TO EXAMINE HOW YOUTH AFFECTED BY FETAL ALCOHOL SPECTRUM DISORDER, INVOLVED IN THE CRIMINAL JUSTICE SYSTEM, ARE DEALT WITH IN OTHER JURISDICTIONS

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Signed: Catherine Crawford
Dated: 7 September 2015
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1. Introduction

The purpose of this project was to examine how children and youth, affected by fetal alcohol spectrum disorder (FASD) were dealt with in the criminal justice system in Canada, the United States and New Zealand.

FASD, as it affects children and youth in the criminal justice system, has not been given much attention in Australia. Indeed the awareness of FASD among justice professionals has been low. It remains difficult to have a person assessed for FASD in Australia. There are few reported cases that mention FASD, and even fewer where the defendant has been diagnosed.

A practical approach was taken to the project. The questions below informed the quest for examples of how other communities has responded to the challenges.

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>How could FASD affected children and youth be identified in the court setting?</td>
</tr>
<tr>
<td>What are the options in terms of courts having children and youth diagnosed?</td>
</tr>
<tr>
<td>What steps might be taken to support affected children and their families?</td>
</tr>
<tr>
<td>Have Policing authorities taken an interest in FASD?</td>
</tr>
<tr>
<td>What about Diversion? How is FASD accommodated within that framework?</td>
</tr>
<tr>
<td>How could representation for FASD affected youth be improved?</td>
</tr>
<tr>
<td>What strategies are used by Courts to accommodate for the impairments?</td>
</tr>
<tr>
<td>Approaches to sentencing of FASD affected youth</td>
</tr>
<tr>
<td>Any special measures for indigenous youth?</td>
</tr>
<tr>
<td>How have accommodation needs of affected youth been addressed?</td>
</tr>
<tr>
<td>How are FASD youth handled in a custodial environment?</td>
</tr>
<tr>
<td>Has any Government taken a systemic approach to addressing the issue of FASD across the society? What does that look like?</td>
</tr>
</tbody>
</table>

This report provides a snapshot of some responses to those issues. It is organized thematically.
Acknowledgements

The project was made possible by the award of a fellowship by the Winston Churchill Memorial Trust. It was an extraordinary opportunity, for which I am deeply grateful. The privilege to meet others engaged in the justice system in various ways, observe them at work in their own communities, gain their insights firsthand and have the opportunity for reflection. Thank you to all who made it possible, and especially Meg Gilmartin.

I would also like to thank the President of the Children’s Court of Western Australia, His Honour Judge Reynolds, for strongly supporting my application for the fellowship and the project itself. His Honour Justice Hall, of the Supreme Court of Western Australia, was generous in his support of my application, for which I am most grateful.

David Childs, Barrister, has provided strong professional support and friendship over the years. I thank him for his strong support of this project. We are kindred spirits when it comes to the service of justice.

Along the way, as I journeyed around Canada, the United States and New Zealand I was treated with the utmost kindness and generosity by those I was so fortunate to meet. Knowledge, material and insights were shared. It was inspiring, and motivating, to see the commitment to addressing the challenge that FASD presents for individuals and families. Thank you.

Finally, I thank my husband, Peter Mathie for his suggestion that I should apply for the fellowship, encouragement and unwavering love and support. He has shared this endeavour.
2. Executive Summary

Project title:

To examine how youth affected by fetal alcohol spectrum disorder, involved in the criminal justice system, are dealt with in other jurisdictions

Catherine Crawford

Magistrate, Children’s Court of Western Australia,
160 Pier Street, Perth, Western Australia 6009
+61 8 9218 0193

Individuals affected by fetal alcohol spectrum disorder (FASD) are at higher risk of involvement in the criminal justice system due to significant cognitive, behavioural and social challenges commonly seen in those with the diagnosis.¹

In addition to the brain damage, and therefore impairments, that result directly from the prenatal exposure to alcohol, environmental, genetic factors and the impact of social expectations play their part in the individuals’ development and abilities. The combined effect, of the impairments suffered and post-natal developmental adversities, has been described as secondary disabilities which include mental health problems, disrupted school experience, involvement in the justice system. Secondary disabilities are potentially preventable, subject to early and appropriate intervention.

The aim of this report is to provide some examples, from Canada, the United States and New Zealand, of how governments, courts, service providers have responded to the challenge posed by FASD affected children and youth in the criminal justice system.

Professor Susan Astley of the FASD Clinic, University of Washington and Judge Tony Fitzgerald of the Youth Court, Auckland in particular prompted me to see FASD as one group of disorders within the category of neurodisabilities. Whilst FASD is a significant group of disorders it is a subset of a broader category. Courts require evidence about any condition within the broader category so as to accurately assess culpability and facilitate appropriate intervention so as to maximize the prospects of rehabilitation for the individual, reduce exposure to the criminal justice system and maximize community protection.

¹ FASD is not a diagnosis. It is an umbrella term which describes the disorders on a spectrum. However it is convenient to use the short hand “FASD diagnosis” from time to time.
There is no one strategy, practice or intervention for courts to use with FASD affected children and youth. Rather Children’s Courts need to adopt a range of strategies, practices and interventions to accommodate to the FASD affected defendant. The starting point to gaining better understanding of the needs and capacities of the individual child, is an effective screen for neurodisabilities including FASD, followed by assessment by appropriate clinicians. That assessment needs to include recommendations as to the child’s needs, strengths and appropriate interventions. The FASD Justice Project in Winnipeg and the approach by Youth Probation and the Custody Centre in Calgary were particularly impressive.

Training and more training is vital for all involved with the child/youth.

The child/youth has to be at the centre of the system, and early intervention is vital if the outcomes for the child, and the protection of the community is to be maximized.

Dissemination has already begun in the form of multiple presentations to for a in New Zealand including a public lecture, during a week there in May 2015, a presentation to a Symposium on FASD at the University of Western Australia on 13 August 2015. A further presentation is scheduled for the Australia New Zealand Psychiatry, Psychology and the Law Association, WA Branch on 16 September. Thereafter it is intended to promote training for relevant justice professionals, the incorporation of screening into the practice of youth justice professionals and encourage the development of better plans for intervention with, and the support of, youth affected by neurodisabilities. That will require collaboration with a range of professionals and agencies.

Prior to commencing the fellowship a website was established to record, report on, and blog about, the observations made during the course of the project. Following submission of this report it is intended to resume building the website by posting information about various initiatives in other jurisdictions.
3. **Program**

The program approved by the Winston Churchill Memorial Trust appears at Appendix A.

Those individuals and organisations visited for the purposes of this project are listed in Appendix B.
4. **How FASD affected Youth are identified: Screening and Assessment in Justice**

A number of Courts have run pilot projects to screen youth for FASD, refer for assessment and diagnosis, and intervene to achieve a number of objectives, principal amongst those being to reduce recidivism. Several of these programs\(^2\) are discussed below.

There is no single screening tool for FASD in the youth offender population that is universally used and accepted.\(^3\) Various screening tools have been used in different populations\(^4\), and different screening options for a corrections population have been developed and discussed in the academic literature. None have been normed for a particular population.

**17th Judicial District, Adams County, Colorado**

In January 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA) FASD Centre for Excellence funded 5 juvenile\(^5\) courts in the United States to develop projects to screen, diagnose and intervene with youth who were involved with the courts. One of those programs was run in the 17\(^{th}\) Judicial District of Colorado. Two of the others were located in Hennepin County, Minnesota and in Toledo, Ohio.\(^6\)

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\(^2\) The standard English spelling of program is used throughout this report, rather than the US English, “program”.


\(^5\) The words “juvenile” and “youth” are used interchangeably. US practitioners/academics are more likely to refer to a juvenile, or a delinquent. Canadian, New Zealand and Australian based practitioners/academics tend to use the word “youth”. Generally when using a US example the terminology used there will be utilized.

\(^6\) Bisgard, op.cit, p479.
An expert panel convened by the FASD Centre of Excellence, comprising expertise in fetal alcohol spectrum disorder and psychological testing in juvenile courts, was asked to recommend screening methods that could be undertaken in 20-30 minutes by non-clinical staff, and to formulate referral criteria that would result in a FASD diagnosis\(^7\) for not less than 80% of those referred.

The expert panel made recommendations for the screening of infants and children up to 7 years of age, and screening juveniles between 8 and 18 years. Apart from identifying information, and caregiver details, the screening form for the juvenile age group sought information in the following categories:

- Whether the juvenile had previously been diagnosed with FASD;
- Whether there was a sibling with a diagnosis of FASD;
- Whether the juvenile had Rank 3 or 4 using the FASD Photograph Screen\(^8\);
- Whether prenatal alcohol or drug exposure was confirmed\(^9\).

Between 2005 and 2011 the Juvenile Court of Colorado’s 17th Judicial District integrated FASD screening, diagnosis and intervention within the Juvenile Delinquency\(^10\) and Child Welfare Courts\(^11\) of Adams and Broomfield counties. “The goal of the project was to improve the functioning of children and youth with a FASD who came before the court”,\(^12\) (“the FASD Project”) It identified youth prenatally exposed to alcohol so as to facilitate diagnosis and appropriate intervention. The objectives of the project were:

- Reduction of recidivism;
- Maintain stability of placement;
- Improve school functioning and
- Improve overall wellbeing.\(^13\)

\(^7\) FASD is an umbrella term for a range of disorders over a spectrum, not a diagnosis. However for convenience the shorthand, “FASD diagnosis” will be used, where appropriate to refer to one or more of the conditions within the spectrum.


\(^9\) See Expert Panel Screening Form ages 8-18 in Bisgard et al., op.cit. p495

\(^10\) In other jurisdictions this may be referred to as the Children’s Court or Youth court, exercising criminal jurisdiction.

\(^11\) “Child Welfare” as an adjective, for a “court” exercising jurisdiction with respect to child protection, appears to be used interchangeably with “Dependency” in parts of the US. In other jurisdictions instead of “Child Welfare Court” or “Dependency Court” such courts may be referred to as the Children’s Court or Youth Court exercising child protection jurisdiction. The terminology of the Court being discussed is utilized in this report.

\(^12\) Annual Report, 17th Judicial District, Adams County Colorado, Option Year 3, August 2010-July 2011.

\(^13\) Bisgard et al, op.cit., p479.
Initially the aim was to screen all adjudicated juveniles in the Delinquency Court who were placed on probation, or ordered to undergo a pre-sentence investigation. Between 2005 and 2008 all adjudicated juveniles between 10 and 18 who fell in that category were screened. However from 2008 onwards the target population was reduced to those between 10 and 16 years.

The needs of the group were identified, initially, as follows:

- Vocational training
- Educational modifications
- Mental health treatment
- Medication management/medical monitoring
- Speech/language services
- Substance abuse treatment, and
- Assistance with social skills

The process for all youth in the target population involved in the Delinquency Court, was as follows:

- The Court ordered a FASD Screen and Recommended Treatment;
- He/she was allocated to a Probation Officer;
- The Probation Officer completed the Expert Panel Screening Tool with the adult who accompanied the youth, completed a screening form, and took photographs required for the FASD Facial Photographic Analysis Software, and obtained a signed release from the guardian that permitted exchange of information between Probation, the FASD Project, the diagnostic team and others, as required, then conveyed all material digitally to the FASD Project Director;
- The Project Director completed a criminal records check of the mother, the facial screen and made a decision on the basis of all material whether to refer the youth for assessment and diagnosis. If there was no prenatal alcohol exposure or facial features then the screen was considered negative, the FASD case closed and the probation officer advised accordingly. If the screen was positive then the youth was assigned to the project intervention specialist;
- The Project Intervention Specialist assisted the family to complete the diagnostic intake information required by the diagnostic team, and collected all available records including birth, medical, educational, mental health records, as well as records of any other evaluations undertaken;
- The diagnostic team, consisting of a paediatrician, psychologist, a physical and/or occupational therapist, a speech pathologist and a clinic co-ordinator, assessed the youth using the University of Washington 4-digit code (2004), and produced a report ("diagnostic report");

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15 This section is based on Bisgard, et al, op. cit., p479-483.
For those youth diagnosed with FASD, the intervention specialist and probation officer met with the youth and family to develop a plan for implementing the recommendations of the diagnostic team, which may have included modifications to the terms and conditions of probation, such as:

- Calling the youth to remind him/her of court dates and appointments,
- Helping the youth to meet curfew by setting a reminder on a mobile phone or watch, or
- Other modifications based on the disabilities identified in the diagnostic report.

Recommendations in the diagnostic report may have included developing or modifying an individualized education plan ("IEP"), support services required for vocational training, securing mental health treatment or other services.

The probation officer monitored service provision.

The intervention specialist met with the school to discuss any modification required to the IEP and other service providers to discuss the youth’s needs.

Between January 2006 and August 2010, the 17th Judicial District screened 718 youth adjudicated delinquent, with the following results:16

**Table 1**

<table>
<thead>
<tr>
<th>Screened for FASD</th>
<th>718</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened positive for PNAE17</td>
<td>183 (25%)</td>
</tr>
<tr>
<td>Completed full diagnostic evaluation</td>
<td>79 (43%)</td>
</tr>
<tr>
<td>Received a FASD diagnosis</td>
<td>40 (50%)</td>
</tr>
<tr>
<td>Received planning &amp; services based on recommendations of diagnostic team</td>
<td>40 (100%)</td>
</tr>
<tr>
<td>Clients declined interventions following diagnosis</td>
<td>0</td>
</tr>
</tbody>
</table>

The following inferences may be drawn from the published results for the 4 year period:

- The number screened equates to approximately 16 per month, or 195 per annum;
- Approximately 1 in 4 youth screened, screened positive;

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16 This table of data is drawn from Bisgard, et al., op. cit., p482.
17 PNAE – prenatal alcohol exposure.
• Less than half of those who were screened positive actually completed the full diagnostic evaluation (43%);
• Half of those who completed the full diagnostic evaluation were diagnosed with FASD (50%).
• Nearly 22% of those screened positive were diagnosed with FASD.

The published material does not discuss the reasons why so many youth who screened positive did not complete a full diagnostic evaluation. However any attempt at replication of the FASD Project would need to examine that issue, and try to improve the proportion of those screened positive who complete the full diagnostic evaluation.

In the following year the FASD project suffered some setbacks however the following results have been extracted from the annual report:

**Table 2**

<table>
<thead>
<tr>
<th>Target Population</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened for FASD</td>
<td>74 (59.7%)</td>
</tr>
<tr>
<td>Screened positive</td>
<td>16 (21.6%)</td>
</tr>
<tr>
<td>Referred for diagnosis</td>
<td>14 (18.9%)</td>
</tr>
<tr>
<td>Received FASD diagnosis</td>
<td>3 (21.4%)</td>
</tr>
</tbody>
</table>

Some caution needs to be exercised interpreting Table 1 and 2. They are not directly comparable. However, the proportion of the youth screened, who screened positive, is comparable, (25-22%). Notable also is the proportion of those screened positive who were in fact diagnosed with FASD (22-21%).

**Child Welfare Court**

The FASD Project took a comprehensive approach to achieving its objectives by making FASD screening, diagnosis and intervention available to the Child Welfare Courts of Adams and Broomfield counties, for a target population, as well as the Delinquency Courts.

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18 Ms Bisgard kindly provided a copy of the Annual Report for the project for August 2010 to July 2011, dated 15 September 2011. Any mistakes are not those of the author/s.
19 Note however that over half who screened positive in Table 1 did not complete the full diagnostic evaluation. That type of information is not available in the Annual Report.
The target population for screening, diagnosis and intervention was children aged between 3 and 5 years, removed from their parents due to substance abuse by the mother, and any other children under the jurisdiction of the dependency court for whom a FASD screen was ordered. The specific objectives for those diagnosed with FASD was to reduce the number of placements, in a 12 month period, to no more than 2, and provide interventions to improve the child’s functioning within 12 months of diagnosis. 20

The needs of the children in the target population of the Child Welfare Court were identified, initially, as:

- Individual Educational Plan (or Individualized Family Service Plan) development or modification
- Speech/Language services
- Occupational Therapy
- Physical Therapy
- Medical care
- Mental Health services

The process in the Child Welfare Court stream, may be summarized as follows21:

- FASD screening occurred at the initial court hearing, (or at the first hearing after the screen is ordered);
- The FASD Intervention Specialist interviewed the mother to determine PNAE with respect to the child;
- Photographs of child taken;
- Mothers’ records checked for any evidence of alcohol consumption during pregnancy;
- If screen is negative, the FASD case was closed;
- If screen is positive for PNAE, the Court ordered a diagnostic evaluation;
- Siblings of child also screened for FASD if Court orders accordingly;
- The FASD team coordinated completion of the diagnostic team’s intake documentation, collected child’s medical, mental health and educational records and submitted to clinic;
- Upon receipt of report from diagnostic team, the Intervention Specialist met with the caseworker and parents (or other caregivers) to develop a plan for fulfilling the recommendations of the diagnostic team. The plan developed was incorporated into the child’s treatment plan with the Court;
- The caseworker was primarily responsible for securing the services required for the child;
- The Intervention Specialist met with service providers about the child’s needs as set out in diagnostic report, and the school if modification to IEP was required; and

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20 Each of the Delinquency and Dependency streams of the FASD Project had specific objectives with numeral targets. See Annual report, op.cit. p3 &5. Unnecessary to replicate here.

21 Based on Annual Report, op.cit., p5.
Service provision was monitored by the Intervention Specialist by contact with caseworker, family and service providers.

The 2011 Annual Report noted that although a small proportion of the children and youth in the Child Welfare stream were being screened, orders for children and youth outside the target age group were increasing “as the judges and other parties are seeing the value of diagnosing the children”.

### Table 3

<table>
<thead>
<tr>
<th>Target Population</th>
<th>159</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened for FASD</td>
<td>150 (94%)</td>
</tr>
<tr>
<td>Screened positive</td>
<td>66 (44%)</td>
</tr>
<tr>
<td>Referred for diagnosis</td>
<td>31 (47%)</td>
</tr>
<tr>
<td>Completed diagnosis</td>
<td>30 (96%)</td>
</tr>
<tr>
<td>Received FASD diagnosis</td>
<td>16 (53%)</td>
</tr>
<tr>
<td>Received Intervention Services</td>
<td>34</td>
</tr>
</tbody>
</table>

Some other inferences from the data which may be worth considering:

- Of all those screened, 11% received a FASD diagnosis;
- Of those screened positive, less than half were actually referred for diagnosis (44%)
- Of those screened positive, just over half received a FASD diagnosis (53%)

The benefits that appeared to flow from the FASD Project may be summarized as follows:

- Training of Judges, Probation Officers, Child Welfare caseworkers, and other court personnel about FASD,
- Greater awareness and knowledge among court personnel, eg Attorneys regarding FASD and the benefits of diagnosis and intervention,

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23 Data extracted from Annual report, op. cit., p17.
24 some children diagnosed had been referred the year before, so percentage not accurate.
25 some of the children who received intervention services had been diagnosed the previous year.
26 My calculation is 52% (with rounding), rather than 53% as appears in the Annual Report, at p 17.
Support for child/youth and families with respect to diagnosis and intervention services,
Education and support for Probation Officers and Child Welfare case workers with respect to ensuring that the child/youth’s needs are met, and service providers better understand the needs,
Inclusion of screening information in the Judges benchbook,\(^{27}\) and
Inclusion of the screening protocol in the Probation Officers intake policy,\(^{28}\)
With respect to the child welfare stream, in the relevant county, a special in home extensive support program was developed for children prenatally exposed\(^ {29}\), and
In the child welfare stream, at least one preschool developed a specialized protocol for these children and there was a much more positive response in the public schools for this cohort.\(^ {30}\)

In terms of minimizing future offending by youth in the Delinquency Court, there was no substantive external evaluation. However the Project Director was able to conduct a small sample evaluation of youth diagnosed and found 15% recidivism up to 3 years post diagnosis and intervention.\(^ {31}\) The baseline objective had been not more than 50% recidivism within 12 months after the completion of probation.

**Hennepin County**

Between August 2008 and May 2012\(^ {32}\), as a result of collaboration between the County’s Departments of Human Services and Public Health, and Community Corrections and Rehabilitation - Juvenile Probation, the Fetal Alcohol Spectrum Disorder Program (Hennepin FASD Program) delivered screening, diagnosis and intervention to adjudicated delinquent youth, aged between 12 and 18 years who screened positive for mental health issues.

The goals of the program were essentially the same as the Colorado project save that the goal pertaining to school engagement was constructed as “creating school success”, and specifically identified improving the youth’s functioning in the home.\(^ {33}\) The goals were described as being consistent with Minnesota statutes requiring that juvenile justice systems provide for public safety, reduce juvenile delinquency, account for the needs of individual youth and their capacity for growth and change.\(^ {34}\)

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27 Information received from Project Director, Ms E.Bisgard, email 9/7/2015
28 ibid.
29 ibid
30 ibid
31 ibid
33 Bisgard et al., op.cit., p483-488.
A Taskforce comprising key decision-makers from a range of disciplines including Justice, Probation, Education, Mental health as well as parents and community members was established to guide the program.35

Referrals for FASD screening in the first two years of the program involved a 2 step process. Since 2004 juveniles who committed more serious offenses in Minnesota had been required to undertake a mental health screen.36 In Hennepin County, as from the commencement of the FASD program, youth adjudicated as delinquent were referred to Juvenile Probation for intake including mental health screening by use of the Massachusetts Youth Screening Instrument, version 2 (MAYSI-2) and, if screened positive, were then referred for FASD screening. This method of screening and referral was chosen for 2 reasons:

➢ To ensure screening and diagnostic capacity within the juvenile justice system, and

➢ Because research by Streissguth and others had demonstrated a very strong correlation between FASD and mental health issues.37

From year 3 of the program onwards the Court and Probation made direct referrals to the FASD program, without the MAYSI-2 screen in cases where PNAE was known or suspected. See the table below for a summary of the referrals, and their source, over the life of the program.

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37 See Bisgard et al., op.cit., 484 and references set out therein.
Table 4: Hennepin FASD Program 2008/12 - Method of Referral for FASD Screen

<table>
<thead>
<tr>
<th>Method of Referral for FASD Screen</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Adjudicated Delinquent Youth</td>
<td>170</td>
<td></td>
</tr>
<tr>
<td>Direct Referral from Court</td>
<td>16</td>
<td>9.4</td>
</tr>
<tr>
<td>Direct Referral from Probation</td>
<td>40</td>
<td>23.5</td>
</tr>
<tr>
<td>MAYSI-2 Score &quot;at risk&quot;</td>
<td>110</td>
<td>64.7</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>2.4</td>
</tr>
<tr>
<td>Total</td>
<td>170</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The process utilized in the Hennepin FASD program may be summarized as follows:

- The FASD program social worker, interviewed the youth and his/her guardian separately and applied the Expert Panel Screening Tool.
- Information regarding the youth is gathered regarding educational success and needs, current and past history with the juvenile justice system, placement history, family life and any alcohol or drug problems within the family. The guardian is asked about the youth’s developmental years, educational needs, placement history, mental health diagnoses within the family, any previous difficulties the youth had with the law or in the home. Evidence of PNAE or physical features associated with fetal alcohol syndrome (“FAS”) is required for evaluation by the diagnostic team.
- The social worker gathered records regarding educational history, previous mental health, court reports and IQ testing, and assists the family to complete the diagnostic team’s intake documentation.
- If the FASD diagnosis is completed before the Juvenile Court has sentenced the youth then, subject to the guardian’s permission, the social worker sent the diagnostic team’s report to the Court and other parties. That will enable the Court determination to be informed by the youth’s needs and public safety.

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39 Process is said to take about 20 minutes, see Bisgard et al., p 484.
40 As developed by the Expert Panel, see note 8 above.
41 Bisgard et al., op.cit., p484.
42 Bisgard et al., op cit., p485.
Where the FASD diagnosis is made post Juvenile Court disposition and/or adjudication, the social worker provided a copy of the report to the Court and other parties and convened the youth’s multidisciplinary team (“the team”) to develop an Intervention Case Plan (“ICP”). The team includes the guardian, the probation officer, service providers, school personnel, and any interested party who may be working with the youth. The Juvenile Court may decide to review the disposition to better address the youth’s needs and determine whether additional court action is necessary.

Each guardian of a youth diagnosed with FASD was referred to the Minnesota Organization on Fetal Alcohol Syndrome (“MOFAS”) for ongoing education and support regarding their youth with FASD.

The FASD program found that consistent treatment at home, school and in the community promoted better outcomes for youth in the program, and that was best achieved by working closely with members of the multidisciplinary team.43

Schools were seen as key players in providing educational services to FASD affected youth. In Minneapolis the public school system designated a fulltime position for a school social worker to assist teachers and advocates for students with FASD. One school district within the county had a program specifically set up for students with FASD.

Table 5: Hennepin FASD Program 2008/12 - Referral and Outcome44

<table>
<thead>
<tr>
<th>Youth referred, direct or via MAYSI-2</th>
<th>N =170</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive FASD Screen</td>
<td>77</td>
<td>45</td>
</tr>
<tr>
<td>Completed Diagnostic Evaluation</td>
<td>67</td>
<td>87</td>
</tr>
<tr>
<td>Received FASD Diagnosis</td>
<td>57</td>
<td>85</td>
</tr>
<tr>
<td>Completed ICP</td>
<td>45</td>
<td>79</td>
</tr>
<tr>
<td>Received services</td>
<td>45</td>
<td>79</td>
</tr>
</tbody>
</table>

43 ibid., p485-6.
44 This table reproduces Figure 1 in the Evaluation Report, op. cit., p5.
45 The denominator appears to be wrong. It ought to be 77, the no. that screened positive.
Youth Treatment Centre, Ohio

The site for the Lucas County FASD program was the Youth Treatment Centre (YTC) of the Lucas County Juvenile Court. The YTC is a secure 44 bed residential facility for felony offenders, aged between 12 and 18 years. The project, entitled “Project Adapt” was implemented through the collaboration of 3 organizations over 2 years: the lead agency, Double Arc, who had experience working with FASD affected children and their families, Lucas County Children Services, a government agency providing child protective services and foster care and the Lucas County Juvenile Court.

The purpose of the YTC program was described as providing “effective residential correction to juvenile-Court involved youth” by “shape[ing] their behaviour so they abide by rules and laws, are successful in school and show respect to others and their property”.

Although working with a captive population Project Adapt was far less successful in terms of the proportion of youths evaluated by the diagnostic team to those screened at the outset. The published data is very limited and difficult to interpret however, it may be summarized as follows:

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46 See Bisgard et al. 488-492.
47 ibid., p489.
48 see Bisgard et al. op.cit., p489-90.
Table 6: Project Adapt, Youth Treatment Centre, Lucas County Ohio

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population</strong></td>
<td>77</td>
<td>(over 24 months)</td>
<td></td>
</tr>
<tr>
<td><strong>No. Screened for FASD (Screen 1)</strong></td>
<td>51</td>
<td>66%</td>
<td>51/77</td>
</tr>
<tr>
<td><strong>No. screened for FASD (Screen 1) &amp; remained at YTC</strong></td>
<td>42</td>
<td>54.5%</td>
<td>42/77</td>
</tr>
<tr>
<td><strong>No screened positive for FASD (Screen 1) &amp; remained at YTC</strong></td>
<td>30</td>
<td>71%</td>
<td>30/42</td>
</tr>
<tr>
<td><strong>No. who completed Screen 2</strong></td>
<td>10.5</td>
<td>35%</td>
<td>10.5/30</td>
</tr>
<tr>
<td><strong>No evaluated by diagnostic team</strong></td>
<td>5</td>
<td>9% of total screened</td>
<td>5/51</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16% of no screened positive &amp; at YTC</td>
<td>5/30</td>
</tr>
<tr>
<td><strong>No diagnosed with FASD</strong></td>
<td>4</td>
<td>80%</td>
<td>4/5</td>
</tr>
</tbody>
</table>

The Expert Panel Screening Tool (EPST) was adapted for use in the program, and used as the initial screen across the target population. When 71% of residents at YTC positively screened for FASD, the project decided to add additional indicators to the EPST and apply a second screen to determine who should be referred for evaluation by the diagnostic team. Screen 2 involved collecting and analysing medical, psychological, school and birth records, and behavioural information for the youth. If Screen 2 was positive and PNAE was confirmed the youth was referred for evaluation by the diagnostic team.49

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49 Bisgard et al., op.cit., p490.
It is not clear why so few of those who initially screened positive (screen 1) and who remained at YTC did not complete screen 2, and hence were not considered for/actually referred to the diagnostic team for evaluation.

Project Adapt caused YTC to modify its intake process, so as to collect and supply more information regarding each youth to staff, including current mental health diagnoses, results from the Vineland Adaptive Behaviour Scale-II indicating developmental age, and likelihood of FASD, based on initial screen, to inform the preparation of the initial treatment plan and the development of strategies to benefit the individual young person. For those who were diagnosed with FASD the information obtained was incorporated into the treatment plan.

Notwithstanding the limitations of Project Adapt it appears that those involved perceived some positive results, which included:

- Staff at YTC had 3 days of training in FASD;
- FASD screening was integrated into the YTC program;
- The training and screening were said to create a supportive environment for the target population;
- Written materials for residents were said to have been translated for residents, eg the “Resident Handbook” and “Thinking Errors Workbook”;
- Visual charts for chores and other tasks were developed to assist youth to complete tasks; and
- Strategies learned by staff and materials developed were integrated into YTC programs.

Although not many youth were referred for diagnosis, comparison of characteristics common to YTC residents who screened positive, and the individuals diagnosed with FASD, was undertaken and a list of characteristics and recommendations for management of the individual was developed. This list appears to be a useful practical guide but no substitute for each child being properly assessed and recommendations made for intervention by a diagnostic team.

After the project ceased YTC continued to use the screening tool as part of its assessment process on intake, and aimed to send new staff for external FASD training within 18 months of commencement. Photographic analysis was no longer utilized and diagnosis was no longer readily available.

50 ibid., p491-2.
51 Bisgard et al., p492.
52 Bisgard et al., p491 & 501-506.
5. Ongoing Programs for Screening, Diagnosis in Justice Populations.

Youth Justice, PLEA FASD project, Vancouver

In about 2005 funding was secured to refer youth, that may be affected by FASD, for diagnosis by the Asante Centre. “Young person” is defined by the federal Youth Criminal Justice Act, as a person between the age of 12 and 18 years.53

There were 3 agencies involved, Youth Probation, the Asante Centre who undertook the assessment and PLEA, a non government agency contracted by Youth Probation to provide a range of services to children and youth,54 who face significant challenges and barriers.

A survey of probation officers was undertaken to determine what was known about FASD. Training was then provided to probation officers, caregivers of FASD affected youth, and one-to-one workers engaged by PLEA.

If the youth needed to be housed for the purposes of the assessment then PLEA could arrange that pursuant to contract arrangements with Youth Probation. There were trained caregivers to work with FASD youth that were being housed.

This program has funded 15 assessments per year by the Asante Centre. As from 1 April 2015 funding increased to permit 30 assessments per annum by Youth Probation for the Province.55

Obtaining a FASD assessment can take 12-24 months.56 Collecting records for the youth takes time. Often tracking the young person down is difficult because they have moved accommodation. The assessment documentation was described as “cumbersome.” The consent of the parent or guardian is required. Many youth are in care and hence the relevant social worker must complete part of the referral form. Once all of that is done the case is ready for referral to the Asante Centre.

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53 section 2(2), Youth Criminal Justice act as amended.
54 and their families.
55 Information supplied by Ms Alison Pooley, Program Director, Asante Centre on 9 March 2015.
56 Ms Sandy Manzardo, Clinical Director, Specialized Youth Probation, Vancouver
Sometimes by the time they are referred the youth is in custody, serving a sentence. In that situation then Youth Probation may plan for the assessment to occur following release, or temporary absence from gaol, which may be possible later in their sentence.

