Neuro-Cognitive Impairments and the Criminal Justice System: A Case Analysis of the Impact of Diagnoses of FASD and ADHD on the Sentencing of Offenders in the Courts of Three Canadian Provinces

by

Petra Jonas Vidovic

M.A., Simon Fraser University, 2003
B.A., Simon Fraser University, 2001

Dissertation Submitted in Partial Fulfillment
Of the Requirements for the Degree of
Doctor of Philosophy

in the
School of Criminology
Faculty of Arts and Social Sciences

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Simon Fraser University

Summer 2012

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Name: Petra Jonas Vidovic
Degree: Doctor of Philosophy

Examining Committee:
Chair: Dr. William Glackman
Associate Professor, School of Criminology
Simon Fraser University

Dr. Simon N. Verdun-Jones, Senior Supervisor
Professor, School of Criminology
Simon Fraser University

Dr. Martin Andresen, Supervisor
Assistant Professor, School of Criminology
Simon Fraser University

Dr. Jodi Vilijoen, Supervisor
Associate Professor
Simon Fraser University

Dr. Marlene Moretti, Internal-External Examiner
Professor, Department of Psychology
Simon Fraser University

Dr. Peter J. Carrington, External Examiner
Professor, Department of Sociology and Legal Studies
University of Waterloo

Date Defended/Approved: May 14, 2012
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ABSTRACT

There has been growing awareness that persons with cognitive impairments, such as Fetal Alcohol Spectrum Disorder (FASD) and Attention Deficit Hyperactivity Disorder, (ADHD) experience difficulties functioning in society and more specifically, within the justice system after they come into conflict with the law. Very few studies, however, have focused on how such individuals are treated in the criminal justice system and more specifically, whether the justice system is properly meeting their needs. Impairments, such as FASD and ADHD, are organic brain disorders which the courts often fail to recognize. There is a paucity of research which examines the impact of ADHD and FASD on the accused in the Canadian courtroom. In order to determine whether the presence of ADHD and FASD exerts any effect on the final sentencing disposition in criminal cases, particular attention was paid to the role of judicial interpretation and expert testimony regarding these specific neuro-cognitive impairments. This research presents the findings of an exploratory case analysis of the impact of diagnoses of FASD and ADHD on the sentencing of offenders in the courts of three Canadian provinces: British Columbia, Saskatchewan and Ontario. The major findings reveal that there appears to be an overrepresentation of FASD cases in the Western provinces of British Columbia and Saskatchewan for both youths and adults, when compared with the Eastern province of Ontario. It was also observed that Aboriginal accused with FASD were over-represented in the courts, which was not the case for aboriginal accused with ADHD. Furthermore, when considering sentencing decisions in adult court, judges did not place as much weight on ADHD as they did on FASD. Also, it was observed that more often than not, no formal assessment of FASD was conducted during the court process. It is recommended that, when judges sentence offenders with FASD/ADHD, the focus needs to be placed on changing their living situation or social situation rather than fixating on their behaviour. Providing these individuals with structure, support and treatment—as well as surveillance and enforcement—in the community is more likely to secure a successful outcome for the sentencing process.
Keywords: FASD; Fetal alcohol spectrum disorder; ADHD; Attention deficit hyperactivity disorder; sentencing; criminal justice system

Subject Terms: Criminology; mental health; cognitive impairment; attention deficit hyperactivity disorder; criminal justice system; sentencing
DEDICATION

To my loving family: mom and dad, my sister Pavlina (R.I.P.) and my three great loves, Nickolas, Baron and Dominick.
You all inspire me to be the best that I can be.
ACKNOWLEDGEMENTS

I would first like to acknowledge Doctor Simon Verdun-Jones. He was extremely helpful, supportive and encouraging throughout this entire PhD journey. Doctor Verdun-Jones is a true mentor and I could have never asked for a more involved and dedicated senior supervisor. I am so grateful to Doctor Verdun-Jones for his editorial help which was tremendous. My thanks are also extended to Doctor Martin Andresen whose supportive nature for this project helped motivate me to keep going. Thank you also to Doctor Peter Carrington, my external examiner, for his very thoughtful, thorough and critical feedback and insight. I am also extremely appreciative to Doctor Jodi Viljoen (supervisory committee) and Doctor Marlene Moretti (examining committee), the other two members of my supervisory committee, for the hours spent reading and commenting on my project. The entire committee provided me with such constructive comments and suggestions. Thank you.

Thank you to my family in encouraging and supporting me to study and to see this dissertation through to its end.
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INTRODUCTION

In recent years, there has been growing awareness that persons with cognitive impairments such as Fetal Alcohol Spectrum Disorder (FASD) and Attention Deficit Hyperactivity Disorder (ADHD) experience difficulties functioning in society and more specifically, within the justice system after they get in trouble with the law. A neurocognitive impairment is a reduction of cognitive function in certain areas of the brain that affects neural pathways and/or cortical networks. FASD and ADHD were selected as a focus, even though many psychological disorders have some sort of cognitive component. It was important to examine the aforementioned impairments because a rather noteworthy percentage of individuals who commit crime are often afflicted with FASD or ADHD, which poses a challenge for the courts, in terms of how to properly diagnose and/or sentence such persons.

Very few studies, however, have focused on how such individuals with FASD and/or ADHD are treated in the criminal justice system and more specifically, whether the justice system is properly meeting their needs. Individuals with FASD and/or ADHD provide criminal justice agents with a challenge as well as an opportunity to better deal with such persons. When faced with the disability of FASD and/or ADHD, the Canadian criminal justice system, which is based on the premise that offenders appreciate the nature and consequences of their actions and that punishment is connected to their actions, clearly has not considered the circumstances of cognitively challenged individuals. Even though the law presumes that individuals intend the natural and probable consequences of their actions, this may not be so for a person with FASD and/or ADHD. For example, in terms of FASD, as Judge Barnett in R. v. Abou (1995) commented, “FAS has been the subject of comment in only a few reported Canadian court decisions…and it is not well understood by most judges, lawyers, probation officers, corrections officers, social workers or other persons likely to encounter it in the context of the justice system (paragraph 11)”.

Similarly, with respect to an offender with ADHD, in R. v. A.R. (2007), the judge stated, “A.R.’s criminal conduct is, in part, related to his vulnerability to peer pressure and his episodic association with a negative peer group. That
vulnerability may very well be connected to his learning disability and his conditions of ADD and ADHD (paragraph 28)’.

Increasingly, there are growing misgivings regarding the appropriate judicial treatment of individuals suffering from neurocognitive impairments (Conry & Fast 2000; Conry & Fast, 2010). Specifically, impairments such as Fetal Alcohol Spectrum Disorder (FASD) and Attention Deficit Hyperactivity Disorder (ADHD) are organic brain disorders, which can often go unrecognized by the courts. Such a lack of recognition or consideration in judicial sentencing may lead to inconsistent and/or inappropriate sentences for many suffering from specific mental disorders. Even though some hold the view that certain mental disorders should be treated as a mitigating factor in the sentencing process, such a view is not always supported by what is observed in the final judicial sentencing decision (Roach & Bailey, 2009). Impairments, other than schizophrenia, typically fall short of being able to establish the defence of not criminally responsible, but nevertheless show an acute mental illness. The question becomes, are such mental states even being considered in judicial sentencing decisions and in what circumstances, since they clearly affect the moral blameworthiness of the accused? It is, therefore, worthwhile to analyze the relationship between impaired mental functioning and sentencing by analyzing how the courts deal with FASD and ADHD for youth and adult offenders in Canadian sentencing decisions.

The present study will begin by presenting a comprehensive literature review on FASD. Specifically, chapter one discusses the prevalence of FASD, what makes it a neuro-cognitive disability, the issues surrounding this particular disorder in terms of assessment/diagnosis and resources as well as the organic effects of it and how such neurobiological problems may explain the facilitation of crime. Moreover, secondary disabilities resulting from having FASD, such as school and employment failure, substance abuse and criminal activity are examined. The link between FASD and other cognitive disorders such as ADHD are elaborated on, as well as the impact of FASD on offenders involved in the legal system, such persons’ treatment by the courts and the current programing to deal with FASD in and out of the criminal justice system.

Chapter two is a continuation of academic literature, specifically focused on ADHD. The chapter begins by concentrating on understanding ADHD as a cognitive disorder and its prevalence in the general population as well as in the
criminal justice system. The neurobiology of ADHD is analyzed in terms of how certain brain malfunctions contribute to characteristics such as inattention, impulsivity and hyperactivity, which perhaps precipitates trouble with the law for many afflicted individuals. The literature pertaining to ADHD and comorbidity is also expanded on, since individuals with ADHD often have conduct disorder, oppositional defiant disorder and/or substance use disorder. The established connection between ADHD and criminal behaviour is analyzed in depth by the presentation of the literature surrounding the integration of biological/psychological and sociological explanations for antisocial behaviour. Specifically, life-course criminology, general strain theory, the general theory of crime and how such theoretical perspectives are linked to ADHD are discussed. ADHD and the risk for crime and recidivism, as well as the prevalence of it in the general population versus the criminal justice system are analyzed.

Chapter three addresses the sentencing of adults in the Canadian criminal justice system as well as the sentencing of youth under the Youth Criminal Justice Act (YCJA). Particular attention is paid to the sentencing provisions that govern judicial decision-making in the determination of a final sentencing disposition for an offender. The complexities surrounding the handing down of a sentence by a judge to a cognitively impaired individual, who has FASD and/or ADHD, is discussed. The judge must consider the sentencing principles that are stipulated in each respective official Act, section 718 and in the ‘declaration of principle’ and section 38 of the YCJA, as well as the specific needs of the offender; therefore, a close examination of the various issues that arise when sentencing a cognitively impaired person, such as ‘blameworthiness’ in law, are discussed. Furthermore, many examples of pre-existing case judgments that deal with the sentencing of cognitively impaired individuals, specifically FASD, are analyzed, to show the challenges that judges face as well as the disparities in judgments. The practice of medical and psychological reports in the courtroom is also examined, with particular attention paid to assessing those with cognitive impairments, followed by an examination of criminal intent and the mental disorder defence.

Chapter four is the methodology chapter, which explains how the present case analysis study of evaluating the current sentencing situation in Canada for the disorders of FASD and ADHD was conducted. The study focuses on judicial interpretation and expert testimony regarding the specific aforementioned neuro-cognitive impairments and the chapter describes the
database selection procedure, the methods for including and excluding particular criminal cases, as well as the process for the selection of variables for the coding form. The research design as well as the research questions are addressed and finally the data-analysis method, which incorporates a descriptive quantitative and in-depth qualitative analysis, is described.

Chapter five is the results chapter (part 1), which reveals the quantitative variable findings for the 107 cases in which FASD and/or ADHD were the principal disorders of interest. A bivariate analysis was incorporated to examine the relationships among certain key variables. The results component begins with the presentation of descriptive univariate and bivariate findings for both FASD and ADHD.

Chapter six is the results chapter (part 2), which delves into the qualitative analysis component and reveals the qualitative variable findings for the 107 cases in which FASD and/or ADHD were the principal disorders of interest. The qualitative analysis was used to generate major themes and emergent sub-themes within and among cases (these themes are presented and discussed in chapter seven).

Chapter seven is the summary and discussion chapter. This chapter summarizes and describes the major findings that were presented in the results chapters. It brings to the forefront key case variable findings and presents the major themes and emergent sub-themes that were found within and among FASD/ADHD cases.

Chapter eight is the conclusion chapter, which summarizes the issues that propelled the interest in research into this area of study and made it come to fruition. Furthermore, the limitations of the exploratory research are highlighted. Finally, based on the results of the study, recommendations and future directions for research in this area are discussed in depth. The present study concludes with the presentation of the sources that were utilized: the case analysis bibliography and the general bibliography.
Chapter 1:  
**FETAL ALCOHOL SPECTRUM DISORDER**

**INTRODUCTION TO FETAL ALCOHOL SPECTRUM DISORDER AND THE CRIMINAL JUSTICE SYSTEM**

Damage from alcohol to the fetus has been observed since biblical times, yet it was not until 1973 that it was formally recognized as fetal alcohol syndrome (Boland, Duwyn & Serin, 2009). It was only approximately 25 years ago that James Ellis and Ruth Luckasson wrote a 78-page monograph on persons with intellectual impairments who were caught up in the criminal justice system (Ellis & Luckasson, 1985; Perske, 2010). Seeing the substantial flow of individuals trickling through the criminal justice system who suffer from cognitive disabilities, such a document was indeed groundbreaking in that it has set the stage for further research in this realm. It has really been in the last decade that professionals and society have become increasingly interested in ensuring fair and just treatment for individuals with intellectual disabilities (Jones, 2007). Fetal alcohol syndrome is one of those cognitive impairments that have gained attention in the past few years, especially its role in the criminal justice system. People with FASD have a permanent organic brain disability and it was first identified in the early 1970s (Fraser & McDonald, 2009). When a mother makes the decision to consume any amount of alcohol during her pregnancy, she may not be aware of the risk to which she exposes her unborn child; specifically, the detrimental consequences of neurological abnormalities and functional impairments, due to fetal alcohol spectrum disorder (FASD). FASD encompasses all the terms that describe alcohol-related defects.

Globally, awareness of the problem of FASD is certainly not uniform and research seems to indicate that, when comparing Canada, the United States, the United Kingdom FASD, Canada and the U.S. have the highest levels of activity and a discernible recognition of the problem (Kyskan & Moore,
In fact, Health Canada has taken a leading role in mounting national public awareness and education campaigns with the goal being to increase knowledge about FASD. Also, the Ministry of Children and Family Development in British Columbia has taken an active approach in the prevention of FASD (Kyskan & Moore, 2005). Despite various government organizations’ attempts to disseminate knowledge about FASD in order to create awareness, this organic brain impairment affects a large number of Canadians and many are not even aware of the disorder until they become defendants in the Criminal Justice System, and even then many go undiagnosed, undetected and unconsidered by the courts.

In fact, if the suspicion that FASD goes largely unrecognized by the courts is true, it then contributes to inappropriate sentences for many suffering from this disorder. However, recent limited study findings demonstrate that some courts are in fact recognizing the condition but there is a great degree of variation as to how it should be taken into account (Chartrand & Forbes-Chilibeck, 2003; Roach & Bailey, 2009). Apparently, some courts do not acknowledge the presence of FASD as deserving of any special consideration, while others do recognize it as one of many mitigating, and in a few cases, aggravating factors (Chartrand & Forbes-Chilibeck, 2003). Apparently, references to FASD in the reported cases vary dramatically among jurisdictions in Canada with more per capita references being made in the three northern territories and Saskatchewan, and with several of the most important decisions being made by only a handful of judges (Roach & Bailey, 2009). Hence, such a finding illustrates the need for awareness of FASD to become more widespread in the Canadian legal system. The few studies that have examined case decisions do show that some judges recognize that an offender with FASD should not be treated like a typical offender (Conry & Fast, 2000; Chartrand & Forbes-Chilibeck, 2003). With this growing awareness by the courts that FASD offenders require unique consideration under the law, such acknowledgement brings about new challenges and barriers in terms of treatment, resources and trained personnel that the criminal justice system must grapple with.

**Prevalence of Fetal Alcohol Spectrum Disorder**

Statistically, the incidence of FASD in the United States general population ranges from 0.26 to 2.29 per 1,000 live births, depending on certain
demographic factors (Abel 1995). Abel (1995), points out that the rates of incidence of fetal alcohol syndrome vary between different locations and such a disparity is attributable largely to the differences in the population examined at such sites. The worldwide prevalence of Fetal Alcohol Spectrum Disorder (FASD) is estimated at anywhere from 0.5 to 9.1 cases per 1,000 live births (Kyskan & Moore, 2005; Burd, Roberts, Olson, & Odendaal, 2007), or as Sampson, Kerr, Carmichael Olsen, Streissguth, Hunt and Barr (1997), and Chudley, Conry, Cook, Loock, Rosales and LeBlanc (2005), postulated—one percent. Overall, there remains a lack of awareness of fetal alcohol spectrum disorder within the Canadian medical profession, as well as a severe lack of FASD diagnostic services (Fraser & McDonald, 2009). In fact, in Canada, there is no official, accurate national data available on the prevalence of FASD, but it is considered one of the leading causes of mental retardation and developmental disability in Canada (Fraser & McDonald, 2009). Of the population-based prevalence studies that were published in Canada to date, so much prevalence variance exists regarding how many individuals have FASD.

When examining the prevalence rates of FASD in Canada, it is imperative to keep in mind that estimates of the prevalence of FASD vary widely owing to differing diagnostic criteria, method of case selection and the population surveyed. It is estimated that 300,000 Canadians are struggling with FASD; meaning, at least one child is born with FASD each day (Kyskan & Moore, 2005). Pemberton (2010) even gave a slightly higher figure by stating that Health Canada most recently estimates approximately 334,000 Canadians are plagued with this disorder. In terms of what FASD costs the system, in Canada, the annual cost associated with FASD at the individual level is approximately $21,642 and the cost to the system annually as a result of so many people having the disorder from the day of birth to 53 years of age is $5.3 billion—direct costs such as medical, education and social services and indirect costs such as productivity: this total does not include criminal justice system costs (law enforcement, corrections), nor does it include child protection service costs (Fast & Conry, 2009). Thus, each child affected by FASD may require an estimated $1-2 million over the course of their lifetime (Campbell & Reid, 2003). Moreover, to illustrate how prevalence rates vary widely across Canada, some small community studies have apparently documented fetal alcohol syndrome rates to be as high as one-in-four pregnancies; whereas, when hospitals in Saskatoon tried to ascertain FASD rates, they reported an estimate of 0.5 cases
per 1,000 live births in the province of Saskatchewan but their diagnostic criterion was ‘prenatal exposure being strongly suspected’, yet, in many cases, the prenatal exposure was not known (Kyskan & Moore, 2005). Furthermore, with FASD being most definitely under-represented, such an occurrence is thereby illustrative of a large dark figure: indeed, Mattson et al., (1998), articulated the point that many children with histories of significant in-utero alcohol exposure simply do not meet the formal diagnostic criteria for FASD and thus may go unnoticed by the medical community. Also, many babies and children slip through the cracks of being diagnosed with FASD, when in fact this disability plays a role in their daily-life functioning.

Pemberton (2010) stated that the Canadian Justice Department study in 2009 reported that slightly more than one in 10 youths who were involved in the justice system had either suspected or confirmed FASD. Approximately 14 percent of accused Aboriginal youth whose cases were analyzed were either suspected or confirmed as having FASD, as opposed to 0.2 percent of their non-Aboriginal counterparts (Pemberton, 2010). Aboriginal over-representation in FASD is further supported by an considerable amount of studies’ results, such as the research conducted by Chartrand and Forbes-Chilibeck (2003), in which, of the 40 offenders with FASD found in court cases, 31 of them were of Aboriginal descent. Apparently, it has been postulated in a report conducted for Correctional Service of Canada in 1999 that the proportion of Aboriginal persons with FASD is 10 times the national rate (Chartrand & Forbes-Chilibeck, 2003). According to Larry Burd, a director of the North Dakota FAS Center, a seven-year-old diagnosed with FASD has a 50 percent likelihood of receiving a custodial disposition. There are more informed pockets of expertise regarding the disorder of FASD in the courts in British Columbia, Saskatchewan and the Yukon, owing to certain clinical doctors’ specialization in the area; specifically, Doctors Looke, Conry and Fast in Vancouver (Chartrand & Forbes-Chilibeck, 2003). Even so, overall in Canada, the judicial system is generally uninformed, misinformed and not well prepared to handle the challenges that persons with FASD present, particularly where sentencing offenders with FASD is concerned (Chartrand & Forbes-Chilibeck, 2003).

Overall, FASD remains highly under-diagnosed among the general Canadian population and often it is only those individuals who come into contact with the criminal justice system that are given a chance to be diagnosed but, even then, such cases are scarce. Boland, Chudley and Grant (2002),
discuss how collecting incidence/prevalence data for FASD is no easy task, thus most affected individuals are not diagnosed. The prevalence of inmates in Canadian prisons who have FASD remains largely speculative. When a study on prenatal exposure to alcohol was conducted on juvenile delinquents housed in youth custody at Willingdon Detention Centre in Burnaby, B.C., it was observed that 23.3% of the youth held at the facility suffered from FASD—67 of the 287 remanded youth; three had full fetal alcohol syndrome and the remaining 64 had fetal alcohol effect (Fast, Conry & Loock, 1999).

UNDERSTANDING FETAL ALCOHOL SPECTRUM DISORDER

Fetal Alcohol Spectrum Disorder (FASD) is a clinically recognized disability. It is considered the single most common non-hereditary cause of mental retardation (Moore & Green, 2004). Fetal Alcohol Spectrum Disorder is an umbrella term that is utilized to describe the continuum of outcomes that include Fetal Alcohol Syndrome (FAS), partial Fetal Alcohol Syndrome (pFAS), and Alcohol-Related Neurodevelopmental Disorder (ARND) (Fast & Conry, 2004; Moore & Green, 2004; Chudley, Kilgour, Cranston & Edwards, 2007; Roach & Bailey, 2009; Whitbeck & Crawford, 2009). Fetal alcohol spectrum disorder is one of the leading causes of developmental disability and mental retardation in Canada (Fraser & McDonald, 2009). When a woman ingests a chronic amount of alcohol during her pregnancy, there is a possibility that such exposure will result in deleterious effects in her offspring. People with FASD have central nervous system damage, which involves varying difficulty with intellect, learning, memory, attention, communication, executive functioning, and adaptive behaviour (Fraser & McDonald, 2009). Characteristics of FAS and pFAS include: pre and/or post-natal growth retardation; short palpebral fissures (short horizontal eye length); thin flat upper lip; and a flattened mid-face (Fast & Conry, 2009; Chudley, Conry, Cook, Loock, Rosales & LeBlanc, 2005).

The Canadian Diagnostic Guidelines require significant deficits in at least three areas of brain function to make an alcohol-related diagnosis (Fast & Conry, 2009; Conry & Fast, 2010). The degree to which prenatal exposure to alcohol damages a person is dependent upon several factors such as genetics, maternal characteristics, nutrition, environment, developmental timing (first trimester versus second or third trimester prenatal alcohol consumption), reactions to other drugs and duration and extent of alcohol exposure. Since the nervous
system of the fetus develops in the first eight weeks, alcohol exposure during the first trimester is then the most vulnerable time period for resulting in the most damaging effects (CNS, heart, eyes, legs, arms, teeth, ears, palate, external genitalia are vulnerable to alcohol in the first trimester) (TCHP Education Consortium, 2000). Even though it has been found that damage to the brain may occur in the last trimester as well, vulnerability to brain damage is highest at 15-25 days (TCHP Education Consortium, 2000). According to the results from the 2010 national survey on drug use and health in the United States (2010), among pregnant women aged 15 to 44, an estimated 10.8 percent reported current alcohol use, 3.7 percent reported binge drinking, and 1.0 percent reported heavy drinking. Binge drinking during the first trimester of pregnancy was reported by 10.1 percent of pregnant women aged 15 to 44. This may be why the prevalence of FASD and ARND (Alcohol-Related Neurodevelopmental Disorder) and ARBD (Alcohol-Related Birth Defects) combined is at least 10 per 1,000, or 1 percent of all births in the United States (May & Gossage, 2001).

Fetal alcohol syndrome is one possible negative outcome of prenatal exposure and is characterized by prenatal or postnatal growth deficiency or both, craniofacial anomalies and central nervous system dysfunction (Mattson, Riley, Gramling, Delis, & Jones, 1998; Fast & Conry, 2009; Conry & Fast, 2010). When CNS dysfunction occurs, typically severe mental retardation, hyperactivity or more subtle behavioural issues may arise. The reason FASD is the most accurate and efficient way to describe a person who experienced prenatal exposure to alcohol is because most studies of neuropsychological functioning in children with FAS or FAE combine all alcohol-exposed children in one group; therefore, an informative understanding of the performance of children with only FAS or FAE is not possible (Mattson, Riley, Gramling, Delis, & Jones, 1998).

Prenatal alcohol exposure has direct effects on two core developmental processes—neurophysiological growth of the brain, nervous system and endocrine system, as well as psychosocial development—personality formation, social conduct and capacity for relationships (Riley & McGee, 2005). In order to officially confirm FASD through a formal diagnosis, evidence of prenatal or postnatal growth retardation must be present, along with characteristic facial features, a cognitive impairment or other developmental or behavioural difficulties of a substantial nature and confirmed excessive alcohol exposure in utero (Boland, Chudley & Grant, 2002). Unfortunately there are a limited number of professionals who have the training and experience to make
an FASD-related diagnosis as well as uncover other potential secondary disabilities (Chudley, Kilgour, Cranston & Edwards, 2007). Often, the aforementioned final diagnostic measure (confirmed excessive prenatal alcohol exposure) is the most difficult to obtain, especially when dealing with a vulnerable inmate population—many of whom did not have a stable home life, nor did they know their biological mother to confirm prenatal alcohol exposure. Chudley et al., (1997) discuss how one of the major challenges for FASD diagnosis is the necessary reliance on prenatal alcohol exposure history and detailed birth records. Hence, in the absence of official records in terms of collateral information from pregnancy or early childhood/school records to confirm prenatal exposure to alcohol, an FASD diagnosis can still be made but the ‘prenatal alcohol exposure not confirmed’ must accompany the result.

FASD, is a disorder that cannot be identified through a blood test. For a proper formal diagnosis to be made, a diagnosis of FAS, pFAS, or ARND must be conducted by a physician (geneticist or pediatrician) in collaboration with a neuropsychologist, a speech language pathologist as well as an individual who can confirm maternal alcohol history during pregnancy. In fact, the diagnosis of FASD is done best when an entire multidisciplinary team is included, which includes a pediatrician/physician, geneticist, psychologist and speech pathologist (Fast & Conry, 2009). In order for qualified doctors to diagnosis FAS, pFAS, or ARND, the individuals under observation need to display impaired functioning in three of the ten brain domains: adaptive behaviour; executive functioning; memory; attention; academic achievement; intellect; language; social communication; neurologic regulatory system; and physical signs (e.g., small head circumference). Executive Functioning has to do with brain functions that activate, organize, integrate and manage other functions (Barkley, Murphy & Fisher, 2008). Interestingly, an individual with FASD who does not meet the diagnostic criteria for the most recognizable form of the full fetal alcohol syndrome may actually be more severely impaired in all or some of the neurological areas than someone with the full FAS (Fast & Conry, 2009). Hence, it is important to keep in mind that even when someone is diagnosed with partial FAS, their cognitive impairment may be extremely serious.
Fetal Alcohol Spectrum Disorder Assessment and Diagnosis

FASD is not in the Diagnostic and Statistical Manual (DSM), and as a result, clinicians often do not consider it. The reason FASD is not in the current DSM-IV, is because FASD is not a medical diagnosis, but instead an umbrella term describing the diverse mental and behavioural phenotypes that results from structural damage to specific areas of the brain involved in mood (Jonsson, Dennett & Littlejohn, 2009). As it stands now, fetal alcohol syndrome is found under Axis III ‘General Medical Conditions’. Since FASD does not appear as an official disorder, the likelihood that research and clinical trials would be conducted is minimal. Hence, recognizing FASD in the DSM-V perhaps will provide the impetus to further research and determine the most effective course of treatment.

As has been alluded to in the previous section, in order to accurately diagnose an individual with FASD, there needs to be a confirmed history of maternal exposure to alcohol, facial dysmorphology, growth retardation and central nervous system dysfunction. However, through magnetic resonance brain imaging techniques, scientific research has confirmed that FAS-related neurological deficits are not related to facial abnormalities (Kyskan & Moore, 2005). Certain individuals can display evidence of central nervous system neurodevelopmental abnormalities without necessarily having growth deficiencies or craniofacial anomalies (Fast & Conry, 2004). Thus, an infant or a child without any manifested FAS facial features may very well have impairments in functional skills as someone who meets the full range of diagnostic criteria. Hence, a person with FASD may go undetected in the home, in the school and possibly in the criminal justice system, unless very specific testing is done. It has also been observed that, because the physical features of FASD are most identifiable in middle childhood, the diagnosis of FASD is even more challenging in newborns, adolescents and adults (Fast & Conry, 2004; Fast & Conry, 2009). The identification of FASD in the adult population is the most challenging undertaking of all, not only owing to the changes in defining characteristics over time but also because such persons may have suffered an additional head injury (Fast & Conry, 2004). Many FASD persons have reported head injuries following violent experiences or accidents. Essentially, when brain damage is present, it is often difficult to disentangle its cause, be that from prenatal exposure to alcohol, genetics and/or the environment. Since FASD is organic brain damage, which includes a range of cognitive shortfalls, and is
invisible to the naïve observer, it is not unusual for the defence counsel, Crown and the judge to overlook the underlying pathology (Moore & Green, 2004).

Recent advances in neurobiology (including neuroimaging) have greatly impacted the assessment and treatment of individuals who may have been prenatally exposed to alcohol (Henry, Sloane & Black-Pond, 2007). Any criminal justice agent, whether it is a judge, defence lawyer, prosecutor or probation officer, can request an FASD assessment to be undertaken. There are more resources available for youth to be diagnosed with FASD than there are for adults because for adults there are fewer special clinics or physicians available; therefore, making arrangements for an assessment can be a daunting task (Conry & Fast, 2000). Typically, the cost for a formal FASD assessment can range from $2,000 to $5,000 for adults because, unlike children, who frequently are able to get assessment funding granted through government contracts as well as funded support services, adults are on their own with the cost (Pemberton, 2010). Very rarely will such an expensive diagnosis be made with respect to an adult. Since the cost is so high, Dr. Sterling Clarren, the CEO of the FASD Research Network, stated it is no wonder that only 2,000 individuals are actually formally diagnosed each year in Canada, not to mention the lack of resources that are available to deal with this continuing health concern (Pemberton, 2010).

Since probation officers are often asked to prepare a pre-disposition report, the probation officer is in a key position to recommend an assessment for FASD prior to sentencing (Conry & Fast, 2000). Fast and Conry (2004) believe that only professionals who are recognized as being experienced in assessing people with FASD should prepare the medical-legal reports, psychological assessments and social histories. Moreover, such a report should definitively document the evidence supporting FASD. This type of thoroughness in report-writing would eliminate the speculative nature surrounding FASD diagnosis, which is often witnessed in the courts.

**Organic Effects of Fetal Alcohol Spectrum Disorder**

Prenatal exposure to alcohol appears to affect the placenta, which results in placenta dysfunction, decreased size, endocrine changes and impaired blood flow as well as nutrient transport, which can therefore affect the fetus and ultimately lead to cognitive and behavioural abnormalities in life (Burd,
Roberts, Olson & Odendaal, 2007). The acronym ‘ALARM’, which stands for adaptive functioning, language, attention, reasoning and memory, is often used to describe FASD persons’ impairments, since supposedly many have significant impairments in one or more of these areas, in comparison to individuals who are not exposed in the womb to alcohol (Conry & Fast, 2000). Adaptive behaviour refers to, “the effectiveness with which a person meets the standard of personal independence and social responsibility expected of an individual of the same age and cultural group…includes life skills such as self-care, positive social relationships, independence, communication, and appropriate judgment in work, school and community situations (Conry & Fast, 2000:17)”. For example, in a study which examined the cases of 189 children between the ages of eight through fifteen years—92 were control and 97 were grouped as FASD, it was observed that the FASD group demonstrated longer reaction and decision times, suggesting deficits in attention; moreover, FASD children also exhibited deficits in planning and spatial working memory that became increasingly pronounced when tasks became more difficult (Green, Mihic, Nikkel, Stade, Rasmussen, Munoz & Reynolds, 2009).

Delving further into the organic impairment deficits that result from FASD, when looking at social skills problems in particular, it has been observed that poor adaptive behaviour becomes more pronounced over time for FASD individuals. One study found that there was an increased discrepancy between FASD persons’ chronological ages and their age-equivalent scores on the Socialization domain on the Vineland Adaptive Behavioral Scales (VABS) test. The VABS is a standard tool used to assess adaptive skills in persons with disabilities such as FASD (Thomas, Kelly, Mattson & Riley, 1998). Thomas et al., (1998), utilized the Wechsler Intelligence scale for children (WISC) as well as the Vineland Adaptive Behavioral Scales (VABS) on 45 children ranging in age from five through twelve. The children were divided into three equal groups of 15: a group of children diagnosed with fetal alcohol syndrome, another group demonstrating low verbal IQ scores as well as a group that served as a control group, with verbal IQ scores in the normal to above average range. Thomas et al., (1998), found that children with FASD had significantly more deficits in social skills than children matched for Verbal IQ or those with IQ scores in the average or above average range, when the VABS was utilized. Such a finding suggests that there may not only be delayed but also arrested development of social abilities. For example, at the age of 12, when a youth
enters the criminal justice system, their IQ score may be regarded as normal but in fact their social functioning may be at a six-through-eight-years level (Fast & Conry, 2009).

In terms of language skills for persons with FASD, it would appear that these individuals often have trouble understanding the language that others use, owing to a superficial comprehension of language, which becomes apparent when FASD persons’ answers change, depending on how questions are asked (Conry & Fast, 2000).

Overall though, very little research has looked into language development but one definite finding has been that many FASD individuals are described as ‘chatty’ (Fast & Conry, 2009). The research that has been done in this area has focused on standardized measures of expressive and receptive language and the results have revealed that youth with FASD showed impairments in both their understanding of spoken language and their ability to produce language forms at the level expected for their age (Fast & Conry, 2009). In a sample size of 20 FASD children between the ages of three-and-a-half to five years of age, the study found that these children had inferior receptive and expressive language skills in comparison to the control group and teachers often rated these FASD students as having poor grammar, reading skills, written expression and spelling ability (Janzen, Nanson & Block, 1995). Also, it was interesting to note in this study that the controls scored significantly higher than the FAS group on being ‘self-conscious’ or being ‘easily embarrassed’, which matches the reports of FASD children’s impulsive and less introspective approach to social situations (inability to delay gratification) (Janzen, Nanson & Block, 1995).

When reviewing various executive functioning skills, which according to Barkley, et al., (2008), can be broken down into four areas: nonverbal working memory, internalization of speech (verbal working memory), self-regulation of affect/motivation/arousal and reconstitution (planning), deficits in these realms for FASD individuals have been cited in many studies. Rasmussen, Manji, Loomes & Andrew (2009), confirmed a memory impairment in their study of 70 children: younger (five to-six-years old) and older (eight-to-ten-years old). The researchers compared younger to older FASD and non-FASD children on a picture memory task and, among both age groups, the result was that the FASD children performed worse than those who did not have FASD (Rasmussen et al., 2009). In terms of reasoning skills, Rasmussen
(2005) noted that individuals with FASD were often found to have impaired executive functioning, with deficits in the areas of cognitive flexibility, inhibition, working memory measures, verbal reasoning, planning and strategy use and emotional regulation. Such executive functioning impairments can lead to life-long challenges adapting to and functioning in society (Rasmussen, 2005). Another study conducted by Rasmussen and Bisanz (2009), on 29 children with a confirmed medical diagnosis of an alcohol-related disorder, falling under the umbrella term FASD (eight-to-sixteen-years of age—16 males and 13 females), examined the executive function deficits and age-related differences among such children. The results of this study again lend support to other studies’ findings that the FASD children had problems with many components of executive functioning, such as cognitive flexibility, inhibition, some measures of verbal fluency, abstract thinking, deductive reasoning, hypothesis testing, problem solving, and concept formation. The children had to complete eight tests from the Delis-Kaplan Executive Function System (D-KEFS) to test for executive functioning dysfunctions. Interestingly, older children with FASD exhibited greater difficulty with respect to some verbal executive functioning tests than some younger children with FASD, which suggests that poor performance on executive functioning tasks appears to become more pronounced with increasing age. However, considering the study was cross-sectional rather than longitudinal, and their sample size was rather small (N = 29), it may have just been a sampling issue.

Streissguth, Bookstein, Barr, Sampson, O’Malley and Young (2004), conducted a study examining the adverse life outcomes not previously documented in patients with FAE or FAS. These researchers considered the following five adverse outcomes: Inappropriate Sexual Behavior (ISB), Disrupted School Experience (DSE), Trouble with the Law (TWL), Confinement (CNF), and Alcohol and Drug Problems (ADP). The sample consisted of 415 patients enrolled in the Fetal Alcohol Follow-up Study of the University of Washington’s Fetal Alcohol and Drug Unit (FADU) and who were at least six years old between August and December 1995. The sample included 162 children 6.0 to 11.9 years (median 8.8 years), 163 adolescents 12.0 to 20.9 years (median 16.0 years), and 90 adults 21 to 51 years (median 28.4 years). Fetal Alcohol Syndrome (FAS) was diagnosed when patients had a positive history of maternal alcohol abuse during pregnancy; growth deficiency of prenatal origin (for height and/or weight); a pattern of specific minor anomalies that
included a characteristic face and Central Nervous System (CNS) manifestations. A diagnosis of Fetal Alcohol Effects (FAE) was used for persons who were exposed prenatally to significant amounts of alcohol. They were examined by the same dysmorphologists, and had some but not all of the characteristics of FAS; 155 patients had FAS and 260 patients had FAE. In terms of the 415 FASD subjects’ victimization experiences, 67% had been the victim of physical abuse, sexual abuse or of domestic violence. For adverse life outcomes, inappropriate sexual behaviours on repeated occasions was the most frequent: 39.1% engaged in inappropriate sexual behaviours between the ages of six to 11.9 years of age, 47.5% between 12-20 years of age and 51.7% from 21 years and older. When it came to trouble with the law, 61.1% had trouble with the law between the ages of 12-20 and 58.4% from 21 years and older. For the ‘disrupted school experience’ variable, 62.3% of the adolescents were either suspended, expelled or had dropped out and the most frequently mentioned learning problems were attention problems and repeatedly incomplete schoolwork. For the ‘confinements’ variable, 50% of adolescents and adults had been hospitalized, 35% of adolescents and adults were incarcerated at some time, 23% hospitalized for psychiatric problems and 15% hospitalized for substance abuse treatment. One critical finding made by Streissguth, et al., (2004), was that the strongest correlate of adverse outcomes for FAS/FAE children, adolescents and adults, was lack of an early diagnosis; the longer the delay in receiving the diagnostic information, the greater the odds of adverse outcomes.

Psychological testing of the 415 FAS/FAE patients showed two striking deficits that have been described previously in small sample studies, specifically an arithmetic disability and problems with adaptive behaviour. In fact, 42% of these patients had reportedly been in special education, 66% had been in a resource room and 65% had received remedial help in reading and arithmetic. When Streissguth et al., (2004) compared Wechsler IQ scores with Vineland adaptive scores in individuals with FAS and FAE, their study revealed that the adaptive scores were significantly lower than the IQ scores, which ranged anywhere from below average to above average. Specifically, in those with FAS or FAE, who were over 21 years of age, their Wechsler IQ mean score was 80.7 (low average) and their Vineland Adaptive Behavior Composite mean score was 61.1 (mental handicap). Delving further into IQ scores and FASD, typically, the average IQ for an individual who has full fetal alcohol syndrome is 74, yet the average IQ for fetal alcohol spectrum disorder (any
alcohol-related disability) is higher—90 (Pemberton, 2010). However, even in circumstances, where someone with FASD scores in the normal IQ range, usually such an individual will still have certain impairments, whether it is in the memory sphere, judgment and/or adaptive living skills. More interestingly, Streissguth, et al., (1996) observed that FASD individuals who had an IQ above 85 (low average) were more likely to have trouble with the law than those with an IQ below 70 (mental handicap)—70% versus just under 50% (Fast and Conry, 2009). Of the 23.3% youths who were diagnosed with FASD in the British Columbia Youth Correctional study, it was observed by the researchers that many had IQs much lower than the controls (non-FASD counterparts). The average full-scale IQ for the 67 youth with FASD was 87.26, ranging from 55 to 129 (Fast, Conry & Loock, 1999). Apparently, 58% of the controls had an average IQ versus 32% of the FASD youth; 16.4% of the controls had a low average IQ versus 32.8% of the FASD youth and lastly nine percent of the controls had borderline versus 18% of the FASD youth. There do exist individuals with FASD who have above-average intelligence; however, research has suggested that there are far more people with FASD who either have mental retardation (approximately half of those diagnosed) or below-average-to-average intelligence (the remaining individuals diagnosed) (Fraser & McDonald, 2009). In terms of academic functioning, it has been reported that average academic functioning for individuals with FASD (including adults) is at the second-to-fourth-grade level.

A longitudinal 14-year follow-up study of a cohort of approximately 500 children was undertaken in order to evaluate aspects of cognitive processing; the adolescents had been exposed to a broad range of maternal drinking patterns before birth (250 infrequent drinkers, 250 heavier drinkers). The results revealed that there were alcohol-related deficits that emerged with respect to speed and accuracy on performance tasks, which may translate into difficulties in successful daily function (Sampson, Kerr, Olsen, Streissguth, Hunt, Barr, Bookstein & Thiede, 1997). Focusing further on longitudinal studies, Streissguth (2007) discussed the results of a 32-year Seattle longitudinal study which followed a birth cohort for three decades, and it was observed that prenatal exposure to alcohol was related to problems with attention, arithmetic, spatial-visual memory, speed of information processing and lower IQ scores.

It is widely accepted that a certain degree of prenatal exposure to alcohol (what amount is not scientifically determined) can result in a lifetime of
physical and/or neurological disorders with implications for serious and far-reaching cognitive impairments in day-to-day functioning (Fast & Conry, 2004). Cognitive and behavioural characteristics associated with FASD vary depending on the parts of the brain affected. FASD definitely affect every individual differently. Some individuals with FASD may exhibit the following characteristics: becoming overwhelmed by stimulation; lack of understanding and respecting of personal boundaries; displaying impulsiveness; distractibility and aggressiveness. Other characteristics of FASD can include problems with: time perception; short-term memory; planning; linking behaviours to consequences and daily living tasks.

SECONDARY DISABILITIES

Owing to the neurological damage caused by prenatal exposure to alcohol, which does affect the entire brain, many studies have shown that FASD individuals have an increased risk for maladaptive behaviours, such as socialization issues, a lack of employment fulfillment or substance abuse problems, that may lead to criminal activity (Fast & Conry, 2009). These maladaptive behaviours are referred to as secondary disabilities because they are disabilities that the individual was not born with and that could be dealt with through better understanding and relevant intervention (Chudley, Kilgour, Cranston & Edwards, 2007). Secondary disabilities are said to be the result of an interaction of behavioural and mental health problems with an adverse environment (Chudley, et al., 2007). Empirical evidence has demonstrated time and again that offenders with FASD are very likely to have persistent, repeated contact with the criminal justice system, since neurological impairments in these individuals facilitate criminal behaviour more easily (Fast & Conry, 2009). There appears to be an interconnectedness between FASD, the environment and trouble with the law. Many researchers postulate that it is the effects of FASD that increase the risk to crime. Specifically, the neurological impairments found in people with FASD, including learning disabilities, impulsivity and poor judgment heighten susceptibility to criminal activity (Fast & Conry, 2004; Fast & Conry, 2009). Since persons with FASD have impaired ‘adaptive behaviour’ – ineffective in reaching the acceptable standard of personal independence and general social responsibility – day-to-day living becomes a challenge. For example, self-care, taking care of finances, retaining
employment and not getting involved in risky behaviour during leisure activities are issues with which an FASD person may find themselves grappling (Fast & Conry, 2004).

Individuals with FASD who committed crime often have a history of disrupted school experiences as well as substance abuse issues (Fast & Conry, 2009). Evidently, secondary disabilities, which may develop as an individual with FASD attempts to cope with daily living, are perhaps precipitating factors to criminal activity. For example, youth with FASD often make inappropriate peer association choices, and such poor social choices may result in them being linked to delinquent peers (Fast & Conry, 2009). In particular, the secondary disabilities of other mental health issues, substance use disorders, lack of scholastic achievement, socialization problems, poor employment opportunities, and/or having a general difficulty dealing with everyday life, contribute to such persons being more vulnerable to experiencing trouble with the law (Conry & Fast, 2000). Many FASD sufferers also develop secondary disabilities later on in their lives. For example, substance use, other mental health diagnoses such as anxiety and/or depression may develop for those inflicted with FASD in childhood, adolescence and/or adulthood, and as a result of all of these problems, school failure, employment difficulties, homelessness, and trouble with the law may ensue. When individuals do not have much structured family and/or community support, their problems may become exacerbated. Another major neurocognitive impairment that FASD persons seem to exhibit frequently is ADHD (Boland, Burrill, Duwyn & Karp, 1998; Burd, Selfridge, Klug & Juelson, 2003).

**FASD and Comorbidity with Other Mental Disorders**

Many of the clinical phenomena seen in children with ADHD also characterize children with FASD (Kooistra, Ramage, Crawford, Cantell, Wormsbecker, Gibbard & Kaplan, 2009). People with FASD often display problems with attention and impulsivity and often those suffering from this disorder also have attention deficit hyperactivity disorder (Fast & Conry, 2004). Hence, such individuals can get involved in crime, simply because they do not think about the consequences of their actions. Interestingly, clinically, children with heavy prenatal alcohol exposure quite often meet the diagnostic criteria for attention deficit hyperactivity disorder (ADHD) (Steinhausen, Willms & Spohr, 1993).
Boland, Burrill, Duwyn and Karp (1998), stated that once a child with FAS/FAE reaches school age, a primary disability includes attention-deficit and hyperactivity. A study that was conducted to compare the adaptive behaviour in 65 children with heavy prenatal alcohol exposure to those who had ADHD found impairments in adaptive functioning in both groups relative to controls (Crocker, Vaurio, Riley & Mattson, 2009). However, the children with prenatal alcohol exposure had an arrest in the development of their adaptive ability, since they did not show improvement with age in socialization and communication scores; whereas, children with ADHD demonstrated a developmental delay in adaptive ability but their scores continued to improve with age, albeit not to the level of the control group children (Crocker et al., 2009).

A longitudinal study was undertaken with respect to 158 children in Germany who were suffering from FASD. The children were initially examined with pediatric, psychiatric and psychological measures between 1977 and 1991 and were diagnosed at various ages. As other studies have demonstrated, Steinhausen et al., confirmed with their result findings that FASD persons displayed an extremely high rate of psychiatric disorders among patients (Steinhausen, Willms & Spohr, 1993). Specifically, in their large cohort study of patients, it was observed that the prevalence rate of psychiatric disorders was extremely high; the prevalence rate amounted to 63%, with almost two-thirds of the patients suffering from at least one psychiatric syndrome: predominantly hyperkinetic disorders (ADHD), followed by emotional disorders, speech disorders, eating disorders and conduct disorders of childhood. In fact, from the time of the FASD children’s first assessment, to follow-up assessments, hyperkinetic disorders (ADHD), emotional disorders, conduct disorders, sleep disorders and speech disorders persisted and/or manifested themselves.

In the Burnaby youth detention study by Conry, Fast and Loock (1997), on alcohol exposure of youth in custody, of the 67 youth diagnosed with an alcohol-related diagnosis (ARD), 34% were afflicted with attention-deficit hyperactivity disorder, 90% with conduct disorder, 51% with substance abuse disorder, and less than 1% with adolescent anti-social disorder (2/67), oppositional defiant disorder (2/67), post-traumatic stress disorder (1/67), borderline personality disorder (3/67), depression (1/67), adjustment disorder (4/67), psychotic disorder (1/67), learning disorder (2/67), developmental delay (5/67), borderline IQ (2/67) and enuresis (1/67). Evidently, most notably, many of the ARD youth had a psychiatric diagnosis of conduct disorder, ADHD and or substance abuse.
FASD & THE LEGAL SYSTEM  
(INVOLVEMENT WITH THE LEGAL SYSTEM) (DISPOSITION)

The effects that result from prenatal exposure to alcohol are not the only reason why people have increased problems with the criminal justice system and of course, not all persons with FASD get in trouble with the law (Conry & Fast, 2000). Moreover, for many individuals who have alcohol-related diagnoses, contact with the criminal justice system becomes a familiar pathway due to various interactions among developmental, environmental, medical and psychiatric conditions (Conry & Fast, 2000). Nonetheless, some people with FASD also have troubles that do go beyond the physical and cognitive challenges. Many experience trouble with the law because there is a significant overrepresentation of FASD sufferers in the criminal justice system. Furthermore, since secondary disabilities often accompany FASD sufferers—specifically, additional mental health issues such as substance abuse, ADHD, conduct disorder, school and employment issues as well as difficulties with daily living (Fast & Conry, 2004; Fast & Conry, 2009)—committing crime appears to be a prevalent occurrence.

It has been established that FASD is indeed a disorder that is under-reported and under-identified in infants, children, adolescents and adults (Malbin, 2004). It, therefore, comes as no surprise that many individuals who come into contact with the criminal justice system have FASD: however, it has gone unnoticed. Despite the prevalence rate of FASD being estimated at approximately 1% of live births, the prevalence rate of FASD within the Criminal Justice System is estimated to be considerably higher (Fast & Conry, 2009). There is ample research evidence that many persons who are diagnosed with FASD will go through the formal criminal justice system process, specifically, the court system.

In fact, Malbin (2004) posits that the disability of FASD is 95% under-diagnosed and 40 times over-represented in juvenile justice. For quite some time, it has been recognized that persons with intellectual disabilities who experience trouble with the law should be dealt with differently from the general population (Jones, 2007); however, such an observation is easier said than done. In general, the prevalence estimates of offenders with intellectual disabilities cannot be accurately predicted due to various definitional and methodological issues as well as by diagnostic variations and inconsistencies of
assessment in the criminal justice system. With FASD being such a challenging disorder to properly diagnose, estimates of this disorder present in the persons coming into contact with the courts and/or the offenders who are presently in the criminal justice system, are particularly difficult to know. Therefore, many youth as well as adults who come in contact with the criminal justice system have not been previously assessed for FASD (Fast & Conry, 2009), and unfortunately some who should be still never are, even when they become part of the court system.

In fact, there are cases in which it is ‘suspected’ that the defendant has FASD, but a formal diagnosis is not undertaken. Individuals with FASD who become part of the criminal justice system are at a profound disadvantage because, as a group, persons with FASD challenge the underlying assumption that accused individuals comprehend the relationship between actions, outcomes, intentions and punishment (Moore & Green, 2004). Hence, the treatment of FASD offenders raises key questions about how the courts need to assess individual responsibility at the guilt-determining and sentencing stages of the adjudicative process (Moore & Green, 2004). Often FASD individuals will encounter the legal system at a very early age, which may become a pattern throughout adulthood. Increasingly, questions have been raised in legal and academic spheres as to whether the Canadian criminal justice system properly and accurately identifies persons with FASD, whether such a legal system considers this disorder in sentencing and what, if any, special considerations for specific treatment options are taken into account and/or available. Currie (2009), articulates how accused persons who have FASD present the most challenging case-in-point for a modern access to criminal justice approach. Such individuals’ cognitive functioning problems, which may be the main cause of their criminal offending, poses difficulty for the criminal justice process, especially the courts when handing down sentences. In R. v. T.J. (1999), T.J. had committed a sexual assault but the proceedings were stayed and he was found unfit to stand trial under section 672 of the Criminal Code due to his fetal alcohol syndrome.

The judge stated the following:

[H]ere is no question in my mind that T.J.’s intellectual deficit renders him incapable of participating in Court process or understanding the nature of Courtroom procedures. This is a product of his Fetal Alcohol Syndrome and is not amenable to treatment and should be considered a permanent state (paragraph 2). I am satisfied that T.J.’s mental disability is permanent
and is unlikely to improve with time. His condition, unlike that described in many of the reported cases dealing with accused who have been found “not criminally responsible on account of mental disorder”, is not responsive to treatment, by drugs or otherwise (paragraph 3).

In R. v. M.N.J. (2002), M.N.J. committed a physical and sexual assault and had ‘suspected’ FASD. No formal assessment was done but there was evidence of significant maternal addiction to alcohol and drugs, which suggested to the court that M.N.J. had FASD. The judge pointed out that, “despite being found to have average intelligence, M.N.J.’s ability to appreciate cause and effect, and to make appropriate choices may be undermined by FASD (paragraph 78) …[f]or these reasons, and many others, M.N.J. may not have the same mental capacity expected of all citizens to fully appreciate how to make prudent choices and to anticipate the consequences of bad choices. His mental disabilities cannot excuse his behaviour but can partially explain his grossly aberrant behaviour (paragraph 79)”. It is evident that some judges do mention, consider and grapple with the cognitive impairment when determining an appropriate sentence, while others do not: such is exemplified in the case of David Trott.

David Trott’s decision to plead guilty to the first-degree murder in the killing of nine-year-old Jessica Russell of Maple Ridge in British Columbia in 2008 was regarded as very unusual. After pleading guilty against Trott’s lawyer’s advice, and being sentenced automatically to life in prison with no eligibility for parole for 25 years, Howard Smith (Trott’s lawyer) resigned. Apparently Trott was in jail awaiting a psychiatric assessment due to a previous assault charge but the assessment never arrived and the judge released Trott. Smith wanted to raise a not-guilty-by-reason-of-insanity defence but Trott stated he wanted to get the proceedings over with and to go to a federal penitentiary where he could smoke (Chartrand & Forbes-Chilibeck, 2003). Trott had fetal alcohol syndrome that went unrecognized and his case is reflective of the growing misgivings regarding the appropriate judicial treatment of persons inflicted with FASD.

Pemberton (2010) discusses how prosecutors, defence counsel, and some judges have directly stated that they do not see the system working for those who have FASD because the same people seem to reoffend. This may be a result of the difficulty they may experience when connecting what is happening to them that day in court to an event that happened months ago; therefore, they do not understand why they are being punished. The question of an ‘operating mind’ is of significance for those with FASD and who find
themselves on the witness stand because are they in fact competent to give evidence (Conry & Fast, 2000)? When it comes to specific intent offences, the mental state is especially crucial because, in such cases the Crown must prove beyond a reasonable doubt that the accused had intended to commit the act as well as the specific result; however, it cannot be assumed that an accused person with FASD has the capability of planning or understanding the consequences that result from his or her actions (Conry & Fast, 2000). Hence, the FASD individual may not be able to formulate an intent that a specific result should transpire.

Thus, it would appear that individuals diagnosed with some form of FASD are found to be at a profound disadvantage within the criminal justice system (Moore & Green, 2004). As a group, individuals who have FASD challenge the underlying assumption that defendants in criminal proceedings can fully appreciate the relationship among their actions, the outcomes, their intentions and punishment (Moore & Green, 2004). It is therefore crucial to realize that the treatment of FASD accused persons in court raises critical questions about how such defendants should be assessed for individual responsibility, both at the guilt-determining (can they in fact be held responsible for their actions?) and sentencing stages of the adjudicative process. For many FASD defendants, the criminal justice system response manages to exacerbate their difficulties. When FASD accused participate in legal proceedings, a wide array of concerns are raised, and to highlight a few, these include witness advocacy, fitness to stand trial, diminished responsibility, pre-trial diversion, investigative procedures, effective representation, the role of expert evidence, persistent recidivism, special supervision needs during probation and/or parole, testimonial capacity and reliability, false confessions and finally sentencing (Moore & Green, 2004).

Of particular interest is the final sentencing process of persons with FASD. Once FASD individuals are convicted, by definition they are ‘special-need defendants’ (Moore & Green, 2004). It may be most appropriate for such persons to be given special programs and services. Unfortunately, all too often, sentencing courts are unaware of the disability altogether and/or there is a lack of services in the area to meet the needs of the FASD person. Other times, sentencing courts are often too powerless to come up with an appropriate disposition or are frustrated in their effort to do so (Moore & Green, 2004). A clear example of a judge’s effort in ensuring a youth with FASD would receive
FASD specific treatment but where the court failed to follow through with the service plan is in \textit{R. v. L.E.K.} (2001). In this case, as part of the probation order, the provincial judge ordered that a youth court worker, with specialized training in organic brain impairment, be assigned to the FASD defendant’s file; however, the Saskatchewan court of Appeal set aside such a portion of the probation order because it exceeded the court’s jurisdiction and the Appellate Court stated, “[t]here is a strong request for help from the provincial authorities to assist youth court judges with appropriate programs so they can impose dispositions that will assist in breaking the insidious cycle of in/out as exemplified by this young offender who, at 16 years of age, has a string of at least 45 convictions” (paragraph 35, \textit{R. v. L.E.K.}, 1999). Clearly, not enough attention is being paid to persons with FASD because many find themselves caught in the revolving door of the Canadian criminal justice system. Furthermore, many criminal justice professionals such as the prosecutors, defence counsel, judges as well as the general public are remarkably uninformed about the disorder (Moore & Green, 2004). Moore and Green (2004) also observed that, in \textit{R. v. Gray} (2001), no program existed for FASD persons who were persistently finding themselves passing through the revolving door of the criminal justice system in British Columbia.

Several United States studies have explored the issue of false confessions for suspects with FASD and this issue has attracted much judicial scrutiny (Moore & Green, 2004). Apparently, many youth with FASD in the U.S. have confessed to crimes they did not commit, perhaps because of ‘suggestibility’. It is suggested to them that they might have committed the crime and since they have a mental handicap (FASD), they confess to crimes such as murder and sexual offences. Had it not been for the DNA evidence, which linked other offenders to the crime, charges would not have been dropped against the various youths concerned.

Realizing the reality that FASD persons have language-based impairments in their understanding of language as well as in their ability to form language is especially important in the criminal justice system realm because such deficits have significant implications for individuals with FASD in the legal system. For example, it has been found that because of many FASD defendants’ talkative nature, their superficial talkativeness may make the judge and the lawyers overestimate their actual competence and level of comprehension of the proceedings. Yet, many FASD offenders have a difficult time
comprehending the proceedings, understanding the questions that are asked of them and providing appropriate answers (Fast & Conry, 2009). Such language deficits, experienced by a large number of FASD defendants, perhaps begs the question of whether such offenders are actually fit to stand trial.

Individuals with FASD and who come into contact with the Canadian criminal court process as accused persons face special challenges. McDonald, Colombi and Fraser (2009), examined Canadian case law, which involved persons suspected or diagnosed with FASD, in order to provide an overview of specific crucial legal issues that concerned individuals with FASD. Their study examined 42 criminal court cases during a 15-month period, which included every province and territory except for Quebec, Nova Scotia and Prince Edward Island. In terms of their methodology, when they searched for criminal cases from December 2005 to March 2008, their key search term was ‘fetal alcohol’, since it would then capture all forms of fetal alcohol spectrum disorder. They observed that many of the FASD offenders committed violent crimes, especially robbery and in some cases sexual assault and most accused persons had an extensive criminal background. For example, in R. v. J.H. (1998), J.H. was 18 years old when he committed a sexual assault against a four-year old girl and then one week later, upon being released after his arrest, he sexually assaulted a five-year old girl. J.H. had 18 prior convictions as a youth, including another conviction for sexual assault. He was diagnosed as suffering from fetal alcohol syndrome and attention deficit hyperactivity disorder. Similarly, in R. v. Sam (1993), Sam was convicted of a sexual assault and was diagnosed with FASD. Judge Stuart, in the Sam case, stated that, in light of his extensive knowledge and awareness of fetal alcohol syndrome, the judge was convinced that the inappropriate sexual behaviour of FASD offenders was a consequence of their inability to delay gratification/impulses because of the neurological and psychological dysfunction that is caused by brain damage. In D.E.K. (1999), another FASD offender who committed a sexual assault, the judge made a very compelling statement about FASD, brain damage and sentencing:

It is clear to me this offence to which Mr. D.E.K. has pled guilty to is not serious enough to require incarceration (paragraph 4)... The reason for this is not because he is a dangerous criminal in the everyday sense of that word, but because he likely and almost certainly suffers from Fetal Alcohol Syndrome or FAS, an affliction he was born with as a result of having an alcoholic mother and most probably is second or third generation alcohol affected. From reviewing all the previous reports prepared on him from his home province, this diagnosis does not appear
to have heretofore been made. If he is FAS, his behaviour may very well be at least partly beyond his control because of permanent brain damage as outlined by Ms. Lawryk, a qualified expert in FAS, Alcohol Related Effects and Neonatal Abstinence Syndrome. For instance, it may be that a person with FAS may be missing the small portion of their brain responsible for causing a person to be remorseful for their actions. It may cause them to be retarded cognitively and be impulsive. He may not be able to recognize inappropriate behaviour or even know that it is inappropriate. Most important as to sentencing, deterrence has no value because he cannot connect the punishment or the sentence to the crime. For that reason alone, incarceration would have no effect except to protect society (Paragraph 5).

