Fetal Alcohol Syndrome: Implications for Sentencing in the Criminal Justice System Part II

Robin A. LaDue, Ph.D., and Tom Dunne

Part I of this article appeared in the last issue of the FEN Pen. To obtain a copy, please call the FEN office at 1-800-462-5254.

Background Information

The background information provided to the court, especially in cases such as Richard's, is critical in helping determine appropriate placements. Questions to be answered in this area include:

- ◊ Place of birth/circumstances of birth/pregnancy;
- ◊ Type(s) of home(s) client raised in, length of time in foster, adoptive, biologic, group home;
- ◊ Reason for change in residence, if any;
- ◊ Medical records, e.g., prenatal exposure history, serious injuries, head trauma;
- ◊ School records, e.g., special education classes;
- ◊ Service records, if any; and
- ◊ Employment history.

Each of these will be discussed in detail as they apply to presentencing and defendants.

Longitudinal studies of people with FAS/FAE often show family and environmental instability. The prognosis for a positive outcome appears to decrease in proportion to the loss of stability in the family environment coupled with a lower level of overall support (6).

As previously described, prenatal alcohol exposure often affects the ability to adequately process information and limits insight. Environmental factors such as neglect, physical, sexual and emotional abuse, along with a chaotic environment can lead to significant psychosocial problems later in life for almost anyone.

These can include Post-Traumatic Stress Disorder (PTSD), Borderline Personality Disorder, and/or Histrionic Personality Disorder. In children and adolescents, these problems may present as acting-out behavior, an Oppositional Defiant Disorder and/or a Conduct Disorder.

Other common diagnoses associated with both early childhood trauma and prenatal alcohol exposure include Attention Deficit/Hyperactivity Disorder and Asperger's Syndrome or high functioning autism.

Data from several longitudinal and retrospective studies of people with FAS/FAE/ARND show both a loss of residential placement and/or premature maternal mortality. Clinical and anecdotal data suggests women who produce children with alcohol-related birth defects are at significantly increased risk of dying young due to alcohol-related causes (7).

Longitudinal studies of people with FAS/FAE often show family and environmental instability.

Those women who survive but continue to drink may not be able to adequately care for their children. In some cases, parental alcohol use may lead to increased risk of abuse and neglect. These factors were present at a significant level among these people with alcohol-related birth defects.

Several concerns emerge when examining the behavioral and psychological consequence of early childhood trauma, continued parental substance abuse, and/or prenatal substance exposure. These include:

- ◊ "Experts" focusing on the over behavior and failing to recognize the myriad of factors which may contribute to such difficulties;
- ◊ Failure to recognize the etiology of behavior may lead to personality disorder; and
- ◊ Failure to recognize either the various contributing factors and the cognitive limitations common with people prenatally alcohol-exposed often leads to inappropriate treatment.

In the above cases, the person is at increased risk for incarceration rather than rehabilitation or community-based programs. This is due to the commonly held belief that people with an anti-social personality disorder are intrinsically more at risk for criminal behavior and less amenable to treatment.

The above often describes the reality of the lives of people with alcohol-related birth defects. They are quite frequently described as not having a conscience. While, in a very few cases, a person may have both FAS and anti-social personality disorder, the more accurate view is one which acknowledges that damage to frontal lobes can often impact insight and the ability to connect cause and effect.

It is critical that the presentencing investigator has enough information to establish the etiology or etiologies, as the case may be, of the defendants behavior. In doing so, the officer is more able to present the Court with appropriate options for placement and treatment.

At the start of this section, several peices of needed information were listed.

continued on page 3...

...continued from page 2

The next item to be discussed follows closely with the evaluation of the defendant's home environment. Medical records can provide information helpful in diagnosing Fetal Alcohol Syndrome and also assessing other factors which may contribute to the defendant's increased or decreased risk to re-offend. The following example demonstrates the need for such in-depth evaluation.

