Fetal Alcohol Spectrum Disorders - A Judge's Perspective

By Judge Chris Melonakis

I first learned about Fetal Alcohol Syndrome (FAS) approximately 15 years ago while still practicing law. A client had been charged with arson after store security video captured him setting fire to a paper products section in a local department store. After his arrest, he also confessed to burning his neighbor's house to the ground.

During my initial conversations with my client and at later meetings, it became manifest that his cognitive functioning was impaired. His mental processes reflected a lack of appreciation for the seriousness of his conduct. I became convinced that he was developmentally disabled; however, all of the historical information I obtained from his parents as well as his medical and mental health history disclosed that he did not meet the criteria for a developmental disability diagnosis.

His parents had nearly bankrupted themselves in obtaining mental health treatment for him over the years. He had been through both in-patient and outpatient mental health treatment, without appreciable inroads. Nobody had conducted a thorough assessment, including biological familial history assessment, in connection with his medical condition.

Since the case was clearly not defensible on the facts or the prevailing law, and in light of my concerns regarding my client's competency, we made the decision to raise the issues of both competency and sanity in the criminal proceedings. Over the course of the psychological and psychiatric assessments conducted in connection with the insanity and competency issues, the evaluators discovered that this young man had been adopted. They requested additional information regarding his birth mother, which my client's adoptive parents were able to produce. This historical information disclosed that his biological mother had seriously abused alcohol during her pregnancy. My client received a full-blown assessment based upon these historical facts as well as new mental health and physical examinations. He was diagnosed with FAS. Unfortunately, he was also determined competent to proceed to trial.

The prosecuting attorney and judge were both willing to permit his sentence to be rehabilitative rather than punitive if I could find an appropriate treatment center. Despite the seriousness of his offenses, all reports from his jailers and others who had contact with him found him to be child-like, pleasant and compliant, and a model prisoner. He was also frail and subject to risk for significant exploitation by his fellow prisoners. It was apparent to everybody that that he was likely to leave prison a far more dangerous person than he was when he entered the penitentiary.

Recognizing this young man's needs, I started learning everything I could about FAS and how it could be treated so that I could give everybody involved some options other than a prison sentence. What I learned was terribly disheartening. There was little information

available in the public domain regarding the condition, although I did learn some important facts about drinking during pregnancy. There was nothing available regarding treatment. The combination of the information contained in the professional evaluations that indicated my client was unpredictable with a high risk for future criminality, the serious nature of the offenses, and my inability to find a facility that could treat his diagnosed condition, resulted in the judge imposing a 16-year sentence.

It is a case that has haunted me for years. There is no doubt that this young man could have been managed in a setting other than prison where he was undoubtedly exploited and abused by other inmates. The structure that the county jail provided permitted him to function with little disruption and without posing a danger to himself or those around him. For years I believed that there had to be a better way to deal with people like him.

When Eileen Bisgard approached me with the opportunity to apply to participate in one of the FASD Center For Excellence's local initiatives, I gladly agreed. We were fortunate enough to be designated one of the local sites for development of screening and assessment services through the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. This designation has permitted us to start the process of screening, assessing and, hopefully, treating young people with a Fetal Alcohol Syndrome Disorder (FASD) diagnosis that have contact with our court system.

Statistically approximately 40,000 people a year are diagnosed with FAS. It is my belief that a much greater number of children are born with FAS or a FASD. Common sense leads me to this conclusion. In 2004 there were 872,000 documented cases of child abuse or neglect in the United States.[1] In my court, in a comparable period, 87% of the families that entered the child welfare system did so with drug or alcohol abuse as a major component of the familial dynamic that led to the filing of the case. It is not a large leap of logic to conclude that children in the child welfare system were likely to have been parentally exposed to alcohol in a significant percentage of these cases.[2]

Moreover, women who abuse drugs and alcohol while pregnant are less likely to seek medical treatment because they fear having their children removed from their custody. Such care may lead to better statistical information regarding the incidence of prenatal alcohol consumption.[3] These dynamics lead to the common sense conclusion that FAS and FASD are substantially underreported.

What is the significance of these conclusions to the court? First, many of the behaviors that children diagnosed with FASD demonstrate are common in delinquent or truant children. The six primary core behavior traits of individuals with FASDs are present in many children who come before the court in delinquency or truancy cases. Second, these children are more likely to enter the child welfare system in order to have their needs met because they come from an environment that is likely to compromise their safety, well being and permanency. Children who are abused or neglected are more likely to face a multiplicity of lifetime difficulties. These issues by their very nature inevitably lead to some type of judicial involvement in dissolution of marriage proceedings, criminal prosecutions or civil proceedings such as dependency cases.