*How were Youth identified for Assessment*

The survey, and training of probation officers informed the preparation of the Snapshot Tool, which is applied to each youth at intake, following sentence by the Provincial Court. It includes several questions pertinent to FASD. The process of preparation of a pre-sentence report (PSR) does not include screening for FASD. If the youth has previously been diagnosed with FASD that fact will be included in the PSR.\(^{57}\)

If the Court orders a report regarding the mental health or psychological functioning of the youth, it is prepared by the Youth Forensic Psychiatric Services, which is part of the Youth Justice Ministry, who also provide intervention ordered by the Court, eg counselling. Youth Forensic Psychiatric services do not screen for or undertake FASD diagnosis.

Approximately 10 years ago, Youth Probation established a specialist arm, Specialized Youth Probation to manage 3 populations of youth offenders\(^{58}\):

- Mentally disordered youth;
- High risk, violent and gang involved youth; and
- Those who have offended sexually.

A case plan is prepared for each youth,\(^{59}\) which in the case of a FASD affected youth, suspected or diagnosed, may involve the allocation of a one to one worker to provide intensive support, and referral to the West Coast Alternative School which specializes in the delivery of education to FASD affected youth.

One to one support may be provided by PLEA\(^{60}\), which is contracted by Youth Probation to provide services to justice-involved youth with complex, or multiple needs and/or at high risk.

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\(^{57}\) Information regarding Youth Probation Service, Vancouver is based on discussion with Ms Sandy Manzardo.

\(^{58}\) FASD affected youth, suspected or diagnosed are dealt with by Specialized Youth Probation.

\(^{59}\) Various tools are utilized, as appropriate, to assess and manage risk, eg Structured Assessment Violence Risk in Youth (SAVRY) to assess risk of violence and generalized offending.

\(^{60}\) PLEA Community Services provide a range of services to children, youth and adults. Services include mentoring, youth outreach, school & work, youth addictions, Youth Justice, Youth and Adult residential care.
PLEA offers a range of youth justice programs including:

- short stay bail placements to youth on a bail order or sentencing order for up to 30 days, to provide safe accommodation whilst planning occurs for more appropriate residential placement;
- community based full time attendance program for up to 6 months, for youth on a sentencing order as an alternative to custody. An individual case plan is developed to address the educational, vocational and personal development needs of each youth;
- intensive support and supervision program, which is a community based one to one service for medium to high risk youth that provides an alternative to custody. The program complements the case management and supervision provided by the referring youth probation officer. PLEA staff work with the youth helping them to develop appropriate educational, vocational, interpersonal and social skills, and to function in the community. Support is provided for the youth in participating in planned activities and monitoring of compliance with conditions of the court order.

With respect to the referral for assessment, the system established as between Youth Probation and the Asante Centre involved the following steps which appear to be designed to manage supply, and therefore cost:

- Following a positive screen for FASD, done by the probation officer, the youth would be placed on a wait list;
- Youth Probation would then commence the process of collecting medical, school and other records required by the Asante Centre;
- Once all the records have been obtained, and the intake documentation completed by the parent, guardian or social worker if the youth is in care, the youth may be referred to the Asante Centre;
- The Asante Centre arrange for a medical practitioner to assess the youth which covers relevant medical issues and check prenatal alcohol exposure.
- Subject to the medical practitioner approving the youth for further assessment by other clinicians, appointments are made for him/her to be assessed by a psychologist, and other clinicians as required.

If the Probation period expired before referral to the Asante Centre occurred then diagnostic assessment may not occur.

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61 In 2013/2014 PLEA Community Services worked with 1275 program participants & residents, represented in 1795 case files. 27% of program participants and residents self-identified as Aboriginal. See www.plea.ca

62 Dr J. Conry, of the Asante Centre developed a screening tool for use by probation officers, however that is not used. For screening tool: http://www.asantecentre.org/FASD_Resources.html
Sheila Burns, author of a research project conducted in Ontario, Canada, found that training plus the use of the Asante screening tool\textsuperscript{63} assisted probation officers in developing plans of care and case management but did not find that knowledge and understanding was reflected in the probation orders.\textsuperscript{64}

**Through an Aboriginal Lens**

In 2014, a 3 year pilot project\textsuperscript{65} involving collaboration between the Native Courtworker and Counselling Association of British Columbia (NCCABC) and the Asante Centre, commenced. It is focused on working with First Nations youth, involved with the justice system and suspected to be FASD affected, to navigate the FASD assessment and the justice system. It is intended to support the youth and their families in a way which is “holistic in nature and rooted in Aboriginal worldview, values and teachings”.\textsuperscript{66}

For 42 years, the NCCABC have provided counselling and referral services to Aboriginal people, in conflict with the law, in British Columbia. The role includes preparing defendants and their families for court, guidance through the process, referrals to legal and non-legal services, overcoming communication barriers, assistance with a bail plan, assisting the court to understand the relevant cultural traditions and values, promoting and facilitating community based justice initiatives and educating Aboriginal communities about justice issues.

Through the project it is hoped to support youth and their families to complete an assessment, understand the diagnosis, the youth’s needs, strengths and challenges, obtain and benefit from relevant services including substance abuse treatment, mental health counselling, housing and social assistance.

Objectives of the program include reducing the involvement of FASD affected youth in the criminal justice system, reducing the number of FASD affected youth entering out of home care, and assist youth to reconnect with family and culture.

It is not clear precisely how that will be done. The program was in the start up phase in early to mid 2015.

The funding of the support workers for the project by the Federal Justice Department suggests an appreciation that the current system for assessment, diagnosis and intervention is not working for Aboriginal youth.

\textsuperscript{63} ibid.  
\textsuperscript{65} The Youth Justice Fund, Department of Justice, (Federal Government) have funded 2 support workers.  
\textsuperscript{66} Presentation by Samaya Jardey, Through An Aboriginal Lens Project Director and Alison Pooley, Asante Centre, Program Director, at 6\textsuperscript{th} International FASD Conference, Vancouver, 3-6 March 2015, and written material about the project is the source for information about the project.
The FASD Youth Justice program, based in Winnipeg, Manitoba, judicially initiated, began as pilot project in September 2004. Eleven years later it is an established program based at the Youth Corrections Centre. The goal is to ensure that FASD affected youth, in conflict with the law, will receive appropriate judicial dispositions, including a multidisciplinary assessment and diagnosis and improved access to services. This was done in the wake of introduction of the *Youth Criminal Justice Act (2003)* which sought to apply the principle that the youth criminal justice system is intended to protect the community by, *inter alia*, supporting the prevention of crime by referring young people to programs or agencies to address the circumstances underlying their offending and, that measures taken against youth who commit offences should be meaningful given their needs, level of development and, where appropriate, involve parents, extended family, the community and support services.

Following a presentation to a Judges conference in 2003, about the impact of FASD on offending, a partnership between Health and Justice began. A steering committee comprising clinicians, judges, lawyers, prosecutors and corrections was established, a proposal for the co-ordination of assessment for justice involved youth was drafted and funded initially by the federal Department of Justice. The Province of Manitoba has continued to fund the program since 2006. The objectives are as follows:

- To assess youth involved in the criminal justice system who may have FASD;
- To provide recommendations to the court for appropriate dispositions consistent with the sentencing principles of the Youth Criminal Justice Act;
- To build capacity within the family and community while enhancing FASD supports and services; and
- To implement multidisciplinary intervention and reintegration plans with supports for FASD affected youth, and their families.

To qualify for entry to the program:

- The young person, must be aged between 12 and 18 years, and have charges awaiting finalization;
- He/she must reside in Winnipeg or The Pas, or plan to;
- Each of the youth and guardian must consent to the process; and
- There must be confirmation of prenatal alcohol exposure (PNAE).

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67 Content of this section is based upon discussion with Teresa Brown, Program Manager, and Coordinators Dee Bissonnette, Dan Neault and Erin Klimpke on 27 April 2015, and written material supplied.

68 Reference to these principles set out in section 3(1)(a)(iii) and (c)(iii) of the Act is made in the program’s brochure.

69 The Pas, is a rural community about 7 hours, by road from Winnipeg, comprising a First Nations community of the Cree Nation and a town.
In order to establish PNAE the co-ordinator will contact the biological mother usually by telephone and will discuss the support that the program offers the youth and family. In the course of that conversation, mum will be asked about her circumstances when she learned she was pregnant, and whether she consumed alcohol during the pregnancy. The approach taken is to offer an opportunity to help the youth and family, and to be matter of fact about PNAE rather than judgemental. Questioned about the response by biological mothers to an enquiry during a telephone conversation about alcohol consumption during pregnancy, the team said they had not encountered any abuse, aggression or emotional outburst. Usually the mother welcomed the opportunity of support and services.

The program relies upon collaboration between:

- the Manitoba FASD Centre which supplies the doctors to undertake the assessment, and administrative support;
- Manitoba Adolescent Treatment Centre which undertakes psychological assessments; and
- Manitoba Justice.

A wide range of people make referrals to the program, including Judges, Probation Services, defence lawyers, staff at the Manitoba Youth Centre, birth mother, teachers, psychologists and other professionals involved with the youth or family, staff at a group home.

Two key goals drive the referrals: firstly to understand the level of functioning of the particular young person and to access support services, upon release to the community.

Many of the youth who come into the program live with biological family, have fallen through the cracks in terms of assessment and/or received an incorrect diagnosis, received no services, live in poverty, are Aboriginal, their families lack education, often one or more parents may be FASD affected themselves and families are disempowered.

The team reported that adoptive families tend to be better off financially and higher functioning. Youth from such circumstances are less common in the program.

Once the criteria for entry to the program have been met, the Crown Prosecutor and Defence Counsel are notified so that an application is made for an order for assessment.

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70 The team recounted one case where a youth had persuaded his mother to lie so he could gain entry to the program!

71 The Manitoba Youth Centre is a youth correctional facility where youth denied bail or sentenced to detention are held.
Once the Court orders an assessment the coordinator’s role is to gather relevant records, undertake a social work assessment and coordinate the assessment by the clinicians, including the following tasks:

- Gather relevant records;
- Meet family members, prepare them for the assessment, complete intake form for psychologist;
- Go to the school, access the school file, speak to teachers, obtain social history, details of any incidents;
- Meet with any foster parents to obtain history;
- Transport the young person, and caregiver, to appointments with each of the forensic psychologist72, the geneticist and the developmental paediatrician;
- Prepare a summary of records, PNAE, social and developmental milestones etc for clinicians;
- On clinic day record weight, height, take facial photographs of youth;

It takes 1 month to complete the assessment. It can be done in as little as 2 days, if necessary. The process of gathering records takes time.

“Based on the assessment recommendations are developed recognizing the youth’s strengths and deficits using a multi-systemic approach.”73 Clinicians will provide feedback, and discuss recommendations with the youth and caregiver, in the presence of the coordinator, who will then support them to understand any diagnosis and recommendations.

The next step is the development of a community plan, that is to source services in the community to match the youth’s needs and strengths, for example placement/accommodation, education/training, counselling/treatment, recreation and support. The coordinator develops the community plan in collaboration with the youth, family and any systems in which they are involved.

A conference may be arranged by the coordinator to facilitate the development of the community plan. Such a conference may be instrumental in having potential service providers commit to involvement, and for the youth to better understand expectations of him/her and conditions that apply.

The coordinator will circulate the community plan to the Crown Prosecutor and Defence Counsel before the Sentencing Hearing and seek agreement. The Court will receive the final version of the community plan, the assessment made by the clinicians and any pre-sentence report that may have been ordered.

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72 Psychologist undertakes a functional assessment.
73 Presentation by Ms Brown 2015, copy supplied to author.
The program offers continued support to the youth and their family after sentence is imposed. That will look different in each case. It may take the form of:

- Ongoing FASD education;
- Appointment reminders, and transport;
- Advocacy;
- Accompanying youth and parent/caregiver to meetings to “translate” after the meeting;
- Identifying appropriate services in the community and helping that service to adapt to the strengths and challenges which the FASD affected youth has;
- Encouraging the probation officer to focus on strengths, whilst being cognisant of challenges;
- Capacity building with the youth’s service providers, eg teachers, group home staff, probation services.

The program also assists FASD affected youth while they are in detention. It may be that advocacy is required to relocate the youth to the Differential Needs Unit, which has 15 places. The co-ordinator will work with the Youth Corrections case manager, the probation officer, the social worker if the youth is in care, the school, and/or the family to develop a plan for reintegration to the community upon release.

The program has been involved in building capacity across the system to support FASD affected youth. It has also facilitated community education about FASD, interventions and planning through informal consultations, presentations, and training for different groups within the justice system including Judges and lawyers.

Since 2004, 265 youth have been assessed for FASD, and 187 have been diagnosed with one of the conditions with the spectrum, that is 70% of those referred for assessment. A system of red flags plus PNAE is used to qualify for assessment.

In 2015, 4 new kids per month are coming onto the program. 80 cases were being managed by 3.5 staff in the program.

Many of those who have been in the program have qualified for adult support services, when they reach 18.

The program has spawned a number of initiatives of benefit to youth, including:

“This is Me – Life Book”, Probation condition icons and the Starfish Pilot program.74

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74 See the Section headed “Strategies /Procedures used in Courts with FASD affected Individuals.”
Whangarei, New Zealand

At Whangarei Youth Court on 21 May 2015, 6 of the 20 young people on the Court List had been diagnosed with FASD, or 30%.75

The current practice in the Youth Court is that a mental health professional from Youth Forensic Services is present throughout every Youth Court list to provide information to the court on any youth on the list that day, ensure that any order for assessment or preparation of a report is implemented, and may undertake a preliminary assessment, on the day, if required by the Court. This is a recent initiative of the NZ Government.

Also recently instituted is the presence in the Youth Court of an Education Department officer to provide information to the Court about any youth’s school participation and performance. Judge Fitzgerald, who is based at the Auckland Youth Court, indicated that he found the education information particularly useful and a reliable indicator of underlying issues that needed to be investigated and addressed.76

There is limited forensic FASD diagnostic capacity. To date court reports are done, pursuant to an order of a Court, by Dr Valerie McGinn, neuropsychologist and either a psychiatrist or paediatrician. The practice has been for each clinician to undertake a separate process of assessment, confer and then prepare separate reports, with the diagnosis being made by the medical practitioner.77

Government agencies focused on care and protection, and assessing needs for those with disabilities, are contracting expert clinicians to undertake FASD assessments.78

FASD assessment has been integrated into the Child Development Service (CDS) at the Hawke’s Bay District Health Board (HBDHB) and into the work of a number of other CDS teams in other regions of New Zealand, utilizing a multidisciplinary team and the Canadian diagnostic tool.

Since 2010, the CDS team at Hawke’s Bay has included FASD as one of the (range of) disorders for which its multi-disciplinary team specialize in assessing children with complex developmental, behavioural and learning problems. Previously the team

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75 Information received from Judge Lindsay, who dealt with 19 of the 20 on the list. The 20th did not appear and FASD status not known.
76 Judge Tony Fitzgerald, Auckland Youth Court on 18 May 2015.
77 Dr Valerie McGinn, in various discussions in September 2013 and May 2015.
78 Dr McGinn, May 2015.
assessed for autism spectrum disorders, attention deficit and attachment issues, not FASD. Those children who had PNAE would be referred for cognitive assessment only where intellectual disability was suspected and did not receive interdisciplinary assessment. To the extent that this cohort was the subject of an interdisciplinary assessment it “did not result in recommendations for specific strategies that are important for children with FASDs.” 79

To maximize benefit, without new or additional resources, the multidisciplinary team have adopted a 2 stage assessment model, whilst providing support for children identified at risk prior to formal evaluation for FASD diagnosis, when the child is 8 years old.80 The first stage is the completion of a FASD proforma by a paediatrician which includes a detailed history of PNAE and data about growth, sentinel facial features, learning and behavioural problems. Facial features are measured and documented according to the University of Washington 4-digit Diagnostic Code. Positive paediatric screen results in a referral to the multidisciplinary team for diagnosis when the child is 8 years old. However once placed on the waiting list for diagnosis the child is visited by the multidisciplinary team’s social worker who considers the family’s needs and support, and provides:

- Basic information about FASD
- Advice on eligibility for child disability allowance
- Information and advice on eligibility for other services, including support services
- Referral to, and involvement with, the Ministry of Education Special Education
- Involvement with the Mental Health Team of the Child, Adolescent and Family Service of the HBDBH81.

The multidisciplinary team which undertakes the diagnostic assessment includes:

- Neuropsychological assessment of key domains of central nervous system dysfunction: cognition, academic achievement, adaptive functioning, executive functioning, memory and attention.
- Speech and language assessment including assessment of the social use of language and problem solving for the domains of language and executive functioning.
- Occupational therapy assessment of the motor and sensory domains of central nervous system dysfunction.
- Social Work assessment to obtain important information regarding the home environment and any factors that may affect development.

80 Rogan, op.cit., p178.
81 Ibid.
- School observation and discussion with the teacher to add context and provide information about functional/academic difficulties
- Further paediatric assessment if required.\textsuperscript{82}

The psychologist coordinates completion of the report. Families are given feedback about the outcomes of the assessment and a draft copy of the report. Recommendations, referrals and possible resources are discussed with the family. Once the family is satisfied with the report the school is visited to talk through supports and strategies that would be most appropriate for the neurobehavioral profile of the child. The child is then followed up by the paediatrician.\textsuperscript{83}

As Rogan and Crawford write, “Diagnosis using the FASD pathway raised understanding about the child’s needs and points the way for tailored intervention. However diagnosis is only part of the process. What happens before diagnosis, and more importantly after, is key.”\textsuperscript{84}

\textsuperscript{82} Ibid.
\textsuperscript{83} Rogan, op. cit., 179-180.
\textsuperscript{84} Ibid., 180-181.
6. Diagnostic Models

Access to diagnosis, and diagnostic method or model, varies enormously between the countries visited, and even within countries.

Broadly there are 4 diagnostic frameworks in practice, with considerable overlap. The 4 Digit Diagnostic Code and the Canadian Diagnostic guidelines appear to have been most influential for Australian purposes. It is the neurocognitive deficits involved in the disorders under the FASD umbrella which are particularly relevant in the criminal justice context. In the clinical context, in North America, diagnosis of the disorders on the spectrum has involved a multidisciplinary team for many years. For children and teenagers, in the forensic context, multidisciplinary assessment has generally involved a physician to undertake a physical examination, direct other investigation/s, exclude other disorders and, after receipt of an assessment by a psychologist, or neuropsychologist, as to deficits in the central nervous system and resulting impairments, make the diagnosis.85

The author visited 3 clinics in the course of her travels and spoke with clinicians involved in 2 others. A summary of the way each works and some salient details is set out below.

University of Washington, Seattle

The FAS Diagnostic & Prevention Network has run an interdisciplinary clinic at the University of Washington, Seattle, for 22 years, providing FASD diagnostic services since 1993. In 1995, it expanded to provide diagnostic services for the State of Washington (FASDPN). It is recognized as a national and international model for FASD diagnosis and prevention. It reflects a partnership between academic research and public health. FASDPN sees its mission as prevention through screening, diagnosis, intervention, research and training.

FASDPN runs a number of programs including a diagnostic program, screening and training programs. Attendance at the FASDPN clinic on 13 March 2015, including the compulsory lecture before the diagnostic evaluations commenced was invaluable.

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85 This statement of forensic practice appears in Brown, N.N. et al. “Prenatal alcohol exposure: An assessment strategy for the legal context”, International Journal of Law and Psychiatry (2015) (NB Advance copy. Article in Press). The statement may be correct for the US. The author is doubtful that it represents the practice across the board, eg the Asante Centre, British Columbia which involves other disciplines as required by the presenting case, including speech pathology and occupational therapy.
The FASDPN is run as a training clinic for training purposes, and is funded by the State of Washington for 110 evaluations annually, that is 2 per week. Those evaluations are done on a Friday, over 8 hours, at a cost of $US 3,000 per evaluation. That cost is the same as obtaining a neuropsychological report. The cost of the FASDPN team undertaking an assessment compares favourably with costs in other parts of North America which can be as high as $CA 7,000-8,000. The demand for FASD diagnostic evaluations far exceed the State’s current capacity. The average wait time for a family seeking an evaluation is 9-12 months.

The Clinic has assessed hundreds of individuals: the youngest was 2 days old, the oldest was 53 years old, however the majority are school age. The assessment is undertaken by a multidisciplinary team (“the team”) comprising a paediatrician, a public health specialist, a social worker, speech and language pathologist, an occupational therapist, a psychologist and a family advocate.

There is one precondition for assessment: confirmation of prenatal alcohol exposure. Disability as such is not required.

In the weeks prior to the assessment, records relating to the child are gathered for the diagnostic team by the clinic coordinator, and reviewed by the social worker, including birth, medical, and school records, any reports by school psychologists, other psychological assessments or clinicians reports, (eg child development service assessments).

In the 4 hours available for each assessment,

- the team convenes (conference room), is briefed by the social worker and goes through the records, to identify diagnoses previously made, identify relevant past events, circumstances and diagnoses, determine the gaps, in terms of investigations/assessments to date, and establish priorities, among the clinicians, for investigation that day; this meeting takes approximately 20 minutes;
- assessment of the child/youth is undertaken by each clinician in turn, according to the priorities set in the meeting;

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86 Figure provided by Professor Astley on 16 March 2015.
87 Professor Astley.
88 Various sources in Western Canada. Precise figure depends in part upon how many clinicians are required to participate in the assessment and whether it is a follow-up assessment some years after the original diagnosis.
89 FAS Diagnostic & Prevention Network.
90 On the day the author attended, 13 March, 2015, Dr Julian Davies.
91 Professor Susan Astley, Epidemiologist.
92 Previously the team included 2 psychologists however more recently a social worker has been substituted for 1 psychologist.
93 Dr Heather Carmichael Olson. Dr Olsen is one of the original members of the diagnostic team. She participated in the assessments on the day the author observed for the last time.
The social worker and paediatrician will simultaneously meet with the parent/guardian/caregiver to check the relevant history, current behaviours, interventions & supports, school performance and so on;

As each clinician finishes their assessment he/she goes to the conference room to complete their section of the report, noting any tests performed, purpose of that testing and results or inferences to be drawn, whilst another clinician begins a new interview/assessment with the child;

The paediatrician conducts a physical examination of the child to assess whether other potential conditions/disorders can be excluded. Height, weight, and head circumference measurements are taken.

A clinical photograph of the face is taken for the purpose of analysis with software developed by Professor Astley for the purpose. The software was developed as part of a study of children in foster care in King County, Seattle.94

When clinical assessments have been completed, or time has expired, the team will come together to discuss their assessments and specifically go through each of the domains, to determine the level at which the child or youth is functioning. Together the team will discuss their findings, and the appropriate diagnosis.

The next step is to invite the caregiver in to discuss the diagnosis made with the diagnostic team and give the caregiver an opportunity to ask any member of the team questions. A private session, without the observers or the team of clinicians, is then conducted by the social worker who will talk through the intervention plan developed by the team with the caregiver.

Within 7-10 days a written report goes out to the caregiver/guardian which summarizes the previous investigations and any diagnoses, reports on the diagnosis made by the team and sets out recommendations for intervention.

FASDPN is funded by the State of Washington as a training clinic, 2 years at a time. Each Friday up to 10 observers attend a 30 minute lecture by Professor Astley before proceeding to observe the team discuss the case, plan the evaluation then observe part or all of the clinician assessments, unseen by the child/youth being assessed, before watching the team discuss their findings, make a diagnosis and then together, meet with the caregiver. The social worker then takes the caregiver to a private room for a brief discussion before the next assessment begins.

On the day the author attended to observe the clinic, 2 children were assessed as usual: a child of 4 years, and a teenager of 14. Neither was in the care of their parent/s. Professor Astley noted that only about 15% of children/youth who are assessed are in the care of the birth mother. About 20% of the clinic's cases are assessments done pursuant to a court order.

94 FAS Facial Photographic Screening Tool used which was evaluated in study undertaken between 1999 and 2001, see Astley, S.J., et al. Application of fetal alcohol syndrome facial photographic screening tool in a foster care population, The Journal of Paediatrics, November 2002, 712-717. Professor Astley informed the author that the database against which any new digital image is assessed is now in excess of 3,000 photographs.
On the day the author observed the multidisciplinary team undertake the evaluation, there were about 7 observers. Three of us were from Australia: two were 2 clinicians from the Gold Coast. Seven other observers were from the State of Washington and included a 4th year medical student, a youth probation officer and a teacher.

Professor Astley made the following points:

- In the feedback session after the team have assessed the child/youth, the family/caregiver “want it simple”, in other words, in plain English what the diagnosis is, and recommendations for intervention.
- That for justice purposes, causation shouldn’t matter. Rather it is the impairment, the underlying brain dysfunction, that is important to understand. In other words those with FASD should not be privileged, in terms of services or programs, in the criminal justice system.
- The multidisciplinary team identifies the strengths, limitations and challenges of the individual.

The FASDPN might be seen as a tertiary process. It maps the investigations and diagnoses made to date so as to identify the gap/s in the context of a comprehensive history based on records obtained, and information supplied by the caregiver, and then concentrates its expertise on those areas that have not previously been assessed. Despite the fact that the diagnosis is technically that of the physician, or in the case of a child or adolescent the paediatrician, in the author’s observation it was a truly collaborative process when each domain was being discussed and a rank allocated, and then when the team was assessing whether the diagnosis which emerged from the ranking allocated to individual domains reflected the overall clinical picture. This may be especially valuable in the case of a child or youth in the justice system for 2 reasons: the opportunity it presents for a comprehensive set of recommendations for interventions and making an assessment of a youth where there are confounding factors such as trauma and/or substance abuse.

**Medigene Services Calgary**

MediGene Services Inc. (MediGene) operates a private FASD clinic in Calgary which undertakes assessments of children, youth and adults, and participates in case conferences. Its principal, Suzanne Johnson has a science based degree from the University of British Columbia, which focused on study of brain. Prior to establishing the clinic she specialized in working with people with disabilities.

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95 The term evaluation is used interchangeably with assessment.

96 Dr Conry, of the Asante Centre, British Columbia has spoken to the writer about the value of the different disciplines, together working through the various domains to arrive at the correct diagnosis. This is especially important where there are confounding factors such as trauma and substance and alcohol abuse.
The clinic was established in 1988-89.

MediGene has an excellent reputation for the quality of the reports produced. Its reports have been quoted at length in some Court judgements.97

The Clinic employs a Nurse Practitioner and Clinic Co-ordinator98, who deals with all enquiries, provides information about the process involved in diagnosis, organizes appointments with clinicians, and gathers records for FASD assessments by clinicians. The clinic is a private clinic which provides assessments and diagnostic services to children, youth and adults, and participates in case conferencing.

In 2014 the clinic completed 120 reports following assessments, at an approximate cost of $CA3800-$6000 per initial assessment including comprehensive report99. A follow-up report may cost $CA3300. Since the clinic opened it has seen 1000 patients, aged between 4 years and 54 years old.

Referrals come from the community, child welfare authorities100 and courts. Some assessments are self-funded by families. Child welfare authorities may contribute to funding an assessment for an adopted child in order to determine what external support required.

Courts, for example the Youth Court of Alberta, allow 3 months for an assessment and report to be produced101. Youth workers for the Youth Criminal Defence Office (YCDO) have consent forms/authority to release records so that a parent can be asked to provide authority at Court, as soon as the order for an assessment is made.

Once the clinic receives the referral it will contact the guardian of the youth and obtain an authority to release birth and other records required by the clinicians undertaking the assessment, if that authority has not already been provided, eg the child is in care.

97 For example R v Charlie 2012 YKTC 5 at [13], R v Ramsay 2012 ABCA 257 at [7], R v Harper 2009 YKTC 18 at [17-18.]
98 Sandy Tilley. I am grateful to Ms Tilley for meeting with Cathy Lane Goodfellow QC and I on 20 April 2015 at the Clinic. The information in this section is based on that discussion, in the main.
99 Subject to the number of clinicians/clinician time required.
100 In Alberta the Ministry of Human Services overseas the delivery of child intervention services provided by 8 regional Child and Family Service Authorities (also known as child welfare authorities), one of which is a Metis Authority. Seventeen delegated First Nations Authorities also provide services by agreement between the Province of Alberta, the Federal Government and the First Nation. The regional body which delivers child intervention services in Calgary is known as the Calgary and Area Child and Family Services Authority.
101 The child welfare authorities archives are held in Edmonton. It can take up to 6 months to get access to the relevant files/earlier reports.
The clinic co-ordinator will then gather all relevant records which may relate to whether there was pre-natal alcohol exposure, any previous medical or educational assessments of the child, including by an educational psychologist. Records are most useful as the young person, and often their carer, are not reliable historians.

Previously the child welfare authorities were referring up to 4 children/youth per week, however since the adoption of the Signs of Safety model, less children are coming into care, less children have been identified as needing assessments and less referrals for assessment have occurred.\textsuperscript{102} The system of referral also changed in early 2015. Whereas previously each office would make any referral of a child for assessment where considered appropriate, now social workers are required to refer the child to a FASD consultant/psychologist, internal to the agency, who will consider whether referral to a FASD clinic for assessment is warranted.

Pursuant to the \textit{Child Youth and Family Enhancement Act}\textsuperscript{103} there are a range of child intervention services that may be provided to a family. As the author understands the position, unless a temporary or permanent guardianship order is made in favour of the Director of the child welfare authority, a child does not leave the care of a parent or family.

In or about 2004, reform of services to families and children was introduced:

- so as to increase services to families before they reach crisis,
- establish permanent homes more quickly for children in government care and
- strengthen involvement of First Nation, Metis and other Aboriginal communities in planning for their children.\textsuperscript{104}

“A key feature of the reform was the implementation of the Alberta Response Model (ARM), a differential response system with 2 legislated streams of activity: family enhancement services and protection services.”\textsuperscript{105} The family enhancement stream uses a different approach than the protection stream: it is an intensive short term intervention program aiming to support the family through establishing links with the community to better address the safety concerns. The family enhancement stream is voluntary, with services (such as family support workers, external addiction services, mental health services, family counselling, using medical or psychological assessments) tailored to match the families specific needs.\textsuperscript{106}

\textsuperscript{102} Ms Tilley, Clinic Co-ordinator.
\textsuperscript{103} Alberta provincial legislation.
\textsuperscript{105} ibid.
It appears there were further reforms implemented following a review process in 2010 which reorganized child welfare authorities as regional offices that report to the Ministry of Human Services.\textsuperscript{107} That is consistent with the experience of the clinic that the referral process has changed and referrals from child welfare have reduced. It would appear that child welfare authorities only refer for FASD assessment if a child/youth is in permanent or temporary care.

By way of aside, before leaving the topic of referrals from child welfare authorities, the author learned that Aboriginal children represent the majority of children in permanent care (72%), with rates rising steadily since 2001 whereas rates of permanent care for non-Aboriginal children have been decreasing.\textsuperscript{108}

The Calgary Fetal Alcohol Network (CFAN) funds 10 assessments per year. Recently those funds have been applied to children or youth living with their biological grandparents on very limited incomes in retirement.

Enviros is a community based organization which works with caregivers of children or youth for up to 6 months who have a FASD diagnosis which has not been made more than 4 years earlier. Enviros will pay for assessments by the clinic. At times when it has spare funds it will prepay for assessments.

Process for Diagnosis. The clinic coordinator will do the standard measurements for the person being assessed, height, weight, head circumference, etc. The clinic does not use the software program developed by Professor Astley, because it is unnecessary to do.

An appointment is made for IQ assessment and an adaptive function test by a psychologist. A questionnaire will be sent out to people who know the youth well including the school, requesting that they complete it to inform the clinicians. The psychologist will interview the caregiver of a child up to 12/13 years. The psychologist will write their section of the report.

