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Fetal Alcohol Spectrum Disorder in Confinement Settings: A Review for Correctional Professionals

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ABSTRACT

Fetal Alcohol Spectrum Disorder (FASD) is a serious lifelong disorder that has been largely understudied within the context of corrections. FASD is a complicated, and often misunderstood and challenging disorder. Individuals with FASD who are confined to a correctional setting may be perceived as lazy, manipulative, irritating and self-defeating, especially when correctional staff lack an awareness and understanding of the disorder. The aim of this article is to present suggested approaches that correctional professionals should consider when interacting with inmates with FASD or suspected of having FASD as well as highlighting various factors that should be taken into account when someone with this disorder is serving a sentence within a confinement setting.

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Introduction

Fetal Alcohol Spectrum Disorder (FASD) is a serious lifelong disorder (Streissguth & O'Malley, 2000) impacting millions of Americans. In fact, recent estimates show as many as 2-5% of the U. S. population may be affected by FASD (May et al., 2009). Prenatal alcohol exposure has shown to contribute to impairments in cognition, behavior, intellect, and a host of other consequences (Astley & Clarren, 2000; Church, Eldis, Blakley, & Bawle, 1997; Fast & Conry, 2009; Kodituwakku, 2009; Malbin, 2004; Rasmussen, 2005; Streissguth, Aase, Clarren, Randels, LaDue, & Smith, 1991; Streissguth, Barr, Kogan, & Bookstein, 1996). One such consequence is the disproportionally high number of individuals with FASD becoming involved in some way in the criminal justice system (McLachlan, Roesch, Viljoen, & Douglas, 2014; Streissguth et al., 1996), especially when community supports and services are not present.

Surprisingly, only a small number of studies have been published on FASD and the correctional system (Bisgard, Fisher, Adubato, & Louis, 2010; Conry & Fast, 2000). Of the studies conducted, two separate samples found that 10% and 24% of inmate participants had been exposed to alcohol prenatally (Conry & Loock, 1999; MacPherson & Chudly, 2007). Based on this evidence, many key, unanswered questions remain and the need for additional research in this area is highly warranted. In a recent review of Canadian records, the authors found that individuals with FASD were 19 times more likely to be incarcerated (Popova, Lange, Bekmuradov, Mihic, & Rehm, 2011). For these reasons and others, it is essential for correctional professionals to recognize the symptoms associated with FASD. Therefore, it is recommended that all correctional and custodial staff learn to identify inmates who may have FASD by observing inmate behavior while in custody and their criminal, personal, medical and employment history.

FASD is a complicated condition often misunderstood among helping professionals (e.g. criminal justice, educational, fire, medical, mental health, employment, and social service professionals). Individuals living with the everyday challenges of FASD often struggle not only to cope with the primary disability of a brain injury, but also with an array of secondary conditions. These comorbid conditions can greatly impact daily function and negatively influence a cycle of destructive behaviors. When strategies and interventions are provided based on the erroneous assumption that the individual has a neuro-typical brain, they are very likely to be unsuccessful. It is crucial for helping professionals to recognize the warning signs of FASD. Table 1 highlights some of the various consequences often associated with FASD (see Appendix A).

FASD in Correctional Settings

Inmates with FASD create challenges for correctional professionals. These challenges include: being victimized and victimizing others, difficulty following prison-based routines and rules, negative social interactions with both inmates and correctional staff, and difficulty maintaining appropriate health and safety (MacPherson & Chudley, 2007). In correctional settings, it is common for confinement

professionals to perceive those with FASD as lazy, manipulative, irritating, and self-defeating (Boland, Burrill, Duwyn, & Karp, 1998). However, these behaviors are often the direct result of severe neurological deficits caused by prenatal alcohol exposure (Mela & Luther, 2013). Raising awareness among correctional staff about the primary and secondary disabilities associated with FASD may create a better understanding and informed approach when issues arise within confinement settings (Boland, Burrill, Duwyn, & Karp, 1998; Streissguth, 1997). Table 2 (see Appendix B) addresses approaches that take into account the underlying neurological damage that may produce more positive results, as well as highlighting various considerations correctional professionals should consider when they encounter an inmate with FASD or suspected FASD.

Identification. Professionals should consider the possibility of FASD when encountering inmates with impaired comprehension, learning, memory, and social skills, as well as behavioral and emotional problems. Common histories of many individuals with FASD is previous involvement in foster care, special education programs, family history of alcohol misuse, inability to manage money, vocational problems [being able to get a job, but unable to keep it], frequent contact with the criminal justice system, and impulsivity and impaired ability to manage conflict and stress (Boland, Burrill, Duwyn, & Karp, 1998; Streissguth, 1997; Streissguth, Barr, Kogan, & Bookstein, 1996), all of which can be highly problematic within correctional settings. It should not be assumed that every inmate who presents with these behaviors and challenges has FASD, however, an offender who exhibits such behaviors should be referred for additional screening, assessment, and testing.