In a compelling article, *Whitecrow Camp for Children with Fetal Alcohol Spectrum Disorder: A Pediatrician's View* published in June 2005 by the British Columbia Medical Association in the British Columbia Medical Journal, Dr. Jonathan Down describes his experience attending a camp for children with FASD. His description of the difficulties he experienced in identifying the "invisible disability" of FASD in some fellow volunteers is instructive. As a highly trained and experienced professional who had routinely dealt with FASD, it was only after these volunteers spoke about their disabilities that he was able to identify their impairments.

The significance of this observation is important when placed in a forensic context. Dr. Down describes the impairment in this way:

"People with FASD often have damage to the part of the brain required for self-regulation. In a medical report, I would term this "inhibition of socially inappropriate behavior." After my experiences at Whitecrow, however, I know that with FASD it really means that "he or she doesn't have an *off* button." This is a very simple idea, but of critical importance if one is aiming to avoid behavioral deterioration. Once those with FASD start down a behavioral pathway, such as becoming increasingly physical toward others, it is very hard for them to change their behavioral direction or trajectory. The take-home message for me was: don't push the *on* button, and if you do, try to recognize it early and redirect.[9] "

In the context of an environment in which a young person with FASD comes before the court for having committed a delinquent act, attempting to "rehabilitate" the juvenile by appropriately sanctioning his or her conduct and then treating the juvenile through traditional modalities such as anger management programs or community service work is likely to have exactly the opposite of the intended result. These young people must be dealt with by a protocol that manages a disability that is the result of brain damage not a behavioral manifestation of an emotional disorder.

A trained professional can often rather quickly identify children with FAS simply by looking at facial features. The more subtle forms of FASD are not so easily identified. If a judge, probation officer or other professional is dealing with a child whose behavior is driven by a child's undiagnosed or unrecognized medical disability as opposed to a mental health or emotional disorder, well-meaning interventions may result in even more social acting out which routinely brings the young person back before the court for probation violations, ultimately resulting in unnecessary detention or institutionalization. Where a young person can be managed in the community through an appropriate intervention after a better, more discrete assessment, the potential savings in human, social and fiscal resources are significant.

One of Dr. Down's anecdotes in his article highlights the significance of this dynamic:

"People with FASD are very literal in their interpretation of language. Alcohol appears to damage part of the brain that is responsible for language nuance and subtlety. Over coffee one evening, we were talking about a school in Victoria that historically used to segregate the *boys* from the *girls*. On the school wall, carved into the stone were the words *boys* and *girls* over their respective doorways. However, when Annie heard the part about girls

and boys being carved into stone, her comment was “that must have hurt them.” I learned to avoid the use of the negative. “Don’t run” was ineffective. “Walking feet” made for good communication. I became extremely aware of my language at Whitecrow. I realized that I enjoy wordplay, but that it could be a barrier. I learned to keep my language simple and unambiguous.

People with FASD have difficulty in the area of generalization. At Whitecrow, the rules applied to everyone, not just the campers. For example, the beach and waterfront were out of bounds except when a lifeguard was present. Volunteers were required to model the behavior that was expected of the campers. This precluded walks to the beach at sunset. It also curtailed any goofing around that might be misinterpreted.

Executive function is usually damaged by prenatal alcohol exposure. For some reason the prefrontal cortex, where this function is mainly located, is particularly vulnerable. Changes in routine, schedule and planning have the potential for creating confusion in the mind of an affected person. This was forcefully brought home to me on the day when a government member of the Legislative Assembly arrived, together with the media, to view the camp. It threw a wrench in the day for many kids, because their schedule was disrupted. There were emotional repercussions to this, as many of the children became hyper and labile later in the day. The limbic system, which is responsible for emotional regulation, is located close to the prefrontal cortex. It is not surprising that emotional volatility may accompany changes *in routine*.