A half day is allocated to the medical assessment by the geneticist and physician, Dr Harris Yee. He will do a medical, psycho-social assessment, and neurological examination of the youth, including an assessment of developmental level and school engagement, and speak to the caregiver. On the same day the clinic coordinator will meet with the caregiver and find out about behaviour, use of drugs and alcohol, any offending, sexual behaviour of the youth, and ascertain what the caregivers understand to be the impairments. A detailed history is important. She will

\textsuperscript{107} For brief overview of 2010 review process see Kyte & Wegner-Lohin, op.cit.

\textsuperscript{108} The Alberta Child and Youth Advocate Annual Report (2012-13).
also access the youth’s Facebook to assess how vulnerable the youth is, whether he/she is managing their own safety/security/health issues etc.

Youth and young adults charged with starting fires and sexual assaults, referred for FASD assessment, would number up to 25 per year, or 21% of the assessments completed in 2014.

The Clinic takes the view that a person diagnosed with FASD should be re-assessed every 5 years. It is not that function reduces with age but rather that expectations of young people increase with age. 109 It appears likely that environmental factors interacting with impairments may also impact on capacity and functioning over time of drug use, reflect

Changes are proposed to make assessments shorter, more efficient to be acceptable to justice system. However there are delays associated with obtaining a signed release from guardian/caregiver and obtaining the relevant documents which make it very difficult to complete assessments and reports quickly.

In Calgary, the Clinic Program Director attends Sentencing Conferences ordered by the Court to assist service providers to understand the youth’s needs and together work out how they will be met.

**Asante Centre, British Columbia**

The Asante Centre has been at the forefront of providing diagnostic and assessment services, family support and advocacy services for children and adults suspected of being affected by FASD, autism spectrum disorder and other brain based disabilities and their families.

It utilizes a multidisciplinary team to undertake diagnosis and assessment. Members of the Asante team, including Dr Asante and Dr J. Conry, with others, have led the way in clinical assessment & research contributing to a better understanding of the spectrum of disorders and the implications for appropriate interventions.

The Asante team have provided training to clinicians from other countries in order to build their capacity to undertake diagnosis and assessment, for example Dr Valerie McGinn and Dr Craig Immelmann from New Zealand.

109 Ms Tilley’s comment.
The Asante Centre has developed, or contributed to the development of resources, such as the Asante Screening Tool for Probation Officers.

Asante’s model for a child’s assessment starts with the paediatrician who will examine the child, the records and satisfy him or herself about prenatal alcohol exposure and whether other conditions warrant consideration. Subject to that examination the child will subsequently be assessed by a psychologist for testing and later a speech pathologist.

Asante has 3 main sources of referrals:

- Youth Probation who have referred up to 15 youth per annum for diagnosis, and assessment up to 2015 when the funding has increased to 30 per annum;
- The Children’s Ministry, British Columbia, between 100-150 per annum;
- Adult, privately funded, about 12 per annum.

The Program Director, Ms Alison Pooley, said that child welfare authorities do not fund diagnosis or assessment ordinarily. Instead those agencies use the child development service, funded by the Health Department. Ms Pooley confirmed that Youth Probation organize their own referral, complete the documentation and obtain relevant records. It can take 1-1.5 years for the child to get to the stage of seeing the first clinician at the Asante Centre. Diagnosis and assessment is done post sentence.

**Auckland Youth Forensic Assessment Model** 110

For some years now Dr Valerie McGinn, neuropsychologist and Dr Craig Immelmann have been undertaking FASD assessments of youth for the Youth Court in Auckland pursuant to an order of the court as and when the court considers that necessary. Each clinician undertakes their own assessment, confers with the other and then prepares their own report, which is submitted to the court.

Otherwise Dr McGinn undertakes assessments for the child welfare authority in Auckland and other parts of the North Island, in conjunction with a paediatrician. Those assessments appear to be accepted by the prosecuting authority if the youth becomes involved in the criminal justice system.

In the Youth Court at Whangarei, north of Auckland on 21 May 2015, of 19111 youth on the criminal list dealt with by Judge Lindsay, 6 had been assessed and diagnosed with FASD.112

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110 Dr Valerie McGinn.
MOFAS

MOFAS runs a part time diagnostic clinic itself. There is a full time case co-ordinator, sessional paediatric nurse\textsuperscript{113} supervised by a paediatrician based at the University of Minneapolis. PNAE is a prerequisite for assessment by the team.

The paediatric nurse undertakes a physical examination and take measurements, check size of head, eyes, lips, philtrum, examine birth records and any reports obtained, eg neuro-psychologist, child psychiatrist. The results of the physical examination may warrant consultation by a geneticist. Otherwise a psychologist will see the child and do some testing.

Once a diagnosis has been made the Clinic’s focus is a plan for the child, which may take up to 18 months. If the child/youth has multiple issues then there will be targeted intervention,

Winnipeg FASD Justice program

Dr Abe Chudley and another clinician undertake diagnostic assessments at the Youth Custody Centre where the defendants are in custody. The conditions are fairly poor, however, the practice reflects a commitment to overcoming barriers to assessments. Room in crowded work space for Youth Probation, Native Court workers, FASD Justice staff, Starfish is utilized.

Content of Reports

The author has had the opportunity to view reports from several different clinics and a template from a third, for the purpose of understanding the type of information included. The following discussion is by no means a comprehensive look at the different types of reports but rather an attempt to spark consideration about what type of report best serves the goal of rehabilitation, common to most youth justice regimes and the interests of the individual youth assessed as a result of involvement in the criminal justice system.

\textsuperscript{111} 20 names were on the list. 1 youth did not appear.

\textsuperscript{112} Judge Lindsay.

\textsuperscript{113} Mary Jo Spencer, met with her in Washington DC at NIAAA in April 2015.
It would appear that there are essentially 3 types of report:

1. Conventional court ordered report/s by expert/s which sets out in detail the information available to the clinician, testing undertaken, clinical findings and process by which diagnosis is made; (Expert Report)

2. A report in which sets out the domains evaluated by the multidisciplinary team, how each domain is assessed, the issues that determine what rank is allocated, then lists all the tests administered as part of the assessment, previous diagnoses made, the results from tests administered during the assessment, the ranking for alcohol exposure during pregnancy, other significant events/exposures during pregnancy and post-natally, then proceeds to make recommendations for follow up, in various areas including medical issues, developmental, educational, vocational, mental health and family issues. (Diagnostic Report)

3. A report which states the diagnosis at the outset with minimal discussion of the process of diagnosis, and then turns to “recommendations for building success” in detail. Recommendations cover genetic, medical, daily living, strength based recommendations, psycho-social recommendations, vocational, judicial, information sharing. Appendices include assessment tools utilized, detailed psycho-educational assessment, etc. (Roadmap Report)

Different approaches have been adopted in different places, no doubt for reasons pertaining to local conditions, the availability of resources and expertise, and so on. Some clinics doing FASD assessments are based in universities, some in hospitals and others in community centres.

In Auckland, New Zealand, the Youth Court receives a report from a psychiatrist and a neuropsychologist, who undertake separate assessments, collaborate and then independently each write a report.

Cost, and the availability of the clinical expertise, are significant barriers to assessments of youth in the Australian criminal justice system.

An Expert Report for court is likely to provide significant detail on a youth’s history, the diagnostic process, the testing undertaken, clinical assessments and so on. The report is prepared for one purpose: use by the court to assess cognitive, psychological or functional capacity. Post sentence the report will be filed away and is unlikely to be utilized again.

A Roadmap Report is prepared with intention of making it useful for service providers/agencies who will need to work with the youth; child welfare, education & vocational, health, disability services and justice. Notionally a cost of a report of this type may be drayed across 4-5 agencies. Rather than being prepared for the specific
and limited purpose of a criminal court to determine the degree of culpability, capacity for a community based order and appropriate sentence, it may be the catalyst for bringing services providers to the table at say a sentencing Conference, it may form the basis for a be utilized by all relevant agencies in their service delivery to the youth.
7. **Programs to Support Youth and Families re FASD (General)**

**FASD Key Worker Program, Vancouver**

The Ministry of Children and Family Development funds the Key Worker and Parental Support program in British Columbia. There are 53 Key Workers based at child development centres, community resource centres and non-government organizations in 5 regions of the Province.114

The services of a Key Worker and Parent Support are available to assist families of children and youth with confirmed or suspected FASD.

Key workers help families in understanding FASD by providing education and information specific to the needs of the child and family. They are familiar with community resources, assist families in accessing support, health and education services and are involved in the development of local support services. They also provide emotional and practical support to families.

A key worker works with parents, family members, adoptive parents, caregivers and service providers in identifying ways to adapt the child’s environment in response to the child’s needs. The key worker also tries to empower the family to become the best advocates for the child.

The relationship will develop over time and may commence with the process of being referred for assessment and diagnosis. The keyworker is able to help the family understand the process, assist with practical steps like transport, provide emotional support, assistance to understand and work through the diagnostic team’s report then assist and support the family to take steps to implement the recommendations for intervention over time. For example, with the consent of the family, the key worker may assist the school to understand the strengths and needs of the child in the school environment, facilitate discussion about how the school will meet the

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114 Vancouver Island, Coastal Vancouver, North, Interior and Fraser. Key Workers and Parent Support Workers are readily accessible. Contact details of all Key Workers and Parent Support Workers are available at www.mcf.gov.bc.ca/fasd/kw_support.htm

115 Parent support includes parent and grandparenting FASD training on a local basis, parent mentoring and support, and referrals within the community.
child’s needs and have the individualized education plan reflect the recommendations of the diagnostic team.¹¹⁶

A similar program operates in the province of Manitoba.

**Youth in Transition, Community Living, British Columbia**¹¹⁷

Youth with special needs may qualify for a range of community living supports and services, to assist them live as fully and independently as possible in the community. Community Living British Columbia (CLBC) is a government agency which sets eligibility criteria, determines whether an individual meets the criteria and if so develops a plan for, and funds, appropriate services.

A young person does not become eligible for such services until they turn 19 years, although planning may commence from the age of 16 years. However if a young person has been in care that status, and any support and services they are entitled to as a consequence, will expire when they turn 18 years.

FASD affected youth often do not qualify for this program because their IQ is over 70 years.

**Transition Planning**

Among professionals, service providers and family members in Western Canada there was concern about the lack of continuity of service provision between adolescents and young adults, the difficulty of accessing appropriate services once the youth turned 18, and the delays in accessing such services. To the extent that support services were available for those affected by FASD, the focus has been on children and youth.

The Lakeland Centre, in south eastern Alberta, developed a resource for families, caregivers and professionals who work with, and support, FASD affected youth, to assist them to support the adolescent transition from childhood services into adult services. The resource consists of booklet entitled: *Transition Planning; Guiding Youth with FASD to Adulthood*. It provides a step by step guide to the issues that need to be considered, the planning process, services available and accessibility criteria, and local service providers.

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¹¹⁶ Malgosia Tomanik, M.Ed, FASD Keyworker/Family Support Worker, Fraser Valley Child Development Centre. See too www.mcf.gov.bc.ca/fasd/kw_support.htm
¹¹⁷ www.communitylivingbc.ca
The Lakeland Centre for Fetal Alcohol Spectrum Disorder (“the Lakeland Centre”) covers a region in southeast Alberta. It has developed a rural integrated model of care through diagnostic and support services for children and adults with FASD, and their families, including:

- Follow up support;
- Education and training;
- Prevention and awareness;
- Resource development;
- Mothers to be mentorship; and
- Summer camp for kids.
8. Policing

Engagement with the police is the entry point to the criminal justice system. Recognition of the critical role police play in their interactions with FASD affected individuals, whether potential suspects, victims or witnesses is evident from several initiatives in different parts of Canada.

FASD Guidebook for Police

A FASD Guidebook for Police Officers was published by the Royal Canadian Mounted Police in 2002.\(^\text{118}\) It was the result of collaboration between police, addictions and FASD experts. The Guidebook was part of a campaign to increase the awareness of frontline police officers of disabilities caused by PNAE and provide tools to enable them to be more effective conducting investigations with FASD affected individuals, whether suspects, victims or witnesses.

Police were not being asked to diagnose but rather to be aware of the possibility that individuals may be so affected, that such individuals were considered to have “diminished capacity” and in such circumstances consideration of their special needs and a compassionate response was required.

The Guidebook which runs to approximately 30 pages, contains information about the nature of FASD, characteristics of the condition, how to approach an investigation involving a FASD affected individual, including discussion of legal process rights, arrest, interviews and obtaining statements, and where to turn for help conducting the investigation. It remains an accurate, practical and useful resource.

In some places police have received FASD training many years ago.\(^\text{119}\) Indeed it was pointed out by several officers that the focus has moved on to training and equipping frontline police to deal with mental illness.\(^\text{120}\)

In a practical guide for legal professionals (27 pages),\(^\text{121}\) published in 2005, Dr Lori Vitale Cox provided examples of situations and behaviours for each professional group, including police, which might suggest the individual is FASD affected. The issue of reliability of confessions by FASD affected individuals is specifically

\(^{118}\) www.asantecentre.org/_Library/docs/latestfasguide.pdf

\(^{119}\) Statements made to author in Vancouver, Winnipeg & Whitehorse.

\(^{120}\) References to initiatives in Vancouver and some Police Departments in US re dealing with those affected by mental health, see Stewart and Glowatski, p17.

discussed. An example of a false confession is given. In 1991, Mr Brian Tate, who suffered from fetal alcohol syndrome (FAS) made a false confession to police regarding a double murder, following which he spent 11 months in gaol before it was discovered he was in custody at the time of the murders.  

A second issue, that of whether a FASD affected accused has understood their legal rights as explained by an investigating officer, and strategies that might be utilized to overcome the challenges.

FASlink, Fetal Alcohol Disorders Society, a non-government organization based in Tucson, Arizona have published a short information sheet about FASD and factors to consider when dealing with a FASD affected individual: “Fetal Alcohol Spectrum Disorders; Fact Sheet for Personnel in Law Enforcement”. It is an informative snapshot of the group of disorders, refers to some common characteristics, identifies factors to consider when engaging with a FASD affected person, eg sensory integration disorder and broadly sketches their needs.

**Training Module for Justice Professionals including Police**

Justice Canada, through a Federal/Provincial/Territorial Coordinating Committee of Senior Officials has prepared 6 training modules about FASD/justice related issues to “promote a common understanding of the knowledge, attitudes, approaches that will help Justice professionals better understand and serve clients with the complex condition of FASD”.

Some of the challenges that FASD affected witnesses, or suspects, may present for police, for example when investigating an incident, or whilst speaking to, or arresting a suspect, are identified and discussed.

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122 Booklet p12.
123 Booklet p14-17.
124 see [www.faslink.org/FASD%20Law%20Enforcement%20Fact%20Sheet.htm](http://www.faslink.org/FASD%20Law%20Enforcement%20Fact%20Sheet.htm)
125 Criminal Justice Steering Committee on FASD.
126 Hard copy of presentations, plus notes, provided by Ms Joanna Wells, Counsel, Criminal Law Section, Justice Canada.
Police-Led FASD Justice Project, Lethbridge, Alberta

The Community Justice Project (CJP), based in Lethbridge, Southern Alberta, commenced in 1999-2000.\textsuperscript{127} It is one of 4 FASD Justice Projects across Canada, but is the only project with a police officer as the lead. Since its commencement youth in the program have aged and transitioned to adulthood. That increased the work of the CYP and service providers, and resulted in expansion of the project. An Adult FASD Project has been established and continues to serve and support these individuals. The Youth Project (CJP)\textsuperscript{128} is led by a police officer, currently Constable Smallbones, who is described as the Community Project Officer.

The purpose of the CJP was, and remains, the identification of youth with FASD in the criminal justice system in an attempt to:

- Influence effective case management;
- Divert them from the system where appropriate;
- Make recommendations to the court;
- Identify high risk youth and their families; and
- Provide advocacy for the family, school and community.

It was intended that the CJP would, \textit{inter alia}:

- Assist in the reduction/prevention of secondary disabilities (eg school failure, substance abuse)
- Increase community awareness of the disability;
- Support a change of beliefs about how to serve this high needs population;
- Assist existing resources to respond appropriately to the disability

Over the years a major component of the work of the Community Project Officer has been to “lead opportunities for” and “participate in” training.\textsuperscript{129}

The Annual Review, for the year ending March 2014, reported that the CJP supports and advocates for individuals affected by FASD by increasing the ability of police officers, and others, to recognize the disorder and appropriately serve them in the community. Referrals to the Justice Committee, which has oversight of the program, ensured that appropriate case plans were put in place and services were coordinated.

\textsuperscript{127} Project documentation, including including Annual Review for year ending 31 March 2014 provided to author.
\textsuperscript{128} Works with youth between 12 and 17 years.
\textsuperscript{129} Copy of the CJP description (draft) supplied by Ms Donna Debolt refers to minimum standard of FASD education required of Community Project Officer, as completion of FASD 150 & 155 through Lethbridge Community College, Alberta.
Table 7: Evaluation of CJP Year Ending March 2014

<table>
<thead>
<tr>
<th>Number of FASD affected Youth assisted at Court</th>
<th>40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total charges withdrawn</td>
<td>5</td>
</tr>
<tr>
<td>Total charges reduced</td>
<td>6</td>
</tr>
<tr>
<td>Alternative action/s to charge taken (ie no court action)</td>
<td>11</td>
</tr>
</tbody>
</table>

Other outcomes reported for the year included:

- Case plans have created positive structured environments that keep youth safe and out of the justice system;
- Community and Police have responded in coordinated manner;
- Law enforcement, community agencies, families and caregivers of FASD affected youth have reported improved relationships and communication;
- There is cross ministry support for the project: In Justice, there is support from judges, crown prosecutors and police. In Children’s Services, there is support from social workers, managers and frontline child youth care workers. In Education, superintendents, principals, teachers and assistants. In Health, physicians and mental health therapists.
- Crown prosecutors continue to accept information and referral packages provided by CJP: a referral package is up to date information about the youth for the court, to improve decision-making. Recommendations may include referral of youth for assessment, appropriate probation conditions, or diversion from the court process, where appropriate.

Referrals come to Senior Constable Smallbones from a wide range of sources. Depending on the circumstances and nature of the behaviour she will try to have youth diverted from the court system. She may speak to a number of people to find out youth’s background, current circumstances, services already in place, try to expedite FASD assessment, check criminal history, speak to Police Officer with conduct of the case. It may be necessary to have a discussion about the nature of the disability and impairments in the particular case, put in place a plan for more structure and supervision. It can be difficult to convey the impact of the disability at times. Some officers focus on law enforcement, on community safety.

At times, Crown and Defence lawyers do not necessarily understand that a FASD affected youth may find it difficult to comply with a probation order. Most of those who come through the CJP are illiterate, don’t understand time and don’t have basic living skills, eg getting themselves up, ready for school/work, get there on time, without support.
In 2014 a very high proportion of those in the CJP were in care as well as involved in the criminal justice system. It can take up to 6-8 months to get a FASD assessment, although sometimes the CJP can have it expedited. An assessment will help caregivers and others better understand that the youth is not lazy, bad and/or defiant, that the young person does understand and shows it in their behaviour when they yell, swear or get aggressive.

If the youth is in care then usually Southwest Alberta Child and Family Services Authority will pay the cost of the assessment, which is approximately $CAN5,000.

Where secure care is required,130 in order to supply extra supervision and structure, and the child or youth is in care, there is a 9 bed facility called Sifton Youth Centre.131 Placement there can be quite lengthy132 however youth will exit when they turn 18 years.

Group Homes for youth in care, often have FASD affected youth placed there. Often in foster care, or a group home, youth don’t have the structure or stability which those with FASD need and their behaviour escalates. At times, the police are called in to deal with unacceptable behaviour at the institution. This has led to a number of FASD- affected youth being charged for relatively minor matters after which the CJP officer has intervened to attempt to divert from court or have charges withdrawn.

Lethbridge Police have an internal reporting system that enables a person to be flagged for “FASD”. With the permission of the carer or guardian, where the youth is FASD affected the Smallbones will flag as such. The system can be instructed to send her any incident reports pertaining to a particular individual, or having a particular status. She can then review them, speak to the investigating officer, and the supervising sergeant. In a recent case a charge was withdrawn and a verbal warning issued. Sometimes the young person can be referred to restorative justice – a pathway that does not involve court proceedings.

Research undertaken by Dr Michelle Stewart with Police in Saskatchewan, Canada about their understanding of FASD, the source of that information and whether further training and information would be welcome, found that Police have an interest

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130 Child or youth continuing to commit crime, engaging in high risk behavior or higher needs.
132 Example given to author of a young person, with FASD diagnosis, being placed there for 2 years.
in receiving more information about FASD but it must be relevant to their frontline experiences.133

**Frontline Police: Knowledge & Perceptions of Police**

It is commonly understood that FASD affected individuals have a much higher level of contact with police and the criminal justice system.134 Hence the knowledge, perceptions and practices of police at the frontline about FASD, and those affected by it, are important. A small sample study carried out with Royal Mounted Canadian Police (RCMP) in Saskatchewan in 2013 made a number of findings135 including:

- Officers had considerable knowledge about FASD;
- Many officers said they had regular contact with FASD affected individuals;
- Most officers had strategies to deal with FASD affected individuals, identifying patience, staying calm, offering simple instructions and repetition as ways to deal with them, whether they were the suspect, the victim or a witness;
- Safety is the primary concern for police, and FASD a secondary consideration;
- Most officers said that the issue of FASD would not effect the way they dealt with individuals; and
- Vast majority realized that behaviours characteristic of FASD may result in negative contact with police but felt strongly that “FASD should not be a mitigating circumstance during the police encounter”.

The study participants reported little or no formal training about FASD. Knowledge about FASD had been learned on the job, or from external sources. They wanted more training about FASD, and delivered in a way that is applicable to situations encountered on the frontline.136

As the study authors point out the findings have a number of implications for policing: principal among those being the need for training which is directly relevant to those on the frontline dealing with the challenges posed by FASD affected individuals.137

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135 Ibid., p21-23.
136 Ibid., p22-23.
137 Ibid., p24.
ID Information Card for FASD affected individual

The Fetal Alcohol and Drug Unit at the University of Washington, School of Medicine and School of Law developed and identification card, described as a Medical Information ID card. The content of the card was very similar to the FASD Business Card used by the Youth Criminal Defence Office in Alberta. However, the card also contained the name of the holder’s doctor or diagnostician. It was recommended the card be laminated, and carried at all times.\textsuperscript{138}

\textsuperscript{138} http://depts.washington.edu/fadu/legalissues/policecard.html and FAS Community Resource Centre at http://come-over.to/FAS/Court.
9. **Diversion**

**Canada**

The Youth Criminal Justice Act (“YCJA”) commenced operation in 2003. It is an Act of the Federal Parliament although it is for Provinces and Territories to enforce.

YCJA applies to youth between 12 and 17. Youth aged 14 to 17 may be sentenced as adults under certain conditions.

YCJA requires that a young person be held accountable through measures that are proportionate to the seriousness of the offence and the degree of responsibility of the young person. The Act puts an emphasis on rehabilitation of the young offender, and reintegration into society. A young offender may be referred directly to programs and agencies in the community to address the circumstances underlying their offending.

The YCJA sets out principles that apply to the use of extrajudicial measures, that is, measures other than judicial proceedings under the YCJA.

Extrajudicial sanctions may be used only where a warning, caution or referral would not adequately deal with the matter because of the seriousness of the offence, the nature and number of previous offences or other aggravating circumstances. Further the person administering the sanction must be satisfied that it would be appropriate having regard to the needs of the young person and interests of society.

The YCJA also permits a province to establish a program of pre-charge screening. That has been done in British Columbia and Alberta. A charge is prepared by the police and forwarded to the prosecutor to determine whether the charge should be filed at court and proceed to be determined, or the youth should be diverted through the use of extrajudicial sanctions. Should the prosecutor’s decision be to use extrajudicial measures the court will have no role in the matter.

**Vancouver Police Department**

Vancouver’s Police Department, a City police force, have an internal position dedicated to diversion. The emphasis in the YCJA Act on diversion appears to have been the catalyst for the creation of the position. Initially staffed by a uniformed officer, for the last 8 years, Amy Powter, a civilian, has filled the role. She is an
internal point of contact when an officer is considering diversion of a young person suspected of committing an offence.\textsuperscript{139}

Where children under 12 are suspected of committing offences then the officer involved may refer the matter to Ms Powter and she will contact the parent, speak to the school, contact the Ministry of Children and Family Development to see what the child’s circumstances are, and what support and intervention, may be appropriate and implemented.

In 2014 Ms Powter had 88 files for young people referred to her to. As at early March 2015 she had 25 files. Many of these files involve intensive interaction with the young person in the short and medium term then being available as issues arise for the youth.

Each of 16 High Schools in the Vancouver area have a police officer attached to them. In more recent times there is much greater collaboration between police officers based at schools and the Ministry of Social Services in an effort to intervene early to provide support and assistance to the family.

Ms Powter said there was a very high rate of mental health issues among the youth referred to her, and/or their families, mostly undiagnosed. She will refer to the appropriate mental health service. There is a quick response team, the Child and Adolescent Response Team ("CART") who will be called in an emergency. CART will deploy a work to do an assessment and undertake immediate care and ongoing counselling, where appropriate.

Referral for counselling through the justice pathway can involve a 4-6 month wait. However in talking to the youth, and considering the options, short term supports can be identified.

The Vancouver Police Department has a dedicated Youth Squad, comprising 7 Detectives, dedicated to investigations involving allegations of youth offending.

Ms Powter says that police officers have received training on what FASD is, how to recognize it, and what to do. She said there was a lot of awareness among police officers of the disorder and its implications in terms of behaviours. There were pockets in the community where FASD was more prevalent. Stigma has dropped in some parts of the community, for example areas of lower socio economic status.

\textsuperscript{139} Amy Powter, Youth Referral Coordinator, Vancouver Police Department, is the main source for information in this section.
At the current time FASD affected youth were not seen as a discrete population who posed a risk to public safety.

The Vancouver Police Department have initiated a number of specialist police teams to deal with youths. For example Yankee 10, is staffed by a probation officer and a police officer. It operates between 4pm (or 6pm) and 2am, in an unmarked police vehicle, to undertake curfew checks, serve arrest warrants, and facilitates information sharing between Youth Probation and policing authorities. The Yankee 10 team get to know those young people who are often on the streets, those who are breaching their probation orders, those who have failed to turn up for appointments with their probation officer or at mandated programs. The Yankee personnel are in plain clothes, mature adults, with plenty of experience in their field.

Yankee 20, is another specialist vehicle. It comprises a police officer and a registered social worker. It operates during day light hours.

The current focus for the Vancouver Police Department is mental health. There is a “mental health” car for adults, operating day and night, comprising a psychiatric nurse and a police officer. It responds to all incidents involving mental health issues.

There has been a suggestion that there should be a mobile youth mental health team, comprising a mental health nurse, or counsellor, and a police officer, focused on youth on the streets, able to make an assessment and link the young person with services.

*Diversion and ExtraJudicial Sanctions in Calgary*

Ron Toner, responsible for diversion programs under YCJA in Calgary said that the introduction YCJA forced police to take a different role. Individual police officers may refer a young person to alternative measures. Through a computer based system called “Gateway” a young person may be referred directly to a program. Prior to a charge being filed, the Prosecutor needs to approve the extrajudicial sanction. If referred to diversion, and the youth completed the program, then the charge will be “withdrawn”

The YCJA also provides that a province may establish one or more youth justice committees to assist in any aspect of the administration of the Act, or services or services. Youth Justice Committees comprised of lay community members, 3 per committee, who volunteer to sit on panels. The role of the Youth Justice Committee

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140 In Canada the prosecuting authority is known as the Crown.
141 Information in this section based mainly on discussion with Mr. Ron Toner.
142 In other words the charge will not proceed.
is to give advice on appropriate extrajudicial measures, ensuring appropriate community support is available to the young person.

In Calgary there is a FASD Justice Coordinator, Marilyn Jerowski, who is available for consultation in respect of children, and youth, engaged in the criminal justice system suspected of being affected by FASD, or where there has been a diagnosis of a disorder within the umbrella term.

A specialized FASD group was established over a year ago to sit as a youth justice committee to deal with youth who are suspected of FASD or have been diagnosed already. In this way the youth may be referred, and supported to complete the diagnostic process and to appropriate intervention.

There are no statistics on the numbers of FASD affected youth referred to Diversion.

**New Zealand**

There are a number of alternative ways that a young person aged between 12 and 17 may be diverted from the court process in relation to offending behaviour.

There are 4 potential pathways that may be used to deal with a youth’s offending without the commencement of criminal proceedings. The first 3 options are initiated and managed by the police:

1. Decision not to charge,
2. Formal warning to the youth,
3. Diversion to Police Youth Aid where Alternative Action can occur,
4. Intention to Charge Family Group Conferences.

Options 1 &2 above are self-explanatory, and commonly available to police officers operating in countries with legal systems inherited from Great Britain.

Alternative Action refers to a process whereby Police Youth Aid gathers information about the youth’s background and circumstances, including visiting the home, if considered necessary. The Youth Aid officer will then meet with the youth and family so as to draw up a plan which may have restorative aspects to it such as letters of apology, reparation, community work and so on. The plan may also address the youth’s needs through attendance at various programs or support services, for
example school and/or counselling. Generally no screening of the youth occurs, no testing and no professional assessment.143

An Intention to Charge Family Group Conference (FGC) involves the convening of a FGC to work out the youth’s needs can be addressed. It is convened without charge/s having been laid. The Youth Justice Coordinator of the conferences has a statutory duty to take all reasonable steps to gather relevant information and advice to inform the discussion and decision-making at the FGC, including for example health and education information and reports. The coordinator may request a social work assessment. Generally that is more likely to highlight drug and alcohol history or mental health issues. Other sources of information may be a court-appointed Youth Advocate or previous court ordered reports, such as psychological or psychiatric reports. It appears there is no power to arrange an assessment of any suspected impairment.

The overall impression gained from speaking to various stakeholders in New Zealand is that as yet there is limited awareness and understanding of FASD among criminal justice professionals, and a limited number assessments of youth for FASD, or other neurodisabilities, occurring. The assessments which have occurred appear to have been done pursuant to an order of the Youth Court, so post the diversion stage, or instigated by the Ministry of Child, Youth and Family.

143 Peirse-O’Byrne, K, “Identifying and Responding to Neurodisability in Young Offenders” Honours thesis, June 2014, unpublished. This work has been the main source for the information re diversion options in New Zealand. The reference to “professional assessment” is intended to refer to clinicians, such as by a pediatrician, clinical psychologist and the like.
10. **Specialist Legal Services**

**Youth Criminal Defence Office, Alberta**

Legal Aid Alberta run a specialist legal service for youth involved in the criminal justice system: the Youth Criminal Defence Office (YCDO)\(^{144}\), established in 1993. It is separately housed to Legal Aid, and has offices in the 2 major cities of Alberta: Edmonton and Calgary.\(^{145}\)

YCDO is a different model of legal service. It comprises staff lawyers (16), youth workers (5), a social worker (1) and administrative staff to provide legal advice, representation and support to clients of the service, aged between 12 and 17 years, at an approximate cost of $CA4m.\(^{146}\) Lawyers can focus on conduct of the legal matter whilst other specialist staff are able to work with the client to address other issues such as homelessness, income support, addictions, other risk taking behaviours and so on.

Staff of the YCDO learn about the social, emotional and developmental issues of young people and have learned over many years to identify the red flags that may signal disabilities. Youth workers have received training in FASD, other disabilities, addictions and suicide prevention.

The model involves a team approach. A matter may start with a call, after hours, for legal advice for a youth under arrest. The staff lawyer on call will provide telephone advice, speak to the police and inform them of any disabilities, represent the youth on a bail application before a Justice of the Peace, if appropriate and brief Duty Counsel before Court the next day. A youth worker will be in court that day and assist in communication with the youth, family and/or caregiver.

