Issues in the Legal Realm:

Fetal Alcohol Syndrome and the Decision to Decline or Retain

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Larry G. was a seventeen year old single male of Native American descent who was referred for an evaluation to determine if he should be retained in the juvenile justice system or declined into the adult correctional system. Larry had been charged with murder in the first degree and attempted murder. He had been involved in a gang fight and had fired a pistol three times. One bullet struck and killed a youth of fifteen. A second youth was paralyzed from the waist down. It is not known where the third bullet went or if anyone else was injured.

Larry was the third of four children born to his mother; each child had a different father. She acknowledged drinking throughout her pregnancy, a fifth of vodka and a six-pack of beer every day by her own estimation. Larry's family background was characterized by chaos, neglect, abuse, and little support or structure. Larry's father was deceased and his mother appeared to have little ability to manage her son's life or take adequate care of him.

Larry dropped out of school in the ninth grade. He had been in regular classes. He was reported to have reading, spelling, and arithmetic problems. Larry also had behavioral problems in school, e.g., fighting, swearing, and truancy. Shortly before his arrest on the murder and attempted murder charges, he had been expelled from school for carrying a concealed weapon. Larry had joined a gang when he was about twelve, but described his involvement in gang activity as minimal. He had several previous legal charges ranging from taking a motor vehicle without permission, to assault in the first degree. The severity and frequency of his criminal activities were escalating prior to the shooting incident.

Larry had recently begun to use and abuse a wide variety of substances including alcohol, cocaine, crack cocaine, LSD, and marijuana. He claimed to get money from selling drugs and to have been moderately successful at this.

Larry was administered a full psychological test battery. His IQ scores were in the average range with no significant difference between his verbal and performance IQ. However, his scores on the Vineland Adaptive Behavior Scales and the Wide Range Achievement Test-Revised were all in the 50th to 60th percentile range, thirty to forty points below his IQ scores.

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Larry appeared to have a few of the facial characteristics associated with Fetal Alcohol Syndrome. He was of average height and weight. However, his behavior and test scores were consistent with what is frequently seen in children who have been prenatally exposed to alcohol. Larry was referred for an FAS diagnostic evaluation. Based on the physical examination, prenatal history, and CNS damage, manifested in his behavior and learning deficits, Larry was given a diagnosis of FAS.

Larry, despite his FAS diagnosis, was declined into the adult justice system. The reason the judge gave for this was Larry's increasing frequency and severity of antisocial behavior, the lack of community and family support systems, his high risk of reoffending, and the continuing risk he presented to the community. He was ultimately charged and convicted of second degree murder. He received a sentence of 21 years in medium to maximum security. He is currently serving out his term in an adult facility.

Brian H. was a thirteen year old male of mixed African American/Caucasian descent. He was referred for testing by his probation officer for an evaluation to determine his level of intellectual and social functioning. Brian, despite his young age, had a long history of criminal behavior. His probation officer was concerned about his risk to reoffend and was also seeking help in making treatment and residential decisions.

Brian was the youngest of three children born to an alcoholic mother. He was removed from his mother's care due to neglect. It is not clear if he was physically or sexually abused; this was a concern as Brian was beginning to act out in a sexually inappropriate fashion. Brian's home life was described as chaotic, unstable, and dangerous. By the age of thirteen, he had already been charged with robbery, assault, theft, and repeated probation violations.

Brian was referred for an FAS diagnostic evaluation and received the diagnosis. It was strongly suggested that Brian be placed in either a structured residential program or therapeutic foster home. In addition, vocational training and learning that was based on visual skills was recommended. These services were not

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implemented for reasons that remain unclear. A presentencing officer later stated, in somewhat ironic fashion, "Brian simply slipped through the service cracks." Brian continued to roam from home to home and to be out on the street. His gang involvement increased. Sadly to say, fourteen months after the first psychological evaluation, Brian shot and killed another youth in a fight.

There was significant discussion, given that Brian was only fourteen years old, as to whether he should be declined or retained in the juvenile system. His increasing level of dangerous behavior and concerns over his risk to reoffend led to him being declined into the adult system. Brian was charged with, and convicted of, second degree murder and assault in the second degree. He was sentenced to fifteen years and is currently serving his sentence in a juvenile maximum security facility. He will be transferred to an adult facility at either age 18 or 21.