Awareness. Correctional level psychologists, doctoral level interns and neuropsychologists may have a basic understanding of FASD. However, entry level and frontline correctional staff commonly lack the appropriate training and education related to FASD. Hence, incorporating specific FASD education into new correctional officer orientation and training programs is highly recommended.

Screening. Proper detection of FASD through screening is often lacking within confinement settings (Bracken, 2008; Brown, Connor, & Adler, 2012). Established guidelines and practices are frequently absent within correctional facilities in order to regularly screen new inmate admissions for FASD (Graham, 2014). In the absence of accurate detection of FASD, within an offender population, additional adverse outcomes, problematic behaviors, and ineffective intervention approaches may result. Ultimately, this may be one variable to consider when examining rates of ongoing criminal justice involvement for individuals affected by FASD. However, there is a lack of scholarly literature on the topic of FASD and criminal recidivism (Burd, Selfridge, Klug, & Bakko, 2004). Hence, screening for FASD within correctional settings should be considered (Fast & Conry, 2009), and may reduce future incarceration for this highly vulnerable population. FASD screening practices should consider an examination of the inmate's attentional, behavioral, and learning challenges, in the early stages of incarceration, to best facilitate appropriate strategies while in custody that can address the unique challenges of this population (Spohr & Steinhausen, 1987). Table 3 highlights intended benefits associated with regular screening for FASD within criminal justice settings (see Appendix C).

Community Supervision. Correctional release planners with an understanding of the challenges of FASD will be in a better position to provide guidance and make referrals to community support providers. When working with FASD-affected inmates, it is imperative to connect them with appropriate services, as reentry can be overwhelming without proper services and support (Boland, Burrill, Duwyn, & Karp, 1998). Correctional release planners are responsible for observing, monitoring, and providing additional support once inmates return to the community (Boland, Burrill, Duwyn, & Karp, 1998). This support is extremely important, as once daily routines and expectations of prison life no longer exist, the individual faces the responsibility of making reliable decisions and choices. As a result of the damage to the areas of the brain that control executive functioning; making decisions and solving problems appropriately can be challenging. Table 4 highlights some of the various community-based services possibly available for individuals with FASD attempting to reintegrate into society (see Appendix D).

The above-mentioned programs provide support (i.e., directly or indirectly) and other services to people with FASD. However, professional experience has shown that few services in the community

gear programs or curricula specifically towards FASD. Even fewer services truly understand the unique challenges and needs of adults affected by FASD, especially those reentering the community from a correctional setting. When services provide a sustained communication among the team of providers, as well as regular coordination meetings, there is a higher likelihood that treatment interventions will be more effective. Individuals with FASD are particularly ill suited to navigate complex service qualification and provision systems unaided. Best possible outcomes for the person with FASD is ensured through maintaining communication among professional providers, the individual's caregivers, and support members. In addition, ongoing and regular supervision or mentoring of persons impacted by FASD, especially those who are incarcerated is paramount. Traditional forms of probation rarely work for these complex individuals. People with FASD often think concretely and do not grasp abstract concepts well (Wartnik, 2007). As a result, successful treatment and supervision require restructuring of the methods through which information, resources, and directives are present.

Communication Suggestions. When working with someone impacted by FASD, it might be helpful for correctional officers to identify whether the individual truly understands the rules and obligations of the prison setting. It is strongly suggested that, when possible, strict "*yes"* or "*no"* questions be avoided when discussing matters related to comprehension. Obtaining a "*yes"* or "*no"* response will often mask the individual's lack of capacity to grasp what is being said and hide a possible inability to think in a complex manner. Frequently, individuals with an FASD will reply with the answer they believe others want to hear, even to their own detriment, in an effort to please people. Further, individuals with FASD experience difficulties with confabulation and unknowingly provide misinformation or a false sense of comprehension.

Keeping questions open ended and encouraging the inmate to repeat what they have heard helps assess the level of comprehension. Asking for a demonstration of what is expected is also useful. Explanations and discussions regarding the correctional officer's expectations should be briefly stated, put into simple words, and modified to match the inmate's developmental age – not his or her chronological age. On the surface, inmates with FASD may appear very capable and knowledgeable during brief check-in meetings; however, after assessing their ability to comprehend complex statements this impression might change. Correctional professionals should employ appropriate strategies for individuals with FASD.

D.E.A.R. is an acronym-based intervention approach developed by our research team. The intent is to assist correctional officers in remembering suggested approaches that may increase positive outcomes for FASD-corrections involved individuals. Table 5 illustrates the various components of D.E.A.R. (see Appendix E).