Just like in Sam, the judge in D.E.K. seems to link D.E.K’s sexual misconduct to FASD, as a result of the brain damage that is inflicted.

McDonald et al., (2009) indicated that, as opposed to the case law review that was completed prior to 2006, the researchers noted that there seemed to be an increase in the number of reported cases that referenced FASD, in particular cases that involved youth. Overall, they did not find any consistent approach to responding to offenders with FASD mentioned in the case law. Of the 42 criminal court cases, FASD was explicitly incorporated into the judicial decision-making in ten of those cases. For example, the researchers focused on a few cases where FASD was considered in sentencing. They cited R. v. L.A.B. (2007), and how FASD was one of the many factors that was considered in her determination as to whether or not she should be tried as an adult for the crime of second degree murder at the age of 14. Ultimately, L.A.B. was tried as a youth due to her insufficient moral culpability that would warrant an adult sentence.

In R. v. Obed (2007), the judge determined that the offender was an unrealistic candidate for rehabilitation due to his diagnosis of FASD. Also, in R. v. C.P.S. (2006), the judge was unaware of any community treatment programs that would meet the offender’s complex needs, one major need being his diagnosis of FASD; thus, he was given a custodial disposition. Furthermore, in the cases of R. v. Mumford (2007), R. v. Vicaire (2007), and R. v. Otto (2006), the fact that FASD was not treatable was mentioned as one of the deciding factors for the final sentencing decision. In Mumford, rather than Mumford receiving a dangerous offender designation, he was given a long-term offender designation due to the incurable nature of FASD, which was listed as one of the deciding factors for the decision. However, in Vicaire, the application for dangerous offender designation was approved after examining personal history factors (FASD and neglectful upbringing) as well as the extensive criminal record and,
in *Otto*, an appeal to the Crown to change the long-term offender designation to a dangerous offender designation was approved, after noting that the offender had FASD and that previous attempts to hold the offender in the community had failed. It is evident from the researchers’ brief case law analysis that FASD can be regarded as a mitigating factor in sentencing in some instances but then in other cases it seems to result in more rigid sentencing options. Evidently a lack of available services to treat FASD offenders in the community resulted in some receiving a custodial sentence instead.

The Ministry of the Attorney General, Province of British Columbia, funded a one-year study to determine the prevalence of alcohol-related diagnoses among youth who were involved in the justice system at the time. The youth remanded to the Inpatient Assessment Unit (IAU) of Youth Court Services (YCS) in Burnaby, B.C., between July 1, 1995 and June 30, 1996 were screened for FASD. During the study period, of the 287 youth who were remanded to IAU, 67 (23.3%) of those youth were found to have an alcohol-related diagnosis (Conry, Fast & Loock, 1997). Such a percentage of FAS youth remanded to the IAU is 30 times the accepted world-wide incidence for this disorder. Specifically, only three had the full fetal alcohol syndrome with confirmed prenatal alcohol exposure, another youth was also found to have the full fetal alcohol syndrome but did not have this diagnosis confirmed with prenatal alcohol exposure, 31 had FAE (fetal alcohol effect) with confirmed prenatal alcohol exposure, another 20 had FAE without confirmed prenatal alcohol exposure and the remaining 12 had an alcohol-related diagnosis (ARD).

In terms of the types of crimes the 67 ARD youth committed, 29 committed theft, five committed robbery, 26 committed assault-related offences, three committed murder, five committed possession/use of a weapon, three committed sex offences, three committed major driving offences, 29 committed breach/failure to comply and 14 committed vandalism/mischief. When comparing these studies’ findings of FASD persons and their criminal activity to another study that looked at the ‘type’ of trouble with the law, conducted by Streissguth, Bookstein, Barr, Sampson, O’Malley, and Young (2004), among adolescents and adults, the most frequently mentioned crime category was crimes against persons (45%), which includes shoplifting/theft (36%), assault (17%), burglary (15%) and domestic violence (15%). Furthermore, among those in trouble with the law, the fraction actually
charged, arrested, and/or convicted increased with age from 13% for children to 67% for adolescents and 87% for adults.

Interestingly, returning to Conry, Fast and Loock’s 1997 study, in comparison to the youth who did not have an alcohol-related diagnosis (control group), the living situations of the ARD group certainly showed a unique pattern. None of the youth with ARD were living with both biological parents, only 14 were living with their biological mother and most were in the care of social services (on admission, 30 of the youth with ARD were permanent wards of the court and eight were temporary wards). In comparison, in the randomly selected control group of 67 youth, who did not have an alcohol-related diagnosis, seven lived with their biological mother and father, 26 lived with their biological mother, 13 were permanent wards and 14 were temporary wards. Similarly, in a study conducted by Steinhausen et al., (1993), when living arrangements were examined for 153 FASD subjects across their lifetime (1977-1991), 26.6% were continuously living with one or both biological parents, 24.1% with foster or adoptive parents, 25.3% were living in institutions and 24.1% had experienced various changes of their domestic status over time. Hence, the Steinhausen, et al., (1993) study supports the Conry, et al., (1997) study insofar as it displays extreme diversification of domestic environment, which may be a reflection of the consequences of maternal alcoholism, translating into family disorganization and subsequent problems in the criminal justice system.

More of the ARD youth had a chaotic family background than the control group (even though both groups showed a considerable amount of family dysfunction). The ARD group experienced much higher rates of reported emotional, physical, sexual or any other type of abuse than the control group: emotional — 46.3% versus 23.9%; physical — 61.2% versus 44.7%; sexual — 35.8% versus 23.9% and any — 73.1% versus 58.2%.

A revealing study of 136 FASD children was conducted on the relationship between one environmental variable — out-of-home placement and neurocognitive and behavioural status. Among the study participants, 19 children were living in their biological home (14%), 40 children (29%) were living in a foster home with ‘no history of changes’ in foster care placement and 77 children (57%) had lived in more than one foster care placement (Victor, Wozniak & Chang, 2008). The results revealed that children with FASD who were removed from their biological homes and placed in one foster-care
placement (not moved around) performed the best on neurocognitive measures and exhibited fewer behavioural problems as opposed to the children who remained in their biological home or who experienced multiple foster care placements. The multiple foster care placements showed an intermediate pattern of cognitive deficits and behavioural patterns and the FASD children who remained in the biological parent home performed the worst (Victor et al., 2008). Hence, the results of this study reveal that it is important to consider FASD child placement with respect to cognitive deficits and behavioural problems. Of course, there are persistent alcohol-related cognitive deficits in children with FASD, regardless of placement history but it is an area of research to pay attention to as well.

**Custody**

A northern judge from Whitehorse was extremely frustrated about not having many options when dealing with offenders with FASD. The judge stated that he had a pile of FASD offenders two inches thick and all he could do was either send them to jail or put them on the street but either way felt there was no effort being made to better their circumstances (Pemberton, 2010). The Canadian Bar Association put out a call for action in 2010 for the police, courts and health authorities to start discussing alternatives to prison for those who suffer from FASD. Canada’s Justice Minister Rob Nicholson responded to the association’s call for action and publicly acknowledged the complex issue surrounding fetal alcohol spectrum disorder. The actual number of individuals with fetal alcohol spectrum disorder within the Canadian prison system is not known because the figure varies anywhere from 15 to 80 percent (Pemberton, 2010). However, John Simpson, of the Fraser Valley Brain Injury Association, who meets FASD offenders while visiting prisons as a consultant, estimates as many as 80 percent of the inmates have a brain injury of some kind. Even Dr. Sterling Clarren, CEO of the Canadian FASD Research Network, stated Simpson’s estimate that 80 percent of the inmates having a brain injury would not surprise him but whether persons with FASD comprise 10, 35 or 50 percent of such an estimate is not known. The reason for such variability in the estimated rates of FASD in particular is because no screening methods exist for inmates either in the provincial or federal corrections system. Proper assessments by medical professionals are extremely time-consuming and costly and, even if corrections did have the ability to conduct proper assessments,
obtaining a reliable history from the inmates about prenatal exposure to alcohol can often be challenging in families where substance abuse is an issue, where family members such as the birth mother are dead or the inmate does not know his biological parents.

There are many individuals with FASD who have lengthy criminal records and who have not yet been diagnosed. Of course, once a diagnosis is made, a judge needs to decide whether to base the sentence on the criminal history of the person or on the disabilities associated with FASD. For example, Fast and Conry refer to the case of R. v. Steves (1998), a B.C. case in which an adult with partial FAS was given a conditional sentence (2004). Steves was allowed to serve his sentence at home under strict supervision. The authors’ point was that, in order to prevent the negative outcomes of incarceration for persons with FASD, receiving a community sentence would allow them to establish a more productive life by perhaps going to school and/or having employment opportunities. Hence, Fast and Conry (2004) recommend diversionary measures or sentencing circles, in order to deflect FASD individuals from the formal criminal justice system court process. Perhaps, many judges select custodial dispositions because the structure and the routine that jail offers is initially positive for FASD sufferers but such an environment may also pose a risk to their personal safety or overall mental health since they may have problems following the rules and expectations that are set for them and these difficulties could result in unfavorable actions against them. Fast and Conry (2004) also postulate that many FASD individuals in custody may be easily influenced by their peers owing to their desire to be liked. Nonetheless, incarceration is inevitable even for those persons with FASD, if they pose a danger to the public. The problem with having FASD individuals housed in prisons, even when resources are available, is that often the support is short-term and inconsistent as the person moves in and out of jail and probation supervision (Conry & Fast, 2010). Even when medications are helpful and available to FASD offenders who are inflicted with other disorders such as ADHD, depression and/or anxiety, many times such persons are unreliable in taking their medication owing to their forgetfulness or refusal to take the prescribed medication, even in custody (Conry & Fast, 2010).

Judge Turpel-Lafond recognized how young people who suffer from fetal alcohol syndrome present a significant challenge to the criminal justice system (2005). Adults with FASD also pose a challenge and Judge Trueman, in
R. v. C.J.M. (2000), stated, “[t]he percentage of individuals with FAS/FAE in the incarcerated population of youths is not yet known. Neither is the percentage of such individuals in the adult prison population. It is fair to surmise, however, that their numbers are disproportionally high, considering the incidence in the general population of Canadians (paragraph 81)”. Judge Trueman in C.J.M., continued to make the statement that, “[t]o incarcerate an individual in a prison setting that fails to recognize FAS, and fails to accommodate those with the disability, is to further the development of socially maladaptive behaviours that occur from forcing those with compromised mental functions to respond daily in a hostile environment. This is not only detrimental to them, but to the rest of society when they are ultimately released (paragraph 82)”. Evidently, when it comes to sentencing offenders with FASD, there are judges who are adamantly against incarceration of FASD offenders if there are no proper programs available in prison to such offenders. Hence, in C.J.M. the judge gave C.J.M. a conditional sentence, claiming that the conditions facilitated contact with the medical profession to further assess the secondary disabilities that accompanied FAS. In fact, Trueman, J. is a very vocal judge regarding FASD in sentencing that goes beyond the C.J.M. case. In R. v. Harris (2002), Trueman, J. made a rather significant statement, which is the very reason why more case studies regarding FASD and sentencing considerations need to be conducted, as well as special programs for FASD sufferers created:

The cognitively challenged are before our courts in unknown numbers. We prosecute them again and again and again. We sentence them again and again and again. We imprison them again and again and again. They commit crimes again and again and again. We wonder why they do not change. The wonder of it all is that we do not change (paragraph 167).

It has been established that the diagnosis and management of people with FASD in the Canadian corrections system is presently unknown but several studies have attempted to shed more light into the FASD inmate population phenomenon. In one study by Burd, Selfridge, Klug and Juelson (2003), each province’s and territory’s corrections system was asked to complete a questionnaire on the demographics of the population and services related to FASD. Responses were gathered from 85% of the provinces and territories in the study sample; the combined population estimates in 2001, including both federal and provincial prison populations, were 148,797 (128,425 provincial and 20,372 federal). In the population of 148,797, 13 were identified
with FAS; thus, the prevalence rate was 0.087 per 1,000 offenders. Since the conservative estimate of FAS in the general population is 0.33 per 1,000 and the high estimate is 9.1 per 1,000 (Masotti, George, Szala-Meneok, Morton, Loock, Bibber, Ranford, Fleming & MacLeod, 2006), using the conservative estimate, there could be as few as 36 undiagnosed cases of FAS to a high estimate of 404 undiagnosed cases of FAS; 937 undiagnosed cases of FAE or a total of 1,341 undiagnosed cases of both (Burd et al., 2003). Clearly, not enough offenders are undergoing proper FASD assessments, if only 13 were identified; therefore, presumably, there are a large number of inmates who are not benefiting from proper therapeutic programing.

With the increasing recognition that FASD is a disability that results in many youth and adults being funneled into the criminal justice system, many criminal justice agents such as judges, lawyers and physicians, realize this type of impairment has become an issue that the courts must deal with. Fast and Conry (2004), believe that a comprehensive medical-legal report can help the judge as well as other criminal justice agents in dealing with an FASD individual, as he or she navigates through the legal process. Fast and Conry (2009), point out that despite the recent increased awareness of FASD by criminal justice agents such as judges, lawyers and other criminal justice personnel, more education and training for these agents is still necessary. Overall, Fast and Conry (2009) believe that, for an FASD person, going to court can be counterproductive, simply because the time between the offence and sentencing can be quite long, and the accused may not connect the consequence with the act. Moreover, the major downfall of incarceration for a person with FASD is that custody itself presents many challenges that other offenders may be exempt from. Specifically, the potential for physical, sexual and emotional victimization is a lot greater and such persons are often made scapegoats (Fast & Conry, 2004).

**FASD and Its Link to Crime**

The CNS dysfunctions linked to FASD take shape in various cognitive deficits such as problems with language, social skills and memory (Moore & Green, 2004). Poor ‘executive control’ is another area of functioning that is damaged in FASD children (Moore & Green, 2004). It is this lack of poor executive control that is crucial in understanding why perhaps persons with FASD
commit crime. *Reasoning* is said to be lacking for persons living with FASD and many professionals who work with such persons claim that they do not connect cause and effect; meaning, they do not learn from their experiences (Fast & Conry, 2004). The lack of appreciation for how their actions affect others, can result in them being regarded as egocentric and seen as if they are unremorseful and not empathetic at all. Displaying poor executive control results in a lack of planning, organizing and most importantly, not learning from past mistakes. Such meagre executive control functioning is further displayed by the demonstration of impulsive and egocentric behaviour (Moore & Green, 2004). To illustrate how poor executive functioning can be linked to crime, in *R. v. J.(T.)*, the Yukon Territorial Judge stated:

FAS patients tend to be impulsive, uninhibited and fearless...have difficulties linking events with their resulting consequences. These consequences include both the physical...and the punitive, e.g. being sent to jail for committing a crime. Because of this, it is difficult for these individuals to learn from their mistakes...[s]imilarly, FAS individuals have trouble comprehending that their behavior can affect others. As such, they are unlikely to show true remorse or to take responsibility for their actions (paragraphs 11 & 12, *R. v. T.J.*, 1999).

It is not unusual for a person with a mental handicap such as FASD to make a false confession to a crime (Conry & Fast, 2000). It is also not unusual for a person with FASD to be exploited in prison, if the person receives a custodial disposition. For example, in *R. v. Steeves* (1998), the judge stated that the doctor expressed the opinion that, “there is an extremely high risk that the defendant would be victimized in a prison (paragraph 12)”. This opinion was also shared in the *R. v. Baptiste* (1994) case, in which the judge stated, “[o]ne significant characteristic of persons afflicted with FAS is a tendency to be involved in sexual offences. Sometimes they are offenders. Sometimes they are victims (mid-judgment, unspecified paragraph)”.

Weinberg, Sliwowski, Lan & Hellemans (2008), pointed out how, regardless of the level of prenatal exposure to alcohol, children could in fact exhibit similar cognitive, neuropsychological and behavioural problems such as hyperactivity, poor attention span, impulsivity, lack of inhibition and poor attention to social cues. These researchers observed how prenatal alcohol exposure in rodents had negative effects on neuroendocrine function, the hypothalamic-pituitary-adrenal axis which plays a central role in response to stress, and that such adverse effects are for the duration of life; hence,
Weinberg et al., (2008), ascertain that persons with FASD may be permanently hyperactive in response to stress and this may be one of the reasons as to why some individuals with FASD develop psychiatric and behavioural problems, which lead to trouble in the legal system.

Youth with FASD are disproportionately represented in the juvenile justice system. As an example, youths in B.C. who were remanded to a forensic psychiatric in-patient assessment unit over a one-year period were evaluated for FAS and FAE and, in this group, 23.3% were diagnosed with one of those forms of FASD. Such a diagnosis was new for most of the offenders because less than one percent had received an alcohol-related diagnosis prior to the study (Fast & Conry, 2009). Conry, Fast and Loock (1997), observed, in their study of the IAU Burnaby ARD youth, that the types of crimes the FASD youth committed prior to being remanded to the Burnaby, B.C. psychiatric assessment unit were largely theft, assault, breach/failure to comply and vandalism/mischief. The significant problem that Conry, et al., 1997 noted was that the FASD offenders who were in the forensic inpatient unit for assessment were socially inept/inappropriate and had poor understanding of personal boundaries, such as inappropriate sexual behaviour by some youth offenders with FASD. Perhaps such behavioural concerns were largely a result of the comorbidity of disorders that the ARD youth experienced, which was discussed earlier when Conry et al., 1997 study was reviewed.

The other Canadian study by MacPherson and Chudley (2007), which was presented at a conference on FASD in Victoria, B.C., was undertaken in an adult correctional facility to screen and diagnose 91 offenders for FASD and it was found that 10% had a confirmed FASD diagnosis, with an additional 18% of offenders fitting in the ‘possible’ category (evidence of significant CNS dysfunction but no available alcohol history to confirm or rule out the diagnosis). When analyzing the study in more detail, using the Correctional Service of Canada (CSC) offender management system, the ten percent of offenders with FASD had significant problems in the personal/emotional category that encompassed not being aware of consequences, poor memory and poor social functioning; furthermore, such persons were more likely to have had a youth court history record with 15 or more convictions as a youth or as an adult as well as a previous adult provincial prison term (MacPherson & Chudley, 1997 conference presentation, as cited in Fast & Conry, 2009).
PROGRAMMING FOR FASD OFFENDERS
IN THE CRIMINAL JUSTICE SYSTEM

An offender who receives an FASD diagnosis should receive a special sentencing consideration that focuses on rehabilitation, treatment and simply addresses the therapeutic needs of the individual, rather than being focused on punishment and deterrence (Chartrand & Forbes-Chilibeck). There is a special protocol, in Nova Scotia, known as the Nova Scotia Protocol for the Prosecution of Cases Involving Persons with Special Communication Needs, which sets out numerous appropriate measures that could help people afflicted with FASD, for example, to access the legal system (Conry & Fast, 2000). Even in the case of R. v. Gadway (1993), the judge referred to the applicability of this protocol for cases in which the offender has FASD: “[i]n the Yukon, Fetal Alcohol Syndrome, Fetal Alcohol Effects and other disabilities that hinder the ability of many witnesses to properly testify makes the special case for adopting a Nova Scotia Protocol impossible to deny, and a failure to do so, impossible to justify (paragraph 45)” “…[s]ome, as accused, will be victimized by being unable to justly defend themselves. Others, as victims, will become easy prey as unprotected prosecution-proof victims (paragraph 47)”. Overall, the Nova Scotia protocol is a broad protocol, which defines a person with special communication needs as those who, because of age, level of literacy, or mental or physical disability are unable, without assistance, to fully access the criminal justice system or understand or be understood by the officials therein (Conry & Fast, 2000).

Pemberton (2010), quoted the Asante Centre Executive Director, Audrey Salahub, who articulated the point that while great strides have been made for children, very little is being done for adults: “there’s always jail for a client—that’s the place that will provide them with a free room and board (A11, The Vancouver Sun)”. Such a statement most likely stems from the fact that, if an adult is fortunate enough to be formally diagnosed with FASD, the Ministry of Housing and Social Development has only recently created a specialized assistance program, which offers those with FASD a $950-per-month disability cheque (Pemberton, 2010).

There are very few assessment centres available in Canada to conduct an FASD diagnosis, which makes the numbers of how many people are actually afflicted with this disorder very imprecise. The Asante Centre for Fetal Alcohol
Syndrome is an FASD assessment centre for youth and it offers programs to help youth deal with this type of disability. Asante is partnered with PLEA Community Services Society of BC because, at the forefront, Asante is concerned about providing high-risk youth who are before the courts with effective alternatives to custody and providing individualized assessments, intensive support and supervision, residential placements and post-program family follow-up services (The Asante Centre for Fetal Alcohol Syndrome, 2010). Fraser (2009), for the Department of Justice in Canada, worked on a study in which 125 agencies were contacted by phone or email throughout Canada, in order to gather information about the programs aimed exclusively at individuals with FASD involved with the Criminal Justice System. Fraser (2009) noted that, as of June 2008, eight programs were operating, of which six were for youth and two for adults involved with the criminal justice system. Four of the programs had sustainable funding through their respective provincial jurisdictions or federal mandates and only one of the programs had been formally evaluated. Hence, the eight programs in existence for youth and adults with FASD who are involved in the Criminal Justice System are: Genesis House FASD Program in B.C., which offers transition housing and programming to adult male federal offenders released on parole; Asante Centre for Fetal Alcohol Syndrome for Youth; Lethbridge Community FASD Justice Project in Lethbridge, Alberta, focused on diverting youth from the criminal justice system where appropriate and to make sentencing recommendations to the court; FASD Justice Support Project for Youth, Alberta, helps to assist youth with FASD (both suspected and diagnosed) involved with the criminal justice system; FASD Youth Justice Project, Manitoba, a youth diagnostic services and specialized programming for youth remanded to custody; Empowering Justice Program, Manitoba, offers support services to youth diagnosed with FASD who are on probation and have extensive auto-theft history; Kairos Youth Outreach Program, Ontario, provides individualized outreach services for youth suspected or diagnosed with FASD who are in custody or on probation; Yukon Community Wellness Court, Yukon, offers an alternative to custody for adult offenders with mental health issues, addictions and/or FASD (both suspected and diagnosed). Evidently, there is a significant lack of up-and-running FASD programs for youth as well as adults across Canada. In terms of adult FASD programs, only B.C. and the Yukon have two programs that assist adults with FASD who are involved in the Criminal Justice System: yet ironically, the B.C. program (Genesis House) only reserves six of the 24 beds for
clients suspected or diagnosed with FASD. It is quite surprising that
Saskatchewan, which has many FASD cases, does not offer any youth or adult
FASD program in affiliation with the criminal justice system.

SUMMARY

The pre-existing literature on fetal alcohol spectrum disorder (FASD),
demonstrates that there is a definite lack of systematic research on the
sentencing of FASD offenders. Various case judgments in which the offender
had FASD were considered, to show what the literature has identified to-date
regarding what judges say and do about FASD in sentencing. It has been made
evident that FASD poses a challenge for the courts, in terms of how to properly
diagnose and/or sentence such persons. Moreover, literature points to
Aboriginal overrepresentation in FASD cases. It has also been shown that the
majority of crimes that FASD offenders commit are violent in nature. Overall,
there is a clear lack of programming availability and it is no wonder that so few
people are properly assessed, diagnosed and/or assisted, even when they are
offenders and part of the criminal justice system. It is interesting to analyze
how Canadian courts deal with offenders who ‘are’ identified as having FASD,
youth and adult, and see how such a diagnosis impacts judicial decision-
making in terms of the final disposition.
Chapter 2:

**ATTENTION DEFICIT HYPERACTIVITY DISORDER**

Typically, interaction and dialogue between the mental health and criminal justice professions take place regarding issues such as the defendant’s claim of Not Criminally Responsible on Account of Mental Disorder (NCRMD) or the making of a determination of ‘fitness’—fitness to stand trial, both of which usually necessitate the accused to suffer from some form of psychosis. However, recently, professionals in these two fields have started to explore a broader range of behavioural disorders that could bring persons into contact with the Canadian criminal justice system, including Attention Deficit Hyperactivity Disorder (ADHD). ADHD, which is predominantly characterized as an inability to control one’s actions, hyperactivity and the lack of social inhibition, has been recognized for over a century and presently affects millions of people. There is certainly a robust consensus in the global village that ADHD is a serious developmental disorder characterized by symptoms of inattention, impulsivity and hyperactivity (Barkley, 2002; Biederman & Faraone, 2005). It is the aforementioned characteristics of the disorder (the inability to delay gratification, lack of concentration and impulsivity), which come into question when trying to determine the extent to which the disorder is causally connected to the crime. Studies indicate that youth and adults with ADHD come into contact with the criminal justice system more frequently than do members of the general population. ADHD is a disability, a cognitive brain impairment, and there has been debate about whether ADHD might offer a justifiable defence for a wide range of different crimes but to-date, the courts have not been particularly receptive to this defense. In spite of an increase in the number of children and adults diagnosed with ADHD, the criminal justice system is failing to provide guidance for judges with respect to handling these types of cases. Nonetheless,
ADHD is often mentioned in criminal cases but it is not often attended to in sentencing by judges. As Victoroff (2009), stated, should there be equal justice for unequal minds? There are certainly some cited cases in which judges do consider ADHD as a factor in lessening an imposed sentence (mitigating factor), and in some instances such an impairment may also be an aggravating factor, since it is associated with increased re-offence risk but continued awareness and research is needed to yield information and results regarding this organic brain deficit and its role in the criminal justice community. Persons with ADHD should be protected at each stage of their lives, especially when they are being accused of a crime (Garza, 2002).

**ATTENTION DEFICIT HYPERACTIVITY AS A DISORDER: UNDERSTANDING ADHD**

Attention deficit hyperactivity disorder (ADHD), was first known to the scientific community in 1902 as a physiological disorder and did not become a part of the public discourse until the late 1960s to 1970s (Weiss & Trokenberg-Hechtman, 1986). In fact, in the 20th century, attention deficit hyperactivity disorder emerged as the first psychiatric disorder to be diagnosed and treated in children (Biederman & Faraone, 2005). Throughout the years, the disorder took on several different names, including attention deficit disorder (ADD) in 1980, until it became its final name today (Weiss & Trokenberg-Hechtman, 1986). Today, and since approximately the early 1990s, scientific researchers have been using technologies such as the magnetic resonance imaging (MRI), for the purpose of discovering the causes of a disability such as ADHD (Shepherd, 2005). ADHD was commonly regarded as a childhood disorder but increasingly it is being recognized as persisting into adulthood (Young & Gudjonsson, 2006). In order to be diagnosed with ADHD, people need to demonstrate impairments in some or all areas of attention, impulsivity and hyperactivity (Babinski, Hartsough & Lambert, 2001; Fast & Conry, 2009). In the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR)*, the criteria for an ADHD diagnosis consists of evaluating three areas: inattention, impulsivity and hyperactivity (1994). Inattention may manifest in academic, occupational or social situations and such individuals have difficulty giving close attention to details or may make careless mistakes in schoolwork or in other tasks; there are nine symptoms that fall under *inattention* (DSM-IV TR, 2000):
1. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities

2. often has difficulty sustaining attention in tasks or play activities

3. often does not seem to listen when spoken to directly

4. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure of comprehension)

5. often has difficulty organizing tasks and activities

6. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

7. often loses things necessary for tasks or activities at school or at home (e.g. toys, pencils, books, assignments)

8. is often easily distracted by extraneous stimuli

9. if often forgetful in daily activities

as well as another six that fall under impulsivity, which manifests itself as impatience, difficulty in delaying responses, blurtling out answers before questions have been completed, difficulty awaiting one’s turn and frequently interrupting or intruding on others to the point of causing difficulties in social, academic or occupational settings (DSM-IV TR, 2000):

1. often fidgets with hands or feet or squirms in seat

2. often leaves seat in classroom or in other situations in which remaining seated is expected

3. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

4. often has difficulty playing or engaging in leisure activities quietly

5. often talks excessively

6. is often ‘on the go’ or often acts as if ‘driven by a motor’

and another 3 that fall under hyperactivity, which manifests itself by fidgetiness or squirming in one’s seat, by not remaining seated when expected to do so, by excessive running or climbing in situations where it is inappropriate, by having
difficulty playing or engaging quietly in leisure activities, by appearing to be often on the go or as if driving by a motor, or by talking excessively (DSM-IV TR, 2000):

7. often has difficulty awaiting turn in games or group situations
8. often blurts out answers to questions before they have been completed
9. often interrupts or intrudes on others, e.g. butts into other children’s games

In order for the individual to be diagnosed with this disorder, the individual must have at least six of the nine symptoms under inattention or six of the nine symptoms that fall under impulsivity and hyperactivity combined for at least six months. There are three sub-types of ADHD. For example, according to the DSM-IV TR (2000), individuals with the ‘Predominantly Inattentive’ (if six or more symptoms of inattention but fewer than six symptoms of hyperactivity-impulsivity) and ‘Combined Type’ (if six or more symptoms of inattention and six or more symptoms of hyperactivity-impulsivity) usually have academic deficits and school-related problems; whereas, those with the ‘Predominantly Hyperactive-Impulsive Type (if six or more symptoms of hyperactivity-impulsivity but fewer than six symptoms of inattention), tend to have more peer rejection and accidental injuries and the gender ratio is less predominantly male in the Predominantly Inattentive type.

Twin, adoption and molecular genetic studies show ADHD to be highly heritable and other research findings show obstetric complications and psychosocial adversity as being the predisposing risk factors (Biederman & Faraone, 2005). The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) will be published in May 2013. This is a highly anticipated manual for the mental health community due to the various proposed revisions and additions.

Prevalence

According to the DSM-IV TR (2000), the prevalence of ADHD is estimated at three to seven percent in school-age children and anywhere from 30% to 60% of youth diagnosed with ADHD will continue to have impairing symptoms into adulthood: this calculation results in an estimate of adult prevalence of approximately four percent (Kessler, Adler, Barkley, Biederman, Conners,
Demler, Faraone, Greenhill, Howes, Secnik, Spencer, Ustun, Walters & Zaslavsky (2006). Biederman and Faraone (2005) postulate that eight to twelve percent of children are affected worldwide and, although the adult rate of ADHD falls with age, at least half of the children with the disorder will manifest impairing symptoms in adulthood. Eme (2009), reiterates the important point that ADHD is the most commonly diagnosed behavioural disorder in childhood, occurring in approximately twelve percent of males and five percent of females aged eight to fifteen in Canada, United States, Germany and the United Kingdom. In the past, explanations of ADHD used to be based upon causal models in which a single, common-core executive function (EF) dysfunction was thought to explain all of the deficits and symptoms of ADHD but recent developments in the understanding of the neuropsychological heterogeneity in ADHD have led to a paradigm shift toward models that conceptualize ADHD as an umbrella construct (Eme, 2008; Eme, 2009). Meaning, ADHD is a disorder that is characterized by a number of different neuropsychological deficits, mediated by different neurological brain circuits, resulting in different manifestations of the symptoms regularly observed in ADHD for youth and adults; therefore, every person with ADHD needs their own unique treatment approach (Biederman & Farone, 2005).

**ADHD AND NEUROBIOLOGY**

It is imperative to understand the neurobiology that underlies ADHD, in order to come to an understanding as to why children and adults with this disorder behave impulsively, or have problems paying attention or both, which can perhaps explain why many get involved in crime. ADHD is a serious complex syndrome of impairments in the brain’s executive functioning mechanism (Brown, 2007). Magnetic resonance imaging techniques (MRI) have enabled scientists to obtain further insight into the brain of individuals with ADHD versus those not suffering from this disability and they have observed brain differences. Specifically, those with ADHD typically have brain abnormalities in the prefrontal cortex, basil ganglia and cerebellum; all regions of the brain that are responsible for executive control, inhibition and attention (Serene, Ashtari, Szeszko & Kumra, 2007). The brain of the afflicted individual is impaired by the disorder in such a way that it makes the organization and management of tasks difficult, avoiding distractibility is a persistent challenge,
regulating emotions in a socially constructive manner cannot be maintained well and attention to detail is lacking (Moore, Biederman, Wozniak, Mick, Aleardi, Wardrop, Dougherty, Harpold, Hammerness, Randall & Renshaw, 2006). In a detailed study that was conducted in UCLA, which utilized MRI technology to compare the brains of 27 children suffering from ADHD to 46 children who did not have the disorder, the researchers found that the region of the brain that was abnormal for the ADHD children was the part that is responsible for attention and impulse control in the bottom area of the frontal lobe region; they also observed that ADHD children had larger areas of the outer layers of the brain (Sowell, Thompson, Welcome, Henkenius, Toga, & Peterson, 2003). The frontal lobe is linked to impulsivity in that it controls anxiety and planning and, if there is any damage to this lobe, it is believed that individuals have difficulty thinking things through and cannot make any plans into the future (only live in the present) and many become anxious (Gilbert, 2006). Of course, if one is only focused on the present, and cannot imagine the future, it is not unforeseen to assume that the individual will act impulsively and self-gratify (for example become truant or commit crime), without thinking about the impending consequences. In terms of inattention, research has found that certain parts of children’s brains with ADHD are slower than their ADHD counterparts and, while this process is going occurring, the critical region of the brain that controls movements seems to develop more quickly; the consequence of this slow/fast brain development is an inability for a child/youth to concentrate their attention as well as suppress socially inappropriate thoughts and actions (Schmid, 2007). Tulman (2003), discussed how studies are also demonstrating that children with ADHD process the neurotransmitters of dopamine and serotonin differently from non-ADHD children, which may result in difficulties in the way they learn and behave. Thus, those with ADHD have a lower level of neural activity in the portions of the brain that affect impulse control and attention; specifically, a deficiency not just in dopamine, as mentioned above, but also in norepinephrine, adrenalin (Johnson & Kercher, 2007). Of the aforementioned neurotransmitters, it would appear that serotonin may play a significant role in the possible etiology of ADHD. When there is a reduction in serotonin levels, a person can become more impulsive and aggressive and these two behaviours are often characteristic of individuals with ADHD. Therefore, since low serotonin levels have been reported in patients with ADHD, it is not unreasonable to assume that reduced serotonin levels may contribute to the development of ADHD.
(Sheehan, Lowe, Kirley, Mullins, Fitzgerald, Gill & Hawi, 2005). The etiology of ADHD is certainly not confirmed—only hypothesized—and it may be that ADHD is inherited. Some twin studies are demonstrating that heritability, genes, are estimated to range in the 60-90th percentile (Thaper, Bree, Fowler, Langley & Whittingter, 2006). Heritability is commonly defined as the proportion of variance which is attributable to genotype within a specified population in a certain environment (Rose, 2006). It takes a value that ranges from 0 to 1, with 1 indicating that all variation in the trait is genetic and 0 indicating that none of the variation is genetic (Rose, 2006). Nonetheless, the etiology of ADHD still remains relatively unknown (Savolainen, Hurtig, Ebeling, Moilanen, Hughes & Taanila, 2010) but as more information about the brain becomes increasingly available to scientists, it is hoped that practitioners in this field will have more answers.

ADHD AND COMORBIDITY

Co-morbidity, the concurrent diagnosis of two or more mental disorders within the same individual, takes place with an abundance of frequency in child and adolescent—as well as adult—populations (Newman, Moffitt, Caspi & Silva, 1998). Co-morbidity is crucial to identify because it has been generally associated with an elevated risk of negative outcomes such as poor treatment response, severe physical illness and high service utilization (Hall, Lynskey & Tesson, 2000). It is assumed that, when a youth or adult has a history of two or more diagnoses, the individual is expected to be worse off psychologically at intake than someone receiving only one diagnosis or no diagnosis at all (Langhinrichsen-Rohling, Rebholz, O’Brien, O’farrill-Swails & Ford, 2005). ADHD, ODD (Oppositional Defiant Disorder) and CD (Conduct Disorder) are categorized as disruptive behaviour disorders under the DSM-IV TR (2000). Langhinrichsen-Rohling et al., (2005), conducted a longitudinal study (data collected over a three-year period) on 159 male youth offenders to see if those with self-reported comorbidity would be correlated with greater reports of psychological symptoms on intake, more negative self-concepts, more external locus of control and increased feelings of hopelessness. The research results demonstrated that, of the 27 young offenders who reported at least two mental health disorders (placing 18.48% of the adolescents in the co-morbid group), co-morbidity was significantly related to an increased level of psychological
symptoms. Furthermore, another substantial longitudinal study, which examined 995 New Zealand-born individuals until the age of 25, found that CD, ODD and ADHD each had a distinctive pattern of associations with longer term consequences; meaning, the findings demonstrated that, although CD and ODD were associated with increased risks of crime, substance use, mental health problems and adverse parenthood and partnership outcomes, ADHD was not associated with these outcomes when comorbidity and confounding variables were accounted for; there was also no evidence to suggest that the developmental consequences of CD, ODD and ADHD differed by gender (Fergusson, Boden & Horwood, 2010).

**Conduct Disorder and Oppositional Defiant Disorder**

It has been found that individuals with ADHD often have additional comorbid disorders, especially conduct disorder (CD) and substance use disorder (SUD), which can increase the risk of trouble with the law (Fast & Conry, 2009) as well as oppositional defiant disorder (ODD) (Eme, 2008). The *DSM-IV TR* categorizes conduct disorder behaviours into four main groupings: (a) aggressive conduct that causes or threatens physical harm to other people or animals, (b) non-aggressive conduct that causes property loss or damage, (c) deceitfulness or theft, and (d) serious violations of rules; CD consists of a repetitive and persistent pattern of behaviours in which the basic rights of others or major age-appropriate norms or rules of society are violated (2004). SUD (substance abuse) is characterized a maladaptive pattern of substance use leading to clinically significant impairment or distress (*DSM-IV TR*, 2004). According to the *DSM-IV TR*, ODD is characterized as an ongoing pattern of disobedient, hostile and defiant behaviour toward authority figures which goes beyond the bounds of normal childhood behaviour (excessive, often persistent anger, frequent temper tantrums or angry outbursts, and disregard for authority) (2004).

ADHD adolescents with comorbid conduct disorder seem to be even at a higher risk for crime, incarceration and possible recidivism (Whalen, Jamner, Henker, Delfino & Lozano, 2002). Apparently, the combined type of ADHD is a very common comorbid condition of CD with estimates of approximately ranging anywhere from 20% to 50% for youth of both sexes (Chronis, Pelham, Lahey, Williams, Bauman & Kipp, 2007). In a study conducted by Vitelli (1996), when the prevalence of childhood CD and ADHD was studied in a
sample of 100 maximum-security inmates, it was observed that there was significant comorbidity between childhood CD and ADHD. Chronis et al., (2007), theorized that CD develops approximately 25% of the time in youth who have ADHD and ODD. Such an occurrence takes place owing to the highly challenging home environment the comorbid behaviour brings with it, which then translates into negative and maladaptive parenting (parents cannot handle an ADHD and ODD child), hence the onset of CD. Also, the risk for developing CD is further exacerbated when young children with ADHD and ODD are reared in dysfunctional families and neighborhoods (Chronis et al., 2007). Furthermore, ADHD is a potential risk factor for the development of ODD, since the symptoms of impulsivity, low frustration tolerance, anger outbursts, emotional liability and academic failure increase the likelihood of the development of ODD; therefore, helps explain a comorbidity rate of at least 55% (Barkley, 2006). Thus, there seems to be a developmental pathway from ADHD to ODD and from ADHD/ODD to CD (Nigg & Breslau, 2007).

**Substance Use Disorder**

Studies have demonstrated that the disorders which have been shown to co-occur with substance use disorders in delinquent adolescents are: anxiety disorders, mood disorders, conduct disorders, antisocial personality disorders and ADHD (Langhinrichsen-Rohling, Rebholz, O’Brien, O’farrill-Swails & Ford, 2005; Young & Gudjonsson, 2006). A study by Young and Gudjonsson (2006) discovered that symptoms of anxiety and depression were the most prominent for the ADHD group as was substance misuse. ADHD offenders are very frequently linked to comorbid substance abuse and this is often examined in literature. The link between substance use (drugs and alcohol) and ADHD has not always been consistent in cross-study findings (Barkley, Fischer, Edelbrock & Smallish, 1990; Fergusson & Horwood, 1995) but according to Whalen et al., (2002), interview and questionnaire studies suggest that young people with ADHD are at an elevated risk for substance abuse. These researchers conducted a longitudinal study on 153 adolescents who had low, middle or high levels of ADHD and substance use was consistent across all three types of ADHD youth (Whalen et al., 2002).

There are two major theories that have been proposed to explain why ADHD increases the risk for licit and illicit substance use and the development of substance abuse in youth and adults (Marshal & Molina, 2006). The first theory
revolves around ADHD increasing the likelihood of developing ODD and CD, which in turn increases the chance for using substances (Marshal & Molina, 2006). Once a youth with comorbid disorders begins engaging in substance use and possibly abuse, Marshal & Molina (2006) articulate how school failure and deviant peer association further exacerbates substance use. The second theory postulates that the initial substance use by ADHD youth, which may be primarily due to curiosity/experimentation, psychological distress and peer acceptance, over time leads to habitual substance abuse (Marshal & Molina, 2006). Nonetheless, Marshal & Molina (2006), point out that it remains unclear which components of ADHD (inattention, hyperactivity-impulsivity or both) put children at the highest risk for deviant/criminal peer association or whether children with comorbid antisocial behaviours such as ODD and CD are at a higher risk for peer-mediated substance use than children without ODD and CD. Marshal & Molina’s 2006 study (142 ADHD children) on the aforementioned query found that the strength of the relation between deviant peer affiliation and substance use was consistently stronger for adolescents with high levels of ODD in childhood than it was for adolescents with low levels of ODD in childhood; likewise, adolescent CD symptoms moderated the relation between deviant peer affiliation and heavy alcohol use, alcohol problems and marijuana problems. Their study findings which showed that the deviant peer pathway was strongest among youth with ODD or CD provides more evidence to suggest that the long-term outcomes of children with ADHD and comorbid antisocial behaviours are less favourable than they are for children with ADHD only, specifically with respect to future deviant peer and substance use/abuse outcomes (Marshal & Molina, 2006). Understanding the extent to which symptoms of CD, ODD, ADHD and substance abuse predict future developmental outcomes, such as crime, still needs to be examined in depth, especially because there may be many confounding (intervening) variables that could be responsible for comorbid individuals’ association to crime (Moffitt, Arseneault, Jaffee, Kim-Cohen, Koenen, Odgers, Slutske & Viding, 2008). It is important to examine why children with ADHD are at risk for adverse life outcomes such as criminality (Chronis et al., 2007), and further explore the reality of how ADHD is treated in the criminal justice system in terms of prevalence, types of crimes and the impairment’s effect on criminal sentencing dispositions.
INTEGRATION OF VARIOUS THEORETICAL PERSPECTIVES FOR ANTISOCIAL BEHAVIOUR

Life-Course Criminology, General Strain Theory, General Theory of Crime and ADHD

A substantial connection has been established between attention-deficit hyperactivity disorder (ADHD) and criminal behaviour. That being said, at this time, little is known about the actual mechanisms that account for the relationship between ADHD and criminal behaviour. It could be that the link between ADHD and crime is spurious, given that this disorder is often associated with other emerging risk factors such as conduct disorder or family problems (Hurtig, Taanila, Ebeling, Miettunen & Moilanen, 2005). Yet, it could also be the case that the connection between ADHD on deviant/criminal behaviour is moderated by additional risk factors or the effect of ADHD on antisocial behaviour may be mediated by sociological processes (from the environment) and related to negative outcomes such as school failure, relationship breakdown and job loss (Moffitt, 1990; Thaper et al., 2006).

It is relevant to delve further into how ADHD, antisocial behaviour and environmental process factors are connected, by paying attention to various theoretical perspectives such as general strain theory and life-course developmental theory. Two key life-course theories (Terrie Moffitt’s dual taxonomy theory and Sampson and Laub’s age-graded theory of informal social control) have been discussed substantially in research as possibly being able to lend insight into the etiology of how ADHD is linked to crime. Thus, it is relevant to examine the key components of these two major life-course frameworks, as well as other theoretical perspectives, in order to demonstrate the association between ADHD and crime. Consistent with Moffitt and Sampson and Laub’s theories, researchers are finding the effect of ADHD on crime to be substantial (Savoilainen, Hurtig, Ebeling, Moilanen, Hughes & Taanila, 2010). Savoilainen et al., (2010) conducted their research from a 1986 Northern Finland Birth Cohort Study (NFBCS) to ascertain whether ADHD influences criminal behaviour independently of other early childhood risk factors. The researchers concluded that when examining the interactive effects between ADHD and other risk factor variables such as sex, family adversity, conduct problems and verbal adversity, ADHD and reading was the only statistically significant effect; consistent with Moffitt’s theory and research, low
verbal ability and high ADHD score emerged as a very strong predictor of criminal behaviour in the data (Savolainen et al., 2010).

**Dual Taxonomy Theory and ADHD**

Terrie Moffitt’s dual taxonomy theory (1993) is predicated on taxonomic predictions regarding developmental course, childhood origins and adult consequences (Odgers, Moffitt, Broadbent, Dickson, Hancox, Harrington, Poulton, Sears, Thomson & Caspi, 2008). The developmental taxonomy theory has fine-tuned an understanding of the importance of childhood-onset behavioural problems by testing expectations regarding the unique developmental course, childhood origins and adult prognosis for adolescents on the adolescence-limited (AL) versus life-course persistent (LCP) pathways (Odgers et al., 2008). Moffitt’s developmental taxonomy assumes that there are two types of delinquents: adolescence-limited (AL) and life-course persistent (LCP) offenders. AL offenders encompass the majority of young offenders—nearly 90% of offenders are of this type (Delisi, 2005). Adolescent-limited offenders engage in delinquency for a brief period during their teen years and Moffitt posits that recognition of their emerging adult status is the primary motivation for delinquent behaviour, so they partake in benign, low-level offences such as substance use, theft under $5000 and vandalism. Generally, such adolescents are mental-disorder-free (not manifesting pathological behaviour) and have average or above-average intelligence, appropriate social skills and begin committing crime in their early youth (Moffitt, 1993). Life-course persistent offenders, on the other hand, have received a lot more empirical attention because they are regarded as very threatening to society (Delisi, 2005). The LCP group is the least common; this group is characterized by neuropsychological deficits, verbal and executive functioning problems, which then give rise to an assortment of antisocial problems (Moffitt, 1993). Unlike the AL offender, the LCP offender begins to show antisocial behaviour from a very young age, may have an assortment of mental disorders, typically has below-average intelligence and poor social skills (Moffitt, 1993). Apparently, LCP youth, due to the various neuropsychological deficits, are often very restless, fidgety, destructive and non-compliant and employ violent outbursts in lieu of conversation; therefore, Delisi (2005) postulates that such a profile definitively matches the behavioural repertoire of persons with ADHD.
Since Moffitt’s development of the dual taxonomy theory, an ample amount of research has gone into testing the empirical validity of Moffitt’s postulations by researching the AL and LCP life trajectories in various ways. For example, one key study by Odgers, et al., (2008), examined whether comparable developmental pathways of antisocial behaviour exist among females, not just males, and their results confirmed the existence of both an AL and LCP antisocial pathway among females. When Lynam, Moffitt and Stouthamer-Loeber (1993) analyzed the link between IQ and school performance, their longitudinal Pittsburgh Youth Study (sample size 249) demonstrated that there was indeed an indirect-effect formulation that held that IQ exerted an effect on delinquency through school performance (Lynam, Moffitt & Stouthamer-Loeber, 1993). When Moffitt, Lynam and Silva (1994), looked further at neuropsychological tests (tests to cover functions such as memory, motor skills and mental self-control) in predicting persistent male delinquency, their longitudinal study on a New Zealand birth cohort of several hundred New Zealand males between the ages of 13 to 18 years of age revealed that neuropsychological dysfunction predicted later delinquency and that poor neuropsychological scores were associated with early onset of delinquency. Neuropsychological theory goes beyond simply looking at IQ in trying to predict delinquency and asserts that people with identical IQ scores can have very different patterns of mental strengths and weaknesses (Moffitt, Lynman and Silva, 1994). The neuropsychological tests conducted on the New Zealand cohort showed that poor verbal, visual-spatial and memory functions contributed to the prediction of delinquency for both boys and girls. It is therefore very conceivable that if a youth has ADHD, an executive function impairment, whether the person suffers predominantly from inattention, hyperactivity or impulsivity, they may not achieve high scholastic achievement, which could then be linked to trouble with the law. Since ADHD children will most likely have difficulty performing well in school due to their symptomatology, it makes sense that they will also have neuropsychological deficits such as poor verbal skills, visual-spatial and memory functions. Such children or youth will have a difficult time learning these skills and tasks because of their attention deficit hyperactivity disorder.
Age-graded Theory of Informal Social Control and ADHD

Sampson and Laub (2005) present a life-course theory that conceives as the persistent interaction between individuals and their environment, together with purposeful human agency and random processes. Human agency is a key principle of life-course theory and the principle states that, “individuals construct their own life course through the choices and actions they take within the opportunities and constraints of history and social circumstances (Elder, 1985:4)”. These theorists pose an age-graded theory of informal social control in which social bonding in the form of strong ties to occupation (whether it is school or work) and family plays a vital role in the desistance from crime for previously criminal youths (Laub, Nagin & Sampson, 1998). Their theory of desistance from crime or the persistence of crime is based on the occurrence of ‘turning points’, which are triggering events, chance events. For example, Laub, Nagin and Sampson (1998) emphasize that people who desist from crime are significantly more likely to have entered into stable marriages and steady employment and such occurrences in their lives are ‘turning points’. Sampson and Laub analyzed the criminal histories of 500 delinquent boys who were followed into adulthood (data collection took place over 25 years from 1940 through 1965 and after an initial interview at age 14, subjects were followed up at ages 25 and 32) by Glueck and Glueck (1950, 1968), as well as the Glueck’s control group of 500 non-delinquent boys (Laub, Nagin & Sampson, 1998). Sampson and Laub found that crime was more likely to occur when an individual’s bond to society was attenuated. Meaning, their age-graded theory emphasized that informal social controls across a person’s life were extremely influential at certain ages by having the potential of being completely transformative; specifically, parenting styles (supervision, warmth, consistent discipline), emotional attachment to parents in childhood; school attachment and peers in adolescence; marital stability, military service, & employment in adulthood. Change of life course (jobs, marriage, new friends) could lead to increased “social capital” and overcome the “closed door” effect of delinquency (Laub, Nagin & Sampson, 1998). If youth, for example, had weak attachment to parents, school and peers, they were more likely to commit crime and persist in such behaviour. Thus, an individual with ADHD may have poor attachments with parents, school and peers because of the impact their ADHD may have on others and also how the disability directly affects the ADHD person in terms of how they relate to family, friends and teachers as well as their performance in school. Sampson and Laub discuss how children with a difficult temperament
(such as ADHD) will most likely lead to poor bonding to parents and school, which in turn could lead to problems with relationships (marriage) and employment; thereby, leading to continued offending until, due to the natural aging process, a person would gradually desist from crime (Sampson, Nagin & Laub, 1998).

**Strain Theory and ADHD**

Studies have been conducted to examine the impact of strain, not only on criminal behaviour, but also to study the role ADHD plays within the framework of General Strain Theory (GST). Robert Agnew’s 1992 GST has received ample empirical support for its explanation of delinquency and crime; such a social-psychological theory not only provides environmental explanations for criminal behaviour but also accounts for the allowance of individual differences that may assist in explaining why people in similar situations act differently (Johnson & Kercher, 2007). Agnew’s theory is that strain can come in three different types, which can push people into criminality: the failure to achieve positively valued goals; the loss of positively valued stimuli; and the presentation of negatively valued stimuli (Agnew, 2002). Agnew acknowledges the fact that people react differently to any one of the three types of strain and some of this may have to do with embedded coping skills as well as people’s unique emotional response, such as anger (Agnew, 1992). In Agnew’s original formulation of the general strain theory (GST), the essential focus of it was on the negative relationships with others, which may result in strains that will increase the likelihood that people will experience a range of negative emotions and such emotions: these may sources of strain create pressure for corrective action, such as crime. Agnew then went further in a later study to postulate and observe that low levels of constraint did condition the effect of strain on delinquency (Agnew, Brezina, Wright & Cullen, 2002) but no actual direct connection with ADHD was made. Regardless, the important finding that came out of Agnew’s study was that a connection was made between the key personality traits of negative emotionality and low constraint in terms of how such traits condition the effect of strain on crime. Agnew postulated that it was important to include personality traits in research, since such traits might lend support for the conditioning effects that are hypothesized in GST; specifically, high negative emotionality and low levels of constraint combined to increase delinquency (Agnew, Brezina, Wright
Even though Agnew did not state it directly in his research, the concept of low constraint can be considered an aspect of ADHD, since it encompasses several of the same behaviours associated with the impulsivity components of ADHD (Johnson & Kercher, 2007).

Personality traits may have a fundamental effect on the experience of—and reaction to—strain and Agnew et al., (2002) study demonstrated this by examining low constraint and criminality (Agnew, Breznia, Wright & Cullen, 2002). Johnson and Kercher (2007), wanted to expand on the general strain theory (GST) and incorporate ADHD directly; therefore, they conducted a study to test the hypothesis that ADHD is positively associated with criminal behaviour and conditions the effect of strain. Their findings revealed that, as predicted, strain and ADHD were significant in the model at p < .001, along with gender (males reporting more criminal behaviour); therefore, providing support for the hypothesis that ADHD conditions the effect of strain on crime. More detailed analysis into the aforementioned findings revealed that when comparing persons with high and low symptoms of ADHD in the study, people with high scores are more likely to react in a criminal way, given similar levels of strain, as opposed to individuals with low scores (Johnson & Kercher, 2007).

**General Theory of Crime and ADHD**

Since Agnew postulated low self-control as being a potential factor that facilitates delinquent coping to general strain, Gottfredson and Hirschi’s general theory of crime also emphasized the concept of low self-control as a salient criminological concern (Pratt, Cullen, Blevins, Daigle & Unnever, 2002). These theorists attribute low self-control to ineffective parenting (Gottfredson & Hirschi, 1990). Still, even in Gottfredson and Hirschi’s statement of the general theory of crime (1990), there was a failure to consider ADHD as a possible source of low self-control; therefore, subsequent research was conducted by other theorists who examined the potential linkages between ADHD and the general theory of crime; specifically whether ADHD may be an independent source of low self-control. Unnever, Cullen and Pratt (2003), conducted a study by using a sample of 2,472 students, to see the impact of ADHD on self-control and delinquency. Their study revealed that a low level of self-control was a strong predictor of both self-reported delinquency and self-reported arrests, while parental monitoring increased self-control and had direct effects on both measures of delinquency: however, most importantly, the
effects of ADHD on delinquency were largely through a low level of self-control (Unnever, Cullen & Pratt, 2003).

**ADHD and Risk for Crime and Recidivism**

My son was formally diagnosed as ADHD when he was 5 years old. The psychiatrist told me he was one of the most severe cases he had seen. He is now 27 and incarcerated, serving out probation violations that started with minor traffic fines. But more seriously, he was recently indicted and is facing trial for statutory rape of a 16 year old…like so many others with ADHD, HE DOESN’T THINK THINGS THROUGH (Mother’s letter to Hurley & Eme, 2008:23).

The association between ADHD and criminal behaviour is becoming increasingly evident (Young, Chesney, Sperlinger, Misch and Collins, 2009). Since it has been established that ADHD, which is the result of deficits in executive functioning, increases the risk for developing conduct disorder, oppositional defiant disorder and substance use disorder, the comorbidity of any two or more of those disorders can often result in school and employment failure, thereby increasing the likelihood of criminal activity (Eme, 2008).

Attention deficit hyperactivity disorder has been found to be as high as 70% for youth in trouble with the law (Fast & Conry, 2009). A 20-year follow-up study was done on childhood hyperactivity for 75 advanced juvenile delinquents. These children were treated in a Swedish unit in 1975-76. The results demonstrated that from all of the subjects who had conduct disorder and 68% who had ADHD during pre-school and/or school years, between the ages of six and 30, the 75 delinquents were sentenced for a total of 12,000 crimes (approximately 1,000 crimes per person when corrected for the dark figure ratio) (Dalteg & Levander, 1998). Dalteg and Levander (1998) observed that in comparison to non-hyperactive youth who were observed, the hyperactives had more pronounced school problems, a higher level of criminality present from the beginning, which became more pronounced in later years and overall a worse social outcome. A very salient finding from the aforementioned study is that hyperactivity appeared to be related to crime volume rather than type of crime and hyperactivity was not related to crimes of violence (Dalteg & Levander, 1998). The study certainly demonstrated that hyperactivity was a major negative factor for long-term outcome of the delinquents who were under study, rather than social background, since the non-hyperactive controls
also came from unfavourable social backgrounds; therefore, the treatment of hyperactivity is critical to possibly circumvent criminal behaviour.

Similar to the Dalteg and Levander’s 1998 study, a study by Babinski, Hartsough and Lambert (1999), found that the symptoms of hyperactivity-impulsivity, rather than inattention, contribute to the risk for criminal involvement over and above the risk associated with early conduct problems alone. Their study consisted of 230 male and 75 female ADHD subjects, who were followed prospectively from childhood to adulthood (average age 26 at follow-up). Hyperactivity-impulsivity and early conduct problems, separately or jointly, were significant predictors of having an arrest record and a high level of self-reported crime for males, but not for females (Babinski, Hartsough & Lambert, 1999). Furthermore, subjects with hyperactivity-impulsivity alone appear to be at a higher risk for less serious crimes such as public disorder and property crimes, rather than serious crimes such as robbery and assault, owing to their impulsivity and inability to delay gratification (Babinski, Hartsough & Lambert, 1999).

Young and Gudjonsson (2006), compared three groups (an ADHD group of 83 adult patients, 60 male & 23 female; clinical control group assessed for ADHD but not meeting ADHD or exclusion criteria; normal control group) and found that there was a significant effect between the ADHD group and antisocial behaviour. The ADHD group reported significantly more antisocial behaviour in the past year than the other groups and such antisocial behaviour consisted of: delinquency relating to aggressive behaviours, damage or theft of property, police contact and substance misuse (Young & Gudjonsson, 2006). Also, in another study that looked at ADHD and criminal involvement, it was observed that respondents who had ADHD were more likely to report that they had committed delinquent acts; ADHD is regarded as a precursor to poor self-control because of its likely genetic/biological origins (Unnever, Cullen & Pratt, 2003).

The three neuropsychological deficits in ADHD that are most relevant for understanding the criminal offender since they account for most of the ADHD symptoms, which increase the risk for criminal behaviour, are: behavioural inhibition, attention and reward (Hurley & Eme, 2008). It is not too surprising that ADHD would predispose many individuals to commit delinquent or criminal acts, considering individuals with ADHD are high-stimulation seekers and do not see the risk for its own sake but are looking for
novel and intense experiences (Eme, 2008; Eme, 2009). Moreover, individuals with ADHD tend to be highly impatient and gravitate toward experiencing immediate reinforcement, which contributes to their carrying out impulsive acts. Such factors, joined with comorbidity of ODD and CD, which contributes to school failure and ultimately increases the risk for substance abuse disorders, may then transcend into the formation of increased antisocial tendencies and self-medication (Eme, 2008; Eme, 2009), which may fuel the involvement in crime.

**ADHD and the Criminal Justice System Involvement**

The prevalence of ADHD in the juvenile justice system is at least 3-4 times the approximate seven percent rate observed in the general population (Nigg, 2006). In general, it is conservatively estimated that the prevalence rate for male and female adolescents and adults in the correctional system is at least 25% and most likely definitely higher (Eme, 2009; Eme, 2009; Hurley & Eme, 2008); therefore, it is of sufficient magnitude to warrant attention. It may be underestimated because comprehensive psychological assessments for adjudicated offenders with a variety of mental health difficulties are not always routine, especially in the juvenile justice system, because of cost-restrictions and staff limitations (Langhinrichsen-Rohling, Rebholz, O’Brien, O’farrill-Swails & Ford, 2005). Furthermore, sometimes individuals who are already afflicted with an organic brain impairment (ADHD) often suffer additional head injury from trauma, such as a motor vehicle accident, which makes it challenging for the appointed criminal justice system mental health professionals to decipher the effects of brain injury that are caused by the pre-existing ADHD or from the environmental head trauma event (Fast & Conry, 2009).

