Jersey. An interview was conducted with a lead staff member and programs materials were collected to demonstrate that effective intervention strategies exist.
A second on site visit was conducted at the Mental Health Court in Anchorage. An interview with the presiding judge and court's manager was conducted to gain fuller understanding of how the court assists people with disabilities.

Organization of Thesis

This thesis is organized as follows: Chapter II describes FAS, issues associated with its diagnosis, and its prevalence in Alaska; Chapter III presents factors that place individuals prenatally exposed to alcohol, at risk for poor life outcomes, such as crime. Additionally, models for viewing protective and risk factors are offered in this chapter; Chapter IV discusses problems people with FAS present in the criminal justice system settings as well as informal strategies used by staff and family members to defuse these problems; Chapter V offers selected results from the survey of probation officers, plus information on the impact of the problem; Chapter VI examines historical and current issues in addressing all people with disabilities in the criminal justice settings. Effective strategies that are being employed in Alaska and other states will be explained; Chapter VI summarizes the material presented.
CHAPTER 2
UNDERSTANDING FETAL ALCOHOL SYNDROME

While references to possible dangerous effects of alcohol use by pregnant women appear in classical, biblical, and early research literature, the condition as it is now understood was not depicted in published medical literature until 1968 (for reviews see, Stratton, Howe, & Battaglia, 1996, p. 17; Streissguth, 1997, p. 35). Credit for naming the syndrome is afforded to Jones and Smith (1973, p. 999). They (1973) are the first to use the term FAS to describe a group of children who present with a cluster of similar physical features and other problems as a result of being born to alcoholic mothers. Early studies on FAS emphasize the urgent need for research that would expand our knowledge of how alcohol causes permanent, diffuse birth defects in children prenatally exposed (Streissguth, 1997, p. 56). The results of these initial investigations continue to inspire countless inquiries in neurology, psychology, education, and other fields into the lasting effects of alcohol on the fetus (e.g. Abel, 1996; National Institute of Alcoholism and Alcohol Abuse (NIAAA), 2000).

Alcohol’s Possible Impacts In Utero

Consumption of alcohol by a pregnant woman places her fetus at risk for developing a host of permanent physical, behavioral, or cognitive problems. Variation in alcohol-related effects or outcomes in children are based on dose-response relations and susceptibility based on genetic make-up of both the mother and child (see Stratton, et al., 1996, p. 35-45; Streissguth 1997, chap. 4).
In its dependency on the mother for nutrition and growth, the fetus is affected by how, how much, and when alcohol is consumed during pregnancy.

During the first trimester of fetal development most of the gross physical formation of the body occurs. Drinking alcohol during this period may produce physical abnormalities of the fetus' face and hands (Stratton et al., 1996). Alcohol, however, in addition to potentially producing physical birth defects, may also have detrimental effects on the developing central nervous system (CNS) of a fetus. “Alcohol has a direct toxic effect on cells and can produce cell death, thereby causing certain areas of the brain to actually contain fewer cells than normal (Streissguth 1997, p. 58).

Fetal brains develop throughout gestation, making them constantly vulnerable to the detrimental effects of alcohol. Animal research and human Magnetic Resonance Imaging (MRI) results suggest that areas of the brain that can be affected by alcohol include the hippocampus, cerebellum, basal ganglia, corpus callosum, and cortex (Band & West, 1996, p. 106; Mattson, Jernigan, & Riley, 1994; Mattson & Riley, 1995; Stratton, et al., 1996, p. 39). “Of the substances that are also known to be harmful for the developing fetus, including heroin, cocaine, and marijuana, alcohol produces the most serious neurobehavioral effects” (Stratton, et al., 1996, p. 35; Streissguth, 1997, p. 61). The type of brain damage an affected individual ends up is most likely related to the developmental stage the fetus was undergoing when the alcohol consumption took place (Olsen, Morse, & Huffine, 1998, p. 269).
While alcohol exposure's definitive negative expressions are still not completely understood for the fetus, researchers agree that biological damage that occurs is permanent. Furthermore, prenatal alcohol effects do not diminish with age (Streissguth, 1997, p. 67; Streissguth, Bookstein, & Barr, 1996).

**Defining and Diagnosing Fetal Alcohol Syndrome**

Fetal Alcohol Syndrome (FAS) is the medical diagnosis given to individuals prenatally exposed to alcohol who have: (1) pre- and post-natal growth deficiencies, (2) minor facial anomalies (e.g., flattened midface, indistinct groove above the lip, short eye openings), and (3) evidence of CNS damage. [Examples of the face of FAS are offered in Figures 1.1.1 and 1.1.2].

![Figure 1. Line drawing of the face of FAS](image-url)

- microcephaly
- short palpebral fissures
- flat midface
- indistinct philtrum
- thin upper lip
- epicanthal folds
- low nasal bridge
- minor ear anomalies
- short nose
- micrognathia
Figure 2. Picture of child with the face of FAS

Not all persons who are prenatally exposed to alcohol will have the FAS. Some individuals, because of the timing of exposure and/or their genetic make-up, may escape all negative effects. Other individuals have partial manifestations of FAS, in particular, neurobehavioral expressions and impaired cognition. Numerous descriptive nomenclatures attempt to explain the expressions in various brain dysfunction caused by prenatal exposure to alcohol (Astley & Clarren, 1999). Fetal Alcohol Effect (FAE), Alcohol-Related Neurodevelopmental Disorder (ARND), and Alcohol-Related Birth Defect (ARBD) are the more commonly used descriptors for conditions that do not reach the physical severity of FAS. Unfortunately, no biochemical test or comprehensive brain imaging
system currently exists that will easily determine if a child has brain damage from prenatal alcohol exposure. [Figure 3 contains an example of an individual with FAE].

![Figure 3. Picture of 16 year old with FAE-No facial features of FAS](image)

Autopsy reports support the contention that there is no single uniform presentation of damage to the brain that is observed in people prenatally exposed to alcohol (Stoltenburg-Didinger, 1996, p. 123). While certain manifestations of the disorder are hallmark, no single description successfully describes every person with an alcohol-related birth disorder. Individuals that escape the facial anomalies requisite for the diagnosis of FAS are equally at risk for impaired adaptive behavior, problems in cognition, and health concerns.
Diagnostic criteria for prenatal alcohol-related conditions is an emerging field (see generally Astley & Clarren, 1999; NIAAA, 2000; Stratton et al., 1996, pp. 63-81). However, the 4-Digit Diagnostic Code System developed by Astley and Clarren (1999) is being more frequently utilized in FAS literature and circles. This code, which uses diagnoses such as “static encephalopathy-alcohol exposed” and “neurobehavioral disorder alcohol exposed”, is helpful in completely describing an affected individual’s learning and adaptive behavior needs (p. 41-42). [See Appendix B for an example of a clinical summary from the code (Astley & Clarren, 1999)]. This is the diagnostic system currently adopted in Alaska.

Having a diagnosis of full-blown FAS frequently makes access to supportive interventions more readily available. Affected individuals who do not have a full diagnosis of FAS commonly cannot access services to support them in dealing with their organic brain-based disability. Individuals without the “face of FAS” often require supportive services and interventions to succeed as much as those with the physical phenotype.

To address this dilemma, Streissguth and O’Malley (2000) propose the term Fetal Alcohol Spectrum Disorders (FASD). The use of FASD should enhance services to those “who manifest mild to severe disturbances of physical, behavioral, emotional, and/or social functioning attributable to in utero alcohol exposure” (p. 178). Streissguth and O’Malley assert, “The urgent need now is to understand how to identify, treat, and manage patients of all ages with
all types of faces who experienced birth defects to the CNS caused by alcohol" (p. 178). The use of this “neuropsychiatric” term is a step in shifting attention of mental health professionals and other diagnosis-based service providers towards a greater understanding of this encompassing disorder and the far-reaching negative effects brought about when access to services is denied (Streissguth & O'Malley, 2000). Adoption of this term is a step in making that happen and offers fuller understanding of the life-long implications of having been prenatally exposed to alcohol. For the remainder of this paper, FASD will be used to discuss the continuum of possible prenatal alcohol-related effects.

Despite improved diagnostic procedures and continued research on FASD, the condition is still frequently misdiagnosed and undiagnosed. Speculations for why the diagnosis is missed are available from research literature (see generally Stratton et al., 1996; Streissguth, 1997). Typically, it is attributable to the: 1) lack of accessible medical practitioners who are trained in effective diagnostic procedures on FAS, 2) tendency of medical and other health care professionals to avoid issues where alcohol use/abuse must be confronted, and 3) variability in the expression of the syndrome over a lifetime (Streissguth, 1997). [Figure 4. offers a view of the expression of change over the lifespan of an individual.]

Because of the continuum of expression of effects and the incomplete consensus within the medical community on the name and form(s) that the diagnosis can take, other descriptors are commonly used to discuss the
Figure 4. Change over a lifespan. Individual with FAS shown at ages 6 months, 2, 8, and 16 years of age. Facial features are less prominent at 8 and 16.
behaviors associated with prenatal alcohol exposure. Attention Deficient/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Reactive Attachment Disorder (RAD), Antisocial Personality Disorder, Behavior Disordered (BD), and Sensory Integration Dysfunction (SI) are some diagnoses that an alcohol-affected individual can acquire across a life span. While these conditions may describe some behaviors observed in people with FASD, they lack insight into the organic cause of the alcohol-affected individual's learning and behavioral patterns (see Malbin, 1999, p. 31).

In depth understanding of the continuum of presentations of FASD is available from the extensive literature describing FASD and effects believed attributable to prenatal alcohol exposure. Several authors (Kleinfeld, 1993 & 2000, Olsen, in press, Streissguth, 1997) discuss common behavioral and educational disabilities found in people prenatally exposed to alcohol. The information below is a summary of current understanding gleaned from research studies, clinical observation, "wisdom of practice" narratives, parent interviews, and personal observations.

**Primary Manifestations of FAS**

Alcohol affected CNS dysfunction occurs on a continuum and may be manifested as problems with: hyperactivity, attention deficits, learning disabilities, mental retardation, memory problems, specific problems in communication skills, reduced abilities to regulate emotions, and sleeping and eating disorders. Because affected individuals present with various combinations of disabling
conditions, a typical phenotype is impossible to describe. Ann Streissguth (1997) clarifies why the presentation of FASD confounds people:

Individuals with FAS/FAE are born with organic brain damage, which constitutes their primary disability. Although the manifestations may change as the child matures, the brain damage remains a part of their endowment across the life span. Because of the complexities and unevenness of the brain damage, people with FAS/FAE may be good at some things and disabled at others. They may have normal overall performance on an IQ test but nevertheless have significant disabilities with abstract thinking, learning and generalizing from their past experiences. They may read well but have difficulty comprehending the subtle social cues of interpersonal relationships. They may talk a lot but lack insight into their own behavior. They may feel distress but be unable to articulate their needs to others. They may have difficulty modulating incoming stimuli and be in danger of being overwhelmed by stimulation and of behaving in an impulsive and maladaptive fashion. They may lack the ability to evaluate their own performance, set realistic goals and organize their behavior to work towards a goal.

These characteristics, so well known to everyone who lives and works with people who have FAS/FAE, are signs of brain dysfunction. They are, in a sense, 'hidden disabilities' because they are not necessarily measured by the tests that we have come to rely on to allocate our special services and remedial help (p. 146).

Understanding of hallmark elements of the FASD offers insight into the disorder.

Thinking and memory skills

Intelligence is the most commonly understood and measurable manifestation of FASD. FASD is cited as the leading known cause of mental
retardation (MR) in the nation (Streissguth, 1997, p. 34). In initial studies on FASD, many participants had mental functioning abilities in the mentally retarded range (i.e., IQ score of 70 or below with accompanying problems in adaptive living skills). As understanding of the disorder evolved and diagnostic services improved, it became apparent that only a small subset of people with FASD have MR (see Streissguth 1997, p. 102). The continuum of IQ abilities for people with FASD is 30 to 120 (Olsen, in press; Olsen, et al., 1998, p. 266; Streissguth, 1997, p. 103). Over half of the people with FAS and three-fourths of the people with FAE have an IQ in the normal range (above 70).

IQ scores are obtained using standardized testing procedures that measure both verbal and performance skills, as well as adaptive living abilities. These scores have frequently come under scrutiny, for while there is considerable effort to make certain tests are not biased or misinterpreted, errors occur. Not only are IQ scores seldom a true reflection of global abilities, they also can be used to do more harm than good (see generally, Gould, 1996). Researchers and parents familiar with the primary manifestations of FASD report the use of traditional IQ tests and interpretations exclusively is of limited value when examining abnormal information processing abilities present in people with FASD (Olsen, 2001, p. 7; Canney & Tony, personnel communication, January 2001). Measures that are more sensitive to problems with one's abilities to predict future outcomes, to store and retrieve information, and sequence a simple schedule, etc. are more helpful in assessing an alcohol-affected individual's
strengths and weaknesses. Research and narrative literature on the cognitive abilities of people with FASD emphasize that difficulties with the ability to think abstractly and the inability to generalize information are the most devastating effects of FASD to people's successful functioning (Lutke, 1997; Malbin, 1999; Tony, personal communication, January 2001).

Difficulties directing and sustaining attention to tasks, modulating incoming stimulation, and problems with memory, impulsivity, and hyperactivity are hallmark features of FASD (Olsen, et al., 1998, p. 266; Streissguth, 1997, chapter 1). Sixty percent of children with FASD have attention deficits problems (Streissguth et al., 1996, p. 35). Hyperactivity that is observed in young children with FASD is believed to evolve into distractibility and difficulties in cognitive and behavioral control in adults (NIAAA, 2000). Being unable to sustain, direct, and manage one's attention has profound implications for planning and organizing all behavior. Underperformance in these functions places alcohol-affected individuals at a disadvantage in most situations that require quick responses and adaptation.

Researchers are continually trying to accurately determine how "executive functioning" skills present in people with FASD (Mattson, Goodman, Caine, Delis, & Riley, 1999). Executive functions are brain-based skills that include problem-solving ability, concept formulation, inhibitory control, and self-regulation (Olsen, in press, p. 8). Deficits in executive function are detrimental to
adequate functioning in learning and social situations that require verbal fluency, planning, and shifting thought groups (Mattson, et al., 1999).

**Language processing**

Disrupted language skills associated with prenatal alcohol exposure hinder successful functioning in society. Coggins, Friet, & Morgan (1997) describe specific language problems in children with FASD as “one of the most debilitating effects of prenatal alcohol exposure” (p. 221). The type of deficit most commonly observed in people with FAS involves their development and use of social communication skills. “Social communication skills enable people to influence “day-to-day” events in their lives...Children with FAS often have good vocabularies and appear to be talkers. Having lots of words does not, however, necessarily mean that one can use those words to make friends or find solutions to socially important tasks” (Coggins, et al., 1997, p. 223). Good expressive language skills are commonly associated with being a clear and effective thinker. For people with FASD, this association is frequently unsound.