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\(^{144}\) Based on discussion with Ms Cathy Lane Goodfellow QC, former Solicitor in Charge of the YCDO, in September 2013, meeting with the YCDO team in Edmonton in September 2013, and discussions with Ms Goodfellow, and meeting with the YCDO team in Calgary in April 2015. See also Lane Goodfellow, C., “How can a youth criminal defence advocacy model assist young people with FASD to navigate the justice system?” in Binnie, I., Trussler, M., & Jonsson, E., (Eds) Legal Issues of FASD: Proceedings from a Consensus Development Conference (2014) Institute of Health Economics, Edmonton.

\(^{145}\) YCDO represents between 70 and 80% of the youth defendants appearing in courts in Edmonton and Calgary.

\(^{146}\) See Lane Goodfellow, op.cit., p 113.
“Youth workers are the relationship builders”\textsuperscript{147}, with the youth, family/caregiver, service providers, government agencies etc., in order to support the youth during the legal matter, often when he/she is in crisis. Youth workers are knowledgeable about the services available in the community. At times the youth is homeless and the youth worker will be tasked with securing safe accommodation.

YCDO have been involved in a number of FASD-related initiatives, including participation in sentencing conferences to develop a sentencing plan for FASD affected youth, the plain English probation conditions initiative.

- ExtraJudicial Sanctions Program Committee, in Calgary, was trained to deal with FASD affected youth, and supported by a Youth Corrections Officer tasked as a FASD specialist (for internal capacity building purposes). A young person suspected of having committed an offence may be diverted by the committee to a sanctions program and if successfully completed the charge will be withdrawn.\textsuperscript{148}

- FASD Business Card - Some years ago, the YCDO printed business cards for use by clients affected by FASD.\textsuperscript{149} On the front of the card the name of the client of the service may be inserted and the person to whom the card is presented is invited to contact the YCDO, with space for the name of the lawyer to be inserted. On the other side of the card there is information for the police which explains that the bearer has FASD, which causes brain damage, invites the police to contact the person named on the front of the card to assist him/her, or indeed if the police require the co-operation of the bearer, and so on. The reverse side of the card reads:

\begin{center}
\textbf{MEDICAL INFORMATION FOR POLICE}

\textit{I have the birth defect Fetal Alcohol Spectrum Disorder, which causes brain damage. If I need assistance, or if you need my cooperation, you should contact the person listed on the back of this card.}

\textit{Because of this birth defect, I do not understand abstract concepts like legal rights. I could be persuaded to admit to acts that I did not actually commit. I am unable to knowingly waive any of my constitutional rights, including my right to counsel.}

\textit{Because of my disability, I do not wish to talk to law enforcement officials except in the presence of and after consulting with a lawyer. I do not consent to any search of my person or property.}
\end{center}

\textsuperscript{147} Ibid., p111.

\textsuperscript{148} Meeting at Calgary Young Offender Centre, a correctional facility for youth, in April 2015.

\textsuperscript{149} The card was supplied by YCDO lawyer Christopher R. McAviney at a meeting with the staff of the Calgary office in April 2015.
From my conversation with several staff of the YCDO it is clear that the card is not widely used, and there are some limitations with the concept. For example, whether the client will be able to ensure that the card remains in his/her possession, and remembers to use it when interacting with the police.
11. Different Approaches by Courts to Sentencing

This report is not the place to examine the criminal law jurisprudence regarding sentencing of FASD affected individuals however it is useful to broadly sketch the different approaches discernible in Canadian jurisprudence, regarding sentencing adults, by reference to several decisions.

The approach taken by His Honour Judge Lilles in R v Harper [2009] YKTC 18, in the Yukon Territorial Court, has been much quoted. Indeed his approach is reflected in the Consensus Statement on Legal Issues of Fetal Alcohol Spectrum Disorder, produced in 2013 following a juried process chaired by the Honourable Ian Binnie, retired Supreme Court judge.150

In R. v. Harper, 2009 YKTC 18, Lilles, J said:

[29] The purposes and principles of sentencing as set out in the Criminal Code assume that accused individuals are fully competent. The Criminal Code in s672, does recognize a very limited exception to criminal responsibility in the case of extreme cognitive impairments that prevent the accused from understanding the proceedings or to appreciate the consequences or wrongfulness of his or her actions. These exceptions are premised on the assumption that most mental disorders can be treated so that a person will eventually be found fit to stand trial or to present no substantial danger to the public and be released. These exceptions were developed several hundred years ago in the M’Naughten case when nothing was known about the complexity of the permanent brain damage that is Fetal Alcohol Spectrum Disorder (FASD).

[30] The cognitive deficits associated with FASD also challenge the basic assumptions of sentencing in the criminal justice system. The purposes and principles of sentencing in the Criminal Code assume that the offenders are capable of making choices, understand the consequences of their actions, and when punitive sanctions are applied, are capable of learning from their mistakes so as not to repeat them. General deterrence, meaning that the punishment given to one person for breaking the law will operate to deter other persons, presupposes the ability of those other persons to process and translate information as well as to remember it. Similarly, rehabilitation, as it is conventionally understood, is largely a cognitive process premised on the ability to understand, to learn, to remember and to make choices. None of these assumptions fit well with what is known about FASD, a permanent form of brain damage that can affect all parts of the brain, and as in the case of Mr Harper, can leave him functioning at the level of an 8 year old child.

Judge Lilles went on to refer to the requirement for the sentence imposed to be proportionate to “the degree of responsibility of the offender”, and asked rhetorically, “what does this mean for an offender who, like Mr Harper, suffers from an organic brain disorder that affects not only his ability to control his actions, but also his understanding of the consequences that flow from them?” [31]. Later in the judgement he commented:

[38] “Where FASD is diagnosed failing to take it into account during sentencing works an injustice to both offender and society at large. The offender is failed because he is being held to a standard that he cannot possibly attain, given his impairments. As noted by Judge Barry Stuart in R v Sam, [1993] YJ No 112 (T.C.) FASD takes away someone’s “ability … to act within the norms expected by society” at para 17 and it is manifestly unfair to make an individual pay for their disability with their freedom. Society is failed because a sentence calculated for a “normal” offender cannot serve the same ends when imposed on an offender with FASD; it will not contribute to respect for the law, and neither will it contribute to the maintenance of a just peaceful and safe society.”

Emphasizing the importance of expert evidence to courts dealing with FASD affected individuals, His Honour Justice Kilpatrick in R v Joamie NUCJ 2013, dealing with a FASD affected individual who had pleaded guilty to a sexual offence, said at [30]:

“A court cannot decide how an offender’s cognitive deficits may have impacted the offender’s degree of responsibility for criminal behaviour in the absence of expert medical evidence related to the offender’s specific cognitive condition. No conclusions can be made on the strength of vague generalizations derived from medical and scientific literature alone without any understanding of the offender’s individual cognitive deficits and their severity.”

Later on his judgement, underlining that point, his Honour said, “The Court must act on evidence, not intuition or guesswork” [58]

The Court was dealing with a young man, aged approximately 21 years at the time of the offence. He had been caught in the process of a sexual assault on a sleeping woman, before penetration occurred. At age 4 he had been diagnosed with FASD and had a minimal juvenile record.

In dealing with an offender with “FASD related cognitive deficits” His Honour concluded that a 2 stage process was required:

“The Court must first assess the moral blameworthiness of the offender in light of the impact that the cognitive deficits attributable to FASD had upon the offender’s behaviour. This assessment cannot be done in the abstract. Forensic medical or psychiatric evidence is required to understand how the offender’s cognitive deficits impacted his or her behaviour and so contributed to the commission of the offence before the court.” at [34]
The second step was to “seek to balance the need to protect the public on the one hand, with the feasibility of reintegrating the offender back into the community through alternative sanctions. Where specialized community based treatment programs are available for an offender that are sufficient to address whether such programs are likely to mitigate or reduce the offender’s risk of reoffending.” at [35]

“Then the court must seek to balance the need to protect the public on the one hand with the feasibility of reintegrating the offender back into the community through alternative sanctions on the other.” [36]

The Court went on to discuss the analysis required to determine whether a non-custodial sanction may be imposed in the event that community based programs were available. Where however, “there is no community based programming appropriate to the offender’s demonstrated needs and level of risk, there may be no practical basis to avoid or otherwise reduce a sentence of custody. This will be so particularly where there is evidence to suggest that the release of an offender with limited impulse control into the community will put the public at risk.” At [38].

There has been discussion in a number of cases about the application of sentencing principles of denunciation, and specific and general deterrence. In *R v Ramsay* [2012] AWLD 4417, the Alberta Court of Appeal at [23-25] said:

“Other courts, and in particular the Yukon Territorial Court, have addressed this issue. In *R v Harper* (citation removed), the court observed that “[t]he role of specific deterrence in sentencing FASD affected offenders decreases in proportion to the severity of the offender’s cognitive deficits” (at para 43). In *R v Quash*, 2009 YKTC 54 at para 70, [2009] YJ No 72 the Yukon Territorial Court noted that “[t]he greater the cognitive deficits of the offender, the less role specific deterrence should play”.

Where the cognitive deficits experienced by the offender significantly undermine the capacity to restrain urges and impulses, to appreciate that his acts were morally wrong, and to comprehend the causal link between the punishment imposed by the court and the crime for which he has been convicted, the imperative for both general deterrence and denunciation will be greatly mitigated (Quash at para 71; Harper at para 47). We agree with the observation of the court in Quash that:

‘That is not to say that the principles of general deterrence and denunciation have no place in sentencing FASD offenders. In certain cases there may be a role, depending on the nature of the offence and the degree of moral culpability of the offender, based upon the extent of his or her cognitive difficulties’ (at para 72).

The degree of moral blameworthiness must therefore be commensurate with the magnitude of the cognitive deficits attributable to FASD. The more acute these are shown to be, the greater their importance as mitigating factors and the less weight is to be accorded to deterrence and denunciation, all of which will serve to “push the sentence ... down the scale of appropriate sentences for similar offences” (for the
His Honour Judge Lilles in *R v Harper* 151 asked himself what sentencing principles were relevant. He said separation, where necessary, for the protection of society, but not necessarily gaol, and rehabilitation should be the primary focus of judges sentencing FASD affected offenders. He explained that separation should be achieved in a secure setting in the community. He noted that children under 12 years were not gaol, and under 18 were detained separately from adults. He opined that FASD affected individuals who function at the level of children should only be placed in gaol as a last resort, and then in a facility separate from adults in order to avoid victimization.

As to rehabilitation, His Honour was of the view that rehabilitation for Mr Harper must accommodate his cognitive disabilities and could not be achieved through typical offender programming. He said “It must involve individualized supports and a focus on improving his life skills through repetitive tasks done under supervision” [48].

In the first Nunavut case 152 to consider the sentencing principles associated with a FASD offender, the Court made the point that where the defence sought to rely upon a FASD diagnosis in mitigation of the sentence that would otherwise be appropriate it had:

> “an evidential burden to put before the court a forensic assessment that outlines the offender’s specific cognitive deficits and their respective severity. This assessment should be performed by a qualified medical or forensic specialist with some expertise in the field and not by a general practitioner. The forensic assessment should relate the offender’s specific cognitive deficits to his or her criminal responsibility. The risk associated with recidivism should be considered. The specialized resources needed to reduce the risk should be outlined.” at [39]

Further, the Court stated that it was incumbent upon the defence to identify resources inside or outside the Territory that might be employed as part of a non custodial sentence.153 Whilst acknowledging it would be difficult for defence counsel to structure an appropriate sentencing plan to present to the court due to the Territory lacking remedial resources the judgement asserted it was,

> “the criminal advocate’s responsibility in Nunavut, as in the rest of the Commonwealth, to fearlessly and tirelessly advocate for the public programs and services needed to address the basic needs of the disadvantaged, marginalized and under-represented citizens that are daily swept into the criminal justice system.” at [49].

151 2009 YKTC 19 at[48].
152 *R v Joamie* 2013 NUCJ 19.
153 op cit at [40].
"It falls upon defence counsel, not the Court, to find a sentencing alternative to custody for citizens of diminished responsibility. It falls upon defence counsel, not the Court, to identify the resources needed to address the offender’s special needs.” At [50]

Reflecting no doubt the Court’s frustration with the situation, His Honour Justice Fitzpatrick summarized the limitations it suffered as follows:

“The Court’s ability to structure a fit sentence is limited to those sentencing tools and sentencing resources provided by government. The Court cannot work miracles. It is the Government of Nunavut that has the legislative and constitutional mandate to determine funding priorities and allocate scarce public resources.” at [60]

Problem Solving approach in Saskatoon, Youth

Judge Sheila Whelan, of the Provincial Court of Saskatchewan has spoken of the experience of the Court in Saskatoon which has been ordering FASD assessments of persons up to the age of 25 since 2001. Since November 2013 there has been a mental health list for adults with FASD, other cognitive impairments and mental disorders. She says that the greatest progress has been made in the Youth Justice Court.

Her Honour has spoken of the need to adopt a problem solving approach, to be guided by crime prevention and therefore focus on the needs of the offender and the community, and on the underlying problems.

Her Honour has addressed the issue of what is in the judges toolkit when dealing with cases involving FASD affected individuals, and identified the following in particular:

- In terms of process, the judge’s responsibility to slow the pace, check for comprehension, ensure that the process accommodates for communication and processing difficulties.
- In terms of crafting a sentence, the judge’s capacity to seek further information where necessary, the involvement of community agencies and use of community resources in the development of a plan, focus on “safety first community based sentences”, require reporting back or follow up to reinforce the plan and ask practical questions directed to who will be responsible for different parts of the plan.

155 referred to as “docket” rather than “list” in North America.
Judge Whelan has identified the following priorities:

- The need for education of persons working with FASD affected individuals, and the community,
- The need for early screening, diagnosis and assessment in health, school and justice,
- Accessible holistic diagnosis and assessment,
- Integration and coordination of programs,
- A seamless approach to support beyond the justice system,
- Advocates and supports for FASD suffers and their families.

In R v Charlie 2012 YKTC 5 His Honour Judge Lilles considered the circumstances of an offender who had been convicted of robbery, committed in company, at age 26 years, although he was diagnosed with fetal alcohol syndrome, and considered to be between 10 and 12 years, developmentally. Charlie was sentenced to 6 months imprisonment, taking into account 27 months already served whilst on remand, for an effective sentence of 2 years 9 months to be followed by 3 years’ probation.

His Honour had the benefit of a “psycho-educational assessment”\textsuperscript{156} which detailed Charlie’s limitations.

His Honour’s expectation was that Charlie’s remaining time in custody should be devoted to preparing a transition plan.\textsuperscript{157} He said:

\begin{quote}
[42] It is my expectation that during the remaining time of his custodial sentence his Probation officer, health and Social services, his parents, his First Nation, FASSY, and other supporting agencies will work together to develop a treatment, supervision and support plan to take effect upon his release. It is imperative that a transition plan be put in place before he is released, and that there are responsible individuals present on his release to receive him. I am respectfully requesting that Mr Charlie be brought back to Court on March 16 at 9am for a review of the transition plan. It would be helpful if those individuals and agencies working with Mr Charlie, including his parents, could be present at the time.”
\end{quote}

The importance of understanding the neurological functioning of a young person involved in the criminal justice system, in order to make “good youth justice decisions” is well recognized by Courts, justice professionals and key agencies.\textsuperscript{158}

\textsuperscript{156} Report was by MediGene, a FASD clinic based in Calgary, model referred to elsewhere in this report.

\textsuperscript{157} Charlie was sentenced for robbery in April 2014 in R v Charlie 2014 YKTC 17. The appeal decision is at 2015 YKCA 3.

\textsuperscript{158} Judge Fitzgerald; Peirse-O’Byrne, K, op. cit., p14 drawing on qualitative research by Alison Cleland published in “Focus on welfare: The Importance of Personal Information to Youth Justice Decisions in Aotearoa/New Zealand [2012] NZ L Rev 573 at 578.
Since June 2015, every Youth Court in New Zealand has a forensic mental health presence on the “list day” day. Over 5 years, since the announcement of the initiative in November 2011, the New Zealand Government have invested $33 million into Youth Forensic Services (“YFS”), which are specialist mental health and drug or alcohol services for young people with mental health disorders, alcohol or drug problems and intellectual disabilities who are involved in the youth justice system.

The mandate of YFS includes screening and assessment of youth offenders, court liaison services, delivery of specific mental health and drug and alcohol treatments, clinical care for youth in residences and specialist consultation for health and justice personnel. The investment has resulted in a doubling of the workforce.

The New Zealand initiative reflects an appreciation at governmental level of the prevalence of underlying mental health conditions in youth involved in the criminal justice system, and is aimed at early, and effective, intervention. In announcing the new service Associate Health Minister Jonathon Coleman said:

“identifying and addressing alcohol and drug issues, as well as any underlying mental health conditions, as part of the court process could help turn young lives around…the new services will help to improve youth mental health and break the cycle of offending by ensuring early intervention, and where necessary, treatment in a secure environment.”

When the author observed the Youth Court in Auckland in May 2015, there was a representative of YFS seated at the bar table, available to offer initial psychological or psychiatric screening as required for any young person appearing in court on the day, provide information required by the court and ensure implementation of any court orders. There has been some comment that there is no statutory or regulatory guarantee of screening on entry to the court system, and no national framework for the type of screening undertaken. Best practice standards are however being developed.

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159 The author is indebted to Judge Fitzgerald, based at the Youth Court in Auckland, for hosting her at the Youth Court on 19 May 2015 when he was presiding in the Youth Court, specifically the Intensive Monitoring Group Court, and otherwise sharing his knowledge and wisdom about youth justice, including introducing her to the concept of Rangatahi courts. The information in this section is based in part on discussions with Judge Fitzgerald and an email on 3 August 2015, unless otherwise acknowledged.

160 See Peirse-O’Byrne, K., “Identifying and Responding to Neurodisability in Young offenders: Why, and How, this Needs to be Achieved in the Youth Justice Sector, (June 2014), unpublished Honours LL. B. dissertation, University of Auckland at p15.

161 Email from Judge Fitzgerald on 3 August 2015.


163 Peirse-O’Byrne, K, op. cit., p34.

164 Ibid., p35.
Education Officers attend the Youth Court on “list” day at 8 of the largest volume Youth Courts in New Zealand and 5 Rangatahi Courts.\textsuperscript{165} They are able to provide information to the Court on the youth’s educational experience, and arrange written reports for future court appearances. In these courts Education Officers have electronic access to their departmental database. In other Youth Courts, written education reports are submitted which address the young person’s education history, and other relevant information such as “stand-downs due to cannabis use, violent behaviour or chronic truancy”. Judge Tony Fitzgerald, of the Youth Court in Auckland, has found the education reports very useful. The information may for example prompt an order for formal screening of the youth, or the preparation of a particular type of report by YFS, flag the need for further investigation, or intervention of a particular type.

\textsuperscript{165} A Rangatahi Court is a Youth Court conducted on the marae, the traditional place of Maori. The cultural context is the critical or fundamental component here. That context offers the opportunity for learning about Maori tradition, practice and responsibilities as a member of the community. “The expectation is that whānau (or family), will be present to support the young person and to help resolve his or her offending and bad behaviour”, Dickson, M. (2011). The Rangatahi Court, \textit{Waikato Law Review}, 19, 86-107.
12. Strategies used in Courts with FASD affected Defendants

In this section reference to some of the practical steps, strategies or procedures used in Courts to deal with FASD affected individuals, are referred to. The discussion below, based on His Honour Judge Jeffries practice relates to adult defendants however it is equally applicable to youth, and instructive of the difficulties, and system barriers, especially in regional locations.¹⁶⁶

Superior Court, Barrow, Alaska

Jefferies, J has spoken¹⁶⁷ and written¹⁶⁸ about the need to develop new approaches for persons appearing in court who may be affected by FASD. Accommodating persons with a cognitive disability is both a human rights issue and a due process issue. He writes:

“Despite the pressures on time and energy, courts must do their best to be understandable, and to be respectful of such persons appearing before them. Failure to do so implicate ethical requirements for both attorneys and judges to insure that persons involved in the justice system understand what is happening to them ... Fetal Alcohol Spectrum Disorder impacts the entire justice system …”¹⁶⁹

Some of the techniques used or adaptions made in a regional court setting include:

- He does not assume that there has been effective communication between the defendant and counsel, and does not try complete the hearing quickly.
- He takes the time to completely explain to local participants what is going on, including at times, taking a break in proceedings to allow a FASD affected person to process what he/she has heard before further information is provided.
- He avoids legal jargon as much as possible, uses clear, concrete language and a more informal tone, noting that the developmental age is likely to be much younger than the chronological age.
- Respect for, and being conscious of, cultural influences which affect many court participants, whether or not they are affected by FASD.
- Each of the Court and defendant must focus on each point, eg each of the bail conditions or obligations/conditions of probation or any community based order.

¹⁶⁶ The author was fortunate to meet, and hear Judge Jeffries speak, at the Vancouver FASD Conference, March 2015.
¹⁶⁷ Ibid.
¹⁶⁹ Ibid., p 614.
• Adaptation of commonly used court forms so that plain English, concrete language, more white space, and a larger font is used. Further, forms require the defendant to insert their initials, to signify agreement to each condition, or obligation entered into, eg conditions of bail, probation or community based order.

An example of the plain language utilized in the court form used by the Superior Court at Barrow\textsuperscript{170}, for the release on the defendant’s own recognizance is:

\begin{quote}
OWN RECOGNIZANCE. I can get out on my "own recognizance." This means: I don’t have to give any money right now. I promise to come back to court or jail. I also promise to follow all the promises in this form. The police could arrest me if I do not come back to court or follow all the promises.

My initials: [________]
\end{quote}

In a context where a FASD diagnosis is rare, Jeffery, J has tried to identify suspected FASD cases, whilst making it clear that he could not diagnose from the bench. The indicators he used to tell whether a person was probably affected by FASD were:

- Comes from an alcoholic family;
- Frequent contact with the justice system, especially similar types of offences and frequent bail or probation violations;
- Impulsive behaviour demonstrated in current situation and/or prior record;
- Often a follower in criminal incidents; but is the one who is caught;
- History of problems with school, including having an individualised education plan, or dropping out of school early;
- Has many mental health diagnoses;
- Short stature;
- Facial appearance;
- Multiple foster home placements;
- History of inappropriate sexual behaviour.

Jeffery, J has spoken about the sensitivity required when discussing FASD in the courtroom, with the defendant, especially when parents are present. He gave an example of the way he may approach the matter in court, as follows:

\textsuperscript{170} Ibid., p595.
Consideration was given to establishing a therapeutic court program to deal with FASD affected defendants and those with other mental health challenges. Although that has not gone ahead there have been 2 other initiatives:

- The Barrow Misdemeanour Resources Project (BMRP) – for adults. Referrals are from the court to the BMRP case manager for assistance in complying with probation conditions immediately, or prior to release back into the community at the end of a prison term. A locally developed mental health screening tool is used, then the probation conditions are reviewed and assistance provided to contact local treatment programs for assessment. If the screen suggests possible FASD the defendant is assisted to make contact with support services and family counselling about guardianship/administration may be provided. Appointments are made to monitor progress. The aim is to facilitate comprehension and compliance, and provide greater support to avoid, or minimize multiple breaches and escalation of penalties.

- For about 2 years, the magistrate based at the Court maintained a program of “monthly compliance hearings” in order to hear from treatment providers and misdemeanour defendants whose probation orders included treatment conditions. Compliance reports were sent to the court by treatment providers and would be reviewed in open court with the defendants. This court based program was based on research which demonstrated the value of ongoing contact, for defendants with mental challenges, with a judicial authority figure. Workload issues and concern by the court administrator about an adverse impact on the program’s treatment relationship with the client caused the program to be suspended.

Effective intervention in Barrow has been hampered by the lack of diagnostic capacity. A quarterly mobile diagnostic team from Anchorage to Barrow was seen as a way of building capacity and expertise in the regional centre, and serving as a model for other rural hub communities.

Judge Jefferies identified some additional barriers, at the system end, to improving outcomes for FASD affected defendants:

- Delivering adequate training to justice system professionals, especially those in regional or remote areas;

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171 ibid., p598-9.
172 ibid., see p602.
173 ibid., p609.
• Turnover of staff in community based corrections, in regional and remote areas can be high;
• Delays between charges filed and consequences imposed, making it more difficult for FASD affected persons to relate consequences to actions;
• Whilst a narrow focus on limited goals might lead to success for a FASD affected young person, lengthy bail orders, case plans, and/or probation conditions make it very difficult for the person to comply;
• Pressures on court staff to complete data entry, and do so accurately, is antithetical to slowing court hearings down so as to facilitate comprehension, and therefore compliance;
• The lack of resources to provide enhanced structure for a FASD affected person, such as an external brain to aid compliance;
• Professional, including judicial officers often do not have sufficient information to understand “how intensely a particular individual is affected by FASD”\textsuperscript{174}

As of 2010, the primary objectives of the FASD program of the Alaska Department of Health and Social Services, Division of Behavioural Health, included diagnosing children as early as possible and improving lifelong outcomes for FASD affected individuals through improved services, which it recognized required partnership with families and caregivers, and a range of disciplines.\textsuperscript{175}

**Sentencing Conferences**

FASD Justice Support Projects For Youth in Edmonton and Calgary. The project in each city consists of a court ordered conference for a young person, in conflict with the law, who has a FASD diagnosis or currently involved in the assessment process with the intention of “build\[ing\] a life plan of structure and support for the young person based on her/his level of functioning, and identified needs and future goals.”\textsuperscript{176}

The Conference is ordered pursuant to section 19 of the Youth Criminal Justice Act 2003, as amended. Section 19(2) provides:

> “The mandate of a conference may be, among other things, to give advice on appropriate extrajudicial measures, conditions for judicial interim release, sentences, including the review of sentences, and reintegration plans.”

Prior to the Conference the co-facilitators, the YCDO Social Worker and the FASD Program Coordinator, Alberta Justice and Solicitor General’s office, review relevant

\begin{itemize}
\item \textsuperscript{174} ibid., p613.
\item \textsuperscript{175} http://dhss.alaska.gov/dbh/fas/Pages/default.aspx
\item \textsuperscript{176} Drawn from the Project Outline and Description provided by Marilyn Jerowsky at a meeting with her, Charlotte MacDonald-Allan, Program Director, Calgary Young Offender Centre on Calgary Young Offender Centre, Calgary, Alberta, in April 2015.
\end{itemize}
documentation including any reports/assessments, interview the young person and
the identified supports in his/her life and identify areas of unmet need. Relevant
government and community organizations, and the support person/s are invited to
the Conference to discuss how the youth’s needs will be met, and goals achieved.
Suzanne Johnson, Director of Medigene Services and Genetics, the diagnostic
clinic, will start by discussing the diagnosis and recommendations of the diagnostic
team.

A comprehensive report is prepared for the Court within 4 weeks of the order, filed
and distributed to the Crown prosecutor and defence Counsel before the sentencing
hearing. The co-facilitators remain involved with the youth, through follow up until all
criminal matters are finalized.

The Court will receive a pre-sentence report and the plan from the case
conference. This initiative has been operating since 2010. Anecdotally it was
estimated that 75% of the referrals to the Conference were Aboriginal.179

The FASD Justice Support Project has been running in Edmonton for 7 years and
dealt with approximately 50 cases. The project in Calgary has been running for 5
years and completed 42 cases, 5 of those in 2014. In total, 90 cases have been dealt
with through these projects.

The “Cross-Over List”/Intensive Monitoring Group New Zealand

Within the New Zealand Youth Court, and justice professionals, there is a recognition
that youth offenders often have concurrent care and protection issues, that those
issues may be related to the offending, and that there may be underlying
neurodisabilities. In New Zealand, as in many other jurisdictions in recent decades,
care and protection, or welfare issues, have been dealt with separately to youth
offending. Criminal matters have traditionally been dealt with in the Youth Court and
care and protection issues, in the Family Court, sometimes by different judges. The
separation of these jurisdictions is problematic for the youth and is antithetical to
ensuring holistic and effective interventions which are likely to reduce recidivism.

177 Organizations who participate in the project, in Calgary, include Calgary Police Service, Calgary Board of
Education, MediGene Services and Genetics Clinic, Alberta Health Services, City of Calgary Youth Probation,
Calgary Youth Offender Centre, Calgary Fetal Alcohol Network, Calgary John Howard Society, McMan Youth,
Family and Community Services and Calgary and Area and Family Services.
178 ibid., p111-2.
179 Estimate by Ms Marilyn Jerowsky, one of the co-facilitators in Calgary.
180 Discussion with Judge Fitzgerald on several occasions including 19 May 2015. See also IMG Protocol dated
April 2013, provided by Judge Fitzgerald. See also Peirse-O’Byrne, op.cit. p49.
Some years ago Judge Fitzgerald initiated the Intensive Monitoring Group or IMG Court as a solution focused court for youth offenders. Young offenders who have “care and protection” status attend a “cross over list day”, when a Youth Court Judge with a Family Court commission will address justice, and care and protection, issues at the same hearing. Offenders who meet additional criteria may remain in the cross over list which involves intensive case management by the court, including fortnightly monitoring of the youth’s compliance with the Family Group Conference plan, using a non adversarial approach, with a multi-disciplinary team. Cases in the IMG Court have judicial intervention at a much earlier point to oversee the Family Group Conference plan, monitor service delivery to the youth and family, and the youth’s progress.

This combination of intensive case management, therapeutic principles and involvement of a multidisciplinary team appears well suited to more complex cases where youth are affected by FASD or other neurodisabilities.

Plain English in Calgary, Alberta and Regina, Saskatchewan

An initiative to convert the “legalese” of probation orders to plain English was pursued by the Youth Criminal Defence Office (“YCDO”) in Calgary, Alberta. YCDO engaged a specialist to translate probation conditions to plain English.181 The exercise was overseen by a committee comprising the Provincial Justice & Solicitor-General’s office, professionals who undertake assessments, probation officers and a representative from the Calgary Young Offender Centre. Although agreement was reached on the plain English substitute for the probation conditions, resistance has been encountered from the Provincial Court, preventing implementation of the plain English version. The initiative has stalled.182

A similar initiative has been instituted by Judge Toth in the Provincial Court of Saskatchewan. In his version, everyday language is used in bold, large font, underneath the formal language of the standard order. For example underneath the standard condition for adults, “Keep the peace and be of good behaviour” are the words,

“Stay out of Trouble”.183

On the Deferred Custody and Supervision Order for youth, the same obligation, keep the peace etc. is translated as, “Be Good”.184

181 Vecova Centre for Disability Research, Calgary, utilized a multidisciplinary team to undertake the translation, and reported in writing on 18 September 2013. Documents provided to author, including proforma plain English probation order in April 2015.

182 Reported by range of stakeholders from different agencies, government and community.

183 Judge Toth’s version of the standard probation order, provided to the author.
This is Me – Life Book, an initiative of the Manitoba FASD Justice Project

The main goal of this project is said to improve the quality of life for the FASD affected youth within the criminal justice system.

Over a period of time, the co-ordinator works with the young person to understand themselves, in light of the diagnosis, and facilitates the young person to have their voice heard through the medium of a book, they create, about themselves so as to tell others, such as caregivers, staff and service providers about their life, their personal views, likes and dislikes - told in their own words, with drawings and clip art. Typical chapter headings are: what I want people to know about me; my goals and plans; my circle of support; and, what helps me to have a good sleep; Other topics youth are encouraged to think about and cover are: what makes me angry and what helps to calm me down.

It can take between 4 and 25 hours for the young person to complete their book. In the first 3 years of the project more than 40 youth participated. Some have continued to update their books.

The “This is Me” Book may be used in Court, at school, with service providers. The book aids the youth in communicating with others when they find themselves in a new environment such as a new school or group home, facilitates better understanding of the young person and the need for others to adapt the environment to accommodate for any impairments, including any sensory issues.

