
**FETAL ALCOHOL SPECTRUM DISORDER AND THE
INCARCERATION OF MÉTIS AND OTHER
ABORIGINALS**

Prepared For: Vancouver Métis Community Association

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The opinions presented in this report are those of the participants and do not reflect the official policy of the Vancouver Métis Community Association

The effects of the habitual use of alcohol seem to be... [that] the children of such persons are apt to be... feeble in body and weak in mind... idiots, fools and simpletons are common among the progeny of such persons... moreover one considers how many children are born of intemperate parents who, without being idiots are deficient in bodily and mental energy... it will be seen what an immense burden the drinkers of one generation throw upon the succeeding...[the] transmitted effect of intemperance may also appear in the form of a propensity to vicious course or dullness of moral perception, or irresistible impulse to crime... the inmates of our penitentiaries, whose history is thoroughly known, present many examples of the operation of this pathological law.”

- G.S. Howe “On the Causes of Idiocy” a report to the Massachusetts Legislature, 1848

Fetal Alcohol Spectrum Disorder (FASD) is a rising concern to the Canadian population. It is increasingly becoming more prominent in the Canadian Federal Correctional System and it may be a leading factor in the ongoing cultural genocide of the First Nations people of Canada.

The Vancouver Métis Community Association (VMCA) and their Walk Bravely Forward program have requested a report that took into consideration the Canadian Federal system and its First Nations and Métis inmate populations who have been diagnosed with FASD.

Little credible information seems commonly available on FASD, especially in terms of its social effects. The available information on the effects of FASD on First Nations communities is almost non-existent. Coupled with these facts, there are also virtually no services or rehabilitation programs designed to meet the needs of individuals who have FASD. The purpose of this report is to bring these issues to light.

The following information was compiled in order to educate the general population about the high volume of First Nations and Métis people who are affected by FASD. The VMCA Walk Bravely Forward program deals with Métis offenders and their reintegration back into the community and the larger society. This program faces a large

problem: reintegrating offenders with FASD back into society is an almost impossible task because of the cognitive barriers that those with FASD face.

Fetal Alcohol Spectrum Disorder is an extremely debilitating condition that inhibits the basic life skills that people need in order to survive in the world of today. Even though FASD is the most common and only known preventable cause of mental handicap, many people are still suffering from it because of a lack of preventative information given to the population and the lack of protection given by the Canadian government to the First Nations and Métis people of Canada.

This report consists of a basic background to the medical phenomenon of FASD, and some background to the aspects of criminal activity related to FASD. Interviews as well are with personnel who work closely with FASD offenders, such as a Counsellor, a House Supervisor, and a Program Facilitator, all of whom work closely with FASD offenders in a Community Residential Reintegration Facility; also interviewed were three members of the VMCA, this shows a view of the opinions of those who work with those with FASD on a near daily basis. Brief case studies and reports are also discussed. Finally, the report provides a basic bibliography and literature review pertaining to the subject of FASD.

A Medical Background on FASD

“Some people who should not drink are any man or woman when proposing to procreate children... rather the embryo should be compacted firmly, steadily, and quietly in the womb...[or they will be] likely to beget unstable and untrustworthy offspring, crooked in form and character”

Plato “On Carthaginian Law” 322 BC

The amount of literature on what Fetal Alcohol Spectrum Disorder (FASD) is in a great abundance. Canada itself holds a large amount of research focusing on FASD

and how it affects young children. Most of the literature dates from the early 1980's to the mid 1990's as this was the time of massive research into what exactly the effects of alcohol on the fetus were was conducted. The more recent literature found focuses on the prevention of FASD and how society must educate each other about the outcomes of consuming alcohol while pregnant.

Fetal Alcohol Spectrum Disorder is a disability resulting from prenatal exposure to alcohol. "With an estimated 9 in 1,000 babies born in Canada affected by the disability, FASD puts a heavy social and economic burden on those with FASD, their families, their communities and our society as a whole. FASD is a life-long disability. While there is no cure, the disorder is preventable. Those with FASD can, with the right supports, approaches and services, lead happy and productive lives".¹ Fetal Alcohol Spectrum Disorder is regarded as the leading cause of mental retardation and developmental disabilities in the Western world. Of all the substances of abuse, including heroin and cocaine, alcohol produces by far the most serious neurobehavioral effects in the fetus. FASD is now cited to be the leading known cause of intellectual disability in children, surpassing both Spina Bifida and Down syndrome². This is an especially significant statement because under-identification of the condition is still surprisingly common.³

FASD was first established as a medical diagnosis in 1973 (then labelled Fetal Alcohol Syndrome). Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term increasingly used to describe the spectrum of disabilities (and diagnoses) associated with

¹ Canada, (2003) Fetal Alcohol Spectrum Disorder: A Framework for Action. Ottawa: Minister of Public Works and Government Services Canada

² Children's Commission, (2001) Fetal alcohol syndrome: A call for action in B.C.

³ (Little, B. B., Snell, L., Rosenfeld, C., Gilstrap, L., & Gant, N. (1990). Failure to recognize fetal alcohol syndrome in newborn infants. American Journal of Diseases of Children,

prenatal exposure to alcohol. FASD is not itself a diagnostic term; rather the diagnoses under the FASD umbrella include:⁴

- Fetal Alcohol Syndrome (FAS)
- partial FAS (pFAS)
- Alcohol-Related Neuro-developmental Disorder (ARND)
- Alcohol-Related Birth Defects (ARBD).

In its report from AADAC the Government of Canada defines the current generally accepted definition of Fetal Alcohol Spectrum Disorder as⁵:

- 1.) Confirmation of heavy drinking during pregnancy
- 2.) Signs of abnormality
 - a.) Growth retardation (before and/or after birth)
 - b.) Central nervous system involvement
 - Neurological abnormality (e.g., hearing disorders)
 - Developmental delay
 - Behavioural dysfunction or deficit
 - Intellectual impairment (e.g., mental retardation) and/or structural abnormalities (e.g., brain malformations)
- a) Characteristic face
 - narrow eye width (short palpebral fissures)
 - elongated, flattened midface
 - thin upper lip
 - underdeveloped groove (philtrum) between the upper lip and the nose

⁴ AADAC *Medical/ Physiological effects of Alcohol*

⁵ Canada, (2003) Fetal Alcohol Spectrum Disorder: A Framework for Action. Ottawa: Minister of Public Works and Government Services Canada.