Hearing problems occur in high frequency in people with FASD (Stratton et al., 1996. p. 157). When not detected and appropriately treated, hearing problems affect successful daily performance. People with untreated, compromised hearing have a decreased ability to affectively process information, further compromising language-processing abilities.
Behavior and associated abilities

Research into behaviors that are influenced by prenatal exposure to alcohol include difficulties with response inhibition, hyperactivity, and memory (see generally, Mattson et al., 1999; Stratton et al. 1996; Streissguth, 1997, p. 58-67). People with FASD often have difficulties modulating behavioral responses to various stimulations in most social situations. They frequently are over- or under-reactive to light, noise, and/or other sensory input. Impulsivity and distractibility lowers their ability to attend to important details and to respond appropriately or quickly to social demands or requirements. Affected individuals are often surprised when they misunderstand a social request or when others misread their behavior as defiant or willful (Malbin, 1999).

The most devastating aspect of having organic-based brain damage is that people cannot readily see the disability. Individuals with FASD often appear able, and are frequently pressed to care for themselves and their daily needs when in truth they cannot. Deficits in adaptive living skills are consistently recorded in clinical literature, research outcomes, and parent descriptions of people with FASD (see Kleinfeld, 2000; Lutke, 1993, 1997, & 2000; Olsen, in press, p. 8; Streissguth, 1997). Shortfalls in adaptive living skills include an inability to communicate effectively with others, meet daily care activities, and make decisions at school, work, or at home. An inability to perceive social cues, failure to consider the consequences of an action, always thinking concretely, and poor judgment make most interactions incommodious. Social delays in
people with FASD are frequently discussed by researchers and family advocates as, “beyond what can be explained by low IQ scores and indicate that there may be arrested, and not simply delayed, development of social abilities in children with FAS” (DeVries & Waller, 2000; Streissguth, 1997; Thomas, Kelly, Mattson, & Riley, 1998, p. 528).

The diagnosis of an alcohol-related birth defect condition is essential to understanding behavioral patterns commonly associated with this disorder (Malbin, 1999; Streissguth et al., 1996). The identification of FASD should lead to an understanding of the individual as someone with organic-based brain damage; which in turn leads to access to informed professional care, effective interventions, and effective support services critical to people with FASD functioning appropriately in their community (Astley & Clarren, 1999; Olson, in press; Streissguth & O'Malley, 2001). Because many of the primary manifestations of FASD are difficult to recognize, the affected individuals’ ability to access assistance is compounded. Even more problematic for this population are observations that even with help, “slow progress and frequent setbacks seem to characterize intervention with alcohol-affected population. Behavior change can be difficult and new problems may readily occur, so that treatments that were initially helpful can become ineffective” (Olsen, in press, p. 25). Manifestations of FASD make aspects of learning and achieving new skills difficult without persistent accommodations and support. People with FASD frequently experience failure because they frustrate well-meaning family members, friends,
and service providers. Often individuals with FASD cannot explain their unique learning and social needs and are not equipped to ask for help. Failure leads to frustration and at times secondary manifestation of FASD.

Secondary Manifestations

Secondary disabilities are problems that arise "after birth and presumably could have been ameliorated through better understanding and appropriate interventions" (Streissguth et. al, 1996, p. 26). Using a Life History Interview (LHI) developed for their study, the Streissguth et al. group (1996) determined six main secondary disabilities: mental health problems, disrupted school experience, trouble with the law, confinement, inappropriate sexual behavior, and alcohol and drug problems. [These problems, as defined in the Streissguth et al. study, are included in Appendix B.]

Worldwide longitudinal research on FASD notes disturbingly high rates of maladaptive behavior and poor life outcomes (Lemoine, summarized in Streissguth, 1994; Spohr & Steinhausen, 1996; Streissguth, 1997). Particularly unsettling about these outcomes is that they occur with higher frequency with FASD than other disabilities (Streissguth, 1997, p. 105). For example, Lemoine (1994), after a 30-year follow-up study, found that mental problems "constituted the most severe manifestation of FASD in adulthood" (quoted in Streissguth & O'Malley, 2000. p. 182). Additionally, anecdotal information from biological, foster, and adoptive families report similar observations (M.L. Canney, personal
Research into causes and long-term consequences of FASD helps determine pertinent risk and vulnerability factors that predispose some affected people individuals to poor life outcomes (Streissguth, 1997; Sreissguth & Kanter, 1997). Understanding how and why maladaptive behaviors occur in people with FASD should lead to improved services, as well as greater acceptance of their learning and survival needs. While information on secondary outcomes for people with FASD is helpful in directing research and improving services, it must be remembered that not all people with FASD suffer poor life outcomes. Individuals reared in environments and homes that accommodate for their learning styles and behaviors have remarkable successes (see Caldwell, 1993; Gere & Gere, 2000; Lutke, 1993 & 2000).

**Fetal Alcohol Spectrum Disorder in Alaska**

The presence of people with FAS/FAE in the United States “constitute a major public health concern” (Stratton, et al., 1996, p.7). Alaska is considered to have the highest measured incidence of FAS in the United States (State of Alaska, 1999). Incidence rates for the state are reported as 1.4 per 1000 live births, about four times the national average (State of Alaska, 2001). This statistic is based on surveillance information for 1995-1998. The report estimates that 14 infants are born each year with FAS and at least an additional 126 infants
born each year are born affected by maternal alcohol exposure during that time (p. 1).

While, these statistics are helpful in beginning to understand the impact of people with FASD in Alaska, it must be noted that until recently, diagnostic services throughout the state have been limited (State of Alaska, 2000). Many people have a diagnosis of a FASD, yet many others are awaiting the opportunity to be seen in diagnostic clinics or have never been diagnosed (S. Dohner, B. Taaffe, A. Turner, personal communications, Diagnostic Team Coordinators, January, 2002). Prevention efforts are underway in Alaska to reduce the further number of people born with disabilities due to prenatal alcohol exposure. However, people already enveloped by the disorder are at high risk for a variety of poor outcomes in many communities throughout the state because their behavior and social needs are misunderstood and not appropriately addressed.
CHAPTER 3
RISK AND ALCOHOL-AFFECTED INDIVIDUALS

The idea of crime as a possible outcome for people with FASD arises from research summaries, clinical literature, and family/advocate reports (Jones, 2000; Olsen, in press; Streissguth et al., 1996). In the Streissguth et al. (1996) study on secondary disabilities, 60% of the study population had trouble with the law while 40% did not (p. 46). Part of the intention of conducting their study was to determine what risk and protective factors were associated with the development of secondary disabilities. Understanding such factors "should improve the quality of life for people with FAS and FAE and their families" (Streissguth et. al, 1996, p. 8).

Suggestions that something in the biological make-up of people with FASD predisposes them to crime frightens prospective and current parents, stimulates continued research, and prevents accurate understanding of the disability. Improved insight into how criminal involvement emerges for a person with FASD helps dispel misconceptions about this disorder. The multifactorial perspective offered below synthesizes awareness of how individual temperament, environment, and contact with various systems influence life outcomes for people with FASD. Examining risk and protection against crime provides insight into this disability and is a springboard from which to discuss options for intervention and change.
Viewing Multiple Influences

Even if researchers understood exactly and entirely what alcohol does to the developing brain, they could only make an educated guess as to the outcome expression of that deviation. A person's behavior is never the result of brain structure alone (Clarren, 2000). Once born, a myriad of factors influence every alcohol-affected individual.

Research findings indicate that having FASD is a risk factor associated with increased susceptibility to crime commission, but they do not support the idea that FASD causes criminal behavior (Conry & Fast, 2000; Dagher-Margosian, 2001; Streissguth, 1997; Streissguth & Kanter, 1997). The current state of research literature suggests that there is no direct causal connection between various disabilities and the propensity to commit crimes (Ashford, 2000, p. 227; Fishbein, 2000; Luckasson, 2001; Malmgren, Abbott & Hawkins, 1999).

To assess what predisposes only some alcohol-affected individuals to crime it is critical to understand that the "teratogenic effects of prenatal alcohol exposure can be influenced by numerous factors, both biological and environmental" (Stratton et al., 1996, p. 47). Certain in-born characteristics, social realities, and environmental disadvantages place some sufferers of FASD at higher risk of committing crimes than others.

A multifactorial perspective is a helpful framework for viewing the many and complex influences that affect different outcomes for alcohol-affected individuals (Stratton et al., 1996, p. 47). This perspective "integrates a wide range
of concepts, models, and theories into a rational organizational structure” (Petersilia, Foote, & Crowell, 2001, p. 22). Several researchers and authors employ this type of model for understanding how secondary outcomes emerge for people with FASD (e.g. Olson, in press; Olson, Morse & Huffine, 1998; Stratton et al., 1996).

Multifactorial influences of life outcomes for people with FASD

Cicchetti (1990) suggests that the idea of observing an organism in its entirety to get a sense of what is actually going on dates back to Aristotle (p. 11-19). A multifactorial model synthesizes numerous environmental factors and internal risk factors (i.e. extrinsic and intrinsic factors) that a person with FASD may confront in a lifetime. Use of the multifactorial framework “assists in helping make connection among phenomena that otherwise seem haphazard and unrelated” (Achenbach, 1990, p. 31).

To understanding how a person prenatally exposed to alcohol may end up in trouble with the law, several theoretical influences are offered on Figure 3. These influences are in an “organismic” or developmental framework that stresses that an individual has a dynamic role within their environments and depicts the individual as one who reacts and acts in response to their surrounds (Cicchetti, 1990, p. 3; Richman & Bowen, 1997, p. 105). This view of development is based on ideas of Piaget (1952) and Werner (1982) but is not restricted to them.
Figure 5. MultiFactorial influences on an individual with FASD. Adapted from IOM Model (Stratton et al., 1996, p. 47).
A developmental perspective appreciates that individuals move through various stages of maturity and become increasingly capable of integrating different demands and expectations as they age and internalize concepts. In a developmental framework, deviations occur because of failures to fully integrate information from one stage and apply it to the next. Cicchetti (1990) calls this a "principle of disintegration" (p. 14). People with FASD often progress through developmental stages at a slower and less integrated pace than other individuals (Malbin, 1999, Thomas et al., 1998).

Developmental maturity equips people with the ability to perform certain tasks better and understand complex/abstract concepts (e.g. independence, responsibility, and trust) that factor into one's life. Inherent to a developmental perspective is the understanding that as individuals age, social, cognitive, and emotional demands will increase. For the alcohol-affected individual, who can be described as "dysmature" (i.e., socially or developmentally younger than their chronological age), the demands of the environment are often mismatched with their ability. This creates many situations where they perform inappropriately or inadequately (see generally, Malbin, 1999). "The chain of developmental impairments starting early in life progresses into later life and causes serious problems for management and life adaptation (Steinhausen, 1996, p. 245).

Absent for the alcohol-affected individual is a good "demand-competencies" fit. Richman and Bowen (1997) write that a goodness-of-fit in relation to demand-competencies "is achieved when individuals are faced with
demands from their environment that are appropriate to their abilities" (p. 104). Because many people with FASD commonly do not: 1) appear physically disabled, 2) have good expressive language ability, and 3) maintain varying levels of social function, there is an assumption that they can meet developmental expectations appropriate to their age. Incongruence between the demands and requirements in an environment, as well as inadequacies for meeting those demands, lead to feelings of self-doubt, frustration, hopelessness, and despair (Richman & Bowen, 1997, p. 104).

A multifactorial perspective for risk and protection in people with FASD is also helpful when discussed in a “diathesis-stress” framework (diathesis is a predisposition to disease). It is used in this framework to suggest that manifestations of FASD lower an affected individual’s “threshold of susceptibility to environmental stressors that may subsequently trigger the onset of maladjustment or psychopathology” (Richters & Weintraub, 1990, p. 69). Researchers are beginning to more systematically examine both hyperresponsiveness to stress in people with FASD and the mechanisms involved (e.g. Kim, Osborn, & Weinberg, 1996).

The diathesis-stress perspective promotes understanding that poor life outcomes across the life span of a person with FASD can be reduced by anticipating certain stressful experiences and controlling for them (Olson, in press, p. 12). Abel (1996) offers:
Implicit in the results of much of the research on FAS/E is the recognition that many of the consequences of maternal alcohol abuse during pregnancy will not be recognized until children reach adolescence or adulthood when they will be challenged with problems and stresses not previously experienced. Some effects that seem short term may only become latent, arising once again with greater intractability later in life (p. iv).

As people with FASD age, separating primary issues related to FASD from problems created by stressful daily interactions, misunderstanding of the organicity of behavior, and other environmental influences becomes increasingly challenging and complex (Conry & Fast, 2000, p. 14). A multifactorial perspective clarifies how "involvement with the criminal justice system is the final common pathway resulting from complex interactions among adverse developmental, environmental, medical and psychiatric conditions" (Conry & Fast, 2000, p. 2).

Guarding Against Poor Outcomes

In the secondary research study by Streissguth et al. (1996), some factors were listed as protectors. A protective factor is a characteristic or condition that decreases the odds of a secondary disability occurring. For example, individuals who did not have disrupted school experiences were only 40% as likely to be in trouble with the law (Streissguth, 1997, p. 109). The most effective protective factor against crime listed in the study is eligibility for and participation in a Developmental Disability (DD) Program (Streissguth et al., 1996). DD Services generally provide case managers, respite care, job placement services, and
more to people with disabilities. These services and eligibility requirements vary from state to state.

The authors identify eight universal protective factors that are found to be “consistently protective” for any of the secondary disabilities that emerged in their study (Streissguth & Kanter, 1997, p. 28). Living in a stable home, being diagnosed before age six, never experiencing violence, staying in each living situation for an average of more than 2.8 years, experiencing a good quality home, being found eligible for DD, having a diagnosis of FAS (rather than FAE), and having basic needs met for at least 13% of life were most important.

Why discuss protective factors

The idea or use of protective factors in research should be qualified. Richters and Weintraub (1990) write:

In a weak form a protective factor is purely a descriptive label, it is synonymous with risk reducer. In that it refers to a high-risk child’s personal and environmental characteristics that are associated with reduced rates of deviance on measures of cognitive, emotional and/or social functioning. In its more ambitious and common form, the protective factors concept carries both with it a descriptive claim and an inferential claim. In this form it implies an understanding of why these factors are associated with reduced probabilities of negative outcomes (p. 79).

Certainly Streissguth et al. (1996) assume that the protective factors identified as a result of their study have implications for understanding people with FASD. They write: 1) the correlations in the their study “may or may not be causative. They nonetheless suggest courses of action that may be beneficial both to these
patients, and ultimately to society, and 2) many environmental influences that appear beneficial for patients with FAS/FAE are, of course, good for all people—all the more reason that society should safeguard them for people born with a birth defect, particularly a ‘hidden’ birth defect like FAS/FAE” (Striessguth & Kanter, 1997, p. 37).

Prior to the release of the Streissguth et al. secondary disability study, clinicians, educators, parents, and advocates clamored for early diagnostic services. The understanding was that the diagnosis was a means to more service options and improved intervention services (see Kleinfeld, 1993, Kronowitz, 1991). Additionally, in case studies and family summaries of alcohol-affected individuals who do not experience secondary disabilities, the value of early diagnosis, consistency at home, and support of insightful programs is consistently verified as critical to life outcome success (see Kleinfeld, 1993 & 2000; Lutke, 1997).

Defeating Factors

Literature on secondary outcomes for people with FASD defines a risk factor as “a characteristic or condition that increases the odds of a particular disability occurring” (Striessguth & Kanter, 1997, p. 27). In a broader sense, risks are any influences that increase the likelihood of a problem condition (Frazer, 1997, p. 3). In essence, risks are probabilities. Just as early diagnosis, living in a constant, stable home, and eligibility for DD services can be protective, the lack of these elements in the lives of alcohol-affected individuals places them at
greater risk of a poor life outcome, such as trouble with the law. In discussing risk in the lives of those with FASD, it is critical to understand that effects of risk factors are seldom specific or linear and therefore difficult to pinpoint (Teerikangas, Aronen, & Martin, 1998).

