Tools for Success

Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System

Facilitator's Manual

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System

Facilitator's Manual: Volume 1

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
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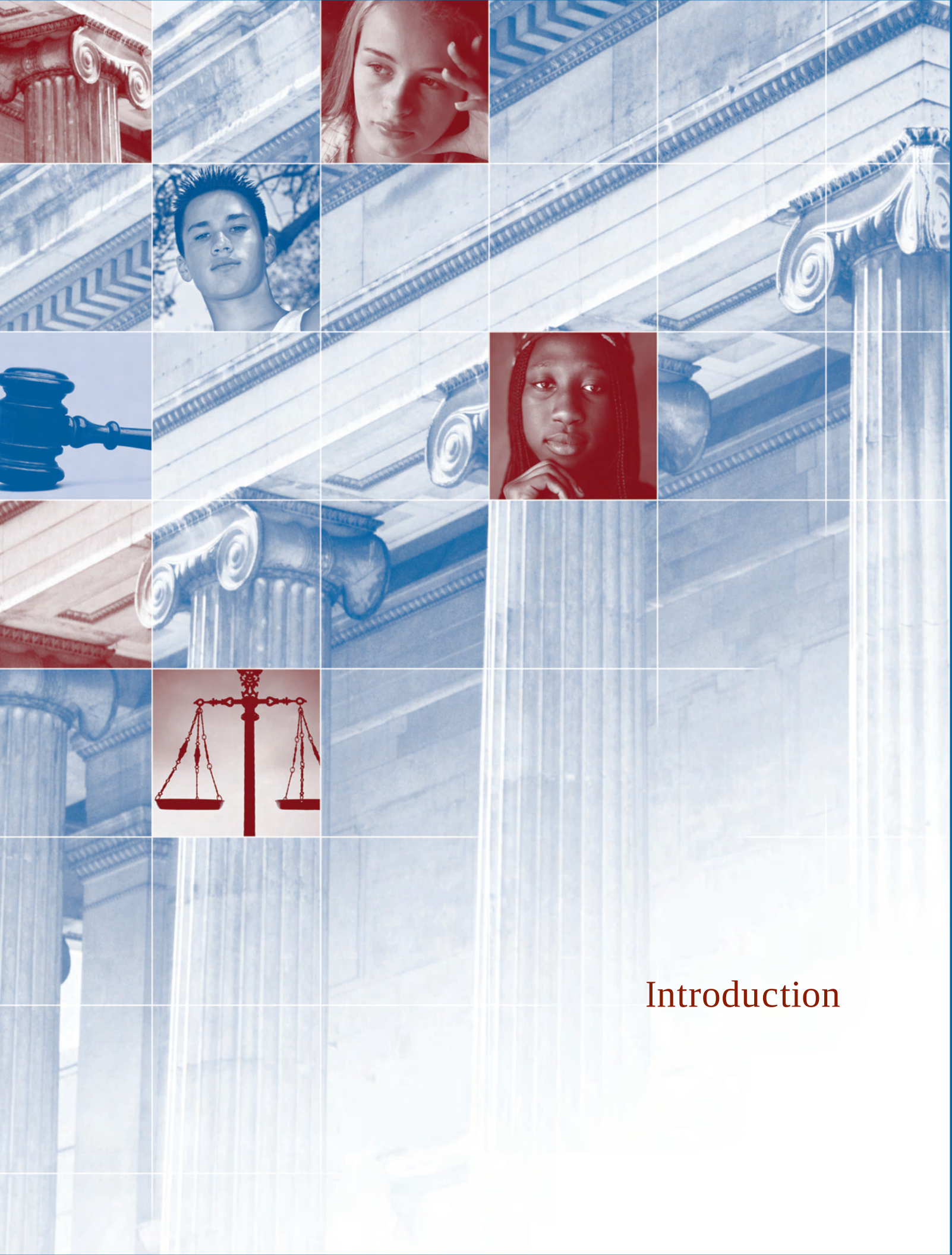

Introduction

Tools for Success Curriculum

Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System

Introduction

Welcome to the *Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System* (also called *Tools for Success*). This curriculum was developed as a joint project of the Substance Abuse and Mental Health Services Administration (SAMHSA) Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence and the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). It is designed to help professionals in the juvenile justice system recognize and address FASD.

"Fetal alcohol spectrum disorders" is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. "FASD" is not a diagnostic term used by clinicians. It refers to conditions such as fetal alcohol syndrome (FAS), partial FAS, alcohol-related neurodevelopmental disorder, and alcohol-related birth defects.

It is estimated that FASD occurs in 1 percent of all live births in the United States each year (May and Gossage, 2001). Many of these infants grow up to commit crimes. One study found that 60 percent of individuals with an FASD ages 12 and older had been in trouble with the law (Streissguth, et al., 1996). Youth with an FASD often cycle through the juvenile justice system with no recognition of their disabilities. Through this curriculum, it is hoped that professionals can learn ways to improve the identification and treatment of youth with an FASD in the juvenile justice system.

Organization Descriptions

SAMHSA FASD Center for Excellence

The mission of the SAMHSA FASD Center for Excellence is to facilitate the development and improvement of prevention, treatment, and care systems in the United States by providing national leadership and facilitating collaboration in the field. After the FASD Center for Excellence was established under section 519D of the Children's Health Act of 2000, SAMHSA launched the Center in 2001. The legislation authorizing the Center includes six mandates to guide the Center's work. The mandates focus on exploring innovative service delivery strategies; developing comprehensive systems of care for FASD prevention and treatment; training service system staff, families, and individuals with an FASD; and preventing alcohol use among women of childbearing age.

Minnesota Organization on Fetal Alcohol Syndrome

MOFAS is the first State affiliate of the National Organization on Fetal Alcohol Syndrome (NOFAS), a nonprofit organization founded in 1990 to eliminate alcohol-related birth defects through increased public awareness and education. MOFAS is dedicated to eliminating birth defects caused by alcohol consumption during pregnancy and improving the quality of life for the individuals and families affected. It is the only statewide organization in Minnesota focusing

solely on prevention and intervention of fetal alcohol spectrum disorders, the leading known preventable cause of mental retardation and developmental disabilities. MOFAS provides leadership and promotes statewide collaboration, problem solving, advocacy, and education with State and community agencies on alcohol-related birth defects.

Background Information

Youth who were prenatally exposed to alcohol may fail to predict or understand the consequences of breaking the law and may lack the ability to conform to the law's requirements, placing them at a very high risk for criminal behavior that extends into adulthood. They may repeat mistakes, take risks, and demand instant gratification. Individuals with an FASD may lack initiative and be unable to connect actions and consequences, respond to subtle social cues, or make reciprocal friendships, even if they have a normal IQ score. This often results in maladaptive behaviors, such as impulsivity and a tendency to lie, cheat, or steal (Streissguth, et al., 1991). In a study of more than 400 youth and adults with FAS and fetal alcohol effects (FAE), 60 percent were found to have been in trouble with the law (Streissguth, et al., 1996). Another study found that 22.3 percent of youth in a specialized psychiatric evaluation unit in the juvenile justice system in British Columbia had brain damage from prenatal alcohol exposure (Conry, Fast, & Loock, 1997). Early intervention can act as a protective factor for people with an FASD, preventing them from getting into trouble with the law and mitigating the development of mental illness (Streissguth, et al., 2004).

Tools for Success Curriculum

Tools for Success is a comprehensive program for professionals working with youth with an FASD in the juvenile justice system. The goal of this program is to provide information to professionals in the juvenile justice system so they can identify youth who may be affected by prenatal alcohol exposure and develop and deliver effective and appropriate services for youth with an FASD. This training will better equip professionals to create and implement more appropriate case plans. Through effective intervention strategies, youth with an FASD will be more successful in completing their programs and moving into healthy, productive adulthood.

The materials in the curriculum contain all that you need to prepare for and deliver the training objectives. The curriculum includes seven modules. Each module includes PowerPoint slides, group activities, additional handouts ready for duplication, and other materials. In addition, all the modules but Module 7 have pre- and posttests.

Trainers and Audiences

The *Tools for Success* curriculum was developed for trainings to be conducted by a team of two professionals: one from the field of FASD and one from the juvenile justice field. MOFAS and the FASD Center for Excellence strongly encourage this team approach to ensure that the training facilitators have the expertise needed to provide training participants with accurate information. This teamwork also models the collaboration that may be needed when providing appropriate services for youth who may have an FASD and are involved in the juvenile justice system. To ensure that they have a strong background in FASD, the facilitators should review two other trainings produced by the FASD Center for Excellence: (1) *FASD—The Course* and (2) *FASD—The Basics*. Both are accessible on the FASD Center for Excellence Web site

(www.fasdcenter.samhsa.gov). These professionals also should be skilled in training and facilitation.

The information in the curriculum is designed for presentation to a wide variety of professionals who work with youth with an FASD in the juvenile justice system. You may be training corrections and legal professionals, as well as health and social service providers who work through juvenile justice courts. Appropriate audiences for this information include advocates, attorneys, social workers, probation officers, and human service providers who interface with children and families affected by FASD. Training sites may include county-based correctional settings, public defenders' offices, probation offices, and community agencies.

Tools for Success contains several components, described in the sections that follow.

Resource Guide

With funding from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), MOFAS developed Tools for Success: Working With Youth With Fetal Alcohol Syndrome and Effects in the Juvenile Justice System Resource Guide (also called Resource Guide), which was used as a basis for the Tools for Success curriculum. This comprehensive guide contains information on the extent of the problem of FASD, background and history of FASD, information on the juvenile justice system, effective and appropriate intervention strategies for youth with an FASD, and resources and referrals. You can purchase a copy of the Resource Guide for more information, and you can recommend it to those you train.

Guide for Parents and Caregivers

Written from a parent's perspective, "A Guide for Parents and Caregivers" increases a parent's understanding of FASD, a child's rights and options in the juvenile justice system, effective advocacy and negotiation strategies, and suggestions for interventions proven most promising for children affected by an FASD. This booklet was developed separately by MOFAS and is included as a resource. You will need to make copies of this guide to distribute to your training participants.

Curriculum Content

The curriculum is presented in seven modules. You will need to determine which modules are most appropriate for the setting in which you are training. You can choose the modules that best meet the audience's needs and time limitations. However, it is important that the first module—Fetal Alcohol Spectrum Disorders (FASD): The Basics—always be presented at the beginning of the training. It is also strongly recommended that you present Module 7: Resources at every training. The entire curriculum is provided on the enclosed CD. The seven modules are described below:

- **Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics**

  This presentation gives attendees an overview of the significance of prenatal alcohol exposure to an unborn child. The module discusses the incidence of the disability, financial costs, characteristics of FASD, and daily challenges.

- **Module 2: FASD in the Juvenile Justice System**

  Module 2 provides a comprehensive overview of youth with an FASD in the juvenile justice system. Presenters focus on the prevalence of disabilities and FASD within the justice system. In addition, presenters review the characteristics of youth with disabilities and those with an FASD that put them at risk for getting into trouble with the law.

- **Module 3: The Juvenile Justice System Response**

  This presentation focuses on alternatives to formal juvenile court, initial contact with the juvenile justice system, screening and assessment, waiver to adult court, competency and capacity issues, and investigations and evaluations.

- **Module 4: Dispositional Options**

  Attendees gain insights into the best practice research around dispositional options, as well as information on awareness, advocacy, community treatment interventions, and probation.

- **Module 5: Special Education and Behavior Management**

  This session focuses on special education services for youth with an FASD, special education in juvenile facilities, and effective behavior management strategies for the juvenile correctional setting.

- **Module 6: Transition and Aftercare**

  Transition and aftercare programs are vital to a child's success as he or she reaches adulthood. Module 6 focuses on these issues, with special attention given to employment and vocational rehabilitation.

- **Module 7: Resources**

  Module 7 provides a discussion on finding resources for parents, professionals, and other individuals, and it addresses building community support systems.

Each of the modules contains the following components:

- **Description of the module and the information being presented**

  Each module begins with a summary of what is to be covered in the time given, as well as the objectives.

- **Outline for facilitators**

  The outline describes each step in the training, delineating the time allotted and the materials needed for each step.

- **Pre- and posttests**

  The curriculum includes a pre- and posttest for each module (except Module 7). Within each module, the posttest contains the same questions as the pretest but presents those questions in a different order.

  Note to facilitators: It is recommended that you develop your own pre- and posttest for your training, depending on which modules you are presenting. For example, if you plan to present Modules 1 and 3, you should create a pre- and a posttest that incorporate questions selected from the existing tests included for Modules 1 and 3. Select five to seven questions from each module, and use the questions as they are worded. Be sure to vary the order of the questions in the posttest. If your training is longer than 1 day, you may want to create daily pre- and posttests that correspond to the modules presented each day. This approach will keep the tests short (e.g., no more than 20 questions) and will ensure that participants are tested on material they just learned.

  After participants take the pretest, it is recommended that the facilitator collect the pretest without reviewing the answers. After participants take the posttest, the facilitator should review the answers before collecting the tests so participants can see how much they learned. By collecting and scoring the participants' pre-and posttests, facilitators can assess the outcomes of the training.

  To compare pre- and posttest scores, you will need to assign each participant a unique identifier. For example, for the pre- and posttests, the identifiers for Student 1 would be "1 pre" and "1 post," the identifiers for Student 2 would be "2 pre" and "2 post," and so on. If you administer a second set of tests on the second day, the identifiers for Student 1 would be "Day 2, 1 pre" and "Day 2, 1 post," the identifiers for Student 2 would be "Day 2, 2 pre" and "Day 2, 2 post," and so on. An individual's identifier can change from day to day, but it is important to keep an individual's identifier the same within the same day's pre- and posttests.

- **PowerPoint slides**

  Each module contains a PowerPoint presentation complete with facilitator's talking points and references. You should use the PowerPoint slides to guide your presentation.

- **Additional activities for training**

  Additional group activities and discussion questions are included. You can select the activities that you are most comfortable presenting and that best fit your presentation style.

- **Camera-ready handouts**

  Your materials also include handouts ready for duplication.

In addition to the materials created for each of the modules, the *Tools for Success* curriculum also includes the following:

- **A list of materials needed for each training**

  This list shares guidance about the equipment and supplies the facilitator needs for each training, such as audiovisual equipment.

- **References**

A section at the end of the curriculum lists all the references cited in the modules. You may want to bring some of these materials with you to each training for participants to review during a break or at the end of the session.

- **Participant evaluation form**

Each time the training is done, the evaluation form needs to be completed by all participants.

Note to facilitators: Prior to each training, you will need to insert the names of the facilitators into sections VII and VIII of the evaluation form. You also will need to insert the objectives for the modules you are presenting into section IX of the form.

Implementation Checklist

Whether you are using this curriculum to train staff in your own agency or you are responding to training requests from others, you will need to plan, prepare items before the training, and take specific steps during and after the training. The lists below assume you are providing a training to a group outside your organization. You may not need to follow all these guidelines if you are already familiar with the audience and training location.

Before You Go

- Consider the parameters of the presentation. If you are working with a contact person at another organization, discuss the time available, the background of the audience, and potential issues for discussion. You also will want to ask if the group has had previous information or education on FASD.
- Determine which modules best suit the needs of the audience. If the group has had other FASD training, you may want to adapt the materials and add some additional information.
- Determine who will make the handout copies and provide audiovisual equipment and supplies (see the included checklist), and follow up to ensure that all preparations are made.
- Determine who will cover the expenses for the trainers, and make travel arrangements.
- Prepare the pre- and posttests and the participant evaluation form as described in the previous section.
- Review the materials you are preparing and coordinate the details of your presentation.

At the Presentation

- Arrive at least 30 minutes early to locate the room where you will be speaking. Meet the contact person and set up audiovisuals.
- Adapt as necessary. The training materials are there to assist you, not limit you. Use your own style when presenting.
- If the group is small enough, begin with introductions. It's always helpful to know what participants' responsibilities are within an agency. It will help you to provide the most

relevant presentation. Always introduce yourself and offer some information about your background and experience. In a large group, you may want to ask people to indicate their role or expertise by a show of hands (e.g., how many of you are probation officers?).

- Distribute the pretest after reviewing the objectives. Ask participants not to put their names on the pre- or posttest (use unique identifiers as descried earlier) and inform them that the tests will not be graded or viewed by their supervisors. The sole purpose of the tests is to help facilitators evaluate the curriculum. Have them complete the pretest and return it to you prior to your presentation.
- During the small group activities, work your way to each of the groups and help facilitate as needed or provide support and encouragement.
- Remember, participants will throw questions and concerns your way. Don't be discouraged! This means they are interested and engaged in the presentation. However, don't let the conversation be dominated by one or two individuals who want to talk about their specific experiences or case loads.
- Because you are training as part of a team—training with one corrections professional and one FASD expert—you will probably be able to field most questions. Don't be afraid to let participants know if you don't know the answer to a question. Follow up with the answer after the presentation, and encourage people to seek more information on the FASD Center for Excellence Web site (www.fasdcenter.samhsa.gov), in the *Resource Guide*, or in other resources that are mentioned in the materials.
- After your presentation, administer the posttest, review the answers with participants, and collect the tests, along with completed evaluation forms, before participants leave.

Followup and Evaluation

- Compile the pre- and posttests and participant evaluation forms and review them to see how much participants learned, what they thought about the training, and what could be improved.

Presentation Tips and Insights

- **Adapt as needed**

There are seven modules, each including PowerPoint presentations and activities that you can use to accommodate whatever amount of time you have. As previously mentioned, you may need to adapt the material to fit the time and audience needs. Materials can be copied onto transparencies and shown on overhead projectors.

- **Respect people's attitudes**

Discussing the issue of drinking during pregnancy can elicit a strong response in many people. On some matters that come up, there may be no "right" or "wrong" answers, and differing points of view are acceptable. However, it is important to distinguish for the group when you are presenting facts and when you are asking for their opinions or ideas.

- **Maintain focus**

This training is about supporting people and getting the best services and resources to individuals and families. It is vital that the participants understand that the focus of this program is not to let youth with an FASD avoid responsibility for their behavior. The goal is to provide information to develop appropriate and effective services for youth with an FASD in the juvenile justice system.

- **Have a dialog, not a monolog**

The success of any presentation depends on interaction between the facilitator and the participants. To foster interchange, work to establish a climate for discussion that makes everyone feel comfortable. The training materials are laid out so that, as a trainer, you can select the resources and activities that work best for your presentation style.

- **Anticipate questions**

Be prepared to take questions, even those for which you do not have answers. If you are unable to answer a question, do not hesitate to say so. Depending on the question, you may want to offer to search out the answer or refer individuals to other resources. Also remember, specific questions about an individual should be directed to appropriate professionals, such as physicians or case managers.

- **Address confidentiality issues**

Questions related to confidentiality issues and juveniles may come up. Make sure you are familiar with confidentiality laws for your State.

- **Keep control**

Often an individual in the audience may start a lengthy discussion on a single topic. To keep the training on track, you may state, "Those are interesting ideas. You might want to continue talking about them at another time. Now let's turn our attention to . . ." Also, if a participant shares misinformation, correct it immediately by saying, for example, "What you said is a commonly held belief. However, research now shows . . ."

- **Share your experience and expertise**

As a *Tools for Success* trainer, you should have professional or personal experience with FASD and/or juvenile justice. Sharing your experiences and expertise in illustrating points in the curriculum is what will make this training most useful for those attending.

- **Recognize the importance of what you are doing**

Presenting this information to people working in juvenile justice and helping them change the way they work with individuals with an FASD can positively impact people's lives. It is a very important task, and your help in disseminating the curriculum content will make a difference.

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Facilitator's Checklist: Materials Needed

Equipment

- ☐ Laptop/PC or overhead projector
- ☐ LCD projector if using laptop/PC
- ☐ Transparencies for overhead projector
- ☐ Microphone/stand
- ☐ Tape recorder
- ☐ Easel
- ☐ Screen

Supplies

- ☐ Extension cord
- ☐ Sign-in sheet
- ☐ Certificates of attendance
- ☐ Handouts
- ☐ Flip chart
- ☐ Markers
- ☐ Audiotapes for the tape recorder
- ☐ Evaluation forms
- ☐ Masking tape
- ☐ Pens
- ☐ Business cards

Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics

Tools for Success Curriculum

Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics

Description

Summary

The first module provides a comprehensive overview of the significance of prenatal alcohol exposure and FASD. The lesson plan focuses on the incidence, financial costs, and characteristics of FASD; challenging behaviors of people with an FASD; and impact on the family.

Objectives

After completing this module, participants will be able to:

- Discuss the lifelong effects of prenatal alcohol exposure on brain development
- Define “fetal alcohol spectrum disorders”
- Describe the impact FASD has on the family, school, community, and society in general

Tools for Success Curriculum

Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics

Facilitator's Outline

Step and Time	Tools Needed
One: Introduction—5 minutes	
You are presenting the *Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System*, a joint project of the Substance Abuse and Mental Health Services Administration (SAMHSA) Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence and the Minnesota Organization on Fetal Alcohol Syndrome. The FASD Center is a Federal initiative devoted to preventing and treating FASD. The Center's goals include advancing the field of FASD and promoting best practices. You may want to have participants introduce themselves, if time allows. Ask participants to state their backgrounds and interest in FASD. *Note: You do not need to do introductions if you combine modules—only conduct introductions at the beginning of a training session.*	
Two: Why We Are Here—5 minutes	
Discuss *Tools for Success*. *Tools for Success* focuses on assisting professionals who work with youth in the juvenile justice system who have an FASD to develop effective and appropriate interventions. It is designed for all correctional professionals, including advocates, attorneys, social workers, and social and human service providers who interact with children and families affected by FASD. *Tools for Success* contains seven modules: ■ Fetal Alcohol Spectrum Disorders (FASD): The Basics ■ FASD in the Juvenile Justice System ■ The Juvenile Justice System Response ■ Dispositional Options ■ Special Education and Behavior Management ■ Transition and Aftercare ■ Resources **2 minutes**	**PowerPoint Slide 1-1**

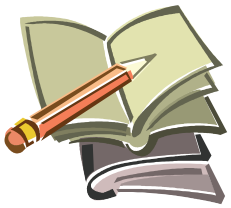
Step and Time	Tools Needed
Two: Why We Are Here (continued)	
Discuss Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics. The first module provides a comprehensive overview of the significance of prenatal alcohol exposure and FASD. The lesson plan focuses on the incidence, financial costs, and characteristics of FASD; challenging behaviors of people with an FASD; and impact on the family. Because subsequent sections build upon the background information in Module 1, it is recommended that trainers begin every *Tools for Success* training with this module or a modified version of this module. **2 minutes**	**PowerPoint Slide 1-2**
Discuss objectives for the module as indicated on PowerPoint Slide 1-3. **1 minute**	**PowerPoint Slide 1-3**
Three: Pretest—10 minutes	
Distribute the pretest and allow time for participants to complete it. After ensuring that each participant has provided a unique identifier on the pretest (see the Introduction), collect the tests. Do not review answers at this time.	**PowerPoint Slide 1-4** **Pretest** 
Four: PowerPoint Presentation—30 minutes	
Using PowerPoint presentation and facilitator talking points, provide overview to the group on alcohol exposure during pregnancy, typical behaviors of FASD, cost, implications, etc.	**PowerPoint Slides 1-5 through 1-41**

Five: Egg Experiment Activity—5 minutes	
Follow directions for Activity 1—Egg Experiment.	**PowerPoint Slide 1-42**  **Activity 1** **sheet in curriculum** 
Six: PowerPoint Presentation—15 minutes	
Using PowerPoint presentation and facilitator talking points, discuss working with challenging behaviors.	**PowerPoint Slides 1-43 through 1-45**
Seven: One of Two Options for Activity—20 minutes	
Follow directions for one of the two Activity 2 options: ■ Challenging Behaviors With Scenario Handout: "H Family" ■ Behavioral Exercises	**PowerPoint Slide 1-46**  **Activity 2** **sheets in curriculum** 
Eight: Posttest—10 minutes	
Distribute the posttest and allow time for participants to complete it. Using the facilitator's notes in the curriculum, review the answers to the posttest. After ensuring that each participant has provided his or her unique identifier on the posttest, collect the tests.	**PowerPoint Slide 1-47**  **Posttest** **Posttest Facilitator's Notes**
Nine: Evaluation—5 minutes	
Total Time: 1.75 hours	

Tools for Success Curriculum

Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics

Pretest



ID # _____–pre

Please answer true or false to the following questions:

1. Individuals who are affected by prenatal exposure to alcohol typically outgrow the effects by the time they reach adulthood.

   True ☐ or False ☐

2. Alcohol is only risky during the first trimester, when the brain is developing.

   True ☐ or False ☐

3. ADHD and FASD are essentially the same disability.

   True ☐ or False ☐

4. A can of beer, a glass of wine, a shot of hard liquor, and a wine cooler all may contain the same amount of alcohol.

   True ☐ or False ☐

5. Individuals with an FASD commonly are affected by a neurological disorder called “sensory processing disorder.”

   True ☐ or False ☐

6. The most disabling effect for persons with an FASD is the facial features.

   True ☐ or False ☐

7. It is better to not seek a diagnosis for a child or adult who may have an FASD, because it is just one more “label” for the individual.

   True ☐ or False ☐

Pretest Facilitator's Notes

Please answer true or false to the following questions:

1. Individuals who are affected by prenatal exposure to alcohol typically outgrow the effects by the time they reach adulthood.

   True ☐ or False ☐

   False: FASD is a lifetime disability. A child does not outgrow it, but early diagnosis along with intensive and appropriate interventions can make an enormous difference in the prognosis of the individual.

2. Alcohol is only risky during the first trimester, when the brain is developing.

   True ☐ or False ☐

   False: Alcohol can affect the fetus during all three trimesters. Alcohol can affect the brain, which develops throughout pregnancy, as well as other systems and organs.

3. ADHD and FASD are essentially the same disability.

   True ☐ or False ☐

   False: Frequently there is an overlap of behavior associated with FASD and other common disorders such as ADHD. Although many people with an FASD may have attention problems, these are two separate issues.

4. A can of beer, a glass of wine, a shot of hard liquor, and a wine cooler all may contain the same amount of alcohol.

   True ☐ or False ☐

   True: A 12-ounce wine cooler, a 1.5-ounce shot of hard liquor, a 12-ounce beer, and a 5-ounce glass of wine all contain the same amount of alcohol and have the same effect on the fetus.

5. Individuals with an FASD commonly are affected by a neurological disorder called "sensory processing disorder."

   True ☐ or False ☐

   True: Sensory processing disorder, or SPD, formerly known as "dysfunction of sensory integration," is a common, but misunderstood, problem that affects children's behavior, influencing the way they learn, relate to others, and feel about themselves. It usually is a considerable problem for children with an FASD.

6. The most disabling effect for persons with an FASD is the facial features.

   True ☐ or False ☐

   False: The most disabling effect for persons with an FASD is the damage to the brain. This damage can cause learning disabilities, behavior problems, memory deficits, attention disorders, and/or mental retardation.

7. It is better to not seek a diagnosis for a child or adult who may have an FASD, because it is just one more "label" for the individual.

   True ☐ or False ☐

   False: Seeking a diagnosis is one of the key protective factors in preventing secondary disabilities. Getting a diagnosis is the beginning of a process, not the end. A diagnosis identifies the disability and begins the process of developing appropriate, individually tailored interventions.

FACILITATOR'S TALKING POINTS:

- This curriculum is based on the *Tools for Success: Working With Youth With Fetal Alcohol Syndrome and Effects in the Juvenile Justice System Resource Guide* (Carlson and Holl, 2001). Since the *Resource Guide* was published, the new term "fetal alcohol spectrum disorders" (FASD) has been more widely used. This curriculum will use "FASD."
- The focus of the curriculum is on youth with an FASD who are in the juvenile justice system. However, the information and strategies discussed would be beneficial to other children and youth.

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

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FACILITATOR'S TALKING POINTS:

- The first module provides a comprehensive overview of the significance of prenatal alcohol exposure and FASD. The lesson plan focuses on the incidence, financial costs, and characteristics of FASD; challenging behaviors of people with an FASD; and impact on the family.
- Because subsequent sections build upon the background information in Module 1, it is recommended that trainers begin every *Tools for Success* training with this module or a modified version of this module.

Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics

- After attending this session, participants will be able to:
  - Discuss the possible lifelong effects of prenatal alcohol exposure on brain development
  - Define "fetal alcohol spectrum disorders"
  - Describe the impact FASD has on the family, school, community, and society in general

HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence

Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics
Slide 1-4

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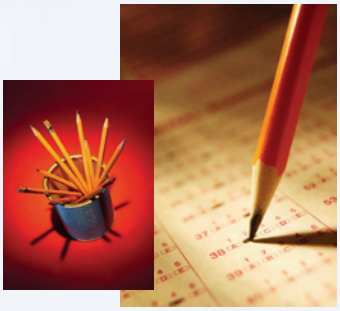
Pencils Out



Pretest!

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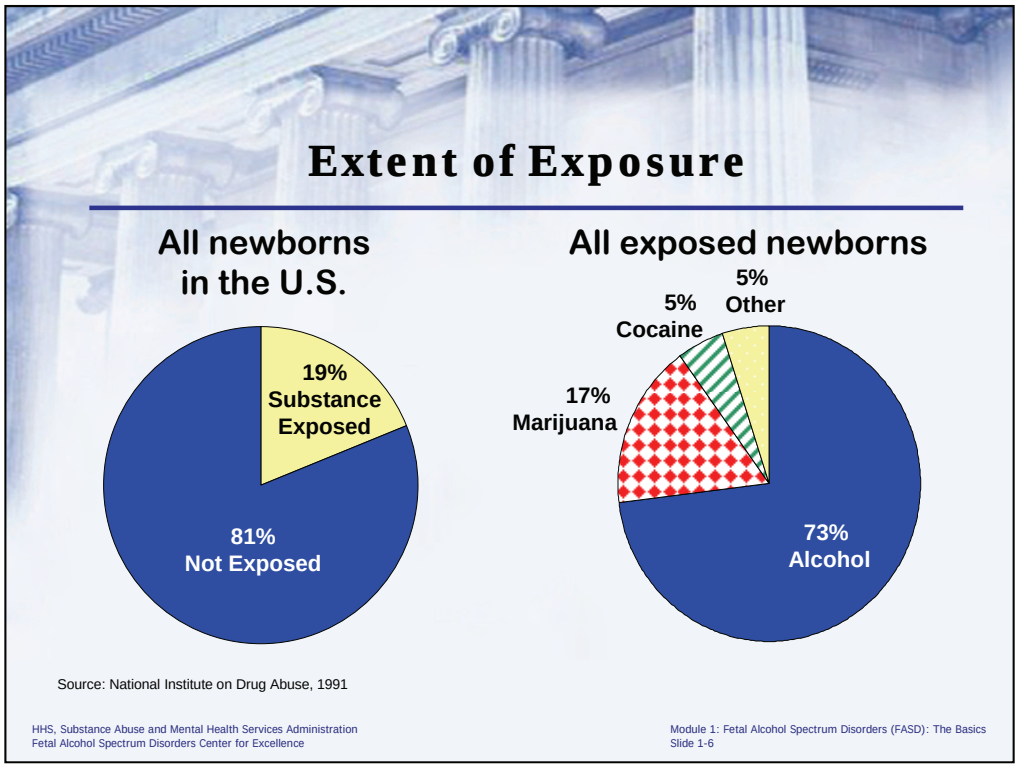
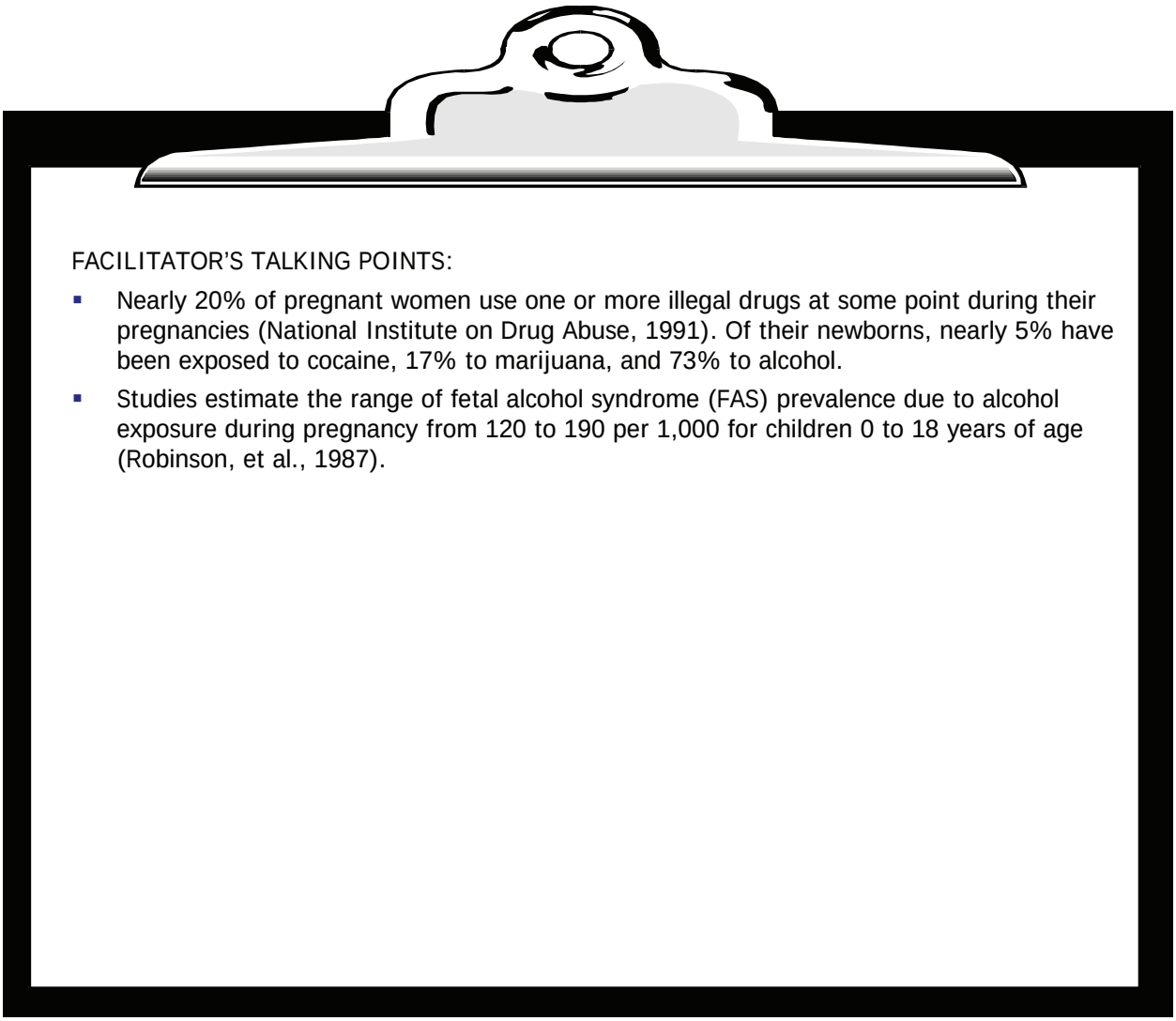
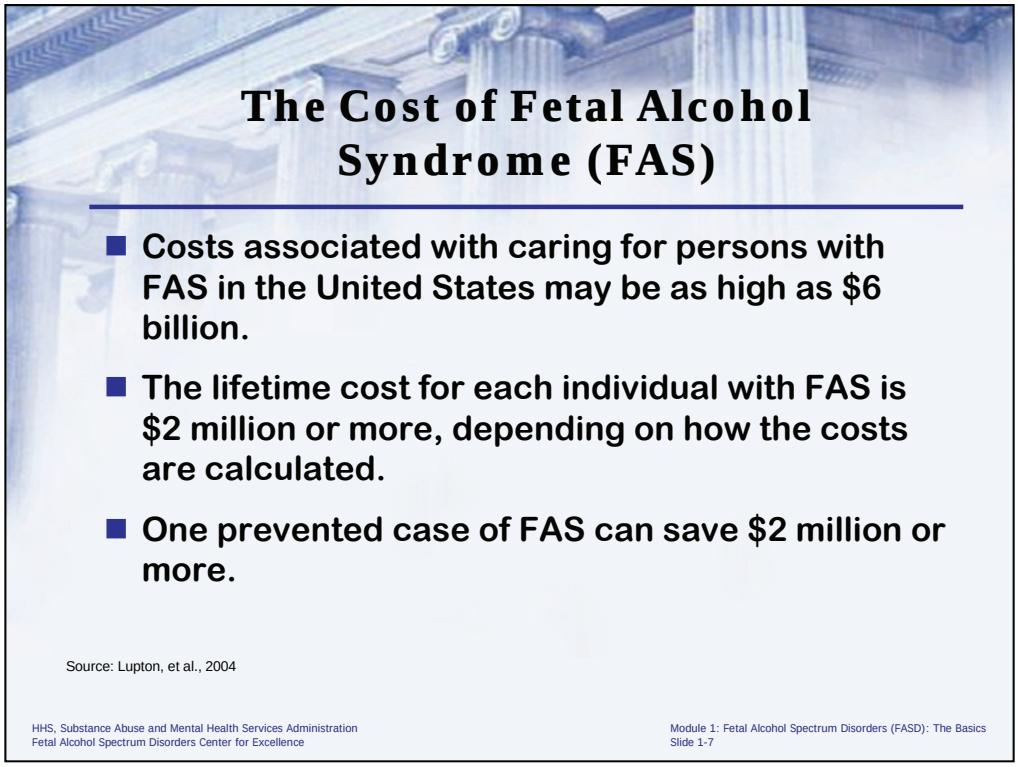




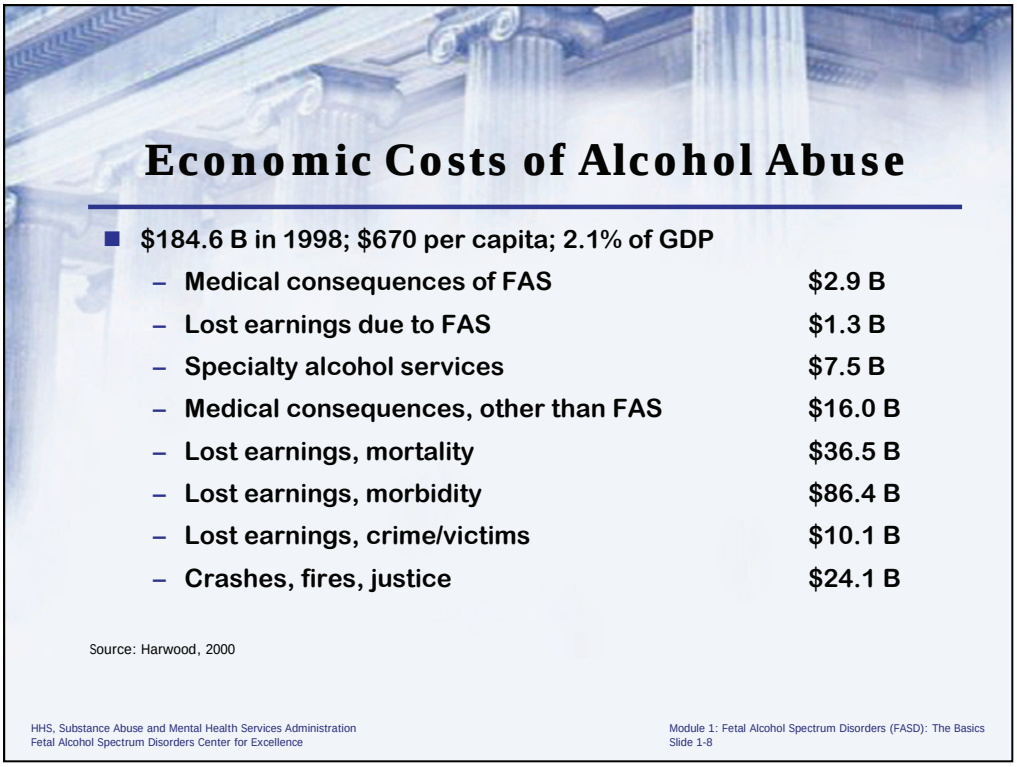
FACILITATOR'S TALKING POINTS:

- Nearly 20% of pregnant women use one or more illegal drugs at some point during their pregnancies (National Institute on Drug Abuse, 1991). Of their newborns, nearly 5% have been exposed to cocaine, 17% to marijuana, and 73% to alcohol.
- Studies estimate the range of fetal alcohol syndrome (FAS) prevalence due to alcohol exposure during pregnancy from 120 to 190 per 1,000 for children 0 to 18 years of age (Robinson, et al., 1987).



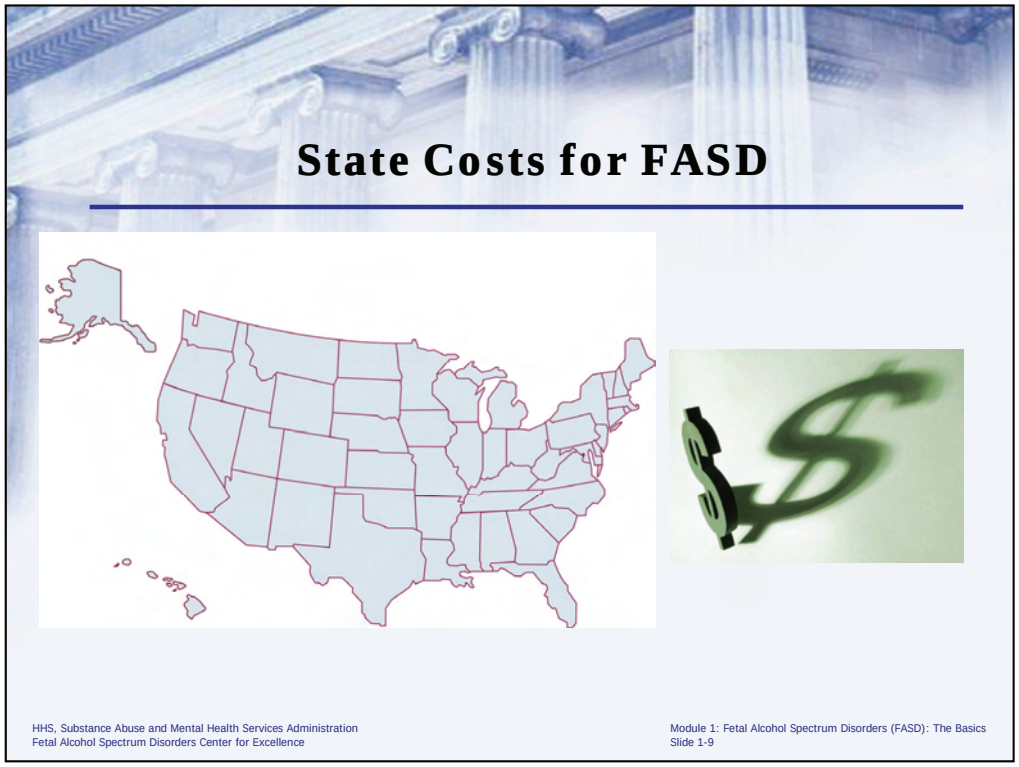
FACILITATOR'S TALKING POINTS:

- Most available cost information addresses total annual cost of FAS to the country or lifetime cost of each child born with FAS.
- Cost figures are only available for FAS, not for other disorders in the spectrum.
- FAS is among the most costly birth defects.
- Cost estimation studies have included costs associated with health care, residential and support services, special education, and productivity losses.
- Some studies estimate costs to age 65, while others estimate costs only to age 21.
- Cost estimates for States can be determined by using the FAS Prevalence and Cost Calculator available online at www.online-clinic.com/content/materials/calculator.asp.
- Cost data do not include costs for juvenile and criminal justice, substance abuse treatment, and mental health care.



FACILITATOR'S TALKING POINTS:

- "GDP" stands for "gross domestic product."
- Individual's lifetime loss of income.
- High costs to the families (foster, adoptive, or biological) who raise and care for children and adults with an FASD.
- Cost of stress caused by divorce, etc.
- Lost income of a parent who must care for a child with an FASD.
- Costs of legal defense for persons with an FASD.
- Costs to families of persons with an FASD who may never live independently.



FACILITATOR'S TALKING POINTS:

- Facilitator should gather local data of costs per State in which presenting prior to the training. This material can be obtained from the FASD Center for Excellence (www.fasdcenter.samhsa.gov).
- Costs for juvenile and criminal justice should be included for local and State data as well as special education. The State costs are not always broken down to include these costs.

FACILITATOR'S TALKING POINTS:

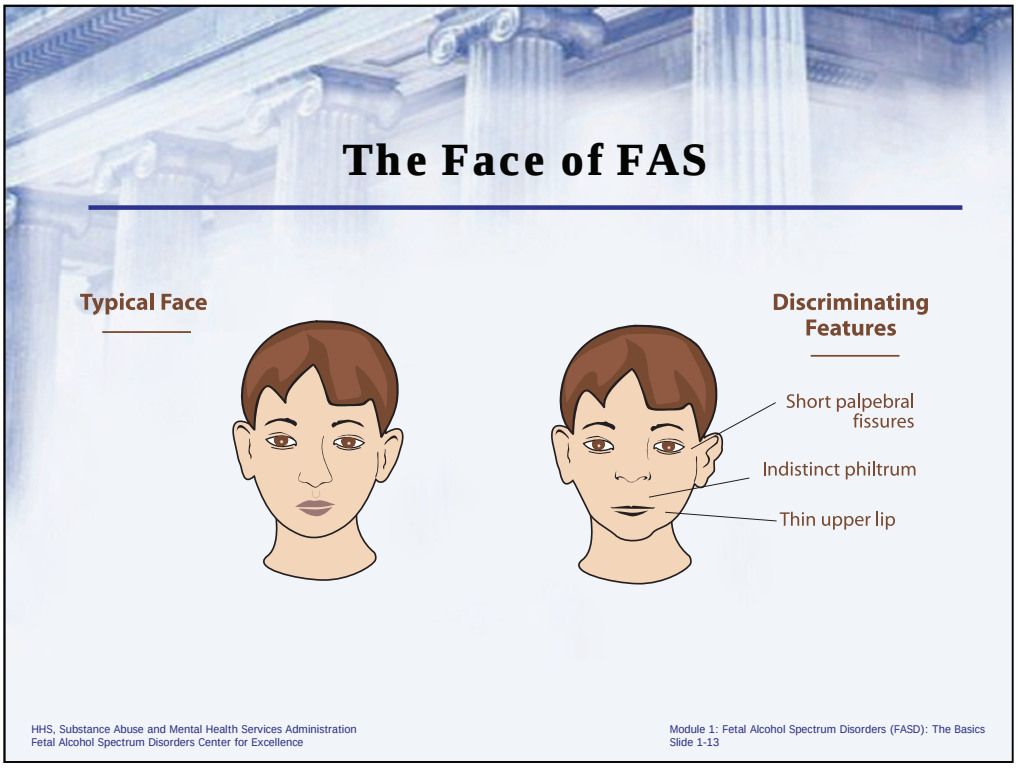
- At an historic summit hosted by the National Organization on Fetal Alcohol Syndrome (NOFAS), national experts—including for the first time representatives from the Centers for Disease Control and Prevention (CDC), National Institutes of Health, and Substance Abuse and Mental Health Services Administration—came together to produce and sign onto a unanimous agreement on terminology for fetal alcohol spectrum disorders. The above definition was agreed upon.

FACILITATOR'S TALKING POINTS:

- "FASD" is a term that has recently been coined to convey the fact that there are a variety of effects of prenatal alcohol exposure. It is meant to capture the notion that it is not only those who have the facial features of "FAS" who are impaired by prenatal exposure. Also, it is important to note that the diagnoses used in "FASD" are not a measure of severity. Terms such as "FAS," "FAE," and "ARND" are all diagnoses that may be found under the broad umbrella of FASD. Again, it is important to note that these diagnostic terms are not necessarily indicative of a certain level of severity.
- It is important to stress that "FASD" is a descriptive term. It is not to be used as a diagnostic term. There are other terms that are currently being used diagnostically, which we will discuss later.

