FASD MANUAL For Legal Professionals

Dr. Lori Vitale Cox
Seamus Cox, LLB

This manual is designed to increase your understanding of the disabilities associated with pre-natal exposure to alcohol and to help you in your professional practice when dealing with people with Fetal Alcohol Spectrum Disorder.

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FORWARD (2005)

It is with honor that I have accepted to write a forward to the FASD Manual for Legal Professionals. This manual is well-disposed and well researched. In a very concise, no-nonsense manner, the authors have thoroughly explained a very serious complex medical problem. It is a must reference manual for judges, lawyers, prosecutors, probation officers and victim impact workers. The reference material index at the back of the manual allows the reader to continue his research if required. The catalogue of Canadian Cases by topic is a priceless tool for all persons in the legal profession.

The New Brunswick Provincial Court is mostly a rural Court which deals with over 90% of all criminal cases in the province. Most of the judges are isolated in the smaller communities. Not only are we isolated from other judges, but also from the medical community as a whole. These factors enhance the value of such a manual in our library.

It is mentioned in the manual that there are no reported cases in New Brunswick. However this does not mean that this disorder is not discussed….since I would venture to say that over 95% of our sentences are never reported……The major problem is not for judges to deal with it when it is mentioned by a defense lawyer or a probation officer, but to suspect the disorder and be proactive when no one mentions it. One must remember that we are dealing with more and more unrepresented litigants. This manual will certainly be useful for judges to ask for more assessments and diagnoses. Mr. Justice David H. Vickers, of the Supreme Court of British Columbia summarizes this dilemma: “Our criminal law and all of the procedures and safe-guards attached to it ignore the challenges people with F.A.S.D. present.”

In summary, congratulations are in order to both authors, Dr. Lori Vitale Cox and Seamus Cox, LLB for a job well done. It is an impressive combination of medical and judicial information, unavailable anywhere else in such a concise manual.

Donald J. LeBlanc
Judge of the Provincial Court of New Brunswick
2005

In 2019 there was a request by legal professionals for an up-dated version of the FASD Manual for Legal Professionals.

In 2020 these revisions were completed. Thank you to Dr. Christine Locke and Ron Friesen LLB for helping with the revisions

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Chapter 1- Introduction

1.1 Purpose of This Manual

This manual will provide general information on FASD, briefly overview some related legal issues, identify some common misconceptions concerning FASD and provide some links to community and legal resources.

1.2 Is FASD A Problem for Legal Professionals?

- According to researchers from Corrections Canada large numbers of individuals with FASD are coming into conflict with the law.[1]
- Most of these individuals have never been diagnosed or received services to help them learn basic educational and vocational skills.
- All youth in a British Columbia youth court who were remanded to the assessment unit were also screened for FASD. Approximately 23.3% of the youths were subsequently diagnosed with FASD [2]
- The TRC, Truth and Reconciliation Calls to Action notes that lack of FASD health service delivery in Indigenous communities is resulting in Indigenous individuals with FASD being incarcerated because of behavior that may be the result of disability rather than criminality.[3]

1.3 Truth and Reconciliation Calls to Action

The Truth and Reconciliation Commission calls for the government to take immediate action to provide access to FASD Health services:

- **Call to Action 33.** We call upon the federal, provincial, and territorial governments to recognize as a high priority the need to address and prevent Fetal Alcohol Spectrum Disorder (FASD), and to develop, in collaboration with Aboriginal people, FASD preventive programs that can be delivered in a culturally appropriate manner.

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[1] Boland F, Burill R, Duwyn M, and Karp J. Fetal Alcohol Syndrome: Implications for Correctional Service. Correctional Service Canada: Research Branch 1998

[2] Conry J and Fast DK. Fetal Alcohol Syndrome and the Criminal Justice System. Vancouver; British Columbia FAS Resource Society: The Law Foundation of BC 2000.

[3] Truth and Reconciliation Canada. *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada*. Winnipeg: Truth and Reconciliation Commission of Canada, 2015.

- **Call to Action 34**. We call upon the governments of Canada, the provinces, and territories to undertake reforms to the criminal justice system to better address the needs of offenders with Fetal Alcohol Spectrum Disorder (FASD), including:
  i. Providing increased community resources and powers for courts to ensure that FASD is properly diagnosed, and that appropriate community supports are in place for those with FASD
  ii. Enacting statutory exemptions from mandatory minimum sentences of imprisonment for offenders affected by FASD
  iii. Providing community, correctional, and parole resources to maximize the ability of people with FASD to live in the community.

1.4 FASD is not only an Indigenous problem

There is a high prevalence of alcohol related birth disabilities any community where prenatal alcohol exposure occurs. It affects individuals of all colors and cultures all over the world.[4] Not everyone who drinks when pregnant will have a baby with FASD due to a complex set of variables that include timing, dosage, nutritional status and health of the mother, and genetics and epigenetic factors. However, long-term longitudinal research indicates that even low to moderate drinking will significantly increase the chances of having a child affected by PAE, prenatal alcohol exposure. Many women drink before they know they are pregnant or because they do not know that light or moderate drinking can affect their baby.[5] Researchers estimate that tens of thousands of Canadian adults are affected with Fetal Alcohol Spectrum Disorders and never diagnosed.[6]

Chapter 2- General Information

2.1 FASD Definition

[4] Riley E, Mattson S, Li Ting-Kai, Jacobson, S wet al. Neurobehavioral Consequences of Prenatal Alcohol Exposure: An International Perspective Al Clin Exp Res 2003; 27 (2) 362
[5] Sood B, Delany-Black V, Covington C, et al. Prenatal alcohol exposure and childhood behavior at age 6 to 7 years: a dose response affect. Pediatric 2001;108 (2): E34
[6]6 Donovan K. Executive Summary of Fetal Alcohol Syndrome: A preventable tragedy. Report of the standing committee on health, welfare social affairs seniors and the status of women 1992

FASD, Fetal Alcohol Spectrum Disorder, refers to the spectrum of physical & neurological conditions occurring as a result of prenatal exposure to alcohol.[7]

2.2 FASD Is a Developmental Disability

FASD disabilities last a lifetime. PAE, Prenatal Alcohol Exposure, can affect all aspects of an individual's development: mental, emotional, social, and physical.[8] FASD is now recognized as one of the leading birth disabilities in North America that seriously affects brain functioning and impairs both intellectual and social development.[9] Alcohol is a neurotoxin that causes more injury to a developing brain than cocaine, heroin, barbiturates or marihuana. [10] It is the leading cause of mental disability in the western world although most people with FASD would not be diagnosed as intellectually challenged. [11] Brain injury caused by prenatal exposure to alcohol can lead to severe functional and behavioural challenges. These can make it difficult for people living with FASD to use their ability to learn and develop unless appropriate environmental adaptations are implemented at home and at school.

2.3 Prevalence of FASD in North America?

A 2018 study in the Toronto area indicated a 2-3% prevalence of FASD in the general population.[12] A large scale study in the US indicated a prevalence of 3.6%. The prevalence rates in some communities in Canada have been found to be much higher. [13] The incidence in one New Brunswick First Nation in 2000 was approximately 20%. [14] If we use the current Canadian estimated rate of 3% more than 1.25 million people are affected with FASD disabilities in Canada.

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[7][7] Cook, Green, et al, *Fetal Alcohol Syndrome Disorder: a guideline for diagnosis across the lifespan*, CMAJ 2015 Retrieved:http://www.cmaj.ca/content/cmaj/suppl/2015/12/14/cmaj.141593.DC1/app1.pdf See appendix for diagnostic criteria

[8] Streissguth A, Barr M et al. Primary and secondary disabilities in Fetal Alcohol Syndrome. In Streissguth AP and Kanter J. The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilites. Seattle Washington; University of Washington Press 1997

[9] LaDue RA, Streissguth AP, Randels SP. Clinical considerations pertaining to adolescents and adults with fetal alcohol syndrome. In: Sonderegger T (ed.) Prenatal Substance Abuse: Research Findings and Clinical Implications. Baltimore; Johns Hopkins University Press 1989

[10] Riley E and McGee CL. Fetal Alcohol Spectrum Disorders: An Overview with Emphasis on Changes in Brain and Behavior. Society for Experimental Biology and Medicine. Symposium 2005

[11] Abel EL and Sokol RJ Fetal Alcohol Syndrome is now Leading Cause of Mental Retardation. The Lancet 2(8517): 1222.

[12] Popova S et al 2018 Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis The Lancet Global Health Volume 5, Issue 3, March 2017, Pages e290-e299

[13] Robinson GC, Conry JL, Conry RF. Clinical profile and prevalence of fetal alcohol syndrome in an isolated community in British Columbia. See also: Square D. Fetal alcohol syndrome epidemic on Manitoba reserve. CMAJ 1997; 157 (1): 59-60. Also: Williams RJ, Odaibo FS, McGee JM. Incidence of fetal alcohol syndrome in northeastern Manitoba. Can J Public Health 1999,90 (3): 192-4

[14] Cox L, Dickenson M The prevalence of FASD in a Maritime First Nation community. Presented at the FACE Research Roundtable 2006

Because FASD diagnostic capacity is limited or even non-existent in some areas of the country many people who come into contact with the law as offenders, witnesses or victims lack access to essential accommodations for their FASD disability.

2.4 Limited Access to FASD Services

FASD disabilities are preventable but access to FASD diagnosis, intervention and prevention services is still limited or entirely non-existent in many parts of Eastern and Northern Canada. The Public Health Agency of Canada now recommends abstinence from alcohol when pregnant. It also recommends the training of health professionals and improved access to FASD diagnosis, intervention and prevention. Despite this a few older physicians in the country may still tell women that drinking in moderation, e.g. a few glasses of wine a day, when they are pregnant will not harm their offspring. [15]

2.5 Alcohol and the Brain

Alcohol can compromise brain growth and development. Researchers have suggested that prenatal alcohol induced brain damage may be related to factors such as decreased umbilical-placental blood flow, reduced placental transfer of nutrients, amino acids, glucose, a build-up of fetal metabolites, and alcohol induced fetal hypoxia or lack of oxygen.[16]

Researchers have been able to use Magnetic Resonance Imaging, MRI technology to study alcohol's effect on the brain.[17] They found that in some areas of the brain there are greater than normal amounts of gray matter (neurons) and in other areas lesser than normal amounts of white matter (connecting cells). There is less symmetry and also distortions in shape. They have found subtle changes in the volume, shape, and location of many brain structures including the corpus callosum, basil ganglia, hippocampus, cerebellum and cerebrum. Changes in these brain structures result in changes in cognitive function and functional behaviours related to areas such as working memory, logic, attention, visual-spatial abilities, executive functioning, and information processing.

