An Exploration of the Knowledge, Experiences, and Practices of Staff towards Fetal Alcohol Spectrum Disorder (FASD) in an Aotearoa New Zealand Prison Context.

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Abstract

Fetal alcohol spectrum disorder (FASD) is a neurodevelopmental disability that occurs through prenatal alcohol exposure. The disability leads to life-long cognitive, behavioural, learning, social, and physical deficits that occur along a spectrum of severity. The heterogeneous manifestation of FASD means diagnosis is extremely challenging, contributing to the lack of accurate, up-to-date prevalence statistics for both local and global communities. Although there are a lack of prevalence statistics, current research estimates suggest FASD is very common in Corrections settings, however prison staff remain largely uneducated and unaware of how to appropriately identify, manage, and support prisoners with FASD. This thesis explored the knowledge, experiences, and practices regarding FASD for prison staff at Auckland South Corrections Facility (ASCF) in Aotearoa New Zealand. The project was conducted in collaboration with ASCF to identify gaps in staff knowledge and inform more effective practice with FASD-affected prisoners. This research was conducted within a qualitative framework with a realist/essentialist epistemology. 16 staff members from Custody, Health, Case Management, Education, the Cultural team, and Psychology departments participated in semi-structured interviews. The data was analysed using Thematic Analysis, focusing on semantic content. Several themes were identified based on interpretations of participant responses. Overall, there was limited awareness of FASD among participants. This lack of awareness was largely due to the unavailability of FASD-related training for staff and problems with internal information sharing systems. Lack of staff awareness was shown to increase vulnerability and reduce access to rehabilitative services for affected prisoners. Participants expressed a willingness to learn more about FASD and adapt their practice to support the needs of prisoners who were suspected or confirmed of having this disability. This reflected a wider organisational culture that was dedicated to innovation and reducing the reoffending of prisoners. Key findings from the research suggest that inclusion of formal FASD-related training for staff and improvements in the way FASD-related information is shared within the institution, including a formal process for sharing this information can improve staff awareness and outcomes for prisoners. More research considering the prevalence of FASD in the Aotearoa New Zealand prison context is needed to increase visibility and ensure resources are dedicated to understanding and managing this disability in prisons.

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Glossary of Prison-Related and Māori Terms

Definitions are derived from my own knowledge working as a Corrections Officer in high security prison in Aotearoa New Zealand, unless otherwise specified.

Ara Poutama Aotearoa	Department of Corrections New Zealand.
Blocks/the floor	A term used by prison staff to refer to prison units or wings.
Case Manager	A person assigned to work with a prisoner to develop sentence and rehabilitation plans.
Charge/Misconduct	An internal offense committed by a prisoner.
Criminogenic needs	Factors in an offender's life that are directly related to their individual offending behaviours (Brown et al., 2023).
Discretion	An operational definition used to describe leniency as applied by prison staff in their application and enforcement of institutional rules (Haggerty & Bucerius, 2020).
File notes	An informal record where staff can share anything they deem to be relevant to the prisoner without loading an official report. File notes are permanent and can be viewed by anyone with IOMS access.
Hōkai Rangi	The current initiative for Corrections in Aotearoa New Zealand that seeks to reduce reoffending of Māori (Ara Poutama Aotearoa, 2019).
Incident report	A formal report that is written to detail any incident the staff deem necessary to inform other prison

	personnel. Incidents can be related to units as a whole (for example, finding alcohol in a common area) or they can be related to particular prisoners and usually involve relate to institutional misconduct, health-related incidents or accidental injury.
IOMS	Integrated Offender Management System. This is the information system used by all Corrections services in Aotearoa New Zealand and holds information pertaining to prisoners held in custody.
Legitimacy	Prisoner's acceptance of staff authority as legitimate (Jackson et al., 2010).
Mainstream	Prisoners who are not identified as being vulnerable and needing to be separated or segregated from others for their own safety. Majority of the prison population is classified as mainstream.
Manaakitanga	Expression of respect and generosity in Māori culture (Gibbs, 2022).
Misconduct report	A formal report that is written to charge a prisoner with an internal offense.
Muster checks	A process where prisoners are physically located and marked as present on a photo identification board.
Non-association	An alert that tells staff when prisoners are not permitted to associate with each other under any circumstances e.g., 'non-association with Joe Bloggs due to fighting'.
Prospecting	The process of initiation into a gang.
Recidivism	Reoffending, prison re-entry.

Rehabilitation Officers	The terminology used to refer to Custodial Officers at ASCF.
RocRoi	An assessment that calculates the risk of reconviction and risk of reimprisonment for prisoners.
SDAC21	The Structured Dynamic Risk Assessment 21 is an assessment that is used by Case Managers for assessing risk of prisoners.
Security classification	Represents the level of risk posed by the prisoner while inside or outside the prison. Risk includes risk of escape, risk to others and risk to the safety and security of the prison. Aotearoa New Zealand has five prisoner classifications: Low, Low-Medium, Medium, High, and Maximum.
Segregated prisoner	Prisoners who are segregated from the mainstream prison population due to additional vulnerability or risk.
Tāne	Māori for men and the current terminology used to refer to prisoners in Corrections, New Zealand.
Units	The building that holds prisoner cells and all facilities pertaining to that unit such as staff offices, prisoner dining rooms and recreation areas.
Wāhine	Māori for women and the current terminology used to refer to female prisoners in Corrections, New Zealand.
Whakawhanaungatanga	Actively pursuing positive relationships in Māori culture (Gibbs, 2022).

Wings	The space within a unit that holds prisoner cells. Units usually have multiple wings.

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Chapter 1: Introduction

1.1. Characteristics of FASD

FASD is an umbrella term used to identify the physical, cognitive, behavioural, and learning difficulties experienced by individuals who have been exposed to alcohol in the womb (Mattson et al., 2019; Rasmussen, 2008). Alcohol has been identified as a teratogen, causing abnormalities in the brain of a developing fetus that can lead to physical, cognitive, and behavioural impairment and central nervous system dysfunction (Rasmussen, 2008; Wozniak et al., 2019). The damage is irreversible, causing affected individuals to cope with lifelong health, social, psychological, behavioural and addiction challenges, currently with very limited support (Rasmussen, 2008). Current research is inconclusive as to whether there is a safe level of alcohol to consume while pregnant, however there is evidence that the amount and timing of drinking may affect the severity of the disability in the unborn child. May et al. (2013) reported that only drinking during the first trimester, usually when unplanned pregnancies have not yet been detected, increases the risk of the child developing FASD 12-fold, whereas drinking throughout all trimesters increases the risk by 65 times. Binge drinking, defined as four or more drinks in two hours, exposes the fetus to higher levels of alcohol and therefore increases the severity of birth defects (Mattson et al, 2019). The risk of a fetus developing FASD is not only dependent on the timing and level of alcohol consumption, but also on other maternal risk factors such as older age, lower maternal body weight, height and body mass index, poor nutrition, lower education, living rurally and having a lower socioeconomic status (Mattson et al, 2019). These demographic characteristics may increase risk by less access to prenatal services and education about the teratogenic effects of alcohol (Mattson et al., 2019). Studies assessing the effect of low levels of alcohol on the fetus are inconclusive, therefore the current messaging is that there is no safe amount of alcohol to drink while pregnant (Gibbs & Sherwood, 2017).

Decreased volume in brain structures such as the basil ganglia and diencephalon have been correlated with facial abnormalities that are seen in only a

minority of cases but still remain key differentiating symptoms confirming prenatal alcohol exposure for most diagnoses under the FASD umbrella. Facial dysmorphology is correlated with drinking during the first three to four weeks of pregnancy, which is a critical period of brain development (Mattson et al., 2019). Abnormalities include smaller palpebral fissures (the length of the opening between the eyelids), a smooth philtrum (the midline groove between the upper lip and the nose), and a thin vermillion border (the contour of the upper lip) (Mattson et al., 2019; Popova et al., 2023). Some individuals may also exhibit growth retardation which is characterised as prenatal or postnatal weight or height below the 10th percentile. Decreased head circumference below the 10th percentile may also be evident (Nguyen et al., 2011). These visible physical abnormalities are not typical of those who suffer from FASD, however (Gibbs & Sherwood, 2017). The presence of physical abnormalities in some, but not in most has made the identification of FASD sufferers difficult, and slow to develop in health and other systems.

1.1.1 Central Nervous System Dysfunction

Individuals with FASD can experience structural or neurological central nervous system (CNS) dysfunction (Nguyen et al., 2011). This can lead to problems with sensory, perceptive, and motor functions (Kully-Martens et al., 2022). Deficits in odour and taste perception can occur, with some adults reporting the smell of alcohol as pleasant, which is also an indicator of increased severity and can be a contributing predisposition to alcohol abuse later in life. Sight can be affected due to disruptions to eye development through cellular toxicity, and individuals may develop hearing, speech, and language disorders due to disruptions in the development of brain structures involved in auditory perception and expression. These deficits compounded by attention and memory problems can lead to difficulties in verbal and written communication causing learning delays (Wozniak et al., 2019). Sensory sensitivity is commonly reported with individuals feeling overwhelmed in situations involving cluttered surroundings, loud sounds, and large groups of people (Chapman, 2008; Oatley & Gibbs, 2020). The disruption to

the CNS can also contribute to problems with executive functioning, as its functioning integrates and relies upon these processes (Kully-Martens et al., 2022).

1.1.2 Executive Function

Executive functioning are higher-order cognitive processes that rely upon successful integration of attention, memory, flexible thinking, goal setting, decision making and problem-solving brain functions to enable the person to adapt to novel situations, inhibit inappropriate behavioural responses and self-regulate emotions. Disturbances in these functions are apparent for people with FASD as a result of brain insult from prenatal alcohol exposure and the lower-order cognitive and CNS processes that are disrupted during in-utero development (Crawford et al., 2020). Specifically, tasks assessing problem-solving in FASD children have showed slower processing times and less time spent on pre-planning and preparation than children without FASD. They tend to implement more time-consuming strategies and exhibit more rule violations, with their difficulties becoming more pronounced with increasingly novel or complex tasks (Mattson et al., 2019). Deficits in working memory have also been associated with FASD, with individuals struggling with manipulating information to achieve a task. Memory deficits are known to contribute to learning difficulties for individuals due to impaired recall (Mattson et al., 2019; Streissguth et al., 2004).

1.1.3 Cognitive Impairment

General intelligence is often impacted by exposure of the fetus to alcohol. An intelligence quotient (IQ) of below 70 is considered an intellectual deficiency, and there have been reports of some people with FASD being assessed as having an IQ score as low as 20, however IQ scores of people with FASD are largely heterogeneous and vary by diagnosis and the degree of alcohol exposure (Mattson et al., 2019). Attentional resources are compromised for individuals with FASD, impacting their ability to organise, divide and sustain attention. Children with FASD are slower to react to attentional stimuli on tasks that measure attention. Verbal fluency tasks that rely on memory retrieval and strategic searching to allow

the person to produce as many words as possible have identified slower processing times and less amounts of words produced by children with FASD (Mattson et al., 2019). Language impairment has also been found in studies with children with FASD, such as difficulties with word ordering, structuring, and combining sentences, grammatical comprehension, and use of syntax (Mattson et al., 2019). Both expressive and receptive language disorders are common comorbidities in individuals with FASD, and speech and language pathologists are often required on multi-disciplinary diagnostic teams to confirm a diagnosis of FASD (Fast & Conroy, 2013).

1.1.4 Adaptive Functioning and Behavioural Challenges

Struggles with cognitive challenges manifest in maladaptive behaviours characterised by hyperactivity, poor impulse control, aggression (Wozniak et al., 2019), and rule-breaking behaviour (Tsang et al., 2016). Adaptive functioning, or the ability to harness appropriate personal and social skills is poor and makes living independently extremely challenging for individuals affected by FASD (Rasmussen et al., 2008). Children who were found to have been exposed to alcohol prenatally saw a decrease in socialisation skills as they grew older, indicating that some deficits in adaptive skills may become more pronounced as the person ages (Whaley et al. 2001). Streissguth et al. (2004) also assessed the adaptive skills of adolescents and adults with fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE). They found people in a sample with a mean age of 17 to be functioning at the levels of 7-year-olds. Problems with adaptive functioning can make it difficult for individuals to communicate effectively with others, causing disruptions in their capacity to perform in school and employment, affecting their ability to progress academically and financially (Brown et al., 2018). Individuals with impaired adaptive functioning are also more likely to have a lower socioeconomic status and struggle with activities of daily living such as managing money and obtaining a driver's license (McLachlan et al., 2020b). Adaptive functioning was identified as the most commonly impaired neurodevelopmental domain for individuals affected by FASD (McLachlan et al., 2020b). This finding is supported by Streissguth et al. (2004) who found adaptive functioning and

arithmetic skills to be the two key areas of deficit for people with FASD. Difficulties in daily living are also apparent for people with FASD with one study involving 726 adolescents and adults reporting 37% of the sample had experienced problems with employment/unemployment, 21% lived in assisted or sheltered housing, and 18% experienced disruptions in schooling (McLachlan et al., 2020b).

1.1.5 Social Challenges

The errors in executive functioning that limit a person's ability to inhibit maladaptive behavioural responses can lead to problems with regulating behaviour and effectively communicating with others. Novick-Brown et al. (2012, p. 2) state that "without the ability to self-regulate in a context of strong emotions, illogical thoughts, and antisocial urges, prenatally exposed adolescents are unable to control aggression and other maladaptive behaviours". The authors refer to this as reactive aggression, which can arise out of perceived provocation, frustration, or threat and is accompanied by fear or anger. Reactive aggression can become more pronounced as adolescents reach adulthood. One theory explaining reactive aggression posits that individuals react aggressively because their limited executive functioning skills have prevented them from developing socially acceptable methods of expressing distressful emotions. That is, development has been arrested during childhood where physical aggression is the dominant response, rather than harnessing the verbal capabilities required to express frustration (Novick-Brown et al., 2012). Hence, this socialisation delay causes disruptions in prosocial relationship building and routinely manifests in violent outbursts.

1.2 Primary and Secondary Disabilities

Primary disabilities are the cognitive and behavioural challenges associated with CNS disfunction (Rasmussen, 2008). Secondary disabilities are the adverse life outcomes that can arise from the primary disabilities related to brain impairment and developmental disruptions (Chu et al., 2022). These include disrupted schooling, dependent living, mental health problems, substance abuse,

trouble with the law, and unemployment issues (Popova et al., 2016). Social cognitive theories of learning suggest that learning occurs in social environments where observing others and experiencing consequences help children learn how to behave appropriately. Children are motivated to engage in skill acquisition when they complete assignments and receive positive feedback from teachers and parents. This increases their self-efficacy or confidence in themselves. They are more likely to behave in ways that elicit positive attention from teachers and regulate behaviours that invite negative attention (Schunk, 2012). For children with FASD, interpersonal difficulties can mean they misinterpret the emotional cues of teachers and parents, and opportunities for self-regulation are missed. Their lack of progress in the classroom can contribute to reciprocal frustration, and confusion about their maladaptive behaviours from teachers (Crawford et al., 2020).

In their seminal study Streissguth (1997) assessed the variety of secondary disabilities that individuals are predisposed to due to their neurocognitive and behavioural challenges and lack of support in addressing these challenges early in life. From a sample of 415 FASD affected children, adolescents and adults, 90% reported mental health problems; 60% of adolescents and adults reported disrupted schooling experiences with the most frequent learning problems being related to attentional issues (70%) and repeatedly incomplete school-work (55%-60%); 60% struggled with getting along with peers and 55%-60% were repeatedly disruptive in the classroom; trouble with the law was reported by 60% of adolescents and adults, and 50% reported being placed in confinement facilities. Inappropriate sexual behaviour was the most common secondary disability for children (39%) and was present for 49% of adolescents. The most common inappropriate sexual behaviours were sexual advances, sexual touching, and promiscuity. Finally, 35% of adolescents and adults reported problems with alcohol and drug abuse.

Secondary disabilities are also a product of adverse childhood environments and the social impact, stigmatisation, and exclusion from health, school and support systems that result from their neurocognitive difficulties (Gibbs & Sherwood, 2017; Sherwood, 2019). The social determinants of health are important to

consider in the context of pregnant women consuming alcohol. Insufficient and unsanitary housing, lack of nutritious food, access to health care, employment, services, justice, and human rights are systemic failings that drive drinking behaviour and form the environments that children with FASD are typically born into (Nguyen et al., 2011). There are impacts of poverty, gender inequality, racism addiction, and abusive relationships on mothers' consumption of alcohol (Nguyen et al. 2011). Children with FASD born into these environments are unlikely to have their basic needs met and are reported to have a lower quality of life than children diagnosed with cancer (Rasmussen, 2008). The socialisation delays and maladaptive coping behaviours that arise from these adverse environments make individuals with FASD difficult to understand and interact with. Early detection is imperative to put in place appropriate supports for children to enhance protective factors and reduce the risk of the development of secondary disabilities (Brown et al., 2019). Five protective factors have been identified that could help to mitigate the risk of secondary disabilities, these are 1. Living in a stable and nurturing home environment; 2. Not being a victim of violence; 3. Receiving developmental disability services; and 4. Receiving a diagnosis before the age of six (Streissguth, 1997). Misdiagnosis and underdiagnosis means neurocognitive challenges go undetected and the person is judged according to their slow intellect, and their aggressive and rule-breaking behaviours (Sherwood, 2019). Having an IQ of lower than 70 has also been identified as a protective factor (Streissguth, 1997). This will be discussed in the following section. Even with a diagnosis, people with FASD struggle to access support because of systemic barriers that fail to recognise FASD as a disability.

1.3 Barriers to Support

Currently, FASD is not a funded disability in Aotearoa New Zealand, leaving affected individuals and their whānau to cope with the challenges of this disorder alone (Gibbs, 2022). Globally and locally, most funded services and programs are only available to those with FASD who are identified as having an IQ below 70 (McLachlan et al., 2020b). This particular benchmark is more often exceeded by individuals with prenatal alcohol exposure, with IQ scores for children with FAS

usually falling within the low 70s to low 80s range (Freckleton, 2016). A report by the Disability Rights Commissioner and Childrens Commissioner (DRCCC) (2020) stated that only 20% of individuals in Aotearoa New Zealand with FASD suffered from intellectual impairment, therefore it is only this small margin of people who are eligible for government funded services such as the Ministry of Health Disability Support Services. While people with FASD with an IQ over 70 are not considered intellectually disabled, their neurocognitive deficits make it impossible for them to function at the level their IQ score dictates (Brintnell et al., 2011). The DRCCC labelled the distinction between those with neurological deficits in executive and adaptive functioning and those with a recognised intellectual disability that dictates whether an individual and their whānau receive support services "utterly arbitrary" and "incongruous with a well-being and equity approach" (DRCCC, 2020, p. 7).

Consequently, having an IQ lower than 70 is considered a protective factor for individuals with FASD as it increases their access to government funded support services and interventions (Streissguth, 1997). The DRCCC (2020) report advocated for eligibility criteria to be based on need rather than diagnosis, and based this on the 'social model of disability', which acknowledges that peoples' inability to participate fully and equally in society is hampered not by their individual impairments, but by policy, social attitudes, stigmatisation, and societal infrastructure that is not designed to accommodate their abilities. Limited access to mediating technologies and the inequitable distribution of resources creates barriers that contribute to the social construction of disability. The perception of people as disabled is therefore, bound up in the social barriers that lead to their inability to equally participate (Baylies, 2002). The social model of disability places responsibility on the state to reduce barriers that disable people so that they can not only effectively participate in society but meet their full potential, rather than ending up on an eventual pathway into criminal justice (DRCCC, 2020).

1.4 Criminal Justice Context

Fetal alcohol spectrum disorder (FASD) is a life-long neurodevelopmental disability that anecdotally affects many incarcerated individuals. It is a disability that has been implicated in orchestrating pathways to prison due to a lack of professional knowledge that pervades community and justice sector services (McCormack et al., 2022; McCormack et al., 2023). A general lack of FASD-related research, training and information continues to perpetuate a cycle of uninformed frontline professionals who work with people with FASD. Children affected by this disability are likely to be misunderstood and misdiagnosed, sending them on pathways of removal from their whānau of origin, exclusion from school, involvement with anti-social peers, employment difficulties, offending against society and being placed in prison (Streissguth, 1997). Unable to comprehend consequences, people with FASD become locked in a cycle of recidivism and are managed by systems that are unaware of more appropriate ways of supporting their needs, and influencing more adaptive behaviours that allow them to live good lives in the community (Novick-Brown et al., 2012). The lack of knowledge of FASD extends into the prison environment, leaving prison staff unable to identify, manage and support affected prisoners in their care. More research is desperately needed to ascertain accurate diagnosis and prevalence statistics that contribute to funding and resources directed at improving the knowledge of professionals working in prisons (McCormack et al., 2021). Increased awareness would likely lead to more visibility, training of prison staff, and improved information sharing systems to inform practice and improve outcomes for prisoners with FASD.

1.5 Summary

This chapter outlined the cognitive, behavioural, physical, social, and adaptive deficits associated with FASD, detailing how these life-long symptoms can affect a person's life. It then gave an overview of primary and secondary disabilities and the barriers to support that often lead to individuals with FASD being involved with the criminal justice system. The next chapter provides a literature review of the available literature on FASD that relates to the current research.

Chapter 2: Literature Review

2.1 Introduction

This chapter will provide a literature review of the current research on FASD in relation to the research topic. It will discuss the diagnosis and diagnostic challenges of FASD before giving an overview of the prevalence of FASD in various populations. It will discuss the factors that increase the risk of people with FASD becoming involved with the criminal justice system before moving to an in-depth discussion of FASD in prisons. It will explore the vulnerabilities of prisoners with FASD that are amplified by limited staff awareness resulting from lack of training and information sharing in prisons. Concluding with a discussion of the implications of a lack of awareness and ineffective interventions, this literature review will offer an overview of alternative approaches and more promising interventions for prisoners with FASD.

2.2 Diagnosis

Along the spectrum of FASD falls multiple diagnoses that are distinguished by the severity of symptoms individuals experience, representing the heterogeneous nature of neurological disability arising from prenatal alcohol exposure (Mattson, et al., 2019). The four categorical diagnoses are fetal alcohol syndrome (FAS), partial fetal alcohol syndrome (pFAS), alcohol-related-neurodevelopmental-disorder (ARND), and alcohol-related birth defects (ARBD) (Easton et al., 2016). In the *Diagnostic and Statistical Manual of Mental Disorders (5th edition)* (DSM-5) ARBD is referred to as neurobehavioural disorder associated with prenatal alcohol exposure (ND-PAE) (American Psychiatric Association [APA], 2013). While FAS is the most severe form of diagnoses under the spectrum of FASD, ARND is the most common, with an estimated three-to-four cases of ARND for every case of FAS (Popova et al., 2016; Salmon & Buetow, 2016). Globally, there are a number of different FASD diagnostic tools and guidelines including the *Institute of Medicine (IOM) Criteria for FASD Diagnosis* (Hoyme et al., 2005), the *4-Digit Diagnostic Code for Fetal Alcohol Spectrum Disorders* (Astley & Clarren, 2000),

the DSM-5 (APA, 2013), and the *Fetal Alcohol Spectrum Disorder: Canadian Guidelines for Diagnosis* (Canadian Guidelines) (Chudley et al., 2005). Although there is no international consensus regarding diagnosis, all diagnostic guidelines recommend assessing for evidence of prenatal alcohol exposure, facial and non-facial dysmorphology, and CNS structure and function utilising a multidisciplinary approach, however the guidelines differ in thresholds of prenatal alcohol exposure, individual diagnostic elements and the elements required to confirm a diagnosis of FASD.

The Canadian Guidelines are the most widely used diagnostic guidelines and were developed from harmonisation of the Institute of Medicine (IOM) guidelines and the 4-Digit Diagnostic Code (Chudley et al., 2005). The Canadian Guidelines relate to six areas of the diagnostic process including 1. Screening and referral; 2. Physical examination and differential diagnosis; 3. Neurobehavioural assessment; 4. Treatment and follow up; 5. Maternal alcohol history and follow up; and 6. Diagnostic criteria for FAS, pFAS, and ARND (Chudley et al., 2005). The diagnostic criteria for each of the diagnostic categories as indicated by the Canadian Guidelines after harmonisation of the IOM and 4-Digit Diagnostic Code are as follows: A diagnosis of FAS and pFAS require evidence of three of the facial abnormalities that are characteristic of prenatal alcohol exposure (short palpebral fissures, a thin vermillion border and a smooth philtrum). Prenatal exposure to alcohol must be confirmed for a diagnosis of FAS, as well as evidence of growth deficiency and abnormal brain growth below the 10th percentile for developmental age, and neurobehavioural impairment. In circumstances where prenatal alcohol exposure cannot be confirmed, a diagnosis of pFAS may be given if facial dysmorphology is present. ARND and ARBD may be diagnosed in the absence of facial dysmorphology, however prenatal exposure to alcohol is required, as well as evidence of one or more physical abnormalities (Chudley et al., 2005). In the DSM-5, ND-PAE requires evidence of prenatal exposure to alcohol, deficits in neurocognition, self-regulation, and adaptive functioning, and can be given both with, or without a diagnosis of FAS (APA, 2013). The Canadian Guidelines are the guidelines used for diagnosis in Aotearoa New Zealand (FASD Centre Aotearoa, 2023).

2.2.1 Diagnostic Challenges

The heterogeneity in the presentation of FASD and lack of consistency regarding diagnostic criteria constitutes one of the foremost challenges of diagnosing this disability (Mattson et al., 2019). For instance, it is now known that roughly only 4% of FASD cases present with facial features consistent with prenatal alcohol exposure (Gibbs & Sherwood, 2017). Additionally, the multidisciplinary nature of diagnosing FASD is difficult due to a general lack of trained clinical personnel both nationally and globally (Cook et al., 2016). The physical and cognitive manifestations of the disability require expertise from health, psychological and neurocognitive specialists including pediatricians, physicians, psychiatrists, psychologists, speech-language pathologists, and occupational therapists (Fast & Conroy, 2011). Audiological, verbal, intellectual and neurological capabilities may be assessed, alongside an exploration of the person's maladaptive behaviours, substance use history, sexual behaviours, and activity. Facial features are evaluated by taking facial measurements and photographs for analysis (Temple et al., 2015). The variety of assessments and diagnostic personnel highlights the extensive resources required in identifying this disorder and explains why so many cases of FASD go undetected.

Confirmation of prenatal alcohol exposure is an especially difficult criterion to establish when assessing for FASD. A lack of training and knowledge on FASD, appropriate screening tools and legal requirements for routine screening of alcohol use means clinicians generally do not assess for alcohol use during pregnancy. It is also difficult to ascertain accurate family histories for specific populations such as children and adults who lived in foster care as biological parents or other relatives may be difficult to locate for an interview (Popova et al., 2023). In cases where the birth mother is available for interview, stigma, shame, guilt, and denial might prevent them from disclosing that they consumed alcohol during pregnancy. Where confirmation of prenatal alcohol exposure is not possible, clinicians may rely on facial dysmorphology for diagnosis. However, facial characteristics are an unreliable criterion for adult cases of FASD as they tend to become indistinguishable as the person ages (Brown et al., 2018).

The lack of knowledge surrounding FASD leads to many adults going undiagnosed as the term 'fetal' generally gives the impression that it is a disability restricted to childhood (Brown et al., 2018). The focus on early diagnosis and intervention of FASD has also led to most research relating to screening tools being concentrated in the childhood life-stage, with very little evidence-based research being directed at adult populations. Further diagnostic related complications for adults are the psychological comorbidities that are often present as a result of secondary disabilities (Brown et al., 2018). Common comorbidities associated with FASD are attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), depression, anxiety including posttraumatic stress disorder (PTSD), panic disorder, and obsessive-compulsive disorder (OCD) (Rasmussen, 2008; Salmon, 2008). Psychological comorbidities are often the reason people seek help and as a result, are the primary focus for clinicians. This is especially true when prenatal alcohol exposure cannot be confirmed, leading clinicians to focus on the symptoms and disorders they are most familiar with, causing the underlying neurological difficulties and secondary disabilities to continue to go undetected (Brown et al., 2018).

2.3 Prevalence

The heterogeneity of FASD that contributes to its diagnostic challenges means there is very little prevalence data on FASD in Aotearoa New Zealand and across the globe. Without accurate diagnoses, current prevalence statistics are merely estimates. Because of this, FASD has been referred to as 'the invisible disability'. Limited awareness of this disability and the amount of people impacted by it limits professional development and perpetuates the inability of clinicians to identify and diagnose affected individuals (Gibbs & Sherwood, 2017). Prevalence data provides concrete evidence that FASD is a pervasive disability that affects a substantial amount of the population and provides a starting point for informing the public health response and scaffolding change (Palmeter et al., 2021). Consequently, knowledge of how many people are affected by FASD is imperative to identifying what resources are required to address their needs (Mattson et al., 2019). Accurate prevalence data would indicate who is most affected by FASD and

what regions require the most support and would benefit from early intervention and prevention methods (McLachlan et al., 2019).