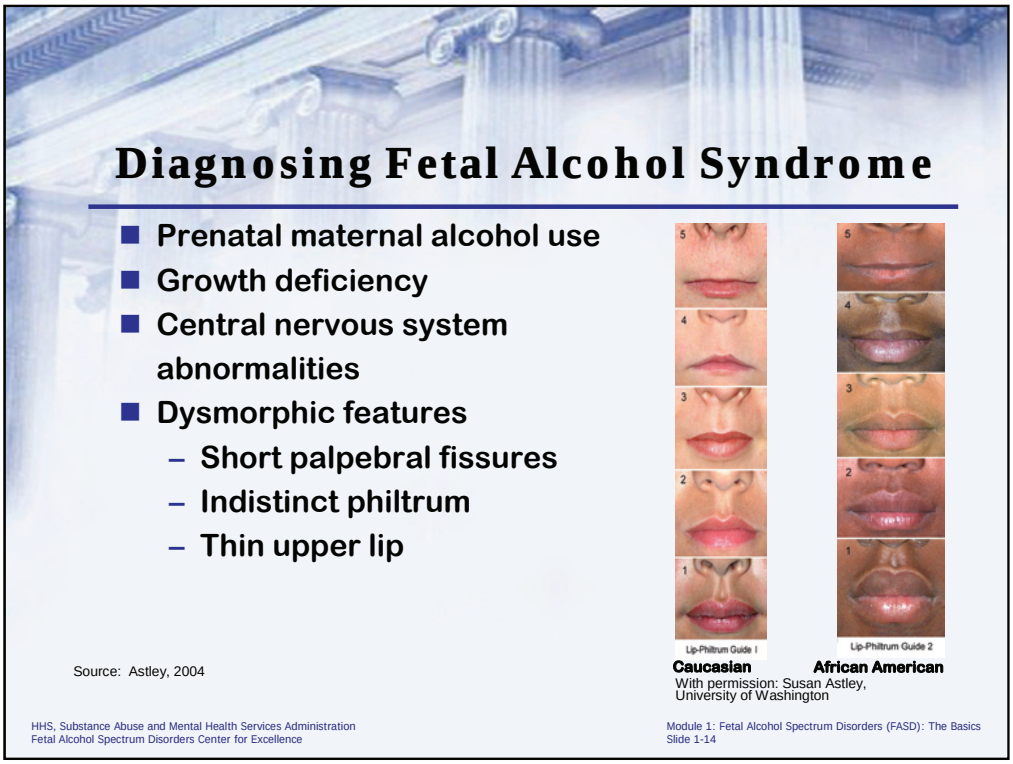
FACILITATOR'S TALKING POINTS:

- Although FAS is the most commonly recognized term, it represents only a small group of individuals who are affected by prenatal alcohol exposure.
- The three characteristics listed here are stated in the Centers for Disease Control and Prevention guidelines for FAS diagnosis. (In July 2004, CDC published *Fetal Alcohol Syndrome: Guidelines for Referral and Diagnosis* [www.cdc.gov/ncbddd/fas/default.htm], a significant effort by a U.S. scientific working group [Bertrand, et al., 2004].)
- Many people focus on the facial features of FAS as the determining factors in the effects of prenatal exposure to alcohol. However, since most individuals with an FASD do not have these facial features, they cannot be identified easily by their look.
- FAS is *not* universally more (or less) severe than other effects of prenatal alcohol exposure.
- Not all children with an FASD are alike or have all the characteristics. The effects range from mild to severe, irrespective of the appearance of FAS facial features. They depend on the amount of alcohol used and the time in which it is used. They also depend on the mother's diet, age, and drinking history, as well as how alcohol is processed by the mother and other, unknown factors.
- Typically, children with an FASD have more physical, developmental, and behavioral problems than other children.
- Growth deficiencies may include:
  - Low birth weight
  - Small size for age in weight and length
  - Head circumference below the norm



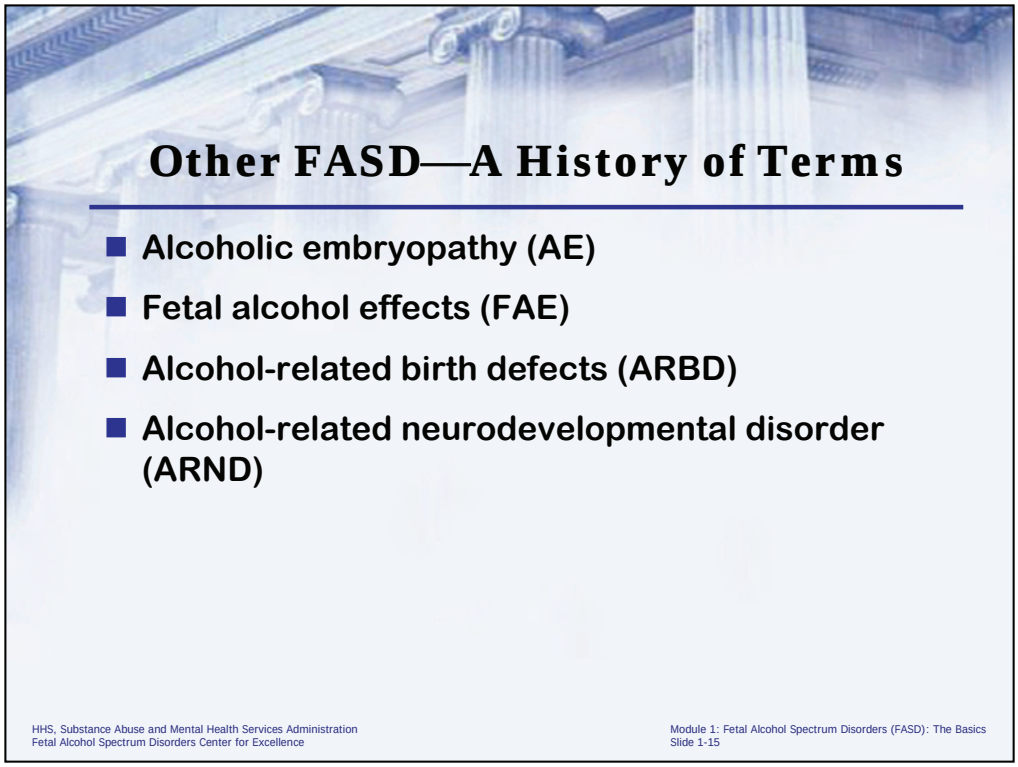
FACILITATOR'S TALKING POINTS:

- This drawing of "the face of FAS" shows the three discriminating features agreed on by CDC's Scientific Working Group on FAS as key to an FAS diagnosis. These features are short palpebral fissures, indistinct philtrum, and thin upper lip. For an FAS diagnosis, all three features must be present (Bertrand, et al., 2004).
- **Short palpebral fissures:** The palpebral fissure is the eye opening. In individuals with FAS, the eye opening is shorter than it should be. This can be measured with a clear ruler or another measuring device. Because of the possibility of incorrect measurement, a diagnostician has to be clear on how to measure the eye opening. This facial feature does not change significantly over time. For a diagnosis of FAS, the palpebral fissures would be below the 10th percentile (CDC guidelines) according to racial norms. (At or below the 10th percentile, according to the University of Washington's guidelines [Astley, 2004]). As children grow, their eye size does not change.
- **Indistinct philtrum:** The philtrum is the ridge between the nose and upper lip. In individuals with FAS, the philtrum is smoother than the norm (scoring a 4 or 5 on the University of Washington's Lip-Philtrum Guide).
- **Thin upper lip:** The upper lip is thinner than the norm in individuals with FAS. The technical term for this is a "thin vermillion" (scoring a 4 or 5 on the University of Washington's Lip-Philtrum Guide).
- Most individuals affected by prenatal alcohol exposure do not have the FAS facial features. Even when individuals do have the facial features of FAS, they are often not easily recognizable to the untrained eye.
- The University of Washington has developed a software program to measure these facial features by importing three standardized facial photographs. FASD Facial Photographic Analysis Software was developed for use by health care and research professionals. The software is designed to measure the magnitude of expression of the key diagnostic facial features of FAS. It is important to know how to use the software properly. For example, when someone is smiling broadly, the philtrum looks much smoother and the upper lip appears to be very thin. Therefore, to be accurate, a photograph should not show a person smiling. More information about this software is available at depts.washington.edu/fasdpn/htmls/face-software.htm.



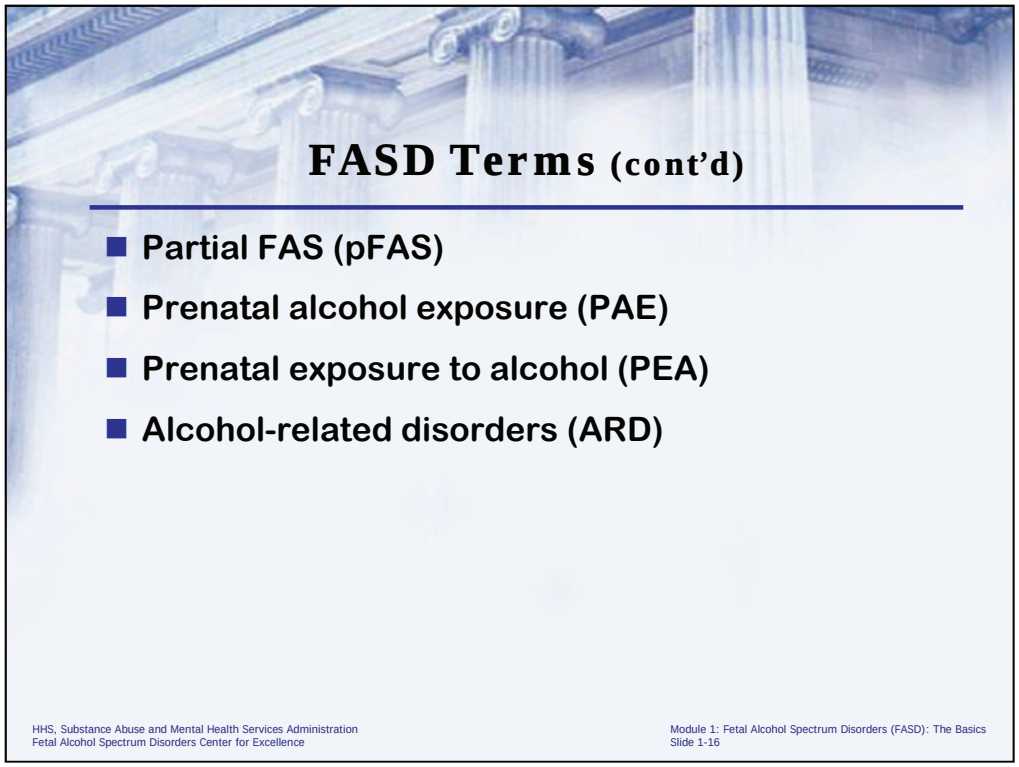
FACILITATOR'S TALKING POINTS:

- The four areas identified in the CDC guidelines as necessary for a diagnosis of FAS (Bertrand, et al., 2004) have been used for several years.
- **Prenatal maternal alcohol use:** The guidelines call for either confirmed or unknown prenatal maternal alcohol exposure.
- **Growth deficiency:** "Confirmed prenatal or postnatal height or weight, or both, at or below the 10th percentile, documented at any one point in time (adjusted for age, sex, gestational age, and race or ethnicity)."
- **Central nervous system (CNS) abnormalities:** The guidelines identify three components of CNS abnormalities: structural, neurologic, and functional deficits. (1) Structural deficits are identified as head circumference at or below the 10th percentile adjusted for age and sex or clinically significant brain abnormalities observable through imaging. (2) Neurologic deficits are identified as neurologic problems not due to postnatal insult or fever, or other soft neurologic signs outside normal limits. (3) Functional deficits include "global cognitive or intellectual deficits (e.g., decreased IQ) representing multiple domains of deficit (or significant developmental delay in younger children) with performance below the 3rd percentile (2 standard deviations below the mean for standardized testing) or functional deficits below the 16th percentile (1 standard deviation below the mean for standardized testing) in at least three of the following domains: cognitive or developmental deficits or discrepancies; executive functioning deficits; motor functioning delays; problems with attention or hyperactivity; social skills; other, such as sensory problems, pragmatic language problems, memory deficits, etc."
- **Dysmorphic features:** The diagnostic guide states that all three features must be present. A number of other syndromes have some of these features, but very few have all three. The CDC scientific working group adopted the Lip-Philtrum Guide developed by Susan Astley and Sterling Clarren of the University of Washington in 1997. Individuals with FAS rank 4 or 5 on the Lip-Philtrum Guide (available from the University of Washington FAS Diagnostic and Prevention Network, www.fasdpn.org).



FACILITATOR'S TALKING POINTS:

- There is no consensus on what terms to use for diagnostic descriptions of the effects of prenatal alcohol exposure. Some people use just FAS, some use FAS and FAE, some use FAS and ARND, some use FAS and ARBD, and some use pFAS and some do not. The terms you see here have been used throughout the years.
- **Alcoholic embryopathy:** This term was used by Dr. Lemoine (1968) in France in the 1960s to describe 127 children that he saw and identified as having the effects of prenatal alcohol exposure.
- **Fetal alcohol effects (FAE):** This term was coined by Drs. Smith and Jones (1973) to describe another small group of children initially seen who had similar patterns of cognitive difficulties, growth deficiencies, and mothers who drank heavily during pregnancy. However, these children did not have the distinctive facial features that those with FAS had. The term "FAE" is not as widely used in diagnostic terminology as it once was and in some cases is not used at all.
- **Alcohol-related birth defects (ARBD):** This term was coined by the Institute of Medicine in its volume on FAS published in 1996 to describe physical anomalies only.
- **Alcohol-related neurodevelopmental disorder (ARND):** This term was also coined by the Institute of Medicine. It refers to neurodevelopmental abnormalities or a complex pattern of behavior or cognitive abnormalities—with documented prenatal maternal alcohol exposure—that are inconsistent with developmental level and cannot be explained by familial background or environment alone.

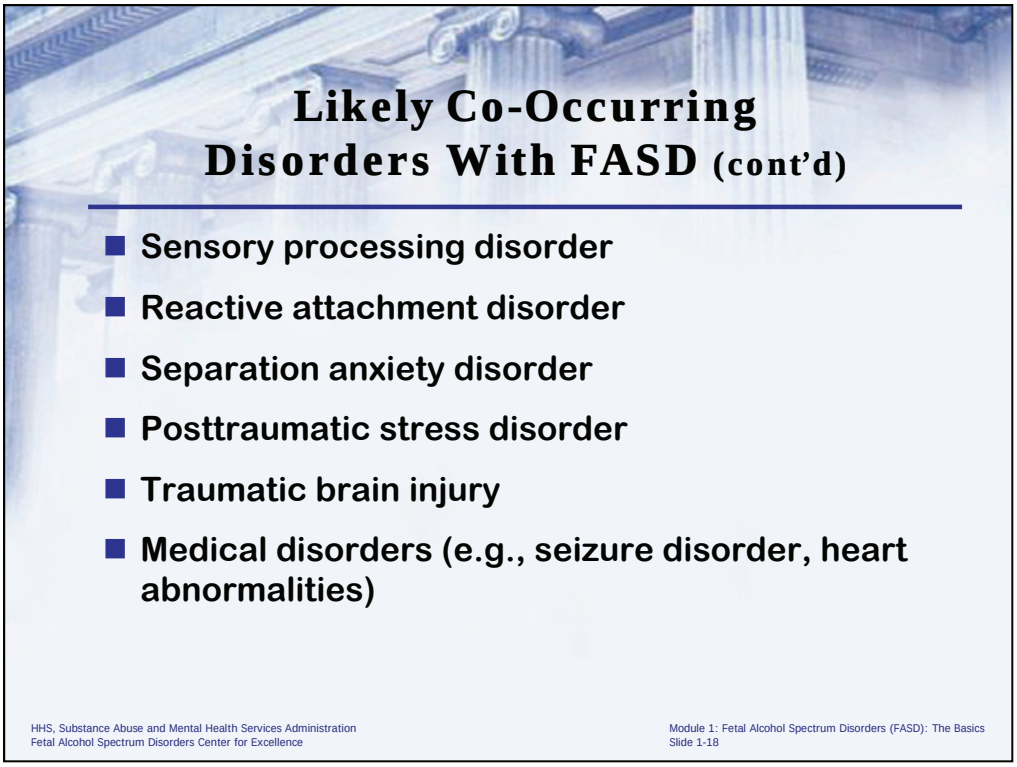


FACILITATOR'S TALKING POINTS:

- **Partial FAS (pFAS):** This term, coined by the Institute of Medicine, refers to children who have some of the facial features of FAS, along with evidence of growth retardation, neurodevelopmental abnormalities, or a complex pattern of behavior or cognitive abnormalities—with documented prenatal maternal alcohol exposure—that are inconsistent with developmental level and cannot be explained by familial background or environment alone.
- **PAE, PEA, and ARD:** These are all terms that are used at times to convey that there is no single effect of prenatal alcohol exposure on the fetus or the individual and that the short- and long-term effects of prenatal alcohol exposure are far more wide reaching than solely FAS. Individuals who experience difficulties throughout their lives may be affected by prenatal alcohol exposure if their mothers drank during pregnancy. These are not diagnostic terms.

FACILITATOR'S TALKING POINTS:

- Every person with an FASD does not have a co-occurring disorder. Common disorders seen among those who do have a co-occurring disorder are listed here and on the next slide. These disorders are not listed in order of prevalence.
- These disorders can co-occur with FASD. Sometimes, however, people with an FASD are incorrectly diagnosed with one of these disorders before their fetal alcohol spectrum disorder is identified.
- Attention-deficit/hyperactivity disorder, schizophrenia, depression, and bipolar disorder have a strong genetic link, so that a person is more likely to develop one of these disorders if a biological parent has one. In addition, there is a higher incidence of substance use among people with these disorders. As a result, mothers who drink during pregnancy and who have one of these disorders are more likely to have a child with an FASD who also is at increased risk for developing one of these disorders.
- Children of people who abuse alcohol are at increased risk for developing problems with alcohol due to a possible genetic vulnerability and possible multigenerational history of alcohol abuse.



FACILITATOR'S TALKING POINTS:

- "Sensory processing disorder," or SPD, is the new term for describing dysfunction of sensory integration. SPD is a common, but misunderstood, problem that affects children's behavior, influencing the way they learn, relate to others, and feel about themselves. It usually is a considerable problem for children with an FASD.
- Reactive attachment disorder (RAD) is a disorder marked by developmentally inappropriate social relatedness. It is associated with extreme cases of neglect and/or abuse and abandonment. Individuals with RAD may have difficulty forming healthy relationships. Although some people with an FASD have a co-occurring RAD, many may have attachment issues due to their experience and the way their brains process information.
- Separation anxiety disorder is a condition in which an individual has excessive anxiety regarding separation from home or from people to whom the individual has a strong emotional attachment (e.g., mother). However, when associated with individuals with an FASD, there are other reasons for anxiety disorders, including chemical imbalances.
- Posttraumatic stress disorder (PTSD) is the reaction to having been exposed to or confronted with traumatizing experiences. Not everyone who experiences trauma develops PTSD, due in part to each individual's coping capacity.
- Traumatic brain injury may co-occur with an FASD because those with an FASD are more likely than others to experience a closed head trauma due to taking risks, getting involved in fights, and getting into accidents.
- Other diagnoses seen among people with an FASD include conduct disorder and oppositional defiant disorder. Often, these are not accurate diagnoses for people with an FASD. These may be co-occurring disorders or may be misdiagnosed if an FASD is not recognized.

The Importance of Recognizing All Co-Occurring Issues

- Optimal outcomes in the treatment of individuals occur when all co-occurring issues are accurately recognized and addressed simultaneously.
  - If one, or more, co-occurring issue is not recognized, outcomes will be sub-optimal.
- Fetal alcohol spectrum disorders are often missed as co-occurring disorders, especially in individuals with mental health difficulties, substance abuse, social difficulties, and learning disabilities.

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Fetal Alcohol Spectrum Disorders Center for Excellence

Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics
Slide 1-19

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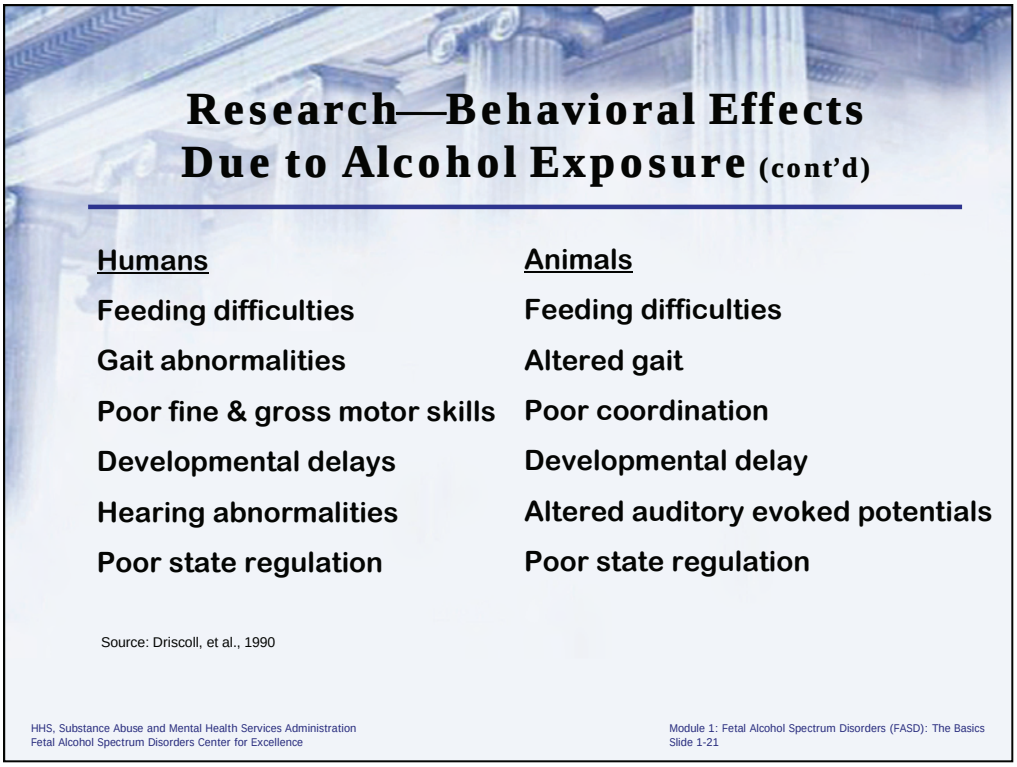
FACILITATOR'S TALKING POINTS:

- The authors of this study compared human and animal literature related to the potential consequences of prenatal alcohol exposure, finding many similarities.

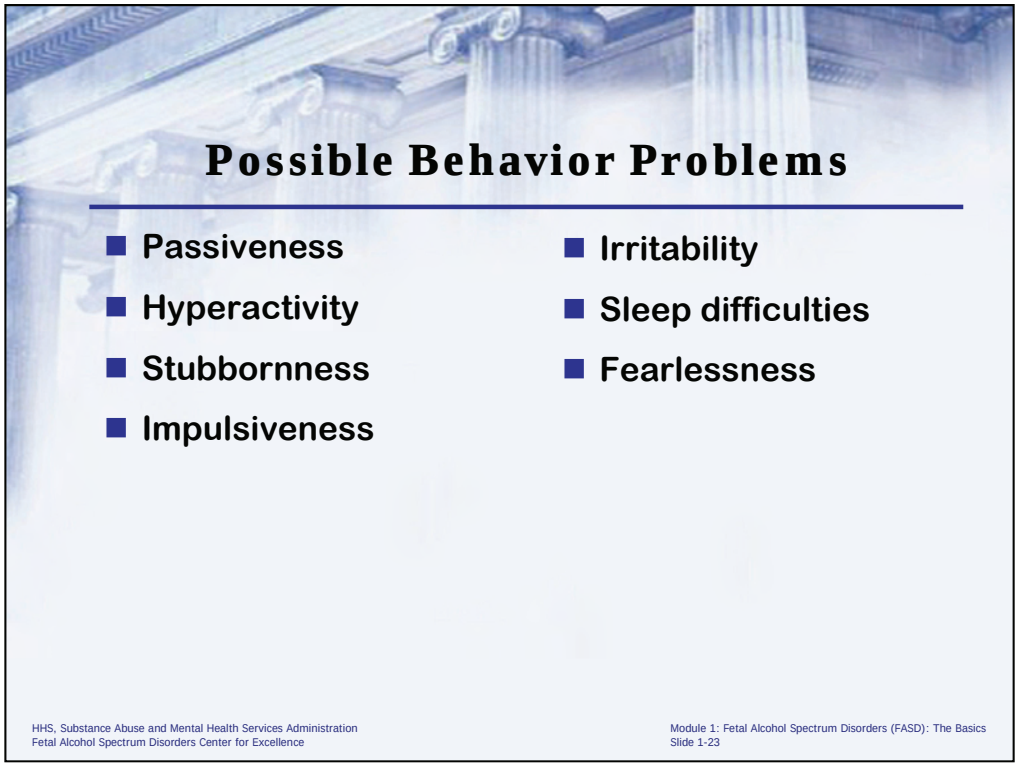


FACILITATOR'S TALKING POINTS

- Individuals with poor state regulation may have several difficulties, such as poor sleep patterns (mixing up days and nights) and hyperactivity issues (not being able to calm themselves, getting excited easily, and getting stressed often). These individuals also may have problems with transitions from activity to activity, changes in daily routines, or changes in their home environment or work environment. These types of problems could lead to behavior issues. These behavior problems can be improved or prevented with structure and other support.

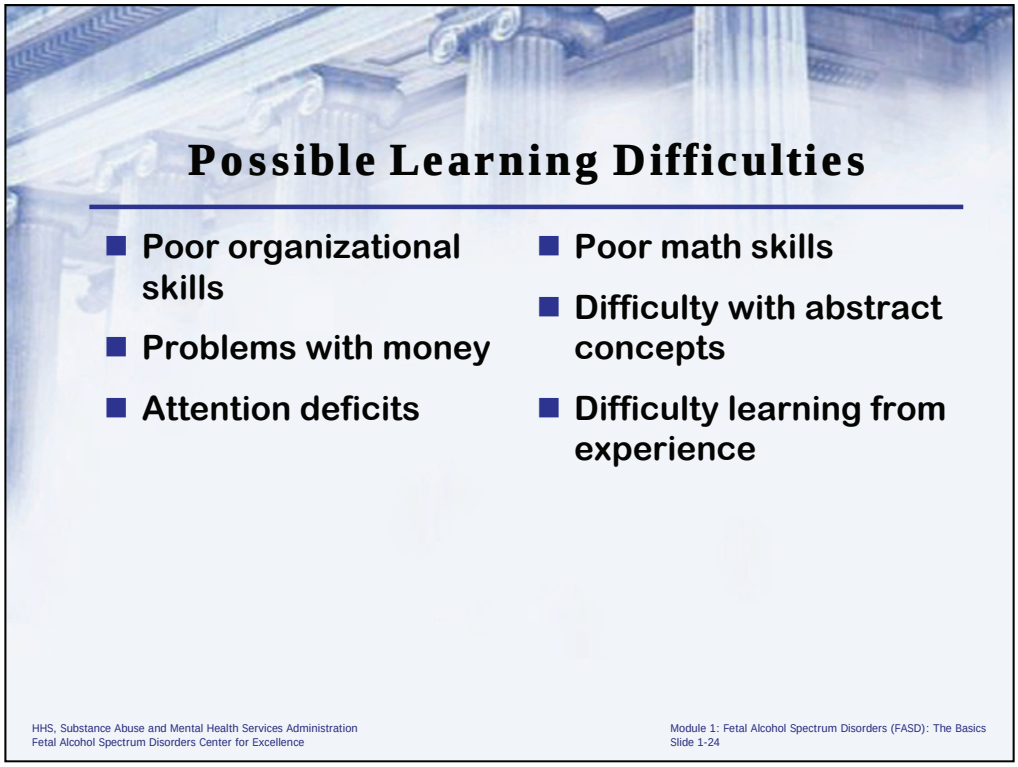
FACILITATOR'S TALKING POINTS:

- A 12-ounce wine cooler, a 1.5-ounce shot of hard liquor, a 12-ounce beer, and a 5-ounce glass of wine contain the same amount of alcohol (Roberts and McCrady, 2003).
- There is no known safe amount of alcohol use during pregnancy. There is no known time when drinking alcohol is safe.
- Of all the substances of abuse, including heroin, cocaine, and marijuana, alcohol produces far more serious neurobehavioral effects in the fetus (Institute of Medicine, 1996).
- It is estimated that 60% of adult women drink at least occasionally (Institute of Medicine, 1996).
- It is estimated that nearly 20% of women use one or more illegal drugs during pregnancy (National Institute on Drug Abuse, 1991).
- According to the 1995 CDC Household Telephone survey, between 1988 and 1995, nearly 15% of pregnant women consumed some alcohol during their pregnancies (Ebrahim, et al., 1998).
- The FASD disability is 100% preventable if women do not drink during pregnancy. This includes the time before they know they are pregnant. Unfortunately, women get mixed messages from society, and some get mixed messages from their providers. Some providers do not ask about alcohol use during pregnancy, and some say it is okay to drink in moderation. The Surgeon General warns that there is no safe level of alcohol use at any time during pregnancy, and this *must* be stressed to prevent this disability.



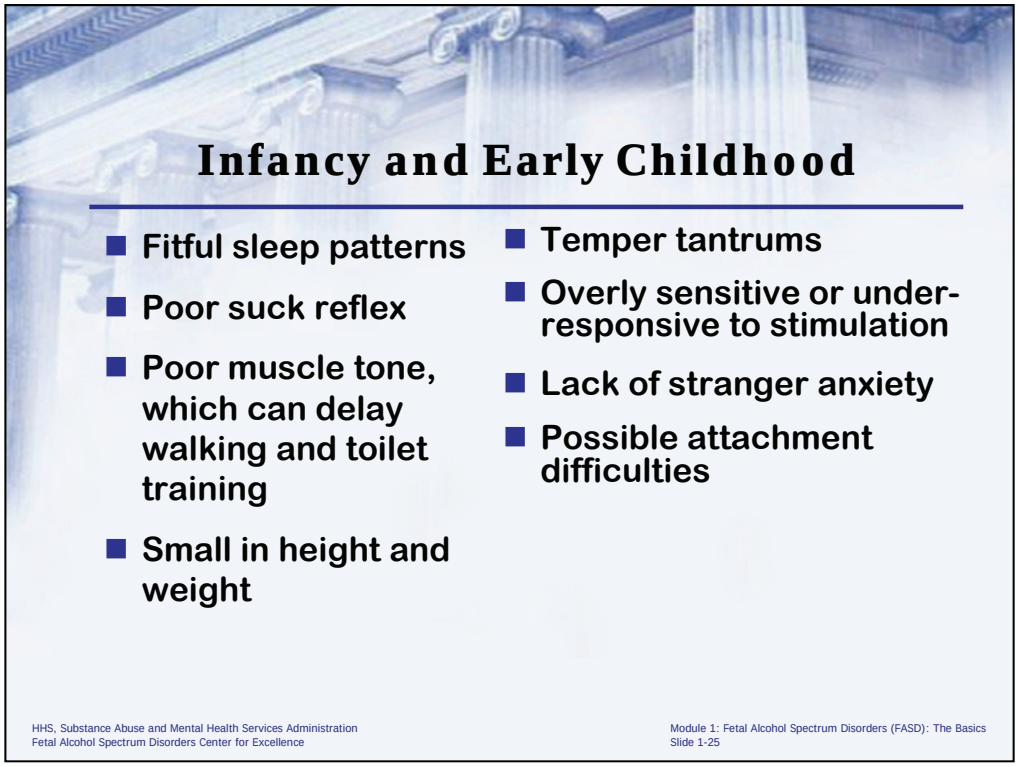
FACILITATOR'S TALKING POINTS:

- Understanding the behaviors associated with FASD will help facilitate implementation of appropriate intervention strategies throughout the lifespan.
- Many problems associated with FASD can be minimized if underlying behaviors are understood and expectations are realistic. We need to redefine success!
- Central nervous system dysfunction often leads to behavior problems. These problems vary from mild to so severe that individuals cannot function independently.
- Behavior problems can include:
  - Passiveness
  - Hyperactivity
  - Stubbornness
  - Impulsiveness
  - Irritability
  - Sleep difficulties
  - Fearlessness
- This is certainly not a complete list, but it highlights examples of issues that families may be dealing with. Remember the FASD disability is a spectrum; therefore, not all people with an FASD will have these problems.



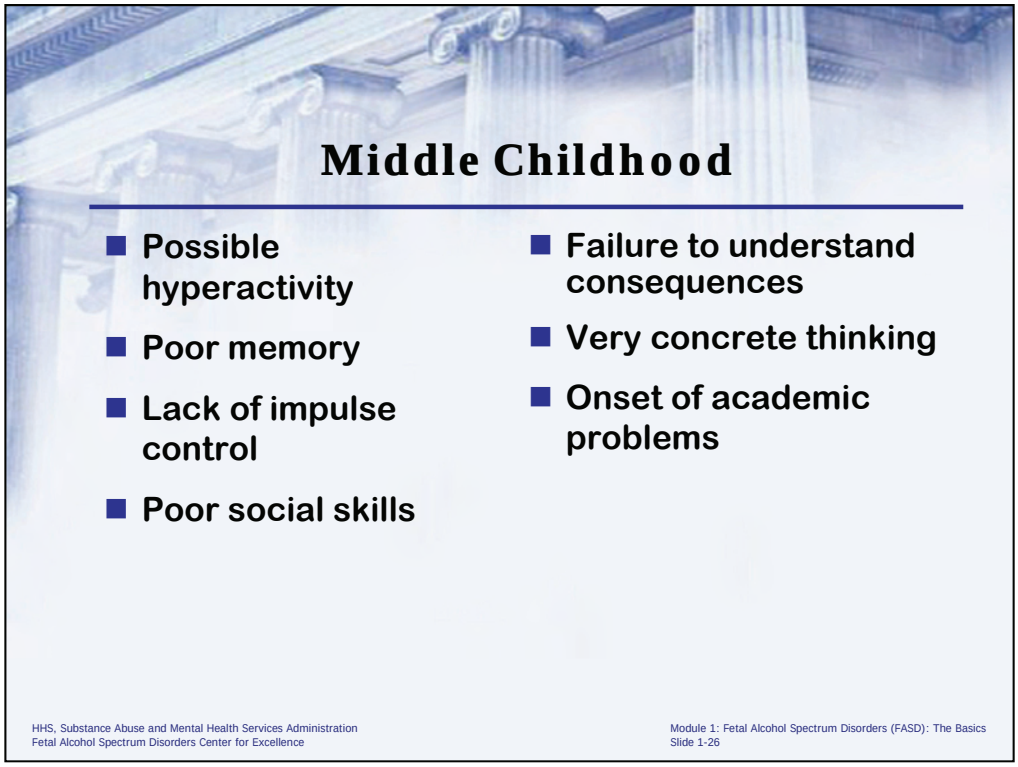
FACILITATOR'S TALKING POINTS:

- Often children and adults with an FASD have learning difficulties related to brain injury. These can include:
  - Poor organizational skills
  - Problems with money
  - Attention deficits
  - Poor math skills
  - Difficulty with abstract concepts
  - Difficulty learning from past experiences
- This is a partial list highlighting examples of learning difficulties. Not all people with an FASD will have these difficulties.



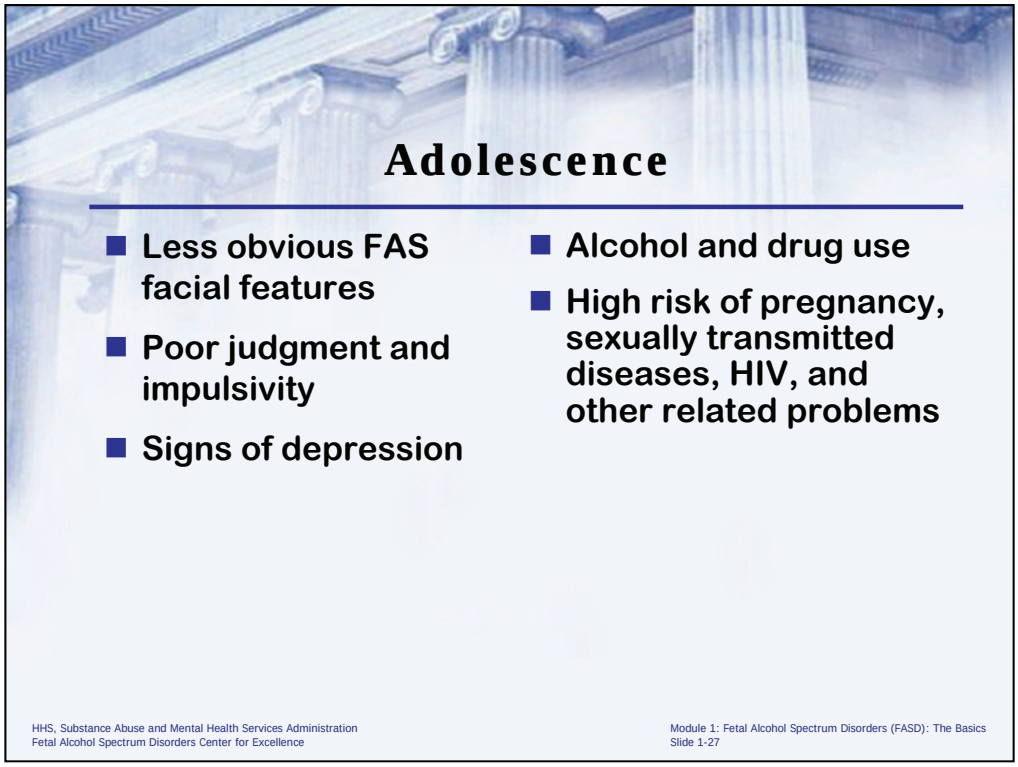
FACILITATOR'S TALKING POINTS:

- Infants born with an FASD may have a difficult first few months. Some may show behaviors related to alcohol withdrawal. Difficulties may include seizures, sleeping problems, stomach problems, and fussiness.
- Infants may be born with low birth weights and may have difficulty getting adequate nourishment due to a poor suck reflex.
- Many infants with an FASD show irritability, jitteriness, sleep disorders, excessive crying, and sensitivity to sound and light. Older infants tend to be easily upset, easily distractible, and hyperactive, and they tend to have poor attention span and developmental delays.
- Toddlers may exhibit temper tantrums.
- Toddlers often do not develop the stranger anxiety that is a common milestone in normal early childhood development.
- Difficulties with attachment to parents and caregivers are most noticeable in childhood.



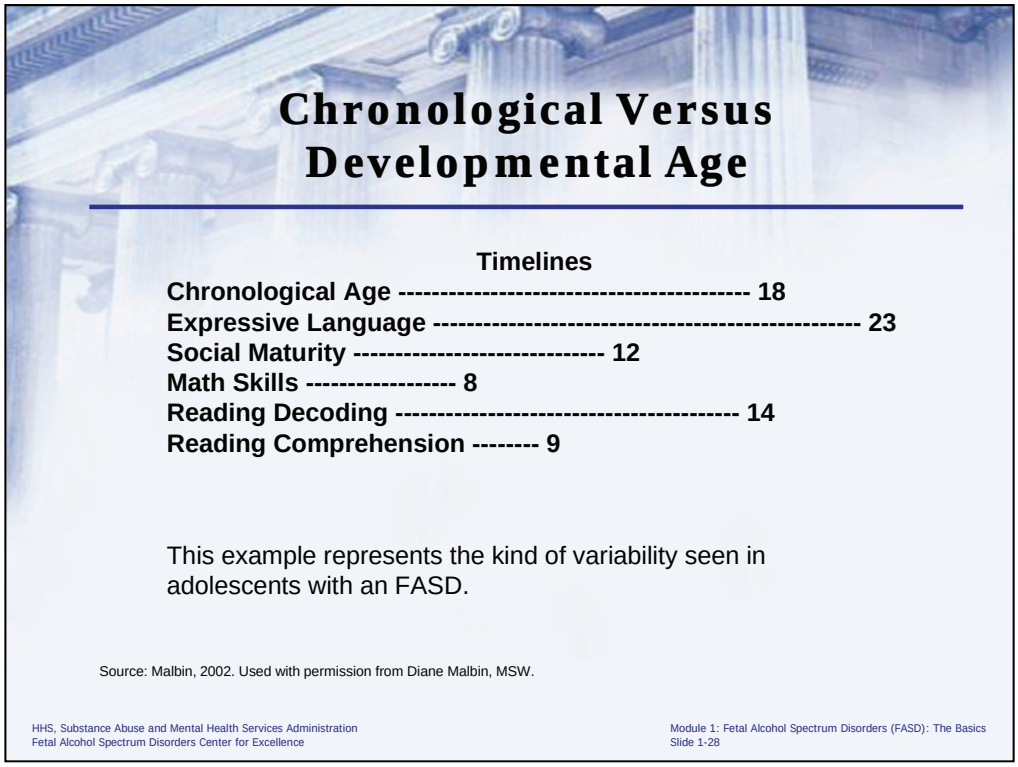
FACILITATOR'S TALKING POINTS:

- School-age children with an FASD may continue to grow slowly and may appear to be malnourished.
- The early school years (age 6 through 11) are often characterized by problems predicting outcomes and understanding consequences, outbursts in behavior, delay in physical maturity, hyperactivity, memory problems, impulsivity, and lack of boundaries.
- The complex school environment may be especially challenging, and children may feel overwhelmed. Anger and frustration may occur, which may be signs that the child is having difficulty.



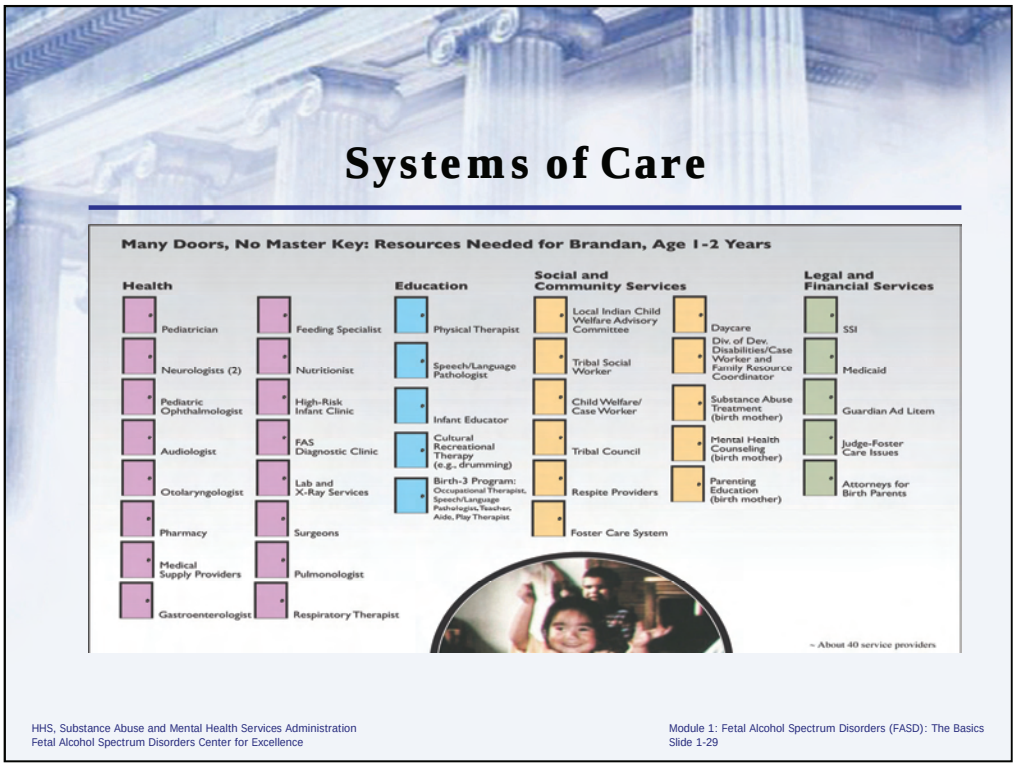
FACILITATOR'S TALKING POINTS:

- Facial features and growth
  - Adolescents with an FASD may look like typical teenagers, but their developmental level may be that of a younger child.
  - Facial features change during puberty, making it harder to recognize the face of FAS.
  - Some boys tend to stay smaller, while girls mature quickly and may have trouble with obesity.
- Poor judgment and impulsivity
  - Adolescents may display problem behaviors such as lying or stealing.
- Depression
  - Depression and other mental health problems may become more pronounced during the adolescent period of physical and emotional change.
- Alcohol and drug use
  - People with an FASD are at greater risk than those without an FASD to develop alcohol and/or drug problems.
- Pregnancy
  - Teens with an FASD are at risk of becoming pregnant or causing a pregnancy because they don't understand cause and effect.



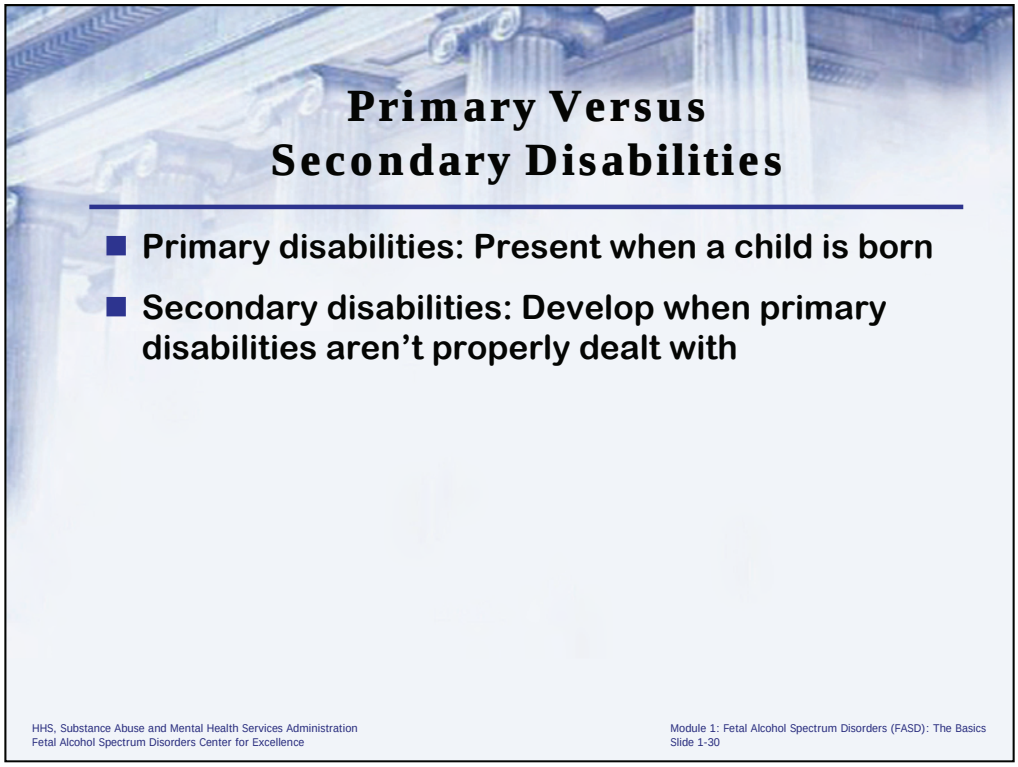
FACILITATOR'S TALKING POINTS:

- An 18-year-old with an FASD may function at a much lower developmental age.
- The greatest gaps between age and development occur during adolescence (Malbin, 2002).
- Frustration occurs when expectations are based on age rather than developmental level of functioning.
- Expectations are for people to "act their (chronological) age." Normal behaviors of an earlier developmental level are seen as inappropriate, as needing to be changed (Malbin, 2002).
- Adjusting expectations to recognize the variability in development lessens problems.



FACILITATOR'S TALKING POINTS:

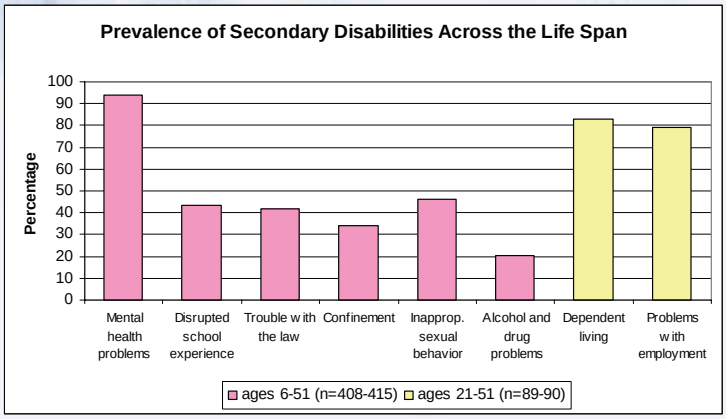
- A person with an FASD may need multiple services involving numerous agencies in various service systems spread across a number of locations. It is rare to find coordination of services or case management for persons with an FASD. Depending on the individual's specific needs, several dozen providers may be involved.
- This child's family was able to access services, thanks to early diagnosis and his mother's connection with the service network.



FACILITATOR'S TALKING POINTS:

- One of the leading researchers on FASD, Dr. Ann Streissguth, and her colleagues conducted a study of over 400 individuals with an FASD to determine the impact FASD had on their lives (Streissguth, et al., 1996).
- This effort was a 4-year study of individuals with FAS and FAE, funded by the Centers for Disease Control and Prevention in 1996.
- Secondary disabilities emerge as a result of the child's primary disabilities (e.g., central nervous system damage).

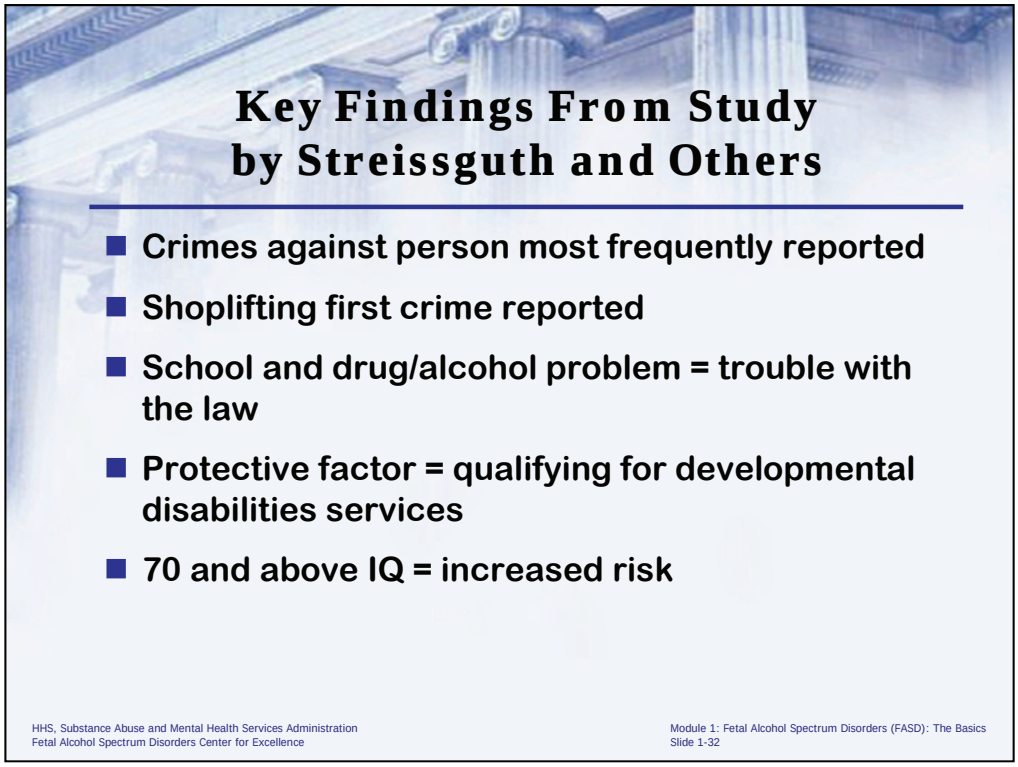
Study by Streissguth and Others



Source: Streissguth, et al., 1996

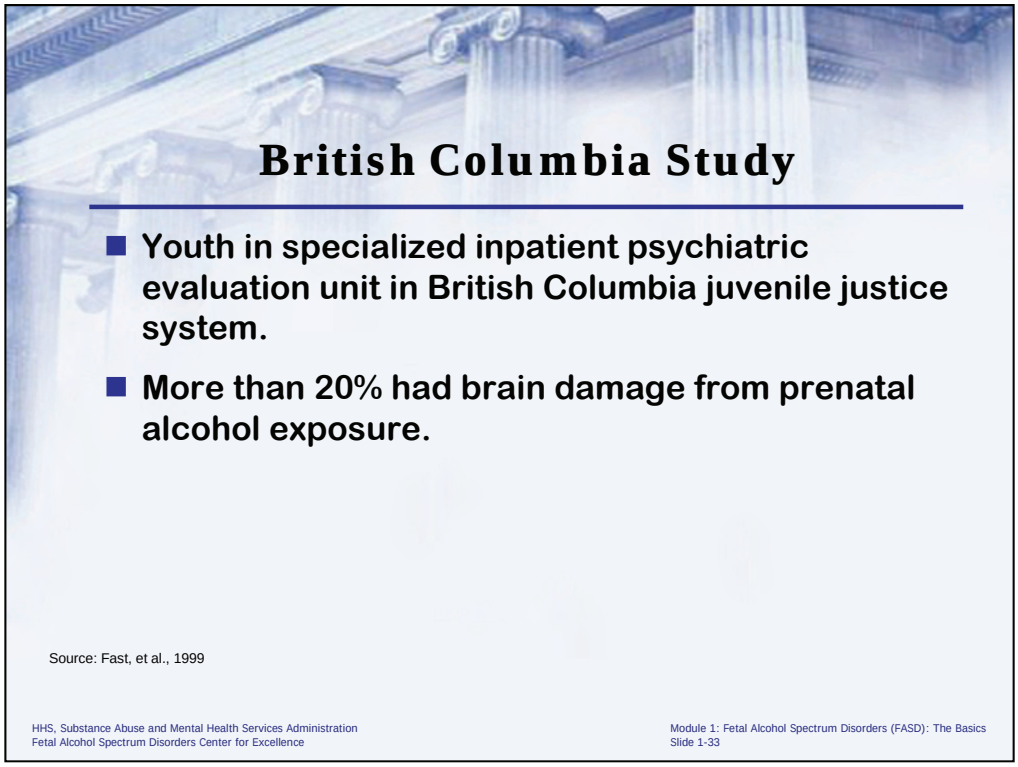
FACILITATOR'S TALKING POINTS:

- All these secondary disabilities were measured in clients 6 years of age and older, with the exception of "inability to live independently" and "problems with employment," which were measured in clients 21 years of age and older (Streissguth, et al., 1996).