People with FASD, because of their organic-based brain damage, are vulnerable to negative outcomes at most stages of development, as well as in any environment that challenges their sense of security and basic skills. Spohr and Steinhausen (1996) note, “Newborn infants who have been exposed to alcohol during fetal life may be much more vulnerable to adverse environmental factors than other babies, which means that they should be taken care of under the best possible psychological circumstances” (p. xv). Unfortunately, research indicates that a number of people with FASD are reared in hectic, unpredictable living conditions by care-providers who are still abusing alcohol (Conry & Fast, 2000, p. 18; Streissguth & O’Malley, 2000, p. 183). In such homes, stress may be high and the family may not be attentive to the needs of an alcohol-affected child. Fishbein (2000) states that:

Inherently vulnerable individuals (by virtue of their genetic make-up or biological constitution), who are subsequently exposed to an adverse environment are at imminently greater risk, particularly when adverse external influences are cumulative over time (e.g., prenatal drug exposure, perinatal complications, child abuse or neglect, exposure to racism, social isolation, economic deprivation, dysfunctional family, negative peer influences, witnessing violence, and so forth) (p. 25-4).
Even in homes where the family is able to identify that a child is experiencing some developmental lags or processing problems, a diagnosis is only helpful if the family understands what having FASD means. As a result of their research on risk and resilience, Werner and Smith (1982) note "a lack of understanding of the diagnosis propels a family into a cycle of misunderstanding, misjudgment, and misguided feelings of inadequacy and doom (p. 33). Parents interviewed for this thesis report that understanding this disability and all of its ramifications is incredibly challenging to the family. They must meet the daily needs of the child and explain the child to everyone they interact with routinely (Peters, personal communication, January 2002; Tony, personal communication, January 2001) Understanding of this diagnosis requires restructuring how simple daily interactions like preparing meals, getting ready for school, and bedtime routines are performed (see generally, Caldwell, 1993; Lutke, 1993 & 1997).

A consistent defeating aspect of FASD is that well-intending people try effective strategies that fail to change behavior or fix an area of breakdown. Service-providers and caregivers find this frustrating and frequently experience "burnout" trying to aid alcohol-affected individuals. People with FASD are often mistakenly viewed as willfully delinquent or defiant, rather than disabled.

Unfortunately, children with multiple "risk factors" are especially likely to be entrenched in a criminogenic life course (Richters, J. & Weintraub, 1990; Rutter, 1990). Assessing risks in the lifespan of an alcohol-affected individual is a never-ending task that requires further scrutiny.
Why people with FASD make bad choices

A normal brain is critical to normal functioning. Individuals with FASD have brain damage (Stratton et al., 1996, p. 2). Failure to anticipate how FASD affects interactions with people and the environment exacerbates many of the primary manifestations of their brain damage. Often individuals with FASD cannot elicit positive responses from the people they need to help them, thus compounding their problems. [A visual representation of this breakdown process is offered in Figure 4].

Many researchers and family advocates describe a “self-defeating cycle” that leads some with FASD to criminal involvement (Olson, in press; Streissguth, 1997, p. 180). Chronic problems with ADHD, impulsivity, and poor judgment place affected individuals at risk for illogical and dangerous choices. Their apparent mastery of speech may mask the shallowness of content or lack of logic, often sounding like they know what they talking about when they do not (Malbin, 1991, p. 14). Often their talking is an ill-fated attempt to win or influence friends and to appear normal (M.L. Canney, personal communication, January, 2002). One parent interviewed for this thesis told how her son talked a therapist into paying him to detail her new, expensive, white car even though he had never performed such a job. When he failed to complete the job, he got in more trouble (L. Philips, personal communication, February, 2002).

Because they have brain damage, alcohol-affected individuals frequently make poor choices and display behavior that is troubling to people around them.
Green represents best-fit path.
Blue is a common path that can lead to good and bad outcomes.
Red is the most destructive path.

Figure 6. Risk and Protection Process and Pathways
The brain damage associated with FASD results in erratic and impulsive behavior that lends itself to inconsistent responses to traditional treatments and behavior modification interventions. Seemingly self-defeating actions and behavior breakdowns are common. However, while pathways to understanding may be damaged, the environments in which affected individuals are raised do not have to be immutable. Societal intervention and familiarity with the disability are needed to avoid negative outcomes, (e.g., crime).

Alaska’s Protective Responses to the Needs of People with FASD

**State law**

In 1990, after much work by Senator Johne Binkley and his aides, various bills were passed that attempted to address the consequences of prenatal alcohol exposure. [See Appendix B for a summary of the bills]. Bill 409 mandated that all the school districts provide in-service training on FAS by June 1992. Alaskan Statute 14.20.680 currently mandates that these trainings continue. The idea behind the legislation is to increase the likelihood that a teacher may know how to respond to the needs of child with FASD in their classroom. Former senator Binkley accordingly received an award for his contribution to families of children with FAS [Figure 4].

Senator Brinkley’s rationale for initiating the school legislation was most likely a reaction to frustrations continuously voiced that school is the place of primary disruption for many individuals with FASD (See generally, Malbin, 1999, Olsen, in press; Streissguth, 1997). Parents consistently report that their children
have been ignored or mistreated by staff, described as behavior problems, and/or frequently labeled as scapegoats for all deviance in the classroom (M. Tony, Q. Peters, M. L. Canney, personal communication, January, 2002). The Binkley legislation is an attempt to change the tide of the school as a first line of failure.

Figure 7. Former senator Binkley receiving recognition for his contribution to children and families coping with FASD.

Surveillance

Alaska is currently part of a comprehensive attempt by the Center for Disease Control (CDC) to glean a more accurate understanding of how many
people in Alaska have FASD. Established in 1998, the Surveillance Project is part of a collaborative effort, involving five states (i.e., Arizona, Colorado, New York, and Wisconsin) Information gathered by this project should improve services for people with FASD. [A summary of the project is included in Appendix B.]

**Office of FAS**

In 2000, Alaska received a 5-year, $29 million grant from the federal Substance Abuse and Mental Health Services Administration to address issues related to FASD. The grant is administered through the State of Alaska, Department of Health and Human Services Office of FAS. The grant is recognition of the prevailing and pervasive needs of the state created by both the presence of people with FASD and the need to end the cycle of alcohol abuse that perpetuates this burden on communities and families.

Briefly, the Office of FAS is addressing ways to: 1) create a change in public norms about women drinking, through Public Service campaigns and grants prevention programs; 2) increase training to all service providers who come into contact with this disability, by providing in-services, contracting with people to provide trainings, and developing training materials; 3) support families of alcohol-affected individuals by advocating for changes in service delivery models and systems, and improving the quality of services; 4) support programs and policies that guarantee all individuals with FAS reach their full potential and receive the services they need; and 5) improve diagnostic services by developing
community based diagnostic teams. Fifteen teams have been trained so far and span the state, from Barrow to Ketchikan (State of Alaska, 2002b, p. 2).

The state's approach focuses on the critical understanding that interventions and treatments must increase the presence and strength of protective influences in the lives of alcohol-affected individuals. Grants are provided to projects that build lasting changes in existing support systems. The staff at the Office of FAS is attempting to respond statewide to voices concerned with the profound impact of people with FASD on their communities and agencies. Currently individuals from DOC and the court system sit on the Office of FAS' advisory board. Additionally, a justice strand is being developed for the yearly statewide conference to explore issues related to working with offenders with FASD. The Office is also developing a manual on addressing the needs of alcohol-affected offenders (Diane Casto, Director of the Office of FAS, personal communication, January, 2002).

The state of Alaska is attempting to secure best outcomes for individuals prenatally affected by alcohol in all settings in which they are encountered. Exploring how having FASD increases the potential for unfair treatment within the Alaska's criminal justice system is critical for protecting people with FASD. When having FASD is de-emphasized or unrecognized in criminal justice settings, affected individuals are more prone to experience behavioral breakdowns and inappropriate reactions to authorities and other inmates (Conry & Fast, 2000; Dagher-Margosian, 2001; Ladue & Dunne, 1997). The invisibility and difficult
nature of FASD makes familiarity with its many expressions in criminal justice settings critical to the hope for justice (Conry & Fast 2001; LaDue & Dunne, 1997; Streissguth, 1997).
CHAPTER 4
THE OFFENDER WITH FASD

The Concerns

The diverse presentation of this disability prevents a definitive picture of an alcohol-affected offender from being developed. However, some consistent target breakdown areas can be examined. Much of the information below is from literature on FASD, parents interviewed for this study, and writings by parents and professionals with insight on this topic. Kleinfeld (1993 & 2000) proposes that from the "wisdom of practice" of parents and other professionals, insight into understanding the needs of people with FASD in every setting is gleaned (p. 16). Streissguth (1997) writes "In the present void of effective research of effective treatment modalities, the experience of parents represents almost the only source of help and understanding regarding what is needed and what isn't needed, what works and what doesn't work..." (p. 180). Additionally, work from authors who have written about crime and hallmark elements of FASD such as ADHD and impulsivity will offer insight on how the offender with FASD presents in criminal justice settings (e.g. Hart & Dempster, 1997; Newman & Wallace, 1993; Richardson, 2000).

Misunderstanding the process and their rights

Individuals who are cognitively, emotionally, or otherwise impaired, confound professionals employed by a system whose reach extends "only to those able to comprehend its terms and abide by its prescriptions" (Conley, Luckasson & Bouthilet, 1992; Conry & Fast 2000; Robinson, 1997, p. 159). Many
people with disabilities lack the cognitive pace necessary to effectively represent themselves to police and other justice personnel (Luckasson, 2001). Compromised cognition, the inability to discern danger, and the inability to appropriately weigh social roles and interactions place people with FASD at higher risk than deviant peers of being arrested, confessing to things they did and did not do, or saying things that they think police, lawyers, judges, or other authorities may want to hear (Conry & Fast, 2000; Dagher-Margosian, 2001; Petersilia, 2000). Offenders with FAS/FAE, frequently unable to adequately modulate their reactions to stressful situations, may be easily convinced to waive their Miranda rights, say things they do not mean, or refuse to cooperate (Boulding, 2001; Conry & Fast, 2000; Dagher-Margosian, 1997; Ladue & Dunne, 1997). Lack of involvement in their own defense and effort at following probation and prison rules can result in police, corrections officials, and lawyers labeling people with FASD as oppositional, lazy, or deviant when in essence they merely do not understand the expectations of the situations.

Interrogation settings, for example, often require rapid thinking and responses on the part of the accused in order to avoid self-incriminating statements and resistance to persuasion (Clare & Gudjonsson, 1993; Pearce, Gudjonsson, Clare, & Rutter, 1998). The slow cognitive pace that frequently accompanies FASD places alcohol-affected offenders at a dangerous disadvantage. They can easily succumb to pressure to confess, may confess to crimes they did not commit in order to please people, or may lie or confabulate in
order to "get out" of the stressful situation. Researchers Conry, Fast, & Loock (1997) believe that impaired cognitive abilities of people with FASD "place them at greater risk of not anticipating or understanding the consequences of their abilities or fully comprehending the implications of court proceedings" (p. 19).

Accompanying attentional deficits (e.g. attention deficient hyperactivity disorder [ADHD], attention deficit disorder [ADD]) commonly associated with FASD hamper the alcohol-affected offender from efficacious participation in the criminal justice process. Coles (2001) notes that the ADHD observed in alcohol-affected individuals causes more problems with learning new tasks and "in utilizing flexibility in problem solving" than what is seen in the typical ADHD individual (p. 201). The unique expression of ADHD in individuals with FASD is the focus of current research (Coles, 2001, p. 200). Information on offenders with ADHD and how they present in criminal justice settings is consistent with reports on offenders with FASD and their criminal involvement (Conry & Fast, 2000; LaDue & Dunne, 1997; Lutke, personal communication 1999, Tony, personal communication, 1999). Richardson (2000), clinician and ADHD/crime researcher, offers:

Offenders with ADHD are often shocked by their impulsive behaviors or what they say, and they frequently do not understand their own actions. Offenders with ADHD often commit impulsive crimes such as car theft or jacking, robbery, petty or grand theft, assault, domestic violence, child abuse, and drug related crimes. These crimes are usually not planned, or planned with little thought of how to execute them...The ADHD brain has problems putting on the brakes and controlling actions; this is called
disinhibition...a common theme among offenders with ADHD is that many are not successful criminals. Due to their attentional problems and impulsivity, they have a tendency to get caught. They often blurt out insults, make threats, or become assaultive...As a result, it is common among adults and juveniles with untreated ADHD to exacerbate their legal problems...They appear to be withholding, confabulating, or lying...Some may even exaggerate the importance of the role they played (p. 18-8). Another useful yet cautious application of information that offers insight on the offender with FASD is from research on impulsivity and psychopathology. Information on impulsivity and crime commission may be helpful for understanding maladaptive behavioral responses in people with FASD. Work by Newman and Wallace (1993) on problems with disinhibition and the neurosystems involved is particularly useful. Individuals with impulse control problems have “difficulty in the automatic switching of attention which, in turn, interferes with their ability to assimilate unattended but potentially relevant information while they are engaged in the organization and implementation of goal-directed behavior” (Newman and Wallace, 1993, p. 712; or see Hart & Dempster, p. 221). While the type of impulsivity specific to brain damage from prenatal alcohol exposure may or may not be the same that is reviewed in Newman and Wallace's work, suggests for interventions based on their research may be useful in programming for alcohol-affected offenders.

In commenting on people with FASD and their understanding the criminal justice process and their rights, Quida Peters, mother of a son who has been arrested and incarcerated in the Alaskan criminal just system, observes that one
of the more difficult things to teach an affected individual is the significance of the role of people in the criminal process (personal communication, January 2002). Weighing what information to share with police, probation officers, and lawyers is a difficult concept for any individual that comes in contact with the law. Teaching this skill to a person with FASD, Peters notes, is almost impossible. She puzzles over an effective way of instructing that one should trust criminal justice personnel, but not freely talk with them. The irony or seeming paradox of additional legal complications, resulting from information freely given to trusted officials, is lost on those with brain damage (also see, Jones, 2000).

**Legal issues related to intentional behaviors**

Competency, responsibility, and capacity are issues of great importance in criminal proceedings. Each is a controversial legal concept that has been subjected to much scrutiny in most legal systems (Arenella, 1992; Fitch, 1992; McGee & Menolascino, 1992; Morse, 1979 & 1992). On many occasions, these concepts have been inconsistently applied in divergent cases (see Dix & Sharlot, 1999; Morse, 1979 & 1992). Competency is generally assessed before a criminal trial to determine if the accused has the ability to understand the legal process and assist in their own defense. Capacity and responsibility address a person’s ability to form the intent necessary to commit a crime (LaDue & Dunn, 1997).