Decline Law and Procedure (1)

The primary issue in a decline hearing is whether a juvenile should be retained in the juvenile system or declined into the adult system. The decision to decline is based on several factors. These include the following:

1. *Rehabilitation:* the juvenile system focusing on responding to the needs of youthful offenders by providing treatment, supervision, and custody;

2. *Period of Incarceration:*
a. juvenile system maximum period of incarceration is commitment to age 21 or no longer than the adult maximum;
b. standard range in the adult system generally carries a longer period of incarceration;

3. *"Kent" Criteria:*
a. Seriousness of the alleged offense to community and whether the protection of the community requires decline;
b. Whether the alleged offense was committed in an aggressive, violent, premeditated or willful manner;
c. Whether the alleged offense was against person or property, greater weight given to crimes against person, especially if personal injury occurred;
d. Prosecutive merit of the complaint;
e. Desirability of trial and disposition of the entire offense in one court when the juvenile's associates are adults charged with a crime;
f. Sophistication and maturity of the juvenile determined by consideration of his home, environmental situation, emotional attitude, and pattern of living;
g. Record and previous history of the juvenile including previous contacts with the law, juvenile courts and other jurisdictions, prior to periods of probation or prior commitments to juvenile institutions; and
h. Prospects for adequate protection of the public and likelihood of reasonable rehabilitation of the juvenile by use of procedures, services, and facilities available to the juvenile court.

"An adolescent once held to adult standards, will always be treated as an adult."

Decisions to decline are based on evaluations performed by a mental health professional such as a psychologist or psychiatrist. The evaluating professional is often expected to determine the above factors by assessing the family background, the educational and achievement level, and the previous history in the juvenile justice system of the alleged offender. Community resources and the possibility of reintegration into the community are also considered.

A decision to decline must be made with serious thought because an adolescent: "Once held to adult standards, will forever be treated as an adult."

FAS and Decline: A Risky Business

Fetal Alcohol Syndrome (FAS) is a birth defect that results from prenatal alcohol exposure. As has been discussed in previous articles (2-4), Fetal Alcohol Syndrome is commonly associated with specific organic damage, especially in the frontal lobe, with a negative impact on abstracting abilities, memory skills, information processing, comprehension or social rules and expectations, an inability to connect cause and effect, and an inability to learn from past experiences (5-6). Given these factors, many people with FAS are at risk to be involved in the legal system if appropriate interventions and structure are not in place, in many cases from birth through the adult years.

Many juveniles with FAS do not have the ability, despite a normal IQ, to connect cause and effect or to predict the outcome of any specific behavior. It is difficult for many professionals in the legal system to understand this as people with FAS often "sound" or "look" competent, capable, and rational. Coupled with a relatively normal appearance, the actual abilities of a person with FAS to truly understand the consequences of their actions is frequently overestimated.

A primary consideration in determining whether to decline a juvenile or not has to do with rehabilitation. In many cases, this involves the offender learning from their mistakes and being able to avoid making the same poor decisions or displaying the same impulsive behavior that lead to problems in the first place. Because of the brain damage associated with FAS, "true" rehabilitation, specifically the ability to learn from past behavior and mistakes, is something that often eludes people with FAS.

The impact of FAS on the meeting of the "Kent" criteria is something that is usually not taken into account in the juvenile justice system.

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Protection of the community is primary and must be considered. However, many times, if the crime is not of a violent and/or repetitive nature, a structured residential placement, with vocational training and behavioral management programs, can achieve the same end as with incarcerations. It is also important that the safety of the offender be taken into account.

Many people with FAS have poor social skills and a high level of impulsivity. Their immaturity puts them at risk for problems both within and without correctional facilities. This is why, based on individual differences, it is often more appropriate to have the offender housed in a juvenile facility where the emphasis is on treatment rather than of a punitive nature.

