

The challenge of Fetal Alcohol Syndrome in adult offender populations

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Offenders suffering from Fetal Alcohol Syndrome (FAS) and its related disorders present a significant challenge within correctional settings. The behavioural and learning characteristics associated with these disorders make it difficult for affected individuals to function effectively in the aggressive and often uncertain environment of a prison. The presence of affected individuals creates issues for institutional staff, program deliverers, parole boards, and those involved in community supervision. How we address these issues is dependent on the number of affected individuals within the correctional system. Unfortunately, to date, no study has been undertaken to estimate the incidence/prevalence of affected individuals within the offender population.

Collecting incidence/prevalence data is not a simple task. No screening instrument with known reliability and validity is currently available. Affected individuals are usually not diagnosed, diagnosis is problematic with adults and interventions must be put in place to address the needs once a diagnosis has been made. The following paper expands on the challenges faced by researchers.

Fetal Alcohol Syndrome (FAS) and related disorders, such as Fetal Alcohol Effects (FAE), are conditions now commonly referred to by the non-diagnostic umbrella term Fetal Alcohol Spectrum Disorders (FASD), where prenatal exposure to alcohol is an important factor in problems an individual exhibits throughout development. In an earlier review paper it was argued that individuals suffering from FASD were at high risk for criminal offending and likely represented an important sub-population within the adult prison system with their own unique needs and challenges.⁴

The connection to crime has largely been based on a follow-up study of youth and adults with FAS/FAE from Washington that showed up to 60% get in to some trouble with the law.⁵ However, this information tells us little about the number who end up in the adult prison system. Two studies do have some relevance. In one, a group of 81 offenders in a “developmentally disabled, emotionally disturbed (non-psychotic) male inmate” unit of the Washington State Prison

system were administered a scale used to help identify those at high risk for FAS/FAE.⁶ Fifteen percent scored in the range typical of FAS/FAE. A lower rate might be expected in a general population of offenders since such a special unit might be expected to contain more cases of FAS/FAE.

A more recent and thorough diagnostic study was carried out in British Columbia on 287 consecutive admissions of youth remanded to a forensic psychiatric inpatient assessment unit over a one-year period.⁷ The authors identified 23% (3 cases of FAS and 67 cases of FAE) in their sample. However, this percentage is likely to be high since it includes only young offenders who were remanded to the psychiatric inpatient assessment unit, a group that would be relatively small relative to the entire offender population. At this point in our knowledge all estimates are speculative since no study of incidence/prevalence has been completed with an adult offender population. Nevertheless, even if a rate of less than 5% existed in our adult prison population, the implications would be very important. We do not know how this subgroup of offenders reacts to current correctional management procedures, rehabilitation programs, or community reintegration efforts. Given what we do know about the cognitive, emotional and behavioural deficits observed in individuals with FASD, we can speculate that they are likely to have difficulty with programs that have a cognitive emphasis, low built in redundancy (i.e., little repetition), low structure, and little emphasis on active long-term maintenance.

By adolescence and adulthood, primary difficulties associated with FASD include memory impairment, poor judgement and abstract reasoning, and low adaptive functioning. These contribute to secondary problems such as being easily victimized, unfocused (attention deficit disorder and hyperactivity are common), having difficulties handling money, problems learning from experience, trouble understanding consequences and perceiving social cues, poor frustration tolerance, inappropriate sexual behaviour, substance abuse and mental health

problems. FASD is not restricted to, but often occurs in the context of poverty, family upheaval, neglect and abuse, multiple drug use, and poor health, features that negatively influence the expression of the syndrome from infancy to adulthood.⁸ Since one of the key principles of good correctional planning and intervention is the assessment of offender criminogenic needs and risk levels,⁹ it is important to identify this sub-population so their needs can be addressed.

Progress

Recent initiatives by Health Canada's Population and Public Health Branch, in collaboration with First Nations and Inuit Health Branch, and with support from the National Advisory Committee on FAS/FAE, have sought to increase awareness and prevention efforts among the public and health professionals and support research initiatives on the problem. A directory of information and support services available in Canada,¹⁰ as well as newsletters¹¹ and web-sites (e.g., www.fas-saf.com) have been established, and a "Best Practices" review on prevention and intervention is available.¹² A recent publication will do much to educate lawyers and judges about handling FAS/FAE cases during criminal trials.¹³ Training efforts directed at professionals and front line workers have also increased. In the long term, these and other initiatives will make it easier to identify those suffering from FAS/FAE and consider their condition at each stage of the criminal justice process. But there is a long way to go. There is little doubt that currently many, if not most, cases of FAS/FAE go undiagnosed and this often prevents the allocation of resources to meet the needs of these individuals. Correctional Service Canada has supported some applied initiatives with offenders. For example, the West Coast Genesis Society, in British Columbia accepts both diagnosed and suspected cases of FAS/FAE and is designing a program for them.¹⁴ Currently, applied efforts are often hampered by a lack of reliable and valid screening tools and the availability of diagnostic services. It will be important for future applied initiatives to build proper evaluation into their programs. This allows vital feedback on improving programs and is a feature important in funding applications. In general, programs should develop a written manual to assure consistency of application and training. Any major aspect of functioning targeted (e.g., improving adaptive functioning, reducing substance abuse, etc.) should be measured pre-post intervention. Long term follow-up is important and can also address issues related to criminality (e.g., parole violations, new crimes, etc.).