Consistently irrational actions suggest that a person with FASD has difficulty engaging in intentional behavior and understanding behavioral consequences, making their ability to form intent suspect or at least diminished.
(Dagher-Margosian, 1997; La Due & Dunn, 1997, p. 150). Robert Steeves, a prison guard and parent of a child with FAS who has committed a crime, comments, “A lot of things he has done and has not even comprehended the consequences. He doesn’t learn from his experiences. Sometimes it is like he doesn’t have his own personality.” June Steeves, Robert’s wife, adds, “People with FAS are definitely followers. They need an external brain so whatever brain it is that is helping them to cope for that day or to give them instructions for that day is what they are. So if they are with a group of people who are criminally inclined he will become exactly that” (Films for Humanities and Science, 1997). La Due and Dunne (1997) report the rate of offending for people with FASD increases with the lessening of supervision (p. 4).

FAS advocates and writers, DeVries and Waller (2000), observe that people with FAS/FAE are highly vulnerable to peer pressure and can easily be described as moral chameleons (p. 4). Personal standards of right and wrong are easily forgotten, and their behavior can misguidedly be matched to that of the any group. Additionally, much like a young child, people with FAS/FAE frequently misunderstand the need for consistent application of societal rules (p. 4). Thomas, Kelly, Mattson and Riley’s (1998) investigation into the social abilities of children with FAS/FAE suggest that people with FAS may have arrested, not delayed, social development. Children and adults with FAS/FAE, “may have impairments in their ability to develop empathy and more advance interpersonal skills” (p. 532).
Mental health clinicians, LaDue and Dunn (1997) state that a diagnosis of FAS raises numerous questions about the fairness of proceedings relative to legal responsibility, competency, and just punishment (p. 149). If, as Morse (1992) writes, “the law’s concept of a person is thus of a practical reasoning, rule-following creature...[and]...legal concepts, including those pertinent to criminal liability, will therefore be grounded in the view of persons as practical reasoners,” then people with FAS are clearly at a disadvantage (p. 210). “The organic brain damage caused by prenatal alcohol exposure often does limit a person’s ability to form intent and understand behavioral consequences. It is a reality that needs to be detailed in an evaluation and clearly communicated to the court” (LaDue & Dunn, 1997, p. 149-150). Capron (1992) suggests that questions of capacity and FAS:

...may simply be too daunting, even though the functional abilities of the victims of the syndrome conform to the Model Penal Code’s definition of circumstances that exclude criminal responsibility —namely, when a person ‘lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law...’ Thus the fact that other mentally retarded persons do not fit our image of ‘the insanity defense’ does not necessarily mean that the victims of FAS would not qualify (p. 3).

Unfamiliarity with the diagnosis of FASD by legal professionals results in the disorder not being raised as a defense early on in trials. Additionally, FASD, like many mental health defenses, is not received well by juries and judges, and are at times misused by convicts (Golden, 1999). Conry, Fast & Loock (1997)
and Barnett (1997) insist that FAS should not be used as an excuse for behaviors: rather, FAS may require special consideration in sentencing and disposition hearings.

**Behaviors that can lead to victimization**

Professionals and parents frequently report that people with FAS/FAE annoy others because of an inability to realize when things have gone too far (Lutke, 2000). “They can be irritating because of their ingratiating, inappropriate behavior. They are often described as having extreme mood swings, going from being reasonable to angry in a few seconds” (Conry & Fast, 2000, p. 74). Conry and Fast (2000) suggest that because of these behaviors, “it may be unrealistic for an individual with FAS/FAE to avoid criminal behaviors while in jail” (p. 73). Irritating behaviors, gullibility, and an inability to understand simple social cues place people with FAS at higher risk of being victimized while incarcerated. Furthermore, alcohol-affected individuals frequently lack an ability to change behavior based on what they might see or say having a negative consequence. Consequently, the commonly employed practice of applying sanctions to avoid behavior breakdowns is ineffective for people with FASD.

An accused person with FAS/E often lacks the ability to complete or follow through on tasks in a timely or reasonable fashion, frustrating busy lawyers, corrections, probation, and police officers. Possessing both a compromised ability to retain information, as well as difficulty understanding abstract concepts like “being on time” or “taking responsibility”, the offender with FAS/FAE is a
prime candidate for rule violations. They will frequently say that they understand what is happening when they do not, repeat mistakes, and violate simple rules. “People with FAS are able to state rules and might say it is wrong to not follow them. However, this does not mean that they make the connection between following the rule and their own behavior” (Conry & Fast, 2000, p. 72).

Parents and researchers describe this area of breakdown as problems with “sustainability over time” (J. Lutke & S. Berg, personal communication, February, 2002). Sustainability over time is an inability to consistently repeat learned skills. This is not misbehavior; it is part of alcohol-related brain damage (See Streissguth’s (1997) reviews of animal studies for this expression in rat studies, p. 64-65). Because of this expression of their brain damage, some adults with FAS/FAE need to be reminded daily of how to dress appropriately, brush their teeth, and when to take a shower. While these seem like odd things to forget, fatigue, distractions, or disruptions in schedules or environments may cause a person with FASD to loose track of simple, necessary activities. They are often seen as resistant or defiant when in actuality they do not understand what is expected of them in a given situation, forget what to do, or are too tired to do the activity (Lutke, 1997). Prison guards, who assume an offender is a capable adult, view such rule-violating behavior as willfulness rather than a sign of brain damage. Often those with FAS are labeled non-compliant when in truth they are non-competent (Lutke, 1997, p. 185).
Another critical component of adaptive skills behavior that proves difficult for people with FASD is the ability to make and maintain friendships and social relationships. Parents report that people with FASD and other non-related disabilities want friends so badly they give people personal possessions, spend much needed money on them, and can be persuaded to do illegal things for them. Often these “friendships” lead to trouble and various types of victimization (L. Phillips, personal communication, February, 2002; V. Hodeski & M.L. Canney personal communications, February, 2002).

Informal Strategies to Address the Needs of Alcohol-Affected Offenders

Parents, professionals, and advocates for people with FASD who commit crimes realize that in the absence of system wide formal methods of addressing the needs of disabled individuals in Alaska’s criminal justice system, informal interventions must be made. Incumbent on them is the duty to efficiently communication to lawyers, judges, and police and probation officers accommodations their family members need in order to adequately understand what is going on and what is expected of them in criminal justice settings. Advocates for offenders with FASD stress the need for the use of concrete communication strategies by criminal justice personnel as being of particular importance.

Communication adaptations

Cases Involving Persons with Special Communication Needs (See Conry & Fast, 2000, p. 35). This is a broad protocol, defining persons with special communication needs as those “who, because of age, level of literacy, or mental or physical disability are unable, without assistance, to fully access the criminal justice system or understand or be understood by officials thereof.” (p. 35).

Based on the need for alternative communication avenues, LegalPIX was developed to assist people with special communication needs navigate the justice system in British Columbia. This unique communication program uses pictures to educate people about their rights and what is taking place in the criminal justice process. The pictures are computer generated and cover a wide range of judicial and corrections situations. [A short description of this program is included in Appendix C.] While this program is not perfect, it is one way of beginning to think alternative methods of communicating complicated information to people with information processing deficits.

Interestingly, individuals interviewed for this thesis who are trying to make needed accommodations for alcohol-affected offenders find using pictures and simplifying written information extremely valuable. In the absence of formalized interventions for working with disabled offenders, DOC, DJJ, and judiciary officials are creating their own methods. One judge reports that he draws pictures on flip charts to help demystify not only what is happening in the courtroom but also what is expected of the offender. Probation Officer supervisor Jim Orr is
constantly trying to revise written probation requirements to meet the needs of people with FASD.

Because "criminal justice systems were not designed with any understanding of FAS[D] and the manifestations of this disability" alcohol-affected offenders offer numerous challenges to standard policing, judicial and corrections procedures (Supreme Court Judge Vickers 2000, xiii). To more clearly understand some of the issues that offenders with FASD present to criminal justice personnel, a view of the issue from part of the criminal justice is offered in the following chapter.
ISSUES OFFENDERS WITH FASD PRESENT FOR ALASKAN PROBATION OFFICERS

A View From Part of the Criminal Justice System

To illuminate some of the issues offenders with FASD present to personnel working in the criminal justice system, a survey of Alaskan probation officers was conducted. Eighty-eight POs from Alaska Department of Corrections (ADOC) and 24 from Division of Juvenile Justice (DJJ) Northern Region were given the opportunity to participate in this inquiry. The response rate for ADOC was 44% and 100% for DJJ. The overall survey response rate was 56%.

Probation officers were chosen as a target group because probation is the most widely used sanction in the American justice system. In a summary of Streissguth et al. (1996) study on secondary disabilities probation was noted as being the most prevalent sentencing alternative (p. 109).

The primary purposes behind the use of the survey were to understand issues POs identify in dealing with alcohol-affected clients and to determine what needs to improve if these issues impact how probation practices are conducted. Low returns from ADOC participants can be attributed to the lack on follow-up in determining if all the participants initially received the mailed survey, and in a failure to send a second notice encouraging people to return their surveys.
Improving awareness and practices

In response to questions that address probation officers perceptions of need for improved awareness and changes in current practices, the following results are recorded:

1) 87% believe that everyone working in the criminal justice system should know about FASD;
2) 89% indicate that the state of Alaska should put efforts into improving services to people;
3) 65% are in favor of seeing people with FASD receiving special considerations in probation practices (of that percentage, 43% are strongly in favor of seeing these changes being made);
4) 39% indicate that current probation practices are “not effective at all” at meeting the needs of offenders with FASD.

None of the respondents indicated that current probation practices are “very effective” at addressing this population.

Interestingly, the DJJ POs indicate that clients with FASD have more impact on their jobs and that higher percentages of their caseloads need to be assessed as being alcohol-affected. Some undocumented speculations for the reasons for the differences in responses for the two groups would be: 1) DJJ personnel may be more familiar with the disorder and its manifestations in criminal justice settings, 2) DJJ POs may actually be working with more alcohol-
affected clients, and 3) there may be more emphasis on diagnosing and deterrence at the DJJ level as the clientele is younger and more malleable.

Four general themes emerged from the comments made by POs to the question of what could be done to improve services to offenders with FASD. 1) the need for specialized caseloads, 2) increased availability of diagnostic services at the DJJ/DOC/judiciary level, 3) improved staff-training paired with permanent on-site help availability, and 4) development of FASD-specific facilities. These themes essentially match suggestions that parents interviewed for this thesis made for improved services (V. Horodyski, J. Lutke, Q. Peters, parents of offenders with FASD, personal communications, February, 2002). Themes that emerged in the survey for correcting inadequacies in probation practices responses are similar to the ones detailed in the Conry & Fast (2000); [see Appendix C.]

Voices behind the concerns

In follow-up interviews with probation officers who responded to the survey, issues specific to four emergent themes were explored. The following statements are representation of the answers shared by POs interviewed:

----"What I have observed is that DOC lumps these offenders into the general population and therefore expects them to have the same abilities, decision-making potential, intelligence, etc. They soon demonstrate they cannot cope and DOC just assumes it is for other reasons than their disability. They need a place of their own, their own mod or section where
they are supervised by staff who have been trained and recognize their behavior as affected. If they are put in general Community Correction Center (CRC)'s, they again come in conflict with structure, rules, regulations, expectations that they cannot meet. They need a separate CRC where they can live and be supervised on a higher level.”

-----“The justice system needs to provide resources for working with these clients. System-wide comprehensive services are needed. These services should not be available to only children but should continue into adulthood. A system where the educational system, justice (adult and juvenile) system, native corporations, public health, substance abuse treatment centers, mental health, and grass roots organizations all working together to provide systematic services. Alcohol-affected individuals are not just the justice system’s problem but are the community’s.”

-----“I think that there are pro’s and con’s to having specific facility for these individuals. If the goal is to have these individuals return to the community, in general, and function, then they need to learn to deal with situations that may occur. I think it is more important that the grouphome/facility have staff who are educated in dealing with FAS/FAE clients…”

-----“Again there is a need for understanding the FAS/FAE offender and this can only come about through specialized training and working consistently with these offenders. They take much more work than the
normal offender so the caseload should be much lighter. I have found that you are constantly chasing them around, assisting them in little every day tasks, making sure they are compliant with probation conditions...A case manager with this caseload would need much supportive assistance and additional resources to help as they will always need a number of people to form a safety net."

----Some of the comments made by the POs reflect their justified frustrations “…but before we can train and expect staff to have an expertise, DOC will have to first provide programs. We can train staff until we are blue in the face but if we have no programs or specialized Community Residential Center (CRC) etc. then all is for naught. DOC staff has little understanding of how to approach, supervise and treat FAS/FAE offenders.”

Crime, FASD, and Alaska

Officials in the DOC and DJJ are aware that individuals with FASD are under their auspices (Hamilton & Hamilton, 2000 & 2001; Honorable Michael Jeffery, personal communication; PO, J. Orr, personal communication, State of Alaska, 2002a, p. 34). However, both organizations point out that the exact number of affected individuals is unknown. Estimates from probations officers on how many people on their caseloads should be assessed for FASD range anywhere from > 30% to < 20%. Jim Orr, regional PO supervisor, describes people with FASD as the “coming storm that will have an undeniable impact”
(personal communication, February 2001). Individuals at both agencies, contacted in connection with this study were helpful and concerned. A working group within DJJ is currently writing up goals and objectives to work with people with FASD. The office of FAS with DJJ is sponsoring training that targets improving DJJ staff skills in working with people with FASD (Heidi Broscious, personal communication).

While specific information on the number of alcohol-affected offenders in the care of DOC is unavailable, some extrapolations might be helpful for creating an impact scenario. Although this information is purely conjecture, it is being placed in this thesis to make the point that in the absence of this knowledge, justice is not being served and the system may be unduly burdening itself. Given: 1) Alaska's FASD incidence rate of 140 per 1000 (State of Alaska, 2001), 2) a 60% rate of those born with FASD committing crimes (Streissguth et al., 1996), and 3) and estimated state offender population of 9800 (based on State of Alaska 2000 Offender Profile and Probation/Parole rate for September 2001, Lynda Zaugg, DOC probations supervisor, e-mail communication), one can extrapolate that 8.4% (i.e., 823 individuals) of Alaska's offender population suffer from FASD.

Another extrapolation could be done using the Canadian 23.3% incidence rate from the Conry, Fast & Loock (1999) study of an incarcerated population. Their investigation offers the only incidence rate for alcohol-affected offenders in primary resource literature. Using a population 4,218 (based on the DOC 's 2000
inmate profile for CCs and CRCs) approximately 983 inmates may be alcohol affected and would benefit from alternative approaches to help reduce recidivism and safeguard the community.

Emerging research on the expression of needs for people with FASD indicates that many mental health issues exist (Famy, Streissguth, & Unis, 1998; Olson, in press; Streissguth & O'Malley, 2000). In the Streissguth (1996) research on secondary outcomes, “mental health problems are by far the most prevalent secondary disability” (p. 34). Because Alaska has no exact numbers on how many offenders with FASD are incarcerated or on parole/probation, information from studies about the state’s special needs offender population might be useful.