The issue of sophistication and maturity is another aspect of the "Kent" criteria in determining the appropriateness of decline. As mentioned above, many people with FAS have a maturity far below their chronological age. They do not, despite attempts at insight therapy or other interventions, increase their skills in this area. It is important that the psychological evaluation assess this area and this be a primary concern before the decision to decline is made.

Yet another area of concern in making a decline determination is the criminal record and previous history of the juvenile. As with the case studies presented at the start of this article, it is not uncommon for juvenile offenders with FAS to have many offenses. What is often seen is that the rate of offending increases with the lessening of supervision. In the second example, Brian had little structure or supervision. Later information strongly suggested that his mother may have FAS, herself.

A hallmark of FAS is the inability of the impacted person to structure their own life and behavior. If external, positive, consistent structure is not available, many youths with FAS find their structure in gangs. Once this happens, the rate and severity of offending often increases. Then, unfortunately, the primary option for structure becomes that provided by penal institutions.

The "Kent" criteria looks at the juvenile's associates. People with FAS are easily influenced, good followers, and freely manipulated. They are the ones who would jump off the proverbial bridge if asked to do so by a friend. Given these factors, it is crucial that the juvenile with FAS be evaluated separately from his peers.

An Alternate Outcome: A Success Story

Kattina was a sixteen year old single female of Hispanic/Filipino descent. She was the only child born to a teenage mother who was thirteen at the time of Kattina's birth. Kattina's mother acknowledged consuming up to 12 beers or more per day. Kattina's biological father was unknown.

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Kattina had been diagnosed as having Fetal Alcohol Syndrome when she was eight. Her biological mother had relinquished her to foster care due to her alcoholism and transient lifestyle. When Kattina was fifteen, she was living on the street, using and dealing drugs, and involved in prostitution. She joined a gang and ended up in an altercation where she stabbed, multiple times, another young woman.

Kattina was referred for a decline evaluation. Her IQ was 102. Her academic scores indicated achievement levels in reading, spelling, and arithmetic to be at the third grade. Her adaptive behavior skills were at age eight. Even with an average IQ, Kattina demonstrated little common sense, a high level of impulsive behavior, almost no sense of cause and effect, and a seeming inability to understand the seriousness of her crime.

She had no family support, having run away from every foster placement, of which there were many. She had not been attending school on a regular basis for two years. However, her only previous criminal history had been two charges of taking a motor vehicle without permission and one charge of prostitution.

Given the above information, the evaluator recommended retention in the juvenile system. Based on the evaluator's recommendations and an examination of the "Kent" criteria, the Court decided to retain jurisdiction in the juvenile system. However, she was given a "Manifest Injustice." What this meant is that, based on aggravating factors, she was sentenced to a longer term than might have been the usual. Kattina was given 102 weeks in a juvenile facility and then put on a "tight" and closely monitored probation for three years following her release.

Part of her probation was to attend school, get a job after school, attend weekly therapy sessions, and attend drug and alcohol treatment on an outpatient basis. These are common conditions of juvenile probation but may not always be followed. In Kattina's case, three critical events happened that lead to a positive outcome.

The first event that occurred was a meeting held just prior to going into Court on the decline hearing. The participants in this meeting consisted of the probation officer, defense attorney, social worker, prosecutor, evaluating psychologist, the presiding judge, and Kattina. Kattina's medical, psychosocial, and school records were all carefully examined. It was decided to let Kattina plead guilty to the assault charge with the provision of the "Manifest Injustice." The judge took the time to educate himself about Fetal Alcohol Syndrome and agreed to the conditions listed above.

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However, it was also understood that, should Kattina reoffend upon her release, she would be tried as an adult on any charges.

The second event was her biological mother entering a shelter and asking for drug/alcohol treatment. The public health nurse running the shelter suspected Kattina's mother had Fetal Alcohol Syndrome. This turned out to be the case and her mother was placed on Social Security, with a protected payee, given subsidized housing, and vocational training. She also entered a long-term treatment program that offered life skills along with vocational training. Kattina's mother is still involved in this program.