[15] Dr. Lori Vitale Cox--Case notes
[16] Gemma S, Vichi S and Testai E. Metabolic and genetic factors contributing to alcohol induced effects and fetal alcohol syndrome. Science Direct: Neuroscience and Behavioral Reviews 31 2007: 221
[17] Mattson S. and Riley E. A Review of the Neurobehavioral Deficits in Children with Fetal Alcohol Syndrome or Prenatal Exposure to Alcohol. Alcohol Clin Exp Res 1998 22 (2) 279

Researchers have found that individuals with PAE with or without characteristic sentinel physical features displayed neurobehavioral deficits in the following areas: [18]

- Language
- Social communication
- Memory
- Adaptive behaviour
- Attention
- Visual-spatial ability
- Abstract reasoning
- Cognition

2.6 Secondary Conditions

Without early diagnosis and support for their primary FASD disorder research indicates that 90% of individuals living with FASD develop secondary disorders. Protective factors identified in the research are early diagnosis, stable family and accommodations in the community. Secondary conditions may include mental illness, addictions, suicide and on-going trouble with the law. [19]

2.7 The Economic Cost of FASD

Research indicates that it costs more than 1.8 billion dollars for the lifetime costs associated with FASD. This includes medical treatment, special education, and institutional care and loss of productivity. [20] The second largest contributor to the cost of FASD is the cost of corrections and policing. [21]

2.8 The Social Cost of FASD

The social cost of FASD is even higher. FASD places a great burden on families and communities as well as our provincial social systems in terms of justice, education, health, and welfare.

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[18] Streissguth AP, Bookstein FL, Sampson PD and Barr HM. Neurobehavioral effects of prenatal alcohol. Neurotoxicol Teratol 1989: 11:493

[19] Streissguth AP, Barr HM, Kogan J, and Bookstein FL. Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). Seattle, Washington; University of Washington School of Medicine

[20] PopovaS,StadeB,LangeS,RehmJ.(2012a).A model for estimating the economic impact of Fetal Alcohol Spectrum Disorder. *Journal of Population Therapeutics and Clinical Pharmacology*, 19(1), e51--e65. Available from http://www.jptcp.com.

[21] Popova S, Lange S, Burd L, Rehm J. Cost attributable to FASD in the Canadian correctional system. *International Journal of Law and Psychiatry,*

2.9 Individuals with FASD Can Learn

With the proper support individuals with an FASD disability can learn and develop their own particular gifts and strengths. Some individuals with FASD graduate from High School. Some have gone on to college and university. With the proper support individuals living with an FASD disability can lead positive and fulfilling lives.[22] Legal professionals could play a significant role in referring youth who might be living with FASD for diagnostic evaluation and subsequent accommodations to support behavioral regulation and development.

Chapter 3 - Legal Issues

> **"There are no simple answers to the challenges presented (to the legal community) by FASD, but recognition of the problem is a *sine qua non* of its solution. A modest first step involves the cataloguing and analysis of recurring FASD-related legal issues, and the identification of the best practices and strategies for dealing with each of them."** [23]
>
> Timothy E. Moore and Melvin Green

3.1 How to Recognize Clients with FASD

A. What the RCMP might encounter—'childlike criminals'

Theft	Steals a car in front of police station
Breaking & Entering	Breaks in, raids fridge, is found in front of TV eating a snack
Vandalism	Friends run away from scene FASD individual just stands there as police arrive- than resists arrest and curses police

[22] Streissguth AP. Fetal Alcohol Syndrome: A Guide for Families and Communities. Toronto: Brooks 1997
Malbin DB. Stereotypes and Realities: Positive Outcomes with Intervention. In Kleinfield J, and Wescott S (eds.) Fantastic Antoine Succeeds! Experiences in Educating Children with Fetal Alcohol Syndrome. Fairbanks, Alaska: University of Alaska Press 1993

[23] Fetal Alcohol Spectrum Disorder (FASD): "A need for Closer Examination by the Criminal Justice System" Criminal Reports Vol. 19 Part 1 July 2004 19 C. R. (6th) 99-108

Lying Claims innocence even when caught in the act

Confesses guilt if interrogated--even if innocent—without seeming to understand the consequences in order to satisfy short–term needs --to be able to go home, to get something to eat, to please the interrogator

No Renunciation Distorted child-like perspective

No Responsibility Blames others--interprets consequences as meanness

Shut-Down May appear not to care-flat affect

Irritable/Defiant Often argumentative especially to those who are helping

B. What a Defense Lawyer might encounter [24]

- Appears to understand more than they do in terms of system
- Will repeat the same offense in the same set of circumstances without learning or modifying behavior--like wearing gloves to avoid fingerprints. Yet they are still surprised that they get caught

[24] Adapted from David Boulding, Lawyer, 'Mistakes I Have Made With FAS Clients' Paper presented FAS National Conference, Vancouver, Feb, 2001

- Will not understand the terms and workings of the system even though they have been through it a number of times—For instance, the consequences of guilty plea
- Will not understand time-difference between sentence of 3 months and 3 years
- Will often have blanks in their memories, failing to remember important facts
- Appear to be pleasant, humorous, engaging in an interview situation
- Appear as if they do not care—late, fail to show up for appointments
- Will be easily misled by police, crown, and probation officers. They will often act against their own interests
- Do not seem to know how to ‘play the justice game’ no matter how many times they have been through it.
- Will be easily led by others—usually the one who gets caught

C. What Crown, Judge, Probation Officers might encounter:

- Are often unable to understand court proceedings and to assist in own defense. Will not respond to step system of punishment-will not take heed of warnings, will breach standard terms of probation
- Will not be able to tell court 'what happened' in a way that makes sense
- May misunderstand questions, be confused by language and confabulate to fill in gaps in memory
- Appear not to respect the court- will stick out tongue, wave to friends, interrupt witness
- Appear to have no remorse sentencing judge-takes no responsibility, no renunciation of crime
- Will act inappropriately in court-for instance will interrupt Crown during 'Show Cause hearing" and correct the Crown Prosecutor's facts without realizing this is an admission that he or she was at the scene and had committed the offense.
- Will participate without guile in pre-sentencing report even when it is against their own interest
- Show a lack of criminal escalation—behaviors are impulsive, opportunistic. Satisfying momentary desires—for a candy bar, a pack of smokes, some money for beer
- Often unable to fully understand abstract concepts, for instance, the concept of guilty or innocent.

- Have been known to confess to crimes they have not committed and in others they will deny crimes they have even when there are witnesses

3.2 False Confessions

In a criminal case in Quebec, Brian Tate, living with FASD, gave a false confession that put him in prison for 11 months for a double murder he could not have committed. Initially he vehemently denied any involvement but finally broke down and repeated the story the police told him they suspected. From that point on his confession diverged from the facts as they were known to police. It was later found that he could not have committed the crime because he was in jail on an unrelated charge when the murders occurred.[25]

Why would someone with FASD make false confession to crime?

- Desire to please people in authority
- Desire to be agreeable--to be liked-watching cues to guess what the interrogator wants
- Difficulty with abstract concepts—'waiving right' being understood as 'waving right'
- Real memory gaps—confabulation
- Inability to understand court proceedings and assist in their own defense
- Inability to understand punishment
- Bluffing, trying to appear knowledgeable of events
- Trying to get out of the situation--thinking after confessing they can go home
- Desire to please accomplices--Plea bargaining of accomplices—the disabled individual may not understand and even brag that s/he is 'taking the rap' for friend

3.3 Unreliable Information

Individuals living with FASD often have a superficial understanding of language and interpret things too literally. For instance, an individual living with FASD might deny they have gone to a "house" because he or she had

[25] *The Montreal Gazette*, 7 October, 199, s. A6.

actually gone to an "apartment".[26] Persons living with FASD also learn to hear verbal cues and respond accordingly, but fail to recognize non-verbal cues.

3.4 Charter Issues

The communication and information processing challenges faced by persons living with FASD may affect their ability to understand the nature and scope of their rights under the Charter of Rights and Freedoms, such as their right to counsel and their right to remain silent.

In light of their FASD disability, special care must be taken to ensure that persons living with FASD understand:

- **Why they are being detained; and**
- **Not only what their rights are, but what these rights mean.** [27]

3.5 Legal Responsibility, Capacity and Competency

Mens Rea: Individuals with FASD tend to act impulsively and with little forethought, and may have a limited capacity to appreciate a sequence of events. Therefore, the extent to which the element of *mens rea* exists should be considered in the context of the person's FASD-related disability.[28]

- Is the accused competent to stand trial?
- Did the accused have the requisite 'Guilty Mind'?
- Does the individual with FASD have the capacity to form specific intent?
- Did the individual understand not only the act but also the specific outcome?