Probation icons

With the assistance of graphic arts students, and in collaboration with youth at the Winnipeg Custody Centre, a set of icons have been developed to provide a visual clue to each of the obligations usually included in a probation order (See appendix D)

Depending upon the particular youth, the coordinator may recommend the use of icons to the probation officer as a tool to enhance comprehension and committing the obligation to memory, or at least prompt recognition when the icon is sighted. A set of the icons appears as an annexure to this report.

184 Standard order, annotated with plain language provided by Judge Toth.
13. Intervention in Criminal Justice

Context

The FASD Youth Justice Program in Winnipeg identified that existing programs to deal with substance abuse failed FASD affected youth. With funding from Justice Canada the Starfish Pilot Program is developing a new model.

Starfish Pilot Program

Addictions Foundation of Manitoba (AFM) have found it very difficult to make their service accessible to FASD affected youth who have problematic substance use. The Starfish Project is a collaboration between an addictions specialist, AFM and Youth Corrections to develop a more effective way to work with the target population. The existing model had failed.

Participation in Starfish is voluntary. Participants may be on bail, on probation or in custody. The model involves participants receiving one on one counselling, participating in small groups and attending recreation and leisure activities. However, staff in the program may tailor involvement according to the needs and challenges of the youth at any particular point in time. Participation is encouraged through relationship building, by providing transportation, appointment reminders via text or phone, meeting in places convenient to, and comfortable for, the youth, at the initiative of the latter or the coordinator, offering food and support beyond the confines of the narrow issue of substance abuse. Youth may move between custody and the community during their participation in the program. The project is designed to enable programming to move with the participant through the different systems as the youth’s needs change.

The program’s maximum caseload at any one time is a maximum of 30 young people. In late April 2015 there were another 12 on a waitlist. In the first year of a 3 year pilot 31 youth have been serviced.

The engagement with any individual young person may be up to a year or more.

The project is developing a model for working with this cohort to overcome substance abuse. It has conceptualized the journey as 3 stages that the youth moves between:

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185 Information in this segment is based on a discussion with Ms Catarina Witt, Program Development and Implementation Specialist (Addictions) and Lorraine Brake, Project Coordinator (Corrections) on 27 April and written material provided.
• Sitting and talking about the alternative to substance use, what would life look like,
• Setting goals, planning action that needs to be taken, working on harm reduction and abstinence,
• Participation in active treatment, when stable, well connected to supports.

Stage 1 & 2 involve intensive involvement with the youth, and assistance to deal with basic needs. It is not a simple progression from one stage to the next. Life is often too chaotic and unstable to focus on the issue of substance use. Youth may move back and forth between all stages, as circumstances change.

Many of the young people are in care. Often placements break down. When the young person is in custody the “carer drops off the map”. A coordinator will commence work with a young person while they are in custody and maintain their contact and support upon release to the community, following them to their new placement. If the youth turns 18 then the coordinator can help support them to establish eligibility and access adult services.

Involvement in the program offers an opportunity to assist the youth to better understand the impact of FASD on their functioning, encourage them to accept supports and focus on strengths.

The program involves intensive support and engagement. It is a work in progress that offers much promise.

Research to Improve Efficacy of Substance Abuse Programs

The McCreary Centre published research in 2014, which sought to better understand the barriers to more effective intervention, regarding substance abuse, with FASD affected youth. Characteristics inherent in FASD, such as understanding abstract concepts, attention span, impulsivity and understanding cause and effect relationships make it more difficult to succeed in traditional treatment programs.186

The research project involved interviews with 50 youth, (60% male) aged between 14 and 24, living in urban and rural areas, and in a range of settings: residential or treatment centre, housing programs, etc., and 55 caregivers and service providers and consolidating that with previous surveys of FASD affected youth it had undertaken, thus representing the voices of 260 FASD affected youth and 55 caregivers and service providers. The authors compared that data with results from the

2013 Adolescent survey completed by 29,832 students attending mainstream schools in British Columbia.\textsuperscript{187}

This appears to be a valuable resource for addiction services as a guide to the life experience and profile of FASD affected youth so as to adapt their service delivery model to cater for this cohort.

Key findings of the report\textsuperscript{188} (the Report), included:

\begin{itemize}
\item Youth with FASD experienced a number of risks and challenges, particularly when compared to youth without the condition, including unstable home life, challenges at school, physical and sexual abuse, victimization, mental health issues and negative peer influences.
\item Youth with FASD were more likely than their peers to be in conflict with the law. The example given: among youth aged 12-19 in mainstream schools, 17\% of those with FASD had been detained in a custody centre at some point, compared with 1\% without FASD.
\item Youth with FASD were more likely than peers without the condition, to have used a variety of substances eg, cannabis, cocaine, crystal meth, heroin, inhalants, hallucinogenic mushroom, amphetamines, prescription medication without doctor’s consent. They were also more likely to have first tried alcohol or other substances at a younger age. The example given: 27\% of those in mainstream schools had their first drink at age 9 or younger compared to 5\% of youth without FASD.
\item Project participants identified barriers to accessing services, and obstacles within some programs which impeded successful outcomes including lengthy waiting times; lack of knowledge about FASD among provider and program staff; lack of program flexibility; unrealistic program expectations; age related barriers; use of group settings which contributed to FASD youth feeling overwhelmed and over-stimulated.
\item FASD affected youth more likely to have missed out on mental health services because of previous negative experience.
\end{itemize}

Promising practices, supports and protective factors were identified as being linked to reduced substance use and other health benefits, including FASD-informed and trauma-informed approaches, individualized support and program flexibility, structure and consistency, a strengths-based approach, focus on skill development and youth involvement in their own treatment planning and goal setting.\textsuperscript{189}

\begin{itemize}
\item Supportive adults played a key role. Youth with FASD who felt there was an adult in their neighbourhood or community who cared about them were less likely to report binge drinking in the past month and to have ever used a variety of other substances;
\end{itemize}

\textsuperscript{187} ibid., p7-8.
\textsuperscript{188} Ibid., p5-6.
\textsuperscript{189} Most of these are strong elements in the Starfish Program in Winnipeg, Manitoba.
Being involved in meaningful community activities was linked to higher rates of self-esteem among FASD affected youth, lower reporting of binge drinking in the last month and having been in custody. Among youth in alternative-to-custody programs, those employed were less likely to report having been arrested, charged with a crime, or having been detained in custody one year later. Involvement in sports and other physical activities, and spending time outdoors contributed to youth feeling good about themselves and reduced substance use.

The Report’s overall conclusion is that substance abuse treatment programs for FASD affected youth should be holistic and address the wide range of factors that might be influencing a young person’s substance use.

**Calgary Serious and Habitual Offender Program**

The City of Calgary has a Serious Habitual Offender Program ((SHOP), operated by the police and working with key community organizations.\(^{190}\) It is a crime intervention program focusing on prevention, reduction and enforcement, targeting habitual youth, and young adult offenders between the ages of 12 and 24.\(^{191}\) The SHOP team monitors approximately 120 offenders at any time. Potential targets are selected and referred to SHOP by a multi-disciplinary resource team. After selection police develop a profile of each youth, looking at the criminal history, their family background, living conditions, psychological history and other relevant factors.

SHOP officers monitor activities and investigate offences committed by these youth. The program website\(^{192}\) states:

> “The officers focus on ensuring the young people have access to rehabilitation programs and, once any sentence has been served, assure their compliance with court orders and connect them with others who can help integrate them into society”

When considering which offenders should be included in the program, factors such as the following may be considered:\(^{193}\)

- Educational risk factors;
- Family risk factors (eg abuse, criminality)

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\(^{190}\) See website at fn 120. Partners are identified as Crown Prosecutors office, CYOC, Calgary and Area Child and Family Services, City of Calgary Youth Probation Services, Calgary Board of Education, Calgary Catholic School Board and various group homes and outreach social agencies.

\(^{191}\) City of Calgary Police Service website: www.calgary.ca/cps/Pages/Youth-programs-and-resources/Serious-Habitual-Offenders-Program-SHOP/Serious-Habitual-Offender-Program.aspx

\(^{192}\) ibid, same website.

\(^{193}\) ibid., same website.
• Substance risk factors
• Number, type and seriousness of offences committed
• Time between charges
• Date last charged
• Degree of violent involvement in past offences (risk to public safety)
• Amenability to supervision, treatment and intervention
• Youth risk factors, eg mental health
• Involvement in structured activities
• Persona (eg co-operative, social skills)

SHOP was raised in the context of early intervention by police with young people identified as at risk. The factors identified above are likely to cast a net which will capture youth with neuro-disabilities including FASD. No recent evaluation of the program, and particularly whether it has referred relevant youth for FASD assessment and the impact of the program on any FASD affected youth has been located by the author.

Other

FASD- Specific Programs Available to Courts.

Judge Cook Stanhope of the Alberta Provincial Court, based in Calgary, said there were no programs specifically tailored to FASD affected youth.

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194 SHOP raised in meeting with Ms C MacDonald Allen and colleagues at CYOC as being a program that may be invited to participate when case planning for youth in custody.
195 Canadian Research Institute for Law and the Family conducted 3 year study of youth offending in Calgary, commencing in 2006.
196 Meeting with Judge Cook Stanhope, at Provincial Court, April 2015.
14. Indigenous Programs

Native Court Workers – Vancouver, Winnipeg and Whitehorse

Native Court Workers, Bert Keeper, of the Ojibway Nation, Treaty 5 and Brenda Fontaine, of the Cree Nation, Treaty 1, are based at the Manitoba Youth Centre (MYC), a correctional facility. There are 13 native court workers in the team, distributed between offices in Winnipeg and 7 other sites in Manitoba.

The role of native court worker at MYC includes supporting Aboriginal youth in custody, attending youth courts in Winnipeg and on circuit to regional and remote locations so as to offer assistance to any Aboriginal youth and their families to understand the court process, obtain legal advice by completing a referral and any application required, if necessary speak in the language of the youth to explain the court process, and assist the court to better understand any cultural or family issues.

When asked whether any specific strategies were utilized with Aboriginal youth in the FASD Justice Program, Winnipeg, one coordinator replied that they did not wish to perpetuate negative stereotypes and that the approach taken is universal, that is the objective is to identify strengths and needs, and develop a plan tailored to the individual; that the primary purpose was addressing FASD, and doing what was necessary to address that.

Nogemag Project

The Nogemag C.A.R.E. Project has offered many different programs since it began in 2002. It is a charitable association dedicated to the development of First Nations youth and their communities, “in body, mind, heart and spirit.”

The Project works in partnership with the Elsipogtog Band and the Elsipogtog School in cooperation with other agencies. It is funded by Justice Canada. It utilises traditional cultural concepts and principles to develop and deliver programs for youth with “invisible disabilities whose behaviour is often misunderstood.”

197 The Government of Manitoba refers to the court worker program, as the Aboriginal Court worker Program. “Native” appeared to be the preferred description of the role in my observation.
198 http://www.nogemag.ca/
199 Ibid. Dr Lori Vitale Cox –speaking at the FASD Conference, Vancouver, 2015 spoke about the success of intensive work done with at risk youth as part of the Nogemag Project which has brought significant social and educational gains for individuals and families and improved the wellbeing of the community.
It is a strength based program, designed to build on the strengths of youth while simultaneously building the capacity of family and the community. Youth mentors and counsellors from the community are hired to work alongside youth at risk. Parents are also encouraged to participate in the project in various capacities. The aim is to develop skills and to empower youth and families.
15. Special Measures for FASD affected Youth in Custody

The Calgary Young Offender Centre (CYOC) houses male and female youth, between 12 and 17 years of age, on remand or while serving a custodial sentence.\(^{200}\)

Co-located with CYOC is the Calgary Youth Attendance Centre and the City of Calgary Youth Probation. These services provide educational and treatment programs and supervision of youth on community supervision and probation orders.

Since the commencement of the Youth Criminal Justice Act in 2003, with its emphasis on diversion the police have changed the way they deal with minor matters. The police may divert the youth without charge, using a police database system,\(^{201}\) which acts as a gateway to community based organizations that deliver appropriate programs, eg an addictions service to address the underlying substance abuse issue.

Alternatively a charge is laid and the youth is referred to the Youth Justice Committee, which is a committee of 3 community volunteers who conduct a meeting with the young person and caregiver/s to deal with the matter in a less formal manner, discuss the youth’s circumstances, eg school attendance and performance, substance abuse, family circumstances to establish whether there are underlying issues and what intervention and /or consequences would be appropriate. A plan of action is developed and, subject to satisfactory completion, the Crown determines whether to withdrawn the charge.

Since about mid-2014, a special panel of community members who have had training regarding FASD sit as the Youth Justice Committee to deal with any youth suspected of being FASD affected. A different approach is taken. There will be a lot more mentoring over a period of time, and an effort made to put supports in place. The parent may be referred to a community based organization, Enviros, which provides FASD-specific support for parents and caregivers.

No statistics are kept on the numbers of FASD affected youth who are diverted from the criminal justice system. Anecdotally it was said that 3 or 4 per 100 diverted were suspected of being FASD affected and referred to the special panel of the Youth Justice Committee.

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\(^{200}\) Serving secure custody. Open custody, that is requirement to stay at a group home is accommodated in the City, not at CYOC.

\(^{201}\) PIMS, Police Information Machine System.
Calgary Youth Offender Centre (CYOC)

Approximately 900 youth are admitted per year. The average stay is between 2 and 3 weeks. Seventy (70%) of those admitted are on remand, rather than sentenced.

On 24 March 2015 there were 77 in custody. Typically it is between 70 and 80 on any day. Ten to fifteen (10-15%) per cent are female. The female population rotates through quickly. By way of snapshot of other demographics,\(^{202}\)

- average age of male, 16.3
- average age of female, 15.5
- 5% over the age of 18
- 35% Aboriginal, 16% other ethnicities
- average length of stay for sentenced youth in custody 51 days
- 88% of youth are in custody 92 days or less
- 3% of youth spent a year or longer in custody.

At intake health, mental health and educational standard are assessed. Within 24-48 hours the youth will have been assessed and placed in the school, where youth are grouped according to age and ability.

Case management of the youth begins from his/her arrival. Issues associated with offending behaviours need to be identified, and a plan developed to address those, promote rehabilitation and prepare youth for reintegration in the community.

There are a large number of programs available to youth at CYOC, delivered either by staff of CYOC, external government and/or community agencies. These programs\(^{203}\) include:

- addictions counselling - including individual, family or other groups
- self-development, covering a wide range of topics including positive self-concept, effective communication, healthy relationships, violence prevention, conflict resolution, relapse prevention, bullying, stress management, victim impact, empathy, fatherhood, personal safety for females, “the baby project”, financial planning etc.
- Aboriginal Programs – including Elder Services, Individual Counselling, Spiritual Guidance, Smudges, Sweat Lodge Ceremony, Arts and Crafts and so on.
- Recreational programs
- Community Partner Programs covering a wide range of activities, and interests including the Aboriginal Friendship Centre, Boy Scouts, Girl

\(^{202}\) Published by CYOC, material supplied to author.

\(^{203}\) The programs referred to are drawn from an internal CYOC document which lists all programs available supplied to author.
Guides, Youth Employment Centre, Duke of Edinburgh, Calgary Sexual Health, McMan–Life Skills

- Transitional services – support with respect to finding accommodation, job search, transport to appointments.

When a youth has been diagnosed with FASD, CYOC will access that assessment\textsuperscript{204} and then invite a local FASD expert in to meet with the staff and work out how best to work with the young person recognizing their strengths, taking a positive and proactive approach. The question asked by CYOC is “what do we need to do?” in the context of the disability and the principles embedded in the Youth Criminal Justice Act (2003), which include:

\begin{itemize}
  \item prevent crime by addressing circumstances underlying young persons’ offending behaviours; and
  \item rehabilitate young persons who commit offences and reintegrate them into society.\textsuperscript{205}
\end{itemize}

FASD prevalence in the youth custodial population was estimated to be 35-40\% by comparison with 1.5-3\% of the general population.\textsuperscript{206}

There is a school on site, West View School\textsuperscript{207}, staffed by the Calgary Board of Education, which operates year round. Staffing includes a principal, assistant principal, 13 teachers\textsuperscript{208}, 2 educational assistants, a career practitioner, justice liaison worker, administrative and library staff.

One of the living units at CYOC is utilized for youth with more complex needs. Many of those are especially low functioning and require supervision to minimize adverse impact on others and protection from victimization. Many of those are FASD affected.\textsuperscript{209} At times there are youth who do not participate in the school on site. Rather 1-2 teachers will attend the unit to provide instruction and activities there, at an appropriate level.

\textsuperscript{204} Subject to it having been paid for by Justice and Solicitor General’s Department, ie a Court report.
\textsuperscript{205} These principles are highlighted in the pamphlet published by the Alberta Justice and Solicitor General’s Department about CYOC, and were evident in the discussion with Ms MacDonald-Allen, colleagues and other staff at CYOC.
\textsuperscript{206} It was clear that many are suspected of being FASD affected. A smaller proportion of youth in custody have been formally assessed and diagnosed. Estimate by MacDonald Allen.
\textsuperscript{207} Details of the West View Secondary School are based on discussions and observations during a visit on 24 March 2015, and material in a brochure and CYOC internal documentation supplied to the author.
\textsuperscript{208} CYOC internal documentation, provided to author, also refers to 5 more teachers who are allocated to other programs associated with West View School.
\textsuperscript{209} Either diagnosed as such, or suspected.
Intensive Rehabilitative Custody and Supervision Sentence

As at 24 March 2015 there were 3 youth in CYOC who were subject to an Intensive Rehabilitative Custody and Supervision Sentence (IRCS). An IRCS sentence is available for youth convicted of specified serious violent offences under the Youth Criminal Justice Act, which include 1st degree murder, 2nd degree murder, attempted murder, manslaughter, sexual assault and a third violent offence where the youth has caused, or attempted to cause, serious bodily harm. Other criteria for eligibility are as follows:

- the youth must be suffering from a mental illness or disorder, a psychological disorder, or an emotional disturbance;
- a treatment plan must be established and available that will reasonably be expected to reduce the risk of the young person repeating the offence or committing another serious violent offence and/or will assist them with their reintegration into the community;\(^{210}\)
- the youth must be committed to and in agreement with the IRCS plan;
- A specified senior official of Justice and Solicitor General’s Department and the clinical director of the Provincial Forensic Psychiatry program have determined that an IRCS program is available and the youth’s participation in it is appropriate;
- The Court approves of the plan, determines whether the youth will receive an IRCS sentence and the length of the sentence.

An IRCS sentence provides intensive treatment and rehabilitation for the youth throughout the course of his/her sentence with the goal of reducing recidivism and promoting successful rehabilitation and reintegration back into the community.\(^{211}\)

The 3 youth, referred to above, serving IRCS sentences, had been diagnosed with FASD.

Justice Canada (federal agency) will fund the rehabilitation and reintegration plan for an IRCS sentenced youth up to $100,000 per year.\(^{212}\)

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\(^{210}\) An IRCS assessment identifying specific risks and needs will be completed by the Provincial Forensic Psychiatry Facility. If that recommends the youth for an IRCS sentence a comprehensive individualized plan will be developed with the IRCS team co-ordinators, in collaboration with the Forensic Team and the identified stakeholders, and submitted for review by the Crown and Defence Counsel: documentation supplied by CYOC personnel on 24 March 2015.

\(^{211}\) The Crown may however seek an adult sentence for a youth 14 years or older at the time of the offence, found guilty of an offence where an adult would be liable to a sentence of imprisonment of 2 years or more: section 64(1) YCJA.

\(^{212}\) Meeting with CYOC, 24 March 2015 and confirmed by email on 15 July 2015 with Ms D. Auger, Justice Canada.
The IRCS sentence may be up to 10 years in length, with a maximum of 6 years\textsuperscript{213} in custody. A portion of the sentence must be served in custody and a portion in the community. The key feature of the IRCS sentence is the individualized treatment plan. Sentences include the following phases:

1. Stabilization Phase: custody
2. Intensive Treatment Phase: in an inpatient Provincial Forensic Psychiatry Facility
3. Reintegration Phase: at a designated community placement – normally a group home like setting
4. Community Phase: transition to the home community or community where the young person will be residing on conditional supervision.

The young person will move between the phases, including regressing to an earlier phase, as he/she is deemed appropriate.

If the youth will turn 18 during the reintegration or community phase then relevant government, and community agencies, who can facilitate access for those with disabilities, to services, will be involved in the case management.

*Young Adults in Custody, Calgary*

On many occasions, FASD affected youth who had been incarcerated at CYOC, will end up in the Adult remand and/or the correctional centre. Adult corrections do not ask CYOC for any assessment report done on the youth, or gather any information to inform their management.

\textsuperscript{213} Maximum length of custody component dependent on nature of offence. Penalties specified in the text are for 1\textsuperscript{st} degree murder.

\textsuperscript{214} Source: Meeting with corrections staff at CYOC on 24 March 2015.
16. Accommodation

Accommodation for young people, especially in the 16-18 age range is very difficult to secure. That age group are also heavy users of police and health systems.215

McMan Youth, Family Community Services Association, Calgary

McMan started with the establishment of a group home in Edmonton, Alberta by 4 graduates that saw the need to provide support to young people who required care. That was 1975. The organization has evolved into a multi regional one responding to the needs of children and families in Alberta, through government funded programs.

McMan run a large number of programs. Many of the participants are children and young people in care and/or young people involved in the criminal justice system. McMan has found that 30% of the youth referred from the CYOC to it are FASD affected.216

McMan run a number of programs relevant to FASD affected children, youth and families. The following may be particularly applicable217:

- Youth and Adult Action Club (YAAC) - which provides a safe environment for youth and young adults who have FASD, to learn about FASD and understand how it impacts daily living.
- Youth Transitions to Adulthood (YTA) - which assists youth who require support in order to live independently yet are unable to stay with their natural families.
- Parent-Child Assistance Program-Expanded Enrolment (P-CAP_EE) - which supports parents diagnosed with, or suspected of having FASD. The program supports parents in order to strengthen parenting skills, decrease breakdowns within the parent-child relationship and build on existing strengths within the home.
- Pathways – a program which supports families with children who display complex behavioural needs.
- Wraparound – a program which assists youth who are in transition from a justice facility, such as CYOC to their family and community.
- High Fidelity Wraparound – delivered in partnership with the Calgary Child and Family Services, and 2 community organizations, this program is

215 Charlotte MacDonald Allen, Kevin Morey, Deputy Director, CYOC & colleagues, at meeting on 24 March 2015.
216 See fn 131.
217 Content drawn from meeting with Ms Darlene Petrie, Manager, Raine Dalrymple, Housing Coordinator, and Pauline Clarke, Program Manager, Housing and Outreach at McMan on March 2015 and material published by McMan about its programs.
intended to enable children and youth to grow up in their natural home and communities. It enables the child/youth/family to identify a team of people to support them to achieve their goals. A very structured process of establishing goals, desired outcomes and identifying who the young person wants to support them is undertaken.

- Youth Transition to Adulthood – for youth between 16 and 22 years, the program assists a participant to live independently with support, where they cannot live with their natural families.

McMahon has various programs focused on accommodation for youth. The majority of its housing/support work for youth, relates to youth in care, especially non status First Nations young. McMan works with Justice to accommodate and support youth coming out of CYOC.

As at late March 2015 it was estimated that there were 1000 young homeless people in Calgary. The number of beds for homeless youth, in Calgary, is in the vicinity of 162.

McMan have recently received a new contract to provide additional beds. As of April 2015 that McMan will manage 27 beds per year. Many of the youth stay for 1-2 years. During that time a case manager will work with the youth to develop goals, including education, employment, skill development. If they work towards identified goals then they can stay in the accommodation. The goal is to support the youth to develop the capacity for independent living, and then when they are ready, graduate to social housing.

There is now a centralized assessment process in Calgary. A number of agencies have staff trained to undertake assessment using the Service Prioritization Decision Assistance Tool (SPDAT). It is a very intensive, deficit based tool that results in an acuity score which is then used to determine allocation of beds as they become available. It can take up to 2.5 hours to complete and the youth may have to wait up to a month for a bed. Each youth, on the list, is reassessed every 3 months.

In recent years there has been a focus on preventative measures, to try to support and assist families to avoid breakdown in family relationships and homelessness. Measures include working with the family on various issues, financial support, rental subsidies.
Long term Housing – FASD Specific- Pilot, Calgary

McMan commenced a pilot project in 2015, with the assistance of Justice Canada to focus on securing long term community based housing for FASD affected youth, who have been involved in the criminal justice system. The FASD Housing Co-ordinator’s role is focused on locating an appropriate placement for each youth and supporting the home provider.

The home provider will offer one to one support for youth in the home, in daily life functions such as cooking, cleaning, shopping, attending appointment, extra-curricular activities etc. It is planned to train home providers to assist them to develop the skills needed and to develop strategies for working with a FASD affected youth.

The pilot will run for 3 years and plans to house 6 FASD affected youth on a long term basis.

Three months into the project, McMan had advertised for home providers and was trying to identify what would be needed in the home provider, in terms of experience and life circumstances, on the one hand, and support from McMan on the other, to make the arrangement durable. The project had 4 proposed home providers to assess, 2 respite providers and 3 suitable FASD affected youth.

A match between youth and home provider is essential. A process of relationship building was planned, again with durability in mind.

The provider was to be offered $1200 per month as compensation (plus an allowance for food), respite on a regular basis and support from the FASD Co-ordinator.

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218 Formal assessment/diagnosis not required. FASD-suspected will be sufficient.
219 Minimum 6 months involvement in the criminal justice system to qualify.
220 Two sources: Ms Deborah Auger, Senior Program Analyst, Youth Justice Fund, Justice Canada, meeting in Ottawa, April 2015, and information provided by McMan at a meeting in Calgary with Darlene Petrie, Raine Dalrymple and Pauline Clarke, and written material supplied.
17. Education & Training

In this chapter some examples of training initiatives in different workforce categories, and tools developed will be given.

General

In Winnipeg Manitoba, FASD training is provided to the following workers in or associated with youth, or adults, involved in the criminal justice system221:

- For Youth Corrections Officers, 3 days training;222
- For Youth Probation Officers, 2 days training; and
- For Correctional Officers (adults), 1 day’s training;
- Police cadets and traffic police, ½ day’s training

Probation Officers in Ontario received an average of 10 hours training on FASD, and then for the purposes of a research project received an additional 5 hours training and introduction to the Asante Screening Tool.223

Lethbridge Police Service224, in southwest Alberta, over the last 5 years has included 1 day’s training on FASD as part of the curriculum for new recruits. Police Officers in the downtown enforcement unit had 2-3 days training on mental health, FASD and alternatives to arrest and charging for low level street offences, a couple of years ago.

Lethbridge Community College, Southern Alberta offers a Certificate in Fetal Alcohol Spectrum Disorder Education, comprising tuition and a practicum over 1 year, which is said to be suitable for professionals planning a career in education, human services, health care, justice studies and other areas supplying services to individuals with FASD.225

Many organizations have developed and published their own materials to inform and educate the community, caregivers and service providers, including those working in the criminal justice system about FASD. One of the best examples of high quality written material is a pocket-sized booklet (30pgs) published by the Regina Community Clinic, in Saskatchewan entitled “The FASD Brain: Making the

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221 Brown presentation, op. cit.
222 Youth Corrections Officers at Calgary Youth Offender Centre also receive 3 days training- information supplied by Charlotte MacDonald-Allan, Program Director.
223 Sheila Burns in email to author 22 July 2015. See her report referred to at [26] , fn 74
224 Senior Constable Smallbones.
225 http://www.lethbridgecollege.ca/program/fasd
Connection”, which provides detailed information in plain English, reflecting current research. It covers topics such as:

- Alcohol Exposure by trimester
- Possible affected areas of the brain
- Executive Functions of the prefrontal Cortex
- Importance of an early Diagnosis
- Possible Behavioural Characteristics, and
- General Strategies for helping a FASD affected person, succeed.

The Regina Community Clinic have produced a suite of brochures about discrete topics related to FASD, including “Life Skill and Addictions”, “Diagnosis and Assessment” and “I have FASD What Comes Next?” as first line, basic information. Then there are more detailed brochures for different audiences, for example, a booklet entitled “FASD in the Workplace: What Employers Need to Know.” which covers topics such as what causes FASD, common challenges that people affected suffer, strategies to overcome challenges of different types, with examples, and how to be a supportive and flexible employer.

Justice Canada has prepared basic training modules for delivery to justice professionals, including PowerPoint presentations.

A Canadian lawyer and FASD Consultant, David Boulding, has produced accessible educational videos and prepared a number of helpful papers on acting for FASD affected clients. 228

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226 Provided by Judges Toth and Hind of the Provincial Court of Saskatchewan, Regina, as a resource that was circulated to legal practitioners at a recent seminar on sentencing issues.
227 Executive Director, Ms Cheryl Charron and Dr Dolores Logan, FASD Centre.
228 http://www.davidboulding.com
Dr Lori Vitale Cox prepared a set of materials for Police, Duty Counsel, Crown Prosecutors, Judges and Restorative Justice, entitled “FASD & Legal Professionals: Developing an Appropriate Response in the Justice System” in 2005. This document provides a practical guide, with examples and suggestions for each role on what FASD might look like, and how best to approach the particular situation.

The American Bar Association produced an online course, with extensive course materials, entitled “Fetal Alcohol Spectrum Disorders (FASD): What you need to Know to help your Clients”

Other organizations are utilizing different methods to raise awareness about FASD, support FASD affected youth, families and caregivers, and undertake workforce training. Some examples are as follows:

- Live to Air/Internet Streaming event – the Different Perspectives of FASD – MOFAS
- Websites to provide support, advocacy, advertise webinars. See MOFAS, NOFAS and others
- Webinars for professionals and service providers, MOFAS, NOFAS, etc.
- Educational DVD, “Recovering Hope”
- Alcohol Healthwatch NZ and Child, Youth and Family & Attitude Pictures, “Risking it All: True Stories; FASD Prevention for a Brighter Future” Educational DVD
- Valerie McGinn, Neuropsychologist, “Recognizing and Meeting Differently the Complex Needs of Children with a FASD”, Educational DVD

In 2010 Alcohol Healthwatch (NZ) arranged a training program in multi-disciplinary FASD assessment which included 3 clinicians from the Hawkes Bay CDS team. That team then were involved in training other child development teams in the country thereby increasing diagnostic capacity.

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229 [http://www.nogemag.ca/resources.htm](http://www.nogemag.ca/resources.htm), then download FASD Legal Manual
230 See [http://www.americanbar.org/content/dam/aba/publications/litigation_committees/childrights/l12juncm1.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/publications/litigation_committees/childrights/l12juncm1.authcheckdam.pdf)
231 Event filmed at community TV station on 23 April, attended by author. Program available (50minutes) [http://www.ctvnorthsuburbs.org/events/event/158-mofas-live](http://www.ctvnorthsuburbs.org/events/event/158-mofas-live)
232 [http://www.mofas.org](http://www.mofas.org)
Judicial Education

Over the years the Judges of the Provincial Court of British Columbia have had educational sessions dealing with FASD. To a greater or lesser extent, first instance courts in Canada and New Zealand, dealing with youth, have received some education during conferences for judicial officers.

Feedback from court users suggested that the awareness of FASD among judicial officers based in western Canada was high, however acceptance of it as a disability and its relevance to sentence varied significantly. However it must be borne in mind that diagnosis for adults remains unusual, even in Canada.

In some places Judges have been active in promoting legal education about FASD. For example Judge Toth and Associate Chief Judge Hinds, of the Provincial Court of Saskatchewan, organized an educational program about FASD and the Regina Mental Health Disposition Court for practitioners. Materials circulated to participants included recent research papers, a FASD Screening Questionnaire, the most recent Court of Appeal decision involving an appeal against sentence for a FASD affected offender and Guidelines regarding Eligibility and Process in the recently commenced Regina Mental Health Disposition Court.