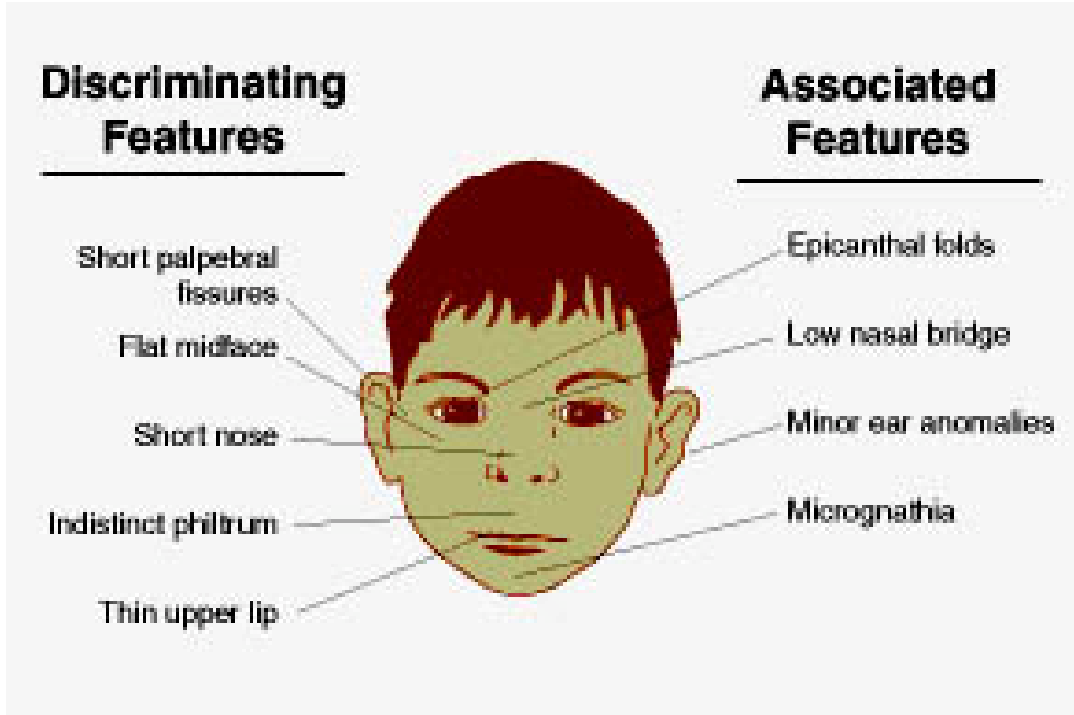


Figure 1 Characteristic Face of Adolescent with FASD

(<http://www.niaaa.nih.gov/publications/Social/Module10KFetalExposure/Module10KFetalExposure.html>)

Many of the people exposed to alcohol while still developing *in utero* have no external physical characteristics, because the facial features of FAS result during specific times during the pregnancy. Many studies have shown that the facial characteristics are affected during the first 16-21 days of conception. Even without any visible characteristics, people with FASD may still have severe brain dysfunction such as those who have full FAS. The diagnosis of FASD is based on “a specific cluster of physical anomalies, growth deficiency, and central nervous system problems.”⁶ Babies and children diagnosed with FASD have a poor prospect for normal development and will require special community services throughout their lifetime. People afflicted with FASD have an extremely high risk for a lifetime of disabilities. There is little to no indication

⁶ Canada, (2003) Fetal Alcohol Spectrum Disorder: A Framework for Action. Ottawa: Minister of Public Works and Government Services Canada.

that the majority of them will ever be able to be self sufficient, financially or socially, or even be responsible parents themselves. They will need care, protection, and appropriate resources throughout the entirety of their lives.

Despite the fact that it is completely preventable, FASD is a complicated, intricate health and social issue that affects all Canadians in each and every single social setting, and in all regions of the country. In some First Nations and Inuit communities, given the history of colonization and devaluation of culture, rates of FASD may be higher than the national average.⁷ Many people believe that children born with Fetal Alcohol Spectrum Disorder mainly come from alcoholic mothers. While this may be true in some respects, many children born with FASD are born from what are termed “binge drinkers”. A binge drinker is a person who, in one sitting, consumes five or more bar-poured drinks.

Many patients with FASD are often raised in alcoholic families during their early developmental years. Families who are not able to sustain abstinence are often unable to protect their children from neglect, physical and sexual abuse, sexual promiscuity, cruelty, maternal death, and social rejection. Despite their good intentions, such mothers face extreme difficulty providing a peaceful, encouraging, controlled, consistent environment, an environment that appears to be helpful to the most advantageous development of children with FASD. The emotional problems and psychological remains of years in negligent and abusive homes are particularly difficult for children with FASD to overcome because of their handicaps. Impulsiveness, lack of inhibition, and naiveté is common among the patients, regardless of age or gender. Because of the lowered abstracting abilities and poor social skills exhibited by the patients, they are at a high risk

⁷ Canada, (2003) Fetal Alcohol Spectrum Disorder: A Framework for Action. Ottawa: Minister of Public Works and Government Services Canada.

for sexual exploitation. Some studies of children with FASD suggest that they are at an increased risk for maladaptive behaviour that may lead to criminal offences.⁸

Presently FASD goes undiagnosed and unrecognized in most adolescents and adults because many physicians and families do not believe that alcohol use can actually do harm to the fetus. Another factor may be that the mothers are humiliated by the fact that they consumed alcohol during their pregnancy and will not admit to it in fear of being unfairly judged and have their child taken from them. Figure 2 below demonstrates how consuming alcohol during pregnancy affects the fetus - it can affect the brain of the unborn child in ways that no other drug can. The agenesis (absence) of a corpus callosum, having cysts or cavities in the brain, and cerebellar hypoplasia (malformation of the rear part of the brain), have been proven to be devastatingly harmful to the development of the children and adults living with FASD.