"Our system of justice is founded on the premise that defendants understand the relationship between actions and outcomes, between intentions and consequences, that people who make choices are responsible for the fallout. The cognitive impairments of persons with FASD call these fundamental premises into question."[29]

Justice Melvin Green

[26] Supra. Note 12.
[27] *R. v. Sawchuck* [1997] M.J. No. 186.
[28] *Supra.* Note 1
[29] Fetal Alcohol Disorders, Symposium for Justice Professionals "A Judicial Perspective", p.4

3.6 Undertakings or Promises to Appear

For someone with FASD, the ability to follow through with his or her promises or commitments to others may be compromised because of communication and memory deficits. A person with FASD may not understand the significance of Undertakings or Promises to Appear.[30]

3.7 Testimony

The Court should appreciate the challenges faced by a person with FASD, when giving evidence in a courtroom[31]:

- Intermittent and short-term memory problems, gaps in long-term memory, can impact upon the ability of an FASD affected person to clearly describe past events.
- People with FASD can have difficulty understanding the concept of time. This can interfere with their ability to describe past events, to keep appointments, and to plan effectively for the future.
- People with FASD typically have significant difficulties with communication. This includes incoming information (what they hear, read and see), information processing (including information retrieval) and expression (speaking, writing and non-verbal). Good expressive verbal skills often mask poor comprehension of the situation.
- Cognitive and memory problems can provide challenges to the ability of a person with FASD to give a clear version of events. Instead, the person may tell his or her story in a more round about way. Be patient and listen carefully, so that you are better able to identify the key facts.

Having specific strategies will help you procure information you want from the person with FASD.

3.8 Helpful Tips for Communication

Be respectful of the unique challenges and strengths of an individual living with FASD and provide necessary accommodations

[30] *Supra.* Note 1
[31] Ibid

A. Questioning a person with FASD [32]

- All statements and questions should be short and to the point
- Ask a question in several different ways
- Avoid inferences
- Avoid asking multi-step questions
- Avoid questions containing complex wording
- Allow the person with FASD more time to respond to questions and tasks
- Be aware of sensory sensitivities that may lead to a person with FASD feeling overwhelmed

B. Use available resources to assist in the process of communication[33]

- Use “visuals” as much as possible (simple diagrams, charts, point form, pictures)
- Use large chart paper, “white boards”
- Utilize technologies (electronic presentation/retrieval of information: video, audio)
- Use scribes as needed for the written information --someone to write information down for the person living with FASD (i.e. forms, statements, etc.)
- In some cases, use audio or video teleconferencing with person with FASD in a separate, quiet room
- If possible schedule more time for a trial involving a person with FASD

C. Use a multi-source approach to gather information and assist with communication

For many reasons, the information gathered from an individual living with FASD may not be reliable or seem to be reliable. A multi-source approach engages as many "knowledgeable" people as possible, thus increasing the amount of accurate and useable information. This will improve understanding as well as communication. The more information you have about an individual living with FASD, the more effective his or her court experience will be. Therefore, it is important to gather as much medical, social, family, educational, psychiatric and judicial information as one can, as early in the process as possible. Make accommodations to the process based on the individual’s neuro-developmental profile. For instance be aware of issues such as sensory sensitivity in terms of bright lights and or noise.

[32] Ibid.
[33] Ibid.

D. Communication Strategies [34]

- Chunk information into small pieces (for what you are presenting to the individual, and in what you expect to receive back)
- All communication must be as concrete as possible
- Read all materials out loud to those who need it
- Speak slowly
- Use the person's name frequently, especially prior to asking a question
- Avoid pronouns – use the names of people to whom you are referring
- Be proximal, but not *too* close to the person
- Try having the individual with FASD role play what happened
- Provide the individual with verbal cues when activities are about to change (3 min. - 5 min. warnings that the something different is about to happen in the court… "In three minutes the court is going to take a break…" "When the long hand of the clock is on the 12 the court will stop for the day."
- Always check for comprehension (not simply by asking if they understand – ask questions about the content)
- Consider cultural differences in behaviour (i.e. In some Indigenous communities, it is considered rude to look at someone directly in the eye)
- Exercise patience -- the communication and processing deficits are not intentional

3.9 Appropriate Courtroom Behavior

People with FASD may not understand the nuances of courtroom etiquette, and therefore their behavior may not be appropriate. Their behavior may be the result of neurological brain damage beyond their control.[35]

I assumed that because we had been to Court many times that my clients would know that they should not interrupt the Crown Prosecutor…[36]

David Boulding

[34] Ibid.
[35] Ibid.
[36] Boulding, David. (2001, September) "Mistakes I have made with FAS Clients." Presentation (location not specified). Coquitlam, B.C., p.2

Crown attorneys, defense counsel, judges, court workers and probation can likely respond more effectively to inappropriate behavior if they understand its origins and how to interpret it.

3.10 Reframing Behaviors

If You Think Offenders Living with FASD Are Misbehaving Intentionally-Reframe It[37]

Negative Behaviour	Misinterpretation "Won't"	Accurate Interpretation "Can't"
Non-Compliance Failure to appear Missing probation meetings	-- Willful misconduct -- Attention seeking -- Stubborn	-- Difficulty translating verbal directions into actions -- Comprehension difficulties
Repeatedly Making The Same Mistakes Recidivistic actions Correction does not work	-- Willful misconduct -- Manipulative	-- Problems with abstract cause and effect reasoning -- Difficulty generalizing learning -- Perseveration
Often Late Late for meetings Late for community service work	-- Lazy, slow -- Poorly parented -- Willful misconduct	-- Cannot understand the abstract concept of time -- Memory problems
Repetitive Behaviors Hitching and wiggling around in court Playing with loose change or clicking a pen	-- Seeking attention -- Bothering others -- Willful misconduct	-- Neurologically-based hyper-activity -- Impulsivity
Poor Social Judgment Inappropriate touching Overly friendly with strangers	-- Poorly parented -- Willful misconduct -- Abused child	-- Misinterpret social cues from peers -- Boundary problems
Overly Physical Inappropriate touching Gets too close to others Abusive, especially if intoxicated	-- Willful misconduct -- Deviancy	-- Over or under-sensitive to touch -- Cannot relate social cues to boundaries
Is Unable To Act Independently	-- Willful	-- Problems with executive

37

? Originally from Diane Malbane. Cited in **Teaching Students with Fetal Alcohol Syndrome/Effects, A Resource Guide for Teachers**, Appendix 3, 1996. Adapted by Mary Cunningham and Dr. Lori Vitale Cox

Can’t perform community service effectively Needs to be led all the time	misconduct -- Passive aggression	function-initiate, shift, working memory, attention, organization -- Chronic health problems

3.11 Sentencing

Some sentencing considerations involving a person living with FASD might include: [38]

- Is FASD a mitigating factor in behavior?
- Is incarceration appropriate?
- Consider whether the offenders FASD disability entails reduced culpability and thus warrants a less severe sentence [39]
- Are supervised alternative interventions available?
- If they are avoid lengthy (or any) incarceration in favor of longer intense supervision
- Is treatment available during/after incarceration or intervention?
- Are probation orders consistent with both needs of individual and protection of society?
- How can FASD affect a person's ability to abide by the terms of his or her sentence?
- What community and/or institutional resources are available to assist the offender living with FASD?

3.12 Probation Orders and Supervision

Terms in probation orders should be carefully crafted to reflect the challenges faced by the probationer living with FASD.

- Judges can use the stature of their position with the defendant—especially if they also are compassionate
- Try to locate a sponsor or advocate who will assist the person with FASD in daily life
- Responsible parents can be partners with the court in sentencing
- Use milder but targeted sanction
- Use the orders to create structure in the defendant's life
- Write out, simplify and repeat rules
- Don't overreact to probation violations, particularly status offenses
- Make sure the defendant's probation officer understands FASD

3.13 People with FASD in Custody

[38] *Supra*. Note 12.

[39] *Sentencing and Supervising Offenders with FASD*, (FAS/FAE Legal Issues Resource Center, Fetal Alcohol Drug Unit, University of Washington – Department of Psychiatry and Behavioral Science, School of Law)

“Because people with FASD are often prone to impulsivity, poor judgment, communication difficulties, and poor memory, they may be especially vulnerable if placed in a custodial setting. In situations where there is no foreseeable risk to the community, including the victim, if the offender with FASD were to be released, it may be helpful if Crowns, Judges and Defense Counsel consider other available options, such as community justice processes. If the offender is a young person as defined under the Youth Criminal Justice Act, then the concept of conferencing as provided in that act, may provide a good forum to develop a meaningful plan for them.” [40]

[40] *Supra.* Note 1

3.14 Alternative Justice

Individuals with FASD may be involved in alternative justice models such as Restorative Justice or Healing Courts. Remember that these processes may also be confusing for an individual with FASD. Individuals living with FASD:

- May appear to understand when they really don't
- May act and think much younger than they really are
- May not accept responsibility for but alternative processes may still be appropriate
- May talk the talk but need support to be able to walk the walk
- May not fully understand their responsibilities after circle

Alternative processes can more effective if advocates:

- Determine if an individual has been assessed for FASD or is at risk of FASD before the justice circle
- Ask open ended questions
- Use concrete examples
- Check out whether individual understands by having them repeat in their own words

Remember that individuals living with FASD:

- May need more supervision and support or time in order to carry out agreement
- May not be able to generalize in terms of changing behavior-it may take longer to learn and require more repetition—Be patient and provide support
- May have difficulties with cause and effect reasoning—understanding consequences-they need structured situation
- May have difficulty with understanding time-or time management-they need supports like visual schedules
- Benefit from repetition—it may be helpful to have more than one circle
- Are impressed with ceremony

3.14 Other Legal Issues

The emphasis in this manual has been on individuals with FASD who come into conflict with the law. But individuals living with FASD are often victims of crime themselves or witnesses to crimes that others commit. They also may be involved in civil law issues such as

- Adoption Issues—Parents not being told that child had FASD or extent of damage
- Parenting/Custody issues for mom's with FASD including termination of rights
- Assignment of suitable guardian, capacity, financial liability

The same principles of communication apply in all of these areas.