Notwithstanding this, research conducted on the drinking patterns of women before and during pregnancy have allowed researchers to produce evidence-based estimates of FASD in select populations (May et al., 2009). Estimates of global epidemiological data for the general population based on the pooled estimates of 76 countries from the World Health Organisation (WHO) European Region, the Region of the Americas, the African Region, the Western Pacific Region, the South-East Asia Region, and the Eastern Mediterranean Region suggest alcohol use during pregnancy has a prevalence of 7.7. per 1000 live births (Popova et al., 2023). These pooled estimates suggest that one in every 13 women who consume alcohol while pregnant will give birth to a child with FASD, resulting in 630,000 FASD affected births globally every year. Based on these estimates and the permanency of the disability, it is estimated that 25 million individuals aged between 25 and 40 years currently have FASD in the general population (Popova et al., 2023). It is important to note that the prevalence of FASD increases in countries where alcohol consumption is higher. World Health Organisation findings indicate that the WHO European region has the highest numbers of women who consume alcohol (about a quarter of the general population). Internationally, this region also has a prevalence of FAS[1] at 2.6 times greater than the global population. In cultures where women are not condoned to drink alcohol the prevalence is much lower. This is the case for the Eastern Mediterranean region (EMR), where Muslim faith values abstention from alcohol and is the dominant religion. It is unsurprising then that the EMR has a prevalence of FAS 50 times less than the global, general population (Popova et al., 2017). However, these estimates do not take into account prevalence estimates of subpopulations such as those who are indigenous, living in state or foster care and those involved in the justice system.

2.3.1 Prevalence in Aotearoa New Zealand

[1] Fetal alcohol syndrome.

In Aotearoa New Zealand, prevalence rates are based on the Ministry of Health estimates that one in every 100 live births are affected by alcohol, which translates to approximately 1,800-3000 children born with FASD each year (McCormack et al., 2021; Ministry of Health, 2022). These are conservative estimates as prevalence rates are expected to be much higher in Aotearoa New Zealand where alcohol is firmly embedded into our daily lives (Chu et al., 2022). McEwan et al. (2010) contend that Aotearoa New Zealand has a culture of intoxication, characterised by increasing rates of men and women engaging in regular binge drinking episodes. An earlier study by Salmon (2008) highlighted that a quarter of women in Aotearoa New Zealand between the ages of 18 and 19 drink to intoxication at least once a week. The author also noted that binge drinking behaviours are more prevalent in women who are at the age when fertility and sexual activity is high, increasing the risk of unplanned pregnancies and the exposure of those pregnancies to alcohol. One longitudinal study found that 71% of women in Aotearoa New Zealand drank prior to awareness of being pregnant, 23% continued to drink during the first trimester and 13% continued to drink after the first trimester. Subsequently, almost a third of women who drank during the first trimester reported drinking at bingeing levels during this period (McCormack et al., 2021). The pervasive drinking culture leads researchers to believe that the current globally accepted prevalence rates of FASD are much higher in Aotearoa New Zealand, signifying a national health concern.

2.3.2 Prevalence in Indigenous Populations

FASD is substantially higher for indigenous peoples. A study by Roozen et al. (2022) exploring drinking patterns among women in Aotearoa New Zealand found that Māori women were the most likely to continue consuming alcohol in their first trimester, compared to European, Asian and Pasifika women. Consequently, this leads to the highest estimates of FASD for Māori estimating a prevalence of 170 to 630 per 10,000 live births among Māori, compared to 130 to 460 per 10,000 live births for non-Māori (Romeo et al. 2023). Similar findings have been reported in various countries. For example, the prevalence rates of alcohol

use for Inuit women in Canada was 60.5%, 10 times higher than that of the general population (Popova et al. 2017).

It is important to note that FASD is not an ethnicity-specific disability and must be considered in the context of depression and intergenerational trauma that is associated with colonisation, loss of language and culture, and disadvantage for indigenous peoples. Risk factors such as lower socioeconomic status, lower education, trouble with the law and substance abuse are amplified for indigenous populations, placing them in environments where consumption of alcohol is normalised and utilised as a coping behaviour (Espiner et al., 2022). In Aotearoa New Zealand and on a global scale, alcohol has been harnessed as a weapon of colonisation, by advertising alcohol as a highly-sought after trade item – driving addiction and creating physiological and psychological reliance of indigenous peoples on the colonising entities, including alcohol, health, and social service providers (Espiner et al., 2022; Walker, 2019). For First-Nations peoples in Canada, some of the only places to cash cheques near reservations are alcohol stores (Yousefi & Chaufan, 2022). Alcohol-related birth defects would not be rampant among indigenous communities if alcohol had never been introduced by European settlers, therefore it would be counterproductive and damaging to assume FASD is an indigenous issue without considering the sociohistorical context behind alcohol consumption for these communities (Yousefi & Chaufan, 2022).

2.4 FASD, Criminal Justice, and Prisons

Trouble with the law is one of the highest incidences of secondary disabilities for adolescents and adults with FASD, and is second to mental health problems (Streissguth, 1997). The international literature consistently highlights these individuals as primed for the justice system due to the primary and secondary disabilities they experience as a result of their arrested brain development, and the prevalence rates of people with FASD in prisons reflects this. Prevalence rates in the Corrections context are also based on research estimates, similar to the general population due to diagnostic difficulties. In a recent study,

Burd et al. (2021) estimated that in Canadian juvenile systems one in six children and adolescents have FASD. These authors also report that this is a seriously conservative estimate, with less than 1% of people with FASD in the criminal justice system ever being diagnosed. McLachlan et al. (2019) reported that individuals with FASD are 30 times more likely to make contact with the criminal justice system, and two Canadian studies showed adults in Corrections systems had prevalence rates of between 10 and 15% compared to 2 and 5% in the general population.

Similar research on the prevalence of FASD in a Western Australian juvenile detention centre found that 36% out of a sample of 99 participants between the ages of 13-17 met the diagnostic criteria for FASD (Bower et al, 2018). Alarmingly, only two of the participants who were diagnosed with FASD were non-Aboriginal. This is reflective of the higher amounts of alcohol use among indigenous communities resulting from a history of colonial dispossession from land and culture, leading to a legacy of "high levels of family violence, drug and alcohol misuse, mental health problems, poverty, disadvantage, marginalisation, trauma and incarceration" (Bower et al., 2018, p. 7). Currently, there are no prevalence statistics of people in prison with FASD in Aotearoa New Zealand, which signifies a need for further research to inform action and appropriate interventions in these spaces (Gibbs, 2018; McCormack, 2021).

2.4.1 Primed for the Justice System

The cognitive, behavioural, social, environmental, and stigmatising problems associated with FASD create somewhat of a perfect storm for entering the justice system. One of the major risk factors that can start individuals on a trajectory toward prison is late or no diagnosis. Streissguth (1997) highlighted diagnosis before the age of six as one of the protective factors reducing the risk of secondary disabilities. With an early, correct diagnosis individuals are eligible for more support and caregivers and teachers are aware of the cognitive difficulties leading to children's intellectual, behavioural, and social problems (Chu et al., 2022). Without appropriate diagnoses, children are at risk of receiving unhelpful

and possibly harmful interventions and being excluded from school due to behavioural issues and a lack of understanding from teachers. This is a significant risk factor as school suspensions are correlated with early entry into the justice system (Chu et al., 2022). Almost 60% of teachers in an Aotearoa New Zealand survey reported they had diagnosed or suspected cases of FASD in their classroom, with only a third having received any support for these children. When aid was offered, this was in the form of wraparound services, training for teachers, referrals to specialists, classroom management strategies and resources and in-class support. While the support was beneficial, teachers often reported that they were only offered for a limited time and were withdrawn once the child's behaviour improved (Chu et al., 2022).

2.4.2 Foster Care to Prison Pipeline

Research also shows there are higher rates of FASD among children and adolescents who have been removed from the home and reside in foster care. Hodas & Becker (2018) report that 70% of children and youth affected by FASD live in foster care. Popova et al. (2023) reported the pooled estimate of the prevalence of FASD among children in foster care as 25.2% in the USA – 32 times higher than global prevalence estimates. Likewise, Bakhireva et al. (2017) highlighted that FAS may be 10-15 times more prevalent in children in foster care compared to the general population. In Aotearoa New Zealand, Oranga Tamariki estimates that FASD affects more than 50% of children in care, based on international prevalence rates (Gibbs, 2022). The adverse environments children with FASD are born into greatly increase their likelihood of being removed from the family home, which explains the higher concentration of FASD within these populations.

Children with FASD are more prone to foster-placement breakdown due to the challenges for foster-parents who receive no training on how to care for these children and meet their extra needs. Multiple breakdowns can lead to worse psychological and emotional outcomes and exacerbate behavioural and attachment problems (Hopner, 2017). Multiple placements are extremely

detrimental to children's attachment, as the child struggles to form new bonds with each new caregiver, and interpersonal skills are damaged as friendships are lost due to transience and changes in schools (Goetz, 2020). The development of the attachment system is instrumental in providing the building blocks of strong interpersonal skills and positive relationships later in life (Choi & Kangas, 2020). Bowlby's attachment theory identifies an evolutionary internal affect regulation system that is regulated by secure attachment figures that care for children as infants. The attachment figure serves as a secure base for which the infant/child can retreat to for safety in moments of distress and builds confidence to explore the world and approach novel situations (Mikulincer & Florian, 2001). Children in foster homes are also estimated to be 4 times more likely to experience sexual abuse than children not living in foster care (Cochran, 2023). Where attachment figures either fail to manage distress or become the source of distress as in experiences of abuse, fear and anger can become chronic emotions, contributing to a sense of helplessness and detachment (Mikulincer & Florian, 2001). The development of a secure attachment style is severely disrupted when a child is taken into foster care, which is a common experience reported by people with FASD (Brown et al., 2015a). This has serious detrimental impacts both then and in the future lives of these individuals and the people they seek to have relationships with across the lifespan.

Children with FASD in care enter the foster system earlier and are usually in care longer than children without disabilities (Fuchs, 2022). In Aotearoa New Zealand, Māori children are overrepresented in the foster care system, with Hopner (2017) reporting that in 2016 there were 3157 Māori children, 1462 Pākeha children, 373 Pasifika children, 79 Asian children, and 133 children from other ethnic backgrounds in state care. Foster children are more likely to experience incarceration than children who lived in permanent residencies (Goetz, 2020). Children in foster care engaged in criminal activities at an earlier age, more frequently and spent more time in incarceration. Higher placement numbers correlated with higher risk of offending, with children in care reportedly 244 percent more likely to demonstrate patterns of chronic offending. It is also important to note that children in care are more likely to be convicted of an offense and often receive more release conditions than those who had not been in care

(Goetz, 2020). Indigenous youth in care with FASD face a three-fold increased risk of coming into negative contact with the law (Fuchs, 2022).

There are a number of identified risk factors that make a pathway to prison pipeline more likely for children with FASD in the foster care system (Fuchs, 2022). As these children age out of care and into adulthood, they are unlikely to have received a diagnosis and therefore be eligible for support. Additionally, their placement in foster homes reduces the type of familial support required to act as a protective factor against secondary disabilities, including involvement with the legal system (Fuchs, 2022). Children in care are more likely to experience disrupted schooling due to multiple placements and are often either excluded from school due to behavioural reasons or drop out voluntarily due to their intellectual and social difficulties (Goetz, 2020). Children who drop out of school and experience adverse foster care relationships are at risk of living in dangerous areas and being recruited by gangs due to their vulnerability to being manipulated and heightened need to fit in (Fuchs, 2022).

Involvement with anti-social peer groups such as gangs can lead to involvement in criminal activity, both as a result of being easily led and manipulated by others and as a means of survival (Brown et al., 2018). Problems with emotionality can affect individuals' ability to feel empathy for others (Freckelton, 2016). Additionally, problems with executive function can lead to individuals with FASD struggling to comprehend the consequences of their actions. Kazdin's Law of Effect theory suggests that consequences that follow behaviour help learning (Moore, 2011). Similarly, Pavlov's theory of operant conditioning has shown that behaviour is discontinued when there is no reward, or it is followed with a punishment (Moore, 2011). The stunted neurodevelopment of people with FASD means they are unlikely to respond to consequences in the same way as someone with all of their cognitive faculties. They are likely to struggle with drawing conclusions that offending behaviours will lead to punishment and will therefore, continue to engage in behaviours that get them into trouble (Brown et al., 2018).

Inability to comprehend consequences can lead individuals to act in the moment in ways that they believe will be of benefit to their current situation

(Freckelton, 2016). Unable to understand cause and effect and attempting to cope with trauma related to adverse experiences, people with FASD are prone to substance abuse, which further exacerbates their risk of being caught up in the justice system due to possession of illicit substances and criminal behaviours being acted out while under the influence (Brown et al., 2018). As children with FASD age into adulthood, they may be perceived as socially deviant when their behaviours are inconsistent with societal expectations. This means that adults, even with a diagnosis of FASD are perceived as people who have autonomy and control over their actions, rather than as victims of their disability. Lack of understanding about FASD as a lifelong condition and the corresponding secondary disabilities increases the risk of these individuals to be relegated to the criminal justice system and often imprisoned as opposed to receiving appropriate support to manage their disability (Brintnell et al., 2011).

2.5 Vulnerability within the Prison System

Prisons are places that have been introduced as a preventative measure for anti-social, offending behaviour. They operate on principles of punishment, victim protection and rehabilitation by holding people who have offended against society in involuntary custody (Kaufman, 2015). Considering the involuntary nature of prisons, prisoners have historically been resistant to institutional rules and the authority of staff (Jackson et al., 2010). Custodial staff have learned to address this resistance by using discretion when enforcing prison rules by showing leniency for minor infractions (Haggerty & Bucerius, 2020). Typically, the use of discretion by prison staff contributes to developing staff-prisoner relationships and encouraging rule-abiding behaviour from prisoners. Applying discretion to minor infractions can build rapport with prisoners who are likely to view staff as fair as opposed to authoritarians who abuse their power (Haggerty & Bucerius, 2020). Discretion, therefore, has a significant impact on the 'social contract' between staff and prisoners. Most prisoners are likely to conform to this social contract, influencing an understanding from both sides that when consistent or major deviations from the rules are exhibited by prisoners, punitive action is likely to follow (Liebling, 2000).

The inability for individuals with FASD to understand and follow societal rules translates to the prison environment and can cause them to be perceived by prison staff as troublemakers (MacPherson et al., 2011). Deficits with executive processes such as planning, problem-solving, and decision making can affect individuals' abilities to comprehend rules and instructions. Additionally, damage to the cerebellum can impair attentional processes, reducing the individual's capacity to focus when prison processes are explained, and can lead to the person becoming overwhelmed during stressful or novel situations (Brown et al., 2015b). Perception of time is impaired, which can lead to frustrations when the individual cannot manage themselves according to prison routines and can also cause them to become frustrated if they perceive tasks to be delayed by prison personnel (Brown et al., 2015b). For example, they may put in a request for something to be completed and expect this to be done instantly due to their inability to comprehend the time required to complete certain tasks within the prison system. A lack of awareness of the cognitive and social difficulties of FASD is likely to lead staff to believe prisoners with FASD are misbehaving out of a lack of respect for the social contract and the reciprocal behaviour that 'should' follow their use of discretion. When discretion as a low-level approach to maladaptive behaviour appears to be fruitless, staff are likely to respond with more punitive measures as patience diminishes, increasing the vulnerability of these prisoners (Gibbs, 2022).

Cognitive deficits and maladaptive functioning that often lead to non-conformity to prison rules and regimes, unprovoked aggression, and a variety of other behaviours can cause frustration among staff and have negative impacts on the individual's rehabilitation pathways (Brown et al., 2015a; Rogers et al., 2013). Staff misinterpret rule-breaking behaviour as intentional non-compliance, meaning prisoners with FASD are more likely to be punished with internal misconducts[2] (Novick-Brown et al., 2012). Formal reports that identify prisoners' repeated failures to adhere to rules within prison suggest to governing bodies such as the parole board that they are not ready to be reintegrated into the community (Connor, 2016), leading to a cycle of prolonged imprisonment, and more exposure to punishment and interventions that that are proven to be ineffective.

[2] An internal charge for breaches of prison rules. Prisoners who are found guilty of internal misconducts typically lose some or all of their privileges for a set amount of days or weeks.

The over-reliance on punitive measures such as formal misconduct reports can also create barriers for prisoners who have reduced access to appropriate education, rehabilitative programmes, and interventions or are barred from programmes on the basis of their unpredictable behaviours (Jampolsky, 2018). Moreover, even if their behaviour meets the threshold for being trusted enough to be accepted into programmes without causing too much disruption or risk to others, their cognitive and intellectual deficits are likely to render them unfit to engage in programmes that are designed for prisoners with neurotypical abilities (Brintnell et al., 2011). On paper, their inability to engage in relevant programmes is likely to be perceived as 'unwillingness to conform', creating missed opportunities for future involvement in programmes that are effective for people with neurodevelopmental disabilities (Brintnell et al., 2011).

The physical, cognitive, intellectual, social, and behavioural difficulties for prisoners with FASD can also make them more vulnerable to manipulation and coercion from other prisoners as they are prone to disclosing too much personal information and trying too hard to make friends (MacPherson et al., 2011). This can lead to their involvement with anti-social peer groups, increasing their likelihood of committing internal offences (Brown et al., 2014). Offenders with FASD are often recruited and used as scapegoats by professional criminals (Brintnell et al., 2011). Exploitation from other prisoners can increase risk of reoffending for individuals who may not have engaged with criminally active peers before their incarceration (McGinn, 2019). They are also more likely to be socially isolated due to their behavioural difficulties, and physically and sexually abused by other prisoners. This victimisation can contribute to cumulative trauma, initiating maladaptive coping behaviours such as aggression or withdrawal, that are often acted out against staff or in rebellion to prison rules (Brown et al., 2014). Diagnostic challenges within the prison can also increase vulnerability.

2.5.1 Problems with Diagnosis Increasing Vulnerability

The problems with diagnosis of FASD that are evident in the overall population also translate to the Corrections environment. Estimates suggest

approximately 680,000 offenders in the USA have FASD, however diagnoses for adult offenders could only be counted on one hand (Burd et al, 2021). An absence of resources, such as multidisciplinary teams and validated screening tools means most offenders with FASD remain undiagnosed (Burd et al., 2021). Screening tools are an essential, cost and time effective solution to identifying offenders as likely to have FASD in order to refer them for a full assessment. Currently, there are no screening tools that have been validated for use in the Corrections environment, however the Brief Screening Checklist (BSC) has been developed for use in Canadian adult Corrections settings to identify adult offenders who may be at risk of having FASD. The BSC has a total of 48 items and identifies behavioural indicators and historical and maternal indicators of evidence of prenatal exposure to alcohol (McLachlan, 2017a). The BSC has yielded positive results, with 78% sensitivity, 85% specificity, 41% positive predictive value, 97% negative predictive value, and 86% accuracy, however further research is required to replicate these findings (McLachlan, 2017; McLachlan et al., 2020a).

One FASD related screening tool that has been validated is the Alcohol Related Neurodevelopmental Disorder Behavioural Checklist (ABC) (Burd et al., 2021). It is suggested that screening for alcohol related neurodevelopmental disorder (ARND) is a potential solution to the diagnostic crisis in Corrections, as this is the most common diagnosis within the FASD umbrella, representing approximately 85% of all FASDs (Burd et al., 2021). The ABC also screens for neurobehavioural disorder associated with prenatal alcohol exposure (ND-PAE) and is now being used as a partial initial assessment in FASD diagnostic assessments. The ABC has a total of 33 items and an example of the tool is available in Burd et al. (2021). The use of screening tools would contribute to targeted assessments and more efficient delegation of limited psychological personnel in these spaces (McLachlan, 2017). Lack of diagnosis in prisons leads to Corrections staff interpreting offending or rule breaking behaviours as intentional, often responding with corrective practices such as physical restraint, internal misconducts, and loss of privileges. Research shows that diagnosis of FASD at any age can help professionals to recognise the neurological deficits behind the behaviour and contribute to more appropriate responses and interventions (Brintnell et al., 2011).

2.6 Lack of Staff Knowledge

Lack of diagnosis and prevalence statistics are arguably the leading causes of invisibility and lack of understanding of FASD. International research has identified a pervasive lack of knowledge regarding FASD among professionals in justice and Corrections settings, which can negatively impact access to rehabilitative pathways and contribute to recidivism. Limited awareness of the presence and characteristics of FASD among justice involved professionals such as prosecutors, judges and forensic clinicians has been shown to lead to higher rates of conviction and imprisonment and misdiagnosis for people affected by this disability (Gibbs & Sherwood, 2017; McLachlan et al., 2019). The lack of knowledge that pervades the justice system extends into the prison where professionals are unequipped to identify and appropriately support people with FASD (Passmore, 2019). Missing prevalence rates contribute to a sense of complacency that characterises the lack of funding, research and resources being allocated to addressing an issue that is likely very common in our prisons (Gibbs, 2022). Limited awareness, funding and resources mean FASD-related training for prison staff is scarce or non-existent (McCormack et al., 2023), even though training has been shown to significantly improve awareness and practices of prison staff working with people with FASD (Passmore et al., 2021).

2.6.1 Lack of Training

Passmore (2019) found that most Custodial staff reported having no training related to FASD, and any behaviour management training was usually offered during their initial intake and was not ongoing. Staff shortages were identified as a contributing factor to lack of on-going training, as participation in training meant that staff were being taken off the floor. Despite this lack of training, most experienced staff felt they were able to identify when an individual suffered from impairments from their daily interactions with them, and as a result, most staff were happy to modify the way they responded to maladaptive behaviours from these individuals (Passmore, 2019). Corrections staff express a desire for FASD-related training and upskilling to assist them in their work (Mutch

et al., 2016; Passmore, 2019). This is not only a reflection of the lack of training regarding a highly prevalent disability in Corrections spaces, but of the motivation of Corrections staff to learn about FASD and how they can improve outcomes for offenders in their care. Without training, Corrections staff remain unaware of the impacts of cognitive deficits on behaviour and increasing vulnerability in prison (Brown et al., 2015a).

2.6.2 Lack of Information Sharing

Problems with lack of information sharing have also been found to limit the awareness of prison staff and perpetuate FASD as the invisible disability. In Aotearoa New Zealand, health information is considered private and therefore confidential under the Health and Information Privacy Code (HIPC) (Privacy Commissioner, 2022). This can lead to significant barriers for sharing information because people are unlikely to inform other professionals of a suspected or confirmed diagnosis of FASD unless given consent by the affected individual (Lips et al., 2011). Diagnostic information is less likely to be identified as relevant for Corrections staff whose roles are not health related (Elger & Shaw, 2017). Passmore (2019) found that information on suspected or confirmed diagnoses of FASD for detained youth was not usually passed on to Custodial staff, impacting their ability to manage these neurodiverse youth (Passmore, 2019). Interestingly, most detained youth who were interviewed believed Officers should be informed of their disabilities so that they can be more understanding and less punitive in their responses. Only two youths said they would want that information to remain private, due to the risk of other prisoners finding out from Officers, which could make them more vulnerable. Officers believed they should be informed of disabilities and suggested regular multidisciplinary meetings between Health, Psychology, and Custody to discuss such matters (Passmore, 2019).

If prison staff are unaware of potential or confirmed diagnoses of the people in their care, they are unaware of how to support them in their rehabilitation (Brintnell et., 2011). In contrast, awareness of a diagnosis can help shift

perspective and inform practice in a way that supports prisoners (Brown et al., 2015a). For example, prisoners in Aotearoa New Zealand are likely to be placed in high security, mainstream units when staff are unaware of their disability (McGinn, 2019). We know that placement in mainstream units is likely to increase vulnerability for prisoners with FASD by increasing exposure to anti-social peers who victimise and exploit people who are less able to protect themselves and more prone to manipulation (Brintnell et al., 2011). Segregation or alternative placement is likely to reduce most of these vulnerabilities (McGinn, 2019).

2.7 Ineffective Interventions

Lack of training and information sharing that limits awareness of FASD also means clinicians in the prison are unlikely to be aware of FASD as a diagnosis and therefore, unlikely to search for evidence-based interventions that meet the needs of these prisoners. Evidence suggests that impairments in executive functioning make it very difficult for individuals with FASD to effectively engage with and benefit from typical prison interventions (Pei et al., 2023). Rehabilitation as a core goal of prison as an institution designed to address reoffending means many of the interventions are based on cognitive therapies that require prisoners to readily identify the role of maladaptive beliefs, thoughts, and emotions in their offending (Brown et al., 2023). These interventions are designed with the presumption that offenders have the cognitive capacity, working memory, intellectual and language skills to understand and remember content, and carry out tasks as requested. People with FASD often fail at these programmes, and are consequently perceived as lazy, uncooperative, or noncompliant (Rutman, 2016). Brintnell et al. (2011) suggest effective programmes for these offenders should be based around capability building, focusing on enhancing behavioural coping skills and social and environmental circumstances.

2.7.1 Promising Interventions

Although there is no treatment that can reverse the neurological damage caused by prenatal alcohol exposure, behavioural modification in youth offenders

have been shown to reduce maladaptive behaviours in favour of appropriate ones. Positive reinforcement and loss of reward for negative behaviours have been effective for offenders where staff have maintained consistency and the offender's environment is structured (Novick-Brown et al., 2012). Checklists, alarms or in-person reminders, signs and calendars can assist with building structure and reducing confusion and frustration for offenders (Quan et al., 2019). Creating structure and routine minimises decision-making, reducing stress. Indeed, maintaining the changes can be challenging once the offender is released and removed from the structured environment of the prison, which is why it is recommend that staff work closely with whānau or support members by ensuring they are involved in behavioural modification training and educated on how to duplicate these behaviours in life outside the prison (Novick-Brown et al., 2012). Research with youth offenders with FASD also shows they generally have better outcomes where less decision-making is required in unfamiliar situations. Contingency planning must be implemented to ensure the offender can appropriately self-direct during unpredictable situations. It is highly likely that applying behavioural modification to the adult offender population will produce similar results (Novick-Brown et al., 2012).

Mentors and advocates appointed by the institution to assist with resolving conflict and defuse potentially explosive responses to stressful situations have been recommended for individuals with FASD in Corrections facilities (Forrester et al., 2015). In the Aotearoa New Zealand context, this person could be a volunteer, chaplain, or Case Manager. Mentors and advocates should receive FASD focused training and education (Chapman, 2008). Brown et al. (2015a) developed an intervention tool for Custodial staff to improve interactions with offenders with FASD. The intervention tool was designed based on an understanding of the cognitive, behavioural, and social difficulties these individuals experience that drive unintentional maladaptive behaviours and rule-breaking in Corrections settings. The acronym D.E.A.R is used to encourage and remind staff to use Direct language, Engage support systems, Accommodate needs, and Remain calm. The intervention tool can be seen in Brown et al. (2015a).

A training intervention developed by Passmore et al. (2021) was well-received by staff at a youth detention centre in Western Australia. Based on blended learning, the intervention combined face-to-face learning with educational videos that were recorded on site, showing the experiences of neuro-disabled youth during their time in detention. The use of the videos for documenting some of the challenges experienced by these youth was influential in eliciting empathy and buy-in from the staff, who then received face-to-face education about FASD and had the opportunity to ask questions (Passmore, 2019). Officers involved in the training rated the delivery of the intervention highly, stating it was relevant to their role and the prison context. Officers reported feeling motivated to change their communication strategies, such as using simpler language and repetition. They reported they would take the time to be more understanding, patient and empathetic to the young people in their care. While the majority of participants stated there was nothing that they did not find useful about the training, they also acknowledged the difficulty implementing all of the training suggestions due to a lack of resources and staff. Overall, the intervention delivered by Passmore and colleagues illustrates the lack of knowledge that is prevalent among Corrections staff, and the positive impact FASD-specific training can have for both staff and the individuals they manage.

Development of FASD-related training and interventions can be enhanced by exploration and consideration of the strengths of offenders with FASD. The narrative regarding this disability predominantly focuses on deficit, which has been shown to increase stigmatisation that increases barriers to social inclusion (Quan et al., 2015). Strengths-based approaches increase self-esteem, quality of life, a sense of competence and resilience. A strengths-based approach can also increase optimism for caregivers and staff, shifting their perspectives of the individual as burdensome and intentionally 'bad' (Flannigan et al., 2021). Identification of positive outcomes and characteristics for individuals with FASD include maintaining employment, being goal-directed, determined, motivated, persistent, and possessing skills in art and sports (Flannigan et al, 2021). Perhaps the most significant strength of individuals with FASD in Corrections facilities is their resilience and ability to survive through adversity. By capitalising on these

strengths, individuals can tap into their talents and interests, increasing participation in training programmes and vocational opportunities.