Marty was an 18-year-old single male who had been referred for a psychological evaluation by the Court to establish or rule out diminished capacity. He had, at the instigation of several "friends," stolen his grandparents' car five times in the previous month. Each time, his grandparents, with whom Marty resided, informed the police. Marty was arrested and spent time in juvenile detention awaiting trial.

However, Marty had turned 18 two days prior to the last offense. Due to this, he was tried on the last offense as an adult. The presentencing officer met with Marty and noted his smaller stature, history of school problems and failure to learn from previous mistakes. He also met with Marty's grandparents and reviewed both the medical and school records available.

It was documented that Marty's mother appeared drunk at each of her prenatal visits and had been killed in a single car crash where her blood alcohol level was .35. Marty, a toddler of just over 18 months, had been in the car with his mother at the time of the accident. He was unbelted and thrown into the windshield resulting not only in several broken bones, but also a skull fracture and subdural hematoma in the right parietal/occipital region.

Marty was placed with his maternal grandparents after his mother's death. At age six, he began school and developed a seizure disorder. He was placed on Dilantin to control his seizures.

In addition, Marty's behavior deteriorated as he started school. He was defiant, showed memory deficits, and was impulsive. An MRI was done when Marty was 12. The results of the MRI showed several small lesions throughout the brain and one fairly significant lesion at the site of the trauma.

School records provided documentation of Marty's behavioral concerns and also of his positive response to structure and consistency. The presentencing officer suspected Marty had FAS as well as significant trauma from his previous head injury. A referral to a diagnostician was made and a diagnosis of FAS was given.

A determination of diminished capacity due to a psychiatric disorder was not found. However, the medical and school records along with evidence showing Marty did respond to positive structure plus the cooperation of Marty's grandparents were presented to the Judge. A plan to place Marty in a long, tight probation rather than incar

It was documented that Marty's mother appeared drunk at each of her prenatal visits...

ceration, was designed and, with the blessing of the Court, implemented. This plan included Marty being placed on Social Security Disability monies due to his brain damage and borderline IQ. His grandparents were designated as the protected payees.

A second point of the plan was for Marty to receive services through the Department of Vocational Rehabilitation (DVR). He was placed in a community-based computer training program and, with the SSD funds as well as those he now earns as a data entry clerk, he has been able to move into a subsidized, structured adult living facility.

Marty has significant memory problems from both his prenatal alcohol exposure and his early childhood head injury. In addition, he has had to deal with the early loss of his mother and never being connected with his biologic father.

The third point of Marty's plan required he attend counseling on a weekly basis. Due to Marty's many problems, an aide picked him up at work and drove him to counseling. Once a month, his grandparents attended the session. This allowed Marty and his grandparents to retain closeness and to improve their relationship.

Marty's probation officer met with Marty after every counseling appointment. His office was nearby the therapist's, allowing for easy access. If it was deemed appropriate, Marty's probation officer would periodically attend the counseling sessions.

This plan has been in place for two years. Factors that have aided in its success were the willingness of all parties to develop and support a plan, the use of limited but existing resources to meet Marty's special needs, and a life of nearly 24 hour a day structure and supervision.

Two areas of challenge still remain unresolved. The first is ways Marty can have a safe social life and the second is Marty having a safe sexual life. He has a pattern of impulsive and sometimes inappropriate sexual behavior towards females in his life. The team is attempting to address these issues but no ideal solution has yet presented itself.

Two final pieces of background were listed at the start of this section: service records if the defendant ever spent time in the service; and employment.

A defendant who was able to do well in the structure of the military may well respond to the types of constant structure implemented for Marty.

Employment records may provide information as to skills and interests the

continued on page 4...

...continued from page 3

defendant has as well as problem areas, e.g. quitting jobs, impulsivity, fighting with co-workers, or an inability to structure their own life to meet even the most basic requirements of employment.

Often, people with FAS, especially those with higher IQ scores and less obvious facial and physical abnormalities, are described as able to acquire employment fairly readily. However, their tenure in jobs is often quite short. This is a continuation of the pattern of instability, poor follow-through, and lack of comprehension of social rules and expectations frequently observed in younger people with alcohol-related birth defects.