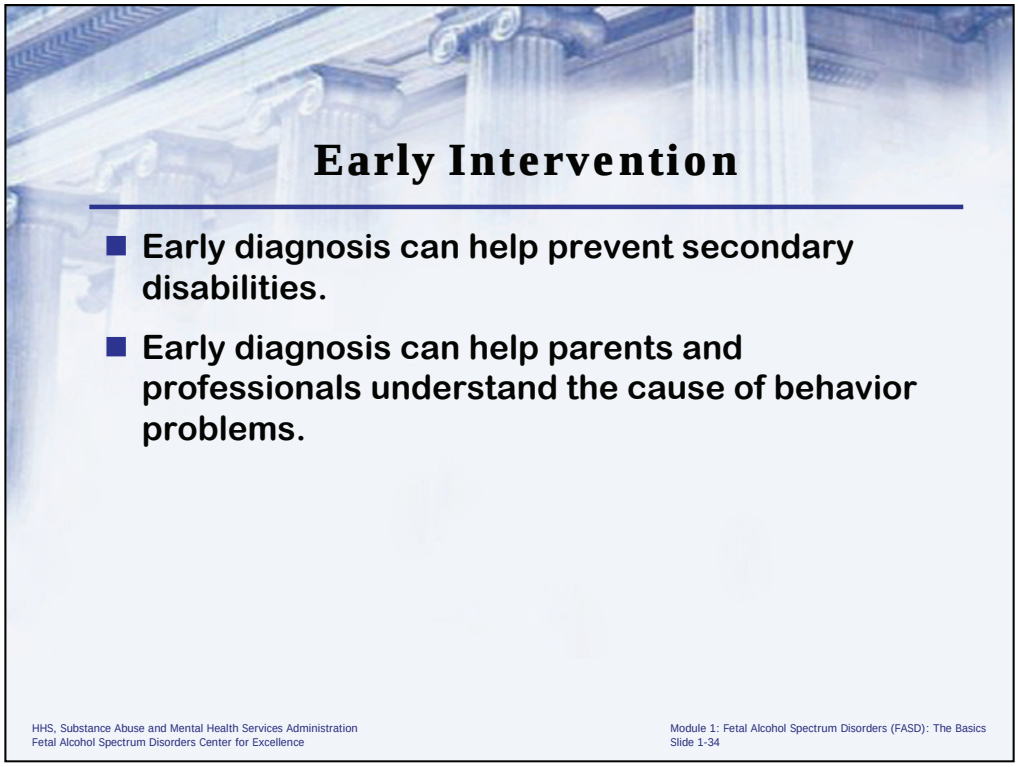
FACILITATOR'S TALKING POINTS:

- Crimes against person (burglary, theft, assault) were most frequently reported.
- Shoplifting was most often the first crime reported.
- Disrupted school experience and alcohol/drug problems correlated highly with trouble with the law.
- Most effective protective factor was qualifying for developmental disability services. The reason is that the identification of a developmental disability brings necessary support from the community.
- Youth with an FASD with IQ scores above 70 were more likely to get into trouble with the law. Having a higher IQ is not necessarily a protective factor, because the youth may be functioning at a higher level yet not understanding the situation they are involved in. They are also less likely to be recognized as having a disability and to qualify for specialized services.
- An important issue to keep in mind is that youth with an FASD often commit crimes that are impulsive and not thought out. This is often because of brain functioning issues. There is limited funding for mental health, and the courts end up working with these youth to seek appropriate services.



FACILITATOR'S TALKING POINTS:

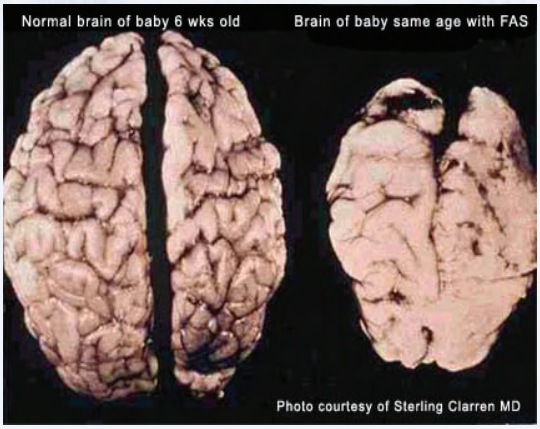
- There are few studies that have looked at youth with an FASD in the juvenile justice system. This study (Fast, et al., 1999) gives us some empirical data to better understand this population and its problems with the law.
- Of the 287 youth evaluated for FAS/FAE in this study, 67 (23.3%) had an alcohol-related diagnosis; 3 (1.0%) had a diagnosis of FAS; and 64 (22.3%) had a diagnosis of FAE.
- This study indicates the need for increased education and awareness among professionals who work with youth involved in the justice system.



FACILITATOR'S TALKING POINTS:

- Early diagnosis along with intensive and appropriate intervention can make enormous differences in the prognosis of the child.
- After diagnosis, parents and professionals often find that their ability to cope with the child's behavior changes dramatically when they understand that the problems are most likely based on organic brain damage, rather than the child's choice to be inattentive or uncooperative.
- Early intervention can help prevent secondary disabilities.

Effects of Alcohol on the Brain



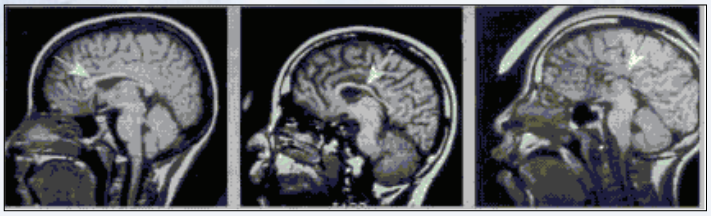
HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence

Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics
Slide 1-35

FACILITATOR'S TALKING POINTS:

- *Prenatal alcohol exposure causes brain damage.* Alcohol can damage the developing brain in a number of ways. The brain may be smaller than normal or may have missing or underdeveloped portions, such as the corpus callosum. The corpus callosum connects the right and left sides of the brain to allow communication between the hemispheres. The picture on the right is an autopsy photo of an infant with FAS so severe that it was fatal. Most people with FAS do not have brains that are this dramatically affected. The picture on the left is the brain of a normal infant who died of other causes.
- One area likely to be impacted is the frontal lobe, but the other parts of the brain may be damaged depending on the stage of development at the time of exposure to alcohol.
- The frontal lobes control judgment, inhibition, concentration, self-control, conscience, personality, and emotional traits, as well as cognition, memory, motor speech, and movement skills.
- The left hemisphere deals with language-based memory—logical interpretation of language, mathematics, abstraction, reasoning, facts, and rules (such as safety and social).
- The right hemisphere deals with holistic functioning—processing images, sound, and touch. Memory here is visual, auditory, and spatial.
- The right side senses input, checks with the left side to see if there are any rules to deal with this pattern of input, integrates the stored information, and reacts in a modified way.
- Damage to any of these systems may cause very poor and inappropriate responses.

Effects of Alcohol on the Brain (cont'd)



A B C

A. Magnetic resonance imaging showing the side view of a 14-year-old control subject with a normal corpus callosum
B. 12-year-old with FAS and a thin corpus callosum
C. 14-year-old with FAS and agenesis (absence due to abnormal development) of the corpus callosum

Source: Mattson, et al., 1994

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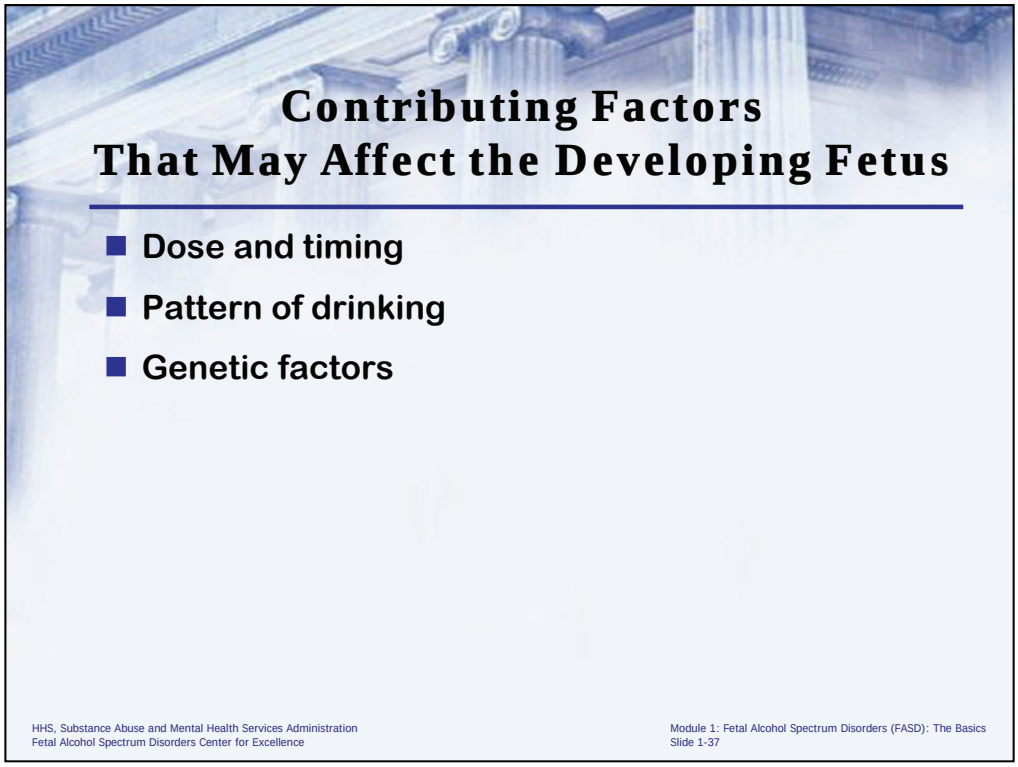
Fetal Alcohol Spectrum Disorders Center for Excellence

Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics
Slide 1-36

FACILITATOR'S TALKING POINTS:

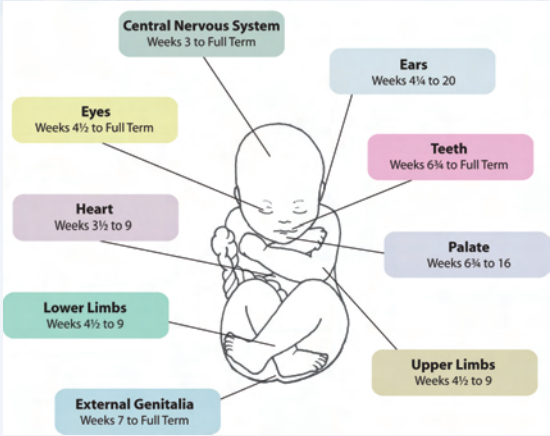
- **Corpus Callosum:** The corpus callosum connects the two hemispheres of the brain, allowing the left and right sides to communicate with each other. Prenatal alcohol exposure can cause thinning or complete absence of the corpus callosum. These abnormalities have been linked to deficits in attention, intellectual function, reading, learning, verbal memory, and executive and psychosocial functioning.
- Approximately 7% of children with FAS lack a corpus callosum, an incidence rate 20 times higher than in the general population (Riley, et al., 1995).



FACILITATOR'S TALKING POINTS:

- There are several factors that contribute to the effects of alcohol on the developing fetus:
  - Dose and timing: The greater the dose, the greater the potential risk to the fetus. The brain is developing throughout pregnancy, and alcohol affects the developing brain. We know of no safe level of alcohol at any point during pregnancy.
  - Pattern: Heavy bouts of alcohol exposure, even occasionally, can affect the developing fetus. Moderate and occasional alcohol exposure can also produce adverse outcomes. In an analysis of women age 18 to 44 from the 2002 Behavioral Risk Factor Surveillance System, a CDC-sponsored telephone survey, more than 50% of women who did not use birth control, and therefore might become pregnant, reported alcohol use, and 12.4% reported binge drinking. Additionally, 10% of pregnant women used alcohol (Tsai and Floyd, 2004).
  - Genetic factors of mother and child: Teratogens affect fetuses differently; not all offspring will share the same effects when exposed to alcohol prenatally (Streissguth, 1997). FASD is a direct result of a mother's drinking during pregnancy. The father's drinking cannot cause an FASD. This condition is not hereditary. A woman has to drink during pregnancy to cause an FASD.
- Other risk factors can include smoking, other substance use, nutrition, overall stress, and age of mother.
- Often what we see in sibling groups is that the oldest child may have an FASD, whereas the youngest has FAS, indicating that the youngest child is the most affected (Streissguth, 1997).

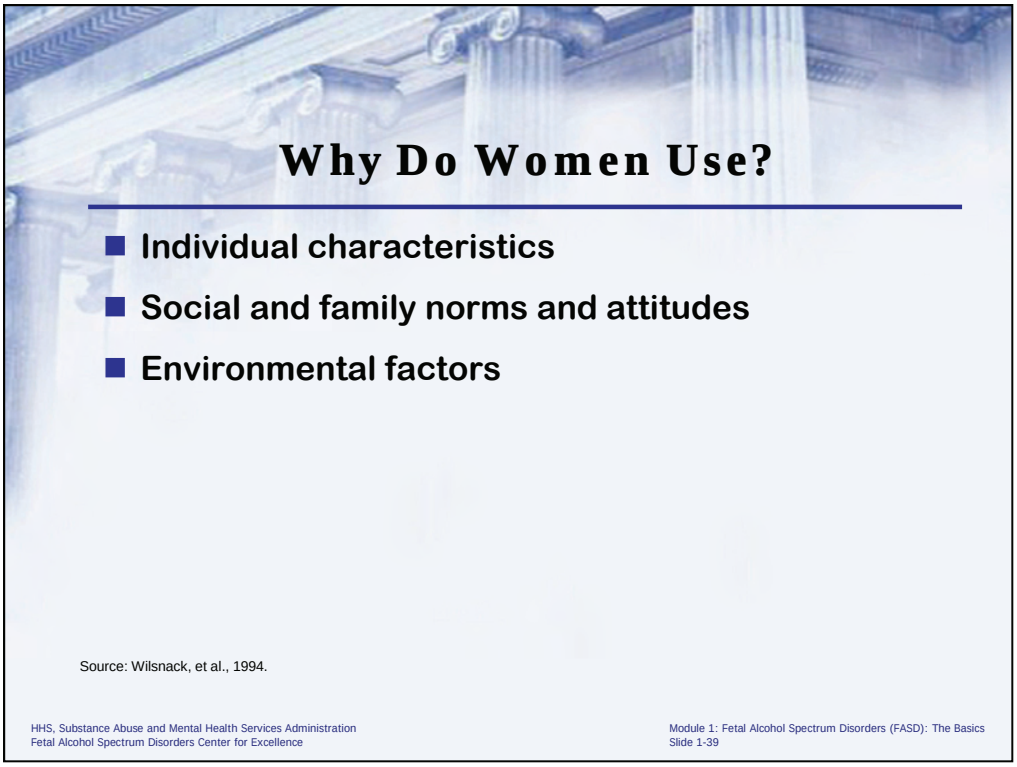
Periods of Fetal Development



Source: Adapted from Moore and Persaud, 1993

FACILITATOR'S TALKING POINTS:

- Drinking at any time during pregnancy can harm the fetus. This figure depicts developing parts and systems in the body of a fetus. These body parts and systems represent some of the sites that may be affected by alcohol. Drinking alcohol while pregnant can result in cognitive, social, and motor deficiencies, as well as other lifelong problems. The fetal brain can be harmed at any time, because the brain develops throughout pregnancy.

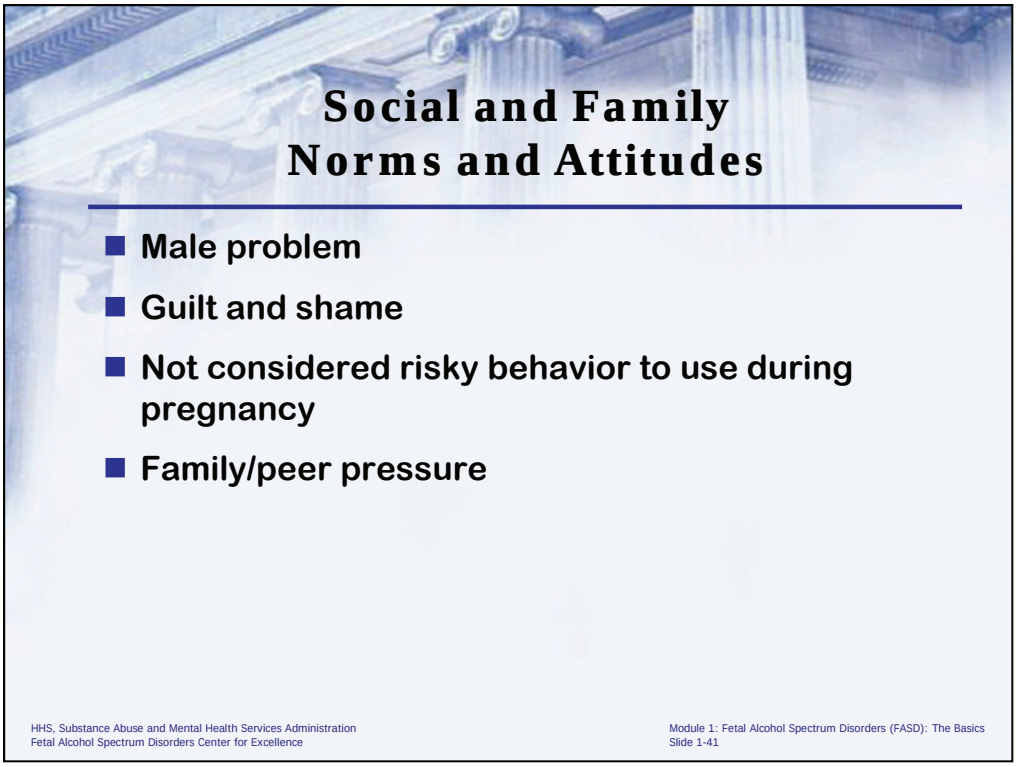


FACILITATOR'S TALKING POINTS:

- When considering substance use issues it is imperative that we understand why women use substances, particularly during pregnancy.
- Women who are alcoholic often perceive that drinking is not the main problem; rather, they believe that alcohol use is a means to cope with a specific crisis.
- Some individual characteristics, social and family norms and attitudes, and environmental factors that may contribute to alcohol use among pregnant women are discussed on the next set of slides.

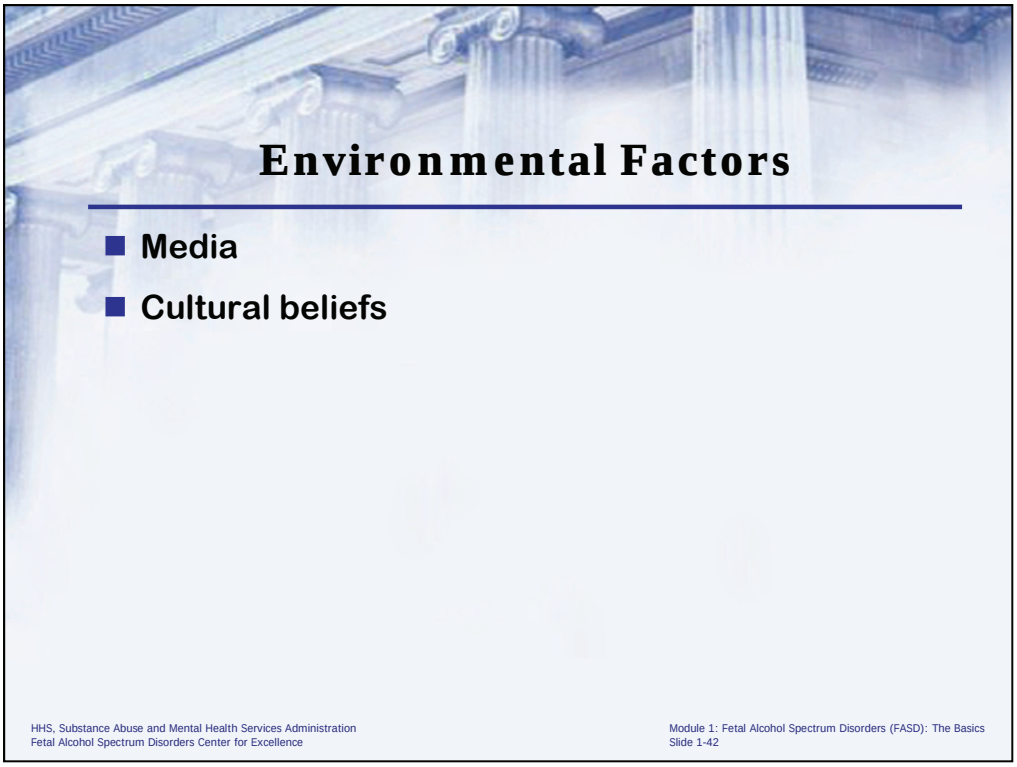
FACILITATOR'S TALKING POINTS:

- Individual characteristics
  - Low self-esteem.
  - Feeling of failure.
  - Feeling of inadequacy.
  - Depression—many women self-medicate by using alcohol.
  - Traumatic life experience—in fact, an early onset of trauma is more prevalent among alcoholic women than men. For example, one study of adolescent and teenage boys and girls receiving substance abuse treatment (Rohsenow, et al., 1988) found that 71 to 90% of girls and 23 to 42% of boys reported histories of childhood sexual abuse.



FACILITATOR'S TALKING POINTS:

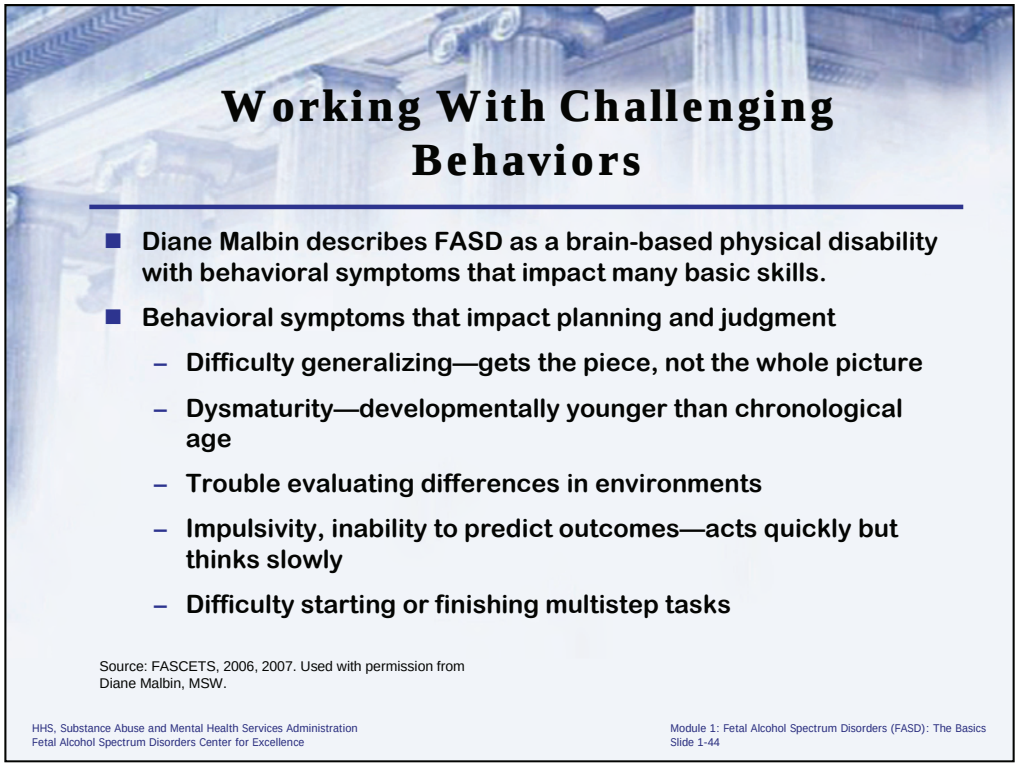
- Social and family norms and attitudes
  - Prior to the 1960s, addiction was viewed as a male problem—there was little information available about the impact of alcohol on women. Pressures from society may play a role for women—alcoholism may be more acceptable for men than women. With this, women may conceal their drinking due to guilt and shame.
  - Until recently, alcohol use during pregnancy was not considered risky behavior. There are still some providers who say it is okay to drink during pregnancy.
  - Partners, family, and friends use—women feel compelled to use alcohol when those around them are drinking as well.



FACILITATOR'S TALKING POINTS:

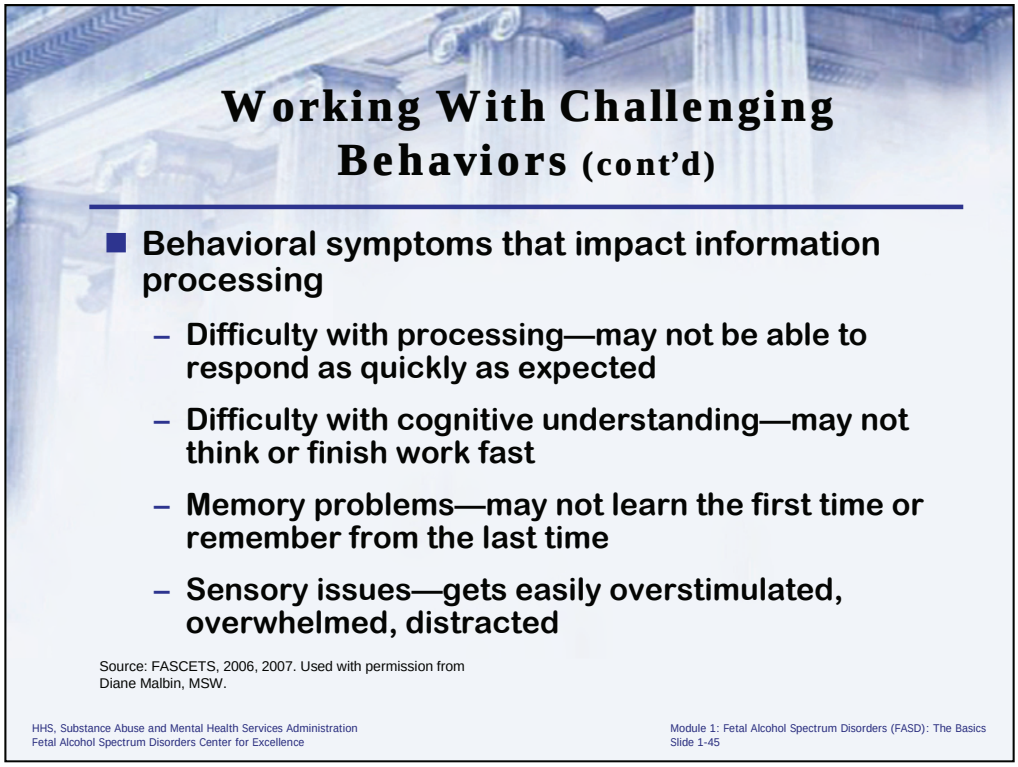
- Media
  - Some media messages link drinking with physical attractiveness and sexual success.
  - The media and beverage industry have fueled the belief that the use of alcohol makes good times even better and bad times more tolerable.
  - The media has publicized the health benefits of red wine without cautioning women to not drink during pregnancy.
- Cultural beliefs
  - There are a variety of cultural beliefs that are interpreted as sanctioning alcohol use among pregnant women. Some of these cultural beliefs include inaccurate information or myths. Examples of these myths are that alcohol can make a pregnant woman stronger and can increase the supply of breast milk.
  - In some cultures, alcohol is used to facilitate bonding. It also plays a role in rites of passage, celebrations, and religious rituals.

See Activity 1 in the Activities section.



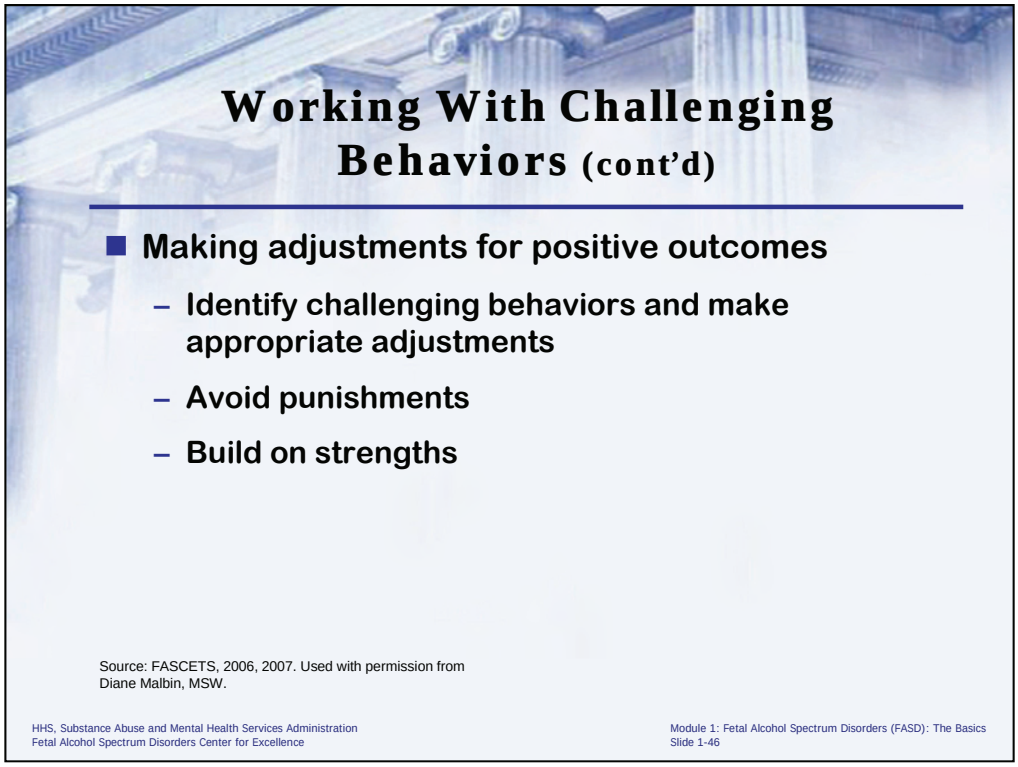
FACILITATOR'S TALKING POINTS:

- Difficulty generalizing and inability to grasp the entire concept may lead to behavior that appears to be negative and/or willful.
- Developmentally younger actions may be deemed socially inappropriate due to the perception that the individual has greater ability than exists.
- Difficulty evaluating an environment leads to difficulty knowing how to behave in social environments.
- Impulsive behavior may be perceived as a lack of caring or disobedience.
- Difficulty with multistep tasks may be perceived as a lack of motivation.



FACILITATOR'S TALKING POINTS:

- Slow processing may be perceived as ignoring or resisting behavior.
- Slow cognitive pace may be perceived as being avoidant or not trying.
- Memory problems may be perceived as a lack of caring or laziness.
- Overstimulation and distractedness may be perceived as a lack of discipline.



FACILITATOR'S TALKING POINTS:

- Reframing behaviors associated with FASD as symptoms of a neurobehavioral disorder may help prevent negative reactions. The following adjustments can be used to help with communication and encourage more productive and positive outcomes:
  - Accept the need to reteach concepts in different settings.
  - Avoid punishments such as taking away privileges, asserting more control, or giving additional homework. These approaches can result in negative secondary behaviors such as anxiety, frustration, and tantrums.
  - Slow down, adjust the work load, or accept a slower pace.
  - Think younger—establish developmentally appropriate expectations.
  - Recognize and allow for memory variability.
  - Evaluate the environment, and adjust it as necessary.
  - Build on strengths—identify interests and talents.
  - Provide different options for learning (e.g., kinesthetic, experiential, relational, visual).

Choose one of the two options under Activity 2 in the Activities section.

Questions

Posttest!

Use this space for your notes.

References

- See References for a complete list of all references in this module.

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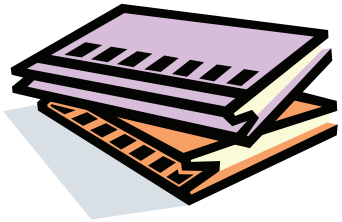
Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics
Slide 1-49

Use this space for your notes.

Posttest



ID # _____–post

Please answer true or false to the following questions:

1. A can of beer, a glass of wine, a shot of hard liquor, and a wine cooler all may contain the same amount of alcohol.

   True ☐ or False ☐

2. The most disabling effect for persons with an FASD is the facial features.

   True ☐ or False ☐

3. Alcohol is only risky during the first trimester, when the brain is developing.

   True ☐ or False ☐

4. Individuals who are affected by prenatal exposure to alcohol typically outgrow the effects by the time they reach adulthood.

   True ☐ or False ☐

5. Individuals with an FASD commonly are affected by a neurological disorder called “sensory processing disorder.”

   True ☐ or False ☐

6. It is better to not seek a diagnosis for a child or adult who may have an FASD because it is just one more “label” for the individual.

   True ☐ or False ☐

7. ADHD and FASD are essentially the same disability.

   True ☐ or False ☐

Posttest Facilitator's Notes

Please answer true or false to the following questions:

1. A can of beer, a glass of wine, a shot of hard liquor, and a wine cooler all may contain the same amount of alcohol.

   True ☐ or False ☐

   True: A 12-ounce wine cooler, a 1.5-ounce shot of hard liquor, a 12-ounce beer, and a 5-ounce glass of wine all contain the same amount of alcohol and have the same effect on the fetus.

2. The most disabling effect for persons with an FASD is the facial features.

   True ☐ or False ☐

   False: The most disabling effect for persons with an FASD is the damage to the brain. This damage can cause learning disabilities, behavior problems, memory deficits, attention disorders, and/or mental retardation.

3. Alcohol is only risky during the first trimester, when the brain is developing.

   True ☐ or False ☐

   False: Alcohol can affect the fetus during all three trimesters. Alcohol can affect the brain, which is developing throughout pregnancy, as well as other systems and organs.

4. Individuals who are affected by prenatal exposure to alcohol typically outgrow the effects by the time they reach adulthood.

   True ☐ or False ☐

   False: FASD is a lifetime disability. A child does not outgrow it, but early diagnosis along with intensive and appropriate interventions can make an enormous difference in the prognosis of the individual.

5. Individuals with an FASD commonly are affected by a neurological disorder called "sensory processing disorder."

   True ☐ or False ☐

   True: Sensory processing disorder, or SPD, formerly known as "dysfunction of sensory integration," is a common, but misunderstood, problem that affects children's behavior, influencing the way they learn, relate to others, and feel about themselves. It usually is a considerable problem for children with an FASD.

6. It is better to not seek a diagnosis for a child or adult who may have an FASD, because it is just one more "label" for the individual.

   True ☐ or False ☐

   False: Seeking a diagnosis is one of the key protective factors in preventing secondary disabilities. Getting a diagnosis is the beginning of a process, not the end. A diagnosis identifies the disability and begins the process of developing appropriate, individually tailored interventions.

7. ADHD and FASD are essentially the same disability.

   True ☐ or False ☐

   False: Frequently there is an overlap of behavior associated with FASD and other common disorders such as ADHD. Although many people with an FASD may have attention problems, these are two separate issues.

Activity 1–Egg Experiment

To be conducted during Slide 1-43

Slide 1-43

Tools needed:

One egg (not boiled) at room temperature, clear jar (canning jar with a lid works best), and rubbing alcohol

Steps:

1. Tell the participants that we all start out as a developing egg. Show the egg.
2. Crack open the egg in the clear jar. Be careful to not break the yolk.
3. Show the egg to the audience and ask what would happen if we placed alcohol on the egg.
4. Pour clear alcohol (about ¼ cup is fine) over the egg.
5. Put the lid on the jar and pass it around the room.
6. Explain to the audience how the clear part of the egg is turning white.

Activity 2–Option 1–Challenging Behaviors

To be conducted during Slide 1-47

Tools needed:

Handout: "H Family" Scenario

Steps:

Slide 1-46

1. Break the participants into small groups of three to five people (depending on the size of the group). Have the participants count off to form groups (1, 2, 3, etc.).
2. Have the groups choose a recorder and a reporter.
3. Distribute the "H Family" handout.
4. Have the groups discuss the challenging behaviors faced by either the youth, the parents, or the professionals in the scenario. They may select one, or you may make assignments. Participants should refer to Slides 1-43 through 1-45 on challenging behaviors. The reporter should be prepared to present findings to the large group.
5. In the large group, ask each reporter to give one or two findings in the scenario.

Activity 2–Option 1–Challenging Behaviors–Scenario Handout

H Family

The second child of the H Family was born preterm by 2 weeks. She weighed 5 lbs. 14 oz. at birth. She was irritable, a poor feeder, slow to gain weight, and tremulous. Her mother entered treatment for alcoholism when this daughter was 3 months old. After treatment, her mother became concerned about the possible effect drinking during pregnancy might have had on her daughter. The pediatrician was very supportive and stated, "This sounds like parental guilt. Don't worry." When the mother asked about the small head size of her daughter, the pediatrician said, "One of my most brilliant professors in medical school was microcephalic."

The baby's early development was fairly normal. She walked and talked "on time." At 3, however, she was unable to consistently follow a series of requests (e.g., put your toy on the shelf, wash your hands, and come to the table). Some days she would, and some days she wouldn't. Since her parents were randomly reinforced by her behavior, when she didn't follow through they thought she was "trying to make us mad," and she was punished. She started having tantrums, was sent to her room for time-outs, and became destructive with her toys and her room. In an attempt to modify her behavior, the time-outs were gradually lengthened until she was spending entire days in her room. Her older sister was constantly irritated by her behavior.

When she entered school, her teacher saw her as bright and capable, based on her keen sense of humor and strong verbal skills. At first, she appeared to be successful in school. She learned to decode words but seemed to need to relearn basics. Halfway through the year, she started acting out at home—kicking the cat, crying, and withdrawing. When asked about school she said, "I want to learn faster." Her teacher sent notes home saying she wasn't staying on task in the classroom, that she would speak out with irrelevant statements, and that she bothered her neighbors. Math concepts appeared to be the most difficult for her. Her parents attempted to support her progress by helping with her homework. This frequently took 2 hours in the evening in the first grade.

She had difficulty with fine motor skills. Her parents worked with her for a full year to teach her how to tie shoelaces. She had few friends; those she had were younger than she was.

By the time she was in the third grade, she was struggling with arithmetic and reading. She was making comments like, "I'm a reject at school. I can't follow the rules." The teacher said she had a choice, that she could do the work and follow the rules if she tried.

H Family (continued)

Behaviors that were "cute" when she was younger were now intrusive and inappropriate. Her level of activity, "touchiness" (need for physical contact), and off-the-wall comments were disturbing. She continued to enjoy playing with much younger children and had few friends. Her choices of games were also those of a younger child. Her parents continued to be frustrated at home and were concerned about her early school failures. They insisted that she be tested for special services, but she did not qualify on the basis of test results.

By the fourth grade she was refusing to go to school, was over a year behind in math, and was still struggling to comprehend what she read. The family spent an entire vacation trying to help her memorize the multiplication tables. Counselors the parents sought to help reduce the volatility in the home recommended parenting techniques that the parents tried. Nothing seemed to work for any length of time. The parents became increasingly frustrated, exhausted, and fearful. They felt blamed for their daughter's behavior.

Her rigidity and resistance increased. She either raged or withdrew. As she entered adolescence, she had difficulty remembering routines, especially those around personal hygiene. She also lied, rarely turned in her homework, fought at school and at home, began sporadic use of alcohol and other drugs, and discovered sex. Sex soon became a focus; it was concrete and specific and gave her a sense of power, mastery, and control. She was easily influenced and impulsive and understood neither safe sex nor birth control. She also lacked predictive skills and appeared not to learn from past mistakes. During discussions about future plans, her goals were unrealistic and included no planning. She envisioned living happily ever after "if only her parents, school, and others would leave her alone."

Activity 2–Option 2–Behavioral Exercises

To be conducted during Slide 1-47

Tools needed:

Flip chart paper

Steps:

1. Break the participants into small groups of three to five people (depending on the size of the group). Have the participants count off to form groups (1, 2, 3, etc.).
2. Have groups choose a recorder and a reporter.
3. Describe each scenario.
4. For each scenario, have small groups determine the youth's challenging behaviors and develop coping strategies for the youth.

Slide 1-46

5. Have the small groups report their ideas to the large group.
6. Write the participants' ideas on flip chart paper. Add any challenging behaviors and coping strategies that do not surface in the discussion. Encourage participants to take notes.

Exercise 1: Youth does not follow directions/noncompliance.

Explain the scenario—The facility has a rule that all youth will return lunch/dinner trays to the proper location in the cafeteria and throw away garbage from trays. The youth always leaves the tray on the table.

Discuss:

Youth's Challenges

- Poor short-term memory
- Does not understand or did not remember the instructions given
- Cannot translate words into actions
- Easily distracted

Coping Strategies

- Give short and concise instructions.
- Verify that the youth understood the instructions given by having the child repeat what was understood in his or her own words.
- Repeat the instructions to the youth.
- Demonstrate what you want him or her to do.
- Remind the youth in a supportive manner as the meal ends.
- Use pictures of the youth performing the task.
- Praise the youth when he or she is correct in completing the task.

Exercise 2: Difficulty completing tasks

Explain the scenario—The youth is asked to clean his or her room. He or she begins the task while the staff is still in the room. Ten minutes later, the youth exits the room. When the staff asks if he or she is done, the youth says, "Yes." The staff checks the room and finds it in the same messy condition as before.

Discuss:

Youth's Challenges

- Poor short-term memory
- Does not understand or did not remember the instructions given
- Cannot translate words into actions
- Easily distracted

Coping Strategies

- Give short and concise instructions.
- Verify that the youth understood the instructions given by having the child repeat what was understood in his or her own words.
- Repeat the instructions to the youth.
- Demonstrate what you want him or her to do.
- Remind the youth in a supportive manner.
- Use pictures of the youth performing the task.
- Praise the youth when he or she is correct in completing the task.

Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

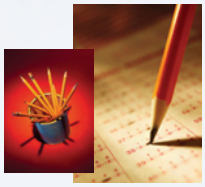
Module 1

Fetal Alcohol Spectrum Disorders (FASD): The Basics

Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics

- After attending this session, participants will be able to:
  - Discuss the possible lifelong effects of prenatal alcohol exposure on brain development
  - Define "fetal alcohol spectrum disorders"
  - Describe the impact FASD has on the family, school, community, and society in general

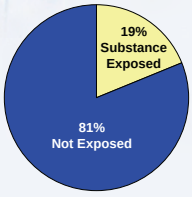
Pencils Out



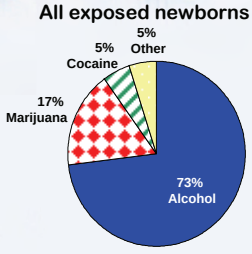
Pretest!

Extent of Exposure

All newborns in the U.S.



All exposed newborns



Source: National Institute on Drug Abuse, 1991

The Cost of Fetal Alcohol Syndrome (FAS)

- Costs associated with caring for persons with FAS in the United States may be as high as $6 billion.
- The lifetime cost for each individual with FAS is $2 million or more, depending on how the costs are calculated.
- One prevented case of FAS can save $2 million or more.

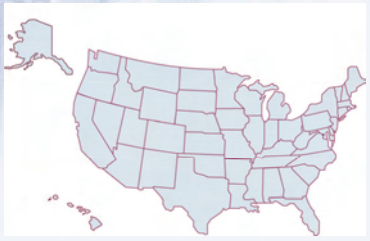
Source: Lupton, et al., 2004

Economic Costs of Alcohol Abuse

- $184.6 B in 1998; $670 per capita; 2.1% of GDP
  - Medical consequences of FAS $2.9 B
  - Lost earnings due to FAS $1.3 B
  - Specialty alcohol services $7.5 B
  - Medical consequences, other than FAS $16.0 B
  - Lost earnings, mortality $36.5 B
  - Lost earnings, morbidity $86.4 B
  - Lost earnings, crime/victims $10.1 B
  - Crashes, fires, justice $24.1 B

Source: Harwood, 2000

State Costs for FASD



Definition of FASD

- "Fetal alcohol spectrum disorders" (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. The term "FASD" is not intended for use as a clinical diagnosis.

Source: Bertrand, et al., 2004

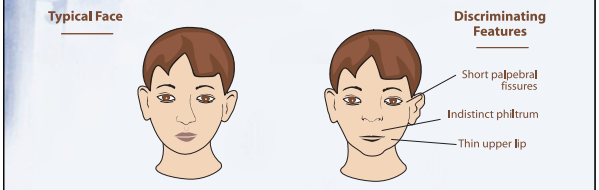
What Are Fetal Alcohol Spectrum Disorders?

- Term used to describe a group of birth anomalies that can occur when a woman drinks alcohol when pregnant
- Descriptive only
- Not a diagnostic term

Fetal Alcohol Syndrome

- Represents only a small group of individuals
- One of the fetal alcohol spectrum disorders
- Characterized by:
  - Certain facial features
  - Growth deficiency
  - Central nervous system damage

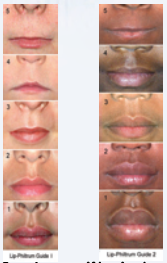
The Face of FAS



Diagnosing Fetal Alcohol Syndrome

- Prenatal maternal alcohol use
- Growth deficiency
- Central nervous system abnormalities
- Dysmorphic features
  - Short palpebral fissures
  - Indistinct philtrum
  - Thin upper lip

Source: Astley, 2004



Caucasian African American

With permission: Susan Astley, University of Washington

Other FASD—A History of Terms

- Alcoholic embryopathy (AE)
- Fetal alcohol effects (FAE)
- Alcohol-related birth defects (ARBD)
- Alcohol-related neurodevelopmental disorder (ARND)

FASD Terms (cont'd)

- Partial FAS (pFAS)
- Prenatal alcohol exposure (PAE)
- Prenatal exposure to alcohol (PEA)
- Alcohol-related disorders (ARD)

Likely Co-Occurring Disorders With FASD

- Attention-deficit/hyperactivity disorder
- Schizophrenia
- Depression
- Bipolar disorder
- Substance use disorders

Likely Co-Occurring Disorders With FASD (cont'd)

- Sensory processing disorder
- Reactive attachment disorder
- Separation anxiety disorder
- Posttraumatic stress disorder
- Traumatic brain injury
- Medical disorders (e.g., seizure disorder, heart abnormalities)

The Importance of Recognizing All Co-Occurring Issues

- Optimal outcomes in the treatment of individuals occur when all co-occurring issues are accurately recognized and addressed simultaneously.
  - If one, or more, co-occurring issue is not recognized, outcomes will be sub-optimal.
- Fetal alcohol spectrum disorders are often missed as co-occurring disorders, especially in individuals with mental health difficulties, substance abuse, social difficulties, and learning disabilities.

Research—Behavioral Effects Due to Alcohol Exposure

Humans	Animals
Hyperactivity	Increased activity, exploration, and reactivity
Attention deficits, distractibility	Decreased attention
Lack of inhibition	Inhibition deficit
Mental retardation, learning disabilities	Impaired associative learning
Perseveration	Perseveration

Source: Driscoll, et al., 1990

Research—Behavioral Effects Due to Alcohol Exposure (cont'd)

Humans	Animals
Feeding difficulties	Feeding difficulties
Gait abnormalities	Altered gait
Poor fine & gross motor skills	Poor coordination
Developmental delays	Developmental delay
Hearing abnormalities	Altered auditory evoked potentials
Poor state regulation	Poor state regulation

Source: Driscoll, et al., 1990

Alcohol Is Alcohol!

Beer • Table Wine • Wine Cooler • Hard Liquor

Possible Behavior Problems

- Passiveness
- Hyperactivity
- Stubbornness
- Impulsiveness
- Irritability
- Sleep difficulties
- Fearlessness

Possible Learning Difficulties

- Poor organizational skills
- Problems with money
- Attention deficits
- Poor math skills
- Difficulty with abstract concepts
- Difficulty learning from experience

Infancy and Early Childhood

- Fitful sleep patterns
- Poor suck reflex
- Poor muscle tone, which can delay walking and toilet training
- Small in height and weight
- Temper tantrums
- Overly sensitive or under-responsive to stimulation
- Lack of stranger anxiety
- Possible attachment difficulties

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Fetal Alcohol Spectrum Disorders Center for Excellence

Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics
Slide 1-25

Middle Childhood

- Possible hyperactivity
- Poor memory
- Lack of impulse control
- Poor social skills
- Failure to understand consequences
- Very concrete thinking
- Onset of academic problems

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Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics
Slide 1-26

Adolescence

- Less obvious FAS facial features
- Poor judgment and impulsivity
- Signs of depression
- Alcohol and drug use
- High risk of pregnancy, sexually transmitted diseases, HIV, and other related problems

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Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics
Slide 1-27

Chronological Versus Developmental Age

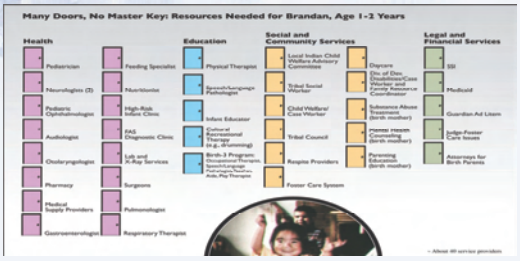
Timelines

Chronological Age ---------- 18
Expressive Language ---------- 23
Social Maturity ---------- 12
Math Skills ---------- 8
Reading Decoding ---------- 14
Reading Comprehension -------- 9

This example represents the kind of variability seen in adolescents with an FASD.