Long-term Case Management has also been recommended for offenders once they are released from prison. Acting as an external brain, the necessity of a long-term Case Manager has been likened to dog guides for the hearing disabled (Forrester et al., 2015). Long-term Case Managers would focus on providing support for activities of daily living such as financial management, vocational support, nutrition and hygiene, shopping, and transportation to appointments. Volunteers may be a potential solution to staff shortages and could provide advocacy and facilitate connection to community services (Novick-Brown et al., 2012). Individualised support may also be offered from whānau members who can assist with things like meal preparation and home maintenance (Quan et al., 2019).

2.8 Purpose of the Study

Global and national information suggests there are significant gaps in understanding and support for people with FASD in Corrections facilities (McCormack et al., 2022), often leading to punitive responses from frontline staff and cognitive interventions that are ineffective (Brintnell et al., 2011). A lack of training and problems with information sharing systems and processes have been shown to create barriers to the identification and appropriate management of prisoners with FASD (Passmore, 2019; Passmore, 2021). In response to these gaps and limited knowledge in the NZ Corrections context, this research is conducted in collaboration with Auckland South Correctional Facility (ASCF). The purpose is to explore the knowledge, experiences, and practices of FASD for staff working in the prison. It is hoped the research will identify gaps in staff knowledge of FASD and help to scaffold change by informing training, practice and more effective usage of institutional information sharing systems. To our knowledge, this is the first research of this kind in Aotearoa New Zealand. Most studies assessing the knowledge, attitudes, and practices of FASD in the Aotearoa New Zealand justice sector have been conducted with Police, court staff, and Corrections Officers, limiting understanding of the perspectives of non-custodial prison staff

(McCormack et al., 2022). This study will explore the knowledge, experiences, and practices of staff from various roles at ASCF including participants from Custody, Case Management, Health, and Psychology, giving a more well-rounded perspective of staff working in various sectors of the prison.

2.8.1 The Prison Context

As of September 2023, there were 8,893 prisoners incarcerated in Aotearoa New Zealand. 959 of those were housed at ASCF (Ara Poutama Aotearoa, 2023b). ASCF is a privately run prison that has been in operation since 2013 and has contractual obligations to The Department of Corrections (Ara Poutama Aotearoa). The Public-Private Partnership (PPP) between these two entities means Serco, who operate under SecureFuture, are responsible for the operations and maintenance of ASCF and are bound by specific requirements set out by Ara Poutama Aotearoa. More detailed information regarding the contractual agreement between Ara Poutama Aotearoa and ASCF is available on the Ara Poutama Aotearoa website (Ara Poutama Aotearoa, 2012). Private prisons have traditionally received a 'bad wrap' due to their monetary incentives to keep more people in prisons (Eisen, 2018). In Aotearoa New Zealand, privatisation has taken on a new model. ASCF is contracted to Ara Poutama Aotearoa to reduce reoffending at rates faster than government-run facilities. Although the traditional nature of prisons as places that enforce the deprivation of liberty still remains, ASCF operates on principles of care and innovation to achieve an upward trajectory of reducing recidivism. A progress report in 2018 stated ASCF had achieved minimum targets of reducing reoffending by 12.53% for Māori prisoners and 36.56% for non-Māori prison (Ara Poutama Aotearoa, 2018). At ASCF, Corrections Officers are referred to as Rehabilitation Officers. To maintain simplicity, Rehabilitation Officers at ASCF will be referred to as Custodial Officers in this thesis.

2.9 Summary

This chapter included an in-depth discussion about the characteristics of FASD as a disability. Diagnosis and diagnostic challenges were explored to explain difficulties associated with prevalence statistics, prevalence in special sub-populations such as children living in foster care and indigenous peoples, and barriers to support. It gave an overview of FASD in the justice system and Corrections contexts, detailing how adverse life experiences such as living in foster care can increase risk of conviction and reimprisonment. Vulnerabilities of prisoners with FASD were explored in relation to the lack of awareness of Corrections personnel that stems from diagnostic challenges, lack of training and information sharing within these institutions. Implications of a lack of staff awareness were discussed in relation to prisoners' with FASD involvement in ineffective interventions, ending with an overview of promising interventions that have been identified in the literature. The following chapter will discuss the methodology used for the current research.

Chapter 3: Methodology

3.1 Introduction

This chapter will discuss the methodology used in designing, executing, and analysing the research. It will also include a section on some of my most meaningful reflections drawn out of reflexivity practices, exploring how my own assumptions, perceptions, and position as researcher impacted the overall findings.

3.2 Methodology

Qualitative research analyses text as opposed to numerical data in quantitative research (Clarke & Braun, 2013). It is less concerned with identifying cause and effect between variables and more concerned with exploring, describing, and understanding how people experience certain conditions and situations (Willig, 2022). Qualitative research is, therefore, often chosen as a research methodology to give voice to participants, especially those who have been historically marginalised in psychological research (Stainton Rogers & Willig, 2017). There is recognition that psychological knowledge generated prior was largely based on a positivist tradition of pre-conceived theoretical formulations that aimed to objectively 'locate' pre-existing assumptions about people that were dominant in society at the time. This meant that people who did not fit into those pre-conceived ideals were typically excluded from traditional psychological research. Qualitative research especially gives voice to those who were historically silenced, recognising that their experiences cannot be understood within theoretical formulations that have been developed from research conducted with populations different from their own (Stainton Rogers & Willig, 2017).

A qualitative approach analyses the personal accounts of people to discover meaning in relation to particular phenomena, and it is concerned with the way people interpret and make sense of their experiences in the world (Clarke & Braun, 2013).This approach grounds the research findings within the cultural milieu,

lived experience and perspectives of both participants and researcher, meaning it is context specific, and arguably inseparable from the context in which it was created (Savin-Baden & Howell Major, 2013). Within qualitative research, participants are acknowledged as co-collaborators. Their knowledge is valued and the relationship between researcher and participant is acknowledged as interdependent, recognising that knowledge is co-constructed through the research process (Savin-Baden & Howell Major, 2013). This means that the background and culture of the researcher must be considered in terms of the impact they can have on the way data is gathered and interpreted. In contrast to quantitative research, objectivity is incongruent with qualitative research, given the role of the researcher in data analysis and interpretation. Subjectivity is recognised as inseparable from the data analysis (Clarke & Braun, 2013).

3.2.1 Preliminary Consultation

Undertaking a co-collaborative approach started with preliminary consultation with key members from the Senior Management Team at Auckland South Corrections Facility (ASCF). This collaboration ensured that the research targeted areas of need and was focused on the goal of improving outcomes for prisoners and staff from the perspectives of the research participants. The conversation led to an agreement that three staff from each of the following four different service departments within ASCF should be invited to be part of the research: Case Management, Custody, Health, and Psychology. This would provide a total of 12 participants and a varied scope of information due to the different perspectives staff from these areas were likely to have. It was agreed that modes of interview offered should range from face to face on-site, or via video conferencing software called Microsoft Teams.

3.2.2 Ethical Considerations

Ethical considerations were guided by Massey University's Code of Ethical Conduct for Human Research Participants (Massey University, 2017) and the Code

of Ethics for Psychologists working in Aotearoa/New Zealand (Code of Ethics Review Group, 2012). Ethical considerations were discussed with supervisors and with staff at ASCF and included informed consent, confidentiality, potential harms and benefits to participants, and engagement with te āo Māori. Once all these issues were discussed, a research proposal was presented and approved by the ASCF Ethics Committee and signed off by the Prison Director. A peer review process also took place at Massey University which assessed the research as being low risk as no potential harms were identified given all participants were professionals working in a high-pressure environment with people from a variety of backgrounds. It was not anticipated that speaking about their professional experiences and understandings of FASD within the prison space would cause any distress. All of the interview questions were based in the context of their employment and did not seek to explore personal experiences. Potential benefits may have included educational value, giving voice to participants, increasing self-awareness and a sense of purpose (Hutchinson et al., 1994). A low-risk notification was then made to the Massey University Human Ethics Committee.

3.2.3 Recruitment and Participants

Participants were invited to participate in an interview via an information sheet that was disseminated to staff emails. Participants registered their interest by contacting the researcher and signing the attached consent form. Examples of the information sheet and consent form are provided in Appendix A. As the research evolved, staff from other areas not included in the initial research proposal requested to participate in the research. All participants were informed of their right to decline or accept an invitation to participate.

Information was provided to participants in a clear, professional, and readable format that ensured information was easily comprehended and understood. The voluntary nature of the research was emphasised. The information sheet was discussed with all participants before beginning the interview as well as issues of consent. Participants were informed they could withdraw their data for up to 21 days following their interview and that video

recordings would be destroyed once transcribed. The signed consent forms will be stored electronically under password protection and destroyed after five years.

Whakawhanaungatanga is a concept central to Māori culture and was the approach used to build trust and ensure comfortability through familiarity for all participants. Participants who identified as Māori were asked if they would like to begin and end the interview with karakia[3] and mihimihi[4] (Macfarlane, 2016). A generous amount of time was given to both researcher and participant to engage in appropriate professional and personal disclosure about themselves to facilitate a relationship based on shared knowledge and power (NiaNia et al., 2019).

In total, the final data set included responses from 17 interviews from 16 participants; 2 from Psychology; 3 from Education, 3 from Case Management, 4 from Custody, 2 from Health, and 2 from the Cultural team. One participant participated in a supplementary interview to provide general information about the prison itself. Of the 16 participants, 11 were female and 5 were male. Participants were from a variety of cultural and ethnic backgrounds. These included (as identified by the participants) NZ European/Pākehā, Other European, Pasifika, Māori, and South-East Asian. Specific ethnicities and country of origin have not been identified to protect anonymity. Participant experience within the Corrections service was also varied, ranging from 0.5 to over 30 years, with an average of 10 years-service across the sample.

Participants were given full anonymity by ensuring no personal details such as name, age, ethnicity, or gender were shared in the research. Participant responses were identified by role only to ensure participants could not be identified.

3.2.4 Data Collection Methods

Once participants had expressed their willingness to participate in an interview, times and modes were established and consent forms were signed and

[3] Prayer.
[4] Sharing of whakapapa or genealogy.

returned through email correspondence. All interviews were conducted via Microsoft Teams (MT) as agreed to by the participants, due to the distance between the researcher being located in Taranaki, New Zealand, and the participants being located in Auckland, New Zealand. All participants were happy to meet via MT.

Semi-structured interviews were employed as the method for gathering data. This most widely used method of data collection in qualitative research allows the researcher to guide the interview while simultaneously encouraging participants to talk about their experience and anything they deem relevant to the research questions (Willig, 2008). The less formal interview structure allows the interviewer and participant to build a rapport, and the researcher to consider the cultural milieu of both themselves, and the interviewee (Willig, 2008).

All interviews were conducted in private spaces in participants' homes or offices. Due to the dynamic nature of working in a prison, participants were sent a reminder on the day of the interview. Participants were given a verbal recap of the interview process as outlined in the information sheet, including the goals of the interview, expected duration, the participant's right not to answer any of the questions or withdraw consent at any time and their rights to confidentiality. The participants were asked if I could record the interview and gave verbal confirmation that they agreed to this. Participants were informed of the researcher's prior experience working as a Corrections Officer and my future goals of becoming a Registered Psychologist. Warm-up questions centred around demographics and role experience were used to build rapport and confidence before asking progressively in-depth questions (Jacob & Furguson, 2012). In closing, participants were thanked for their participation and reminded they would receive a koha[5] for their contribution. They were informed of similar research that had been conducted overseas in Corrections facilities and the positive outcomes that had been generated from these research projects. Participants were given the opportunity to ask the researcher any further questions before the interview ended. If the interview had been opened with a karakia, a closing karakia was

[5] Māori for a gift, offering, or contribution that has connotations of reciprocity in the interest of maintaining social relationships.

conducted. Due to the participants working in different service departments in the prison with varying levels of experience and understanding of FASD, the content of some of the interview questions varied significantly, and new areas of direction were developed once I noticed a saturation of data regarding initially formulated questions (McGrath et al., 2019). A copy of the interview schedule is included in Appendix B. Interviews were between 30 and 80 minutes long.

Interviews were recorded using software built into Microsoft Teams and were manually transcribed with the assistance of an artificial intelligence online software program named Otter. All participants were offered an opportunity to review their transcripts to ensure appropriate and fair representation. Raw data was restricted for use in the research study only and were password-protected. Only the researcher viewed interview recordings and all interview recordings were permanently deleted once transcriptions had been completed. The interview transcriptions generated 251 pages, averaging 16 pages per interview. The interviews were transcribed verbatim. Participants received a koha for their participation to the value of a $40 New World voucher.

3.2.5 Data Analysis

The current research was based in a realist/essentialist epistemological stance focusing on the semantic content of data. A realist approach takes what participants say at face value, assuming that their account of the processes of why they do the things they say they do represent reality (Willig, 2022). This meant that themes were not analysed according to preconceived notions about codes and themes that might fit into a particular theory. Rather, direct quotes were interpreted as having meaning in and of themselves, using an inductive/bottom-up approach to generate codes and themes (Braun & Clarke, 2006).

Through the analysis process and my reflective practice, three themes were identified. These were ‘Limited Awareness’, ‘Barriers to Information Sharing’ and ‘Practices and Relationships’ and are discussed in the following chapters. These themes were interpreted within a post-positivist paradigm using a range of

different theories. Such a paradigm or approach seeks to acknowledge that knowledge is socially constructed and context specific (Fox, 2008). Social Cognitive Theory was drawn upon to interpret the interview data as it usefully explains how human functioning is impacted by the interaction between behaviour, cognitive and personal factors, and the environment, referred to as 'triadic reciprocality' (Bandura, 1986; Bandura, 1999). The theory posits that humans are agentic in that we are not merely influenced by external factors, rather, we are active agents in our experience and understanding of the world (Bandura, 1999). The ways in which people respond to their environment is determined by both internal and external factors and the sociocultural context in which behaviour occurs, in an indeterminate pattern of reciprocal interaction (Bandura, 1999). The attitudes and practices of participants in the present study were influenced by internal values, morals, and beliefs; affective responses to the experience of prisoners with FASD; and various barriers and facilitators that were dictated by prison systems, policy, and procedure. While responses to different situations were highly individualised, they were also influenced by role requirements and organisational structures and expectations, reflecting the interaction between thoughts, feelings, and the environment.

The overall thesis was written with the intention of having practical implications for ASCF as an organisation, therefore, an overarching framework of Organisational Learning guided data collection and analysis. Organisational Learning Theory asserts that areas of deficit in organisational practice must be identified in order to enhance performance and adaptability (Basten & Haamann, 2018). Organisational Learning Theory refers to this process as double-loop learning. Within double-loop learning "a feedback loop exists, which connects the detection of error not only to strategies and assumptions of effective performance but [also] to the values and norms that define effective performance" (Basten & Haaman, 2018, p. 3). In the current study, staff experiences and practices were explored to increase awareness of the gaps in knowledge about FASD, to increase awareness and potentially inform alternative strategies to improve practice and decision making for prison staff working with prisoners affected by FASD.

Participant responses were analysed using Reflexive Thematic Analysis (RTA). RTA allows the researcher to analyse data by searching for patterns and organising it into themes. RTA is a relatively simple analysis method, providing information that can be comprehended by a variety of audiences. This makes it an appropriate method for analysing and reporting on a topic that is largely under-researched within its specific context (Braun & Clarke, 2022). It is important to note that the themes that come out of the data are dependent on the cultural context of the researcher rather than being inherently embedded within the data waiting to be 'discovered'. Within RTA there is no objective truth, only patterns and themes of interest that have been selected by the researcher (Braun & Clarke, 2006). A detailed section on reflexivity will be discussed in subsequent sections.

The data was analysed according to Braun and Clarke's (2006) six phases that are discussed in their step-by-step guide:

1. Familiarising oneself with the data. Transcripts were read at least once before I began to generate codes. This allowed me to get an overall feeling for the most common patterns. The authors emphasise immersing oneself into the data as this will shape the way patterns are coded.
2. Generating initial codes. Codes are words or short phrases that summarise what a participant has said. Once familiar with the data, I began generating initial codes to begin organising the data into items and patterns I thought were of interest and relevant to the research question. Transcripts were converted into Microsoft Word documents and codes were generated using the 'Comments' function under the 'Review' tab. Parts of the transcript were highlighted and comments generated against the corresponding response. This was the most convenient way of coding such a large amount of data as it allowed me to readily search for codes with the 'Find' function under the 'Home' tab. Clicking on a comment (or code) would also highlight the correct part of the transcript, so it was clear which part the code was attached to.
3. Searching for themes. Once all the data was coded, I began organising the codes into potential themes by grouping the codes that were similar and identifying codes that showed up in the data the most. I did this by creating

a word document with all of the codes and creating a tally of how many times they were used to find the most common patterns, creating another document of 'main themes' and 'subthemes'.

4. Reviewing themes. During this phase, codes were redeveloped according to the initial themes or removed if they were not very common. I then created an updated list of codes and read through the data again, assigning the new codes to relevant pieces of information. I created colour-coded thematic maps in Microsoft Word to organise the updated codes into core themes and potential subthemes.
5. Defining and naming themes. Once the core themes were identified, I worked in consultation with my supervisor Dr. Veronica Hopner to give names to themes and subthemes. During data analysis, the names and subthemes evolved and changed along with the interpretation, however the core themes remained the same.
6. Producing the report. This is the final phase of the step-by-step process and involved relating the data to the themes and back to the overall research question.

3.3 Reflexivity

Within RTA, the researcher's position is understood as an analytic tool used to create knowledge from the voices of participants (Braun & Clarke, 2006). Reflexivity is therefore a central component of RTA (Braun & Clarke, 2022). Reflexivity is a process whereby the researcher considers how their values shape knowledge produced in the research. They do this by reflecting on their personal beliefs, biases and assumptions, stereotypes, personal experiences, culture, and position in society. They must consider how these factors might influence their interactions with participants and how they engage with and interpret the data (Dodgson, 2019). Reflexivity brings credibility to the research by acknowledging the context in which knowledge was created rather than claiming the outcomes of the research to be universal truth (Dodgson, 2019).

Following each interview, I engaged in a reflexive practice in a journal where I wrote down any feelings or thoughts that came up throughout the interview especially regarding any parts of the conversation that challenged my personal values, beliefs, and biases. I also wrote down what I thought went well and what could be improved on in subsequent interviews. I continued to write reflexive entries in my journal throughout the data analysis process to identify any personal values, beliefs, biases, or assumptions that were influencing the way transcripts were interpreted. Below is a summary of the reflections I had throughout the research process.

At the time of writing this thesis, I am a 30-year-old woman who identifies both as Māori and Pākehā. Before enrolling to complete a Postgraduate Diploma in Psychology with Massey University, I was employed by The Department of Corrections/Ara Poutama Aotearoa as a Corrections Officer (CO) for five years. During my time here I was involved in multiple roles including training and mentoring new recruits and being promoted to the role of Senior Corrections Officer (SCO). Once I left Corrections, I also worked with youth who had been excluded from school to keep them engaged in alternative education and mentor them toward finding employment or re-entry into the mainstream school system. Given my previous experience as a CO in a publicly run prison, it was imperative to engage in ongoing reflection to understand how my own assumptions and preconceptions would inevitably influence the research design, execution, and data analysis.

Throughout my time as a CO and even throughout my postgraduate studies, fetal alcohol spectrum disorder (FASD) was not a disability I was familiar with. The research topic was given to me when my supervisor Professor James Liu introduced me to my co-supervisor Dr. Veronica Hopner. Veronica had been wanting to get the research off the ground but sought a student who had worked in a prison, given the unique culture of these spaces. My ignorance towards FASD as someone who had worked in a prison for five years and had completed a postgraduate diploma in Psychology reflects the pervasive lack of knowledge of the professionals who work with individuals living with this disability. Nonetheless, after being introduced to some of the literature and New Zealand-based

documentaries about the lack of support and advocacy for these people, it sparked an interest within me that I believe will continue throughout my career.

The entire research process has challenged many of my own preconceptions and biases towards FASD, along with the rest of the population with no or limited knowledge of the disability. FASD was not a disability I ever considered to be affecting any of the prisoners in my care while I was working as a CO. Engaging in a full literature review before conducting my interviews was helpful in identifying and re-shaping these views. Identifying and addressing these preconceptions before conducting my interviews most certainly affected the way I led interviews and analysed the data. After a deep dive into the literature, I was able to see that FASD is likely very prevalent in Aotearoa New Zealand Prisons and prisoners with FASD do not receive the support they need. Had I conducted my interviews before my literature review, my lack of understanding of how limited my own knowledge of FASD was, even as a person with higher education experience would have completely changed the interview questions and the way I presented them to the participants.

Taking a deep dive into the literature also allowed me to make connections between some of the prisoners and young people I had worked with, recognising that many of them 'fit the bill' for potentially having FASD. Joining the prison service at the age of 23 and coping with the challenges that come with being a young female in a position of authority over involuntarily detained men had hardened me toward taking a 'no-nonsense' approach. I, like many other CO's, looked to treat prisoners based on the behaviour that was in front of me. I was completely unaware of the possibility that a neurodevelopmental disability might be causing a lot of the maladaptive behaviours I dealt with on a daily basis. Absorbing the literature on the subject of FASD forced me to engage in processes of very confronting introspection that revealed I had probably responded in punitive ways that were ineffective on many occasions, missing opportunities to really engage with and support the men.

I believe my prior experience and separation from my role as a CO had a direct impact on the way I designed the research and engaged with the literature,

participants, and data analysis. My own experiences largely dictated the way I conversed and found common ground with participants, as I held underlying assumptions that they must have had similar experiences to me. This was especially true when interacting with the Custodial participants. In this manner, my own assumptions may have influenced responses that more clearly aligned with my own experience and information found in the literature. My focus was to continue being reflexive and maintain a safe space for participants to give responses that were as authentic as possible. Participants challenged me many times on some of the assumptions I held and for this I am thankful because it lends credibility to the research.

My position as an insider/outsider researcher undoubtedly influenced the outcomes of the research. Insider status comes from sharing some group identity with participants and outsider status comes from possessing a different group identity to participants (Clarke & Braun, 2013). My insider status came from my experience having worked in the prison setting and having an understanding of policies and processes but most importantly, the intricacies of 'prison culture'. I understood through first-hand experience staff-management, staff-staff and staff-prisoner relationships, and brought more than a 'voyeuristic interest' to my interactions with participants and prison officials. I had lived experience of the challenges prison staff face, so it was important to me that participants and their efforts be represented in a way that empowered and honoured them. Researchers deemed as insiders can increase trust and information sharing (Parker Webster & John, 2010). My insider status became most evident to me when I was welcomed to the site and shown aspects that might be not usually be shown to 'visitors'. There seemed to be an inherent feeling of trust afforded to me as someone who had lived experience of their current reality. Staff appeared to feel comfortable sharing stories of prisoners they had worked with (while maintaining confidentiality), who had FASD and some of the approaches they had taken. Some staff did appear apprehensive upon first meeting me, only having been told that I was a researcher, however, they appeared to become more open once they were told I was an 'ex CO'.

I believe it was my insider status that encouraged participants to feel as though they could open-up about more 'politically correct' issues and some of their

experiences working for Corrections and with prisoners more generally (Parker Webster & John, 2010). I also believe that my insider status contributed a lot to people participating in the research, as prison staff tend to tread very carefully with outsiders and can be gatekeepers of information, especially with researchers, and rightfully so (Beyens et al., 2015). Beyens et al. (2015) discuss the mistrust of researchers and academics that has resulted from a long history of literature that focuses on the issues and perspectives of prisoners and prison administrators, largely ignoring those of the staff in these spaces. To get an inside look into the knowledge, experiences, and practices of staff, a researcher with prior Custodial experience hopefully put participants at ease and gave them some assurance that their perspectives would be heard and validated.

While my prior experience placed me as an insider, it was clear that I was also an outsider in many respects. My Custodial experience did not allow me an insider's perspective into the roles of participants from Education, Psychology, Health, and the Cultural team. Custodial experiences and interactions with prisoners are usually very different to non-Custodial or civilian staff. Custodial staff maintain security through authority and legal powers, whereas non-custodial staff must rely solely on cooperation and work with prisoners more collaboratively toward their rehabilitative goals. These two different occupational orientations have been reported to influence different role-related attitudes and contribute to suspicion of other organisational roles within the prison environment (Williams, 1983). My understanding of the behaviours of prisoners and prison processes was largely gained from a security perspective, limiting the relatability I could have with non-custodial participants and potentially the information they chose to share.

Constant revisiting of transcripts was vital to ensuring participant experiences were interpreted as accurately as possible, as well as working closely with my supervisors during analysis to gain perspectives outside of my own awareness. My supervisors' input was essential for guiding me to look further into psychological theories for explanations of participant responses outside of my own experience.

3.4 Summary

This chapter discussed the methodology used to conduct this research including the research design, data collection methods, data analysis, and gave a summary of some of my most meaningful reflections. Organisational Learning Theory, Social Cognitive Theory, and Organisational Theory as theoretical frameworks were utilised to interpret the three themes of, 'Awareness of FASD', 'Barriers to Information Sharing' and 'Practices and Relationships'. Results of the thematic analysis and discussion of the findings are presented in the following chapter.

Chapter 4: Analysis- Limited Awareness

4.1 Introduction

The aims of this research were to explore the knowledge, experiences, and practices regarding FASD for staff at Auckland South Corrections Facility (ASCF) to identify the barriers and facilitators of staff knowledge and the implications for prisoners with this disability. Three themes and various subthemes were identified from the analysis of participant interviews. These were:

4.2 Awareness of FASD

- 4.2.1 Continuum of Awareness
- 4.2.2 Lack of Visibility and Discussion
- 4.2.3 Role Definition and Priority Setting
- 4.2.4 Lack of Training
- 4.2.5 Implications of Limited Awareness of FASD
  - 4.2.5.1 Vulnerability
  - 4.2.5.1 The Impact of Awareness on Staff-Prisoner Relationships
  - 4. 2.5.3 Barriers to Appropriate Interventions
  - 4.2.5.4 Moral Responsibility to Support Prisoners

4.3 Barriers to Information Sharing

- 4.3.1 Accessing Information
- 4.3.2 Siloed Teams
- 4.3.3 Confusion around Confidentiality
  - 4.3.3.1 Informed Consent
  - 4.3.3.2 Potential Stigma and Increasing Vulnerability
  - 4.3.3.3 Staff Exercise Discretion

4.4 Practices and Relationships

- 4.4.1 Staff-Prisoner Relationships as a Facilitator of Wellbeing
  - 4.4.1.1 Intuitive Sense and Identification

4.4.1.2 Rapport and Familiarity

4.4.1.3 Humour as a Facilitator of Rapport

4.4.1.4 Patience, Empathy and Understanding

4.4.1.5 Recognising Strengths

4.4.2 Strategies for Working with Prisoners with FASD

4.4.2.1 Communication Strategies

4.4.2.2 Teaching Styles

4.4.2.3 Individualised/Tailored Approaches

4.4.3 Organisational Culture as a Facilitator of Change

4.2 Awareness of FASD

Awareness was characterised as both knowledge of suspected or confirmed cases of prisoners with FASD, and a general awareness of the characteristics associated with the disability itself. Participant's awareness of FASD occurred along a continuum from a lack or limited awareness to basic awareness, to greater awareness. Although awareness occurred on a continuum, participant awareness was generally limited in terms of how FASD was understood, identified, and managed. The first part of this theme looks at awareness of FASD and outlines the causes offered by participants for limited awareness within the sub-themes of 'lack of visibility and discussion', 'role definition and priority setting' and 'lack of training'. This theme then highlights the implications of limited awareness of FASD in terms of 'vulnerability', 'the impact of awareness on staff-prisoner relationships', 'barriers to appropriate interventions' and a 'moral responsibility to support prisoners'.

4.2.1 Continuum of Awareness

Knowledge exists at different levels, shifting trajectory as rudimentary information becomes more familiar. Previously independent, cognitively stored pieces of information become more familiar when they can be interpreted and given meaning in relation to a common denominator, such as an event, action,

behaviour, concept, principle, characteristic, decision, or policy (Akbar, 2003). Knowledge is dynamic and flexible, thus existing on a continuum. It is argued that a depth of knowledge occurs in five stages: novice, advanced beginner, competent, proficient, and expert (Perksy & Robinson, 2017). Knowledge capacity, organisation, and retrieval get better with more experience and progressive problem solving. As knowledge becomes more integrated, people develop deeper understandings of the subject matter and can readily recognise patterns and draw meaningful connections between individual pieces of information. Without maintenance and practice, knowledge can also degrade (Persky & Robinson, 2017).