There has been an increased recognition of risks for the defendant inflicted with psychological vulnerabilities. Moreover, there are persistent consequences associated with the failure to identify and diagnose ADHD before or during the time an accused has been charged with a crime, and such ramifications are significant. The criminal justice system appears to neglect ADHD as a disability and often overlooks this immense vulnerability (Gudjonsson & Young, 2006). The accused is, therefore, severely disadvantaged throughout various stages of the criminal justice process, from the time they are interviewed as a suspect by the police, to being on the witness stand as
well as when being sentenced by a judge. Such a major oversight is detrimental to the rehabilitation and overall well-being of the offender because ADHD does not simply vanish once a person has been arrested; in fact, the symptoms of ADHD are often exacerbated, owing to the stress of going through the criminal justice system (Hurley & Eme, 2008).

A pivotal case in the United Kingdom (R. v. Billy-Joe Friend [1997], Cr. App. R. 231) illustrates how the failure to identify and diagnose ADHD pretrial resulted in a wrongful conviction of a 15-year-old youth for murder (Gudjonsson & Young, 2006). Billy Joe Friend was convicted of murder but Professor Gudjonsson testified during the voire dire that he was very concerned about whether the witness could do justice to himself in the witness box, considering he had poor intellectual functioning, attentional problems and distractibility (Gudjonsson & Young, 2006). In 1997, the original trial judge’s decision was appealed and the English Court of Appeal delivered a detailed judgment regarding the weight of the psychological evidence. In 2003, when the Criminal Case Review Commission referred the case to the Court of Appeal because a forensic psychiatrist concluded that Billy Joe Friend’s learning disability, inattentiveness and emotional state at the time of the trial would have significantly impaired his capacity to participate effectively in the trial (Gudjonsson & Young, 2006). In 2004, the Billy-Joe Friend case was resolved, and specific mention of ADHD was made. Dr. Susan Young, an ADHD expert, wrote a report, which the judge in the final appeal court judgment cited and stated that Billy-Joe Friend suffered from ADHD and Dr. Young believed that, for that reason, he was unlikely to have effectively participated in the trial proceeding, since he had all of the symptoms associated with ADHD that Professor Gudjonsoon emphasized (Gudjonsson & Young, 2006). Ultimately, this case demonstrates the importance of identifying and properly diagnosing ADHD. Knowledge about ADHD among criminal justice professionals could mean all the difference for the accused, at various stages of the process. By learning the common symptoms and behaviours of ADHD defendants, criminal justice professionals can better identify defendants who might have ADHD and refer them to diagnosing professionals. The diagnostic professionals need to be qualified experts in conducting comprehensive ADHD evaluations, as not every mental health professional is qualified in this area (Hurley & Eme, 2008). For judges specifically, having knowledge that an offender has ADHD could result in the proper follow-up treatment as part of
the sentencing decision. Treatment for ADHD takes place either medically, psychosocially, and/or through coaching and such methods can be combined and tailored to meet the needs of the person afflicted with ADHD; when such treatment measures are properly executed, they have proven to be highly successful for those in the correctional system (Hurley & Eme, 2008).

**SUMMARY**
ADHD, like FASD, is a challenge for the courts, in terms of how to sentence such persons. Literature is lacking in the examination of how the courts are dealing with ADHD offenders in the final sentencing judgments. A considerable amount of literature has been focused on the comorbidity of disorders that exist for those who are afflicted with ADHD. Specifically, findings reveal that ADHD increases the risk for developing disorders such as Conduct Disorder, Oppositional Defiant Disorder and Substance Use Disorder. The research also lends support to the finding that a comorbidity of any two or more of those disorders can often result in secondary disabilities such as school and employment failure, thereby increasing the likelihood of criminal activity. Since ADHD is a serious cognitive impairment, as is FASD, there has been debate about whether ADHD might offer a justifiable defence for a wide range of different crimes but to-date, the courts have not been particularly receptive to this contention. It is important to analyze how Canadian courts deal with offenders who are identified as having ADHD, both youths and adults, and to evaluate how such a diagnosis impacts judicial decision-making in terms of the final disposition.
Many of the problems that face the criminal justice system can be attributed to perceived disparities in sentencing. There are so many factors governing judicial discretion that it is not surprising that the perception of disparity frequently arises among observers of the courts (Andrews, Robblee, Saunders, Huartson & Robinson, 1987). Judicial decision-making is informed by statutory provisions, case precedents, convention/common law and the opinion of legal professionals in the field. Judicial sentencing is an onerous, complex and significant task, especially when the judge is determining the fate of a cognitively impaired offender. In R. v. Gardiner (1982), the court noted that, when a defendant pleads guilty, the judge has tremendous scope in terms of the types of evidence upon which to base the sentencing decision. Typically, the judge wants to obtain the complete picture of the offender’s background so that the judge can make sure the sentence fits the offender, not just the crime (R. v. Gardiner, 1982). “One of the hardest tasks confronting a trial judge is sentencing. The stakes are high for society and for the individual. Sentencing is the critical stage of the criminal justice system,... (R. v. Gardiner, 1982; paragraph 2 F).” In sentencing, rules versus discretion, reason versus emotion, rational deduction versus intuition, consistency versus individualization, offence versus offender factors, decision-making versus its rhetorical expression and aggravating versus mitigating circumstances are all factors that judges must grapple with when making a decision about an offender (Tata, 2007). Often the aggravating and mitigating factors in a case are rooted in the general concerns for retribution, general deterrence, specific deterrence, rehabilitation and reform (Andrews, Robblee, Saunders, Huartson & Robinson, 1987). According to Tata (2007), much judicial work is boring to judges because the criminal process normalizes and standardizes individual circumstances and thus renders the unfamiliar familiar and repetitious; therefore, most cases
before the court are regarded as usual, mundane, ordinary, common place and even dull. However, Tata’s (2007) aforementioned reflection, may not be representative of how all judges perceive the cases that they preside over. Considering sentencing has such a tremendous impact on the life of the offender and members in society at large, judges need to treat every ‘ordinary’ case as ‘extraordinary’, in terms of the attention they pay to it when determining the appropriate disposition; boredom in sentencing should not exist.

Provincial and Superior court judges are given the pivotal task of handing down sentencing dispositions, to youth under the specially designated Youth Criminal Justice Act (YCJA) and adults, under the standard Canadian Criminal Justice System (CJS), and such decisions not only have a very specific immediate outcome for the offender but also have significant far-reaching short-term and long-term ramifications for the individual as well as the community. When judges are faced with an offender who has a cognitive impairment, such as FASD and/or ADHD, the responsibility of handing down the appropriate sentence becomes challenging and complex. The judge must consider the sentencing principles that are stipulated in the Criminal Code or the YCJA but presumably the judge must also grapple with the role that the offender’s disorder played in the commission of the crime itself, and the treatment possibilities available to him/her due to the impairment. As time passes, there appear to be evolving ideas about the nature and causes of mental disorders, which may require changes in people’s views of blameworthiness (Victoroff, 2009). Certain cognitive deficits, such as FASD, present a fundamental challenge to the standard assumptions of the Canadian criminal justice system, which is that, “people act in a voluntary manner that is determined by free will and that they can make informed and voluntary choices both with respect to the exercise of their rights and the decision to commit crimes (Roach & Bailey, 2009: 3)”. However, certain individuals have mental disorders that should possibly exempt them from criminal responsibility but there is much uncertainty surrounding the requisite degree of severity that should be necessary to absolve them of culpability. For example, with FASD as a cognitive impairment, the growing jurisprudence on FASD has been developed almost entirely by judges and overall it is not uniform in its treatment of FASD, specifically with respect to sentencing (Roach & Baily, 2009). In fact, even though, at times, the recognition of FASD by the court works to the advantage of the offender, there are times when, rather than FASD
being a mitigating factor (which it certainly is sometimes), it has also been used as an aggravating factor owing to concerns about future danger and the need for incapacitation or long-term and intense supervision; appellate courts to-date have not weighed in yet on how the criminal law needs to handle FASD (Roach & Bailey, 2009). It is pertinent to examine the major principles that guide judges in making their determination of the final sentencing disposition for adults in the adult criminal justice system as well as for youth in the youth justice system: throughout such an examination, it is also very relevant to discuss the issues surrounding cognitive impairments in judicial sentencing for disorders, such as FASD/ADHD.

**ADULT CRIMINAL JUSTICE SYSTEM**

Purpose and Principles of Sentencing

Section 718 of the Canadian *Criminal Code* is absolutely pivotal in guiding judges when handing down a final disposition to an offender. The section stipulates that the fundamental purpose of sentencing is, “to denounce unlawful conduct, to deter the offender and other persons from committing offences, to assist in rehabilitating the offender and to protect society”, the judge must also consider the gravity of the offence and the degree of responsibility of the offender (Fast & Conry, 2004).

Sections 718, 718.1, and 718.2 articulate the basic principles that guide judges in making appropriate sentencing decisions:

**718.** The fundamental purpose of sentencing is to contribute, along with crime prevention initiatives, to respect for the law and the maintenance of a just, peaceful and safe society by imposing just sanctions that have one or more of the following objectives:

(a) to denounce unlawful conduct;
(b) to deter the offender and other persons from committing offences;
(c) to separate offenders from society, where necessary;
(d) to assist in rehabilitating offenders;
(e) to provide reparations for harm done to victims or to the community; and
(f) to promote a sense of responsibility in offenders, and acknowledgment of the harm done to victims and to the community.

**718.1** A sentence must be proportionate to the gravity of the offence and the degree of responsibility of the offender.
718.2 A court that imposes a sentence shall also take into consideration the following principles:
(a) a sentence should be increased or reduced to account for any relevant aggravating or mitigating circumstances relating to the offence or the offender, and, without limiting the generality of the foregoing,
(i) evidence that the offence was motivated by bias, prejudice or hate based on race, national or ethnic origin, language, colour, religion, sex, age, mental or physical disability, sexual orientation, or any other similar factor,
(ii) evidence that the offender, in committing the offence, abused the offender’s spouse or common-law partner,
(ii.1) evidence that the offender, in committing the offence, abused a person under the age of eighteen years,
(iii) evidence that the offender, in committing the offence, abused a position of trust or authority in relation to the victim,
(iv) evidence that the offence was committed for the benefit of, at the direction of or in association with a criminal organization, or
(v) evidence that the offence was a terrorism offence shall be deemed to be aggravating circumstances;
(b) a sentence should be similar to sentences imposed on similar offenders for similar offences committed in similar circumstances;
(c) where consecutive sentences are imposed, the combined sentence should not be unduly long or harsh;
(d) an offender should not be deprived of liberty, if less restrictive sanctions may be appropriate in the circumstances; and
(e) all available sanctions other than imprisonment that are reasonable in the circumstances should be considered for all offenders, with particular attention to the circumstances of aboriginal offenders.

In 1996, significant changes were made to the Criminal Code; specifically, the sentencing provision that was significantly amended was s. 718(2)(e). Such a section instructs judges to find alternatives to imprisonment that are reasonable in the circumstances for all offenders, “with particular attention to the circumstances of Aboriginal offenders” (Criminal Code, s. 718(2)(e)). The Gladue (1999) decision was pivotal in the interpretation of s. 718(2)(e), in which it was determined that this section “is a direction to judges to go about the process of sentencing Aboriginal offenders differently, albeit not altering the fundamental duty to impose a sentence that is appropriate to both the offence and the offender”, and “section 718.2(e) is intended to ameliorate the problem of the over-incarceration of offenders in Canada generally, and to ameliorate the more acute problem of the disproportionate incarceration of Aboriginal peoples in particular” (R. v. Gladue, 1999).
Following *Gladue*, in 2001, the federal government of Canada promised to eliminate Aboriginal overrepresentation in the criminal justice system within a generation (Rudin, N/D). Unfortunately, despite this pledge from the government to eliminate Aboriginal overrepresentation, Aboriginal overrepresentation in the Canadian criminal justice system remains extremely high. For example, Aboriginal adults comprise four percent of the Canadian population, yet represent 24% of adult admissions to provincial or territorial custody, 19% of admissions to remand and 18% of admissions to sentenced custody (Landry & Sinha, 2008). Aboriginal youth, which comprise six percent of Canada’s population, reflected 31% of admissions to sentenced custody, 23% of admissions to remand and 22% of admissions to probation (Milligan, 2008). It could be the case that judges are simply not receiving enough fundamental information about a particular Aboriginal offender that they would normally require in order to apply *Gladue* in a meaningful manner.

**COGNITIVE IMPAIRMENTS AND PRINCIPLES OF SENTENCING**

Despite the seemingly rigid stipulations (very specific sentencing principles as mentioned above), there are many mitigating circumstances and certainly ample room for interpretation of the sentencing principles articulated in s. 718 of the *Criminal Code*. Clearly cognitive abilities and reasoning abilities are major considerations in culpability; therefore, they are also major factors in the principles of sentencing. Many judges recognize that the sentencing principles under section 718 of the *Criminal Code* may not apply equally to all offenders; therefore, there are examples of judges who do hold the view that cognitive impairments pose a challenge for the legal system and do deserve special consideration. Rather than simply focusing on the fact that an offender has been found guilty, courts need to explore the concept of diminished capacity when a crime has been committed, if a mental disability such as FASD is present. Mental disorders such as FASD or ADHD, which fall short of meeting the criteria for unfitness to stand trial or the NCRMD defence, may still be pertinent to determining the degree of the offender’s responsibility (Roach & Bailey, 2009).

FASD is the cognitive impairment that is receiving a considerable degree of attention in the courts and this is not all that surprising given the difficulty of fitting it into traditional criminal law doctrines of fault and defences;
therefore, FASD is most commonly alluded to in judgments at the sentencing stage (Roach & Bailey, 2009). In R. v. Sam (1993), the judge stated, “…I do recognize in imposing this jail sentence that I cannot assess this crime against the standards of a normal person. Fetal alcohol syndrome has taken away from Mr. Sam the ability others have to act within the norms expected by society (paragraph, 17)”. For example, in the British Columbia case of R. v. Williams (1994), the accused was mildly mentally retarded, most likely owing to his fetal alcohol effects; thus, Williams was functionally illiterate, impulsive, easily led, lacked ordinary life skills, had a hearing deficit, exhibited poor memory, slow cognitive processing and had a substance abuse problem. When it came to Williams’ final disposition for the crime of robbery, the judge stated the following:

Williams, an extremely vulnerable person, was led by a friend and relative with a lengthy criminal record to do the dirty work. He alone is now called upon to pay the penalty. To that extent he is also a victim. His impulsive nature and alcohol dependence was exploited that evening by his cousin. The criminal law applies equally to persons who are handicapped and consequently Williams must accept responsibility for his anti-social behaviour. In addition, the community is entitled to expect protection from all persons who break the criminal law and an intellectual handicap can be no barrier to prosecution in appropriate cases (paragraph 16,17).

The judge in R. v. Williams (1994), reiterated the point that, when it came to the section 718 principles of sentencing, the emphasis a court would place on each of the factors would vary from case to case and would depend completely on the nature of the crime as well as the circumstances of the accused. In the Williams case, the judge concluded that the primary sentencing consideration was substance abuse treatment and the establishment of a probation plan, so perhaps FASD did play a role in the final sentencing disposition. More importantly, the judge in the Williams case rejected Crown Counsel’s sentence request, which had to do with the sentence principally encompassing the principle consideration of general deterrence. The judge did not see the general deterrent approach as being an applicable principle in the Williams case, most likely because the accused did have a cognitive impairment. In fact, in R. v. Clement (1994), the judge also alluded to the general deterrence principle of sentencing as not being appropriate in Clement’s case. Clement was being sentenced for a sexual assault and he had fetal alcohol syndrome. The judge in the Clement case stated, “sometimes judges, when they send persons to jail, say that it is necessary to show that person and the community that these matters
are treated seriously, and jail is how we show that. I do not think that would be sensible in this case (paragraph 17)”.

Also, in *R. v. Abou* (1995), the judge refers to how in the *Williams* case, Justice Vickers made the right decision in rejecting Crown counsel’s request for a sentence that would meet the requirements for the general deterrence principle. In fact, the judge in *Abou* stated that in the present case (24-year-old FASD Aboriginal woman being sentenced for two counts of assault), the court also rejected the submission that the principal consideration should be general deterrence. The judge in *R. v. Abou* (1995), continued on with the following statement:

“It is, I believe, simply obscene to suggest that a court can properly warn other potential offenders by inflicting a form of punishment upon a handicapped person who has, indeed, committed an offence for which some sanction must follow. That is not justice. That is unthinking retribution. If it were inflicted upon Ida Abou she could not fully comprehend it or possibly learn from it (paragraph 23).

In terms of the actual disposition in *Abou*, the judge stated that it was necessary to focus on two essential needs: to provide a measure of protection for other persons and to provide a realistic framework for her possible “rehabilitation”. Hence, the judge gave Abou a three-year probation order with specific conditions, such as residing in a transition house and meeting with a life skills worker five days a week. This sentence was meant to be considerably more constructive for Abou than her previous custodial disposition in which prison authorities did not cooperate to provide a form of sentencing that would have aided her.

Thus, how does section 718 of the *Criminal Code* apply to an individual who has FASD and whose cognition and reasoning may be severely disabled? The concepts of ‘consequences’, ‘rehabilitation’ and ‘deterrence’, when used at a sentencing hearing of a person diagnosed with FASD, may not apply (Fast & Conry, 2004). There is a tremendous difficulty facing the Judge when sentencing an offender with a cognitive impairment. This is reflected in *R. v. Steeves* (1998), a case in which the defendant did have FASD, and the judge stated, “[c]rafting a fit sentence for the particular offender and offence before the Court, and taking into account the necessary societal ramifications of that sentence, is often the most difficult task a judge has to perform. That task becomes all the more difficult when the offender is either an otherwise law-abiding citizen who has committed a serious offence or someone afflicted with a disease or mental condition which radically affects his or her behaviour.
Since FASD encompasses some degree of cognitive disability, and since the judicial system is based on a standard of ‘normal’ mental functioning, this type of disorder could be considered as part of the degree of responsibility of the offender under section 718.1, or as a mitigating factor under section 718.2 of the Criminal Code (Conry & Fast, 2000). Offenders with FASD are in need of uniquely structured probation as well as intense supervision and rehabilitation services in order to break the cycle of getting into trouble with the law (R. v. Mitchell, 1990).

Another interesting legal consideration in sentencing pertains to proper mental health assessment/diagnosis. In terms of how the court is to regard the testimony of an expert, where there is contradictory expert testimony given, the court can accept or reject it, in whole or in part or as it sees fit and even more importantly, a judge does not have to adopt even an uncontradicted view of an expert: “[a] judge is required to consider any testimony tendered and determine the weight to be given to it. But if, having conscientiously done so, he concludes that he cannot predicate any findings on the basis of that evidence, he is at liberty to reject the evidence in its entirety. The final decision in these matters must rest with the Court, not with the experts (R. v. Prairie Schooner News Ltd. And Powers, 1970, paragraph 21)”.

Unfortunately, the courts do not always have appropriate mental health experts readily available or even called upon to make proper assessments. Moreover, for the diagnosis of FASD, it is not always required that an offender be assessed for FASD, even when there is a suspicion that the accused has such a cognitive impairment; instead, the courts either take judicial notice of the potential disorder—even if there is only circumstantial evidence that is adduced by the lawyer for the defendant—and consider it in their sentencing disposition, or they simply overlook the possibility of the disorder since no proper assessment was done. In R. v. Gray (2002), section 15 (equality rights) under the Charter was raised when it came to the offender not being able to have a proper cognitive impairment assessment done for FASD, owing to a lack of provincial health care coverage. In Gray, Judge Trueman ruled that the court would have been breaching s. 15 of the Charter, and possibly other Charter rights, by sentencing Gray while suspecting FAS/ARND and without receiving an assessment and taking it into account. If the offender had been treated like everyone else and his mental disability had not been taken into account, the offender’s s. 15 Charter right would have been infringed. The Gray case was not
decided on the s.15 issue because, in the end, the judge ruled that a provision in the Criminal Code allowed the court to make an order for an assessment to be undertaken. The important point to be made here is that to treat offenders with fetal alcohol like any other non-mentally disabled offender could risk violating their Charter right to equality under the law. Nonetheless, quite often the courts are likely to turn a blind eye to the possibility that the offender may have FASD or simply not have enough background understanding of the condition to alert them to the chance that the defendant does have fetal alcohol spectrum disorder (Chartrand & Forbes-Chilibeck, 2003). If correctional service of Canada authorities fail to provide an appropriate assessment or rehabilitation to FASD offenders, such inadequate measures can be regarded as discriminatory against the person who has a disability; moreover, it also sends a message that the offender is not worthy of respect or dignity (Chartrand & Forbes-Chilibeck, 2003). The key objective of providing therapeutic programs in prison or while out on probation for all offenders will not be met if such programs do not exist for those suffering from FASD. Furthermore, such a principle is most definitely violated if the court is forced to incarcerate the offender owing to a lack of therapeutic resources available in the community for the FASD offender (Chartrand & Forbes-Chilibeck, 2003). The inability of the present Canadian criminal justice system to effectively provide meaningful rehabilitation to persons suffering from FASD, results in increased vulnerability to further victimization; therefore, it is not acceptable for the Canadian judicial system to continue to minimize the real impact FASD has on people. The traditional principles of sentencing, which emphasize punishment, deterrence/denunciation and incapacitation have little or no effect on such individuals because the organic nature of FASD impedes the person’s ability to adapt their behaviour (Chartrand & Forbes-Chilibeck, 2003). With proper treatment and care, FASD individuals’ behaviour can be managed; therefore, they can be helped to some degree (Chartrand & Forbes-Chilibeck, 2003). Unfortunately there is no available literature which examines precisely ‘how’ such individuals can be managed in the community; this is an area of research that certainly requires close examination.

Legal and corrections personnel must educate themselves about FASD and an appropriate, suitable facility must be found for the impaired individual, whether they receive a custodial disposition or not. There definitely needs to be a transfer of communication between the courts and the correctional staff,
especially if the person with FASD is going to have to go to prison (Conry & Fast, 2000). Ideally, prior to sentencing, lawyers and classification officers should cooperate in finding a placement that meets the needs of the offender.

Fast and Conry (2004) discuss how judges should utilize effective sentencing for those with FASD, which would include sentencing dispositions that could positively change the people’s lives—diversionary measures or sentencing circles. In the literature, more elaboration on how diversion or sentencing circles could effect ‘positive change’ in the lives of people with FASD would be warranted. With respect to sentencing circles, Fast and Conry (2004), realize how challenging it would be to implement such a process in most provinces across Canada especially in urban centres, considering sentencing circles are presently used in Aboriginal communities. Such communities take on very active involvement and assume responsibility for resolving the crime that was committed by one of its community members. The authors articulate the point that, since the time between the offence and sentencing is quite long, the person with FASD may not relate the legal consequences to the act which brought them before the court (Fast & Conry, 2004). Also, if the FASD sufferer has committed other offences before the trial for the original offence, the person with FASD may not understand which events are linked, especially if some offences are more serious than others. Thus, diversion allows decisions and programs to be made well before adjudication by the court; therefore, the process is expedited and the FASD offender has a better chance of comprehending what is happening to them. For those who do need to be incarcerated because the community must be protected and they are regarded as a threat to people’s safety, special consideration must be given to preventing victimization and misunderstanding in the prison system. If probation is granted, Fast and Conry stress how important constant supervision is for those with FASD: otherwise, even if the FASD person can reiterate the stipulations of the probation orders, appearing to understand the orders, they may not be able to follow them owing to an inability to carry them out in the community (2004).

Overall, the courts are inconsistent and divided on how to deal with FASD offenders, irrespective of the fact that increased attention is being paid to specific cognitive impairments and their role in sentencing dispositions. For example, another case that confirms the difficulty that judges have in determining what to do with an accused who has FASD is R. v. Faulkner (2007).
In this particular case, the court accepted that FASD was indeed a mental disorder but the judge held that the evidence did not establish “that the accused lacked the capacity to know right from wrong or that he did not appreciate the nature and consequences of his acts (paragraph, 21)”.

Hence, Faulkner was not entitled to defence under s.16 of the Criminal Code defence (not criminally responsible—they must have been unable, by virtue of mental disorder, to appreciate the nature and quality of the act or know that it is wrong). The court believed that Faulkner had the intent to commit the assault and, even though he was being threatened, he could have escaped the threats (he was assumed to have subjective knowledge of the physical consequences of his actions, despite having FASD).

With respect to ADHD, in terms of how it is considered in sentencing, it is not discussed to the same degree as FASD is in recent years, but since it is also an organic cognitive impairment, the same sentencing considerations that apply to FASD should be utilized for ADHD, in terms of possible mitigation, rehabilitation as well as appropriate custodial therapeutic programming. ADHD is a serious cognitive impairment: therefore, the courts should give it consideration, since a diagnosis of this particular deficit does create an involuntary diminished capacity to deliberate upon the outcome of one’s criminal actions, due to inattention, hyperactivity and impulsivity.

Nonetheless, both FASD and ADHD are not mental disorders that warrant any absolution from criminal responsibility for a person’s criminal behaviour; however, it is imperative for the major players in the criminal justice system (lawyers, mental health experts, doctors and judges) to be aware of such disorders and the impact these impairments have on the wrongful actions in which these individuals

**Youth Justice System**

*Youth Criminal Justice Act (YCJA) Principles of Sentencing*

Even though general sentencing principles apply to both youths and adults, for example, there is less focus on general deterrence for youths, as opposed to adults, because the highly emphasized principles for young offenders are rehabilitation and adherence to their special needs. The *Youth Criminal Justice Act* has its own set of specific sentencing principles and largely narrows in on the principles of proportionate sentencing and rehabilitation. Even though
there is no specific section in the YCJA that stipulates a process that should be adhered to when a young person has received a diagnosis of ADHD or FASD, there are sections in the Act that address mental disorder.

The YCJA came into fruition in 2003, replacing the highly criticized Young Offenders Act (YOA). The YCJA is considered to be a Modified Justice Model (not in strict adherence to a pure justice philosophy) because it draws from different justice principles, ranging from the rehabilitation and reintegration of youth to the protection of society (Kuehn & Corrado, 2009). It is rendered in the ‘Declaration of Principle’ in the YCJA that the youth justice system is premised on, “fair and proportionate accountability that is consistent with the greater dependency on young persons and their reduced level of maturity” (Youth Criminal Justice Act, 2002). The YCJA differs significantly from the earlier YOA model, which was heavily scrutinized for being too crime control oriented by having an increased reliance on custodial punishment in order to deter further crime. Thus, the YCJA was enacted with the intent of decreasing the use of the court process and limiting the use of custody for adolescent offenders (Bala, Carrington & Roberts, 2009). Section 38(1) of the YCJA states that, “[t]he purpose of [youth court] sentencing…is to hold a young person accountable for an offence through the imposition of just sanctions that have meaningful consequences for the young person and that promote his or her rehabilitation and reintegration (Youth Criminal Justice Act, 2002)” . It is evident from this YCJA statement that there is an omission with respect to deterrence, which has contributed to the decrease in the number of custodial sentences handed down (Cesaroni & Bala, 2008). In contrast, the adult Criminal Code clearly stipulates specific and general deterrence in its sentencing principles, so its absence in the YCJA suggests deterrence is not intended to be one of the objectives of sentencing in youth court (Bala, Carrington & Roberts, 2009). The YCJA established a new sentencing regime for young offenders in Canada and in R. v. B.W.P. (2006), the judge stated that the Act, “sets out a detailed and complete code for sentencing young persons under which terms it is not open to the youth sentencing judge to impose a punishment for the purpose of warning, not the young person, but others against engaging in criminal conduct. Hence, general deterrence is not a principle of youth sentencing under the present regime (paragraph 4)”.

The key sentencing principles of the YCJA are as follows: under s. 38(2)(c), ‘proportionality’ (a principle of fundamental justice in which the
State’s response to an offender’s crime must be measured) is a pivotal principle, as is the concept of restraint with respect to imprisonment under s. 38(2)(d), which states that, “all available sanctions other than custody that are reasonable in the circumstances must be considered”; s. 38(2)(e) requires that, “the sentence must be the least restrictive sentence that is capable of achieving the purpose of sentencing” (both of these general principles have also been codified at the adult level); s. 38(2)(a) places a limit on the severity of sentencing in youth court by making the point that the sentence must not result in a punishment that is more severe than the punishment that an adult offender convicted of the same offence in similar circumstances would receive (Youth Criminal Justice Act, 2002). Another critical component related to youth sentencing is the mental health assessment that guides judges in determining the most appropriate sentence for the young person.

**Medical and Psychological Reports**

In general, whether in youth or adult court, mental-health expert opinion evidence in criminal trials is common place today. Even mental illness evidence given by a general practitioner who is acquainted with the patient is typically well received in court and considered to be valuable (Slobogin, 1999; Silverman, 1972). In the past, until approximately the 1970s, psychiatric evidence presented in court was viewed with uncertainty and skepticism and even laughter by many and since then the potential scope of psychological testimony in criminal trials has expanded immensely (Slobogin, 1999; Silverman, 1972). To-date, mental health professionals have added to their trial repertoire opinions about criminal propensity in sentencing proceedings (Slobogin, 1999). Presently, Section 34 of the YCJA pertains to youth justice court under the subdivision of Medical and Psychological Reports/Medical or Psychological Assessment and this section assists lawyers and judges who request assessments for any mental health disorder that they believe may be present. Section 34(1) states that, “a youth justice court may, at any stage of proceedings against a young person, by order require that the young person be assessed by a qualified person who is required to report the results in writing to the court (Youth Criminal Justice Act, 2002)”.

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Criminal Intent, Defence of Mental Disorder

Whether a youth or an adult, it is a principle of fundamental justice that an accused shall not be found guilty unless the person possessed a blameworthy state of mind when he or she committed an unsanctioned act (Knoll, 1988). So how does mental disorder fit in, when analyzing the required elements—actus reus and mens rea, in an act? The minimum necessary mental element for most crimes is knowledge of the material circumstances (actus reus of the crime) and foresight or intention with respect to any consequences required to constitute the actus reus of the crime (Knoll, 1988). When a person is found to be mentally ill, the notion that the mental illness can undermine an individual’s ability to form blameworthy intent (mens rea) entitles them to a mental disorder defence, in very specific circumstances; namely, the person suffers from a psychosis (temporary or permanent) and once found guilty, seeks a Not Criminally Responsible on Account of Mental Disorder (NCRMD) defence. The defence is laid out in s. 16 of the Criminal Code and applies equally to youth under s. 141 of the YCJA: (1) No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong (Criminal Code, 1985). The difficulty lies in determining how to proceed with disorders other than ‘insanity’.

Reverting back to youth and the issues surrounding cognitive impairments and sentencing, even though there are case precedents for the proposition that FASD is a disease of the mind and therefore a mental disorder, the issue of whether FASD rendered an accused incapable of appreciating the nature and quality of the act, however, is in question (Verbrugge, 2003). There are many youth cases that have addressed the issue of FASD and whether or not it could be raised as a mental disorder in sentencing. For example, in R. v. R.F. (2002), the youth was unsuccessful in her attempt to raise the defence of mental disorder, on the basis that she suffered from FASD. Even though the court accepted the expert opinion that R.F. had fetal alcohol syndrome, severe attention deficits, extreme impulsivity and an inability to make good decisions, the youth failed to show that she was unable to appreciate the nature and consequences of her criminal acts. It was in the expert’s opinion that R.F. did have the ability to appreciate the immediate consequences of her actions. More importantly, the court ascertained that the standard in this type of test is quite
low; therefore, the youth’s appreciation of the nature and quality of her acts need not be very sophisticated:

I find that the evidence fails to meet this branch of the test; certainly the Defence has failed to meet the burden of proving on a balance of probabilities that R.F. lacked an appreciation of the nature and quality of her acts by reason of her mental disorder. From my careful reading of the discussions in the cases cited, I am of the view that the standard in this branch of the test is set relatively low, in that the offender’s appreciation of the nature and quality of his acts need not be very sophisticated. It is required that he/she have an appreciation of the consequences, impact and results of each of the physical acts for which she has been charged. There was some suggestion in her testimony and the assessment of Dr. Nanson and that she had that limited appreciation (paragraph 77).

Due to certain disorders, such as FASD, it is very probable that a youth may not be able to apply the moral reasoning that would be expected of him/her at a particular age, owing to developmental impairment (R. v. R.F., 2002). Moreover, it is also conceivable that a young person with FASD may be truly unaware that his/her behaviour is inappropriate because of the person’s cognitive deficits. The latter scenario is exemplified in the case of D.J. v. Yukon Review Board (2000). D.J. had been diagnosed with fetal alcohol syndrome as well as attention deficit hyperactivity disorder. As a youth, he had been charged with three counts of sexual assault and was found not criminally responsible by reason of a mental disorder. He received a conditional discharge and was placed in a home. D.J. had raised a s. 16 defence, based on FASD, in response to the charge of sexual assault and was successful. Irrespective of the conclusion in this particular case, typically, as was seen in R. v. R.F. (2002), the mental disorder defence has certainly not been developed with FASD in mind (Roach & Bailey, 2009).

Typically, when it comes to the mens rea element of general intent offences, it is unlikely that the cognitive, intellectual or attention deficits associated with FASD could fully negate it (Verbrugge, 2003), since intention is simply inferred from the commission of the act itself. However, since specific intent offences require proof by the Crown of the formation of a higher level of intention (specific intent crimes include: assaulting a peace officer, attempted murder, being unlawfully in a dwelling-house, breaking and entering with intent to commit an indictable offence, breaking and entering and committing an indictable offence of specific intent, causing bodily harm with intent, murder, offering a bribe, possession of stolen property, public mischief,
robbery and theft), the intellectual, cognitive and social deficits of an individual with FASD might be raised to create a reasonable doubt with respect to his/her awareness of specific preconditions of an offence (Verbrugge, 2003). Nonetheless, the courts are ‘not’ justified in “doing whatever it takes” to correct the lives of youth with FASD (Verbrugge, 2003). Verbrugge (2003), contends that whether or not youth who have FASD will receive more intrusive sentences relative to youth in general is a question that can be answered empirically but to date there is no research on this issue and the only way to determine this would be to compare the sentences given to youth who have FASD with those given to other youth for similar offences. It is Verbrugge’s assumption that youth who have FASD would likely have a greater number of aggravating factors at sentencing because of the secondary disabilities that are found as a result of the disorder (2003).

In essence, to-date, the determination of an appropriate sentence for a disorder such as FASD, certainly remains a daunting task for judges in the courtroom. Despite the recognition of FASD as a disability that can have a profound impact on the level of an offender’s moral culpability, often the need to ‘protect the community’ seems to supersede the mitigation consideration of altering (changing and/or shortening) the final sentencing disposition. Furthermore, even though custody is the harshest sanction the courts may impose, many judges will give an FASD offender jail time, regarding such a disposition as the best way to secure therapeutic programing. Overall, it can be concluded from the aforementioned research that any type of cognitive impairment needs to be uncovered during the court process and considered in sentencing, because of its potential impact on the crime and the overall well-being of the offender. Throughout a trial, court process, in which a person displays any symptoms of some type of disorder, such as ADHD or FASD, the pertinent required assessments should be requested by the court. If disorders such as ADHD or FASD, which are recognized as mental health impediments under the DSM-IV TR, are assessed for in a trial and it is confirmed that the offender does in fact have one or more of these disorders, the impairment(s) should be considered a mitigating factor and proper programing and treatment recommendations be given as sentencing solutions, whether a youth or an adult. However, the reality of the YCJA and even the adult criminal justice system is that the Canadian courts do not always provide appropriate therapeutic programs, mostly due to lack of resources and also there is
insufficient screening or assessment for ADHD and FASD for both youth and adults, so many offenders proceed through the system undiagnosed (Fast & Conry, 2004; Eme, 2008).

The other major concern is that not all judges consider cognitive impairments as being mitigating factors in sentencing. Roach and Bailey (2009) discuss how many more judges, including those on appellate courts, may soon have to grapple with determining the relevance of disorders such as FASD to their decisions regarding the admissibility of statements, fitness to stand trial, the determination of criminal liability and sentencing. Despite a cognitive impairment’s influence on moral culpability, with respect to the commission of a crime, even when a disorder such as FASD should be regarded as a mitigating factor, its effect on sentencing does not always reflect such a characterization. There are a number of cases in which the diagnosis of this type of disorder serves to increase an offender’s time in custody; such a sentencing decision may be due to inadequate judicial understanding of the consequences of FASD, a desire to maximize the best rehabilitative prospects that are available at the time or simply looking out for the best interests of the public (community safety). There is a strong opposition to custodial placements for offenders with FASD or other cognitive impairments because such an environment may subject these individuals to negative peer influences, victimization and persistent deterioration in their mental states (Mitten, 2004).

**SUMMARY**

There appear to be evolving ideas about the nature and causes of mental disorders, which may require changes in people’s views of blameworthiness. The literature presented has demonstrated that certain cognitive deficits, such as FASD and ADHD, present a fundamental challenge to the standard assumption of the Canadian criminal justice system that people act in a voluntary way, yet overlooks the fact that some people have mental disorders that should possibly exempt them from criminal responsibility: however, there is much uncertainty surrounding the requisite degree of severity that should be necessary to absolve such individuals of culpability. It is, therefore, imperative to evaluate the current sentencing situation in Canada for the disorders of FASD and ADHD, by carrying out a case analysis.
Chapter 4:
METHODOLOGY

DATASET DESCRIPTION

Province and Time-Frame Selection Process

There is a paucity of research which examines ADHD and FASD’s impact in the Canadian courtroom with respect to the accused. In order to determine whether ADHD and FASD have any sort of impact on the final sentencing disposition in criminal law case proceedings, particular attention was paid to the role of judicial interpretation and expert testimony regarding the specific neuro-cognitive impairments. It has been established by the British Columbia Supreme Court that, when there exists evidence of a mental state that falls short of that which is required to establish the defence of not criminally responsible, but nevertheless reflects an acute mental illness, then such a state is relevant to the assessment of the moral blameworthiness of the accused when determining the appropriate sentence. Hence, exploring how expert witnesses and the judge attribute risk and treatability to ADHD and FASD is of interest, as is whether ADHD and FASD are treated as mitigating factors in select sentencing cases. A descriptive statistical analysis of various coding variables has been conducted in conjunction with the incorporation of a qualitative, reflexive component to complete the research.

In the present study, ‘case’ refers to the Canadian judgment(s) available for a single offender (defendant) and the ‘offender’ (defendant) is the unit of analysis. Juvenile and adult defendants, male and female, are included in the judicial sentencing case review. All court levels are under investigation — Provincial Court, Supreme Court and the Court of Appeal for the provinces of British Columbia (BC), Saskatchewan (SK) and Ontario (ON). The Superior Court of jurisdiction in Ontario is the Superior Court of Justice, in B.C. it is the Supreme Court and in Saskatchewan it is the Court of Queen’s Bench. These
provinces were selected to examine judicial sentencing decisions in cases where a link is made between an offender who is either suffering from Attention Deficit Hyperactivity Disorder (ADHD) or Fetal Alcohol Spectrum Disorder (FASD). The provinces were chosen because provincially they reflect a very large portion of ADHD and FASD cases in all of Canada. For example, in a ten-year span (March 17, 1999 through March 17, 2009), BC had 84 cases in which the term fetal alcohol was searched successfully, representing 25% of all fetal alcohol cases in Canada during the ten-year period, followed by Ontario with 59 fetal alcohol cases (18%), and Saskatchewan displayed 51 fetal alcohol cases (15%). Thus, these three provinces represented 58% of all reported fetal alcohol cases in Canada in the articulated ten-year duration. It must be emphasized that the databases do not include all cases and there is no systematic protocol which determines which cases are or are not included. Similarly, when ADHD was searched during the same ten-year period, Ontario had 155 cases in which attention deficit was mentioned in the case, demonstrating a 33% representation of all Canadian cases, followed by British Columbia which had 98 cases (21%) and Saskatchewan which displayed 41 cases (9%). See table below.

**Fetal Alcohol Cases Found in QuickLaw**

<table>
<thead>
<tr>
<th>Province</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>84</td>
</tr>
<tr>
<td>Alberta</td>
<td>59</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>51</td>
</tr>
<tr>
<td>Manitoba</td>
<td>19</td>
</tr>
<tr>
<td>Ontario</td>
<td>59</td>
</tr>
<tr>
<td>Quebec</td>
<td>10</td>
</tr>
<tr>
<td>Newfoundland/Labrador</td>
<td>16</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>1</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>5</td>
</tr>
<tr>
<td>Nunavut</td>
<td>2</td>
</tr>
<tr>
<td>Yukon</td>
<td>17</td>
</tr>
<tr>
<td>PEI</td>
<td>0</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total (All Provinces/Territories Last 10 yrs)</strong></td>
<td><strong>332</strong></td>
</tr>
<tr>
<td><strong>Total (BC, SK, ON—Last 10 years)</strong></td>
<td><strong>194</strong></td>
</tr>
<tr>
<td><strong>Total (BC, SK, ON—Last 5 years)</strong></td>
<td><strong>110</strong></td>
</tr>
</tbody>
</table>
If a ten-year span were to be selected to examine ADHD and FASD cases in BC, SK and ON, 488 cases would have to be individually examined to determine which cases would be included. Considering this Canadian judicial sentencing decision analysis involves a very detailed variable search, which will be discussed in the latter part of the methodology chapter, it was considered to be more feasible to conduct the case examination on the neuro-cognitive impairments by selecting a five-year time span; March 17, 2004 through March 17, 2009 was selected as period for the judicial sentencing case study. With the selection of this period, 286 cases in total from BC, SK and ON would be considered for inclusion in the analysis, since the key search terms, ‘fetal alcohol’ and ‘attention deficit,’ were readily retrieved during the database search.

**Database Selection Procedure**

In order to conduct an exploratory analysis of judicial sentencing considerations for the neuro-cognitive impairments of fetal alcohol spectrum disorder (FASD) and attention deficit hyperactivity disorder (ADHD), several Canadian database search engines were originally compared to see which
would generate the most results. The database that displayed the largest selection of Canadian cases for the search criteria under study was the *Quicklaw* Canadian resource database, in comparison to, *CanLII, Criminal Source* and *Criminal Spectrum*. *Quicklaw* contains published provincial and federal case law as well as the opinions of superior courts and the Supreme Court of Canada: it covers both trial and appellate decisions. In the *Quicklaw* database, only provincial, superior and appellate criminal law cases in British Columbia, Saskatchewan and Ontario were selected and cases of interest were those that matched the key search term ‘fetal alcohol’ and ‘attention deficit’ in the five-year span of March 17, 2004—March 17, 2009. A total of 286 criminal law cases were under investigation, in order to determine which cases would be included and which would be eliminated, if they did not meet the inclusion criteria.

**Criminal Case Inclusion and Exclusion**

The definition of the search criteria was purposefully broad in order to capture all of the cases in BC, SK and ON during a five-year period, which contained the terms ‘fetal alcohol’ and ‘attention deficit’. Each case was systematically reviewed for possible inclusion in the study. Young offenders, adult offenders, males and females were all included in the study. Fetal alcohol spectrum disorder as well as attention deficit hyperactivity disorder had to be related to the defendant. For fetal alcohol (FASD), after carefully reviewing the 110 criminal cases, in which ‘fetal alcohol’ appeared as a search term somewhere in the case document, 40 cases were identified as being directly related to the defendant. For attention deficit hyperactivity disorder (ADHD), after analyzing the 176 potential criminal cases in which ‘attention deficit’ appeared as a search term somewhere in the case document, 67 cases were identified as being directly related to the defendant. Cases were excluded for one of the following reasons: family law—custody and access case; guilty verdict only—not a sentencing judgment case; mother just makes an assumption person has principal disorder but it is not discussed further; issue of whether defendant needs court-appointed counsel owing to his disorder is the sole purpose of the hearing; court does not accept one evaluator’s assessment of the disorder at issue and lets another evaluator’s opinion that the defendant does not suffer from the disorder override the former opinion; a suggestion is made that the accused may suffer from the disorder in light of a supposed diagnosis at an
early age but from all of the recent psychologist/psychiatrist reports, in none of their reports or testimony was there any suggestion that the disorder in question was suspected as a problem in treating the accused; discussion of search term “disorder” in the academic literature but only to make a reference point about disorder, nothing to do with the accused; one sentence mention of a medication trial for disorder in question but no other reference to the disorder is made at all; issue of monetary damages (e.g., drinking/driving case); not guilty—the evidence of the investigating officer was insufficient to support the conviction—no evidence to support the expert’s opinion of disorder so it is not further mentioned in the case; a one line statement about the disorder in question such as, “academically, he did poorly due to issues pertaining to an attention deficit hyperactivity disorder,” and nothing further is ever mentioned; a single-sentence-purely-speculative statement about the defendant suffering from residual effects of the disorder in question and no further elaboration.

Hence, in summary, the final case coding sample size was 107. Each case was coded on a possible total of 150 individual variables. Criminal law was the type of legal proceeding and both youth and adult cases were of interest. Also, male and female offenders were included in the case analysis for fetal alcohol spectrum disorder (FASD) and attention deficit hyperactivity disorder (ADHD) in the provinces of BC, SK and ON within a five-year period (March 17, 2004 – March 17, 2009).

**CODING FORM VARIABLE SELECTION**

In order to gather as much comprehensive information as possible regarding ADHD and FASD in the context of judicial sentencing decisions (reasons for judgment case analysis), an extremely detailed coding form was created. This coding form, in conjunction with piloting 25 cases to determine the form’s attention to detail and the overall relevance of the selected variables for these types of cases, took approximately four months to finalize. After reading and coding 25 cases, several versions of the coding form were piloted until the final version was reached. The final version of the coding form focused on the type of court and offender descriptors, number of mental disorders and classification, all statements made about the principal disorder, inference of risk/treatment due to principal disorder, detailed information regarding expert
testimony about the principal disorder, risk and treatability, judge role—
mental disorder case placement/consideration given in sentencing and finally
an appeal-court component. Operational definitions were provided in order to
make sure that cases were coded consistently and reliably. The sole researcher
of this project coded all of the cases, so inter-rater reliability was not an issue;
therefore, it was not necessary to include coding instructions. Furthermore,
there were no ethical concerns when conducting this research; therefore, ethics
approval was not required, considering Canadian court case sentencing
decisions are a matter of public record. Below are ‘all’ of the individual
variables in the coding form that ‘each’ case was coded on.

**Variables Coded**

**Type of Court and Offender Descriptors:**
- Case #
- Case Year
- Case Saved As
- Case Name
- Principal Disorder Under Investigation
- Location of Court
- Type of Court
- Coding Date
- Ethnicity
- Youth/Adult
- Gender
- Present Age
- Is this age exact or approx?
- Total Number of Paragraphs
- Type of Legal Proceeding
- Current Charges
- Classify Current Charges
- Past Convictions
- [If yes] # of Past Convictions
- [If Available] List Past Convictions
Number of Mental Disorders and Classification:

- # of Paragraphs Where Statements Are Made About Principal Disorder (Entire Judgment)
- How Many Other Disorders are Mentioned in the Case
- List All Other Disorders That are Mentioned
- Classification of Other Disorders
  - [If Applicable] AXIS 1
  - [If Applicable] AXIS 2
  - [If Applicable] AXIS 3
- An Evaluator Directly States That The Accused Has The Principal Disorder
- [If Yes] Direct Statement from Evaluator Report or Testimony Regarding Principal Diagnosis
- [If No] An Evaluator Assumes That The Accused May Have the Principal Disorder
- Was It Clearly Stated That A ‘Formal’ Diagnosis of the Principal Disorder Was Made
- [If Yes] Who Made the Formal Principal Diagnosis
- Is It Evident in the Sentencing Case that the Defendant Has Co-occurring Disorders—comorbidity (presence of 2 or more disorders)
- Issue(s) Surrounding Comorbidity Is Explicitly Expressed In The Case
- [If Yes] Select Representative Direct Statement

All Statements Made About Principal Disorder:

- 1st ‘key’ paragraphs(s) in which statement(s) made about Principal Disorder
- ‘key’ statement(s) made about Principal Disorder
- Direct Quote?
- ***repeat above 3 variables as many times as needed depending on how many paragraphs for disorder***

Inference of Risk/Treatment Due to Principal Disorder:

- Was the Principal Disorder mentioned directly when drawing an inference about the accused’s TREATABILITY (whether accused can be treated or not) and/or TREATMENT PLACEMENT?
- Explanation for Response
- Overall Direction of Inference About Treatability & Principal Disorder
- Direction of Inference About Violence In Connection to Principal Disorder
- Direction of Inference about ‘General Recidivism’ in Connection to Principal Disorder

Detailed Info Regarding Expert Testimony About Principal Disorder, Risk & Treatability:

- Background of ‘Key’ Evaluator 1
- Did Evaluator 1 Make Any Reference to the Accused’s Principal Disorder?
[If Yes] Evaluator 1’s Statement About Disorder
Whether Evaluator 1 believes Principal Disorder is present or absent
Did Evaluator 1 Make Statement in Direct Reference to a Test/Tool Used to Diagnosis Principal Disorder
[If Yes] What Test/Tool
Evaluator 1 Inferred Accused As Being a Risk for Future Violence
Did Evaluator 1 Directly State Accused Poses a Risk for Future Violence?
[If Yes To Inference or Direct] List Statement About Risk of Violence
Evaluator 1 Made Statement Regarding Treatment
[If Yes] List Statement About Treatment (especially prognosis or amenability to treatment)
Evaluator 1 Made Statement Regarding Placements/Sentencing
[If Yes] List Statement About Placements/Sentencing

***repeat above 14 variables as many times as needed depending on how many experts testified***

How Many ‘Key’ Evaluators Specifically Mentioned In Judgment In Total

(JUDGE) Mental Disorder Case Placement/Consideration Given in Sentencing:
Of the Various Disorders Mentioned in the Case, Which One Is Mentioned the Most (Find Function)
Did Judge Directly Mention Principal Mental Disorder In Sentencing Judgment?
[If Yes] (LOCATION) Where Did Judge Directly Mention Principal Disorder In Judgment
Did Judge Directly Mention Other Disorder(s) In Sentencing Judgment?
[If Yes] (LOCATION) Where Did Judge Mention Other Disorder(s) In Judgment
IF JUDGE MENTIONED MORE THAN 1 Disorder in Sentencing Judgment, judging solely from location of disorder in the sentencing judgment, which disorder did judge refer to more:
[IF APPLICABLE & MORE THAN 1 DISORDER] Judge’s Statement(s) Exemplifying ‘Disorder Of Most Consideration’ in Sentencing Judgment
Did Judge Make a Direct Link b/w Principal Disorder & Accused Being a Risk to the Community
[If Yes] Judge’s Statements
Did Judge Make Direct Statement(s) About Principal Disorder Being Linked to Likelihood of Recidivism?
[If Yes] Judge’s Statements
Did the Judge Voice Support to any Court Evaluators’ Sentencing Opinion, Which Directly Impacted Final Sentencing Outcome?
[If Yes] To Which Evaluator?
How Much Weight Did the Judge Place on Principal Disorder Statements?
Judge Challenges or Disputes Principal Disorder Evidence By Any Evaluator
[If Yes] Describe Challenge
Legal Decision
What is the Actual Disposition?
Does the Judge Explicitly Refer To A Need for Greater Supervision/Monitoring Due to the Principal Disorder (CUSTODIAL)
[If inferred or yes] Judge’s Statement
Does the Judge Explicitly Refer To A Need for Greater Supervision/Monitoring Due to the Principal Disorder (NON-CUSTODIAL)
[If yes] Judge’s Statement
Does the Judge Explicitly State A Need for a Lesser Sentence Due to the Principal Disorder (mitigating factor)
[If yes] Judge’s Statement
Overall, Based on All of the Variable Information Previously Coded, Does it Appear that the Principal Disorder is A Mitigating Factor in the Sentence?
Does the Judge Comment on Treatment or Rehabilitation in Direct Connection with the Principal Disorder
[If yes] Judge’s Statement
Whether or Not the Judge Emphasizes the ‘Importance’ of Treatment in the Final Disposition
[If yes] Judge’s Statement
Judge Emphasizes ‘External Structure’/’Supported Structure’ (perhaps inferring custody) Needed Due to Principal Disorder BUT Does Not Specify Exactly What Type
Does the Judge Mention Resources in the Province In Connection to the Final Disposition?
[If yes] Judge’s Statement
Does the Judge Directly Mention the Offender’s Culpability/Responsibility in the Commission of the Crime?
[If Yes] Direct Quote

Appeal Court:
Appeal Allowed (Upheld)?
Name of ‘Reasons for Judgment’ Judge
How Many Concurring Judgments
How Many Dissenting Judgments
Did the Issue of the Appeal Have to Do With the Principal Disorder in Any Way?
[If Yes] How Is Principal Disorder An Issue in the Appeal
[If Yes] Relevant Statement(s) Depicting The Manner In Which the Principal Disorder is At Issue

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86
Pertaining to Principal Disorder—Did The Original Trial Judge Err According to the Reasons for Judgment Judge?
[If Yes] Relevant Statement(s) From Reasons for Judgment Judge Regarding How Original Trial Judge Erred
Pertaining to Principal Disorder—Did The Original Trial Judge Err According to the Concurring Judge?
[If Applicable] Relevant Statement(s) From Concurring Judge
Pertaining to Principal Disorder—Did The Original Trial Judge Err According to the Dissenting Judge?
[If Applicable] Relevant Statement(s) From Dissenting Judge
The Final Sentencing Disposition Is Somehow Relevant To the Principal Disorder?
[IF Yes or Indirectly]—Sentence is Somehow Relevant To Principal Disorder, What Sentence Did Appellate Court Reinforce (keep the same) Or Substitute?
[IF Yes]—Sentence is Somehow Relevant To Principal Disorder AND IF The Sentence is Altered—Is The Sentence More or Less Severe?
If Appeal Allowed, Does Appeal Court Directly Mention Principal Disorder in Final Reasons for Judgment
If Appeal Allowed, Does Principal Disorder Appear To Be a Major Consideration In the Final Appeal Judgment?

The coding form was contained in an Excel Workbook Spreadsheet because it was very easy to colour-code variable columns, adjust column and row width, size and to cut and paste statements from cases directly into the specific variable rows. The 107 cases took four months to code, considering each case had to be carefully scrutinized and there were between 100-150 variables to be coded for every single case. Anywhere from 100-150 out of a possible maximum of 150 variables were coded, depending on the information presented in each sentencing judgment case. The more information, the more variables were coded for. Furthermore, the length of time to code also included reading and excluding the 179 ADHD and FASD cases (as discussed in the criminal case inclusion and exclusion section) because originally there were 286 cases to sift through in detail.

**Research Design**

The unit of analysis for this project is the case (sentencing decision). In order to acquire a better picture of the impact of neuro-cognitive impairments on sentencing decisions, the offender, expert witnesses and the judge are the units of observation. For example, gender, ethnicity, youth or adult are variables of
interest when they relate to the offender and then very specific variables are used to gather information about the expert witnesses as well as the judge. The judges’ documented perspectives concerning FASD/ADHD constitute the major unit of analysis.

It is acknowledged more and more that many research projects in the social sciences can benefit from both quantitative and qualitative approaches (“mixed-methods”) and this is the selected approach for this project. This criminal court case project investigates 107 cases, which is not a significant number in comparison to some research projects where the N (sample size) can be in the thousands but for this type of study, 107 is definitely a very large sample size, considering an abundance of variables are coded and under investigation for each case. Hence, the data for this project is more varied, detailed and extensive. All of the cases share one commonality, which is that the defendant has been linked to having either ADHD/FASD; therefore, the approach taken is that the cases under examination have similar paths (all accused in the criminal cases suffer from a neuro-cognitive impairment) but different outcomes (the offenders will predominantly have very different dispositions). This is a cross-sectional study, frequently used by social scientists, since observations are conducted on each case at a limited point in time (Maxfield & Babbie, 2001). Even though a cross-sectional study is not attempting to capture time, change, or process, it is very useful for exploratory, descriptive and explanatory research. Typically, the progress of a research area flows from exploratory to descriptive to explanatory, even though it has been often ascertained that descriptive and exploratory research blur together or one follows another. This particular project is somewhat descriptive, since it summarizes a set of sample observations and largely exploratory in nature (Yin, 2011). It is descriptive in the sense that it provides a detailed picture of the various variables under investigation and their interaction, there is a focused topic and research questions that guide the study but there is also an exploratory dimension to the research, since it uncovers interesting facts about the topic at hand, identifies major themes and emergent themes, formulates and focuses questions for later studies and does suggest the feasibility and directions of future research. Much research in criminology and criminal justice is carried out to explore the nature or frequency of a particular problem or about an issue that little is known about (Maxfield & Babbie, 2001). Data collection is less structured in an exploratory study when a key objective is to
understand how participants’ conceptions or values emerge through their speech or narrative (Ritchie & Lewis, 2003). In the case of the present study, judges’ direct quotes in sentencing judgments regarding FASD and ADHD are explored.

RESEARCH QUESTIONS
Since the current study is descriptive and also exploratory in nature, there is no setout hypothesis; rather, there is a set of original research questions that were created in order to help guide this project, to get it up and running by assisting in the formulation of the dataset coding form variables. The following are the research questions of interest. It is important to keep in mind that the results are not limited only to the questions that were created during the dataset coding form phase and when the 25 cases were piloted. Other interesting questions and findings resulted from the inclusion of variables in the dataset coding form and those will be analyzed in the results and discussion chapters, in conjunction with the major research questions listed below.

RESEARCH QUESTIONS AND LINK TO PRE-EXISTING LITERATURE
The major research question was largely derived from the lack of pre-existing literature that has been done on FASD/ADHD and sentencing. The major research question was: What is the impact of a diagnosis of FASD/ADHD on sentencing decisions, as articulated by the judges concerned? This question arose in response to an absence of empirical research in this area and also in order to address the concern that very little is known about sentencing individuals with cognitive impairments. Since there is a paucity of information with respect to the sentencing of individuals with cognitive impairments, variables were created to rectify this lack of research and address how the courts are dealing with individuals afflicted with FASD/ADHD. It is most surprising that there is a lack of systematic research on the sentencing of mentally impaired offenders, especially those with FASD or ADHD; therefore, the current dissertation is meant to be the first major study of the role of FASD and ADHD in sentencing decisions in Canadian courts. Many of the other research questions were derived from the previous literature that has
addressed this topic, while other research questions were created to fill in the missing gaps. For example, the literature points out that a rather noteworthy percentage of individuals who commit crimes are afflicted with FASD/ADHD. Many of the research questions addressed the type of crime(s) the offender committed, if it was a violent or non-violent crime and whether or not the offender had a previous criminal record. Also, the literature has found that Aboriginal people with FASD are often overrepresented in the Canadian courts; therefore, ethnicity is a variable of interest in the present study. Since the literature points out that such impairments pose a challenge for the courts, in terms of how to properly diagnose and/or sentence such persons, variables of interest were added to address the judicial sentencing of offenders with FASD/ADHD, if official diagnoses of disorders were made and by whom, and whether such disorders were somehow considered in the final sentencing disposition. Such variables are pivotal considering very few studies have focused on how such individuals with FASD/ADHD are treated in the Criminal Justice System and whether the justice system is properly meeting their needs.

With respect to FASD, the pre-existing literature identifies the issue that some courts do not acknowledge the presence of FASD as deserving of any special consideration, while others do recognize it as one of many mitigating or aggravating factors in sentencing (more often mitigating than aggravating). As is the case with FASD, there has been debate about whether ADHD, which is also a persistent cognitive impairment, might offer a justifiable defence for a wide range of different crimes but, to-date, the courts have not been particularly receptive to this contention. It is for this reason that a pivotal element of the dissertation revolves around an examination of the number of cases in which the FASD and/or ADHD were identified as the principal disorders of interest and were treated as mitigating factors in the final sentencing decisions.

According to the literature, ADHD increases the risk for developing other disorders, such as Conduct Disorder, Oppositional Defiant Disorder and Substance Use Disorder. Also, the literature points out that the comorbidity of any two or more of those disorders can often result in secondary disabilities, such as school and employment failure, thereby increasing the likelihood of criminal activity. It is for this reason that many of the research questions sought to identify whether FASD/ADHD offenders had a comorbidity of disorders and what those disorders were. Below are the various research questions that are then analyzed and reported on in the results and discussion chapters.
In cases where the courts do acknowledge the neuro-cognitive impairment, is there a great degree of variation as to how it should be taken into account? For example, some courts may recognize it, by mentioning it, but then not let it have an impact on their sentencing judgment while other courts may regard it as a mitigating factor in sentencing. There may also be variation in how the sentence is mitigated by the disorder in question (treatment, reduction in custody etc...). Finally, some courts may not give any consideration or acknowledgment to ADHD/FASD in their sentencing judgment even though it was mentioned by an expert witness or witnesses.