Source: Malbin, 2002. Used with permission from Diane Malbin, MSW.

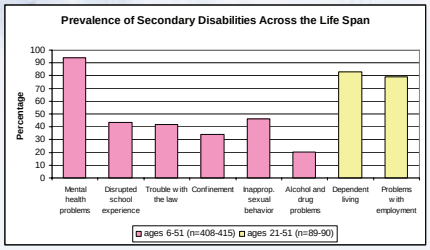
Systems of Care



Primary Versus Secondary Disabilities

- **Primary disabilities: Present when a child is born**
- **Secondary disabilities: Develop when primary disabilities aren't properly dealt with**

Study by Streissguth and Others



Source: Streissguth, et al., 1996

Key Findings From Study by Streissguth and Others

- Crimes against person most frequently reported
- Shoplifting first crime reported
- School and drug/alcohol problem = trouble with the law
- Protective factor = qualifying for developmental disabilities services
- 70 and above IQ = increased risk

British Columbia Study

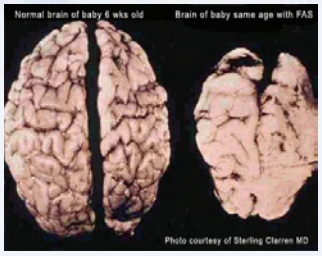
- Youth in specialized inpatient psychiatric evaluation unit in British Columbia juvenile justice system.
- More than 20% had brain damage from prenatal alcohol exposure.

Source: Fast, et al., 1999

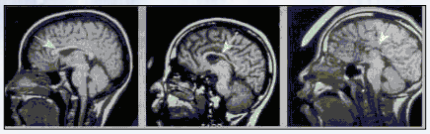
Early Intervention

- Early diagnosis can help prevent secondary disabilities.
- Early diagnosis can help parents and professionals understand the cause of behavior problems.

Effects of Alcohol on the Brain



Effects of Alcohol on the Brain (cont'd)



A B C

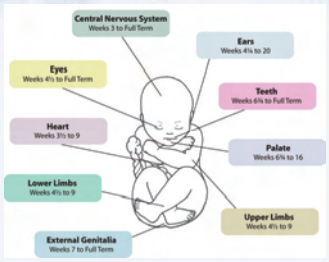
A. Magnetic resonance imaging showing the side view of a 14-year-old control subject with a normal corpus callosum
B. 12-year-old with FAS and a thin corpus callosum
C. 14-year-old with FAS and agenesis (absence due to abnormal development) of the corpus callosum

Source: Mattson, et al., 1994

Contributing Factors That May Affect the Developing Fetus

- Dose and timing
- Pattern of drinking
- Genetic factors

Periods of Fetal Development



Source: Adapted from Moore and Persaud, 1993

Why Do Women Use?

- Individual characteristics
- Social and family norms and attitudes
- Environmental factors

Source: Wilsnack, et al., 1994.

Individual Characteristics

- Low self-esteem
- Feeling of failure
- Feeling of inadequacy
- Depression
- Traumatic life experience

Social and Family Norms and Attitudes

- Male problem
- Guilt and shame
- Not considered risky behavior to use during pregnancy
- Family/peer pressure

Environmental Factors

- Media
- Cultural beliefs

Activity

Working With Challenging Behaviors

- Diane Malbin describes FASD as a brain-based physical disability with behavioral symptoms that impact many basic skills.
- Behavioral symptoms that impact planning and judgment
  - Difficulty generalizing—gets the piece, not the whole picture
  - Dysmaturity—developmentally younger than chronological age
  - Trouble evaluating differences in environments
  - Impulsivity, inability to predict outcomes—acts quickly but thinks slowly
  - Difficulty starting or finishing multistep tasks

Source: FASCETS, 2006, 2007. Used with permission from Diane Malbin, MSW.

Working With Challenging Behaviors (cont'd)

- Behavioral symptoms that impact information processing
  - Difficulty with processing—may not be able to respond as quickly as expected
  - Difficulty with cognitive understanding—may not think or finish work fast
  - Memory problems—may not learn the first time or remember from the last time
  - Sensory issues—gets easily overstimulated, overwhelmed, distracted

Source: FASCETS, 2006, 2007. Used with permission from Diane Malbin, MSW.

Working With Challenging Behaviors (cont'd)

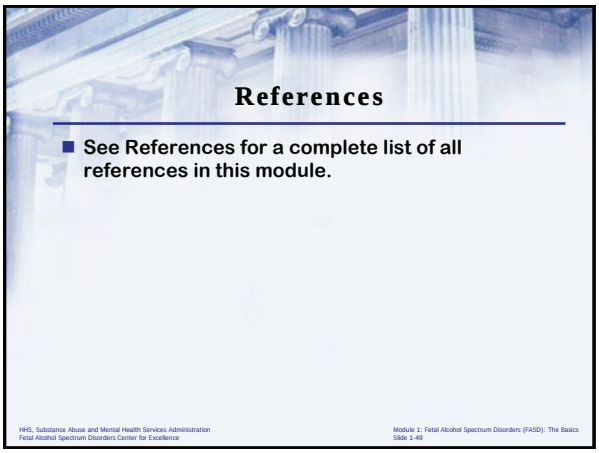
- Making adjustments for positive outcomes
  - Identify challenging behaviors and make appropriate adjustments
  - Avoid punishments
  - Build on strengths

Source: FASCETS, 2006, 2007. Used with permission from Diane Malbin, MSW.

Activity

Questions

Posttest!


References
See References for a complete list of all references in this module.
HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence
Module 1: Fetal Alcohol Spectrum Disorders (FASD): The Basics
Slide 1-49

Module 2:
FASD in the Juvenile Justice System

Description

Summary

The second module provides a comprehensive overview of youth with an FASD in the juvenile justice system. The lesson plan focuses on the prevalence of disabilities and FASD within the justice system and reviews the characteristics of youth with disabilities and those with an FASD that put them at risk for getting into trouble with the law.

Objectives

After completing this module, participants will be able to:

- Describe difficulties of individuals with disabilities within the juvenile justice system
- Explain why youth with an FASD may be more likely to come into contact with the juvenile justice system
- Examine issues faced by youth with an FASD in the juvenile justice system

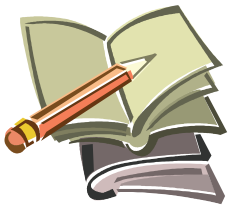
Facilitator's Outline

Step and Time	Tools Needed
One: Introduction—5 minutes	
You are presenting the *Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System*, a joint project of the Substance Abuse and Mental Health Services Administration (SAMHSA) Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence and the Minnesota Organization on Fetal Alcohol Syndrome. The FASD Center is a Federal initiative devoted to preventing and treating FASD. The Center's goals include advancing the field of FASD and promoting best practices. You may want to have participants introduce themselves, if time allows. Ask participants to state their backgrounds and interest in FASD. *Note: You do not need to do introductions if you combine modules—only conduct introductions at the beginning of a training session.*	
Two: Why We Are Here—5 minutes	
Discuss *Tools for Success*. *Tools for Success* focuses on assisting professionals who work with youth in the juvenile justice system who have an FASD to develop effective and appropriate interventions. It is designed for all correctional professionals, including advocates, attorneys, social workers, and social and human service providers who interact with children and families affected by FASD. *Tools for Success* contains seven modules: ■ Fetal Alcohol Spectrum Disorders (FASD): The Basics ■ FASD in the Juvenile Justice System ■ The Juvenile Justice System Response ■ Dispositional Options ■ Special Education and Behavior Management ■ Transition and Aftercare ■ Resources **2 minutes**	**PowerPoint Slide 2-1**

Step and Time	Tools Needed
Two: Why We Are Here (continued)	
Discuss Module 2: FASD in the Juvenile Justice System. The second module provides a comprehensive overview of youth with an FASD in the juvenile justice system. The lesson plan focuses on the prevalence of disabilities and FASD within the justice system and reviews the characteristics of youth with disabilities and those with an FASD that put them at risk for getting into trouble with the law. **2 minutes**	**PowerPoint Slide 2-2**
Discuss objectives for the module as indicated on PowerPoint Slide 2-3. **1 minute**	**PowerPoint Slide 2-3**
Three: Pretest—10 minutes	
Distribute the pretest and allow time for participants to complete it. After ensuring that each participant has provided a unique identifier on the pretest (see the Introduction), collect the tests. Do not review answers at this time.	**PowerPoint Slide 2-4** **Pretest** 
Four: PowerPoint Presentation—40 minutes	
Using PowerPoint presentation and facilitator talking points, provide overview to the group on youth with disabilities in general in the juvenile justice system, treatment of youth with disabilities in the system, and issues around primary and secondary disabilities.	**PowerPoint Slides 2-5 through 2-23**

Five: Think Outside the Box Activity—15 minutes	
Follow directions for Activity 1—Think Outside the Box: What Would You Do Differently? Distribute Scenario Handout: "Gerry G." Distribute Resource Handout: "Youth With an FASD in the Juvenile Justice System."	**PowerPoint Slide 2-24**  **Activity 1** **sheets in curriculum** 
Six: Posttest—10 minutes	
Distribute the posttest and allow time for participants to complete it. Using the facilitator's notes in the curriculum, review the answers to the posttest. After ensuring that each participant has provided his or her unique identifier on the posttest, collect the tests.	**PowerPoint Slide 2-25**  **Posttest** **Posttest Facilitator's Notes**
Seven: Evaluation—5 minutes	
Total Time: 1.5 hours	

Pretest



ID # _____–pre

Please answer true or false to the following questions:

1. School failure is a strong predictor of illegal behaviors.

   True ☐ or False ☐

2. Adults and adolescents with an FASD frequently experience trouble with the law and have disrupted school experiences.

   True ☐ or False ☐

3. The secondary disabilities study by Streissguth, et al. (1996) noted that shoplifting was often the first type of crime reported.

   True ☐ or False ☐

4. Youth with disabilities and/or mental health problems are less likely to get into trouble with the law.

   True ☐ or False ☐

5. A youth with a diagnosis of FAS is more at risk of getting into trouble with the law than a youth with another FASD.

   True ☐ or False ☐

6. Juveniles with learning disabilities are less likely to be arrested than juveniles without learning disabilities.

   True ☐ or False ☐

7. Youth with an FASD and IQ scores 70 or below were more likely to get into trouble with the law than youth with an FASD and IQ scores above 70.

   True ☐ or False ☐

Pretest Facilitator's Notes

Please answer true or false to the following questions:

1. School failure is a strong predictor of illegal behaviors.

   True ☐ or False ☐

   True: School failure is one risk factor consistently associated with delinquency, violence, and other illegal behaviors (Huizinga, et al., 2000).

2. Adults and adolescents with an FASD frequently experience trouble with the law and have disrupted school experiences.

   True ☐ or False ☐

   True: The 1996 secondary disabilities study found that a majority (60 percent) of adults and adolescents with an FASD experienced trouble with the law and had disrupted school experiences (Streissguth, et al., 1996).

3. The secondary disabilities study by Streissguth, et al. (1996) noted that shoplifting was often the first type of crime reported.

   True ☐ or False ☐

   True: Shoplifting was most often the first type of crime reported. Crimes against person (theft or burglary) were the most frequently reported offenses.

4. Youth with disabilities and/or mental health problems are less likely to get into trouble with the law.

   True ☐ or False ☐

   False: Experts in mental health and juvenile justice estimate that the rate of mental disorders among youth in the juvenile justice system is substantially higher than among the general population—possibly as high as 60 percent, compared to 22 percent in the general population of youth (Rotenberg, 1997).

5. A youth with a diagnosis of FAS is more at risk of getting into trouble with the law than a youth with another FASD.

   True ☐ or False ☐

   False: Because of his or her facial features and lower IQ, a youth with FAS is more likely than a youth with another FASD to be identified and to receive early intervention. As a result, a youth with FAS is actually less likely than a youth with another FASD to get into trouble with the law.

6. Juveniles with learning disabilities are less likely to be arrested than juveniles without learning disabilities.

   True ☐ or False ☐

   False: Those who have learning disabilities are 200 percent more likely to be arrested because they lack avoidance strategies. They can lack the ability to predict or understand the consequences of the behavior and are less likely to discern how, when, and with whom to talk.

7. Youth with an FASD and IQ scores 70 or below were more likely to get into trouble with the law than youth with an FASD and IQ scores above 70.

   True ☐ or False ☐

   False: Youth with an FASD with IQ scores above 70 were more likely to get in trouble with the law.

Use this space for your notes.

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

Use this space for your notes.

Use this space for your notes.


Module 2: FASD
in the Juvenile Justice System
After completing this module, participants will be able to:
– Describe difficulties of individuals with disabilities within the juvenile justice system
– Explain why youth with an FASD may be more likely to come into contact with the juvenile justice system
– Examine issues faced by youth with an FASD in the juvenile justice system
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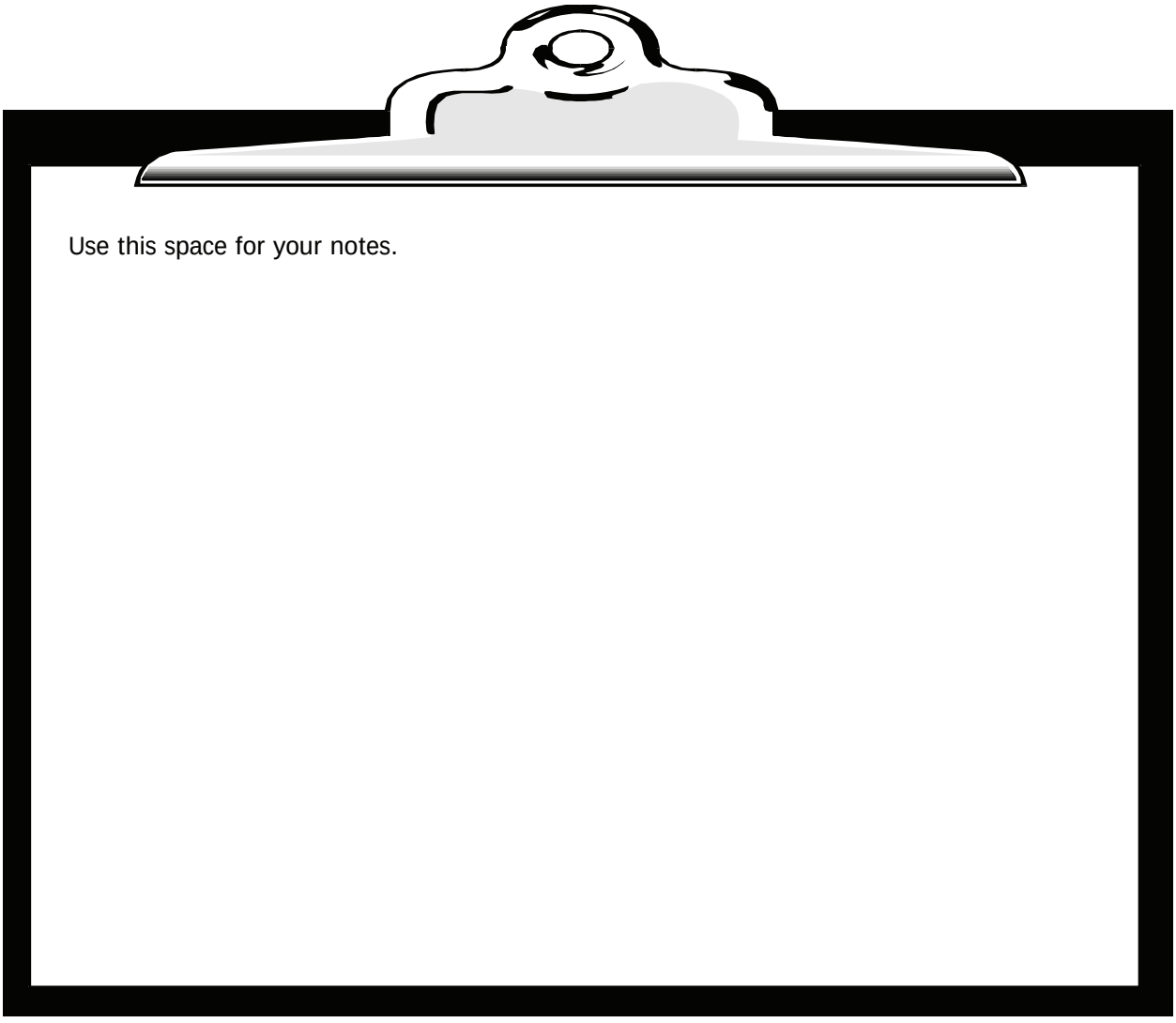
Fetal Alcohol Spectrum Disorders Center for Excellence
Module 2: FASD in the Juvenile Justice System
Slide 2-4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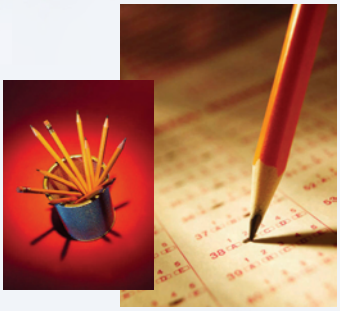
Pencils Out



Pretest!

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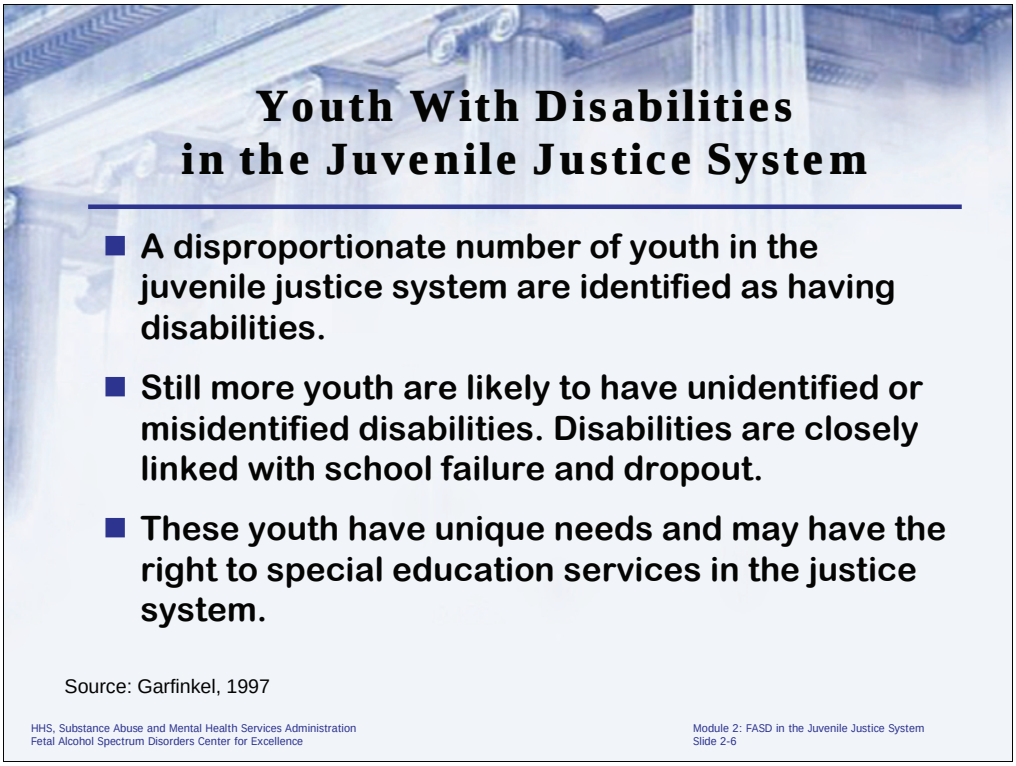
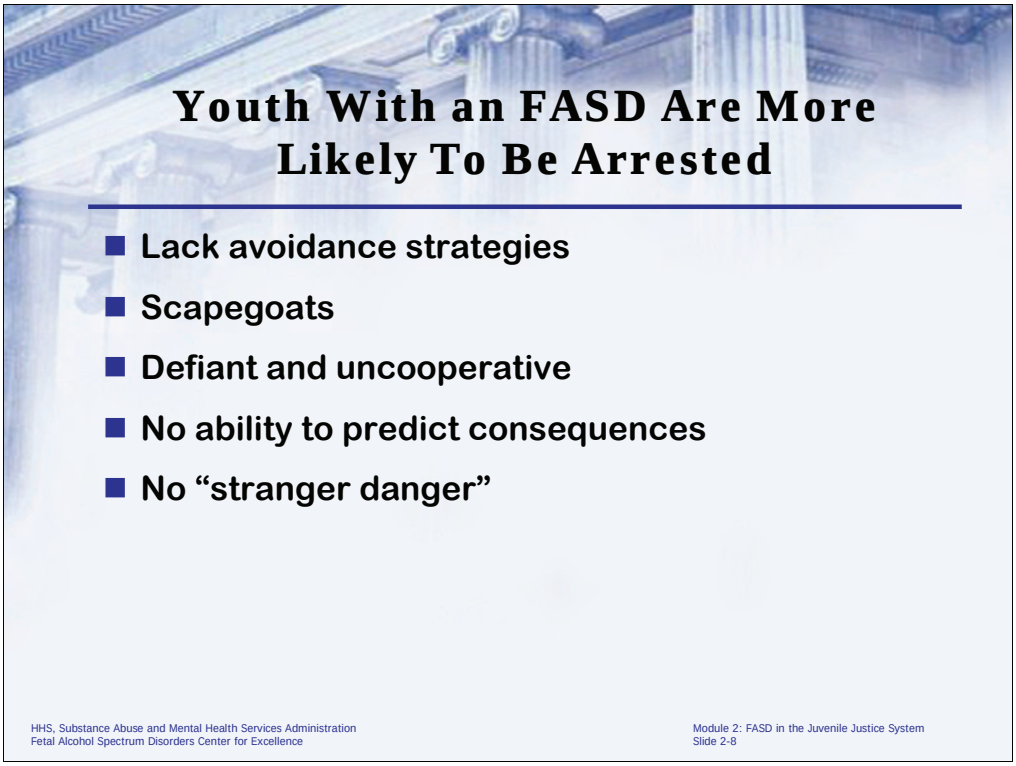


FACILITATOR'S TALKING POINTS:

- Experts in mental health and juvenile justice estimate that the rate of mental disorders among youth in the juvenile justice system is substantially higher than the rate among the general population—possibly as high as 60% compared to 22% in the general population of youth (Rotenberg, 1997).
- The prevalence of mental retardation among juvenile offenders is 13%, and the prevalence of a learning disorder among them is 36 to 53% (Boesky, 2002).
- Mental health problems and learning disabilities put these youth at extreme risk for not performing well in school. School failure is one risk factor consistently associated with delinquency, violence, and other illegal behaviors (Huizinga, et al., 2000).

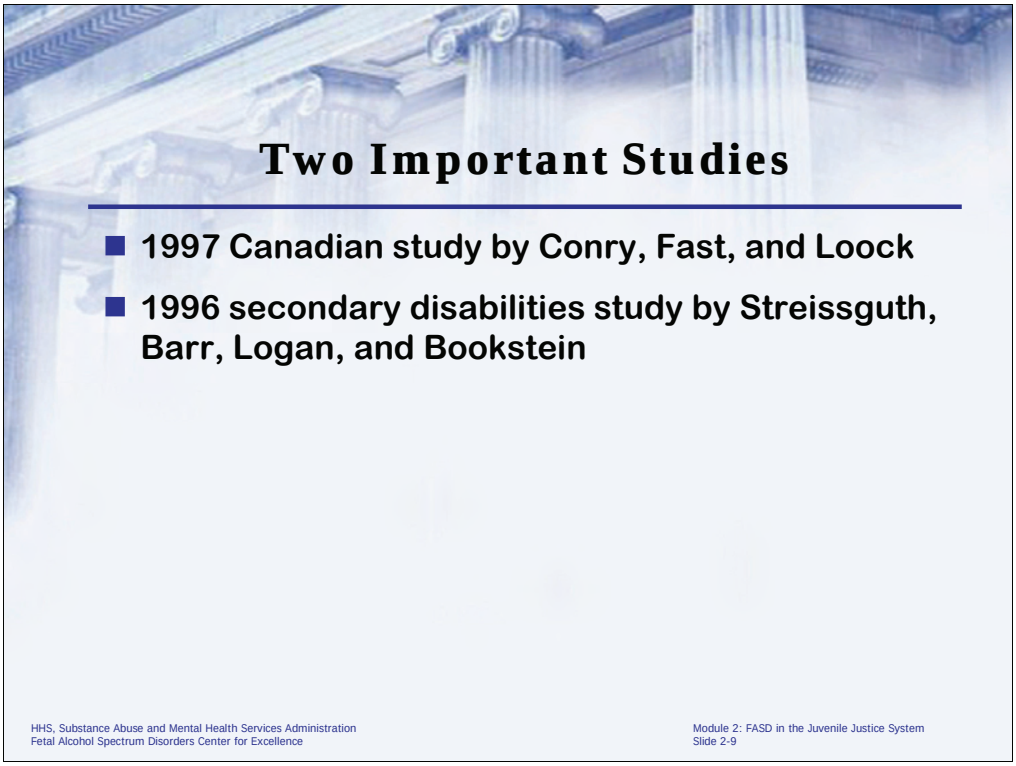
FACILITATOR'S TALKING POINTS:

- A 1998 paper by Dr. Nancy Cowardin explored the link between learning disabilities and engagement with the criminal justice system. Although the paper was related to learning disabilities in general, the discussion applies to youth with an FASD. The paper discussed reasons for differential treatment for youth with learning disabilities.
- When these youth are arrested, or are in court, they can be surly and belligerent, often because of impaired social perceptions and problem-solving abilities. This increases the likelihood of harsher punitive measures.
- Judges tend to be unaware of the learning disabilities in the youth before them. They usually do not question school reports or ask the school to identify underlying causes for failing grades or bad behavior. If they did this, it could result in identification and targeted remediation for youngsters with learning disabilities, since Federal law requires prisons to provide special education services to youth entering the system with an Individualized Educational Plan (IEP).
- If special education is not provided, these youth end up with the same basic remedial education that failed them before. They become trapped within a system that does not understand or respond to their needs.



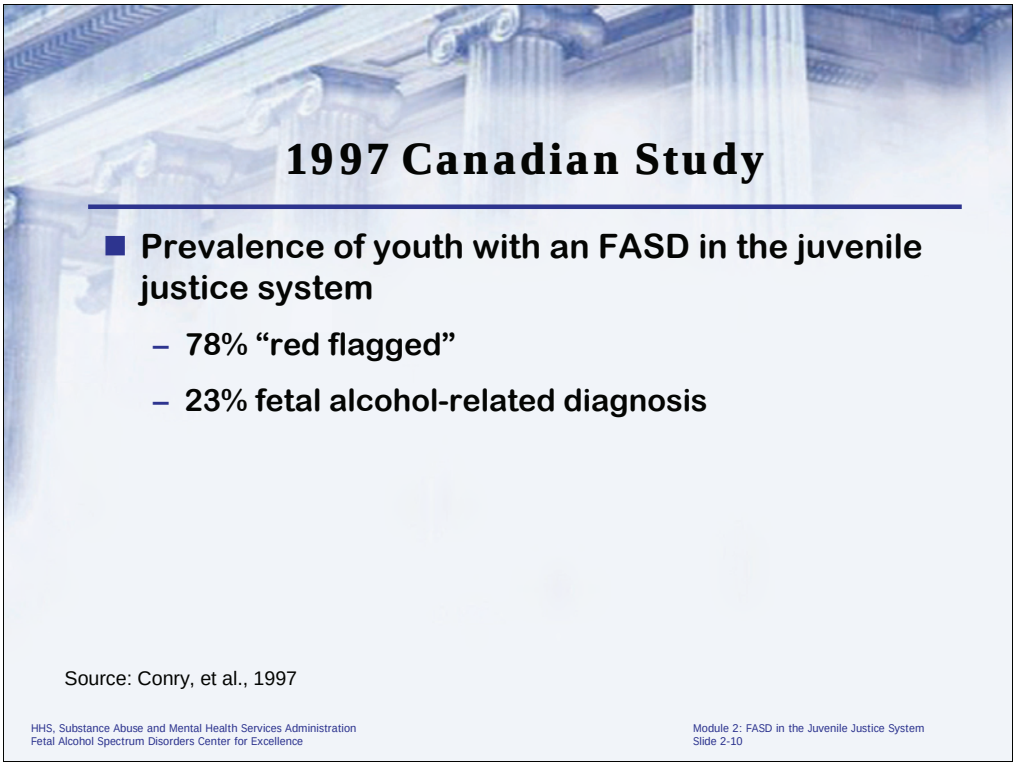
FACILITATOR'S TALKING POINTS:

- Youth with an FASD are more impulsive and their crimes are less planned; therefore, these youth are at a higher risk of getting caught.
- Typically, youth with an FASD lack avoidance strategies and often lack common sense. For example, a youth with an FASD will not know when to walk away from a potentially volatile situation.
- Because of their willingness to make friends at any price, they are often used as scapegoats.
- At the same time, youth with an FASD can be defiant and uncooperative. They can also appear to be uncooperative because they don't understand.
- "Cause and effect" perspectives can be spotty or absent from brain function, so they have limited ability to predict consequences or learn from past mistakes.
- They are also less capable of knowing how, when, and with whom to talk.



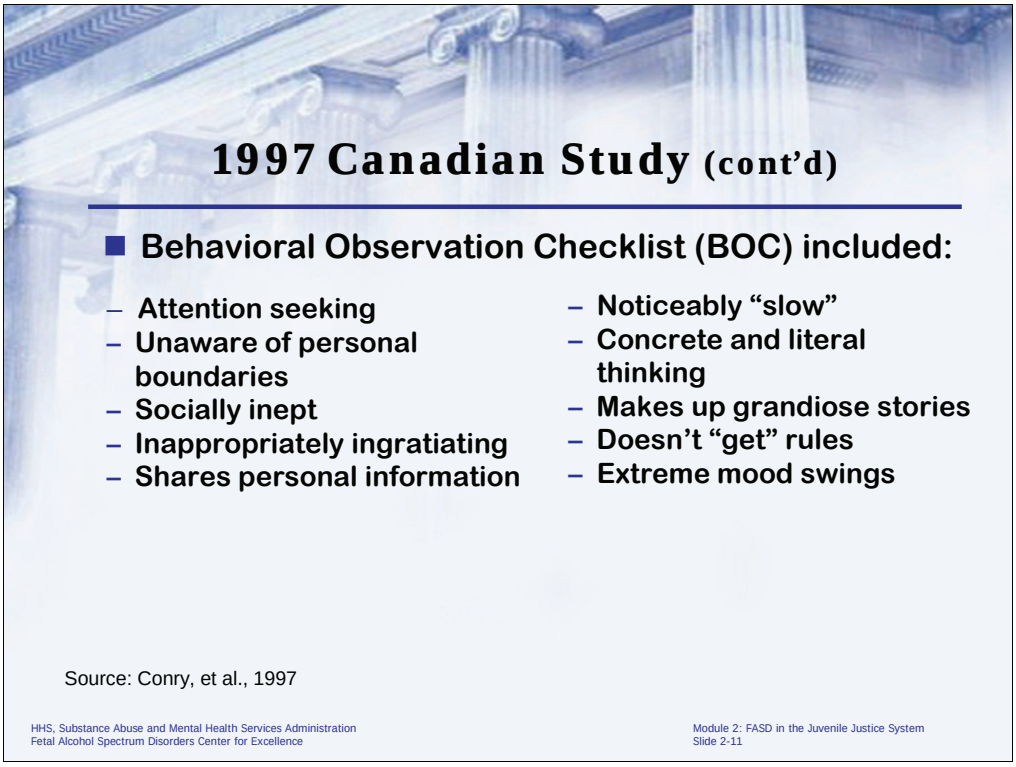
FACILITATOR'S TALKING POINTS:

- These are two important studies that have given us some good information to consider. The Canadian study gives us information comparing FASD and delinquent juveniles to other delinquent juveniles regarding scores of adaptive behavior and IQ. The secondary disabilities study shows us information on those with an FASD over time.
- We will first talk about the Canadian study.



FACILITATOR'S TALKING POINTS:

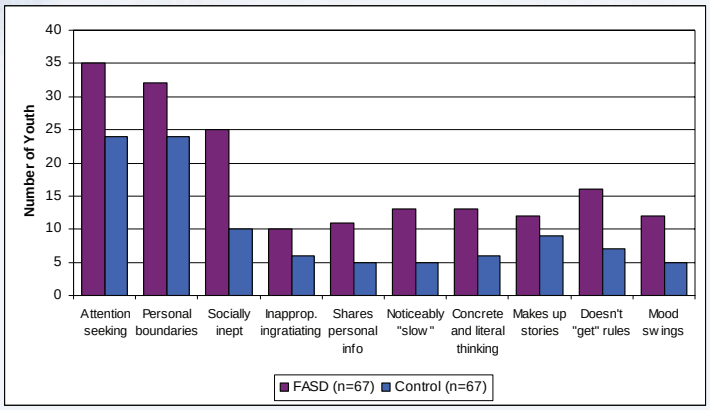
- Although there is substantial evidence suggesting a link between FASD and the risk of getting into trouble with the law, there is little research examining the prevalence of the disorder in either the adult criminal or juvenile justice system. One of the few studies, a 1997 Canadian study, examined all youth (N=287) remanded to the Inpatient Assessment Unit of Youth Court Services in Burnaby, British Columbia. They were assessed for a 1-year period (between 1995 and 1996).
- All youth had been referred to the unit for a psychiatric/psychological assessment.
- The youth were between the ages of 12 and 18 years old and had committed delinquent offenses.
- Staff used a screening checklist to flag youth for further review. Assessment included:
  - Physical exam
  - Psychiatric exam
  - Psychological exam
  - Social history
- Using the screening criteria, 224 (or 78%) of the youth were flagged for further review.
- Only seven youth initially screened positive on the basis of known maternal alcohol consumption during pregnancy, due to the difficulty of obtaining this information.
- Fetal alcohol-related diagnosis was made in 67 of these youth.



FACILITATOR'S TALKING POINTS:

- Although few studies have looked at youth with an FASD in the juvenile justice system, both the 1996 secondary disabilities study (Streissguth, et al., 1996) and the 1997 British Columbia, Canada, study (Conry, et al., 1997) provide important information to better understand youth with an FASD and their problems with the law.
- We will discuss these findings now.
- In conjunction with the other assessments, the staff at the Canadian juvenile facility completed a BOC that summarized the youth's behaviors.
- The BOC assessed youth in the above areas.

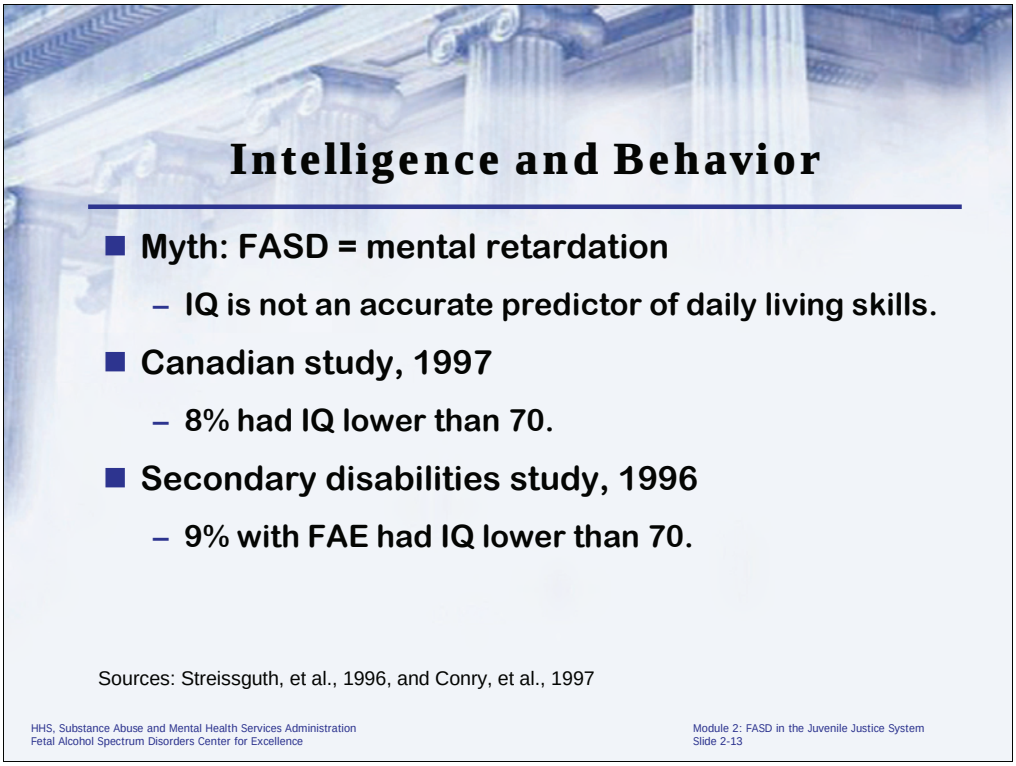
Problem Behaviors for Youth With an FASD and Controls (Canadian Study)



Source: Conry, et al., 1997

FACILITATOR'S TALKING POINTS:

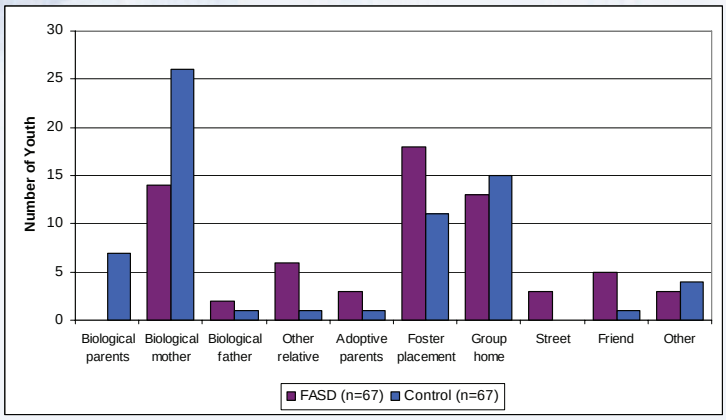
- The Canadian juvenile facility staff focused on the youth's adaptive/maladaptive behavior while in the unit.
- In nearly every category of problem behaviors measured, youth with an FASD exhibited more maladaptive behaviors than offenders who were not affected.
- The most frequently noted constellation of behaviors for the group with an FASD was related to attention seeking and socially inappropriate behavior that would provoke other youth.



FACILITATOR'S TALKING POINTS:

- One of the institutional markers used to measure central nervous system damage is IQ score. Many believe all people with an FASD have mental retardation. This is not true.
- In the secondary disabilities study, individuals with FAS had a mean IQ of 79 and individuals with FAE had a mean IQ of 90 (90 to 100 is considered average).
- What's important to note is that IQ is *not* an accurate predictor of daily living/coping skills.
- According to Fast, et al. (1999), "People with FAS/FAE are not always mentally handicapped, but still can have significant neurologically based learning and behavior difficulties."

Home Environment for Youth With an FASD vs. Controls (Canadian Study)



Source: Conry, et al., 1997

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Fetal Alcohol Spectrum Disorders Center for Excellence

Module 2: FASD in the Juvenile Justice System
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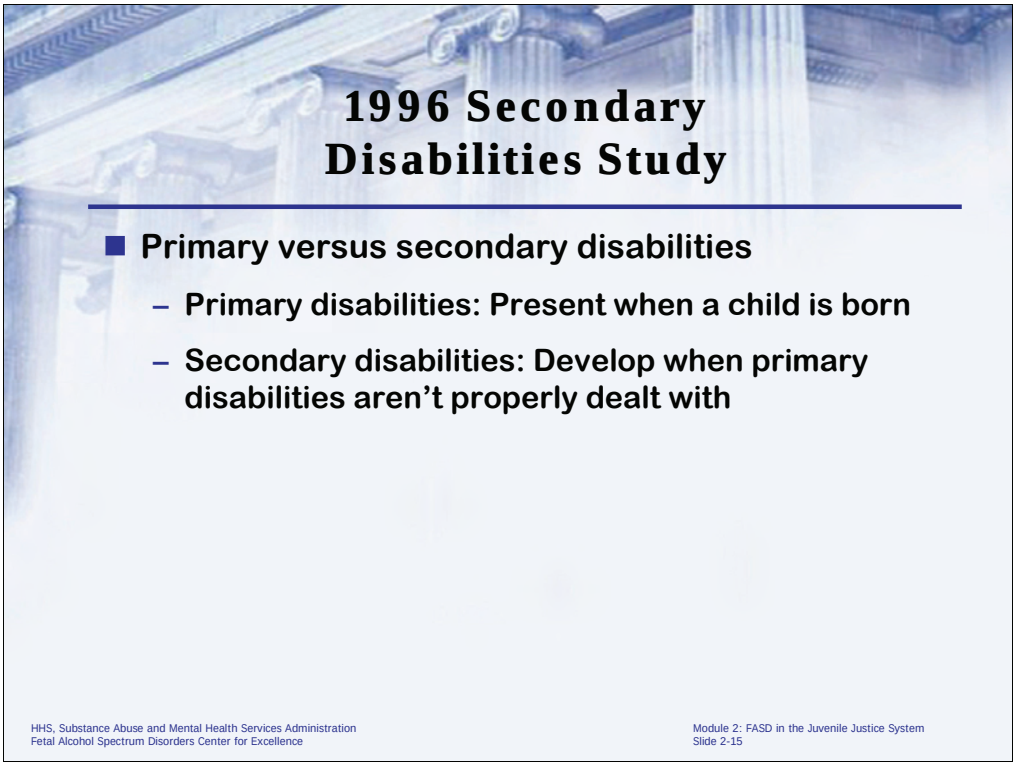
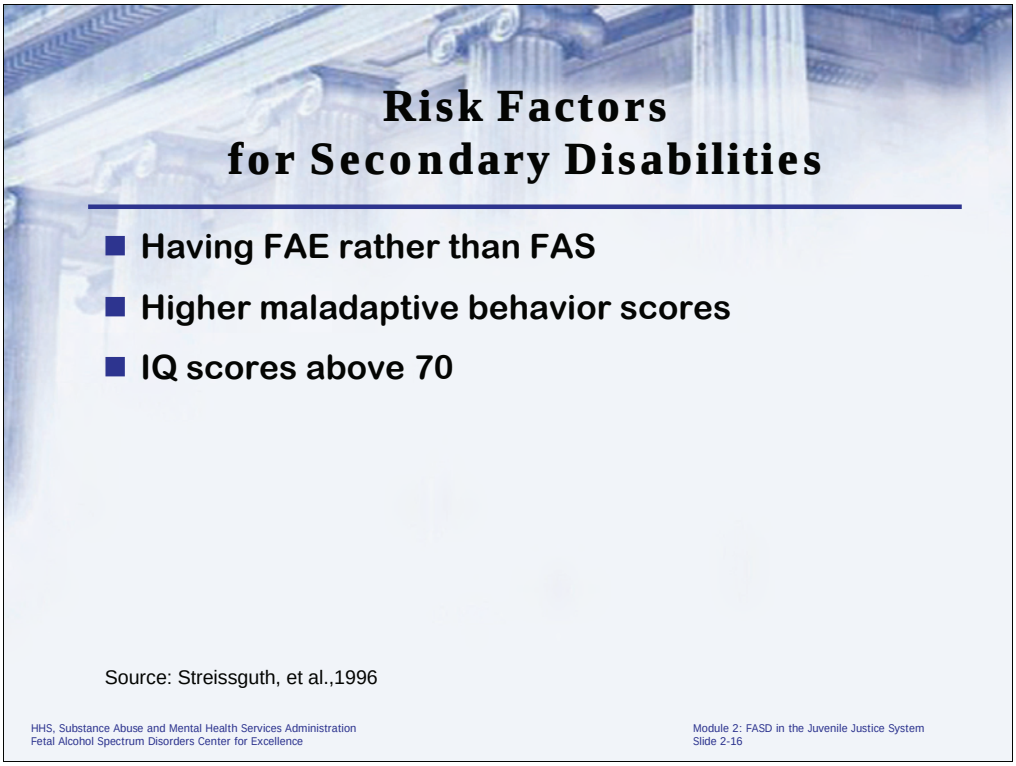
FACILITATOR'S TALKING POINTS:

- Canadian study.
- Of those who obtained a fetal alcohol-related diagnosis, none were living with *both* biological parents and most were in the care of a social service agency. About 45% had a legal status of "permanent ward."
- 73% had a history of emotional, physical, or sexual abuse.
- The home environment can contribute to how a youth with an FASD handles situations. For example, a youth living in an unstable home environment with few rules will have more disruptive behavior than a youth living in a structured home with rules.



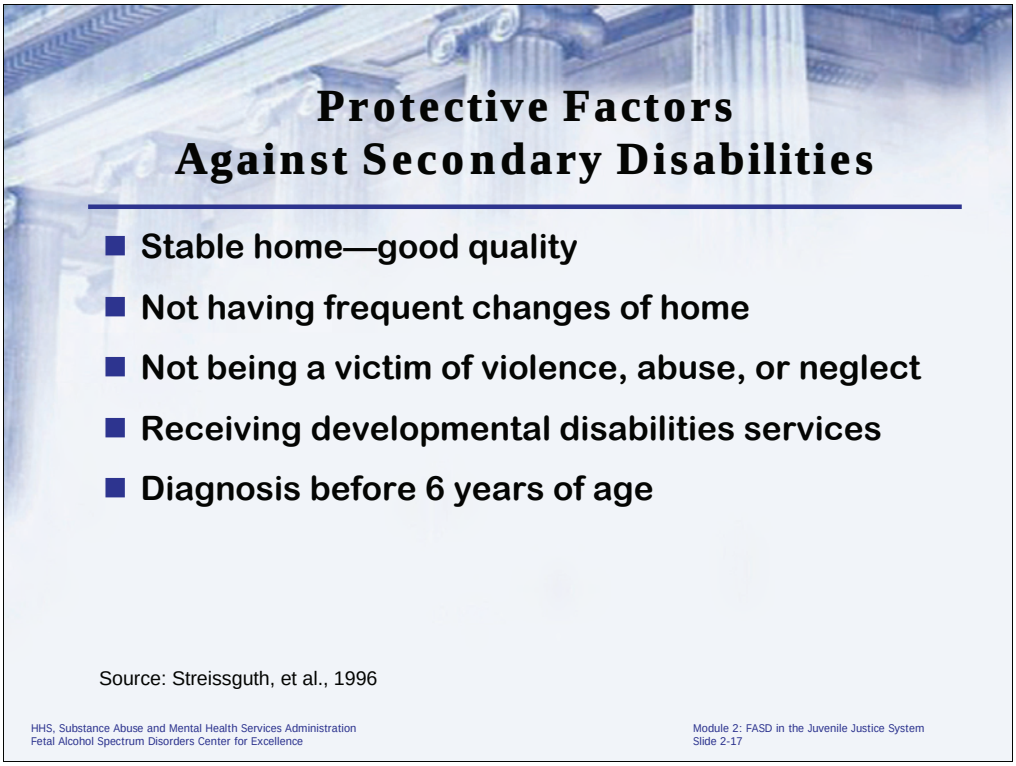
FACILITATOR'S TALKING POINTS:

- The 1996 secondary disabilities study (Streissguth, et al., 1996) describes the difference between primary disabilities and secondary disabilities.



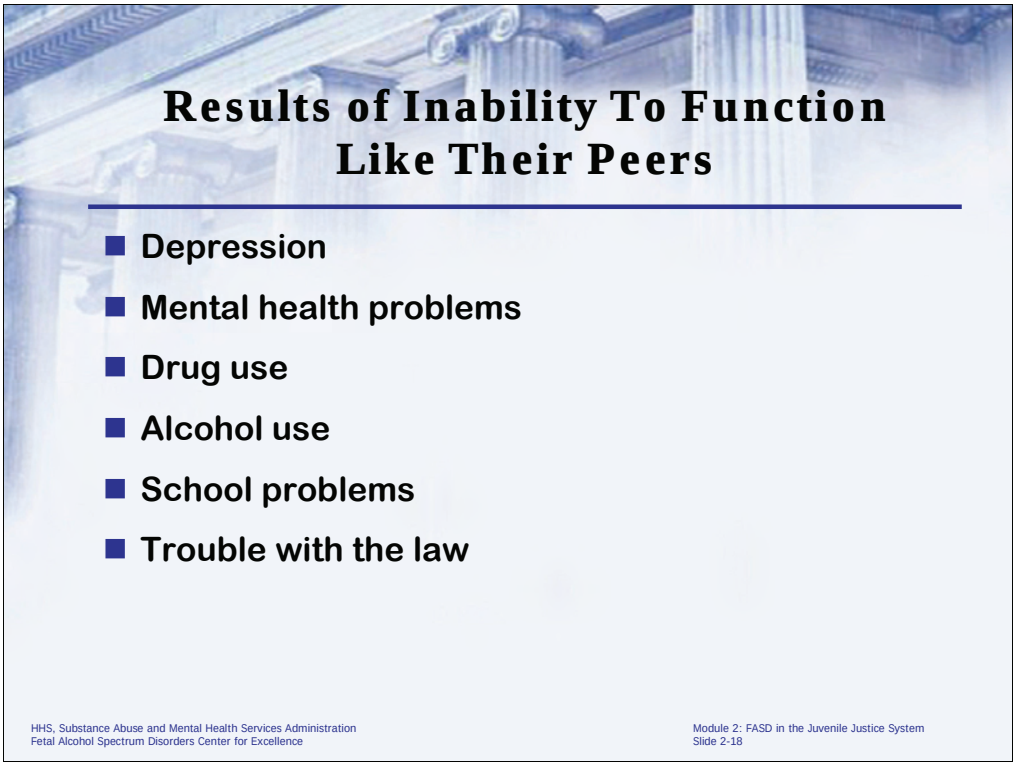
FACILITATOR'S TALKING POINTS:

- The risk factors were having FAE rather than FAS, higher maladaptive behavior scores, and IQ scores above 70. Having the more obvious FAS and lower IQ will generally increase the likelihood of detection and early intervention.
- Unfortunately, even the best parents and loving homes cannot prevent a child with an FASD from developing further problems. LaDue, et al. (1992) found that in day-to-day living, attentive parents in tightly structured homes were able to minimize but not eradicate problems. They assert, "Although a positive environment can minimize problems and an unstructured environment puts patients with FASD at even higher risk, a good home does not always prevent the psychosocial difficulties experienced by so many of these patients, particularly those who remained several years in alcoholic households as young children."