In summation, the information contained in the background materials can provide a longitudinal view of the defendants:

- ◊ Family history: the family's support, strengths, concerns, and availabiltiy as a resource;
- ◊ Medical history: can provide information on prenatal exposure to toxin and teratogens; mother's and/or father's health; parental cause of death, if applicable; information to aid in various diagnoses; and other injuries or medical problems that may affect the defendants' functioning; and
- ◊ School, military, and employment records: these may aid in identifying a defendants' strengths.

All of this can be used as a foundation on which to build a case for either probation or incarceration.

The next area, an evaluation of the defendant's criminal history, should be viewed in the context of the background information just described.

Criminal History

An evaluation of the defendant's criminal history should include a review of:

a. All charges pressed, past and current, regardless of the disposition;

b. At what age the defendant first became involved in the legal system, e.g. as an adult or juvenile;

c. The type of disposition for each charge and conviction, e.g. diversion, detention, probation, work-release, and incarceration;

d. Seriousness of the offense;

e. Dangerousness of the defendant;

f. Circumstances surrounding each offense, e.g. committed alone, with one other person, in a group, a new offense or repeat of a prior offense; and

g. the defendant's response to previous actions taken by the court.

The information contained in items a-g, again, provide vital clues as to the defendant's cognitive, social, and adaptive functioning. People with FAS are frequently described as being "poor leaders but great followers." If a defendant has FAS and all of their crimes are minor and at the instigation of their peers, this may argue for either a shorter period of incarceration or straight probation. These two options, however, should be considered only if there is adequate community support and supervision.

If a defendant has FAS and all of their crimes are minor and at the instigaton of their peers, this may argue for either a shorter period of incarceraton or straight probation.

In addition to a review of items a-g, it is helpful to have police and victim's reports from the current offense as well as past incidents, if at all possible. This information can be used in a variety of ways such as clarifying the defendant's version of the offense, their comprehension of the legal issues and possible outcomes, and an informal check of the defendant's memory and ability to recall information.

The defendant's risk of reoffending and level of dangerousness are often considered in determining the type of incarceration, placement and length of sentence. These items can often be difficult to predict for any defendant. Assessing them in people with FAS can be especially difficult as the following example demonstrates.

Gerald was a youth of sixteen who had been in a stable home with his biologic mother and step-father. His biologic father died of cancer when Gerald was four years old. His mother entered drug/alcohol treatment at that time and has been sober ever since. She remarried when Gerald was five and he was adopted by his step-father. Gerald's step-father was twenty years older than his mother and was the father of two grown sons. Gerald was raised as an only child, described as very loved by his step-siblings, step-father, and mother.

Gerald's mother had consumed a moderate amount, approximately two drinks of alcohol every day during her pregnancy. Gerald was small and irritable when he was born. He reached his developmental milestones later than his age mates and showed learning problems, hyperactivity, and memory problems from early in life.

By the age of twelve, he was at the 50th percentile for height and weight, but still had learning and psychosocial deficits. Gerald's mother had brought these concerns to her pediatrician, but was told Gerald was "fine."

When Gerald was a preteen, his mother returned to college. She was taking a psychology class when the issue of Fetal Alcohol Syndrome came up. She recognized the pattern of behavior displayed by Gerald as consistent with the information provided in her class. She spoke with her professor who suggested she contact the genetics department at the local medical school.

Gerald was scheduled for an evaluation and, at the age of twelve, received a diagnosis of Fetal Alcohol Effect.

Gerald's mother and step-father eduated themselves as much as possible about alcohol-related birth defects and interventions. They joined a parents support

continued on page 5...

...continued from page 4

group and met with Gerald's teachers. They hired a behavioral consultant to work with the family and school personnel to ensure that there was as much consistency between the home and school as possible.

Gerald was given a psychological evaluation which showed his IQ to be around 75-80. He had been in a Resource Room, but after the evaluation was place in Special Education classes and in courses teaching daily living skills.