Operational Definition of ‘mitigating factor’: ADHD/FASD have a direct effect on the final sentencing disposition by somehow moderating or alleviating its severity.

To what degree if any, do judges mention ‘expert’ and/or medical testimony in reference to ADHD/ FASD, in their sentencing decision?

Did the judge make a direct link between the principal disorder (ADHD/FASD) and the accused being a risk to the community?

Did the judge make a direct statement about the principal disorder (ADHD/FASD) being linked to the likelihood of recidivism?

Did the judge voice support to any court evaluators’ sentencing opinion which directly impacted the final sentencing outcome?

What is the most prevalent sentencing disposition given by a judge?

Does the judge explicitly refer to a need for greater supervision/monitoring owing to the principal disorder (custodial)?

Does the judge explicitly refer to a need for greater supervision/monitoring owing to the principal disorder (non-custodial)?

Does the judge explicitly state a need for a lesser (reduced) sentence or a deliberate sentence requiring specific treatment/supervision/combination sentence, owing to the principal disorder (mitigating factor)?

Overall, does it appear that the principal disorder is a mitigating factor in the disposition (lesser sentence, specific treatment/supervision, combination sentence)?

What type of comments does the judge make about treatment or rehabilitation in direct connection with the principal disorder?

Does the judge emphasize the importance of treatment in the final disposition?

Does the judge mention resources in the province in connection to the final disposition?

Does the judge directly mention the offender’s culpability/responsibility in the commission of the crime?

**Demographics/Characteristics**

Does ethnicity (Aboriginal versus Non-Aboriginal) and having ADHD/FASD make a difference in sentencing outcomes, in terms of whether the neuro-cognitive deficit is regarded as a mitigating factor?

Does gender and having ADHD/FASD make a difference in sentencing outcomes, in terms of whether the neuro-cognitive deficit is regarded as a mitigating factor?
Does being a youth versus an adult and having ADHD/FASD make a difference in sentencing outcomes, in terms of whether the neuro-cognitive deficit is regarded as a mitigating factor?

What is the provincial variation with respect to the number of ADHD/FASD defendants in BC, SK and ON?

Other Disorders

How many defendants who have ADHD/FASD have comorbidity (presence of two or more disorders)?

What is, if any, the most common secondary type of diagnosed disorder, other than the principal disorder ADHD/FASD that is under investigation?

If the judge mentioned more than one disorder in the sentencing judgment, judging solely from the location of the disorder in the sentencing judgment, which disorder did the judge refer to more?

Criminal History and Current Crime

Are those defendants who are currently being charged for violent crimes less likely to have ADHD/FASD treated as a mitigating factor than those who are being sentenced for a non-violent crime?

How many defendants with ADHD/FASD have a history of past convictions?

Evaluator(s)/Expert Witness

In how many cases was it clearly stated that a formal diagnosis of the principal disorder was made?

Was the principal disorder mentioned directly when drawing an inference about the accused's treatability (whether accused can be treated or not) and/or treatment placement?

What was the overall direction of the inference about treatability in connection to the principal disorder (ADHD/FASD)?

What was the overall direction of the inference about violence in connection to the principal disorder (ADHD/FASD)?

What was the overall direction of the inference about general recidivism in connection to the principal disorder (ADHD/FASD)?

Is the evaluator’s statement regarding treatment similar or different to the judge’s final sentencing placement disposition?

Is the evaluator’s statement regarding placement/sentencing similar or different to the judge’s final sentencing placement disposition?
Policy Questions

Do the sentencing options that are currently available to Canadian courts adequately deal with the special needs of ADHD, FASD, mentally disordered offenders?

Does the sentencing of offenders who have neuro-cognitive deficits reflect addressing therapeutic needs (rehabilitation and treatment) or is the focus primarily on punishment and deterrence?

Appeal Court Questions

For which principal disorder (ADHD/FASD) was the appeal presumably allowed?

In how many cases did the issue of the appeal have to do with the principal disorder (ADHD, FASD)?

For the cases that the issue of the appeal has to with the principal disorder, how is the principal disorder (ADHD, FASD) an issue in the appeal?

Pertaining to the principal disorder (ADHD, FASD), did the original trial judge err in the opinion of the appellate judge who delivered the majority opinion or the opinion of the Court of Appeal?

If the final sentencing disposition is somehow relevant to the principal disorder (ADHD, FASD), and if the sentence is altered, is the sentence more or less severe?

If the appeal is allowed, does the appeal court directly mention the principal disorder (ADHD, FASD) in the final reasons for judgment?

If the appeal is allowed, does the principal disorder (ADHD, FASD) appear to be a major consideration in the final appeal judgment?

DATA ANALYSIS

SAS statistical software was utilized to conduct basic descriptive frequency distributions on selected case variables and to formulate univariate and bivariate analyses on specific variables for the 107 cases. This type of case study project is not dependent upon determining a statistically significant relationship between variables; therefore, it does not rely on access to a large dataset or elaborate, sophisticated statistical methods. It is difficult to compare and evaluate judicial decision-making empirically through quantitative advanced statistics: indeed, there is a considerable degree of variance in terms of the specific factors which judges choose to document in their final sentencing decisions. Certain relevant information may influence judges in their sentencing outcomes and yet it will not be specifically identified in their written decisions. There is no consistent document that articulates exactly what judges need to include in their final sentencing reports. Every criminal sentencing case contains unique information as presented by the judge. Some
sentencing judgments contain far more details about the offender, criminal history, mental health, medical history, circumstances leading up to the crime, the actual crime, expert witness testimony, and specific ‘reasons’ for judgments by judges than do other cases.

For this research project, descriptive statistics played a large role in providing a more detailed picture about the various variables and how some of the variables interacted together. The descriptive statistics certainly helped uncover many interesting patterns/findings with respect to acquiring an overview of how neuro-cognitive impairments are perceived in the Canadian courtroom and the impact that they have on sentencing decisions. The main methods of quantitative analysis were univariate and bivariate descriptive tables.

Similarly, a detailed qualitative analysis was incorporated to ultimately draw-out relevant major patterns and emergent themes and to capture very important commentary and quotes. Ultimately, the qualitative analyses elucidated themes and subthemes in the judges’ written decisions. The qualitative component was an imperative element for this type of collective case study research (where a number of cases are studied in order to investigate a specific phenomenon). The qualitative component presented in this project resulted from a purposive sampling method, in which specific cases were selected to illustrate some feature and process that was of interest; in this case the purposive sampling inquiry was focused on ADHD and FASD criminal sentencing judgment decisions that took place within a specific time frame. Such a qualitative method was largely inductive in nature and ultimately many emergent themes in various facets of the court case dataset on ADHD and FASD were revealed. In order to identify and draw-out themes from the FASD and ADHD cases under examination, a detailed, systematic method was incorporated. The 150 variables of interest were colour-coded in an Excel workbook. Each statement about FASD/ADHD, by any evaluator/judge, was captured and recorded into Excel for all 107 cases. The variables of interest from Excel were then transferred into a WORD document and all of the remarks made about the disorders were directly pasted into WORD under each identified variable. All statements were then carefully read and themes under each variable for every case were identified.

An additional four months was utilized to select the relevant variables for quantitative analysis, in order to conduct the statistical analysis and then to
examine the dataset as a whole, as well as to qualitatively analyze many of the case variables. Hence, one year was set aside for the purpose of selecting the appropriate coding form, coding the cases and analyzing the results. Both quantitative and qualitative methods greatly assisted in producing the results of this project, recommendations, discussion/conclusion and future recommendations. In the next two chapters, a detailed examination of the results of this case study project will be presented.

**SUMMARY**

The present study reports detailed quantitative and qualitative analyses of results. The data were obtained from Quicklaw with respect to 107 cases heard in youth court and adult criminal court (both first instance and appellate) in British Columbia, Saskatchewan and Ontario between 2004 and 2009 (five-year period). The cases were selected in which the condition of FASD or ADHD was raised as a consideration in the sentencing decision. The main research question concerned the impact of a diagnosis of FASD or ADHD on sentencing, according to the judge’s recorded decision, and there were many subsidiary research questions concerning all aspects of the handling of such cases by the courts. For the quantitative analyses, a considerable number of aspects of the cases were coded, resulting in between 100 and 150 variables for each case. The main methods of quantitative analysis were univariate and bivariate descriptive tables. The qualitative analyses elucidated themes and subthemes in the judges’ written decisions.
Chapter 5:

RESULTS

PART 1: QUANTITATIVE DESCRIPTIVE ANALYSIS

UNIVARIATE AND BIVARIATE ANALYSIS

The quantitative analysis component encompassed the gathering of information in a descriptive statistical format, since descriptive statistics are used to summarize and describe data in manageable forms. SAS software was utilized for this purpose and a univariate analysis was undertaken in order to examine the distribution of cases on one variable at a time and then subgroup comparisons were made by employing bivariate analysis (since two variables were involved in the analysis). Bivariate analysis is primarily concerned with the examination of the relationships among certain variables: this approach proved to be a very useful method for the examination of the data. The qualitative analysis also generated some fascinating themes both within and among cases (these themes are presented and discussed in Chapter Six). The results component will begin with the presentation of descriptive univariate and bivariate findings for both FASD and ADHD before delving into the qualitative analysis component.

DESCRIPTIVE STATISTICS

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>FASD</td>
<td>40</td>
<td>37.4</td>
</tr>
<tr>
<td>ADHD</td>
<td>67</td>
<td>62.6</td>
</tr>
</tbody>
</table>

In the period of March 17, 2004 through March 17, 2009, there were 40 FASD and 67 ADHD cases available to be coded and analyzed (after excluding irrelevant cases). The Court of Appeal cases for FASD and ADHD (24 cases in
total; 9 fetal alcohol cases and 15 attention-deficit cases) will be discussed separately, since they were not coded in the same manner as the other sentencing decision cases. Hence, when excluding the appellate court cases, 31 fetal-alcohol and 52 attention-deficit cases were coded for all of the variables listed in the methodology chapter under ‘variables coded’ (except for the distinct appellate court variable coding section which was exclusively for the 24 Court of Appeal cases).

![Table 2: Gender](image)

<table>
<thead>
<tr>
<th>Gender</th>
<th>BC</th>
<th>SK</th>
<th>ON</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>6</td>
<td>1</td>
<td>6</td>
<td>12.1</td>
</tr>
<tr>
<td>Male</td>
<td>41</td>
<td>18</td>
<td>35</td>
<td>87.9</td>
</tr>
</tbody>
</table>

Females were largely underrepresented in the case studies in all of the provinces. In BC, for both FASD and ADHD, there were six women versus 41 men, SK had one female versus 18 males and ON had 35 men versus six women. Therefore, men represented 87.9% of the data collected and women represented 12.1%.

![Table 3: Youth versus Adult](image)

<table>
<thead>
<tr>
<th>Youth versus Adult</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth</td>
<td>30</td>
<td>39.0</td>
</tr>
<tr>
<td>Adult</td>
<td>77</td>
<td>61.0</td>
</tr>
</tbody>
</table>

In terms of youth versus adults, there were 30 youth cases (39.0%) and 77 (61.0%) adult cases, with ON holding the highest number of youth cases (16), followed by SK with eight and BC displaying six cases.

![Table 4: Number of FASD & ADHD Cases in BC, SK & ON During 5-year Period](image)

<table>
<thead>
<tr>
<th>disorder</th>
<th>BC</th>
<th>SK</th>
<th>ON</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FASD</td>
<td>18</td>
<td>12</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>ADHD</td>
<td>29</td>
<td>7</td>
<td>31</td>
<td>67</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>19</td>
<td>41</td>
<td>107</td>
</tr>
</tbody>
</table>
When breaking down the cases by province and by disorder, an interesting finding was observed for the fetal-alcohol-spectrum-disorder cases. Of the 40 FASD cases in total, including the appellate court cases, in BC there were 18 cases (making up 45.0% of the total FASD cases in BC, SK and ON in the five-year period), 12 cases in SK (making up 30.0% of the total FASD cases in BC, SK and ON in the five-year period), and 10 cases in ON (making up 25.0% of the total FASD cases in BC, SK and ON in the five-year period). For FASD, in BC, when excluding appellate court cases, there were 13 cases (making up 41.9% of the total FASD cases in BC, SK and ON, excluding the appellate court cases, in the five-year period), eight cases in SK (making up 25.8% of the total FASD cases in BC, SK and ON, excluding the appellate court cases, in the five-year period), and ten cases in ON (making up 32.3% of the total FASD cases in BC, SK and ON, excluding the appellate court cases, in the five-year period).

For ADHD, of the 67 ADHD cases in total, including appellate court cases, 29 (43.3%) were found in BC, only seven (10.5%) in SK and 31 in Ontario (46.3%). For ADHD, in BC, when excluding appellate court cases, there were 19 cases (making up 36.5% of the total ADHD cases in BC, SK and ON, excluding the appellate court cases, in the five-year period), four cases in SK (making up 7.7% of the total ADHD cases in BC, SK and ON, excluding the appellate court cases, in the five-year period), and 29 cases in ON (making up 55.8% of the total FASD cases in BC, SK and ON, excluding the appellate court cases, in the five-year period).

**Ethnicity, Gender and Youth versus Adult**

Ethnicity was coded as either ‘First Nations’ or ‘Other’ for all cases because, when an offender was of Aboriginal descent, it was always stated in the judgment, while no other ethnic background was identified.
Interestingly, for the 40 FASD cases, 25 were for defendants of Aboriginal descent (62.5%) and the remaining 15 (37.5%) were their non-Aboriginal counterparts. When excluding the appellate court cases, there were 31 FASD cases and of those 31 cases, 20 of them comprised Aboriginal offenders (65.0%). Yet, for the ADHD cases, 17 of the 67 (25.4%), the offender was Aboriginal and, when excluding the ADHD appellate court cases, in 14/52 cases (26.9%) the offender was Aboriginal.

**Table 5: Number of Aboriginal versus Non-Aboriginal Offenders**

<table>
<thead>
<tr>
<th>Table of Disorder by Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>disorder</strong></td>
</tr>
<tr>
<td><strong>Frequency Row Pct Col Pct</strong></td>
</tr>
<tr>
<td>FASD</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>ADHD</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

In terms of ethnicity and gender, there were 39 First Nation males in the case study, in comparison to 55 males who fit in the ‘other’ category (41.5% Aboriginal versus non-Aboriginal males). There were three First Nations
women and the remaining ten women were in the ‘other’ category (23.0% Aboriginal versus non-Aboriginal women).

<table>
<thead>
<tr>
<th>Table 7: Ethnicity by Youth versus Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table of Ethnicity by Youth versus Adult</td>
</tr>
<tr>
<td>ethnicity</td>
</tr>
<tr>
<td>Frequency</td>
</tr>
<tr>
<td>Row Pct</td>
</tr>
<tr>
<td>First Nation</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

There were ten First Nations youth in the study versus 32 adult First Nations offenders (23.8% Aboriginal versus non-Aboriginal male youth). Also, 20 youth were in the ‘other’ ethnicity category, which made Aboriginal youth comprise 33.3%.

**COMORBIDITY AND THE PRESENCE OF ‘OTHER’ DISORDERS**

For all of the cases that were coded for either FASD and/or ADHD, information was gathered with respect to how many disorders, other than the principal disorder (FASD or ADHD), were linked to the defendant. It was observed in 26.5% of the cases that no other disorder was alluded to, in 32.5% of the cases, one other disorder was mentioned, in 22.9% of the cases two other disorders were associated with the offender and for three or more disorders, the percentages were miniscule. Thus, it is evident that comorbidity was certainly a reality for the majority of offenders.
Table 8: Number of Cases in which Offender also has Co-Occurring Disorder(s)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Frequency Row Pct</th>
<th>Frequency Col Pct</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FASD</td>
<td></td>
<td></td>
<td>22</td>
<td>9</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>70.97</td>
<td>36.67</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADHD</td>
<td></td>
<td></td>
<td>38</td>
<td>14</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>73.08</td>
<td>63.33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>60</td>
<td>23</td>
<td>83</td>
</tr>
</tbody>
</table>

In the cases in which FASD was investigated as the principal disorder, 71% of the cases included the defendant having more than just the principal disorder. For ADHD, the figure is very similar—in 73.1% of the cases, the defendant had a co-occurring disorder.

Table 9: Number of Cases in which Offender also has Co-Occurring Disorder(s)

<table>
<thead>
<tr>
<th>Youth or Adult by Co_Occuring</th>
<th>co-occurring</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency Row Pct</td>
<td>Yes</td>
<td>No</td>
<td>Total</td>
</tr>
<tr>
<td>Frequency Col Pct</td>
<td>Yes</td>
<td>No</td>
<td>Total</td>
</tr>
<tr>
<td>Youth</td>
<td>18</td>
<td>9</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>66.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>30.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>42</td>
<td>14</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>75.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>70.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>23</td>
<td>83</td>
</tr>
</tbody>
</table>

For youth, 66.7% had a co-occurring disorder and adults had a co-occurring disorder in 75.0% of the cases. Males had a co-occurring disorder in 71.6% of the cases and females in 77.8% of the cases.
When delving further into the comorbidity issue, it was interesting to determine if there was any pattern of the ‘type’ of disorder with which the offender was diagnosed, in conjunction with either having FASD or ADHD. The majority of offenders who had any other additional disorder, other than the principal disorder under investigation—FASD or ADHD, fell alone in the AXIS 1 (clinical disorders, including major mental disorders, learning disorders and substance use disorders) category (58.6%), 8.6% fell alone in the AXIS 2 (personality disorders and intellectual disabilities) category, and 32.8% fell both in the AXIS 1 and AXIS 2 categories.

Table 10: Number of FASD & ADHD Cases in which Offender has a Classification of ‘Other’ Disorders that Fit(s) Under AXIS 1, AXIS 2 or Both AXIS 1 & 2 Disorder(s)

<table>
<thead>
<tr>
<th>disorder</th>
<th>axis_class</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Row Pct</td>
<td>Col Pct</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Axis 1</td>
<td>Axis 2</td>
<td>Axis 1 and 2</td>
<td>Total</td>
</tr>
<tr>
<td>FASD</td>
<td>17</td>
<td>0</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>80.95</td>
<td>0.00</td>
<td>19.05</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50.00</td>
<td>0.00</td>
<td>21.05</td>
<td></td>
</tr>
<tr>
<td>ADHD</td>
<td>17</td>
<td>5</td>
<td>15</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>45.95</td>
<td>13.51</td>
<td>40.54</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50.00</td>
<td>100.00</td>
<td>78.95</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>5</td>
<td>19</td>
<td>58</td>
</tr>
</tbody>
</table>

For the cases in which FASD was the principal disorder under investigation, in 80.9% of the cases the co-occurring disorder fell under AXIS 1, no cases for AXIS 2 and 19.1% of cases for AXIS 1 and 2. For the cases in which ADHD was the principal disorder under investigation, in 45.9% of the cases the co-occurring disorder fell under AXIS 1, 13.5% of the cases for AXIS 2 and 40.5% of cases for AXIS 1 and 2. Hence, those being investigated for ADHD definitely had more AXIS 2 diagnoses than when FASD was being investigated as the primary disorder.

In terms of whether there was any discernible pattern for the type of ‘other’ disorder the majority FASD/ADHD offenders were classified as having, the AXIS 1 substance-related disorder category was the most common. In 42 of the 55 AXIS 1 diagnoses, substance abuse was the disorder accounted for. Therefore, 76.0% of the offenders who were diagnosed with another disorder in
the AXIS 1 category had substance abuse disorder. Overall, it was evident from the sentencing cases that co-occurring disorders (the presence of two or more disorders) took place in 72.3% of the cases and more importantly, in 74.7% of the cases, the judge did ‘directly’ mention other disorders in the sentencing judgment.

Table 11: Disorder Mentioned the Most in Sentencing Case for the Cases where FASD was Investigated as the Principal Disorder

<table>
<thead>
<tr>
<th>Disorder</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>FASD</td>
<td>58.1%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>22.6%</td>
</tr>
<tr>
<td>No Particular Disorder</td>
<td>9.7%</td>
</tr>
<tr>
<td>Sexual/Gender Identity</td>
<td>3.2%</td>
</tr>
<tr>
<td>Intellectual Impairment</td>
<td>3.2%</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Looking at which exact disorder was mentioned the most in the sentencing case (counting the exact time the disorder was discussed either by the judge or any other evaluator), for the cases where FASD was investigated as the principal disorder, FASD was mentioned the most frequently in 58.1% of the cases, followed by substance abuse, which was mentioned the most in 22.6% of the cases. There was no particular attention paid to any particular disorder in 9.7% of the cases. Otherwise, when still analyzing the cases where FASD was the principal disorder under investigation, in only 3.2% of the cases was either sexual and gender identity disorder, intellectual impairment or borderline personality disorder mentioned the most. Hence, FASD was certainly mentioned the most frequently in the cases where FASD was under investigation as the principal disorder.

Table 12: Disorder Mentioned the Most in Sentencing Case for the Cases where ADHD was Investigated as the Principal Disorder

<table>
<thead>
<tr>
<th>Disorder</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>46.2%</td>
</tr>
<tr>
<td>No Particular Disorder</td>
<td>26.9%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>7.7%</td>
</tr>
<tr>
<td>Antisocial Personality</td>
<td>7.7%</td>
</tr>
<tr>
<td>FASD</td>
<td>5.8%</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>3.9%</td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td>1.9%</td>
</tr>
</tbody>
</table>
When ADHD was the principal disorder under investigation, 46.2% of the cases mentioned ADHD the most frequently, followed by no particular focus on any disorder (26.9%), substance abuse disorder was mentioned the most frequently in 7.7% of the cases, as was antisocial personality disorder. Interestingly, in all of the cases where the offender was diagnosed with antisocial personality disorder and the diagnosis was mentioned the most frequently, imprisonment was the final disposition with a long-term offender (LTO) designation in one of the cases and a dangerous offender designation (DO) in another case. Finally, when ADHD was the principal disorder under investigation, FASD was mentioned the most frequently in 5.8% of the cases, followed by conduct disorder (3.9%) and then psychotic disorder was only mentioned the most in 1.9% of the cases. Hence, ADHD was certainly mentioned the most frequently in the cases where ADHD was under investigation as the principal disorder.

The Tables below (Tables 13 & 14) on FASD and ADHD (youth versus adults comorbid disorders) display all of the comorbid disorders that accompanied either FASD or ADHD.

Table 13: (FASD) Youth versus Adult Comorbid Disorders

<table>
<thead>
<tr>
<th>Youth (Y)</th>
<th>Adult (A)</th>
<th>Type of Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Y</td>
<td>SUD</td>
</tr>
<tr>
<td>Y</td>
<td>A</td>
<td>SUD</td>
</tr>
<tr>
<td>A</td>
<td>Y</td>
<td>Pedophilia</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>SUD</td>
</tr>
<tr>
<td>A</td>
<td>Y</td>
<td>SUD</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>SUD</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>ADHD</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>SUD, Paranoid Schizophrenia, Mixed Personality, Borderline Mental Functioning</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>ADHD, CD, SUD, APD, Dyslexia, Borderline Mental Functioning</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>ODD, ADHD, SUD, Learning Disability NOS</td>
</tr>
<tr>
<td>A</td>
<td>Y</td>
<td>SUD, Intellectually Impaired</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>Personality Disorder, Pedophilia</td>
</tr>
</tbody>
</table>

104
<table>
<thead>
<tr>
<th>Youth (Y)</th>
<th>Type of Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult (A)</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>SUD</td>
</tr>
<tr>
<td>A</td>
<td>SUD, Borderline Personality</td>
</tr>
<tr>
<td>A</td>
<td>SUD</td>
</tr>
<tr>
<td>A</td>
<td>SUD</td>
</tr>
<tr>
<td>A</td>
<td>SUD</td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>CD, ADHD, ODD, PTSD, Mild Mental Retardation, Learning Disability NOS, Anxiety Disorder, Depression</td>
</tr>
<tr>
<td>A</td>
<td>SUD</td>
</tr>
<tr>
<td>A</td>
<td>ADHD, Depression</td>
</tr>
<tr>
<td>A</td>
<td>SUD</td>
</tr>
<tr>
<td>A</td>
<td>SUD, APD, Paraphilic Disorder, Borderline Personality Traits</td>
</tr>
<tr>
<td>A</td>
<td>ADHD, SUD</td>
</tr>
</tbody>
</table>

Legend:
ADHD – Attention Deficit Hyperactivity Disorder
APD – Antisocial Personality Disorder
CD – Conduct Disorder
FASD – Fetal Alcohol Spectrum Disorder
OCD – Obsessive Compulsive Disorder
ODD – Oppositional Defiant Disorder
PTSD – Post Traumatic Stress Disorder
SUD – Substance Use Disorder

With respect to FASD, of the 31 FASD offenders, the most prevalent disorder was SUD (18 in total), followed by ADHD (five in total), CD (two in total), APD (two in total) and ODD (two in total).

Table 14: (ADHD) Youth versus Adult Comorbid Disorders

<table>
<thead>
<tr>
<th>Youth (Y)</th>
<th>Type of Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult (A)</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>SUD</td>
</tr>
<tr>
<td>A</td>
<td>SUD</td>
</tr>
<tr>
<td>A</td>
<td>CD, APD, Learning Disability</td>
</tr>
<tr>
<td>A</td>
<td>SUD, CD, PTSD</td>
</tr>
<tr>
<td>Y</td>
<td>SUD, CD, APD</td>
</tr>
<tr>
<td>Youth (Y)</td>
<td>Adult (A)</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
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<td>A</td>
<td>A</td>
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<td>A</td>
<td>A</td>
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<td>A</td>
<td>A</td>
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<tr>
<td>A</td>
<td>A</td>
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<tr>
<td>Y</td>
<td>A</td>
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<tr>
<td>A</td>
<td>A</td>
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<td>A</td>
<td>A</td>
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<td>A</td>
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<td>A</td>
<td>A</td>
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<tr>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Y</td>
<td>A</td>
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<tr>
<td>Y</td>
<td>A</td>
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<td>Y</td>
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</tr>
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<td>Y</td>
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<td>Y</td>
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<td>A</td>
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<td>A</td>
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</tr>
<tr>
<td>Y</td>
<td>A</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Youth (Y)</td>
<td>Type of Disorder</td>
</tr>
<tr>
<td>----------</td>
<td>------------------</td>
</tr>
<tr>
<td>Adult (A)</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Y</td>
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<td>A</td>
</tr>
<tr>
<td></td>
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<td>A</td>
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</tr>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>A</td>
</tr>
</tbody>
</table>

**Legend:**

ADHD – Attention Deficit Hyperactivity Disorder  
APD – Antisocial Personality Disorder  
CD – Conduct Disorder  
FASD – Fetal Alcohol Spectrum Disorder  
OCD – Obsessive Compulsive Disorder  
ODD – Oppositional Defiant Disorder  
PTSD – Post Traumatic Stress Disorder  
SUD – Substance Use Disorder

For ADHD, of the 52 ADHD offenders, the most prevalent disorder was SUD (21 in total), followed by CD (11 in total), APD (seven in total), ODD (five in total) and FASD (five in total).

Another result concerned both FASD and ADHD cases and analyzing the co-occurring variable to see whether the offender was currently being sentenced for having committed a violent or non-violent offence. The finding revealed that there was no difference in terms of whether the offender committed a violent or non-violent offence and had a co-occurring disorder. In 73.2% of the cases, the offender had committed a violent offence and had a co-occurring disorder and, in 70.4% of the cases the offender committed a non-violent offence and had a co-occurring disorder.
**Placement of Disorders in Sentencing Judgment**

Since the principal disorder under investigation, either FASD and ADHD, was not the only disorder being discussed in 72.3% of the cases, in order to determine to which disorder the judge gave the most priority, the location of the points in the judgments where the judge mentioned the principal disorder as well as the other disorder(s) were compared. Hence, in the cases where a judge did directly mention other disorders, judging solely from whether the judge mentioned the disorder at the beginning, middle or end of the judgment; throughout the judgment, beginning and middle or the middle and end of the judgment, the judge referred to the ‘other’ disorders the most in 38.7% of the cases, both equally in 37.1% of the cases and the principal disorder the most in 24.2% of the cases. It is, therefore, evident that, in the majority of the cases, the judge either referred to disorders other than the principal disorder the most or emphasized the principal disorder as well as another disorder equally; in effect, the sentencing judge focused mostly on the principal disorder in only one quarter of all the cases.

**Table 15: If Judge Mentioned More than 1 Disorder in Sentencing Judgment, Judging Solely from Location of Disorder in Sentencing Judgment, which Disorder did Judge Refer to More**

<table>
<thead>
<tr>
<th></th>
<th>Table of Disorder by Judge_Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>disorder</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
</tr>
<tr>
<td>Row Pct Col Pct</td>
<td></td>
</tr>
<tr>
<td>FASD</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>33.33</td>
</tr>
<tr>
<td>ADHD</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>42.11</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
</tr>
</tbody>
</table>

Specifically, for the cases where FASD was the principal disorder under observation, only in 37.5% of the cases was the principal disorder given the most priority, in 33.3% of the cases another disorder other than the principal disorder was given more priority and in 29.2% of the cases, both the principal
disorder and another disorder were given the same priority. For the cases where ADHD was the principal disorder under observation, even less priority was given to the principal disorder than was found for FASD, (15.8%); however, in 42.1% of the cases another disorder other than the principal disorder was given more priority and equally in 42.1% of the cases, both the principal disorder and another disorder were given the same priority.

Table 16: If Judge Mentioned More than 1 Disorder in Sentencing Judgment, Judging Solely from Location of Disorder in Sentencing Judgment, which Disorder did Judge Refer to More for Youth Versus Adult

<table>
<thead>
<tr>
<th>Table of Adult by Judge_Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>adult</strong></td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
</tr>
<tr>
<td><strong>Row Pct</strong></td>
</tr>
<tr>
<td>Youth</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Adult</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

When comparing the priority given to the principal disorder, the ‘other’ disorder or both equally to youth versus adults, it was observed that in 42.1% of the youth cases, the judge gave priority to the principal disorder, when simply basing ‘priority’ as to the placement of the disorder in the sentencing judgment. Whereas, for the adult case population, only in 16.3% of the cases did the principal disorder receive the most priority based on its location in the judgment. When the ‘other’ disorder was given more priority, not much of a difference was seen between youth (36.8%) and adults (39.5%) but when both the principal disorder and the other disorder were treated equally, this was seen in 21.1% of the youth cases versus 44.2% of the adult cases.
When strictly analyzing the placement of where the judge directly mentioned the principal disorder in the sentencing judgment, the following was observed. For all of the cases in which FASD was the principal disorder under investigation, in 29.0% of the cases the judge directly mentioned the principal disorder throughout the judgment, 25.8% of the cases were directly mentioned in the middle of the judgment, 16.1% at the beginning, 12.9% at the middle and at the end, 6.5% at the beginning and middle as well as at the beginning and the end and only in 3.2% of the cases was the principal disorder of FASD directly mentioned at the end of the sentencing judgment. When ADHD was the principal disorder under investigation, the patterns of the placement of the principal disorder in the sentencing judgment was different than that of FASD. In particular, in 42.3% of the cases, the judge directly mentioned the principal disorder in the middle of the judgment, 32.7% at the beginning of the judgment, 9.6% at the beginning and middle, 7.7% throughout, 3.9% at the middle and end and 1.9% at both the beginning and end as well as at the end.
It was also pertinent to see whether there was any discernible pattern with respect to where in the case the judge directly mentioned the principal disorder and whether the principal disorder turned out to be a mitigating factor in the sentencing judgment. Mitigating meaning, the principal disorder is a consideration in the final sentencing disposition (results in a reduction in sentence or the sentence is deliberate in requiring treatment/supervision or a combination sentence). Of the 83 FASD/ADHD cases, excluding appellate court cases, there were 18 cases in which the judge either explicitly stated FASD or ADHD as being a mitigating factor in sentencing or somehow alluded to the disorder being a mitigating factor in their statement(s). It was relevant to examine where in the sentencing judgment the judge had directly mentioned the principal disorder in order to see if there was any pattern that could be discerned. In six of the eighteen cases in which FASD/ADHD were regarded as ‘mitigating’ factors in sentencing, the principal disorder was mentioned throughout the entire sentencing judgment. Only in one case was the principal disorder mentioned solely at the end of the sentencing judgment—when it was regarded as a mitigating factor; in two of the cases, the principal disorder was mentioned at the beginning and the end of the sentencing judgment; in two of the cases the principal disorder was mentioned at the beginning and the middle of the sentencing judgment; in one of the cases the principal disorder was mentioned only at the beginning of the sentencing judgment; in four of the cases, the principal disorder was mentioned in the middle of the sentencing judgment and finally, in two of the cases, the principal disorder was mentioned in the middle and end of the sentencing judgment.

<table>
<thead>
<tr>
<th>18 Mitigating FASD/ADHD Cases</th>
<th>Placement In Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/18</td>
<td>throughout</td>
</tr>
<tr>
<td>4/18</td>
<td>middle</td>
</tr>
<tr>
<td>2/18</td>
<td>beginning &amp; middle</td>
</tr>
<tr>
<td>2/18</td>
<td>beginning &amp; end</td>
</tr>
<tr>
<td>2/18</td>
<td>middle &amp; end</td>
</tr>
<tr>
<td>1/18</td>
<td>beginning</td>
</tr>
<tr>
<td>1/18</td>
<td>beginning</td>
</tr>
</tbody>
</table>
There were five cases out of the 83, excluding the appellate court judgments, which exemplified the diagnosis of FASD/ADHD as possibly contributing to the lengthening of the sentencing disposition, or not having any impact at all on the final outcome and this was stated directly by the judge. When looking at five cases for FASD/ADHD, in which the principal disorders did not influence the judge to impose a more lenient sentence, or turn out to be a consideration in the final sentencing disposition, it was relevant to examine where in the sentencing judgment the judge had directly mentioned the principal disorder, to see if there was any pattern that could be discerned. Unlike in the 18 ‘mitigating’ factor cases, in which the principal disorder was often directly discussed not only in the middle or throughout the cases, but also in various locations, the principal disorder was only mentioned at the beginning of the judgment, in four or five of the cases, and—in one of the cases—the principal disorder was mentioned both in the middle and at the end.

**Sentencing Disposition**

The most utilized and noteworthy sentencing disposition for both FASD and ADHD cases was some type of imprisonment.

<table>
<thead>
<tr>
<th>Frequency Row Pct Col Pct</th>
<th>Custody</th>
<th>Conditional Sentence</th>
<th>Probation</th>
<th>ISSO</th>
<th>Detention Order Youth</th>
<th>IRC</th>
<th>Actual Sentence Not Yet Determined</th>
<th>17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FASD</strong></td>
<td>23</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>31</td>
</tr>
<tr>
<td>74.19</td>
<td>12.90</td>
<td>57.14</td>
<td>50.00</td>
<td>3.23</td>
<td>3.23</td>
<td>3.23</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>34.85</td>
<td>100.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ADHD</strong></td>
<td>43</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>52</td>
</tr>
<tr>
<td>82.69</td>
<td>5.77</td>
<td>42.86</td>
<td>50.00</td>
<td>1.92</td>
<td>0.00</td>
<td>3.85</td>
<td>100.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65.15</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>66</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>83</td>
</tr>
</tbody>
</table>

When FASD was viewed as the principal disorder in the case, imprisonment was handed down by the judge in 74.2% of the FASD cases (23/31) and in 82.7% of those cases in which ADHD was considered to be the
principal disorder, (43/52), demonstrating it was a favoured disposition by the judge. Hence, when combining the FASD and ADHD cases together, some form of a custodial sentence was granted in 80% of the cases (66/83). Evidently, there is certainly no major difference in the ‘handing down’ of the custodial disposition for FASD versus ADHD cases. Breaking the imprisonment variable down even further for youth versus adults, youth received custody in 59.2% of all FASD and ADHD cases and adults received custody in 89.3% of all cases. For the other dispositions, which included a conditional sentence, probation, Intensive Support and Supervision Order (ISSO), Intensive Rehabilitative Custody Supervision (IRCS) or an actual sentence not yet determined, the number of cases were so small, it was not worth breaking down into percentages.

**Criminal Offence Type and Past Convictions for FASD Offenders**

In order to examine whether FASD offenders commit more violent, as opposed to non-violent types of crime, as has been presented in current FASD academic literature (McDonald, Colombi & Fraser, 2009), the 31 FASD cases were analyzed for their present crime type and history of past convictions.

<table>
<thead>
<tr>
<th>Case Name</th>
<th>Youth /Adult</th>
<th>Current Crime(s)</th>
<th>Violent (V) /Non-Violent (NV)</th>
<th>Past Convictions (P)/No Past Convictions (NP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>R. v. Pauls (2005)</td>
<td>Adult</td>
<td>Failing to appear in court, failing to report to a bail supervisor, being in a private motor vehicle</td>
<td>NV</td>
<td>P</td>
</tr>
<tr>
<td>R. v. Stein (2006)</td>
<td>Adult</td>
<td>Theft under $5,000, attempted theft, mischief and break and enter</td>
<td>NV</td>
<td>P</td>
</tr>
<tr>
<td>Case Name</td>
<td>Youth /Adult</td>
<td>Current Crime(s)</td>
<td>Violent (V) /Non-Violent (NV)</td>
<td>Past Convictions (P)/ No Past Convictions (NP)</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>R. v. Potter (2006)</td>
<td>Adult</td>
<td>Offence contrary to s. 811—rode bicycle past elementary school ground and looked in direction of the children who were out for recess</td>
<td>NV</td>
<td>P</td>
</tr>
<tr>
<td>R. v. M.S. (2004)</td>
<td>Youth</td>
<td>carrying a concealed weapon and failing to comply with his probation order</td>
<td>NV</td>
<td>P</td>
</tr>
<tr>
<td>R. v. Edwards (2005)</td>
<td>Adult</td>
<td>purpose of facilitating commission of offence—unlawfully attempt for a sexual purpose a person believed to be under 14 contrary to sections 152 and 463 of CC</td>
<td>NV</td>
<td>P</td>
</tr>
</tbody>
</table>
Of the 31 cases in which FASD was the principal disorder under investigation, eight of those cases were for youth offenders. Six of the eight youth FASD defendants committed violent crimes and five of the eight youth defendants had prior criminal records. For the purpose of this dissertation, violent crime is defined as offences that deal with the application or threat of force to a person. Such offences include homicide, attempted murder and various forms of sexual and non-sexual assault, robbery and abduction. For the violent youth crimes, youths with FASD committed second degree murder, criminal negligence causing death, robbery (in three cases), sexual assault and assault.

The remaining 23 FASD cases involved adult offenders and 17 of the defendants committed violent crimes. Furthermore, 21 of the 23 adult FASD offenders had a prior criminal record. In terms of the types of violent crimes that the adults committed, the crimes were as follows: manslaughter, aggravated sexual assault, aggravated assault (three cases), robbery (six cases), unlawful confinement, sexual assault causing bodily harm (two cases), sexual assault (two cases), assault with a weapon, assault causing bodily harm, assault, forcibly seizing a woman and uttering death threats and uttering a threat.

Evaluators and Presence of Principal Disorder

Every key evaluator whose contribution was discussed in each sentencing case was assigned a code. Evaluators included mental health professionals (psychologist or psychiatrist), medical doctor, probation officer, prosecutor and the counsel for the defendant. It was of importance to gain further insight into how offenders suffering from FASD and ADHD were regarded by professionals in specific fields, especially as far as diagnosis, risk and treatability were concerned. This evaluator variable will be greatly expanded upon in the qualitative component of the results chapter.
For all of the FASD and ADHD cases combined, in 83.1% of the cases an evaluator directly stated that the defendant had the principal disorder and, in the remaining 16.9% of the cases, it was implied that the accused may have the principal disorder. ‘Implied’, in this context, refers to an evaluator not stating directly that the accused has the disorder but rather making a statement of ‘assumption’ about the accused possibly having the disorder. In 64.5% of the FASD cases, an evaluator directly stated that the accused had the principal disorder; whereas, for the ADHD cases, in 94.2% of the cases an evaluator stated that the accused had the principal disorder. However, when it came to the issue of a formal diagnosis of the principal disorder being mentioned in the sentencing judgment, only in 51.8% of the FASD and ADHD cases combined was a direct, official diagnosis made or referred to. In the cases where a formal diagnosis was made, 52% were made by a mental health professional, 20% were unclear (not clearly specified who made the formal diagnosis) and eight percent were provided by a medical doctor.
When separating out the FASD cases from the ADHD ones, only in 32.2% of FASD cases was a ‘formal’ diagnosis referred to in the sentencing judgment and yet for ADHD, in 63.5% of the cases a formal diagnosis of the disorder was noted.

For those cases in which FASD and ADHD were under investigation as the principal disorders, a variable of interest was ‘treatability’ (whether any evaluator in the sentencing judgment mentioned the principal disorder directly
when drawing an inference about the accused’s treatability — whether the accused could be treated or not). In 45.2% of the FASD cases and in only 19.2% of the ADHD cases, did an evaluator directly connect the principal disorder to the issue of treatability (this will be examined more fully in the qualitative component). In terms of whether evaluators commented directly more on the principal disorder and treatability for youth rather than adults or for females versus males, no such patterns were observed. Again, as stated earlier, the qualitative component will analyze the evaluators’ statements regarding FASD and ADHD, in terms of their stated inferences about treatment, placement, violence and recidivism as well as offering a detailed portrayal of the judges’ decision-making patterns, distinct disposition themes between youth and adults as well as an overview explanation of the appellate court cases that were under investigation.

**SUMMARY**

The major outcomes of the quantitative component of the study were as follows: Females made up a very small percentage of the overall sample cases, when FASD or ADHD as principal disorders were investigated: this accords with overall crime statistics, year after year, in terms of women partaking in less crime than their male counterparts. It does not mean that women do not have the disorders of FASD and ADHD just as much as their male counterparts but rather they do not engage in as much criminal activity as men do. British Columbia encompassed the largest number of FASD cases, in comparison with Ontario and Saskatchewan: however, there was a greater incidence of FASD cases in the two Western provinces than in the Eastern province of Ontario. Furthermore, Aboriginal people were over-represented in sentencing decisions in which FASD was the major disorder: however, this finding was not made with respect to decisions in which ADHD was the major disorder.

A high percentage of co-occurring disorders was found in most of the sentencing decisions involving offenders living with FASD and/or ADHD,

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1 For all of the youth cases, in 33.3% of them treatability was clearly stated by an evaluator versus 26.8% in the adult cases. For all of the cases when comparing gender to treatability, in 33.3% of the female cases a direct link was made between treatability and the principal disorder versus 28.4% in the male cases.
whether they were youths or adults, males or females. A substance-related diagnosis was the most prevalent disorder identified for both FASD and ADHD offenders. For FASD, the most prevalent disorder was SUD (substance-related diagnosis), followed by ADHD, CD, APD and ODD; whereas, for ADHD, the most prevalent disorder was SUD (substance-related diagnosis), followed by CD, APD, ODD and FASD. Another important finding was that the presence or absence of a co-occurring disorder had no effect on whether the offender committed a violent as opposed to a non-violent offence. It was also observed from the results that, when an accused person has a comorbidity of disorders, it is simply uncertain either what disorder or disorders a judge will emphasize the most in a sentencing judgment or where in the sentencing judgment a judge will discuss the disorder. In practically three-quarters of the cases, a judge mentioned ‘other’ disorders with equal or even greater frequency than the principal disorder of FASD or ADHD: thus it could be inferred that the disorders of FASD and ADHD were not given high priority, as opposed to the other disorders with which the accused persons were afflicted.

The placement of the discourse with respect to FASD/ADHD in the sentencing decisions that resulted in the judge considering these disorders to be mitigating factors most frequently occurred in the middle of, or throughout, the sentencing judgments. However, since it was also observed in several of the 18 cases that the principal disorder was mentioned in various parts of the judgment, other than just the middle or throughout, the findings reflected that there was no definitive pattern. In four of the five cases involving FASD/ADHD, which identified the diagnosis of FASD/ADHD as possibly contributing to the lengthening of the sentencing disposition or not having any effect on the final sentencing judgment, the principal disorder was only mentioned at the beginning of the judgment and, in one of the cases, the principal disorder was mentioned in the middle and at the end.

In terms of dispositions and the types of crime committed when an offender had FASD/ADHD, imprisonment was the most common sentencing disposition handed down for both principal disorders and such a custodial disposition was given more frequently to adults than to youths. Perhaps, a custody term was imposed quite frequently since many of the offenders were convicted of committing a violent crime. Almost all of the FASD youth in the case study committed a violent crime and almost all of the FASD adults in the case study committed a violent crime. Such findings supported previous
academic literature in this area, which concluded that FASD offenders often commit violent crimes, such as robbery and assaults, as well as assaults of a sexual nature.

In well over three-quarters of the FASD and ADHD cases combined, an evaluator directly stated that the defendant had the principal disorder. In terms of the actual diagnosis of the principal disorder being mentioned in the sentencing decision, only in approximately half of the FASD and ADHD cases combined was a direct, official diagnosis made or referred to. Moreover, when FASD cases were separated from ADHD cases, only in approximately a third of the FASD cases was a ‘formal’ diagnosis referred to in the sentencing judgment and, yet for ADHD, a formal diagnosis of the disorder was found in two-thirds of the cases. In 45.2% of the FASD cases and only in 19.2% of the ADHD cases, did an evaluator directly connect the principal disorder to the potential for treatment.
Chapter 6:
RESULTS

PART 2: QUALITATIVE ANALYSIS
Qualitative research has been described as a naturalistic and interpretive approach. The current collective case study fits well into this type of research trajectory since it is primarily about unraveling the role and impact of neuro-cognitive impairments in sentencing decision judgments. Hence, the perceptions and actions of mental health professionals and other expert witnesses as well as the judge are crucial in determining the manner in which the Canadian courts treat ADHD and FASD with respect to both young and adult offenders.

EVALUATORS’ AND JUDGE’S COMMENTARY IN COURT REGARDING PRINCIPAL DISORDER
Variable of Interest: ‘Treatability’
The variable of interest ‘treatability’ was operationalized as, was the principal disorder mentioned directly when drawing an inference about the accused’s likelihood of being treated or not. In 28.9% of all of the FASD and ADHD cases, for youths and adults, the treatability variable in connection to the principal disorder was clearly discussed, either by a mental health expert, the judge or both. It is also worthwhile to take notice that in 71.1% of the cases, treatability, as it pertained to the principal disorder, was ‘not’ mentioned in direct connection to the treatment of the offender. That being said, in practically a quarter of the cases reviewed, when FASD and ADHD were being scrutinized, a direct inference was drawn between the principal disorder and treatment by an evaluator for the court and or by the judge. Often the judge
Fetal Alcohol Spectrum Disorder

Youth FASD

Beginning with the five youth and nine adult cases, in which FASD was the principal disorder under observation, the following results were obtained qualitatively. In the first youth FASD case in British Columbia, *R. v. D.R.U.*, (2004), the judge did note the recommendations in the pre-sentence report made by two psychiatrists regarding the importance of the youth being subjected to rigorous substance abuse counseling in order to address his predisposition to alcohol abuse stemming from the presence of fetal alcohol syndrome. The judge followed the recommendation in the psychiatric assessment to place the young person into a therapeutic foster home, to finish school and to complete psychological counseling programs as well as those programs aimed at substance abuse. The youth was thus given an Intensive Support Supervision Program (ISSP) order for a period of one year, since the youth had already spent what amounted to 12 months in custody. The overall thrust of the inference about treatability and the principal disorder was that the...
youth was difficult to treat because of the substance abuse disorder, which the judge attributed to FASD (serious substance abuse due to FASD). As the judge stated in *R. v. D.R.U.*, (2004), “unless the young person is subjected to rigorous alcohol and drug abuse counseling and/or treatment, to address his predisposition to alcohol abuse because of the Fetal Alcohol Syndrome, as well as proper therapy to deal with the traumas of his sad life, he may relapse into alcohol abuse (paragraph 43)”.

In the B.C. case of *R. v. C.J.M.*, (2006) the judge strongly acknowledged Mr. C.J.M. as having partial fetal alcohol syndrome by referring to him being properly diagnosed with this syndrome, and how C.J.M. did meet with experts in the field of fetal alcohol syndrome, emphasizing the part played by psychologists in particular. The judge made reference to the defence counsel’s role in presenting the court with an abundance of material surrounding the diagnosis of partial fetal alcohol syndrome, which the judge claimed to be “very interesting and helpful” (paragraph 18). The judge also stated that, “prison is a difficult place for somebody with fetal alcohol syndrome or partial fetal alcohol syndrome, that there is no basis to make logical and well-founded decisions that enable somebody to work, even within that system (paragraph 18)”.

The judge also pointed out in the sentencing judgment that British Columbia has a non-profit society which runs the Asante Centre in Maple Ridge, and that this centre does perform FASD diagnoses, develops programs and makes recommendations as to how to appropriately deal with inmates who are diagnosed, as is Mr. C.J.M., with fetal alcohol syndrome or one of the alcohol-related neuro-development disorders, ARND. The judge stated that C.J.M. fell clearly within the guidelines of somebody who needs that assistance. Nonetheless, despite the judge’s observation that prison is not necessarily the appropriate venue for dealing with an FASD diagnosis, the judge directly stated that the court is in agreement with Crown counsel’s recommendation of a prison sentence of eight years, owing to the severity of the crime, and specifically because of C.J.M.’s constant repetition of the same behaviour, with very limited time in society being spent without committing crime. Thus, C.J.M. was placed in custody but the judge made it clear that the treatment he was to receive should be geared toward addressing his FASD diagnosis: “I am also strongly recommending that he be very quickly put in touch with a psychiatrist for the ongoing maintenance of his medication and ongoing medical treatment, psychiatric treatment, counseling, specific treatment with
respect to the fetal alcohol issues, and overall life skills counseling so that he has his best chance at success when he is next released (paragraph 33)”. The judge also articulated that treatment to address C.J.M.’s issues must be completed well before he is released; in particular, “[i]t has to start right at the outset with the proper connections, medication and counseling, and hopefully one-to-one counseling and hopefully fetal alcohol counseling either through the Asante Centre in Maple Ridge or, if he is transferred to Alberta, the Lakon (phonetic) Centre in Cold Lake (paragraph 33)”. In the final line of the sentencing judgment (paragraph 39), the judge reiterated the point that it is the court’s hope that the strength of the judge’s recommendations will get through to those professionals involved in the assessment process. Clearly such a statement reflects the judge’s strong opinion about the diagnosis of FASD being taken seriously and thus needing to be dealt with appropriately, even if such treatment must take place in custody. Hence, the overall direction of inference about treatability and the principal disorder was that treatment was needed to address the disorder.

In the Saskatchewan case of R. v. J.L.M (2005), the judge in the sentencing judgment discussed J.L.M.’s diagnosis of FASD in great detail and certainly acknowledged court experts’ opinion with respect to the diagnosis of FASD, as well as their list of recommendations for the defendant. It is important to note that, in all of the future cases where ‘partial fetal alcohol spectrum disorder’ is discussed, “the term FAE has commonly been replaced by the term “Partial FAS (R. v. P.J.M., [2008] S.J. No. 203, paragraph 40)” . The judge pointed out that, despite J.L.M. being diagnosed with Partial Fetal Alcohol Syndrome two years prior, when the defendant was 15, the current psychiatric assessment report, provided to the Court and the Provincial Director by Dr. Patricia Blakley, reiterated the important point that, “[i]t is important to recognize that the degree of disability can be as significant for youths with Partial FAS as those with full FAS” (paragraph 11)”. The judge directly referred to expert witnesses such as Dr. Jo Nanson, a neuropsychologist, with recognized expertise in assessing persons suffering from FASD, and after displaying such evaluators’ assessment results, came to the conclusion that J.L.M. had been profoundly affected by FASD and that, consequently, J.L.M. also acquired many of the secondary disabilities associated with someone who is diagnosed with FASD late on and does not receive supervision and support appropriate to her disability. In the sentencing judgment, the judge directly showed great disdain as to how a
risk assessment could be conducted at the insistence of the provincial director as part of the pre-sentence report process without greater attention being given to the diagnosis of Partial Fetal Alcohol Syndrome (PFAS), since the implications for behaviour and supervision are profound. The judge then went on to discuss how in *R. v. W.A.L.D.* (1)[2004] S.J. No. 120, at paragraph 40, FASD research by Dr. Ann Streissguth was cited by the judge, to show the significant implications for the individual of a diagnosis in the fetal alcohol syndrome spectrum. In the present sentencing judgment case, the judge directly quoted excerpts from Streissguth’s (1996) final report, by focusing specifically on the sections of the paper that discussed primary (mental functioning and brain damage) and secondary (mental health problems, disrupted school experience, trouble with the law, confinement, inappropriate sexual behaviour, alcohol and drug problems, dependent living, and employment challenges) disabilities that are linked to FASD. Furthermore, the judge highlighted from the academic report direct excerpts concerning specific FASD risk factors associated with secondary disabilities as being low IQ and exposure to violence; whereas the key protective factors include early diagnosis of FASD, eligibility for services, living in a stable, nurturing environment and protection from witnessing or being a victim of violence. In terms of the overall inference about treatability and the principal disorder, based on the disposition that the judge issued, it was evident that treatment for the partial fetal alcohol syndrome needed to be administered. The judge determined that a probationary sentence was appropriate, despite custody being an option, and was ultimately persuaded to make this disposition, since J.L.M. was substantially affected by FASD—a condition which the judge believed could be controlled if J.L.M. received some measure of stability in the community. The judge stated that having a pro-social plan in the community would be critical in light of her ‘lifetime disability’. Thus, at the direction of the youth worker, J.L.M. was ordered to attend an addictions assessment and follow through with any education, counseling or treatment, including in-patient treatment, as may be recommended by the assessment; to attend an educational or day program, and refrain from the use, possession or consumption of alcohol and non-prescription illicit drugs. It was evident that the judge did consider the past and current psychiatric assessments of J.L.M., as it pertained to the diagnosis of partial fetal alcohol spectrum disorder and this made a difference in the ultimate treatment plan.
The judge (S.P. Whelan) in the Saskatchewan case of R. v. P.J.M., (2008), was the same sentencing judge as discussed in the aforementioned J.L.M. case. This judge also referred to Dr. Jo Nanson in the sentencing case, as having assessed and diagnosed the present youth, known as P.J.M., and it was stated that the ‘very recent’ diagnosis of partial fetal alcohol spectrum disorder made several parties, such as the defence counsel (Miss Sikora) and the defendant’s father, capable of better understanding P.J.M. Even the staff who were presently working with P.J.M. in the remand facility had only recently been made aware of his diagnosis. The judge described a statement made by Dr. Zahara, which was to the effect that P.J.M.’s functioning in the community could be summarized as low and in secure custody as high. The judge went on to say that such is often an observation made with respect to FASD-diagnosed young persons and that a supportive structure is a key to their success. Interestingly enough, in this particular case, unlike in the case of J.L.M., in which the judge had given J.L.M. a community supervision sentence, the judge felt that, in this case the supported structure of custody would best assist P.J.M. in dealing with the FASD diagnosis, rather than a community sentence: “This diagnosis presents the Youth Justice System with an opportunity, having regard to the principles affecting sentence, to embark on a sentence, which, while responding to the needs of the community insofar as the long term protection of the public, may also respond to P.J.M.’s needs in an FASD appropriate way. This, I believe, is the most effective way to achieve the goal of protecting the public, i.e., by endeavouring to prevent criminal behaviour, rehabilitate P.J.M., and impose meaningful consequences (paragraph 39)”. Therefore, the overall direction of inference about treatability and the principal disorder was that treatment was needed to address the disorder, as was exemplified by the same judge in the J.L.M. case. In further exploring the ‘treatment’ variable, insofar as the principal disorder is concerned, the judge stated that in making plans, the court strongly recommends consultation with persons who are knowledgeable about FASD and one appropriate resource in Saskatchewan would be the FASD Support Network of Saskatchewan Inc. Clearly, the judge who presided over the J.L.M. and the P.J.M. cases, felt very strongly about making treatment very specific to meeting FASD needs by finding the appropriate treatment resources in the province, as well as giving great weight to the psychiatric assessments made by the professionals diagnosing this particular disorder.
In the Ontario case of *R. v. L.A.B.*, (2007), psychiatric expert testimony for the diagnosis of FASD and the issue of treatment for this disorder was a major consideration for the judge. In fact, the issue of treatment and the supervision required for L.A.B., in light of the impairment suffered as a result of FASD, was a pivotal reason as to why L.A.B. received the final sentencing disposition that she did. At the age of 14, L.A.B. had committed second-degree murder and the major issue before the court was whether to sentence L.A.B. as a youth or as an adult. The judge relied heavily on evaluators’ testimony and referred to specific doctors’ comments directly in his justification for the final sentence administered. L.A.B.’s developmental deficits were identified over a decade prior to the recent case, owing to a series of referrals for assessments by concerned family physicians regarding fetal alcohol effects. In the present case, when it was suggested that L.A.B. should be placed in an adult facility, the judge referred to a concern that was raised by one of the court’s expert witnesses about the lack of treatment available to address L.A.B.’s fetal alcohol diagnosis: “[F]ederally sentenced young offenders are unique in themselves. She knows of no specialists in the federal system in the area of alcohol related neuro-development disorder or fetal alcohol spectrum disorder, although there may be one staff member at the Kingston Penitentiary for men who has this specialty who could possibly be used as a resource assistant (paragraph 13)”.

The judge incorporated many direct quotes from various mental health professionals who evaluated L.A.B., and the overall theme that all of the experts agreed upon was that L.A.B. functioned in the developmentally handicapped range (cognitively—mental competency resembled that of a six-to-eight-year-old child), and she was considered as ‘at risk’ for lifelong problems. All experts agreed that L.A.B. required very close monitoring and protection for safety purposes and stated that she would not be able to make appropriate decisions for day-to-day living, primarily because of her lack of sound judgment. Both Dr. Meen and Dr. Wong, who were in agreement about L.A.B.’s FASD diagnosis, reiterated the importance of L.A.B. being placed in a youth Intensive Rehabilitative Custody and Supervision program (IRCS), showing concern for her being moved to an adult facility, since she would be vulnerable to the adults around her.

IRCS is a sentencing option for youth convicted of a specified serious violent offence under the *Youth Criminal Justice Act* (YCJA). It provides intensive treatment and rehabilitation for a youth throughout the course of
his/her sentence, with the overall goal being to reduce recidivism, to successfully rehabilitate the young person and to reintegrate them back into the community. The judge explicitly and repeatedly points out in the sentencing judgment that all of the experts recommend an IRCS disposition for her and acknowledges the...”many mitigating factors in this sentencing, not the least of which is the evidence called from all of the experts that this young person, through no fault of her own, has the cognitive capacity of a six to eight year old child (paragraph 72)”. The following quote, which is the second to last paragraph in the sentencing judgment, reflects the judge’s ultimate decision to give L.A.B. an IRCS youth sentence and the court’s great weight given to the expert testimony surrounding her diagnoses, especially as it pertains to fetal alcohol syndrome:

I have also considered her difficult background, her diagnosis of fetal alcohol effect and her early years of development which were severely wanting and for which she herself cannot be held responsible. I have also considered her lack of criminal record. In my view an adult sentence even if served in a youth facility until the age of 20 or beyond, would be too severe a penalty for this young person given her limitations and indeed society’s own expectations of those who suffer from such severe personality and intellectual deficits at her age and stage of maturity and development. L.A.B. warrants a strong community commitment now and throughout her life to her betterment in the interests of reducing her risk to herself and to society at large. There is no question on the evidence I have heard and noting that all of the experts who testified agree that this youth’s needs would best be served through the imposition of a youth sentence with the added overlay of an I.R.C.S. disposition.

In the end, the judge gave L.A.B. an IRCS sentence of intensive rehabilitative custody for the maximum of four years, followed by three years of community supervision.