3.17 FASD a challenge and also an opportunity

People with (FASD) provide everyone who works in the field of criminal justice with both challenge and opportunity. A system based on the premise that offenders appreciate the nature and consequences of their acts and that punishment is connected to their actions has not been designed with any understanding of their particular disability. Our criminal law and all of the procedures and safe-guards attached to it ignore the challenges people with (FASD) present. The opportunity lies in planning and creating alternatives that meet the goals of public safety and protection, in safeguarding constitutional guarantees for all people, and, in addition, in meeting the individual offender's need to be restored to his or her community. [41]

Mr. Justice David H. Vickers
Supreme Court of British Columbia, Vancouver

[41] *Supra.* Note 12, Foreword by Justice Vickers, at xiii

Appendices

Appendix A Websites with Justice Related Resources

1. FASD and the Justice System: www.fasdjustice.on.ca

2. University of Washington, School of Law FASD Legal Issues Resource Center www.depts.washington.edu/fadu/legalissues

3. Canada FASD Research Network: https://canfasd.ca/about/contact-us/

4. Assante Centre: https://www.asantecentre.org/

Appendix B. Where to Get Diagnosis in Canada—FASD Clinics by Province

Multi-disciplinary FASD diagnostic services are very limited in most regions of the country and completely lacking in others. Adult diagnostic services are more limited than those for children and youth.

Legal professionals do have the ability to make a difference and have been key in advocating for FASD diagnostic services. For instance, in NB in 2005, there were no FASD diagnostic clinics in the province. NB. Judges and Crowns in the province participated in a research survey about FASD and the CJS reporting that the lack of provincial FASD diagnostic capacity was negatively affecting the legal system in the province. This research helped convince provincial decision makers of the need to provide diagnostic services. In 2006 the Eastern Door Clinic opened in Elsipogtog FN followed a few years later by the provincial NB FASD Centre of Excellence.

A list of FASD clinics by province follows. If you practice far from these clinics you can email Canada FASD Research Network, Can FASD, for more information regarding diagnosis in your area.

Email: info@canfasd.ca

Alberta **A** = Adult Clinic **C** = Child Clinic

Cumulative Risk Diagnostic Clinic C
Alberta Children's Hospital, Child Development Ct
2888 Shaganappi Trail NW Calgary, AB T3B 6A8
[P] 403.955.5878
MediGene Services-FAS Diagnostic Clinic A|C
Foothills Professional Building
Suite 110, 1620-29th St. NW Calgary, AB T2N 4L7
[P] 403.571.0450
Pediatric Specialty Clinic C
Children's Rehabilitation Services-Central Zone
#300 Professional Centre5015-50 Ave. Camrose, AB T4V 3P7 [P] 780.608.8622

Prairie Central FASD Clinical Services A
#4838 49th St. Camrose, AB T4V 1N2
[P] 587.386.0186

Lakeland Centre for FASD A|C 4823 50th St. P.O. Box 479 Cold Lake, AB T9M 1P1 [P] 780.594.9905

Pediatric FASD Clinical Services C Glenrose Rehabilitation Hospital 10230-111 Ave. Edmonton, AB T5G 0B7 [P] 780.735.8278

Glenrose Adult FASD Assessment Clinic A Glenrose Rehabilitation Hospital
10230-111 Ave. Edmonton, AB T5G 0B7
[P] 780.735.6166

Canadian FASD Diagnostic & Training Centre A|C
316 Kingsway Garden Mall NW Edmonton, AB T5G 3A6 [P] 780.471.1860

Centrepoint Young Offender Program C
Suite 701, 10242-105 St. Edmonton, AB T5J 3L5
[P] 780.428.4524

Alberta Health Services/NEAFAN A|C
600 Signal Rd. Fort McMurray, AB T9H 3Z4
[P] 780.750.6678

NW Peace FASD Diagnostic Clinic A|C
#204 9805 97 StGrande Prairie, AB T8V 8B9
[P] 780.533.5444

Northwest Primary Care Network C
Children and Youth FASD Diagnostic Clinic 11202-100 Ave. High Level, AB T0H 1Z0 [P] 780.841.3253

Northwest Regional FASD Society Mackenzie Network A
Box 3668 High Level, AB T0H 1Z0
[P] 780.926.3375

Northern Association for FASD A|C
4826 51 Ave. High Prairie, AB T0G 1E0
[P] 780.523.3699

Foothills FASD Assessment & Diagnostic Clinic A|C
101, 520 Macleod Trail, High River, Alberta T1V 1M3
[P] 403.652.4776

FASD Assessment & Support Services
South East Alberta A|C
Bridges Family Programs
477 Third St. SE Medicine Hat, AB T1A 0G8
[P] 403.526.7473

Central Alberta Organic Brain Dysfunction Clinic A|C#206 33 McKenzie Cres. Red Deer County, AB T4S 2H4 [P] 403.342.7499 ext. 2

Complex Needs Diagnostic Clinic C
Wapski Mahikan Society, Alexander First Nation
Box 3479 Morinville, AB T8R 1S3 [P] 780.853.7723

Siksika FASD Clinic C
Box 1130 Siksika, AB T0J 3W0
[P] 403.734.5687

North West Central FASD A|C
Assessment & Diagnostic Team
Box 5389 Westlock, AB T7P 2P5
[P] 780.284.3415

Lethbridge Family Services A|C
FASD Assessment & Diagnostic Clinic
1107-2nd Ave. "A" N. Lethbridge, AB T1H 0E6
[P] 403.320.9119

Alberta Hospital Edmonton
Turning Point Program [12-21yrs]
17480 Fort Rd. Edmonton, AB T5J 2J7
[P] 780.342.5002

British Columbia

Complex Developmental Behavioural Conditions (CDBC) Team
Sunny Hill Health Centre for Children
3644 Slocan St. Vancouver, BC V5M 3E8
[P] 604.453.8300 ext. 8208

Complex Developmental (CDBC) Clinic
Nanaimo Child Development Centre
1135 Nelson St. Nanaimo, BC V9S 2K4
[P] 250.753.0251
Beacon Community Services
FASD Circle Adult Diagnostic Clinic
2723 Quadra St. Victoria, BC V8T 4E5
[P] 250.595.6626
www.beaconcs.ca

Diagnostic and Assessment Services
FASD Society for British Columbia
O/A The Asante Centre and Minga Marketplace
Unit 103, 22356 McIntosh Ave. Maple Ridge, BC V2X 3C1
[P] 604.467.7101
www.asantecentre.org

Northern Health Assessment Network [NHAN]

Provincial Health Services Authority
1st Floor, 1444 Edmonton St. Prince George, BC V2M 6W5
[P] 250.565.5827
www.northernhealth.ca/YourHealth/PublicHealth/NorthernHealthAssessmentNetwork/ComplexDevelopmentalBehaviouralConditions.aspx

Interior Health Children's Assessment Network [IHCAN]
#309-1664 Richter St. Kelowna, BC V1Y 8N3
P] 250.712.0416
www.interiorhealth.ca

Fraser Developmental Clinic
Harper and Associates, Psychology
261-610 6th St. New Westminster, BC V3L 3C2
[P] 604.522.7979

Complex Developmental and Behavioural Conditions (CDBC) Clinic
Queen Alexander Centre for Children's Health
Vancouver Island Health Authority
2400 Arbutus Rd. Victoria, BC V8N 1V7
[P] 250.519.5390 ext. 36340
www.viha.ca/cyf_rehab/assessment/vican/

Manitoba

Manitoba FASD Centre
SSCY Centre
1155 Notre Dame Avenue
Winnipeg, Manitoba
R3E 3G1
P: 204.258.6600
www.fasdmanitoba.com

New Brunswick

Eastern Door Centre
342 Big Cove Rd.
Elsipogtog FN, E4W 2S3
Tel: 506-523-4608
Fax 506-523-8234

NB FASD Centre of Excellence
667 rue Champlain St, Suite 105 A
Dieppe, NB E1A 1P6
Tel: 506-862-3783 Fax: 506-869-2147

Northwest Territories

FASD Family and Community Support Program FASD Coordinator
Northwest Territories Health and Social Services Authority
Stanton Territorial Hospital
550 Byrne Rd.
Yellowknife NT
X1A 2N1
[P] 867.669.4195
http://www.stha.hss.gov.nt.ca/outpatient-services/child-development-team/fasd-clinic-community-support

Nunavut

Akausisarvik – Mental Health Children & Youth Division
P.O. Box 1000 Stn.
1035 Iqaluit, NU
X0A 0H0
[P] 867.979.7633

Ontario C = Child Clinic M = Mother Clinic A = Adult Clinic F = Family Clinic

Mothercraft (Breaking the Cycle)FASD Diagnostic Clinic C|M
860 Richmond St West, Suite 100
Toronto, ON M6J 1C9
P: 416.364.7373
www.mothercraft.ca

KidsInclusive Centre for Child and Youth Development C
166 Brock St Kingston, ON K7L 5G2
P: 613.544.3400
http://kidsinclusive.ca

Grandview Children's Centre C
600 Townline Road South
Oshawa, ON L1H 7K6
P: 905.728.1673 Toll Free: 1.800.304.6180
http://grandviewkids.ca/

Resources for Exceptional Children and Youth C
865 Westney Road South
Ajax, ON L1S 3M4
P: 905.427.8862
http://www.rfecydurham.com/

Peel FASD Clinical Service
Child Development Resource Connection Peel C
120 Methson Blvd E., Suite 201
Mississauga, ON L4Z 1X1
P: 905.890.9432 Ext. 306
www.cdrcp.com

NEO Kids FASD Clinic
Health Sciences North C
41 Ramsay Lake Road
Sudbury, ON P3E 5J1 P: 705.523.7120 Ext. 1073
www.hsnsudbury.ca

Anishnawbe Health Toronto C|F 225 Queen St. East
Toronto, ON M5A 1S4 P: 416.360.0486 Ext. 252
https://www.aht.ca/

St. Michael's Hospital Fetal Alcohol Spectrum Disorder Diagnostic Clinic C 61 Queen Street, 2nd Floor, Pediatric Clinic
Toronto, ON M5C 2T2
P: 416.867.3655

Northwestern Ontario FASD Diagnostic Clinic C|F
820 Lakeview Drive
Kenora, ON P9N 3P7
P: 807.468.5551
http://www.fireflynw.ca/

Children's Hospital of Eastern Ontario (CHEO)
Eastern Ontario Regional Genetics Program C|A