Gerald did demonstrate many of the behavioral concerns seen in children with alcohol-related birth defects. He was often intrusive, had poor comprehension of social rules and expectations, and was often taken advantage of by his "friends."

These concerns were distressing to Gerald's parents but they felt it was also necessary for him to have as normal a life as possible. His family had him in scouts and he also participated in Special Olympics.

Gerald had some problems with inappropriate sexual comments and touching. He was placed in therapy for sexually aggressive youth and his parents worked diligently to set up structure ensuring not only his safety, but the safety of any children he might come in contact with.

No serious incidents occurred until Gerald was sixteen and a 10th grader in high school.

At that time, he met a young woman of nineteen who had significant cognitive deficits and a long history of sexual abuse and emotional instability. Gerald and the young woman, Suzanna, became sexually involved with this activity occurring primarily at Suzanna's house when no one else was home. According to Gerald's mother, he was quite infatuated with and committed to this young woman.

His behavior changed with him becoming quite moody and developing a pattern of skipping school with his girlfriend.

About three months after they became involved, Gerald was told by one of his friends that Suzanna was seeing at least two other men, both in their 20's. After he had confronted Suzanna with what he had been told, she broke up with him. Gerald was very upset by this news and discussed the situation with his mother. He said he did not know what to do. His mother suggested he "give it some time" and consider asking another young woman from his school out on a date. Gerald said he was "too much in love with Suzanna" to do this.

A week later, on a Saturday night, Gerald was at home watching a TV movie with the same "friend" who had told him of Suzanna's infidelity. During the course of the movie, a scene was shown depicting a drive-by shooting. Gerald's friend, according to police reports, turned to Gerald and, "laughingly" suggested Gerald do the same thing to Suzanna, telling Gerald about the small caliber pistol the friend's father kept in his car.

"on TV when someone gets shot and they fall down they stand back up. No one told me that, in real life, they wouldn't"

Later that night, sometime after midnight and after the friend had left, Gerald went out his bedroom window, walked down the block to where his friend lived, hot wired the father's car, and drove the five blocks to Suzanna's house.

He took the gun out of the glove box, walked up to the front door, and knocked. Suzanna opened the door and, when she did, Gerald fired the gun five times. Four of the bullets hit Suzanna, killing her instantly. Suzanna's mother had come up behind her daughter to see who was at the door. The fifth bullet struck her in the face and she died three hours later at the hospital.

Gerald was arrested at the scene after a younger child in the house had called 911. He was charged with two counts of second degree murder and tried in the adult system. A psychological evaluation was ordered to assess his intellectual abilities and to get recommendations for an appropriate placement in the corrections system. The most striking comment from Gerald during the clinical interview was in response to what he thought would happen when he fired the gun.

His response was, "on TV when someone gets shot and they fall down they stand back up. No one told me that, in real life they wouldn't."

He pleaded guilty to a charge of manslaughter in the first degree. Gerald had had no previous legal charges, his family was supportive, had provided structure and were willing to continue this structure, and he had a high possibility of him being abused and/or exploited in an adult facility.

The judge took these factors into account and discussed the options with the prosecutor, defense attorney, presentencing officer, family, and evaluating psychologist. After weighing the above and other factors, the judge gave a sentence of five years to be served in a juvenile facility until Gerald was 21 years of age.

If Gerald is able to comply with the requirements of the facility and receives no infractions, he will be able to complete his sentence in 42 months. Gerald has had a hard time finally comprehending that his girlfriend is dead and that he cannot go home because "he is ready to and because he is sorry for what he did." He also cannot understand why his mother is mad at his friend.

In reviewing Gerald's history, it appears unlikely that he would, with constant supervision, be back in a similar

continued on page 6...

...continued from page 5

situation. However, people with FAS, as stated, are easily lead and often do not understand all possible outcomes and ramifications of their behavior. Again, it is essential that the brain damage associated with FAS leading to such deficits is presented clearly and thoroughly to the Court and presentencing officer.