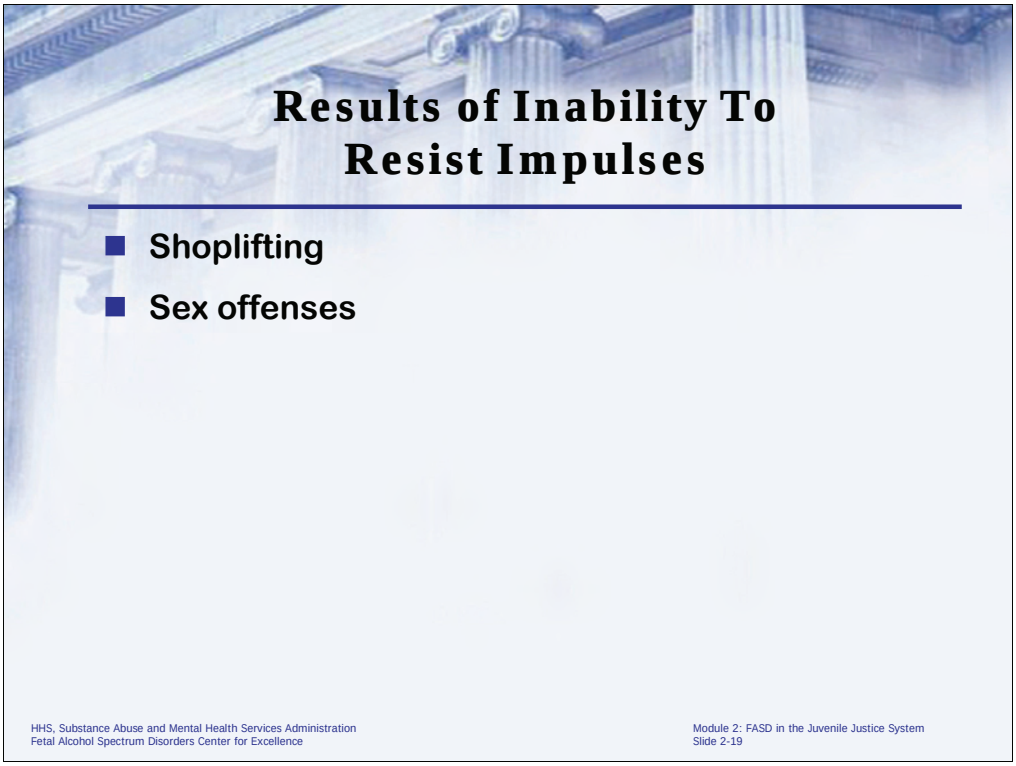
FACILITATOR'S TALKING POINTS:

- Not all youth with an FASD get into trouble with the law. Certain risk and protective factors can work to either buffer or exacerbate the effects of FASD.
- Streissguth's secondary disabilities study found that the main protective factors were the above.



FACILITATOR'S TALKING POINTS:

- Youth with an FASD often do not "fit in" with their peers. Since for most adolescents (with or without disabilities) the most important thing is to be accepted by others and to "fit in," being different can result in the above.
- Ann Streissguth's research suggests that secondary disabilities can be lessened or prevented with early intervention.



FACILITATOR'S TALKING POINTS:

- Youth with an FASD may exhibit poor judgment and lack the ability to anticipate consequences. This may make it difficult for them to resist impulses or say "no" to peers (or others) that may encourage illegal, dangerous, or inappropriate behavior.


Results of Poor Frustration Tolerance
Frequently getting into trouble
Behavior problems
Disorderly conduct
Offensive behavior
Leaving/running from home
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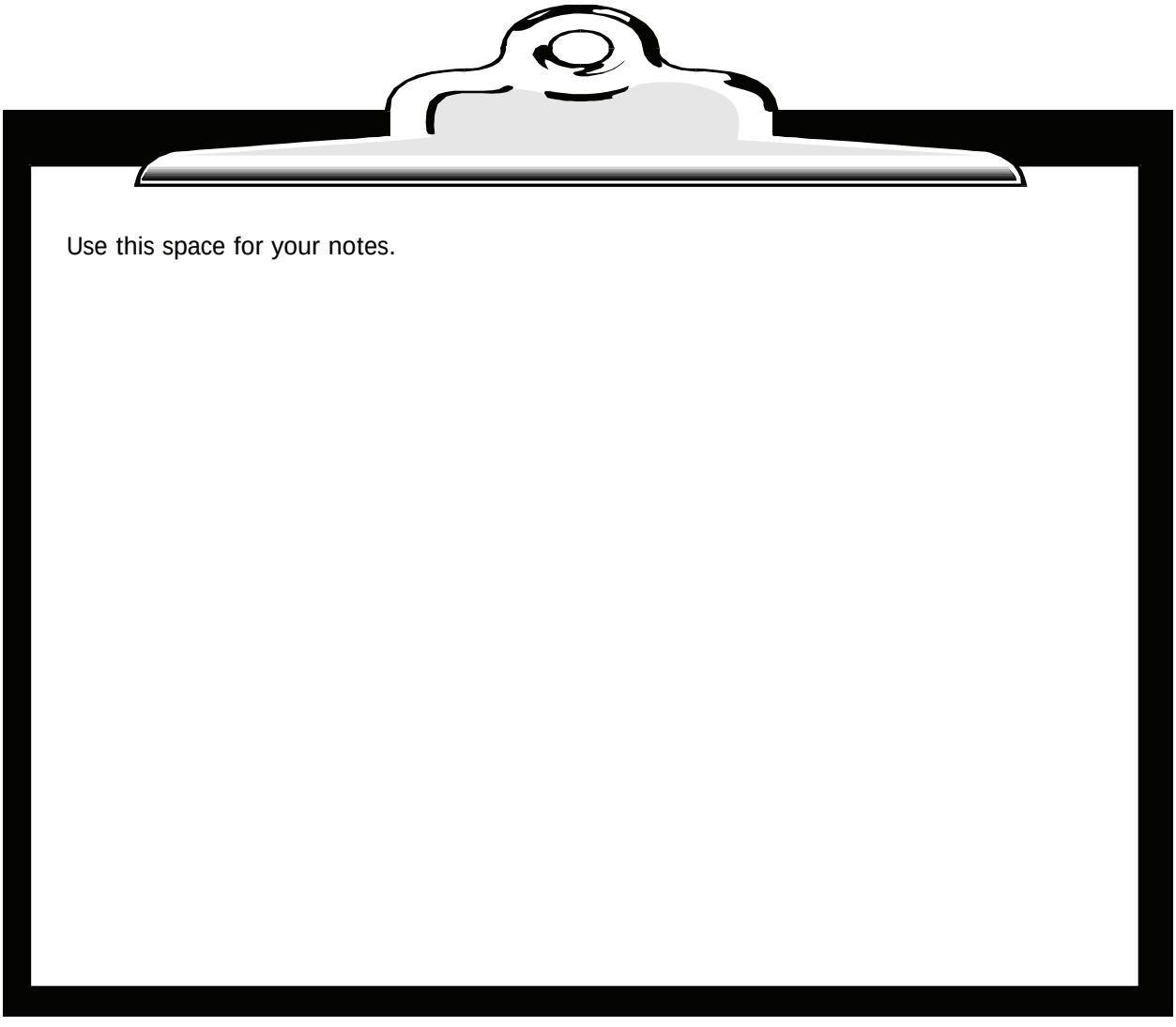
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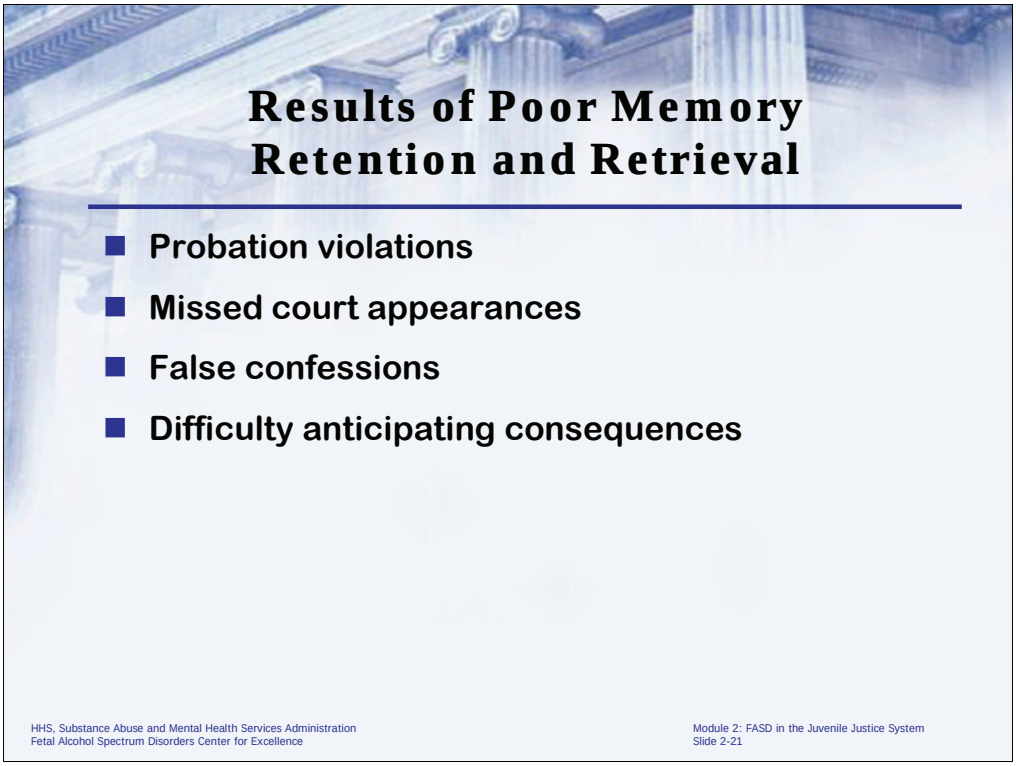
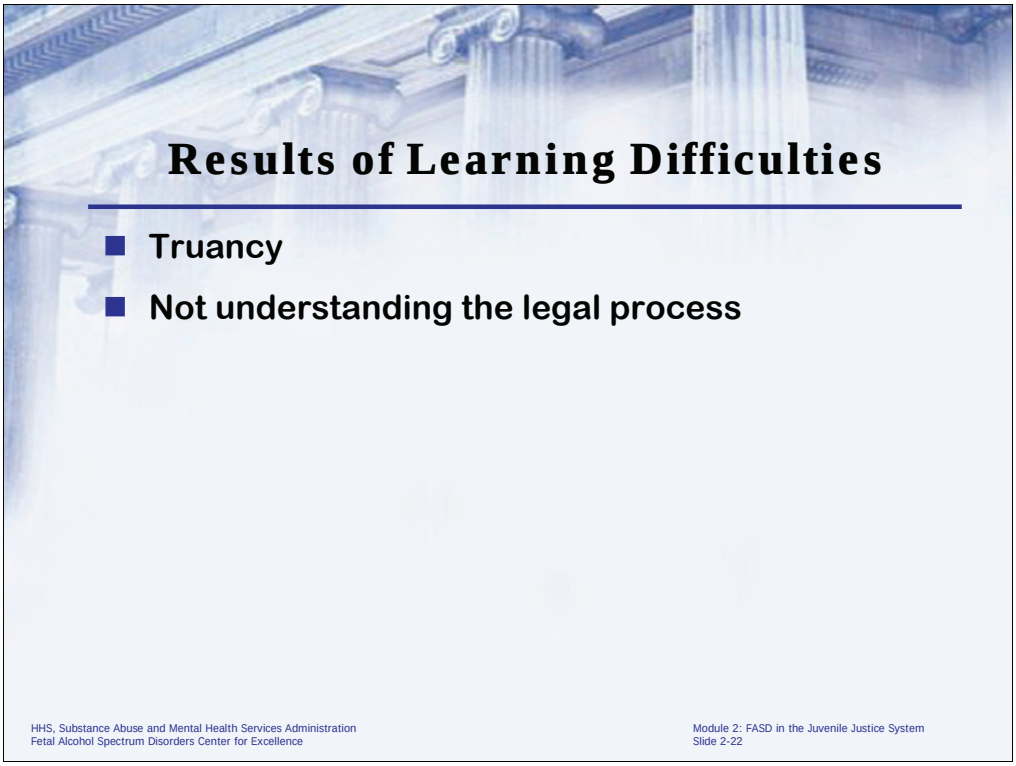


FACILITATOR'S TALKING POINTS:

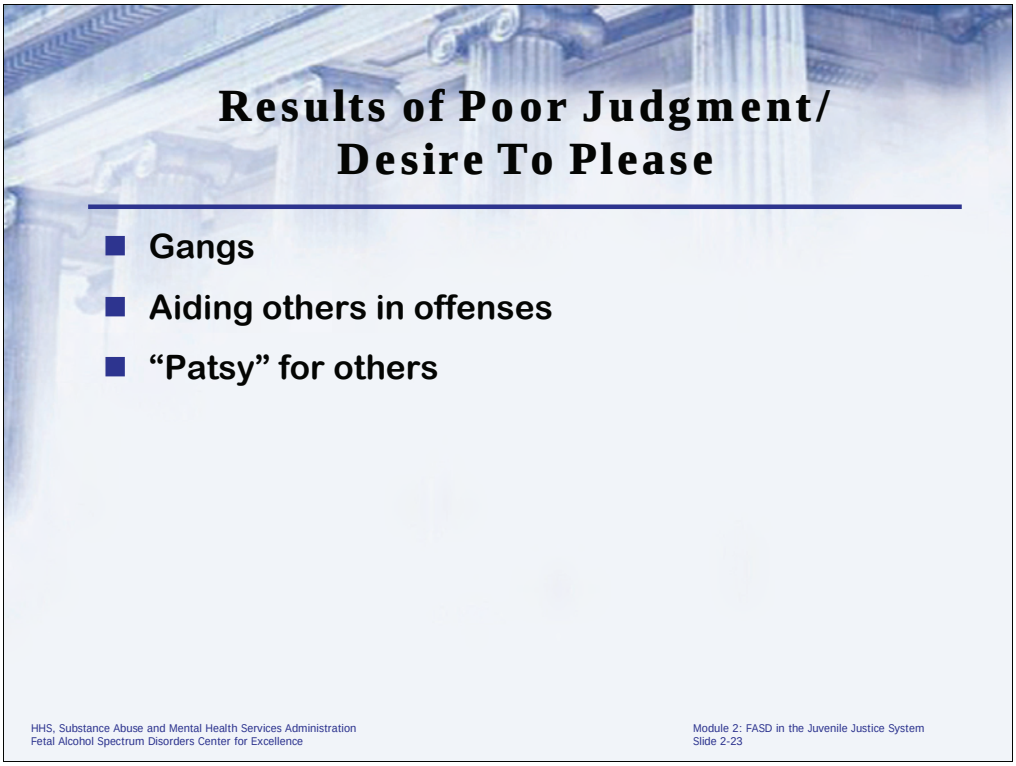
- Individuals with an FASD may experience problems resulting from an inconsistent and unreliable memory.
- Memory deficits may make it difficult to translate hearing into action.
- A slow cognitive pace may create a time lag from input to understanding to action.

Source: Better Endings New Beginnings, 2006



FACILITATOR'S TALKING POINTS:

- People with an FASD may experience learning difficulties associated—in part—with memory deficits, challenges in understanding abstractions (e.g., time, math, money), and problems generalizing, such as forming links between behaviors and consequences.



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See Activity 1 in the Activities section.

Questions

Posttest!

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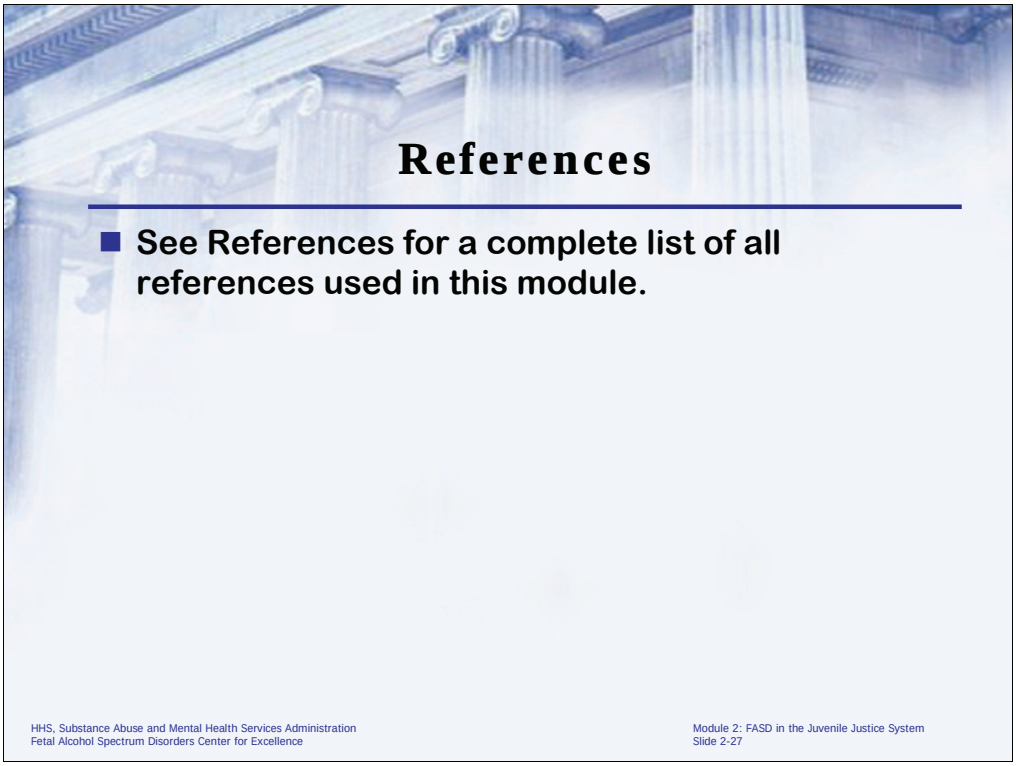
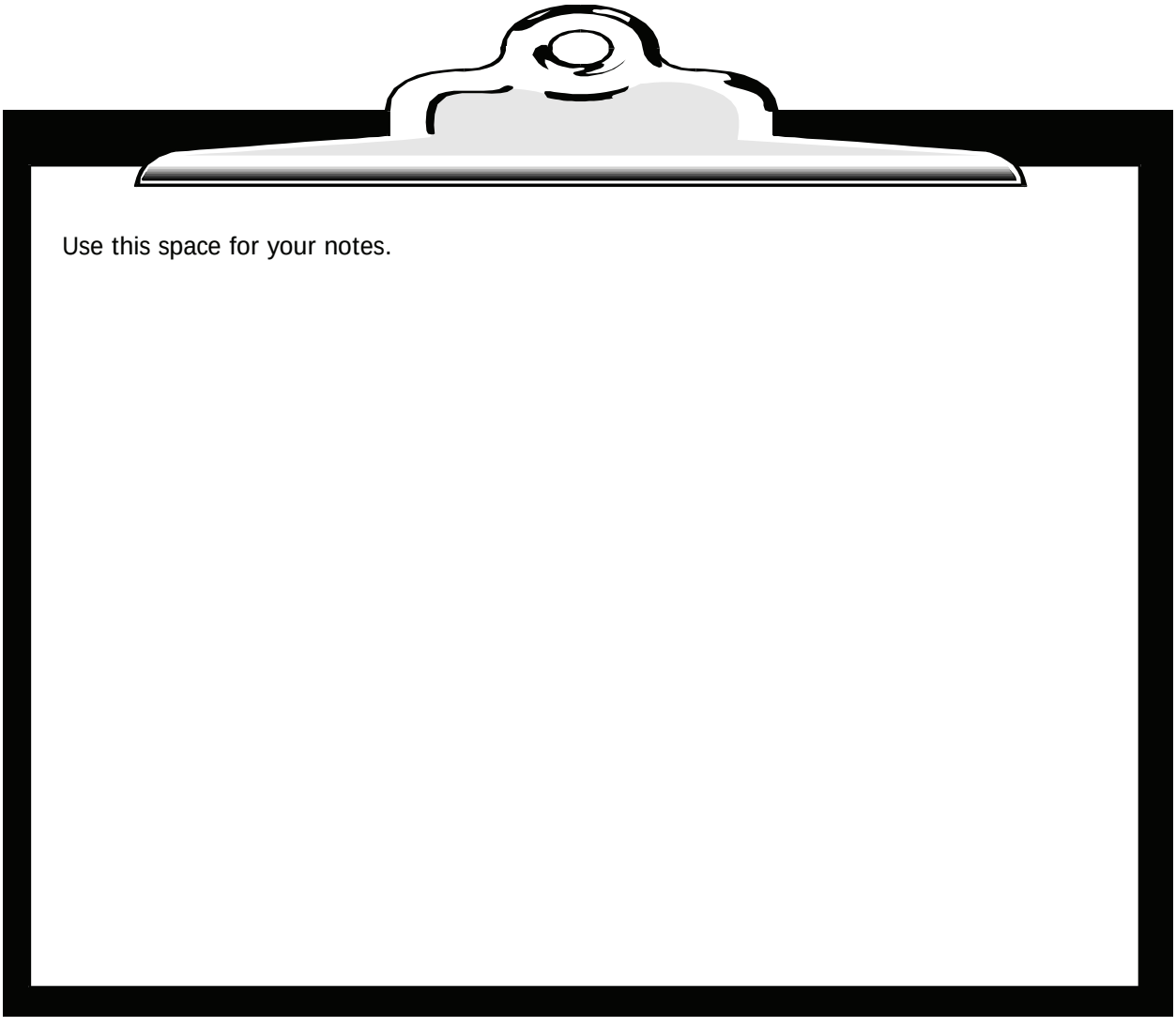

References
See References for a complete list of all references used in this module.
HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence
Module 2: FASD in the Juvenile Justice System
Slide 2-27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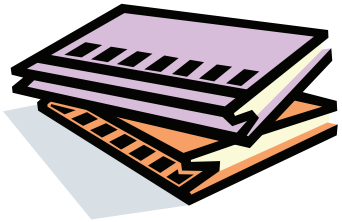


ID # _____–post

Please answer true or false to the following questions:

1. Adults and adolescents with an FASD frequently experience trouble with the law and have disrupted school experiences.

   True ☐ or False ☐

2. Youth with disabilities and/or mental health problems are less likely to get into trouble with the law.

   True ☐ or False ☐

3. School failure is a strong predictor of illegal behaviors.

   True ☐ or False ☐

4. Juveniles with learning disabilities are less likely to be arrested than juveniles without learning disabilities.

   True ☐ or False ☐

5. The secondary disabilities study by Streissguth, et al. (1996) noted that shoplifting was often the first type of crime reported.

   True ☐ or False ☐

6. Youth with an FASD and IQ scores 70 or below were more likely to get into trouble with the law than youth with an FASD and IQ scores above 70.

   True ☐ or False ☐

7. A youth with a diagnosis of FAS is more at risk of getting into trouble with the law than a youth with another FASD.

   True ☐ or False ☐

Posttest Facilitator's Notes

Please answer true or false to the following questions:

1. Adults and adolescents with an FASD frequently experience trouble with the law and have disrupted school experiences.

   True ☐ or False ☐

   True: The 1996 secondary disabilities study found that a majority (60 percent) of adults and adolescents with an FASD experienced trouble with the law and had disrupted school experiences (Streissguth, et al., 1996).

2. Youth with disabilities and/or mental health problems are less likely to get into trouble with the law.

   True ☐ or False ☐

   False: Experts in mental health and juvenile justice estimate that the rate of mental disorders among youth in the juvenile justice system is substantially higher than among the general population—possibly as high as 60 percent, compared to 22 percent in the general population of youth (Rotenberg, 1997).

3. School failure is a strong predictor of illegal behaviors.

   True ☐ or False ☐

   True: School failure is one risk factor consistently associated with delinquency, violence, and other illegal behaviors (Huizinga et al., 2000).

4. Juveniles with learning disabilities are less likely to be arrested than juveniles without learning disabilities.

   True ☐ or False ☐

   False: Those who have learning disabilities are 200 percent more likely to be arrested because they lack avoidance strategies. They can lack the ability to predict or understand the consequences of the behavior and are less likely to discern how, when, and with whom to talk.

5. The secondary disabilities study by Streissguth, et al. (1996) noted that shoplifting was often the first type of crime reported.

   True ☐ or False ☐

   True: Shoplifting was most often the first type of crime reported. Crimes against person (theft or burglary) were the most frequently reported offenses.

6. Youth with an FASD and IQ scores 70 or below were more likely to get into trouble with the law than youth with an FASD and IQ scores above 70.

   True ☐ or False ☐

   False: Youth with an FASD with IQ scores above 70 were more likely to get in trouble with the law.

7. A youth with a diagnosis of FAS is more at risk of getting into trouble with the law than a youth with another FASD.

   True ☐ or False ☐

   False: Because of his or her facial features and lower IQ, a youth with FAS is more likely than a youth with another FASD to be identified and to receive early intervention. As a result, a youth with FAS is actually less likely than a youth with another FASD to get into trouble with the law.

Activity 1–Think Outside the Box: What Would You Do Differently?

To be conducted during Slide 2-24

Slide 2-24

Tools needed:

Handout: "Gerry G." Scenario
Handout: "Youth With an FASD in the Juvenile Justice System"
Flip chart paper

Steps:

1. Break the participants into small groups of three to five people (depending on the size of the group). Have the participants count off to form groups (1, 2, 3, etc.).
2. Have groups choose a recorder and a reporter.
3. Distribute the "Gerry G." handout.
4. Have the small groups discuss what they would do differently to assist the youth.
5. Have the small groups report their ideas to the large group.
6. Write the participants' ideas on flip chart paper.
7. Distribute the "Youth With an FASD in the Juvenile Justice System" handout.

Activity 1—Think Outside the Box: What Would You Do Differently?—Scenario Handout

Gerry G.

Gerry is a 17-year-old male. Gerry's parents were known alcoholics who died in a car crash when Gerry was 3 years old. He was placed in an adoptive home with five younger adoptive siblings. Gerry had a history of mild behavioral problems that were managed by his parents using schedules; clear, concrete, and immediate positive and negative consequences; and a level system where Gerry could earn privileges.

Gerry was in special education programs and did well in these because the same type of structure was used in both his school and home environment. He was doing well until age 13, when his behavior began to deteriorate. At this time, two of Gerry's younger female siblings disclosed that he had sexually molested them several times in the past 6 months. Gerry also began to show severely violent behavior and to act out in school. His family had Gerry placed in a group home to protect his siblings.

He resided in this group home with constant supervision and monitoring, and his sexually aggressive behavior was contained. His acting out in school, poor impulse control, lying, stealing, and instigating behavior decreased but still remained a concern. Gerry was placed in therapy for sexually aggressive youths and participated, albeit reluctantly. He was able to be transitioned to a foster home with a single foster father and one other boy. However, the foster father in this home did not provide adequate supervision and structure. Due to serious concerns about Gerry's safety, he was returned to his original group home.

Gerry has had two legal charges placed against him, one for setting a fire to a garbage can at his group home and another for painting gang-related graffiti on a store near his group home. He served 3 months in detention for the first charge and has yet to be sentenced on the second. Gerry is approaching his 18th birthday. He has not had any reported sexual offending in the past 3 years. Since the store vandalism 2 months ago, he has not displayed any physically or verbally aggressive behavior. Therapy continued, and at this point Gerry is a far more active participant.

Activity 1–Think Outside the Box: What Would You Do Differently?–Resource Handout

Youth With an FASD in the Juvenile Justice System

1. Inability to function like their peers leads to:
   - Depression, mental health problems
   - Use of drugs, alcohol
   - School problems, trouble with the law
2. Inability to resist impulses leads to:
   - Shoplifting
   - Sex offenses
   - Inability to anticipate consequences
3. Poor frustration tolerance leads to:
   - Always getting into trouble
   - Behavior problems
   - Disorderly conduct, assaultive behavior
   - Leaving home without parent's permission
4. Poor memory retention and retrieval leads to:
   - Probation violations
   - Missed court appearances
   - False confessions
   - Difficulty anticipating consequences of actions
5. Learning difficulties lead to:
   - Truancy
   - Not understanding the legal process
6. Poor judgment/desire to please lead to:
   - Gangs
   - Aiding others in offenses
   - Patsy for others
7. Communication difficulties lead to:
   - False confessions
   - School problems
   - Relationship problems

Used with permission from Susan Carlson, JD (2001)

Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

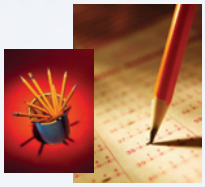
Module 2

FASD in the Juvenile Justice System

Module 2: FASD in the Juvenile Justice System

- After completing this module, participants will be able to:
  - Describe difficulties of individuals with disabilities within the juvenile justice system
  - Explain why youth with an FASD may be more likely to come into contact with the juvenile justice system
  - Examine issues faced by youth with an FASD in the juvenile justice system

Pencils Out



Pretest!

Youth With Disabilities in the Juvenile Justice System

- A disproportionate number of youth in the juvenile justice system are identified as having disabilities.
- Still more youth are likely to have unidentified or misidentified disabilities. Disabilities are closely linked with school failure and dropout.
- These youth have unique needs and may have the right to special education services in the justice system.

Source: Garfinkel, 1997

Treatment in the Juvenile Justice System

- Youth with undiagnosed disabilities receive harsher treatment at arrest, adjudication, and disposition
  - Often display disruptive, belligerent, and defiant behavior
  - Needs are not met when judges and other officials do not understand learning disabilities or know about FASD
  - Opportunities for remediation are lost

Youth With an FASD Are More Likely To Be Arrested

- Lack avoidance strategies
- Scapegoats
- Defiant and uncooperative
- No ability to predict consequences
- No “stranger danger”

Two Important Studies

- 1997 Canadian study by Conry, Fast, and Loock
- 1996 secondary disabilities study by Streissguth, Barr, Logan, and Bookstein

1997 Canadian Study

- Prevalence of youth with an FASD in the juvenile justice system
  - 78% "red flagged"
  - 23% fetal alcohol-related diagnosis

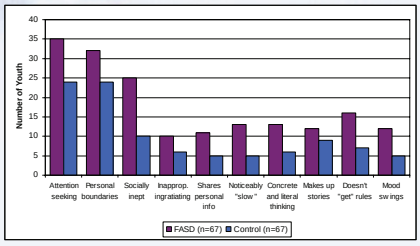
Source: Conry, et al., 1997

1997 Canadian Study (cont'd)

- Behavioral Observation Checklist (BOC) included:
  - Attention seeking
  - Unaware of personal boundaries
  - Socially inept
  - Inappropriately ingratiating
  - Shares personal information
  - Noticeably "slow"
  - Concrete and literal thinking
  - Makes up grandiose stories
  - Doesn't "get" rules
  - Extreme mood swings

Source: Conry, et al., 1997

Problem Behaviors for Youth With an FASD and Controls (Canadian Study)



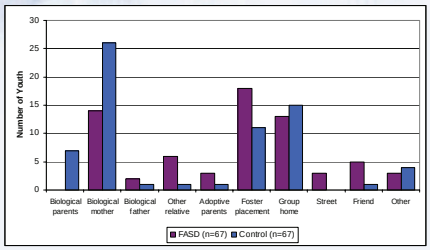
Source: Conry, et al., 1997

Intelligence and Behavior

- Myth: FASD = mental retardation
  - IQ is not an accurate predictor of daily living skills.
- Canadian study, 1997
  - 8% had IQ lower than 70.
- Secondary disabilities study, 1996
  - 9% with FAE had IQ lower than 70.

Sources: Streissguth, et al., 1996, and Conry, et al., 1997

Home Environment for Youth With an FASD vs. Controls (Canadian Study)



Source: Conry, et al., 1997

1996 Secondary Disabilities Study

- Primary versus secondary disabilities
  - Primary disabilities: Present when a child is born
  - Secondary disabilities: Develop when primary disabilities aren't properly dealt with

Risk Factors for Secondary Disabilities

- Having FAE rather than FAS
- Higher maladaptive behavior scores
- IQ scores above 70

Source: Streissguth, et al.,1996

Protective Factors Against Secondary Disabilities

- Stable home—good quality
- Not having frequent changes of home
- Not being a victim of violence, abuse, or neglect
- Receiving developmental disabilities services
- Diagnosis before 6 years of age

Source: Streissguth, et al., 1996

Results of Inability To Function Like Their Peers

- Depression
- Mental health problems
- Drug use
- Alcohol use
- School problems
- Trouble with the law

Results of Inability To Resist Impulses

- Shoplifting
- Sex offenses

Results of Poor Frustration Tolerance

- Frequently getting into trouble
- Behavior problems
- Disorderly conduct
- Offensive behavior
- Leaving/running from home

Results of Poor Memory Retention and Retrieval

- Probation violations
- Missed court appearances
- False confessions
- Difficulty anticipating consequences

Results of Learning Difficulties

- Truancy
- Not understanding the legal process

Results of Poor Judgment/ Desire To Please

- Gangs
- Aiding others in offenses
- "Patsy" for others

Results of Communication Difficulties

- False confessions
- School problems
- Relationship problems

Activity

Questions

Posttest!

References

- See References for a complete list of all references used in this module.

Module 3:
The Juvenile Justice System Response

Description

Summary

The third module provides a comprehensive overview of the steps the juvenile justice system takes in response to delinquent and maladaptive behavior. The lesson plan focuses on developing an understanding of the juvenile justice process and how it impacts youth with an FASD.

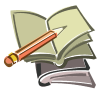
Objectives

After completing this module, participants will be able to:

- Identify juvenile justice issues facing youth with an FASD
- Describe the juvenile court process
- Discuss the importance of identification and assessment of FASD in youth in the juvenile justice system

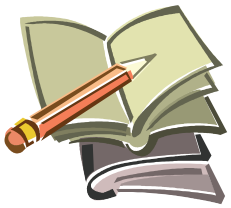
Facilitator's Outline

Step and Time	Tools Needed
One: Introduction—5 minutes	
You are presenting the *Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System*, a joint project of the Substance Abuse and Mental Health Services Administration (SAMHSA) Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence and the Minnesota Organization on Fetal Alcohol Syndrome. The FASD Center is a Federal initiative devoted to preventing and treating FASD. The Center's goals include advancing the field of FASD and promoting best practices. You may want to have participants introduce themselves, if time allows. Ask participants to state their backgrounds and interest in FASD. *Note: You do not need to do introductions if you combine modules—only conduct introductions at the beginning of a training session.*	
Two: Why We Are Here—5 minutes	
Discuss *Tools for Success*. *Tools for Success* focuses on assisting professionals who work with youth in the juvenile justice system who have an FASD to develop effective and appropriate interventions. It is designed for all correctional professionals, including advocates, attorneys, social workers, and social and human service providers who interact with children and families affected by FASD. *Tools for Success* contains seven modules: ■ Fetal Alcohol Spectrum Disorders (FASD): The Basics ■ FASD in the Juvenile Justice System ■ The Juvenile Justice System Response ■ Dispositional Options ■ Special Education and Behavior Management ■ Transition and Aftercare ■ Resources **2 minutes**	**PowerPoint Slide 3-1**

Step and Time	Tools Needed
Two: Why We Are Here (continued)	
Discuss Module 3: The Juvenile Justice System Response. The third module provides a comprehensive overview of the steps the juvenile justice system takes in response to delinquent and maladaptive behavior. The lesson plan focuses on developing an understanding of the juvenile justice process and how it impacts youth with an FASD. **2 minutes**	**PowerPoint Slide 3-2**
Discuss objectives for the module as indicated on PowerPoint Slide 3-3. **1 minute**	**PowerPoint Slide 3-3**
Three: Pretest—10 minutes	
Distribute the pretest and allow time for participants to complete it. After ensuring that each participant has provided a unique identifier on the pretest (see the Introduction), collect the tests. Do not review answers at this time.	**PowerPoint Slide 3-4** **Pretest** 
Four: PowerPoint Presentation—35 minutes	
Using PowerPoint presentation and facilitator talking points, provide overview on juvenile justice system, initial contact with police, questioning, arrest, etc., for individuals with an FASD.	**PowerPoint Slides 3-5 through 3-11**
Five: Police Arrest Recommendations Activity—15 minutes	
Follow directions for Activity 1—Police Arrest Recommendations. Distribute Handout: "Police Arrest Recommendations."	**PowerPoint Slide 3-12**  **Activity 1 sheets in curriculum** 

Step and Time	Tools Needed
Six: Miranda Warning Activity—15 minutes	
Follow directions for Activity 2—Miranda Warning. Distribute Handout: "Miranda Warning in the Eyes of Youth With an FASD."	**PowerPoint Slide 3-12**  **Activity 2** **sheets in curriculum** 
Seven: PowerPoint Presentation—10 minutes	
Using PowerPoint presentation and facilitator talking points, continue to discuss the issues related to juvenile court.	**PowerPoint Slides 3-13 through 3-24**
Eight: Develop Case Plan Activity—30 minutes	
Follow directions for Activity 3—Develop Case Plan. Distribute Scenario Handout: "Kattina." Distribute Scenario Handout: "Kattina: Resolution."	**PowerPoint Slide 3-25**  **Activity 3** **sheets in curriculum** 
Nine: PowerPoint Presentation—40 minutes	
Using PowerPoint presentation and facilitator talking points, continue to discuss the issues related to juvenile court.	**PowerPoint Slides 3-26 through 3-39**
Ten: Posttest—10 minutes	
Distribute the posttest and allow time for participants to complete it. Using the facilitator's notes in the curriculum, review the answers to the posttest. After ensuring that each participant has provided his or her unique identifier on the posttest, collect the tests.	**PowerPoint Slide 3-40**  **Posttest** **Posttest Facilitator's Notes**
Eleven: Evaluation—5 minutes	
Total Time: 3 hours	

Pretest



ID # _____–pre

Please answer true or false to the following questions:

1. It is important in conducting victim-offender mediation to remember that if the offender has an FASD, he or she may not remember the victim or the crime and may not be able to express remorse.

   True ☐ or False ☐

2. Youth with an FASD seldom confess to a crime.

   True ☐ or False ☐

3. All persons with an FASD, regardless of their comprehension ability, easily understand the Miranda warning.

   True ☐ or False ☐

4. Youth with an FASD often appear to be "competent" when they are really not.

   True ☐ or False ☐

5. A corrections professional has little ability to impact the life of an individual with an FASD.

   True ☐ or False ☐

6. The juvenile court system is structured the same way in each State and is part of the Federal court system.

   True ☐ or False ☐

7. Evaluation of both capacity and diminished capacity is a process anyone can administer.

   True ☐ or False ☐

Pretest Facilitator's Notes

Please answer true or false to the following questions:

1. It is important in conducting victim-offender mediation to remember that if the offender has an FASD, he or she may not remember the victim or the crime and may not be able to express remorse.

   True ☐ or False ☐

   True: This is very important to evaluate before using this type of diversion. The lack of the expression of remorse or connection may be more detrimental to the victim than an alternative form of justice.

2. Youth with an FASD seldom confess to a crime.

   True ☐ or False ☐

   False: Youth with an FASD often willingly confess to a crime, whether or not they are guilty. This stems from a high desire to please people in authority, a false sense of trust in those who are questioning, a need to cover up a memory gap, and a lack of understanding of what they are being asked.

3. All persons with an FASD, regardless of their comprehension ability, easily understand the Miranda warning.

   True ☐ or False ☐

   False: Individuals with an FASD may not be able to discern the meaning of their advice of rights and may not waive them voluntarily. Statements such as "exercise these rights" are confusing for a literal, concrete thinker.

4. Youth with an FASD often appear to be "competent" when they are really not.

   True ☐ or False ☐

   True: Whenever a youth with an FASD enters the juvenile justice system, the issue of competency should be considered. What is often lacking for these youth is a deeper understanding of the consequences of behavior and all possible outcomes.

5. A corrections professional has little ability to impact the life of an individual with an FASD.

   True ☐ or False ☐

   False: Professionals who work with juveniles have an opportunity to make a big impact on the direction a youth with an FASD is headed. Early diagnosis, coupled with strong interventions and insights, can prevent many secondary disabilities.

6. The juvenile court system is structured the same way in each State and is part of the Federal court system.

   True ☐ or False ☐

   False: The juvenile court is part of the judicial system in all 50 States and the District of Columbia. Each State's juvenile court system is unique.

7. Evaluation of both capacity and diminished capacity is a process anyone can administer.

   True ☐ or False ☐

   False: Determination of both capacity and diminished capacity will require an evaluation by an expert.

Use this space for your notes.

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

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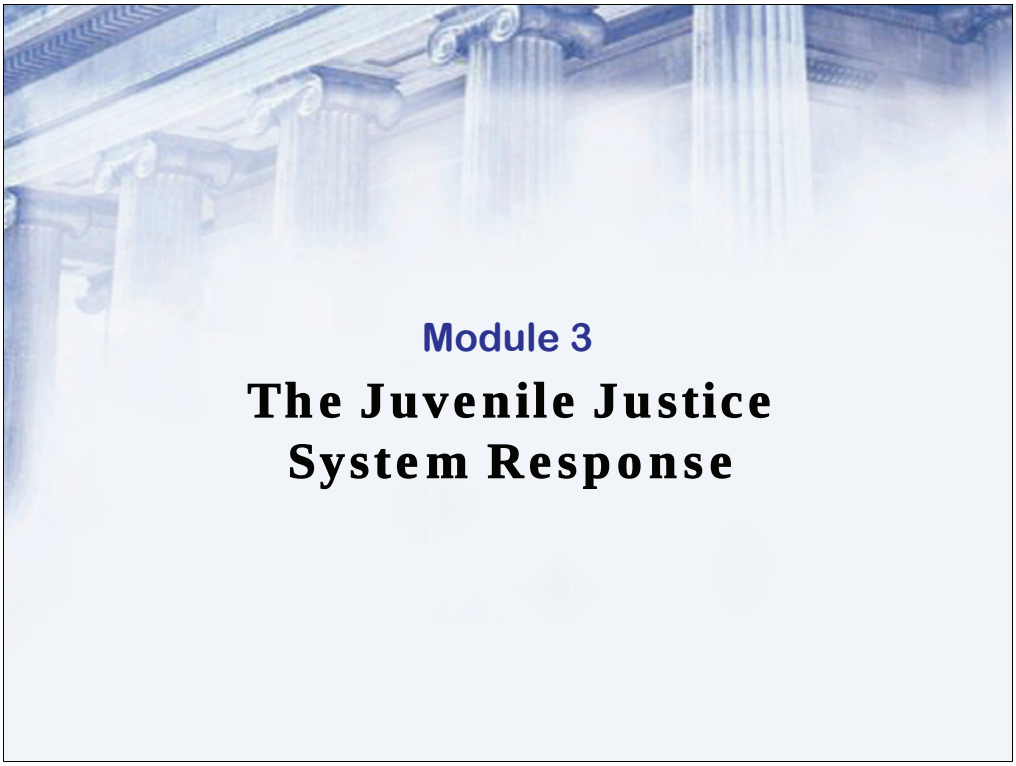

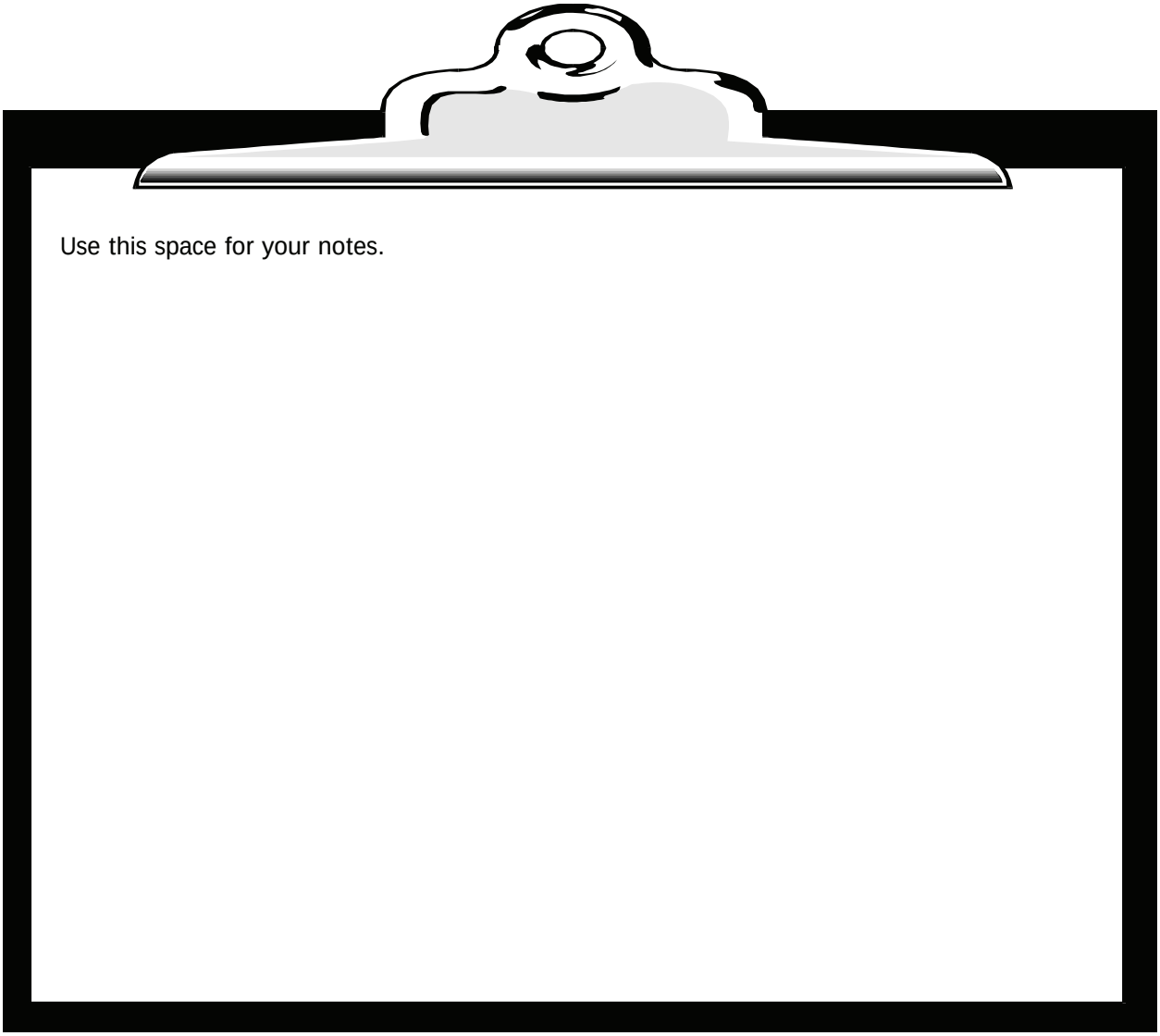

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Module 3: The Juvenile Justice System Response

- After completing this module, participants will be able to:
  - Identify juvenile justice issues facing youth with an FASD
  - Describe the juvenile court process
  - Discuss the importance of identification and assessment of FASD in youth in the juvenile justice system

HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence

Module 3: The Juvenile Justice System Response
Slide 3-4

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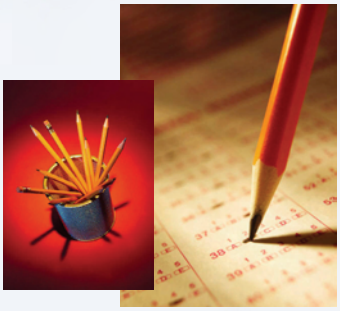
Pencils Out



Pretest!