401 Smyth Rd
Ottawa, ON K1H 8L1
P: 613.737.7600 Ext. 3218
http://www.cheo.on.ca/en/genetics

CMHA Guelph-Wellington FASD Team C
485 Silvercreek Parkway North, Unit 1
Guelph, ON N1H 7K5 P: 519.824.5544

NorWest Community Health Centres C|A
525 Simpson St
Thunder Bay, ON P7C 3J6
P: 807.626.8485
www.norwestchc.org

Waterloo Region FASD Diagnostic Clinic
Front Door C
1770 King St E., Suite 1
Kitchener, ON N2G 2P1
P: 519.884.1666 Ext. 2263
www.fasdwaterlooregion.ca

Halton FASD Collaborative
www.haltonfasd.cam

Private FASD Diagnostic Team
Dr. L.A. Scott and Associates
P.O. Box 21016
Paris, ON N3L 4A5
P: 519.442.9994
www.drscottassociates.com

Quebec

James Bay Cree FASD Diagnostic and Intervention Clinic/Neurodevelopmental Clinic
Cree Board of Health and Social Services of James Bay
Box 250
Chasasibi,QC J0M 1E0
(819) 855-2744

Saskatchewan

Regina Community Clinic FASD Centre
1106 Winnipeg St.
Regina, SK S4R 1J6
[P] 306.543.7880 ext. 268

Regina Qu'Appelle Health Region Child and Youth Services
1680 Albert St.
Regina, SK S4P 2S6 [P] 306.766.6700

Prince Albert Health Region Child and Youth Services
Lower Level, Victoria Square
2345 10th Avenue West, Box 3003
Prince Albert, SK S6V 6G1 [P] 306.765.6068

Alvin Buckwold Child Development Program
Kinsmen Children's Centre
1319 Colony St.
[P] 306.655.1070
Saskatoon, SK S7N 2Z 1

Saskatoon Genetics/Teratology Clinic
Royal University Hospital
Saskatoon, SK
[P] 306.966.8112

Adult FASD Assessments
Dr. Gerald Block
Saskatoon, SK
[P] 306.373.3110

Onion Lake FASD Diagnostic Team
PO Box 70
Onion Lake, SK S0M 2E0
[P] 306.344.2330
www.onionlake.ca

Yukon

Child Development Centre Yukon
1000 Lewes Blvd.

PO Box 2703
Whitehorse, YT Y1A 2C6
[P] 867.456.8182
[TF]1.866.835.8386
www.cdcyukon.ca

Adult Assessment Clinic

Services for People with Disabilities, Adult Services
3168 3rd Ave.
PO Box 2703 H-4
Whitehorse, YT Y1A 2C6
[P] 867.667.8040
http://www.hss.gov.yk.ca/disabilites.php

Appendix C FASD Misconceptions vs FASD Facts

Misconception
FASD is just used by defense lawyers as an excuse for bad behavior.
Fact
FASD is a neurological disability that affects learning and behavior. The disability occurs as the result of brain damage caused by pre-natal exposure to ethanol, a neurotoxin. People living with FASD have difficulty with self-regulation as well as abstract thinking.. They can be of average overall ability but they have difficulty using these abilities in daily life. They need appropriate accommodations and support in school, in the workplace and in the CJS and corrections. When individuals living with FASD get the supports they require they learn to behave in ways that are socially acceptable. Research shows that individuals living with FASD will develop secondary problems that include trouble with the law and mental illness if they do not have access to diagnosis and adaptive interventions appropriate to their disability.
Misconception
Individuals with FASD can be dangerous since they do not understand consequences.
Fact
Aggression has not been identified as a core neurological characteristic of individuals with FASD. Most people with an FASD are not dangerous by nature. They could become dangerous, however, if they experience repeated trauma. With diagnosis and the right support, people with FASD can finish school, go to college, get a job, and have a family. If they do get in trouble with the law they could learn from specialized system interventions and supports put in place in relation to their disability. The responsibility to accommodate for the invisible disability of FASD caused by brain damage is the same as the responsibility to accommodate for a visible disability.
Misconception
FASD diagnosis is uncertain and diagnostic criteria are not clear
Fact The Canadian Guidelines for FASD diagnosis, published in 2005 and 2015 by the Canadian Medical Association, fully operationalizes the diagnosis of FASD condition

Misconception
Diagnosis makes no difference because FASD can't be cured and there are few interventions available.
Fact
There is no cure for FASD but an individual's outcome can be changed. Research shows the outcome of an individual living with FASD can be influenced by environmental accommodations and factors such as access to early diagnosis, stable home placement, and lack of trauma. FASD is an invisible disability and environmental accommodations need to be made within most social institutions if people living with FASD are to function effectively within them. They need initial high levels of structure, support and supervision that can be lessened to often minimal levels as they learn routines. With the proper support people with FASD can learn at school, in jail or in the community and socially unacceptable behaviors can be eliminated. Diagnosis offers hope because it can leads to appropriate accommodations in the CJS and corrections. Adaptations can be built into probation orders and conditional sentences. These can be structured to take into account the need for more intense supervision as well as difficulty with time and keeping appointments. Diagnosis made by a multi-disciplinary professional team as recommended by the Canadian Guidelines for FASD Diagnosis always includes recommendations based on the specific and varying brain dysfunction of each individual.

Appendix D-Examples of FASD Justice Initiatives

Lethbridge Community Justice Project--Case Management of Fetal Alcohol Spectrum Disorder

General Description:

The Community Justice Project was established as a partnership of service providers created to increase awareness and management of Fetal Alcohol Spectrum Disorder (FASD) within the criminal justice system. The purpose of the project was to influence change in the criminal justice system through mentorship, education and training about FASD.

Objectives of the project:

- To influence case management for youth living with FASD
- To divert youth affected by FASD from the system, where appropriate
- To make recommendations to the court
- To identify high-risk youth and their families and connect them with appropriate services and supports
- To provide community and justice system advocacy for families, schools and service partners

Outputs:

- Increased community awareness of FASD
- Increased understanding of family members, caregivers, the criminal justice system and other community supports and services regarding FASD
- Improved well-being and stability of youth living with FASD and their families
- Changes in beliefs about how best to serve youth with FASD
- More appropriate response of service providers to clients with this disability through professional education and training
- Reduction of related difficulties such as school disruption, placement disruption and drug/alcohol misuse

Results:

Approximately 80% of the youth who were supported by the FASD Youth Justice Committee had no further involvement with the Justice System.

Nogemag Healing Lodge for Youth---Elsipogtog, NB
Youth Justice Project using a Medicine Wheel Approach

Project Lead:

Dr. Lori Vitale-Cox

General Description:

The Nogemag Justice Initiative was implemented in 2000 to:

- Decrease youth crime by providing special needs based intervention for Mi'kmaq youth at risk who have been:
  -
  - in trouble with the law or at risk of offending
  - in trouble at school
  - diagnosed with FASD or pre-natally exposed to drugs and/or alcohol

The main goals of the project were:

- To help youth recognize their strengths and gifts and their responsibility to all things
- To provide youth with life and academic skills that will enable them to develop
- To strengthen their relationship to self, family and community culture
- To prevent secondary disabilities associated with FASD

Results:

The original cohort of youth involved with the Nogemag project all returned to the regular school. They were reported by RCMP to have remained out-of trouble for 12 months following project. External evaluator noted significant reduction in youth crime rate in the community after implementation of interventions at school and Nogemag project. 80% of the youth involved with the Nogemag project went on to graduate high-school.

The Nogemag Healing Lodge continues to serve youth at risk living with FASD and other trauma related conditions.

Genesis House – New Westminster, B.C.

General Description:

The Genesis House Community Residential Facility and Programs Centre opened in July 2000. It provides comprehensive residential services, serves as a program delivery site for the Correctional Service of Canada's Core Living Skills and Substance Abuse programming and offers specialized programming for individuals living with Fetal Alcohol Spectrum Disorder (FASD). Operated by the West coast Genesis Society, Genesis House strives to actively promote the physical, psychological, emotional, and spiritual well-being of federal offenders on various types of conditional release. Genesis House is particularly accommodating to persons dealing with substance abuse issues. The facility provides a structured environment, specialized support and accepts residents on the Methadone Maintenance Treatment Program. A total of twenty-four residents can be accommodated at Genesis House in single, double, and triple occupancy rooms. The locked rooms are assigned in a way that maximizes resident harmony. Residents at Genesis House are provided shelter, meals, reasonable privacy, and access to telephone and laundry facilities.

Winnipeg FASD Youth Justice--In Court Project

Project Lead:

Justice Mary Kate Harvie

General Description:

The FASD Youth Justice Project (YJP) is collaboration among Justice Canada – Youth Justice Renewal Fund, Manitoba Justice, Interagency FASD Program, Clinic for Drug and Alcohol Exposed Children (CADEC), Manitoba Health, Winnipeg Police Service and Youth Forensic Services.

The goal of the YJP is to ensure that youth affected with FASD in conflict with the law will receive appropriate judicial dispositions, including a multidisciplinary assessment and diagnosis and improved access to services. The project also assists in identifying and developing family oriented and community based resources.

Description of the Youth Justice Project (YJP) Process:

- Referral: Referrals are accepted from representatives of the justice system, parents/caregivers.
- Screening: Screening criteria:
    - Youth in pre-sentence phase.
    - Youth living in City of Winnipeg.
    - Confirmation of pre-natal alcohol exposure.

- No prior FASD diagnosis.
  - Guardian and youth consent.
- Court ordered FASD assessment of the youth.
- Multi-Disciplinary Team assessment which includes a psychologist and physicians
- Family debriefing.
- Court report prepared and submitted.
- Judicial conference when required.
- Sentencing of youth.
- Community re-integration and planning with youth and caregivers.
- Referral to appropriate community resources and ongoing support and advocacy.
- Community Development and Facilitation of FASD education, interventions and planning through informal consultations and community presentations.