From the five youth cases in which a connection between the principal disorder and treatability was made, the qualitative analysis of youth FASD and the ‘treatability’ variable for all of the youth cases discussed in great detail resulted in the identification of five major themes and several emergent sub-themes:
In the B.C. case, *R. v. Pauls* (2005), the judge only ‘suspected’ that Pauls may be suffering from FASD: “Mark, I have listened to what your lawyer said and I have been to a number of sessions about Fetal Alcohol Syndrome and because you do not know about your biological mom, you may want to see if you have any problems with what they call Fetal Alcohol Syndrome because a lot of the things that your lawyer is talking about are consistent with that (paragraph 1).” The judge definitely demonstrated a great deal of care regarding the diagnosis of fetal alcohol because he made a direct statement regarding the importance of a follow-up with respect to Pauls in order to determine if he did indeed have the disorder, since the judge did consider that Pauls had many of the identifiable behavioural characteristics. The judge did not seem clear about how FASD could be assessed, since he stated, “…you can help to see if they have any way of assessing if he has Fetal Alcohol Syndrome in his history (paragraph 5)” The judge reiterated the point that, if Pauls did have FAS, it was not his fault and he could not be seen as being responsible for such a predicament. The judge did not refer to any mental health professional or medical expert directly in his judgment regarding FASD and ultimately based
his sentencing disposition on the assumption that Pauls may have been suffering from FAS. Pauls received a two-year custodial sentence, specifically two years, so that he remained in federal custody where he could receive better treatment options: “...by being in a federal custodial setting you will get the assistance of a lot more structured programs than you might in the provincial system by being in a federal custodial sentence (paragraph 6)”. It was also directly stated that Pauls was receiving the two-year federal sentence so that he could get the help for his suspected fetal alcohol syndrome. Evidently, treatment of the ‘not-formally-diagnosed’ FASD was a high priority for this particular judge, to the degree that the judge went so far as to ensure that Pauls served federal time.

Another adult case in which the diagnosis of FASD was unclear was the B.C. case of R. v. Mackenzie (2007). In this particular case, the judge made reference to a doctor’s statement regarding fetal alcohol and manageability which was, “…whether or not Mr. MacKenzie can be definitely diagnosed with FASD or not, that the manageability of the accused in the community would be identical because the emphasis must be on helping him control and modify behaviours that are not conducive to pro-social functional living (paragraph 14)”. Thus, it was the mental health expert’s opinion that the treatment protocol would be the same, irrespective of whether or not Mackenzie had FASD. In the final sentencing outcome, the judge acted as if Mackenzie did have FASD, by stating, “[I] am taking into account the accused’s Aboriginal background, that he has an organic impairment and has functional disabilities and deficits similar to persons who are identified as having FASD (paragraph 24)”. Mackenzie was sentenced to two-years-less-a-day but was allowed to serve it in the community. When it came to actual treatment considerations, the judge placed Mackenzie in a residential treatment program where he would be receiving alcohol and drug counseling but no specific attention was paid to addressing Mackenzie’s potential FASD. The reason the judge may not have paid direct attention to Mackenzie’s possible FASD diagnosis is because of Dr. Murphy’s concurring opinion with Dr. Koopman that, “…the management plan of the accused will be identical regardless of whether he is diagnosed with FASD (paragraph 15)”.

The official diagnosis of FASD was also not formally determined in the Saskatchewan case of R. v. C.P.S., (2004). The judge stated that Dr. Adeluga did not know whether the accused suffered from FASD but whether he did or not
would make little difference in the treatment outcome. The judge discussed another doctor’s comments on C.P.S.’s potential FASD condition by stating,

...S.’s cognitive impairment likely also results from FASD. S.’s mother was an alcoholic, and died of alcohol related problems. FASD cannot be formally tested on adults, so this is only an assumption. But, in the final analysis, Dr. Nicholaichuk clarified it does not matter what caused the cognitive impairment (paragraph 40).

FASD was not mentioned anywhere else in the sentencing decision and it appeared as if the judge assumed the diagnosis was inconsequential, considering it was the opinion of two experts that treatment would not be affected by knowing what caused the actual cognitive impairment. Such statements seem surprising considering there are many programs geared toward helping those who do suffer from FASD. Furthermore, for mental health professionals to state that it is not possible to diagnose FASD in adulthood is inconsistent with those cases in which adults are diagnosed with some form of FASD. In the end, the judge agreed with the Crown and gave C.P.S. an indeterminate sentence and treatment was not mentioned in any way by the judge.

Owing to the severity of the crime, the Saskatchewan case of R. v. W.T. (2004) required the judge to impose either a dangerous offender or long-term designation. Prior to the judge reviewing the specific criteria for a dangerous offender designation, the judge felt it was worthwhile to discuss W.T.’s ‘potential’ of having some form of FASD. Even though the judge was not absolutely certain that W.T. had FASD—“formal confirmation of material prenatal drinking is required to complete the diagnosis and, to date, only hearsay has been provided” (paragraph 13)—the judge felt compelled to review the various points of view as to how such a diagnosis should be considered in sentencing. Interestingly, the judge articulated that some have considered the diagnosis of FASD as an ‘aggravating’ factor, and noted how essentially the behaviours associated with FASD may be fixed (unchangeable). For example, the judge stated, “in the context of a dangerous offender application, when a pattern of violent sexual behaviour has been confirmed, one might conclude that it is likely to persist since the condition, itself, cannot be changed (paragraph 13)”. However, the judge went on to state that, “…as more is learned about the behavioural management of this disorder, some optimism has begun to emerge (paragraph 13)”. The judge then directly said, “…some have argued that when such a diagnosis is present, the overriding sentencing consideration should be rehabilitation, since the disorder is likely to have at least contributed to the offence and since specific deterrence is
ineffectual with individuals suffering from this kind of cognitive deficit and general deterrence and denunciation are not applicable due to the idiosyncratic nature of the offender (paragraph 13)”. Nonetheless, the judge made it clear that such a rehabilitative opinion ignores the principle of public safety, and cited this as being implicit in the dangerous-offender criteria, as well as pointed out how public safety has been considered of paramount importance elsewhere with offenders having FASD. The judge also pointed out how, “[n]onetheless, there are various points of view as to how such a diagnosis should be considered in sentencing. Some have considered it an aggravating factor (paragraph, 13)”.

On a final note regarding how FASD factors into sentencing, the judge stated that public safety for those FASD offenders who pose a significant threat to the community is best served by a combination of a short incarceration sentence combined with a court-sanctioned, comprehensive, strict, maximum treatment plan. Ultimately, the judge imposed a long-term rather than a dangerous offender designation, since only two percent of federally incarcerated offenders are given the label of ‘dangerous offender,’ which carries very serious implications. W.T. was given a ten-year custodial sentence (six and one-half years remaining) primarily because he was assessed as having an 80% chance of sexually recidivating, this would be followed by a ten-year community supervision order. Thus, despite the judge’s detailed remarks about FASD, sentencing and the importance of rehabilitation for FASD offenders, once he had sentenced W.T. as a long-term offender, he no longer alluded to any special FASD treatment. Regardless, the fact that the judge examined the complex issues surrounding the sentencing of an FASD offender, demonstrates that some consideration was paid to the disorder.

In the B.C. case of R. v. J.N.J. (2004), J.N.J. was diagnosed as suffering from fetal alcohol syndrome. Dr. Posthuma’s mental health evaluation showed that it was highly likely that J.N.J. was suffering from an acquired brain impairment, which was probably the result of his being born with Fetal Alcohol Syndrome. Evidently, there was no formal test done to directly confirm FASD. The judge directly acknowledged the serious impact of FASD by stating, “[o]ne of the troubling realities of J.N.J.’s condition is that he is profoundly limited by the combination of his mental illness, his brain impairment resulting from being born with Fetal Alcohol Syndrome and by other cognitive deficits (paragraph 68)”.

The judge further stated how since J.N.J. will suffer the effects of his fetal alcohol syndrome and his intellectual deficits for the rest of his life
and will need community supports beyond ten years to assist him with his daily living in the community, irrespective of the risk of his re-offending. In terms of providing J.N.J. with the proper support, the judge agreed with one of the mental health professionals’ recommendations, which was to establish a surrogate social support network of professionals and other community supports if J.N.J.’s family was not able to provide this. The judge made the decision to designate J.N.J. a long-term offender (LTO); he was to be placed in custody for two years, followed by supervision in the community for ten years. The treatment stipulation, that the judge added as part of the sentencing decision, was for every effort to be made to enable J.N.J. to access the North Star program, prior to his release from custody. This program is specifically aimed at addressing the needs of intellectually disabled sex offenders.

In the Saskatchewan case of R. v. J.W.K. (2009), the judge did address the treatment issues as well as how specific sentencing principles factored into the FASD diagnosis. J.W.K. was assessed at the FASD Centre by Dr. Logan and it was confirmed that J.W.K. met the criteria for an FASD diagnosis. He had some of the physical features, as well as an impairment in his brain function. Through his counsel, the accused sought a lengthy probation order. Specifically the judge stated that the accused’s counsel said that, “Mr. J.W.K.’s FASD should reduce the impact of his criminal record and further asserting that general or specific deterrence is an illusory goal for those who do not have the ability to adapt their behaviour (paragraph 38)”. In this particular case, the judge also cited the advice from Ms. Charron, an FASD co-ordinator in Regina, who stated the following:

We have yet to discover a treatment program that works well with persons with FASD. Many programs run on talk therapy but, given J.W.K.’s auditory processing dysfunction, he will not do well. One of the biggest barriers for J.W.K. is that his responses suggest a great level of understanding that what is occurring. Given J.W.K.’s length of custody, he has learned what are appropriate responses. Health and wellness, isolation, life skills and anger issues are all concerns for this individual, but substance-abuse related problems come first. His capacity will drop further if abuse of substances continues. Mr. J.W.K. is a special needs offender who requires the services of a caseworker/mentor to be with him and work with him a minimum of 20 hours per week, and the writer is unaware of an agency who can provide this support (paragraph 42).

Clearly, there is still significant doubt about the availability of appropriate programing for adult offenders who are plagued with FASD. To add to this assertion, Dr. Nanson advised that there is an attempt to develop
services for adults with FASD at the Regional Psychiatric Centre in Saskatoon and that the Prince Albert Federal Correctional Facility is also attempting to develop programs for offenders with FASD but they are not yet well developed. The judge considered the expert-witness testimony as well as counsel’s position on the matter of sentencing and treatment and concluded the following:

The application of the sentencing principles becomes more of an issue with FASD offenders. The literature would suggest that the principles of punishment and deterrence have little or no effect on FASD individuals because they are unable to understand cause and effect at a fundamental level. A better focus may be on the need to protect the public which includes the need to separate offenders from society where necessary and the need to attempt to provide a realistic framework for the offender’s rehabilitation— which in the case of FASD offenders may not be true rehabilitation, but rather a structured modification of their behaviour (paragraph 50).

Hence, for the judge, as it is further articulated in the concluding remarks, the more serious the crime, the more emphasis must be placed on the protection of the public and less on the rehabilitation of the offender. The judge sentenced J.W.K. to the maximum term possible in the provincial correctional system, followed by the maximum period of probation that is permitted in the Criminal Code. The judge hoped that the probationary period would assist the offender in following through with the suggestions made on his behalf by his counsel and if successful would prevent him from returning to custody. He concluded by stating that he did consider the time J.W.K. had spent in custody up to this point awaiting sentence; thus, gave him double credit for time spent on remand and ultimately the judge believed such a sentence adequately addressed the principles of sentencing, in particular the need to protect the public and also recognized the significant challenges faced by Mr. J.W.K. due to his FASD and his chaotic upbringing.

In the Ontario case of R. v. Dayfoot (2007), the court considered that Dayfoot was an offender with fetal alcohol syndrome and, in this case, the accused did raise the issue of fetal alcohol syndrome as a mitigating factor. Originally, the trial judge had adjourned sentencing for a period of approximately five months, for the purpose of conducting further testing in relation to the possible existence of FASD. Thus, once Dayfoot underwent the necessary assessment, Dr. Pripstein concluded that Mr. Dayfoot suffered from Alcohol-Related Neurodevelopmental Disorder (ARND) with confirmed maternal alcohol exposure. Such a diagnosis is included in the constellation of problems
referred to in FASD. Once the judge was satisfied that a diagnosis has been made, the judge could then carefully consider what impact fetal alcohol would have on the sentencing process. The judge referred to the popularly cited article by Moore and Green (2004), regarding FASD and the CJS, in which the authors discuss the extensive issues that result from FASD in relation to trial issues for accused persons suffering from FASD. The judge cited a direct quote from Moore and Green’s 2004 article, “[c]onvicted FASD persons are, by definition, special needs defendants. The special programs and services essential to meeting these needs are woefully lacking (Moore and Green, 2004:107)”.

The judge explained that, despite the violent offence, which luckily was at a low level, the presence of the confirmed ARND diagnosis warranted a conditional sentence—18 months to be served in the community. The judge acknowledged that Dayfoot was negatively influenced by his co-accused, which the judge claimed is symptomatic of a person suffering ARND. The judge went on to say that, “…to punish behaviour which results from a clinically recognized disability runs contrary to the principles of criminal law, certainly where treatment is available (paragraph 21)”.

The judge did remark that, if Dayfoot continued to be untreated, the continued disability would render Dayfoot dangerous. Hence, the judge reverted to the fundamental principle of sentencing that is expressed in Section 718.1. The principle relates to the degree of responsibility of the offender, by coming up with a sentence that takes into account the role played by an Alcohol Related Neurological Disorder (ARND). The judge acknowledged how the Court must also be aware of the shocking prevalence of suspected FASD/ARND among the Aboriginal population. The judge directly stated how, “[t]he abuse of alcohol and other intoxicants has resulted in a high proportion of FASD in members of the community. This court can only speculate on the systemic impact of FASD with respect to the high proportion of aboriginals in conflict with the law, and in the prison system in some parts of the country (paragraph 22)”.

The judge set forward strict community-supervision provisions, one of which was treatment—to adhere to whatever treatment was prescribed by Dr. Cheral or a designate. Overall, it was evident that the judge in this case took the ARND diagnosis very seriously when devising a treatment/sentencing and placement plan for Mr. Dayfoot.

In the Ontario case of R. v. Brown (2009), Brown was born with fetal alcohol syndrome and was presently an alcoholic. The judge sentenced Brown
to 18 months in jail. The judge stated that Mr. Brown should be enrolled in whatever treatment and counseling programs for alcohol addiction and anger management are available in the provincial correctional system.

The final FASD case in which fetal alcohol was mentioned directly when drawing an inference about the accused’s treatability was the Ontario case of R. v. Mumford (2007). This case very strongly exemplified FASD as being a pertinent consideration in sentencing because the judge was direct and vocal about stressing the importance of the accused receiving treatment for FASD, despite the fact that the Crown was seeking a dangerous offender designation for Mumford. Mumford had a criminal record that included a number of violent sexual offences, including his guilty plea to two extremely serious offences involving choking and sexual assault. The defence’s stance was that, although the criteria for a dangerous offender designation were met, Mumford could be treated and controlled in the community, so long as a long-term offender designation was given to him instead. Ultimately, the judge focused on the evidence of the psychiatrist who diagnosed Mumford as having fetal alcohol and in the judge’s view, the FASD diagnosis was very relevant to treatability and eventual control of the offender. Even though the Crown tried to demonstrate how, in the past, Mumford was not responsive to treatment programs, this did not dissuade the judge in the least. In fact, the judge believed that the problem was the fact that the programing was not responsive to the limitations Mr. Mumford had as a result of FASD and inferred that, “it was equally probable that the lack of achievement in these programs was related to the failure to provide programs which responded to his cognitive needs (paragraph 231)”.

The case of Mumford is pivotal because the court declined to declare an accused a dangerous offender as he had Fetal Alcohol Spectrum Disorder and could be treated and managed (this statement was made directly in the case summary introduction). The judge wanted Mumford to attend St. Michael’s Hospital Fetal Alcohol spectrum Disorder Clinic or a similar type specialized clinic and follow any recommendations for medication, treatment or counseling as determined by the personnel of the clinic. The judge directly spoke to Mr. Mumford and stated...”but now we know that you have Fetal Alcohol Syndrome. Now the prison authorities can create programs that you can understand. I am counting on you to participate in the programs that are offered to you (paragraph 277)”.
The qualitative analysis of adult FASD and the 'treatability' variable for all of the adult cases resulted in the identification of seven major themes and some emergent sub-themes among cases.
ATTENTION DEFICIT HYPERACTIVITY DISORDER

Carrying on qualitatively with the ‘treatment’ variable when the principal disorder of interest was ADHD, there were four youth and six adult cases in which evaluators and/or the judge identified a direct relationship between the principal disorder and treatment.

Youth ADHD

In the B.C. youth case, R. v. A.J. (2008), A.J. was assessed by Dr. Stephenelli and it was recommended to the court that, for the ADHD with which he was previously diagnosed, he should continue on the medication he was taking because it seemed to help. The judge acknowledged that the mental health professional, Dr. Stephenelli, was under the impression that his ADHD was under control and that he was a low risk to the community and that he be treated as a youth for his crime. Despite the mental health professional’s opinion about the youth and how he should be given a youth disposition, the judge felt that a two-year adult sentence was appropriate. Hence, the youth having ADHD under control with medication did not sway the judge in his sentencing decision, nor did the mental health expert’s opinion. The judge did emphasize treatment in general as being an important part of the sentencing disposition by stating that the youth should receive counseling, substance-use treatment and any other treatment recommended by the probation officer with a doctor or psychiatrist. The judge made no further remarks about ADHD.

In the youth Saskatchewan case of R. v. M.D.D. (2004), M.D.D. was diagnosed with ADHD and conduct disorder. The judge made a rather direct statement about mental health and sentencing. The judge stated:

in a case such as this, where the young person been diagnosed with ADHD and Conduct Disorder (Severe), it is important that his mental health needs not be given too much weight. At the same time, these diagnoses and consideration of background information pertaining to behavioural concerns are both relevant and essential to arriving at an appropriate sentence…I hasten to add that where the court has the power to determine the level of custody, it is important as well that information pertaining to child protection, mental health or other social measures not be inappropriately used to lengthen what would otherwise be an appropriate custodial sentence nor to impose closed custody when open custody would otherwise be appropriate (paragraph 37).

Hence, the judge was very cognizant of the defendant’s mental health needs and wanted to make it clear that extending a sentence because of mental
health issues would be very inappropriate but at the same time relevant in the
determination of an appropriate final sentence. In the end, the judge gave
M.D.D. an open custody sentence, stressing the point that the open-custody
sentence allowed him to access a range of therapeutic measures. In fact, the
judge stated very clearly that, “[a] wide variety of programming is available to
a youth in open custody that is not available or as readily accessible in closed
custody (paragraph 48)”.

In the Ontario case of R. v. L.A.B., (2007), ADHD was given secondary
consideration in terms of mental-disorder diagnoses. This was because, as
indicated in the ‘youth FASD section above, psychiatric expert testimony for
the diagnosis of FASD and the issue of treatment for this disorder was a major
consideration for the judge. Ultimately, the impairment that L.A.B. suffered as
a result of FASD was a key reason as to why L.A.B. received the final
sentencing disposition that she did. The only comment made in reference to
her ADHD diagnosis was Dr. Bassarath’s, who conducted a risk assessment for
L.A.B. The mental health expert stated that, “…[s]he has had fewer aggressive
outbursts since she has been in custody, although her low frustration tolerance
ADHD hasn’t changed and likely will not (paragraph 33)”. Again, the judge’s
priority in this case was the FASD and, overall, the judge had a strong belief in
intensive treatment and community support, which was reflected in the judge’s
intensive rehabilitative custody and supervision order.

In another Ontario case, R. v. M.D. (2008), the judge referred to Dr.
Gojer’s impression that the elements of attention deficit disorder (ADD) as well
as conduct disorder seemed to have attenuated (meaning diminished). It was
the mental health expert’s opinion that M.D. had matured and the programs he
was involved in appeared to be working. Nonetheless, it was Dr. Gojer’s
professional opinion that M.D. should continue further programs, such as the
African Youth Justice program and the Breaking the Cycle program, as well as
counseling. The judge made no further reference to ADHD but seemed to
consider the mental health expert’s opinion because he gave a period of
custody and supervision order of 12 months—eight of which would be spent in
youth open custody and the remaining four under supervision with the
persistent emphasis on rehabilitative efforts, as well as probation for two years.

The qualitative analysis of youth ADHD and the ‘treatability’ variable
for all of the youth cases resulted in the identification of four major themes and
one emergent sub-theme in the cases:
Adult ADHD

In the B.C. case of *R. v. K.A.B.* (2004), the judge did not have conclusive evidence that K.A.B. had attention deficit hyperactivity disorder (ADHD) but stated directly that the defendant appeared to be suffering from the disorder, based on his behaviour. “…[O]ver the period of his life it appears that he has suffered from a problem that is possibly related to ADHD and these other issues that probably have contributed to his immaturity. Of course, that is not an excuse for his criminal behaviour, but it also shows that his maturity level is probably explained by him having a disability of some sort and he has never had the medical or treatment (paragraph 32)”.

It is interesting to take notice that the judge acknowledged ADHD as being a disability, which apparently lent insight into the defendant’s behaviour. The judge did not refer to any mental health experts’ opinion on the matter of ADHD because no such assessment was made; however, in the final sentencing decision, the judge recommended K.A.B. be assessed while in custody, and that he be examined for ADHD and other problems. In terms of his treatment, the judge made the comment that he hoped K.A.B. would be given some assistance to help in his rehabilitation in the future.

In the other adult B.C. case, *R. v. Paul* (2005), the defendant was directly quoted in court as having ADHD and his counsel also stressed this point, by stating that Mr. Paul was on prescription medication for his deficit disorder but this was not effective due to his substance-abuse problem. It was the counsel’s belief that, with a conditional sentence, he could receive the proper treatment for his substance abuse and then he would no longer pose a risk to the community, since he would be continuing with his medication for ADHD. The
judge made no further comment or reference to ADHD and, although he mentioned what the counsel for the defence would like to see imposed, he sided with Crown counsel and imposed 18 months of custody and one year of probation. Upon his release from custody, the defendant would attend counseling at the direction of the probation officer, including residential treatment if so directed.

Another B.C. case where ADHD was directly mentioned by a judge and a mental-health expert in terms of treatment was in the case of R. v. Blind (2008). The judge commented on how the Psychiatric Assessment prepared by Dr. Chale found that Mr. Blind had a long history of psychiatric difficulties and the report noted that the treatment given to Mr. Blind for ADHD had limited impact on his symptomology. Dr. Chale further commented that the defendant had shown poor response to previous treatment, including treatment for ADHD and anger management. The judge felt that two-and-a-half years was an appropriate disposition in terms of treatment, by stating, “I am to consider the possibility of rehabilitation. There is little in Mr. Blind’s history, criminal record or current conduct at KRCC to encourage me to believe that there is very much likelihood of rehabilitation at all. However, it must still be factored into the sentencing given Mr. Blind’s young age (paragraph 44).” It is apparent that the judge felt quite pessimistic about the possibility of rehabilitation and the only reason he considered it was because Mr. Blind was twenty-one years of age.

In the Ontario case of R. v. Zidner (2004), Zidner was formally diagnosed with attention-deficit syndrome and carried specific features that would qualify as suffering from attention-deficit-hyperactivity disorder. The judge gave Zidner a sentence of two years less a day to be served in the community. The judge simply made an all-encompassing statement about treatment which was for Zidner to attend any treatment program arranged or recommended by Dr. Sandor.

In the next Ontario case, R. v. McBride (2005), the judge included Dr. Gojer’s risk assessment, which stated that McBride “...had a history of anger and attention-deficit symptoms that further aggravated his features that have resulted in aggression and most likely were a very important contributory factor in the index offence (paragraph 20).” Dr. Gojer was under the impression that treatment of his Attention-Deficit Disorder with medication and with appropriate psychotherapy could reduce his impulsivity. The judge seemed more interested in the antisocial and borderline personality features
and, since the mental health expert considered McBride a high risk for future violence, the judge sentenced him to imprisonment for life without eligibility for consideration for release on parole until at least 15 years of his sentence was served. He made no further comment regarding ADHD.

Finally, in the Ontario case of R. v. Egan (2009), Dr. Gojer conducted the psychiatric evaluation of Egan and stated how he had problems with attention and concentration along with hyperactivity and impulse behaviours since his childhood and consequently has received a diagnosis of Attention-Deficit Disorder. Egan’s impulsivity persisted into adulthood and psychological testing was suggestive that residual features of the attention-deficit-hyperactivity disorder have remained in his adulthood. Dr. Gojer stated that Egan never had any treatment for any psychiatric problems, such as attention deficit disorder, other than brief trials of the drug when he was a child. Dr. Gojer testified about the interventions he would consider, including giving Egan medication to improve his attention and alertness for attention-deficit disorder. Dr. Gojer stated how, “...you can look at the attention deficit disorder as a possible treatable condition and you can look at the substance use disorders as possible treatable conditions... (paragraph 135)” . Unlike Dr. Gojer, the judge did not comment on treatment whatsoever and found Mr. Egan to be a dangerous offender and since Mr. Egan was also diagnosed with antisocial personality disorder, the judge was more concerned about that particular disorder classification in terms of giving it a lot of emphasis in the sentencing judgment.

The qualitative analysis of youth ADHD and the ‘treatability’ variable for all of the adult cases resulted in the identification of five major themes and one emergent sub-theme among cases:
Before looking at ethnicity, youth-versus-adult and gender variables, in connection to the treatability variable, it is relevant to review overall ethnicity findings. Since the total number of Aboriginal offenders out of the 83 cases (excluding the court of appeal judgments) was 30 (36%), 58% of the total FASD cases (excluding the court of appeal judgments) involved Aboriginals (18/31 FASD cases) and only 23% of the total ADHD cases (excluding the court of appeal judgments) were Aboriginal (12/52). Hence, evidently there are more Aboriginal offenders linked to FASD than there are connected to ADHD, at least in the five-year period of sentencing judgments for such disorders in the provinces of BC, SK and ON. It can, therefore, be assumed that there would be more Aboriginal offenders than non-Aboriginal ones linked to the 24 ‘treatability’ variable cases described below.

There were a total of 24 cases out of 58 (excluding the 24 court of appeal judgments) in which the ‘treatability’ variable was observed in connection with the principal disorder (either FASD or ADHD), and such a variable was examined in the 24 provincial/supreme court sentencing judgments above. Of the 24 cases examined, 62.5% of the offenders were adults and 37.5% were youth. Interestingly, in 66.6% of the cases (16/24), the offender was of Aboriginal descent. Broken down further, 73.3% of the adult offenders were Aboriginal (11/15) and 56% of the youth offenders were Aboriginal (5/9). More specifically, of the 14 cases in which the variable, ‘treatability,’ was linked to the principal disorder of FASD, in 86% of those cases the offender was Aboriginal (12/14). Breaking the 14 FASD cases down further, 36% of them involved youth (5/14) and the remaining
64% (9/14) involved adults. Of the five youth cases in which the ‘treatability’ variable was linked to FASD, in 4 of the cases the youth was Aboriginal (80%). Hence, of the nine adult cases in which the ‘treatability’ variable was linked to FASD, in 8 of the cases the adult was Aboriginal (89%). For the ten ADHD cases in which the variable of interest was ‘treatability’, there were certainly less Aboriginal offenders for this principal disorder. For example, unlike for FASD and the ‘treatability’ variable, in which 86% of the cases involved an Aboriginal offender, for ADHD 40% of the offenders were Aboriginal (4/10). Of the ten ADHD cases, 3 of the cases were for youth (30%) and the remaining 7 (70%) were for adults. In terms of the ethnic breakdown for ADHD and the ‘treatability’ variable of interest, only in 25% of the youth cases was the offender Aboriginal (1/4) and in only 43% of the adults (3/7) was the offender Aboriginal.

**Variable of Interest: ‘Judge Treatment in General’**

Other than looking at the cases in which a judge directly commented on treatment/rehabilitation in connection to the principal disorder of FASD or ADHD, which was analyzed in detail in another section of this chapter, another variable of interest was ‘judge-treat-gen’, which was operationalized as, [whether or not the judge emphasizes the importance of treatment in the final disposition — treatment in general]. Hence, for this variable, it was simply interesting to see in how many cases judges emphasized treatment, did not emphasize treatment, believed treatment to be unlikely or regarded treatment as being a secondary concern to the court. In 43 of the 83 cases (51.8%), judges emphasized treatment; in 33/83 cases (39.8%) judges did not emphasize treatment; in 6/83 cases (7.2%) judges stated treatment to be unlikely or judges stated treatment was a secondary concern to the court. Even though there were not many cases in which the judge demonstrated having a disbelief in the likelihood of treatment for the offender, or when the judge regarded treatment as a secondary concern, the fact that there were even a few such cases dictated closer qualitative examination.

There were six cases in which the judge believed treatment to be unlikely or blatantly gave it secondary consideration. The first case was R. v. Blind (2008), in which an adult Aboriginal male in British Columbia was the offender being sentenced. This case was discussed in the section above since the judge did mention ADHD (the principal disorder under investigation) in his commentary regarding the unlikelihood of treatment. As was stated earlier, the judge said, “I am to consider the possibility of rehabilitation. There is little in Mr. Blind’s
history, criminal record or current conduct at KRCC to encourage me to believe that there is very much likelihood of rehabilitation at all. However, it must still be factored into the sentencing given Mr. Blind’s young age (paragraph 44)”. However, the judge did not completely rule out treatment because he did state that he needed to consider it, since Mr. Blind was only twenty-one years of age.

In the Saskatchewan case of R. v. Turcotte (2008), Turcotte was a youth. The judge made no direct mention of treatment/rehabilitation in connection with the principal disorder, which was ADHD. Rather, the judge did make a statement regarding treatment in general and stated that, because of his personality disorder, he represented a poor candidate for treatment. “In my view Turcotte, with his personality disorder, represents a poor candidate for treatment. The psychological reports reflect that Turcotte did not want to attend treatment sessions, including anger management courses; as he thought it was a waste of time. He preferred to hang out with his friends and do drugs (paragraph 86)”. Evidently, in this case, the personality disorder (conduct disorder) was given primary consideration when determining the offender’s likelihood of treatment.

In the British Columbia case of R. v. Simpson (2008), the sentencing was in relation to an adult Aboriginal male. The judge made no direct comment regarding treatment/rehabilitation in connection to the principal disorder of ADHD. However, in terms of treatment in general for the offender, the judge stated, “[t]he primary sentencing principles at stake here are denunciation and deterrence, both general and specific, as well as protection of the public. In my view, the accused’s rehabilitation, although important, is a secondary concern. However, I am pleased to hear that the accused is desirous of making further positive changes in his life (paragraph 105)”.

In R. v. S.J. (2004), S.J. was an adult offender being sentenced in Ontario. The judge did not make any reference to S.J.’s ADHD, which was the principal disorder being examined, nor did he mention any other disorder. In this particular case, the judge made it clear that, while the judge did not abandon the principle of rehabilitation, the principles of denunciation and deterrence were of utmost importance; therefore, evidently, rehabilitation was a secondary consideration.

In the Ontario case of R. v. Waldo (2004), Waldo was a youth and the judge did not consider Waldo’s ADHD in connection to treatment/rehabilitation and made it quite clear that rehabilitation for this youth would be a difficult outcome.
since Waldo was not taking any responsibility for his actions. Further to the discussion of his denial in the involvement in the serious crime, the judge stated that, “I conclude that he will not—he will need more help to address his actions and his problems than can be provided in a youth sentence. In saying that, I accept that rehabilitation is not the only factor for a sentencing court to consider (paragraph 47)”. Similar to this case, in which the judge was very doubtful that proper rehabilitation could take place in a youth setting, was the case of R. v. McKenzie (2009). This was an Ontario youth case in which the judge never mentioned ADHD or any other disorder in connection with treatment/rehabilitation but did make a similar statement to the one that was made in the Waldo case. In the McKenzie case, the judge stated, “[w]ith respect to the issue of reintegration and rehabilitation, it is impossible to predict the future. I can only conclude that based upon all of the evidence heard during the trial, and during this section 71 hearing, that I am not reasonably assured that Shawn McKenzie can be rehabilitated and reintegrated safely into society through a youth court sentence (paragraph 28)”.

One major theme and three emergent sub-themes were identified:

**List 5: Themes**

- **judicial pessimism or disbelief in the likelihood of treatment**
- being a youth or a young adult made treatment a necessary consideration by a judge
- youth sentence does not adequately address the needs of the offender
- principles of denunciation and deterrence take precedence
Variable of Interest: ‘Direction of Violence’ and ‘Direct Recidivism’

The variables ‘direct violence’ and ‘direct recidivism’ are clumped together in the following section because both of these variables appeared in three of the five case judgments [R. v. Dayfoot (2007), R. v. E.M. (2005), R. v. McBride (2005)]. ‘Direct violence’ was operationalized as, “the direction of inference about violence in connection to the principal disorder”. ‘Direct recidivism’ was operationalized as, “the direction of inference about recidivism in connection to principal disorder”. Only in 3.6% of all of the FASD and ADHD cases, for youths and adults, was a direct statement made either by a mental health expert, the judge or both about the offender’s likelihood of violence in connection to the principal disorder. However, in 96.4% of the cases, there was no statement in the sentencing case that made a direct link between the defendant’s propensity for violence in relation to the principal disorder under investigation, either for FASD or ADHD. Similarly, only in 6.2% of all of the FASD and ADHD cases, for youths and adults, was a direct statement made either by a mental health expert, the judge or both about the offender’s likelihood of recidivism in connection to the principal disorder. In 93.8% of the cases, there was no statement in the sentencing case that made a direct link between the defendant’s propensity for recidivism in relation to the principal disorder under investigation, either for FASD or ADHD.

The ‘direct violence’ and ‘direct recidivism’ variables both appeared in the following sentencing judgments: R. v. Dayfoot (1997), R. v. E.M. (2005) and R. v. McBride (2005). In the Ontario case of R. v. Dayfoot (2007), which was also discussed previously in the context of the ‘treatability’ variable with respect to the principal disorder of FASD, the probation officer addressed a concern with Mr. Dayfoot as, “not willing or able to comply with community based sentences… Mr. Dayfoot’s substance abuse seems to be escalating for him and correspondingly the seriousness of his offences is increasing (paragraph 8)”. Thus, there was a possibility that Dayfoot would recidivate in the future and the direct comment of “not willing or able to comply…” could be either an assumption made owing to his substance abuse or his FASD or both. The judge also directly addressed Dayfoot’s likelihood for future violence in connection with the fetal alcohol spectrum disorder. The judge determined that Dayfoot was not likely to endanger the community; however, he did articulate that his behaviour in the execution of the robbery was consistent with the manifestations of FASD. The judge went on to cite the Moore and Green article on FASD and
quoted the authors directly: “[p]lanning, organizing and learning from past mistakes are not in their repertoire ... [t]ypically they do not make connections between cause and effect, anticipate consequences or take the perspective of another person... This combination is a recipe for non-compliance with a court order (paragraph 17)” . Hence, the judge appeared concerned about possible non-compliance with sentencing stipulations by Dayfoot owing to his FASD; meaning, there was a possibility of recidivism, yet the judge was not under the impression he would be a danger to the public at large because of his disorder.

The other case in which ‘direct violence’ and ‘direct recidivism’ was mentioned was in the Ontario case of R. v. E.M. (2005), for the principal disorder of ADHD. This case was not previously discussed in the ‘treatability’ variable component. In R. v. E.M. (2005), Dr. Orchard reached the conclusion that, in his opinion, Mr. E.M.’s Attention-Deficit and Hyperactivity Disorder did not cause him to be a risk to reoffend and he also considered him a low risk for future violence because the offender would rather do anything than have this type of crime ever happen in the future. Therefore, it is evident that the judge wanted to include Dr. Orchard’s above statement with respect to violence, recidivism and the defendant’s diagnosis of ADHD, and perhaps did not feel it was necessary to allude further to these issues anywhere in the final sentencing judgment.

‘Direct violence’ and ‘direct recidivism’ were also discussed in the Ontario case of R. v. McBride (2005), and this particular case was also discussed in the previous section in which the ‘treatability’ variable was of interest. McBride was regarded as a high risk to violently reoffend by Dr. Gojer and this risk assumption was made within the context of his attention-deficit-hyperactivity disorder. The psychiatrist stated, “[h]e has a history of anger and attention deficit symptoms that further aggravate his features that have resulted in aggression and most likely were a very important contributory factor in the index offence. It goes without saying that Mr. McBride is at a high risk to reoffend in a violent manner (paragraph 20)”. Thus, McBride was not only regarded as being violent, in which his ADHD was seen as aggravating his aggression, but he was also seen as reoffending in the future owing to his present disorders.

Finally, in the B.C. case of R. v. Mackenzie (2007) and the Ontario case of R. v. L.A.B. (2007) (both of which were analyzed in the ‘treatability’ variable component), FASD was the principal disorder under investigation and, in each
case, ‘direct recidivism’ was brought up in direct connection to FASD. In the Mackenzie case, Dr. Koopman acknowledged that Mackenzie was a low risk to re-offend, irrespective of the fact that he may have been suffering from FASD, since he had many of the characteristics associated with the behaviour, such as impulsivity, manipulative behaviour, lying, self-destructive criminal activity, limited ability to learn from past mistakes etc… (no formal diagnosis was made at the time of sentencing but FASD was ‘assumed’). In terms of the ‘direct recidivism’ variable in the L.A.B. case, since L.A.B. was diagnosed with FASD and did have permanent brain damage, Dr. Bassarath believed that regardless if she received an I.R.C.S. disposition, which he fully supported, ample programing, at best, would perhaps help L.A.B. overcome her present high-level of risk to reoffend in approximately five years. But overall, the doctor stated that, “…it is possible to lower L.A.B.’s risk to re-offend although it is possible that with extensive programing and therapy that her risk will never lower” (paragraph 34).

PRINCIPAL DISORDER AND FINAL SENTENCING CONSIDERATIONS BY THE JUDGE

Principal Disorder As A Mitigating Factor:

The variable, ‘judge_mitigate’, was operationalized as, “does the judge explicitly state or allude to the principal disorder being a mitigating factor and/or a need for a lesser (reduced) sentence or deliberate sentence requiring specific treatment/supervision or combination sentence, due to the principal disorder.” When combining the FASD and ADHD cases (total of 83, excluding the appellate cases), in 21.6% of them, the principal disorder was mentioned by the judge explicitly or alluded to as being a mitigating factor (18/83 cases). Eleven of the 18 cases, in which the judge considered the principal disorder as being a mitigating factor (61.1%) involved FASD and the remaining seven mitigating cases (41.2%) involved ADHD as the principal disorder. In 91.0% of the FASD cases, in which the judge somehow made FASD a mitigating factor in the sentencing judgment, the offender was Aboriginal (10/11 of the cases); however, for the seven ADHD cases, none of the accused persons were of
Aboriginal descent. Overall, in slightly over half of the cases (in which the judge considered the principal disorder of either FASD or ADHD to be a mitigating factor), the person sentenced was of Aboriginal origin. Another significant finding was that 80% of the FASD cases, in which the judge did find the disorder to be a mitigating factor, were the same cases that were linked to the variable of interest ‘treatability’, discussed above. Only one of the seven ADHD cases, in which the judge found ADHD to be a mitigating factor, was the same case that was discussed in the ‘treatability’ variable section. Thus, 37.5% of the cases discussed in the ‘treatability’ variable of interest section were the same cases in which the judge considered the principal disorder to be a mitigating factor. It was worthwhile to capture in detail what judges said about the principal disorder when they either explicitly or implicitly alluded to FASD/ADHD as being a mitigating factor; to analyze the kinds of final dispositions they handed down in such cases; and to examine what they had to say about available resources and finally the offender’s remorse.

Judges ‘Explicitly’ Stating FASD as A Mitigating Factor
As articulated above, many of the cases discussed below are the same cases that were discussed in depth in the ‘treatability’ variable of interest component of this chapter; however, the focus in this section is on the mitigating factor aspect. Perhaps, one of the most profound and pivotal examples of FASD being regarded as a mitigating factor by the courts is exemplified in the Ontario R. v. Mumford (2007) case. In this particular case, Mumford, an adult Aboriginal male, pled guilty to two counts of aggravated sexual assault and two counts of choking to commit the offence of aggravated sexual assault. There was an application by the Crown for a dangerous offender designation or, in the alternative, a long-term offender designation and, in the end, the judge gave Mumford a long-term offender designation and sentenced him to ten years’ incarceration. In this case, it was deliberately stated that the Court declined to declare the accused a dangerous offender as he had Fetal Alcohol Spectrum Disorder and could be treated and managed. The following direct statements made by the judge to Mumford signify the judge’s willingness to consider FASD in the sentencing disposition.

It is important that you gave evidence in this case. For a day and a half, you talked about your history. You told me that you want treatment. You have said that in the past and you have not followed through. But now we know that you have Fetal Alcohol Syndrome. Now the prison authorities can create programs
that you can understand. I am counting on you to participate in the programs that are offered to you (paragraph 277).

Thus, since the accused had Fetal Alcohol Spectrum Disorder and, while he could not be cured, the appellant was regarded as treatable and manageable. If it had not been for Mumford’s FASD, he would have most likely been labeled as a dangerous offender, since it was directly stated below:

The Court accepted expert testimony to the effect that the accused was a very high risk to re-offend and would likely attack someone violently and sexually upon release. However, the accused had Fetal Alcohol Spectrum Disorder and, while he could not be cured, the appellant could be treated and managed. In those circumstances, the Court declined to declare the accused a dangerous offender (HELD).

For the variable ‘judge_resource’, which was operationalized as [does the judge mention resources in the province in connection to the final disposition], the judge did not make any mention of whether there was an adequate program in prison or outside of prison to address Mumford’s FASD, even though he indicated a confidence in the correctional institution for being able to create programs that Mumford would understand. The judge did not further elaborate on this statement. The variable ‘judge-culp’ was operationalized as, “does the judge directly mention the offender’s culpability/responsibility/remorse or lack of it in the commission of the crime.” In the Mumford case, the judge stated: “[h]e did say he was sorry for what he had done to his victims and that he knew he had ruined their lives. I agree with Ms. Sweeney that it was somewhat superficial remorse particularly since he resisted being reminded of some of the details of the predicate offences. But I accept that on the intellectual level that he is capable of, he knows that what he did was wrong (paragraph, 199)” . Evidently, the defendant’s remorse level did not play a role in the determination of a DO or an LTO designation, since Mumford was clearly not very remorseful and this did not sway the judge from giving him the less severe disposition.

The B.C. case of R. v. Mackenzie (2007), was indeed interesting, considering the fact that the same case was heard in 2005—B.C.J. No. 796, in which the judge wanted a closer psychological assessment conducted; then in Mackenzie’s 2007 hearing—B.C.J. No. 793, Mackenzie had requested a stay in proceedings owing to a Charter right being violated on the grounds that an FASD test was not performed but the judge during this particular hearing dismissed his argument stating that the State had enough assessment
information about him to proceed, despite not knowing 100% if he suffered from FASD. Thus, Mackenzie’s case proceeded in 2007 and, despite a competent FASD assessment being conducted on Mackenzie, his ‘possible’ FASD diagnosis was explicitly stated as being a factor in consideration for sentencing by the judge. Mackenzie was an adult Aboriginal male who was given a conditional sentence of two years less a day followed by one year of probation for the crime of breaking and entering. The Crown had sought a six-year jail sentence but MacKenzie claimed that, because he was an Aboriginal person with fetal alcohol syndrome, the appropriate sentence was time served or an 18-month conditional sentence. It was held that MacKenzie’s sentence was based on numerous factors, such as the time that MacKenzie spent in custody, his performance on bail and the lack of new substantive charges since 2004. Nevertheless the Court also considered MacKenzie’s Indigenous heritage, his organic brain impairment and functional disabilities that are commonly attributable to persons who are identified as having FASD. The judge stated:

I am taking into account the accused’s Aboriginal background, that he has an organic impairment and has functional disabilities and deficits similar to persons who identified as having FASD. He poses a low risk to re-offend violently and a low-to-moderate risk of recidivism. He is remorseful and motivated and has insight into his substance abuse and criminal activity” (paragraph, 24).

In terms of the ‘judge-culp’ variable, the above quote demonstrates the judge’s belief that Mackenzie was in fact remorseful and, since the judge mentions his remorse in the same paragraph in which the various factors of consideration are listed, one may assume Mackenzie’s remorsefulness also played a role as a mitigating factor in his sentence. For the variable of ‘judge-resource’, the judge made no mention of any type of programming issues or requests with respect to FASD.

In the Ontario case of R. v. Dayfoot (2007), the judge also explicitly spoke of FASD very adamantly as being a mitigating factor in sentencing. Dayfoot was an adult Aboriginal male who was being sentenced for the crimes of robbery, uttering a threat, failing to comply with recognizance, and a failure to appear in court. Dayfoot did raise the issue of FASD as a mitigating factor. It was held that the court considered Dayfoot to indeed be an Aboriginal offender with fetal alcohol syndrome who was not a danger to the community. The judge gave the accused an 18-month conditional sentence after pleading guilty to the aforementioned offences. The judge in this case made some strong
statements about why an alcohol-related neuro-developmental disorder, specifically FASD, should be considered a mitigating factor in sentencing. When describing Dayfoot’s criminal behaviour, the judge postulated the following:

...[a]gain this is symptomatic of a person suffering ARND. To punish behaviour which results from a clinically recognized disability runs contrary to the principles of criminal law, certainly where treatment is available. Unaided, the continued disability leaves Mr. Dayfoot more dangerous than he might be with treatment. Thus fundamental principle of sentencing expressed in Section 718.1, relating to the degree of responsibility of the offender, is properly interpreted by fashioning a sentence taking into account the role played by ARND, and the prospect of eradicating this source of criminal misconduct (paragraph 23).

Evidently, the judge took a very strong position with respect to the interpretation of Section 718.1, in terms of the offender’s degree of responsibility, and felt that an appropriate sentence had to take into consideration Dayfoot’s FASD. The judge was very direct in believing that to not consider FASD and instead punish the offender’s behaviour, despite having an organic brain impairment, would be completely against the principles of criminal law. The judge felt strongly about Dayfoot receiving treatment for his disorder. The judge made no mention of Dayfoot’s culpability in terms of remorse; however, for the variable of ‘judge-resource’, the judge did allude to resources and stated, “[c]onvicted FASD persons are, by definition, special needs defendants. The special programs and services essential to meeting these needs are woefully lacking” (paragraph 13). There is no further elaboration on this statement which clearly reflects the judge’s displeasure with the services available to people who suffer with FASD.

The final FASD case in which this particular disorder was explicitly referred to as being a consideration in sentencing was in the R. v. L.A.B. (2007) Ontario case. L.A.B. was a female Aboriginal youth who was being sentenced for second-degree murder. She was 14 at the time of the murder, so she could have been tried as an adult under the Youth Criminal Justice Act (YCJA); however, the judge felt that an adult sentence would be too severe, given her age and mental limitations. Her sentence was being committed to intensive rehabilitative custody for the maximum sentence of four years of closed custody to be followed by three years of community supervision. The judge stated, ...”many mitigating factors in this sentencing, not the least of which is the evidence called from all of the experts that this young person, through no
fault of her own, has the cognitive capacity of a six to eight year old child (paragraph 72). “I have also considered her difficult background, her diagnosis of fetal alcohol effect and her early years of development which were severely wanting and for which she herself cannot be held responsible” (paragraph 74). With respect to the ‘judge-culp’ variable, the judge made no mention of L.A.B’s remorse or lack of it except for stating that she could not be held responsible (as previously directly quoted). For ‘judge-resource’, the judge did not allude to resources in the youth system in connection to FASD anywhere in the judgment.

Judges ‘Alluding’ to FASD as a Mitigating Factor

In the Saskatchewan case of R. v. Otto (2004), Otto was an Aboriginal adult male who was being sentenced for robbery and breach of probation. The judge stated how Dr. Nicholaichuk’s assessment was extremely thorough, fair and balanced, and proposed to quote at length from his assessment as the assessment embodied many of the factors which were important in considering Mr. Otto’s current situation. Dr. Nicholaichuk was quoted as stating the following regarding Otto’s possible FASD:

> There is a significant discrepancy between Mr. Otto’s intellectual functioning and his ability to function in the community. Although a diagnosis is not entirely possible at this stage, it is quite likely that he has suffered some neurological damage as a result of his mother’s drinking. For example, his history demonstrates an inability to learn from experience, poor social judgment, trouble with the law and poor anticipation of consequences, all of which are often associated with fetal alcohol effects. His current offence is an example of how he can be easily lead [sic] by others, a problem which is typical in this population (paragraph 13)....Unfortunately, Mr. Otto has experienced all of the risk and none of the protective factors associated with the disorder. It is possible that his risk for violence will decrease as Mr. Otto ages. This is common in other offender populations. Mr. Otto was realistic in his assessment that he will need support and guidance if he is to successfully adjust to life in the community. In the past, these supports have not been available and he has failed (paragraph 13).... If he is to be returned to the community, treatment and supervision will have to take into account Mr. Otto’s limitations and his difficulty living independently (paragraph 13).

The fact that the judge not only cited such long excerpts from the mental health expert regarding Otto’s possible FASD diagnosis but also cited the academic literature pertaining to FASD by Boland et al., 1998 in his judgment,
certainly showed a keen interest in the ramifications of the diagnosis and, therefore, it must have been a consideration in the final sentencing outcome. In fact, after sentencing him as a long-term offender to a determinate period of imprisonment of at least two years, followed by a period of community supervision of up to ten years, the judge did articulate, “I am persuaded that appropriate conditions can be placed upon Mr. Otto’s eventual reintegration into the community to the extent that the risk which he presents is one which is reasonably open to eventual control in the community...Mr. Otto’s ultimate period of community supervision will, of necessity, be highly structured... (paragraph 38). Evidently, the judge conceded to Dr. Nicholaichuk’s assessment recommendations for Otto. Perhaps Otto would have received a longer minimum custodial term, had it not been for his FASD and the recommendation that he could be controlled in a very structured, controlled community setting? In terms of the ‘judge-culp’ and ‘judge-resource’ variables, no comments were made by the judge to address such factors.

In the Saskatchewan case of R. v. Head (2004), Head was an adult Aboriginal male who was being sentenced for a sexual assault. The judge gave Head a conditional sentence of 20 months, together with an additional probation order of 12 months, stating that with respect to whether a conditional sentence is consistent with the need to denounce and deter the conduct of which Head was guilty, denunciation was a less important consideration when dealing with an ‘intellectually-impaired’ person. Specifically, when considering section 718.1, the judge in this case referred to another case, R. v. D.J.J (1998), in which at paragraph 34 of the majority opinion of the Court it was held that an accused’s intellectual capacity may be considered in fashioning an appropriate sentence. The judge stated, “[w]hile the accused in the present case is not at the most extreme end of the range, I proceed on the basis that he is intellectually-impaired. There may be a Fetal Alcohol issue as well but the Pre-sentence Report indicates that there is no proper diagnostic tool available at this time” (paragraph 14). It appears that, even though the judge did not know conclusively whether Head suffered from FASD, the judge was sufficiently satisfied that Head did in fact have a cognitive-impairment and thus considered this fact in the final sentencing decision. It is also quite interesting that, at the time of this judgment (2004), the judge was told that there was ‘no proper diagnostic tool available.’ The judge further alluded to FASD when stating that Head was to attend personal counseling, psychological
or fetal alcohol assessment, if directed to do so by the conditional sentence supervisor or probation officer. In terms of the variables ‘judge-resource’ and ‘judge-culp’, no comments were made at all in the case.

In another Saskatchewan case, R. v. W.T. (2004), W.T. was an adult Aboriginal male who was sentenced for sexual assault causing bodily harm and he received six-and-a-half years in a penitentiary, followed by a ten-year community supervision order. He was granted long-term offender designation by the judge, rather than being declared a dangerous offender. The judge made it known that, in this particular case, W.T.’s FASD diagnosis was hearsay, simply because no formal confirmation of maternal drinking was provided; however, the judge did agree that W.T. clearly suffered from an organic condition, which was most likely FASD. The judge in this case discussed FASD in the context of sentencing and pointed out that some judges have considered this disorder an aggravating factor, especially in the context of a dangerous offender application:

...when a pattern of violent sexual behaviour has been established, one might conclude that it is likely to persist since the condition, itself, cannot be changed (summary and recommendations, paragraph 2)”. However, as more is learned about the behavioural management of this disorder, some optimism has begun to emerge. Others have argued that when such a diagnosis is present, the overriding sentencing consideration should be rehabilitation, since the disorder is likely to have at least contributed to the offence and since specific deterrence is ineffectual with individuals suffering from this kind of cognitive deficit and general deterrence and denunciation are not applicable due to the idiosyncratic nature of the offender. This opinion, however, ignores the principle of public safety, which is implicit in the dangerous offender criteria, and has been considered of paramount importance elsewhere with offenders having FASD. A final position pertaining to the sentencing of offenders with FASD who are perceived to present a significant threat to the community is that public safety is best served by a combination of brief incarceration coupled with a court-sanctioned, comprehensive, strict, maximum treatment plan” (paragraph 13).

The judge did not further elaborate on whether W.T.’s FASD should be considered as mitigating per se, but evidently the judge acknowledged the complexity of this disorder in terms of how it fit in with the sentencing principles of s. 718.1. In terms of ‘judge-culp’, the judge did state that one factor that was part of the analysis that went into determining W.T.’s sentence was his lack of remorse throughout the trial and the judge stated how W.T. needed to take responsibility for his actions and not to blame the alcohol or the
victim. Overall, the judge was not very optimistic about W.T.’s treatment, stating, “…the nature of some of these problems suggests that treatment would be fairly challenging, with the treatment process likely to be difficult and reversals should be expected” (paragraph 13). The judge made no further reference to FASD, nor did the judge make any statement that was applicable to the ‘judge-resource’ variable.

In the Ontario case of R. v. Edwards (2005), Edwards was an adult male who was charged with facilitating the commission of an offence through a computer; specifically, he attempted to meet with a girl, believed to be under the age of 14, in order to have sexual relations with her. Edwards was sentenced to 15 months in an Ontario reformatory. In this particular case, the judge stated directly that the mitigating factors in this case were Edwards’ background (the judge was aware of Edwards’ FASD) and that at the time he was heavily into drinking and drugs.

The background of Mr. Edwards could be described as more than unfortunate. He has had a lot to cope with in his life. He was born with fetal alcohol syndrome, which caused the right side of his face to be deformed. He also had spinal problems and bad nerves due to fetal alcohol syndrome (paragraph 13).

Despite the judge having acknowledged and recognized Edwards’ lifelong reality of suffering with FASD, in the end, the judge stated that, “[t]he dominant components of this sentence are denunciation and specific and general deterrence. Section 718 sets out the fundamental purposes of sentencing and I am not going to read the section but I have considered it (paragraph 27)”…”I find that in this case the punitive objective such as denunciation and deterrence are particularly pressing and that incarceration is the necessary sanction (paragraph 32)” . The judge did not make any reference to resources, which would be appropriate under the ‘judge-resource’ variable, but he did address ‘judge-culp’ by stating that Edwards had shown remorse and appeared to be amenable to counseling.

In the Saskatchewan case of R. v. J.W.K (2009), J.W.K. was an adult Aboriginal male who was being sentenced for robbery and extortion. He received a two-year custodial disposition, followed by a three-year probationary sentence. The judge certainly alluded to FASD as being a consideration in sentencing by stating the following:

I would note that in imposing this sentence I have taken into consideration the time he has spent in custody to this point awaiting
sentence. I have given him double credit for time spent on remand which effectively makes this a sentence of almost five years in custody followed by three years probation. In my view this adequately addresses the principles of sentencing, in particular the need to protect the public and also recognizes the significant challenges faced by Mr. J.W.K. due to his FASD and his chaotic upbringing (paragraph 53).

The statement above, with respect to the sentence handed down as recognizing the significant challenges faced by J.W.K., is rather vague in the sense that it is unclear whether the judge is placing the offender in custody because he considered him a risk to the public owing to his FASD condition or if, in fact, he has reduced his sentence because J.W.K. could not have been held culpable for his crime owing to having FASD (not being able to appreciate the nature or quality of the act committed to some degree). In terms of the ‘judge-culp’ variable, the judge does not make any reference to J.W.K.’s level of remorse or responsibility but for the ‘judge-resource’ variable, the judge refers to Dr. Nanson’s observation regarding resources for FASD. Dr. Nanson advised that an attempt was being made to develop services for adults with FASD at the Regional Psychiatric Centre in Saskatoon. The doctor pointed out how Bow Unit, which is the adult unit for offenders with significant neurological problems, did indeed recognize that many of the offenders in the Unit have FASD and that the people in charge of the unit were trying to develop some resources and programming for adults with FASD in the correctional system. Furthermore, Dr. Nanson pointed out that the Prince Albert Federal Correctional Facility was also attempting to develop programs for offenders with FASD but they were not yet well-developed.

In another Saskatchewan case, R. v. P.J.M. (2008), FASD was alluded to as a mitigating factor, based on the manner in which the judge addressed the disorder in the treatment component of sentencing. P.J.M. was an Aboriginal male youth and he was being sentenced for break and enter, theft, possession of marijuana, being unlawfully at large from open custody and obstruction by provision of a false name. The judge sentenced him to five months of custody and supervision and really stressed ‘supportive structure being a key to success’, which was noted as being especially important in most FASD cases. The judge stated the following:

Plans for his reintegration into society must be made having regard to his abilities and disabilities and they must be realistic having regard to the diagnosis of Partial FAS and the “blueprint” of cognitive challenges described in Dr. Nanson’s neuropsychological report. I found it interesting
that in the past P.J.M. has had periods of “good behaviour” or compliance with expectations. Attempts might be made to reproduce the conditions that were in place at those times. It would not be appropriate, having regard to the nature of his disabilities, to assume that after a period of satisfactory performance, supervision and supports may be removed with the expectation that he will do well on his own (paragraph 48).

Evidently, the judge certainly acknowledged the need for P.J.M. to have structured support to deal with his FASD. In terms of the ‘judge-resource’ variable, the judge stated clearly, “[i]n making plans, I strongly recommend consultation with persons who are knowledgeable about FASD. One very good resource in Saskatchewan is the FASD Support Network of Saskatchewan Inc., which has an office here in Saskatoon (paragraph 48)”. There was no reference made to the offender’s remorse or responsibility (judge-culp variable) in the sentencing judgment.

The final FASD case in which fetal alcohol is somewhat inferred and, therefore, possibly viewed as a mitigating factor in sentencing was the Ontario case of R. v. Brown (2008). Brown was an adult Aboriginal male who pled guilty to an aggravated assault and he was sentenced to 18 months in custody, followed by three years’ probation, with treatment and counseling as ordered by his probation officer. It was stated in the offender’s history that he had been apprehended from his parents’ home when young because they were alcoholics and he was born with fetal alcohol syndrome. The judge also directly stated that Mr. Brown endured a number of mental and physical challenges, one of which was fetal alcohol syndrome. In terms of the judge’s statement which exemplified FAS as perhaps being considered in the overall sentencing, the judge stated, “[h]owever, here we have an aboriginal offender whose actions that day on the subway platform — intoxicated and angry, lashing out for no reason at a complete stranger — can be traced directly to his long-standing alcohol addiction which itself is traceable to his birth parents and the circumstances of his youth (paragraph 49)”. Since the judge originally acknowledged Brown being born with FASD, the quote, even though it does not directly mention FASD, certainly implies it. Hence, the judge appeared to consider this impairment in some capacity. In terms of ‘judge-culp’, the judge did state that Brown was remorseful and had no memory of the actual criminal act, owing to his state of intoxication. There was no statement made with respect to the ‘judge-resource’ variable.
Overall, out of the 11 cases in which FASD was either explicitly stated or alluded to as being a mitigating factor in sentencing, only in three cases was the issue of resources mentioned. The sole Ontario judgment case in which the judge essentially stated that appropriate programs for those suffering from FASD were lacking was *R. v. Dayfoot* (2007). The other remaining cases in which resources for those with FASD was brought up were *R. v. J.W.K.* (2009) and *R. v. P.J.M.* (2008). In the *J.W.K.* case, it was the expert witness, Dr. Nanson, who discussed two specific correctional facilities that were creating special programming for offenders dealing with FASD. In the *P.J.M.* case, the judge acknowledged the importance of having the offender consult with a specific FASD support network.