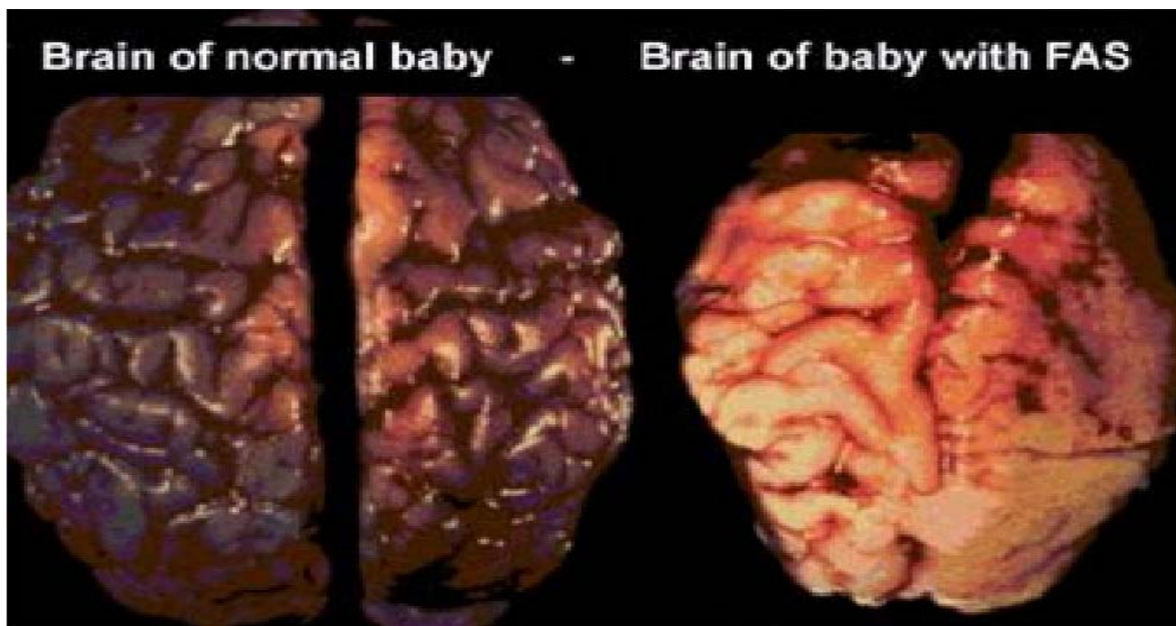


Figure 2 – Brain Comparisons

⁸ Conry, J., & Fast, D. (2000) Fetal alcohol syndrome and the criminal justice system Vancouver: Law Foundation of British Columbia. p.1.

Furthermore, according to some experts, “prenatal exposure to alcohol is associated with a wide range of neuropsychological and neuroanatomical abnormalities.”⁹ Mental health problems are common among those diagnosed with FASD. Overall, 94% have at least one of the following in adulthood:¹⁰

- Depression – 52%
- Suicide threats – 43%
- Panic attacks – 33%
- Psychosis – 29%
- Suicide attempts – 23%
- Continuing ADHD problems – 40+%

The total births in Canada in 2003 were 331,522; out of that total an estimated 3,314 children were born with FASD - approximately 1% of the population. In British Columbia alone, an estimated 400 children, were born with FASD. These statistics are frightening as we are learning that people afflicted with FASD often possess functioning abilities in the mentally handicapped range (>70 IQ) although their cognitive IQ may be on the verge of low average to average. Determining their intelligence through IQ is misleading and unreliable because many people who have a somewhat normal IQ are unable to function like most people with the same scores. They will need assisted housing and specialized help throughout their lives, which can be very costly, which is an added expense for the Canadian society.

Fetal Alcohol Spectrum Disorder is a fully preventable disability that affects each and every single person. The social effects of FASD, including the effects on family dynamics, childhood education, and more specific to this study, the legal and correctional

⁹ Streissguth, Ann & Kanter. J (1997) The challenge of fetal alcohol syndrome: Overcoming secondary disabilities. Seattle: University of Washington Press

¹⁰ Streissguth, A. P., Barr, H.M., Kogan, J. and Bookstein, F.L. (1996b). Understanding the occurrence of secondary disabilities in clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). Seattle: University of Washington School of Medicine, Fetal Alcohol and Drug Unit

system, have been shown to be a growing and insurmountable problem under present conditions. Especially with regard to the effects on individuals in the correctional system, the First Nations people of Canada have been highly affected by this medical phenomenon that looks as if it will further threaten an already struggling society. These effects will be outlined below.

FASD and the Criminal Justice System

“Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability”

Canadian Charter of Rights and Freedoms - 1982

In *FAS and the Legal Process*, Julianne Conry, a renowned UBC professor of Educational Psychology, asserted that “On any one day in BC there are 306 youth in custody, 94 in remand, 1000 on bail, 4450 on probation and 10 in the Input Assessment Unit”. Of these numbers, 23.3% are youth with FAS and partial FAS.¹¹ It is safe to say that these statistics correspond with the adult offenders as well, although there are no found formal studies to support this.

Many people with FASD have trouble connecting action vs. reaction: they are often unable to foresee consequences and act impulsively, which more often than not leads to criminal behaviour. Because people do not ‘outgrow’ FASD, they are faced with extreme challenges their entire lives. Many of their learning disabilities and behavioural problems will eventually lead to a criminal lifestyle if they are not addressed as a child.

¹¹ (FAS – A Community Responds: A Conference With a Difference, February 1999).

Even still, with the best of parenting, some of those afflicted with FASD still end up in the justice system because they lack the structural setting that would best be suited to their specific needs.

People with FAS can have normal IQ's, but have substantial impairment to their memories, judgement, and living skills. Therefore, they are highly susceptible to being lead into confessions of crimes they did not commit. For many First Nations people, direct eye contact communicates harsh disapproval,¹² and because many questioning sessions with police have direct communication, this may lead to a coerced or a quicker confession. Because First Nations people know there are severely racist attitudes towards their culture in today's society they may believe that they will be convicted of the crime regardless of their innocence, and think it is better to simply avoid the whole trial process, accept punishment, and get on with their lives.

In general, many people with FASD lack the ability to structure their time they are easily controlled and abused by others. Many are strong-armed into committing crimes that they could not formulate on their own and often take the fall for these types of crimes when they are caught. Most criminals with FAS do not realize that they are actually committing crimes when following an urge or their "friends". This is not to say that all FAS offenders are innocent; many of them do commit crimes, and should be punished for doing so, but they should be assessed as to why they committed the crime to begin with and punished in an according way.

A common opinion among people who work with FASD offenders believe that those with FASD thrive in the federal prison system because of the daily structure that it

¹² Shebib, Bob., (2003) Choices: Interviewing and Counseling Skills for Canadians. Toronto ON: Pearson Education Canada Inc.

provides. They follow a daily routine that is set out for them which helps them to maintain a somewhat healthy lifestyle. Although they may thrive in the system because of the intense structure, they also become the victims of abuse and many become rape victims, drug mules and scapegoats. Because First Nations men are grotesquely over-represented in the prison system and they have a high incidence of FASD, they tend to be these victims. (Although the First Nations people of Canada make up three percent of the population they represent over 17% of the prison population) Upon their release they are not only traumatized by their lives outside of the justice system, but they are then traumatized by their lives within the system.

Many people with FAS start each day with a “clean slate” and are unable to learn from previous lessons; therefore, many of them do not understand what they are confessing to, or being tried for.¹³ Trivial language may contribute to their lack of understanding a question. For instance, the minute difference between using the word “house” instead of “apartment” may result in miscommunication. If asked if they were at someone’s house at the time of a murder, they may answer no, because they in fact were at someone’s apartment.

Normal disciplinary practices are more often than not ineffective for people with FASD. These methods of punishment suppose a normally functioning brain understands the concept of punishing consequences for inappropriate behaviours. Unfortunately, these are techniques that are often ineffective. The effectiveness of incarceration for an adult as a punishment requires the ability of the brain to store and retrieve information and predict

¹³ Conry, Julianne., (2000) Fetal Alcohol Syndrome and the Criminal Justice System, Vancouver: Law Foundation of British Columbia.

outcomes. These are precisely the types of information-processing shortfalls that are characteristic of patients with FASD.