Participants' knowledge of FASD varied in terms of how much awareness they had. Participants who worked in areas such as Case Management, Psychology, and Cultural teams generally had more awareness than participants who worked in Health, Education, and Custody. Unsurprisingly, participants with tertiary qualifications in Psychology or Education, or who had prior experience working with people with FASD had the highest amount of awareness. Although awareness was varied, it was found that overall, most participants had a limited awareness of FASD.

A quarter of the participants including some from Health and Education were found to have a limited or lack of awareness of FASD. A lack of awareness was characterised as having no or very limited knowledge of the disability prior to participating in the research. These participants had generally heard about fetal alcohol syndrome and were aware that babies could be born with birth deficits if they had been exposed to alcohol in the womb, however they were unable to identify any of the specific cognitive, behavioural, or physical deficits that could arise:

> *It's when they got exposed to an alcohol when they were still inside the womb? Yeah. Yeah, that's all, that's all I know.* (Education).

The majority of participants (43%) from Case Management, the Cultural Team and Custody were categorised as having a basic awareness of FASD. Participants in this category were typically able to mention some of the cognitive,

behavioural and/or physical deficits associated with FASD, however, most struggled to clearly articulate their understanding.

Two participants were able to describe some of the deficits associated with FASD by drawing on their experience of working with prisoners they knew were affected by the disability, however they only had knowledge of what they had directly observed:

> *He's quite, I think he's quite good at um, at kind of fitting in socially, like he comes across as if he's following conversations, he understands everything, but in actual fact he's not taking it in, or he's not comprehending what's going on.* (Education).

> *To me he was sort of, maybe underdeveloped? I don't know. But yeah, I sort of found him very different* […] *I find, found that he was a bit slower in processing things, and yeah, like, his maturity wasn't quite there as much as the others.* (Custody).

It was found that just over 30% of participants from Custody, Case Management and Psychology had the greatest awareness of FASD. Participants with greater awareness were clearly able to recognise more specific cognitive, behavioural and/or physical deficits associated with FASD in more detail, however they acknowledged they would find it difficult to differentiate FASD from other common disabilities or the characteristics of prisoners in general:

> *Yeah, I mean, I suppose if you're just thinking about youth, you, you'd, you'd be hard pushed to separate out what is or isn't potentially FASD because obviously, youth are quite impulsive anyway and don't necessarily have the best problem solving skills* […] *Yeah, easily led, easily manipulated into doing the dirty work of the gangs or what have you* […] *Yes, and inability to control their anger as well, you know, really quick to blow up – and I mean, you look across the prison population, and my goodness, you'd probably say that was about 75% of the population, wouldn't you?* […] *Yeah, I mean, like I say, all*

those, all those potential things that could be going on for somebody […] *you know, in violent fights as they've gotten older in the gangs and things like that, ADHD, all of those things can present with the same issues, right? Memory, impulse control, ability to kind of control their impulse – whatever. And it would be very hard to say it's a definite one thing or that diagnosis, I suppose.* (Case Management).

A lot of the symptoms are identical to people that have got ADHD so the symptoms can get lost, especially that hyperactive behaviour, you know the memory, the poor memory, learning abilities, speech, and language that, you know, they can, can go from zero to a-hundred percent erratic in seconds, and then on the other side as well. So, a lot of the signs and symptoms of FASD can cross over to other diagnosis. (Health).

Regardless of participants being understood on a continuum of awareness around FASD, it was evident that overall, there was limited awareness of the how to identify FASD and best practice approaches to working with prisoners with FASD. A lack of visibility and discussion about FASD, role definition and priority setting, and a lack of training were all identified as contributing factors to a lack of awareness in this area, as a senior member of the health team noted:

The problem is the lack of resources, the lack of knowledge, the lack of discussion within this environment – within a Correctional environment. And, and if you look at – if you look at the setup of staffing, the setup of staffing plans within health, or within R&R, which is the rehabilitation arm, you know, within Psychology, and how much is put into FASD?

4.2.2 Lack of Visibility and Discussion

Lack of diagnosis and a shortage of resources have contributed to the invisibility of FASD in justice settings. Without prevalence rates, there is very little research and funding being dedicated to FASD, leaving professionals with a lack of

training and awareness, and misperceptions about this disability (Gibbs, 2020). A dearth of research means there are currently no validated screening tools for FASD in Corrections and therefore, no way to assess actual numbers of prisoners affected by this disability (McLachlan, 2017). It has been estimated that one in three prisoners could be diagnosed as having FASD if prenatal exposure to alcohol is confirmed (Burd et al., 2021).

Participants attributed a lack of discussion and visibility to the lack of diagnosis within prisons:

> *I think there's been numerous* [prisoners with FASD] *that have come in front of us* […] *you have that discussion around yourselves as a clinician team, you know "I think there's some you know, I think this tāne[6] or this wāhine[7] has got some, some FASD?", but usually it's PTSD, you know? So, and that's only because there's – it's not spoken about, FASD. There's not enough kōrero about it out there.* (Health).

FASD expression varies considerably depending on the severity of damage. This means that individuals can present with a wide range of behaviours that are difficult to differentiate from other, more commonly understood disorders such as attention deficit hyperactivity disorder (ADHD), for example (Bagley, 2019). In a study conducted by Gibbs (2020), justice professionals in Aotearoa New Zealand acknowledged their limited awareness had led to the missed or misdiagnosis of young offenders with FASD.

One participant with over 30 years' working in the Corrections space also reflected on the lack of discussion of FASD:

> *But I can't recall actually ever discussing FASD. I mean, I mean, it would get mentioned in passing type thing, but there was never any, it was never ever taken seriously, if I could put it that* way […] *and the more I've reflected on*

[6] Māori word for men and how some staff refer to male prisoners.
[7] Māori word for women and how some staff refer to female prisoners.

this […] I'm *of the belief that we've got a lot of people who, who suffer from FASD but it's just undiagnosed.* (Custody).

This participant acknowledges that FASD is a problem, but no one is talking about it because of the lack of diagnosis. This is theme consistent across the justice sector, with Aotearoa New Zealand champions such as Judge Andrew Becroft and Judge Stephen O'Driscoll continuing their political campaign for more awareness of FASD in the court system. They argue that more awareness is critical to ensuring young offenders with FASD receive appropriate representation and consideration of their neurodevelopmental disabilities in relation to their offending (Gibbs & Sherwood, 2017).

4.2.3 Role Definition and Priority Setting

Participants suggested that awareness of FASD is not currently understood as a priority in their roles. Participant responses indicated they were exceedingly busy with the operational requirements of the prison and felt like there was limited time to dedicate to FASD related training. Fundamentally, prisons are concerned with reducing risk to the public, staff, and prisoners. They are purposed to keep offenders securely contained in a place where their offending behaviours can be addressed. This social exclusion serves as a punishment, acting primarily to deter unsanctioned and socially deviant behaviour (Kaufman, 2015). The nature of prisons determines the responsibilities that are prioritised by staff. Liebling et al. (2010) discuss how prison roles are also defined by the individual. For Corrections Officers, they are likely to perceive their role as predominantly security or service focused, which is partly based on their attitudes towards prisoners. Shaufeli and Peters (2000) reported that role ambiguity develops out of an expectation that Prison Officers must balance security and service equally, two goals that are fundamentally at odds with each other. Some Officers may orient towards a more disciplinary style in an effort to cope with this ambiguity, and these Officers generally believe that all prisoners should be treated alike, using this as a strategy for maintaining consistency and clarity in their roles (Liebling et al., 2010).

The below extract represents the ambiguity experienced by Custodial staff when asked if a module on FASD should be included in their initial training:

> *There's a fine line because ultimately, from a Custodial perspective our number one job is to maintain the safety and security of the prisoner, and the prison and the community* [...] *So yeah, it's hard of while it's good for Officers to know, as like, what is their actual job you know? We're doing at-risk assessments, we're trying to prevent suicide, we are trying to look at the triggers of suicide, and depression and what that looks like* [...] *And it's like, "well, what else do you want us to know?" You know what I mean?* (Custody).

Concerns about service provision were echoed by one of the Health participants in terms of priority setting and allocation of resources:

> *It's not, there is this lack of knowledge in prison here in New Zealand* [...] *it's not a priority* [...] *because there's no assessment for it when tāne are incarcerated* [...] *they acknowledged the PTSD and things like that, but there's nothing for FASD – it's something that's been thrown around and that's where it is at the moment, really.*

> *The, the issue is resources, there is no resources for it, you know?* [...] *And all these, all these assessments, all these concerns like TBI[8], you know, FASD, all come down on the RN[9]. And then to do their, all their chronic diseases, metabolic monitoring, and you know, there's only so much before something's gonna give.*

Prisoner wellbeing is also highly focused on minimising risk rather than addressing the neurodevelopmental disabilities of the prison population (Liebling & Crewe, 2013). For example, in light of 11 suicides in Aotearoa New Zealand

[8] Traumatic brain injury.
[9] Registered Nurse.

prisons in 2015/2016, Ara Poutama Aotearoa[10] placed a spotlight on the mental health and wellbeing of prisoners, introducing a number of initiatives intending to reduce these numbers. One of the recommended initiatives was to improve training for prison staff for identifying at-risk behaviours and early intervention (Jones, 2017). Giving precedence to mental health difficulties and the identification of risky behaviours speaks to the overarching focus of minimising risk. It also means that addressing the needs of prisoners with FASD and equipping staff to deal with these needs is likely to be a much lower priority.

Case Managers also expressed a lack of spare time available for training and upskilling. Case Managers schedule and plan the programmes an individual should complete based on their criminogenic needs[11] (Johnstone, 2022). Although Case Managers function as support for prisoners in their journey to reintegration, they are also oriented toward managing risk – risk of reoffending and risk to public safety. "They are responsible for ensuring that prisoners and remandees have an individualised pathway of rehabilitative and reintegrative interventions which are aligned to their assessed risk and identified needs" (Ryan & Jones, 2016, p. 10). As one participant noted:

> *Risk is determined via the Roc*Roi (Risk of Reconviction and Risk of Reimprisonment), and also through the use of the Structured Dynamic Risk Assessment 21 (SDAC21) which looks at current risk factors, responsivity barriers and protective factors. The Case Managers will use these tools in conjunction with and recent psychological reports, criminal traffic history, attitude towards the offending, frequency, seriousness of offending, and overseas offending etc.*

One of the primary roles of the Case Manager is ensuring prisoners complete rehabilitative programmes in an effort to reduce their risk to the public once released. Programmes in prison are tailored for prisoners according to their criminogenic needs rather than underlying neurodevelopmental disabilities

[10] Department of Corrections New Zealand.
[11] Needs related to offending behaviours.

(Johnstone, 2022). Again, the fundamental characteristics of the prison are likely a barrier to implementing FASD related training when mitigating risk and reducing recidivism are the primary goals.

Additionally, high prison populations and staff shortages can create challenges for Case Managers in terms of the depth of the service they can provide (Maguire & Raynor, 2017). Case Managers indicated a lack of service provision given that the majority of their time was dedicated to writing reports for the Parole Board, which was generally time consuming and dictated where their efforts were prioritised:

> *So basically, 90% of it is report writing* […] *You're doing – 90% of the time I'm just writing reports and throwing it out. So, I might have a 15-minute interview and it's a day's work then writing everything out, you know what I mean?*

> *Like, I've got I've got 45 guys on my caseload* […] *and it's not even the most, there's some people with more than me* […] *but I have these, these are high risk, high needs people, and there's only so many hours in the day.*

The high workload was also identified as a potential barrier to being involved in FASD-related staff training:

> *And I mean, Case Managers, if* [training] *was, you know, like an hour, that would be all right, but if it was, you know, like half a day or a whole day, then that really cuts into getting parole reports in on time, which is the main thing that Case Managers here have to deal with.*

Although report writing was seen as the dominant priority for Case Managers, one Case Manager suggested the role had much more potential for supporting people with neurodevelopmental disabilities and mental disorders because of the one-on-one approach, saying:

A lot of the stuff in Case Management is just draw out the information, spit it out and then refer them on to the people to deal with it, whereas my point of view is that like, we're the point of contact, so, you know, what I mean? Like, like, basically, I'm doing a brief intervention most of the times I'm going in there, you know? But it doesn't have to be like that, but, you know, it'd be much better if it is.

The reality of Case Management appears to be at odds with what staff would like to be able to offer in terms of support for prisoners. In a qualitative study exploring prisoner perspectives and experience of Case Managers in Aotearoa New Zealand, participants in Johnstone (2022) discussed feeling like Case Managers were kind people who did their best with what they had. Unfortunately, an under-resourced prison system meant prisoners also felt like they were just a number to be ticked off, reporting their experiences and needs were only really considered in any depth at the end of their sentence when it was time to produce their parole report. This highlights that responsibilities such as assessing risk and completing parole reports currently take precedence across Aotearoa New Zealand prisons, leaving little time for addressing neurodevelopmental disabilities such as FASD through professional development or other forms of training.

4.2.4 Lack of Training

Majority of the training schedule at ASCF focuses on the operational tasks of maintaining security and minimising risk. Core training includes modules on fire, first aid, hostage and suicide responses, de-escalation and the control and restraint of prisoners. Most of the training consists of learning the practical aspects of the role and day-to-day operational tasks such as searching prisoners and facilities, drug management, incident management, use of IOMS[12] and muster checks[13], to

[12] Integrated Offender Management System.
[13] A process where prisoners are physically located and marked as present on a photo identification board.

name a few. During the nine-week training schedule, there are modules dedicated to rehabilitation where speakers from departments such as Case Management, Psychology and Reintegrative Services address the Custodial Officers. There are also modules dedicated to Māori and Pasifika awareness and the Hōkai Rangi initiative.

Consistent with findings in international and local research regarding FASD related training (Passmore 2019; McCormack et al., 2022; McCormack et al., 2023), all participants, regardless of their level of awareness, reported never having received any formal FASD related training at any of the organisations they had worked, during their employment at ASCF, or in the Corrections landscape in general:

> *And there is no FASD training, there is no training that's given to Custodial staff about how to support and how to manage people that do have the diagnosis, let alone don't have the diagnosis, you know?* (Case Management).

Clinicians based in the prison are also oriented towards addressing risk, as one participant from the psychology department said their role was primarily focused on assessing individuals' risk of reoffending:

> *I think, yeah, we don't do any of the diagnostics, yeah. Our work is more focused on the risk assessments, rather than diagnosis, yeah* […] *Risk of reoffending, yeah* […] *and then in the mental health they do the risk of suicide, and we do that in the sessions as well in the moment, but yeah, nothing, nothing diagnostic for us* […] *But yeah, for us Psychologists, at the moment, it's all offense focused.* (Psychology).

When asked if they had ever received any training on FASD, the same participant reflected:

No, I used to work in mental health NGO[14] before, yeah, FASD never came up in there. And we've had constant trainings for the last two months with Department of Corrections, and FASD hasn't come up. Yeah, I think the only time, yeah, the only time I heard was when I think it was, yeah, we talked about your proposal in the ethics meeting. That was the first time I had heard about FASD.

This participant's experience shows how the absence of prevalence rates, research, and funding perpetuates a lack of awareness and prioritisation of FASD across the service sector (McCormack et al., 2021). This highlights a systemic issue, where professionals who are working in roles where they are likely to encounter people affected by FASD are not receiving the training they need to appropriately support those people (McCormack, 2022).

The majority of participants discussed staff shortages as being one of the barriers to training and management of FASD. Some participants felt that coming off the floor for training would be challenging, and noted staff turnover[15] as making it difficult to capture all staff for new training initiatives:

I can't leave the blocks[16] at the moment. We're short staffed and, but that's just a everyday thing at the moment so you just got to carry on. (Custody).

And you know with staffing changes like on a prison site, you can't run [training] *all the time. So, so yeah, it's, it's kind of hard to keep going when people move on, then you get new people and that kind of thing.* (Case management).

When asked what they thought the main barrier to training was, one participant responded:

[14] Non-governmental organisation.
[15] Turnover was characterised by this participant as promotion or shifting to other departments rather than leaving Corrections as a career.
[16] A term used by prison staff to refer to prison units or wings.

Staff – because every single prison is just so short of staff at the moment […] *So just can't get those things, those operations, and those processes up and running. So* […] *so as soon as staff numbers increase, absolutely.* (Custody).

Aotearoa New Zealand is currently at crisis point regarding severe staff shortages across the prison estate. As of January 2023, there were 850 unfilled Custodial positions country wide. A lack of staff means prisons cannot execute their core duties, such as allowing prisoners access to visits from whānau, rehabilitation programs, and sufficient time out of their cells (Corlette, 2023), which makes taking staff off the floor for further staff development in specialist areas challenging, at the very least.

It is interesting to note that FASD was not prioritised in the same way other components of staff roles are, even though most participants indicated they thought FASD was common in the prison:

Yep, it's quite common, yeah, I'd say it's quite common, indeed, yeah. Yeah, some of them diagnosed, a lot of them not diagnosed […] *I would say there's quite a lot when you're looking back at the histories that have been reported of their childhoods, and, you know, alcoholism and drugs, then family harm and all that stuff, it's kind of that, you know, that kind of typical situation you see so often that you think, "Well, yeah, okay, if all that was going on prior to you arriving, then there's probably a good chance that you've been impacted by some or all of that, including alcohol."* (Case Management).

But, uh, yeah, my, my feeling is it's very common, just depending on the spectrum, because you know what I mean, it doesn't affect everyone the same way and the severity and that, but yeah, I would say, to a different degree, it's like, it would be a large percentage of the prison, yeah. (Case Management).

FASD has been reported to be as high as 36% in Corrections populations, suggesting it is very common (Bower et al., 2018). However, the nature of the prison and staff roles means that FASD related training is relegated to the

periphery while issues of risk and rehabilitation dominate professional practice in these spaces. Participant responses indicate that limited awareness and training have a bidirectional relationship – as a lack of awareness contributes to a lack of training, a lack of training perpetuates a cycle of limited awareness of a disability where 60% of those affected have trouble with the law.

4.2.5 Implications of Limited Awareness of FASD

There was consensus among participants that limited awareness was potentially harmful and contributed to negative outcomes for both staff and prisoners by increasing vulnerability, negatively impacting staff-prisoner relationships and creating barriers to appropriate interventions. Prisoners with FASD were identified as vulnerable when placed in mainstream units as their challenges can make them more susceptible to being both recruited and victimised by gang members. Negative interactions with gang members could also lead to them getting into more trouble with staff as they become involved in activities that breach prison rules, creating barriers to rehabilitative services that are provided on the basis of good behaviour. Staff-prisoner relationships are impacted by miscommunication that stems from a lack of awareness. All participants talked about a moral responsibility to support prisoners with FASD, and this manifested in the ways they spoke about the men as vulnerable people who needed their support.

4.2.5.1 Vulnerability

Participants acknowledged that a limited or lack of awareness of FASD can increase vulnerability for affected prisoners. Without an awareness of FASD as a disability, prisoners are treated the same as the neurotypical, mainstream[17] prison population and therefore placed and managed in mainstream units (McGinn, 2019).

[17] Prisoners who are not identified as being vulnerable and needing to be separated or segregated from others for their own safety. Majority of the prison population is classified as mainstream.

Vulnerability was identified as one of the main challenges for prisoners with FASD by a number of staff as noted below:

> *Because if you mix them with other mainstream prisoners, with gang members and stuff, they're very vulnerable. So yeah, it's the environment. You need to like, keep them – find them a safer place to, to stay* [...] *Because* ... [other prisoners] *use them as a punching bag, because they're very vulnerable, yeah.* (Health).

> *And occasionally, you will get people that come in and they've already got the diagnosis and you, you kind of, yeah, for me, I kind of look at them and think to myself, "Okay, what are we going to do differently with these people? How, how are we going to support them to succeed and achieve and not just get gobbled up by the gangs and all of that kind of stuff?* (Case management).

In Aotearoa New Zealand, prisoners are placed in units according to their risk, which determines their security classification. The security classifications are minimum, low, low-medium, high, and maximum. High security units are generally the most volatile because they are not as structured or staffed as maximum-security units, but still hold violent offenders (Lett, 2021). The volatility of high security mainstream units, the need to fit in and susceptibility to manipulation makes people with FASD in these units more vulnerable to being recruited by gangs, either as members or supporters (Brown et al., 2018). A participant described a particular case of a prisoner with FASD and his eventual pathway into association with a gang:

> *I think him being bullied by others, definitely. So, he came in – to my knowledge, um not being associated or affiliated with any gangs, but so he was, was high security* [...] *And I think by the end, he was sort of prospecting for the Killer Beez and, yeah, was quite impressionable really, of the others. And yeah, he was, you know, stood over*[18] *and those sorts of things. So, pretty*

[18] Prison slang for being forced or intimidated to hand over items of value to other prisoners, such as food or other belongings.

much, I'm pretty sure, well, I think that he definitely, you know, wanted to, wanted to align himself with someone who he thought would protect him as well, he was quite vulnerable. (Custody).

However, such protection through integration with a gang in prison does not always eventuate as noted by this participant when asked if the prisoner was protected by gang prospecting or membership:

No, no, I don't know, maybe, maybe in some respects [...] *And he was always, you know, one to, you know, if the Killer Beez were fighting, he would always jump in as well, even though he's quite smaller than the rest. But um, yeah* [...] *He definitely got himself into more trouble than what he could have by staying out* [of the gang], *that's for sure*.

The cognitive, behavioural, and physical deficits that can cause people with FASD to be socially isolated, physically, and sexually victimised by others can naturally lead them to gravitate toward gang members, who are higher in the social hierarchy and can offer the protection of a group (Brown et al., 2014; Lett, 2021). Indeed, gang protection comes at a price, which can lead to institutional misconduct. Gangs continue to operate their illegitimate businesses in prisons, typically through intricate networks that facilitate the flow of contraband and illicit substances (Lett, 2021). A person with FASD is an ideal target for a career criminal seeking someone who is eager to please and appears indifferent to future consequences (Fuchs, 2022). They are often used as scapegoats, happy to break the rules for the benefit of the gang if it garners their acceptance (Brintnell et al., 2011).

However, acceptance into a gang may be short lived or highly conditional. The behaviours expressed by people with FASD can cause frustration among peers, leading to their social demise. One participant discussed how a prisoner with FASD can frustrate other men in the wing[19]:

[19] Wings are the spaces within a unit that contain prisoners' cells.

No, no, no, "they're annoying" [the other prisoners] *say, yeah. Yeah, they want everyone to be on their train of thought. And yeah, this, this particular guy's very* [hyper]*. I think he's got a lot else going on.*

So, I think he, he also is taking staffs time a lot, so then that annoys the other prisoners because it's always him and he'll come to the door and push everyone else out of the way, it's like "me!" and "oh, it's more important!" And he truly believes that his issues are way more important than, than everyone else […] *so that's frustrating for* [other prisoners]. (Custody).

Emotional lability or a lack of empathy for others is typical for people with FASD. These characteristics paired with poor impulse control can influence the demanding behaviours expressed by this participant, causing frustrations among the people around them (Oatley & Gibbs, 2020). With only a limited number of staff and hours in the day, these sorts of behaviours can cause conflict and lead to prisoners with FASD being socially isolated or victimised. The same participant discussed how prison administrators struggled to find appropriate placement for this particular prisoner because he has a number of non-associations[20] with other prisoners due to conflict:

Oh, yes, yep. Heaps. Heaps and heaps, lots [of non-associations], *yeah* […] *And then people just don't really want him 'cause he's hard work.* (Custody).

One participant recognised mood swings and 'odd' behaviour as factors causing a prisoner with FASD to be socially isolated:

One of them is a little bit, one of them seems a bit, he's a bit odd, he's a bit, yeah, he's a little bit in – how to say it, you know, his grasp on reality is not particularly strong […] *he'll bounce around a bit and sort of, you know, exaggerate quite a lot – he's a little bit isolated.* (Case Management).

[20] A 'non-association' is an alert that tells staff when prisoners are not permitted to associate with each other under any circumstances e.g., 'non-association with Joe Bloggs due to fighting'.

Being identified as different can be stigmatising for individuals with FASD, which can lead to isolation and vulnerability in the prison. “Stigmatization is a social and culturally constituted process whereby a person is first identified as different and then devalued, leading to status loss and discrimination” (Roozen et al., 2022, p. 754). In exploring the perspectives of people living with FASD in Aotearoa New Zealand, Salmon and Buetow (2012, p. 45) found that individuals were often ‘othered’ and socially excluded once people found out about their diagnosis, one of them stating “It’s almost like they think it’s contagious”.

One participant spoke about a prisoner with FASD intentionally isolating himself:

> *Yeah, they, he, he sort of isolates himself, because in the unit at the end of the day, they, or at the start and end of the day they all come around and sit in a circle – big circle. They sort of say karakia for the day, discuss any issues – uh yeah, I've always noticed that he finds that, like, he always sort of distanced himself, yeah from that, so yeah. Could be very well overwhelmed* […] *but I think, the other things he's, yeah he's hyperactive, you know one burst, he's and, he's jumping from one thing to the next to the next and then next thing he's slowed right down.* (Cultural).

A lack of confidence and self-esteem can lead FASD affected individuals to find solace in isolation. Participants in Salmon and Buetow (2012) reported feeling ‘lonely’ and ‘desperate for friendship’ but struggled with communication, often getting their words muddled up and being taken the wrong way. Struggles with mental health and mood swings also made it difficult for participants to engage with others in a socially acceptable way, which contributed to their isolation and feelings of insecurity. The neurodevelopmental disabilities associated with FASD can also make comprehending the rules and intricacies of the prison challenging for these individuals. This can lead to the demanding behaviours or mood problems that cause conflict with other prisoners manifesting during interactions with staff. This can lead to miscommunications and negatively impact the staff-prisoner relationship (Novick-Brown et al., 2012). Unable to cognitively make sense of what is expected of them can also lead to unintentional breaches of

institutional rules (Oatley & Gibbs, 2020). This can have negative implications for relationships with staff, especially where prison staff have limited knowledge of the challenges experienced by these individuals (Novick-Brown et al., 2012).

4.2.5.2 The Impact of Awareness on Staff-Prisoner Relationships

Staff-prisoner relationships are an essential component to maintaining the safety and order of a prison (Crewe et al., 2015). Prisons can be negative, violent, and unpredictable places to work. The power imbalance, loss of rights, privileges and autonomy of incarcerated individuals means most research into prisons has focused on the experiences and perspectives of prisoners. The dominant narrative situates prisons and prison staff in a negative light as they are responsible for involuntarily kept members of society, maintaining control of people by enforcing state powers (Dennard, 2021).

This is evident not only in the literature, but in the ways prison staff are portrayed in movies and the media. Prison Officers in particular, are often stereotyped as being uncaring, violent abusers of power. Common perceptions of Prison Officers as lazy have been shaped by referring to them as 'guards', which is typically conceptualised as people who are in charge of preventing prisoners from escaping (Ricciardelli et al., 2023). Additionally, the invisibility of the work of Corrections Officers means that the work they do helping and protecting people behind prison walls is usually overshadowed by negative, sporadic media accounts that highlight rare incidents such as deaths in custody. In reality, the role of the Corrections Officer is complex, contradictory and can be psychologically draining (Liebling et al., 2010). Liebling et al. (2010) also note that Corrections Officers must balance 'honesty' with the ability to negotiate, cajole and persuade prisoners. They need to be equally as empathetic as they are assertive and manage the unpredictable emotions of prisoners as they are often the bearers of bad news, such as informing a prisoner he cannot have or do something, that his partner did not show for his visit, or that his cell was searched and excess items had been removed.

Prisoners cannot be entirely controlled through coercion, rather they are motivated to comply with prison rules and staff expectations when they perceive staffs' authority as 'legitimate' (Jackson et al., 2010). Legitimacy is determined through staffs' use of discretion[21] in the enforcement of prison rules (Liebling et al., 2010). The use of discretion as an alternative to rigid rule enforcement presents the officer in a fair manner to the people they are policing. This encourages voluntary obligatory behaviour, manifesting in an unspoken social contract between staff and prisoners (Liebling, 2000). One example participants discussed that showed this social contract in action was in the cultural units. These units operate as an alternative to mainstream high security units by addressing rehabilitation through cultural engagement. In the high security areas, ASCF currently has a Pasifika focus unit and a Māori focus unit.

One participant discussed how discretion or 'leniency' is a major contributor to building staff-prisoner relationships in these units, where prisoners and staff work together to overcome conflict and maintain harmony:

> *We're a little bit more lenient, but there's an expectation that the behaviour sort of matches, you know, the leniency that's given* […] *Yeah, still, still in its new sort of phase, but a lot of good things, you know, we've seen major, major reduction in incidences, misconducts[22] – think everyone's sort of held to a higher standard. Give the men a bit of responsibility and man it's done wonders. You know, they, they step up, they love to step up, they love to do it, so, yeah.*

> *Like it's, it's sort of working in a way to remove 'us versus them', you know? As, I mean, that's going against the grain and however long prisons ever stood, so yeah, and then there's set perceptions from both sides, you know, from officers, and prisoners about each other and then just kinda, yeah, I think that's the hard parts, sort of working, trying to work across and work*

[21] Discretion is used by prison staff when deciding when and how to enforce prison rules on a case-by-case basis.
[22] An internal charge for breaches of prison rules. Prisoners who are found guilty of internal misconducts typically lose some or all of their privileges for a set amount of days or weeks.

together with that, too, yeah, to either overcome or find a way. (Cultural team).