One theme and one emergent sub-theme was identified:

**List 6: Themes**

- offender’s culpability
- offender’s culpability a mitigating factor

Another major theme and sub-theme was identified:

**List 7: Themes**

- judge resource consideration for FASD
- some judge resource consideration for FASD
Judges ‘Explicitly’ Stating ADHD as a Mitigating Factor

There were five cases in which the judge specifically made a statement that reflected ADHD as being a mitigating factor in sentencing and one of those cases was the Ontario case *R. v. A.R.* (2007). A.R. was a male youth who pleaded guilty to break and enter with intent to commit theft, possession of a criminally-obtained firearm and possession of an unlicensed firearm. The judge gave him a six-month deferred custody-and-supervision order to be served in the community, 40 hours of community service, as well as 12 months of probation. The judge directly stated that there were many factors specific to the young offender’s background and prospects for rehabilitation that weighed in his favour. “Those mitigating factors may be summarized as follows: A.R.’s criminal conduct is, in part, related to his vulnerability to peer pressure and his episodic association with a negative peer group. That vulnerability may very well be connected to his learning disability and his conditions of ADD and ADHD (paragraph 28).” The judge also acknowledged in his sentencing judgment that A.R. was formally diagnosed with Attention-Deficit-Hyperactivity Disorder and was on medication to assist him in coping with the behaviour that was typical of such a condition. There was no mention of resources for ADHD by the judge, thus making the ‘judge-resource’ variable inapplicable but for ‘judge-culp’, the judge read the following statement about A.R.’s remorse:

A.R has expressed his regret for his involvement in the offence before the courts. He realizes the consequences of his actions and does accept responsibility for his conduct. He admits that some friends have a negative influence on him, however A.R. never attempted to defer all the blame on his co-accused (paragraph 28).

It was stated directly that A.R.’s remorse was a consideration in sentencing.

In another Ontario youth case, *R. v. A.B.* (2005), A.B. was a male as well as a young offender who was being sentenced for second-degree murder after sexually assaulting and beating the deceased. He was 16 at the time of the offence. The judge sentenced A.B. to 18 months in custody in the Intensive Rehabilitative Custody Program in addition to 36 months, three days of pre-trial custody and five years of conditional supervision. Dr. Ramshaw diagnosed A.B. as having borderline intellectual functioning, Attention-Deficit-Hyperactivity Disorder with inattention and impulsivity. A.B. had a severe cognitive disability, so severe in fact that after his diagnosis of having a serious learning disability and ADHD in 1995, he was transferred to another school.
and placed in a specialized class for developmentally challenged students. The judge recognized the severity of the crime committed and listed several aggravating factors but also spent time stating the mitigating factors and ultimately giving a sentence that was the least restrictive and that was capable of achieving the sentencing principles under section 18(2) of the Youth Criminal Justice Act. In terms of the mitigating factors, the judge explicitly listed A.B.’s significant intellectual limitations as being a mitigating factor. Considering that his learning disability and his ADHD-related inattention problems were always being grouped together when discussed, either by the mental health professional or the judge, it is not far-fetched to assume the judge was including ADHD as an intellectual limitation. For the variable ‘judge-culp’, the judge did state that he accepted A.B.’s remorsefulness for the crime committed. In terms of the variable ‘judge-resource’, the judge did not mention resources specific to his ADHD.

In the Ontario case of R. v. Schroeder (2004), Schroeder was an adult male who was being sentenced for unlawfully conspiring to murder, unlawfully attempting to murder and aggravated assault. For such serious offences, the judge sentenced Schroeder to twelve years’ imprisonment for attempted murder and eight years for conspiracy to commit murder, served concurrently. A formal diagnosis of ADHD was not directly mentioned but the judge did state that Schroeder suffered from ADHD as well as Tourette’s syndrome and that, in the past, he did take Ritalin for his ADHD condition but since then turned to illicit drug use. In terms of how Schroeder’s ADHD factored into sentencing as a mitigating factor, the judge directly stated that, “[m]itigating factors include the youth and relative immaturity of the offender; his turbulent family background; his mental and emotional condition, including his Tourette’s, ADHD and current difficulties with depression (paragraph 20)”. The judge did not mention resources in the context of ADHD (judge_resource variable) but, in terms of the ‘judge-culp’ variable, the judge did include Schroeder’s remorse as a mitigating factor by stating in the overall mitigating factor section, “…I also accept Mr. Schroeder’s expressions of remorse, and Christian beliefs as a first step towards potential rehabilitation (paragraph 20)”. In the Ontario case of R. v. Vukmanich (2007), Vukmanich was an adult male who was being sentenced for three counts of assault and two counts of failure to comply with a condition of his recognizance. The judge sentenced Vukmanich to six months of imprisonment, followed by a period of probation
of two years. The judge stressed how the Criminal Code stipulates in s. 718.2 that a court must take into consideration the principle that a sentence should be increased or reduced by any relevant aggravating or mitigating circumstances relating to the offence or the offender. Thus, one of the mitigating factors that the judge directly listed was Mr. Vukmanich’s history of Attention-Deficit Disorder. There was no special mention of resources for ADHD (judge-resource variable) but for the ‘judge-culp’ variable, Vukmanich’s remorse and apology for his actions was stated directly as being a mitigating factor.

The final case in which ADHD was stated explicitly as a mitigating factor was the Ontario R. v. McCauley (2007) case. McCauley was an adult female who was charged for and convicted of aggravated assault. The judge sentenced her to twelve months of incarceration, followed by three years of probation. In this particular case, the crime that was committed was against McCauley’s baby and, because of that, the judge made the point that, for the wider public interest expressed through the principles of denunciation and deterrence, the circumstances of angry abuse of a very young baby warranted nothing less than incarceration.

Nonetheless, the judge stated the following:

In the balance in mitigation of sentence, the court takes into account that: the offender likely suffers from ADHD which, along with other evidence relating to Ms. McCauley’s mental makeup, provides some context to the offender’s limited coping abilities as a parent (paragraph 30). Second, but for the offender’s youth at the time of the offence, and the modest contribution of her ADHD condition to the circumstances of the offence, a more severe sentence would be warranted (paragraph 36).

Hence, the judge clearly indicated that, had it not been for the offender’s age and attention-deficit-hyperactivity disorder, Kayla McCauley would have received a more severe sentence—most likely longer incarceration. Kayla was originally diagnosed with ADHD between the ages of six through 14 years, and was treated with Ritalin. The judge also appeared to characterize her poor parenting style as a circumstance of her ADHD. No special mention was made regarding resources for ADHD (judge-resource variable) but for the ‘judge-culp’ variable, the judge stated, “as with most crimes, remorse of the offender, contributes to mitigation of sentence (paragraph 28)” . However, in McCauley’s case, the judge noted that it was difficult to determine her level of remorse, considering she had limited insight, blamed others and took no responsibility for her actions, as well as feigned memory loss as to the circumstances of the
abuse against the child, nor did she take any steps toward anger management, cognitive-behaviour therapy or Ritalin intervention to control impulsivity since the time of the criminal incident. Regardless, based on what the judge stated about remorse and mitigation in sentencing, had McCauley been remorseful, it would have factored into her sentencing disposition.

There were two identified themes and one emergent sub-theme:

**List 8: Themes**

- **ethnicity**
- **Aboriginal descent**
- **ADHD being a mitigating factor in sentencing**

**Judges ‘Alluding’ to ADHD as a Mitigating Factor**

The remaining two cases reflected ADHD as being possibly considered by the judge in sentencing but the disorder was not specifically stated as being a direct mitigating factor, although it may have been. The first one was the B.C. case of *R. v. McGoran* (2004), in which McGoran, an adult male, was being sentenced for manslaughter. The judge sentenced him to two years less a day in a provincial facility, followed by a three-year probationary sentence. The judge cited a component of Dr. Janke’s psychiatric assessment, with which the defence provided the court, in order to illustrate that McGoran’s actions (the criminal act) may have been largely owing to the drugs he had taken as well as the ADHD from which he suffered. “In my opinion, Mr. McGoran’s behaviour in this incident represents a combination of the impulsivity that is seen in individuals with attention deficit disorder, his previously-expressed propensity to use aggression in interpersonal relationships, and the effects of both acute and prolonged use of psycho-stimulants such as cocaine and methamphetamine (paragraph 29)”. How much weight the judge gave to the doctor’s statement is not directly stated but he certainly described it in his sentencing decision. In terms of the probationary component of the sentence, the judge acknowledged the offender’s ADHD and stated that, so long as he complied
with taking his medication, probation would be granted. It is not clear how much of a consideration ADHD was in the overall sentence that was handed down to McGoran, but evidently the judge did consider ADHD in some capacity, at least in terms of the treatment component of it, when granting McGoran a probation order. Nonetheless, it could also be inferred that, had he not consented to taking medication for his ADHD, then having ADHD would have actually prevented him from getting a probationary order and perhaps he would have received a federal custodial disposition. It was stated earlier in the case that, “[i]n the past, Mr. McGoran has treated his ADHD with Ritalin. However, he voluntarily ceased using that drug because he thought he no longer needed it (paragraph 19)”. In terms of the ‘judge-culp’ variable, the judge was satisfied that McGoran’s remorse was genuine, as he had expressed it directly to the victim’s family. There was no mention of resources (judge-resource variable), with respect to ADHD.

The Ontario case of R. v. L.A.B. (2007), was also discussed above in the mitigating factor section for FASD. To reiterate, L.A.B. was a female Aboriginal youth who was sentenced for second-degree murder. In the end, the judge felt that an adult sentence would have been too severe given her age and mental limitations; therefore, she was committed to intensive rehabilitative custody for the maximum sentence of four years of closed custody to be followed by three years of community supervision. L.A.B. had been formally diagnosed with attention-deficit-hyperactivity disorder, one of many diagnoses, and a doctor who had assessed L.A.B. (Dr. Bassarath) stated that, “…her low frustration tolerance ADHD hasn’t changed and likely will not (paragraph 33)”. In terms of how her ADHD may have been a mitigating factor in sentencing, the judge stated, “I have considered her age, just turned 14 at the time of the offence, her relative immaturity in relation to others her own chronological age, and her character including her extreme difficulty in being able to understand and control on her own her aggressive and impulsive tendencies (paragraph 74)”. The part about her not being able to control her aggressive and impulsive tendencies could be in reference to her ADHD diagnosis, considering the judge did mention Dr. Bassarath’s statement about L.A.B.’s ‘low frustration tolerance ADHD’. Of course the judge also considered her diagnosis of FASD and her tumultuous upbringing, as described in the previous FASD mitigating factor section. In terms of the ‘judge-culp’ variable, as stated in the previous section, the judge only stated that she could not be held responsible and for the ‘judge-
resource’ variable, the judge did not mention resources in the youth system in connection to ADHD at all in the judgment.

One theme and one emergent sub-theme was identified:

**List 9: Themes**

- **offender’s culpability**
  - **offender’s culpability as a mitigating factor**

Another theme and emergent sub-theme was identified:

**List 10: Themes**

- **judge resource consideration for ADHD**
  - **no judicial resource consideration**

It is interesting to note that, of the 18 cases involving FASD and ADHD as mitigating factors in sentencing, nine were also discussed in the ‘treatability’ variable component (24 cases in total were analyzed in the ‘treatability’ variable component); specifically, eight from the ‘treatability’ variable section were explored in the FASD mitigating factor component: R. v. Mackenzie (2007), R. v. W.T. (2004), R. v. L.A.B. (2007), R. v. Dayfoot (2007), R. v. J.W.K. (2009), R. v. P.J.M (2008), R. v. Mumford (2007), R. v. Brown (2008) and only one case, R. v. L.A.B. (2007), which was discussed in the ‘treatability’ variable section was also revisited in the ADHD mitigating factor component. In terms of the ‘judge-
resource’ variable in the ADHD mitigating factor section, unlike in the FASD mitigating factor section, in which there were several cases where judges discussed resources or lack thereof for FASD, there was not a single case for ADHD in which resources were considered. In terms of the ‘judge-culp’ variable, the offender’s remorse/responsibility was addressed in five of the 11 FASD mitigating factor cases and in six of the seven ADHD mitigating factor cases; thus, in 11 out of the 18 cases, remorse was mentioned by the judge. In some instances, remorse was simply stated as either being present or not, but in several other cases the judge specifically listed the offender’s level of remorse as being a mitigating factor or, in a rare case, such as R. v. W.T. (2004), the offender’s lack of remorse was regarded as being an aggravating factor. For example, in W.T., as already mentioned previously in the FASD mitigating factor section, the judge stated directly that the one factor that was part of the analysis that went into determining W.T.’s sentence was his lack of remorse throughout the trial and the judge stated how W.T. needed to take responsibility for his actions and not to blame the alcohol or the victim. Evidently, the consideration of ‘remorse/responsibility’ for the crime committed is a major consideration in sentencing for judges.

Evaluator Direct Reference in Sentencing Judgment to Principal Disorder as being Present and whether the Judge Mitigates the Sentence Due to the Principal Disorder

List 11: Evaluator Direct Reference to Principal Disorder as Being Present and Whether the Judge Mitigates the Sentence Due to the Principal Disorder

| of the 11/40 FASD cases mitigated by judge | only in 2/11 was an evaluator quoted as having stated that the disorder was present |

Another variable of interest was whether one or more of the evaluators in each case was directly mentioned as having stated that the principal disorder was present or absent and, if it was present, in how many such cases did the judge mitigate the final sentence owing to the principal disorder. In terms of the FASD cases, of the 11 out of 40 FASD cases which were mitigated by the judge,
as discussed in the preceding component of the chapter, only in two of them where one or more evaluators was directly quoted as having stated in the sentencing judgment that the disorder was present/significant features of the disorder were present, did the judge mitigate in light of the principal disorder.

**List 12: Evaluator Stating the Disorder was Present**

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>in 13/40 FASD cases, evaluator quoted as stating disorder was present</td>
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<tr>
<td>• only in 2/13 cases did the judge consider FASD a mitigating factor</td>
</tr>
<tr>
<td>6/13 FASD cases - 1 evaluator stated disorder was present</td>
</tr>
<tr>
<td>5/13 FASD cases - 2 evaluators stated disorder was present</td>
</tr>
<tr>
<td>2/13 FASD cases - 3 evaluators stated disorder was present</td>
</tr>
<tr>
<td>9/27 cases judge considered FASD mitigating factor, despite no direct mention of disorder presence by evaluator</td>
</tr>
</tbody>
</table>

In 13 of the 40 FASD cases, an evaluator or evaluators were directly quoted as stating the disorder was present or significant features of the disorder were present and yet, only in two of those cases in which the judge mentioned the diagnosis of the disorder, did the judge actually consider FASD as a mitigating factor in sentencing. In six of the 13 cases, one evaluator was directly quoted as stating the disorder was present/significant features of the disorder were present; in another five of the 13 cases, two evaluators were directly quoted as stating the disorder was present/significant features of the disorder were present; and, in two of the 13 cases, three of the evaluators were directly quoted as stating the disorder was present/significant features of the disorder were present. In the remaining 27 FASD cases, the judge never included any direct statement made by an evaluator or evaluators regarding the presence or features of the principal disorder and yet, in nine of those instances, the judge still considered FASD as a mitigating factor in sentencing: this demonstrates that not all direct diagnostic statements made by an evaluator in some previous
report, such as a pre-sentence report, that a judge reflects upon, are necessarily included in the final sentencing judgment.

The first of the two of the 13 cases, in which the judge did directly quote the evaluator(s) about the disorder being present/significant features of the disorder as present and then ultimately did consider FASD as a mitigating factor, was the British Columbia case of R. v. Mackenzie (2007). In this case Dr. Koopman stated, “[a]lthough there has yet to be an official diagnosis of FASD, it is the writer’s opinion that Mr. MacKenzie has many of the characteristics associated with this behaviour: impulsivity, manipulative behaviour, lying, self-destructive criminal activity, limited ability to learn from past mistakes, et cetera (paragraph 13)”. The judge did list Mackenzie’s supposed FASD as being a mitigating factor in sentencing and stated directly that, even though an FASD test was not performed, the judge felt the State had enough assessment information about Mackenzie to proceed irrespective of not knowing 100% if he suffered from FASD. Evidently, the judge took the evaluator’s statement about Mackenzie displaying many characteristics of FASD as meaning he did have it, since he included it as a mitigating factor.

The second case was the Ontario case of R. v. L.A.B. (2007), in which the judge stated that Dr. Bassarath diagnosed L.A.B. as suffering from alcohol related neuro-developmental disorder. The judge then later stated in the judgment, “I have also considered her difficult background, her diagnosis of fetal alcohol effect and her early years of development which were severely wanting and for which she herself cannot be held responsible (paragraph 74)”.

FASD/ADHD Explicitly Stated by Judge as Contributing to the Lengthening of the Final Sentence or Being Dismissed of Importance

There were five cases out of the 83, excluding the appellate court judgments, which exemplified the diagnosis of FASD/ADHD as possibly contributing to the lengthening of the sentencing disposition, or not having any impact at all in the final outcome and this was stated directly by the judge. Five such cases appeared for FASD and one of the five cases was also applicable to both FASD and ADHD.

In the British Columbia case of R. v. Pauls (2005), in which an adult male was being sentenced for failing to appear in court, failing to report to a bail supervisor and being in a private motor vehicle when he was not permitted to do so, the judge sincerely appeared to place importance on Pauls’ FASD
condition. As discussed in the ‘treatability’ variable component of this chapter, the judge made the point that, if Pauls did have fetal alcohol, it was not his fault and he could not be seen as being responsible for such a predicament. The judge did ultimately base his sentencing disposition on the assumption that Pauls may have been suffering from fetal alcohol. The manner in which FASD can be seen as an aggravating factor in this case is because Pauls would probably have received a lighter, provincial custodial disposition had it not been for his fetal alcohol. Instead, Pauls received a two-year custodial sentence, specifically two years, so that he remained in federal custody where he could receive better treatment options: “…by being in a federal custodial setting you will get the assistance of a lot more structured programs than you might in the provincial system by being in a federal custodial sentence (paragraph 6)”. The judge also directly stated that Pauls was receiving the two-year federal sentence so that he could get the help for his suspected fetal alcohol syndrome. This is not a case which exemplifies in any way a judge’s disregard for the diagnosis of FASD, or lack of care for the disorder; rather, it demonstrates that even ‘suspected’ FASD, since it had not been formally diagnosed, was a high priority for this particular judge, to the degree that the judge went so far as to sentence Pauls to serve federal time so that he could receive better care. Hence, the term ‘aggravating’ was used very loosely, since considering lengthening the offender’s sentence, in order for Pauls to receive intensive treatment benefits, was perhaps a viewed as a positive consideration by the judge. This case clearly reflects again the lack of resource availability for offenders suffering from FASD, since at times judges have to give heftier sentences in order to deal with the disorder.

In another British Columbia case, R. v. Pickerill (2005), the adult male was being sentenced for robbery, theft and breach of probation. In this case, the judge stated the following:

[substractions have been made about the fact that you suffer from fetal alcohol syndrome and therefore have a very real problem connecting consequence to action and also ingesting, adapting, taking on for yourself the need to think before you act. That may very well be true. But if it is true and if the result of that is serious criminal activity, then emphasis clearly has to be put on separating you from the community (paragraph 8).]

In the end, the judge did exactly as stated in the above quote and gave Pickerill a 29-months custodial sentence. The judge made no other mention of Pickerill’s FASD, except in the quoted excerpt. Evidently, from the quote, the
judge seemed certain that Pickerill did have FASD and appeared to focus on his cognitive impairment, which is a result of the disorder, in justifying an incarceration sentence. It would appear that this judge considered Pickerill a danger to the community, owing to his disorder; therefore, the judge stipulated such a strict measure.

In the British Columbia case of *R. v. Toplass* (2009), the adult female was being sentenced for arson. Both FASD and ADHD were considered by the judge in the discussion of sentencing.

Ms. Arkesteyn-Vogler does have some challenges such as ADHD and fetal alcohol effect. I am aware people such as her can have problems with impulse control, and that may certainly have been a factor in this particular offence. It may well be you did not think through the consequences, you just acted without thinking about what so easily could happen, but when I take into account the circumstances of the offence, Ms. Arkesteyn-Vogler’s particular background, and the degree of involvement with respect to all of these people, in my view there is no basis for deviating or differentiating Ms. Arkesteyn-Vogler from Ms. Toplass, in giving anything less than the 30 months that Crown is suggesting (paragraph 10).

Evidently, the judge in the *Toplass* case certainly accepted the fact that Toplass suffered from ADHD and FASD. Despite having those disorders, which, as the judge indicated, may have explained why she committed the crime by not thinking things through, in the end, the judge did not see such cognitive limitations/challenges as negating her responsibility in the crime.

In the Saskatchewan *R. v. C.P.S.* (2004) case, in which an Aboriginal adult male was being sentenced for forcibly seizing a woman and uttering death threats against her, the judge certainly discussed C.P.S.’s potential FASD in relation to treatment as well as his ‘cognitive impairment’ as warranting an indeterminate sentence. As discussed in the ‘treatability’ component of this chapter, an official diagnosis of FASD was never made. However, the judge stated that whether or not C.P.S. suffered from FASD made little difference in the treatment outcome. This was explored in the ‘treatability’ component in more depth. Overall though, it certainly appeared as if the judge did not deem it necessary to probe further in order to find out whether C.P.S. did in fact have FASD. Such a disregard for diagnosis was probably a result of the experts’ opinion regarding the nature of the treatment not being impacted by knowing what caused the actual ‘cognitive impairment’. In the end, the judge agreed with the Crown and gave C.P.S. an indeterminate sentence. The judge stated,
“S. has a myriad of problems, from a personality disorder to alcohol and substance abuse, to cognitive impairment, and an inability to either cope or control his impulses. I find that the Crown has proved beyond a reasonable doubt that S.’s sentence ought to be one of indeterminate length, and I order accordingly (paragraph 51)”. By ‘cognitive impairment’, the judge must have been referring to C.P.S.’s suspected FASD, and went forward with the final sentencing disposition without any regard for how best to deal with such an impairment or was simply resigned to C.P.S. never being rehabilitated owing to the ‘undiagnosed’ cognitive impairment.

In the Ontario case of R. v. Boyd (2004), Boyd was an adult female sentenced for aggravated assault and was sentenced to seven months of imprisonment. The judge was extremely pessimistic about her ability to be treated; therefore, the sentence did not reflect any rehabilitative strategy. It would appear as if Tamela Boyd’s FASD made the judge even more inclined to believe that she could not be treated. The judge in this case stated the following:

I am satisfied that she probably suffers from fetal alcohol effect. We will probably never get a diagnosis of that, because since birth, she has been living a hell. She has abused her body with alcohol and intoxicating volatile vapors. She obviously suffers from cognitive difficulties and it is impossible now to know what part of it is fetal alcohol effect and which part of it is neurological damage that has been caused by her substance abuse (paragraph 2).

Based on what we have heard from Mr. Gilfix, rehabilitation is unlikely, in view of the neediness of Tamela Boyd. We are not going to see any striking change in her situation as a result of alcohol abuse treatment or solvent abuse treatment in the near term. Her cognitive difficulties are so extreme that change in her life situation is going to be measured by very, very small increments. All counsel and the probation officer agree that Tamela Boyd is facing the risk of retaliation when she returns to her home community. It is not often that the court has that presented so clearly, but it brings to bear the importance of the court imposing a sentence that meets some requirement of justice that clearly denounces this behaviour so that the victim’s family might well feel that the sentence satisfies the needs (paragraph 2).

Based on the judge’s commentary in the Boyd case, it would appear as if the judge had a lack of concern in fully understanding whether Boyd suffered from FASD, since the judge stated it was impossible to know what part of her neurological damage was from fetal alcohol and what component was from her persistent substance abuse. Overall, the judge’s statement with respect to Boyd’s prospects for rehabilitation was extremely negative, especially when the
judge said she could not be rehabilitated in view of her ‘neediness’. It was as if the judge had completely given up on Boyd, considering the judge referred to her cognitive impairment as being so extreme, that her life situation would be measured by very small increments. The judge saw her as recidivating in the future and the path to achieving justice, according to this judge, was to make sure that the sentence reflected the denunciation of her behaviour and to appease the victim’s family.

Despite there being 24 cases in which the treatment component of the principal disorders (FASD/ADHD) referred to by the judge and/or mental health professionals was being discussed, there were 18 cases in which FASD/ADHD were either explicitly mentioned or alluded to as being mitigating factors in sentencing. There were also five cases in which FASD and only one case of ADHD that reflected these disorders as either being considered but then being disregarded as important enough to warrant a reduction in the sentence, or actually had the effect of lengthening the outcome of the final disposition handed down by the judge. Interestingly, of the five cases in which the principal disorder appeared to make the final disposition more severe, or simply was not important enough to mitigate, only one instance involved an Aboriginal offender. Furthermore, in terms of gender, two of the five cases involved a female offender. When excluding the 24 appellate court cases in this study, of the 83 FASD/ADHD cases, there were only eight female cases and the remaining 75 were males. Moreover, two of the female cases (R. v. L.A.B (2007), and R. v. A.B. (2005) were both examined for FASD and ADHD so, in fact, there were only six separate cases in the entire dataset (excluding the appeal court cases) that involved female offenders.

Below are five identified themes:
Variable of Interest: ‘Judge-Community’

The variable of interest was ‘judge-community’. ‘Judge-community’ was operationalized as, “did the judge make a direct link between the principal disorder and the accused being a risk to the community”. There was only one case where the answer was yes and eight other cases in which it was inferred. In six of the nine cases, a judge did attribute some risk to the community as being connected to FASD as the principal disorder, and the remaining three cases were for ADHD.

There was one identified theme and two sub-themes:

List 14: Themes

- **Impairment is regarded as a risk**
  - Risk to the community due to the disorder
  - Impairment results in a need to be separated from the community
FASD

In the FASD case of *R. v. Pickerill* (2005), as discussed in a previous section of this chapter, Pickerill was an adult male being sentenced in British Columbia. In the judge’s statement below, it is evident that, although the judge acknowledged that Pickerill could not connect consequences to actions, and could not adapt well or think before he acted owing to his FASD, the judge stressed the point that, if criminal activity was the product of such an impairment, then Pickerill must be separated from the community.

Submissions have been made about the fact that you suffer from foetal alcohol syndrome and therefore have a very real problem connecting consequence to action and also ingesting, adapting, taking on for yourself the need to think before you act. That may very well be true. But if it is true and if the result of that is serious criminal activity, then emphasis clearly has to be put on separating you from the community. There are many people with FAS who do not get into serious criminal difficulty. Sort of like the alcoholic who says, “Well, I never get into trouble when I’m sober, so you shouldn’t be mad at me when I harm others because I was just drunk and didn’t know what I was doing.” The fact of the matter is the rest of the world has a right to get on with their lives (paragraph, 8).

In the British Columbia case of *R. v. J.N.J* (2004), J.N.J. was an adult male and in the case of J.N.J, the judge did infer that his FASD did pose a risk to the community but the judge did feel that such a risk could be eventually managed appropriately under the long-term offender supervision order. The judge stated that J.N.J. would suffer from fetal alcohol syndrome and his intellectual deficits for the rest of his life and with the combination of also having schizophrenia, “...J.N.J. would need community supports beyond ten years to assist him with his daily living in the community, irrespective of the risk of his re-offending (paragraph, 83). Nonetheless, the judge was not satisfied on the evidence by the Crown that the eventual control of the risk within the duration of a long-term supervision order would not continue to be effective after the order’s expiry; thus, in the end, the judge felt that the sentencing sanctions available under the long-term offender provisions were sufficient to reduce the threat to an acceptable level.

Similarly, in *R. v. W.T.* (2004), a case that involved an Aboriginal male offender in Saskatchewan, which was discussed in an earlier component of this chapter, the judge provided detailed remarks about FASD, in terms of the accused’s cognitive impairment being seen as an aggravating factor in sentencing and a mitigating factor or a consideration that required specific rehabilitative measures for FASD offenders: however, when it came to the
actual sentencing of W.T., he was sentenced as a long-term offender, with six-and-a-half years remaining in custody, followed by a ten-year community supervision order. It would appear that the judge did consider W.T.’s FASD to be a risk to the community at the time, since he spent so much time analyzing the complexities surrounding sentencing someone with such a disorder and he also stated, “…there is little doubt that without community based controls, his risk in the community will be higher. It should also be pointed out that sexual recidivism also decreases with age and, therefore, depending on the length of his current sentence, this factor may also lower his ultimate risk in the community (paragraph 13).”

In the Saskatchewan case of *R. v. Potter* (2006), Potter was an Aboriginal male who was being sentenced and, in Potter’s case, it was only assumed that he suffered from FASD, since there was a record of maternal drinking but no formal diagnosis confirmation. The judge in this case inferred Potter’s risk to the community in light of his FASD by stating, “I was persuaded that a probation order for a period of three years would be most appropriate due to the following circumstances, not listed according to the weight given: Mr. Potter is cognitively impaired, likely suffering from FASD, and will require external structure for his lifetime (paragraph 42).” The judge cited Dr. Mela’s statement about Potter’s reintegration into the community, stating that Dr. Mela felt that, if Marc continued with the appropriate medication and the proper support in the community, the risk he presented to the community should be manageable. The judge then reiterated the point that Potter was not capable of managing his own behaviour owing to his cognitive status and personality functioning and that, without a sufficient environmental structure in which to function, he would likely re-offend. The judge stated that Potter was very influenced by his environmental circumstances, good and bad.

In another Saskatchewan case, *R. v. P.J.M.* (2008), P.J.M. was an Aboriginal male youth who was formally diagnosed with partial FASD. In this case, the judge seemed cautiously optimistic about P.J.M.’s functioning in the community. The judge stated the following:

Plans for his reintegration into society must be made having regard to his abilities and disabilities and they must be realistic having regard to the diagnosis of Partial FAS and the “blueprint” of cognitive challenges described in Dr. Nanson’s neuropsychological report. I found it interesting that in the past P.J.M. has had periods of “good behaviour” or compliance with expectations. Attempts might be made to reproduce the conditions that were in place at those times. It would not be
appropriate, having regard to the nature of his disabilities, to assume that after a period of satisfactory performance, supervision and supports may be removed with the expectation that he will do well on his own (paragraph 48).

Based on the above quote, the judge felt that—for the time being—P.J.M. did require structure and support; hence, he may have been inferring that, owing to P.J.M.’s fragile cognitive capabilities resulting from his FASD, he could have been a risk to the community. The judge made it clear that a supportive structure was a key to success and stated this to be the case in most FASD cases. The judge also stipulated that, when making sentencing plans for P.J.M., the court strongly recommended P.J.M. consult with persons who were knowledgeable about FASD and felt that one very good resource in Saskatchewan was the FASD Support Network of Saskatchewan Inc. In the end, the judge gave P.J.M. 150 days in custody, followed by 150 days of supervision.

The final FASD Saskatchewan case in which a judge inferred that the offender being sentenced was a risk to the community due to his disorder was R. v. C.P.S. (2004). C.P.S. was an adult Aboriginal male who was not formally diagnosed as having FASD and based on the judge’s statement about what various doctors said, it did not make a difference to his treatment. “Dr. Adelugba does not know whether C.P.S. has been formally assessed with Fetal Alcohol Spectrum Disorder (“FASD”), but whether he suffers from FASD or not makes little difference in the outcome of treatment (paragraph 35).”

Another mental health professional—Dr. Nicholaichuk—suggested that C.P.S.’s cognitive impairment was likely the result of FASD; however, it could not be diagnosed in adults. In the final analysis, Dr. Nicholaichuk stated clearly that it did not matter what caused the cognitive impairment. Nonetheless, the judge did not discredit the possibility that C.P.S. may suffer from FASD but seemed to adopt the mental health professionals’ view of the issue. In the final sentencing judgment, the judge stated that, “C.P.S. has a myriad of problems, from a personality disorder to alcohol and substance abuse, to cognitive impairment, and an inability to either cope or control his impulses. I find that the Crown has proved beyond a reasonable doubt that C.P.S.’s sentence ought to be one of indeterminate length, and I order accordingly (paragraph 51)”. The judge goes on to state how the expert testimony made it clear that no prediction could be made of a time frame for successful treatment such that C.P.S. would no longer be a public threat. The judge felt that, without any prediction of the time required, a determinate sentence would be merely guesswork on the court’s part. As the judge stated,
“[a]nd it takes more than guess work to conclude that the public threat could be reduced to an acceptable level (paragraph, 50)”. Thus, even though the judge did not state outright that, based on C.P.S.’s cognitive impairments, he was a risk to the community, with the statements about being a threat to the public and by giving him an indeterminate sentence, he must have perceived him that way.

There are four identified themes:

**List 15: Themes**

- cognitive impairment did pose a risk to the community but could be adequately managed
- needing community controls to address cognitive impairment or risk will be higher
- require external structure and proper support to reduce risk
- encourage offender success

**ADHD**

In the Ontario case of *R. v. McBride* (2005), discussed earlier in this chapter, McBride was an adult male who was diagnosed with ADHD. The judge in this case stated that, “[the offender] has a history of anger and attention deficit symptoms that further aggravate his features that have resulted in aggression and most likely were a very important contributory factor in the index offence (paragraph 20)”. The judge did not directly state that his ADHD made him a risk to the public but, by stating that his inattention aggravated the features that have resulted in aggression, it could be inferred that the judge perceived his ADHD as being a risk to the community, insofar as his impulsivity was concerned. However, the judge did state in the sentencing hearing that the court was optimistic that treatment for ADHD would solve McBride’s impulsivity issue. Regardless, the judge stated that it went without saying that McBride was a high risk to re-offend in a violent manner. Nonetheless, in this
In the B.C. case of *R. v. A.J.* (2008), A.J. was a male youth who was diagnosed with ADHD. The doctor’s report and his *viva voce* evidence indicated that he did not support the imposition of an adult sentence because A.J.’s impulsivity caused by his ADHD was under control since he was taking daily medication. Nonetheless, in terms of A.J.’s risk of re-offending, Dr. Stephenelli stated that A.J.’s risk was low but would increase if he continued to associate with a negative peer group and if he persisted in abusing substances. Thus, the doctor believed that a higher rate of supervision would keep the risk lower. The judge did consider A.J.’s ADHD as being a possible threat to the public: thus the judge was very clear to A.J. about complying with the medication used to treat ADHD. “Mr. A.J., I heard from Dr. Stephenelli that you are taking some medication and that that is helping you. The purpose of those conditions that I just read to you is to make sure that you continue to see someone, and if you are prescribed with medication that you take it because that will help you, sir, and it will protect the public as well (paragraph, 41).”

The final case where the judge inferred that the offender’s diagnosis of ADHD was a possible risk to the community was in the Saskatchewan case of *R. v. K.L.C.* (2004). In this case, the judge noted from K.L.C.’s assessment that K.L.C was an Aboriginal male youth who had special needs, which included attention-deficit, attachment disorders and conduct disorder. According to the judge, Dr. Peter Matthews, “held out little hope for success with the resources available in the community, being individual sessions and medication. He regarded him as a seriously damaged child. He did recommend a course of medication to address the ADHD and CD and that he be closely followed by a psychiatrist for the next 3-4 years (paragraph 14)”. The judge recognized the multiple impediments that K.L.C. was facing owing to his various disorders, specifically the fact that at age 14 he read at a grade-one level and the fact that he was diagnosed with significant disorders such as Attachment Disorder, ADHD, Conduct Disorder and Oppositional Defiant Disorder and addictions. Based on this information, the judge felt that it would seem, “...his needs may only be met either in the parental or extended family home or in custody, given that family home has been found to be suitable...(paragraph, 40)”. In the end the judge gave him a sentence of six months of deferred custody and supervision, so that K.L.C. could be monitored in the home under strict curfew
and association restrictions. The judge did conclude that KLC was a high-risk youth, and required a psychological assessment and counseling, special academic arrangements, and a secure, residential living situation. The judge also stated that it was important to match KLC’s special needs to any available resources, which could assist him in his rehabilitation.

The judge included a discussion about what the YCJA has to say about the issue of resources. The judge pointed out that the YCJA does certainly allow provincial governments in some cases to choose which sentencing options it will offer, such as intensive support and supervision sentences (s. 42(2)(l)), intermittent sentences (s. 47(2)), and attendance orders (s. 42(2)(m)). Furthermore, the judge noted that the provinces also have considerable discretion to determine how a program will be offered, with extrajudicial measures and conferences being examples. However, it was important to match K.L.C.’s special needs to any available resources which could assist him in his rehabilitation; yet there did not seem to be a solid, available program for him. The judge stated that it is implicit in s. 39(3)(a) of the YCJA, pertaining to the alternatives to custodial sentences, that society cannot be required by the provisions of the YCJA to create many of the community resources which might be envisaged by application of the purposes and principles contained in the YCJA. This is precisely what happened to K.L.C., in terms of the school not being able to meet his needs. Ms. Linda Stanviloff of the Saskatoon School Division, who had been provided with the psychiatric and psychological assessments, felt that K.L.C. would likely be best suited for the Visions Program at City Park Collegiate. She was willing to explore his options to obtain additional teaching resources but the specialized, one-on-one, education program envisioned by Dr. Vandergoot, was not available. Interestingly enough, Linda Stanviloff stated that his diagnosed disorders of Conduct Disorder and Attention-Deficit-Hyperactivity Disorder did not qualify him for additional resources. There was no elaboration as to why K.L.C.’s diagnoses precluded him from accessing additional resources in the school. In the end, there would potentially be a teacher’s aid hired for K.L.C. to assist him but this would depend upon him regularly attending school.

One theme was identified:
For ADHD, in 33 of the 52 cases (63.5%) a formal diagnosis was made; whereas, for FASD, in ten of the 31 FASD cases (32.3%) a formal diagnosis was undertaken. Clearly, many more formal diagnoses were undertaken for ADHD than for FASD, and this is supported in the literature, since it is reiterated time and again that a formal FASD diagnosis is challenging, expensive and quite rare (only 2,000 individuals are actually formally diagnosed each year in Canada) (Pemberton, 2010). Since an abundance of literature is cited about the lack of proper diagnosis for the disorder of FASD, it was relevant to see the types of cases in which a formal diagnosis was made. Out of the ten cases, four of the cases where a formal diagnosis was made involved youth court cases, and the remaining concerned adult cases, although in one of the adult cases, the actual diagnosis of FASD was made when the individual was a youth (R. v. Ritchie, 2006). In eight out of the ten cases in which a formal diagnosis was made, the defendant was of Aboriginal heritage. It was made quite evident in some of the cases in which a formal diagnosis took place that an assessment occurred owing to the efforts of a specific advocate of FASD testing and diagnosis. For example, in the B.C. case of R. v. C.J.M. (2006), in which an Aboriginal youth male was being sentenced, it was directly stated, “…he appeared before one of my colleagues, Judge Trueman, who is well known within legal circles and others for her efforts on behalf of accused persons who may be affected by fetal alcohol syndrome or fetal alcohol effect (paragraph 10)”. “…as a result, steps were taken to have Mr. C.J.M. properly diagnosed, and he ultimately did meet with experts in the field of fetal alcohol syndrome, psychologists in particular…[h]e was ultimately diagnosed as demonstrating findings that were consistent with a diagnosis of partial fetal alcohol syndrome (paragraph 11)” . Other times FASD assessments were done at the request of counsel for the defendant, as was seen in R. v. J.N.J. (2004), R. v. J.L.M. (2005) and R. v. J.W.K (2009), in which a court ordered assessment of
this disorder was sought after. Only recognized experts in the field can properly carry out FASD assessments. For example, in J.L.M., J.L.M. was assessed by Dr. Jo Nanson, a neuropsychologist who is a recognized expert in assessing persons suffering from FASD and this was a court-ordered assessment prior to the commencement of the court dates. Consequently, J.L.M. was diagnosed with partial fetal alcohol syndrome. Similarly, in the Saskatchewan case of R. v. J.W.K. (2009), J.W.K was an adult Aboriginal male who was assessed at The FASD Centre by Dr. Logan, who is trained and experienced in conducting FASD assessments.

In the Saskatchewan case of R. v. P.J.M. (2008), an Aboriginal male youth was diagnosed with Partial Fetal Alcohol Syndrome just prior to his court date, and in none of his previous court appearances for other crimes that he was sentenced for did the Court have the FASD diagnosis in hand. The judge stated, “[t]his diagnosis presents the Youth Justice System with an opportunity, having regard to the principles affecting sentence, to embark on a sentence, which, while responding to the needs of the community insofar as the long term protection of the public, may also respond to P.J.M.’s needs in an FASD appropriate way. This, I believe, is the most effective way to achieve the goal of protecting the public, i.e., by endeavouring to prevent criminal behaviour, rehabilitate P.J.M., and impose meaningful consequences. Armed with this diagnosis and the accompanying neuropsychological assessment, an effort must be made to address the underlying causes of his offending behaviour (paragraph 39)” . The judge in the Ontario case of R. v. Dayfoot (2007) shared similar sentiments about the benefit of having the FASD assessment done prior to the court date. “Mr. Dayfoot raises the issue of Fetal Alcohol Syndrome Disorder (FASD) on his sentencing hearing, as a mitigating factor. The Court, and more particularly, Mr. Dayfoot, has had the benefit of extensive testing for the symptoms of both FASD and Autism prior to sentencing (paragraph 2)”.

One major theme and one emergent sub-theme were identified:
Variable of Interest: ‘Clearly-State’ and ‘Judge-Mitigate’

‘Clearly-state was operationalized as, as it clearly stated that a formal diagnosis of the principal disorder was made.” It was worthwhile to see in how many of the cases in which a formal diagnosis of the disorder (FASD or ADHD) was made the judge considered the disorder as a mitigating factor in sentencing. For FASD, there were five cases out of 11 in which a direct diagnosis was made and the judge considered fetal alcohol as a mitigating factor: R. v. P.J.M. (2008), R. v. J.W.K. (2009), R. v. Dayfoot (2007), R. v. L.A.B. (2007) and R. v. Mumford (2007). What such a finding demonstrates is that judges still consider FASD a mitigating factor in 55.0% of the cases in which a formal diagnosis has ‘not’ been made. On the other hand, interestingly for ADHD, there were five out of seven cases (approximately 71%) in which a direct diagnosis was made and the judge considered ADHD as a mitigating factor: R. v. McGoran (2004), R. v. A.R. (2007), R. v. L.A.B. (2007), R. v. A.B. (2005) and R. v. McCauley (2007). Thus, it was only in two cases in which a judge considered ADHD as a mitigating factor, even though a formal diagnosis was not made. Such a finding also demonstrates that judges do not rely on conclusive evidence pertaining to diagnoses but often simply rely on informal claims made about disorders by mental health professionals.
Section 718 of the *Criminal Code* and Judicial Application of the Provision In Sentencing

The sentencing objectives that are mandated in section 718 include denunciation, specific and general deterrence, separation of offenders from society, where necessary, reparations for harm done, promote a sense of responsibility in offender and acknowledgement of harm done to victims and to the community and rehabilitation of offenders. Rehabilitation sets out that the punishment must fit the offender. Only one of the sentencing provisions in the *Criminal Code* is mandatory. Section 718.1 mandates that a sentence must be proportionate to the gravity of the offence and the degree of responsibility of the offender. Thus, every sentence must meet this fundamental and overarching principle of proportionality; the punishment must fit the crime. Section 718.2 of the *Criminal Code* stipulates that a court must take into consideration the principle that a sentence should be increased or reduced by any relevant aggravating or mitigating circumstances relating to the offence or the offender. Section 718.2(e) of the *Criminal Code* is also a very important section because it directs incarceration to be used as a last resort, especially for Aboriginal offenders.

When analyzing the 83 cases for FASD and ADHD to see which ones included a mention of the section 718 sentencing provision of the *Criminal Code*, all of the youth cases (26 in total) had to be excluded, since section 718 is not a provision under the YCJA; hence, 57 cases remained. In 36/57 cases (63.2%), section 718 was mentioned as being a consideration in the final disposition. Thus, approximately 37.0% of the sentencing judgments did not allude to section 718 of the *Criminal Code* at all and this was most apparent for the cases in which ADHD was the principal disorder under consideration. Of the 34 adult ADHD cases, 20 included a reference to section 718 in the sentencing judgment (58.8%), whereas 16 of the 23 FASD adult cases mentioned this
Criminal Code provision (70.0%). Such a result has most likely to do with the fact that there were more Aboriginal adult offenders in the 31 cases in which FASD was a principal disorder (16 cases—51.6%) than in the 52 cases in which ADHD was a principal disorder (16—30.8%). Since there were more Aboriginal offenders in the FASD cases, when section 718 was analyzed, judges seemed to mention section 718.2(e) [all available sanctions other than imprisonment that are reasonable in the circumstances should be considered for all offenders, with particular attention to the circumstances of Aboriginal offenders] a great deal. For example, in the B.C. case of R. v. Mumford (2007), it was clearly stated that the principles articulated in the Gladue (1999) decision should be applied: Gladue was a landmark Supreme Court of Canada case that imposed a duty on the sentencing judge to approach the sentencing of Aboriginal people differently. Hence, since the Gladue analysis must be performed in all cases involving an Aboriginal offender, regardless of the seriousness of the offence, it was not surprising to see section 718.2(e) being discussed in so many of the cases in which the offender was Aboriginal. Specifically, of the 16 adult FASD cases in which section 718 was mentioned by the judge, the offender was Aboriginal in 14 of them and section 718.2(e) was brought up by the judge as a sentencing consideration in ten of those cases (71.4%). Yet, for the 20 ADHD cases in which ADHD was the principal disorder and section 718 was discussed by the judge, there were only eight cases in which the offender was of Aboriginal descent. Of those eight cases in which the offender was Aboriginal, in five of those cases the judge brought up section 718.2(e) but not in the remaining four cases (63.0%).

In total, there were 16 FASD adult Aboriginal cases (excluding the appellate court cases) and of those only in ten did the judge make any direct reference to section 718.2(e) (62.5%). Similarly, in total, there were 16 ADHD adult Aboriginal cases (excluding the appellate court cases) and of those only in five did the judge make any direct reference to section 718.2(e) (31.3%). Thus, when all of the adult Aboriginal cases for FASD and ADHD were combined (32 cases), section 718.2(e) was directly mentioned by a judge in 15 of them (46.9%), which left close to half of the Aboriginal cases in which this special sentencing provision was not directly discussed.

Of the 36 FASD and ADHD cases which mentioned section 718 directly, other than section 718.2(e), which was definitely discussed separately as a sentencing consideration in quite a few cases, there were 13 cases in total (four
cases when FASD was the principal disorder of interest and nine cases when ADHD was the principal disorder of interest), in which the judge simply listed entire components of 718 verbatim without making any section of the provision particularly worthy of unique attention or discussion. Basically, section 718, 718.1 and 718.2 were quoted verbatim from the Criminal Code but no further discussion was made. Furthermore, there were also five cases in which a judge simply made a ‘blanket statement’ about section 718 being considered in sentencing but did not provide any further elaborating remark(s) (one case when FASD was the principal disorder of interest and four cases when ADHD was the principal disorder of interest).

Section 718(a) to denounce unlawful conduct, and 718(b) to deter the offender and other persons from committing offences were specific components of section 718 that were singled out by judges in several cases. As stated by the judge in the case of R. v. Vukmanich (2007), “[t]he principle of denunciation focuses on the conduct of the offender, not on the personal characteristics of the offender. The principle of deterrence seeks to provide an example to the offender or to others in order to discourage crime by making it clear that criminal behaviour will result in punishment (paragraph 28)”. Most judges combined these two elements by stating that the sentence had to take into account the elements of ‘denunciation and deterrence’. For example, in R. v. Egan (2009), the judge stated that, “[g]iven one complainant was a person under the age of 18 years, primary consideration to the objectives of denunciation and deterrence of such conduct must be given as well (paragraph, 176)”. In the Ontario case of R. v. Sylvestor (2007), the judge stated, “[o]ther relevant factors include the traditional sentencing objectives of deterrence to the offender and to others, denunciation, as well as the other codified objectives of sentencing set out in s. 718 of the Criminal Code (paragraph 38)”. It seems as if many judges choose to focus on the deterrence and denunciation component before listing other sentencing principles.

It was also interesting to see out of the 36 adult cases where judges mention section 718 as a consideration whether section 718.2(a), in particular, is ever directly stated, [a sentence should be increased or reduced to account for any relevant aggravating or mitigating circumstances relating to the offence or the offender, and, without limiting the generality of the foregoing. In terms of the 16 FASD cases in which the judge specifically mentioned section 718, there were only three cases in which section 718.2(a) was directly mentioned. In R. v. W.T. (2004), it
was simply presented as a list, part of the other sentencing objectives; whereas, for example, in the Saskatchewan FASD case, R. v. Potter (2006), the judge said, “I have also considered 718.2(a) and do not consider that there are any particularly aggravating or mitigating circumstances (paragraph 29)”. In the Ontario FASD case of R. v. Brown (2009), the judge stated, “[m]y task in this sentencing decision is to consider the circumstances of the offence and the offender, paying particular attention to his aboriginal status and the aggravating and mitigating factors and impose a sentence that is fit and just (paragraph 43)”.

Of the 20 adult ADHD cases, in which the judge mentioned section 718, there were seven cases in which section 718.2(a) was either listed or discussed by a judge. In the Ontario case of R. v. Iozzo (2004), the section was simply listed along with the other objectives of sentencing under section 718. In the Ontario case of R. v. Vukmanich (2007), the judge stated, “[t]he Criminal Code also directs in s. 718.2 that a court must take into consideration the principle that a sentence should be increased or reduced by any relevant aggravating or mitigating circumstances relating to the offence or the offender (paragraph 29). In the other Ontario cases of R. v. Beasley (2005), R. v. Schroeder (2004), R. v. McCauley (2007), and the British Columbia case of R. v. Simpson (2008), the judges essentially made the exact same brief statement about the Court needing to regard the aggravating and mitigating factors in the particular case or the judge stated in R. v. J.E.T. (2005) that the judge had considered the aggravating and mitigating circumstances.

After reading all of the commentary for the 36 adult FASD and ADHD cases, in which section 718 of the Criminal Code was mentioned by the judge, there was a noteworthy quote in the B.C. case of R. v. Pickerill (2005). In this case, the judge raised an interesting point about how some of the objectives in the sentencing provisions list are contradictory. The judge stated how it was impossible in any one specific sentencing case to put equal weight on each principle and he gave the following example:

For example, the need to denounce as well as the need to rehabilitate; the need to deter and the need to provide reparations. Obviously if you are in jail, you are not going to be able to provide reparations. Obviously if programs dealing with rehabilitation are important, then that militates against denunciation and specific deterrence by means of locking a person up. In any particular case the specific facts of the crime, of the offender, and the past conduct of the offender must be taken into consideration and various weightings assigned to those objectives (paragraph 3).
However, the judge in *Pickerill* did point out that the bottom line is in the preamble to 718, “[t]he fundamental purpose ... is to contribute ... to respect for the law and the maintenance of a just, peaceful and safe society... (paragraph 4)”. Clearly judges grapple with the various sentencing objectives stipulated in section 718 of the *Criminal Code* and making sure that their final judgment coincides with at least one of those listed principles.

**APPellATE COURT DECISIONS**

From the 107 cases that were analyzed between March 17, 2004 through March 17, 2009, 24 of those cases were appellate decisions in which FASD and or ADHD were mentioned somewhere in the judgment. Each of the 24 cases was coded across 19 different variables. After coding all of the cases and reading through every single one carefully, there were nine appellate cases in which the issue of the appeal had to do with the principal disorders under investigation—FASD (five cases) and ADHD (four cases).

**FASD**

There were five appellate court cases in which FASD was the issue of the appeal in some manner. Four of the five cases were from British Columbia and one was from Saskatchewan. In three of the five cases, the appeal was instigated by the defence and in two of the five cases, it was pursued by the Crown. The appeal was allowed in two of the cases by the Crown and in one of the cases by the defence. In three of the appeal cases, the individual was Aboriginal; in one of the cases the offender was a male youth; in another case, the offender at issue was an adult female; and, in the remaining three cases, the offender was an adult male.

Beginning with the B.C. case of *R. v. J.M.R.* (2004), J.M.R. was an adult female. The appeal had to do with an unjust sentence being administered owing to a lack of proper provincial resources. The judgment of the Court, delivered by Esson, J.A., was that the original trial judge erred with respect to the principal disorder. The appellate court Justice Esson stated, “[t]he point of that direction was a recognition that persons with a condition such as FASD generally do poorly in prison and are often victimized by other inmates. In this case, it does not appear that any publicly funded course of treatment such as
that envisaged by Vickers J. was available (paragraph 7)”. Thus, the original trial judge had given a custodial disposition to the female offender, simply because there was no proper treatment available for her FASD. The appellate Court’s final sentencing disposition was relevant to the principal disorder. The Court decided that, in the particular circumstances of the case, the rejection of a conditional sentence resulted in an unfit sentence; therefore, the appeal was allowed to the extent of setting aside the order for incarceration and substituting an order for a conditional sentence on restrictive conditions.

In the B.C. case of *R. v. Synnuck* (2005), Synnuck was an adult male and the issue of the appeal had to do with the need for a diagnosis of FASD. It was thought that perhaps the original trial judge erred in not considering Synnuck’s FASD in sentencing. However, the judgment of the Court, delivered by Newbury, J.A., held that there was no clear evidence for Synnuck’s supposed FASD, thus the original trial judge did not err and the appeal was denied.

When he first appeared on this appeal, it was thought he might suffer from fetal alcohol syndrome or a variant thereof. By seeking the neuropsychological assessment, his counsel sought to show that he was, in the words of Mr. Justice Donald, “minimally responsible for his criminal behaviour and that his diminished responsibility affects the proportionality of the sentences he received.” With regard to considering the possibility of diagnosis of Fetal Alcohol Syndrome (or Effects) it is felt that although some of the fallouts noted on testing could be consistent with this diagnosis, there is no objective background information available to the writer to support the contention that Mr. Synnuck’s mother actually did use alcohol during the gestation period. As mentioned earlier in the current report, Mr. Synnuck was “told” that his mother used alcohol during the pregnancy, his father report that she drank occasionally, whereas his mother flatly denies ever using alcohol. Mr. Bay states that Mr. Synnuck had never mentioned the possibility that fetal alcohol syndrome may have played a role in his life, and that at the time of intake, he had never mentioned the possibility that he could be suffering from that disorder.

It is interesting that if it could have been demonstrated that Synnuck had minimal responsibility for his criminal behaviour, which would have directly affected the proportionality of his actual sentence, it is perplexing that the appellate court justices did not order an FASD test that should have been administered by a medical doctor who specializes in such a diagnosis. Instead, the possibility that Synnuck suffered from FASD was a reality, but owing to lack of evidence because of what ‘he’ said or ‘she’ said, Synnuck was treated as if he did not have the disorder.
In the B.C. case of *R. v. Barnes* (2005), Barnes was an adult Aboriginal male. The appeal had to do with unjust sentencing in light of the principal disorder—FASD. The judgment of the Court, delivered by Ryan, J.A., stated, “[t]he appellant is a 20 year-old Aboriginal male who may suffer from Fetal Alcohol Syndrome, Fetal Alcohol Effects, or Neo-Natal Abstinence Syndrome...counsel for the appellant says that the sentencing judge sentenced him to a term of preventative detention and that the sentence is therefore unreasonable and unfit (paragraph 4)”. The Court did not feel that the trial judge erred in the administration of the final sentencing disposition. The Court disagreed with counsel that the appellant was not a risk to again commit the types of offences set out in the Information. The Court believed that there was a well-grounded fear that the defendant had an interest in committing violent and/or sexual criminal acts; therefore, he was dangerous to the community. Moreover, the appellate Court ascertained that there was little likelihood Barnes would change unless he was treated. Interestingly, the judgment of the Court did not address the counsel’s point regarding Barnes’ potential FASD. Thus, the appeal was dismissed.

In the B.C. case of *R. v. Andrew* (2008), Andrew was an adult Aboriginal male and the appeal was raised by the Crown because the State felt that the sentence Andrew received was too lenient owing to the mitigating factors that the original trial judge considered, including Andrew’s FASD. Andrew had originally received a conditional sentence of two years less a day, after his conviction of manslaughter. Andrew grew up in an Aboriginal reserve community and was assessed as a teenager to have fetal alcohol syndrome. The Crown felt that the sentencing judge took into account a number of mitigating factors. In the opinion of the appellate Court, the sentencing judge took the mitigating factors of the case into account to their fullest possible extent. The judgment of the Court, delivered by D.F. Tysoe, J.A., felt that it was debatable whether the mitigating factors constituted unusual circumstances such that a sentence of less than four years could be considered appropriate, but the appellate Court was not persuaded that the conclusion of the sentencing judge in this regard should be disturbed. The Court allowed the appeal and substituted a prison sentence of two years and five months.

In the Saskatchewan case of *R. v. M.J.H.* (2004), M.J.H. was an Aboriginal male youth and the issue of appeal had to do with the final sentence. The original trial judge saw the principal disorder (FASD) as a mitigating factor but
the appellate Court, majority decision given by Richards, J.A., regarded the original trial judge’s sentence as being too lenient. The appellate Court felt that no fetal alcohol syndrome assessment had been undertaken because no proper diagnostic tool was available, which made the diagnosis questionable. The majority judgment of the Court further stated that the assessment relied on by the trial judge, that indicated that M.J.H. was intellectually impaired, was faulty. Hence, the appellate Court felt that in any event, nothing suggested that M.J.H. was unable to appreciate the gravity of his own actions and more importantly, intellectual impairment did not always equate to diminished responsibility. The appeal was allowed. There were four identified themes for FASD and appellate court cases:

**List 19: Themes**

*original sentence by trial judge with FASD as part of the consideration regarded as too lenient by appellate court*

**List 20: Themes**

*FASD a mitigating factor in sentencing by appellate court*

**List 21: Themes**

*ambivalence about FASD official diagnosis considered but not rectified by appellate court*
ADHD

In the British Columbia case of *R. v. J.M.R.* (2004), J.M.R. was an adult female and the appeal had to do with the question of whether, because of J.M.R.’s various mental disorders, including ADHD, she should be placed in a more rehabilitative setting. J.M.R.’s counsel focused on the fact that Ms. J.M.R.’s condition would not benefit from a custodial disposition, that she could not be expected to be rehabilitated by a jail sentence, and that what she needed was a conditional sentence, which could take into account the earlier recommendations of treatment, support, counseling and structure. The judgment of the Court, delivered by Esson, J.A., was that the original trial judge did not err; therefore, did not allow the appeal by the defence.

Similarly, in another British Columbia case, *R. v. McDonald* (2005), McDonald was also an adult female and the appeal had to do with the fact that McDonald was responding well to medication for ADHD so a request was being made for a community-supervision order rather than her original disposition. The Court was of the opinion that, even though McDonald claimed she had not before been diagnosed with ADHD and that she felt much better now that she was on the proper medication, it was not appropriate to reduce her sentence. The Court was not persuaded by the appellant’s expression of genuine desire to change her life following her diagnosis of attention deficit disorder. The appellate Court felt that the materials she filed in support of her appeal would be better tested by a parole board.

In the British Columbia case of *R. v. Harvey* (2006), Harvey was an adult male and the reason for the appeal by the defence was that the original sentence was unjust despite the presence of the principal disorder—ADHD as well as other disorders. The trial judge appeared to consider Harvey’s various disorders, including ADHD, and gave a rather lengthy custodial sentence. The application for an appeal was allowed and the sentence was reduced to time...
served. The appellate Court felt that the seriousness of the offence did not warrant a sentence of the magnitude imposed regardless of the appellant’s background, including his disorder history.

The final appeal case in which ADHD was the principal disorder was the Saskatchewan case of R. v. B.J.F.W. (2005), involving an adult male. The appeal was presented by the defence and had to do with the principal disorder in sentencing, specifically, its lack of consideration in the final sentence. The appellate Court rejected the appeal. The Court felt that there was no evidence of recognizable probative value to indicate that B.J.F.W.’s early childhood diagnosis of ADHD was linked to his deviant sexual behaviour. Furthermore, the Court decided that there was no evidence to suggest that, whatever possible treatment may later become available to B.J.F.W. to curb his sexual impulses, could be administered to him with reasonable success while he is in the community. The Court judge felt that the trial judge was correct in imposing an indeterminate sentence.