Alcoholism is viewed as a broken hoop, or broken circle of issues, in many aboriginal cultures; this signifies a misbalance in harmony, in the way the people were meant to be. For a First Nations person to be diagnosed with FASD only helps to accentuate this misbalance in their culture and way of life. Furthermore, for a First Nations person to be punished by a system in which they have little confidence is in many ways an insult. Therefore it is necessary for the First Nations people of Canada to be given the opportunity to implement justice in their own way with their own people.

There are many alternatives to sentencing people afflicted with FASD who have been convicted of a crime, but it is particularly important to look at the resources that are available to this person. Many options are not feasible, accessible, or even known about to the parole officers, social workers, lawyers, and families. Much of Canada's First Nations population lives in isolated areas, and is not able to access the resources that are available in the larger centers. This isolation provides the perfect opportunity to utilize the First Nations healing circles, sweat lodges, and sentencing circles as a form of alternative sentencing. If the community becomes involved in the sentencing and they work together they not only show that they support the offender but are willing to help rehabilitate them. The Canadian government is willing to be culturally sensitive and assist the First Nations people in these forms of unorthodox sentencing. The sentencing process must be outlined by a Federal Judge and used in accordance with the Canadian Justice system to ensure that the offender is being rehabilitated and is in fact healing.

Restorative Circles Initiative is a new pilot project in Saskatoon sponsored by the Department of Justice Canada its emphasis is on reducing the number of young people in custody, with the support of a local school (King George Community & School Association). The program has the potential of dealing with FASD youth. All-encompassing the family and community unit, the Restorative Circles Initiative aid youth in the justice system to come up with an alternative method of dealing with their problems, through better life styles and more effective choices, all the while upholding respect and pride for themselves and others. The circles that the Restorative Circles Initiative constructs are based on restorative justice, and may be either pre-sentence circles (with those victims involved), or post-custody circles (supporting the youth during a period of rehabilitation and reintegration). The circles may be attended by the youth and victim(s), elders, families, justice staff, and a judge or facilitator. Pre-sentence circles are ordered by a judge in search of recommendations for sentencing from the community and to find the resources that support the sentencing opportunity. Mentors, who are trained by Restorative Circles Initiative, are found to be extremely effective with FASD youth and become part of a integral support team that have been selected to work with the troubled youth. The hope is that the mentor will provide ongoing support with the youth, chiefly following custody, for a minimum of a six-month period.

In Canada there is only one Community Residential Reintegration Facility (Genesis House) that specializes in adult male offenders with FASD. The house places the FASD offenders in programs specifically suited to their needs and helps reintegrate them back into society. They are taught specific life skills and placed in cognitive behavioural programs that are designed to specifically help the offenders lead healthy,

productive lives. Case management strategies are tailored specifically to the individuals living with FASD. This re-integration facility is a highly structured environment with a high staff-to-client ratio. Intensive therapeutic case work tailored to meet the unique needs of each client is delivered by extensively trained staff. The program objectives are to support individual affected by FASD in their successful re-integration into the community as well as to reduce re-offence rates.

The mere fact that there is only one of these facilities goes to show the lack of education, information, and government services available for people with FASD. It also goes to show the lack of motivation on the part of the federal and provincial governments in implementing new programs and services in order to meet the needs of these individuals.

Some researchers argue that approximately fifty percent of adult offenders suffer from undiagnosed FASD. Of individuals affected by FASD between the ages of twelve and fifty, it is estimated that sixty eight percent will experience difficulties with the law. Research conducted by Dr. Fred Boland et al (1998) entitled “Fetal Alcohol Syndrome: Implications for Correctional Service” made several recommendations in order to provide appropriate and effective services for those offenders impacted with FASD. One key recommendation was to develop appropriate case management strategies and programming to sufficiently address the specific needs of these individuals while under the mandate of The Correctional Service of Canada.

The Canadian Charter of Rights Section 16 of the Criminal Code (3) defines the law regarding the “not criminally responsible on account to mental disorder” (NCRMD) defence. It holds that:

- 1) No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or knowing that it was wrong.
- 2) Every person is presumed not to suffer from a mental disorder . . . until the contrary is proved on the balance of probabilities.
- 3) The burden of proof . . . is on the party that raises the issue.

Many people with FASD, but not all, should be considered NCRMD because of their lack of “appreciating the nature and quality of the act or omission or knowing that it was wrong.” Unfortunately, the burden of proof is difficult to obtain if there is no official diagnosis, and because of the Canadian justice system’s lack of knowledge about FASD, many will go through the mainstream prison system. Once again, this is not to say that all people afflicted with FASD should be considered NCRMD but there are those that are not capable of understanding their crimes and should therefore be placed in an environment more suitable to their condition. It is blatantly clear that because of the mental disorders that individuals with FASD have, prison is not appropriate, as it leaves such individuals to be subjected to victimization, negative peer influences, and subsequent deterioration in their mental states, as discussed in Section 1.1.

In order to better illustrate the situation surrounding individuals with FASD in the Canadian corrections system, it is necessary to highlight specific case studies, as well as to conduct interviews in order to ascertain a perspective from inside the system. These case studies and interviews are presented below.

Interviews and Case Studies

“Children and adults with FAS have permanent, irreversible brain damage – You do not outgrow it, and you cannot fix it, love it away, punish it away, or ignore it away. You can, however, provide the types of long-term intervention, support, structure and supervision that encourage, promote and allow adequate function”.

Jan Lutke

Director of FACES, Society for FAS/E Support Network of B.C. and adoptive mother of 12 children with FAS

When planning the research needed to complete this report, interviews were organized for personnel who were in close contact with adult male offenders with FASD. The interviews were focused on people who all offered different types of support and who had different experiences with the offenders. The interviewees consisted of a Counsellor (C1) at a Community Residential Reintegration Facility (CRF), a House supervisor (C2) and a program facilitator (C3); both are employed by the same CRF. Also interviewed were three members of the Vancouver Métis Community Association, (C 4-6) who all participate in the Walk Bravely Forward program offered by the Association. Each speaker will be identified as C1-6 to ensure confidentiality.

When questioned on what types of structures those with FASD thrive in, all interviewees indicated that with the same verbal regurgitation of “a highly structured environment” was best. Some variations were quite evident though, C1 and 4-6 all admitted that the offenders with FASD seem to thrive in a prison like setting, because the structure of a prison offers a consistent schedule and routine. C1 especially stressed that the offenders need “environments that will not over stimulate their senses and give them a sensory overload”; and this is indeed exactly the type of environment that the prison system offers.

When questioned what FASD is, once again, all answered what would have been found in a medical journal. C3 answers “Fetal Alcohol Spectrum Disorder refers to the variety of deficits that can occur in individuals who are exposed to alcohol during the mother’s pregnancy. This can involve cognitive deficits, such as impulsivity, and inability to plan, as well as physical problems such as facial features or stunted growth”. Although C3 also answered that FASD can result in having cognitive deficits, C3 initially must participate in facilitating programs to those with FASD that require the participant to have the ability and the capacity to understand their actions.