Māori and Pasifika cultures are collectivist cultures that emphasise positive relationships and prioritise the needs of the group. Gibbs (2022, p. 12) discusses how "the concepts of manaakitanga (expression of respect and generosity) and whakawhanaungatanga (actively pursuing positive relationships)" are central to Māori culture. Similarly, Pasifika are relational peoples. They assign divinity to every individual, believing that everyone has their own unique gifts and an important role to play (Ioane, 2017). Within these cultural units at ASCF, relationships are prioritised through the use of discretion. Although it can be seen as a risk giving prisoners more leniency, it appeared that in the cultural units this risk was paying off as the men were given more autonomy to self-manage and regulate themselves. Prioritising relationships also had a positive impact on the way men with FASD were treated by fellow prisoners, as one participant observed:

Yeah, [prisoners in the cultural unit's] *approach is different. They're, they're pretty, you know, I think the time that I've seen they're pretty loving on them – ah fellas with certain disabilities, and, or are differently-abled, so, yeah.*

But they were pretty good to him like, they'd give him small responsibilities that he can sort of carry out and then, yeah, and they'll sort of work with him on that. (Cultural).

Discretion is not a tool unique to cultural units but is essential to maintaining harmony between staff and prisoners. Of course, prisons do not operate in a constant state of harmony because staff use discretion, however, prisoners are less likely to breach prison rules or cause unprovoked conflict if they have some respect for staff authority (Liebling et al., 2010). Breaches of the social contract between staff and prisoners are likely to occur more often by prisoners with FASD who are socially challenged and have poor impulse control. Continuous, unprovoked breaches can result in staff misrepresenting this behaviour as intentional, or bad (Gibbs, 2022).

Participants with greater awareness of FASD suggested a lack of awareness could lead to miscommunications between staff and prisoners, causing frustration that could lead to institutional misconduct:

> *They might flare up if they don't understand something, or you say something, you know, they might misconstrue something and that could flare up and become a tense situation quite quickly, and you would be quite shocked, you wouldn't know, you know, what, what had happened*. (Case management).

> *Yeah, I think misunderstood is probably the biggest thing. And then their misunderstandings can have, you know* [...] *consequences from other prisoners beating them up, or, you know* [...] *it doesn't sort of sync well with an officer that has not known, you know, this one person, before* [...]*So yeah, I think the ramifications are still twofold in the sense of, yeah, it could either rub off the wrong way with a prisoner one day, or it could land him, yeah, the prisoner, yeah, in hot waters with an Officer.* (Cultural).

In situations where there is miscommunication, Prison Officers are more likely to respond with punitive action if they do not have an awareness of where the prisoner's frustrations are coming from (Jackson et al., 2010; Jampolksy, 2018). Negative interactions between staff and prisoners as a result of a lack of awareness can have negative outcomes for prisoners. For example, staff have the authority to write formal reports and case notes that can potentially create barriers to rehabilitation (Crewe et al., 2015).

4.2.5.3 Barriers to Appropriate Interventions

Just about all prisoners eventually get released, so the goal of the prison is to reintegrate people into society in a way that mitigates risk to others (Johnstone, 2022). What this means is that sentence plans are more likely to follow a pathway of completing relevant programmes that can lower a person's risk of reoffending rather than identifying and providing appropriate interventions for specific

neurodevelopmental deficits that have led to their offending. Case notes and formal reports can prevent prisoners from progressing through the appropriate rehabilitative steps that can facilitate reintegration (Jampolksy, 2018). One participant reflected on the invisibility of FASD and its implications in the prison system:

> *Yeah, I mean* [...] *if it's the unseen disability, people are treated in the same way as everybody else, right? You have policies and procedures that are blanket – blanket rules for everybody. Everybody has to adhere to the same things, everybody gets the same punishment, everybody gets the same rewards, and so on, and so forth. But one size does not fit all, especially when you're dealing with people that have barriers and challenges, which means they cannot learn from their previous punishments, or, you know, they cannot control their behaviour to such a degree where they'll become eligible for a security class reduction, and then go on to be able to take part in a programme, because you have to have a low or low-medium security class. So, you've got these people that are going to sit here, not progress, be blamed for their lack of progression, but have limited ability to control the reasons they're not progressing. They're treated the same way as everybody else, so they're punished more often, I would suspect. And it's just a revolving door, isn't it? They just keep on coming back because nothing is tailored to their needs – it's tailored to the mainstream.*
>
> *So again, if you're going to get into trouble left, right and centre, you're never going to get lower than a high security, you're never going to get on programs. And I can understand the rationale for that, you don't want people that can't behave in group settings because you can't run a group then, I understand that. But also, you're prohibiting people from being able to engage in the things that we're saying they need. The things that we're saying we're holding them here because they need – actually, we're prohibiting them from that.* (Case Management).

Current programmes and interventions are developed based on the needs of neurotypical prisoners, with very little resources being directed at developing programmes for people with learning or neurodevelopmental disabilities, which can mean the criteria for being accepted into such programmes may be set too high for people with FASD (Brintnell et al., 2011). According to participants, prisoners with FASD were also much more likely to be barred from engaging in the programmes designed to help with rehabilitation and reintegration:

> *And the main thing with their rehabilitation, you know, like, one of the guys hasn't been able to engage in the courses because of his understanding and that.* (Case Management).

> *Even rehabilitation, you know, you can't get on to a lot of the programmes until your security class[23] fits their eligibility.* (Case Management).

Even when prisoners with FASD had been accepted into educational programmes, participants working with the men within Education or cultural programmes suggested that the lack of awareness among Custodial staff often led to miscommunications between Officers and prisoners, leading to the prisoner being internally charged and barred from attending education:

> *So that's another challenge – when they are removed from our classes saying that, "Oh, they've been playing up, they've got misconducts, they've got incidents happening", this and that. But when they're actually in class, they're good.* (Education).

> *Yep, there is a disconnect. He's very violent in the wings. He's got about eight or nine alerts for, for fighting and aggression and non-associations[24]. And when you look into it, it'd be a fighting in the wing, instigating or fighting in the wing, and I'm going to – yeah this is the symptoms of it and it's because he*

[23] Many rehabilitative programs require prisoners to be classified lower than high security.
[24] A 'non-association' is an alert that tells staff when prisoners are not permitted to associate with each other under any circumstances e.g., 'non-association with Joe Bloggs due to fighting'.

can't cope because of what he's got, you see? And they get impatient with him so […] *you know, and, but when he's with me, he's like a gentle… you know?* (Cultural).

Limited awareness of FASD was also identified as a barrier to accessing appropriate therapeutic interventions. Participants acknowledged that most offending-related interventions were based on models such as cognitive behavioural therapies that address crimonogenic behaviours. These therapies are likely to be ineffective for people who do not have the cognitive capacity to comprehend the consequences of their actions (Novick-Brown et al., 2012):

It's a problem brought up with, with cognitive behavioural therapy is it's just like, you know, you need a certain amount of IQ for abstract, for abstract thinking, and it's just not as – it's just not a one size fits all solution, you know? (Case Management).

And it sounds weird that we focus on this side, the criminogenic side of it, but we're not focusing on the root causes though? Yeah, it seems like we're just on the superficial side, rather than going down to the root cause. (Psychology).

Limited awareness was also identified as a barrier to supporting prisoners in their rehabilitation because staff were generally unsure about how to help them, or what procedures and processes may be in place to provide support to people with FASD:

I just think here's this guy, he needs help, you know, but how, how do you help him in a prison situation, yeah? How do you get the help that he needs? (Cultural).

I don't know if there's any assessments for FASD, I don't think I can do anything. (Psychology).

But to be honest, yeah, I do not have any knowledge into what process it will be. (Psychology).

This is a problem that is echoed throughout the justice sector, with Cox et al. (2008) reporting that judges and prosecutors wanted more information regarding who defendants can be referred to for FASD assessment and intervention. Professionals in this study indicated that they would be willing to adapt their practice and decision making for people with FASD if they had more awareness about what steps to take and what services were available when someone suspected of having FASD comes to their attention.

4.2.5.4 Moral Responsibility to Support Prisoners

Research in this area has shown that staff are generally committed to improving outcomes for prisoners and reducing recidivism (Passmore, 2019). Within the Aotearoa New Zealand context, policies are directed at positive staff-prisoner relationships to achieve these goals. The Hōkai Rangi values seek to encourage positive staff-prisoner interactions by emphasising the values[25] of manaaki, rangatira, kaitiaki, wairua, and whānau. These values orient prison staff toward a more caring attitude, which was reflected in the way participants spoke about the men in their care. Additionally, the Right Track Framework was introduced by Ara Poutama Aotearoa to encourage suitable engagement with offenders and promote positive change. "It defines desired staff behaviours, emphasising good communication, empathy, sound judgement and decision making, as well as personal integrity" (O'Fallon, 2014, p. 42). Staff are educated on the five stages of change[26] and encouraged to engage in motivational conversation and goal setting with prisoners to help them progress toward making positive change (O'Fallon, 2014). The Right Track framework emphasises caring attitudes

[25] Manaaki (respect), rangatira (leadership), kaitiaki (guardianship), wairua (spirituality), whānau (relationships).
[26] Stages of change: Denial, open to change, motivated to change, committed to change, maintenance, and relapse.

and humanises the prisoner, something that was evident in conversations with the participants:

> […] *and if the system is the system as is, then I think we owe it to* [prisoners with FASD] *to be able to find a way to educate the staff that are managing them, to look at ways within the prison that we can keep them safe, to look at rehabilitation options tailored to their needs, and to create or adapt services in the community that can offer them the support that they need.* (Case Management).

> *They are men, they're people, they're humans. So, you know, they've made mistakes, and since I've joined, and I've seen that, you know, you, you come through all these challenges, but at the same time, you feel happy when you see them going across the line.* (Education).

Contrary to popular belief, Deannard (2021) found that although prison staff from a variety of roles faced various stressors such as lack of resources, limited training, and continuous change, they discussed helping prisoners to manage their distress and difficult behaviours as the most rewarding part of their roles. Participants stated they felt helpless when they were unable to provide the level of support that they wanted to due to resource constraints. Staff became despondent if they felt they had let the men down in any way and perceived themselves as having a moral responsibility to protect prisoners by rapidly responding to dangerous situations and suicidal behaviour (Dennard, 2021). It is reassuring that most prison staff from all roles approach their work with altruistic intentions and a moral responsibility to improve the lives of prisoners. However, the negative attention that shapes social perceptions of prison staff can impact on their self-esteem and self-efficacy. Prison staff can be left feeling that the intricacies of their roles are misunderstood and undervalued (Ricciardelli et al., 2023), and in some cases can experience psychological distress when they feel like they lack the skill involved to appropriately support prisoners (Dennard, 2021). Training and professional development are therefore imperative to improving self-efficacy and job performance through increased awareness (Dachner et al., 2021).

'Training value', or "the degree to which trainees see workplace training as meaningful, useful and important to their job performance" is critical to ensuring 'training transfer'[27] (Andoh, 2022, p. 690). The caring attitudes of staff mean they are more likely to assign value to FASD related training, especially when they are more aware of the negative outcomes for affected individuals within the prison system.

Unsurprisingly, all staff expressed a willingness to be involved in any training related to FASD to increase their awareness and provide more support to affected prisoners:

> *Yeah, of course, that will be, I think that will be really helpful because it's not something that is known very well, like, the information I found out is not very well known. And potentially even the way to approach assessment and intervention would be great, yeah, we would, we would really appreciate that.* (Psychology).

> *Because the more knowledge you have, the more you can help a person, right?* (Education).

> *Yeah, I mean, whatever is there, I'm open to learning* [...] *Just, I guess, just whatever, whatever needs to be done in order to have a better understanding.* (Cultural).

Participants endorsed training that would improve their ability to identify potential cases of FASD and inform their practice in ways that would help them to effectively manage some of the difficult behaviours expressed by people with FASD:

> *Probably how to identify others might be, might be really useful for me and then for others in my team as well.* (Custody).

[27] The process whereby staff transfer new knowledge or skills learned in training to their practical roles.

I suppose, like the best way to, to manage to calm down someone who's with unruly behaviour that's caused by FASD, or also how to yeah, just how to, how to communicate best with, with people who do have that. (Education).

Participant responses regarding the type of training they would like to receive mirrors international findings. There is a lack of awareness among prison staff and in particular, Custodial Officers, for identifying and managing prisoners with FASD (Passmore, 2019). Moreover, staff who received FASD related training have reported increased confidence with managing difficult behaviours and improvements in communication with affected prisoners, which helped to prevent negative interactions and incidents (Passmore, 2021).

The majority of participants stated they preferred face-to-face or blended[28] learning citing the benefits of face-to-face learning as more interactive, encouraging discussion and a chance to hear the perspectives and experience of others:

Face-to-face I think, for me, I prefer that, yeah. Kinda so you can bounce ideas off each other. I think that, you know that, I never used to like that but I see the benefit in you know, when you get together as a group and you discuss it and then you, you present it that way, I like that kind of interactive type learning for me. (Custody).

[…] *when you're researching or looking at aspects that are human nature or human bound, any training on that needs to be human, face-to-face. You need to keep it to that reality base.* (Health).

Yeah, I mean, I guess face-to-face training is always nicer, because you get taken out of the work environment, and you're in a kind of confined space where all there is to do is listen, you know, and to engage in that. Whereas I

[28] A blend of traditional, or face to face learning, with online or e-learning.

guess, if it's online, you're in the office, you know, there's people milling around, whatever, you've got to do it of your own accord and try and find the time to fit that in […] (Case Management).

Traditional learning may be preferred by learners because of its social elements (Bali & Liu, 2018). Learners typically report more engagement during face-to-face training as they can discuss concepts with other learners in real-time and can ask the facilitator questions (Atwa et al., 2022).

Blended learning was suggested as a mixture of face-to-face learning, with online learning to supplement what they had learned in the workshop such as online refreshers or written guidelines they could refer back to as necessary:

> […] *yeah, having maybe a half day or a couple of hour workshop will be great, and then, then having a reference guide you know what I mean?* […] *having a workshop with maybe roleplay, yeah, you go through it or someone does a presentation and then having a reference guide, that'd be, that'd be best* […] *And then if, then if you have something face-to-face like that, as well, you're more likely to remember and reference that material, "Oh, I had that workshop on fetal alcohol syndrome, that was actually quite interesting. I've got one on my caseload now, that can be quite exciting now, I can go back, have a read through and implement what I've learned".*
> *And maybe the refreshers don't have to be face to face, you know, they could just be* […] *like after six months or something you just receive like this kind of like a scenario in your inbox of somebody who might have a FASD, how are you going to respond?* (Psychology).

Only two participants indicated a preference for e-learning:

> *I would prefer online because I can do at my own convenience on my time, because I have other stuffs to manage.* (Case Management).

> *Probably online, yeah* […] *You can just work on your downtimes, your non-working hours, yeah. Especially if I'm, I'm working in a shift work, so yeah, I'll just do it on my days off.* (Health).

E-learning is a growing field and rapidly became popular during the COVID-19 lockdowns, which required institutions and organisations to implement online education for learners to ensure learning could continue (Singh et al., 2022). Consequently, e-learning is typically beneficial as an alternative where traditional learning is impractical (Singh et al., 2022). Ara Poutama Aotearoa utilises e-learning to provide regular refreshers for learners following their initial training through online modules that re-deliver concepts already learned. E-learning is also cost effective, giving organisations the ability to train larger cohorts of learners at once without having to fit learners into a physical space (Bartley & Golek, 2004). Another benefit of e-learning is that it allows learners the flexibility to complete the modules in their own time (Kemp & Grieve, 2014).

4.3 Barriers to Information Sharing

This theme provides an analysis of the barriers that prevent FASD-related information about prisoners being shared between staff within the prison. This includes the sharing of information about prisoners who are either suspected or confirmed of having FASD. Lack of information sharing was identified as a barrier to the identification of prisoners who could potentially have FASD or neurodevelopmental disabilities. Where prisoners were confirmed of having an FASD diagnosis, this information was not always shared with all staff working with that person. This lack of information sharing was identified as having negative outcomes for prisoners. Causes for a lack of information sharing will be analysed under the subthemes of 'accessing information', 'siloed teams' and 'confusion around confidentiality'.

4.3.1 Accessing Information

Participants identified a number of barriers that disrupted or prevented the flow of FASD-related information in the prison. Multiple information technology systems contribute to difficulty with navigating formal information sharing and retrieval processes, causing challenges for staff trying to locate specific information. Participants also identified issues with diagnosis being available as part of the prisoner's record but difficult to locate. This information was generally mentioned in file notes[29], psychological reports or judges sentencing notes and was therefore available for staff with access to view. The problem was that, that information could have been imported into the prisoner's file years earlier and was buried underneath a pile of more recent documentation. Participants also felt that there was not always sufficient time to spend looking through prisoner files and that the dynamics of staff-prisoner relationships further inhibited staff from looking through prisoner information more generally, hence creating barriers to accessing FASD-related information.

[29] An informal record where staff can share anything they deem to be relevant to the prisoner without loading an official report. File notes are permanent and can be viewed by anyone with IOMS access.

The Department of Corrections and, ASCF both use IOMS to collect, store, and retrieve information related to prisoners. IOMS holds personal information relating to an individual's convictions and sentence management and allows staff to report and monitor behaviours and offences of prisoners through the use of file notes, incident[30] and misconduct reports[31]. Demographic information, aliases, gang associations, and sentence plans are examples of some of the types of information that is shared through IOMS.

MedTech is also used by ASCF. It is a separate system for storing all offender medical information that cannot be accessed through their IOMS file. As such, only Health personnel have access to information in MedTech. Additionally, individual prison sites and community centres also have their own G-Drive databases where unit-specific information is updated on excel spreadsheets and stored in live, limited access folders (Boshier, 2022).

As mentioned earlier, one of the barriers to information sharing was that if information was available in IOMS, it was difficult to find and was not readily accessible:

> *In terms of like alerts and that sort of thing it's not really usually on the alerts, so, sometimes it can be, but generally it's just through digging through all the information they got on file that will find it or* [the prisoners] *tell us, yeah.* (Case Management).

> *And even, even if, like searching for keywords* […] *there's, you know, years and years and years of file notes, yeah.* (Education).

> *There was a young man that came in a few months back* […] *and I'd read his file. There was information there that clearly stated he'd been diagnosed* [with FASD] *fairly young, which was obviously a positive thing. But it wasn't*

[30] A formal report detailing incidents that occur within the prison e.g., prisoners fighting, the location of contraband.
[31] A formal report following an incident report where an individual prisoner is charged with an internal offence e.g., prisoner assault, possession of contraband.

obvious like, you know, you go into IOMS, you look at the header, whatever, look at the alerts, there's nothing in there – you'd have to dig pretty deep to find that information. So, I put it in his alerts. (Case Management).

At Ara Poutama Aotearoa there are strict privacy controls in place, with staff only authorised to access information relating to prisoners for whom they have a working responsibility (Ara Poutama Aotearoa, 2021). Being a large entity, the ASCF's Code of Conduct and privacy policies are less specific to the prison context, generally informing staff of the expectations of maintaining confidentiality and the integrity of private information as required by law (Serco, 2023a). However, as a department that is contracted to Ara Poutama Aotearoa, the same principles apply when working with the personal information of prisoners in staff care.

In 2022 an Ombudsman [32]report expressed concerns that information management systems were variable and siloed across the Corrections infrastructure, which presents problems with easily locating information. Multiple, systems mean there is also a heavy reliance on the institutional knowledge of experienced staff for information that is not stored in information systems and when those employees leave, information can be lost (Boshier, 2022). Lips et al. (2011) found public sector staff frequently utilised manual work-around techniques such as duplicating data and sending private information through emails because certain systems were inaccessible by other roles or departments. This shows that a lack of interoperability and accessibility of shared systems can force staff to obtain information important relevant to their roles through largely informal means.

A Case Manager talked about searching through learning assessment reports to ascertain whether a prisoner had any neurodevelopmental disabilities such as FASD. However, this strategy would require the staff member to have access to learning assessments and an awareness of how to locate them:

[32] An independent Officer of Parliament who has been appointed to investigate complaints about public sector agencies.

[…] *another way to dig it out would be on the learning stuff on Education that when they do the literacy and numeracy tests* [FASD] *might come through in there because usually, that's one of the first things, that's one of the things that's, that's done usually.*

Additionally, this strategy for accessing information would require the staff member who was conducting the learning assessment to have a certain level of understanding of FASD to infer this as a potential factor in a prisoner's learning difficulties. Similarly, if all that was shared was the raw data or overview of the assessment, it would be open to the interpretation of the staff member reading those assessments. As a result, the same participant suggested:

I mean, but yeah, so it's a problem I think, that we should know if there has been a diagnosis, it should be clear, easy to find it in black and white for us to inform our practice, yeah.

Leisnter (2010) reported lack of prioritisation as being one of the main barriers to information sharing in organisations. Lack of prioritisation is believed in part to arise from a lack of time to be able to explore and process information about a prisoner:

And I don't think, predominantly Custodial do much of a deep dive into what that person's situation is because they just don't have the time […] *and it's, you know, it's always the old adage, you know, you've got to make time to, you know, reap the rewards, but nobody's got the time.* (Case Management).

In high security units, prisoners must be accompanied everywhere they go by one or more Officers, depending on their security classification and risk. Custodial Officers must continuously monitor prisoners, fulfil daily duties such as muster checks[33], cell searches, facilitate and supervise mealtimes, assist health

[33] A process where prisoners are physically located and marked as present on a photo identification board.

staff with administering medication, manage conflict, respond to any incidents that occur throughout the day and complete the corresponding paperwork. All these duties leave little room for Officers to be placed at a computer, let alone conduct a thorough search of a prisoner's history. Where Custodial Officers *are* more likely to search for this information is in 'Prisoner Alerts'.

Participants mentioned searching for diagnostic information in Prisoner Alerts, identifying Alerts as where they perceive to be the most likely place to find this information:

> *And, you know, no medical assessments or anything had happened or occurred, and I haven't seen anything on his alerts.* (Cultural).

> *Probably, I mean, I would, I would look into IOMS and see if they've got any alert for FASD to see if yeah, if they've got any health-related alerts or health related file notes.* (Custody).

Prisoner Alerts are located under the Prisoner Header in IOMS. The Prisoner Header remains at the top of the screen while staff search through information pertaining to that prisoner and Prisoner Alerts are highlighted in red. Prisoner Alerts offer an easily accessible snapshot of important, operational information pertaining to that prisoner. They are accessible to every staff member with IOMS access and are updated regularly. Alerts are used to let staff know whether the prisoner has any non-associations[34], whether they can be placed in a double cell, what gangs they are associated with, and many more. They are used to consolidate all health and safety risks associated with an individual to ensure the safety of the prisoner, other prisoners, and staff. Because alerts show health, safety and security risks, more staff are likely to check them when they come into contact with an unknown prisoner. For this reason, many participants suggested FASD diagnostic information should be readily available in Prisoner Alerts:

[34] A 'non-association' is an alert that tells staff when prisoners are not permitted to associate with each other under any circumstances e.g., 'non-association with Joe Bloggs due to fighting'.

It would be good if there was some kind of alert you know? […] *Because they're easily accessed and a lot of staff look at them when they're doing – like when people are doing file reviews, but also Custodial staff look at them as well.* (Education).

It'd be great if there was an alert, I mean, to be honest, I don't, I don't think there is, but it'd be great if there was an alert, kind of like an NTDB – not to double bunk, that would be great if we had like an FASD alert. (Custody).

And Custodial, when they're looking at the alerts, when they're looking to do the SACRA[35], or whatever, they're gonna see that. And even if they don't know what that is, potentially, they're gonna go and have a look now, or they're gonna contact that Case Manager and say, "hey, what can you tell me about this? Does this mean he shouldn't be placed with somebody else, or does this mean?" you know, so, yeah. (Case Management).

Alongside information systems operating in prisons, there are also psychological systems that are likely to be inhibiting the flow of information. The dynamics of the relationships between Custodial Officers and prisoners might explain the lack of exploration into prisoner information beyond what is required to do the job. Halsey and Deegan (2017) found that because of the risk involved with working with potentially manipulative and violent offenders, Corrections Officers seek to maintain a level of social distance from prisoners. The responsibility to discipline prisoners means there is always a professional boundary that ensures Officer-prisoner relationships are fair, but impersonal. To maintain this boundary, Corrections Officers tend to avoid looking into prisoner histories to ensure they can remain as fair and impartial as possible. Corrections Officers emphasise treating all prisoners the same, and treatment is based on their behaviour within the prison rather than their offending or personal characteristics.

[35] Shared Accommodation Cell Risk Assessment: An alert that informs staff whether or not individual prisoners are able to be placed in a double cell.

Treating all prisoners the same helps Officers to achieve perceptions of legitimacy[36] through consistency (Halsey & Deegan, 2017).

These dynamics were illustrated by a Custodial Officer, explaining:

> […] *and I think the whole, you know, "they're prisoners, they're prisoners", which is true, and I do – you know, they are, but I feel like being here and being locked up is, is the punishment. Having no freedom is the punishment and whatever they've done out there is no business of mine, it's how they behave from now, and that's what's important.* (Custody).

4.3.2 Siloed Teams

Teams were siloed within the prison, which presented other informal and formal barriers to information sharing. Organisational 'silos' is a term used to describe the social and cognitive barriers to communication between departments within organisations. Teams can be located in close physical proximity to each other but can also be separated through the silo mentality that arises out of the ways staff perceive their roles and the overarching goals attached to those roles (Bento et al., 2020). This meant that different departments within the prison were not always communicating as much as they thought they should be. Participants noted:

> *Custodial staff in general, we don't have a lot of interaction with, and that's something that we've been talking, talking about trying to improve because having that relationship would really, really help.* (Psychology).

> *I think, on this site, there is a bit of a disconnect between Case Management and Custodial, because they've got their own roles, and they're busy running*

[36] Prisoner perceptions of staff authority as legitimate. Legitimacy improves staff-prisoner relationships and influences voluntary compliance.

around doing that, that there… I think there isn't really enough kind of information sharing going on. (Case Management).

It's actually kind of a problem, I feel, you know, that we're so separated from the Health department, like, I always want to know, because of my psych background what the diagnosis is if there is one, sometimes it'll be in [the prisoner's file]*. But mainly, it's only if they've got schizophrenia.* (Case Management).

Specifically, prisons can have a disconnect between the security and rehabilitation arms, especially when people see their roles ending at a certain point in time.

For example, a participant perceived there was a disconnect between prison and external Corrections departments such as Probation, where important information relating to diagnosis was being lost along the way:

If it's true, then we need to tell the Probation Officer he needs help on the outside, he needs support from that on the outside, but I don't know how that's handled. You know what I mean? My job stops here… I can't say "okay, this is what you gotta do". (Cultural).

The more interrelated a persons' social needs are, the more services and agencies are required to meet those needs, therefore, seamless collaboration between departments and agencies related to meet those needs becomes necessary (Lips et al., 2011). In reality, information can get lost because professionals typically prefer to share 'soft' information. Soft information is informally shared usually through face-to-face interactions or email communications. Staff make judgements about what information can be shared. It is usually information that can prevent risk or harm toward individuals or groups of people that is shared and acted upon rather than officially recorded (Lips et al., 2011).

Because of this reliance on soft information, a lot of the information prison officials know about prisoners before they are released is likely to stay within prison walls. Participants in this study appeared apprehensive about being involved in the care of prisoners once they are handed off to other departments. Notwithstanding this, and in contrast to any silo's operating in the prison environment or a lack of information being passed to organisations outside the prison, the Health department was identified as a 'hub' where information relating to FASD was likely to be directed and shared. Participants explained that:

> *Yeah, I'd definitely send, send Health an email as well and just say, look, even if, like maybe they hadn't assessed… And I'm assuming they would have, but, you know, maybe just yeah asking for, yeah, for any ideas as to how I might be able to manage that person or asking them if they do have FASD? Yeah.* (Custody).

> *Ah, yeah. So I, I wouldn't be allowed to share it on IOMS because of all the health confidentiality... Um I would probably only talk about it with people in Health.* (Education).

> *If I, if I was writing it in an email, it would probably only be to Health, to the Health team. Yeah, I would be unlikely to share in an email with anyone else I think.* (Education).