Factors which increase the risk of dangerousness and reoffending include a poor suport system and/or family instability, or little ongoing structure in the defendant's either not being in school or having a poor employment history. Gang involvement and easy access to guns are deadly ingredients when combined with the impulsivity, poor planning, and lack of understanding of cause and effect inherent in people prenatally exposed to alcohol.

Mitigating Factors

Mitigating factors such as brain damage, mental retardation or other influencing factors are often considered when determining an appropriate sentence. Such factors can work towards either a shorter or longer sentence as well as help determine where the defendant should be housed.

In Gerald's case, his lack of criminal behavior, good school attendance, strong family support, age, naivete, and FAS diagnosis were all considered in allowing him to plead guilty to a manslaughter charge.

In cases where there is a long history of criminal behavior, more serious misdemeanors and felonies, a history of violence, and little family support, the defendant may be viewed as being at higher risk and a longer sentence may be imposed.

Response to Service and Prognosis

A final area often considered when determining the length of a defendant's sentence is related to their participation in and response to previous services, e.g. therapy and diversion programs. The more responsive the defendant has been, the better the possible prognosis. However, if the defendant has been offered services with no noticeable improvement, incarceration may be viewed as the best possible placement.

One concern in this area is that people with FAS often do not respond to insight-oriented therapy and, therefore, their prognoses seem poorer than might actually be the case.

The young man, Richard, described in part one of this article, had been in a stable, loving, and nurturing home. He had received a variety of services at school and in the home. It is not clear if these services were appropriate to Richard's level of functioning. What is clear is that Richard, for whatever reason, had never fully engaged in these services. The prognosis for Richard's future looks poor; incarceration appeared the most viable option at the time of his sentencing but this does not provide an answer for the future.

Marty, too, had received services and was fairly functional. However, his ability to function was based on 24-hour per day structure and supervision. Despite this, there were still areas where Marty was not doing as well as might be hoped. His overall prognosis, even with structure is, at best, guarded to fair.

Gerald's prognosis, despite the extreme seriousness of his crime, is fair to good with the following caveat: that he does not pick up too many antisocial behaviors and attitudes while in jail; that he receives intensive and ongoing therapy and support while in jail; that he receives educational and vocational training; and that he return to "the world" with as much support and structure as possible.

Gerald truly had little comprehension of what his actions meant. This does not mean he is not accountable, rather it means that given his background, it should not be assumed that he is a danger to his community. Clearly, however, Gerald's friends must be screened and his social life highly structured. If all the above is in place, Gerald is more likely to live a relatively safe life.

In summary, FAS and other alcohol-related neurodevelopmental disorders place people at greater risk for psychological and legal problems. This risk, however, can be somewhat lowered with structure, supervision, and a clear awareness of the types of external situations that increase the risk of these problems.

Prenatal alcohol exposure, if present, along with concomitant behavioral problems, must be included in any presentencing evaluation and presented to the Court as a possible mitigating factor.

References

1. Jones, KL and Smith, DW (1973) Recognition of the Fetal Alcohol Syndrome in early infancy. Lancet, 2, 999-1001.
2. Streissguth, AP, Aase, JM, Clarren, SK, Randels, SP, LaDue, RA, Smith, DF (1991) Fetal Alcohol Syndrome in adolescents and adults. The Journal of the American Medical Association, 265 (15), 1961-1967.
3. West, JR (1986) Alcohol and Brain Develoment. New York: Oxford University Press.
4. Jones, KJ, Smith, DW, Ulleland, CN, Streissguth, AP (1973) Pattern of malformation in offspring of chronic alcoholic mothers. Lancet, 1, 1267-1271.
5. Dorris, M (1989) The Broken Cord: A family's ongoing struggle with Fetal Alcohol Syndrome. New York: Harper Collins.
6.Streissguth, AP, Barr, HM, Kogan, J, & Bookstein, FL (1986) Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). Seattle, WA: University of Washington Press.
8. Streissguth, AP, LaDue, RA, Randels, SP (1986) A manual on Adolescents and Adults with Fetal Alcohol Syndrome with Special Emphasis on American Indians. Washington, DC: Government Printing Office.