C3’s answer points to an important policy issue; Corrections Canada requires many of their offenders to participate in such programs that essentially are ineffective for those with FASD. This is done because it is in Corrections Canada’s mandate to rehabilitate the offenders, and ensure that they are safe to return into society. Unfortunately, to offenders with FASD, these programs are useless as they require them to have abilities that they simply do not have as a result of their disability. This oftentimes has the result of recycling offenders with FASD right back into the system.

When questioned what those with FASD seem to need, C1 answered “They seem to need a disability model approach to treatment and care, individuals that work with them who realize it is a life long disability and realize that they are not non-compliant, it’s just that they are not able to do the things that we expect of them. They need people to have expectations that are realistic to the FASD person’s capabilities.” Fortunately, this counsellor works at a CRF and works closely and specifically with those in the facility who have FASD. What was stated is true; each individual with FASD needs someone who realizes exactly what FASD is. Although much of the Canadian prison

population has some form of FASD, much of the prison system does not seem to have an adequate understanding what FASD is. Many of the workers in the legal and justice field do not know about or fully understand FASD, and it is the offenders who are paying the price for this ignorance to their disability.

C1 and C3 and C4-6 all recognized that those with FASD need an environment that gives them a great amount of structure, but once released back into society most, if not all, FASD offenders are thrust back into a chaotic world where they become homeless or they head straight back into the environments they were in before their incarceration. Because of this lack of structure many of the offenders do not follow the conditions of their parole and are suspended and sent back into the prison population. Many who have spent years in custody get so used to the environment that they knowingly commit crimes to be incarcerated again because it has become easier “inside” than “outside”.

While none of the interviewees were questioned specifically on Métis or Aboriginal offenders, they were questioned about what they think should be done about the rising number of aboriginal women having FASD children. C4-6 answered “education, they all need to be educated.” The Canadian population is bombarded by articles and ads telling expectant mothers not to smoke cigarettes during their pregnancy, yet there is hardly any information advising expectant mothers that consuming alcohol is also detrimental to the child’s health, and it is also more damaging to the child than smoking cigarettes. In bars across Canada, there are ads in bathroom stalls warning about the dangers of smoking during pregnancy, yet it is very rare to find any advertisements pertaining to the dangers of drinking during pregnancy.

When asked what they think people in the surrounding community should know about FASD and the people who have it, both C1 and C6 answered that it is not something that you can generalize, and that blame and shame should not be associated with it. They want people to understand that it is a life-long disability that will affect the entire community as a whole. C1, C4, and C5 also want the population to know that the expectations of the individuals must be suited to their abilities and not someone else's.

C1 believes that people with FASD are prone to becoming offenders because they “are vulnerable and are easily manipulated by others, due do the fact that they are not receiving the proper support and are marginalized by society and are being slowly pushed towards a life that leads to crime. The progression of an individual and the types of symptoms they emit are deemed as problematic and prison seems to be the only answer.”

Some well-known case histories seem to support those observations of these professionals. A fairly famous case in the early 1990's focused on a young First Nations youth (Bryan Tait) who was convicted of murdering a mother and daughter by stabbing them to death. He was 20 years old at the time of his conviction and had been diagnosed with FASD. At first Bryan fervently denied any involvement in the murders, but after long questioning periods by police and being presented with two statements made by “friends” placing him at the scene, he confessed to the crimes. Although much of the information he told police was contradictory to the evidence, he was still charged with the murder. “Tait, who is mildly mentally retarded as a result of fetal alcohol syndrome, at first vehemently denied any involvement but finally broke down and repeated the story police have read to him from the statements.”¹⁴ After having spent 11 months in a federal penitentiary, Tait was cleared of all charges because it was found that he in fact was in

¹⁴ The Gazette. Montreal, Que.: Oct 7, 1991. pg. A.6

police custody at the time the murders took place. This case exemplifies how some people with FASD are not capable of understanding their rights or what they are being charged with.

Another case in Canada involving a First Nations man with FASD involved Philip Moses, a 26 year old man who had 43 previous convictions. He was convicted of carrying a baseball bat for the purpose of committing an assault on a police officer. He was also found guilty of theft and breach of probation. Each time Mr. Moses was released back into society he was angrier and more violent than the previous time he went in. Finally, a judge arranged for a sentencing circle with his community and laid out a plan for his rehabilitation (not punishment). The chief of his Nation and other community members were finally able to show Philip that they cared about him and were not trying to drive him out of their community, they wanted him, and they wanted him to get better. This knowledge of acceptance and the willingness of a community to participate in the rehabilitation of the offender help offenders learn how to function in society rather than being incarcerated. Of course, to be successful the entire community must be involved, and they must take a large amount of responsibility.

Conclusions and Recommendations

The successful use of sentencing remedies primarily depends upon the work invested by counsel, probation officers and the community in exploring and developing proposals for sentencing before a sentence hearing

Judge Stuart in *R. v. Moses* (at [1992] 3 C.N.L.R. 166 at 121ff)

There is plenty of information out concerning the topic of what FASD is, and how it affects the brain and the behaviour patterns of those affected. What is needed is more

financial and public support from the Canadian government and the Canadian population and directed towards meaningful programs. The Canadian government has published a lot of information on what they plan on doing in regards to FASD, but they have to date not actually come through on their proposals. Something must serve as a catalyst in order to jump-start these plans and make sure they are the right ways to approach this overwhelming situation.

Although the Canadian government is attempting to implement programs which they believe will help offenders, they are failing to recognize that the programs are a waste of time and money if the offender is afflicted with FASD. As people with FASD lack cognitive reasoning skills, these programs are useless and do not help the offender learn. They can even frustrate the offenders as they are not able to do the work required in the programs, as they do not have the ability to make the necessary logical connections.

The Canadian government implemented a cognitive skills program to teach to offenders upon their release that teaches them critical thinking, problem solving and decision making, general strategies for recognizing problems, conceding to non-criminal alternatives, to stop and think before they act, to think logically, and rationally without distorting facts and externalizing blame onto others. What's worrisome is that the Aboriginal offenders who participated were not positively influenced by this program. More Aboriginal people are offenders than non Aboriginals, and their offences are mainly from not following the conditions of their parole. This may very well be because there is a lack of support in their communities, as many are from secluded areas without a lot of support and lack the appropriate programs for offenders.

FASD is an epidemic in First Nations communities. A study conducted in the Yukon Territory and in British Columbia indicates that for every one Caucasian with FASD there are 10.9 Aboriginals with FASD¹⁵. This alarming statistic illustrates the need for an outstandingly effective solution to the widespread disease that is essentially disabling the entire Canadian First Nations population.