From: www.fasdjustice.on.ca

Alberta v. RJH, 2006 ABQB 656
DO/LTO Applications - R. v. GNB/R v. Bunn, 2011 SKQB 21
R. v J.P., 2018 SKQB 96 (Elson J)
R. v. Gray, 2002 BCSC 1192
R. v. Harris, 2002 BCCA 152
R. v. Mackenzie2005 BCPC 106, 2009 BCPC 57,2007 BCPC 109
R. v. Synnuck, 2005 BCCA 155:
R. v. TK, 2006 NUCJ 15
R. v. Williams, [1994] BCJ No. 3160, 1994 CanLII 576
Saskatchewan - R. v. G.N.B., 2011 SKQB 21 (Acton J.)

Not Criminally Responsible

Adult - R. v. Faulkner [2007] NJ No. 46, 2007 CanLII 3092
Adult - R. v. VAE/R v. Elias, 2010 YKTC 139
Youth - R. v. Manitowabi, 2014 ONCA 301
Youth - R. v.RF, 2002 SKPC 137 (PC)

Unfit to Stand Trial

Adult - R. v. Dewhurst, 2009 YKTC 10
Adult - R. v. Jobb, 2007 SKPC 129, 2008 SKCA 156
Adult - R. v. Sewap, 2008 SKPC 171
Adult - R. v. TJ [1999] YJ No. 57 (Terr. Ct)
Re Njootli, 2016 CarswellOnt 5797 (ORB)
Re. CASD, 2016 CarswellBC 3916 (BCRB)
Youth - R. v. DB, 2003 SKPC 155, 2004 SKPC 43
Youth - R. v. JI, 2000 BCSC 175
Youth - R. v. RLF, 2010 NBPC 35
Youth - R. v. WALD (1), [2001] SJ No. 70 (Youth Court; Turpel-Lafond J.), 2002 SKPC 37 (Whelan J.), 2004 SKPC 40 (Whelan J.), 2004 SKPC 87
Youth - R. v. WALD (2), 2002 SKPC 38, 2004 SKPC 42

Custody - Child with FASD

Alberta - Alberta (Director of Child Welfare) v. AC 2000 APBC 195
Alberta - Alberta (Director of Child Welfare) v. CR, 2003 ABPC 127 (PC)
Alberta - Alberta v. TL, 2010 ABPC 43
Alberta - BW v MW, [1998] AJ No 1566
Alberta - FM v SS, 2010 ABQB 195

Alberta - GTR v DAB (1998) 222 AR 84 (PC)
Alberta - K.R.W. v. S.L.M., 2013 NBQB 247 (Morrison J.)
Alberta - Rabbit v. Alberta [1981] AJ No 793 (QB)
Alberta - RE ADM, [1989] AJ No 860
Alberta - Re BG [1996] AJ No 780
Alberta - Re J.M., 2013 ABPC 291 (D'Souza J.)
Alberta - Re JNDW (1990), 104 AR 48 (PC)
Alberta - Re KAAM, 2002 ABPC 67 (Lipton J.)
Alberta - Re KMW (1993), 143 AR 374
Alberta - Re LS, 2007 ABPC 274
Alberta - Re SJH, 2003 ABPC 208
Alberta - Re T.F., 2012 ABPC 5 (Lipton J.)
Alberta - Re TF, 2012 ABPC 5
Alberta - Re TL, 2000 ABPC 14
Alberta - SG v. Alberta (Director of Child Welfare), 2002 ABQB 1062, 2003 ABQB 1047
Alberta - SM v. Alberta, 2008 ABPC 101
British Columbia - Alec v. Peters, [1997] BCJ No. 2603, 1997 CanLII 1391 (SC)
British Columbia - AS v BC (Director of Child, Family and Community Service), 2003 BCSC 54
British Columbia - BC (Director of Child, Family and Community Services) v. LSN, 2008 BCPC 402
British Columbia - BC (Director of Family and Child Services) v AH, 2001 BCPC 270
British Columbia - BC (Director of Family and Child Services) v CD, 2002 BCPC 462
British Columbia - BC (Director of Family and Child Services) v JN, 2000 BCPC 98
British Columbia - BC (Superintendent of Family and Child Service) v DS (1983) 47 BCLR 324, 1983 CanLII 517 (SC); (1985) 63 BCLR 104, 1985 CanLII 452
British Columbia - BC (Superintendent of Family and Child Service) v. CJ [1994] BCJ No 1952
British Columbia - JM v British Columbia (Director of Child, Family and Community Service), 2004 BCPC 562
British Columbia - JT v BC (Superintendent of Family and Child Service) 1994 BCJ No 3109 (PC)
British Columbia - MK (Re), [1998] BCJ No 2984 (Rae J.)
British Columbia - NM v JM, [1999] BCJ No 1652 (PC)
British Columbia - Re RS, [1999] BCJ No 2957 (PC) (Rae J.)
British Columbia - Re RSB, [1994] BCJ No. 419 (PC)
British Columbia - RG v AP, [1999] BCJ No 1655
Child and Family Services for York Region v JV and NB, 2017 ONSC 4770
Children's Aid Society (Ottawa) v SL and MB, 2017 ONSC 7019 (Desormeau J)
Manitoba - Cree Nation Child and Family Caring Agency v. R.L., 2013 MBQB 267 (Hatch J.)
Manitoba - Manitoba (Director of Child and Family Services) v. MPS [1993] MJ No 78 (PC)
Manitoba - Metis Child, Family and Community Services v RLL 2007 MBQB 198
Manitoba - Northwest Child and Family Services Agency v. LAC (1988) Man R (2d) 146
Manitoba - Winnipeg (Director of Child and Family Services) v AJK 2005 MBQB 51
Manitoba - Winnipeg Child and Family Services v. ZDV, [2000] MJ No 77 (QB)
New Brunswick - NB (Minister of Health and Community Services) v WL (1995) 169 NBR (2d) 81 (QB)
Newfoundland and Labrador - Newfoundland (Director of child, Youth and Family Services, St. John's Region) v. TL (2001) 199 Nfld. & PEIR 78, 2001 CanLII 37594 (SC)
Newfoundland and Labrador - Newfoundland and Labrador (Child, Youth and Family Services, Director) v. CT 2010 NLTD(F) 19
Newfoundland and Labrador - Newfoundland and Labrador (Director of Child,Youth and Family Services Health and Community Services Board – St. John's Region) v. JLB, 2008 NLUFC 35
Nova Scotia - Children's Aid Society of Halifax v. AM (1986) 76 NSR (2d) 18 (Fam Ct)
Nova Scotia - DRL v. LAE, 2007 NSSC 195
Nova Scotia - ES v. Children's Aid Society of Cape Breton-Victoria 2006 NSSC 303
Nova Scotia - Nova Scotia (Minister of Community Services) v. GM, 2012 NSFC 1

Nova Scotia - Nova Scotia (Minister of Community Services) v. MJ, [1988] NSJ No. 546 (Fam Ct)
Nova Scotia - Nova Scotia (Minister of Community Services) v. NL, 2010 NSSC 328
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More information on the Gladue decision available at Aboriginal Legal Services of Toronto's Gladue pages at http://www.aboriginallegal.ca/gladue.php
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Appendix F- In Depth Diagnostic Information

The term FASD, Fetal Alcohol Spectrum disorder, refers to the spectrum of physical and neurological conditions occurring as a result of prenatal exposure to alcohol. FASD is a developmental and behavioral disability. In 2015 new Canadian Guidelines for FASD diagnosis were published. the "2015 Canadian Guidelines" (Cook, Green, et al, *Fetal Alcohol Syndrome Disorder: a guideline for diagnosis across the lifespan*, CMAJ 2015). The diagnostic categories in these guidelines:

FASD—with Sentinel Facial Features replaces FAS

FASD—without Sentinel Facial Feature replaces pFAS and ARND

Note: Sentinel (diagnostic) physical features: refers to 3 key diagnostic facial anomalies: palpebral fissure length (PFL), long smooth phyltrum, thin upper Lip (see chart 1)

Another important diagnostic tool for justice professionals in relation to FASD is the recognition DSM-5. (American Psychiatric Association, *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington: American Psychiatric Association, 2013.). The DSM-5 has a diagnostic category for a neurodevelopmental disorder associated with prenatal alcohol exposure: 315.8--Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure, ND-PAE.

In the main body of the DSM-5 there are no precise diagnostic criteria for ND-PAE 315.8. However, in the appendix the authors include provisional diagnostic criteria similar to that required for FASD diagnosis of the Brain domain.

The DSM-5 diagnostic category 315.8 has special significance for justice professionals, because often individuals with suspected mental impairments are referred for forensic psychological evaluation. Before the DSM-5 was published FASD was often invisible to forensic psychologists: because it was not recognized in their diagnostic manual it could not be assigned a code in their assessment. Inclusion of FASD as ND-PAE in the DSM-5 opens the door for possible FASD consideration in the courts through forensic psychological evaluation. This is especially important since access to a full multidisciplinary FASD diagnosis is often difficult initially for the court to obtain. Subsequent

evaluation by a multi-disciplinary FASD diagnostic team would offer more accurate information to the court in terms of brain function and the kind of interventions that would be appropriate.

Other FASD Diagnostic Categories

If you are a justice professional encountering clients with FASD who have been brought into the criminal justice system, they may have been diagnosed before 2015 and the publication of the new Canadian FASD Guidelines. These diagnostic categories are still accurate but understanding all of the diagnostic terminology of FASD can be confusing because there are many diagnostic terms in use.

Diagnostic terms within the FASD spectrum include:

- **FAS** Fetal Alcohol Syndrome
- **pFAS** Partial Fetal Alcohol Syndrome
- **ARBD** Alcohol-Related Birth Disorder
- **ARND** Alcohol-Related Neurodevelopmental Disorder
- **ND-PAE** Neurodevelopmental Disorder-- Prenatal Alcohol Exposure
- **FASD-w/sff** FASD With Sentinel Facial Features
- **FASD-w/o sff** FASD Without Sentinel Facial Features

Understanding the history of FASD Diagnosis

Origins of diagnosis

In the late 1960s and early 1970s, clinicians in France and the US concurrently observed a pattern of developmental anomalies (changes) that occurred in the children of women who were heavy drinkers. In 1972, Dr. Cristy Ulleland published an article that described the clinical observations of a team of clinicians and researchers from the University of Washington. ("The Offspring

of Alcoholic Mothers" Annals of New York Academy of Sciences, Harbourview Medical Clinic, 1972: https://depts.washington.edu/fasdpn/pdfs/ulleland.pdf)
In 1973, Drs. David Smith, Ken Jones, Ann Streissguth, and Cristy Ulleland coined the term Fetal Alcohol Syndrome **(FAS)** and catalogued in more detail the birth anomalies they were observing.