Most of us would agree that the best and first goal must be the prevention of FASD. However, it is

also important to simultaneously meet the needs of those currently afflicted with the disability. It is known that a favourable environment and early intervention can do much to ameliorate the consequences of FASD. This still leaves a major problem with those who are undiagnosed or, lacking a favourable early intervention, come in contact with the youth or adult criminal justice system. The challenge is to detect these individuals through screening and diagnosis. Once identified, consideration can be given to their condition at all levels of the criminal justice system¹⁵ and allow the development of appropriate management and intervention strategies that will help them maximize their potential for adaptive living and reduce the long term costs to society of this debilitating disability.

Diagnosing FAS/FAE: The challenge with adults

Since it was first described,¹⁶ the diagnosis of FAS and related disorders has proven to be a complex process that requires a major effort on the part of caregivers and professionals to track down key elements in the history of an individual that would aid in diagnosis. The best proven approach is to use a team that might include physicians, dysmorphologists (physicians expert in birth defects and abnormalities of the facial features), psychologists, educators, social workers, occupational therapists, speech and language therapists, and family advocates.

For a diagnosis of FAS, evidence for the criteria presented in Table 1 must be available. For the diagnosis of FAE, evidence for all criteria need not be present. Variations on the application of the diagnostic criteria can be found in the literature.¹⁷

Table 1

Criteria for a FAS diagnosis	
1.	Prenatal or postnatal growth retardation.
2.	Characteristic facial features (mainly short palpebral fissures (eye slits), short mid-face, poorly formed philtrum (groove between nose and upper lip) and a thin vermilion border of the upper lip).
3.	Cognitive impairment or other developmental or behavioural difficulties of a substantial nature.
4.	Confirmed excessive alcohol exposure in utero.

There are many difficulties diagnosing adults. Official records from pregnancy, early childhood and school are often unavailable, and older records may not be complete. Memory related pre-natal alcohol use may be inaccurate and self and collateral information may be limited or unavailable. Facial structures change with age and the characteristic features may be lost. Most research on developing diagnostic criteria have been based on children and there are few experts available who are experienced in adult diagnosis.

Screening as an alternative

Theoretically, one way to identify offenders with FASD is to do a full diagnostic assessment on all incoming offenders. However, this would be prohibitively expensive and neither the expert personnel nor financial resources could possibly be found. The alternative is to develop a reliable and valid screening tool that would identify the much smaller subgroup at “high risk” for FASD who could then be sent for a diagnostic assessment. This is a difficult task. As reviewed elsewhere,¹⁸ a good screening instrument should be relatively cost efficient compared to a diagnostic assessment, be sensitive (have a high rate of FASD detection) and be specific (a low rate of false positives). For example, an IQ test using cut-off scores (e.g., 70) would be a poor screening instrument because the range of IQ scores seen in FASD is so broad that most cases would be missed (insensitive). Nor does it help to use the pattern of sub-tests, as they are not specific enough to FASD.¹⁹ Ideally, information from the screening should be available at the time the offender intake assessment is carried out in order that the information can be used to help meet the needs of the offender during incarceration and when planning reintegration strategies in the community. It should be recognized that a good screening instrument might tell us little about the severity of the problem or provide enough information for diagnostic purposes.

The authors have initiated a research project to develop a potential screening instrument that could be used with adult offenders. The basic strategy is to use a preliminary screener based on an empirically derived checklist of known characteristics of those with FAS/FAE along with historical data to determine who is at “high risk” for having FASD. This assessment will take place during the period immediately after sentencing, but prior to the offender being transferred to a prison. During this period offenders remain in their home communities where collateral contacts can be used to verify information on past behaviours and maternal alcohol use. Those scoring high on the preliminary screener will receive a full diagnostic assessment, at the reception centre. A comparison group of offenders known not to have FASD would also be assessed.

At the reception centre, offenders will complete the standard offender intake assessment process

(lasting about 6 to 8 weeks) with the staff unaware of the results of the preliminary screener. Intake assessment information, which includes assessment of offender needs in the areas of education/employment, community functioning, substance abuse, marital/family relations, attitudes, associates/social interactions, personal/emotional status, and criminal history will then be analyzed to determine if this information, together with data from the preliminary screener, will allow differentiation of those offenders known to have FASD from those who are known not to have FASD. If successful (a validation study would still be needed), the outcome could serve as a screener for identifying those at “high risk” for FASD (thus good candidates for a diagnostic assessment) and also allow some prediction of the general incidence/prevalence of FASD in the overall prison population.

It is anticipated that final planning for the project will be completed in the fall of 2002 with data collection to commence as soon as possible. The project must receive ethical approval before starting and an important ethical issue revolves around the type of intervention that can be offered after an offender has been diagnosed as being FAS/FAE affected. It is being proposed that an advocate be in place at the reception centre(s) where offenders are assessed. The advocate, who will be familiar with FASD, can intervene on behalf of the offender’s welfare during the development of correctional plans, including release planning. The advocate can also serve as a general educational resource within the institution for issues related to FASD.

Summary

Despite these challenges it is hoped that the proposed research initiative will lead to a reliable and valid method of identifying adult offenders who suffer from FASD and help develop estimates of incidence in the federal offender population. It is encouraging that other jurisdictions are showing interest in the research and we are looking forward to collaboration with a number of groups. When we know the magnitude of the challenge, appropriate resources and effective interventions can be directed at reducing the impact of FASD on the lives of individuals affected, and on the communities they will return to. ■

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