Participants were most likely to inform Health as opposed to anyone else in the prison, including prison management, if they had information that a prisoner could have or was confirmed as having FASD. In prisons, there is a clear distinction between staff involved in the operations of the prison and the provision of medical treatment. There are legal requirements and expectations that non-health personnel are not involved in any decisions regarding the treatment of prisoners as this is solely the responsibility of the health practitioners employed at prison sites (Elger & Shaw, 2017).

If, and/or when the information made it to Health, participants working in the health team stated it would be shared on MedTech and potentially with other health professionals and departments, but not placed on IOMS:

> *Well, it should be documented on MedTech, for starters. And then referred accordingly, whether it's referred to an RN, to mental health nurse or referred across to Psychology.* (Health).

However, this sharing of information with Health also meant that there was the potential for information to flow inward to Health but not outward, limiting the opportunity for collaborative care and support for all areas that work with prisoners affected by FASD. The perception that FASD is a purely health-related problem within the prison was presenting challenges for the sharing of FASD-related information. What appeared from the interviews was a lack of understanding or awareness of the utility of other areas in responding to individuals with FASD and the benefit of sharing diagnostic information with all personnel involved in the care of the prisoner (Lips et al., 2011).

Although staff were confident to forward the information to Health there was no formally agreed process or system for sharing this information, which meant it had the potential to be lost, forgotten, or disregarded. Informally sharing FASD-related information presents a barrier to informing all staff from different roles that are involved in a prisoner's sentence. Aside from informing the health team, this information was likely to remain within specific departments or teams as opposed to being documented as official information that could assist staff to provide holistic support.

4.3.3 Confusion around Confidentiality

Privacy and issues of confidentiality were also a significant barrier to information sharing. There were mixed ideas about whether staff could share diagnostic information with other staff in the prison, and generally conflicting

views regarding confidentiality of health information. Operational requirements presented challenges to maintaining the privacy of prisoners' health information and participants identified confusion arising out of inconsistent views regarding informed consent; the use of discretion; potential stigma and the perception of increased vulnerability associated with sharing a diagnosis of FASD.

Within the current study, confidentiality was identified as a barrier to increasing visibility and generating conversation about how to appropriately support affected prisoners:

> *The confidentiality of health issues just seems to block so many conversations, and yeah, yeah. So, I mean, it just seems like lots of people's needs are totally unknown about by everybody else on site because of confidentiality.* (Education).

> *Yeah, and then not just getting the information to confirm* [FASD], *but also, okay, now that I've got it, because I've got to respect this person's privacy, how do I get this across to other colleagues that work with him, daily?* (Cultural).

The complexity of interpreting privacy laws can lead to staff being overly cautious by defaulting to a decision not to share information with other colleagues (Lips et al., 2011). It was evident that participants were unsure about when, how, or what information should be shared.

Currently staff with IOMS have access to other highly sensitive and privileged prisoner information, leading to a participant questioning whether sharing a diagnosis of FASD was much different. This participant was under the impression that everything relevant to the management of prisoners should be shared as it would be helpful for both prisoners and staff, considering that confidentiality should only apply to sharing information with people outside of the prison, or who were irrelevant to the management of the prisoner:

I think we kind of operate in a system, I hope I'm not saying the wrong thing, operate in a system where everything we do within this space is confidential […] *What I've been told is everything we see, talk about is confidential within these walls, yeah.* (Psychology).

This participant was aware that they were privy to an abundance of confidential prisoner information. They suggested that all relevant prisoner information should be shared with all relevant roles within the prison and suggested that confidentiality only applied to people outside of the prison or who did not have a working responsibility for prisoners.

Prisoners and staff see each other on a daily basis and are often involved in very sensitive, raw interactions that they would not normally have in their ordinary relationships (Appelbaum et al., 2001). Prison staff respond to things like suicide attempts and health-related incidents (seizures, for example), talk prisoners through emotional hardships and see them at their most vulnerable (Appelbaum et al., 2001). Because of the on-going nature of relationships between prisoners and staff, there is often not a lot that prison staff do not know about the people in their care (Liebling, 2000). Therefore, knowledge of FASD was seen as just as vital to their roles as all the other information regarding prisoners that they have access to.

The close-knit culture of the prison and open access for staff with IOMS to other personal aspects of prisoners' histories appeared to create confusion around whether diagnostic information could be shared among professionals working within the prison. All participants had inconsistent views regarding confidentiality.

Some participants appeared to be genuinely unsure about whether diagnostic information could be shared, or not:

Is it, should it be private health information, or should it be public? (Custody).

I don't know if it will be okay for me to share with the rest of the team, yeah. (Psychology).

Health information is considered sensitive and is protected by specific legislation. The Health Information Privacy Code (HIPC) (Privacy Commissioner, 2022) "is a Code of Practice issued by the Privacy Commissioner under section 32 of the Privacy Act which gives extra protection to health information because of its sensitivity" (Ministry of Health.1, 2020, n.p). Under the HIPC, information is not to be disclosed to anyone other than the individual it pertains to unless there is significant risk or threat that can be minimised through disclosure, or if the individual gives their consent for the information to be shared (Privacy Commissioner, 2022). One participant explained the web of rules and regulations that determine when and how health information is shared between professionals:

Health can't unless given consent by the patient, or unless subpoenaed by the courts, or subpoenaed by the police, if there's a safety issue […] *And then you'd have to – if you're going to pass it on to other parties, then that needs to be made quite clear to the patient, because that's where you get into trouble.* (Health).

Lips et al. (2011) discuss how the complexity of the law and lack of guidance on specific matters can lead to a lack of clarity and confidence in knowing what information to share or not to share. The confusion generally leads staff to err on the side of caution, prioritising protecting the information of individuals rather than sharing it.

A number of participants referred to the need to 'cover themselves' which was interpreted as ensuring they remained within the parameters of the law to avoid any repercussions from legal breaches. A Custodial participant avoided anything to do with health-related matters to achieve this:

Email, probably to our Health, yeah, and then let them decide whether... Yeah, I don't really make any health decisions at all for anything just to cover myself, you know how it is.

Another participant suggested more guidelines were needed so staff could feel more confident about what information should or not be shared:

So, I suppose it would help us to have clearer guidelines around [sharing FASD-related information], *like, when and why do we do that? Like, I have a fair idea of a case-by-case basis, but being able to cover myself and that like, like, yeah* […] *So you wouldn't have to think about it, you would just say," okay, it's this situation, I let them know", yeah.* (Case Management).

Reflecting further confusion around confidentiality, one participant suggested basic diagnostic information could be shared as long as the information given was not too specific:

I was just talking about the, the medical records – we can't disclose those information. But like information, just, just like basic, like, yeah, [37]ADHD – those kind of stuff, yeah, we can […] *I guess that's no different with the guys with ADHD then because we share their information of the diagnosis, too.* (Health).

The conflict between privacy regulations and operational requirements meant participants thought there needed to be more clarity around information sharing with respect to FASD:

[…] *and have a policy, like a Corrections wide policy for how to work with, with these people, and yeah, maybe a bit more transparency around information sharing.* (Education).

[37] Attention deficit hyperactivity disorder

Because I think if we had a kind of strategy, I'm not sure if that's the right word, or definitely, a process of "this is the way to, to interact with these people", I think it will really go a long way to just managing them appropriately. (Custody).

FASD-related policy is necessary to inform and improve practice (Pedruzzi et al., 2021). The issues and needs of prisoners with FASD cannot be appropriately considered when staff are uninformed about the people in their care. Interactions with frontline staff, access to appropriate programmes and individualised sentence and release plans cannot be facilitated without knowledge that a diagnosis exists or could exist for someone (Brintnell et al., 2011).

A senior Custodial participant believed that all staff should be informed about FASD diagnoses, and suggested having a screening tool for new arrivals into prison to increase staff awareness and inform practice:

I wonder whether, or not there's some way, when they came, when they come through the Receiving Office on reception, that we couldn't do some form of assessment? I have no idea what form that would take. But that kind of makes sense to me, especially here. And I think it's the same on every site, we get the Nurse to interview these fellows on arrival, and in my mind, if we can just get those Nurses to probe into it somehow or rather, and just even, even if we could identify or at least suspect, I suppose for want of a better word, that […] *that's affecting that person, then we can manage them accordingly, you know?*

It just makes sense to me that if we got that screening tool over the new arrivals on their, you know, because […] *everyone that comes to jail, has a first time in jail. And if we, we only have to identify it once, right? Once we've identified that this is an ailment that this person has, then it's on record, and that's there every time they come back.* (Custody).

A member of the Health team also agreed with the idea of a screening tool, suggesting this is something the Health staff could work into their assessments when they see new arrivals:

> *Yeah, well it should be included in their mental health assessment. You have the mental health assessment so there should be triggers in there, you know, there's triggers for PTSD so there should be triggers for FASD* […] *if mental health nurses, for starters, and RN's had the training they would be able to assess that and put it in their assessment – you know… "query FASD – will refer patient to mental health for further assessment".*

There are currently no screening tools that have been developed for use with adult prisoners in Aotearoa New Zealand. A screening tool to target incoming prisoners would be a cost-effective alternative to assessing for high-risk individuals in Corrections settings where there is limited access to multidisciplinary diagnostic teams (MacPherson et al., 2011). It would also inform staff from first entry into prison that a particular individual may not adjust to prison expectations, rules, and regimes in the same way a neurotypical prisoner might. Staff would be forewarned and less likely to adhere to the common perception that all prisoners must be treated the same (Brown et al., 2015a).

4.3.3.1 Informed Consent

Some participants disagreed with the idea of disclosure of FASD-related information without consent from the prisoner, a Health team member explaining:

> *There are huge privacy laws and the privacy outside of Health has just changed as well. But from Health, you need the consent from the, from the patient*. (Health).

Under the HIPC, obtaining consent is one of the exceptions where health information can be shared with other professionals (Privacy Commissioner, 2022).

Informed consent is often a matter of contention within the prison space considering the vulnerability of prisoners and the coercive nature of prisons in general (Hayes, 2006). Intellectual difficulties such as problems with literacy and numeracy among prisoner populations can also affect their ability to provide genuine informed consent (Isaila & Hostuic, 2022).

A participant highlighted some of the challenges that prisoners with FASD face while trying to navigate the processes of the justice system with their cognitive difficulties, making their situation worse:

> *And* [Talking Trouble[38]] *supported the team to, I guess, understand from* [the prisoner's] *perspective what it's like to be in situations, like court, like to be presented with things like parole board reports, and electronic monitoring forms, and all these, you know, long words and complicated kind of things that they don't understand most of the time, but that they pretend to understand, and that they spend a lifetime pretending to understand*. (Case Management).

This raises questions of competence and an ability to understand benefits and costs of sharing information which are likely to be more difficult for people with FASD (Rasmussen, 2008). Furthermore, the process of providing informed consent to a variety of different professionals and agencies has proven to be a barrier to service provision for vulnerable people. The necessity for people with complex needs to navigate the requirements of public service systems has been shown to delay service provision, inadvertently causing more harm to the individuals that confidentiality protocols are designed to protect (Lips et al., 2011).

Moreover, other, non-health related, yet highly personal information is shared through IOMS without the consent of prisoners, usually in the interest of 'safety and security'. The primary functions of the prison that are centred around punishment, rehabilitation and public safety means prisoner autonomy is regularly

[38] An organisation that supports the speech, language and communication needs of people involved with the justice, social, mental health and behaviour services in Aotearoa New Zealand.

breached, which can lead to prisoners mistrusting professionals working within the justice system. A general mistrust of people employed in the justice system can lead to prisoners ignoring potential benefits and refusing to give informed consent, as in the case of refusing to receive healthcare (Vandergrift & Christopher, 2021).

Additionally, staff at ASCF are unlikely to request consent from prisoners to share FASD-related information unless they are looking to refer him to outside services (Personal communication, 2023). However, studies show, for example, that awareness of ADHD among prison staff is essential to ensuring prisoners with this disability are managed and supported appropriately (Young et al., 2018). In contrast to FASD, research into prevalence rates and interventions for ADHD have increased its visibility and general awareness that knowledge of ADHD is imperative for staff working with affected prisoners (Young et al., 2018). The following participants suggested that having an awareness of FASD diagnoses would inform their practice and improve the way prisoners were managed:

> *Yeah, I don't know if that was sort of, you know, like, confidentiality and whatnot, but I think it would be useful. Because it would change the way you know, you know, in an appropriate way, which way and how we manage that person, yeah.* (Custody).

> *And if it's gonna help us, if it's going to help everyone, then I just don't see why we wouldn't be sharing that information to be honest.* (Custody).

There is, however, a tension that exists between gaining informed consent and making paternalistic decisions on behalf of prisoners. Research indicates that at times there can be a tendency for professionals to be 'overprotective' of prisoners by making decisions they deem to be in their 'best interest' (Hayes, 2006). Discussions around confidentiality with participants highlighted a very real moral and legal conflict relating to acting with altruistic intentions by neglecting an individual's autonomy.

4.3.3.2 Potential Stigma and Increasing Vulnerability

A minority of participants thought a diagnosis of FASD should remain confidential, suggesting that it could be stigmatising:

> *We have, we have an oath, we take quite a serious oath when we are registered that we protect, protect health information, because it can be quite discriminative for an individual unless that patient consents.* (Health).

> *I don't think that term* [FASD] *is relevant. I don't think that has any meaning for people* […] *because there's not much awareness around it and it's probably labelling in a way* […] *I think people get put in a box and I don't think that's very helpful, especially in this situation, it's better to get to know them.* (Custody).

One participant illustrated how sharing knowledge through making staff aware of a diagnosis was likely to lead to them treating affected prisoners differently, prompting suspicion from other prisoners about why they were receiving 'special treatment':

> *We've seen that with some with some of the prisoners in the past where we've given inadvertently, um, you know, paid them more attention* […] *and it's negatively impacted on the other prisoners, they've, more or less, you know, sort of targeted that person like, "oh, you're special, you're this, you're that".* (Custody).

However, participant responses were mixed on this subject, with some rejecting the idea that sharing knowledge about FASD and staff treating affected prisoners differently would make them more vulnerable among other prisoners:

> *I think that's underestimating the prisoner population to be fair. I mean, we've already discussed that these particular people behave in a particular way, and everyone knows that, everyone sees it, everyone witnesses it. So, so*

basically, I think, whether you – whether it's ever shared or whether staff are informally told that they have this condition it's kind of irrelevant, because all the prisoners that live and live with them in that wing know that there is something different about this bloke, and they probably don't even care about putting a label on it, they just know that he's different […] *put it this way, I don't see it creating risk, put it that way.* (Custody).

Other prisoners are yeah, pretty understanding so far, you know? They, they sort of help [prisoners with FASD] *out. They, they, you know, they'll banter here and there and say he's the special child of the wing* […] *but they were pretty good to him like, they'd give them small responsibilities that he can sort of carry out and then, yeah, and they'll sort of work with him on that.* (Cultural).

A study conducted by Winfree et al. (2002) found that across cultures, prisoners appear to be united under a social code that brings them together through their joint disdain for the prison system. Perhaps there is an unspoken culture among prisoners where people are more accepting of each other because they have all fallen victim to the justice system. One participant explains:

[…] *and I think, because there's quite an odd sort of mix of people, I think they're quite accepting of, you know, a bit of eccentric characters and that. So not to my, not that I've, I would say there'd be a possibility* [of victimisation] *perhaps, but I haven't seen it, no.* (Case Management).

4.3.3.3 Staff Exercise Discretion

It did appear that participants thought discretion should be applied when considering whether to share FASD-related information, given majority of the sample agreed it was necessary in order to increase staff awareness and improve outcomes for prisoners. The potential harm associated with a lack of awareness of a diagnosis was explained by one Case Manager:

Yeah, I guess the challenge is, because the majority of them don't have a diagnosis, we can only you know, we can only assume or 'guesstimate' that we think they have got underlying challenges that are undiagnosed, but on paper, they're just a troublemaker, they're just somebody that doesn't take direction, they're just somebody with a sense of entitlement, with a negative attitude towards authority, so on, and so forth.

The use of discretion has been identified by Wilson (2023) reporting that health staff in New Zealand prisons do share information with Custodial staff relating to the traumatic brain injuries (TBI's) of prisoners. Sharing information with relevant staff in the prison space did not appear to be constrained by confidentiality barriers as it was noted that informing non-Health staff about the presence of TBI's was essential to ensuring affected prisoners were managed appropriately.

Participants in Wilson's study acknowledged that having an awareness of a TBI directly impacted the way they managed affected prisoners and interpreted their behaviours. These participants indicated that they were more lenient and mindful of offering additional support to prisoners with TBI's (Wilson, 2023). Likewise, participants in the current study commented that not sharing diagnostic information could be harmful to prisoners with FASD because staff were likely to be unaware that many of their behaviours were being caused by their neurodevelopmental difficulties.

4.4 Practices and Relationships

This theme will provide an analysis of participant strategies for managing and supporting prisoners with FASD or suspected of having FASD. An in-depth exploration into the function of rapport and familiarity and how the characteristics of humour, patience, empathy, and understanding highlight the importance of relationships between staff and FASD-affected prisoners. The subthemes of communication styles, teaching styles and individualised/tailored approaches examine the strategies discussed by participants. Finally, a look into the organisational culture of (ASCF) helps to provide insight into the relationships and practices examined in this chapter.

4.4.1 Staff-Prisoner Relationships as a Facilitator of Wellbeing

In the absence of training, participants who were aware that certain prisoners were suspected or confirmed of having FASD had intuitively found ways to adapt their practice to support these men. Staff-prisoner relationships both influenced and were impacted by these changes in practice. It was recognised that prisoners with FASD can be very difficult to work with, requiring creativity and discretion from the staff working with them. Participants emphasised the need for patience, understanding, and building rapport with affected prisoners.

4.4.1.1 Intuitive Sense and Identification of FASD

Participants alluded to an intuitive sense that aroused their suspicions that something was not quite right with particular prisoners:

> *I can sense it, and I will tell there's something wrong with them, or, you know, some kind of disorder and stuff like that.* (Education).

> *And I think after three or four sessions you kind of pick up that alright, there's something that's not quite, you know, right, yeah, not quite right.* (Cultural).

This intuitive sense led to judgements based on their experience and familiarity with prisoners to discern that they were different to neurotypical prisoners. However, intuitive judgements without supporting evidence can lead to inaccurate assumptions. Intuitive judgements can be guided by heuristic schemas, or mental shortcuts that are derived from experience with similar situations. While heuristic schemas can be effective, they can also lead to heuristic errors where further information is unavailable (Dane & Pratt, 2007). Where formal diagnoses did not exist or were unable to be shared, participants were left to ponder the idiosyncrasies of prisoners who displayed problematic behaviours, relying on intuitive judgements to make their own assumptions about what could be causing them.

FASD is extremely difficult to differentiate from other disorders or disabilities without confirmation of prenatal alcohol exposure (Novick-Brown et al., 2012). Reliance on this intuitive sense meant participants with limited awareness of FASD were more likely to assume the prisoner might have ADHD[39] because the presentations of FASD can be similar to ADHD (Gibbs & Sherwood, 2017), a disability participants had more awareness of and experience with:

> *And I know there's like 900 plus prisoners in here and I think there's a lot of undiagnosed men in here because I just think a lot have ADHD and I know – I was told by psychologists that there's more FASD than there is ADHD in here and I'm going "whoa, what? We don't know that", you know?* (Cultural).

> *I suppose when I first met this guy* [who has FASD]*, I automatically thought ADHD or, or, or whatever. So that's not really helpful because everything is different.* (Custody).

Not only are the symptoms of FASD similar to ADHD, but it can also be comorbid with FASD (Rasmussen, 2008). ADHD has been estimated to be prevalent among 26.2% of adult prison populations and 30.1% in youth prison populations (Capuzzi et al., 2022). This is less than the highest current estimates of

[39] Attention-deficit hyperactivity disorder.

FASD at 36% of youth prison populations (Bower et al., 2018). It is unclear why participants may be more likely to assume ADHD to be causing FASD symptoms, given the high rates of misdiagnosis of ADHD and that global prevalence rates are also based on estimates rather than concrete statistics (Salari et al., 2023).

4.4.1.2 Rapport and Familiarity

Rapport was frequently talked about among participants as important for relationship building. Rapport was necessary for increasing familiarity and opening space for trust to facilitate more meaningful interactions and alternative ways of managing the difficult behaviours of prisoners with FASD:

> *In terms of my approach? Yeah, my, my approach is always, yeah, just try build a relationship first with the person and establish a rapport and then just, yeah, go from there* […] *So you know, I mean, that's the starting point* […] *so I just sort of take time with them and talk with them, encourage… So, yeah.* (Cultural).

The staff-prisoner relationship has been cited as being at 'the heart of prison work' (Liebling et al., 2000). Rapport is central to the staff-prisoner relationship, defined as a 'harmonious relationship' (Butt, 2021), and can be built over time the more staff and prisoners interact and establish boundaries (Ingel, 2020). Qualities such as honesty, consistency, active listening, and empathy have been shown to facilitate rapport between prisoners and staff (Ricciardelli & Perry, 2016). Rapport can initiate trust and respect, two components essential to the staff-prisoner relationship. Building on established trust and respect with prisoners can encourage openness, giving insight into some of the challenges experienced by prisoners and the type of support that can be offered by staff (Ricciardelli & Perry, 2016).

Building rapport and familiarity with prisoners can help staff to navigate difficult situations by knowing when it is appropriate, safe, and beneficial to apply

discretion in decision-making (Haggerty & Bucerius, 2020). For example, a Custodial participant talked about having leniency with an FASD-affected prisoner displaying inappropriate behaviour. This participant understood that there was a high likelihood that the prisoner had misread a situation and felt that a conversation with the prisoner would be more effective than punishing him with a formal misconduct. This participant thought that a misconduct might damage the rapport they had built over time, risking the prisoner losing a key support person:

> *But um, you know, and then he wrote this, he wrote this massive letter, which I did have to forward to Intel and sit him down and go, "you know, what, yes, we've spoken about this before, this isn't, this is strictly professional", and, you know, whatever else* […] *But um, yeah, but he was, um, yeah, I had a lot of time for him. But yeah, I think it was just* […] *taking the time out of your out of your day to, you know, go over things, or, yeah.*
>
> *And he had a laugh about that, because* […] *you know, he wasn't charged or nothing like that because I knew that, you know, he's… I knew his intentions weren't, weren't bad* […] *So, yeah, at the end he, um, yeah, he was, he was all good.*

Although this participant had not had any formal training on FASD, they had demonstrated an ability to consider the cognitive challenges of the prisoner and respond in a way that addressed the behaviour without a formal misconduct, risking an increase in their security classification. Therefore, the leniency displayed by the participant can initiate and perpetuate rapport. Although they had the authority to reprimand the prisoner for their behaviour, this participant chose to exercise tolerance and respond with communication, considering the impact of their actions on the long-term relationship with the prisoner (Haggerty & Bucerius, 2020). Additionally, the tolerance demonstrated by the participant offered an opportunity to model social skills such as kindness, patience, and effective communication in a brief-intervention style of interaction (Novick-Brown et al., 2012).

4.4.1.3 Humour as a Facilitator of Rapport

Humour was identified as a facilitator of rapport, with one participant illustrating the role of humour in having more light-hearted interactions with FASD-affected prisoners:

> *Pretty good that some of these Officers are* […] *some of these old heads like they, they still have a bit of humour to their approach and yeah, some humour works with, with that one case in particular.* (Cultural).

Some 'Old-school' Officers can be resistant to change, having negative attitudes toward the leadership team especially where they are perceived as not having any frontline experience and providing limited social support to prisoners (Tait, 2011). However, 'old-school Officers' also demonstrate genuine concern for prisoners and prisoners identify them as caring and appreciate their humour and interpersonal skills (Tait, 2011). Even in the most 'hardened' prison staff, humour can show a softer side and invite good relationships with prisoners.

The transformative nature of humour means it can level and stabilise the social structure between individuals, particularly where there is a power imbalance as Nielsen (2011, p. 505) eloquently articulates: "The humorous exchange allows both parties to distance themselves from their respective position in the prison context whereby they expose unofficial aspects of themselves and reduce the inequality that officially characterizes the relationship". Humour may be an effective tool for building rapport with prisoners with FASD as a way of reducing stigma by temporarily redefining social roles to one where both individuals can interact on an equal basis (Nielsen, 2011; Rutman, 2016).

One participant used humour as a vehicle for communicating potentially aggravating information to a prisoner with FASD, making light-hearted reference to some of their annoyances to ensure rapport remained intact:

> *So he would like to do things on a certain, you know, like his way, obviously, and he did mention that to me that his flatmate* [outside of prison] *was annoying, and I said, "oh, that's funny, I think you would be quite annoying to*

live with, quite hard work aye?", and he just laughed, and he was like, he was like, "oh, yeah, I probably am", like, and it never occurred to him. (Custody).

This participant acknowledged that a solid foundation of rapport was required before entering into these types of interactions with prisoners:

But I said this to him after a long time of knowing him, you know, yeah, there's, you know, there's certain things you can't discuss with a prisoner until you know them and they know you.

In many interactions between prisoners and staff, rapport is a prerequisite for the use of humour in the prison. This is likely because of the inherent conflict that exists between people who are involuntarily detained and the people in charge of enforcing their imprisonment (Tarrant & Torn, 2021). Humour at the expense of others may be taken in the wrong way without an appropriate level of familiarity with between the prisoner and the staff member (Mathies et al., 2016; Nielsen, 2011). Within the prison, humour can be used to communicate requests and instruction in a light-hearted manner and as such, is used regularly by staff and prisoners to minimise any potential conflict and generate rapport (Nielsen, 2011). Humour can also diffuse stressful or unpleasant situations. However, the use of humour in inappropriate situations or with an audience that does not share the same beliefs and behavioural expectations as the 'sender' can have negative effects on the relationship (Mathies et al., 2016). For this reason, humour is often referred to as a double-edge sword that can either diffuse or facilitate conflict depending on how it is received (Nielsen, 2011).

4.4.1.4 Patience, Empathy, and Understanding

In terms of the general scope of practice – patience, empathy, and understanding were spoken about as necessary to be able to work with prisoners with FASD:

Definitely, definitely the patience, you know, the empathy and yeah, just having, I guess, a bit of compassion, really. (Custody).

And patience – you really have to have patience, and you really have to set your day in a way that it suits him, not you as a supervisor. (Education).

But yeah, having an understanding that, you know, this person is wired differently. (Cultural).

Patience, understanding, and empathy are valued and necessary qualities in people working with prisoners, in general (Tait, 2011). However, as indicated by the above participants, the importance of possessing these qualities is far greater when working with prisoners affected by FASD. Patience is necessary when working with people who are less likely to initially comprehend instructions, are highly reactive, have an inability to control their impulses, and who are extremely unlikely to value consequences as an inhibiting factor in their behaviour (Brown et al., 2015a). Understanding refers to the ability to be tolerant and flexible, recognising that maladaptive, disruptive, or inappropriate behaviours stem from impairments in the brain and triggers in the environment rather than intention (Brown et al., 2018). Empathy is thought to be generated out of rapport, familiarity and building genuine professional connections with prisoners. Responding to prisoners with empathy can humanise both the staff member and prisoner, solidifying a foundation of rapport and encouraging trusting interactions. Trust can encourage prisoners to be open and honest with staff, increasing their ability to facilitate appropriate support and rehabilitative pathways (Tarrant & Torn, 2021). These characteristics are essential for anyone working with people with FASD given the cognitive impairments that mean more time, effort and persistence are required to achieve the things that would require minimal effort with neurotypical people (Brown et al., 2018).

Although participants strived to be understanding and patient, they acknowledged that this can be difficult at times:

I think a lot of people are pretty busy in, and you know, don't particularly, don't have that level of care […] *but somebody who doesn't have a psych background or hasn't worked with low functioning people before might not have the patience or even care to have the patience they just like, you know, 'whatever' type thing*. (Case Management).

Patience, yeah, I mean, not everyone […] *has the same level of patience, and I get that, you know, I understand that, you know, humans are humans, you know, we either could have a surplus of supply, or very, very, very little supply of patience and just understanding* […] *And it could be, it could be the lack thereof in training, or, you know, people are just sort of exhausted, tired from the working week and don't want to, don't want to have a bar of it and all the people skills just go out the window.* (Cultural).

And you do have to take the time and you know, sometimes there isn't any time or sometimes you just not feeling super patient. (Custody).

Patience is the propensity to remain calm in the face of frustration, adversity, or suffering (Schnitker, 2012). As indicated by the above extracts, patience occurs along a continuum. The amount of patience an individual possesses varies from person to person and is influenced by context. Socio-cultural norms, past experiences, and personality disposition can influence how much patience a person has in any given situation (Schnitker, 2012). The participants above illustrate various aspects of the prison employee's experience that can limit the extent of their patience when working with challenging prisoners.