Over the course of the next few years the description of FAS was further refined. Clinicians measured anomalies (or changes) in 3 key areas: Growth, Face, and Brain which were found to be highly correlated with prenatal alcohol exposure **(PAE)**.

Over the next decade animal researchers noted there were neurological effects of prenatal exposure to alcohol even when these characteristic physical anomalies were absent. These researchers used the term Fetal Alcohol Effect **(FAE)** to describe these neurological effects. The term was adopted by clinicians in their practice in the 1980s. While the 3 key features of FAS were measureable, the term FAE lacked precise, operational, diagnostic criteria.

Diagnostic developments in the 1990s

In the 1990s, two diagnostic systems emerged in the U.S. to "operationalize" or give diagnostic clarity to **FAE** or Fetal Alcohol Effects. Note that a diagnosis is "operationalized" when experts in the field develop specific measurable criteria that define it. In 1996, the Institute of Medicine (IOM) published Guidelines for FAS diagnosis that included 3 categories aside from FAS that enable a clinician to diagnose a range of fetal alcohol effects: Partial Fetal Alcohol Syndrome (**pFAS**), Alcohol-Related Birth Defects (**ARBD**), and Alcohol-Related Neurological Disorder (**ARND**) (Institute of Medicine, "*Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment*", Washington: New Academies Press, 1996.).

However, the IOM diagnostic category of ARND still lacked measureable diagnostic criteria. In 1997, the University of Washington published "The Diagnostic Code for Fetal Alcohol Syndrome and Related Conditions: the 4-Digit Diagnostic Code". This tool further defined or operationalized the diagnosis of FAE, Fetal Alcohol Effects, by including criteria to measure specific areas of brain function in order to determine the possibility of brain injury.

The 4-digit approach was very precise but the terminology was more medical than the IOM. For instance the 4-Digit Code diagnostic term for ARND is: Static Encephalopathy/No Sentinel Physical Features/Alcohol Exposed (Astley and Clarren, *Diagnostic Guide for Fetal Alcohol Spectrum Disorders: The 4-Digit*

Diagnostic Code, University of Washington: 2004 University Publication Services) The 4-Digit Diagnostic approach required the involvement of a multi-disciplinary team of clinicians to ensure accurate assessment of all of the 4 domains required for diagnosis: Growth, Face, Brain and Pre-Natal Alcohol. This means the physician would collaborate with other health professionals such as a psychologist trained in assessment. Optimally, the diagnostic team would also include a Speech and Language Pathologist, Occupational Therapist and Social Worker.

Canadian diagnostic developments—Fetal Alcohol Spectrum Disorder

This multi-disciplinary approach to diagnosis was adopted in the 2005 Canadian Guidelines for Diagnosis (Chudley, Conry et al., *Fetal alcohol spectrum disorder: Canadian guidelines for diagnosis*, 172 CMAJ 5, 2005). The 2005 Canadian Guidelines harmonized the IOM and 4-Digit Code in terms of the IOM's simplicity in terminology and the 4-Digit Code's operationality in assessing the "brain injury" component of the diagnosis. ARND now had measurable diagnostic criteria

The 2005 Canadian Guidelines use the following terms:

- Fetal Alcohol Syndrome (FAS)
- Partial Fetal Alcohol Syndrome (pFAS)
- Alcohol-Related Neurodevelopmental Disorder (ARND)

The IOM diagnostic category, Alcohol-Related Birth Defects (ARBD) was removed from both the 4-Digit Diagnostic Guidelines and the 2005 Canadian Guidelines because the authors noted that the physical congenital anomalies (changes) associated with ARBD might not necessarily be specific or caused only by the PAE. These physical changes are considered associated features rather than key diagnostic features. The new IOM Guidelines (Hoymes revision) continue to use ARBD as a diagnostic category but only if there is also evidence of behavioral or CNS, Central Nervous System, dysfunction. In the original IOM system (1996), however, the diagnostic category ARBD was not a brain based disability. This has particular relevance for justice professionals who may come into contact with clients diagnosed using the original IOM diagnostic system.

The 2005 Canadian Guidelines were adopted in clinical practice throughout Canada and have provided a model for the development of other national guidelines in the world. Despite the success of the 2005 Canadian Guidelines in refining FASD diagnosis, there were still problems in practice.

Challenges with public perception of the diagnostic categories pFAS and ARND

In clinical practice as well as in the research it was clear that individuals without facial features or growth restriction could have significant brain dysfunction. Yet often the public perception of the Fetal Alcohol Spectrum conditions was to put FAS on one end of the spectrum as the most severe and disabling, and pFAS and ARND towards the other end. This misperception was reported to have consequences for individuals who were diagnosed with these conditions. Individuals diagnosed with pFAS, (partial Fetal Alcohol Syndrome), were often reported to be denied funding or services because their condition was considered to be "partial' despite the fact that their brain based disability could be as significant as or even more significant functionally than that of a person diagnosed with FAS. Diagnostically, the distinction between FAS, pFAS, and ARND relates to measurements of the face and growth. These measurements provide physical markers of the condition rather than measures of an individual's brain dysfunction.

Current state in Canada – 2015 Canadian Guidelines

To solve this problem of terminology, researchers revised the 2005 Canadian Guidelines in 2015, establishing the "2015 Canadian Guidelines" (Cook, Green, et al, *Fetal Alcohol Syndrome Disorder: a guideline for diagnosis across the lifespan*, CMAJ 2015). The 2015 Canadian Guidelines use the term FASD diagnostically by defining it precisely and collapsing all FASD diagnosis into two categories: FASD with sentinel facial features and FASD without sentinel facial features. It should be noted that growth retardation is now not required for diagnosis under the 2015 Canadian Guidelines.

2015 CANADIAN GUIDELINES DIAGNOSTIC CATEGORIES

FASD—with Sentinel Facial Features replaces FAS

Sentinel (diagnostic) physical features: refers to 3 key diagnostic facial anomalies: palpebral fissure length (PFL), long smooth phyltrum, thin upper Lip (see chart 1)

FASD—without Sentinel Facial Feature replaces pFAS and ARND

At Risk of FASD

This category is not diagnostic. The term is assigned when there is not yet enough evidence for diagnosis: for example, where someone is reported to have PAE but this has not been confirmed, or where a child is too young for the assessment of brain function.

Note: Justice Professionals should be prepared for the fact that in FASD literature published previous to the 2015 Guidelines, FASD is not considered to be a diagnostic term.

General characteristics of FASD diagnosis: brain injury and physical changes

Despite the differences in FASD diagnostic systems diagnosis of FASD always relates to a consideration of two things:

- Brain damage - CNS dysfunction
- Gestational alcohol exposure-both pattern and quantity

In all diagnostic systems confirmation of prenatal alcohol exposure, PAE is required for diagnosis of FASD conditions. When an individual has significant dysmorphology (the 3 characteristic changes to the face) this is taken as confirmation of prenatal alcohol exposure; this facial pattern is correlated 99.9% of the time with gestational alcohol. The 3 key facial changes are : short palpebral fissure length, smooth elongated philtrum, and thin upper lip. These changes must be significantly different from those of most people--that is at least -2 SD, Standard Deviations below the mean. Associated features of the face also include: flat mid-face, small nose and micrognathia or small chin.

Characteristic Facial Features

Often the characteristic sentinel facial features are lacking or insignificant so an accurate assessment of cognitive function or the brain domain is a key consideration diagnostically. Julie Conroy, one of the authors of the Canadian Guidelines came up with an acronym for the ”brain domains” that are affected by prenatal exposure to alcohol :

Since the mid-1990s the diagnostic focus in FASD has been on the brain injury caused by PAE. The physical changes have only been considered as markers of that damage. FASD diagnosis continues to evolve, however, as we learn more about the condition. Recent research in the field among adults with FASD who were diagnosed as children indicates that the effects of FASD on lifelong physical health are significant and should be considered diagnostically. Some clinicians consider FASD as a Congenital Alcohol Related Disorder (CARD) from what is called a Developmental Origins of Health and Disease (DOHaD) perspective that include the long-term effects on emotional, cognitive, social and physical health including autoimmune disorders.