**List 23: Themes**

- request for rehabilitative/community setting due to ADHD rejected by appellate court

**List 24: Themes**

- original trial sentence unjust due to a lack of consideration of ADHD
Summary

The results revealed that there were certainly many more Aboriginal offenders with the principal disorder of FASD than with ADHD, insofar as a direct link was made by a judge and/or mental-health expert to the likelihood of treatability in connection to the principal disorder. In 12 of the 14 cases (86.0%) in which the variable, ‘treatability,’ was linked to the principal disorder of FASD, the offender was Aboriginal. However, only 40.0% of the offenders in the ten ADHD cases in which the variable, ‘treatability,’ was linked to the principal disorder were Aboriginal. In approximately half of the cases (51.8%), the judges did emphasize treatment; in just over a third of the cases (39.8%) judges did not emphasize treatment; and in 7.2% of the cases judges either considered treatment to be unlikely or stated that treatment was a secondary concern to the court. Interestingly, there were a few cases in which the judge exhibited a disbelief in the likelihood of treatment for the offender, or the judge regarded treatment as a secondary concern, which resulted in the identification of a major theme and several emergent themes in six of the cases, as presented in the results and summary and discussion chapters.

There was a very small percentage of FASD and ADHD cases in which a direct statement was made about the offender’s likelihood to engage in violence or recidivism in connection to the principal disorder either by a mental-health expert, the judge or both. Such cases reflected a diversity of judicial commentary with respect to a direct link being made between FASD/ADHD and the future risk for violence and/or recidivism. In slightly less than a quarter of the cases, the principal disorder was mentioned by the judge explicitly or alluded to as being a mitigating factor and, in 91.0% of the FASD cases, in which the judge somehow identified FASD as a mitigating factor in the sentencing judgment, the offender was Aboriginal; however, with respect to the seven ADHD cases, none of the offenders were of Aboriginal descent. Also, the 80.0% of the FASD cases, in which the judge did find the disorder to be a mitigating factor, were the very same cases that were linked to the variable of interest, ‘treatability’, discussed earlier. Yet, only one of the seven ADHD cases, in which the judge found ADHD to be a mitigating factor, was the same case as was found in the ‘treatability’ variable section.

When the variable of judges explicitly stating or alluding to FASD as a mitigating factor was examined, the major theme, ethnicity, was observed, along with the emergent themes, Aboriginal descent and FASD being a mitigating
factor in sentencing. In several of the FASD mitigating cases, the judge made no mention of the offender’s culpability in terms of remorse. Remorse was certainly noted as a mitigating factor by a few of the judges in some of the FASD cases; therefore, the major theme was offender’s culpability and the emergent theme was offender’s culpability a mitigating factor. When it came to the ‘judge resource’ variable as presented in the ‘judge_mitigate’ cases, the major identified theme among the cases was judge resource consideration for FASD and the emergent theme was some judge resource consideration for FASD.

For the results that pertained to the variable of judges explicitly stating or alluding to ADHD as a mitigating factor, the major theme, ethnicity, along with ADHD being a mitigating factor in sentencing were identified. For the ‘judge culpability’ variable as presented in the ‘judge_mitigate’ identified cases, offender’s culpability was the major identified theme and offender’s culpability a mitigating factor was the emergent theme. Finally for ADHD, when it came to the ‘judge resource variable as presented in the ‘judge_mitigate’ identified cases the major theme was judge resource consideration for ADHD and the emergent theme was no judicial resource consideration for ADHD.

The findings also revealed that, when the judge concerned referred to an evaluator’s diagnosis or opinion about the principal disorder, it was shown that some judges considered FASD a mitigating factor, even when there was no diagnostic confirmation of the disorder by a mental-health professional. Furthermore, not all judges considered FASD to be a mitigating factor in sentencing, since there were many cases in which FASD was formally diagnosed and yet the judges did not appear to consider it in their final judgments. The findings also demonstrated that, in the remaining 27 FASD cases, the judge never included any direct statement made by an evaluator or evaluators regarding the presence or features of the principal disorder. Nonetheless, in nine of those instances, the judge still considered FASD a mitigating factor in sentencing, which showed that not all direct diagnostic statements made by an evaluator in some previous report are necessarily included in the final sentencing judgment.

Another important finding concerned five out of 83 cases, excluding the appellate court judgments, in which the judge directly stated that the diagnosis of FASD/ADHD had possibly contributed to the lengthening of the sentencing disposition or had not had any impact at all on the final outcome. There were many identified major themes within the cases that emerged as reasons why
judges either lengthened or disregarded FASD in sentencing and those were represented and analyzed in the results and summary and discussion chapters.

The results revealed that there were six FASD cases in which a judge did make a direct link between the principal disorder and the accused being a risk to the community. The overarching theme was *impairment is regarded as a risk* and two emergent themes were *risk to the community due to the disorder* and *impairment results in a need to be separated from the community*. Other major themes among a few of the FASD cases and the ‘judge_community’ variable were: *cognitive impairment did pose a risk to the community but could be adequately managed, needing community controls to address cognitive impairment or risk will be higher and require external structure and proper support to reduce risk and encourage offender success*. The three ADHD cases in which a judge did make a direct link between the principal disorder and the accused being a risk to the community revealed the overarching theme, *impairment is regarded as a risk*. Overall, the FASD/ADHD cases revealed that, in some cases, judges did see an association between the principal disorder and the accused being a risk to the community. For FASD, there was significant discussion with respect to the importance of management, structure and support in the community to minimizing the risk of future crime. On the contrary, for ADHD, there was reference to the importance of adherence to medication in order to lower risk to the community, but little emphasis on structure and support, except for the one youth case, in which the judge was dissatisfied with the lack of resources available for the youth concerned.

With respect to formal assessment and diagnosis of the principal disorders, there were more formal diagnoses made for ADHD (63.5%) when it was the principal disorder under investigation than there were for FASD (32.3%). As noted in the discussion chapter, such a finding makes sense considering an FASD assessment is much more complex in terms of the type of expert who is capable of assessing for FASD as well as the costs associated with making a proper FASD diagnosis. The major theme among cases that emerged from looking at cases in which an actual FASD diagnosis was made was, *formal assessment occurred due to a specific advocate of FASD testing and diagnosis*. For the variable of interest, ‘clearly_state’ and ‘judge_mitigate’, a major theme among such cases for both FASD and ADHD was, *judges often rely on informal claims made about disorders by mental-health professionals in their final sentencing judgments*. 
When examining how judges referred to section 718 of the Criminal Code, it was observed that some judges, more than others, were explicit about discussing the sentencing objectives directly in their judgment while others most likely considered the sentencing principles without stating them verbatim or focusing on specific sections altogether. Judges certainly grappled with the various sentencing objectives and made sure that their final judgment coincided with at least one of those objectives.

Finally, the FASD cases in which the point of the appeal had to do with this particular principal disorder, the following major themes were found: original sentence by trial judge with FASD as part of the consideration regarded as too lenient by appellate court; FASD a mitigating factor in sentencing by appellate court; ambivalence about FASD official diagnosis considered but not rectified by appellate court and reducing sentence due to FASD was rejected by appellate court. For the ADHD cases in which the point of the appeal concerned this particular principal disorder, the major themes of request for rehabilitative/community setting due to ADHD rejected by appellate court and original trial sentence unjust due to a lack of consideration of ADHD were revealed.

The significance of the data presented in the quantitative and qualitative results chapters will be examined in the subsequent chapter.
Chapter 7: SUMMARY AND DISCUSSION

DESCRIPTIVE STATISTICS; SUMMARY AND DISCUSSION

Gender and Youth versus Adult Variables

Without the appellate court decisions, there were 31 fetal-alcohol and 52 attention-deficit criminal-sentencing decision cases under observation. Adults, in general, made up 61.0% of all analyzed cases and youth encompassed the remaining 39.0%, showing that there were more adults signaled out with possibly having FASD/ADHD and/or more adults who were simply in trouble with the law between the years of March 17, 2004 and March 17, 2009. Also, females only made up 12.1% of all of those cases across British Columbia, Saskatchewan and Ontario, reflecting that they were either less likely to be connected with those disorders and/or, in most probability, they took part in less crime than their male counterparts, which reflects the trend that is evident in Canadian crime statistics year after year. For example, in 2009, approximately 233,000 females and 776,000 males were accused by police of having committed a Criminal Code offence in Canada (Hotton Mahony, 2011). Women made up more than one quarter (28.0%) of youth accused by police and more than one fifth (22.0%) of adult accused.

Provincial Variation, Ethnicity

It was interesting to see that British Columbia encompassed the largest number of FASD cases, in comparison to Ontario and Saskatchewan (see results section for detailed figures and Table 4). One would expect Ontario to have considerably more FASD cases than Saskatchewan, considering Ontario’s population size is nearly 13 times larger than Saskatchewan’s. British Columbia would also be expected to have considerably more FASD cases than Saskatchewan since its population is almost four times larger. Furthermore, British Columbia had more
FASD cases than did the province of Ontario, even though Ontario’s population is three times that of British Columbia. As it currently stands in 2009, the Eastern province of Ontario has a population of 13,512,406 million and the Western (Prairie) province of Saskatchewan has a population of 1,071,217 million, leaving British Columbia with a population of 4,615,171 million (Statistics Canada, 2012). Thus, it is evident that there appears to be an overrepresentation of FASD cases in the Western provinces when compared with the Eastern province of Ontario. It has been well supported in literature that FASD is more common in areas where there is a high prevalence of alcohol consumption, such as in some Canadian Aboriginal communities (Masotti, George, Szala-Meneok, Morton, Loock, Van Bibber, Ranford, Fleming & MacLeod, 2006). Provincialy, (percent of the provincial population that is Aboriginal) Saskatchewan has a very high population of Indigenous people (14.9%) and 12.1% of all Indigenous people in Canada; British Columbia has a 4.8% provincial Indigenous population and 16.7% of all Indigenous people in Canada, while Ontario has a 2.0% provincial Indigenous population and 20.7% of all Indigenous people in Canada, according to the 2006 Census Statistics. As discussed in the literature review, the incidence of FASD has been particularly high in distinct Aboriginal population communities and it is the Western and Prairie provinces that seem to be taking the most initiative in raising awareness and developing a response to the challenges raised by FASD. Pacey (2008), postulates, from a cultural perspective, that the lack of research coming from Eastern Canada may signify that many Aboriginal nation groups e.g., the Algonquin, Ojibway, Micmac and Haudenosaunee are under-represented in the estimates of FASD that have been made in the medical literature. Meaning, if more research was done on these groups, with respect to FASD testing, perhaps such groups would show higher numbers of FASD cases? Furthermore, it may well be argued that there are not many criminal cases in Ontario in which offenders are diagnosed with FASD. When identifying the ethnicity of the FASD offenders in the case-analysis study, the results revealed that, of the 40 FASD offenders, including the appellate court cases, 62.5% were of Aboriginal descent, and they were tried primarily in the province of British Columbia, followed by Saskatchewan and lastly Ontario (fewer Aboriginal peoples were residing in Ontario as opposed to the Western and Prairie provinces) (see results section for detailed figures and Table 5). In terms of the ADHD cases and provincial variation (see detailed results section and Table 4), Ontario received the majority of ADHD cases within the five-year period, followed by British Columbia and finally Saskatchewan and such provincial case
variation would be expected, considering the population density of the provinces; therefore, there were no surprising findings for ADHD when it came to provincial distribution of the disorder being raised in court. Aboriginal people were not as over-represented for ADHD as they were for FASD, since the offender was of First Nations descent for 25.3% of the cases. Nonetheless, when combining all FASD and ADHD cases, Aboriginal offenders (male and female) comprised 39.2% of all cases, exhibiting general Aboriginal overrepresentation in crime statistics, supported by current literature in the field (Chartrand & Forbes-Chilibeck, 2003).

Comorbidity
For both FASD and ADHD, a large majority of the offenders had the presence of at least one other disorder, in addition to the principal disorder under investigation (see detailed results section and Table 8 & 10). Overall, the results demonstrated great similarity across disorder (FASD or ADHD), whether youth or adult and even for gender, in terms of displaying a high percentage for co-occurring disorders in the cases (see detailed results section and Table 9). More importantly, a substance-related diagnosis was the most prevalent disorder identified for both FASD and ADHD offenders. Such an observation is supported by both FASD and ADHD literature in the field. For example, as Fast & Conry (2009) found in their research, individuals with FASD often develop secondary disabilities, including substance-abuse problems, which develop out of their difficulty in dealing with challenging life situations. Similarly, for ADHD, countless studies have shown that people with ADHD are at an elevated risk for substance abuse (Langhinrichsen-Rohling, Rebholz, O’Brien, O’farrill-Swails & Ford, 2005; Whalen et al., 2002; Young & Gudjonsson, 2006 & Marshal & Molina, 2006).

In the initial FASD and ADHD literature review chapters, much of the research associated particular comorbid disorders with FASD as well as ADHD. In terms of FASD, it was mentioned in several studies that many FASD offenders have ADHD as well as substance-abuse disorder. For ADHD, several research studies postulated a link between ADHD, conduct disorder (CD), substance-use disorder (SUD) and oppositional defiant disorder (ODD). The current study’s research findings did lend support to what is postulated recently in the research literature. For FASD, of the 31 FASD offenders, the most prevalent disorder was SUD (substance-related diagnosis), followed by
ADHD, CD, APD and ODD (2 in total). For ADHD, of the 52 ADHD offenders, the most prevalent disorder was SUD (substance-related diagnosis), followed by CD, APD, ODD and FASD (see detailed results section and Table 13 & 14). As was mentioned in research and discussed in the earlier ADHD chapter, many people afflicted with ADHD also have other comorbid disorders, most specifically conduct disorder (CD) and substance-use disorder (SUD), which can increase the risk of trouble with the law (Fast & Conry, 2009) as well as oppositional defiant disorder (ODD) (Eme, 2008). The case study analysis certainly confirmed such a finding because many of the offenders who had ADHD were also diagnosed with SUD, CD and ODD (see Table 14). The final interesting finding regarding comorbidity was that, when both FASD and ADHD cases were analyzed for co-occurring disorders along with whether those who had co-occurring disorders were more likely to have currently committed a violent or non-violent offence, the result was that there was no difference in terms of whether the offender committed a violent or non-violent offence and had a co-occurring disorder.

**Placement of Principal and ‘Other’ Disorders in Sentencing Judgment**

Since the principal disorder under investigation, whether FASD and ADHD, was not the only disorder mentioned in 72.2% of the cases, it was worthwhile to determine to which disorder the judge gave the most priority (either the principal disorder or another disorder), by analyzing the location of where the judge mentioned the principal disorder as well as the other disorder(s). Hence, priority was determined by location of the disorder in the sentencing judgment. The results revealed that, in the majority of the cases, the judge either referred to disorders other than the principal disorder the most or emphasized the principal disorder as well as another disorder equally (see detailed results section and Table 15). Perhaps what this finding reveals is that, when an accused person has a comorbidity of disorders, it is simply uncertain what disorder or disorders a judge will emphasize the most in a sentencing judgment or where in the sentencing judgment a judge will discuss the disorder. It could be that ‘priority of disorder’ cannot be determined by location in the sentencing judgment; judges may not necessarily focus on any particular disorder in a specific section in their judgment. The other possibility is that, even though the principal disorders under investigation were FASD and ADHD, it may be the case that these disorders are not accorded a high priority in relation to the other disorders.
with which the accused persons are afflicted: indeed, in practically three-quarters of the cases, a judge mentioned other disorders either to a greater or the same extent as the principal disorders of FASD and ADHD.

An interesting finding was observed with respect to youth versus adults when looking at ‘priority of disorder’ based on ‘location of disorder’ in the sentencing judgment. The results revealed that, in 42.1% of the youth cases, the judge gave priority to the principal disorder, when simply basing ‘priority’ on the basis of the placement of the disorder in the sentencing judgment. Whereas, for the adult case population, only in 16.3% of the cases did the principal disorder receive the most priority based on its location in the judgment (see detailed results section and Table 16). This finding could mean that, in youth court, judges pay more attention to the diagnoses of FASD and ADHD than other disorders, perhaps taking these disorders more seriously than in adult court. Pre-existing research does lend support to youth encountering trouble with the law early in their lives as a consequence of FASD and/or ADHD. Because of the significant cognitive impairments that often result from FASD, the impact of having lower IQ scores, language and memory deficits as well as poor socially-adaptive skills, often transcends into poor school performance, which can lead to youths committing crimes (Moore & Green, 2004; Currie, 2009). ADHD is said to be at least 3-4 times the approximately seven percent rate observed in the general population and some have postulated it may be present in as much as 70% of young people who commit crime (Nigg, 2006; Fast & Conry, 2009). It is, therefore, understandable why judges in youth court emphasize such disorders. Yet, when the ‘other’ disorder was given more priority in the youth judgments (on the basis of its placement in the sentencing judgment), very little difference was observed between youth and adults (see detailed results section). However, the judges in the adult cases treated both the principal disorder and the other disorder equally in 44.2% of the cases as compared with 21.1% in the youth cases.

Placement of Principal Disorder in Sentencing Judgment

Another component of the results analysis was to look at the placement of the principal disorder alone in the sentencing judgment. It was interesting to observe that overall, for ADHD, the largest proportion of discussion by judges regarding the principal disorder took place in the middle of the judgment, followed by the beginning of the judgment; whereas, for FASD, the discussion
took place the most throughout the entire sentencing case, followed by the middle and then the beginning of the judgment. For both FASD and ADHD, it was very rare for there to be discussion by the judge only at the very end of the judgment; this only occurred in one case in which FASD was the principal disorder under investigation (3.2%) and in one ADHD case, where the principal disorder was under investigation (1.9%) (see detailed results section and Table 17).

Another component of the ‘principal disorder’ and ‘location in judgment’ analysis involved identifying the point in the case at which the judge directly mentioned the principal disorder and whether the principal disorder was determined to be a mitigating factor in the sentencing judgment (the judge explicitly states—or alludes to—the need for a reduced sentence—less custody, no custody, specific treatment consideration). Evidently, the location placement of FASD/ADHD in the sentencing decisions that resulted in the judge considering these disorders to be mitigating factors occurred most frequently in the middle or throughout the sentencing judgment. Interestingly, when examining five cases in which a diagnosis of FASD/ADHD was considered to have possibly contributed to the lengthening of the sentencing disposition, or to have had no effect on the final sentencing judgment, the principal disorder was only mentioned at the beginning of the judgment in four of these cases and in the middle and at the end of the judgment in the other case. Perhaps, when there is less consideration for the principal disorder by the court, or if it is mentioned in such a manner as to enhance the severity of the sentence, rather than to mitigate it, judges do not mention it throughout the case but rather point it out at the beginning of the judgment.

**Sentencing Disposition**

Imprisonment was definitely the most common sentencing disposition handed down in both FASD (74.1%) and ADHD (82.7%) principal-disorder cases, including both youth and adults (see detailed results section and Table 19). When the imprisonment disposition was further investigated in order to compare results between youth and adults, young offenders were granted some form of a custodial disposition in 59.2% of all FASD and ADHD cases and adults were given custody in 89.3% of all such cases, showing a higher custodial disposition for adults. Of course, the sentence depends largely on the offence type but the overall 30.0% higher incarceration rate for adults versus
youth certainly reflects the unique sentencing principles that are specific to youth in the *Youth Criminal Justice Act*. As discussed in the earlier sentencing chapter, part of the YCJA model is to focus less on general deterrence, unlike for adults, and strongly emphasize proportionate sentencing while also considering the maturity of the young person and rehabilitation. In fact, the *YCJA* was enacted with the objective of decreasing the use of the court process and limiting the use of custody for adolescent offenders (Bala, Carrington & Roberts, 2009); therefore, it is not surprising to see the result of less custody being given to youths, as opposed to their adult counterparts.

**Criminal Offence Type and Past Convictions for FASD Offenders**

McDonald, Colomib and Fraser (2009), found that many of the FASD offenders committed violent crimes, predominantly robbery, that certain cases involved sexual assault and that most defendants had extensive criminal histories. Fast and Conry (2004), also discussed how often FASD offenders have lengthy past criminal records. Past or current literature does not focus on ADHD-offence types, in terms of discerning any type of pattern, so it was relevant to focus exclusively on the criminal-offence types and past convictions associated with FASD offenders in the present study in order to ascertain if there is a pattern of violent offences. The results revealed that almost all of the FASD youth in the case study committed a violent crime; six of the eight youth-FASD accused persons committed violent crimes and five of the eight youth-accused persons had prior criminal records (see detailed results section and Table 20). Similarly, for the adults, 17 of the 23 FASD offenders had committed violent crimes and 21 of the 23 adult-FASD offenders had a prior criminal record (see detailed results section and Table 20). Evidently, the present research lends support to the previous researchers’ findings: namely, that FASD offenders appear to commit a high number of violent crimes—specifically, robbery and various forms of assault, including sexual assaults—and that many have previous criminal convictions for violent offences.

**Evaluators and Presence of Principal Disorder**

The results revealed that, for all of the FASD and ADHD cases combined, in 83.1% of the cases an evaluator directly stated that the defendant had the principal disorder and, in the remaining 16.9% of the cases, it was implied that the accused may have presented with the principal disorder. Broken down
even further, for the FASD cases being analyzed, in 64.5% of the cases, an evaluator directly stated that the accused had the principal disorder; whereas, for the ADHD cases, in 94.2% of the cases an evaluator stated that the accused had the principal disorder (see detailed results section and Table 21). However, when it came to a formal diagnosis of the principal disorder being mentioned in the sentencing judgment of a case, only in 51.8% of the FASD and ADHD cases combined was a direct, official diagnosis made or referred to (see detailed results section and Table 22). Furthermore, when FASD cases were separated from ADHD cases, only in 32.3% of the FASD cases was a ‘formal’ diagnosis referred to in the sentencing judgment and yet, for ADHD, a formal diagnosis of the disorder was found in 63.5% of the cases. Evidently, more ‘formal’ diagnoses of ADHD are being made or are simply being recorded more frequently in sentencing judgments. It could be the case that, because FASD requires very skilled and expensive testing by a qualified medical practitioner, less formal diagnoses are taking place. Such a research finding supports the findings of the current FASD literature pertaining to assessment and diagnosis. Many scholars have pointed out that only highly specialized doctors can provide FASD assessments and that such assessments are extremely costly (Fast & Conry 2000; Pemberton, 2010): in light of these circumstances, obtaining an assessment becomes a daunting task and, even though a judge, defence lawyer, prosecutor or probation officer, can request that an FASD assessment be undertaken, such assessments are frequently not requested and/or not conducted. In fact, there is frequent speculation as to whether an offender has FASD, and some judges assume the person does, even though a formal assessment has not been undertaken, and other judges treat the offender as if he/she does not have FASD, even though there is a possibility that the accused may have it.

For the cases when FASD and ADHD were under investigation as the principal disorders and the ‘treatability’ variable (whether any evaluator in the sentencing judgment mentioned the principal disorder directly when drawing an inference about the accused’s treatability — whether the accused could be treated or not) was investigated, the results revealed that, in 45.2% of the FASD cases and in only 19.2% of the ADHD cases, an evaluator did directly connect the principal disorder to the potential of treatability (this will be discussed in detail in the qualitative component discussion below) (see Table 23). Evidently, a more substantial connection was made between an evaluator’s comments about FASD
and the accused’s treatability than it was for ADHD and the accused’s treatability (whether the offender could be treated or not, in connection to the principal disorder). There was no major statistical difference with respect to gender or youth versus adults in terms of an evaluator making a direct link between the principal disorder and treatability (see detailed results section).

**QUALITATIVE SUMMARY AND DISCUSSION**

**Treatability Variable**

A very detailed qualitative analysis was undertaken in relation to the FASD and ADHD cases and the ‘treatability’ variable. For this part of the results analysis, only the cases in which the principal disorder was being mentioned directly in order to draw some kind of an inference about the accused’s ‘treatability’ (whether the accused could be treated or not) were scrutinized in depth (see detailed qualitative results section). It is worthwhile to summarize the major results of all 24 cases by focusing first on the youth-FASD cases, then the adult-FASD cases, followed by the youth-ADHD cases as well as the adult-ADHD cases.

**Youth-FASD and the ‘Treatability’ Variable**

There were five youth-FASD cases in which a connection between the principal disorder and treatability was made (see List 1: Themes in qualitative results section).

A couple of these major themes also had several ‘emergent’ sub-themes, which will be addressed. Beginning with judicial adherence to mental health experts/Doctors, all five of the youth cases in the sample contained treatment recommendations made by the judge with respect to the offender: in these cases, the judge paid close attention to what the mental health experts had to say about the offender’s FASD. The judges seemed to be particularly interested in the evidence supporting the diagnosis of FASD, and directly referred to mental health experts/Doctors who specialized in assessing fetal alcohol spectrum disorder. The professionals’ diagnosis of FASD did appear to make a difference to the judges in terms of their tailoring a treatment plan, which addressed dealing with the identified disorder—fetal alcohol spectrum disorder. Overall, the psychiatric expert testimony appeared to be very important to the judges in
the five youth cases because, in each case, they relied heavily on the evaluator’s testimony and referred directly to specific doctors’ comments in their rationale for the administration of the final sentence and treatment protocol. It was encouraging to see that judges were relying on expert testimony for the diagnosis of FASD: this finding is supported in the academic literature, insofar as researchers have reported an increased awareness of FASD by criminal justice agents, such as judges, lawyers and other criminal justice personnel (Fast & Conry, 2009); however, it is important to keep in mind that the recent trend towards increased awareness of FASD by the courts does not always translate into proper assessment/diagnosis or consideration in all cases.

The second identified theme that emerged was judge’s emphasis on treatment in connection to the principal disorder. In all five of the youth cases, each judge emphasized treatment in connection with the principal disorder. Hence, the third major theme was type of treatment, and a few ‘emergent’ sub-themes were identified. First, no matter where the offender was ultimately placed, making sure that the treatment was geared toward addressing the FASD diagnosis was an emergent theme. For example, some young offenders were still placed in custody, rather than being given a community sentence, owing to the nature of the disorder and the belief that consultation with persons who were knowledgeable about FASD could still take place inside a prison setting. Other young offenders, because of their FASD, were placed in a youth Intensive Rehabilitative Custody and Supervision program (IRCS), followed by a certain period of community supervision. The second emergent theme that was derived from the type of treatment theme was control of the disorder. Recognizing that the offender had FASD, some judges made it clear that ‘controlling’ the disorder by achieving some measure of stability in the community was the key consideration. Evidently, the judges recognized that FASD is a lifetime disability that does not go away; therefore, controlling it in a structured environment, whether that was in the community or in a secure setting, is the paramount objective. Thus, another emergent sub-theme derived from the type of treatment theme was support for the disorder. Whether the young offender with FASD was better suited for custody or the community was very offence-specific, as well as a judge-specific, decision: however, what remained consistent was that each judge pointed to the importance of a ‘supported structure’.

The fourth major identified theme was court observations regarding FASD related to academic literature. In three of the five youth cases, judges drew
information about FASD from the academic literature. For example, one judge noted how the offender acquired many of the secondary disabilities associated with someone who is diagnosed with FASD late on and did not receive supervision and support appropriate to her disability. Such a statement reflects the academic literature that surrounds the acquisition of secondary disabilities associated with FASD. Another example concerns a judge who commented that the mental health professional had noted that the offender’s functioning in the community could be summarized as low and in secure custody as high: the judge noted that this was an observation that was frequently made in relation to FASD-diagnosed young persons and stated that supported structure is a key to their success. Again, such a statement by the judge reflects an awareness of the academic literature surrounding the life events of persons with FASD and their need for a supportive structure. As Conry & Fast (2000) postulated, when persons with FASD do not have a great deal of structured family and/or community support, their problems may become exacerbated. Another judge in a youth case demonstrated a concern that the FASD offender was being moved to an adult facility, since she would be vulnerable to the influence of adults around her. Again, the judge is clearly coming to such conclusions based on the academic literature which alludes to youths being vulnerable in an adult prison-setting in general, or, more specifically, to cognitively-impaired youths struggling more an adult facility. It was also noted by some judges that FASD offenders cannot make appropriate decisions for day-to-day living, primarily because of their inability to exercise sound judgment, owing to their FASD. Clearly, judges are referring to the considerable amount of literature that addresses the debilitative effects that result from the acquisition of FASD. For example, as postulated in the literature, the neurological impairments found in individuals with FASD include learning disabilities, impulsivity and poor judgment (Fast & Conry, 2004; Fast & Conry, 2009).

The final major identified theme was overall direction of inference about treatability and principal disorder. The emergent theme that was derived from this major theme for all five of the youth cases was treatment is needed to address the disorder. The judge in each of the youth cases made treatment decisions that involved addressing the offender’s FASD.
Adult FASD and ‘Treatability’ Variable

There were nine adult-FASD cases in which a connection between the principal disorder and treatability was made (see List 2: Themes in qualitative results section). The qualitative analysis of adult-FASD and the ‘treatability’ variable for all of the adult cases resulted in the identification of seven major themes among cases: judicial deference to mental health experts/doctors; unclear FASD diagnosis; judge emphasis of treatment in connection to the principal disorder; type of treatment; observations regarding FASD related to research; overall direction of inference about treatability and the principal disorder and judge feeling compelled to review how FASD should be considered in sentencing. A few of these major themes also had ‘emergent’ sub-themes, which will be addressed.

Beginning with judicial adherence to mental health experts/doctors, in all five of the youth cases under observation, the judge paid close attention to the formal diagnosis of FASD by mental health professionals/doctors: however, there was more diversity in the adult-FASD cases in terms of the extent (if any) to which judges paid attention to what the mental health experts/doctors had to say about FASD. In one case, the judge did not refer directly in his judgment to any statement of a mental health professional or medical expert regarding FASD and ultimately based his sentencing disposition on the assumption that the offender may have been suffering from fetal alcohol spectrum disorder. Similarly, in another case, there was no mention of FASD as a diagnosis or possible diagnosis by a mental health professional/doctor. However, one emergent theme derived from judicial adherence to mental health experts/doctors, is judicial adherence to mental health experts/doctors opinion about FASD prognosis/outcome. In four of the adult-FASD cases, the judge did refer to the assumption made by the mental-health experts or doctors with respect to the offender having FASD, even though no formal diagnosis was made. The judges then proceeded to speak about the offender as if she or he definitively had FASD. Furthermore, in two of the cases, the mental-health experts/doctors were of the opinion that whether or not the offender suffered from FASD would make little difference in the treatment outcome; therefore, the judges assumed the diagnosis was inconsequential, considering it was the experts’ opinion that treatment would not be affected by knowing what caused the cognitive impairment in question. Moreover, in one of these cases, the judge referred to the doctor’s statement about it not being possible to test for FASD in adults, and how it did not matter what caused the offender’s impairment. In
another case, the judge accepted the mental-health professional’s ‘assumption’ that the offender had FASD. The judge then accepted that this condition greatly reduced the offender’s cognitive capacity. Evidently, judges took the opinions of mental-health experts/doctors very seriously, even when these professionals were negative about the treatment prognosis for offenders ‘possibly’ having FASD. It was disheartening to see that judges were not pushing for a ‘formal’ diagnosis of FASD as part of a pre-sentence report to be made for these adult-FASD offenders. In addition, there were three adult FASD cases in which the judges did refer to formal diagnoses that were made for the offenders. For example, in one case, the judge focused on the evidence of the psychiatrist who diagnosed the offender as having FASD and in the judge’s view, this diagnosis was very relevant to the treatability—and eventual control—of the offender.

Hence, the second major identified theme was unclear FASD diagnosis. In five of the nine adult-FASD cases, the judges directly stated that FASD was not formally diagnosed and yet they proceeded with sentencing the offender under the assumption that the accused ‘did’ indeed have FASD. The emergent theme derived from unclear FASD diagnosis was judges proceed without proper assessment. As indicated above from the judicial adherence to mental health experts/doctors opinion about FASD prognosis/outcome theme, one of the major reasons why judges did not order an FASD assessment to be made was because, in many of the cases, the court listened to the mental health experts/doctors who were claiming that the treatment protocol would be the same either with or without a diagnosis of FASD: the other reason was that some mental health experts claimed that adults could not be properly diagnosed with FASD. Interestingly, even though the academic literature does support the view that the identification of FASD in the adult population is the most challenging undertaking of all (Fast & Conry, 2004), it is still very possible to identify a variety of cognitive shortfalls that could lead to the diagnosis of FASD. Moreover, for judges to listen to mental health experts who claim that the manageability of the accused in the prison setting or in the community would be identical, whether they have FASD or not, is highly inappropriate, considering there is ample research that indicates that FASD-specific-tailored programs, even for adults, make a difference. Indeed, as Judge Trueman stated in R. v. Harris (2002):
The cognitively challenged are before our courts in unknown numbers. We prosecute them again and again and again. We sentence them again and again and again. We imprison them again and again and again. They commit crimes again and again and again. We wonder why they do not change. The wonder of it all is that we do not change (paragraph 167).

As Moore & Green (2004) stated and clearly their observation was supported by this study’s results, sentencing courts are either unaware of the disability altogether and/or there is a lack of services in the area to meet the needs of the FASD person, or sentencing courts are too often powerless to conjure up an appropriate disposition or are frustrated in their effort to do so.

The other emergent theme, relating to judicial adherence to mental health experts/doctors opinion about FASD prognosis/outcome was judges concerned about lack of proper FASD assessment. There were a couple of adult-FASD cases in which the judge suspected FASD was a possible diagnosis for the offender and emphasized in the judgment a needed follow-up for a proper diagnosis to officially confirm FASD. For example, one judge stated that formal confirmation of maternal prenatal drinking was required to complete the diagnosis and, to date, only hearsay evidence had been provided. Evidently, some judges do consider a formal diagnosis to be necessary so this finding again illuminates how differently each judge approaches a diagnosis of cognitive impairment.

The third identified theme that emerged was judge emphasis of treatment in connection to the principal disorder. In all five of the youth-FASD cases, the judge emphasized treatment in connection with the principal disorder: however, in the adult-FASD cases, not all judges emphasized treatment with respect to the principal disorder. In four of the nine adult-FASD cases, the judge did not make any treatment recommendations that were specific to addressing this particular cognitive impairment. For example, in one of the cases, the judge mentioned the residential treatment program, in which the offender would be taking alcohol and drug counseling, but no specific attention was paid to addressing the offender’s potential FASD. It could be that, in this particular case, even though it was assumed that the offender had FASD, the judge nevertheless cited the doctor’s concurring opinion with another doctor that the management plan of the accused would be identical regardless of whether or not he was diagnosed with FASD. In another case, the judge’s made detailed remarks about FASD, sentencing and the importance of rehabilitation for FASD offenders; however once the accused was sentenced as a long-term offender, the judge no longer alluded to any special FASD treatment. Yet
in five of the adult-FASD cases, the judges did consider FASD in their treatment plan for the offender. In fact, in one case in which the accused did receive a long-term designation, the judge made an effort to include treatment for the offender’s cognitive impairment (FASD) and, in another case, the judge was direct and vocal about stressing the importance of receiving treatment for FASD. Clearly, such a finding demonstrates how some judges do emphasize the impact of FASD and the importance of treatment with this disorder in mind, while others do not consider it in their treatment plans for the offender.

The fourth major theme was *type of treatment* (same major theme identified in the youth- FASD cases) for the five adult cases in which judges did link FASD and treatment together. As with the FASD-youth cases, the same ‘emergent’ themes came out of the *type of treatment* variable: *control of the disorder* and *support for the disorder*. Whether being placed in prison or in the community, managing FASD in a controlled, supported and structured setting was a key issue for all of these FASD-adult offenders who received treatment dispositions that addressed their cognitive impairment. Furthermore, regardless of where the offender was ultimately placed, making sure that the *treatment was geared toward addressing the FASD diagnosis* was another emergent theme.

In three of the five cases, the offenders were ordered to serve custodial dispositions and, in the other two, community sentences. Even in the cases in which the FASD offenders were sentenced to custody, the judge brought up treatment either in the prison setting, at a different location, or in the community afterwards. For example, one offender received a two-year custodial sentence so that he remained in federal custody, where he could access better treatment options because the judge believed that he would have better assistance and would be involved in more structured programs. The judge directly stated that the accused was receiving the two-year federal sentence so that he could get the help for his ‘suspected’ fetal alcohol spectrum disorder.

There was one case in which the judge believed that, since the offender would suffer the effects of his fetal alcohol syndrome and his intellectual deficits for the rest of his life, he would need community supports beyond ten years in order to assist him with his daily living in the community; therefore, the North Star program, a program specifically aimed at addressing the needs of intellectually disabled sex offenders, was part of his treatment plan. In another case, the judge wanted the accused to attend St. Michael’s Hospital Fetal Alcohol Spectrum Disorder Clinic, or a similar type of specialized Clinic:
in this respect, the judge directly stated that now that the court knew the offender had fetal alcohol spectrum disorder, prison personnel could create programs geared toward helping him deal with this disorder.

With respect to the fifth theme, observations regarding FASD related to research, there were certainly not as many remarks made by judges, which reflected their academic knowledge base surrounding FASD, as there were in the aforementioned FASD-youth cases. In fact, there was only one such adult-FASD case. In that particular case, the judge referred to the popularly cited article by Moore and Green (2004), regarding FASD and the criminal justice system, in which the authors discussed the extensive issues that result from FASD in relation to trial issues for accused persons suffering from FASD. The judge pointed out how the abuse of substances has resulted in a high proportion of FASD persons living in the community.

The sixth theme in the adult FASD cases, overall direction of inference about treatability and the principal disorder, did not result in the same finding as in the youth-FASD cases. There was a mixed result. Unlike all five of the youth-FASD cases, in which the emergent theme was treatment is needed to address the disorder, in only five of the nine adult-FASD cases, did the judge make treatment decisions that involved addressing the offender’s FASD, while in the remaining four, treatment was not linked to this particular cognitive impairment.

The final major theme in the adult-FASD cases was judge feeling compelled to review how FASD should be considered in sentencing. In a couple of the cases, the judges felt compelled to review the various points of view as to how FASD should be considered in sentencing. For example, in one case, the judge articulated the view that some have considered the diagnosis of FASD as an ‘aggravating’ factor, and how essentially the behaviours associated with FASD may be fixed (unchangeable). The judge made it clear how some have said that, when such a diagnosis is present, the overriding sentencing consideration should be rehabilitation. The judge stated that some have articulated the proposition that the overriding principle should be rehabilitation because the disorder is likely to have at least contributed to the offence and therapeutic intervention is paramount, since specific deterrence is ineffectual with respect to individuals suffering from this kind of cognitive deficit and general deterrence and denunciation are not applicable owing to the idiosyncratic nature of the offender. However, this judge stated that such a rehabilitative opinion ignores the principle of public safety and cited this as being implicit in
the dangerous offender criteria. The judge also pointed out how public safety has been considered of utmost importance elsewhere with regard to offenders having FASD. In another case, once the judge was satisfied that a diagnosis was made, the judge could then carefully consider what impact fetal alcohol spectrum disorder would have on the sentencing process.

**Youth-ADHD and the ‘Treatability’ Variable**

There were four youth-ADHD cases in which a connection between the principal disorder and treatability was made (see List 3: Themes in qualitative results section). The qualitative analysis of youth ADHD and the ‘treatability’ variable for all of the youth cases resulted in the identification of four major themes in the cases: judicial adherence to mental health experts/doctors, judge emphasis of treatment in connection to principal disorder, type of treatment and overall direction of inference about treatability and principal disorder, along with some emergent themes.

In terms of the first major theme, judicial adherence to mental health experts/doctors, unlike the situation with respect to FASD-youth cases in which the majority of the judges did adhere to mental-health experts’ opinion about the principal disorder, the opposite was found for ADHD as a principal disorder. Of the four youth-ADHD cases, there was only one in which the judge seemed to consider the mental-health expert’s opinion regarding ADHD, since the expert’s diagnosis was cited in the sentencing judgment. In another case, whether or not the judge considered the mental-health expert’s opinion regarding ADHD as being important for sentencing was unclear because the judge discussed the issues surrounding an accused’s mental-health needs in general but did not emphasize whether or not an evaluator’s recommendations with respect to ADHD were considered; rather, the judge emphasized how the court was cognizant of the defendant’s mental-health needs and the judge wanted to make it clear that increasing the length of a sentence because of mental-health issues would be very inappropriate but, at the same time, the mental health state of the offender was relevant in the determination of an appropriate final sentence. In another youth-ADHD case, the judge did consider a mental-health expert’s opinion about the accused’s illness as being of value for sentencing; however, the consideration was for FASD, not ADHD. In the final youth-ADHD case, despite the mental-health professional’s opinion that the offender should be given a youth disposition, the judge felt that a two-
year adult sentence was appropriate. Thus, even though the mental-health expert reiterated the point that the youth had ADHD under control with medication, neither this information nor the opinion of the mental-health expert swayed the judge in his sentencing decision.

The second major youth-ADHD theme identified in the present study was judge emphasis of treatment in connection to principal disorder. The emergent finding for this theme was very different from the same theme in the FASD-youth component. For the FASD youths, many judges did tie the treatment component of the final disposition specifically to their suspected or confirmed FASD diagnosis. However, the opposite was observed for the ADHD-youth cases and the theme that emerged was ADHD treatment is not identified by judges. In all four of the cases, none of the judges link any treatment connection specifically to ADHD. The treatment recommendations were all very general. For example, the youth were to receive counseling, substance-use treatment or open custody, allowing for a range of therapeutic measures, but there was no mention of ADHD-treatment programing. Hence, what coincides with this particular emergent theme is the third theme, type of treatment. There were no ADHD-treatment-program types to discuss, since the judges never incorporated ADHD treatment anywhere in their final-disposition statements. It can then be said that, for the overall direction of inference about treatability and principal disorder theme, there was certainly no emphasis made by judges with respect to treatment and ADHD for the youth cases.

**Adult-ADHD and the ‘Treatability’ Variable**

There were six adult-ADHD cases in which a connection between the principal disorder and treatability was made (see List 4: Themes in qualitative results section). The qualitative analysis of youth ADHD and the ‘treatability’ variable for all of the adult cases resulted in the identification of five major themes among cases: judicial adherence to mental health experts/doctors, ADHD diagnosis (unclear or formal), judge emphasis of treatment in connection to principal disorder, type of treatment and overall direction of inference about treatability and principal disorder, as well as some emergent themes.

For the first major theme, judicial adherence to mental health experts/doctors, as with the FASD-adult cases, in which there was a considerable degree of diversity in terms of the extent to which the judges paid attention to the opinions of mental-health experts/doctors about FASD, there
was a similar degree of diversity in the ADHD-adult cases. In one of the cases, the judge did not refer to any mental-health experts’ opinions on the matter of ADHD because no such assessment was made. In two of the other cases, the judge directly quoted the mental-health expert’s opinion about the offender having ADHD but then no further reference was made to the disorder in the sentencing judgment. Similarly, in another case, the judge made no further comment or reference to ADHD and, although he mentioned what the counsel for the defence would like to see imposed, he sided with Crown Counsel and imposed an 18-month custodial sentence and one-year probation, rather than community supervision as requested by the defence. In a couple of the other ADHD-adult cases, the judge cited the mental-health expert’s opinion about ADHD and treatment but was completely focused on the offender’s antisocial personality disorder when it came to sentencing; therefore, the judge never mentioned ADHD again.

The second identified theme was ADHD diagnosis (unclear or formal). Again, as with the FASD-adult cases, a formal diagnosis was not made in every ADHD-adult case in which it was assumed that the offender had ADHD. However, there were more formal diagnoses of adult ADHD than there were for adult FASD. In four of the six ADHD cases, a formal diagnosis was conducted, as compared with only four of the nine FASD cases.

When it came to the third major identified theme judge emphasis of treatment in connection to principal disorder, as with the ADHD youth cases, the ‘emergent’ theme was ADHD treatment is not identified by judges. It was quite startling to observe that only in one of the six ADHD-adult cases did the judge recommend that the offender be properly assessed for ADHD while in custody but that was as far as the judge went in terms of connecting ADHD to a treatment protocol. In all of the other five cases, there was absolutely no direct mention of any type of ADHD treatment; only general treatment statements were made but were never specifically linked to this particular principal disorder. This result was markedly different from the FASD-adult cases because, in those cases, many judges did make a direct link between FASD and treatment. It is, therefore, not surprising that, for the fourth major theme, type of treatment, as was also reflected in the ADHD youth cases, no ADHD treatment protocols were mentioned, since the judges did not incorporate ADHD treatment into their final disposition statements.
The final theme, overall direction of inference about treatability and principal disorder, can be gathered from the six ADHD-adult cases in which the judges appeared to acknowledge the presence of ADHD, either assumed or confirmed. However, not even in one ADHD-adult case, did the judge make a direct statement about ADHD treatment as being part of the offender’s protocol. Rather, in a few cases, mental-health professionals discussed the importance of treatment for ADHD in order to curb future crime.

Overall, in contrast to the cases involving FASD, there were no identified themes for ADHD with respect to ‘observations regarding the principal disorder being related to research’ or ‘the judge feeling compelled to review how the principal disorder should be considered in sentencing’. It was interesting to note that many judges made references to FASD, in terms of how it is perceived in the academic literature with respect to its poor cognitive prognosis and its link to crime; whereas, there were no such ADHD cases. Also, for ADHD, the judge did not address the issue of how ADHD fit into the final sentencing consideration, unlike the judicial approach in a number of the FASD cases.

**‘Ethnicity’, ‘Youth versus Adult’ Variables and Their Link to the ‘Treatability’ Variable**

In terms of ethnicity and youth-versus-adult variables of interest in connection with the ‘treatability’ variable, the results for this component revealed several findings (see qualitative results section) but, overall, one major result can be underscored: there are considerably more Aboriginal offenders presenting with the principal disorder of FASD than there are with ADHD: this finding is based on a direct link having been made by a judge and/or mental-health expert about the likelihood of treatability in connection with the principal disorder. There were only 24 cases in which the principal disorder, either FASD or ADHD, was being mentioned with the objective of drawing some kind of an inference about the accused’s ‘treatability’ (whether the accused could be treated or not). The Aboriginal connection with FASD and the ‘treatability’ variable was remarkable. For example, in 12 of the 14 cases (86.0%) in which the variable, ‘treatability,’ was linked to the principal disorder of FASD, the offender was Aboriginal. Whereas, for ADHD, only four (40.0%) of the offenders in the ten cases in which the variable ‘treatability’ was linked to the
principal disorder were Aboriginal. Such a finding is not a surprise, considering there was a larger sample of Aboriginal offenders than non-Aboriginal offenders presenting with FASD. As mentioned in the results section, 58.0% of the total FASD cases involved Aboriginal offenders and only 23.0% of the total ADHD cases involved Aboriginal offenders (see detailed qualitative results section). There were more Aboriginal adults with FASD or ADHD in connection with the treatability variable than there were for youth (of the 24 FASD cases, 89.0% of the adult cases involved Aboriginal offenders and 80.0% of the FASD youth cases involved Aboriginal youths; for ADHD, 43.0% of the adult cases involved Aboriginal offenders and 25.0% of the ADHD youth cases involved Aboriginal youths). In terms of youth-versus-adults and the ‘treatability’ variable, the results give a very detailed statistical overview but, in summary, there were more Aboriginal youth with FASD linked to the treatability variable (80.0% of the youth cases) than there were for Aboriginal youth with ADHD linked to the treatability variable (30.0%). Overall, the results confirm that there are more Aboriginal offenders linked to FASD than there are connected to ADHD, as far as the five-year period of sentencing judgments for such disorders in the provinces of BC, SK and ON are concerned. Aboriginal individuals being overrepresented in the criminal justice system has been supported in literature (Chartrand & Forbes-Chilibeck, 2003; Pemberton, 2010); therefore, the results of this study confirm this observation.

**JUDGE TREATMENT IN GENERAL VARIABLE**

Another variable of interest was ‘judge_treat_gen’, which was operationalized as, [whether or not the judge emphasizes the importance of treatment in the final disposition — treatment in general]. The results revealed in how many of the 83 cases the judges emphasized treatment, did not emphasize treatment, believed treatment to be unlikely or regarded treatment as being a secondary concern to the court (see detailed qualitative results section). Interestingly, in approximately half of the cases (51.8%), judges did emphasize treatment; in just over a third of the cases (39.8%), judges did not emphasize treatment; and, in 7.2% of the cases, judges stated treatment to be unlikely to be effective or stated that treatment was a secondary concern to the court. The few cases, in which the judge exhibited a disbelief in the likelihood of treatment for the offender or
when the judge regarded treatment as a secondary concern, are worthy of closer qualitative examination and the results revealed the following:

There were six cases which reflected a major theme—*judicial pessimism or disbelief in the likelihood of treatment* (see List 5: Themes in qualitative results section). Such a theme was reflected in all six of the cases; however, there were some important emergent themes. One such emergent theme was *being a youth or a young adult made treatment a necessary consideration by a judge*. For example, in both the case of a youth and another case involving a young adult, the judge stated that, in light of the offender’s youth, rehabilitation must be factored in, despite a genuine belief that it would not be successful. In the youth case, irrespective of the fact that the youth had ADHD, the judge focused on the personality disorder (conduct disorder) and gave it primary consideration when determining the offender’s likelihood of successful treatment (conduct disorder overshadowed ADHD). In two other youth cases, *youth sentence does not adequately address the needs of the offender* was another emergent theme. In both of those cases, the judge mentioned how difficult rehabilitation would be for these youths. In one of the cases, the judge stated that the youth would need more help to address his actions and problems than could be provided in a youth sentence and, in the other case, because the youth would not take responsibility for his actions, the judge was very pessimistic about treatment in general and also felt that a youth sentence was not the appropriate outcome. Finally, in the remaining two adult cases, another emergent theme was *principles of denunciation and deterrence take precedence*. In both of these cases, the principles of denunciation and deterrence were of utmost importance and the principle of rehabilitation was a secondary concern. Overall, it was interesting to see that, even in a few cases, the judges were quite negative about the prognosis for offender treatment, whether a youth or an adult was involved, and they appeared to give it only secondary consideration.

**Direction of Violence and Direct Recidivism Variables**

The results on ‘direct violence,’ which was operationalized as [the direction of inference about violence in connection to principal disorder] and ‘direct recidivism,’ which was operationalized as [the direction of inference about recidivism in connection to principal disorder], revealed a very small percentage of FASD and ADHD cases in which a direct statement was made
either by a mental health expert, the judge or both about the offender’s likelihood of violence or recidivism in connection with the principal disorder (see detailed qualitative results section). Such a finding is worthy of reflection. Going back to the literature review component of this dissertation, and beginning with FASD, some pre-existing case analysis undertaken with respect to FASD and the types of crimes committed by persons with this cognitive impairment, has revealed a pattern, which is that many FASD offenders seem to commit violent crime, such as robbery and sexual assault (McDonald, Colombi & Fraser, 2009). Thus, it was interesting that in the majority of the present study’s cases, judges and/or the mental health experts rarely commented on any direct link between FASD and future violence or recidivism. Furthermore, for ADHD, even though the academic literature does not appear to show any pre-existing pattern with respect to the ‘type’ of offences that ADHD offenders are likely to commit, research does point to crime volume as being an issue; namely, ADHD offenders are more likely to recidivate than those who do not have this cognitive impairment (Dalteg & Levander, 1998; Whalen, Jamner, Henker, Delfino & Lozano, 2002). It is, therefore, interesting that in the majority of the present study’s cases, the judges and/or the mental health experts rarely commented on any direct link between ADHD and future recidivism.

It is also worthwhile to note that four of the five cases that were discussed in the direction of violence and direction of recidivism variables section, in which a direct inference was drawn about violence and/or recidivism in connection to the principal disorder (either FASD or ADHD), are the very same cases that were analyzed in the variable discussion section on ‘treatability’ (inference was drawn about treatability and the principal disorder). This finding indicated that, in a few of the sentencing judgments in which either the judge or a mental-health professional referred to or discussed the defendant’s potential for treatment, the judge and/or mental health expert was also inclined to discuss the offender’s likelihood of committing future violence and/or future recidivism, in the context of their principal disorder (FASD or ADHD). Nonetheless, what also crystalized from the results was that 19 of the 24 cases that directly linked treatability and the principal disorder did ‘not’ directly link a low or high potential for violence and or recidivism risk in any way directly to the principal disorder.
However, in the few cases in which a direct link was made between the principal disorder (either FASD or ADHD) and risk of future violence and/or recidivism, such cases reflected the following judicial reasoning. There were three FASD cases in which a direct link was made between the principal disorder and future violence/recidivism. In one of the FASD cases, the judge felt that owing to the presence of FASD, the offender could commit violent crime and recidivate in the future. The judge did not feel that the offender was a danger to the public but the offender’s present behaviour (committing a robbery) was consistent with the manifestations of FASD (violent crime connection made), and the judge cited academic literature to support such an assertion. The judge then discussed the court’s concern about possible non-compliance to sentencing stipulations by the offender owing to his FASD; meaning, there was a possibility of recidivism. In the other two FASD cases, ‘direct recidivism’ was brought up in connection with FASD. In one case, a doctor assessed the offender as a low risk to re-offend, irrespective of the fact that he may have been suffering from FASD and, in the other case, the doctor believed that this particular offender would always be at some type of risk to re-offend (perhaps lower than at the present time, depending on the treatment) because of her severe brain impairment, a ramification of FASD.

Finally, the future violent and recidivism variables in connection with the principal disorder of ADHD revealed the following: in one case, the judge stated that ADHD did not cause the offender to be a risk to reoffend and the judge also considered him a low risk for future violence because the offender would rather do anything than have this type of crime ever happen in the future; in the other ADHD case, the offender was considered a high risk to violently reoffend by a mental-health expert and this risk assessment was made within the context of his ADHD. The judge stipulated that the offender’s history of anger and attention-deficit symptoms further aggravated the features that have resulted in aggression and most likely were a very important contributory factor to the present index offence. Hence, the offender was not only regarded as being violent, in which his ADHD was seen as aggravating his aggression, but he was also seen as likely to reoffend in the future owing to his present disorders. Overall, these five cases reflect the diversity in judicial commentary with respect to a direct link being made between FASD/ADHD and future risk for violence and/or recidivism.
Principal Disorder as a Mitigating Factor

‘Judge_Mitigate’, ‘Final Disposition’, ‘Judge_Resource’ and ‘Judge_Culpability’ Variables

A pivotal component of the results section pertained to the ‘mitigating ‘judge_mitigate’ variable, which was operationalized as, [does the judge explicitly state or allude to the principal disorder being a mitigating factor and/or a need for a lesser (reduced) sentence or deliberate sentence requiring specific treatment/supervision or combination sentence, due to the principal disorder]. The results revealed that in 21.6% of the cases, the principal disorder was mentioned by the judge explicitly or alluded to as being a mitigating factor (see detailed qualitative results section). Hence, there were 18 cases in total in which the ‘judge_mitigate’ variable was discovered: eleven of the 18 cases were for FASD (61.1%) and the remaining seven mitigating cases were for ADHD (41.2%). Interestingly, and this was mentioned in the results section, in 91.0% of the FASD cases, in which the judge somehow made FASD a mitigating factor in the sentencing judgment, the offender was Aboriginal (10/11 of the cases); however, for the seven ADHD cases, none of the offenders were of Aboriginal descent. Evidently, fetal alcohol syndrome was overrepresented in the Aboriginal realm in comparison to the ADHD ‘judge_mitigate’ factor variable cases in which none of the offenders were referred to as Aboriginal.

The other worthwhile finding, as discussed in the results section, was that, in 80% of the FASD cases, in which the judge did find the disorder to be a mitigating factor, those were the very same cases that were linked to the variable of interest ‘treatability’, discussed in the results section as well as earlier in this chapter. Yet, only in one of the seven ADHD cases, in which the judge found ADHD to be a mitigating factor, was it the same case as was found in the ‘treatability’ variable section. The fact that 37.5% of the cases that were discussed in the ‘treatability’ variable of interest section were the same cases in which the judge considered the principal disorder to be a mitigating factor, shows that in many cases where the judge and or mental health evaluator discuss the offender’s principal disorder in the context of treatment, the judge also recognizes the principal disorder as possibly being a mitigating factor in sentencing.

The results captured in detail what judges said exactly about the principal disorder when they either explicitly or alluded to FASD/ADHD as being a mitigating factor, as well as revealed the various final dispositions that
were handed down, what the judges had to say about available resources and finally what was being said about the offender’s remorse level. This discussion will summarize the very detailed findings in the results chapter by identifying major themes within/among cases as well as emergent ones. It is worthwhile to begin with the cases in which judges explicitly stated or alluded to FASD as being a mitigating factor.

**Judges ‘Explicitly’ Stating or ‘Alluding’ To FASD As A Mitigating Factor**

In all four of the ‘judge_mitigate’ variable cases, in which the judges ‘explicitly’ stated FASD to be a mitigating factor, the offender was Aboriginal. Furthermore, in six of the seven ‘judge_mitigate’ variable cases, in which the judges ‘alluded’ to FASD as being a mitigating factor, the offender was Aboriginal. Hence, the first identified theme among cases is *ethnicity* and the emergent theme is *Aboriginal descent*, seeing as though in ten out of the eleven FASD mitigating cases (90.9%), the offender was of Aboriginal descent.

In nine of the eleven ‘judge_mitigate’ variable cases, the offender was an adult and in the remaining two, the offender was a youth. It was evident from all of these eleven cases that the judges did put some thought into how FASD fit into the present sentencing process by somehow considering it in their sentencing decision; therefore, *FASD being a mitigating factor in sentencing* was another major theme among cases (see detailed qualitative results section). The results component goes into great detail in describing how each of the eleven FASD cases contains the ‘judge_mitigate’ component but it is pertinent to highlight the main mitigating considerations in each case.

Beginning with the adult cases only, in the first case, the judge stated that, while the FASD offender could not be cured, the appellant was regarded as being treatable and manageable. In the second case, the judge took a very strong position in the application of Section 718.1, in terms of the offender’s degree of responsibility, and felt that an appropriate sentence had to take into consideration his FASD. The judge was very direct in believing that to not consider FASD and instead punish the offender’s behaviour, despite his having an organic brain impairment, would be completely against the principles of criminal law. Furthermore, the judge felt strongly about the offender receiving treatment for his disorder. In the third case, the judge directly stated that the court considered the offender’s organic brain disorder and the functional disabilities that were commonly attributable to persons who were identified as
having fetal alcohol syndrome in the sentencing decision. In the fourth case, the judge cited long excerpts from the mental-health expert regarding the offender’s possible FASD diagnosis and cited the academic literature pertaining to FASD in the case judgment, which certainly showed a keen interest in the ramifications of the diagnosis and, therefore, it must have been a consideration in the final sentencing outcome. Furthermore, it was recommended that the offender be placed in a very structured, controlled community setting, which reflects the needs of an FASD person. In the fifth case, the judge held the view that denunciation was a less important consideration when dealing with an ‘intellectually-impaired’ person; specifically, when considering section 718.1, the judge in this case referred to another case—R. v. D.J.J (1998), in which, at paragraph 34, the majority opinion of the Court held that an accused’s intellectual capacity may be considered in fashioning an appropriate sentence; even though the judge did not know conclusively whether the offender suffered from FASD, the judge was sufficiently satisfied to ascertain that the offender did in fact have a cognitive impairment and thus considered this fact in the final sentencing decision. As was discussed in the results section, it was interesting that, at the time of this judgment (2004), the judge was told that there was ‘no proper diagnostic tool available’ at the time (FASD testing was available). This particular judge also made sentencing recommendations that took into account the offender’s potential diagnosis. In the sixth case, the judge addressed the fact that the FASD diagnosis was based on hearsay, simply because no formal confirmation of maternal drinking was provided; however, the judge did agree that the offender clearly suffered from an organic condition which was most likely FASD. The judge then proceeded to acknowledge the complexity of this disorder in terms of how it fit in with the sentencing principles of s. 718.1. In the seventh case, it was unclear whether the judge was placing the offender in custody because he considered him a risk to the public in light of his FASD condition, or if in fact he had reduced his sentence because the offender could not have been held totally culpable for his crime owing to having FASD (not being able to appreciate the nature or quality of the act committed to some degree). Nonetheless, his mention of FASD in the sentencing disposition made it appear as if this condition was a mitigating factor, especially because of the comment about not being able to appreciate the nature or quality of the act committed to some degree. In the eighth case, when the judge’s comments with respect to FASD were pieced together, it appeared as if the court took FASD into consideration in the sentencing decision. Since
the judge originally acknowledged that Brown had been born with FASD, the judge went on to imply the significance of FASD in a quote that discussed the unfortunate circumstances of the offender’s life. Hence, the judge appeared to consider this impairment in some capacity. In the ninth case, the mitigating factors in this case were the offender’s background (the judge was aware of the offender’s FASD). Even though the judge did acknowledge the offender’s lifelong reality of suffering with FASD, in the end, the judge found that the punitive objectives such as denunciation and deterrence were particularly pressing and that incarceration was the necessary sanction.