Prison staff also work in one of the most difficult vocational environments where they are exposed to traumatic events, verbal abuse, and sexual harassment (Dennard, 2021). This experience can naturally have an impact on the way some staff interact with prisoners. For example, Tait (2011) identified a group of Corrections Officers who lacked patience and empathy for prisoners resulting from their own victimisation by prisoners in the past. Moreover, increasingly demanding workloads along with high prisoner numbers and (prisoner) turnover

rates mean they have limited time to engage in extended interactions with every prisoner in their care (Shaufeli and Peters, 2000; Vaswani & Paul, 2019). Even with the most genuine intentions, staff who are working in such a volatile environment can become burnt out and lose patience. The behaviours of prisoners with FASD can also make them very difficult to work with and can test the patience of even the most well-intentioned staff as explained below:

> […] a*nd, yeah, it can be quite difficult to deal with in terms of their, their understanding and their anger, especially when not getting their way and that sort of thing.* (Case Management).

> *But he, yeah, he want, wants us to follow the rules but he doesn't want to do that himself. But when you sort of speak to him and say, "now, come on, you want me to follow the rules, you need to follow the rules"... He will and then, and then he won't again, yeah.* (Custody).

Schlanger (2017) reports that in general, prisoners with disabilities can be disruptive, threatening, provocative and sometimes dangerous. For prisoners with FASD, inability to control their impulses can lead to reactive aggression or render these individuals incapable of focusing for long periods of time; poor concept of time can mean they show up late to employment and leave before being permitted to do so; and slow cognitive processing speed and problems with memory can mean instructions are either misunderstood or forgotten soon after they are given (Novick-Brown et al., 2012). As explained by one participant:

> *You give him an instruction to do the process, he doesn't follow* […] *He will not do it, or he'll just do one part and then he'll leave the rest, or he'll leave the task undone and then he'll start wandering in the building and going to other classes, and he'll start talking to everyone* […] *Yeah, like he forgot he's there trialling for the job and I have to follow after him, or I'll get a call from the Officer, "How come your* [worker] *is upstairs?" You know? "He's disturbing other classes, he's talking to everyone", and then so that's where I come in,*

and it's more like, I'm babysitting him rather than him to be independent. (Education).

Socialisation delays can mean that individuals with FASD struggle to live with and respect social boundaries and group norms. As one participant explained:

And yeah, he comes with this list, he has a list every day and you've got to go through the list or some of everything that all his issues that he needed sorting out. So that would be it, taking staff time […] *everyone has a routine – you know what prison's like – and he would just be disrupting that all the time with his, his prioritising himself, and not being able to understand how to live with others.* (Custody).

People with FASD can also seek gratification through staff attention, which might explain some of the demanding behaviours illustrated by participants (Novick-Brown et al., 2012). Given these characteristics, lack of training and awareness of FASD, it is understandable why staff may have periods of limited or exhausted patience when working with prisoners affected by this disability. Notwithstanding this, participants had also observed a number of strengths in prisoners with FASD.

4.4.1.5 Recognising Strengths

Although prisoners with FASD can be difficult, strengths-based research shows individuals with FASD also possess many strengths. Self-reports and information from primary carers highlight these individuals as kind and compassionate. From a strengths-based perspective, their social 'deficits' are understood as a strong capacity and desire for human connection (Flannigan et al., 2021). Participants readily identified a number of strengths they had observed in affected individuals:

Oh, organised, organisation. Yes, yeah, yeah, very organised, and very... He would probably make a great leader if he, he could, you know, didn't have all his other issues, like... Confidence as well, and, you know, always with his list and wanting to just, you know, have his life all planned out and get all these things to happen. (Custody).

An ability to cope with the difficulties that come with the primary and secondary disabilities associated with FASD demonstrates optimism, resilience, and sheer willpower (Flannigan et al., 2021), as observed by participants:

Their strengths have been like, in the 'doing', whether that's... So, in the focus units, we have practices like singing practices, ah, cultural dance practices, you know, when they're in it, they're in it! You know, and they do it well, they give it all. They might not be perfect, but they, you know, they, they, they go for it. (Cultural).

Um, I think he was good from well, this is my, my opinion, I think he was good by telling you, like, in being quite upfront and honest, like, he didn't really have a filter. He basically just said it the way he was thinking it – I think that was definitely, you know, he didn't beat around the bush […] *what was in front of you was what he said pretty much so yeah, I think that was definitely a, that was a positive strength*. (Custody).

Um, for this one, the strengths that he has is he's vocal, which is good. He talks, rather than being quiet and you don't know what's happening in his mind […] *He talks and that, it helps me, helps me to know, okay, this is where he's at, yeah.* (Education).

Rutman (2016) suggests an FASD-informed approach should be strengths-based to reduce stigmatisation and limit internalisation of failure for affected individuals. Prisoners with FASD have likely come from homes, schools, and systems where their deficits have been focused on and amplified (Rutman, 2016). Identifying and capitalising on the strengths and abilities of FASD-affected

individuals can improve self-identity, self-esteem, and perceptions of resilience – characteristics that are essential for improving a sense of self-agency and determination through increased engagement and wellbeing (Flannigan et al., 2021).

An intuitive sense, rapport, staff characteristics that emphasise caring attitudes and identification of strengths are all factors that enabled staff to consider alternative, more effective strategies of working with prisoners with FASD.

4.4.2 Strategies for Working with Prisoners with FASD

Where participants were aware of a potential or confirmed diagnosis of FASD, they acknowledged these individuals needed to be treated differently and explained some of the strategies they used to manage, and support affected prisoners. Because the challenges of FASD vary considerably from person to person (Kully-Martens et al. 2022), participants exhibited a range of different strategies they implemented for diverse people in different circumstances. These strategies were categorised according to 'communication strategies', 'teaching styles', and 'individualised/tailored approaches'.

4.4.2.1 Communication Strategies

Prisoners with FASD often appear to be quite articulate when in reality, they lack the cognitive processing ability to fully and readily comprehend novel or abstract information (Hand et al., 2015). Because of their ability to appear as though they understand, professionals working with these individuals often mistakenly hurry through the material. The communication challenges experienced by individuals with FASD can lead frustration and disengagement with professionals if the individual does not understand what is being communicated to them.

Case Managers often referred to the slower processing of FASD affected individuals and talked about using a slower pace and repeating information to ensure they understand:

> *I have to slowly repeat the information until he understands. Because you know, like others when you say things, they can like, get an idea, it's like, "yeah, okay, I get that", but for him, you have to explain it like very slow until he understands.* (Case Management).

> *So, you know, when dealing with someone with fetal alcohol syndome and what I see on their alerts and that, I'll make sure that you know, I'm using very simple clear language, and I'm not bombarding them with questions. We go nice and slow. I try and keep it to maybe two, a minute or even less, and then go back as well, "do we understand that? Are you okay with that?", and just keep reassuring, you know – what I mean.* (Case Management).

Other effective communication strategies are to provide small amounts of information at a time, and deliver information in ways that engage the client (e.g., visual, or written communication). Limited vocabulary and difficulties retrieving words from memory can cause challenges with expressive language for individuals with FASD (Lundgren, 2019). Professionals should be aware of and consider these challenges by allowing extra time and space for the individual to consider and communicate responses and check in with them to assess for understanding, providing reassurance as they go along (Brown et al., 2018).

One Case Manager talked about the necessity to provide extra care by checking in on a particular prisoner more regularly than is expected of them to ensure the prisoner receives regular reminders about important information:

> *I really engage more with him. Like, if I'm seeing a prisoner, like every three weeks, I go see him like at least every week, because you know, you have to keep reminding and updating him.*

An FASD informed approach requires professionals to recognise that missed appointments are not due to negligence or lack of interest but are likely due to brain-based challenges such as forgetfulness (Rutman, 2016). Damages to the frontal lobe can affect an individual's planning, problem-solving, and everyday coping ability. They can also experience difficulties with time perception, which can affect their ability to adequately prepare for important meetings such as Parole Board hearings, for example (Brown et al., 2015a). Frequent contact from a key support person can help to ensure prisoners prepare for and make engagements that are important for their sentence and rehabilitation pathways (Rutman, 2016).

4.4.2.2 Teaching Styles

Some participants implemented deliberate teaching styles as strategies for working with prisoners with FASD. One participant talked about how they supported the learning needs of a prisoner with FASD not by singling him out and giving him extra attention, but by slowing down the pace of the whole classroom to match the capabilities of the slowest learner:

> *So, you know, when talking with the, the whole class, I actually put out certain rules and kawa, and be that, "let's all learn together, let's not leave anyone behind". So, there are going to be times where I want to keep repeating myself and it's just because I know that you guys, you know, may get it, but I just want to make sure you do and you need to repeat yourself so that I know that you you've got it", but it was really for, you know, this one guy that I wanted him to understand.*
>
> *And I've said to the men "it's gonna be a longer session so we might be stretching it", "oh yeah, that's alright", but they're willing to go slow. But it's for everyone's learning and I don't, you know just show it's for him, I do the same to everybody else and go, "did you get that? I need you to repeat that back to me" so it's not just him repeating, it's them as well.* (Education).

This participant's strategy of slowing down the pace of the entire class is in line with a kaupapa Māori informed approach. Kawa can be explained as Māori protocol or etiquette, or the practice of Māori tikanga (Mead, 2016). By introducing kawa into the classroom, the participant subscribes themselves and the learners to Māori values similar to those exercised on a marae[40], to moderate relationships in the learning space. Manaakitanga and whanaungatanga are key Māori values that emphasise relationships, caring for others and being mindful about how others are treated (Mead, 2016). By slowing down the pace, the participant strategically takes the men through their learning journey as one rōpu[41] on the same waka[42], ensuring no one is left behind or isolated, reducing embarrassment, bullying and stigma.

This participant's strategy appeared to have a positive impact on the prisoner:

> *After, you know, after the sessions, he comes up to me and he goes, "thank you, thank you"* […] *he's asked me if I could do another class with him, but I think it's because I've allowed him to learn, and I've allowed them to grow together as the group.*

Salmon and Buetow (2012) reported that people with FASD are more vulnerable to bullying or harassment when they are singled out and seen as different in the classroom space. By giving special attention to their learning difficulties, educators can inadvertently draw attention to these individuals, amplifying their difference to the rest of the group (Salmon & Buetow, 2012). By slowing down the pace of the entire class, this educator was able to prevent stigmatisation and embarrassment for the prisoner and ensure he was able to engage with the course content. Bertram et al. (2021) reported that communal pacing was deemed to be effective by teachers because having to move on to new content too quickly meant slower learners were left behind.

[40] Māori meeting house.
[41] Māori for 'group'.
[42] Māori reference to boat.

Slowing down the pace of the group risks other prisoners becoming bored or frustrated, however, as indicated by the above extracts, this was not the case for the participant and the other learners. Furthermore, more time spent in Education is likely to be perceived as a positive by prisoners. Garner (2020) discusses the issue of having an abundance of time in prison, reporting that having too much unstructured time can have a negative impact on prisoner wellbeing. Having too much unstructured time can lead to depression, boredom, frustration, and life dissatisfaction. Education is a productive way of passing the time, however, high numbers of prisoners can mean spaces on programmes are limited (Garner, 2020). Behan (2021) also reported findings that prisoners appreciate their time in Education, viewing it as a sanctuary, a more positive environment away from the wings and mundane routine of prison life.

It should be noted that the same participant also acknowledged that it was only their experience as an educator and extensive experience in the Corrections space that allowed them to navigate these difficulties in a way that empowered the prisoner, and that training would enhance their ability to implement effective techniques moving forward:

> *But we're just like, feeling our way through this, nobody's been really actually trained on what to do.*

Another participant from Education spoke about the challenge of staying focused for prisoners with FASD and finding creative ways to keep them engaged:

> *So, they can't concentrate for that long, so we just have to make sure we are using different types of, you know, like, we've got different types of learners anyway... But we have to use these different modes of learning, we have to try to visualise or, you know, like, show them pictures and stuff, so just to keep them engaged.*
>
> *Sometimes I put music on as well so you know, just to, because when they are actually doing the work, I put on the soothing music so that at least they can still listen and still get engaged.*

Sensory sensitivity and the inability to concentrate for long periods of time is a key issue for those with FASD, with Chapman (2008) suggesting that educators find creative ways to create a calming space and minimise distractions in the classroom to keep prisoners with FASD engaged. Learners should be given frequent breaks and short assignments. Pictures or verbal cues can be used to assist comprehension of abstract concepts (Chapman, 2008).

4.4.2.3 Individualised/Tailored Approaches

Participants spoke about how ordinary approaches to inappropriate or challenging behaviour did not work for prisoners affected by FASD, who required a different, often individualised approach:

> *But yeah, I sort of found him very different, and wanted to treat him... Not, not overtly different to the others, but yeah, I sort of I gave him a bit of extra time, because, you know, I find, found that he was a bit slower in processing things and yeah, like, his maturity wasn't quite there as much as the others.* (Custody).

> *Um, yeah, we treat him, manage him differently to everybody else. Very repetitive, very immature, very, just, yeah, he's, he will, he's told me many times, "I don't care what the rules are, I'm just gonna do what I want anyway".* (Custody).

Occurring along a spectrum, FASD is an extremely heterogeneous disability, with the issues and needs of affected individuals varying greatly (Rutman, 2016). Participants expressed a willingness to adapt their practice to the needs of the individual to prevent smaller problems being escalated where they could be managed and resolved at a lower level.

Some participants described using more individualised approaches with affected individuals. Individualised/tailored approaches were dependent on

awareness of a diagnosis and a considerable amount of familiarity and rapport with affected individuals.

A participant from Psychology suggested having knowledge of a potential or confirmed diagnosis of FASD would be critical to informing their approach and tailored interventions:

> *You are much better able to kind of conceptualise how your client is kind of, you know, taking in the knowledge or the intervention that you're disseminating to them like, because at the moment what I'm thinking like, I have really high expectations – I'm like "yes, I'm going to do this, they are going to do this and we're going to get there", and when that doesn't happen, I'm just like, "oh, I have to reset".*

Within the Custodial space, it was noted that creative, individualised ways of working with prisoners with FASD were required because of their challenges with consequential thinking:

> *So it's quite easy with the other guys – you charge[43] you know, they have their misconduct[44], security class[45] comes up, they can't do what they need to do, they can't progress, they're like "oh shit, okay, yep, okay, this is making sense", and if they don't, you know, you go on and on and on then, then we maxi[46] them* […] *But for him it just yeah, like I said before the constant charging that would work for someone else was just absolutely pointless.* (Custody).

This participant spoke to some of the strategies they would use with a particular prisoner who was confirmed as having FASD:

> *He does get moved on when it gets too much, he gets regressed to the, the high segs[47]* […] *he will get moved back and forth and when he behaves, he, he*

[43] An internal prison misconduct.
[44] An internal charge for breaches of prison rules. Prisoners who are found guilty of internal misconducts typically lose some or all of their privileges for a set amount of days or weeks.
[45] The classification of a prisoner's security risk. Security classifications in Aotearoa New Zealand are maximum, high, medium, low-medium, low, and minimum.
[46] Prison slang for upgrading a prisoner's security level to maximum.
[47] Prison slang for segregated prisoners. Segregated prisoners are prisoners who must be kept separate from the mainstream prison population for their own safety.

comes back. So, basically, he – we gave him a job even though if another prisoner acted like him, you would not give him the job […] *But for him it's best to keep him busy, so he, he needs that job. I don't know how effective he is at the job, I think he, he's kind of disruptive up there, but it gives him a purpose.*

Because there's nothing else you can really do because the, yeah, the punishment, it was, it was charge and charge and charge, charge. It just wasn't getting anywhere with him. And we found when we did do that – leave him with the job, give him some responsibility, that he definitely behaved.

Jobs for prisoners are in high demand as a productive way to pass the time (Garner, 2020), so it is typically unlikely for misbehaving prisoners to be offered employment. However, engaging prisoners with FASD in work may be beneficial because of the structure a job can provide, which can assist with self-regulation (Novick-Brown et al., 2012). Other, more obvious benefits of prison employment are monetary gain and more unlock time.

Individualised communication strategies also proved to be effective when working with a prisoner who had a diagnosis of FASD:

He hated it when I embarrassed him in front of other people by yelling at him, so, always – even though I wanted to screech at him across the wing, in the end […] *it just wasn't working. So, I'll go, and I'd be like, hold it, hold my rage inside, walk all the way up to him and go stand in front of him* […] *and I'll say, "can you please stop doing that right now? You – I've told you a million times".*

He could still tell I was really angry with him, but it was just quiet angry, and then, yeah, [he] *responded really well to that, yeah.*

The tactics employed by this participant highlight an individualised approach that goes against the grain of what the justice system seeks to achieve – deterrence through punishment (Vandergrift & Christopher, 2021). An FASD informed approach recognises that to achieve better outcomes, it is the system and

the individuals in its employ who must make changes, not the individual with FASD (Rutman, 2016). A system is referred to as "a collection of parts that, through their interactions, function as a whole" (Foster-Fishman et al., 2007, p. 198). Systems can refer to organisations, communities, and the justice system, for example. "Systems change refers to an intentional process designed to alter the status quo by shifting and realigning the form and function of a targeted system" (Foster-Fishman et al., 2007, p. 197). In order to change a system, the underlying structures and supporting mechanisms, such as the attitudes and beliefs of staff, current practices and processes, relationships, resources, and policies must be altered to meet the overall objectives of the change process (Foster-Fishman et al., 2007).

Most research in this area agrees that focusing on one element of the system without considering how it is impacted or will impact on the other interacting elements often leads to change failure within organisations (Al-Haddad & Kotnour, 2015). For example, changes in policy regarding interventions for prisoners with FASD that focus solely on their offending behaviours and 'risk' are necessary to ensure interventions for these individuals are effective. Implementing interventions that consider the individual's cognitive capabilities, such as social skills training would require a shift in perspective from clinicians in the prison who currently rely heavily on cognitive behavioural therapy (Brown et al., 2023). However, if the underlying attitudes and behaviours of clinicians do not support a change in their current policies, routines, or practices, this can lead to resistance and ultimately, change failure. Therefore, the culture of the organisation must be assessed based on whether the attitudes, behaviours, routines, and practices of staff match the objectives of the change process or if they need to be altered (Foster-Fishman et al., 2007). Responses from participants indicated an organisational culture that is open to change and exploring different strategies for supporting vulnerable prisoners.

4.4.3 Organisational Culture as a Facilitator of Change

The strategies implemented by participants may be the product of a wider organisational culture that encourages rehabilitation through caring attitudes and openness to change. “Organizational culture is defined as a set of beliefs, values, and assumptions that are shared by members of an organization” Gregory et al. (2009, p. 673). Organisational culture is shaped by expressed values, underlying assumptions, and deep beliefs. “Expressed values are consciously held convictions, clearly stated or practiced, that influence the behavior of members” (Warrick, 2017, p. 398). ASCF has four clearly stated values: Trust, Care, Innovation and Pride. Staff are encouraged to take personal responsibility for doing the right thing, prompted about the importance of providing genuine care, empowered to influence change, and reminded of the value of their roles to individuals and society as a whole (Serco, 2023b). These values explicitly inform staff of the expectations of the organisation and influence behaviours that match those values.

Participant responses indicated subscription to these values and an organisational culture that emphasises genuine care and support for prisoners:

> […] *because that's what we're here to do, right? That's what we're here to do. We're here to support people to be able to make positive change, to be able to go out and not come back, you know? To have something on the outside that they can invest into and be part of, and, you know, have the support in place that provides that scaffolding so that there is not a revolving door.* (Case Management).

Participants were interested in being part of something that was innovative and responsive to the needs of prisoners and that had the potential to teach them something new:

> *I think it's really important what you're doing, yeah.* (Education).

> *No, thank you so much for giving me more information about FASD and I am more interested and keen to learn more information* […] *to support here.* (Case Management).

One participant from Psychology said that unlike public prisons where bureaucracy limits innovation and overstepping boundaries, there was room to adapt interventions to match the needs of the prisoner at ASCF:

> *Oh, the stuff we deliver is definitely not set in stone. I think, maybe it's my experience at Serco, and Serco is a little bit more flexible and open to kind of working with the client. So, I think, yeah, that's definitely possible to add things, and especially if it's evidence based and things like that. I think that would be welcomed within the work, yeah.*

Where private prisons have traditionally made a profit for the more prisoners they house, ASCF is financially compensated for reducing re-entry to prison rates (Harding et al., 2019). The benevolent nature of the contractual agreement between Ara Poutama Aotearoa and ASCF encourages and expects innovation. ASCF as a private provider has therefore been given considerable autonomy to adapt practice and interventions where they believe it will contribute to reducing reoffending (Eisen, 2018). During interviews with participants, there appeared to be an organisational culture where participants valued and prioritised the needs and rehabilitation of prisoners. Organisational culture is also transmitted to the members of an organisation through various means such as leaders, artifacts such as dress code and the way the environment is presented, how people are treated and how decisions are made (Warrick, 2017).

The architecture of the prison was also innovative, designed to minimise feelings of confinement where appropriate, such as having an open area where prisoners who are low risk can move freely to their appointments. The prison was designed to offer prisoners the prospect of progression, where engagement with rehabilitative programmes and behaviour that worked toward lowering security classifications meant they could move from the high security units to self-care residences (Eisen, 2018). The residences are similar to apartments situated within the wire, where prisoners live in a flat-share situation. They each have their own rooms to which they have their own key and are free to move wherever they need to go within the prison without being escorted by Custodial staff (Personal Communication, 2023). The structure of ASCF can be seen as an artifact designed

to motivate prisoners to focus more on their rehabilitation, which can influence the behaviours and attitudes of staff to mirror the values of the organisation (Warrick, 2017).

Prison architecture has been found to influence staff-prisoner relationships and prisoner wellbeing. Research suggests that the design and layout of a prison can either stimulate or discourage staff-prisoner interactions, influencing the social climate within the institution. The way prisons are designed have historically been based on the penal policies of the day (Beijersbergen et al., 2016). For example, prisons that were built with a focus on control and surveillance, such as those based on Jeremy Bentham's panopticon design, discouraged staff-prisoner interactions, having a negative impact on staff-prisoner relationships (Beijersbergen et al., 2016). The panopticon design places the Custodial surveillance guardroom at the centre of the unit surrounded by prisoner cells, offering Corrections Officers a 360-degree view of the unit (Engstrom et al., 2022). Undisturbed visibility leaves little need for Officers to venture outside of the guardroom and interact with prisoners unless they witness some form of rule breach. This dictates that most interactions with prisoners are likely to be negative and based on maintaining control. Some early panopticon designs even included one-way windows, where Officers could observe prisoners without their knowledge, creating even further social distance (Beijersbergen et al., 2016).

In contrast, prisons designed as campus layouts have typically been built with a focus on rehabilitation and reintegration. Campus layouts consist of multiple buildings in a large open space. At ASCF there is a large open grass area and a garden that is tended to by selected prisoners. Prisoners in the residences have access to a basketball hoop and some of the upstairs rooms even had views of the ocean. Examples of the various prison layouts can be found in Beijersbergen et al. (2016).

One of the participants specifically referred to ASCF as fitting this campus-style layout:

> *I haven't been to many prisons... We had a training up at Pare – the Auckland prison and that prison just... It's a old prison and it's very much like what you*

see in the movies. So um, but Auckland south, it looks more like a University campus […] *So just, it seems very familiar and it was just easy to get used to.*

This participant's explanation of the layout of ASCF indicates that they found the space less threatening being newly introduced to the prison environment. This is congruent with research on the architecture of prisons that suggest prisons designed with a campus layout have a positive impact on staff-prisoner relationships and prisoner wellbeing (Engstrom et al., 2022). Increased visibility and direct access to nature, more focus on the use of discretion and the responsibilisation of prisoners encourage positive staff-prisoner interactions (Beijersbergen et al., 2016; Engstrom et al., 2022). Giving prisoners who have earned the privilege more autonomy to move freely throughout the prison is also likely to have influenced staff attitudes to apply more discretion where coercive and restrictive control is not permitted. This can lead to staff adopting more caring or 'prisoner-focused' roles (Clemons, 2021) that can ultimately benefit all prisoners but especially those with FASD.

Participants talked about the unique physical setting of ASCF and the positive culture in comparison to publicly run prisons in Aotearoa New Zealand and suggested that it trickled down to prisoners as well:

It's really, it's really good because the men are really, really good here. I mean, you know, it's a different culture, I guess. (Cultural).

It is a very different vibe to be honest, yeah. I've only yeah, only been to Pare[48] *and this one, and yeah, it's, it's like day and night, the difference is just so apparent.* (Psychology).

It's not like, not like a Corrections [public] *site and I say that in the nicest possible way. But it's not like a Corrections site where they're just treated like a number. They are a person and the staff here do treat them like that. And so,*

[48] Paremoremo – Aotearoa New Zealand's maximum-security prison.

> *they do make allowances and they, yeah, they cut them some slack and – but even that said* [our prisoners with FASD] *don't involve themselves in incidents and the like. And I think a big part of that is because the staff do take the time and are patient with them, so they don't have to act out.* (Custody).

Participants in the current study appeared to subscribe to the more benevolent roles associated with the physical layout and organisational values of the prison. These attitudes were shown to influence the way participants worked with prisoners with FASD by adapting their practice to support their needs. The layout and values of ASCF have created a unique culture and setting where staff can be more responsive to the needs of prisoners with FASD.

4.5 Summary

This chapter has provided an analysis of participant responses in relation to their knowledge, experiences, and practices regarding working with prisoners with FASD. According to the responses of participants, lack of training and problems with sharing FASD-related information within the prison contribute to limited knowledge of FASD and create barriers to rehabilitation for prisoners in various ways. In the absence of training and availability of diagnostic information, participants identified rapport and relationships as central to being able to identify potential disabilities and strategies for managing affected individuals. Humour, patience, understanding, empathy, and recognition of prisoner strengths were important factors influencing the strategies participants implemented with this prisoner population. Adaptations to communication styles, teaching styles, and individualised/tailored approaches were some of the strategies mentioned by participants. Overall, participants illustrated an organisational culture that valued the rehabilitation and care of prisoners with FASD, and a roster of staff who are willing to explore creative and alternative ways of supporting these goals.

The following chapter will provide an interpretation of this analysis to form recommendations for how to improve the management of FASD at ASCF. It will include limitations of the study and directions for future research.

Chapter 5: Discussion

5.1 Introduction

This chapter will discuss the implications of the research in relation to the analysis of participant responses. It will identify key findings and recommendations and include a discussion of the strengths, limitations of the research before offering recommendations for future research in this area.

5.2 Key Findings and Recommendations

This thesis set out to explore the knowledge, experiences, and practices regarding fetal alcohol spectrum disorder (FASD) for staff working at Auckland South Corrections Facility (ASCF). Participant interviews reflected international findings that awareness of FASD for prison staff in Aotearoa New Zealand is limited. Factors such as a lack of visibility; lack of formal training; and problems with sharing FASD-related information contribute to the current state of awareness at ASCF. Although knowledge of FASD was hindered by these factors, participants utilised rapport and familiarity with FASD-affected prisoners to inform strategies that helped them to provide support to these individuals. Participants appeared to be motivated by an organisational culture that prioritised prisoner wellbeing and rehabilitation. The primary recommendations from this study are to introduce formal FASD-related training for staff and explore the possibilities of using pre-existing information systems to inform staff if prisoners are suspected or confirmed of having FASD. It would also be worthwhile to consider the feasibility of a formal process for sharing FASD-related information between departments to reduce staff confusion around confidentiality and increase integration of services for prisoners. Interviews with participants suggested that combining the willingness of staff to support vulnerable prisoners with changes in training and information policies can have lasting benefits for FASD-affected prisoners who remain invisible and may continue to recidivate under current institutional practices.

5.2.1 Limited Awareness and Training

Participant responses indicated limited awareness regarding the identification and management of prisoners with FASD. Participants cited a number of factors contributing to limited awareness. A lack of visibility and discussion was identified as one of these factors. The invisibility of FASD both locally and globally has been well-cited in the literature. The variability in the expression of FASD contributes to great difficulty in accurately identifying and diagnosing the disability (Mattson et al., 2019). Additionally, confirmation of prenatal alcohol exposure is required for most diagnoses under the FASD umbrella such as FAS, ARND (Mattson et al., 2019), and ND-PAE (American Psychiatric Association, 2013). Attaining information on the prenatal experience of incarcerated adults suspected of having FASD has proven to be extremely difficult. The accounts of affected individuals can be inaccurate, and fragmentation of families is high for offenders who are more likely to have been raised away from the family of origin. This makes it difficult to connect with birth mothers to ascertain information of prenatal alcohol exposure (Burd et al., 2006; Popova et al., 2023).