A self-paced educational program on FASD for Judges entitled, Tools For Success: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System was developed some years ago by (retired) Judge Susan Carlson and MOFAS, delivered in module form, online, with notes and questions. The FASD Justice Committee (ICC) of the National Institute on Alcohol Abuse and Alcoholism, is supporting the rewriting of the guide which is being led by Susan Carlson and Ruth Richardson, Program Director of MOFAS.

Conferences have played a key role in bringing professionals from different disciplines together with service providers and family members to report on research outcomes and share advances in knowledge and practice. Participation by judges and the legal profession appears to have been relatively limited.

235 Chief Judge, Hon T.J. Crabtree, BC Provincial Court, on 6 March 2015 and Dr J. Conry on 11 March 2015, who delivered FASD training to the judges on one occasion some years earlier.
236 Seminar on 10 April 2015. Speakers included Crown Counsel, Prosecutions, Saskatchewan Legal Aid and the Director of the Regina FASD Clinic, Ms. Charron.
237 Supplied by Judges Toth and Hinds.
239 R V Charlie 2016 YKCA 3.
241 Sally Anderson kindly invited the author to participate in a meeting to discuss the rewrite, and supplied draft chapters.
Until relatively recently there has been limited participation by judicial officers, crown prosecutors and defence counsel however the following conferences appear to have been very influential:

- Access to Justice Yukon 2008,
- Legal Issues concerning FASD, Consensus Development Conference Edmonton 2013

**Child Protection Training, Alberta**

Responding to the need for workforce training and development of the capacity to work effectively with one or other parent affected by FASD or plan for the needs of a child in care, training of case workers has taken the form of 6 days training, including 3 days participation in collaborative case management involving real cases.

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18. Leadership

Leadership has been shown by many individuals, in different walks of life, from different vantage points, in seeking to better understand the harm done by exposure to alcohol in utero and secure appropriate intervention for those affected.

Some Governments and institutions have also led the way in responding.

In this chapter a few initiatives taken elsewhere, from which Australia may learn, if not emulate.

Alberta’s 10 Year FASD Strategy 2007-2017

In 2007 the Province of Alberta adopted a 10 year strategic plan to provide a framework for a coordinated approach to addressing FASD in the province. Cabinet had directed the formation of a Cross Ministry Committee (CMC), comprising representation from 9 ministries, to develop and monitor the implementation of the strategy.

The vision was to have “a comprehensive and coordinated provincial response to FASD across the lifespan and a continuum of services that is respectful of the individual, family, culture and community diversity.”

The CMC, which developed the Strategy, and was responsible for its implementation, was chaired by the Ministries of Health and Wellness, and Children and Youth Services. However other partners in the initiative included Education, Justice and Attorney General, Aboriginal Relations, Seniors and Community Supports, Employment and Immigration and Solicitor General and Public Security.

Health Canada, a federal department, also had a seat at the table.

The following areas were identified as key:

- Awareness and Prevention;
- Assessment and Diagnosis;
- Supports for Individuals and Caregivers;
- Research and Evaluation;
- Strategic planning;
- Training and Education; and
- Stakeholder Engagement.

The Provincial Government funded the establishment of 12 FASD Service Networks ("the Networks) in the province, so as to bring together on a regional basis all the stakeholders, to foster collaboration between sectors, identify the needs and priorities within each region, and coordinate the service delivery. One of the principles adopted at a provincial level was that existing services were expected to accommodate the needs of FASD affected individuals, or adjust their service delivery.245

This is not the place for a detailed discussion of the content of the strategic plan and the outcomes. Rather it is hoped to offer a snapshot of the commitment shown by the Province of Alberta and a window into the achievements.

At the 5 Year mark an independent evaluation was commissioned for the Provincial Government and the findings published.246 A few examples of the outcomes demonstrate increasing capacity and evolving and more sophisticated service delivery:

**Assessment and Diagnosis**

- The number of clinics in Alberta increased to 24.247
- Assessments by multidisciplinary teams associated with the Networks increased from 129 to 401 per year from 2008 to March 2011.
- All teams were following Canadian guidelines for standardized procedures and diagnosis.

**Supports for individuals and Caregivers**

- “a framework to address service coordination at three scales (system/CMC level, agency/Network level, and client/family level) has been created”.
- “The literature identifies the need to shift the purpose of assessment from diagnosis to intervention, and to apply an integrated lifespan approach to providing wraparound services where key caseworkers and mentors assist clients and caregivers with accessing coordinated services”.

The Year 5 evaluation added 2 more outcomes by estimating the potential impact of the Networks on secondary disabilities associated with FASD. These include: crime, homelessness, mental health problems, and school disruption (for children) or unemployment (for adults).

245 Janice Penner, Co-Chair, Cross Ministry Committee FASD
247 Increase in clinics by Year 5 to 24 in the Province (?)
The questions posed in the Year 5 evaluation were:

Is there evidence of a reduction in secondary disabilities associated with FASD and their impact on Albertans?

Has the cost of FASD to Albertans been reduced?

Corresponding to effectiveness rates ranging from 40% to 80%, the Networks were estimated to reduce the following number of occurrences: 248

- school disruption among children, between 187 and 281 occurrences;
- adults being unemployed, between 144 and 289;
- crimes committed, between 297 and 593;
- mental health problems, between 456 and 930, and
- being homeless, between 74 and 148.

The total gross monetary benefits of reducing these occurrences range from $8.87 to $17.73 million per year with annual program costs estimated at approximately $6.12 million. 249

Advocacy by Legal Organizations

The Canadian Bar Association led the way, in the justice sphere, in 2010, by passing a resolution calling on all levels of government to:

- “allocate additional resources for alternatives to the current practice of criminalizing individuals with FASD”,
- “develop policies designed to assist and enhance the lives of those with FASD to prevent persistent over-representation of FASD affected individuals in the criminal justice system” 250

Further the resolution called on the Federal government to amend criminal sentencing laws to accommodate the disability of those with FASD.

That was followed by a resolution, and detailed report, of the American Bar Association (ABA) in August 2012 which urged:

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248 The text is drawn from the Evaluation overview. See fn 3 above. Results referred to were qualified due to inadequate data. The Year 7 evaluation has not been published yet.
249 Ibid.
• the legal profession, judiciary and others to respond to FASD through training and collaboration with professionals in the health and mental professions, and
• the passage of laws and adoption of policies that acknowledge the effects of prenatal exposure and better assist individuals with FASD.\textsuperscript{251}

The report of the ABA which accompanied the resolution canvassed various issues including the impact of FASD on the justice system, the child welfare system and on disability benefits.

In 2013 the Canadian Bar Association passed a second resolution on FASD, this time entitled, “Accommodating the Disability of FASD to Improve Access to Justice”. The resolution sought amendments to the Criminal Code, and other legislation, to:

• provide a legislative definition of FASD;
• empower judges to order a medical assessment of an adult suspected of having FASD;
• specify that FASD is a mitigating factor for the purposes of sentencing;
• empower a judge to make an order approving an external support plan recommended by a probation officer, which may continue beyond the expiration of any probation order;
• Require the Correctional Services of Canada (CSC) to accommodate FASD as a disability when providing correctional services to inmates who have, or are likely have, FASD.\textsuperscript{252}

Subsequently Ryan Leef, Member of the Canadian Parliament for Yukon, tabled a private members Bill C-583 which sought to amend the Criminal Code consistent with much of the 2013 Canadian Bar Association resolution.\textsuperscript{253} The Bill was referred to the Parliament’s Standing Committee on Justice and Human Rights, which reported to Parliament on 30 June 2015 after a very brief period for submissions and hearings.

\textsuperscript{251} http://www.americanbar.org/content/dam/aba/administrative/mental_physical_disability/Resolution_112B.authcheckdam.pdf
\textsuperscript{253} 31 March 2014.
Recommendation 1

The Committee recommends that more resources be allocated to crime prevention and diversion programs for individuals with fetal alcohol spectrum disorder.

Recommendation 3

The Committee recommends that Royal Canadian Mounted Police and Correctional Service Canada officers receive training on fetal alcohol spectrum disorder as part of their standard training.

Recommendations 4 & 5 were directed to the Correctional Service of Canada, and focus on that part of the prison population for which the federal government has responsibility.

Recommendation 4

The Committee recommends that Correctional Service Canada continue to evaluate community-based best practices to screen offenders for FASD and that FASD be built into the existing mental health evaluation upon admission to a penitentiary.

Recommendation 5

The Committee recommends that Correctional Service Canada consider strategies to help the integration and rehabilitation of individuals with fetal alcohol spectrum disorder who are sentenced to two years or more in prison.

The Government response focuses on summarizing the Canadian Government's approach with respect to FASD and makes several recommendations directed to CSC's management of (adult) prisoners.254

254 Government response can be found at:
19. **Legal Initiatives**

**Judicial Bench Card**

The North Dakota Fetal Alcohol Syndrome Centre produced a Judicial Bench Card on prenatal alcohol exposure, which has a series of questions to enable screening by the judicial officer for exposure to alcohol during pregnancy, and the amount of exposure.

The National Council of Juvenile and Family Court Judges and Casey Family Programs produced and circulated a 2 card set of bench cards for judicial officers comprising sets of detailed questions for use in the child welfare jurisdiction regarding education.\(^{255}\) The cards are entitled:

1. “Critical Questions Every Judge Should Ask About Education in Every Case”, and divides those into 2 categories
   - Preliminary Issues: Placement, Decision-making, Attendance and Records
   - Educational Success
2. “Critical Questions Every judge Should Ask About Education and Older Youth”
   - Secondary Education Information
   - Post secondary Planning.

**FASD and Justice System Website**

Some years ago, funded by the Federal Government, the website FASD and the Justice System\(^{256}\) was established in Canada. It is aimed at justice professionals, and provides information, resources and links about FASD under the following headings:

- FASD Basics: Definitions, characteristics, incidence and cost
- FASD and Behaviour: Primary and secondary disabilities and diagnostic process
- Recognizing FASD in the Justice System: Typical scenarios, screening tools and strategies
- Investigation, Pre-trial and Bail: Ways to protect rights of a person with FASD
- Trial: Evidentiary challenges, how to get relevant info, defences

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\(^{255}\) Cards supplied by Professor Linda Chezem. These cards are not specifically directed to FASD.

\(^{256}\) fasdjustice.ca.
• Sentencing: Weighing responsibility of accused with FASD, diversion and alternatives
• What Works: Reframing behaviour, adapting environment, setting up external brain
• Aboriginal People and FASD: Incidence and prevalence, cultural traits, biological susceptibility and other factors
• Cases: Documented cases involving FASD in the Canadian justice systems
• More Information: Annotated FASD bibliography and additional resources

The website has been viewed by approximately 1.75 million. It is an excellent source of information on the issues.

Tools for Change

See discussion on page 93 above.

American Bar Association online course

See discussion on page 93 above.
20. **Initiatives involving Adults**

The scope of the topic approved by the Trust for the fellowship did not include adults. However, the author could not ignore initiatives involving adults where they appeared to offer promise in the Australian context and/or may be applied to youth.

In parts of Canada, some Governments and/or agencies have accepted that FASD is an issue across the lifespan and thus intervention and service delivery cannot be limited to children and youth, although that section of the population appears to have been prioritized.

**Statutory Provisions Alaska**

Alaska Statute 12.55.155(d)(20), Section 1, chapter 54, SLA 2012, effective 19 September 2012, provides for fetal alcohol spectrum disorder to be taken into account as a mitigating factor in certain circumstances. The relevant provision reads as follows:

"(d) The following factors shall be considered by the sentencing court if proven in accordance with this section, and may allow imposition of a sentence below the presumptive range set out in AS 12.55.125:

(20) except in the case of an offense defined under AS 11.41 [assaults] or 11.46.400 [arson in the first degree], the defendant

[1] committed the offense while suffering from a condition diagnosed as a fetal alcohol spectrum disorder,

[2] the fetal alcohol spectrum disorder substantially impaired the defendant's judgement, behaviour, capacity to recognize reality, or ability to cope with the ordinary demands of life, and

[3] the fetal alcohol spectrum disorder, though insufficient to constitute a complete defense, significantly affected the defendant's conduct;

in this paragraph, "fetal alcohol spectrum disorder" means a condition of impaired brain function in the range of permanent birth defects caused by maternal consumption of alcohol during pregnancy."

The above provision is subject to certain exceptions and qualifications which retired Judge Michael I. Jeffery, formerly of the Superior Court of Alaska, based in Barrow, has summarized as follows:257

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• The provision is restricted in its application to certain classes of felonies and sexual felonies: AS 12.55.155(a);
• The provision cannot be relied upon if it has been relied upon at trial to reduce the charge to a lesser offense: AS 12.55.155(e);
• If the low end of the presumptive range of sentence is 4 years or less, if find the mitigating factor, can impose "any sentence below the presumptive range": AS 12.55.155(a)(1)
• If the low end of the presumptive range more than 4 years, may impose a sentence below the presumptive range but not less than 50% of the low end of the presumptive range;
• Notice of intention to rely upon a mitigating factor must be filed not later than 10 before the date set for imposition of sentence AS 12.55.155(f)(1) and
• “Factors in mitigation must be established by clear and convincing evidence before the court sitting without a jury”: AS 12.55.155(f)(1).

Sentencing Courts

Regina Mental Health Disposition Court (RMHD), Saskatchewan258

There are a number of places where Courts, or individual Judges, have taken the initiative and included FASD, in a special mental health list for the purposes of sentencing or case management. Judge Toth in Regina, Saskatchewan has established such a list for adults and invited community based organizations to attend court and provide assistance to accused persons. It is a recent initiative and depends upon the support and cooperation of the Regina FASD Centre, based at the Regina Community Clinic and the Manager of FASD Services, Ms Cheryl Charron. Neither the Court, nor the Clinic, have received any additional funding to provide additional services, including assessments259 however they perceive a need and, at least in the short term, existing services are being stretched to try to service it.

Recently established at the Provincial Court of Saskatchewan, the RMHD is a collaborative model to coordinate treatment, and criminal justice, needs for individuals exhibiting mental health, FASD or cognitive issues who have been charged with a crime260.

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258 Based on discussions with Judges Toth and Hinds, 2 May 2015, and earlier presentation by Toth, J at the Law Day, preceding International FASD Conference, Vancouver, March 2015.
259 Dr Logan works with the Regina Community clinic to do assessments. She told the author about having to do a submission to the relevant medical insurance authority, some years earlier, to have an item number for FASD assessments to be allocated.
260 Guidelines for RMHD circulated to practitioners, provided to author by Judges Toth & Hinds.
The Court issued guidelines state that the initiative will:

- provide better background information to the Court, about the offender through the involvement of health and social services professionals;
- better support the offenders with mental health, FASD or cognitive issues facing incarceration, who could be better managed in the community.

The process involves referral of a defendant to the Crown for an assessment of eligibility for the RMHD. Crown are required to use agreed criteria to assess eligibility including the nature of the charges, the criminal record and the risk to community safety. Legal Aid will provide advice to the defendant about his/her options. Crown and Defendant must agree to case being dealt within the RMHD Court. The Court may require the defendant to meet clinicians for assessment of needs and/or strengths and make recommendations regarding case management. Issues of housing and financial management may also need to be assessed and support provided.

If the defendant can be managed safely in the community and agrees to the case management plan, a guilty plea is entered and as part of the sentence imposed he/she is required by court order to follow the case management plan. The time taken to conclude the case will depend on the case management plan and the defendant’s progress in that plan.

Saskatoon

Since about 2001 the Provincial Court, and the Youth Justice Court, in Saskatoon have been ordering FASD assessments, paid for by the Court Services Division of the Ministry of Justice. Since 2013 the Provincial Court has established a “specialty docket”, a special list for persons with cognitive disabilities including FASD and mental disorders in Saskatoon, Saskatchewan. (See discussion in chapter 10).

At the time of the author’s visit to Saskatchewan there appeared to be some ongoing consideration of whether the Provincial Government ought announce a FASD-specific strategy. That emerged during a meeting with the Honourable Greg Ottenbreit, Minister Responsible for Rural & Remote Health and the Honourable June Draude, former Minister for Social Services, at the Legislative Building, Regina.

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261 The author is grateful to the Hon. Minister Ottenbreit and the Hon. J. Draude, for the welcome to the Parliament and Regina, see http://www.youtube.com/watch?v=hKKT3MISs58&sns=em
262 on 29 April 2015.
The Yukon Community Wellness Court (CWC) was established in 2007 on a therapeutic court model, to work with offenders to address underlying causes of their offending behaviour. There was recognition that a substantial proportion of offenders in Yukon, in particular repeat offenders, experience multiple psycho-social issues such as alcohol and drug addictions, mental health problems or FASD, as well as inadequate housing and unemployment.

Offenders who are eligible for CWC are required to plead guilty to charge/s against them, as a condition of acceptance. Suitability for the program is assessed by Offender Supervision and Services (“OSS”) and an individualized Wellness Plan is developed to address their particular needs. “The Wellness Plan typically involves the coordination of a team of professionals and community partners to provide the required supports identified during the assessment phase.” Completion of the Wellness Plan may take up to 18 months. Sentencing takes place upon completion of the Wellness Plan, or if offender opts out or faces new charges after the Wellness Plan has been filed at Court.

To be eligible for the CWC the accused must have at least 1 charge under the Criminal Code or Controlled Drugs and Substances Act pending, and one or more of the following must be a contributing factor to the offending:

- an addiction to alcohol and/or drugs;
- a mental health problem; and/or
- an intellectual disability, including but nor limited to FASD.

Various types of offences, or circumstances, make the offender ineligible to participate in CWC, such as offences resulting in death, involving violence against children or the elderly, crimes of a sexual nature and/or involving serious violence. In a case of sexualized violence, if there is a cognitive issue then it may be accepted into CWC. The approach is to focus on the offender not necessarily the charge.

Generally decisions regarding admissibility to the CWC are made on a collaborative basis, however the Prosecution may veto an offender for reasons of public safety and public interest.

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263 It is not necessary to plead guilty to all charges.
264 staffed by Probation Officers.
266 Statement made by Ms MacKenzie, Justice Centre Co-ordinator.
267 In those circumstances the Prosecutor may agree to the offender being assessed or further assessed for admission, before determining the prosecution’s position.
The CWC Primary Case Manager (PCM), completes the suitability assessment over a 2 week period. It will take 4/5 hours. The PCM meets with the offender to determine the issues that make him/her suitable, and conducts a preliminary assessment of other needs that are likely to become part of the Wellness Plan, eg accommodation, family support, employment. Motivation is assessed. Entry to the program is voluntary. Various other tools and screens are applied as part of the suitability assessment, including:

- a risk assessment and case management tool,
- a drug abuse screening tool,
- an assessment of the severity of alcohol misuse problems, and
- a general health questionnaire which includes mental health concerns.

If the offender is considered suitable for CWC then referrals are made by the Primary Case Manager to various services to assist and support the offender in stabilization for example: detoxification, substance use counselling, mental health assessment and treatment, medical assessment and treatment. If the offender is Aboriginal then with his/her permission, input/assistance may be sought from the First Nations community and/or from an Aboriginal Court Worker.

Once the offender is assessed as suitable, and a guilty plea entered to one or more charge, close monitoring of the offender begins. There are standard bail conditions which are generally imposed although they may be varied in accordance with individual circumstances. For example, usually there will be a requirement to report daily, or at regular intervals each week, to a Probation Officer based at the Justice Wellness Centre (the Centre), located within about 30 metres of the OSS office. There will be a residential condition, a curfew, a requirement to attend programs as directed. The offender may be required to submit to a breathalyser upon request and urinalysis. The combined bail conditions provide structure and address the issue of public safety.

The Wellness Plan, which requires probation to work with the offender to develop, has to be filed at Court within 60 days of acceptance on to the program. It is required to be completed within 18 months. Generally offenders are on the program between 12 and 24 months. They are then sentenced and given credit for participation in the

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268 Yukon Offender Services Inventory, see Evaluation at [24].
269 DAST – an assessment of the severity of drug misuse problems, see Evaluation.
270 Problems Related to Drinking – assessment of severity of alcohol misuse problems, see Evaluation.
271 A profile of the offender’s more recent health issues, and a screen for mental health issues such as anxiety, depression and thoughts of self-harm.
272 Disputes as to the facts are resolved at the outset.
273 Note reporting is not done to the RCMP (Police). The CWC cohort reports at the Centre. That is a deliberate strategy to separate that group from the high risk group that report at the Probation office: Ms Mackenzie.
274 Reference was made to the offender signing a waiver to enable these requirements to be imposed: see Evaluation.
program. Many would have been sentenced to immediate imprisonment but for the program.

The philosophy of CWC is very different to mainstream courts. It is focused on safety of the community and the individual offender. It is not punitive. It tries to address the unique circumstances of the offender and provide support while underlying issues are addressed. Many of those coming into CWC have suffered trauma. For those with FASD, the program may be very successful so long as they have stable accommodation. In Whitehorse, low cost accommodation is in very short supply. Unless accommodation can be accessed the offender will not be able to enter and complete the program. Judge Ruddy characterized the approach as follows: “Do we have the ability to put structure around them so they have the assistance they need to comply? It starts with accommodation.”

The Centre opened in 2010. It is open for business 6 days a week. Probation officers responsible for providing support and programs, such as addictions counselling, employment, educational and skills development, and Nicole Bringsli, the contract psychologist, who works with offenders, are based there. Nicole spends 2 days a week at the Centre and 1 day a week at the correctional centre. Over some years she has seen some people, on and off. Developing a relationship for therapeutic purposes is really important. The population serviced by the centre is a traumatized population with major trust issues. Some of those dealt with, FASD is flagged, rather than diagnosed, due to limited diagnostic capacity. Up to 2014, a mobile diagnostic team visited Whitehorse annually for a week, and assessed up to 10 people. As from July 2015 there will be an Adult FASD Clinic based in Whitehorse. Local clinicians were being trained to undertake assessments in early 2015.

A strategy used up to early 2015 was to administer a complex needs screen to an offender in the CWC where it was suspected he/she was FASD but undiagnosed and a certain score would result in referral to Nicole for her to do a brief functional assessment, so as to alert Probation and service providers to challenges the offender faced. Otherwise the wait list for Nicole is 6 months, and in that time the

275 Meeting with Judge Ruddy on 11 May 2015.
276 Fetal Alcohol Syndrome Society Yukon (“FASSY”) is a non profit organization dedicated to FASD prevention and direct service provision: the author met with Ms Wenda Brackey on 12 May 2015 who kindly provided many materials including publications by FASSY and the FASSY Direct Service Provision Framework.
277 Nicole Bringsli, psychologist had attended training provided by Dr Jacqui Pei, neuro-psychologist and academic ( 3 days), had completed the University of Washington online FASD training, and was working her way through training materials to equip her to administer various neuro-psychological tests to adults, as part of a FASD assessment by a multi-disciplinary team (including WAIS, WICAT, ABAS (adaptive functioning). Total training time estimated 40-60 hours. Dr Pei would be providing clinical supervision.
offender may not be able to comply with bail and other requirements if he is treated as normal. 278

A range of life skills are the subject of counselling and group work, such as building new support systems, healthy relationships and dealing with social anxiety. 279 Other agencies come in to the centre to deliver programs dealing with issues such as budgeting, nutrition, tenancy and healthy lifestyles. Referrals are made to get food, social assistance and legal assistance, or if the offender is an Aboriginal person, and has addiction issues, to a First Nations agency. 280

The Centre operates like a drop-in centre, where offenders can do their reporting, complete programs and drop in for social interaction, support, a hot drink, simple food, such as hot soup and bread, and warmth. This environment is particularly attractive in bitter, northern winter conditions and especially effective for lower functioning individuals. Offenders may drop in to the Centre every day, get some basic nourishment, see the same faces, develop a routine and relationships.

Once a fortnight on a Monday morning there is a pre Court meeting involving the presiding Judge of CWC, the Prosecutor, Defence Counsel for the offenders on the court list that day, the Primary Case Manager, the Centre’s Co-ordinator, the Native Court Worker 281 and representatives of agencies providing services to offenders, eg. the main accommodation provider, the alcohol and drug service etc.

The caseload of the CWC as at early May 2015 was 28. Some data from the evaluation assists to understand the intensive nature of the program. See the table below:

278 Ms MacKenzie.
279 Meeting with Ms. Theresa Brown, Co-ordinator of the Justice Wellness Centre, on 11 March 2015 and on several other occasions during that week.
280 Source is Ms Brown. First Nations agency referred to was BloodTies based in Whitehorse, Yukon. The Evaluation referred to in footnote 213 described programming at the Centre as comprehensive.
281 Kyle Risby works for the Council of Yukon First Nations, which comprises 12 First Nations who have come together as a political entity for the purpose of negotiating a land claim settlement.
Table 8: Wellness Court Evaluation Data 2007-December 2013

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offenders referred to CWC &amp; met legal criteria</td>
<td>194</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offenders found suitable for CWC</td>
<td>115</td>
<td>115/194</td>
<td>59%</td>
</tr>
<tr>
<td>Offenders not suitable</td>
<td>79</td>
<td>79/194</td>
<td>41%</td>
</tr>
<tr>
<td>Of those found suitable, met final criteria and accepted by CWC</td>
<td>103</td>
<td>103/115</td>
<td>90%</td>
</tr>
<tr>
<td>Offender Opted out after assessed suitable</td>
<td>8</td>
<td>8/103</td>
<td></td>
</tr>
<tr>
<td>Offender Rejected by CWC - new offences</td>
<td>10</td>
<td>10/103</td>
<td></td>
</tr>
<tr>
<td>Wellness plan prepared and filed</td>
<td>85</td>
<td>85/103</td>
<td>83%</td>
</tr>
<tr>
<td>Wellness plan filed but offender opted out before completion</td>
<td>18</td>
<td>18/85</td>
<td>42%</td>
</tr>
<tr>
<td>Wellness plan filed, offender exited CWC, new offences</td>
<td>18</td>
<td>18/85</td>
<td>42%</td>
</tr>
<tr>
<td>Wellness plan filed, monitored, not completed (Partial Completion)</td>
<td>49</td>
<td>49/85</td>
<td>57%</td>
</tr>
<tr>
<td>Completed Wellness plan &amp; sentenced (Completion) (by Dec 2013)</td>
<td>26</td>
<td>26/85</td>
<td>30% *</td>
</tr>
</tbody>
</table>

* The Evaluation report analyses the number of suitable clients by year when they commenced and the numbers which completed each year, referring to average time taken to complete the program and concludes that the completion rate was 38%.

Dr Hornick, who completed the evaluation, analysed demographic characteristics for those involved in the program at various stages. Extracted below is data from the Evaluation Report, showing the gender breakdown in 2 categories: those that completed the Wellness Plan and were sentenced by the CWC. The second and larger category is those were assessed as suitable for the CWC and entered the

282 Extracted from Evaluation Report referred to in footnote 221, [41-43]
program. In the latter category women comprised 25%. One factor which may contribute to that is the difficult with low cost accommodation in Whitehorse.283

Table 9 Selected Demographic Data

<table>
<thead>
<tr>
<th></th>
<th>Completed (N= 26)</th>
<th>%</th>
<th>Suitable &amp; Accepted CWC (N=103)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender -Male</td>
<td>20</td>
<td>86.9</td>
<td>77</td>
<td>74.7</td>
</tr>
<tr>
<td>Gender -Female</td>
<td>3</td>
<td>13.0</td>
<td>26</td>
<td>25.2</td>
</tr>
<tr>
<td>First Nations</td>
<td>13</td>
<td>50.0</td>
<td>59</td>
<td>58.4</td>
</tr>
</tbody>
</table>

283 Ms Mackenzie and others raised the issue of accommodation as a barrier to entry into the program generally and especially for women.
### Table 10: Presenting Issues for 2 groups

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Completed N =26</th>
<th>%</th>
<th>Suitable &amp; Accepted N =103</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>14</td>
<td>60.9</td>
<td>51</td>
<td>51.5</td>
</tr>
<tr>
<td>FASD</td>
<td>0</td>
<td></td>
<td>5</td>
<td>5.0</td>
</tr>
<tr>
<td>Addiction &amp; MH</td>
<td>4</td>
<td>17.4</td>
<td>26</td>
<td>26.2</td>
</tr>
<tr>
<td>Addictions &amp; FASD</td>
<td>2</td>
<td>8.7</td>
<td>11</td>
<td>11.1</td>
</tr>
<tr>
<td>Addictions, Mental Health and FASD</td>
<td>0</td>
<td></td>
<td>3</td>
<td>3.0</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2</td>
<td>4.3</td>
<td>3</td>
<td>3.0</td>
</tr>
</tbody>
</table>

The data available in the Evaluation Report indicates that offenders affected by FASD comprised 18% of those assessed as suitable and accepted into the program. Of those who completed the program, 2 or 7% were affected by FASD. That corresponds with feedback in conversations with many people that the program was especially challenging for those affected by FASD.284 The report noted that the group which partially completed the program and were exited prior to filing of the Wellness Plan, were overrepresented by participants with addictions and FASD (28%).

In an evaluation of the Court completed in mid 2014, the primary objectives upon its establishment were stated as:285

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284 Evaluation Report [45].
• The revolving door of recidivism and re-offending is reduced for the individuals who participate;
• The safety of Yukon communities is enhanced by providing individuals who participate with supports that reduce their risk to re-offend;
• The needs of those victimized during the commission of the offence/s are adequately addressed;
• The capacity of the core partners is adequate to the roles they are required to play, and partnerships are fostered with other key stakeholders in support of the Court's objectives; and
• The use and effectiveness of alternative justice approaches in Yukon, including community-based justice, therapeutic or problem-solving approaches and restorative justice, is increased.

In terms of funding the CWC has not been allocated any additional funds to run the Court. The Centre is funded through Corrections/Probation at a cost of $CA450,000 per year, which includes the part time psychologist. Funding for a further 3 years has been approved.

Most offenders that are FASD affected are found unsuitable for CWC. To be in the program the offender needs to be capable of management in the community. That requires strong advocacy and case management, walking with them as their external brain, for example helping the offender make the next appointment. The CWC program provides much more support than a probation order does. It also requires stable accommodation. There is limited transitional housing for men. There is none for women. Probation has 10 beds at a halfway house called ARC, in Whitehorse. Most in the program stay at a cheap hotel during winter at a cost of $CA1100 per month for room only. Groceries may cost $400 per month. Social assistance is about $675 per month. In summer the hotels evict the locals to accommodate tourists at much higher rates. The locals then relocate to caravan parks on the outskirts of town which pose difficulties for compliance with bail conditions and accessing the support available at the centre and FASSY.

Judge Ruddy said that FASD affected offenders are treated very differently. When a Wellness Plan is developed for a person with that disability one must ask, what kind of structure can be built around them to support them and keep them out of trouble. Whereas with someone else, with compliance over time the more stringent or onerous conditions may be reduced in severity or removed. Not so with FASD affected offender. FASD affected offenders need an external framework and the Court must redefine success. The Court is looking to prevent more substantive offences. It is not looking to be punitive. Any program must be tailored to the offender’s strengths and abilities. Judge Ruddy says the question is what can be put in place to support them.
FASD is the most difficult of the conditions suffered by those in CWC.

**Gladue Reports by Aboriginal Legal Services of Toronto**

Obtaining any assessment for an adult, involved in the criminal justice system, in Toronto, or indeed in Ontario is very difficult.

The Aboriginal Legal Services of Toronto (ALST) prepare Gladue reports to assist Courts when sentencing Aboriginal offenders in the province of Ontario. ALST have 12 offices in the province, including an office in Toronto.

Gladue reports are named after *R v Gladue*, a Supreme Court of Canada decision, that discussed s 718(2)(e), as it applies to Aboriginal offenders before the courts for sentence. The section, enacted in 1996, directs a sentencing judge to consider "all available sanctions other than imprisonment that are reasonable in the circumstances for all offenders, with particular attention to the circumstances of aboriginal offenders."