An Alaska Mental Health Trust Authority (AMHTA) study of offenders under supervision of the ADOC found that 34% of the offender population had one or more diagnoses that made them eligible for Mental Health Trust status (i.e., beneficiary groups being: the mentally ill; the mentally defective and retarded; chronic alcoholics suffering from psychoses; and senile people, who as a result of their senility, suffer from mental illness; Care Systems North, 1997, p. 6). [See Appendix B for expanded definitions of each of these groups.] Given that life outcomes for people with FASD often result in mental health issues, it might be reasonable to assume that some of these individuals with mental health needs in ADOC custody have FASD. Additionally, results of this same study are suggestive of a general under-recognition of people with disabilities in ADOC
care; only 0.2% of the total population of inmates has a developmental disability (DD). "The low numbers of DD identified in this study compared to the national prevalence rate indicate that there may be a number of individuals in all parts of the ADOC system that have gone undetected and served “ (Care Systems North, 1997, p. 86). [A definition of DD is included in appendix B and would include some people with FASD.]

A lack of knowledge of both the actual number of affected people and how their presence impacts the system, creates undo stress on the people who work for ADOC, blocks access to needed adapted strategies to assist people with FASD in understanding the criminal justice process, and places the offender with FASD at risk for victimization. Additionally, lack of adequate numbers of special needs offenders highlights the need for increased access for diagnostic services at the judiciary/ADOC level, as requested that by parents, POs, judges, and other DOC staff members.

The themes that arise from the parents, POs, and community members interviewed for this study are reflective of the premise of this thesis that offenders with FASD are being under-identified and ineffectively addressed by traditional practices in Alaska’s criminal justice system. Inferring from the concerns presented by these groups, there is clearly a need for a different approach in best assisting alcohol-affected offenders. Until there is a system for improving diagnostic services, however, it behooves ADOC to begin to implement strategies that will assist an offender with organic brain damage in more
judiciously navigating the system. Rather than trying harder with these individuals and failing, it seems a more appropriate strategy would be to try differently.
CHAPTER 6
SOLUTIONS: “TRYING DIFFERENTLY RATHER THAN HARDER”

In the last appropriately 25 years, American society has made significant advances in providing support to people with developmental disabilities in the efforts of these individuals to achieve fair treatment. Major societal institutions, including education, business, and medicine have responded to create fairer and less discriminatory treatment for all people with disabilities...But I don’t think there is much question that of all societal institutions, the criminal justice system is the last to adequately respond to the special circumstances of people with developmental disabilities. .. For people with developmental disabilities, the criminal justice system is the last frontier of integration.”

Ruth Luckasson (2001, p. 41)

The Disabled and the Criminal Justice System

The American criminal justice system has long struggled with how to fairly meet the needs of individuals with disabilities who commit crimes (see generally Ashford, Sales, & Reid, 2001; Conley, Luckasson, & Bouthilet, 1992; Keyes, Edwards, & Derning, 1998; Pelka, 1997; Petersilia, 2000). Dealing effectively with people recognized as having FASD is a new aspect to this challenge. Advocates for improved services to offenders with disabilities are calling for change. Standard, “one size fits all” criminal justice system approaches to arrest, interrogation, judicial proceedings, and corrections programming are antiquated and harm people with disabilities (Baker, Knight & Simpson, 1995; Conley, Luckasson, & Bouthilet, 1992; Perske, 1991 & 2000). The task facing the criminal justice system is to create a process that meets both the goals of public safety
and protects the needs of each disabled offender (Vickers, 2000, p. xv). Criminal justice researcher, Petersilia (2000) suggests that “a system that satisfies the public's demand for accountability, while at the same time, recognizes that individual cognitive differences that may limit one’s ability to obtain justice” is a consuming but necessary challenge that the criminal justice systems needs to tackle (p. 2).

Criminal justice system personnel are often overloaded and overworked (Lustig, 1998). Change is often misinterpreted as applying more work to a problem that is already unmanageable. When standard techniques for dealing with individuals are not useful, there is a tendency to implement the same strategy with more gusto. More rules, more restrictions, harsher sanctions, and more staff are common ways to address troubling defendants (see generally Day & Berney, 2001; Finn, 1992; Perske, 1991). What is really needed is the application of a commonly applied strategy for working with people with FASD which is “trying differently rather than harder” (Malbin, 1999, p. 9-11).

Developing different strategies for addressing abnormal behaviors frequently does not occur to people employed by a system that has strict, standard methods for dealing with people they perceive as functionally able to follow rules (Malbin, p. 10). However, “the appearance of functionality has little to do with understanding the surrounding world and possessing the range of skills and emotions necessary to interact fully within it” (McGee & Menolascino, 1992, p. 58). Individuals most effective in fostering positive outcomes for those with
FASD identify a constant need to try different ways to present information and explain social expectations (M.L. Canney, personal communication, January 2002; M. Tony, personal communication, January, 2001).

Within the criminal justice system structure trying to address each offender differently may seem tantamount to public disservice and absolute chaos. Discussions of treating groups of offenders differently inspire renewed charges that the justice system is “soft” on crime. Yet, judicial and corrections programs currently exist that support the needs of special offenders and these programs are having measurable success (e.g., Hamilton & Hamilton, 2000 & 2001, Lustig, 1998). Chaos is thwarted and people with special needs are being held accountable for their actions and treated equitably.

**Trying Differently With Offenders With FASD**

“Crime is a complex, multifaceted problem that will not be overcome by simplistic, singularly focused solutions...Workable, long-term solutions must come from the community and be embraced and actively supported by the community” (Petersilia, 1998, p.8). In a review of research on public thought on how sanctions that should be imposed on offenders, Turner and Cullen (1997) determine that the public not only possesses complex views about how to control crime, but also is open to interventions that seek to help, and not merely inflict pain, on offenders (p. 2). Additionally, results from their polling data reveal that the public is not totally wed to the need for incarceration, and that they support
shaping sanctions to match the offense and offender under consideration (Turner & Cullen, 1997, p. 3).

The above information is an important component for developing just solutions for dealing with people with disabilities who commit crimes. Individuals interviewed for this study, as well as advocates for the rights of the disabled, uniformly agree that avoidance of jail or prison is critical to reducing recidivism rates, minimizing the acquisition of worse inappropriate behaviors, and avoiding victimization. However, accountability and responsibility remain essential when discussing solutions for people with FASD who break the law. The need for public safety and protection is always a factor when discussing solutions for addressing special needs offenders. Support from the community is paramount when suggesting creative, workable sanctions that may involve having the law-breaking individual back in the community. Effective programs that address the needs of the disabled in criminal justice settings always highlight the need for accountability for actions that harm the community. Lustig (1998) a legal advocate who has developed one such program, points out that accountability can be interwoven into any service plan that is provided to disabled individuals who break the law (p. 10).

In attempting to determine what is most beneficial to people with FASD who commit crimes, programs/models that are effective in supporting people with mental retardation and mental illness are useful. Aspects of these programs are beneficial to people with FASD who commit crimes. In general, effective
programs use three strategies that address offenders' poor language processing skills, short-term memory problems, poor attending behaviors, and susceptibility issues. The strategies include: 1) specialized case coordination services, 2) heavy reliance on direct communication with the client and people immediately involved in their daily care, and 3) improved utilization of interagency support. These strategies match requests for improved services that parents, probation officers, and community members suggest in connection with this thesis. Staff working with these programs have specialized training in dealing with certain special needs populations and are versed on the nuances of working within the criminal justice system.

**The Developmentally Disabled Offenders Program**

Advocates and researchers for alcohol-affected individuals suggest that applications of interventions for designed for persons with mental retardation are generally not effective. People with FAS have complex profiles of strengths and weaknesses in cognition, learning, and adaptive behavior, as well as an "unsettling degree of recognizable psychopathology" that does not often conform to the template of mental retardation (Olson, in press, p. 24). While this distinction is important when intervening with young people with FASD, models and interventions developed to assist people with mental retardation in the criminal justice system are exactly what are needed to ensure that the rights of those with FASD are addressed.
One example of this model is the Developmentally Disabled (DD) Offenders Program of New Jersey. [See Appendix C for program materials]. The DD Offenders Program provides alternatives to incarceration at critical stages in the judicial and corrections process. As of 1998, program had a 6.5% recidivism rate for its clients, unparalleled when compared with other criminal justice program in the country (Lustig, 1998, p. 18). The New Jersey courts are extremely receptive to the alternatives employed by the program because they are very successful at providing needed services to defendants with mental retardation (Lustig, 1998).

Two key components of the DD Offenders Program are the reliance on personalized justice plans (Figure 6) and strong advocacy. "The right program begins with a knowledgeable advocate within the human service field with extensive prior experience with the criminal justice system" (Lustig, 1998, p. 9). The DD program finds it critical to employ people who can offer technical assistance to attorneys, as well as understand and adapt information in such a way that it addresses the needs of the many players within the justice system (Lustig, 1998, p. 10).

Focusing on service coordination, the DD Offender program operates to keep people with disabilities out of jail or prison. Because in situations where they feel threatened people with cognitive disabilities responses are more likely to be physical, they are more prone to getting into fights and becoming a
The Developmentally Disabled Offenders Program
985 Livingston Ave., North Brunswick, NJ 08902 • Telephone (732) 246-2525 •
e-mail: slustig@arcnj.org • Visit our website at http://www.arcnj.org

Suzanne Lustig, Esq., Director

PERSONALIZED JUSTICE PLAN

PROGRAM CASE #: 02-15046-00

DEMOGRAPHICS:

Name: Smith__________________John  AKA:

Address: XX Anywhere Street Maplewood NJ 07040

Date of Birth: 1/1/67 Age: 33

Sex: Male Ethnic Group: _____________________

Type of Disability: Mild mental retardation

Referral Source: Robert Laurino, Esq., Essex County Prosecutor – Sex Crimes Unit

SUPPORT COMPONENTS/RECOMMENDATIONS

This Personalized Justice Plan (PJP) has been developed by the Developmentally Disabled Offenders Program. The following areas have been identified as support components which addresses the habilitative needs of JOHN SMITH while increasing his accountability and balancing the needs of the community

- Residential
- Vocational/Employment
- Education
- Social/Recreational
- Psychiatric
- Family
- Medical
- Psychological
- Advocacy
- Transportation
- Restitution
- Stipulations

Figure 8. Individualized Justice Program. This a sample of the program used by the DD Offender Program of New Jersey, Pg. 1.
1. Residential Recommendations: JOHN will continue to reside with his mother at the address listed above. See advocacy section for alternate living options.

   Contact Person: Jane Smith
   Agency/Resource: Mother
   Phone: 973/555-0000 (W) 8:30 - 4 Date to Begin: immediately

2. Vocational/Employment Recommendations: JOHN will begin services with the Division of Vocational Rehabilitation Services, 124 Halsey Street, Newark (973) 648-3488. John is motivated regarding vocational training and would like to go into competitive employment.

   Contact Person: Shirley Hirshon
   Agency/Resource: DVRS, Newark
   Phone: 973/648-3488 Date to Begin: 10/18/00 @ 11:00 a.m.

3. Psychological Recommendations: JOHN will begin counseling with Psychometric Services. After the initial intake appointment, he will begin weekly group therapy once the intake process is completed. Updates from Dr. Fulford and his associates will be requested periodically to ensure that John is participating in group sessions to the best of his ability.

   Contact Person: Dr. Paul F. Fulford
   Agency/Resource: Psychometric Services, 24 Commerce St. Newark, NJ
   Phone: 973/278-1203 Date to Begin: 10/19/00

4. Transportation Recommendations: JOHN will take the #25 bus from his home in Maplewood to downtown Newark to participate in the above services. If this transportation arrangement is not working, the DDOP will set up transportation through Essex County transportation services for individuals with disabilities. John will let us know if he is having problems using the bus.

   Contact Person: n/a
   Agency/Resource: NJ Transit

Figure 8. (Cont.) Individualized Justice Program. This a sample of the program used by the DD Offender Program of New Jersey, pg. 2.
6. Advocacy Recommendations: JOHN, with the help of his mother will apply for services with the Division of Developmental Disabilities. If John is accepted, we recommend requesting a placement on the waiting list for residential placement. This will ensure that, if his mother is no longer able to accommodate John residentially that an alternate placement will be available. Note: the residential waiting list is a minimum of 3 years or more. Waiting list is not applicable if John is found ineligible for DDD services.

Contact Person: Intake Department
Agency/Resource: Division of Developmental Disabilities, 153 Halsey St, Box 47013
Phone: 973/693-5080 Date to Begin: Apply immediately

7. Special Conditions/Stipulations Recommendations: JOHN will abide by all conditions set forth by this program and the PTI Probation Officer. This will include payment of restitution as well as child support. John will be required to contact us 2x per week until he is established in services and reporting to probation for at least 2 months. At that time the Coordinator of Community Resources will review the frequency of contact needed to maintain case.

Contact Person: Denise Goobic
Agency/Resource: Coordinator of Community Resources, DD Offenders Program
Phone: 732/246-2525 x31 Date to Begin: weekly, Tues. & Thurs.

III. SUMMARY STATEMENT:

JOHN and his mother are extremely motivated to participate in this Program and are eager to follow the recommendations set forth by this Program. A copy of this PJP will be forwarded to John's PTI Probation Officer once assigned and all modifications to this plan will be made following a consultation with John's PTI Probation Officer and other service providers listed above if applicable.

Contact Person: Suzanne Lustig, Esq. Program Director
Agency/Resource: DD Offenders Program, 985 Livingston Ave., North Brunswick, NJ
Phone: (732) 246-2525 Date to Begin: 9/28/00

Figure 8. (Cont.) Individualized Justice Program. This a sample of the program used by the DD Offender Program of New Jersey, pg. 3.
correctional management problem both for their outbursts and high potential for victimization (Finn, 1992, p. 12). Programs that work to keep individuals with disabilities out of jail/prison settings are a needed step in finding just treatment. Strengths of this model would be beneficial in meeting the needs of people with FASD.

**Mental Health Court**

A second model is the Court Coordinated Resources Project, otherwise known as or Mental Health Court which was set up to address the needs of mentally disabled misdemeanants. The Mental Health Court in Anchorage, Alaska is one of only a few in the in the nation. The court was modeled on ones in Broward County, Florida and King County, Washington. [Figure 7 offers an over review of the court.]

Again, while there is a difference in the manifestations of mental illness and FASD, as well as the needs of the sufferers thereof, the ideals and strategies employed by this model make the judicial and corrections process more accessible. The project relies on collaboration of designated corrections, judicial, prosecution, and defense staff to quickly identify nonviolent, low risk, mentally disabled misdemeanants for diversion from expensive jail beds to community-based behavioral health treatment (Hamilton & Hamilton, 2000, p. 1). The program is dependant on supervision and knowing the antecedents that cause people to fail in the community and trying to work with other agencies to correct for these deficits. The pace of court proceedings is slower than in traditional
courtrooms. And communication is emphasized to the extent that the judge, attorneys, and court case managers spend a great deal of time insuring that the offender understands the process and is not consumed by it.

Alaska Court System  
ANCHORAGE DISTRICT COURT  
COURT COORDINATED RESOURCES PROJECT (CRP)  
MENTAL HEALTH COURT

What is the mental health court?

In 1999 the Alaska Court System established a mental health court project—the Court Coordinated Resources Project (CRP)—in the Anchorage District Court to address the needs of mentally disabled misdemeanants. It is a special court that hears cases involving individuals with mental disabilities charged with misdemeanor offenses. Anchorage's mental health court is one of only a few in the nation and was modeled after two others located in Broward County, Florida and King County, Washington.

The CRP has five broad purposes: (1) to preserve the public safety, (2) to reduce inappropriate incarceration of mentally disabled offenders and promote their well-being, (3) to relieve the burden on the Department of Corrections presented by inmates with mental disabilities, (4) to reduce repeated criminal activity among mentally disabled offenders (legal recidivism), and (5) to reduce psychiatric hospitalization of mentally disabled offenders (clinical recidivism).