Conclusion

Incarcerated individuals with FASD can be a challenging. This population presents with a wide array of impairments and limitations. Effective supervision requires an active effort on the part of the correctional officer and other staff. To support success, correctional officers must have an understanding of FASD and its complexities. Correctional professionals must remember that this population is often highly suggestible, easily manipulated, impulsive, hyperactive, distractible, socially inept, and may present as superficially charming and competent, yet ingenuous. Moreover, correctional staff must remember that the primary disability of FASD is an irreversible, irreparable brain injury, caused by prenatal alcohol exposure. As a result, impairments caused by FASD frequently place affected inmates at significant disadvantages within correctional settings. Recommendations include that criminal justice professionals establish coordinated and documented processes and practices that take into account the unique needs and challenges of this group (whether diagnosed or not), who are involved in any way with the justice system (Cox, Clairmont, & Cox, 2008). It is important to note that using the strategies and interventions identified in this document on a person who does not have FASD should not result in any injury or impairment. However, our experience tells us that when not using these strategies on individuals

who do have FASD may contribute to secondary disabilities and possibly result in recidivism and even suicidal ideation or self-harm.

A high level of monitoring and supervision is often necessary for this population. By doing so, this may reduce the risk of further victimization and aid the individual in completing their prison sentence and successfully reintegrating into society. Ongoing education and awareness efforts for correctional professionals and further research into the incidence, prevalence, and outcomes within this population are paramount.

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APPENDIX A

Table 1. FASD: Possible Consequences Associated With Prenatal Alcohol Exposure

Possible Consequences
• Chronic homelessness
• Confabulation
• Easily influenced by others
• Educational and learning deficits
• Failure to comply with probation and conditions of release
• Failure to learn from past mistakes
• History of adoption or living in a variety of foster homes
• History of prostitution
• History of unstable relationships
• Impaired memory
• Inability to maintain employment
• Inability to parent appropriately
• Inflexible behavior
• Lack of insight
• Money management issues
• Multiple childhood mental health diagnoses including Attention Deficit/Hyperactivity Disorder (ADHD), Conduct Disorder (CD), Oppositional Defiant Disorder (ODD), Reactive Attachment Disorder (RAD), etc.
• Multiple treatment failures
• Multiple unexplained medical problems
• Poor coping skills
• Poor impulse control
• Rage control problems
• Regular involvement with the criminal justice system
• Sensory Integration Disorder resulting in difficulty focusing when there is too much visual,

auditory, or kinetic stimulation

- Sexually inappropriate behaviors
- Sleep related problems
- Social boundary violations
- Special education involvement
- Substance use disorders

Note: The above consequences are not intended to be exhaustive and should never take the place of a comprehensive FASD assessment. No one consequence is a confirmation of FASD. The complexities associated with FASD illustrate the importance of continued education and training about these issues.

Adapted from: Brown, J., Long-McGie, J., Wartnik, A., Oberoi, P., Wresh, J., Weinkauf, E., Falconer, G., & Kerr, A. (2014). Fetal Alcohol Spectrum Disorders in the Criminal Justice System: A Review. *The Journal of Law Enforcement, 3*(6), 1-10.

APPENDIX B

Table 2. FASD: Considerations for Correctional Professionals

Correctional Professionals
Correctional staff should…

- be encouraged to give one command at a time
- be aware that many individuals with FASD have slow processing speeds and may require additional time to respond to each command
- avoid asking the FASD-impacted inmate complex and/or multiple questions at any given time
- be prepared to use repetition when explaining |teaching the rules and regulations of the prison environment

Inmates with FASD…

- may be incapable of self-regulation; i.e. the ability to control one's thoughts, emotions, behavior, and desires in order to achieve goals
- find it difficult to delay gratification
- experience frequent lapses in emotional and behavioral control and should not be seen as willful wrong doing
- commonly experience profound memory deficits that may impair their ability to appropriately comply with various services and programs. Increasing structure and supervision to match the memory deficits will improve their ability to appropriately comply with various services and programs – additionally, this memory impairment may manifest as being capable of successfully completing a task one day, but forgetting the task the next day - it is important to understand that this is not within the control of the individual
- may become easily overwhelmed and lack the ability to manage stressful situations appropriately while incarcerated – their response to stress may be anger and aggression
- are at an elevated risk of exploitation and victimization by other inmates
- frequently experience sensory integration problems and may become overly stimulated by various aspects of the prison environment
- may be at a greater likelihood to not recognize other inmates' personal space and boundaries because of social boundary and interpersonal functioning deficits often observed in individuals with this disorder
- may accept blame for illegal activities and behavioral misconducts they did not commit
- may be at an increased likelihood to provide correctional staff with erroneous information and a greater propensity to confabulate – this is not always within their control
- may be more likely to participate in inappropriate and unwanted sexual encounters with other prisoners because of the extreme vulnerability and deficits associated with this disorder
- should be appropriately monitored for self-injury
- are often targeted by other inmates and as a result, upon reentry into the community, emerge with increased propensity for recidivism
- have age-appropriate or higher expressive language ability that is unmatched by their comprehension – consequently it can be wrongly assumed that the individual understands instructions, concepts, models and regulations because he says he does
- can be superficially charming and are often "people pleasers"

- are commonly hyperactive, impulsive, and easily distractible
- should be referred to appropriate FASD-specific support/services upon community reentry

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Please note: The information from this table was collected through various interviews with caregivers and professionals with an advanced understanding of FASD.