The effect of Gladue is to require sentencing courts to receive and consider evidence regarding the circumstances of the Aboriginal offender, as an Aboriginal person, including the impact of colonization on him/her, the family and community; the history of, and relationship with, his family and Aboriginal community; and so on. One of the issues addressed in Gladue reports, prepared by ALST, is FASD. The Program Director of ALST, Jonathan Rudin, is of the view that many of the Aboriginal offenders coming up for sentence (in Ontario) are affected by FASD, but most are undiagnosed. The organization has worked out a way of assisting the courts to understand the impact of FASD on the individual offender without the benefit of a FASD assessment, and offering recommendations about programs that work well with the offender.

In the preparation of the Gladue report, the Asante Centre screening tool, prepared for probation officers to screen for FASD, is completed with an offender and the results are included in the report. With adequate information provided to the court, even without a formal diagnosis, Mr Rudin has reported that judges are willing to sentence with “real understanding of the people’s life … it makes a real difference.”

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Gladue reports prepared by ALST are labour intensive, taking between 8 and 20 hours to prepare inclusive of interviews and involving multiple informants, including the offender.287 ALST has approximately 18-19 writers who each generate about 30-40 reports per year.288

Gladue reports do not appear to be ordered or are received much less frequently, in other provinces and territories. For example, in Vancouver it was said that Gladue reports may take up to 4 months to prepare and courts could not delay sentencing to that extent.289

ALST has negotiated funding from a First Nations Health Authority and the Law Foundation for up to 30 adult FASD assessments, over a 2 year period, for Aboriginal offenders who are in custody awaiting sentence.

Advocacy and Support Services

FASSY – Fetal Alcohol Syndrome Society Yukon

FASSY is a community based organization, funded in the main by the Territory government of Yukon to provide advocacy and support services to FASD affected adults. It was established in 1996, led by Judy Pakodzky, a nurse and parent of adoptive children. Its services include:

- Case management of up to 45 adults at a time;
- Arrange annual visit to Whitehorse by diagnostic team for 1 week;
- Advocacy; and
- Education of service providers and others about FASD;
- Parent Support Group;
- Group sessions to reduce isolation, encourage peer support and connect/link to other organizations.

First and foremost FASSY aims to support FASD affected adults, “to do whatever needs to be done”.290 Some years earlier Donna Debolt, FASD Consultant taught FASSY to be collaborative care facilitators focused on FASD. FASSY is called in to facilitate case meetings, and ensures that the individual and the nature of the

288 Statement by Jonathon Rudin at meeting with Amanda Carling, Legal Education Counsel, Association in Defence of Wrongly Convicted and Chairperson of ALST, Solicitor Claire Millgate and author, on 1 April 2015.
289 Hon. T.J. Crabtree, Chief Judge, Provincial Court of British Columbia and a number of Vancouver based defence lawyers. Rudin said BC funds Gladue reports through Legal Aid and had run out of money. Alberta too had run out of money to fund Gladue reports. The Provinces of Saskatchewan and Manitoba did not fund or prepare Gladue reports (despite large aboriginal populations). Neither did Yukon. Courts in the provinces of Quebec and Nova Scotia were beginning to receive such reports.
290 Wenda Bradley, Executive officer
disability is at the centre of the planning. Usually case management starts with housing or accommodation. It is in extremely short supply in Whitehorse but is fundamental to securing stability for the individual before other issues can be addressed. In Whitehorse hotels with more basic facilities permit those on lower incomes to occupy rooms during the low season and then evict them in the tourist season.

FASSY engages in “snowploughing” or “helicoptering”. With respect to accommodation that involves working out the possibilities for accommodation, how that might work for the client, interviewing relevant landlords and then giving the client the options and guiding them to make a choice that suits their circumstances. FASSY will then sign a lease with the landlord, pay rent in advance, assist the client to move in and comply with tenant obligations, including financial management. Social services will then reimburse FASSY by way of a rental allowance.

FASSY has taken a cautious approach to support private accommodation for clients in this way, concerned at the risk it was assuming and the potential for that to cause serious financial loss for the organization. The Board has decided to hold $10,000 in reserve to cover any liability that may arise.

Blood Ties Four Directions Centre, an agency dedicated to information and support for those with HIV/AIDS and/or hepatitis C in Whitehorse, provided the model for the accommodation initiative FASSY has taken, and have been entering into private leases for their clients for over 2 years with only 1 problem tenancy.

FASSY employ 5 staff to service up to 45 clients at any one time. Each staff member has responsibility for specified clients. FASSY views FASD as a “thinking disability”. Clients need time to process information. It needs to be simplified. A quieter environment is necessary. FASSY aims to guide the client and be an interpreter of the world and the environment. It’s necessary to get relevant agencies to accept the disability and make accommodations for the impairments. The 15 minute appointment for example at the doctor or the dentist doesn’t work for the FASD affected individual. Often service providers, even in the health sector, will not accept that the client has a thinking disability and resist the FASSY worker facilitating communication. FASSY aims to walk alongside the client to have their needs met including accommodation, health issues, income and community participation. The latter encompasses participation in healthy activities or work, connection with culture, reduced criminal justice involvement and reduced victimization. The service involves quite intensive client support and case management, with oversight of all the client’s issues.
In addition to its intensive case management focus FASSY has developed programs for delivery to FASD affected individuals on various topics including parenting for new mothers, healthy communication, healthy relationships, budgeting, self-awareness and confidence building, child safety and relaxation.

FASSY has been a leader in advocacy for, and facilitating service delivery to, adults with FASD, for many years in Yukon. It plays a critical role in supporting them to live stable and healthy lives.

**Community Living British Columbia**

Community Living British Columbia ("CLBC") is a provincial government agency

Established by Act of Parliament that funds support and services for adults with developmental disabilities and their families in British Columbia. CLBC says it works to create communities where people with developmental disabilities have more choices about how they live, work and contribute.

In 2010 a regulatory change expanded eligibility CLBC criteria to include adults with FASD and autism spectrum disorder. Individuals over 19, with a diagnosis in either of those spectrums and who “have a very hard time doing things on (their) own like shopping and managing money”\(^{291}\) may qualify for services through the “Personalized Supports Initiative” (PSI). In other words they do not have intellectual disabilities but face significant challenges in daily life.\(^{292}\) CLBC uses special tests to decide who can get support.

**Adult Supervised Accommodation**

**Adult Residential Accommodation, Dun Kenji Ku, Whitehorse**

Dun Kenji Ku, or People’s Place, a 14-unit independent living apartment building opened in downtown Whitehorse, Yukon in February 2014. It is accommodation for adults with FASD. It was funded by the Yukon Housing Corporation\(^{293}\), working in partnership with Options for Independence. By August 2014, 7 men and 6 women were living at Dun Kenji Ku. Each occupant has their own apartment which includes a washrooms and a kitchen, including a stove. Staff are rostered, minimum of 2 per shift, to provide assistance 24/7.

\(^{291}\) Quote from the [www.communitylivingbc.ca](http://www.communitylivingbc.ca) website.

\(^{292}\) Community Living British Columbia, “Supporting Success for Adults with Fetal Alcohol Spectrum Disorder (FASD) p3. This resource (41 pages) aims to be an introduction to FASD and suggests accommodations to assist in supporting adults so affected.

\(^{293}\) There was a contribution to funding the project by a federal program, the Affordable Housing Initiative.
The long term goal of the facility was reported to be the reduction of interactions with police and emergency services. Precautions to minimize violence and self-harm include security cameras in hallways and stairwells. Some residents are permitted to cook for themselves including access to knives. Others have restrictions.294

294 Morin, P. “Yukon’s ‘pioneer’ FASD residence is working: staff”, CBC News posted 20 August 2014
21. Children and Young People in Care

Time did not permit the author to explore how National, State or Provincial child protection authorities are dealing with FASD affected children and youth in their care, nor how Courts exercising this jurisdiction deal with matters where the subject child, or a parent, are FASD affected. There is widespread recognition however by judicial officers, justice professionals and service providers that children in State care constitute a major component of those involved in the criminal justice system, and that a significant proportion of this cohort are FASD affected.

Several examples of communities responding constructively to the challenge of FASD among children and youth in State care are instructive.

The Response of the Child Welfare System in Alberta to FASD.

“FASD diagnosis puts us in the right city but assessment puts us on the right street.” So says Donna Debolt, Social Work Consultant, talking about the challenge of FASD among the children in the child welfare system.295 Diagnosis, she says gives child protection workers:

- Prognosis,
- Detection,
- Early intervention,
- Risk counselling and support,
- Prevention of secondary disabilities, and
- Multi-system organization of care.

Assessment requires many levels of professional service. It enables understanding of how the brain has been impacted through assessment of cognition, adaptive functioning, executive functioning, speech, memory etc.

Anecdotally, social workers in the field tell her that half their cases involve FASD, and about half those children have parents affected by FASD. Debolt recommends

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295 The quote was from a conversation in March 2015, subsequently confirmed by email dated 17 July 2015.
Ms Debolt spent 25 years working for the Ministry of children and families, the last 10 years of which she was an internal consultant on FASD, before establishing her own consultancy some years ago.
that the concept that FASD is common needs to be embraced so as to effectively address it in this population.296

Ms Debolt points out that children placed in care have unique risk factors for development even without the complications of organic brain disorders and prenatal substance exposure. “Critical case management errors often occur because the system fails to consider the possibility of FASD, both in the child and in the parent.”297 She notes that the child welfare system spends the least amount of money on children in care up to age 6, then spends increasingly more as they get older which reflects a philosophy of not getting interested or proactive until there is a reason to do so.

It is necessary to understand why a child has come into care. It may be that the behavioural complexities of the organic brain disorder are such that the child’s needs exceed the caregiver’s ability to care.298

A FASD affected child, with a range of impairments and secondary disabilities including multiple residential and school placements, is at a serious disadvantage. Giving an example of an 11 year old child, diagnosed with FAS, who had had 14 foster placements, 22 school placements and 5 social workers in 3 years, Debolt said “Nobody really knew him. Nobody really understood what he needed. Nobody really was invested in any kind of process.”

Making case management specific to FASD is considered essential as:

• it would focus intervention planning on the specific medical and developmental needs of the child,
• it would create focus on supporting the birth mother to reduce her risk of having other children with FASD, and
• it would allow for care to be specific to the needs of the family and help to increase placement stability.

Debolt urges focus on what good outcomes for FASD affected children are. They are:

- Stable placement;
- Coach families, caregivers and those providing support to the families;
- Respite for the carer and the school; and
- Support family/carer/service providers to deal with grief and loss.

296 This section is based on conversations, emails and an article as follows: Debolt, D., “What Specific Characteristics of FASD need to be taken into account in Family Court and in the Child Welfare System?” published in Binnie, I. et al. Legal issues of FASD: Proceedings from a Consensus Development Conference, (2013) Institute of Health Economics, Alberta, Canada p123.

297 ibid.

298 ibid., p 124.
Debolt refers to the need to anticipate and support the “predictable developmental trajectory of FASD”\(^{299}\) She writes:

“We need to know that, when children are four years old, they are going to have a certain set of needs, and that those needs are going to develop as expectations increase over time. If we do not anticipate needs, we are going to be in crisis; and I think most case management of FASD in the child welfare system is crisis management. I am known for saying to child protection workers that I wonder who the slow learners are. We wait for it to fall apart, and then we get excited. What about anticipating needs as they are coming at us? I think that placement stability is going to be achieved when we recognize it is at the feet of the child protection workers, that the job in engaged casework supervision is to be a good guardian.”\(^{300}\)

Ms Debolt has noted that very few of the child welfare agencies in Canada recognize the complexities of FASD in the child protection system and are providing training to deal with those complexities. However in Alberta the Ministry of Children and Families have embarked upon intense training of “frontline child protection and intervention workers around FASD” which has involve 10 days training, 4 days of which are spent looking at the principles of case management of FASD, and 6 days of consultation where workers participate in working through 3 cases per day learning about the kinds of decisions that need to be made for a FASD affected child/ren and/or parent in the child welfare system. Debolt says that this type of intense training results in early identification, service delivery through a collaborative model spanning many systems, providing specialized training to agency staff, families and caregivers. It will drive interventions directed to increasing placement stability and the reduction in severity of secondary disabilities, and planning for “meaningful and effective transition of youth to adult services.”\(^{301}\)

**Whakatapokai Care and Protection Residence, Auckland New Zealand**

The Whakatapokai Care and Protection Residence (“the Residence”) in Manurewa, Auckland is a care and protection residence which accommodates 20 young people, who are cared for by 76 staff, of which 51% are female, with a diverse ethnic makeup including NZ Maori, NZ European/Pakeha, Samoan, Tongan, Fijian, Tahitian, Cook Island Maori, British, Scottish, Romanian, Filipino, Chinese and Indian.

Previously the facility was home to youth on youth justice orders as well as care and protection orders however the youth justice function ceased in 2004.

\(^{299}\) ibid., p 126
\(^{300}\) Ibid.
\(^{301}\) ibid., p125.
The author was very fortunate to meet with the Acting Residence Manager, Kapeliele Su’a; the Clinical Team Leader, Deb Kent; Case Leaders, Dave Evans, Lisa Hall and Judy Wheal; Residential Youth Worker, Special Projects, O’Dell Toi; Harley Kaihi-Katterns, Program Coordinator; Craig Loane, Team leader Operations, and Roxanne Hughes, Clinical Practice Leader, West Auckland, Child, Youth and Family Ministry, together with Rose Hawkins, Regional Disability Advisor, 302 and Christine Rogan, Alcohol Healthwatch, to discuss the needs of, and services delivered to, youth resident at the Residence, have a tour through the facilities, and finally was honoured to be invited onto the Marae which has many beautiful carvings and tukutuku panels which O’Dell Toi and young residents have made. The Residence provides safety, and intervention, for young people with especially complex issues. It has a secure unit, used as a last resort, for any young person at high risk of harming themselves or other, or at risk of absconding. The secure unit can accommodate up to 5 young people at one time.

Apart from the units to accommodate the young people there is a large gymnasium, a pool and school building on site. In the centre of the residence there is a large compound with grassed area and a tennis/basketball court often used for sports and other recreational activities.

A multi-agency team meets weekly to review the progress of young people at the residence. The team includes a paediatrician, clinical psychologist and/or mental health nurse, a cultural representative, a nurse from the onsite medical service, the team leader from the onsite educational service and a transition teacher. The site social worker is invited to attend and discuss the young person’s progress.

A young person at the residence is reviewed at least 3 weekly and more where there are complex issues. When a young person is newly admitted the focus is on presenting concerns, formulating an understanding of the difficulties so as to inform intervention. Referrals for further assessments may need to be made. Subsequently planning for permanency and progress to transition out of the residence are addressed.

While young people are at the residence they have the opportunity to engage in one to one sessions with clinicians from a mental health service. That intervention usually involves cognitive based therapy to assist young people to develop coping skills and emotional regulation skills. There is a strong focus on essential life skills including personal hygiene, safe relationships and how to use public transport. There are strong sporting, cultural and craft programs at the residence.

Recently the residence has piloted the use of Dialectical Behaviour Treatment, a cognitive based therapy to develop capacity to manage emotions and behaviours.

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302 Child, Youth and Family Ministry.
Although the program, entitled “Riding the Waves” appears to have excellent content and depth, it may be problematic for those with FASD, who often have difficulty reasoning, or learning from mistakes, taking the perspective of another, and have poor capacity to read and comprehend social cues. The impairments that accompany FASD make cognitively based therapies or interventions inaccessible, or unsuitable.

FASD was not identified or prioritized for attention by staff, or management, at the residence. There had been no specific training about FASD. Rather, the approach was to treat each young person as an individual whose special needs required accurate identification, careful planning and targeted intervention on a temporary basis before transition into permanent living arrangements. There was an institutional understanding, and respect, for the fundamental importance of relationship, and culture, as holding the keys to emotional and psychological growth and wellbeing.

The ethic of care was deeply embedded in the place. A symbol of that was the Marae which was replete with carvings, and tukutuku panels, created by young people and staff. Another was the efforts of staff to undertake painting, carving and other refurbishment of one of the 10 bed accommodation units which had become very rundown and tired, with assistance from some young people, when there was insufficient funds available from Government to undertake the previously planned work using contractors.

Development of Expertise Internal to Child Welfare Authorities

The New Zealand Ministry of Child Youth and Family have regional disability advisors, an internal specialist available to child protection workers for consultation.

Rose Hawkins, the Regional Disability Advisor for the Auckland and Te Tai Tokerau regions, has been advocating for staff training on FASD, and developed, or contributed to, the development of tools, to facilitate improved knowledge and capacity among child protection workers to manage FASD affected youth.

**FASD Eyebites** consists of a pack of cards, the size of playing cards, with messages for carers, child protection workers, and others, about how to manage behavioural issues to de-escalate the young person. There is an accompanying video which talks about how to use the principles outlined in the cards to work with a FASD affected young person. The messages on the cards include:

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303 Rose Hawkins created this very useful tool, and generously gave the author a set of homemade cards. Professionally printed cards were launched with the video resource on 2 September 2015.
Talk to like a much younger child

Can't not Won't

It's all about relationship

Clear directions – one at a time

Supervise like a much younger child

Teach One thing at a time, over and over

Do alongside rather than independence

Managed Across the whole day – Routines

Lifelong Support – changing over time

Set up Positive Social interactions

Structure, Support, Supervision, Keep it Simple, Build on Strengths

Support not consequences

Visuals rather than verbals

De-escalation – come underneath. Not above, Not control, Not restraint

It's in the brain So don't take it personally

Decide for Based on the relationship and knowing the person

Oppositional? Overwhelmed or confused

Enable and reward Success

Don't reason because they can't

No wriggle room

Change the environment Not the person

Give in because they can't

Anticipate problems Reduce demands

Every day is a New Day

Give your attention Not “he’s attention-seeking”

Are they definite and insistent? Distract and divert.
The Alberta Ministry of Child, Youth and Families have undertaken a major shift in practice to develop a FASD informed practice, FASD best practice standards and training of staff to be able to lead the work of the agency. The agency has internal FASD specialists, regionally based who are available to consult on individual cases. This change process has been intensive, evidence based and subject to careful evaluation. 304

The Signs of Safety framework is used by the Alberta Ministry of Child, Youth and Family to discuss and plan for appropriate support and intervention for children and youth in care, framing it as a FASD Safety map. For example, a child’s behaviour at home and school may be perceived as aggressive and “bad”. With placement stability as the primary objective the team analyse the behaviours, identify the strengths in the environment, and necessary accommodations for the disability, identify what support and respite is needed and who will be responsible for delivering the various outcomes. Knowledge of, and relationship with, the particular child together with expertise working with FASD, working in collaboration with the child’s team, a better understanding of what underlies the child’s behaviour and strategies and interventions to achieve the best outcomes are developed, and implemented. This is innovative and demanding work which offers the prospect of better quality of life for FASD affected children and their families, less involvement with the criminal justice system and improved community safety. It requires front end investment in training and support for professionals and families to change thinking, practice and systems.

Other Tools

The New Zealand Ministry of Child, Youth and Family has developed another training tool in the form of a DVD entitled “Success for children and young people with FASD”, aimed at educating social workers about FASD. 305

Dr Valerie McGinn, paediatric neuropsychologist, has produced an educational DVD, entitled, “Recognizing and Meeting Differently the Complex Needs of Children with Fetal Alcohol Spectrum Disorder.”306

304 This section is based on discussion with Donna Debolt.
305 Rose Hawkins generously supplied a copy of this DVD.
306 Dr McGinn undertakes FASD assessments, in conjunction with a pedestrian, for the Ministry of Child, Youth and Family, and consults on management and intervention. She generously provided a copy of the DVD.
On the theme of prevention, rather than management and intervention, the Ministry of Child, Youth and Family in collaboration with Alcohol Healthwatch have produced an educational DVD, entitled “Risking it All: True Stories, Fetal Alcohol Spectrum Disorder, Prevention for a Brighter Future”.\textsuperscript{307}

\textsuperscript{307} Copy generously supplied by Christine Rogan, Health Promotion Advisor and FASD Project Coordinator, Alcohol Healthwatch. Christine generously organized the author’s itinerary in New Zealand.
22. Conclusions & Recommendations

This paper has attempted to report thematically on the author's observations during the fellowship so as to provide a snapshot of relevant developments in the countries visited. Of necessity this report refers to a selection only of the initiatives taken by communities to respond to the challenges presented by FASD.

The response within the justice setting in the selected jurisdictions has been limited. In North America the response has been patchy, sometimes excellent, but not always sustained. The New Zealand Government have announced that a national FASD Strategy is being developed.

A List of Individuals and Organizations Visited appears at Appendix B. It is comprehensive in that it provides a complete list of all those the author met with or discussed issues or discussed issues of relevance to the project.

This report aims to generate discussion in Australia about the appropriate response within the criminal justice system. Of course there are differences in substantive law and process between jurisdictions, however the following points are clear:

- Australia has a similar colonial history, broadly similar legal tradition, cultural and social mores;
- Prevalence of FASD in the Australian population is likely to be similar to the other countries, or higher, based on alcohol consumption rates in Australia relative to the other jurisdictions;
- FASD is a lifelong condition;
- Other comparable countries have acknowledged the significance of FASD and taken steps to fund research, support and advocacy.
- Leadership has been shown by national legal organizations, such as the Canadian Bar Association and the American Bar Association urging law reform to avoid criminalization of this vulnerable group, training for justice professionals and resourcing of support services;

The criminal justice system is simply one ecosystem within the broader society. An effective response to deal with FASD requires collaboration across government, State and Federal, involving all key human service departments including police, justice, child protection health, disability services, education and corrective services. Alberta is the model to be emulated.

Early identification and effective intervention holds the key to better outcomes for FASD affected individuals and their families and to improving community safety by minimizing the harm which will otherwise result we continue to ignore the impact of FASD in the community. Currently courts in Australia are ignorant of FASD in the criminal justice population. Of youth incarcerated, 25% or more may be FASD affected. Without diagnosis and appropriate intervention, the profile of the disorders suggests a trajectory of escalating behaviours, including aggression and violence. The impairments which attend the disorders in the FASD umbrella will not be ameliorated by increasing prison sentences. FASD is a disability. For children or youth so affected, entry to the criminal justice system needs to focus on achieving 2 goals: improving the outcomes for the individual and community safety.

The recommendations below are informed by:

- the observations made by the author whilst undertaking the fellowship,
- the conversations with professionals, academics, service providers, public servants, parents and carers,
- exposure to the literature, research and other material, dealing with FASD and neurodevelopmental disabilities,

in the context of the author’s work as a judicial officer in a specialist jurisdiction dedicated to dealing with children and youth, aged 10 to 17 years, charged with criminal offences, and separately, in the child welfare jurisdiction, focused on whether children, between birth and 17 years ought be in State care due to abuse suffered, the risk to, or needs of the child.

This project focused on FASD however it became clear that as a group of disorders it should be viewed as part of a category, or perhaps a continuum which has been described as neurodisability.

How Court is Conducted

Children’s Courts, dealing with children or youth as defendants, should be conducted in a way that reflects the age, developmental level and maturity of the child or youth. Principles such as the best interests of the child, the need to facilitate the rehabilitation of the child/youth and enhancing community safety must underpin the

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310 Fast, D.K., Conry, J., & Loock, C. (1999) Identifying fetal alcohol syndrome among youth in the criminal justice system. *Journal of Developmental and Behavioural Paediatric*, 20(5), 370-372. The study reported on 287 youth remanded to a youth forensic facility in British Columbia, over one year who were evaluated. Researchers found 23.3% had FASD, only 1% of those with FASD were diagnosed with FAS, the balance with Alcohol Related Neurodevelopmental Disorder (ARND). Both conditions involve brain damage and associated neurocognitive dysfunction due to prenatal alcohol exposure. The author suggests that the prevalence in Australia among children and youth in detention may be more than 25% due to higher rates of alcohol consumption relative to other countries, for example the US. See WHO Report on Global Status Report on Alcohol and Health 2014: [http://www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_1.pdf?ua=1](http://www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_1.pdf?ua=1)

operation of these courts and decision-making by judicial officers, stakeholders and service providers.

Court process, involving a child between 10 and 18 years, should be child centred, and operate in a manner that enhances the child defendant’s access to justice. Specialist defence lawyers, prosecutors and service providers should be utilized wherever possible, receive training and have their specialist skills recognized by relevant authorities and funding bodies.

Child centred court process extends to the direct involvement of parents, family and/or significant adults in the preparation of any sentencing or rehabilitation plan for the child/youth. It also requires recognition of the child’s needs, including emotional or psychological needs in the court setting as well as in the medium to long term.

Effective communication in the court process, including in the court room is essential. It is the responsibility of the Court and stakeholders. A variety of methods and strategies need to developed, and utilized, to ensure understanding by the child defendant. That may include the use of an interpreter, an intermediary, the use of plain, and street, language in the courtroom, the use of pictures or icons by youth justice officers, the use of aids to communication developed for distinct populations.

Judicial officers, professionals working with children and youth engaged in the criminal justice system, other stakeholders and service providers should have training to develop the skills necessary to ensure effective communication with children and young people in the court process, including where necessary, the use of interpreters and intermediaries.\(^{312}\)

\(^{312}\) An intermediary is a person, usually a speech and language therapist, who assists another who has language and communication difficulties. International research indicates that about 60% of the young people involved in youth justice systems have significant difficulties with oral language (e.g. Bryan K, Freer J, Furlong C. Language and communication difficulties in juvenile offenders. International Journal of language and communication difficulties, 2007; 42, 505-520. See Talking Trouble NZ  http://talkingtroublenz.org and see Australian academic Professor Pamela Snow’s blog at  http://pamelasnow.blogspot.com.au .
**Screening**

Every young person charged with an offence and referred to Court should be screened for fetal alcohol spectrum disorder (FASD), post traumatic stress disorder (PTSD), and other neurodisabilities in a timely manner, and certainly before the matter is finalized by the Court.

Every young person diverted from the criminal justice and process should be screened for FASD, PTSD and other neurodisabilities, and referral for further assessment by a paediatrician made if appropriate, as part of the action plan.

Every young person remanded in custody and accommodated at a detention facility operated for, or on behalf of any youth correctional service, for a State or Territory Government, should be screened for FASD, PTSD and neurodisabilities, unless he/she has been screened, or diagnosed, within the preceding 12 months.

Care and Protection Authorities need to ensure that children and youth coming into State care are screened for FASD, PTSD and neurodisabilities within a reasonable period of coming into care, for example 30 days and then referred for assessment by a paediatrician. Where screening suggests full assessment is appropriate that needs to be done by a multidisciplinary team (“the team”) within a reasonable period, say 3 months of entry into State care and the team’s recommendations for intervention implemented.

**Assessment to determine Young Person’s Needs, Strengths and Challenges**

In order to assess culpability, determine capacity to comply with any sentence imposed, facilitate rehabilitation of the young offender and minimize future offending, Children’s Courts require more information about the functioning of the child. The relevant youth corrections service (Youth Justice), should administer the screening tool referred to above, at an early stage of the proceedings, and subject to the result, refer the youth for assessment by a paediatrician and/or other clinician so as to diagnose any disorders and/or ailment/s and obtain the clinician’s advice about the young person’s needs, strengths, challenges and recommendations for intervention.

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313 Peirse-O’Byrne, K. in her LLB Thesis, “Identifying and Responding to Neurodisability in Young Offenders: Why, and How, this needs to be Achieved in the Youth Justice Sector?” (unpublished, p6) defined neurodisability as “the product of an atypical neurological profile, whether due to biological factors, including genetics, or environmental factors, such as pre-birth or birth related trauma, injury or illness in childhood, or a combination of these”, deriving that definition from Nathan Hughes and others, “Nobody made the Connection: the prevalence of neurodisability in young people who offend”, Office of the Children’s Commissioner for England, October 2012 at [1.5-1.7].
Based on the report of the paediatrician\textsuperscript{314}, and in consultation with the youth’s parent/s\textsuperscript{315} or carer (if applicable), family members, defence counsel, the prosecutor and relevant service providers, Youth Justice should develop a plan identifying the young person’s needs, how each of the identified needs will be met and by whom.

Youth Justice may convene a Sentencing Conference, to include relevant parties including clinician/s and potential service providers to:

- discuss the youth’s needs and appropriate interventions, and
- determine how those needs will be met, and
- prepare a draft plan to submit to the Court, to form the basis of a sentencing plan.

Youth Justice will circulate the draft plan to relevant parties, and submit it to the Court prior to the Sentencing Hearing.

Assessment of a child/youth suspected of having FASD, PTSD and/or other neurodisabilities should be undertaken by appropriately trained, qualified and experienced clinicians.

\textit{Training}

So as to better understand the challenges faced by those affected with FASD, PTSD and other neurodisabilities, improve the outcomes for those individuals and minimize the risk of harm, all those who work with this group of children and young people require training about FASD, PTSD and other neurodisabilities including:

- those working with children and youth in State care,\textsuperscript{316}
- those working with children/youth involved in the criminal justice system,\textsuperscript{317}
- frontline police dealing with children and youth,
- staff in agencies providing services to children and youth, including residential services, counselling, addictions, disability services and other programs,
- custodial, health and teaching staff in youth custodial facilities, and
- teachers and teachers assistants.

Selected workforce groups require more intensive training to enable them to screen for FASD & other neurodisabilities, at intake eg youth justice workers, care and protection workers, custody officers at youth detention facilities.

\textsuperscript{314} The paediatrician is assumed to be the lead clinician.
\textsuperscript{315} Or guardian, where child in State care.
\textsuperscript{316} For example, case officers, foster carers, contact supervisors.
\textsuperscript{317} For example juvenile justice officers, those supervising bail, youth workers, mental health workers, addictions workers, lawyers, judicial officers etc.
Selected agencies delivering specialist services to children and young people, for example based on cognitive based therapy (eg addictions), must reassess their service delivery and adjust their services, and the method of delivery to accommodate the impairments and challenges of those affected by FASD, PTSD and other neurodisabilities.

Agencies, government\textsuperscript{318} and non-government, must embark upon a process of assessing their interaction with children and youth, affected by FASD, PTSD and other neurodisabilities, and adjust their service delivery so that they may receive the benefit of the service despite their impairment/s, or put another way, services are made accessible to youth in this cohort.

\textit{Transition FASD affected youth out of State care}

Any diagnosis of a disorder within the FASD spectrum, of a child in State care should be reviewed by a multidisciplinary team prior to the youth turning 18\textsuperscript{319} so as to identify the needs and challenges with precision, develop an individualized transition plan and source appropriate accommodation, support and intervention services. The same should apply to youth suffering other neurodisabilities.

\textit{Leadership}

Governments, Federal, State and Territory, in collaboration with each other and relevant community based organizations, must lead the way in responding to the challenge which FASD\textsuperscript{320} presents in the Australian community by:

\begin{itemize}
  \item the development of a National FASD Strategy, building on the FARE Australian FASD Action Plan 2013-2016;
  \item the establishment of a Federal inter departmental committee, including departments of Health, Attorney General/Justice, NDIS, Education to oversee implementation of the National FASD Strategy, foster collaboration, identify law reform and policy change required.
  \item resourcing the establishment of FASD (Diagnostic) Clinics in each State and Territory\textsuperscript{321}
  \item enabling State and Territory based advocacy and support agencies for FASD affected individuals and their families;
\end{itemize}

\textsuperscript{318} For example the following departments: Education, Disability Services, Police, Care and Protection, Health, Mental Health, Drug and Alcohol Office, NDIS.

\textsuperscript{319} unless assessment was previously done within 12 months.

\textsuperscript{320} It is not intended that FASD should be singled out from other neurodisabilities for planning or resourcing purposes. In this recommendation the reference to FASD should be taken to include other neurodisabilities.

\textsuperscript{321} That may be for a defined period pending incorporation of such clinics in State and Territory based health structures.
• funding the establishment of regional networks to drive appropriate local service delivery, identification of needs and collaboration between relevant agencies.