The tenth and eleventh cases involved FASD youth and interestingly, in both cases, the judge really stressed structure, supervision and rehabilitation. In the first case, the judge sentenced the offender to 5 months of custody and supervision and really highlighted ‘supportive structure being a key to success’, which was noted by the judge as being especially important in most FASD cases. In the other youth case, the judge considered her diagnosis of fetal alcohol effect, among other factors, and felt that an adult sentence would be too severe given her age and mental limitations so she was committed to intensive rehabilitative custody for the maximum sentence of four years of closed custody, to be followed by three years of community supervision.

‘Judge Culpability’ Variable as Presented in the ‘Judge_Mitigate’ Identified Cases

The variable ‘judge_culpability’ was operationalized as, [does the judge directly mention the offender’s culpability/responsibility/remorse or lack of it in the commission of the crime]. This variable was assessed in the context of the eleven FASD ‘judge_mitigate’ cases in order to see whether perhaps the judge was more inclined to mitigate the final sentence when the offender took responsibility for his/her actions. Hence, it was important to consider what judges had to say about offender culpability. Interestingly, in six of the eleven FASD-mitigating cases, the judge made no mention of the offender’s culpability in terms of remorse. Such a finding illustrates that not all judges focus on how the offender feels about his/her criminal act, demonstrating that it does not make a difference in their final sentencing judgment. In the five cases in which the judges did mention culpability, the following was stated (see detailed qualitative results section): in the first case, the defendant’s remorse level did not play a role in the determination of a DO or an LTO designation, since the
offender was clearly not very remorseful and this did not sway the judge from giving him the less severe disposition; in the second case, the judge believed that the offender was in fact remorseful and, since the judge mentioned remorse in the same paragraph in which the various factors of consideration were listed, it can be assumed that the offender’s remorsefulness also played a role as a mitigating factor with respect to his sentence. In the third case example, one factor that was part of the analysis that went into determining the offender’s sentence was his lack of remorse throughout the trial and the judge stated how the offender needed to take responsibility for his actions and not to blame the alcohol or the victim. In the fourth case, the judge simply stated that the offender had shown remorse and appeared to be amenable to counseling and, in the final case, the judge stated that the offender was remorseful and had no memory of the actual criminal act, owing to his state of intoxication. It was interesting to note that remorse was certainly noted as a mitigating factor by a few of the aforementioned judges in some of the FASD cases; therefore, one emergent theme from the major identified theme among cases offender’s culpability, was ‘offender’s culpability a mitigating factor’ (see List 6: Themes in qualitative results section).

‘Judge Resource’ Variable as Presented in the ‘Judge_Mitigate’ Identified Cases

The variable ‘judge_resource’ was operationalized as, [does the judge mention resources in the province in connection to the final disposition]. This variable was assessed in the context of the eleven FASD ‘judge_mitigate’ cases in order to see what judges had to say about the availability of resources for FASD treatment, since the academic literature makes it clear that such resources are scarce and often judges feel they have no choice but to give a custodial disposition because of the absence of any viable alternative (Conry & Fast, 2010; Pemberton, 2010). Hence, it was important to see what judges had to say about FASD resource availability, if they even mentioned it.

The identified theme among cases was judge resource consideration for FASD. In seven of the eleven FASD cases, judges did not mention any type of programing issues or requests with respect to FASD. In the remaining four cases, judges did make some commentary with respect to resources (see List 7: Themes in qualitative results section). Hence, the emergent theme among cases from judge resource consideration for FASD was ‘some judge resource consideration
for FASD’. To summarize, judges stated the following about resources in the FASD-mitigating-factor-variable cases: in one case, the judge did not make any mention of whether there was an adequate program either in or outside of prison to address the offender’s FASD but rather indicated a confidence in the correctional institution for being able to create programs that the offender would understand; in another case, the judge did allude to resources by stating that FASD special programs and services that were essential to meeting such needs were woefully lacking. In the third case, the judge referred to a doctor’s observation regarding resources for FASD. The doctor advised that an attempt was being made to develop services for adults with FASD at the Regional Psychiatric Centre in Saskatoon. One specific correctional unit known as Bow Unit, an adult unit for offenders with significant neurological problems, recognized that many of its offenders had FASD, so correctional service staff were trying to develop some resources and programming for adults with FASD in the correctional system. Moreover, the doctor also stated in the sentencing judgment that Prince Albert Federal Correctional Facility was also attempting to develop programs for offenders with FASD but they were not yet well advanced. The judge did then directly link the offender’s FASD with resources by stating that in making plans for the offender, a consultation with persons who are knowledgeable about FASD was important and that one very good resource in Saskatchewan was the FASD Support Network of Saskatchewan Inc. Those were the only comments made about resources and FASD in the sentencing judgments. Even from the few comments that were made, it was evident that FASD programs are quite scarce and this point was emphasized by some of the judges. Other judges and/or mental health professionals highlighted the already developed or developing FASD programs, again signifying the lack of current programing in the correctional system, which has been stated as being a significant problem in the academic literature.

Judges ‘Explicitly’ Stating or ‘Alluding’ to ADHD as a Mitigating Factor
There were five cases in which the judge directly made a statement that reflected ADHD as being a mitigating factor in sentencing and two cases that reflected ADHD as being a possible consideration by the judge in sentencing but the disorder was not specifically stated as being a direct mitigating factor, although it appeared to have been. In terms of the identified theme—ethnicity, a theme that reflected Aboriginal descent as an emergent theme for the FASD
‘judge_mitigate’ variable cases, only in one out of the seven ADHD cases was the offender Aboriginal see (see List 8: Themes in qualitative results section). Hence, such an observation supports the finding in this study that there were more Aboriginal offenders with FASD being sentenced than there were for ADHD and consequently more Aboriginal offenders having their sentence mitigated as a result of FASD than those with ADHD.

In four of the seven ‘judge_mitigate’ variable cases, the offender was an adult and, in the remaining three, the offender was a youth. It was evident from all of these seven cases that the judges did consider how ADHD fit into the present sentencing process, just as they did for the eleven ‘judge_mitigate’ variable FASD cases; therefore, ADHD being a mitigating factor in sentencing was another major theme among cases (see detailed qualitative results section). The results component explains in great detail how each of the seven ADHD cases have the ‘judge_mitigate’ component but it is pertinent to highlight the main mitigating considerations in each specific case.

In the first adult case, even though a formal diagnosis of ADHD was not directly mentioned, the judge did state that the offender suffered from ADHD and that, in the past, the offender took Ritalin for his condition but since then he had turned to illicit drug use. In terms of how the offender’s ADHD factored into sentencing, the judge directly stated that ADHD was a mitigating factor. In the second adult case, the judge stressed how the Criminal Code stipulates in s. 718.2 that a court must take into consideration the principle that a sentence should be increased or reduced by any relevant aggravating or mitigating circumstances relating to the offence or the offender. Thus, one of the mitigating factors that the judge directly listed, in terms of having to take into account in determining an appropriate sentence, was the offender’s history of ADHD. In the third adult case, the judge was explicitly quoted (see detailed qualitative results section) as stating that, had it not been for the offender’s age (youth at the time of the offence but now an adult and tried as an adult) and ADHD, the offender would have received a more severe sentence, most likely a longer custodial one. In the fourth adult case, the judge cited a component of a doctor’s psychiatric assessment, which stated that the crime may have been largely committed under the influence of the drugs that the offender had taken as well as the ADHD from which he suffered from (see direct quote in the detailed qualitative results section). The amount of weight that the judge gave to the doctor’s statement was not directly stated in the judgment but the fact
that the judge described it in the court’s sentencing decision shows possible consideration of the disorder in sentencing. Moreover, in terms of the actual disposition in this case, probation, the judge acknowledged the offender’s ADHD and stated that, so long as he complied with taking his medication, probation would be granted. It appears as if the judge did consider ADHD in some respect, at least in terms of the treatment component of it, when granting the offender a probation order.

The fifth, sixth and seventh cases involved ADHD youth. In the fifth case, the mitigating consideration was the offender’s vulnerability to negative peer association and that vulnerability was stated as perhaps being connected to his learning disability and his conditions of ADD and ADHD. The judge also acknowledged in his sentencing judgment that the offender was formally diagnosed with ADHD and was on medication to assist him in coping with the behaviour that was typical of the condition. In the sixth case, the judge explicitly listed the offender’s significant intellectual limitations as being a mitigating factor. Since his learning disability and his ADHD-inattention problems were always being grouped together when being discussed, either by the mental health professional or the judge, it could, therefore, be strongly inferred that the judge was including ADHD as an intellectual limitation. In the seventh youth case, the part in the judge’s direct quote (see detailed qualitative results section) about the offender not being able to control her aggressive and impulsive tendencies, could be related to her ADHD diagnosis, considering the judge did mention the doctor’s statement about the offender’s ‘low frustration tolerance ADHD’.

‘Judge Culpability’ Variable as Presented in the ‘Judge_Mitigate’ Identified Cases

The variable ‘judge_culpability’ was operationalized as, [does the judge directly mention the offender’s culpability/responsibility/remorse or lack of it in the commission of the crime]. This variable was assessed in the context of the seven ADHD ‘judge_mitigate’ cases in order to see whether the judge was more inclined to mitigate the final sentence when the offender took responsibility for his/her actions. Hence, it was instructive to see what judges had to say about offender culpability. Interestingly, in all seven of the mitigating cases, the judges mentioned the offender’s culpability in terms of remorse, yet this was not seen for all of the eleven FASD-mitigating-factor cases.
In the first ADHD case, the judge stated that the offender realized the consequences of his actions and took responsibility; remorse was a consideration in sentencing. In the second case, the judge stated that he accepted the offender’s remorsefulness for the crime committed. In the third and fourth cases, the judge did refer to the offender’s remorse as being a mitigating factor. In the fifth case, despite remorse being a mitigating factor, the judge noted that it was difficult to determine the offender’s level of remorse, considering the offender had limited insight, blamed others and took no responsibility for her actions. Regardless, based on what the judge stated about remorse and mitigation in sentencing, had the offender been remorseful, it would have been factored into her sentencing disposition. In the sixth case, the judge was satisfied that the offender’s remorse was genuine, as he had expressed it directly to the victim’s family and, in the seventh case, the judge only stated that the offender could not be held responsible for her crime.

It is significant that remorse was definitely noted as a mitigating factor in several of the ADHD cases; therefore, one emergent sub-theme from the major identified theme among cases, offender’s culpability, was ‘offender’s culpability a mitigating factor’, as was exemplified in the FASD ‘judge-culpability’ variable section (see List 9: Themes in qualitative results section).

‘Judge Resource’ Variable as Presented in the ‘Judge_Mitigate’ Identified Cases

The variable ‘judge_resource’ was operationalized as, [does the judge mention resources in the province in connection to the final disposition]. This variable was assessed in the context of the seven ADHD ‘judge_mitigate’ cases in order to see what judges had to say about the availability of resources for ADHD treatment. Unlike the FASD cases in which several judges and/or mental health professionals/doctors did refer to FASD resources, in connection with the final disposition, there was not a single ADHD case in which resources were considered.

Therefore, from the identified major theme among cases, judge resource consideration for ADHD, the emergent theme was no judicial resource consideration for ADHD (see List 10: Themes in qualitative results section). It may be that judges assume medication is the most feasible way to treat ADHD and, in the court’s eyes, there appears to be less need for highly structured, specialized ADHD community and/or correctional programming.
Evaluator Direct Reference in Sentencing Judgment to Principal Disorder as Being Present and Whether the Judge Mitigates the Sentence Due to the Principal Disorder

Another variable of interest was whether one or more of the evaluators in each case was directly mentioned as having stated that the principal disorder was present or absent and, if it was present, in how many such cases did the judge mitigate the final sentence in light of the principal disorder. The results revealed that, in terms of the FASD cases, only in two of the 11 ‘judge_mitigate’ variable cases, where one or more evaluators was directly quoted as having stated, in the sentencing judgment, that the disorder was present/significant features of the disorder were present, the judge mitigated the sentence in light of the principal disorder. Such a finding shows that judges consider FASD to be a mitigating factor, even when there is no diagnostic confirmation of the disorder (rather an assumption) or there is diagnostic evidence of the disorder, that was undertaken by a mental health professional, but the judge does not include it in the sentencing judgment summary. Furthermore, the results showed that, in 13 of the 40 FASD cases, an evaluator or evaluators were directly quoted as stating the disorder was present/significant features of the disorder were present. Yet, only in two of those cases in which the judge mentioned the disorder diagnosis did the judge actually consider FASD as a mitigating factor in sentencing (see detailed qualitative results section). Such a finding shows that not all judges consider FASD to be a mitigating factor in sentencing, since there were many cases in which FASD was formally diagnosed and yet the judges did not appear to consider it in their final judgments. Finally, the results also demonstrated that, in the remaining 27 FASD cases, the judge never included any direct statement made by an evaluator or evaluators regarding the presence or features of the principal disorder. Nonetheless, in nine of those instances, the judge still considered FASD as a mitigating factor in sentencing, which shows that not all direct diagnostic statements made by an evaluator in some previous report are necessarily included in the final sentencing judgment.

FASD/ADHD Explicitly Stated by Judge as Contributing to the Lengthening of the Final Sentence or Being Dismissed of Importance

There were five cases out of the 83, excluding the appellate court judgments, which exemplified the diagnosis of FASD/ADHD as possibly contributing to the lengthening of the sentencing disposition, or not having any impact at all...
on the final outcome and this was stated directly by the judge. Five such cases appeared with respect to FASD and one of the five cases was also applicable to both FASD and ADHD. These cases were reviewed in detail in the results section. It is pertinent to summarize and discuss the ways in which judges considered FASD/ADHD to be an ‘aggravating’ factor in sentencing or simply have no impact on the final disposition.

In the first case, the judge based his sentencing disposition on the assumption that the offender may have been suffering from FASD and, consequently, gave the offender a two-year federal custodial sentence, where he would receive better treatment options. Thus, had the offender not had FASD, he would have most likely received a lighter, provincial custodial disposition. It is interesting that the judge felt compelled to give the offender a more stringent sentence, simply to receive better treatment because, as was discussed in the FASD literature review chapter, in some cases, judges do not like to give incarceration sentences when the offender has FASD. Specifically, Judge Trueman, in R. v. C.J.M. (2000), felt that, when it came to sentencing offenders with FASD, there are judges who are adamantly against incarcerating them if there are no proper programs available in prison for such offenders and rather decide to select community dispositions. Most likely, in the Pauls case being described, it was an issue of inadequate resources for FASD. There are very few adult FASD centers in Canada and in British Columbia specifically, there are only two programs that assist adults with FASD who are involved in the Criminal Justice System: yet, ironically, one of those programs, Genesis House, only reserves six of the 24 beds for clients suspected of—or diagnosed with—FASD (Fraser, 2009).

In the second case, R. v. Pickerill (2005), the judge seemed certain that Pickerill did have FASD and appeared to make use of the offender’s cognitive impairment, which is a result of the disorder, in justifying an incarceration sentence (see judge’s direct quote in the detailed results section). It would appear that this judge considered Pickerill to be a danger to the community owing to his disorder and, therefore, stipulated such a strict measure. In the third case, the judge in the Toplass case did accept the fact that Toplass suffered from ADHD and FASD (see judge’s direct quote in the detailed results section). Despite having those disorders, which, as the judge indicated, may have explained why she committed the crime by not thinking things through, in the end, the judge did not consider that the cognitive
limitations/challenges negated her responsibility for the crime. Such a judicial decision simply reinforces the fact that there is considerable disparity in the criminal justice system when it comes to handing down sentences for individuals with an FASD impairment.

In the fourth case, the judge stated that whether or not C.P.S. suffered from FASD made little difference in the treatment outcome and such a disregard for the diagnosis was probably a result of the experts’ opinion to the effect that treatment would not be affected by knowing what caused the actual ‘cognitive impairment’. In the end, the judge did not consider how to treat the offender’s suspected FASD-related cognitive impairment and went forward with the Crown’s recommendation for sentencing (see detailed qualitative results section). In the final case, the judge was extremely pessimistic about the offender’s ability to be treated; therefore, the sentence did not reflect any rehabilitative strategy (see detailed qualitative results section). It would appear as if her FASD made the judge even more inclined to believe that she could not be treated. In fact, the judge was extremely tough with this female offender. The judge said that she could not be rehabilitated in view of her ‘neediness’ and also referred to her cognitive impairment as being so extreme that her life situation would be measured by very small increments. Furthermore, the judge believed that she would recidivate in the future and, according to this judge, justice demanded that the sentence should reflect the denunciation of her behaviour and to appease the victim’s family. Evidently, the judge showed no consideration for her FASD-related cognitive impairment.

In summary, there were themes within cases that emerged as reasons why judges gave lengthy sentences or disregarded FASD in sentencing: (see List 11: Themes in qualitative results section).

**Variable of Interest: ‘Judge_Community’**

For the variable of interest, ‘judge_community’, which was operationalized as, [did the judge make a direct link between the principal disorder and the accused being a risk to the community], the results revealed that there was only one case in which the answer was yes and eight other cases in which it was inferred. In six of the nine cases, a judge did attribute some risk to the community as being connected to FASD which constituted the principal disorder and the remaining three cases involved a diagnosis of ADHD.
The six FASD cases in which a judge did make a direct link between the principal disorder and the accused being a risk to the community revealed several themes within/among the various cases. See List 12: Themes in qualitative results section.

For all of the cases, the overarching theme was *impairment is regarded as a risk*. In two of the cases, the themes were *risk to the community due to the disorder* and *impairment results in a need to be separated from the community* emerged. For example, in one case, because, according to the judge, the offender could not connect consequences to actions, nor could he adapt well or think before he acted owing to his FASD condition, the judge stated that, if criminal activity was the product of such an impairment, then the offender had to be separated from the community. The judge made a rather pessimistic, cynical statement about FASD (see entire direct quote in the detailed results section):

> There are many people with FAS who do not get into serious criminal difficulty. Sort of like the alcoholic who says, “Well, I never get into trouble when I’m sober, so you shouldn’t be mad at me when I harm others because I was just drunk and didn’t know what I was doing.” The fact of the matter is the rest of the world has a right to get on with their lives (R. v. Pickerill, 2005, paragraph, 8).

To compare an alcoholic to a person who has a permanent life debilitating impairment seems rather unwarranted because it is a completely unequal and unfair comparison. With treatment, an alcoholic can recover and be cognitively stable; whereas, a person with FASD cannot. An FASD individual needs a lifetime of structure and support. Similarly, in the second case, the judge did state that the offender was a threat to the public and the FASD-cognitive impairment was one of the myriad of problems listed as rendering the offender a risk to the community; consequently, the judge gave him an indeterminate sentence.

See List 13: Themes in qualitative results section to see the four identified themes for ‘FASD’ and ‘risk to the community’.

For example, in one case, the judge did infer that the offender’s fetal alcohol condition posed a risk to the community but the judge felt that such a risk could be eventually adequately managed under the long-term offender supervision order. In another case, the judge did consider the offender’s FASD as a factor which contributed to increasing the risk that the offender posed to the community by stating that, without community-based controls, his level of risk in the community would be higher. Moreover, in another case, it was
stated outright that since the offender was cognitively impaired, likely suffering from FASD, the offender would require external structure for his lifetime. The judge reiterated the point that the offender was not capable of managing his own behaviour owing to his cognitive status and personality functioning and that, without a sufficient environmental structure in which to function, he would likely re-offend. In the final case, where structure, management and community support were seen as being key concerns, the judge felt that, for the time being, the offender did require structure and support and made it clear that a supportive structure was critical to the offender’s success and stated this to be so in most FASD cases.

**ADHD**

The three ADHD cases in which a judge did make a direct link between the principal disorder and the perception that the accused posed a risk to the community revealed an overarching theme: (see List 14: Themes in qualitative results section).

In the first case, the judge did not directly state that the offender’s ADHD made him a risk to the public but, by stating that his inattention aggravated the features that have resulted in aggression, it could be inferred that the judge perceived his ADHD as being a risk to the community, insofar as his impulsivity was concerned. Furthermore, the judge stated that it went without saying that McBride was a high risk to re-offend in a violent manner (see detailed qualitative results section). In the second case, the judge did consider the offender’s ADHD as being a possible threat to the public, thus the judge was very clear to him about complying with the medication used to treat ADHD by stating that, if the offender is prescribed with medication, he must take it because that will help him and it will protect the public as well. In the third case, the judge held out little hope for success for this youth with the resources that were available in the community to treat his disorders, one of which was ADHD; therefore, the judge implemented a sentence in which the offender would be monitored under strict, secure supervision and curfew in the home.

Overall, the nine FASD/ADHD cases revealed that some judges definitely made a link between the principal disorder and the accused being a risk to the community. For FASD, there was considerably more discussion with respect to the importance of management, structure and support in the community to minimize risk of future crime. Whereas, for ADHD, there was
reference to the importance of adherence to medication in order to lower the risk to the community but little emphasis on structure and support, except for the one youth case, in which the judge was dissatisfied with the lack of resources available for the youth. It seems as if medication for ADHD, rather than programs combined with medication, is the only proposed solution that is utilized to deal with offenders who have this type of cognitive impairment.

**Formal Assessment and Diagnosis of FASD**

Considering the literature presented on FASD and the nature surrounding a diagnostic assessment, a formal assessment for FASD is very expensive and can only be conducted by highly specialized doctors. As Pemberton (2010) stated, rarely will such an expensive diagnosis be made in relation to an adult and, since the cost of the diagnosis is approximately $2,000, it comes as no surprise that so many individuals are left undiagnosed. Hence, in terms of the results, it is no wonder then that more formal diagnoses were made of ADHD (63.5%) when it was the principal disorder under investigation than was the case for FASD (32.3%) (see detailed qualitative results section).

It was stated in the results section that, since there is a considerable body of literature addressing the lack of a proper diagnosis for FASD, it was relevant to see the types of cases in which a formal diagnosis was indeed made. The findings showed that, out of the ten cases, four of them, in which a formal diagnosis had been made, were youth-court cases, and the remaining were adult cases, although—in one of the adult cases—the actual diagnosis of FASD was made when the individual was a youth (R. v. Ritchie, 2006). The results also demonstrated that, in eight out of the ten cases in which a formal FASD diagnosis was made, the defendant was Aboriginal. See List 15: Themes in qualitative results section.

One of the major themes that emerged from examining cases in which a diagnosis of FASD diagnosis was made was, *formal assessment occurred due to a specific advocate of FASD testing and diagnosis* (see detailed qualitative results section). For example, in a few of the ten FASD cases, such as R. v. P.J.M. (2008), and R. v. Dayfoot (2007), in which a formal diagnosis was made, it had been conducted on the request of the judge and, in the other cases, such as R. v. J.N.J. (2004), R. v. J.L.M. (2005) and R. v. J.W.K (2009), the assessments were undertaken at the request of counsel for the defendant. An emergent theme was, *only recognized experts in the field can properly assess FASD.* It was evident
from some of the cases that assessments were being conducted by neuropsychologists who were recognized experts in assessing persons suffering from FASD or sometimes offenders were sent to FASD centres where there were experienced doctors who had been trained to conduct such assessments.

Variable of Interest: ‘Clearly_State’ and ‘Judge_Mitigate’

The variable ‘clearly_state’ was operationalized as, [was it clearly stated that a formal diagnosis of the principal disorder was made]. The results revealed in how many of the cases, in which a formal diagnosis of the disorder (FASD or ADHD) was made, that the judge considered the disorder as a mitigating factor in sentencing (see detailed qualitative results section). In summary, there were five out of 11 cases in which a direct diagnosis was made and the judge considered the fetal alcohol condition as a mitigating factor. As was stated in the results section, such a finding demonstrates that judges still consider FASD to be a mitigating factor in 55.0% of the cases in which a formal diagnosis has ‘not’ been made. This shows that judges rely on assumptions made by mental-health professionals regarding alcohol-related diagnoses, probably because formal FASD testing is still undertaken very rarely. On the other hand, for ADHD, there were five out of seven cases (approximately 71.0%) in which a direct diagnosis was made and the judge considered ADHD as a mitigating factor. Such a finding further solidifies the observation that judges do not rely on conclusive evidence pertaining to diagnoses, but often simply depend on informal statements made about disorders by mental-health professionals; therefore, there was a major theme among such cases for both FASD and ADHD, which was judges often rely on informal claims made about disorders by mental health professionals in their final sentencing judgments. See List 16: Themes in qualitative results section.

Section 718 of the Criminal Code and Judicial Application of the Provision In Sentencing

The results chapter reflects in detail how section 718 of the Criminal Code, was mentioned by judges in the FASD and ADHD cases. In summary, some interesting observations were made. For example, in 36/57 cases (63.2%), section 718 was mentioned as being a consideration in the final disposition. Therefore, approximately 37.0% of the sentencing judgments did not allude to section 718 of the Criminal Code at all and this was the most apparent for the
cases in which ADHD was the principal disorder under consideration. As the results reflect, for ADHD, in 20 of the 34 adult cases, section 718 was pointed out in the sentencing judgment (58.8%), whereas with respect to FASD, 16 of the 23 FASD-adult cases mentioned this Criminal Code provision (70%). Such a finding is most likely connected to the fact that there were more Aboriginal adult offenders in the 31 cases where FASD was a principal disorder (16 cases—51.6%) than in the 52 cases in which ADHD was a principal disorder (16 cases—30.8%). As the results revealed, since there were more Aboriginal offenders in the FASD cases, when the application of section 718 was analyzed, judges seemed to frequently mention section 718.2(e)[all available sanctions other than imprisonment that are reasonable in the circumstances should be considered for all offenders, with particular attention to the circumstances of Aboriginal offenders]. Section 718.2(e) was mentioned in 62.5% of the Aboriginal-FASD cases as opposed to 31.3% of the Aboriginal-ADHD cases.

The results also revealed that of the 36 FASD and ADHD cases which mentioned section 718 directly, other than section 718.2(e), which was discussed separately as a sentencing provision consideration in many cases, there were 13 cases in total, in which the judge simply listed entire components of 718 verbatim without making any particular section of the provision worthy of unique attention or discussion (see detailed qualitative results section). There were also five cases in which a judge simply made a ‘blanket statement’ about section 718 being considered in sentencing but did not provide any further remark(s) of elaboration. Furthermore, section 718(a) to denounce unlawful conduct, and 718(b) to deter the offender and other persons from committing offences were specific components of section 718 that were singled out by judges in several cases. It appeared as if many judges liked to focus on the deterrence and denunciation component before listing other sentencing principles. Finally, with respect to section 718.2(a) [a sentence should be increased or reduced to account for any relevant aggravating or mitigating circumstances relating to the offence or the offender, and, without limiting the generality of the foregoing], there were only three cases in which section 718.2(a) was directly alluded to and only seven cases involving ADHD in which section 718.2(a) was either listed or discussed by a judge (see detailed qualitative results section). Overall, it is evident that some judges, more than others, are explicit about discussing the sentencing objectives directly in their judgment while others most likely consider the sentencing principles without stating them verbatim or focusing on
specific sections. As was stated in the detailed qualitative results section, clearly judges grapple with the various sentencing objectives and making sure that their final judgment coincides with at least one of those objectives.

**APPELLATE COURT DECISIONS**

There were nine appellate cases in which the issue of the appeal concerned the principal disorders under investigation – FASD (five cases) and ADHD (four cases) (see detailed qualitative results section). The results revealed that, generally, each point of appeal was unique, but there were a few themes among cases.

**FASD**

An examination of two of the five FASD cases in which the point of the appeal had to do with this particular principal disorder, revealed the following theme:

In the first case, the appeal was launched by the Crown because it believed that the sentence Andrew received was too lenient in light of the mitigating factors that the original trial judge considered, including Andrew’s FASD. In conclusion, the appellate court allowed the appeal and varied the conditional sentence of two-years-less-a day to a prison sentence of two years and five months. Hence, the appellate court disregarded FASD as being a reason for imposing a less stringent sentence and instead substituted a custodial disposition. See *List 17: Themes* in qualitative results section.

Similarly, in the other case, the original trial judge saw FASD as a mitigating factor but the appellate court regarded the original trial judge’s sentence as being too lenient. In conclusion, the appeal court stated that no fetal alcohol syndrome assessment had been undertaken on the basis that no proper diagnostic tool was available, which made the diagnosis questionable and, furthermore, the appellate court felt that, in any event, nothing suggested that the offender was unable to appreciate the gravity of his own actions. More importantly, the appeal court concluded that intellectual impairment did not always equate to diminished responsibility; hence, the appeal was allowed. See *List 17: Themes* in qualitative results section.

The other three cases in which FASD was an issue in the appeal revealed unique themes within cases. In the first case, the original trial judge had given
a custodial disposition to the offender, since there was no proper treatment available for her FASD. The appellate court considered the offender’s FASD condition and decided that, in the particular circumstances of the case, the rejection of a conditional sentence by the trial judge had resulted in an unfit sentence; therefore, the appeal was allowed to the extent of setting aside the sentence of incarceration and substituting a conditional sentence on restrictive conditions. See List 18: Themes in qualitative results section.

In the second case, the issue of the appeal concerned the necessity of obtaining a diagnosis of FASD for the offender. It was thought that perhaps the original trial judge had erred in not having considered the offender’s FASD in sentencing. In conclusion, the judgment of the court was that there was no clear evidence for the offender’s supposed FASD, thus the original trial judge had not erred and the appeal was denied. See List 19: Themes in qualitative results section.

What was very perplexing in this case was that the appellate court did not order an FASD test that should have been administered by a medical doctor who specializes in such a diagnosis. The possibility that the offender suffered from FASD was a reality, but owing to the lack of evidence, the offender was treated as if he did not have the disorder.

In the final case, the point of the appeal concerned the possibility of unjust sentencing with respect to an offender with FASD. The appellate court did not feel that the trial judge had erred in the administration of the final sentencing disposition. The appellate court believed that there was a well-grounded fear that the defendant had an interest in committing violent and/or sexual criminal acts; therefore, he was dangerous to the community. Consequently, the appellate court judge did not address defence counsel’s point regarding the offender’s potential FASD and the appeal was dismissed. See List 20: Themes in qualitative results section. Evidently, in this case, the fear that the offender would once again commit violent crimes superseded any sentencing consideration that took into account the offender’s FASD, and the protection of the public was the main priority.

**ADHD**

An examination of the four ADHD cases in which the point of the appeal concerned this particular principal disorder, revealed the following theme among two of the cases: *request for rehabilitative/community setting due to ADHD*
rejected by appellate court. See List 21: Themes in qualitative results section. In the first case, the point of the appeal concerned whether the offender should be placed in more of a rehabilitative setting in light of her various mental disorders, including ADHD. The appellate court did not feel that the original trial judge had erred; therefore, the Court did not allow the appeal. In the second case, the point of the appeal concerned the fact that the offender was responding well to medication for ADHD, so a request was being made for a community supervision order rather than the original disposition. As in the first case, the appeal court judge did not feel it was appropriate to reduce her sentence. The judgment of the court decision held that the materials she filed in support of her appeal would be better tested by a parole board.

The remaining two appeal court cases in which ADHD was part of the reason for the appeal, presented the following theme: original trial sentence unjust due to a lack of consideration of ADHD. See List 22: Themes in qualitative results section. In the first case, the argument made in the appeal was that the trial sentence was unfair, since it did not consider the presence of the ADHD as well as other disorders. The appeal was allowed and the sentence was reduced to time served. Nonetheless, it did not appear as if the appellate court reduced the original trial judge sentence because the court wanted to consider ADHD or other disorders; rather, the appeal court felt compelled to reduce the sentence because the seriousness of the offence did not warrant a sentence of the magnitude imposed—irrespective of the appellant’s background, including his disorder history. A similar issue was observed in the second appellate case, in which the appeal involved the assertion that ADHD had not been considered in the final sentence. The appeal court felt that there was no evidence of recognizable probative value to indicate that the offender’s early childhood diagnosis of ADHD was linked to his present deviant sexual behaviour. Also, the appellate court found that there was no evidence to suggest that whatever possible treatment may later become available to curb the offender’s sexual impulses would be able to be administered to him with reasonable success while in the community. Thus, the appellate court rejected the appeal. Evidently, a lack of probing into the offender’s present-day ADHD condition as well as a lack of confidence in dealing with the offender in the community, irrespective of his potential ADHD, made the Court dismiss the appeal.
Chapter 8:
CONCLUSION

LIMITATIONS OF THE STUDY
It is important to view the present research study in light of its limitations. British Columbia, Saskatchewan and Ontario were the only provinces selected to examine sentencing decisions in cases where a link was made to an offender who was either suffering from FASD or ADHD. The provinces were chosen because they reflected a very large portion of FASD and ADHD cases in all of Canada. Nonetheless, the fact that not all Canadian provinces were included in the five-year study period means that there were many other judgments pertaining to the principal disorders of FASD and ADHD, for which important sentencing judgment information was not gathered. Furthermore, since it was a five-year study (March 17, 2004 through March 17, 2009), had it been extended further (10 years or 15 years), many more insightful judicial sentencing decision cases would have been captured and expanded upon. Of course such a strategy was not feasible, considering this particular Canadian judicial sentencing decision study involved a very detailed variable search, coding and analysis, all completed by one person, the researcher.

After a considerable amount of information gathering with respect to search terms, the database that displayed the largest selection of Canadian cases for the search criteria under study was the Quicklaw Canadian resource database, in comparison to, CanLII, Criminal Source and Criminal Spectrum. Thus, in order to conduct an exploratory analysis on judicial sentencing considerations for the neuro-cognitive impairments of FASD and ADHD, Quicklaw was chosen. However, a limitation of this search approach is that database search engines do not contain every judgment made in every Canadian criminal case; instead, such search engines represent a selection of cases, making it plausible that some FASD/ADHD cases were missed. Also,
the research only focuses on what occurred to offenders with FASD/ADHD within the formal YCJA/criminal justice system, and does not take into account diversionary mechanisms (offenders with these disorders may have been dealt with outside of the courts). Such a diversionary method was more likely practiced with respect to youth cases, considering restorative justice measures are a more common occurrence in relation to young offenders. Hence, the more serious crimes that were committed by young offenders were likely captured and the less serious crimes may have been diverted out of the formal YCJA. Unfortunately, the other limitation with respect to the number of cases obtained was the paucity of youth FASD/ADHD cases that occurred within the five-year period. Only 28.0% of all cases were youth cases; therefore, it was not feasible to glean many examples of how judges dealt with neurocognitive impairments. Furthermore, gender was not a variable that could be examined thoroughly because only 12.2% of the entire case study was comprised of women. The search strategy (key search term selection for cases—‘fetal alcohol’ and ‘attention deficit’) was nevertheless comprehensive and elicited 286 criminal law cases and, from that point, it was determined which cases would be included and which would be eliminated. Thus, the author is quite confident that the search terms were efficient in capturing the cases in which FASD/ADHD were connected to the offender in the study’s five-year span.

Finally, a limitation that may receive the most attention and skepticism concerns the fact that the research is based on judges’ accounts of facts/evidence pertaining to FASD/ADHD. Some may view judges’ selection of unique aspects of cases to emphasize in their reasoning as a major limitation, since it may be difficult to obtain an account of what was fully said, argued and presented during a trial/sentencing hearing, as opposed to what was interpreted, understood or focused on by the judge. However, the research findings were derived exactly from what the judge seized on as being important to mention in the sentencing judgment. The research was not meant to capture every nuance of what was stated during a court proceeding but rather to discuss what judges did select as being relevant to mention in their final sentencing judgment. Such selection helped in the identification of various themes, with respect to how FASD/ADHD were regarded by the courts, within the limits of what judges said about such disorders and which mental-health-expert summaries/quotes they decided to emphasize. Naturally, because the identified major themes and emergent themes are
qualitative in nature, according to Silverman (2005), the problem of anecdotalism (whether findings are genuinely based on critical investigation of all data and not just on a few well-chosen examples) is an issue that must be addressed in research. This study did combat the issue of anecdotalism by reviewing every single identified case and then discussed, summarized, analyzed and created themes both within and among cases.

RECOMMENDATIONS

Whether individuals living with FASD/ADHD remain entangled within the criminal justice system, in terms of future recidivism, depends largely on how the system responds to them initially; meaning, there must be some recognition of the organic brain impairment, followed by specific accommodations to meet their special needs. Judges in criminal proceedings need legislative and appellate sanction to enforce FASD/ADHD-sensitive dispositions. It has been established in literature, as well as the present case study, that many offenders go undiagnosed with FASD/ADHD, especially with a fetal–alcohol condition. In any case of suspected FASD, an immediate referral should be made to the appropriate medical team for diagnosis. Only experienced professionals in the medical, psychiatric, psychological fields who are trained to assess those with FASD should testify before the courts.

Without proper diagnosis, people will not be able to obtain the services that they need to improve their standard of living and to help them stay out of the criminal justice system. It is imperative that a comprehensive medical and legal report is provided, in order to inform the trial judge properly and to ensure that no undiagnosed individual manages to slip through the cracks because their disorder(s) goes unnoticed. In terms of who makes the diagnosis of FASD for the courts, only a professional who specializes in assessing individuals suspected of FASD should provide the report to the judge (medical-legal reports, psychological assessments and social histories).

With respect to FASD, the paucity of diagnostic clinics that serve children and adults (even less clinics for adults) and the total absence of FASD diagnostic centres in remote areas (Chudley, Conry, Cook, Loock, Rosales & LeBlanc, 2005) are critical, urgent issues. One option to better circumvent this problem may be to support the creation of community-based diagnostic facilities in rural places, such as the one that is operating in Cold Lake, Alberta.
The Lakeland Centre for Fetal Alcohol Spectrum Disorder (LCFASD) has been operating since 2001, and it was created by a group of dedicated, hard-working professionals, who were eager for a community-based diagnostic team to be developed, in order to meet a rural need (McFarlane, 2011). The clinic has six phases of diagnosis for children as well as adults (first diagnostic service for adults with FASD in Canada): pre-clinic (referrals for suspected FASD recipients), clinic days (battery of tests completed in one day), diagnosis and recommendations (team meets to review all of the gathered information and to make a determination of diagnosis), case conference (patient and member of support team provides diagnostic information and recommendations), emotional support (mental-health therapist meets with the patient privately to review diagnostic results and provide emotional debriefing), team debriefing (team members debrief about patient diagnoses) and outreach support (family receives outreach support following diagnosis). Considering research demonstrates how imperative it is to diagnose children with FASD early having regionally-based diagnostic teams established all over the country is critical so that these children can avoid the possible secondary disabilities and overall adverse life outcomes (Chudley, Conry, Cook, Loock, Rosales & LeBlanc, 2005), such as school and unemployment failure and trouble with the law. If the first time an individual is ever assessed for FASD is as a consequence of a court-ordered mental-health assessment, it is already quite late in the game considering the individual has already been accused of a crime and/or convicted of one.

Punishment is not an effective deterrent to those who struggle from a serious cognitive impairment because many are unable to understand the consequences of their actions. This is why so many criminals who have FASD or ADHD are repeat offenders. Even though cognitive impairments, such as FASD and ADHD, have been considered to be a mitigating factor in sentencing in some criminal cases, there are still many cases in which judges follow traditional jail-sentence dispositions, which for these types of offenders is often quite counter-productive as a means of rehabilitation and reduction in the rate of recidivism. Many FASD/ADHD offenders will not require incarceration from a rehabilitation standpoint, and, for those who do need a custodial disposition, owing to the nature and gravity of the crime, many will receive short sentences. Short sentences of incarceration are of no significance to cognitively-impaired persons who are not able to connect the criminal act with
the consequences. It may be that certain individuals commit such serious crimes and continue to pose a danger to society; therefore, they should receive a long-term offender designation (a required time of custody, followed by a community disposition). On the other hand, implementing the harshest sentence possible, designating a person with FASD a dangerous offender, seems like an extreme step and a sign that both society and the legal system have utterly failed a person with a permanent mental disability. Whether a person has FASD or ADHD, sending them into custody to ‘teach them a lesson’ is completely ineffective since their organic brain impairment negates their understanding or appreciation of cause and effect. Thus, sentencing a neuro-cognitively impaired sufferer on the principle of specific deterrence is meaningless and will most likely result in the individual recidivating in the future. For example, one individual, Lyle Tenale, a 47-year-old Aboriginal male who was born with FASD, stated that over the years he went to so many court hearings for various crimes and that his fetal-alcohol condition was never raised and had not been considered during sentencing (Pemberton, 2010). Tenale had only learned of his FASD in jail when a visiting native outreach worker told him his facial features resembled that of someone who had the syndrome (Pemberton, 2010). Rather than being incarcerated, being part of a special support group for those suffering from brain damage in the community and seeing an occupational therapist in order to learn how to manage anger seems more of an appropriate plan for those who commit crimes who are diagnosed with neurocognitive impairments. Moreover, in order to ensure that FASD/ADHD offenders do not recidivate, questions such as, where will the person reside, with whom, will the person go to school and for what purpose, need to be asked. Furthermore, employment considerations, curfews or other restrictions—essentially a rigid 24-hours a day, seven days a week structure of support for the offender must be planned; a delivery of very specific services and programs: of course, such a management plan is time-consuming and expensive but it certainly addresses the needs of meeting the goals of public safety and protection as well as the needs of the offender. This type of structured program is essentially what prison provides and perhaps that is why judges justify custodial sentences for such offenders but, if this can take place in the community, it may be a lot more meaningful and helpful to these offenders and pose less risk to their personal safety from other inmates.
The disabilities of people with FASD in the legal system need to be accommodated and judges should pay particular attention to the placement of these individuals. Rather than allowing FASD offenders to be victimized, misunderstood and mismanaged in a custodial setting, community living through intense supervision and support is perhaps a better option. It could be argued that these offenders could just as likely be misunderstood and mismanaged in the community but that is why the program would have to be carefully crafted to meet the needs of each individual offender. Their mental disorders and substance-abuse disorders need to be treated, but this can be done outside of a prison setting. If the courts could hand out more conditional sentence dispositions, even 24 hours of intense supervision if necessary, the negative outcomes of incarceration may be prevented and the establishment of a structured, productive lifestyle (education, work) can be the end result for people with FASD. Furthermore, the use of diversion processes such as sentencing circles could also be introduced. Circles have traditionally been used in First Nations communities and this process allows wider community involvement and more responsibility is assumed by the membership for its members. Diversion allows for decisions and programs to be made at various points in the system, including at sentencing, so the FASD individual can immediately connect more easily with the consequence of the act. When a judge hands down a disposition to a person with FASD/ADHD, studies need to be conducted to see whether it would be more worthwhile for the focus to be on changing their living situation or social situation and enforcing management, structure and support, rather than fixating on their behaviour.

When an organic brain injury is suspected and perhaps not formally identified, it is important for offenders who are sent to prison to have functional life-skills training. For example, the rehabilitation unit in the maximum security Regional Treatment Centre in Abbotsford, B.C., has a 96-bed unit that has been open for six years and is the only facility that offers specific programs to inmates who have been identified as having a brain injury or cognitive impairment. The typical stay at this facility to learn life skills is nine months to one year before the offenders are released or placed in another correctional facility (Pemberton, 2010). Clearly there need to be more units of this type which will help inmates who have FASD or ADHD overcome challenges such as impulsivity and learning disabilities and give them more insight into their disabilities and build on their strengths.
Education
With respect to FASD specifically, there is an ongoing need for education in the field of FASD so that professionals can make referrals more easily as well as become more skilled in the actual diagnosis of this disorder. Early detection of FASD may make all the difference in the life of the person afflicted with this disability and with the end goal being to ultimately reduce over-representation of this group in the Canadian criminal justice system. The federal justice minister’s office representing Rob Nicholson, made a statement to the Vancouver Sun stating, “the federal government continues to work with provincial and territorial governments in raising awareness and ultimately putting forward improved responses for individuals with FASD who are involved in the criminal justice system”. When FASD offenders go through the court process, much research has also questioned whether such persons are capable of giving truthful statements, since many have been known to give false confessions. The federal government agrees that FASD education is very critical and that it engages many levels of government; therefore, it is important that the federal, provincial and territorial ministers responsible for justice address this issue and continue to work together (Pemberton, 2010: A13).

Prevention
Much can be done in terms of prevention—early intervention through diagnosis, and specially-tailored school programs, socializing and living arrangements; such interventions would minimize secondary disabilities that accompany FASD and certainly control and treat the various disorders that accompany ADHD, such as conduct disorder, oppositional defiant disorder and substance abuse disorder. There should most definitely be continuing education about FASD/ADHD and the impact of cognitive impairments on individuals within the criminal justice system (diagnosis, intervention, treatment, diversion and sentencing); ongoing training about FASD/ADHD should be implemented for probation officers and custodial personnel, such as correctional officers, lawyers, Crown counsel and judges. A lengthy probation order or more conditional or alternative sentences under section 742.1 of the Criminal Code should be imposed rather than a custodial disposition. There should be an establishment of community-interest groups, so that they can create non-custodial sentencing initiatives for FASD individuals who are accused or convicted of a crime. Furthermore, as previously discussed, alternatives to
traditional sentencing should be considered, such as diversion and sentencing circles, in appropriate circumstances and with effective safeguards.

Moreover, information about public and private resources for people with FASD/ADHD should be easily accessible to all criminal-justice agents. The creation of more resources for the supervision, education, vocational training and treatment of offenders with FASD/ADHD should be developed in every community across Canada. For example, there is a protocol known as the ‘Nova Scotia Protocol’ for FASD. This protocol postulates the principles of accommodating the special communication needs of people with disabilities, in order to provide assistance to people with FASD when they must pass through the legal system.

Until recently, most risk assessment instruments for adults such as the PCL-R or the HCR-20 stress risk factors and disregard protective factors. Even though the identification of protective factors for violent behavior is seen as the major challenge for the near future (Farrington, 2003), it may be the way to go. In fact, there is a relatively new risk management tool called SAPROF (Structured Assessment of Protective Factors), which has been developed for violence risk by assessing protective factors (de Vogul, de Ruiter, Bouman & de Vries Robbe, 2007). SAPROF looks at the protective factors in the community for previously violent individuals (de Vogul, de Vries Robbe, de Ruiter & Bouman, 2011). This type of tool could be utilized for the FASD/ADHD offenders who are released into the community and require supervision.

Of course, if incarceration is inevitable for those with FASD or ADHD, the correctional system needs to ensure the safety and protection of these vulnerable offenders and to provide highly-specialized rehabilitative programs for them. Hence, education and training are pivotal for incarcerated offenders as well as correctional service staff. Without special programming and support for FASD sufferers in prison, such convicted offenders will face a reduced likelihood of parole simply because they will not demonstrate appropriate progress in their rehabilitation venture. On the other hand, if a probation order is warranted, such orders should be very clearly laid-out so that the person with FASD or ADHD is not confused or overwhelmed by the stipulation orders that are set out in the document. While the individual is on probation, very close monitoring/supervision is ideal if a relapse into crime or a violation of the probation order is to be prevented.
Focusing more specifically on FASD, one way to ensure that offenders with FASD are not overlooked in custody would be to screen all of them fully upon arrival (some offenders’ FASD may not be recognized during the court process) but, of course, such a diagnostic assessment would be extremely expensive, not to mention the required numbers of expert personnel may not be available for such a significant undertaking; therefore, the alternative would be to create a reliable and valid screening tool that would identify a much smaller subgroup of inmates at high risk for FASD.

For example, Streissguth, Bookstein, Barr, Press and Sampson (1998), conducted a study to see whether their fetal alcohol behaviour scale FABS could be used to detect people with FASD from among a deviant subgroup population—prison. The FABS was a 36-item scale in a yes/no format and the scores did appear to be correlated with maternal-alcohol problems: this finding also indicates that the scale appeared to reflect the behavioural phenotype of fetal alcohol rather specifically. Therefore, creating a checklist to potentially screen offenders who could then receive a proper, full diagnostic assessment seems feasible. If the criminal justice system does initiate its own pre-sentence investigative screening to determine if the person in question has FASD, apparently the intake form developed by the Asante Centre could be used as a prototype for this screening device (Chartrand & Forbes-Chilibeck, 2003).

Evidence certainly exists to support the use of a FASD diagnostic checklist, so long as it is conducted by experts in the field. For example, a study which examined the performance characteristics of a Fetal Alcohol Syndrome Diagnostic Checklist (FASDC) on a sample of 658 subjects from North Dakota, determined that the FASDC scores did produce diagnostic groupings that approximated expert clinical judgments (Burd, Klug, Li, Kerbeshian & Martsolf, 2010); this means that, when the FASDC was compared against clinical expert diagnosis, the validity of the instrument was very high because it had excellent performance in distinguishing between FAS and the non-FASD group with accuracy, sensitivity and a specificity rating of 99% (Burd, Klug, Li, Kerbeshian & Martsolf, 2010).

Another preventive possibility for FASD/ADHD offenders would be to create a Mental Health Court in every province, such as the mental-health courts that exist in Toronto and New Brunswick (Richardson, 2011). Such a specialized court system could address the legal matters of the mentally ill, such as those suffering from FASD or ADHD. The alternative to creating
Mental Health Courts all over the country, considering Canadians may not have the population density in most parts of the country to support such a specialized service, would be to create within the existing courts in Canada an office of Court Commissioner for the Mentally Ill, such as the one in Los Angeles (Chartrand & Forbes-Chilibeck, 2003). Furthermore, in the mental health courts in Seattle, monitors are clinicians who provide front-line screening and assessment services and make client-specific referrals for mental health services. Such court monitors, clinicians, essentially function as treatment brokers, in that Seattle mental health court clients are officially given priority access to services that they require (Trupin & Richards, 2003). A commissioner or court monitor could help provincial and Supreme Court judges in every province screen accused persons that may have a mental illness such as FASD or ADHD and work together and coordinate services and create appropriate therapeutic programs to meet their distinct needs.

**Future Research Directions**

Of course, for future research endeavours, it would be beneficial to obtain trial transcripts in conjunction with judgments for offenders with FASD/ADHD, so that differences could be discerned between the exact information given during the trial, versus the information that was emphasized and understood by judges. Moreover, it would be interesting to compare the outcomes for offenders with FASD/ADHD who were diverted from the criminal justice system or who received a conditional discharge/community disposition with the outcomes for those who received some type of a custody disposition. A more recent (past two-years) larger-sample study that would focus on all of the provincial sentencing judgments for offenders suspected or diagnosed of having FASD/ADHD across Canada, youth as well as adults, would be beneficial, in order to include a detailed, comprehensive, provincial comparative analysis of judicial consideration of these cognitive disorders. Since, in recent years, more attention is being paid to these disorders by the courts, especially FASD, perhaps the more recent judgments (2010, 2011), show an even larger trend towards treating such disorders as mitigating factors or as being worthy of ample discussion in sentencing, either by mental health experts, judges or both.
In the Canadian legal system, the disabilities of people with FASD/ADHD need to be accommodated by the courts. Neither FASD nor ADHD are new fads but rather very real and serious cognitive impairments and it has been established in the literature that such impairments continue to be under-recognized by the courts or—much worse—sometimes individuals suffering with this impairment are misdiagnosed, which then leads to failing treatment protocols. Therefore the best way to make sure that nobody slips through the cracks in the criminal justice system is for judges to ask other criminal justice agents, “did you consider FASD or ADHD?”, when some evidence points in the direction of a possible diagnosis. Thus, FASD/ADHD defendants in criminal-court proceedings require serious consideration by the judge for their disabilities in order for appropriate support to be given to them. When FASD/ADHD individuals participate in the criminal justice system as defendants, a wide array of concerns still have not been addressed regarding their fitness to stand trial, their diminished responsibility in the crime owing to their cognitive impairment as well as how to deal with their persistent recidivism.

CONCLUDING REMARKS

Only a few studies exist to date that examine how persons with the cognitive impairments of FASD or ADHD are dealt with in the criminal justice system, from their treatment in the courts to the resource offerings for their respective disorders within and outside of prison. Those offenders who are afflicted with FASD or ADHD pose a challenge for criminal justice agents, especially the courts when it comes to handing down sentencing dispositions. The objective of the present study was to expand on the literature in the area of cognitive impairments and the criminal justice system by conducting a unique study on FASD and ADHD in the select provinces of British Columbia, Saskatchewan and Ontario, over a five-year span (March 17, 1999 through March 17, 2009).

The initial literature review chapters on FASD, ADHD and sentencing, revealed that both FASD and ADHD are heavily linked to trouble with the law, since a clear overrepresentation of FASD and ADHD offenders in the criminal justice system was observed. Both disorders are serious cognitive impairments that facilitate the onset of secondary disabilities and a comorbidity of other disorders. For example, persons with FASD often develop secondary...
disabilities such as school and employment failure, substance abuse and participation in criminal activity. Moreover, individuals with ADHD are frequently living with other disorders, such as conduct disorder, oppositional defiant disorder and substance use disorder.

Convicted FASD individuals are, by definition, special needs defendants (Moore & Green, 2004). Similarly, persons with ADHD have an organic brain impairment; therefore, they should be regarded as ‘special-need’ offenders like their FASD counterparts. These types of cognitively impaired defendants are in serious need of specialized programs and services that can address their unique needs; however, such systems of support are woefully lacking. Despite the absence of appropriate rehabilitative resources for FASD and ADHD persons, the criminal justice system still moves forward with the sentencing of such individuals since they were found guilty of committing a crime. Consequently, the determination of an appropriate sentencing disposition for an FASD or ADHD offender poses a challenge for the courts. Some courts are more mindful than others about the problem of exercising proper dispositions for offenders with cognitive impairments and are frustrated at the lack of options that they have for such persons. Unfortunately, many criminal justice agents, such as the Crown, defence counsel and judges remain quite uninformed about the ramifications of such disorders and this lack of awareness has significant, negative outcomes for FASD and ADHD offenders. For example, when special programs/services are not available to help offenders to manage their disorders in or outside of prison, many offenders will be denied parole because they will not be showing any progress in regular rehabilitative programs that are offered to everyone, since their special needs are not being met.

The present case-analysis study examined whether the mental states of FASD and ADHD are being considered by judges and mental health experts and, if so, in what circumstances, and what exactly is being said about them and whether such disorders have an impact on the final sentencing process. Thus, the relationship between impaired mental functioning and sentencing was analyzed in depth in order to see how the courts deal with FASD and ADHD for youth and adult offenders in Canadian sentencing decisions. The results of the study were gathered from the final case-coding sample of 107, which encompassed British Columbia, Saskatchewan and Ontario cases, over a five-year span and each case was coded on 100-150 individual variables.
The major quantitative findings revealed that there exists an overrepresentation of FASD cases in the Western provinces of British Columbia and Saskatchewan when compared with the Eastern province of Ontario. Also, Aboriginal people are over-represented for FASD, unlike for ADHD. Furthermore, a substance-related diagnosis was the most prevalent disorder identified for both FASD and ADHD offenders. For FASD, the most prevalent disorder was substance related diagnosis, followed by attention deficit hyperactivity disorder, conduct disorder, antisocial personality disorder and oppositional defiant disorder. For ADHD, the most prevalent disorder was also substance-related diagnosis, followed by conduct disorder, antisocial personality disorder, oppositional defiant disorder and FASD. Imprisonment was the most common sentencing disposition handed down for both principal disorders and there was a higher custodial disposition for adults overall than for youth. Almost all of the FASD youth and adults in the case study committed a violent crime. Only in a small percentage of FASD cases was a ‘formal’ diagnosis referred to in the sentencing judgment and yet for ADHD, there were considerably more cases in which a formal diagnosis of the disorder was noted.

When a qualitative analysis was incorporated to identify possible themes in—and among cases—for select variables many interesting findings and patterns emerged. Such major themes and emergent sub-themes were thoroughly examined in the results and summary and discussion chapters. Tables and lists of themes outlined the patterns and thematic representations.

For FASD, for both youth and adult cases, judges seemed particularly interested in evidence supporting the diagnosis of FASD and directly referred to mental health experts/doctors who specialized in assessing this particular disorder. In many instances, judges directly stated that FASD was not formally diagnosed and yet they proceeded with sentencing the offender under the assumption that the accused did indeed have the disorder. Moreover, in a few of the FASD youth cases, judges drew information about FASD from the academic literature. In terms of treatment for FASD, many cases demonstrated that no matter where the offender was ultimately placed, the judge made sure that treatment was geared toward addressing the FASD diagnosis. Also, for FASD youth and adult cases, managing FASD in a controlled, supported and structured setting seemed to be a commonly shared theme. Specifically, some judges made it clear that ‘controlling’ the disorder by achieving some measure of stability in the community was the key consideration. Finally, some judges
considered FASD a mitigating factor, even when there was no diagnostic confirmation of the disorder (rather an assumption).

For ADHD, unlike the situation with respect to FASD cases in which the majority of the judges did adhere to mental-health experts’ opinion about the principal disorder, the opposite was found for ADHD as a principal disorder. There was only one ADHD case in which the judge seemed to consider the mental-health expert’s opinion regarding ADHD. Unlike what was found in the FASD cases, in which many judges did tie the treatment component of the final disposition specifically to their suspected or confirmed FASD diagnosis, the opposite was observed for the ADHD cases; there was certainly no emphasis made by judges with respect to treatment & ADHD. There were more formal diagnoses of ADHD than there were for FASD. The overall finding for British Columbia, Saskatchewan and Ontario show a lack of uniformity in the three provinces in terms of sentencing offenders with FASD/ADHD.

The recommendations section in this chapter analyzed in-depth the type of measures criminal justice agents could take with individuals who are inflicted with organic brain disorders, specifically FASD and ADHD. It was stated clearly that whether FASD/ADHD individuals remain part of the criminal justice system, in terms of future recidivism, depends largely on how the system responds to them initially. For criminal proceedings, judges require legislative and appellate sanction to enforce FASD/ADHD sensitive dispositions. The presence of undiagnosed FASD/ADHD offenders in the court system is simply unacceptable. Even though the present study did demonstrate that FASD and ADHD were considered to be mitigating factors in sentencing in some criminal cases, in many cases they were not and instead judges followed traditional jail-sentence dispositions. Such harsh dispositions for cognitively impaired offenders are counter-productive, in terms of having any significant effect on rehabilitation and a reduction in recidivism.

If a person has FASD or ADHD, sending them to jail serves no benefit, except that it is retributive in nature: their organic brain impairment negates their understanding or appreciation of cause and effect. Therefore, when a judge hands down a disposition to a person with FASD/ADHD, the focus needs to be placed on changing their living situation or social situation rather than fixating on their behaviour. Providing these individuals with structure, support and treatment as well as enforcing management in the community
would secure a more desirable outcome. Of course, in order for proper community placement to be feasible in every province/territories across the country for cognitively impaired individuals, the federal, provincial and territorial Governments will have to come together and allocate more resources to deal more effectively with these individuals.

Insofar as future research is concerned, it was earlier recommended that trial transcripts should be obtained in conjunction with judgments for offenders with FASD/ADHD: by adopting this strategy, it would be possible to discern differences between the exact information given during the trial, versus what was emphasized and understood by judges. Also, it would be important to compare the outcomes for offenders with FASD/ADHD who were diverted from the criminal justice system or who received a conditional discharge/community disposition, as opposed to those who received some type of a custodial disposition.

The most significant findings of the current study were that there appears to be an overrepresentation of FASD cases in the Western provinces of British Columbia and Saskatchewan for both youths and adults, when compared with the Eastern province of Ontario. It was also observed that Aboriginal accused with FASD were over-represented in the courts, which was not the case for Aboriginal accused with ADHD. Furthermore, when considering sentencing decisions in adult court, judges did not place as much weight on ADHD as they did on FASD. Also, it was observed that more often than not, no formal assessment of FASD was conducted during the court process. It is recommended that, when judges sentence offenders with FASD/ADHD, the focus needs to be placed on changing their living situation or social situation rather than fixating on their behaviour. Providing these individuals with structure, support and treatment—as well as surveillance and enforcement—in the community is more likely to secure a successful outcome for the sentencing process. FASD and ADHD are serious cognitive impairments and it is absolutely imperative that they should be recognized as such by the courts: such recognition should prompt the courts to insist on proper diagnosis, unique sentencing dispositions and appropriate treatment protocols.
CASES USED IN ANALYSIS

CASES REFERENCED

STATUTES REFERENCED

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