The third event that occurred was Kattina meeting and beginning a relationship with the adoptive parents of another young girl while in the juvenile facility. These parents had worked with special needs children before, including several with Fetal Alcohol Syndrome, and were actively involved in a community support group. The Court allowed this placement and, as of today, with tight supervision and consistent structure, Kattina is living with her foster parents and doing better with no drug use, no truancy, and no seriously assaultive behavior reported.

She has become sexually active again and this is of some concern. Kattina, so far, has tested negative for HIV but has had several bouts with venereal warts, chlamydia, and gonorrhea. She has had difficulty, despite her normal IQ, truly comprehending things such as "safe sex" and personal boundaries. However, the therapy and other aspects of her probation have been strictly adhered to by her foster family. In addition, Kattina has connected with her biological mother and is attending some therapy sessions with her. Art therapy and behavioral management have been the primary tools of this therapy rather than insight.

Kattina is no longer in regular school courses. She is in a community-based vocational training program for computer skills and has a part-time job where she earns a salary for using these skills. She still have periods of anger outbursts but these are lessening. Her family has a schedule written out and posted in several spots around the house. This has made it easier for Kattina to understand expectations and boundaries.

Summaries and Recommendations

The two case studies presented at the start of this article demonstrate two primary points the authors wish to make:

1. the common manifestations of FAS; and

2. the tragic result of someone with FAS not receiving the proper interventions and structure early on in life and continuing across the lifespan.

Both of these young men, sad to say, met many of the criteria that led to a decision to decline. Both came from chaotic environments, both had serious histories of criminal behavior, and both were at high risk to reoffend. Both of these youth had had serious difficulties in school and a long history of acting out behavior. It is also important to note that it was only through the legal system that these young men finally were evaluated for and received a diagnosis of FAS.

How could better, earlier interventions have been made to more appropriately address the needs of these youths?

What might have been a different outcome? How could better, earlier interventions have been made to more appropriately address the needs of these youths? This section will examine these questions and present possible alternatives.

First of all, an assessment of the family history and present environment should be made. This will include parental/caregiver resources such as finances, emotional stability, ability to participate in decision-making, and the ability to provide positive, consistent, and nurturing structure. These factors will play a crucial role in whether preventative steps can be taken to keep the youth in the community or if a more restrictive environment will be needed.

Second, if the youth is in an offending pattern, the factors that are either supporting or possibly disrupting this pattern need to be assessed. The youth's skills and community resources that support his skills need to be accessed and incorporated into a positive support system. This can be accomplished by a team approach of:

a. an initial diagnosis by a dysmorphologist or other qualified expert in the diagnosis of birth defects;
b. consultation with an educational specialist, psychologist, behavioral management specialist, and court advocate, e.g., attorney, social worker;
c. close consultation with the parent, caregiver, or advocate of the patient; and
d. careful consideration of the needs and wishes of the patient.

This evaluation should, ideally, occur prior to any court proceedings and in conjunction with the evaluating psychologist. The team approach can assess all of the factors listed under the "Kent" criteria and, hopefully, provide enough data to make choices that will truly benefit the needs of the patient, the family, the community, and society.

Now, to return to the rest of Kattina's tale. The ending of her story is not yet here. What has made the difference was the juvenile justice system allowing enough flexibility for Kattina's needs to be met in an unusual fashion and the good fortune she had in finding foster parents who understood about Fetal Alcohol Syndrome and would advocate for their child.

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She will need this type of support for the rest of her life. The question is, where will such support come from? Hopefully, the Courts will take more time, hold pretrial meetings, and work together to support and aid these children, not just to punish and warehouse them.

In conclusion, the diagnosis of FAS alone is not enough to rule against a decline decision. However, FAS and its impact on brain functioning and behavior must be taken into account when making such a decision regarding a person who is affected. The team approach detailed above can be an invaluable tool in collecting needed data to help the Court make the best, most appropriate, and most humane determination.

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A Day in the Life...

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aggressive to me and self-abusive to himself. After a particularly explosive tantrum in which he wrecked household items and injured himself, I got tired of waiting for him to get used to the medication.

I called his doctor, who cut the dosage by half. I am happy to say that Mike has none of the negative side effects now and is benefitting from the positive aspects of the drug.

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