For the thousands of First Nations people in the prison system, schools, and communities, there are very few specific programs being delivered by trained personnel to meet their needs. Most First Nation people with FASD do not complete high school; they suffer memory, reading, and writing problems. They exhibit poor problem recognition, they are unable to create solutions to problems, they are impulsive, and have poor stress management. They tend to be unaware of the consequences of their acts and have very low frustration tolerance. Being secluded on reserves does not help as they tend to be a long distance away from any available resources that could help them meet their specific needs. There needs to be more community support with trained personnel who can educate the communities on how dangerous this disability can be.

There is a massive gap in the research conducted on and by First Nations people even though they present the largest population of people afflicted by FASD. Although there have been certain studies based on specific communities, there needs to be research done on Canada as a whole. The lack of information can only contribute to the cultural genocide of the First Nations people.

”In Canada, the scales of justice and equity continue to be tilted against individuals with special needs, including those with FASD, in conflict with the law, and

¹⁵ Boland, Fred and Duwyn, Michelle. (1999) Fetal Alcohol Syndrome: Understanding its impact. Queen’s University.

in the public school systems. Unless we move rapidly... such individuals with FASD will slide off the scales of justice and equity entirely.”¹⁶

Canada’s responsibility is to do whatever is necessary so every person afflicted with FASD receives services appropriate to their specific individualized needs in a timely fashion. The Canadian government needs to start putting their “money where their mouth is” and following through on the promises they made in their publication, *Fetal Alcohol Spectrum Disorder: a Framework for Action* in 2003. They state that they will:

1. Increase public and professional awareness and understanding of FASD and the Impact of Alcohol use during pregnancy
2. Develop and increase capacity
3. Create effective national screening, diagnostic and data reporting tools and approaches
4. Expand the knowledge base and facilitate information exchange
5. Increase commitment and support for action on FASD

Although they have been slowly implementing these strategies, they are not being implemented fast enough. The population is growing faster and faster each day and that means there are more and more people being born with FASD, and this is not acceptable.

There needs to be support in place for offenders when they step back out into society, screening needs to be implemented immediately when there are signs of FASD in an offender, and there needs to be support specifically geared towards their disabilities. The communities need help stopping their people from abusing alcohol, and there needs to be supports in place, so they can go and get help dealing with their issues.

¹⁶ Henteleff, Yude M., (2005) The human rights of individuals with FASD: Still largely unmet, FASD National Conference. [unpublished]

In sum, more work needs to be done. For a single problem to cause so many problems in society, and to still go undiagnosed, untreated, unnoticed, and unchecked is not only an unfortunate state of affairs, it is an unacceptable standard that must be changed.

Selected Bibliography

- Abel, E. L. (1973). Ancient views on the origins of life. Rutherford, N.J.: Farleigh Dickenson University Press.
- Abel, E. L. (1984). Fetal Alcohol Syndrome and Fetal Alcohol effects. New York, N.Y.: Plenum Press.
- Abel, E. L. (1997). Was the fetal alcohol syndrome recognized in the ancient Near East? Medical Council on Alcoholism.
- Abel, E. L. (1998). Fetal Alcohol Abuse Syndrome. New York, N.Y.: Plenum Press.
- Adams, M. (2002). Our son, a stranger: adoption breakdown and its effects on parents. Montreal: McGill-Queens University Press.
- Alcohol and Gaming Commission of Ontario. (2003). Liquor advertising guidelines: liquor sales licensees and manufacturers. Toronto: Alcohol and Gaming Commission of Ontario.
- Amato, P. & Booth, A. (1997). Generation at risk: growing up in an era of family upheaval. Cambridge, Mass.: Harvard University Press.
- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders, volume IV. Washington, D.C.: American Psychiatric Association.
- Armand, Laurence. (2004). Alcohol and other drug addictions among Native Americans: The movement toward Tribal-Centric treatment programs. Alcoholism Treatment Quarterly, 22, 81-91.
- Armstrong, E. M. (1998a). Diagnosing moral disorder: the discovery and evolution of fetal alcohol syndrome. Social Sciences and Medicine, 47, 2025-2042.
- Astley, S. J., & Clarren, S. K. (1999). Diagnostic guide for fetal alcohol syndrome and related conditions: The 4-Digit Diagnostic Code, 2nd Ed. Seattle: University of Washington Press.
- Astley, S. J. & Clarren, S.K. (2000). Diagnosing the full spectrum of fetal alcohol-exposed individuals—Introducing the 4-digit code. Alcohol and alcoholism, 35(4), 400-410. Washington State Fetal Alcohol Syndrome Diagnostic and Prevention Network (DPN), <http://alcalc.oupjournals.org/cgi/content/full/35/4/400>.
- Barber, K. (Ed.) (2001). The Canadian oxford dictionary. Oxford: University Press.
- Beal, B. and Macleod, R. Prairie Fire. (1994). The 1885 North-west rebellion. Toronto: McClelland & Stewart.

- Boland, F.J., Burrill, R., Duwyn, M. and Karp, J. (1998). Fetal Alcohol Syndrome: implications for correctional services. Ottawa: Correctional Services Canada.
- Boland, Fred., & Duwyn, Michelle.(1999) Fetal Alcohol Syndrome: Understanding its Impact. Queen's University.
- Bruininks, R. H.; Woodcock, R.; Weatherman, R., and Hill, B. (1996). Scales of independent behavior revised. Scarborough, ON: Nelson Thomson Learning.
- Burd, L., Selfridge, R, Klug, M.G. & Juelson, T. (2003). Fetal Alcohol Syndrome in the Canadian corrections system. JFAS Int., 1, e14. The Hospital for Sick Children.
- Burgess, Donna M. (1994). Helping prepare children with FAS or FAE for school and beyond. Alcohol Health & Research World, 18 (1), 73.
- Canada, (2003) Fetal Alcohol Spectrum Disorder: A Framework for Action. Ottawa: Minister of Public Works and Government Services Canada.
- Canada, Report on the Royal Commission on Aboriginal Peoples: Bridging the cultural divide. Ottawa: Supply and Services Canada, 1996.
- Canada, Report on the Royal Commission on Aboriginal Peoples: Looking forward, looking back, vol. 1. Ottawa: Supply and Services Canada, 1996.
- Canada, Report of the Royal Commission on Aboriginal Peoples: Perspectives and realities, vol. 4. Ottawa: Supply and Services Canada, 1996.
- Canadian Broadcasting Corporation. (Producer). (1997). Life Sentence: Fetal alcohol Syndrome. In CBC (Producer), The National. Toronto: CBC International Sales Ltd.
- Chavkin, W., & Breitbart, V. (1997). Substance abuse and maternity: The United States as a case study. Addiction, 92(9),1201-1205.
- Children's Commission, (2001) Fetal alcohol syndrome: A call for action in B.C.
- Cicero, T. J. (1994). Effects of paternal exposure to alcohol on offspring development. Alcohol Health and Research World, 18, 37-41.
- Clarren, S. K., & Astley, S. J., et al. (1988).Physical anomalies and developmental delays in non-human primate infants exposed to weekly doses of ethanol during gestation. Teratology, 37, 561-569.
- Clarren, S.K. and Smith, D. W. (1978). The fetal alcohol syndrome. New England Journal of Medicine, 298(19), 1073-1067.