The court works to divert non-violent offenders with mental disabilities away from jail and into appropriate community treatment. The court focuses mainly on the therapeutic needs of the defendant. Mentally disabled defendants who adhere to treatment requirements cycle through jails and psychiatric hospitals far less than those who do not. The mental health court involves the judge, designated prosecutors and defense attorneys, the defendant and his/her community treatment provider(s) who provide hands-on monitoring of the defendant's treatment plan through regularly held status hearings.

Who is eligible?

Anyone charged with a misdemeanor who suffers from a mental disability and who wishes to voluntarily participate in the treatment oriented court process in lieu of traditional district court criminal case processing.

How do people get referred to the court?

Any one can refer a person to the mental health court. Police, corrections staff, lawyers, friends, family members, community behavioral health providers, judges and court staff can alert the court that a defendant may eligible to have the case heard in the mental health court.

What happens when a defendant is accepted into the mental health court?

The defendant is required to obtain an individual treatment plan to address his/her specific behavioral health needs and present the plan for court approval. Some defendants are eligible for assistance in coordinating a treatment plan from the Department of Corrections' Jail Alternative Services (JAS) project. If approved, the terms of the treatment plan are court ordered as conditions of bail or probation. Thereafter, the court through regular status hearings monitors the treatment conditions. During status hearings, the court hears reports on the defendant's progress in treatment. If treatment non-compliances occur, the court may adjust the plan to motivate compliance or employ non-jail-based sanctions or incarceration for non-compliance.

For more information contact:

Judge Stephanie Rhoades or CRP Project Manager, Kathi Trawver  
Anchorage District Court  
825 W. 4th Avenue  
Anchorage, AK 99501-2004  
(907) 264-0886

Figure 9. Mental Health Court Summary
Figure 10 is a comparison of traditional court structure and a therapeutic structure.

**Comparison of Traditional & Therapeutic Justice Processes**

<table>
<thead>
<tr>
<th>Traditional Process</th>
<th>Therapeutic Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dispute Resolution</td>
<td>• Problem-Solving Dispute Avoidance</td>
</tr>
<tr>
<td>• Legal Outcome</td>
<td>• Therapeutic Outcome</td>
</tr>
<tr>
<td>• Adversarial Process</td>
<td>• Collaborative Process</td>
</tr>
<tr>
<td>• Claim or Case-Oriented</td>
<td>• People-Orientated</td>
</tr>
<tr>
<td>• Rights-Based</td>
<td>• Interest or Needs-Based</td>
</tr>
<tr>
<td>• Emphasis on Adjudication</td>
<td>• Emphasis Placed on Post-Adjudication &amp; Alternative Dispute Resolution</td>
</tr>
<tr>
<td>• Interpretation and Application of Law</td>
<td>• Interpretation and Application of Social Science</td>
</tr>
<tr>
<td>• Judge as Arbiter</td>
<td>• Judge as Coach</td>
</tr>
<tr>
<td>• Backward Looking</td>
<td>• Forward Looking</td>
</tr>
<tr>
<td>• Precedent-Based</td>
<td>• Planning-Based</td>
</tr>
<tr>
<td>• Few Participants or Stakeholders</td>
<td>• Wide Range of Participants and Stakeholders</td>
</tr>
<tr>
<td>• Individualistic</td>
<td>• Interdependent</td>
</tr>
<tr>
<td>• Legalistic</td>
<td>• Common-Sensical</td>
</tr>
<tr>
<td>• Formal</td>
<td>• Informal</td>
</tr>
<tr>
<td>• Efficient</td>
<td>• Effective</td>
</tr>
</tbody>
</table>

Anchorage Mental Health Court  

**Figure 10. Comparison of Traditional & Therapeutic Justice Processes**
Offenders Programs rely on assertive case management services in order to be effective. Harris and Rice (1997) in writing about effective strategies for mentally disordered offenders suggest:

Case managers cannot wait in their offices for clients to make and keep appointments; rather, effective case managers seek out their clients in the clients' environments. Second, effective case management seems to depend on the quality of the relationship between case manager and client. That is, effective case managers tailor the intensity of each client's social interaction to his or her fluctuating ability to handle social stimulation; give clients responsibility and permission to make some mistakes; and employ positive (praise, reward, reinforcement, encouragement) rather than negative (scolding, withdrawal, punishment, sanctions) means to effect changes in client's behavior (p. 379-380).

Each program relies on extensive information sharing with all agencies involved in the client's life. This particular emphasis ensures the courts, probation, corrections, and other agencies work together to assist the disabled offender obtain just outcomes and avoid, in most cases, incarceration.

Like the preceding projects, successful programs for people with FASD must focus on reducing the number of time that alcohol-affected individuals have to independently interpret complicated materials and requirements. The need for effective case management must be paired with communication systems or styles that are less complicated than the ones currently used by the criminal justice system. For people with FASD to have equal access to just services in the
criminal justice system many adaptations to current practices in Alaska are necessary. Creating programs to implement new strategies requires different thinking. This is a formidable challenge and requires, at times, Legislative and community help. Canadian Supreme Court judge, David Vickers, believes the key to success with FASD offenders is the use of “differential treatment to more nearly equalize outcomes” (Statement at FAS Conference, February, 2002). Treatment of people with disabilities requires different approaches within the criminal justice system so that access to humane treatment is readily available.
CHAPTER 7
CONCLUSION

FASD is a complicated and, at times, troubling disability. While, services to people with FASD are improving in Alaska, many affected people exist without the benefit of a diagnosis and access to supportive services. Critical to avoidance of unacceptable life outcomes for people with FASD are families and environments that plan for the inconsistent responses and compromised language processing skills associated with this disorder. Individuals who do not receive protective supports are vulnerable to secondary conditions like mental health issues, school failure, and trouble with the law (Sreissguth et al., 1996).

People with undiagnosed FASD or those who have not received consistent adaptive services may be under the supervision of Alaska’s criminal justice system. The definitive impact these individuals have on the system is currently unknown. However, families, POs, and other justice officials interviewed for this thesis suggest the impact is formidable. Therefore, it behooves Alaska’s criminal justice system to look at this issue and address the needs of this population in order to: 1) ensure equal access to justice for those who come in contact with the criminal justice system, 2) reduce the frustrations of criminal justice personnel who require more effectively methods of addressing alcohol-affected offenders, and 3) make improved use of state resources by forcing interagency cooperation and client responsibility sharing.
The Alaskan criminal justice system could more competently meet the needs of people with FASD by increasing training on FASD and other disabilities for criminal justice personnel. Such knowledge encourages people to act and treat others differently. The first level of protection for better quality care for people with disabilities is acceptance and understanding of the disability and all its manifestations. No one should ever be punished for having a handicapping condition. Quida Peters, parent of an individual with FASD notes that a key to best practices in any setting is;

People [that work with alcohol-affected individuals] have to want to understand the disability. That is the key right there. If you can be the kind of person, an educator, a probation officer, or friend, who will accept this person the way they are and try to understand why they are the way they are, then you have met half the battle—and won it—but if you go in there and you do not even acknowledge that you might not be right in your assessment, nothing is ever gonna change...

To ensure that help is available to criminal justice personnel after training, the ADOC and DJJ need to employ specialists with knowledge of FAS. These specialists would presumably offer workable solutions for staff and offenders.

Every effort should be made to increase the availability of diagnostic services at the corrections and judicial levels. Awareness of the breadth of the problem should inspire aggressive measures to solve it. Offenders suspected of having FASD require a combination of services to assist them from re-offending and living productive, crime-free lives. Accurate diagnosis of FASD will ensure
that interventions are based on the strengths and weaknesses associated with common manifestations of the condition.

Finally, the state should review and implement strategies to assist people with disabilities used by other criminal justice programs. Individualized justice program and therapeutic court techniques are two examples. Formalizing institutional steps may require Legislative help and aggressive advocacy from within the criminal justice sector. Corrections and judicial personnel must appreciate that an “alternative solution takes time. It takes patience and a willingness to learn. But most importantly, this solution takes action” (Lustig, 1998, p. 8).

Offenders with FASD represent a challenging conundrum for Alaska. They are troubled people who cause trouble. Failure to adequately address their disabling condition places them at risk for trouble with the law. In continuing to not address the problems associated with their disability, once in the criminal justice system they may never be capable of law-abiding lives. In essence, they are punished for having a disability.

Confronting the issues this population presents for the criminal justice system is formidable, but not addressing them is immortal. Finn (1992), writing about people with disabilities and the justice system, concludes that “if we are truly concerned about people with disabilities we must be willing to extend the limits of our systems and accept responsibility for shedding light upon the enigma that they represent. If we are not, then the lost potential of their lives will become
our own dubious legacy (Finn, 1992, p. 16). Because solutions are possible, this legacy should not be acceptable for Alaska.
IRB Approval Letter

University of Alaska Fairbanks

INSTITUTIONAL REVIEW BOARD

Suzy Pence
Research Committee Coordinator
Office of Research Integrity
University of Alaska Fairbanks
206 Eielson Building, P.O. Box 757560
Fairbanks, AK 99775-7560
(907) 474-7800
e-mail: s.pence@uaf.edu

November 25, 2001

Subject: IRB review of Human Subjects Application form

Dear Maureen Harwood:

The following Human Subjects Application was reviewed by the University of Alaska Fairbanks Institutional Review Board (IRB) during its November meeting. This protocol was approved.

IRB Protocol Number: #01-38
Investigator/Instructor: Maureen Harwood
Title of Project/Course: Survey on How Alaskan Probation Officers View the Issue of Fetal Alcohol Syndrome and Fetal Alcohol Effects.
Date Received: 6/28/01
Date Approved: November 25, 2001
Annual Renewal: November

Procedural changes or amendments must be reported to the IRB, and no changes may be implemented without prior IRB approval.

Suzy Pence
Research Committee Coordinator
This questionnaire is part of a process to help better understand:
1) How the presence of people with Fetal Alcohol Syndrome/Effects (FAS/E) in our criminal justice system impacts service delivery, 2) what accommodations are being made to meet the needs of people with FAS/E by probation officers, and 3) what steps need to be taken to help alcohol-affected offenders.

Please answer all of the questions on this questionnaire. If you wish to make additional comments on any of the questions or have information that will help us better understand this issue feel free to use the space on the back cover or on the pages. Your comments will be read and taken into account.

Thank you for your help.

University of Alaska Fairbanks
Please circle the number of the answer that best applies.

Q-1. People working in different social service fields have varying degrees of familiarity with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). How would you describe your knowledge of:

1) the physical characteristics of this disorder?

1 EXTREMELY KNOWLEDGEABLE
2 KNOWLEDGEABLE
3 FAMILIAR
4 SOMewhat FAMILIAR
5 UNACQUAINTED

2) the behaviors associated with the disorder?

1 EXTREMELY KNOWLEDGEABLE
2 KNOWLEDGEABLE
3 FAMILIAR
4 SOMewhat FAMILIAR
5 UNACQUAINTED

Q-2. These are some statements that have been written about people with FAS. Do you tend to agree or disagree with them?

"They have no conscience."

1 AGREE
2 DISAGREE
3 UNCERTAIN

"FAS may negate the 'guilty mind' requirement essential to establishing legal culpability."

1 AGREE
2 DISAGREE
3 UNCERTAIN

Q-2 (cont.) Do you tend to agree or disagree with this statement?

"It is not clear that incarceration is of any value in punishing the FAS offender, or in assuring the community that he or she will not be a threat to public safety upon release."

1 AGREE
2 DISAGREE
3 UNCERTAIN
Copy of Survey (cont.)

Q-3 Is it reasonable to assume that everyone working in the criminal justice system should know about FAS/E?

1 YES
2 NO

Q-4 In your experience, how effective are current probation practices in addressing the needs of people with FAS/E?

1 VERY EFFECTIVE
2 SOMEWHAT EFFECTIVE
3 NOT EFFECTIVE AT ALL
4 UNCERTAIN

Q-5 Which of the following do you feel is responsible for an offender with FAS/E violating a probation condition or repeating crimes?

- LIMITED MENTAL ABILITY
- POOR JUDGEMENT
- LACK OF SUPERVISION
- LOW MOTIVATION
- POOR COMMUNICATION SKILLS

Have you seen or figured out something that addresses any of these issues? Explain below↓

Q-6 What percentage of your current caseload would you estimate should possibly be assessed as having FAS or FAE?

1 MORE THAN 50%
2 MORE THAN 30%
3 LESS THAN 20%
4 LESS THAN 1%

Q-7 People differ in the extent they feel that certain populations should be given special accommodations within a system. In general, how would you feel about people with FAS/E receiving special considerations in probation practices?

1 STRONGLY IN FAVOR
2 SLIGHTLY IN FAVOR
3 NEUTRAL
4 SLIGHTLY OPPOSED
5 STRONGLY OPPOSED
Copy of Survey (cont.)

Q-8 How does having clients with FAS/E impact your job?

1 A GREAT DEAL (TAKES UP ABOUT 50% OF YOUR TIME)
2 SOME (TAKES UP ABOUT 25% OF YOUR TIME)
3 MODEST (TAKES UP ABOUT 10%)
4 VERY LITTLE (TAKES UP ABOUT 5%)
5 NOT AT ALL

A major purpose of this study is to learn more about what people in your field feel needs to occur to help offenders with FAS. The following questions are designed to get your insights, so please feel free to write in the margins or on the back cover if you have other ideas.

Q-9 Describe things that you feel could be done to improve services in the criminal justice system to people with FAS/E? Please use short answers.

Q-10 Do you have any specific approaches that you use in working with people with FAS/E? Or that might be helpful to other POs?

Q-11 How critical is the issue of staff shortages in providing individualized services to people with FAS/E?

1 A BIG FACTOR
2 AN AVERAGE FACTOR
3 A MINOR FACTOR
4 NOT A FACTOR

How critical is the issue of financial constraints?

1 A BIG FACTOR
2 AN AVERAGE FACTOR
3 A MINOR FACTOR
4 NOT A FACTOR

How critical is the issue of large caseloads?

1 A BIG FACTOR
2 AN AVERAGE FACTOR
3 A MINOR FACTOR
4 NOT A FACTOR
Q-12 Should the State of Alaska put efforts into improving services to people with FAS/E who have a criminal history?

1 YES
2 NO

Q-13 A. At what level of your organization are changes in practices most likely to occur?

1 ADMINISTRATION
2 SUPERVISORS
3 FIELD PROBATION OFFICERS
4 OTHER

SPECIFY________

B. Where do you feel that knowledge about FAS/FAE would be most useful?

1 ADMINISTRATION
2 SUPERVISORS
3 FIELD PROBATION OFFICERS
4 OTHER

SPECIFY________

Finally, we would like to ask a few personal questions to help with statistical information.

Q-14 Your sex

1 MALE
2 FEMALE

Q-15 On which of the following have you spent the most time during the last week (shift)? Circle one.

1 DOING PAPERWORK
2 ATTENDING COURT OR OTHER HEARINGS
3 MEETING WITH CLIENTS
4 TRAVEL
5 OTHER

PLEASE SPECIFY
Copy of Survey (cont.)

Q-17  How long have you worked in Probation/Parole?