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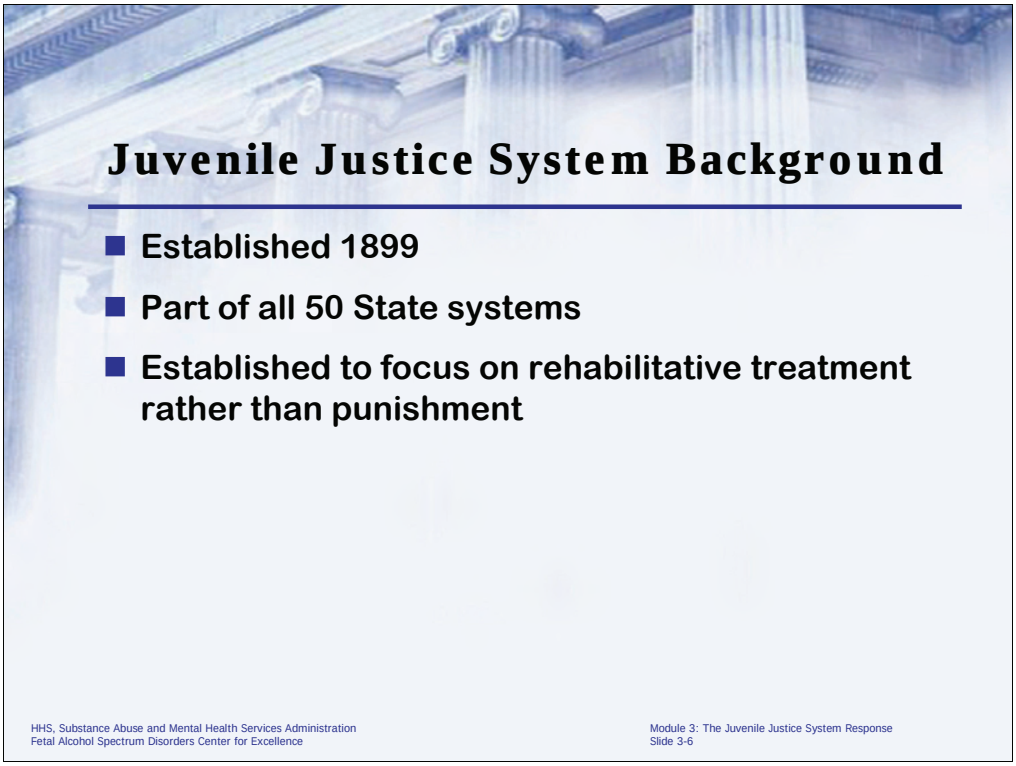
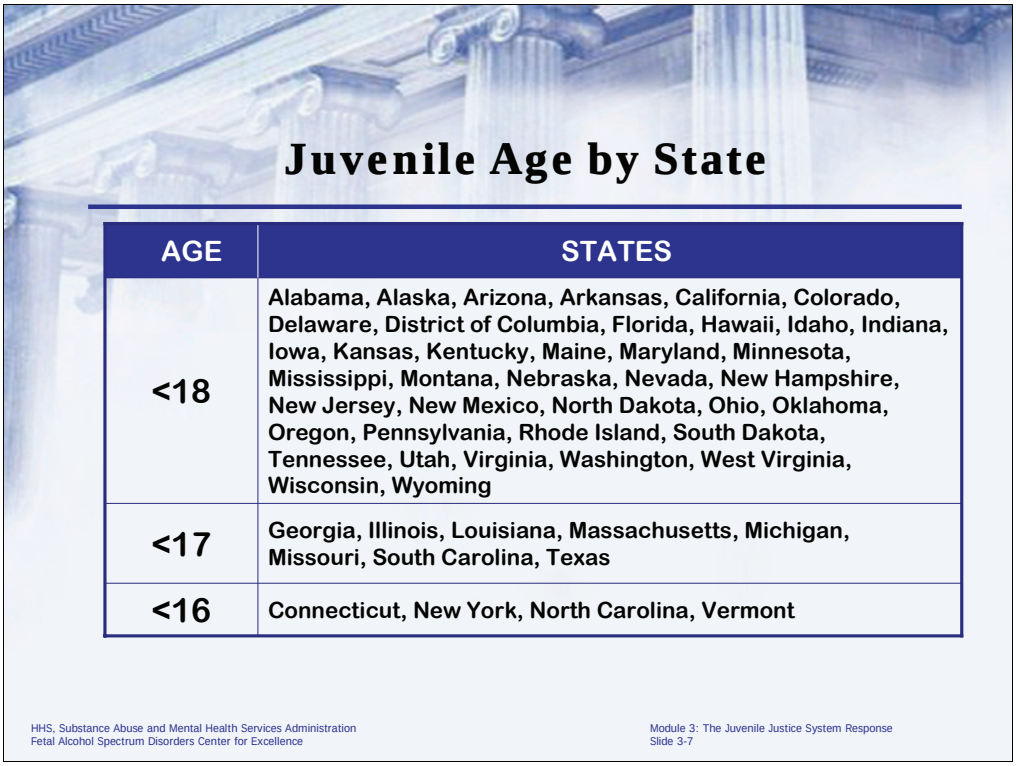


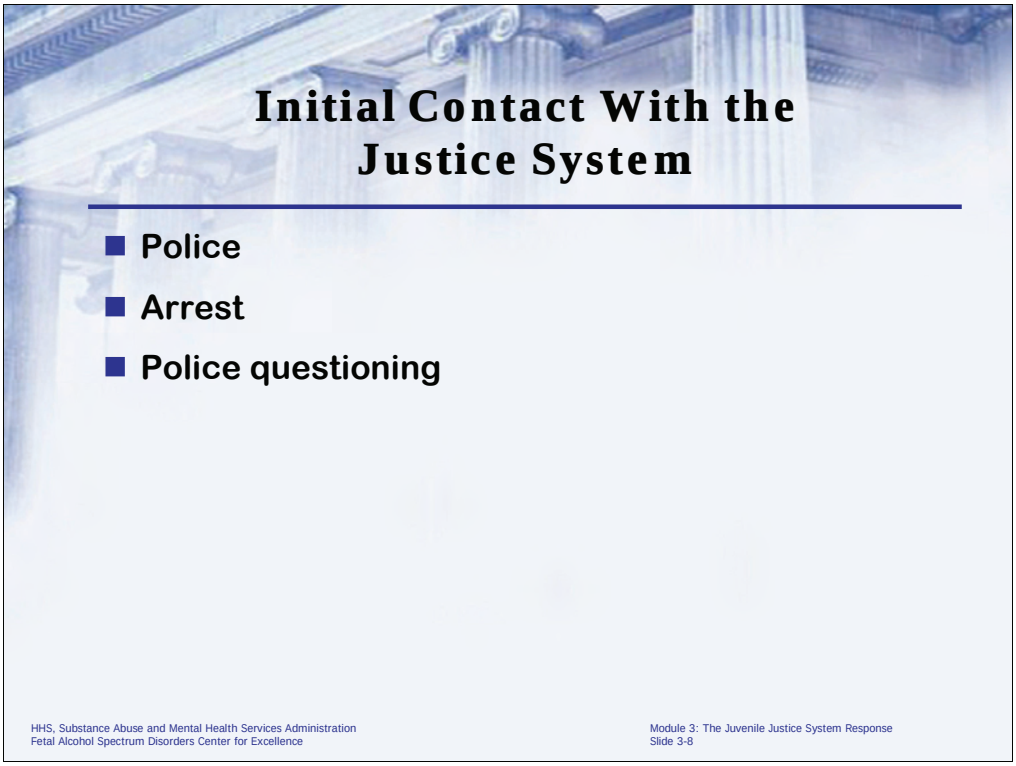
FACILITATOR'S TALKING POINTS:

- Juvenile court has been a part of the judicial system in all 50 States and the District of Columbia. Each court is unique in the way it is structured, but there are also substantial similarities.
- Juvenile court commonly hears cases involving the following:
  - Delinquency
  - Status offenders (runaways, truants)
  - Children and adolescents who have been abused, abandoned, or neglected
- Those in the juvenile justice system should have an understanding of FASD, special considerations needed, and appropriate interventions.
- There has been a trend over the years in making the juvenile justice system more like the adult system, for example, giving youth certain constitutional rights and trying more youth as adults.



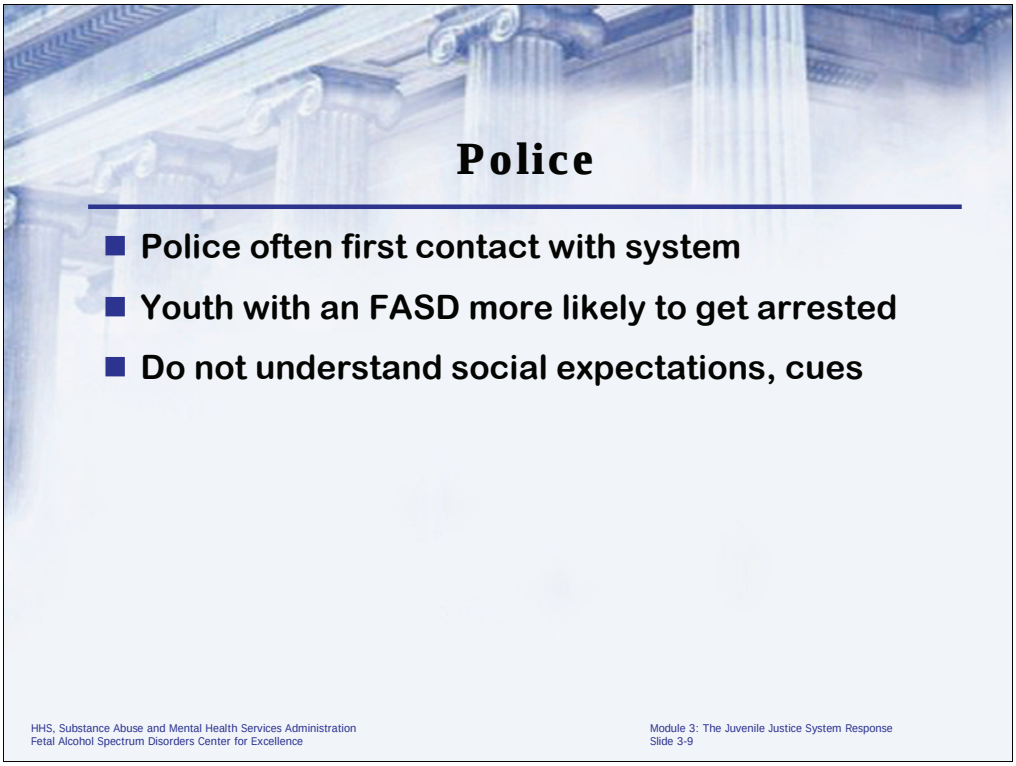
FACILITATOR'S TALKING POINTS:

- Compared with adult courts, juvenile courts have more limited sanctions that can be imposed, even for the most violent offenders. Sanctions by juvenile courts are limited by the juvenile's age.
- States vary in their age limits for original juvenile court jurisdiction. This table organizes the States by the juvenile's age.



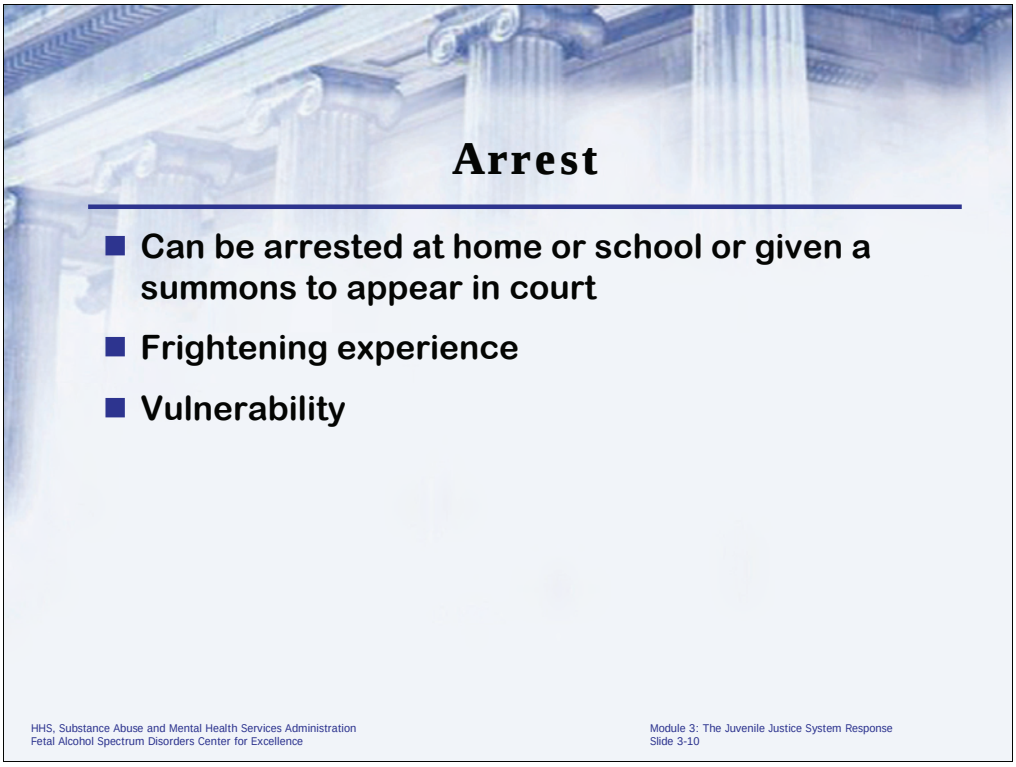
FACILITATOR'S TALKING POINTS:

- The initial contact point between a youth with an FASD and the juvenile justice system is critical to positive outcomes.
- Understanding FASD is essential in knowing how to deal with these youth.



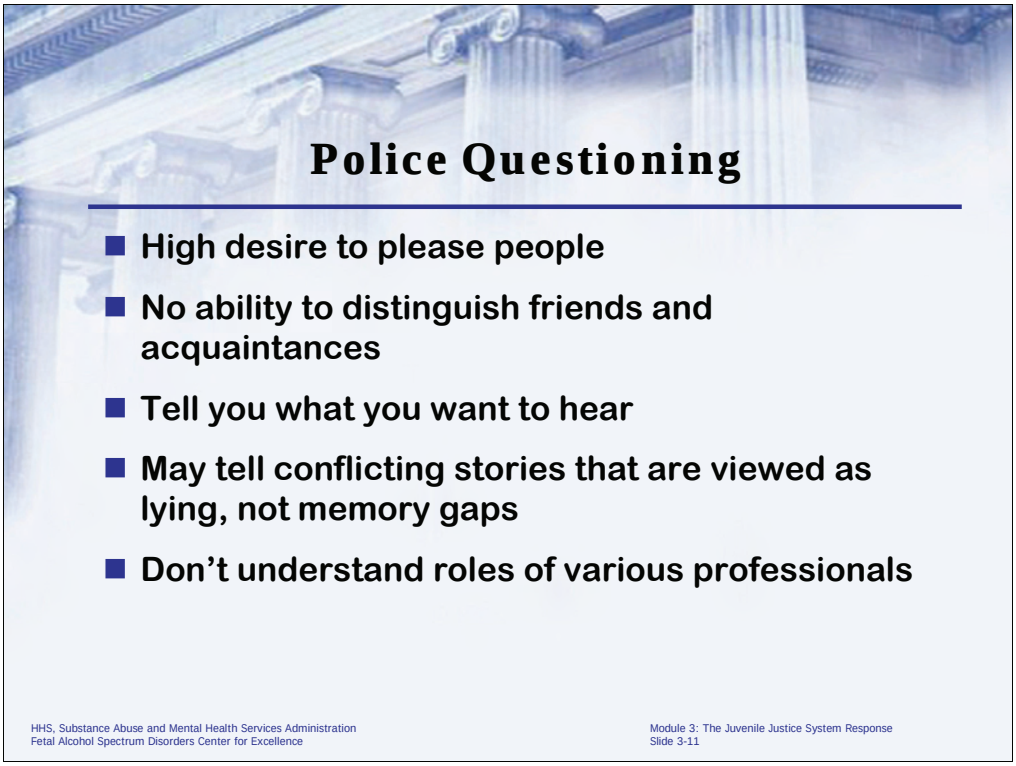
FACILITATOR'S TALKING POINTS:

- The first offense is often shoplifting or breaking curfew. A youth with an FASD may be more likely to be arrested because he or she may not understand "unwritten rules," such as politely responding to authority figures.



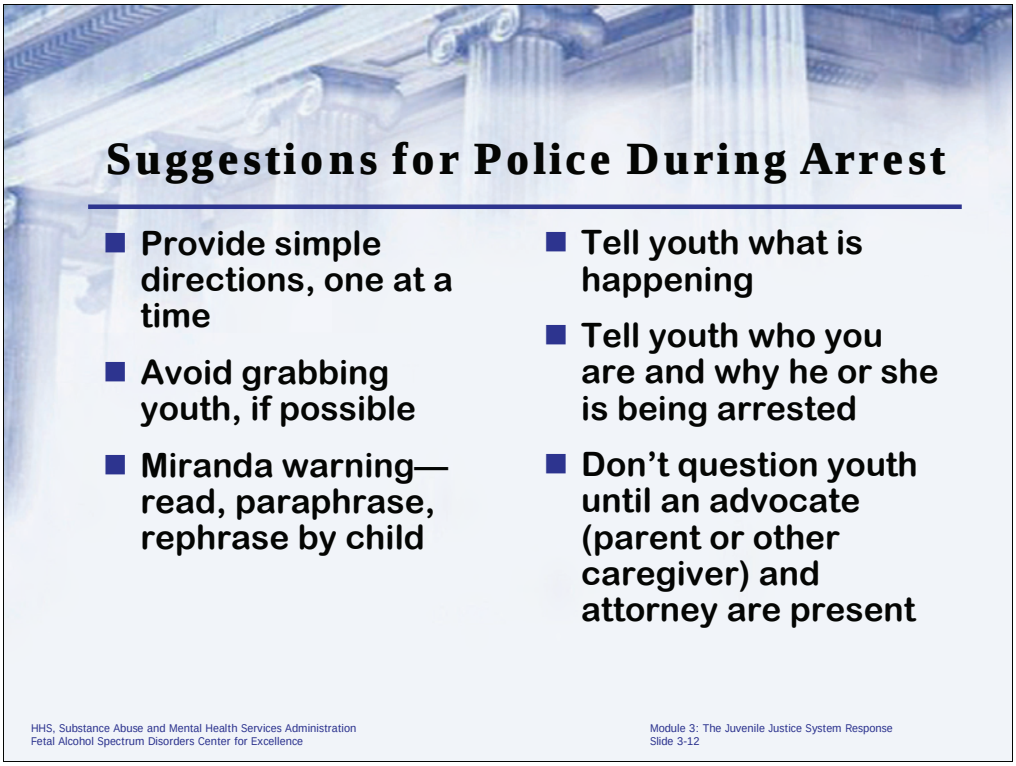
FACILITATOR'S TALKING POINTS:

- A child with an FASD when frightened or confused may have outbursts and lack insight into the situation.
- He or she may be willing to say or do anything and may not be aware of the seriousness of the situation.
- After an arrest is made, the child is generally brought to a detention center.
- During the arrest, a youth with an FASD can be very vulnerable and prone to volatile behavior due to fear, stress, and confusion.



FACILITATOR'S TALKING POINTS:

- Youth with an FASD often want to please people and will say what they think you want to hear.
- Youth with an FASD may tell conflicting stories because of poor recall, memory, and articulation skills.
- Youth with an FASD can be "too" trustful and may not be able to identify who is a stranger and who is a friend; who is safe and who is not. They may not understand everyone's role in the situation (lawyers, judges, probation officers, advocates, etc.) or how they should behave.



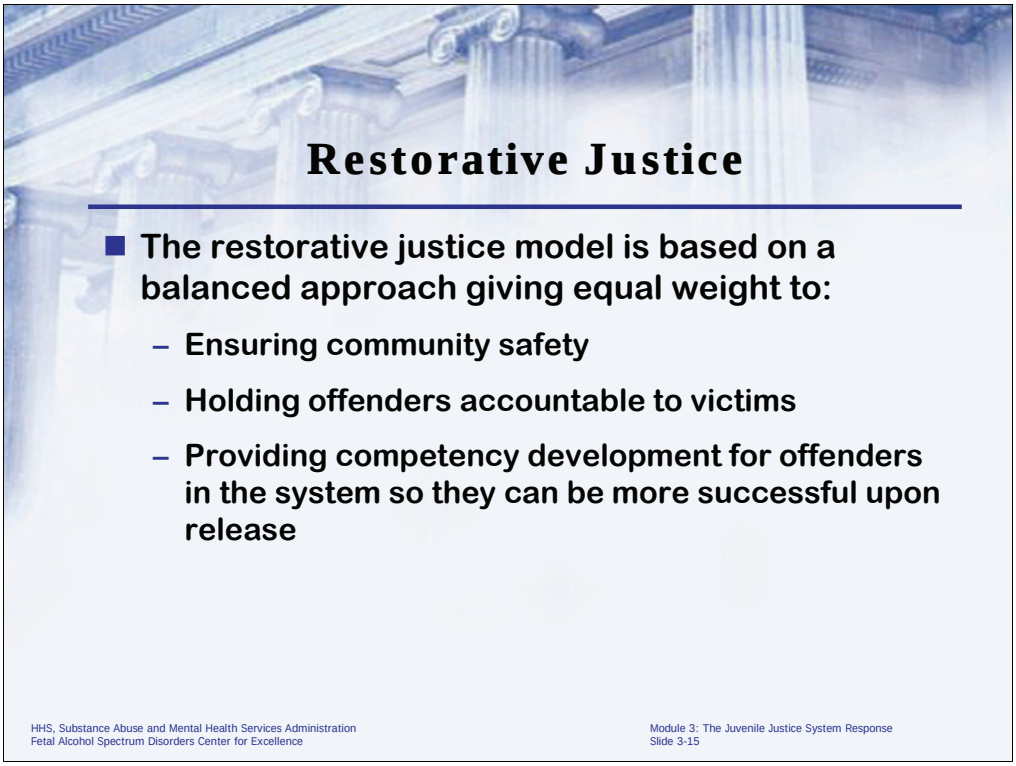
FACILITATOR'S TALKING POINTS:

- Youth with an FASD can only take in one thing at a time. Multiple instructions may confuse them, and they will not be able to comply.
- Youth with an FASD often have sensory issues; they can be very sensitive to touch and become defensive.
- Whenever possible, tell the youth verbally what you are doing (e.g., "I am putting on your handcuffs now").
- Youth with an FASD can have poor recall. They will make up information or agree with you to fill in the holes in their memory.
- The Miranda warning should be read and then paraphrased, and the child should be asked to explain what it means in his or her own words.
- A program in Washington State created a card for youth with an FASD to give to a police officer explaining they have an FASD disability. If the police officer knows a detained youth has an FASD, these suggestions may help avoid unnecessary difficulties. The suggestions above would be ideal points to consider when dealing with any juvenile offender.
- Some States may only allow the parent(s) and attorney(s) to assist/represent youth in court.

See Activities 1 and 2 in the Activities section.

FACILITATOR'S TALKING POINTS:

- Typically, first-time offenders are diverted through a process in which the youth enters a contract, and prosecution is deferred if the youth complies with the contract. Generally under this contract, the youth may complete community service; pay restitution; and/or participate in mental health treatment, substance abuse treatment, or family counseling. A youth with an FASD will need help to be successful in this process.
- *This is an excellent opportunity for FASD screening and intervention, especially if it is the first time the youth has been in trouble with the law.*
- If a family does not get services at this time and FASD is not recognized, this could be the beginning of the cycle of failure for the youth.

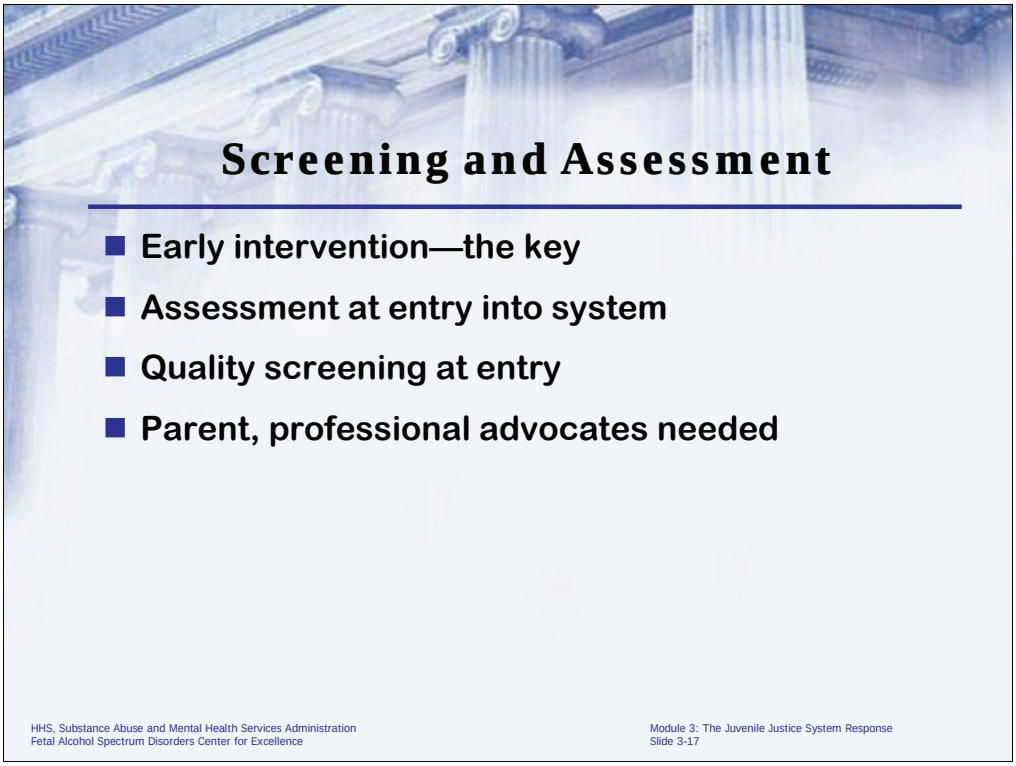


FACILITATOR'S TALKING POINTS:

- Restorative justice is a type of diversion.
- This model has advantages for a youth with an FASD because it may allow the victims to understand the FASD disability.
- Those involved in the process need to have a basic understanding of FASD and strengths and weaknesses of the offender.

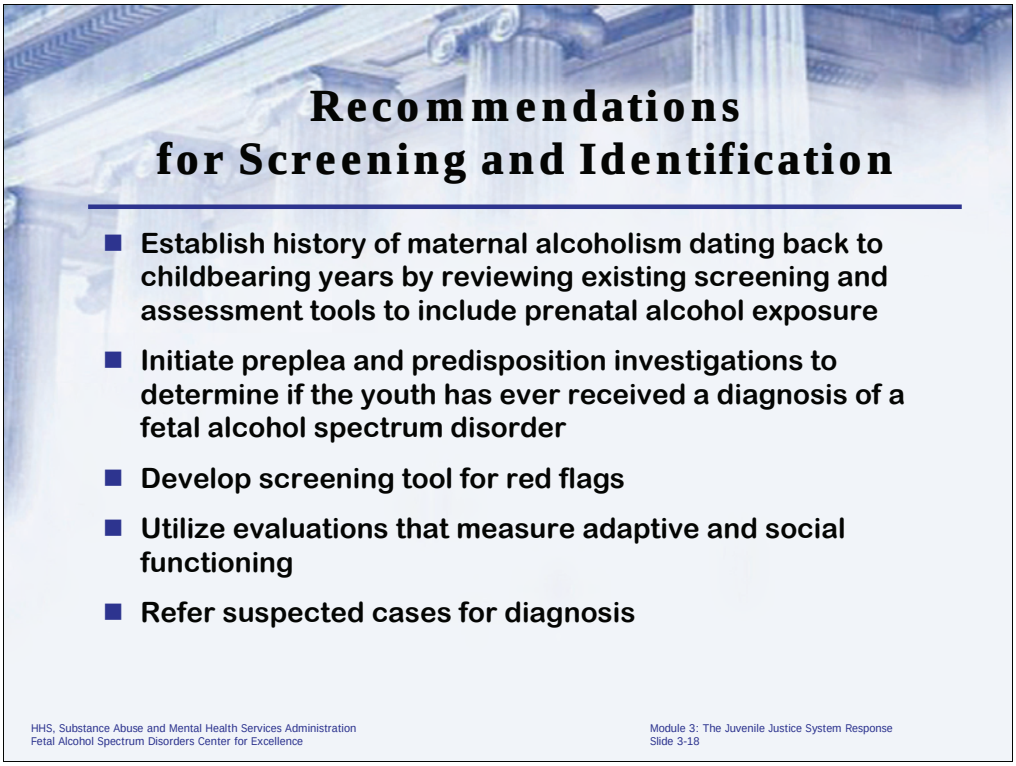
FACILITATOR'S TALKING POINTS:

- Victim-offender mediation
  - Victims and offenders meet in a safe and structured setting and engage in a mediated discussion of the crime.
  - It is important to assess if this would do more harm than good—the offender with an FASD may not understand remorse or how to express it, and the victim may not understand the FASD disability. It may not be the best solution if the offender doesn't understand what he or she has done wrong.
- Family group conferencing
  - Families have strengths and decisionmaking power.
  - Family group conferencing gathers together the people most affected by the crime—the victim, offender, family, friends, and key supporters of both—in deciding resolution.
  - It is led by trained facilitators.
- Peacemaking circle
  - It is based on a Native American concept.
  - This community-directed process is a partnership between the juvenile justice system and the community.
  - Decisions about who participates and which topics are discussed are based on the particular needs of the offender.
  - Participants are encouraged to listen to others, share their experiences, and work toward a common goal.
- All of these require a basic understanding of the FASD disability.



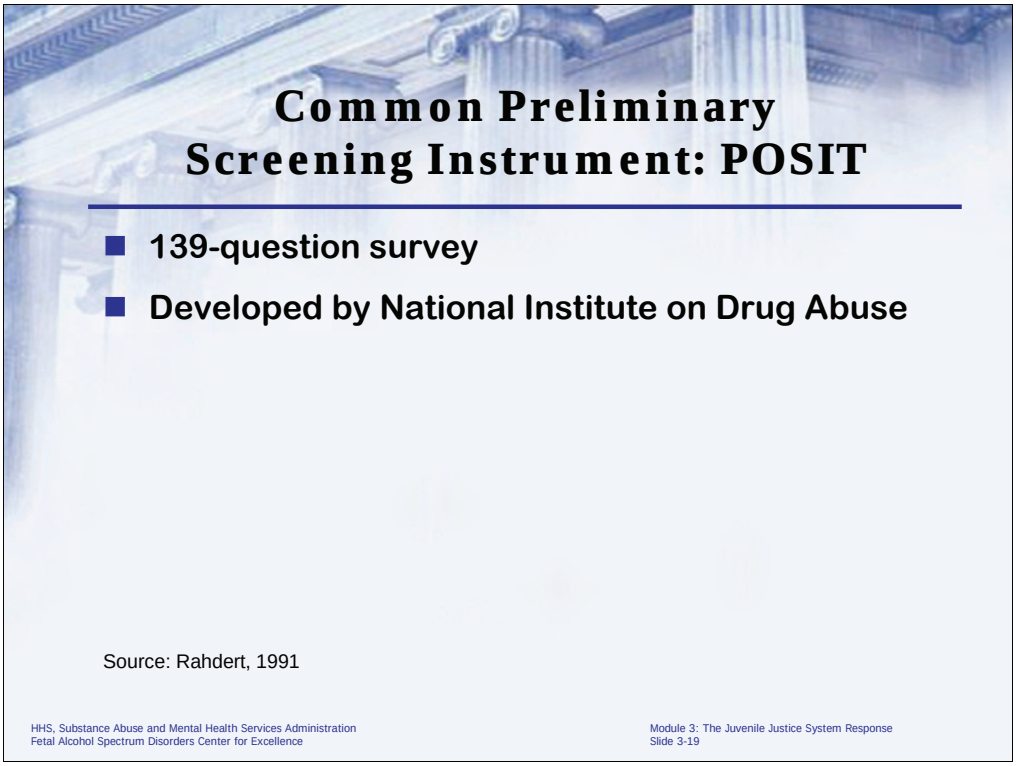
FACILITATOR'S TALKING POINTS:

- Early intervention is key to reducing delinquency effectively.
- Ideally, juvenile justice interventions should require assessment of the juvenile at his or her entry into the system.
- Unfortunately, quality screening and indepth assessment at entry do not happen consistently in juvenile systems around the country.
- Parents and professionals need to advocate for screening and assessment to stop the downward spiral of failure with no diagnosis, ineffective interventions, etc.



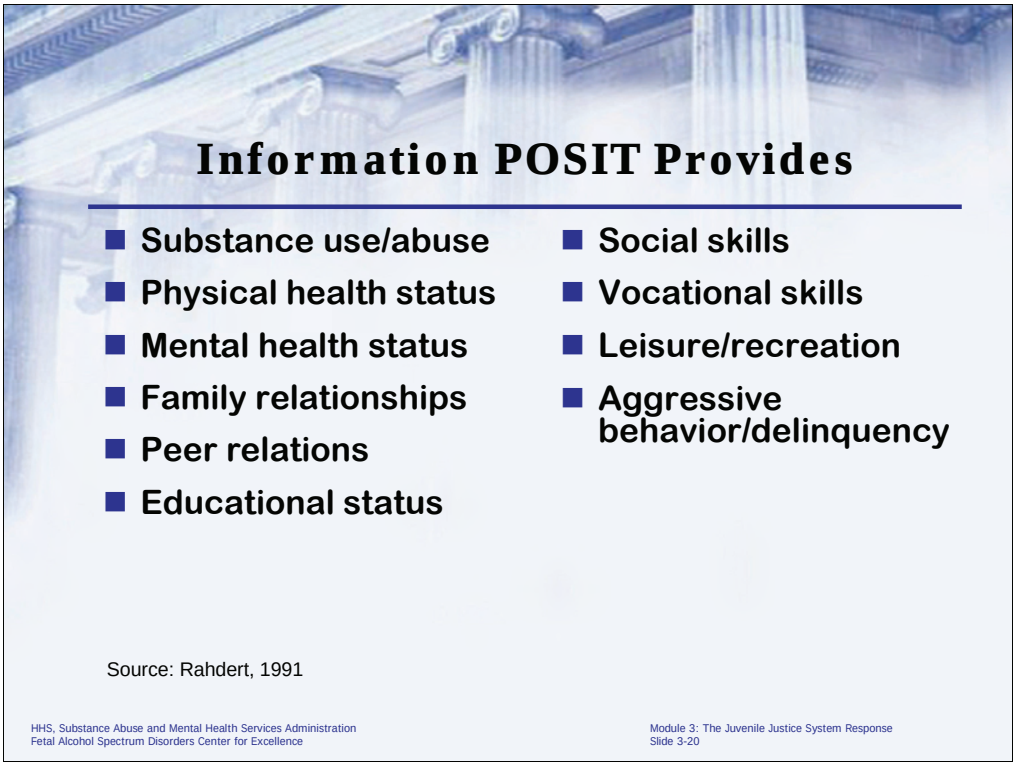
FACILITATOR'S TALKING POINTS:

- Currently there are no screening tools validated by research for identifying individuals who may have an FASD. There are screening tools to assess a woman's risk factors for drinking during pregnancy; however, they do not detect fetal alcohol spectrum disorders among her children. Work is being done in Canada to develop an FASD screening tool for juveniles.
- Facial photographic software, designed to measure the magnitude of expression of the key diagnostic facial features of FAS, is being used in several settings to screen for FAS specifically.



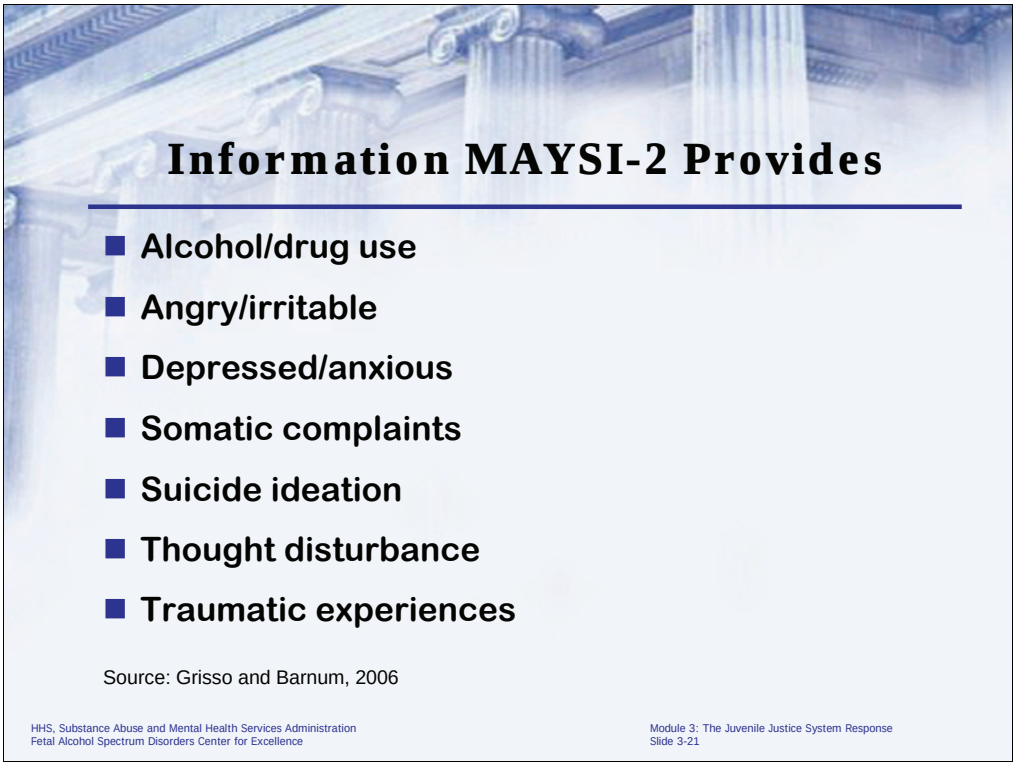
FACILITATOR'S TALKING POINTS:

- The common preliminary screening instrument used in many juvenile justice jurisdictions is the POSIT (Problem Oriented Screening Instrument for Teenagers). This 139-question survey instrument was developed by the National Institute on Drug Abuse (NIDA) and provides information on potential problems in one or more of 10 psychological functioning areas.



FACILITATOR'S TALKING POINTS:

- The POSIT is a brief screening tool designed for adolescents ages 12 through 19 to identify problems requiring subsequent indepth assessment. It can also determine a potential need for treatment. It is a self-report questionnaire and assesses the areas above. It is not designed to identify FASD.

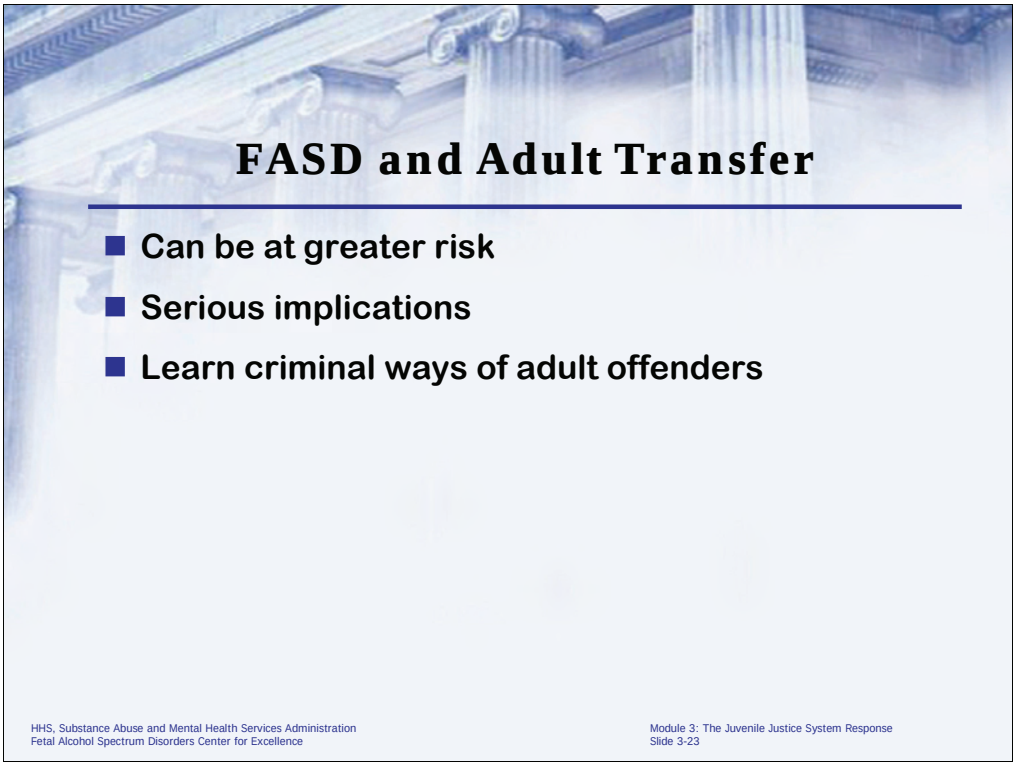


FACILITATOR'S TALKING POINTS:

- The MAYSI-2 (the second version of the Massachusetts Youth Screening Instrument) is a standardized, reliable, 52-item, true-false method for screening for mental health problems in youth ages 12 through 17 entering the juvenile justice system. It is not a diagnostic instrument. It serves as a "triage" tool for decisions about the possible need for immediate intervention. Again, it will not detect an FASD; however, it may assist in being aware of "red flags."

FACILITATOR'S TALKING POINTS:

- Juveniles who commit serious and/or violent crimes may find themselves going to adult court rather than juvenile court. This can vary from case to case and from State to State. State laws dictate which youth may be ordered to adult court. Generally a juvenile would have to commit a serious (felony) offense to go to adult court. Older juveniles and those who are repeat offenders are more likely to go to adult court (varies by State and crime committed, e.g., murder).
- The decision to refer to adult court is the first step in the juvenile justice process.
- The length of incarceration and/or probation can be a lot longer for a juvenile in the adult system.



FACILITATOR'S TALKING POINTS:

- Youth with an FASD who commit serious offenses may be at greater risk of being sent to adult court.
- They often have lengthy offense records and fail probation. They can appear to lack remorse, which comes across as callous.
- Chronological age is well beyond their actual social maturity, so treatment and services don't meet their needs.
- They easily become victims of predatory crimes, learn adult behaviors, etc.
- They often learn from modeling others. If they have negative models, they learn negative behaviors.

Juveniles Charged and Sentenced as Adults

- Are at greater risk of being a scapegoat or sexually or physically abused
- Are at greatest risk of sexual assault if younger, in the early part of their prison term, and housed in higher security settings
- Have greater difficulty successfully completing parole

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Juveniles Charged and Sentenced as Adults (cont'd)

- Juveniles sentenced as adults have higher suicide rates than those in juvenile facilities (Beyer, 1997).
- Recidivism is higher when juveniles and adults are incarcerated together (Elliot, et al., 2001).
- Correctional settings do not provide adequate schooling for more than half of incarcerated youth with disabilities (Rutherford, et al., 1985).

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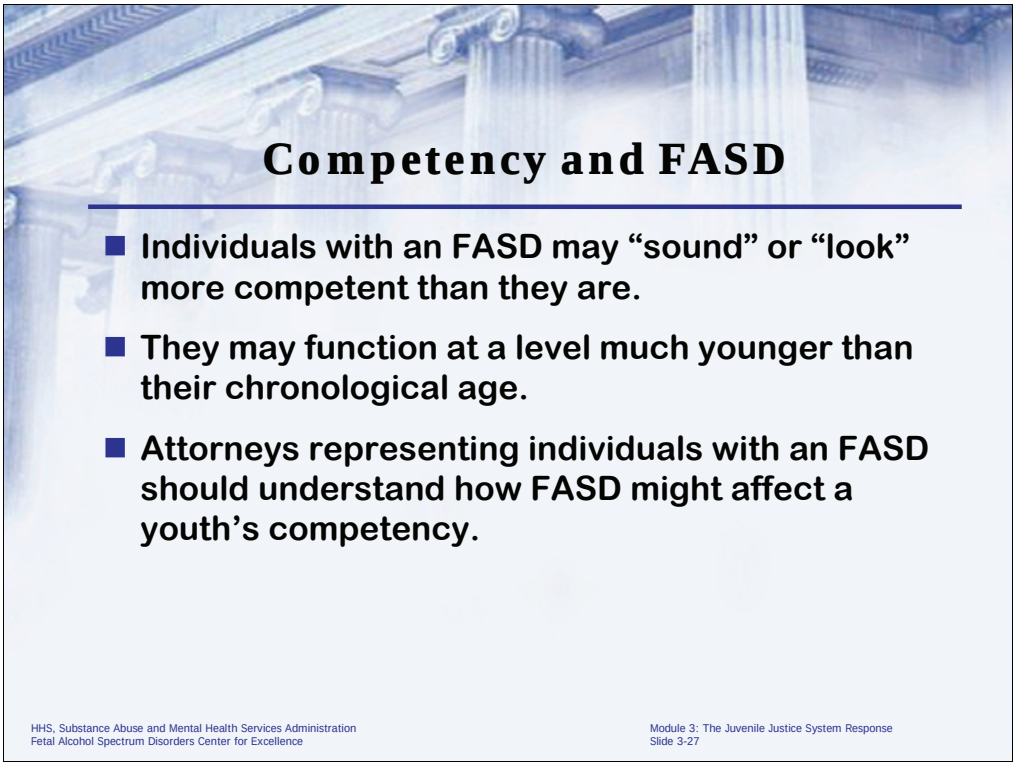
See Activity 3 in the Activities section.

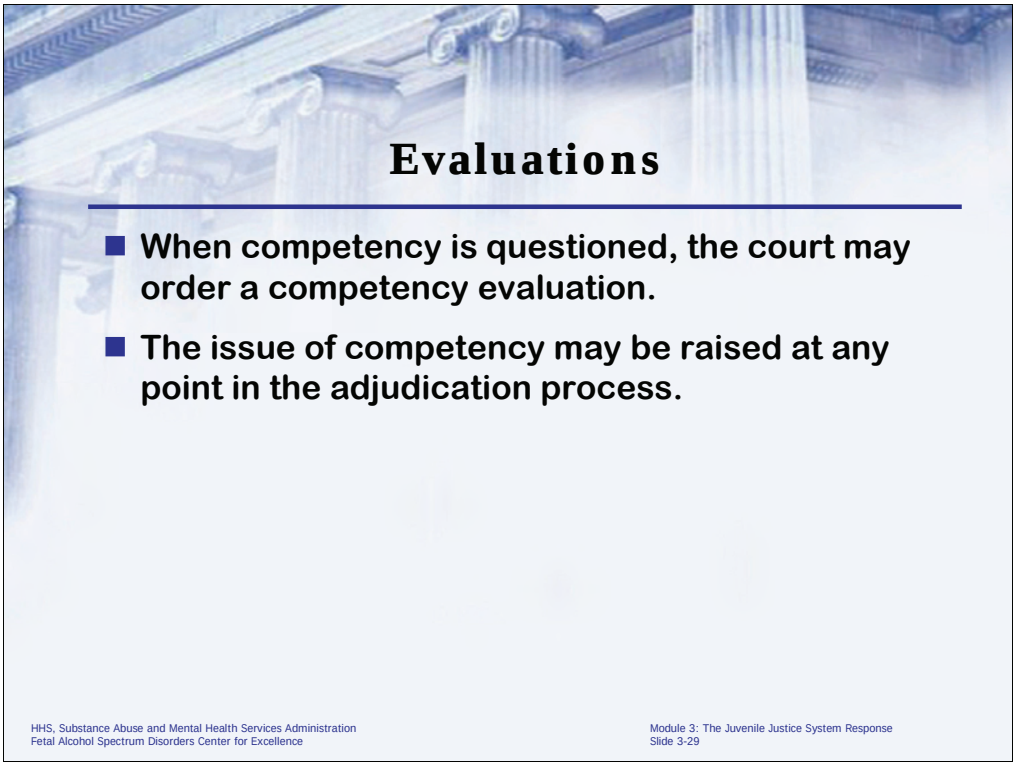


FACILITATOR'S TALKING POINTS:

- What is lacking for youth with an FASD is a deeper understanding of the consequences of behavior and all possible outcomes.
- Evaluators need an understanding of FASD.
- Youth with an FASD may understand information but not be able to apply it to their situation.

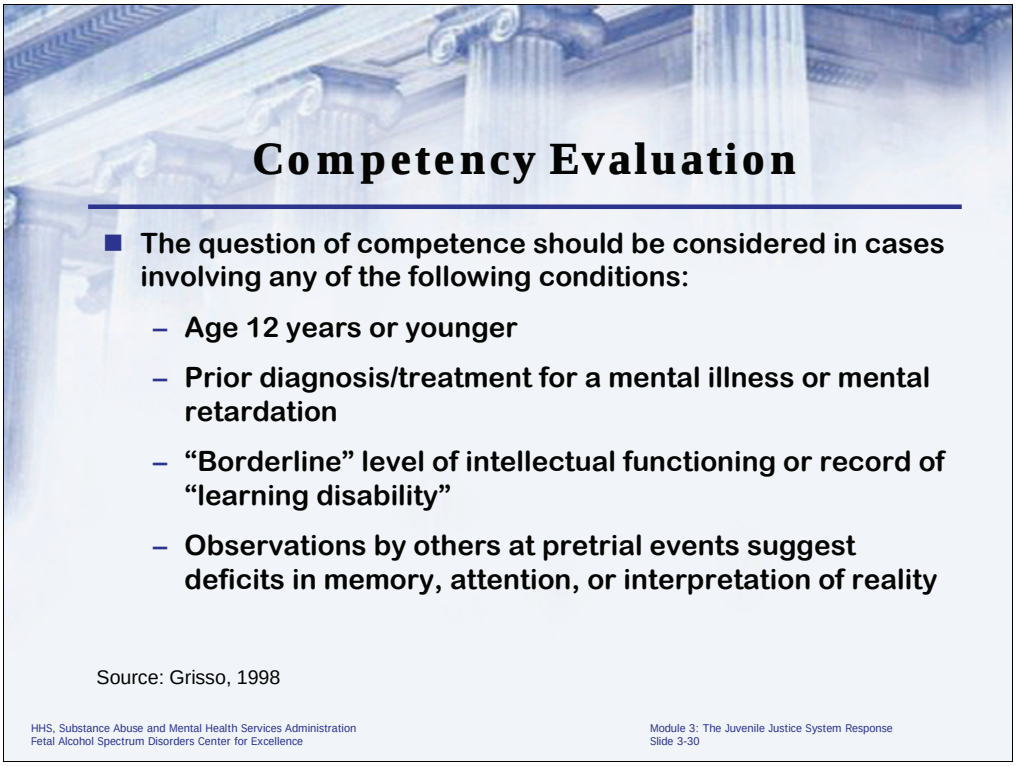
FACILITATOR'S TALKING POINTS:

- Case law has reflected that defendants should have the capacity to understand information relevant to specific decisions, to appreciate their situation as a defendant confronted with a specific legal decision, to think rationally about alternative courses of action, and to express a preferred choice among available alternatives. In addition, in States that use blended sentencing (juvenile and/or adult correctional sanctions), juveniles will need to understand the implications of a plea in ways that are different from the traditional juvenile court.
- It is important to be able to determine the client's ability to truly understand the potential consequences of different decisions.
- As a professional, you must try several different strategies to make sure that your client understands the implications of the decision. It is not enough to ask "Do you understand?" It is better to ask "What does that mean?" and "How would you follow that rule?" as a start.