- Coles, C. D., Platzman, K. A., Raskind-Hood, C. L., Brown, R.T., Falek, A., & Smith, I. E. (1997). A comparison of children affected by prenatal alcohol exposure and attention deficit, hyperactivity disorder. Alcoholism Clinical and Experimental Research, 21, 150-161.
- Conry, J., & Fast, D. (2000). Fetal alcohol syndrome and the criminal justice system. Vancouver: Law Foundation of British Columbia.
- Cowichan Valley FAS Action Team. (1999, March). Seeking alternatives: community interventions with youth who are neurologically impaired. Duncan: Cowichan Valley FAS Team.
- Dagher-Margosian, J. (1997). Representing the FAS client in a criminal case. In A. Streissguth & J. Kanter (eds.) The challenge of fetal alcohol syndrome. Seattle: University of Washington Press.
- Davis, V. E. (1980). The fetus and alcohol. Medical Journal of Australia, x, xx-xx.
- Diller, J.V. (1999). Cultural diversity: A primer for the human services. Scarborough, ON: Brooks/Cole.
- Driver, D. (2003). Saskatchewan judges lead fight for handling of FASD victims. The LawyersWeekly 23(11) (July 11, 2003).
- Ebrahim, S. H., Diekman, S.T., Floyd, L., & Decoufle, P. (1999). Comparison of binge drinking among pregnant and nonpregnant women, United States, 1991-1995. American Journal of Obstetrics and Gynecology, 180, 1-7.
- Fast, D.K., Conry, J. L., and Loock, C.A. (1990). Identifying fetal Alcohol Syndrome (FAS) among Youth in the Criminal Justice System. Journal of Developmental and Behavioral Pediatrics, 20(5), 370-372.
- Food and Drug Administration. (1981). Surgeon General's advisory on alcohol and pregnancy. FDA:Washington, Drug Bill. 11.9-10.
- Giunta, Carole T. & Streissguth, Ann Pytkowicz. (1988). Patients with Fetal Alcohol Syndrome and their caretakers. Social Casework, 69, (7) 453-459.
- Grant, Therese; Huggins, Janet; Connor, Paul; Pedersen, Julie Youngblood; Whitney, Nancy & Streissguth, Ann. (2004). A Pilot community intervention for young women with Fetal Alcohol Spectrum Disorders. Community Mental Health Journal, 40 (6), p499.
- Habbick, B. F. (1996). Fetal alcohol syndrome in Saskatchewan: unchanged incidence in a 20-year period. Canadian Journal of Public Health, 87, 204.

- Hamilton, A. C. and Sinclair, C.M., for the Province of Manitoba. (1991). Volume 1: Report of the aboriginal justice inquiry of Manitoba. Altona, Alta.: D. W. Friesen & Sons Ltd.
- Hankin, J.R. (2002). Fetal alcohol syndrome prevention research. The Journal of the National Institute of Alcohol Abuse and Alcoholism, 26(1), 58-65.
- Henteleff, Yude M., (2005) The human rights of individuals with FASD: Still largely unmet, FASD National Conference. [unpublished]
- Hogg, P. (2003). Constitutional law of Canada, student edition. Scarborough, Ontario: Carswell.
- Huntington, D. & Bender, W. (1993). Adolescents with learning disabilities at risk? Emotional well-being, depression and suicide. Journal of Learning Disabilities, 26, 159-166.
- Joffe, J. M., & Soyka, L. F. (1982). Paternal drug exposure: Effects on reproduction and progeny. Seminars in Perinatology, 6, 116-124.
- Johnson, B.F. (2000). Stolen wombs: indigenous women most at risk. Native Americas, 38-42.
- Jones, K. L., Smith, D.W. (1973). Recognition of the fetal alcohol syndrome in early infancy. Lancet, 2, 999-1001.
- Jones, K.L., Smith, D.W., Streissguth, A.P. Myriantopoulos, N.C. (1974). Outcome in offspring of chronic alcoholic women. Lancet, 1, 1076-1078.
- Jones, D.L., Smith, D.W., Ulleland, C.N., Streissguth, A.P. (1973). Pattern of malformation in offspring of chronic alcoholic mothers. Lancet, 2,1267-1271.
- Kanter et al. (eds.). (2001). The challenge of Fetal Alcohol Syndrome. Seattle: University of Washington Press.
- Kerns, Kimberly & Don, Audrey. (1997). Cognitive deficits in non-retarded adults with fetal alcohol syndrome. Journal of Learning Disabilities, 30(6), 685-696.
- Koopman, P.R.S. (1983). Cognitive disorders and syntactical deficiencies in inmate populations of federal penitentiaries in Canada. University of British Columbia: Report for the Solicitor General of Canada.
- Koren, G., Nulman, I., Chudley, A.E., & Loocke, C. (2003). Fetal alcohol spectrum disorder. Canadian Medical Association Journal, 169(11), 1181-1185.

- LaDue, R.A. and Tom Dunne. (1995). Legal issues and the fetal alcohol syndrome. In The FEN Pen, Fall, 1995.
- Lennings, C.J. (1994). A cognitive understanding of adolescent suicide. Genetic, Social & General Psychology Monographs, 120 (3), 289-308.
- Little, R. E., & Sing, C. F. (1986). Association of father's drinking and infant's birth weight. New England Journal of Medicine, 314, 1644-1645.
- Little, B. B., Snell, L., Rosenfeld, C., Gilstrap, L., & Gant, N. (1990). Failure to recognize fetal alcohol syndrome in newborn infants. American Journal of Diseases of Children, 144, 1142-1146.
- Malbin, D. (2002). Findings from the FASCETS Oregon Fetal Alcohol Project: Efficacy of a neurobehavioral construct; interventions for children and adolescents with Fetal Alcohol Syndrome/Alcohol-Related Neurodevelopmental Disabilities (FASD). Unpublished manuscript.
- Mathews, Duncan J. (1988). On alcoholism and gynaecology and obstetrics. Transactions of the Edinburgh Obstetrical Society 12, 105-120.
- McShane, Damian. (1988). An analysis of mental health research with American Indian youth. Journal of Adolescence, 11 (2), 87-116.
- Normand, Claude Louise & Rutman, Deborah. (1996). Caring for children with fetal alcohol syndrome. Child Family & Community Research Program: School of Social Work, University of Victoria.
- O'Malley, K. D., & Nanson, J. (2002). Clinical implications of a link between fetal alcohol spectrum disorder and attention deficit hyperactivity disorder. Canadian Journal of Psychiatry, 47, 349-354.
- Page, K. (2001). Fetal Alcohol Spectrum - The hidden epidemic in our courts. Juvenile and Family Court Journal 21. 52(4)
- Philp, M. (2003). Middle-class FAS: A silent epidemic? Saturday, February 1, 2003, Globe and Mail, page F6.
- Piaget, Jean. (1972). Psychology and epistemology: Towards a theory of knowledge. Middlesex: Penguin Books Ltd.
- Plato, (reprinted 1952) Laws, Harvard University Press, Cambridge, MA
- Randall, Carrie L. (2001). Alcohol and pregnancy: Highlights from three decades of research. Journal of Studies on Alcohol, 62 (5), 554-561.