Establishment of Carer Support & Advocacy Groups

Parent/Carer Support and Advocacy Groups should be established to provide:

• Information & training and regarding neurodevelopmental disorders, including FASD,
• Advocacy to Government and service providers regarding neurodevelopmental disorders, including FASD, and the interventions and services required to facilitate FASD affected youth living meaningful lives,
• Support networks for parents and families of FASD affected youth, which may include use of social networking platforms to overcome geographic isolation.
• Opportunities for FASD affected youth to engage in recreational activities in a safe and supervised environment, in order to facilitate the development of social skills, and friendships.
• Respite for carers and families of FASD affected youth.

Accommodation for Youth with Neurodevelopmental Disabilities

The Federal, State and Territory Governments should undertake a process of considering, and then establishing, a range of accommodation options, one of which would consist of 24/7 supervised accommodation, for FASD affected youth, and other neurodevelopmental disabilities, to cater for their needs, challenges and any risks they pose for the wider community so as to maximize autonomy whilst providing supervision and support within the community.

Management in Custody

Any child or young person admitted to a custodial institution should be screened within 24 hours of intake for FASD, PTSD and other neurodisabilities.

Subject to the result of the screening tool, every child or young person sentenced to a period of detention should be assessed by a paediatrician, and other allied health professionals as recommended by the paediatrician, and recommendations obtained for appropriate therapy, support and intervention.

The report and recommendations of the paediatrician should be the basis for a rehabilitation plan (“the plan”) for the child or young person, to be developed by a

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322 Again the reference to FASD in this recommendation may be read so as to include other neurodisabilities.
323 Unless the child/youth has been screened and/or assessed by a paediatrician within a defined period, say the previous 12 months.
youth justice officer, working in collaboration with the parent/s, carer and/or guardian, other significant adults in the life of the child, and service providers. The plan should address the youth’s needs including health and education, accommodation upon release, and identify intervention required. Implementation of the plan should begin as soon as possible while the youth is in custody, with service providers coming into custodial facilities to build relationships and commence programs before transitioning to community.

Staff working within youth custody facilities should be trained to understand the impact of neurodevelopmental disorders on children and youth, the range of impairments and best practices to manage such youth.

Existing management practices in custodial facilities, for example use of confinement, alone, in an observation cell, without any materials or other stimulation, to be reviewed so as to:

- determine the impact of such practices on a child or young person with neurodevelopmental disabilities,
- obtain expert advice on best practices for the management of children and young people with neurodevelopmental disorders in custodial facilities,
- develop appropriate strategies, and practices, for the management of children and youth with neurodevelopmental disorders in custodial facilities (‘best practices’) based on 2 principles:
  - what is in the best interests of the child or young person, and
  - what will enhance the safety of the community upon the child/young person’s release back into the community.
- Detail permissible management practices and strategies in standing orders, rules or appropriate format, and make them available to staff working in custodial facilities, and the public.

All staff working in custodial facilities should be trained in best practices for the management of children/youth with neurodevelopmental disorders, and refresher training undertaken at reasonable intervals.

**Sentencing**

In order to craft appropriate and effective sentences, Courts make judgements about culpability of the offender, and capacity to comply with a Court order, which depends on:

- high quality information about the functioning and capacity of a child/youth, including developmental level,
• the availability of appropriate accommodation & care, and
• tailored intervention, including programs to address the child’s needs.

Children’s Courts depend upon Youth Justice authorities to supply relevant and appropriate evidence regarding the child/youth and options for intervention.

Youth Justice authorities must develop the capacity to provide the high quality information required by Children’s Courts, source324 community-based accommodation options and the capacity to deliver tailored intervention. That would best be done for each child by preparing a draft sentencing plan as referred to above, to be submitted to the Court with a presentence report.

Bail

Youth Justice authorities need to establish youth bail hostels which can accommodate children/youth with neurodevelopmental disorders for whom suitable community based cannot otherwise be located.

Programs

Children/youth with neurodevelopmental disorders, involved in the criminal justice system, require assessment by qualified and experienced clinician/s, 325 before sentence. The lead clinician, or assessment team, should be requested to provide recommendations for intervention. Those recommendations should be the basis for formulation of the draft sentencing plan, and any tailored programming required to address the child’s needs.

Police Forces

Frontline police officers should receive training about neurodevelopmental disorders and the impact they may have on the behaviour and communication skills of a child or youth.

Police Forces need to develop a protocol/standing orders regarding the conduct of any interviews or communications with:

• those who have been diagnosed with FASD, PTSD and neurodisabilities,
• those suspected of being so affected or
• those who appear to suffer cognitive or communication difficulties,

324 And resource community based accommodation options if necessary.
325 A paediatrician should be considered as the lead clinician who may recommend further assessment by clinicians in other disciplines.
so as to ensure procedural rights against self-incrimination are respected and the affected individual is not treated unlawfully or unfairly.

Parents, Caregivers, Families

Parents, caregivers and families of those affected by FASD, PTSD and neurodisabilities have an important role to play in:

- enabling stakeholders in the criminal justice system to understand the impairments, challenges and strengths of a child or youth, so affected,
- supporting the child/youth to be screened, and assessed by a clinician/s,
- working with Youth Justice and service providers to develop a plan to address the child/youth’s needs, and
- implementing the plan, with the active support of Youth Justice and relevant agencies.

Parents, caregivers and families of those affected by neurodevelopmental disabilities must be supported by Youth Justice and other relevant agencies such as the Disability Services Commission to better understand the impact of the child/youth’s impairments and work with service providers to advance the wellbeing, capacity and integration in the community of the affected youth.

In order to ensure support for parents, caregivers and families of those affected by neurodevelopmental disorders in the community, Governments should consider the establishment of a support worker based in the community whose role would be to assist the parent/carer to access appropriate services in the community, for example education, relevant programs, or appropriate accommodation, as the child grows and needs change. The FASD Keyworker program, implemented in various provinces in Western Canada, over some years, should be considered as a model.
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The Snow Report

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Mencap, the voice of learning disability ([https://www.mencap.org.uk/](https://www.mencap.org.uk/))

**Advocacy, Support and Intervention**

FASlink Fetal Alcohol Disorders Society, Research Information, Communications ([www.FASlink.org](http://www.FASlink.org))
Fetal Alcohol Syndrome Society Yukon ([www.fassy.org](http://www.fassy.org))
MOFAS
NOFAS
## Appendices

### Appendix A: Program – Itinerary Approved before departure

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Institute Visited</th>
<th>Contacts</th>
<th>Issues Raised</th>
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<tr>
<td>28/02/15</td>
<td>Perth/Vancouver</td>
<td>FASD Conference Legal Day</td>
<td>Kay Kelly</td>
<td>Justice/Courts/Services</td>
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<td>6th International Conf FASD</td>
<td>Hon Michael Jeffery (Retired)</td>
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<td>Prof Sterling Clarren</td>
<td>FASD Diagnostic Clinics Study</td>
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<td>Asante Centre</td>
<td>Julianne Conry</td>
<td>Diagnosis, Links b/n Courts &amp; diagnostic clinics</td>
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<td>Rita Francis</td>
<td>Speech Language Pathologist</td>
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<td>Alison Pooley</td>
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<td>Provincial Court, BC</td>
<td>Frances Gordon, Crown Counsel</td>
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<td>Boulding, Defence Solicitor</td>
<td>Representing FASD youth</td>
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<td>Ministry of Children &amp; Family Development, BC</td>
<td>Christine Fuller, RN</td>
<td>Provincial FASD Consultant, Youth with Special Needs Policy</td>
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<td>13/03/15</td>
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<td>Carolyn Hartness</td>
<td>Carer FASD Children, Native American</td>
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<td>Paul D Connor,</td>
<td>Neuro-psychologist</td>
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<td>Dr Therese M Grant</td>
<td>Director, Fetal Alcohol &amp; Drug Unit, Uni Washington</td>
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<td>19/03/15</td>
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<td>Youth Criminal Defence Office</td>
<td>Nicole Mizzi</td>
<td>Social Worker/Courts/Services</td>
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<td>Bernadette O'Donnell</td>
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<td>John Howard Society</td>
<td>Katerina Jansen</td>
<td>Advocacy, FAS Action Hall</td>
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<td>Arlin Pachet, Clinical Psych</td>
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<td>Cathy Lane Goodfellow</td>
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<td>Calgary Young Offender Centre</td>
<td>Charlotte MacDonald-Allan</td>
<td>Program Manager</td>
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<td>Justice &amp; Solicitor General's office</td>
<td>Marilyn Jerowsky</td>
<td>Youth FASD Project, Prosecutor</td>
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<td>25/03/15</td>
<td>Toronto, Canada</td>
<td>University of Toronto</td>
<td>Prof. Kent Roach</td>
<td>Law and Public Policy</td>
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<td>Dr Anthony N. Doob</td>
<td>Centre for Criminology and Sociolegal Studies</td>
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<td>Professor Gideon Koren</td>
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<td>Jonathon Rudin</td>
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<td>31/05/15</td>
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<td>Gladue(Ab Persons) Court</td>
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<td>Dr Jocelynn Cook</td>
<td>Executive Director, Revised Can Diagnostic Tool</td>
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<td>Correctional Services Canada</td>
<td>Dr John Weekes</td>
<td>Head, psychological services, adults</td>
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<td>6/04/15</td>
<td>New York</td>
<td>Centre for Court Innovation</td>
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<td>Provincial Court of Manitoba</td>
<td>Judge Mary Kate Harvie</td>
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<td>Manitoba FASD Centre</td>
<td>Teresa Brown</td>
<td>FASD Youth Justice, Program Manager</td>
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<td>Holly Gammon</td>
<td>Lead on Manitoba FASD Strategy</td>
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<td>Mary Cox-Millar</td>
<td>Manager of the FASD Centre</td>
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<td>University of Manitoba</td>
<td>Prof Albert E Chudley</td>
<td>Dept Pediatrics, Child Health and Genetics</td>
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<td>Manitoba Legislative Assembly</td>
<td>Corey La Berge</td>
<td>Children’s Advocate, FASD Youth in Care</td>
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<td>28/04/15</td>
<td>Regina, Saskatchewan</td>
<td>University of Regina</td>
<td>Dr Michelle Stewart</td>
<td>FASD Research Network, Police, Justice</td>
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<td>Saskatoon, Saskatchewan</td>
<td>Youth Criminal Defence Office</td>
<td>Pat Yuzwenko SC</td>
<td>Defence Lawyer</td>
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<td>Dr Kaitlyn McLachlan</td>
<td>Transition needs for Youth in CJS</td>
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<td>Dr Carmen Rasmussen</td>
<td>Screening for Sub Use in FASD youth</td>
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<td>University of Calgary</td>
<td>Dorothy Badry</td>
<td>Faculty of Social Work, Treatment Improvement Protocol</td>
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<td>CASA Child &amp; Adolescent &amp; Family Mental Health</td>
<td>Dr Rebecca Marsh</td>
<td>Director of Research &amp; Evaluation</td>
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<td>Alberta Legal Aid, F/L Office</td>
<td>Lydia Bubel</td>
<td>Working with Parents &amp; Carers</td>
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<td>Alberta Provincial Court</td>
<td>Judge Larry G Anderson</td>
<td>FASD Legal Issues Conf 2013 Jury Member</td>
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<tr>
<td>6/05/15</td>
<td>Edmonton, Alberta, Canada</td>
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<td>University of Alberta</td>
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<tr>
<td>12/05/15</td>
<td>Whitehorse, Yukon, Canada</td>
<td>Hon. Ryan Leef MP</td>
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<td>Bill re FASD in Canadian Parliament</td>
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<td>Human Rights Commission</td>
<td>Attorney Fia Jampolsky</td>
<td>Chair, Human Rights Commission, Yukon</td>
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<td>Former President Canadian Bar Association</td>
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<td></td>
<td></td>
<td>Rod Snow QC</td>
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<tr>
<td>15/05/15</td>
<td>Auckland, New Zealand</td>
<td>Alcohol Healthwatch Trust</td>
<td>Christine Rogan</td>
<td>National Co-ord, Fetal Alcohol Network</td>
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<td>Youth Court</td>
<td>Judge Tony Fitzgerald</td>
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<td></td>
<td>Valerie McGinn</td>
<td>Neuro-psychologist</td>
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<tr>
<td>20/05/15</td>
<td>Wellington, New Zealand</td>
<td>Youth Court</td>
<td>Judge Andrew Becroft</td>
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<tr>
<td>Date</td>
<td>Location</td>
<td>Institute Visited</td>
<td>Contacts</td>
<td>Issues Raised</td>
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<tr>
<td>23/05/15</td>
<td>Perth, Western Australia</td>
<td>Return Home</td>
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Appendix B: List of Individuals & Organizations Visited

Vancouver

Frances Gordon, Crown Prosecutor, Youth Court, Vancouver
Linda Selbie MacDonald, Administrative Crown Counsel, Ministry of Justice
Flora Raynes, Native Courtworker and Counselling Association of British Columbia
Sandra Manzardo, Clinical Supervisor, Youth Probation Services
Yankee 10 car, Youth Probation Services & Police Officer
Amy Powter, Youth Referral Coordinator Youth services Section Vancouver Police Department
Sally Anderson, FASD Activities Co-ordinator, FASD Activities Coordinator, NIAAA ICC/FASD
Retired Judge Michael Jeffery, Superior Court, Barrow, Alaska
Chief Judge Hon.Thomas J. Crabtree, Provincial Court of BC
Judge Lindsay Smith, Provincial Court
Richard S. Fowler QC, Defence Barrister
Julianne Conry, Forensic Psychologist, Academic and Author
Audrey Salahub, Executive Director, Asante Centre
Allison Pooley, Program Director, Asante Centre
2 Polish visitors:
Katarzyna Okulicz-Kozaryn, psychologist
Krzysztof Brzozka, Director Institute for Prevention of Alcohol Harm, European member of WHO
Malgosia Tomanik, (FASD) Key Worker/ Family Support Worker
Anne- Marie Richmond, FASD Key Worker Nanaimo, BC
3 Defence Lawyers – met in Counsel Lounge, Supreme Court building:
Michael Connaghan, Kelly Merrigan &
Jennifer Dyck, Barrister, acting for kids in care (crime)
Defence lawyer, Frances’ Principal
Daniel…. Indigenous Law Clinic, East side
Britta West, Psychologist
Professor Harry Blagg, University of Western Australia ( UWA)
Raewyn Mutch, Paediatrician, Associate Professor, UWA, Research Lead Banksia Prevalence Study,
TelethonKids
Seattle

Professor Susan Astley

(Diagnostic team included Dr Julian Davies, Paediatrician, OT Jen, Social Worker Julie, Speech & Language Pathologist, FASD Family Advocate

Heather Carmicheal Olsen

Hon. C Kimi Kondo, Chief Judge, Municipal Court, including Mental Health Court (MH)

Sonya Oh, Court Liaison, Sound Mental Health, contracted to assess if meet MH Court entry criteria

Judy Ashley, Court Liaison, Sound Mental Health

Peter S. Holmes, City Attorney

Ms Kay Kelly, Director, FASD Legal Issues Resource Centre, University of Washington

Eric S., Attorney and Law Professor, employment discrimination, University of Washington

Associate Professor Therese Grant, Director Parent Child Assistance Program, 1991-present.

Judge Ron J. Whitener, Judge, Tualalip Tribal Court

Ms Saza Osawa, Reservation Attorney, Dependency Jurisdiction, Tualalip Tribal Court

Khia Grinnell, Reservation Attorney and Relative Carer, Tualalip Tribal Court

Judge Wesley Saint Clair, Juvenile Court (specialist jurisdiction of the Superior Court)

Calgary, Alberta

Cathy Lane Goodfellow QC

Shandy Tilley, Nurse Practitioner and Clinic Co-ordinator, MediGene Services Inc.

Madelyne Porter, MSc, Prevention Conversation Facilitator, Calgary Fetal Alcohol Network ("CFAN")

Kaylee Ramage, MSc, Research Project Co-ordinator, CFAN.

Judge Cook-Stanhope, Judge Provincial Court, Alberta

Charlotte MacDonald-Allan, Program Director, Calgary Young Offender Centre

Marilyn Jerowski, FASD Co-ordinator, Solicitor General’s Office, Calgary Area

Ron Toner, Diversion Program Manager, Youth ,City of Calgary,

Kevin Morey, Deputy Director, Calgary Youth Detention Facility

Darlene Petrie, McMan Calgary, Community Engagement Specialist

Pauline Clarke, McMan Calgary, Manager Outreach and Community

Ian McNeish, Lawyer, Youth Criminal Defence Office, ("YCDO")

Nicole Mizzi, Social Worker, YCDO

Diana Mah, Lawyer, YCDO

Christopher R. McAviney, Lawyer, YCDO

Leea Ramparen, Youth Worker, Diversion, YCDO

Sandra Fellger, Guardian of Hope, FASD affected young person

Kathleen Reyes, Lawyer, YCDO.
Toronto

Jonathon Rudin, Counsel, Aboriginal Legal Services of Toronto
Amanda Carling, Counsel – Legal Education, Association in Defence of Wrongly Convicted ("AIDWYC")
Claire Millgate, Lawyer (Aboriginal/Child Welfare)

Ottawa

Liam Curran, Social Worker, Ph.D Candidate McGill University, Author, Trainer
Joanna Wells, Counsel, Criminal Law Policy Section, Justice Department
Robin Trombley, Counsel, Youth Justice Policy, Justice Department
Debbie Auger, Manager, Youth Justice Programs, Justice Department

Washington DC

Attended National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health (NIH)
Interagency Coordinating Committee FASD Justice Committee (NIAAA/ICC) & Public Meeting & Dinner

Sally Anderson, FASD Activities Co-ordinator, FASD Activities Coordinator, NIAAA ICC/FASD
Susan Carlson, Retired Judge, Chair NIAAA/ICC FASD Justice Committee,
Eileen Bisgard JD, Attorney, Parent, project Director, Colorado Project
Professor Linda L. Chezem J.D, Purdue University, Retired Judge, Indiana Court of Appeal and Trial Division
Karen J. Bachar, Senior Policy Advisor, U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention
Howard Davidson, Centre on Children and the Law, American Bar Association
Sharon Newburg-Rinn Ph.D, US Department Health & Human Services, Research Analyst, Children’s Bureau
Dr Kenneth R. Warren, Deputy Director, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health (NIH)
Mary Jo Spencer, Paediatric Nurse Practitioner, MOFAS Minneapolis
New Orleans

Chief Judge Ernestine S. Gray, Orleons Parish Juvenile Court, (Dependency Court)
Judge Desiree Cook-Calvin, “E” Section, Orleans Parish Juvenile Court, Delinquency Court, recently appointed judge (since Jan 2015)
Judge Mark Doherty, Orleans Parish Juvenile Court, Delinquency Court.

Minneapolis St Paul

Ruth Richardson, Program Director, MOFAS
Sarah Messelt, Executive Director, MOFAS
Mary Margaret, Supervisor Family Interventions
Michelle Furnier, Education and Support of women in Treatment Programs
Sue Terwey, Early Childhood screening Director and Parent
Kendra..., Prenatal screening
Dinner with 3 people plus Ruth and Sarah at MOFAS Office:
Jennifer Moore, Attorney, Family Law, Custody, Care and Protection and Guardianship & Parent
Jason Schland, Attorney, Delinquency and Guardianship
Marc Laurie, DEA Federal Agent & Parent

Ted Talk type Event (MOFAS)

Rebecca Wallin, Adoptive mother of Alexi (Russian born)
Alexi, (15/16 year old)
Alex, (15 years old)
Laura Bloch, Parent of Alex, Accountant and MOFAS Board member
Judith K Eckerle MD, Paediatrician
Meghan Louis, Program Director, Youth Justice Screening Program, Probation (4 year pilot)

Winnipeg, Manitoba

Therese Brown, Manager FASD Justice Project and team (3), Dee Bissonnette, Dan Neault, Erin Klimpke, Coordinators, and Veronica Curtis, Student
Lorraine Brake, Starfish (Pilot) Program, Program Co-ordinator, FASD Addictions Services Project
Catarina Witt, Starfish Program, Project Development & Implementation Specialist, FASD Addictions Services Project
Native Courtworkers (2), Bert Keeper and Brenda Fontaine
Holly Gammon & Ken Lamoureux, Manager FASD Programs & Policy Officer, Healthy Child Manitoba
Corey La Berge, Deputy Children’s Advocate
Regina, Saskatchewan

Dr Michelle Stewart, Assistant Professor, University of Regina
June Draude, Member of the Legislative Assembly in Saskatchewan & (former Minister)
Greg Ottenbreit, Minister for Rural Health, see http://www.youtube.com/watch?v=hKKT3MISs58&sns=em for Welcome in Parliament
Judge Toth and Associate Chief Judge Hinds, Saskatchewan Provincial Court
Ron Anderson, Assistant Deputy Minister, Ministry of Justice
Linda Meyer, Psychologist Ranch Erhlo Society
Dana R. Wilkins, Director Community Corrections
Bonny Gerber, FASD Specialist, Manager of Probation Programs
Pamela Burkholder, Director of Programs, Community Corrections, South Region & 1 other
Cheryl Charron, Director, The FASD Centre, Regina Community Clinic and Dr Dolores Logan, Regina Community Clinic
Lisa Brownstone, Adoptive Mother 2 FASD children & OT

Saskatoon, Saskatchewan

Craig Nyirfa, Executive Director, Centre for Responsibility, new Hub and Core
Jo Nanson, retired Neuropsychologist
Cheryl Starr, First Nation & Regional Child Advocate
Judge Sheila Whelan and Judge Metvier, Provincial Court

Edmonton, Alberta

Janice Penner, Co-Chair Cross Ministry FASD Committee
Sharon Enslen, Co-Chair
Del August, FASD Program Co-ordinator, FASD Initiatives, Young Offenders Branch
Neuropsychologist and Academic

Whitehorse, Yukon

Tanya Mackenzie, Justice Wellness Centre
Judge Karen Ruddy, Territorial Court of Yukon, Community Wellness Court
Kyle Risby, Aboriginal Courtworker, Council of Yukon First Nations
Nicole Bringsli, Contract Psychologist, Adult Probation Services (based at Wellness Centre)
Lianne Couch-Lacey, Probation Officer
Leah White, Manager, Offender Supervision and Services
Wenda Bradley, Executive Director, FASSY- Fetal Alcohol Syndrome Society Yukon & Gerard, Outreach Worker
Fia Jampolsky , Attorney, Member of Human Rights Commission, Yukon
David Christie, Legal Aid lawyer
Valarie Binder, Co-ordinator Restorative Community Conference Program
Patricia Anderson, Supervisor Youth Probation
Brooke McKenzie, Diagnostic Co-ordinator, Child Development Centre
Cameron Grandy, Counsellor at Adult Probation Services, and at Group Home
John W. Phelps, Chief Federal Prosecutor, Yukon Regional Office
Jane Bates & ?Department of Family and Child Services (Kids in Care)

Others
Brian Jarrett, Academic Lawyer Restorative Justice from Alaska
Polly E. Hyslop, First Nation Restorative Justice administrator, Mediator and Ph.d student
Mark Stevens (does Gladue Reports for First Nations)

By Phone
Donna Debolt, Consultant Social Worker and Trainer
Roberta Smallbone, Constable, Lethbridge Police, FASD Justice Project
Sabrina Hacker, Corrections Officer, Adult Justice Office

New Zealand – Auckland and Whangarei
Christine Rogan, Health Promotion Advisor and FASD Project Coordinator, Alcohol HealthWatch
Dr Valerie McGinn, Neuropsychologist
Rose Hawkins, Regional Disability Advisor, Child Youth and Family Services Department
Claire Gyde, Parent and Chairperson, FASD-CAN ( Care, Action, Network)NZ
Judge Tony FitzGerald, Youth and Family Court Judge, Auckland
Judge Susan Lindsay, Youth and Family Court Judge, Whangarei
Deb Kent, Psychologist, Clinical Team Leader, Whakatakapokai Care & Protection Residence,
Dave Evans, Case Leader, Whakatakapokai Care & Protection Residence,
Judy Wheal, Case Leader, Whakatakapokai Care & Protection Residence
O’Dell Toi, Residential Youth Worker, Special Projects, Whakatakapokai Care & Protection Residence
Lisa Hall, Case Leader, Whakatakapokai Care & Protection Residence
Harley Kainh-Kittems, Program Co-ordinator, Whakatakapokai Care & Protection Residence
Kapeliele Su’a, Acting Manager, Team Leader Operations, Whakatakapokai Care & Protection Residence
Craig Uarvani, Whakatakapokai Care & Protection Residence
Roxanne Hughes, West Auckland, Child and Youth Family Services
Noel Morrison, Principal, Aubury Park Centre Inc., School for Disabled and Riding for Disabled program
Dave Hookway, Health Promotions Advisor, Northland District Health Board
Tania Henderson, Kaitautoko Matua, Rural Education Activities Program, Parenting Education & Dale Johnson, Parenting Support, Education Manager.
Ruth Gillingham, Psychologist, Whangarei
Lucy Postlewaight, Lawyer, other lawyers (criminal, family & guardianship) & social workers (approx. 20), Meeting/Dialogue at Whangarei Courthouse,

Others

Sally Kedge, Speech and Language Pathologist and Ph.d Student, Talking TroubleNZ Project,
Appendix C: Dissemination Undertaken to date and Proposed

New Zealand

During the week 17-23 May 2015, the following presentations were delivered:

Auckland

**FASD Justice Forum** on 19 May 2015
(organized by Alcohol Healthwatch Whakatupato Waipiro)
“How Youth affected by FASD are treated in criminal jurisdictions”

**Public Lecture**, University of Auckland Law School, on 19 May
(arranged by Professor Warren Brookbanks and Christine Rogan of Alcohol Healthwatch)
“How Youth affected by FASD are treated in various criminal jurisdictions seen in the context of international human rights instruments”

May be accessed at:
https://www.youtube.com/watch?v=CIlo3ij0pE&feature=youtu.be

Audio only may be accessed:
https://mediastore.auckland.ac.nz/uploaded/project/CMS_LAW/public/05-2015/67B0FAAEE5FF4E43BA1103FF38E139FC.preview

Whangarei Northland

**Short Presentation to, and Discussion with, Lawyers** at Youth Court, on 21 May 2015.
“FASD: What we can learn from North America.”

**FASD Justice Forum** on 22 May 2015
(Organized by Alcohol Healthwatch Whakatupato Waipiro)
“How Youth affected by FASD are treated in criminal jurisdictions”
Western Australia

The author contributed to the following events:

**Symposium: Fetal Alcohol Spectrum Disorder: Sharing Solutions,**
Institute of Advanced Studies, University of Western Australia, on 13 August 2015. Keynote speakers Dr Julianne Conry and Dr Nathan Hughes.

The author presented:

“Can Courts do Justice when Youth, affected by FASD, have been failed by Health, Education and Care and Protection Authorities?”

**Seminar: Children’s Court of Western Australia, Perth on 14 August 2015.**

**Neurodisability and Youth Offending; Implications for Practitioners, Presentation by Dr Nathan Hughes, and reflective discussion** including Dr Julianne Conry, Canadian FASD Expert and multidisciplinary audience including legal professionals (attracted CPD points), health and allied health professionals, and representatives drawn from Health, Justice, Care and Protection, Disability Services Commission, Mental Health Commission on 14 August 2015 (arranged by author, with assistance from Legal Aid and Children’s Court).

**Proposed Future Dissemination**

*Presentations planned:*

Australia & New Zealand Psychiatry, Psychology and the Law (ANZPPL) WA Branch, *Seminar Presentation* scheduled for 16 September 2015, entitled,

“FASD affected children and youth in the criminal justice system: Plan of action drawing on the experience in other comparable jurisdictions.”

*Other steps planned:*

*Website:* http://benchpressfasd.weebly.com

The above website was established before travel for the fellowship commenced. It is dedicated to the topic of FASD and Justice. A blog is included on the site.
It is intended to post this Report on the website, then further develop the website to provide information drawn from overseas experience, especially through the links developed as a result of the fellowship, and contribute to discussion and progress in the field in Australia.

*Providing Information on Initiatives in Other Jurisdictions*

It is intended to identify individuals and agencies working with, or involved in service delivery to, children and youth involved in the justice system, so as to disseminate this Report, including

- Police,
- Care and Protection authorities,
- Heads of Jurisdictions in Children’s/Youth Courts in Australia,
- Juvenile Justice/Youth Probation/Corrective Services,
- Youth Legal Services, Legal Aid and Aboriginal Legal Services,
- Peak bodies concerned with service delivery to youth in various areas including accommodation, drug and alcohol, disabilities and the like.

*Presentations to Professionals & Students*

Promoting better understanding of how FASD may affect children and youth in the justice system among students, and professionals, in various disciplines such as social work, youth work, addictions, psychology & law is a priority.

It is hoped to stimulate awareness, screening and better service delivery by presentations and participating in discussion of the challenges that individuals and their families encounter. For this purpose it is intended to seek opportunities to engage with professionals and students in an educational context.

*Submissions and/or Presentations where possible*

Where appropriate, it is intended to make submissions to State or Federal Parliamentary Inquiries dealing with FASD and Justice, and seek opportunities to make presentations at relevant events and conferences.

*Contribute to the Establishment of Networks, Professional and Consumer*

There is a need for local & regional, advocacy and support networks for FASD affected children, youth and adults. There are 3 major objectives:

- Advocacy for FASD affected individuals and their families/carers,
- Support for the families/carers of, and FASD affected individuals, and
• Driving decision-makers and influencers to implement change to address the needs of FASD affected individuals and their families/carers.

This involves identifying organizations, and champions, who may commit resources to developing local support & advocacy strategies, networks and/or services.

National organizations in the field such as NOFASD Australia, www.nofasd.org.au and the Russell Family Fetal Alcohol Disorders Association, www.rffada.org have been involved in education, advocacy and support for years with few resources.

The author hopes to contribute indirectly to the fostering of local advocacy and support networks by making links with local agencies and service providers to draw their attention to initiatives in other jurisdictions.
Appendix D: Probation Icons. Winnipeg FASD Project
**Glossary**

**Assessment/Diagnosis/Evaluation** – reference to a process undertaken by one or more clinicians to determine whether a person suffers from one of the disorders which come within the umbrella of fetal alcohol spectrum disorders or the proposed new diagnostic category included in the 2013 diagnostic and statistical Manual for Mental Health Disorders (DSM-5), described as “neurobehavioural Disorder Associated with Prenatal Alcohol Exposure” (ND-PAE).

In this report where quoting another, the language of the speaker/writer is used.

Otherwise the word “assessment” should be read to include diagnosis and a report setting out the nature of the impairments and making recommendations for support and intervention.

**Children's Court** – phrase used in Western Australia and some other jurisdictions to refer to the court which deals with children and young people charged with criminal and traffic offences.

**Delinquency Court** – phrase generally used in US jurisdictions to refer to a court that deal with youth charged with criminal offences.

**Dependency Court** – phrase generally used in US jurisdictions to refer to a court which deals with child welfare issues.

**FASD diagnosis** – there is no such thing. FASD is an umbrella term for a number of disorders along a spectrum, however the phrase, or similar, is occasionally used as shorthand.

**State care** – where a child, or youth, has a statutory office holder as guardian.

**Youth Court**- phrase used in New Zealand and some other jurisdictions to refer to the court which deal with young people charged with criminal offences.

**Youth Justice Officers** – public servants whose role includes preparation of pre-sentence reports for courts dealing with children or young people charged with criminal offences, arranging expert reports such as a psychological or psychiatric report, supervising youth on Court orders, appearing in the Children’s/Youth Courts to assist the court with respect to what services are available to youth/bail options/information regarding the youth and family support etc.

In some jurisdictions they may be known as probation officers or youth probation officers.

**Youth Probation Officers** – see description for Youth Justice Officers