Prisons lack the resources to have the multidisciplinary teams required to diagnose FASD (Burd et al., 2011). The seriousness of FASD also continues to be understated outside of the justice sector as government funding is still out of reach for individuals and whānau affected by FASD (Disability Rights Commissioner & Childrens Rights Commissioner, 2020). The lack of visibility of FASD is clearly a pervasive problem both within and outside of the prison. Evidently, it is not 'taken seriously' in the same way as other problems that are more visible or measurable and therefore, perceived as more important (Mattson et al., 2019). Without diagnostic evidence supporting the prevalence of FASD in prisons, staff remain uninformed, and it continues to be an invisible disability (Gibbs & Sherwood, 2017). The lack of diagnosis was suggested by participants as being a key factor limiting visibility and discussion of FASD and therefore, limiting any urgency to offer staff any training.

None of the participants in the study had ever received any formal training on FASD during their time working in prisons. Within the prison, all staff roles are

oriented toward reducing risk – risk of reoffending; risk of escape; risk to the security of the prison; risk to others; and risk to oneself. This focus on risk meant training and resources were typically directed at initiatives that could minimise immediate risk of harm rather than those aimed at the identification and management of prisoners with neurodevelopmental disabilities. Any staff shortages also meant staff directed their attention to the areas of their roles that maintained the safety and security of the institution and its members. The lack of FASD-related training for justice professionals has been recognised as a pervasive problem both locally and internationally (Passmore 2019; McCormack et al., 2022; McCormack et al., 2023). Prioritising FASD related training for staff would be in-line with the Department of Corrections Hokai Rangi strategy of reducing recidivism for Māori by enhancing support for those affected by FASD (Ara Poutama Aotearoa, 2019), given it has been estimated that Māori have the highest rates of FASD compared to non-Māori (Romeo et al., 2023), and Māori are shown to make up over 50% of the prison population in Aotearoa New Zealand (McIntosh & Workman, 2017). This highlights an urgent need to implement identification, management, and intervention strategies to address the needs of those affected by FASD if national goals of improving outcomes for Māori are to be met.

Limited or lack of awareness of FASD was a concern among participants who suggested this increased vulnerability for affected prisoners. Prisoners with FASD are typically housed in high security units where there are high rates of gang activity, increasing their susceptibility to violence. Additionally, participants noted that the characteristics associated with FASD such as social challenges, problems with self-regulation and impulse control can lead to social isolation and victimisation. Participants suggested that affiliating themselves with gangs was a strategy that some FASD affected prisoners used to minimise their vulnerability and increase their standing in the prison hierarchy, however, this also increased their risk of being involved in institutional misconduct by aligning themselves with anti-social peers. Prisoners with FASD who were not involved with gangs prior to imprisonment found themselves getting into more trouble, such as fighting and rule-breaking, as indicated by participants. This can reduce their chance of parole as they may still be seen as posing significant risk to the public if they cannot

conform to institutional rules (Connor, 2016). Awareness of people with FASD as more vulnerable to gang recruitment, manipulation, and poor decision making might lead prison staff to consider alternative placement to prevent recruitment and troublesome behaviours that limit access to rehabilitative programmes (Novick-Brown et al., 2012).

Contrary to popular opinion that prison staff have attitudes that are authoritarian toward prisoners (Ricciardelli et al., 2023), it was evident from participant responses that expressed values such as manaaki, rangatira, kaitiaki, wairua and whānau[49] had oriented staff to more caring attitudes and a moral responsibility to support the men in their care. Participants appeared frustrated by the lack of support they could offer because of systemic barriers such as a lack of training and awareness of FASD. These frustrations manifested in the entire sample of participants expressing a desire for more training and increased awareness in this area. Participants believed that training would be beneficial for prisoners and staff-prisoner relationships by informing staff about how to identify, manage and appropriately support prisoners with FASD or neurodivergence. Most participants preferred face-to-face training with a minority stating they would prefer e-learning or online training. The need to balance training that encourages staff engagement with efficiency suggests that blended learning could be an effective way of introducing FASD training for prison staff.

Blended learning is a blend of face-to-face and online learning. Across contexts, blended learning has been found to be more effective than traditional or online learning alone. The blended approach gives learners the opportunity to engage in discussion, ask questions and form relationships while also allowing them the time and space to reflect and digest information before putting that information into practice. Learners typically report more satisfaction from blended learning, which improves retention (Namyssova et al., 2019). Blended learning is becoming progressively more popular across institutions and organisations. Initial

[49] The values that underpin the Hōkai Rangi initiative for all Corrections employees in Aotearoa New Zealand. Manaaki (respect), rangatira (leadership), kaitiaki (guardianship), wairua (spirituality), whānau (relationships).

Officer training for prison staff in Aotearoa New Zealand is blended, as evidence suggests this is an effective way of teaching theoretical concepts and operational tasks to Corrections staff (Pearson, 2012). Facilitators assist learners with online modules in a classroom, which is supplemented with practical sessions and on-job learning. An international FASD-related training programme delivered to Prison Officers involved a three-hour face-to-face workshop that was supplemented by educational videos. The training was well-received by officers who felt their practice had been informed because the training was specific to the prison context (Passmore et al., 2021). Similar training may be useful in the Aotearoa New Zealand context.

5.2.2 Information Sharing

One of the greatest factors contributing to limited awareness of FASD was barriers to information sharing systems and processes. Participants identified problems with accessing diagnostic information about prisoners confirmed or suspected of having FASD; a lack of formal information sharing between teams; and confusion around confidentiality and the sharing of FASD-related information.

Multiple information systems meant that diagnostic information was not centrally located in a readily accessible folder or link, meaning participants were unaware of where to look to find this information. A number of participants reported that diagnostic information was difficult to access because it was buried underneath years of file notes[50], reports, and other prisoner information. It was unclear whether this was a problem specific to FASD diagnoses or if it was the case for all psychological conditions. Moreover, where participants had a limited awareness of FASD, they did not tend to go 'digging' for diagnostic information at all, especially where staff shortages and increasing role demands meant learning about the health information of prisoners was not a priority.

[50] An informal record where staff can share anything they deem to be relevant to the prisoner without loading an official report. File notes are permanent and can be viewed by anyone with IOMS access.

Custodial staff in particular, were not perceived to have the time or motivation to search through prisoner files for information they did not deem to be relevant to their occupational role. As custodians, Corrections Officers are primarily responsible for maintaining the safety and security of the prison by completing a number of operational tasks throughout the day. They are also responsible for ensuring institutional rules are adhered to, enforcing those rules by reprimanding prisoners who break them (Halsey & Deegan, 2017). In order to maintain a sense of authority, Corrections Officers set personal boundaries to safeguard against manipulation and complacency with prisoners. Officers typically refrain from searching into prisoner histories to ensure they can remain impartial, treating prisoners only according to their behaviour while incarcerated (Halsey & Deegan, 2017). Participants suggested that this was one of the reasons Custodial staff were unlikely to go searching through prisoner files and therefore, unlikely to 'stumble upon' a diagnosis or suspicion of FASD.

Many participants suggested the information should be shared in 'Prisoner Alerts'[51], a platform that all staff, including Corrections Officers, are likely to go to for important operational information about prisoners in their care. Prisoner Alerts are a potential solution where information that affects the care and management of a prisoner can be shared and easily accessed. Participants who had suspected a prisoner may have FASD or some neurodevelopmental disability reported searching in Prisoner Alerts for this information. Similarly, other participants suggested that this would be the most likely place they would search for any operationally relevant information for prisoners and therefore, recommended a diagnosis or suspicion of FASD should be available there. Participants suggested that placing FASD-related information in Prisoner Alerts would immediately raise awareness of all staff interacting with affected prisoners. It would inform practice by notifying staff that a particular prisoner may indeed need to be treated based on their history as opposed to the behaviour they see in

[51] Prisoner Alerts are located under the 'Prisoner Header' in IOMS and offer an easily accessible snapshot of important, operational information pertaining to that prisoner. They are accessible to every staff member with IOMS access and are updated regularly.

front of them and prompt staff to seek further guidance on how to appropriately support affected individuals.

Siloed teams represented another barrier to information sharing within the prison. According to participants, different departments within the prison were separated by the differing purposes of their roles regarding interactions with prisoners. This meant that there was no formal process for sharing information with other roles relevant to a prisoner's sentence about whether staff suspected or knew an individual had FASD. Although in principle, no health information should be shared without the consent of the affected person, staff did appear to suggest a need to exercise discretion for other notable health conditions such as cancer or ADHD[52]. However, in the case of FASD, it appeared that worries about sharing this information were heightened, with staff tending to err on the side of caution because of uncertainties and inconsistencies regarding ideas about stigma and vulnerabilities associated with a diagnosis of FASD. Lack of a formal process means information is shared informally as soft information within organisations (Lips et al., 2011). Soft information is shared among colleagues however, it does not make it into the formal document that is shared both within and between institutions. This can have significant impacts for prisoners once they are released from prison, limiting their access to services that can provide support for their diagnosis (Lips et al., 2011). Also contributing to a lack of information sharing was likely the invisibility of FASD. Other health conditions such as cancer or ADHD required the administration of medications and prison outings to receive specialised treatment, all of which must be facilitated by Custodial staff, making it difficult to maintain confidentiality (Elger & Shaw, 2017).

Although teams were siloed within the prison, most participants said they would inform Health about any information pertaining to potential or confirmed diagnoses of FASD. Participants were aware of FASD as a health issue and felt obligated to inform the health team if they had gained information relating to prenatal alcohol exposure of prisoners or had observed behaviours that raised

[52] Attention-deficit hyperactivity disorder.

concern. The inward flow of FASD-related information to Health appeared to remain there, given issues of confidentiality, and sharing private health information. Perception of FASD as purely a health-related issue with no operational implications meant opportunities for collaborative support were being missed with the information remaining within the health team. FASD is a permanent disability that impacts not only on the health and wellbeing of an individual but influences many of the behaviours that contribute to entry and re-entry into the prison system (Sherwood, 2019). While in custody, prisoners make contact with a variety of staff for different purposes. Sharing FASD-related information between departments would contribute to addressing FASD as a disability that requires support from all relevant staff involved with a prisoner's sentence and would help to provide integrated services.

Health participants talked about legal and ethical guidelines such as the Health and Information Privacy Code (HIPC) (Privacy Commissioner, 2022) as one of the primary factors inhibiting the flow of information. Although these guidelines were clear for Health participants, there was confusion among participants from other departments regarding their responsibilities around sharing health information. While participants agreed sharing FASD-related information would improve outcomes for prisoners, the entire sample had inconsistent views about whether the information *should* be shared. Issues of informed consent and vulnerability associated with a diagnosis of FASD were mitigating factors. Participants acknowledged that obtaining consent was one of the only exceptions that allowed them to disclose health-related information, however, it was noted that staff would be unlikely to seek consent unless looking to refer the prisoner to outside services. This reflected the lack of awareness of FASD and the potential benefits to sharing FASD-related information. For example, staff who engage with prisoners might end up in interactions where prisoners inform them of a diagnosis or that their mother drank while she was pregnant and choose to keep this knowledge as soft information informing their practice with that individual, rather than seeking consent from the prisoner to be able to inform other relevant staff. Overall, participants generally agreed that sharing FASD-related information would improve outcomes for prisoners, however, difficulties interpreting privacy

laws led to participants erring on the side of caution by keeping this information confidential.

Cultural perspectives of confidentiality and privacy that must also be considered. Eurocentric concepts of autonomy, privacy and confidentiality are highly valued in Western culture and are a product of individualism (Hayes, 2006). In contrast, Māori culture tends to value the sharing of information within communities when there are clear benefits to the individual and wider society. Māori view health and wellbeing as a community concern and acknowledge that the sharing of health information can facilitate access to support and advocacy from whānau. In some instances, Māori whānau will even prioritise the community over individual autonomy, which is a direct contrast to Western ideals of autonomy and self-determination (Menkes et al., 2008). While Corrections services are bound by laws such as the Privacy Act (2020) that prioritise the confidentiality of health information, the Hōkai Rangi initiative and its commitment to shift from systems based on Western schools of thought to those that prioritise mātauranga Māori also identifies tensions at an organisational level (Ara Poutama Aotearoa, 2019). Areas where confidentiality is proven to be a barrier to support may need to be explored within the Corrections space.

5.2.3 Organisational Culture as a Facilitator of Change

Within the current study, there was evidence that knowledge of an FASD diagnosis did inform participant practice with affected prisoners, even in the absence of formal training. An analysis of staff-prisoner relationships identified how these dynamics informed various strategies that staff used to support and manage prisoners with FASD. Participants talked about how the importance of establishing rapport and familiarity with prisoners was essential to informing strategies they implemented with affected individuals. Participants drew on characteristics such as humour, patience, empathy, and understanding to build rapport with prisoners who likely had a distrust of authority and government officials. These qualities reflected the genuine attitudes that participants had

towards supporting vulnerable prisoners in their care. Regardless of the difficulties of working with prisoners with FASD, participants reported a number of strengths of prisoners affected by the disability. Strengths typically included perseverance and passion for the arts (music, dance, culture) and honesty. Participants drew on their rapport and familiarity with prisoners to identify qualities that might be viewed by others as frustrations. For example, participants appreciated the lack of 'filter' that prisoners with FASD presented with, seeing their show of emotions and verbal outbursts as indications that they trusted them enough to express themselves and talk out their frustrations. This reflected how rapport between staff and prisoners can shift perspectives regarding people with FASD from a deficit to a strengths-based approach, which has been shown to increase self-esteem and promote engagement with service providers.

Staff-prisoner relationships provided a foundation for strategies that participants implemented with prisoners affected by FASD. Participant strategies typically included changes in communication styles; teaching styles; and individualised or tailored approaches. Participants reported that punitive measures were ineffective for prisoners with FASD who required creative, individualised strategies to manage difficult or inappropriate behaviours. Once incarcerated, people with FASD are more likely to face internal misconducts because they are easily led by antisocial peers and prone to impulsivity (McGinn, 2019). Factors such as blunted affect, reduced capacity for understanding the perspectives of others, challenges with comprehending and remembering rules and regimes, irritability and impulsivity can all cloud the judgement of prisoners with FASD, making punishment ineffective in most circumstances (Freckelton, 2016). Internal misconducts that were usually effective for curbing non-compliant behaviours of neurotypical prisoners were recognised by participants as having no effect on prisoners with FASD. Participants found alternative ways to address behaviour and maintain boundaries to the best of their ability in the absence of formal training or processes. Prisons and their staff are typically portrayed in the literature, media, and popular culture as punishing, having negative attitudes toward prisoners, corrupt and violent (Ricciardelli et al., 2023). The responses received during interviews with participants at ASCF painted a very different

picture. It was both enlightening and encouraging to learn that even in the absence of formal training and processes dedicated to FASD or other neurodevelopmental disabilities, participants worked to find creative, positive ways to adapt their practice in support of affected prisoners.

The strategies mentioned by participants reflected a wider organisational culture that encouraged a genuine commitment to the rehabilitation of prisoners. It was evident that organisational values such as Trust, Care, Innovation, and Pride and the architecture of the institution oriented participants toward more benevolent attitudes. As a private prison in partnership with Ara Poutama Aotearoa, ASCF is contracted to reduce reoffending as opposed to the traditional model of private prisons that are financially compensated for the more people they hold in custody. It is this contractual agreement that allows ASCF the space to innovate and create a prisoner-centric atmosphere that prioritises going the extra mile to support prisoners in their rehabilitative journey. Participant interviews reflected the potential for ASCF as more of an autonomous Corrections facility to create space for change as opposed to public facilities where layers of bureaucracy can stifle innovation and staff willingness to participate in new policy. Participants felt that they were a part of an organisation that welcomed and represented a new way of 'doing prison'. The organisational culture of ASCF appeared to empower participants to consider the individual differences of prisoners with FASD, promoting the institution as a pioneer for new initiatives that could significantly improve outcomes for prisoners affected by this life-long disability.

Capitalising on the motivation of staff attitudes to explore new ways of managing FASD can be achieved by facilitating access to information that enhances staff knowledge and awareness of the vulnerabilities of affected prisoners. Exploring the use of pre-existing information sharing systems to share information about prisoners with FASD would be highly worthwhile for ASCF as an institution that has the potential to facilitate real change. Participant interviews highlighted confusion about what FASD-related information can be shared and where it should be placed. Participants also appeared confused at who this information should be shared with and how. Although the Privacy Act (2020) prevents the sharing of

health-related information between organisations, it was unclear to the researchers whether FASD-related information could be shared *within* the institution. It would be helpful to clarify whether privacy and confidentiality laws do prevent this type of information sharing within prison walls. What was clear was that all relevant staff would be of great benefit if prisoners are suspected or confirmed of having FASD to ensure affected prisoners are appropriately managed and supported to be involved in effective programmes and FASD-informed interventions. Utilising an easily accessible pre-existing information sharing platform such as Prisoner Alerts to hold FASD-related information may be a simple, yet effective solution. Additionally, creating and informing staff of a formal process for sharing FASD-related information would reduce confusion and siloes between departments, and ensure information was not lost or treated only as soft information.

The benevolent incentive structure of ASCF also highlights the potential for private prisons in general to implement policies directed at improving outcomes for prisoners with FASD. The campus-style layout which was influenced by the Private-Public Partnership (PPP) highlights the importance of the contract on the way prisons are ultimately designed and managed (Beijersbergen et al., 2016). The campus-style layout incentivises prisoners to follow their sentence plans and reach the self-care residences that are offered to those individuals with lower security classifications. These internal incentive structures may well reduce violence toward vulnerable prisoners. This was reflected in interviews where participants stated they had not observed increased victimisation of prisoners with FASD by the mainstream population. Prison incentives and earned privileges schemes allow prisons to operate less punitively by encouraging compliance through self-regulation and rational thinking (Khan, 2022). This might explain why prisoners with FASD at ASCF, despite their interpersonal difficulties and disruptive behaviours, did not appear to be overwhelmingly victimised by participant accounts. Prisoners have something positive to work for within the structure of ASCF, which is likely to lead them to prioritise their own progress through the system as opposed to honing in on the vulnerabilities of FASD affected individuals.

The literature regarding FASD in prisons and the wider justice system provides overwhelming support for increasing staff awareness in this area. Providing staff with formal training; identifying a pre-existing information sharing platform as a 'system of notification'; introducing a formal information sharing process; and understanding the benefits of an organisational culture that appears to have an effect on the way both staff and prisoners interact would significantly improve the management of FASD at ASCF. These key findings emphasise ASCF and the potential for other institutions operating under the PPP principles to create a space where real support for prisoners with FASD can be implemented. Change in this area can help to reduce some of the vulnerabilities of these prisoners that stem from a lack of awareness, difficulties in staff-prisoner relationships and limited access to effective interventions that can help to reduce a life spent behind bars.

5.3 Strengths and Limitations

The purpose of this research was to work collaboratively with ASCF to identify gaps in staff knowledge of FASD and areas where change can lead to improvement. Working collaboratively with the organisation means the data will be useful as they navigate the many complexities associated with FASD in the prison environment, which was a strength of the study. Working collaboratively with ASCF ensured I, as the researcher, was accountable to the organisation and that the research was driven from their needs rather than imposed by the researcher (Jones et al., 2006). The wide variety of participants in terms of their roles within the prison, cultural backgrounds and experience working in the prison ensured that there was a number of different experiences and perspectives obtained (Brink, 1993). Another strength of the study was the semi-structured interviews and my ability to tailor interview questions to the individual experiences of the participants, given that the different roles within the prison were likely to have different levels of experience and understanding of FASD. This allowed me to probe further into the individual experiences of participants to gain a deeper understanding of the various barriers and facilitators contributing to their knowledge of FASD.

Semi-structured interviews also presented some limitations. Semi-structured interviews and analysis of the corresponding data is very time intensive, which limited the sample size significantly in comparison to using survey, for example (Williams, 2015). Although semi-structured interviews allowed me to gain a deeper understanding of participant experiences, the small sample size significantly limits the ability to generalise the findings to the rest of the 300 plus staff at ASCF. Moreover, given ASCF is a privately run men's prison, this may also limit generalisability to other contexts, such as females and public prisons (Williams, 2015). Semi-structured interviews also hold the potential for social desirability bias. Social desirability bias refers to a tendency for participants to respond with what they believe the researcher wants to hear, masking their true thoughts or feelings. Participants are more prone to social desirability bias if the research is focused on more socially sensitive issues (Grimm, 2010). Given the stigma surrounding FASD and social connotations associated with the research project that prisoners with FASD are more vulnerable and in need of support, participants may have felt the need to emphasise attitudes that favour supporting affected prisoners. However, given the honesty of the replies to my questions and my somewhat insider status as a former Corrections Officer, the possibility for social desirability bias appeared to be limited but cannot be ruled out.

Finally, the reliance on video conferencing technology (VCT) to conduct all interviews contributed to further strengths and limitations of the study. VCT had a number of advantages such as allowing both participants and researcher the convenience of conducting the interviews from a place that was familiar and easy to access such as our own homes or offices, avoiding the need to travel. Online interviews can also facilitate power sharing (Brown, 2022). Participants may have felt more comfortable participating in the interview in a place familiar to them and less inhibited without the pressure that can be experienced during face-to-face interviews. The use of VCT also allowed for interviews to be easily recorded and clearly transcribed as opposed to relying on a handheld digital voice recorder that would likely be inferior in sound quality (Brown, 2022). However, online contact can also be a barrier to rapport building, limiting feelings of proximity and the depth of participant responses. Brown (2022) states that this distance can limit the researcher's ability to pick up on non-verbal cues that are necessary for directing

the conversation. Glitches in internet speed can also interrupt flow. Technological difficulties such as problems with some participant cameras and microphones may have also limited the extent of rapport that was developed, negatively affecting data collection. Notwithstanding this, it is hoped that a focus on whakawhanaungatanga and genuine commitment to making participants feel comfortable mitigated some of these limitations.

5.4 Directions for Future Research

The current research explored the knowledge, experiences, and practices regarding FASD for staff in an Aotearoa New Zealand prison context. It would also be beneficial to conduct research based on the experiences and perspectives of prisoners diagnosed with FASD to gain deeper understanding of the impacts of this disability and how affected individuals can be appropriately supported. Future research could take a further step backwards and look at the needs of individuals with FASD in the justice system before any imprisonment occurs.

To my knowledge, this was the first study of this kind to be conducted in an Aotearoa prison. It would be useful to conduct similar research with staff within public prisons in Aotearoa New Zealand that house both men and women. Participant responses identified that staff have a limited awareness of FASD due to a lack of visibility. It would be beneficial to conduct research that assesses the prevalence of FASD among prisoners in Aotearoa New Zealand to increase visibility and awareness. Future research could ascertain the resources and staff competencies required and identification of the training needs to meet this resource investment and workforce upskilling.

Ultimately future research would be most focused on how to best prevent FASD from occurring. To look at why women are consuming alcohol during pregnancy and how best to support alcohol-free pregnancies for all New Zealand women.

5.5 Conclusion

Consistent with international literature, this research posits that Aotearoa New Zealand prison staff have limited awareness of FASD. It identified lack of formal FASD-related training for staff, problems with the use of internal information sharing systems and inconsistencies in information sharing as barriers to the appropriate identification, management, and support for prisoners affected by FASD. Participant willingness to adapt their practice when working with prisoners with FASD reflected a benevolent organisational culture that positions ASCF as an institution that is dedicated to finding innovative ways to support these vulnerable prisoners. Enhancement of training processes and information systems have the potential to improve outcomes for prisoners with FASD by facilitating access to appropriate rehabilitative services and behavioural interventions that are developed within an FASD-informed approach. As a disability that is still widely misunderstood, it is hoped that this research will contribute to ongoing discussion and future research that will contribute to the improvement and integration of services for prisoners coping with the life-long effects of FASD.

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Appendix A

An Exploration of the Knowledge, Experiences, and Practices of Staff towards Fetal Alcohol Spectrum Disorder (FASD) in an Aotearoa New Zealand Prison Context.

INFORMATION SHEET

Kia ora, my name is Kahlia Kawana, and I am conducting a research project to complete a Master of Arts in Psychology at Massey University. Before returning to University, I was a Senior Corrections Officer at Manawatu Prison. Before this, I spent four years working as a Corrections Officer where I was a member of Advanced Control and Restraint (ACR) and the Site Emergency Response Team (SERT). I also spent time at the National Learning Centre (NLC) assisting with training and signing off recruits.

I am excited to return to the prison space to explore staff knowledge of Fetal Alcohol

Spectrum Disorder (FASD) in prisons. Some of you may be more familiar with the term Fetal Alcohol Syndrome, which is one of the diagnoses that is given when a baby has been exposed to alcohol during pregnancy. This is a disorder that presents many challenges for affected individuals throughout their lives, and current research shows there are high rates of prisoners world-wide who have this disorder. We have little knowledge of the Aotearoa New Zealand situation.

Project Description and Invitation

The aim of the research is to assess the knowledge about FASD that professionals (Health, Custody, Case Management and Psychology) working at Auckland South Corrections Facility (ASCF) currently have. Understanding the depth of staff awareness will help to identify the gaps in knowledge, and the implications for working with prisoners who may have FASD. This study has been approved by ASCF.

You are invited to take part in an interview around 45-60 minutes long if you work at ASCF in the following areas – Health, Custody, Psychology, or Case Management. The interviews will be arranged at a time and place that suits you, either in person or using Microsoft Teams. You will be given a $40 grocery voucher as a koha in appreciation for your time and participation.

If you would like to participate or would like more information, please contact Kahlia directly at the email address at the bottom of this form. Any personal information shared will remain completely confidential from other ASCF personnel including prison management.

What happens to the data?

You will be given full anonymity, pseudonyms will be used, and data files will be password-protected. If your role within the prison is reported this will be done in such a way that you are unable to be identified. The interview data will only be available to the researcher and university supervisors.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time during the interview and your data for up to 21 days after the interview date;
- ask any questions about the study at any time during participation; • provide information on the understanding that your name will not be used;
- be given access to a summary of the project findings when it is concluded.

Making contact

If you would like more information or have any questions you are welcome to contact the researcher and/or supervisors directly

Kahlia Kawana [redacted]

Professor James Liu (supervisor) J.H.Liu@massey.ac.nz +6492136279

Dr. Veronica Hopner (supervisor) V.Hopner@massey.ac.nz +6492136101

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Prof Craig Johnson, Director, Research Ethics, telephone 06 356 9099 x 85271, email humanethics@massey.ac.nz".

Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
Te Kura Pūkenga Tangata

An Exploration of the Knowledge, Experiences, and Practices of Staff towards Fetal Alcohol Spectrum Disorder (FASD) in an Aotearoa New Zealand Prison Context.

CONSENT FORM

I have read, and I understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study up until 21 days after my interview.

1. I agree to the interview being sound recorded.
2. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

I _____ hereby consent to take part in this study.

Signature: _____ Date: _____

Appendix B

Interview schedules

SQ = Stemming question

<u>General questions (for all participants)</u>

1. Can you please explain a bit about your role within the prison and your day-to-day responsibilities?

   SQ: How many prisoners are on your case load/in your care?

   SQ: How much time do you have to spend with prisoners to get to know them personally?

2. Can I ask what made you interested in participating in the research?
3. Can you please explain your current understanding of FASD?

   SQ: What behaviours might lead you to suspect a prisoner has FASD?

(Provide some basic knowledge on FASD if participant has limited understanding, such as):

- Basic symptoms and presentation
- Common comorbidities
- How prisoners with FASD might present on a day-to-day basis

4. Can you picture a prisoner who you think might have FASD?

   SQ: How do they typically behave?

   SQ: What are some of their most common difficulties in prison?

   SQ: Can you think of any strengths and weaknesses this person has?

   SQ: How common do you think FASD might be in the prison?

5. What knowledge of FASD (if any) do you think might be relevant to your role?

<u>Knowledge sharing systems</u>

6. If you knew a prisoner had, or could have FASD, would you share this with other roles?

    SQ: With whom would you share this information?

    SQ: Why should this information be shared?

    SQ: How would you share this information?

7. What input do you get from the floor about the mental health problems of prisoners?
8. What challenges or barriers can you see regarding knowledge sharing?

    SQ: Can you think of any solutions to those problems?

<u>Training</u>

9. What training have you received on FASD during your time working in prisons?

    SQ: How often does this training occur?

    SQ: What have been your main sources of information on FASD?

10. Would you be interested in further training?

    SQ: How much time do you have for training in your role?

    SQ: If you had to choose between internet platforms, face-to-face face, or written communication, what method of delivery would you prefer to receive training or education on FASD?

<u>(Additional questions for participants with a greater understanding of FASD)</u>

Challenges, barriers, solutions

11. To your knowledge, what (if any) are the biggest problems regarding FASD in NZ prisons?

    SQ: Do you see any solutions?

SQ: What challenges or barriers are there to diagnosis in prisons?

SQ: Do you have any solutions as to how diagnosis could be approached in prisons?

Approaches to FASD in prisons

12. Imagining that money and resources aren't an issue, what would an ideal response to FASD look like to you?
13. Is there anything else you would like to share with me regarding your knowledge, experience, or practices regarding FASD?
14. Do you have any questions for me?