1  LESS THAN TWO YEARS
2  THREE TO FIVE YEARS
3  SIX TO EIGHT YEARS
4  NINE TO 11 YEARS
5  12 OR MORE YEARS

Q-18  Are you a

1  ADULT-FIELD PROBATION OFFICER
2  INSTITUTIONAL
3  JUVENILE PROBATION OFFICER

NAME (Optional)___________________________________________

Would you be willing to be interviewed about your responses?

1. YES
2. NO

If yes, please provide a phone number or e-mail address

Your contribution to this effort is appreciated.

Additional comments:
Dear Probation Officer,

Statements from judges, probation officers, and other individuals in our criminal justice system indicate that youth and adults affected with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) are committing crimes. Brain damage from prenatal exposure to alcohol makes affected individuals more susceptible to criminal involvement and victimization. Unfortunately, we have little understanding of meeting the needs of people with FAS/E as they proceed through the system. Without information on what special accommodations should be implemented to assist offenders with FAS/E, there is little hope of ensuring that these clients will be served justly and adequately.

As a probation officer who is possibly in direct contact with people with FAS/E you have the first hand knowledge that is necessary to begin to understand the needs of these offenders. Your input on this survey is voluntary and is not related to your job performance. However, your answers will be invaluable in providing us with needed information on how to assist people with FAS in the criminal justice process. The survey will take about 15 minutes to complete.

The results of this survey will be used to share information within the justice system and examine which, if any, policy changes are needed. The answers will be included in a thesis presentation entitled, Alaska's Crime Conundrum: Alcohol-Affected Offenders.

You may be assured of complete confidentiality in your answers. However, if you want a copy of the results or want your comments or concerns attributed there is a space on the survey booklet where you can write your name.

If you have any questions or want to share any thoughts or reactions on this topic feel free to contact me at 474-6536 or email me at ftmfh@uaf.edu. The research supervisor for this survey is Judith Kleinfeld. She can be reached at 474-5266. If you have any questions about the University's relationship to this survey please contact the Institutional Review Board at (907) 474-7314.

I hope that you will take a few minutes of your time to fill out this questionnaire.

Many thanks for your help.

Maureen Harwood
Graduate Student
Northern Studies Program
### IV. Diagnostic Categories

The 256 Diagnostic Codes can be logically grouped into 22 Diagnostic Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Fetal alcohol syndrome (alcohol exposed)</td>
</tr>
<tr>
<td>B</td>
<td>Fetal alcohol syndrome (alcohol exposure unknown)</td>
</tr>
<tr>
<td>C</td>
<td>Atypical fetal alcohol syndrome (alcohol exposed)</td>
</tr>
<tr>
<td>D</td>
<td>Fetal alcohol syndrome phenocopy (no alcohol exposure)</td>
</tr>
<tr>
<td>E</td>
<td>Sentinel physical findings / static encephalopathy (alcohol exposed)</td>
</tr>
<tr>
<td>F</td>
<td>Static encephalopathy (alcohol exposed)</td>
</tr>
<tr>
<td>G</td>
<td>Sentinel physical findings / neurobehavioral disorder (alcohol exposed)</td>
</tr>
<tr>
<td>H</td>
<td>Neurobehavioral disorder (alcohol exposed)</td>
</tr>
<tr>
<td>I</td>
<td>Sentinel physical findings (alcohol exposed)</td>
</tr>
<tr>
<td>J</td>
<td>No cognitive/behavioral or sentinel physical findings detected (alcohol exposed)</td>
</tr>
<tr>
<td>K</td>
<td>Sentinel physical findings / static encephalopathy (alcohol exposure unknown)</td>
</tr>
<tr>
<td>L</td>
<td>Static encephalopathy (alcohol exposure unknown)</td>
</tr>
<tr>
<td>M</td>
<td>Sentinel physical findings / neurobehavioral disorder (alcohol exposure unknown)</td>
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</tr>
<tr>
<td>O</td>
<td>Sentinel physical findings (alcohol exposure unknown)</td>
</tr>
<tr>
<td>P</td>
<td>No cognitive/behavioral or sentinel physical findings detected (alcohol exposure unknown)</td>
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<td>Q</td>
<td>Sentinel physical findings / static encephalopathy (no alcohol exposure)</td>
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<tr>
<td>R</td>
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<td>S</td>
<td>Sentinel physical findings / neurobehavioral disorder (no alcohol exposure)</td>
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<tr>
<td>T</td>
<td>Neurobehavioral disorder (no alcohol exposure)</td>
</tr>
<tr>
<td>U</td>
<td>Sentinel physical findings (no alcohol exposure)</td>
</tr>
<tr>
<td>V</td>
<td>No cognitive/behavioral or sentinel physical findings detected (no alcohol exposure)</td>
</tr>
</tbody>
</table>
THE FETAL ALCOHOL SYNDROME CLINIC
DIAGNOSTIC SUMMARY

Final Diagnosis:  (1) Static encephalopathy
(2) Sentinel physical findings
(3) Alcohol exposed

Fetal alcohol syndrome (FAS) is defined by evidence of growth deficiency, a specific set of facial characteristics, and evidence of brain damage in individuals exposed to alcohol during gestation. Not all individuals exposed to alcohol during gestation have FAS.

In this patient's case, some but not all of the characteristic growth and facial features associated with FAS were present and there was evidence of brain damage as you will see noted on the attached pages. There was also a clear history of exposure to significant amounts of alcohol during gestation. In this situation, we use the term "static encephalopathy" and "sentinel physical findings" to describe the patient's condition. Static encephalopathy literally means non-progressive brain dysfunction. The diagnoses of "static encephalopathy and sentinel physical findings" in the presence of alcohol exposure do not mean that alcohol is the only cause of the problem. A number of other factors could contribute to the present issues such as the patient's genetic background, other potential exposures or problems during gestation, and various experiences since birth. These kinds of differences may partly explain why there is so much variability in the kinds of specific difficulties that patients with static encephalopathy and alcohol exposure have.

The diagnoses made today are based on the information available at the time of this assessment. If this patient's alcohol exposure was considered "low risk" and new information is uncovered which documents higher exposures; or if the patient's facial features, growth, or neurobehavioral problems were judged "probable" and further growth or development suggest a "definite" problem is present, then reconsideration of the diagnosis of fetal alcohol syndrome would be appropriate. Alternately other birth defect syndromes not related to alcohol exposure may also need reconsideration.

Individuals with static encephalopathy have brain damage which is a major component of their cognitive and behavioral problems and they should be viewed as individuals with disabilities. The static encephalopathy diagnosis has implications for educational planning, societal expectations, and health. On the attached sheet you will find a list of specific problems that have been identified that need attention.

Physician's Signature ___________________________ Date ___________________________

University of Washington, FAS Diagnostic & Prevention Network
Definitions of Secondary Problems

Definitions of the six main secondary disabilities identified in the Streissguth (1996) study are:

1) **Mental Health Problems** - defined as ever having gone to a psychotherapist or counselor for a mental health problem or having any one of the mental health problems listed:
   - Attention deficit problems, Depression, Behavior problems,
   - Assultive behavior, Conduct disorder, Anger problems, Suicide threats, Sexual acting out, Psychotic behavior, Suicide attempts
   (Streissguth, Barr, Kogan, Bookstein, 1996, p. 36).

2) **Disrupted School Experience** - defined as having been suspended or expelled from school or having dropped out of school.

3) **Trouble with the law** - defined as ever having been in trouble with authorities, charged or convicted of a crime.

4) **Confinement** - defined as a restriction of personal freedom including inpatient treatment for mental health problems or alcohol/drug problems, or ever having been incarcerated for a crime.

5) **Inappropriate Sexual Behavior** - defined as having been reported to have repeated problems with one or more of 10 inappropriate sexual behaviors, or ever having been sentenced to a sexual offenders’ treatment program. The ten behaviors include:
   - Sex with animals, Obscene phone calls, Incest, Masturbation in public, Voyeurism, Compulsions, Exposure, Promiscuity, Sexual touching, Sexual advances (p. 49).
6) Alcohol/Drug Problems - defined as having been in treatment for an alcohol or drug problem or as having alcohol and/or drug abuse problems. (For more details see Streissguth and Kanter, 1997).

Senator Johnne Binkley’s FAS Legislation-1990

SCR 44 Relating to Alcohol-Related Birth Defects Awareness Week
PASSED

Mother's Day Week - May 13-19, 1990
Asks schools, health providers and all Alaskans to get involved, by learning more and supporting pregnant women.

SCR 45 Relating to medical education about fetal alcohol syndrome and fetal alcohol effects
PASSED

Asks for continuing medical education opportunities for doctors and nurses be provided.

Senate Bill 407 Setting a priority relating to treatment of persons for alcoholism, drug abuse, inhalant abuse, and intoxication.
PASSED/VETOED

Priority established for persons whose actions could harm others, including pregnant women who abuse substances.

Senate Bill 408 Requiring health care providers to report cases of fetal alcohol syndrome
PASSED

Physicians, nurses, or other health care professionals shall submit a confidential report and DSHS shall report each year on incidence of FAS in state. Names of individuals are not reported.

Senate Bill 409 Relating to training for teachers and certain school officials.
PASSED

Would require school districts and REA’s to provide inservice training teachers and other school personnel on ways to work with children exposed prenatally to alcohol and other drugs.

Senate Bill 410 Relating to warning signs about the effects of alcohol consumed during pregnancy.
PASSED

Mandates posting of sign to be 1/2 inch high and in contrasting colors. Allows for posting to patrons who will be purchasing alcohol must be able to read the sign.

Senate Bill 411 Relating to sale of alcoholic beverages by a package liquor store.
PASSED

Requires mail order shipments to contain brochure warning about FAS and FAE.

Senate Bill 412 Relating to the distribution of information on the health effects of alcohol consumption.
PASSED as HB 364

Marriage license applications to be accompanied by brochure warning about dangers of drinking during pregnancy.

Senate Bill 413 Relating to eligibility for receiving a career education student loan.
PASSED

Vocational training in alcohol field must include FAS/FAE training if student loan funds are used to pay for costs.

Senate Bill 414 Relating to commitment to treatment programs for pregnant women who are alcoholics.
PASSED

Spouse, guardian, relative, physician, or administrator of treatment facility may petition for commitment to custody of treatment facility if individual “is pregnant and unless committed is likely to harm the fetus by continued use of alcohol.”
Alaskan Statute 14.20.680


(a) A school district or regional educational attendance area shall train each teacher, administrator, counselor, and specialist on the needs of individual students who have alcohol or drug related disabilities. The training must utilize the best available educational technology and include an overview of medical and psychological characteristics associated with alcohol or drug related disabilities, family issues, and the specific educational needs of students with alcohol or drug disabilities.

(b) A newly hired teacher, administrator, counselor, or specialist who has not previously received the training required under (a) of this section shall receive the required training within 45 days after the first day the teacher, administrator, counselor or specialist begins to work.

Alaska's FAS Surveillance Project

The Alaska FAS Surveillance Project was established in 1998 by the State's Section of Maternal, Child, and Family Health, within the Division of Public Health. The Project is part of a collaborative effort with the Centers for Disease Control and Prevention (CDC) and four other states (Arizona, Colorado, New York, and Wisconsin). These five states and CDC make up the National FAS Surveillance Network.

In general, public health surveillance is used to determine the number of people in a population who have a specific health condition. FAS surveillance gives us a better understanding of how many Alaskan children are at risk for having an alcohol-related birth defeat and how many of these meet the surveillance case definition for FAS. By looking at these numbers over a period of time, prevention efforts can be evaluated. For example, an indication that prevention efforts are working would be when the number of children with FAS decreases over several years.

In addition to determining the number of children in Alaska who have FAS, the Alaska FAS Surveillance Project also obtains demographic information about
women who give birth to children with FAS. This information aids in regional prevention planning.

The goals and objectives of the Alaska Surveillance Project are to:

1) develop a standard case definition that accurately reflects how many Alaska children have FAS,

2) provide an accurate statistical number of children in Alaska with FAS and compare these within regions of Alaska and Nationally,

3) provide demographic information about mothers of children in Alaska with FAS for planning prevention programs,

4) provide information about children in Alaska with FAS for use in assessing the need for resources (Adapted State of Alaska website; www.hss.state.ak.us/dph/mcfh/epi/FAS/default.htm).
A. Definition of beneficiary groups

The RFP delineated the scope of the disorders the contractors were to identify by providing the statutory definitions. The 1994 legislation that provided the framework for the Alaska Mental Health Lands Trust settlement defined the beneficiaries as follows in 47.30.056:

(d) In (b)(1) of this section, "the mentally ill" includes persons with the following mental disorders:

1. schizophrenia;
2. delusional (paranoid) disorder;
3. mood disorders;
4. anxiety disorders;
5. somatoform disorders;
6. organic mental disorders;
7. personality disorders;
8. dissociative disorders;
9. other psychotic or severe and persistent mental disorders manifested by behavioral changes and symptoms of comparable severity to those manifested by persons with mental disorders listed in this subsection; and
10. persons who have been diagnosed by a licensed psychologist, psychiatrist, or physician licensed to practice medicine in the state and, as a result of the diagnosis, have been determined to have a childhood disorder manifested by behaviors or symptoms suggesting risk of developing a mental disorder listed in this subsection.

(e) In (b)(2) of this section, "the mentally defective and retarded" includes persons with the following neurologic or mental disorders:

1. cerebral palsy;
2. epilepsy;
3. mental retardation;
4. autistic disorder;
(5) severe organic brain impairment;
(6) significant developmental delay during early childhood indicating risk of developing a disorder listed in this subsection;
(7) other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.

(f) In (b)(3) of this section, "chronic alcoholics suffering from psychoses" includes persons with the following disorders:

1) alcohol withdrawal delirium (delirium tremens);
2) alcohol hallucinosis;
3) alcohol amnestic disorder;
4) dementia associated with alcoholism;
5) alcohol-induced organic mental disorder;
6) alcoholic depressive disorder;
7) other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with disorders listed in this subsection.

(g) In (b)(4) of this section, "senile people who as a result of their senility suffer major mental illness" includes persons with the following mental disorders:

1) primary degenerative dementia of the Alzheimer type;
2) multi-infarct dementia;
3) senile dementia;
4) presenile dementia;
5) other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.

B. Operational definitions

Each beneficiary board had further refined the definition of their respective beneficiary group by providing operational definitions to the Alaska Mental Health Trust Authority, who will eventually promulgate regulations with specific definitions for each group. The contractors obtained each board's current operational set of definitions to utilize in executing the contract. A summary of those definitions, as they relate to adults, follows:
Developmentally Disabled (mentally defective and retarded): Governor's Council on Disabilities and Special Education:

"The Governor's Council on Disabilities and Special Education uses the state's definition of a person with a developmental disability to define the Trust's beneficiaries. Alaska's definition of a developmental disability, amended in 1992, is consistent with the federal definition. According to AS 47.80.900(7):

(7) "person with a developmental disability" means a person who is experiencing a severe, chronic disability that

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;\(^4\)

(B) is manifested before the person attains age 22;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

(E) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated."

\(^4\) For screening purposes, in accordance with national prevalence criteria, the contractor considered individuals who scored <70 IQ as having an indication of a DD diagnosis.
Conry and Fast (2000) Summary of Recommendations

The following are taken with a few modifications from *Fetal Alcohol Syndrome and the Criminal Justice System*:

1) There should be continuing education for legal professionals about FAS/FAE. Such education is particularly important in order to identify those with FAS/FAE who have not been diagnosed before their involvement with the law. This should include information about diagnosis, intervention treatment, diversion, and sentencing.