APPENDIX C

Table 3. Intended Benefits of Routine Screening for FASD within Criminal Justice Settings

Routine Screening
Routine screening for FASD may promote the use of a standardized, evidence-based metric of FASD signs and symptoms across mental health, correctional, and legal systems
Screening for signs and symptoms of FASD will enable mental health, correctional, and legal professionals to communicate more effectively with individuals diagnosed with the disorder, especially through the subsequent use of prompts and language matched to their cognitive abilities
Correctional and legal professionals need not rely solely on professionals with medical and mental health expertise to preliminarily screen for evidence of FASD
Legal counsel will be able to better guide individuals with FASD through complex legal proceedings
Judges will be able to make informed sentencing decisions, including the use of diversion opportunities to promote treatment rather than incarceration
Correctional and forensic mental health professionals will be better able to ethically obtain informed consent for both intra-institutional and community treatment
Preventative measures (e.g., increased monitoring) can be put into place to reduce the likelihood of peer-victimization common with this population in correctional settings
More effective reentry plans can be established by parole and probation boards to maximize the likelihood of individuals with FASD being able to adhere to the conditions of their release by matching them with available social services, ultimately reducing rates of recidivism and unnecessary spending of state funds
Researchers could extract easy-to-analyze quantitative data from completed screening tools and run independent studies on the accuracy and reliability of the screening tool to validate its evidentiary support
Early identification of FASD may help to minimize the detrimental effects of confabulation and false testimony during criminal investigations and court processes
Predicting the efficacy of different treatment modalities will become easier for mental health and correctional professionals (especially those working with sexual offenders) due to a better understanding of the signs and symptoms of FASD
Appropriate screening and diagnosis will allow individuals without support to self-advocate after release

Adapted from Brown, J. (2014). The Importance of Screening for FASD in Criminal Justice Settings. *Fetal Alcohol Forum, 12*, 43-44.

APPENDIX D

Table 4. Possible Services Available for Individuals Impacted by FASD

Services
Adult Rehabilitative Mental Health Services (ARMHS)
Case Management Services
Community Support Groups
Children Therapeutic Support Services (CTSS)
Drug and Alcohol Treatment
Educational and Vocational Support Services
Independent Living Skills (ILS)
Individual and Group Psychotherapy
Personal Care Attendants (PCA)
Psychiatrist Services
Supportive Housing Services
Disability Services

APPENDIX E

Table 5. D.E.A.R.: An Intervention Approach

D.E.A.R.
DIRECT LANGUAGE When interviewing an individual diagnosed with, or suspected of having FASD use simple and direct language. This population has difficulty with abstract thinking. Using abstract concepts and idiom will not result in the individual understanding the actual context of the conversation. Use concrete language that is based in the here and now. Explain things slowly to allow more time to process the information. Ask the interviewee for an explanation of what was said to ensure they understand the direction or question.
ENGAGE SUPPORT SYSTEM When interviewing an individual diagnosed with, or suspected of having FASD, be sure to ask whether they carry with them a card of a mentor, advocate, or case worker who can offer support and/or act as interpreter. Given that this population frequently does not understand the consequences of providing police with incriminating statements, avoid leading questions and, if possible, do not begin instruction or inquisition until a member of their support system is present.
ACCOMMODATE NEEDS When interviewing an individual diagnosed with, or suspected of having FASD, conduct the interview in a quiet place without distractions. Give the individual space and avoid physical confrontation. As this population usually functions at a lower developmental level than their chronological age, adapt your choice of words and your style of communication accordingly. Additionally, those individuals with FASD who also have a Sensory Integration Disorder may experience a light touch on the shoulder as a hit and react accordingly. Therefore until the individual is better known, avoid touch unless necessary.
REMAIN CALM When interviewing an individual diagnosed with, or suspected of having FASD, do not rush, as this will cause stress and may result in the individual becoming overwhelmed. This population is characterized by an inability to manage their emotions and situations may escalate quickly. It is necessary to maintain a calm and collected demeanor with this population.

Adapted from Brown, J., Herrick, S., & Long-McGie, J. (2014). Fetal Alcohol Spectrum Disorders and Offender Reentry: A Review for Criminal Justice and Mental Health Professionals. *Behavioral Health, 1*(1), 1-19.