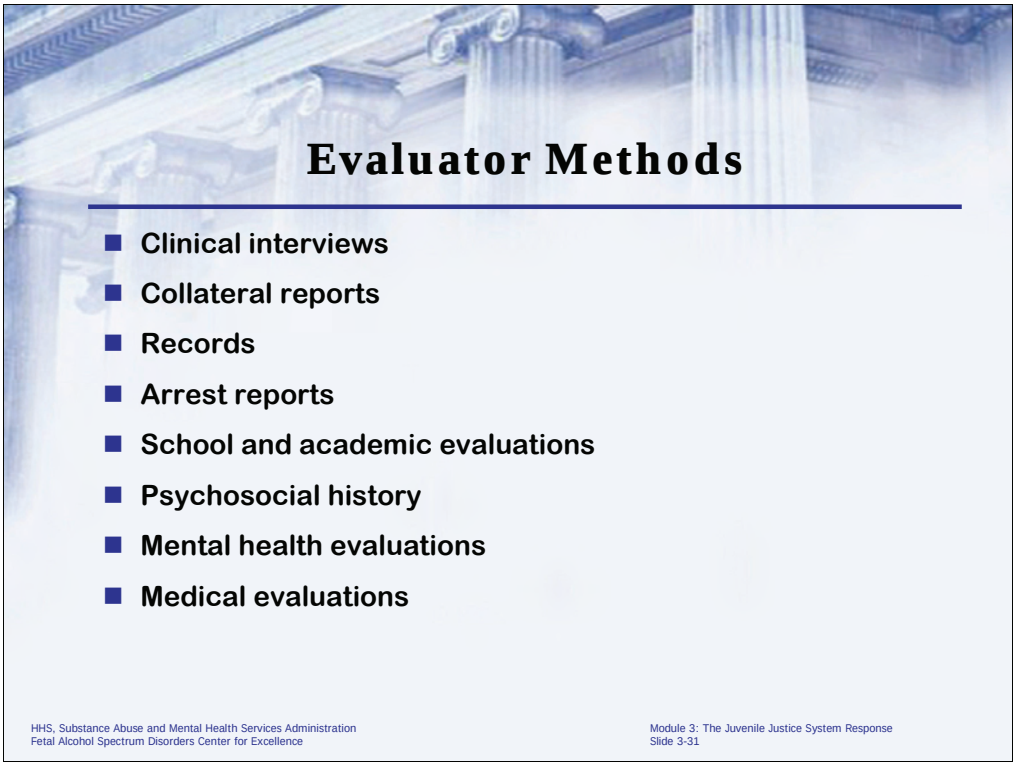
FACILITATOR'S TALKING POINTS:

- Competency is a legal definition. Therefore, it is up to the court to rule on competency.
- Competency evaluations should examine maternal drinking and include information such as the youth's:
  - Medical and family history
  - Home environment
  - School records
  - History of services received (e.g., therapy)
  - Prior involvement in the juvenile justice system



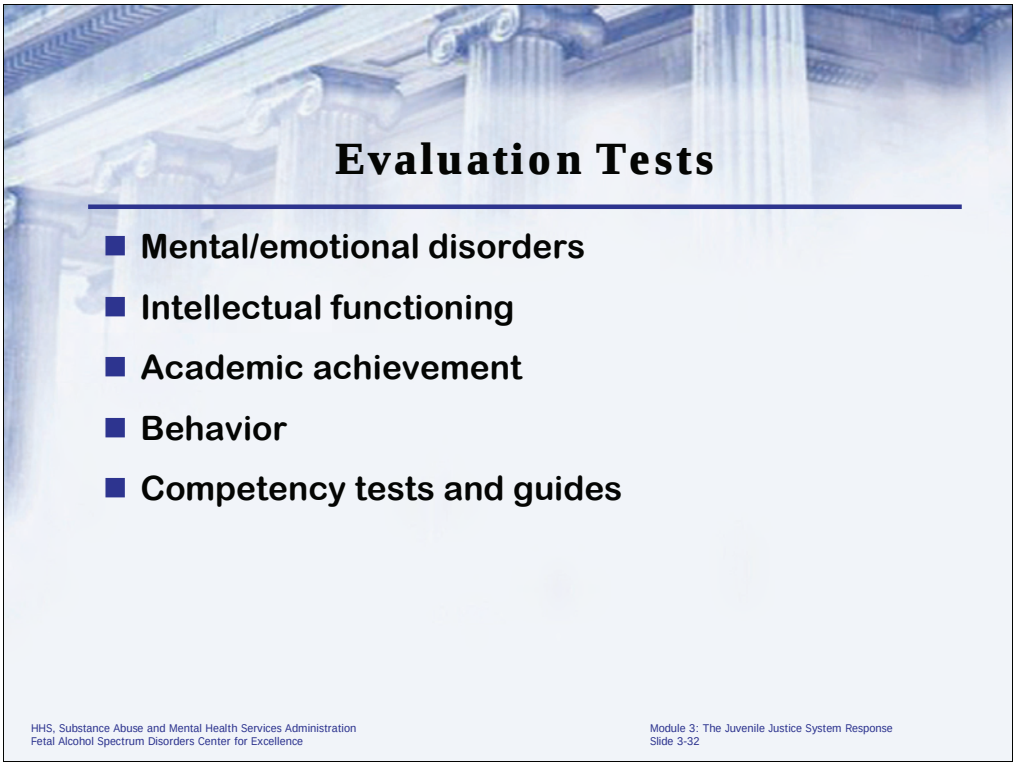
FACILITATOR'S TALKING POINTS:

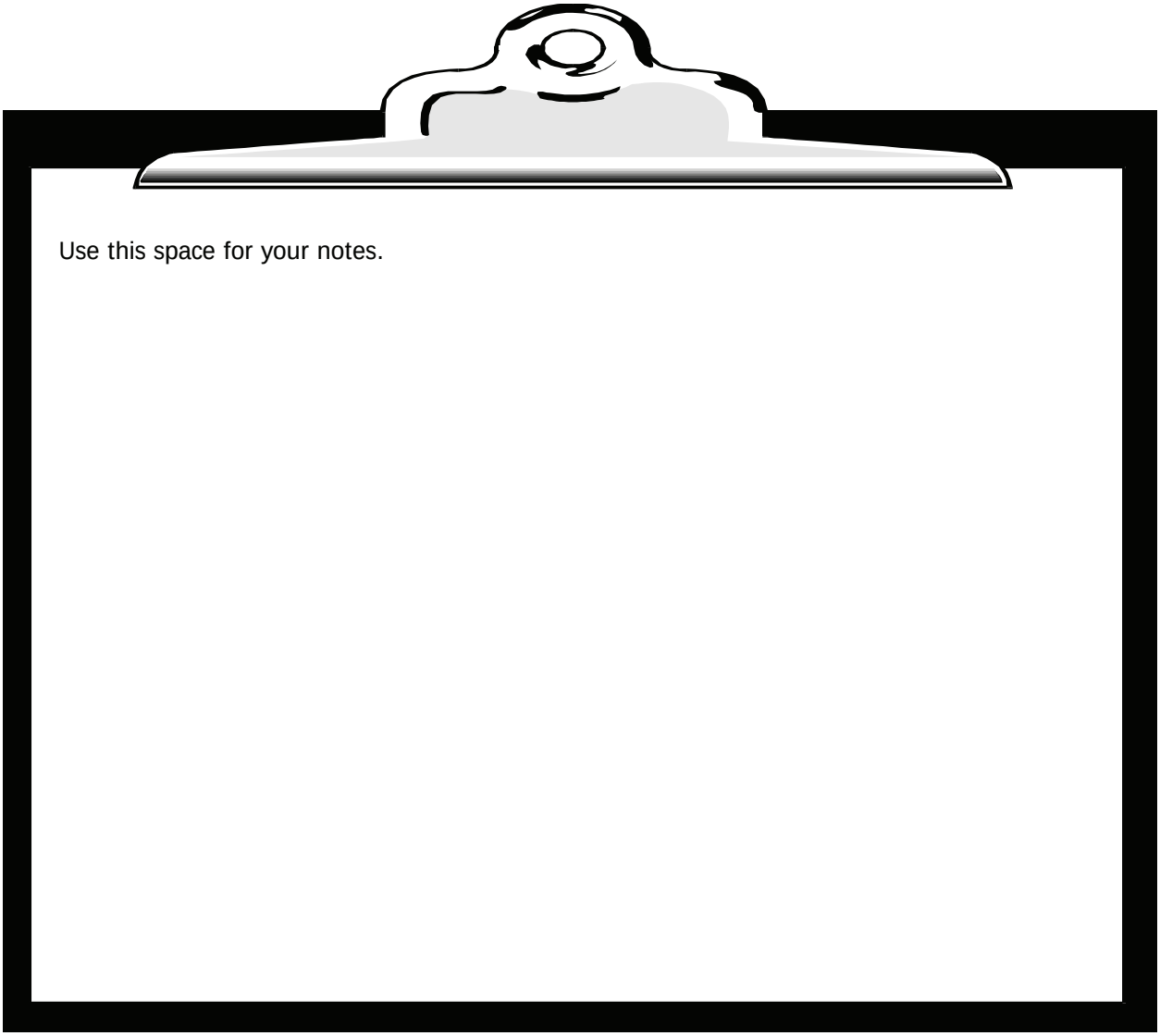
- Dr. Thomas Grisso, an award-winning researcher and author who has studied developmental psychology and adolescent decisionmaking capacity, recommends that youth meeting any of these criteria be evaluated to determine their competence.
- A diagnosis of an FASD may be considered in the judicial decisionmaking process and could result in a lighter sentence, especially if the offense is minor.
- Evaluation procedures may differ by State and jurisdiction, but a common preliminary screening instrument used in many juvenile justice settings is the POSIT, described earlier in this module.



FACILITATOR'S TALKING POINTS:

- A psychologist doing a competency evaluation may not understand FASD and its impact on the youth's ability to understand. If that is the case, the attorney representing the youth should engage an expert on FASD or refer the youth for an FASD evaluation.





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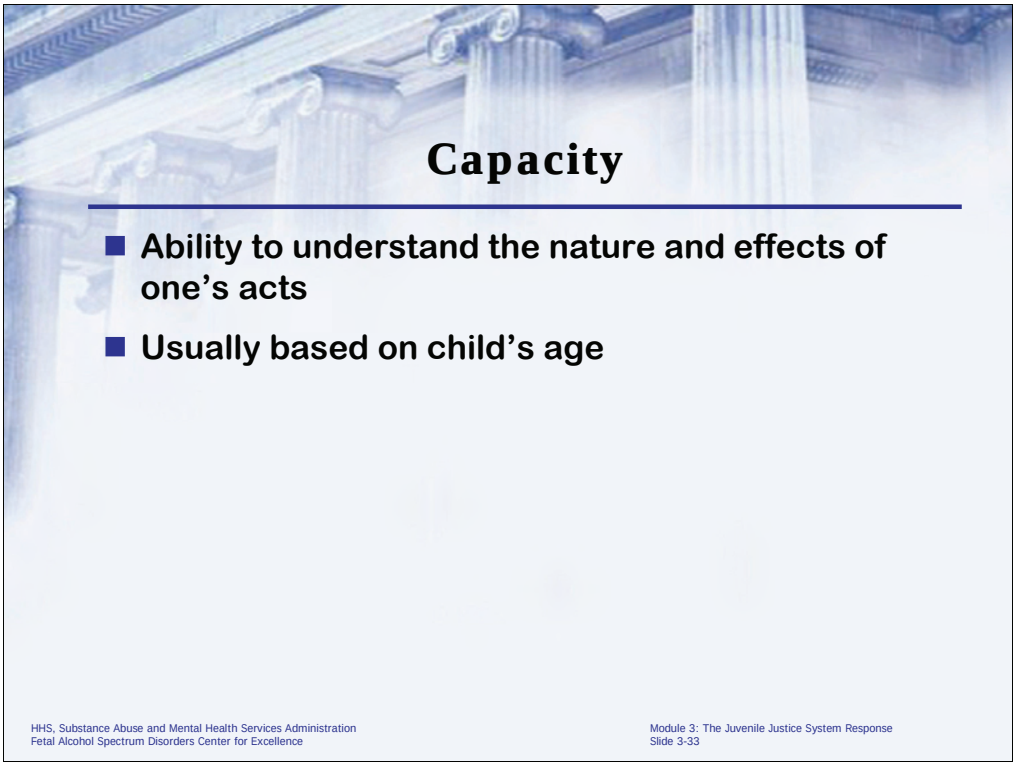
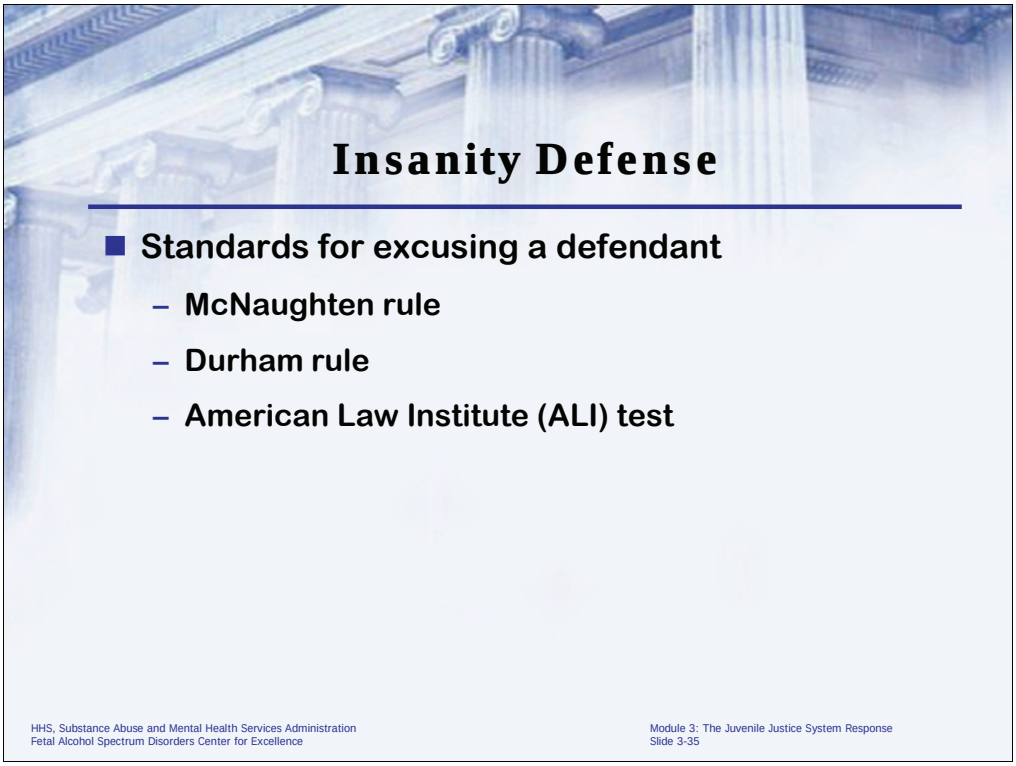


FACILITATOR'S TALKING POINTS:

- In some States, children under a certain age (age varies by State and jurisdiction) are presumed to be incapable of committing a crime.
- For anyone referred for a capacity evaluation, a preliminary question must be asked: Was the individual exposed prenatally to alcohol?
- If the answer is yes, then the child should have an FASD evaluation.
- Because prenatal alcohol exposure can cause brain damage, youth with an FASD may not have the capacity to understand and predict the consequences of their actions.

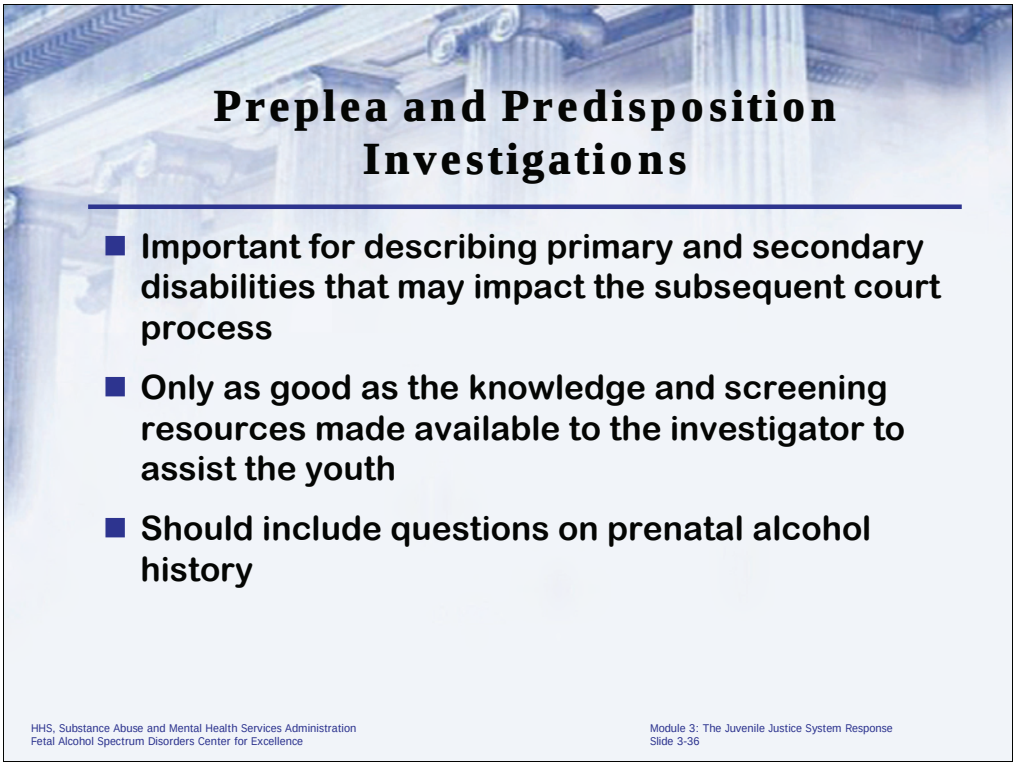
FACILITATOR'S TALKING POINTS:

- Mental illness at the time of the alleged offense can give rise to two types of mental-state defenses: diminished capacity and insanity.
- The legal definition of "insane" is different from the psychiatric definition of "mentally ill" and may vary from one jurisdiction to another.
- Diminished capacity and insanity are mental-state defenses negating an element of the charged crime (usually intent), most often reducing a defendant's liability.
- A plea of "diminished capacity" means that although the accused was not insane, due to emotional distress, physical condition, or other factors, he or she could not fully comprehend the nature of the criminal act he or she is accused of commiting.
- Those representing youth with an FASD should consider these defenses early in the process.
- Determination of capacity and diminished capacity will require an evaluation by an expert who needs to work in conjunction with an FASD expert.



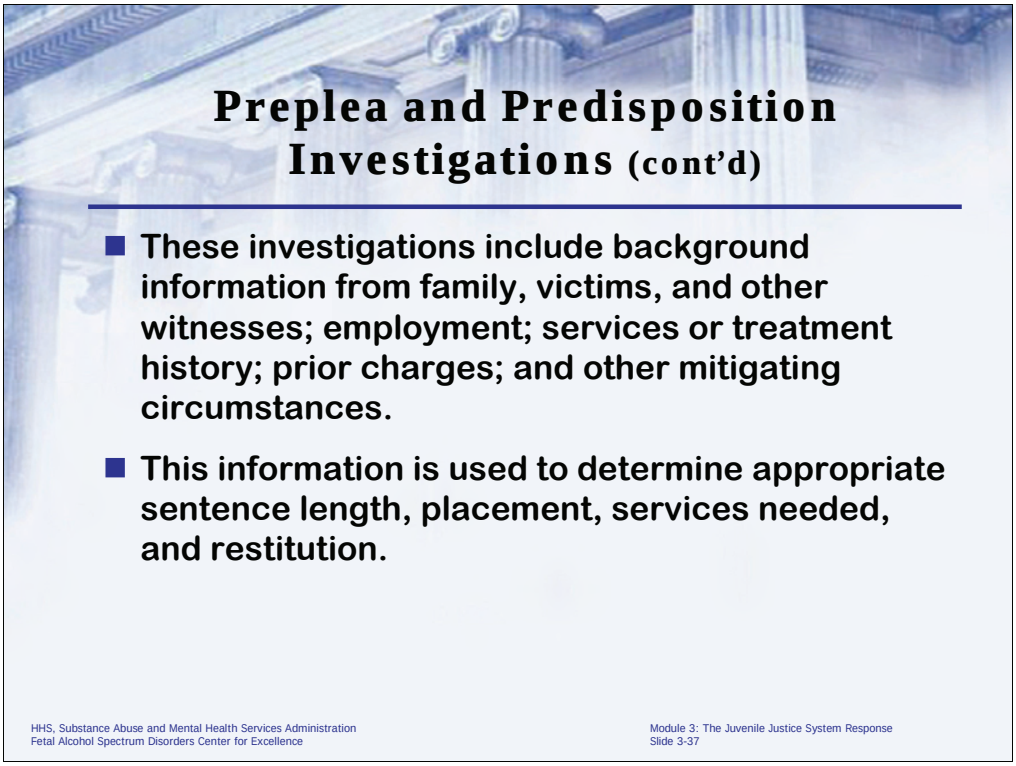
FACILITATOR'S TALKING POINTS:

- The insanity defense excuses a defendant for his or her conduct because of a mental disease or defect. This is true whichever of the following three standards is used:
  - McNaughten rule: excuses a defendant who, by virtue of a defect of reason or disease of the mind, does not know the nature and quality of the act, or if he or she does, does not know that the act is wrong. The McNaughten rule is based on an old English case (House of Lords, Mews' Dig. i. 349; iv. 1112. S.C. 8 Scott N.R. 595; 1 C. and K. 130; 4 St. Tr. N.S. 847 May 26, June 19, 1843).
  - Durham rule: excuses a defendant whose conduct is the product of mental disease or defect. (Durham v. United States, 214 F.2d 862)
  - ALI test: excuses a defendant who, because of a mental disease or defect, lacks substantial capacity to appreciate the criminality (wrongfulness) of his or her conduct or to conform his or her conduct to the requirements of the law.
- FASD has not been found legally to be a mental defect eligible for this defense, but youth with an FASD may have other secondary disabilities, including psychiatric disorders, which might bring this defense into play.



FACILITATOR'S TALKING POINTS:

- More education needs to be done on every level to ensure that those who are conducting screenings and investigations, making recommendations on sentences, etc., understand *effective* interventions for youth who have been prenatally exposed to alcohol (e.g., establishing the youth's functional ability; providing simple directions, one at a time; repeating information).
- It is imperative to include questions on prenatal alcohol history in all screenings or evaluations.

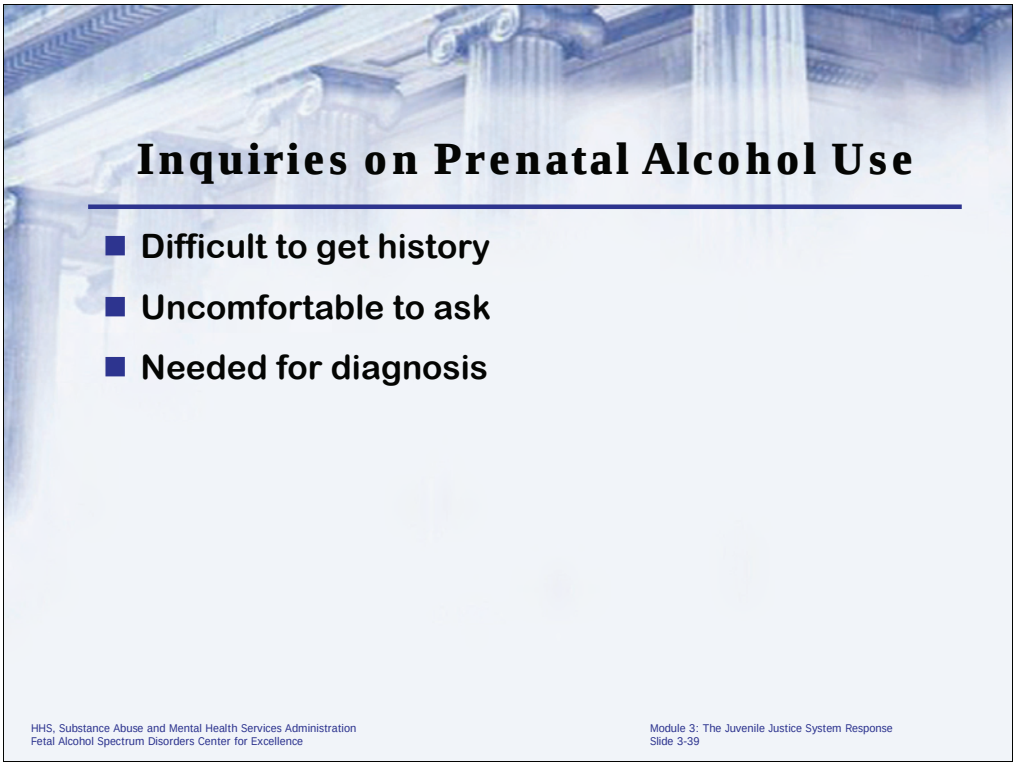


FACILITATOR'S TALKING POINTS:

- These investigations can occur prior to a plea, after an admission, or following a court trial but before disposition or sentencing.

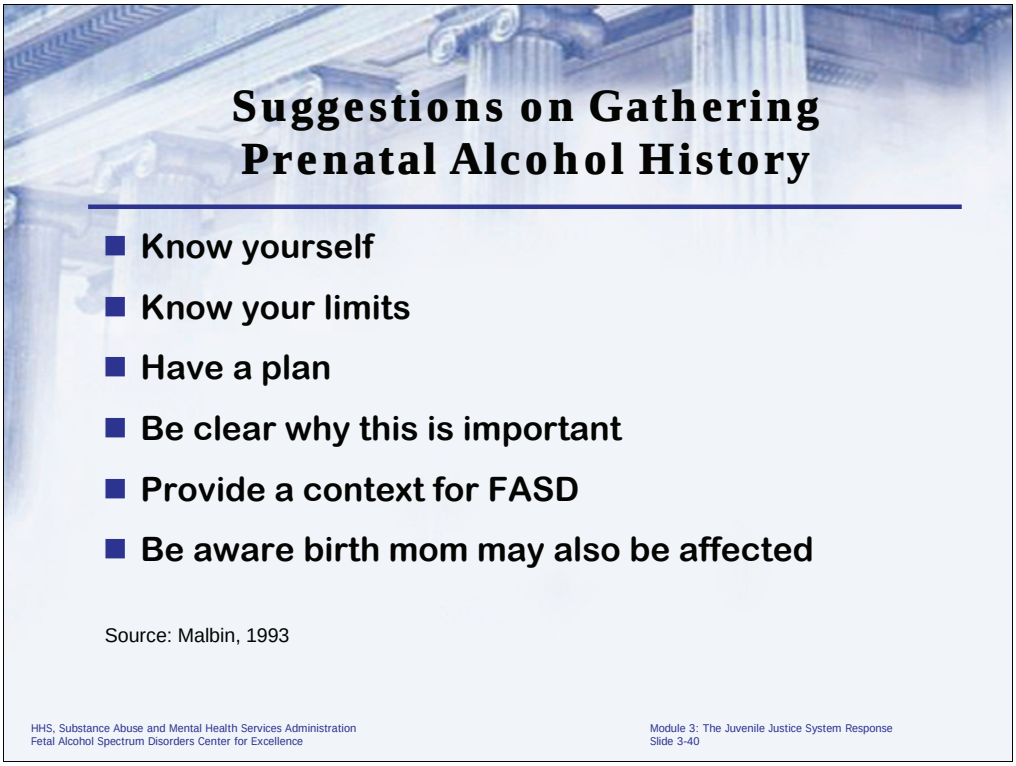
FACILITATOR'S TALKING POINTS:

- Evaluations of youth with an FASD do not always identify their fetal alcohol spectrum disorder; however, these youth may have many other diagnoses—ADHD, PDD, ODD, CD, etc. People working with a youth who has a diagnosis of one of these other disorders should consider the possibility that the youth rather has, or additionally has, an FASD.
- Static encephalopathy is characterized by permanent or unchanging brain damage. The effects on the person's functioning depends on the areas of the brain damage and on the severity of the damage.
- Descriptions of other disabilities:
  - ADHD is a condition characterized by behavioral and learning disorders. The clinical features may include difficulty sustaining attention, distractibility, and difficulty playing quietly.
  - PDD are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills or the presence of stereotyped behavior, interests and activities. PDD includes autism and related conditions such as Rett syndrome and Fragile X syndrome.
  - ODD is a disorder in which the individual (usually a child or adolescent) consciously refuses to do what he or she is told.
  - CD is a disorder in which the individual's behavior is often similar to those with ODD, but he or she additionally demonstrates physical aggression against people or property that is often planned.
- If there are red flags, the system needs to refer the youth for an FASD evaluation and begin to respond to the youth with interventions, consequences, and strategies that will address the characteristics of the FASD.



FACILITATOR'S TALKING POINTS:

- It is often difficult to get an accurate history for a number of reasons:
  - Birth family may not be available.
  - Alcohol use during pregnancy may be covered up or forgotten.
  - Stigma gets in the way of honest responses.
- Professionals may be uncomfortable asking about prenatal alcohol exposure.
- When the individual does not have the facial features of FAS, confirmed prenatal alcohol exposure is necessary for a possible diagnosis of an FASD.



FACILITATOR'S TALKING POINTS:

- Know yourself. Discomfort discussing FASD is normal. Role-playing with a colleague may be helpful.
- Know your limits. Get outside help if you need assistance and need more information on FASD.
- Have a plan. Evaluate your community and agency for resources in a continuum of care.
- Be clear with the birth mother and others about why this information is important. A diagnosis can lead to greater understanding of the complex behaviors/deficits and aid in the development of appropriate treatment and interventions.
- Explain that many people drink, and few people plan their pregnancies so they don't know when they first become pregnant. We know that women who drink during their pregnancies don't do so because they want to harm their babies. We're finding that with accurate identification, there's help and hope for families."
- Be aware that the birth mothers may also have an FASD. Due to drinking patterns from generation to generation, we know that FASD may recur, particularly if it is not identified. If parents have an FASD, they will require more support and a different approach.

Source: Malbin, 1993

Questions

Posttest!

Use this space for your notes.

References

- See References for a complete list of all references used in this module.

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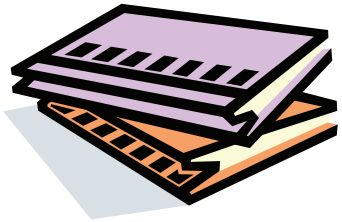
Posttest



ID # _____–post

Please answer true or false to the following questions:

1. The juvenile court system is structured the same way in each State and is part of the Federal court system.

   True ☐ or False ☐

2. Youth with an FASD seldom confess to a crime.

   True ☐ or False ☐

3. All persons with an FASD, regardless of their comprehension ability, easily understand the Miranda warning.

   True ☐ or False ☐

4. It is important in conducting victim-offender mediation to remember that if the offender has an FASD, he or she may not remember the victim or the crime and may not be able to express remorse.

   True ☐ or False ☐

5. A corrections professional has little ability to impact the life of an individual with an FASD.

   True ☐ or False ☐

6. Youth with an FASD often appear to be "competent" when they are really not.

   True ☐ or False ☐

7. Evaluation of both capacity and diminished capacity is a process anyone can administer.

   True ☐ or False ☐

Posttest Facilitator's Notes

Please answer true or false to the following questions:

1. The juvenile court system is structured the same way in each State and is part of the Federal court system.

   True ☐ or False ☐

   False: The juvenile court is part of the judicial system in all 50 States and the District of Columbia. Each State's juvenile court system is unique.

2. Youth with an FASD seldom confess to a crime.

   True ☐ or False ☐

   False: Youth with an FASD often willingly confess to a crime, whether or not they are guilty. This stems from a high desire to please people in authority, a false sense of trust in those who are questioning, a need to cover up a memory gap, and a lack of understanding of what they are being asked.

3. All persons with an FASD, regardless of their comprehension ability, easily understand the Miranda warning.

   True ☐ or False ☐

   False: Individuals with an FASD may not be able to discern the meaning of their advice of rights and may not waive them voluntarily. Statements such as "exercise these rights" are confusing for a literal, concrete thinker.

4. It is important in conducting victim-offender mediation to remember that if the offender has an FASD, he or she may not remember the victim or the crime and may not be able to express remorse.

   True ☐ or False ☐

   True: This is very important to evaluate before using this type of diversion. The lack of the expression of remorse or connection may be more detrimental to the victim than an alternative form of justice.

5. A corrections professional has little ability to impact the life of an individual with an FASD.

   True ☐ or False ☐

   False: Professionals who work with juveniles have an opportunity to make a big impact on the direction a youth with an FASD is headed. Early diagnosis, coupled with strong interventions and insights, can prevent many secondary disabilities.

6. Youth with an FASD often appear to be "competent" when they are really not.

   True ☐ or False ☐

   True: Whenever a youth with an FASD enters the juvenile justice system, the issue of competency should be considered. What is often lacking for these youth is a deeper understanding of the consequences of behavior and all possible outcomes.

7. Evaluation of both capacity and diminished capacity is a process anyone can administer.

   True ☐ or False ☐

   False: Determination of both capacity and diminished capacity will require an evaluation by an expert.

Activity 1–Police Arrest Recommendations

To be conducted during Slide 3-12

Tools needed:

Handout: "Police Arrest Recommendations"
Flip chart paper

Slide 3-12

Steps:

1. Break the participants into small groups of three to five people (depending on the size of the group). Have the participants count off to form groups (1, 2, 3, etc.).
2. Have groups choose a recorder and a reporter.
3. Distribute the "Police Arrest Recommendations" handout.
4. Have the small groups review the handout and discuss how they would be able to incorporate these recommendations into their work.
5. Have the small groups report their ideas to the large group.
6. Write the participants' ideas on flip chart paper.

Activity 1– Police Arrest Recommendations–Handout

Police Arrest Recommendations

If a police officer suspects or knows the youth has an FASD, it is helpful to have parents or a guardian present to aid in the process of the arrest. If this cannot be done, the police officer should keep the possible disability in mind as he or she proceeds. Although there are no proven, research-based techniques to use in this situation, some helpful suggestions may include:

1. **Provide clear, concise directions**. Avoid using strings of commands such as, "Lie on the floor, face down, put your hands behind your back and don't move!" Use one direction at a time. Repeat if necessary.
2. Break desired actions and orders into **single steps**. Once each is accomplished, add the next step. Repeat if necessary.
3. Try to **avoid grabbing** the youth unexpectedly, if possible. Youth with an FASD may have sensory integration problems as discussed in Module 1 and can be very defensive when touched. Touch, especially if unexpected, may cause a very negative reaction. If restraint or touch is necessary, tell youth what you are going to do.
4. Whenever possible, **tell the youth verbally what is about to occur**. If you are going to be handcuffing him or her, say so prior to the action. Say, "I am going to be putting handcuffs on you now." In addition, they may have suffered from abuse and may be hypersensitive to touch, interpreting a grab as an attack.
5. **Tell the youth who you are** and why he or she is being arrested.
6. It is best to **wait until parents or attorneys are present** before questioning a suspect with an FASD. Often, youth with disabilities do not understand their rights and have poor recall. Youth with an FASD tend to make up information to fill in the holes in their memory. An attorney will examine any confession to ensure it was obtained properly.
7. Read the **Miranda warning** and then **paraphrase it**. Have the child explain what it means in his or her own words. Even when the youth is given the Miranda warning, the child's counsel can still challenge the question of a true understanding.

Activity 2–Miranda Warning

To be conducted during Slide 3-12

Tools needed:

Handout: "Miranda Warning in the Eyes of Youth With an FASD"
Flip chart paper

Slide 3-12

Steps:

1. Break the participants into small groups of three to five people (depending on the size of the group). Have the participants count off to form groups (1, 2, 3, etc.).
2. Have groups choose a recorder and a reporter.
3. Distribute the "Miranda Warning" handout.
4. Have the small groups break down the Miranda warning to help a person with an FASD. How would they change the wording to help a person with an FASD understand the meaning of the Miranda warning?
5. Have the small groups report their ideas to the large group.
6. Write the participants' ideas on flip chart paper.

Activity 2–Miranda Warning–Handout

Miranda Warning in the Eyes of Youth With an FASD

> *"You have the right to remain silent. Anything you say can be used against you in a court of law. You have the right to consult an attorney before questioning. You have the right to have your attorney present with you during questioning. If you cannot afford an attorney, one will be appointed for you at no expense to you. You may choose to exercise these rights at any time."*

- **You have the right to remain silent:** Youth with an FASD are highly verbal, although at a fairly superficial level. They may also tend to chatter nonstop, especially in strange, unfamiliar places when they are feeling nervous; they often misconstrue this right to mean that they should remain silent until they are told to speak.
- **Attorney:** If you don't know what an attorney is, how do you know whether you need one? They may not understand they have the right to obtain an attorney "now."
- **Court of law:** Again, if you have no understanding of what a court of law is, how could you possibly understand that what you say can be used against you?
- **Rights:** With an inability to understand abstract concepts, the meaning of rights and the implication of waiving those rights would be very difficult to grasp.
- **Exercise these rights:** Even if you understand what "rights" are, for a concrete, literal thinker, exercise may only mean the physical definition of jogging, working out, etc.

Individuals with an FASD may not be able to discern the meaning of their advice of rights and may not waive them voluntarily (Streissguth and Kanter, 1997). Attorneys representing clients with an FASD should scrutinize the circumstances under which confessions are obtained and challenge any confession in which the waiver is not made voluntarily, knowingly, and intelligently, based on the totality of the circumstances.

Activity 3–Develop Case Plan

To be conducted during Slide 3-25

Tools needed:

Handouts: "Kattina" Scenario and
"Kattina: Resolution" Scenario

Slide 3-25

Steps:

1. Break the participants into small groups of three to five people (depending on the size of the group). Have the participants count off to form groups (1, 2, 3, etc.).
2. Have groups choose a recorder and a reporter.
3. Distribute the "Kattina" handout.
4. Have the small groups develop recommendations for a case plan.
5. Have the small groups report their ideas to the large group.
6. Write the participants' ideas on flip chart paper.
7. Distribute the "Kattina: Resolution" handout and review it with participants.

Activity 3–Develop Case Plan–Scenario Handout

Kattina

Kattina was a 16-year-old single female of Hispanic/Filipino descent and the only child born to a teenage mother who was 13 at the time of Kattina's birth. Kattina's mother acknowledged consuming up to 12 beers or more every day during her pregnancy.

Kattina was diagnosed as having FAS when she was 8 years old. Her biological mother had relinquished her to foster care due to her alcoholism and transient lifestyle. When Kattina was 15, she was living on the street, using and dealing drugs, and involved in prostitution. She joined a gang and ended up in an altercation in which she stabbed another young woman multiple times.

Kattina was referred for a waiver evaluation. Her IQ was 102, and her academic scores indicated achievement levels in reading, spelling, and arithmetic to be at the third grade.

Her adaptive behavior skills were at age 8. Even with an average IQ, Kattina demonstrated little common sense, a high level of impulsive behavior, almost no sense of cause and effect, and a seeming inability to understand the seriousness of her crime.

She had no family support, having run away from every foster placement, of which there were many. She had not been attending school on a regular basis for 2 years. However, her only previous criminal history had been two charges of taking a motor vehicle without permission and one charge of prostitution.

Activity 3–Develop Case Plan–Scenario Handout

Kattina: Resolution

The evaluator recommended that Kattina remain in the juvenile system. Based on that recommendation and an examination of "Kent" criteria (factors on whether to certify juvenile offenders to adult court), the court decided to retain jurisdiction in the juvenile system. However, the court ordered a longer term of incarceration and probation than might have been the usual sentence. She was given 102 weeks in a juvenile facility and then a very closely monitored probation for 3 years following her release. Her probation conditions required her to attend school, get a job after school, attend weekly therapy sessions, and attend drug and alcohol treatment on an outpatient basis. These are common conditions of probation, but three critical events led to a positive outcome. First, prior to the waiver hearing, there was a meeting of the probation officer, defense attorney, social worker, prosecutor, evaluating psychologist, presiding judge, and Kattina.

The judge took time to educate himself about FAS and agreed to the conditions listed above. It was also understood that should Kattina reoffend upon her release, she would be treated as an adult on any charges.

The second event was Kattina's mother entering a shelter and asking for alcohol/drug treatment. She was diagnosed with FAS and was placed on Social Security with a protected payee and given subsidized housing and vocational training. Kattina has been reconnected with her biological mother and is attending some sessions with her.

The third event occurred while Kattina was in the juvenile facility. She met another juvenile whose parents had worked with children with special needs, including FAS, and who was actively involved in a community support group. The court allowed Kattina to be placed with this family. With tight supervision and consistent structure, she is doing better, with no drug use, no truancy, and no seriously assaultive behavior reported. Art therapy and behavioral management have been the primary tools of therapy rather than insight therapy. She is no longer in regular school but attending a community-based vocational training program for computer skills, and she has a part-time job where she earns a salary for using these skills.

Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

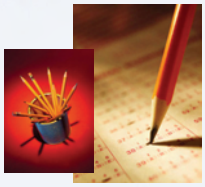
Module 3

The Juvenile Justice System Response

Module 3: The Juvenile Justice System Response

- After completing this module, participants will be able to:
  - Identify juvenile justice issues facing youth with an FASD
  - Describe the juvenile court process
  - Discuss the importance of identification and assessment of FASD in youth in the juvenile justice system

Pencils Out



Pretest!

Juvenile Justice System Background

- Established 1899
- Part of all 50 State systems
- Established to focus on rehabilitative treatment rather than punishment

Juvenile Age by State

AGE	STATES
<18	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Virginia, Washington, West Virginia, Wisconsin, Wyoming
<17	Georgia, Illinois, Louisiana, Massachusetts, Michigan, Missouri, South Carolina, Texas
<16	Connecticut, New York, North Carolina, Vermont

Initial Contact With the Justice System

- Police
- Arrest
- Police questioning

Police

- Police often first contact with system
- Youth with an FASD more likely to get arrested
- Do not understand social expectations, cues

Arrest

- Can be arrested at home or school or given a summons to appear in court
- Frightening experience
- Vulnerability

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Module 3: The Juvenile Justice System Response
Slide 3-10

Police Questioning

- High desire to please people
- No ability to distinguish friends and acquaintances
- Tell you what you want to hear
- May tell conflicting stories that are viewed as lying, not memory gaps
- Don't understand roles of various professionals

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Module 3: The Juvenile Justice System Response
Slide 3-11

Suggestions for Police During Arrest

- Provide simple directions, one at a time
- Avoid grabbing youth, if possible
- Miranda warning—read, paraphrase, rephrase by child
- Tell youth what is happening
- Tell youth who you are and why he or she is being arrested
- Don't question youth until an advocate (parent or other caregiver) and attorney are present

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Module 3: The Juvenile Justice System Response
Slide 3-12

Activity

Diversion

- Alternative to formal juvenile court process
- Youth's movement out of the system
- Can include referrals to treatment

Restorative Justice

- The restorative justice model is based on a balanced approach giving equal weight to:
  - Ensuring community safety
  - Holding offenders accountable to victims
  - Providing competency development for offenders in the system so they can be more successful upon release

Restorative Justice (cont'd)

- Victim-offender mediation
- Family group conferencing
- Peacemaking circles
- Restitution
- Community service

Screening and Assessment

- Early intervention—the key
- Assessment at entry into system
- Quality screening at entry
- Parent, professional advocates needed

Recommendations for Screening and Identification

- Establish history of maternal alcoholism dating back to childbearing years by reviewing existing screening and assessment tools to include prenatal alcohol exposure
- Initiate preplea and predisposition investigations to determine if the youth has ever received a diagnosis of a fetal alcohol spectrum disorder
- Develop screening tool for red flags
- Utilize evaluations that measure adaptive and social functioning
- Refer suspected cases for diagnosis

Common Preliminary Screening Instrument: POSIT

- 139-question survey
- Developed by National Institute on Drug Abuse

Source: Rahdert, 1991

Information POSIT Provides

- Substance use/abuse
- Physical health status
- Mental health status
- Family relationships
- Peer relations
- Educational status
- Social skills
- Vocational skills
- Leisure/recreation
- Aggressive behavior/delinquency

Source: Rahdert, 1991

Information MAYSI-2 Provides

- Alcohol/drug use
- Angry/irritable
- Depressed/anxious
- Somatic complaints
- Suicide ideation
- Thought disturbance
- Traumatic experiences

Source: Grisso and Barnum, 2006

Transfer to Adult Court

- Adult court—depends on State and nature of crime
- Referral from juvenile court
- Jail time and/or probation can be longer

FASD and Adult Transfer

- Can be at greater risk
- Serious implications
- Learn criminal ways of adult offenders

Juveniles Charged and Sentenced as Adults

- Are at greater risk of being a scapegoat or sexually or physically abused
- Are at greatest risk of sexual assault if younger, in the early part of their prison term, and housed in higher security settings
- Have greater difficulty successfully completing parole

Juveniles Charged and Sentenced as Adults (cont'd)

- Juveniles sentenced as adults have higher suicide rates than those in juvenile facilities (Beyer, 1997).
- Recidivism is higher when juveniles and adults are incarcerated together (Elliot, et al., 2001).
- Correctional settings do not provide adequate schooling for more than half of incarcerated youth with disabilities (Rutherford, et al., 1985).

Activity

Competency and FASD

- Individuals with an FASD may "sound" or "look" more competent than they are.
- They may function at a level much younger than their chronological age.
- Attorneys representing individuals with an FASD should understand how FASD might affect a youth's competency.

Competency of Juveniles

- Need to verify whether juveniles can:
  - Understand information relevant to decisions
  - Know they are confronted with a legal decision
  - Think rationally about options
  - Express choices among available alternatives

Evaluations

- When competency is questioned, the court may order a competency evaluation.
- The issue of competency may be raised at any point in the adjudication process.

Competency Evaluation

- The question of competence should be considered in cases involving any of the following conditions:
  - Age 12 years or younger
  - Prior diagnosis/treatment for a mental illness or mental retardation
  - "Borderline" level of intellectual functioning or record of "learning disability"
  - Observations by others at pretrial events suggest deficits in memory, attention, or interpretation of reality

Source: Grisso, 1998

Evaluator Methods

- Clinical interviews
- Collateral reports
- Records
- Arrest reports
- School and academic evaluations
- Psychosocial history
- Mental health evaluations
- Medical evaluations

Evaluation Tests

- Mental/emotional disorders
- Intellectual functioning
- Academic achievement
- Behavior
- Competency tests and guides

Capacity

- Ability to understand the nature and effects of one's acts
- Usually based on child's age

Diminished Capacity/ Insanity Defenses

- Two types of defense: diminished capacity and insanity
- May reduce defendant's liability
- Consider this type of defense early
- Requires clinical expert and FASD expert

Insanity Defense

- Standards for excusing a defendant
  - McNaughten rule
  - Durham rule
  - American Law Institute (ALI) test

Preplea and Predisposition Investigations

- Important for describing primary and secondary disabilities that may impact the subsequent court process
- Only as good as the knowledge and screening resources made available to the investigator to assist the youth
- Should include questions on prenatal alcohol history

Preplea and Predisposition Investigations (cont'd)

- These investigations include background information from family, victims, and other witnesses; employment; services or treatment history; prior charges; and other mitigating circumstances.
- This information is used to determine appropriate sentence length, placement, services needed, and restitution.

Psychological Evaluation

- Most people with an FASD do not have an FASD-related diagnosis (e.g., FAS, ARND, static encephalopathy).
- Many other diagnoses are used:
  - Attention-deficit/hyperactivity disorder (ADHD)
  - Pervasive developmental disorders (PDD)
  - Oppositional defiant disorder (ODD)
  - Conduct disorder (CD)

Inquiries on Prenatal Alcohol Use

- Difficult to get history
- Uncomfortable to ask
- Needed for diagnosis

Suggestions on Gathering Prenatal Alcohol History

- Know yourself
- Know your limits
- Have a plan
- Be clear why this is important
- Provide a context for FASD
- Be aware birth mom may also be affected

Source: Malbin, 1993

Questions

Posttest!

References

- See References for a complete list of all references used in this module.

Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System

Facilitator's Manual: Volume 2

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention





Table of Contents

Table of Contents (Volume 2)






Module 4:
Dispositional Options

Description

Summary

The fourth module provides a description of dispositional options available for sentencing youth with an FASD. The lesson plan focuses on outlining these options and identifying the issues that contribute to the success and failure of a youth with an FASD.

Objectives

After completing this module, participants will be able to:

- List issues to consider during disposition of youth with an FASD
- Analyze dispositional options available for youth with an FASD
- Describe dispositional options that could lead to better outcomes for repeat juvenile offenders with an FASD

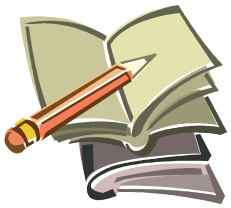
Facilitator's Outline

Step and Time	Tools Needed
One: Introduction—5 minutes	
You are presenting the *Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System*, a joint project of the Substance Abuse and Mental Health Services Administration (SAMHSA) Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence and the Minnesota Organization on Fetal Alcohol Syndrome. The FASD Center is a Federal initiative devoted to preventing and treating FASD. The Center's goals include advancing the field of FASD and promoting best practices. You may want to have participants introduce themselves, if time allows. Ask participants to state their backgrounds and interest in FASD. *Note: You do not need to do introductions if you combine modules—only conduct introductions at the beginning of a training session.*	
Two: Why We Are Here—5 minutes	
Discuss *Tools for Success*. *Tools for Success* focuses on assisting professionals who work with youth in the juvenile justice system who have an FASD to develop effective and appropriate interventions. It is designed for all correctional professionals, including advocates, attorneys, social workers, and social and human service providers who interact with children and families affected by FASD. *Tools for Success* contains seven modules: ■ Fetal Alcohol Spectrum Disorders (FASD): The Basics ■ FASD in the Juvenile Justice System ■ The Juvenile Justice System Response ■ Dispositional Options ■ Special Education and Behavior Management ■ Transition and Aftercare ■ Resources **2 minutes**	**PowerPoint Slide 4-1**

Step and Time	Tools Needed
Two: Why We Are Here (continued)	
Discuss Module 4: Dispositional Options. The fourth module provides a description of dispositional options available for sentencing youth with an FASD. The lesson plan focuses on outlining these options and identifying the issues that contribute to the success or failure of a youth with an FASD. **2 minutes**	**PowerPoint Slide 4-2**
Discuss objectives for the module as indicated on PowerPoint Slide 4-3. **1 minute**	**PowerPoint Slide 4-3**
Three: Pretest—10 minutes	
Distribute the pretest and allow time for participants to complete it. After ensuring that each participant has provided a unique identifier on the pretest (see the Introduction), collect the tests. Do not review answers at this time.	**PowerPoint Slide 4-4** **Pretest** 
Four: PowerPoint Presentation—15 minutes	
Using PowerPoint presentation and facilitator talking points, provide introduction and background on the court and overview of dispositional options for youth.	**PowerPoint Slides 4-5 through 4-10**
Five: Questions From the Bench Activity—30 minutes	
Follow directions for Activity 1—Questions From the Bench. Distribute Activity Handout: "Questions From the Bench."	**PowerPoint Slide 4-11**  **Activity 1 sheets in curriculum** 

Step and Time	Tools Needed
Six: PowerPoint Presentation—60 minutes	
Using PowerPoint presentation and facilitator talking points, discuss dispositional issues, information to help defense attorneys and other advocates, best practices, and interventions.	**PowerPoint Slides 4-12 through 4-32**
Seven: What Would You Do Differently? Activity—25 minutes	
Follow directions for Activity 2—What Would You Do Differently?	**PowerPoint Slide 4-33**  **Activity 2 sheet in curriculum** 
Eight: Posttest—10 minutes	
Distribute the posttest and allow time for participants to complete it. Using the facilitator's notes in the curriculum, review the answers to the posttest. After ensuring that each participant has provided his or her unique identifier on the posttest, collect the tests.	**PowerPoint Slide 4-34**  **Posttest** **Posttest Facilitator's Notes**
Nine: Evaluation—5 minutes	
Total Time: 2.75 hours	

Pretest



ID # _____–pre

Please answer true or false to the following questions:

1. There are specific advocates trained to support juveniles with an FASD through the court process in every State.

   True ☐ or False ☐

2. Judges who are educated about FASD have shown more of a willingness to consider alternative sentencing.

   True ☐ or False ☐

3. "Disposition" is considered sentencing for youth who have been found guilty of a crime.