2) If FAS/FAE is suspected, the individual should be referred to the appropriate medical team for diagnosis.

3) In order to have accurate information before the courts, the legal profession and probation officers should stress the importance of having medical, psychiatric, psychological, and social history reports prepared by professional experienced in assessing people suspected of having FAS/FAE.

4) A protocol should be developed by police forces to ensure that the cognitive and communication challenges that those with FAS/FAE present are addressed in such a way that the Charter rights and the integrity of the statement taking process are protected.

5) Parents and others, such as social workers and teachers, who are involved with an individual with FAS/FAE, should be made aware of how vital their experience may be, regardless of the age of the offender, in assisting those in the criminal justice system to understand the disability in general and how it affects the individual in particular.

6) The parents or caregivers should prepare a portfolio that could include general information about FAS/FAE and should include specific information on the background and disabilities of the particular individual.
A copy of this portfolio should be given to the court. The portfolio should travel with the individual through the court and corrections system.

7) Communication adaptations must be put in place.

8) Other mental health problems, including substance abuse and depression, need to be addressed during the legal process.

9) Information about the resources for people with FAS/FAE should be readily available to legal professionals. This would include information about public and private resources, and about people from government and other agencies who may be able to assist in finding appropriate resources.

10) Alternatives to traditional sentences should be considered and may include conditional sentences, diversion, or sentencing circles, with appropriate safeguards and supervision.

11) Established community interest groups should be encouraged to develop non-custodial bail and sentencing initiatives for individuals with FAS/FAE who are accused or convicted of crimes.

12) Resources for the supervision, education, vocational training, and treatment of offenders with FAS/FAE should be developed in the community.

13) The conditions on bail, probation, and conditional sentence orders should be stated clearly and simply, and repeated often. Individuals with FAS/FAE may be capable of repeating the terms of an order. Even so, they may not understand it, they may not remember it, and they may not be capable of obeying without the supervision and assistance of a responsible adult.
14) It should be recognized that people with FAS/FAE have difficulty with transitions such as from custody to community, and this should be considered in sentencing and treatment plans. A lengthy alternative sentence or probation period can allow more time for structure and supervision.

15) Efforts are needed to insure the consistent transfer of information to, and from, the courts, probation, corrections, and other agencies. Inter-agency cooperation and protocols needs to be put in place to maximize this process.

16) Ongoing training about FAS/FAE should be implemented for probation officers and custodial personnel.

17) Corrections officials should review available custodial resources and programs with a view to minimizing the victimization of individuals with FAS/FAE by other inmates and by the measures taken to ensure their safety. They should also consider the provision of specialized programs and habilitative or rehabilitative services to inmates with FAS/FAE, by either modifying what is presently available or creating new services (p 105-107).
LEGALPIX Description

Information below is from: http://mindlink.net/kindale/legalpix.html

LEGALPIX: A Pictorial Journey Through British Columbia's Criminal Justice System

Jutta Prem-Stein, M.A., S-LP©
Speech-Language Pathologist, Kindale Developmental Association

Abstract

The LEGALPIX series will assist persons with special communication needs and their caregivers to understand how British Columbia's justice system operates. This first completed publication contains material specific to the criminal justice system. Included are: a dictionary of 98 picsyms; a detailed educational curriculum; and, a brief guide to criminal justice system personnel for using legalpix to enhance communication.

Content

The LEGALPIX project was developed to assist persons with special communication needs, and their caregivers, to understand how British Columbia's justice system operates. The project is a joint effort of the Law Courts Education Society of British Columbia and Kindale Developmental Association, with the added support of Canadian Heritage, Women and Disabled Persons Participation Program.

LEGALPIX is useful to persons with physical and/or mental challenges, mental illness, brain injury, language learning difficulties, FAS/FAE, and English as a second language. The publication serves as a secondary resource to any entry-level educational program pertaining to law and, specifically, to the criminal justice system. While the project deliberately addresses the justice system of British Columbia, some components are generic, and adaptable to other jurisdictions.

The completed first phase of the project has produced print materials specific to the criminal justice system. These include a dictionary of 98 legalpix, a detailed educational curriculum, and a brief guide to justice system personnel suggesting ways in which to use the legalpix to enhance communication with clients.

Legalpix are line drawings representing concepts, people, places, and processes associated with the justice system, thus providing a specialized picsym vocabulary. As included in the publication, they are black and white, and 1 ½" square. All 98 are also separately reproduced on card stock, 8 ½" by 11". They are suggested for use independently, or in combination, to enhance meaning.
YOU WILL BE FINGERPRINTED AND PHOTOGRAPHED

THE GUARD WILL SEARCH YOU BEFORE YOU GO TO YOUR CELL

"YOU WILL BE DETAINED IN A CELL HERE"

YOU WILL HAVE TO GIVE UP PERSONAL EFFECTS
WE WILL LOG THEM, AND THEY WILL BE RETURNED TO YOU WHEN YOU LEAVE

YOU CAN SPEAK TO YOUR LAWYER IN PRIVATE WHEN HE ARRIVES
SAMPLE ADVOCACY LETTER

August 12, 1998

The Honorable , J.S.C
Superior Court Judge
Hudson County Courthouse
595 Newark Avenue, Room 201F
Jersey City, NJ 07306

Re: State vs. John Doe

Dear Judge:

I am writing on behalf of John Doe, who is appearing before you for sentencing on April 17, 1998 on a charge of possession of a controlled dangerous substance. Mr. Doe was referred to this Program by his Public Defender, , who thought he could benefit from our services. It is my hope that this Program can meet the Court's requirements concerning Mr. Doe, our interventions be considered as an alternative to incarceration, and our Program as a special condition of probation. Before I discuss the specifics of Mr. Doe's case, please allow me to give you a brief background of the DD Offenders Program, and how our services can be utilized by the court system in advocating for defendants with developmental disabilities.

The DD Offenders Program is one of few Programs nationwide that provides alternatives to incarceration for defendants with developmental disabilities. It is a clearinghouse for information about this population, and serves as a liaison between the criminal justice and human service systems. The Program monitors the quality of care and service provided to those with developmental disabilities as they move from one system to another. The continuing challenge is to investigate how linkages between state service systems can be established, strengthened, and maintained to the benefit of offenders with developmental disabilities.

The Program accomplished this by creating a Personalized Justice Plan (PJP). A constant obstacle, which confronts the Court when considering if probation should be granted, is the risk the individual may pose if released into the community. The PJP identifies community supports that emphasize the use of the least restrictive community-based alternatives, while holding individuals accountable for their behavior. When presented as a condition of probation, the PJP can help stabilize the individual in the community. The Program intervenes at each stage of the criminal justice process to help overcome the obstacles created by the defendant's disability. Our primary goal is to identify community supports that will address our clients' criminal and social behavior.
Concerning Mr. Doe, he has a developmental disability. Mr. Doe was classified as emotionally disturbed and neurologically impaired by the Jersey City Public Schools and placed in special education classes throughout his academic career. Emotionally Disturbed means the exhibiting of seriously disordered behavior over a period of time which adversely affects educational performance. This is characterized by an inability to build or maintain satisfactory interpersonal relationships, behaviors inappropriate to the circumstances, a general or pervasive mood of depression, or the development of physical symptoms or irrational fears. Neurological impairment affects one's ability to listen, think, speak, read and write. When individuals are neurologically impaired, their level of functioning is substantially and negatively affected in many areas that include peer interaction skills, learning related skills, language and communication, social acceptability and destructive behavior.

On December 17 & 19, 1997, Mr. Doe received a neuropsychological evaluation from Dr. Jonathan of Neuropsychology and Rehabilitation Associates, P.C. Mr. Doe achieved a full scale IQ score of 72 which places him in the borderline range of intellectual functioning. Reading comprehension was at the second grade level and arithmetic was at the third grade level. Mr. Doe was also diagnosed as having a cognitive disorder secondary to developmental brain dysfunction, which is an impairment in cognitive functioning as evidenced by neuropsychological testing; personality change due to developmental brain damage, which is a persistent personality disturbance that is judged to be the result of a medical condition; and Dysthymic disorder with recurrent bouts of major depression, severe with psychotic features, which is a chronically depressed mood that occurs daily for over a two year period.

Dr. states, "...Mr. Doe is an individual who has marked neuropsychological problems in the moderate range of brain damage...Neuropsychological testing is indicative of multiple problems in cognitive and social-emotional functioning...His ability to sustain and focus his attention was severely impaired...His self-care skills and ability to take care of himself are observed to be very poor...It is my considered opinion that Mr. Doe does meet the criteria for developmental disability classification...This is clearly a young man who has been chronically unable to function due to a variety of psychiatric and neurological problems which have been lifelong and chronically problematic...".

Once this Program is contacted about a particular case, we begin to intervene as much as possible. We develop a PJP by identifying various services in the community. In regards to our suggestions for Mr. Doe, I am able to share with you our preliminary recommendations which are subject to modification pending agreement of all involved parties, and solidification of the identified services:

1. **Residence:** Upon his release, Mr. Doe will reside with his grandmother, Jane Doe, at 114 Neptune Avenue, Jersey City, NJ, 07305. We have been in contact with Mr. Doe's grandmother and his aunt, Mary Doe, and they will provide Mr. Doe with the support and supervision he requires while residing in the community, as well as ensuring that he keeps all scheduled appointments.

2. **Vocational Training and Employment:** Mr. Doe will be referred to the Hudson County Division of Vocational Rehabilitation Services (DVRS), at 438 Summit Avenue, Jersey City, NJ, (201) 217-7180. This agency provides counseling, training, and assistance with job placement for people with disabilities. Mr. Doe's records will be reviewed and his learning and functional ability will be assessed, as well as his vocational interests. We will monitor the intake process to ensure that Mr. Doe receives the services he requires.

3. **Psychological and Psychiatric Counseling:** Upon his release Mr. Doe will return to the Jersey City Medical Center's Adult Outpatient Psychiatry Department at 50 Baldwin Avenue, Jersey City, NJ, 07304, (201) 915-2272. Mr. Doe will be assigned a therapist for individual counseling. Mr. Doe will also be seen by a psychiatrist and prescribed medications as needed.

4. **Substance Abuse Counseling:** Mr. Doe will be referred for a substance abuse evaluation to determine the most appropriate treatment method. We will follow all recommendations of this evaluation.
5. **Advocacy:** The Program will remain in contact with Mr. Doe and the other parties involved. We will ensure that Mr. Doe is receiving the services he requires, as well as assist and encourage him in meeting the conditions of his probation.

Mr. Doe has been referred to the Division of Developmental Disabilities. This is the state agency mandated to provide life long services to people with disabilities.

6. **Stipulations:** These include any stipulations ordered by the Court or the Probation Department. We will work with the Probation Officer and monitor the plan for the duration of the sentence and provide updated progress reports as requested. Also, Mr. Doe will cooperate with the DD Offenders Program by following his PJP to the best of his ability.

The Program believes that the above PJP begins to address the problematic behavior that may have contributed to Mr. Doe's charges and these support mechanisms, along with his participation in probation, should provide him with the appropriate services to remain in the community. We strongly believe in keeping responsibility with our clients and by increasing his accountability, the likelihood that Mr. Doe will recidivate in the future will be decreased. We understand that this is not an easy population to work with, especially a high-risk defendant with a long history of inappropriate behavior, like Mr. Doe. Fortunately, this Program has substantial experience in dealing with the behaviors associated with Mr. Doe, and we have developed a successful alternative to incarceration Program to work with this population.

If Mr. Doe is placed on probation, he will be monitored weekly by us for a minimum of three months, until such time he can progress into bi-weekly, monthly, and then quarterly monitoring throughout the duration of his sentence. The court could also request status conferences in this case, where Mr. Doe would be brought back before the court periodically to account for his progress and behavior, and we would supply a full progress evaluation. This tool has worked very well with our high-risk population. I hope these recommendations provide you with sufficient information about Mr. Doe's case, as well as the services this Program can provide for him. As advocates working for offenders with developmental disabilities, we appreciate your interest and concern in Mr. Doe's case. If you are in need of any further information, please contact me at (732) 246-2525, ext. 26.

Sincerely,

Suzanne Lustig, Esq.
Program Director

c: Public Defender
   Hudson County Prosecutors Office
   Jane Doe
   Client File
Mental Retardation occurs in 3% of the general population. Yet 4 - 9% of the criminally offending population is estimated to have mental retardation. Thus, three times as many people with mental retardation find themselves involved in the criminal justice system than we might expect based on its frequency in the general population with mental retardation.

There are distinct disadvantages faced by offenders with mental retardation at each stage in the criminal justice process. The DD Offenders Program can help overcome these disadvantages by its intervention, technical assistance, and advocacy skills. Enclosed is information about how the Program accomplishes this at each stage of the criminal justice process.

By providing consultation and a range of stage-specific program interventions, The DD Offenders Program seeks to provide "least restrictive" alternatives within the criminal justice system which insure that responsibility and accountability remain with the individual.
Disadvantages in the Criminal Justice System

Initial Appearance
- Often confess quickly
- Say what they think a police officer wants to hear
- May not understand implications of the Miranda Rights

Arraignment
- Mental retardation will not be recognized by various members of the criminal justice system

Pre-Trial Conference
- Plead guilty more readily than non-DD defendants
- Plea bargaining is used less frequently
- Pre-trial psychological exams are often never requested

Trial
- May not be able to assist in own defense
- May not present well as witness
- May be easily led during cross-examination

Sentencing
- Probation used less frequently
- Appeals of conviction are sought less frequently
- Post-Conviction Relief is rarely requested

Program Interventions

Initial Appearance
1. Initiate development of the Personalized Justice Plan to identify ties the defendant has within the community
2. Advocate that the defendant’s mental condition be considered when determining the amount of bail
3. Advocate for the defendant to be released into the custody of parent or guardian
4. Contact the appropriate jail social service staff about the detainee’s special needs status

Arraignment
1. Program advocates, when appropriate, that the defendant be considered for Pre-trial Intervention (PTI)
2. Program continues to develop the PJP for the purpose of:
   a. Diverting the defendant from prosecution
   b. Setting the tone for the upcoming proceedings should the defendant not be accepted into the PTI
3. Program provides critical technical assistance to attorneys about defendants with mental retardation

Pre-Trial Conference
1. Program advocates that the PJP be used as an effective bargaining tool by being:
   a. Considered as an alternative to incarceration and incorporated into a probationary sentence
   b. Incorporated into the defendant’s jail term, when facing a mandatory sentence
   c. Used as a mitigating factor to reduce the defendant’s sentence

Sentencing
Program advocacy letters are presented to the Court for the purpose of:
1. Addressing deficiencies of the client
2. Identifying potential community service providers
3. Allowing accountability and responsibility to remain with the client
4. Giving the Court the option to allow the client to live in the community

Correctional Facility
Program monitors inmate to insure:
1. Correctional and social service staff are aware of the inmate’s special needs with respect to proper orientation, housing and job assignment, hygiene needs, and appropriate discipline consideration.
2. Habilitative needs are identified and addressed
3. Appropriate pre-release plans are developed, coordinated, and presented to the State Parole Board
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