One of the more difficult personal challenges for me was withholding physical contact with the kids, unless they initiated it first. With my own children, that was always part of the fun of being at the beach. At Whitecrow, roughhousing in the water at the beach was a no-no. This related to the “on-off switch” phenomenon and also the need to model behavior. Alcohol often interferes with sensory processing. For those with FASD, a simple hug or chance touching may be painful and may elicit an aggressive response. Professionally, I realized that I would need to stop giving reassuring touches to my patients.[10]”

In *Fetal Alcohol Spectrum Disorder and the Role of Family Court Judges in Improving Outcomes for Children and Families*, Diane V. Malbin nicely summarizes the challenges in dealing with persons with FASD in a legal setting. Ms. Malbin relates successful treatment plans that dealt with system-involved children. Prior treatment plans had failed because:

“Standard assessments that determined IQ, academic achievement, and behavior profile were descriptive findings that only captured Fred’s symptoms. Fred was diagnosed and treated for behavioral problems, not brain damage.

Years of interventions for his behaviors were ineffective. Improvements were achieved not by employing methods to stop presenting symptoms, but rather by recognizing their source and providing appropriate accommodations. These were inexpensive and effective. Symptomatic behaviors previously targeted for intervention became cures for identifying points of poorness of fit. *The shift was from trying to change Fred and seeing*

his behaviors deteriorate to providing adaptations appropriate for his disability and achieving changes in his behaviors as a result. (Emphasis supplied)[11] "

In order to deal with children who have are diagnosed with FASD, judges, probation officers, social workers and other professionals must undergo a paradigm shift in approach. The appropriate approach is to accommodate a physical disability through appropriate structure rather than attempt to attain compliance by intermediate sanctions. The latter approach is likely to simply initiate a process that results in escalating behavior with completely predictable and costly consequences.

Recognizing this dynamic has caused our judicial district to refer every juvenile who is adjudicated delinquent to the Seventeenth Judicial District FASD Initiative to be screened for FASD. If the screen is positive, there is a referral for further assessment to an agency specializing in diagnosing and treating FASD. Thereafter, treatment planning for addressing the the disability as opposed to dealing with behavioral symptoms of the disability is integrated into the probation order. This process is still in its infancy and our court has not yet fully assessed our success rates. We are, however, very hopeful that there will be positive outcomes for children, families and community safety.

The process has required many hours of multi-disciplinary planning meetings, numerous inter-agency trainings and a willingness by all stakeholders to revisit some well-established practices. Ultimately, we are hopeful that we can have a direct and positive impact upon the quality of life in the communities that we serve by addressing a frequently overlooked cause for community disruption.

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Citations

[1] *Source, Child Maltreatment 2004*, United States Department of Health and Human Services, Administration for Children and Families.
[2]The national statistics indicate that, of the children who were maltreated in the reporting year, 62.4% of the maltreatment was as a result of neglect, 2.1% were medically neglected and 14.5% of the victims suffered from "other" abuse or neglect including "congenital drug addiction". Almost all of these case types that came into my court involved long-term drug or alcohol abuse. Source for Statistics: Child Maltreatment 2004,United States Department of Health and Human Services, Administration for Children and Families.
[3]*Starting the Conversation: Town Hall Meetings on Fetal Alcohol Spectrum Disorders, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration (2004).*
[4]Wasserman, G. A., Keenan, K., Tremblay, R., Coie, J. D., Herrenkohl, T. I., Loeber, R. and Petechuk, D., *Risk and Protective Factors of Child Delinquency, Child Delinquency Bulletin Series*, United States Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (April, 2003).

[5]These traits as identified in the publication FAS Terms and Conditions by the Family Resource Institute in 2005 are: (1) Extreme vulnerability to peer influence; (2) Volatile/dangerous behavior without predatory intent; (3) Inability to see the need to follow rules; (4) Continuing childlike innocence regardless of age, IQ and experience; (5) Egocentricity: living in the moment for immediate gratification; and (6) Disrupted understanding of cause and effect in every life domain: physical, social, mental, and moral. *Compare*, Wasserman, Ibid.

[6]*Child Maltreatment 2004, supra*.

[7]Widom, C. S., *Childhood Victimization: Early Adversity, Later Psychopathology*, National Institute of Justice Journal (January, 2000).

[8]Ibid.

[9]Down, J., *Whitecrow Camp for Children with Fetal Alcohol Spectrum Disorder: A pediatrician's view*, BC Medical Journal, Volume 47, Number 5, pp. 269-270 (June, 2005).

[10]Ibid.

[11]Malbin, D. V., *Fetal Alcohol Spectrum Disorder (FASD) and the Role of Family Court Judges in Improving Outcomes for Children and Families*, National Council of Juvenile and Family Court Judges, Juvenile and Family Court Journal at page 60 (Spring, 2004).