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Fetal Alcohol Spectrum Disorders (FASD) and competency to stand trial (CST): Suggestions for a 'best practices' approach to forensic evaluation

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ABSTRACT

Fetal Alcohol Spectrum Disorders (FASD), an umbrella term for neurodevelopmental conditions caused by prenatal alcohol exposure, is overrepresented in the U.S. juvenile and adult criminal justice systems. The brain damage in FASD manifests in a combination of cognitive and adaptive impairments that potentially reduce ability to function adequately during the criminal justice process, including capacity to stand trial (CST). Despite the high risk of arrest and conviction in this population, relatively little research guides CST assessment for defendants who have or may have FASD. Therefore, the purpose of this article is to describe how FASD may affect CST and suggest ways forensic professionals might modify assessment protocols to address possible effects of FASD-associated impairments on adjudicative capacity.

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1. Introduction

The purpose of the criminal justice system is to deliver justice to all by convicting and punishing the guilty while protecting the innocent. The right to a fair trial is a core principle of the legal system. Criminal

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justice is a process involving a series of steps that begin with arrest and investigation and end with a trial. During this process, criminal defendants must have the present ability to be able to understand legal proceedings and actively participate in their own defense, which are referred to as psycholegal capacities (Kruh & Grisso, 2009). However, for those defendants with developmental disabilities, cognitive impairments may compromise these psycholegal capacities. In particular, defendants with Fetal Alcohol Spectrum Disorders (FASD) have been found to be a particularly vulnerable population due to cognitive impairments that reduce capacity to stand trial (CST; McLachlan, Roesch, Viljoen, & Douglas, 2014).

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term (and not a diagnosis) used to characterize the scope of damage arising from prenatal exposure to alcohol (Benz, Rasmussen, & Andrew, 2009). FASD includes commonly accepted diagnoses such as fetal alcohol syndrome (FAS), partial FAS, alcohol related neurodevelopmental disorder (ARND), and alcohol related birth defects (ARBD), all of which are congenital abnormalities. Although the term "FASD" is not controversial, there is evolving clarity in how the conditions under the umbrella are defined. For example, with respect to neurodevelopmental dysfunction, diagnostic criteria published by Stratton, Howe, and Battaglia (1996) vaguely define the five conditions under the umbrella noted above but do not specify how to measure the diagnostic criteria for each condition. In contrast, the Centers for Disease Control (Bertrand et al., 2004) provide specific guidelines for measuring the criteria (e.g., cognitive impairment is defined as 1 or more standard deviations below the mean except for IQ, which requires 2 or more standard deviations below the mean). However, the CDC criteria only address diagnostic criteria for FAS. In Canada, diagnostic guidelines (Cook et al., 2015) do not distinguish between conditions as in the IOM's conceptualization and instead designate "FASD" in terms of two diagnoses: FASD with sentinel facial features and FASD without sentinel facial features. Like CDC, three or more domains must be impaired, but the degree of impairment must be "severe" under the Canadian guidelines. "Severe" is defined as ≥2 standard deviations below the mean in a global score or major subdomain score on a standardized neurodevelopmental measure.

Brain damage in FASD may cause a range of cognitive deficits (e.g., intellectual functioning, attention, learning and memory, sensory processing, executive functioning) and associated adaptive impairments (e.g., communication, practical skills, and socialization). Many of these deficits are relevant to criminal behavior and the adjudication process (Brown, Gudjonsson, & Connor, 2011; Brown, Wartnik, Connor, & Adler, 2010; Fast & Conry, 2004; Fast, Conry, & Loock, 1999; Greenspan & Driscoll, 2016; MacPherson, Chudley, & Grant, 2011; Mela, 2015; Wartnik, Brown, & Herrick, 2015; Wartnik & Carlson, 2011). Moreover, many of the cognitive impairments found in FASD are directly relevant to CST (Zapf & Roesch, 2009).

To help address diagnostic complexities and make the diagnostic process more accessible to mental health professionals, Neurodevelopmental Disorder Associated with Prenatal Alcohol Exposure (ND-PAE) was included as an example under the diagnosis "Other Specified Neurodevelopmental Disorder" in the Diagnostic and Statistical Manual – Fifth Edition (DSM-5; American Psychiatric Association, 2013). Thus, DSM-5 currently allows for a clinical diagnosis of "Other Specified Neurodevelopmental Disorder – Neurodevelopmental Disorder Associated with Prenatal Alcohol Disorder" although diagnostic criteria for the condition are found in a section of the Manual designated "Conditions for Further Study." Despite empirical support for DSM-5's diagnostic criteria (Kable et al., 2016), this rather confusing bifurcation of the diagnosis and diagnostic criteria leaves ND-PAE largely unidentified in the general population, which means that FASD assessment, if indicated, must occur prior to trial.