- Raymond, M. and Belanger, J. (2002). Literarcy-based supports for young adults with FAS/FAE. Prepared for the Province of British Columbia, Ministry of Advanced Education, Training and Technology, and Human Resources Development Canada, The National Literacy Secretariat. Retrieved Oct. 2, 2002, from the World Wide Web:
<http://www.nald.ca/fulltext/lbsupport/Doc/pdfDirectionsPersonalPlanningTool>.
- Riley, E. (2003, September). Keynote presentation: FAS—Not just another pretty face:Alcohol and the developing fetus. Center for behavioral teratology and department of psychology, San Diego State University. Hope for Women in Recovery, Baltimore,MD.
- Roberts, G. and Nanson J. (2000). Best practices: Fetal Alcohol Syndrome/Fetal Alcohol Effects and the effects of other substance use during pregnancy. Ottawa: Health Canada.
- Robinson, G.C., Conry, J.L., Conry, R.F. (1971). Clinical profile and prevalent of Fetal Alcohol Syndrome in an isolated community in British Columbia. Canadian Medical Association Journal,137, 203-7.
- Sampson, P.D., Streissguth, A.P., Bookstein, F.L., Little, R.E., Clarren, S.K., Dehaene P., Hanson, J.W., & Graham, J. M. (1997). Incidence of Fetal Alcohol Syndrom and prevalence of alcohol-related neurodevelopmental disorder. Teratology, 56, 317-326.
- Shebib, Bob. (2003). Choices: interviewing and counseling skills for Canadians. Toronto ON: Pearson Education Canada Inc.
- Smith, D. W. (1981). Fetal Alcohol Syndrome and fetal alcohol effects. Neurobehavioral Toxicology and Teratology, 3, 127.
- Sokol, Robert J.; Delaney-Black, Virginia; Nordstrom, Beth. (2003). Fetal Alcohol Spectrum Disorder. JAMA: Journal of the American Medical Association, 290 (22), p2996, 4p.
- Spohr,H.L.& Steinhausen,H.C.(1987).Follow-up studies of children with fetal alcohol syndrome. Neuropediatrics, 18, 13-17.
- Square, D. (1997). Fetal Alcohol Syndrome epidemic in Manitoba reserves. Canadian Medical Association Journal, 157, 59-60.
- Standing Committee on Health & Welfare, Social Affairs, Seniors & the Status of Women. (1992-1993). Fetal Alcohol Syndrome. 3rd Session, 34th Parliament, No.s. 10-22, 1992-1993 Index, 1-29.

- Stangeland, Melvin. (1990). The role of cognitive systems in behavioral controls and emotional adjustment in juvenile delinquents. Doctoral dissertation, University of Victoria.
- Stratton, K., Howe, C., & Battaglia, F. (Eds.) (1996). Fetal alcohol syndrome: Diagnosis, epidemiology, prevention, and treatment. Washington, DC: National Academy Press.
- Streissguth, Ann Pytkowicz. (1997). Fetal alcohol syndrome: A guide for families and communities. Baltimore: Paul H. Brookes.
- Streissguth, A.P. (2001). Fetal Alcohol Syndrome, a guide for families and communities. Toronto: Paul Brookes Publishing Co.
- Streissguth, A. P., Barr, H. M., Kogan, J., & Bookstein, F. L. (1996a). Understanding the occurrence of secondary disabilities in clients with fetal alcohol syndrome (FAS) and Fetal alcohol effects (FAE). Final Report, Centers for Disease Control and Prevention. Grant #R04/CCR008515.
- Streissguth, A. P., Barr, H.M., Kogan, J. and Bookstein, F.L. (1996b). Understanding the occurrence of secondary disabilities in clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). Seattle: University of Washington School of Medicine, Fetal Alcohol and Drug Unit. [unpublished]
- Streissguth, Ann P., Bookstein, Fred L., Sampson, Paul D., & Barr, Helen M. (1993). The enduring effects of prenatal alcohol exposure on child development: Birth through seven years, a partial least squares solution. Ann Arbor: University of Michigan Press.
- Streissguth, A. P., LaDue, R.A., Randels, S.P. (1988). A manual on adolescents and adults with Fetal Alcohol Syndrome with special reference to American Indians. Seattle, WA: University of Washington, Department of Psychiatry and Behavioral Sciences, the Child Development-Mental Retardation Center, and the Alcoholism and Drug Abuse Institute.
- Streissguth, Ann & Kanter, J. (1997). The challenge of fetal alcohol syndrome: Overcoming secondary disabilities. Seattle: University of Washington Press.
- Streissguth, Ann P; Moon-Jordan, Abbey; Clarren, Sterling K. (1995). Alcoholism in four patients with Fetal Alcohol Syndrome: Recommendations for treatment. Alcoholism Treatment Quarterly, 13 (2), 89-103.
- Sullivan, W. C. (1899). A note on the influence of maternal inebriety on the offspring. Journal of Mental Science, 45, 489-503.

- Tait C. (2000). A study of the service needs of pregnant addicted women in Manitoba. Winnipeg, MB: Prairie Women's Health Centre of Excellence.
- Tait, C. (2002). Fetal Alcohol Syndrome among Canadian Aboriginal Peoples: review and analysis of the intergenerational links to residential schools. Ottawa: Aboriginal Healing Foundation [unpublished].
- Tuormaa, Tuula E. (1996). The adverse effects of alcohol on reproduction: A review of the literature. International Journal of Biosocial and Medical Research, 14, 5-20.
- Vanderbrink, David., Kanata Productions (Producers). (1996). David with F.A.S.: a story of fetal alcohol syndrome [Videotape]. Montreal: National Film Board of Canada.
- Warner, R. H. and Rosett, H. L. (1975). The effects of drinking on offspring: an historical survey of the American and British literature. Journal of Studies on Alcohol, 36, 1395-1420.
- Weiner, L., & Morse, B. (1993). Intervention and the child with FAS. Alcohol Health and Research, 18(1), 67-70.
- Williams, Robert J; Gloster, Susan P. (1999). Journal of Studies on Alcohol, 60 (6), 833-836.