Charts

In order to provide you with more specific diagnostic information we are including the following charts:

Chart 1: Canadian Guidelines 2015—Diagnostic Criteria

Chart 2: A comparison of the 2015 Canadian Guidelines and other Diagnostic Systems

Chart 3: Summary of the difference between the 2005 Canadian Guidelines and the 2015 Canadian Guidelines

Chart 4: Overlapping Conditions

Chart 5: Diagnostic Algorithm

	Canadian Guidelines 2015		
	FASD with Sentinel Facial Features	**FASD without Sentinel Facial Features**	***At Risk for FASD***
GROWTH	**None Required**	**None Required**	**None Required**
	3 facial features	**None Required**	**None**

FACE	**-2 SD below the mean**		**Required**
BRAIN	**Significant Impairment in 3 Key Areas of Brain Function**	**Significant Impairment in 3 Key Areas of Brain Function**	**Impairment in Brain Function or Delays in Development**
ALCOHOL	**Confirmed Prenatal Alcohol Exposure not required**	**Confirmed Prenatal Alcohol Exposure required**	**Suspected or Confirmed**

Chart 1 : Canadian Guidelines 2015 Diagnostic Criteria-from Appendix 1

http://www.cmaj.ca/content/cmaj/suppl/2015/12/14/cmaj.141593.DC1/app1.pdf

A diagnosis of FASD is only made when there is evidence of pervasive brain dysfunction, which is defined by severe impairment in three or more of the following neurodevelopmental domains:

- **Motor Skills**
- **Neuroanatomy/Neurophysiology**
- **Cognition**
- **Language**
- **Academic Achievement**
- **Memory**
- **Attention**
- **Executive Function, including Impulse Control and Hyperactivity**
- **Affect Regulation**
- **Adaptive Behaviour, Social Skills, or Social Communication**

Severe impairment is defined as a global score or a major subdomain score on a standardized neurodevelopmental measure that is 2 or more standard deviations (SD) below the mean with appropriate allowance for test error. In some domains, large discrepancies among subdomain scores may be considered when a difference of this size occur with a very low base rate in the population (≤ 3% of the population). Clinical assessment with converging evidence from multiple sources and DSM-5 diagnostic criteria [2] for certain disorders may also be considered in specific domains which are not easily assessed by standardized tests. For example, in the affect regulation domain specific mental health diagnoses may be taken as an indication of severe impairment. These include:

- **Major Depressive Disorder/Persistent Depressive Disorder**
- **Disruptive Mood Dysregulation Disorder (DMDD)**

- **Separation Anxiety Disorder**
- **Selective Mutism**
- **Social Anxiety Disorder/ Generalized Anxiety Disorder**
- **Panic Disorder**
- **Agoraphobia**

Chart 2 A comparison of the 2015 Canadian Guidelines with other Diagnostic Systems

Diagnostic System			
	Canadian Guidelines 2015		
	FASD with Sentinel Facial Features	**FASD without Sentinel Facial Features**	***At Risk for FASD***
Canadian Guidelines 2005	**FAS (no growth)**	**pFAS ARND**	
Institute of Medicine IOM	**FAS pFAS 3 facial features-no growth)**	**ARND pFAS**	
Hoyme's Protocol—Revision of IOM	**FAS (3 facial features)**	**pFAS ARND**	
4-Digit Diagnostic Code	**FAS pFAS-(3 facial features-no growth)**	**Static Encephalopathy pFAS**	**Neurobehavioral Disorder-PAE**
DSM-5 315.8	**ND-PAE Neurodevelopmental Disorder-PAE**	**ND-PAE Neurodevelopmental Disorder-PAE**	
FAS/FAE	**FAS**	**FAE**	
ICD-10	**Q 86.0**	**Q 86.8 Q86.99**	**Q 86.8 Q 86.99**
Center for Disease Control (CDC)	**FAS**		

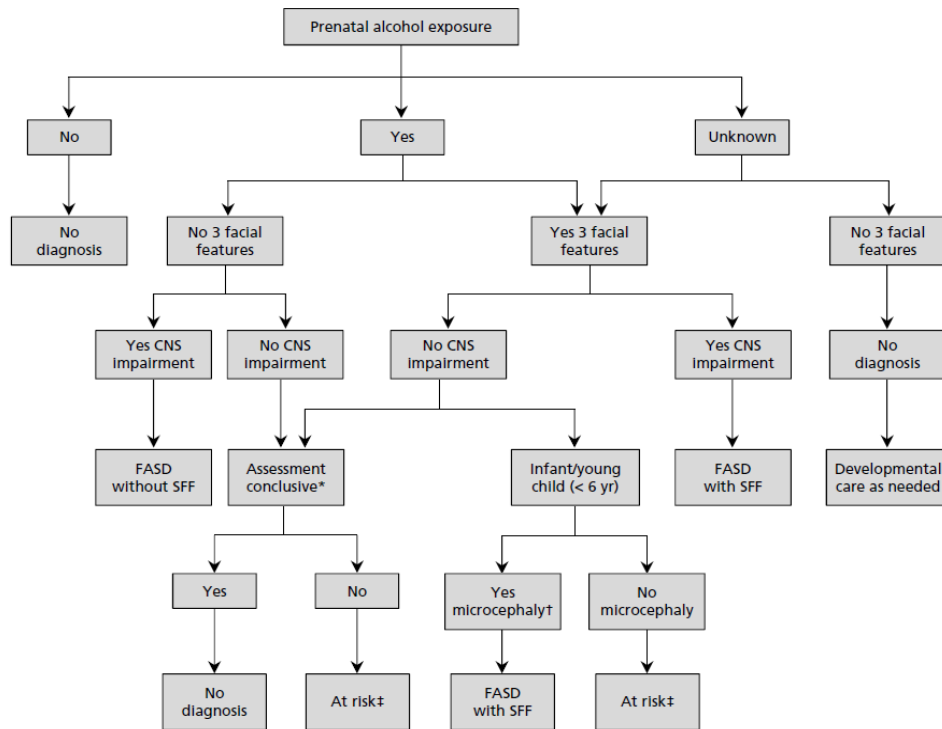
Chart 3-- Summary of Difference Between 2015 and 2005 Canadian guidelines

- In 2015 Guidelines FASD is a diagnostic category
- In 2015 Guidelines growth is eliminated as a key diagnostic feature
- In 2015 Guidelines pFAS is eliminated as a diagnostic category—merging it with ARND into the new category--FASD-no sentinel features
- In 2015 Guidelines ”affect regulation” is included as a brain domain—recognizing that mental health can be a primary as well as secondary FASD disability
- In 2015 Guidelines ‘Sensory-Motor’ domain is changed to ‘Motor’. Sensory dysregulation and sleep dysregulation are included under Structure and Neurophysiological Function

Chart 4 Overlapping Conditions with Features similar to FASD

Syndrome	Overlapping features	Features of this syndrome that differentiate it from FAS
Aarskog syndrome	Widely spaced eyes, small nose with anteverted nares, broad philtrum, mid-facial recession	Round face, downslanted palpebral fissures, widow's peak, prominent "lop" ears, specific contracture of digits on extension. Inherited as an x-linked trait. Molecular defect identified.
Brachman-deLange or Cornelia deLange syndrome	Long philtrum, thin vermilion border of upper lip, depressed nasal bridge, anteverted nares, microcephaly	Single eyebrow across eyes and forehead (synophrys), long eyelashes, downturned corners of mouth, short upper limbs particularly involving ulnar side, very short stature. Molecular defect identified.
Dubowitz syndrome	Short palpebral fissures, widely-spaced eyes, epicanthal folds, variable ptosis (droopy eyes) and blepharophimosis, microcephaly	Shallow suprorbital ridges, broad nasal tip, clinodactyly
Fetal anticonvulsant syndrome (includes fetal hydantoin and fetal valproate syndromes)	Widely-spaced eyes, depressed nasal bridge, mid-facial recession, epicanthal folds, long philtrum, thin vermilion border of upper lip	Bowed upper lip, high forehead, small mouth
Maternal phenylketonuria (PKU) fetal effects	Epicanthal folds, short palpebral fissures, long poorly formed philtrum, thin vermilion border of upper lip, microcephaly	Prominent glabella, small up turned nose, round face
Noonan syndrome	Low nasal bridge, epicanthal folds, wide spaced eyes, long philtrum	Down-slanted palpebral fissures, wide mouth with well-formed philtrum, protruding upper lip. Molecular defect identified.
Toluene embryopathy	Short palpebral fissures, mid face hypoplasia, smooth philtrum, thin vermilion border upper lip, microcephaly	Large anterior fontanelle, hair patterning abnormalities, ear anomalies
Williams syndrome	Short palpebral fissures, anteverted nares, broad long philtrum, maxillary hypoplasia, depressed nasal bridge, epicanthic folds, microcephaly	Wide mouth with full lips and pouting lower lip, stellate pattern of iris, periorbital fullness, connective tissue dysplasia, specific cardiac defect of suprvalvar aortic stenosis in many. Chromosome deletion on FISH (fluorescent in situ hybridization) probe analysis of 7q.
Other chromosome deletion and duplication syndromes	Many have short palpebral fissures, mid-facial hypoplasia, smooth philtrum.	Chromosomal analysis by standard analysis and some select syndromes by specific FISH probe analysis

Chart 5 Diagnostic Alogorithm for FASD—2015 Guidelines



*Assessment conclusive = clinician conducting the neurodevelopmental assessment is satisfied that the session was a true representation of the person's ability and that any deficits reported were not due to extenuating circumstances. Assessments may be inconclusive for children under six years of age, because some domains cannot be assessed with confidence until the person is older or because of other confounding factors, such as temporary life stress or illness; see the text for more information.

The Authors

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Dr. Lori Vitale Cox works as the Director of the Eastern Door Centre—an Indigenous community center that offers multi-disciplinary diagnosis, intervention, research, and prevention for trauma based conditions such as FASD. She has been active in FASD research, diagnosis, and intervention for many years developing tools for FASD screening, diagnosis intervention and prevention in collaboration with indigenous elders. These tools are based in science as well as the principles of Two-Eyed Seeing as developed by Mi'kmaq elders Murdena and Albert Marshall. She is also the Director of the Nogemag Healing Lodge for Youth. She is an adjunct professor at UBC in the Faculty of Medicine, Department of Pediatrics. She has also been involved in giving training workshops throughout the Eastern region to diverse groups such as the provincial judges in NB, Innu elders and teachers in Labrador and psychologists and Indigenous community members in PEI. A few years ago in a James Bay Cree First Nation in northern Quebec, community members attempted to teach her how to clean and take the feathers off of a partridge as part of an informal knowledge exchange. Although Lori attended Dalhousie University in Halifax obtaining her PhD in 1996 and her Masters in 1984--- she recognized that she hadn't mastered the art of plucking partridge.

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Seamus Cox graduated from Dalhousie Law School in 2003 and completed his articles with the Province of New Brunswick by working with the Human Rights Commission, Legal Services and Special Prosecutions. He was employed as a lawyer with the New Brunswick Human Rights Commission for many years and is now in private practice. Seamus has a keen interest in human rights law, criminal law and Indigenous law. He is a member of both the Canadian Bar Association and the New Brunswick Law Society. In conjunction with his work with the Human Rights Commission, Seamus was a regular instructor with the New Brunswick Bar Admissions Program, in both employment law and the equity law sections