A cautionary statement in DSM-5 notes that while diagnosis can assist legal decision makers in determining such things as level of culpability, there is an imperfect fit between the information in a clinical diagnosis and questions of ultimate legal concern. For example, impairments and disabilities may vary widely, which certainly is true in FASD although a baseline of *multiple* impaired domains is required for diagnosis. There is ample evidence in the mental health and legal literature that cognitive impairments may impair competency (Mossman, 2007; Simpler & Parmenter, 2011; White, Batchelor, Pulman, & Howard, 2012). Thus, rather than diagnosis per se, it is the degree and scope of impairments secondary to prenatal alcohol exposure that may provide a valid basis for a judicial finding of incompetence.

Although a recent review of the FASD literature found an overall prevalence rate of 3.35% in the United States (Roozen et al., 2016), prevalence in the legal context appears to be much higher. For example, studies have found that approximately 25% of juvenile (Fast et al., 1999) and adult (MacPherson et al., 2011) offenders have or are likely to have an FASD. Taking this disproportionate risk into account, it is almost a certainty that mental health professionals who routinely conduct CST evaluations will encounter defendants with FASD on a fairly regular basis. Given the lack of FASD training programs in graduate and postgraduate colleges and universities (Cox, Clairmont, & Cox, 2007), it also is likely forensic evaluators will not know how to identify and assess FASD and its impact on particular cognitive skills needed for CST (e.g., intellectual functioning, attention, memory, communication, executive functioning, and social awareness). Consequently, there is a real need for specialized forensic training in FASD as well as research that clarifies the impact these conditions have on psycholegal capacities. For example, FASD symptoms may make it difficult for defendants to understand and effectively handle interactions with counsel, plea negotiations, and courtroom proceedings (Wartnik et al., 2015).

Recently, FASD in young offenders (ages 12–23) was found to correlate with impaired psycholegal abilities specific to CST (McLachlan et al., 2014), such as understanding legal proceedings, making informed decisions, serving as a witness, behaving appropriately in the courtroom, accurately completing legal documents, and participating in legal defense. Legal abilities were measured by Grisso's Miranda instruments (Grisso, 1998), Canadian Rights Comprehension Supplement (McLachlan, 2006), and Fitness Interview Test-Revised (FIT-R; Roesch, Zapf, & Eaves, 2006). The primary finding in this study that the majority of young offenders (90%) showed impairment in at least one psycholegal ability, which was considerably different than results for an age-matched normative sample, provides preliminary empirical support for the relevance of FASD to CST. Although a judge determines whether defendants are competent to proceed to trial, forensic evaluators (e.g., psychologists or psychiatrists) figure prominently in this process by providing relevant information to the court regarding cognitive, adaptive, and psychiatric factors that might affect competency (Christy, Douglas, Otto, & Petrila, 2004; Johnson & Candilis, 2015; Murrie & Zelle, 2015; Zapf & Roesch, 2009). Despite the number of well-validated instruments that assess CST in unimpaired defendants (Pirelli, Gottdiener, & Zapf, 2011), there is no structured protocol for guiding CST evaluation for defendants who have or may have FASD.

Cognitive and adaptive deficits in FASD may complicate the validity of standardized CST measures in those with FASD who have not been diagnosed. For example, this population often displays average but superficial verbal skills that mask below-average comprehension (Fast & Conry, 2009). The common tendency for those with developmental disabilities to try to conceal their limitations highlights the importance of using a developmentally sensitive approach when evaluating defendants in the CST context. Second, suggestibility (Brown et al., 2011) and memory (Kodituwakku, 2009) deficits, both of which appear to be common in FASD, may predispose defendants with FASD to blindly follow defense counsel's assumptions and influence, possibly leading to inappropriate legal strategies and poor decision making, and eventually, wrongful conviction (Brown et al., 2011; Fast & Conry, 2004; Greenspan & Driscoll, 2016; Mela, 2015). Third, varying interview techniques and styles of questioning may generate misleading impressions of a defendant. For example, evaluators who do no cognitive testing and are overly reliant on closed-ended rather than open-ended