   True ☐ or False ☐

4. Although there is little research on "what works" for a youth with an FASD, there is a commonly held belief that programs that are short in duration are most effective.

   True ☐ or False ☐

5. When professionals understand that often the behavior of youth with an FASD is a result of brain damage, they are more effective in working with these youth.

   True ☐ or False ☐

6. Intensive probation and surveillance has shown some promise of being successful for youth with an FASD.

   True ☐ or False ☐

7. Cognitive-behavioral therapy may be more effective for youth with an FASD than insight-oriented therapy.

   True ☐ or False ☐

Pretest Facilitator's Notes

Please answer true or false to the following questions:

1. There are specific advocates trained to support juveniles with an FASD through the court process in every State.

   True ☐ or False ☐

   False: Specifically trained advocates for youth with an FASD are rare. However, understanding the system can often be very confusing for the youth and family. It is essential that a youth have an advocate assigned to him or her. This advocate can be a parent, caregiver, guardian ad litem, mentor, or another individual who has the time, expertise in FASD, and understanding of the youth's needs.

2. Judges who are educated about FASD have shown more of a willingness to consider alternative sentencing.

   True ☐ or False ☐

   True: Examples include combinations of community-based programs or mental health facilities for treatment instead of correctional punishment-based facilities. Some judges have been willing to suspend sentences if the individual with an FASD completes an appropriate treatment program.

3. Disposition is considered sentencing for youth who have been found guilty of a crime.

   True ☐ or False ☐

   True: "Disposition" is defined as the order of a juvenile court that sets out the conditions a juvenile must comply with. It is similar to sentencing in an adult criminal case.

4. Although there is little research on "what works" for a youth with an FASD, there is a commonly held belief that programs that are short in duration are most effective.

   True ☐ or False ☐

   False: Interventions that last between 7 months and 18 months improve outcomes for chronic juvenile offenders and youth with an FASD.

5. When professionals understand that often the behavior of youth with an FASD is a result of brain damage, they are more effective in working with these youth.

   True ☐ or False ☐

   True: When professionals understand the disability and the brain damage, and have insights into the behavior, they are able to do more effective case planning and management.

6. Intensive probation and surveillance has shown some promise of being successful for youth with an FASD.

   True ☐ or False ☐

   True: This model is often used for serious adult offenders. Probation officers have only 10 offenders on their caseload, which allows for more one-on-one attention and support.

7. Cognitive-behavioral therapy may be more effective for youth with an FASD than insight-oriented therapy.

   True ☐ or False ☐

   True: There is no current research on how cognitive therapy works for individuals with an FASD, but because the therapy is more structured, it is more likely to be a success than insight-oriented therapy.

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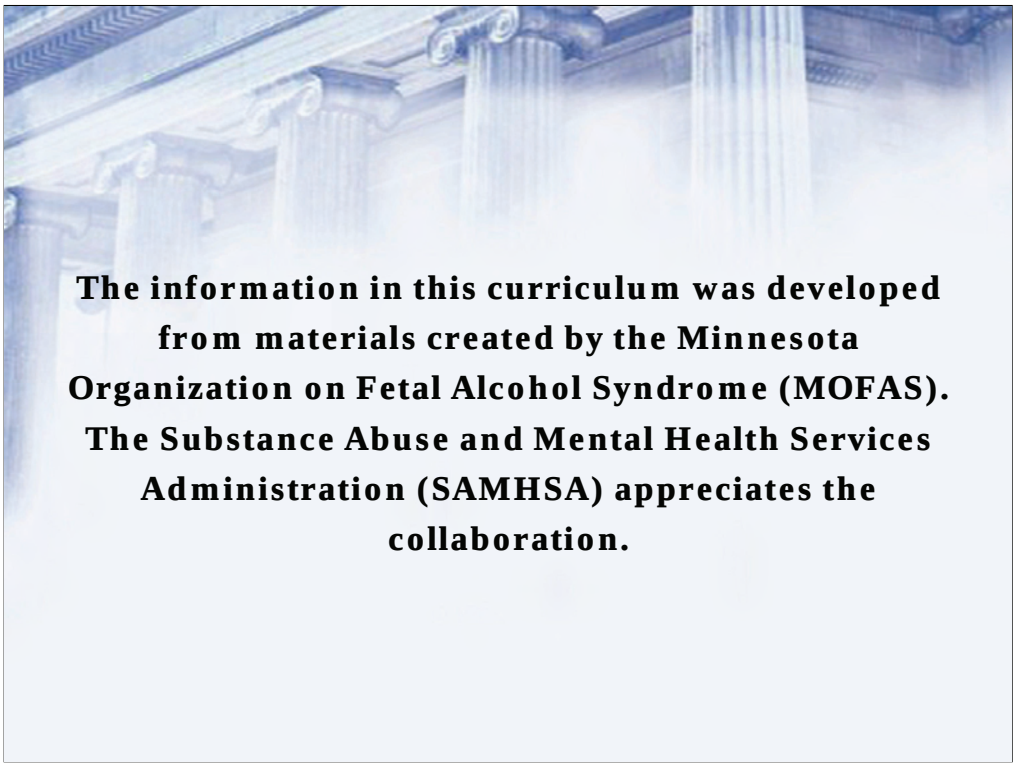
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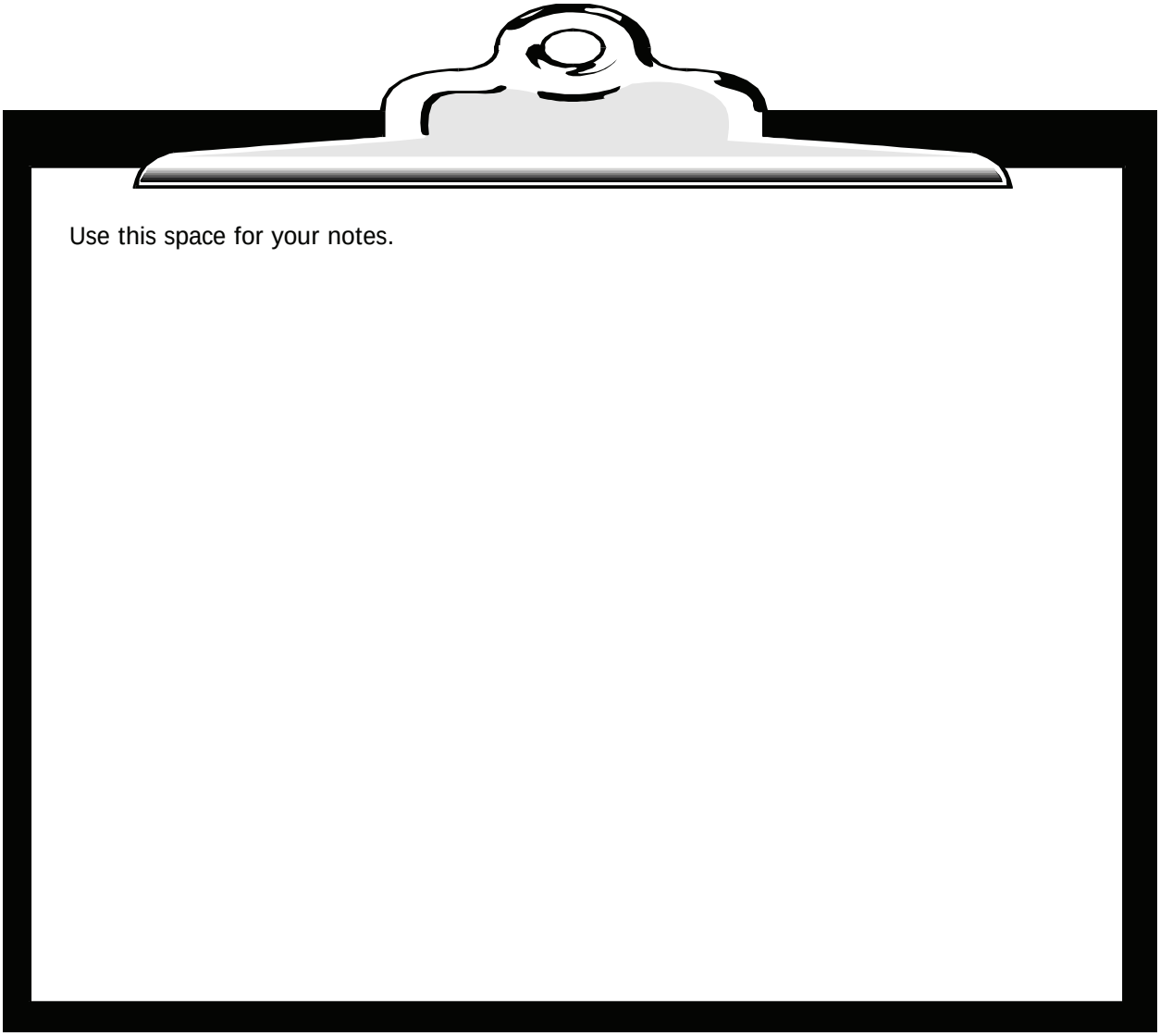
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Module 4

Dispositional Options

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Module 4: Dispositional Options

- Objectives: After completing this module, participants will be able to:
  - List issues to consider during disposition of youth with an FASD
  - Analyze dispositional options available for youth with an FASD
  - Describe dispositional options that could lead to better outcomes for repeat juvenile offenders with an FASD

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Module 4: Dispositional Options
Slide 4-4

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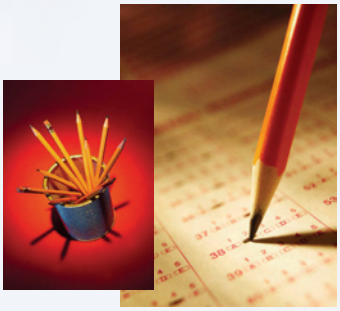
Pencils Out

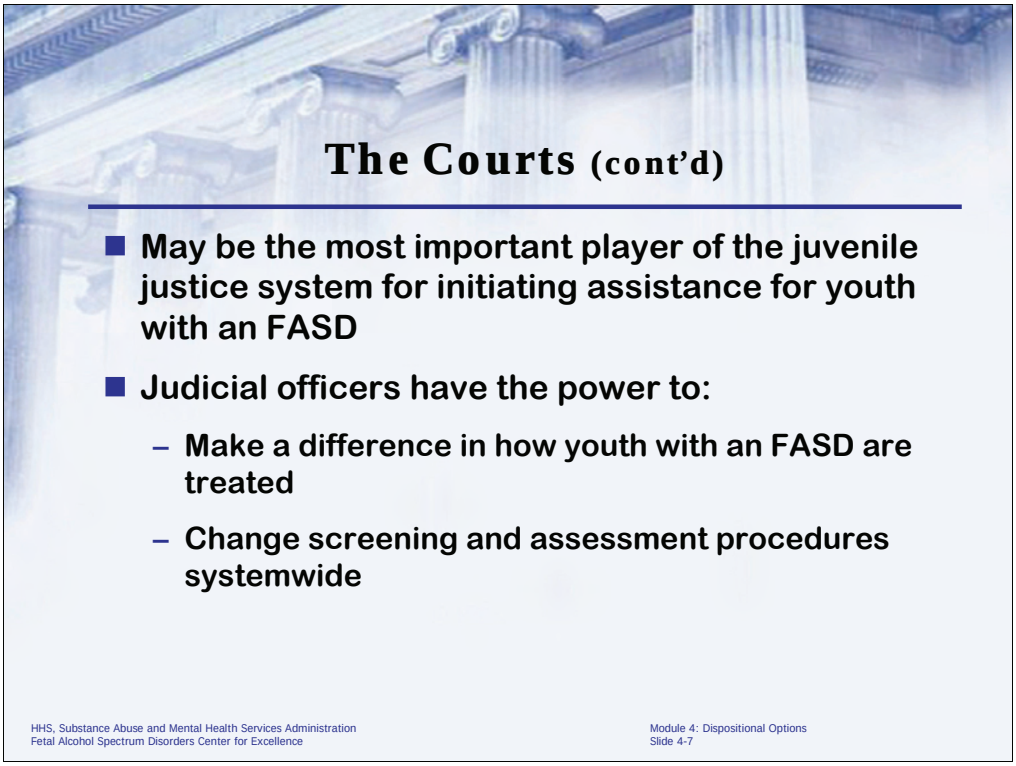


Pretest!

Use this space for your notes.

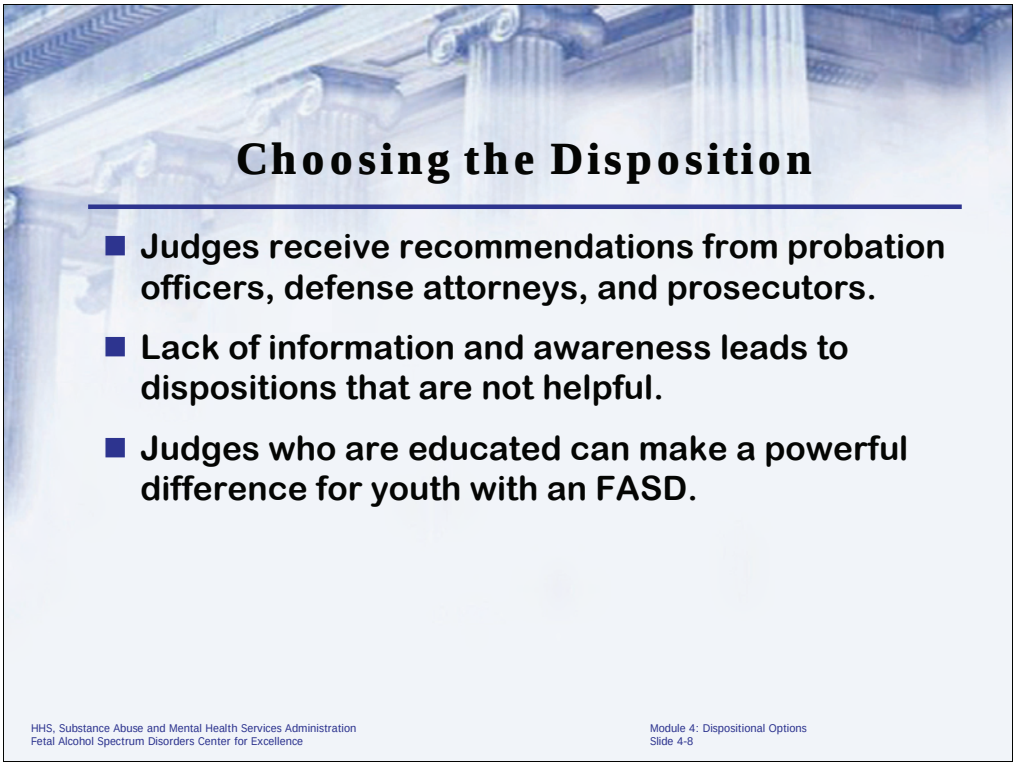
FACILITATOR'S TALKING POINTS:

- Once the youth has been found delinquent (adjudicated) of the offense, the next phase is what the judge decides to do with the juvenile as far as consequences, treatment, probation, placement, restitution, etc.
- In most juvenile courts this is called "disposition" to distinguish it from "sentencing" in the adult court.
- This is also the procedure for juveniles who admit to truancy, runaway, or other status matters.



FACILITATOR'S TALKING POINTS:

- Astute judges who have become educated on FASD have the power to make a difference in how youth with an FASD are treated in the juvenile justice system. They also have the power to change screening and assessment procedures systemwide to ensure that these youth do not fall through the cracks.

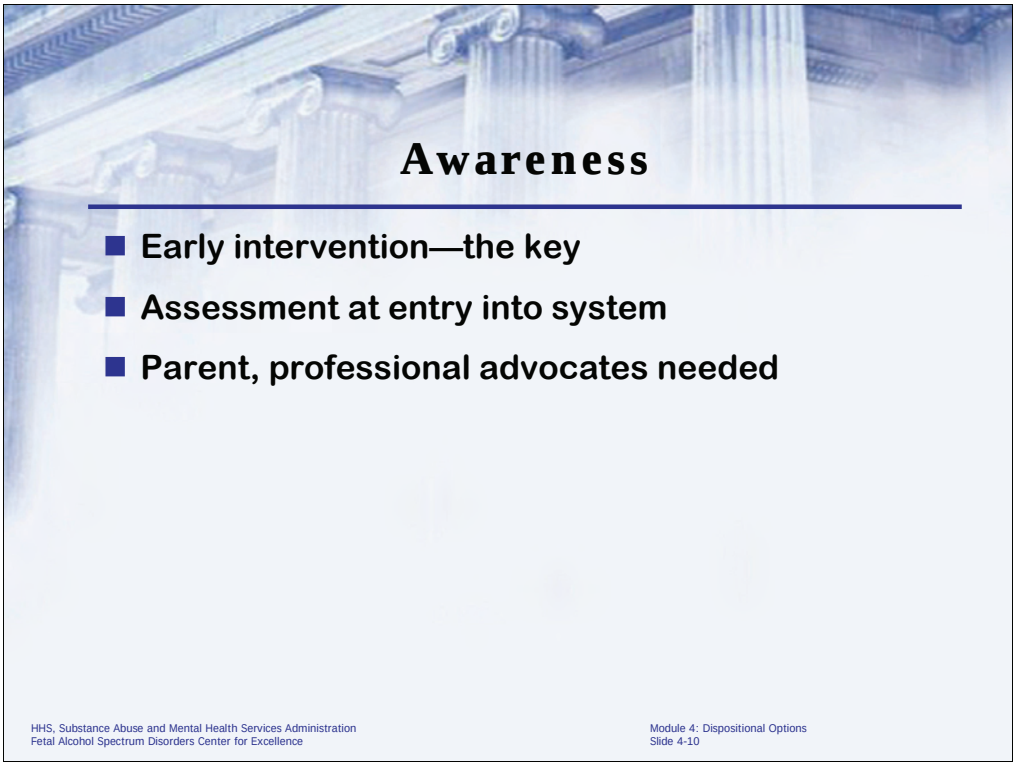


FACILITATOR'S TALKING POINTS:

- Judges receive disposition recommendations from probation officers, defense attorneys, and prosecutors. Therefore, it is essential that these individuals have a solid understanding of FASD.
- Because of the widespread lack of awareness, many youth appear before a judge without any knowledge (on the part of the judge, the attorneys, and the child) about FASD and its impact on a child's life.
- If an FASD is not recognized, the dispositions will often not be the most appropriate for the person, especially if they involve multiple directions or rules to follow.
- Juvenile systems need to "think outside the box" in fashioning interventions.
- Educate judges so they understand that coming down harder on youth with an FASD does not work—give institutions suggested behavioral methods to work with these youth. It is helpful for judges to understand that those with an FASD, regardless of their IQ, have difficulty processing information given to them verbally.

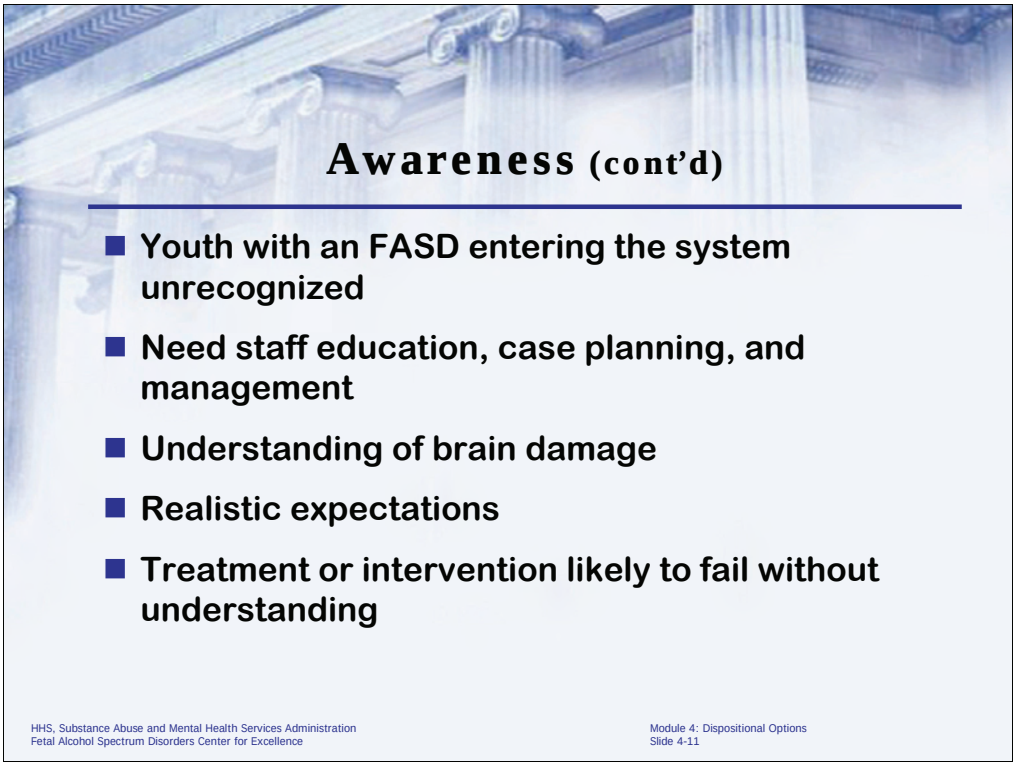
FACILITATOR'S TALKING POINTS:

- Judge Turpel-Lafond wrote a decision—*R. v. L.E.K.*, [2001] S.J. No. 434 (Sask. Youth Ct.)—that ordered senior officials in the Department of Social Services to structure a plan for a youth with FAS. She found that such a plan "required coordination across professions and a network of support for the youth with her FAS disability and attendant learning and health needs."
- Judge Barnett wrote a decision—*R. v. W.D.*, [2001] S.J. No. 70 (Sask. Prov. Ct.)—in sentencing a woman with FAS in which he refused to impose a term of incarceration as punishment, even though it was argued that this was necessary to deter others from similar conduct. Judge Barnett found that his sentencing should focus on two essential needs: To provide a measure of protection for other persons and to provide a realistic framework for possible rehabilitation.
- Judges who are educated about FASD often show more willingness to consider alternative sentencing. Judges are in a unique position to make a difference. They can use their skill and creativity to develop insightful and appropriate sentencing and programs for individuals with an FASD.



FACILITATOR'S TALKING POINTS:

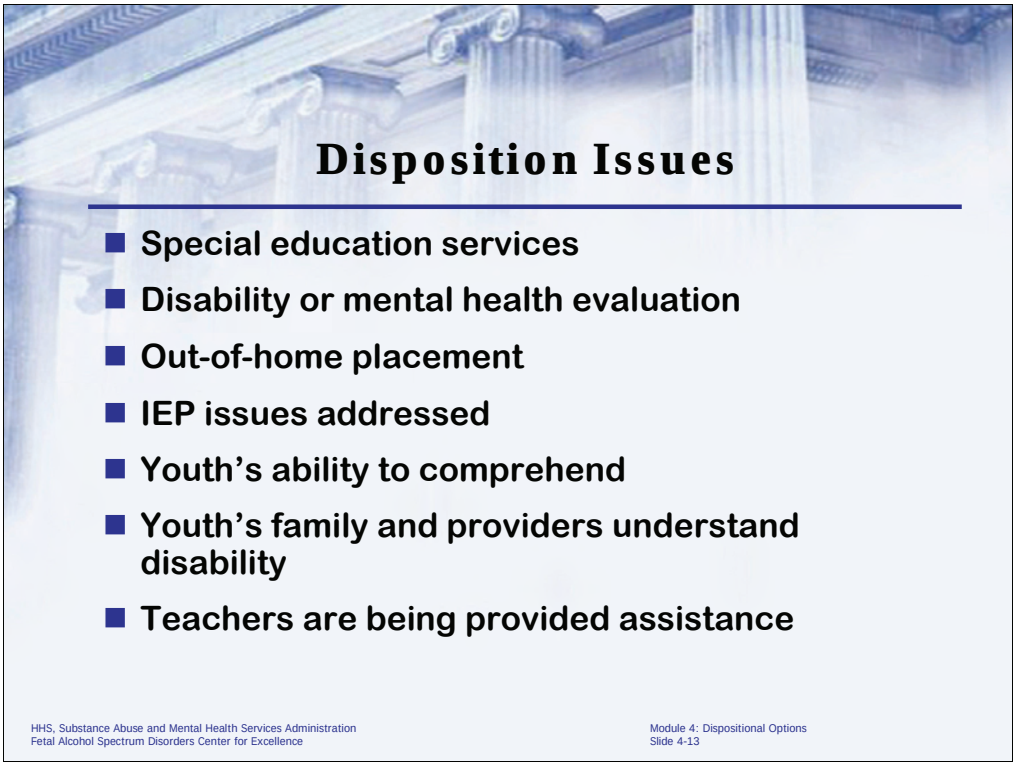
- Early intervention is key to effectively reducing delinquency for youth with an FASD (Streissguth, et al., 1996).
- Juvenile justice interventions should require assessment of a juvenile at his or her entry into the system. This may be difficult, as the court lacks jurisdiction or control over the child at this point. An alternative recommendation would be to require screening for FASD anywhere screening or assessments occur in a juvenile justice system.
- Screening and assessment modalities vary from jurisdiction to jurisdiction. In the juvenile justice system, it is most likely that youth will receive mental health screening and assessment.
- Work is being done in Canada to develop an FASD screening tool for juveniles.
- The Vineland Adaptive Behavior Scale can be used to establish a youth's functional ability. Youth with an FASD often function at developmental levels far below what an IQ score alone would indicate.
- Parents and professionals need to advocate for early assessment for an FASD to stop the downward spiral of failure with no diagnosis, ineffective interventions, etc.



FACILITATOR'S TALKING POINTS:

- Most youth with an FASD enter the juvenile justice system unrecognized. They tend to be verbal and look "okay," so people assume their behavior is purposeful.
- Often, line staff officers recognize that there are youth who "just don't get it."
- Educating staff who provide services to youth with an FASD is a critical step to appropriate and effective intervention. They need increased understanding of the permanent brain damage aspect of the disability. Clients need case planning and management, realistic expectations, and additional support.
- Refer to Slide 1-28, which shows the number of interventions Brandan needed in his young life.

See Activity 1 in the Activities section.

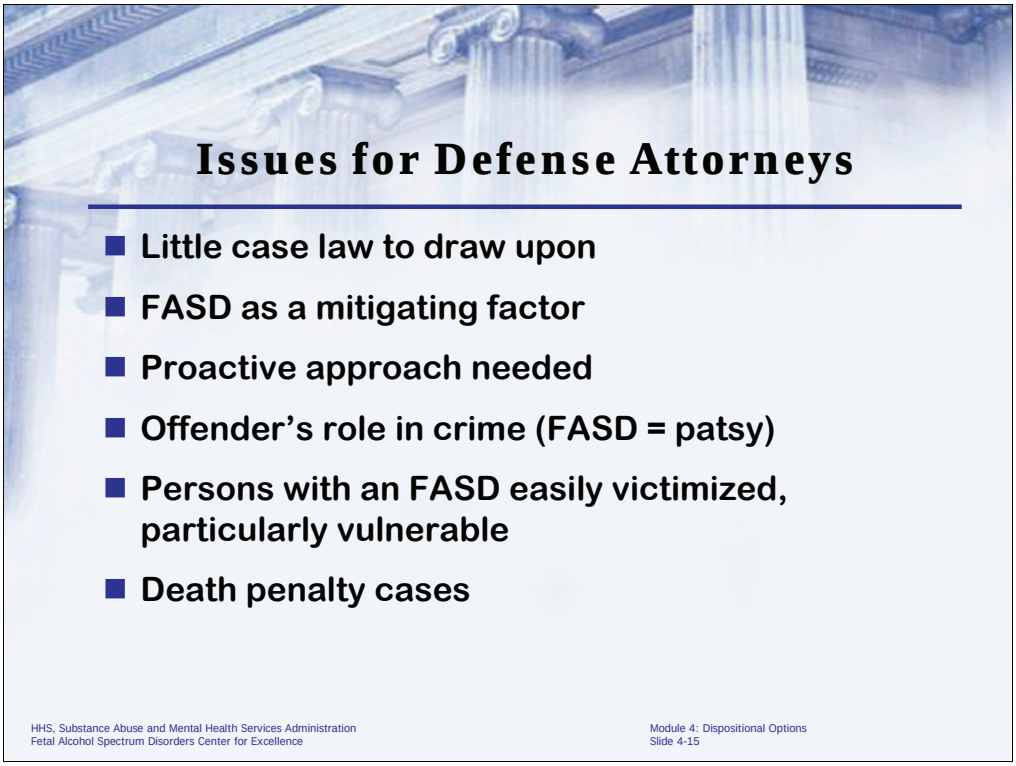


FACILITATOR'S TALKING POINTS:

- To make appropriate decisions regarding disposition of youth with disabilities, including youth with an FASD, all juvenile justice system professionals should consider the following:
  - Has the youth received special education services in his or her previous school placement? Is there a current IEP (Individualized Education Program)?
  - Is an updated or more comprehensive disability or mental health evaluation needed? Have any such evaluations been conducted in the past?
  - Does the out-of-home placement being considered for this youth have programs that can accommodate and specifically address his or her disability?
  - Are the needs addressed in the youth's IEP considered and integrated into the disposition by the court?
  - Does the youth understand the court's order, and is there a plan to address the risk-taking or illegal behaviors that are not related to the youth's disability?
  - Do parents (guardians, foster parents, extended family caregivers), education professionals, program staff, employers, and others involved with the youth understand the youth's disability needs?
  - Are teachers or employers being provided with the assistance and knowledge they need to address this youth's disabilities or problematic behaviors?
- The information gathered through these inquiries needs to be used in developing effective disposition plans.

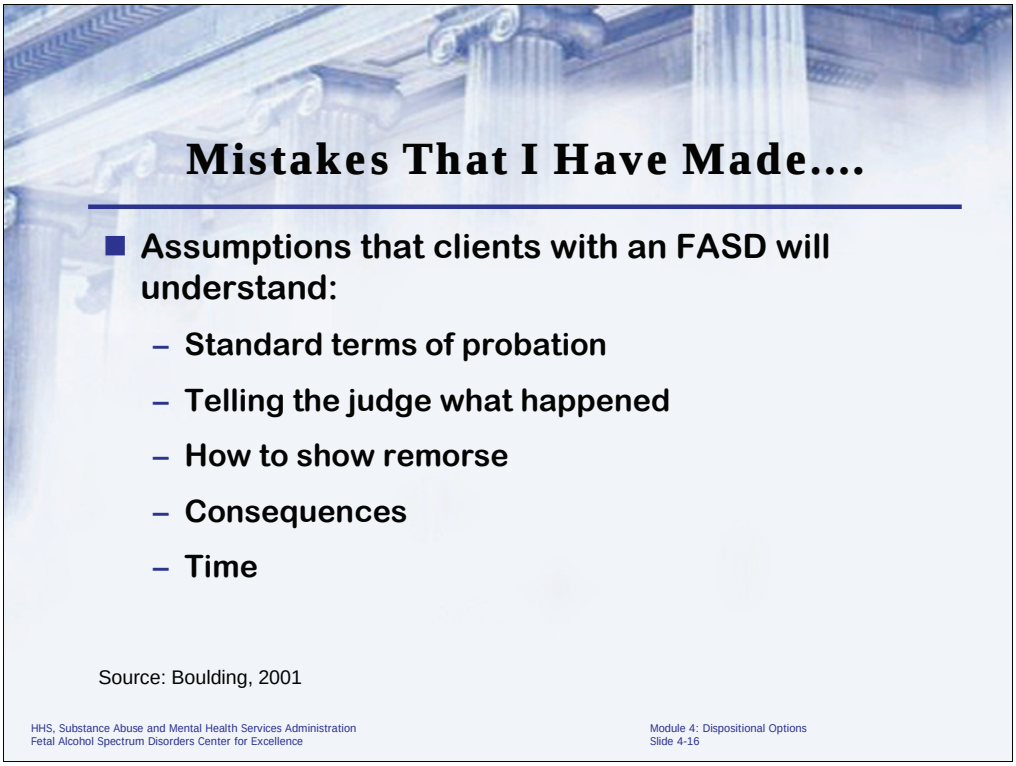
FACILITATOR'S TALKING POINTS:

- It is important to note that, most of the time, youth will not enter the system with a diagnosis of an FASD. However, that does not mean there aren't critical steps you can take. There are certain issues or experiences in the youth's life that can raise the possibility that the youth may have an FASD. These are referred to as "red flags." Asking the following questions may help identify some of these red flags:
  - Are there aspects of the youth's behavior that warrant a screening for a disability (FASD)?
  - Has the youth experienced a history of behavioral or learning problems? How, if at all, have these issues been addressed by the family or the school?
  - Does the youth have a history of being in protective services as a child?
  - If the biological mother is present, does she have an alcohol abuse problem? Has she been in treatment for chemical dependency?
  - Does the youth have any siblings that have an FASD?
  - Does the youth have a history of substance use?
  - Has the youth had a thorough medical workup to rule out any physical health cause of his or her behavior?



FACILITATOR'S TALKING POINTS:

- Because of the lack of awareness, there is little case law to draw upon when defending a client with an FASD.
- Attorneys should consider the issue of FASD as a mitigating factor and take a proactive approach in researching and recommending appropriate dispositional options.
- Youth with an FASD are easily influenced by their peers. Defense attorneys should examine the facts of each case to determine the level of participation in planning and carrying out the offense when representing these youth.
- FASD has been used successfully as a mitigating or aggravating circumstance in some cases in which the sentence has been affected. In the 1995 case U.S. v. Janis, the victim was affected by prenatal alcohol exposure and considered by the court to be unusually vulnerable. The court used this as a reason to adjust the sentence upward by two levels of sentencing guidelines.
- In death penalty cases, defense attorneys have used FASD as a defense in arguing for clemency or having the sentences reduced to life imprisonment. This has had mixed results. In 1992, former California Governor Pete Wilson denied Robert Alton Harris's motion for a stay of execution based on his diagnosis of FAS.



FACILITATOR'S TALKING POINTS:

- In "Mistakes That I Have Made With FAS Clients," attorney David Boulding from British Columbia describes the mistakes he made with these clients, including making these faulty assumptions:
  - Clients with an FASD could be helped by using standard terms of probation and orders.
  - Clients with an FASD could tell the judge what happened in a way that would make sense.
  - They would be able to demonstrate remorse to the judge.
  - They would understand the notion of consequences—if you steal from cars and get caught, you go to jail.
  - They would understand the notion of time—3 days in jail is not the same as 3 months in jail.

Mistakes That I Have Made.... (cont'd)

- I failed my clients with an FASD by:
  - Never asking about drinking during pregnancy when the history was known
  - Not seeking a psychological or neurological assessment
  - Not asking social services for records on the family
  - Not seeing that jail had no effect on their behavior

Source: Boulding, 2001

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Mistakes That I Have Made.... (cont'd)

- "I never put into place structures that would help my clients with follow-through…or put into place some type of support system to check on my clients in an ongoing way."

Source: Boulding, 2001

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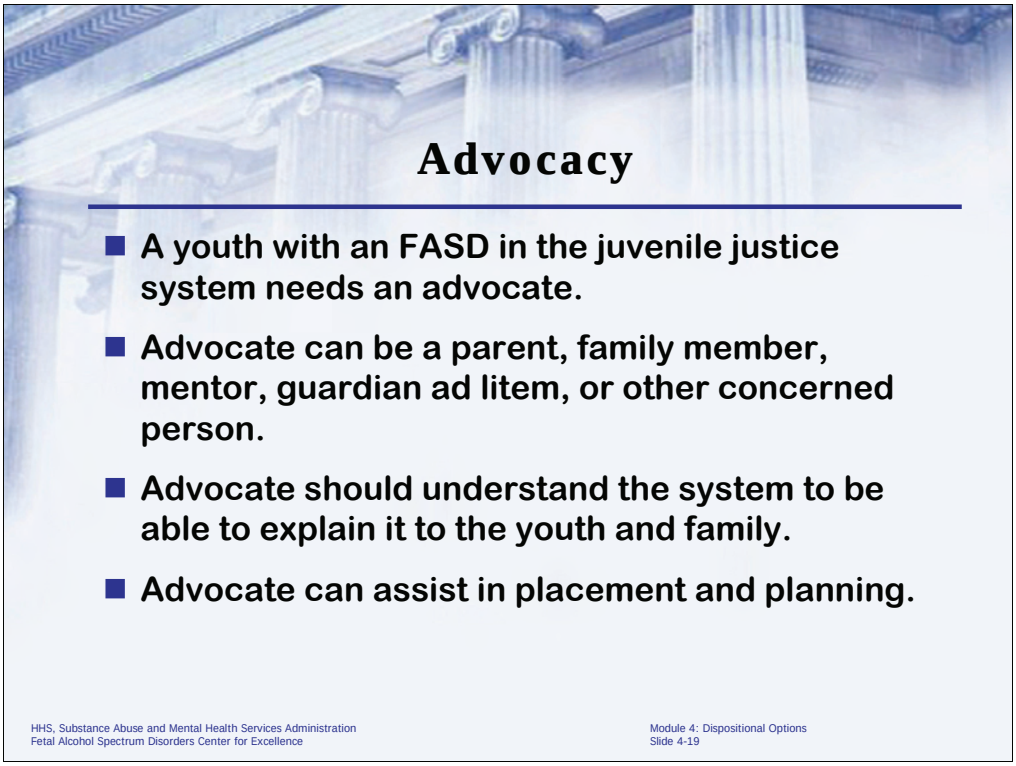
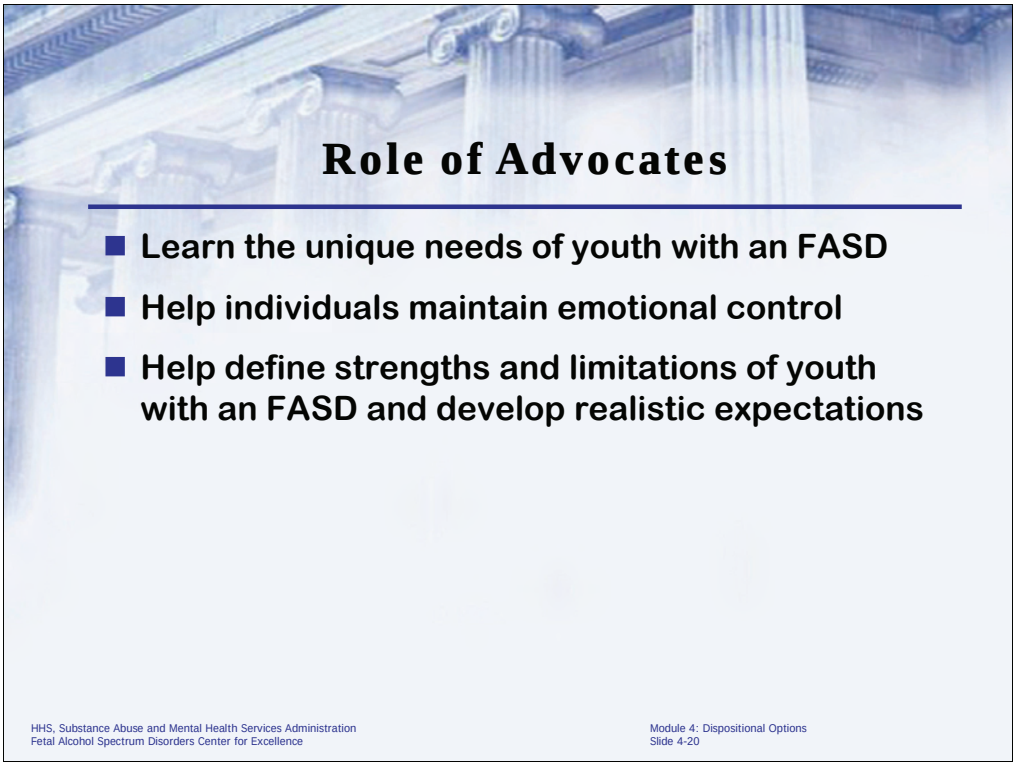


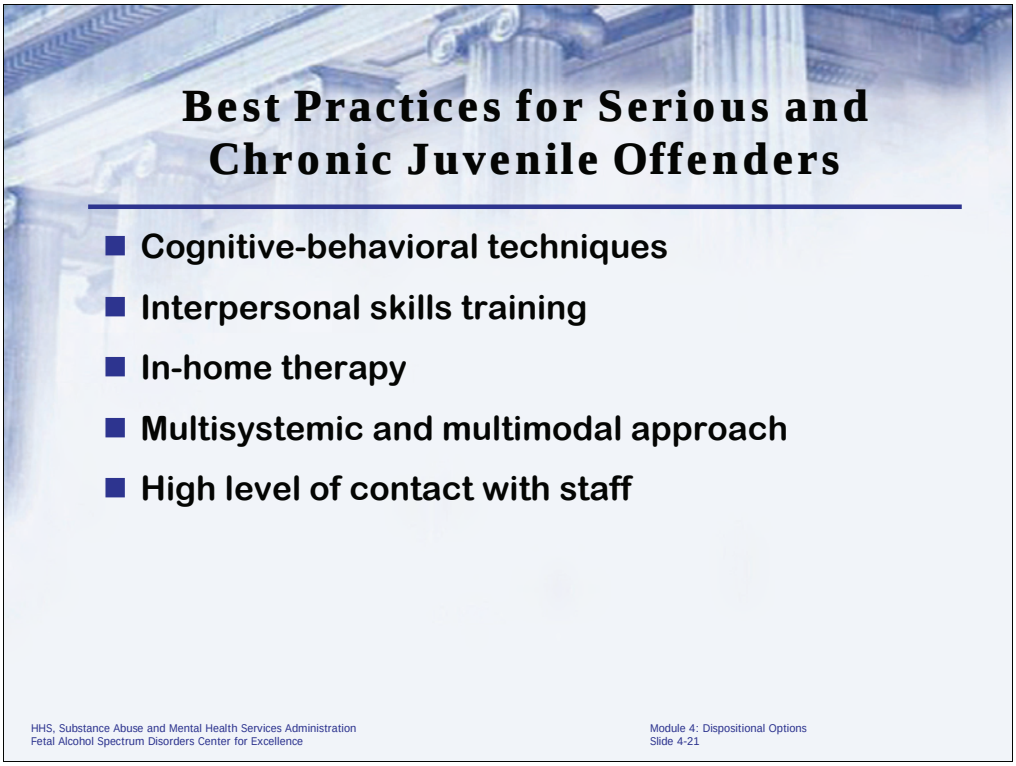
FACILITATOR'S TALKING POINTS:

- One of the most important ways the juvenile justice system can respond to youth with an FASD is to ensure that these youth have advocates to help them through the process and understand what's expected of them and to communicate their needs to the professionals.
- Advocates can be family members, mentors, or guardians ad litem (court appointees). They need to understand the disability and the system.
- Although funding can dictate staff decisions, the court might want to consider appointing FASD-trained advocates for all youth with an FASD. Under most systems, these individuals act as friends of the court and are known as "court-appointed special advocates" (CASAs).
- Advocates can assist the court and other professionals in devising placement and case management plans for the juvenile. They could also instruct professionals on devising more effective strategies, work with family members to educate them, and link the client and family with support and social service agencies.



FACILITATOR'S TALKING POINTS:

- Advocates can:
  - Learn the unique needs of youth with an FASD. Youth with an FASD often cannot articulate their feelings. Advocates need to learn to understand the signs and behaviors of these youth and help them adjust and adapt to situations. The advocate needs to understand the *cause* of the "bad" behavior and consider questions such as, Was the setting too distracting for the youth? Was the task too demanding? Did the youth follow the suggestions of others (or follow along)? Were there multiple directions or rules given at one time? Were the instructions all verbal?
  - Help youth maintain emotional control. Due to a tendency toward impulsive behavior, youth with an FASD need assistance in maintaining their emotions. Advocates can assist other professionals in making sure these youth are given clear, simple, and repetitive directions.
  - Identify strengths in the youth, the family, and the provider systems.
  - Develop realistic expectations. Understanding their strengths and limitations is important in successful interventions.



FACILITATOR'S TALKING POINTS:

- There is little or no research on what works for juvenile offenders with an FASD. There is considerable research on what works for serious and chronic juvenile offenders.
- Research does stress that "what works" must fundamentally be understood as "what works for this young person." What this means is that the juvenile system needs to do risk assessments of these youth and match these assessments with the proper interventions. It is critical to identify youth with an FASD so that proper interventions can be implemented.
- Research has shown what works for serious and chronic offenders includes interventions that:
  - Use cognitive-behavioral techniques focused not on why a person feels or behaves a certain way but on what thoughts precede negative behavior and how to reconstruct those thought patterns in the future.
  - Provide interpersonal skills training, such as anger management and conflict resolution.
  - Work with the youth and family in their home. This strategy increases the level of communication in the home and may address barriers like chemical dependency.
  - Are multisystemic and multimodal. Interventions address all areas of a youth's functioning.
  - Provide high levels of contact with good staff and frequent contact with well-trained staff who model good behavior. Use concrete and direct communication and teaching styles.
- These interventions would most likely need to be adapted for youth with an FASD because of language processing difficulties, memory difficulties (taking in, storing, recalling, and using information), literal thinking, and cognitive impairments.

FACILITATOR'S TALKING POINTS:

- Aftercare and transition service components include prerelease assessment and transitional planning, family-based services, high frequency of contact, motivated and energetic staff, recreational opportunities, prevention programs, and development of community support systems and networks.
- Services need to be responsive and flexible and tailored to each juvenile's understanding, personality, verbal and intellectual capacity, learning style, age, gender, race, and ethnicity.
- It is important to use validated needs assessments.

FACILITATOR'S TALKING POINTS:

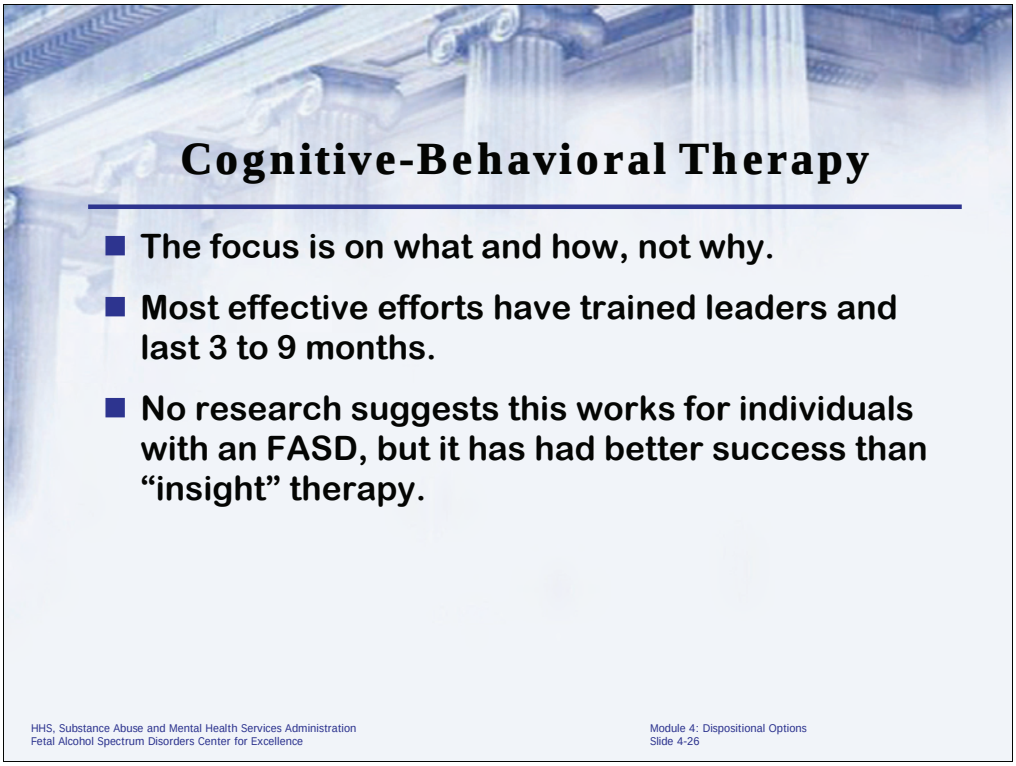
- Criminogenic risk factors are characteristics of an offender that are associated with future criminal behavior. To decrease dynamic criminogenic risk factors (risk factors that can be changed), the focus is on changing antisocial attitudes; promoting family communication; providing mentoring and identification with noncriminals; increasing school success; and teaching self-control, self-management, and problem-solving skills.
- Interventions lasting between 7 months and 18 months improve outcomes.
- Behavior modification using highly structured techniques that are adapted for people with an FASD may work.
- Gradual "stepping up" to a residential placement and "stepping down" from a placement through transition and aftercare planning can be essential for success as long as the needed supports for the person are in place.

FACILITATOR'S TALKING POINTS:

- Intensive case management with staff who understand FASD can be highly effective. Programs that provide training for families are effective in helping families better understand their child's disability. A case manager who works directly with the family as an advocate is best for families in crisis.
- Restitution and probation together can be effective.
- Because individuals with an FASD often seem to learn most by modeling the behavior of others, providing the youth with a trained and supervised mentor who can model prosocial, positive behaviors can be very effective.
- Providing the youth with successful educational/vocational opportunities can increase self-esteem and prosocial behavior.
- The Parent-Child Assistance Program (PCAP) is a home visitation intervention program that works with high-risk women who abuse alcohol or drugs during pregnancy. The aim is reducing future alcohol- and drug-exposed births among these mothers, as well as reducing other risky behaviors and addressing the health of the mother and her children (Parent-Child Assistance Program, no year).

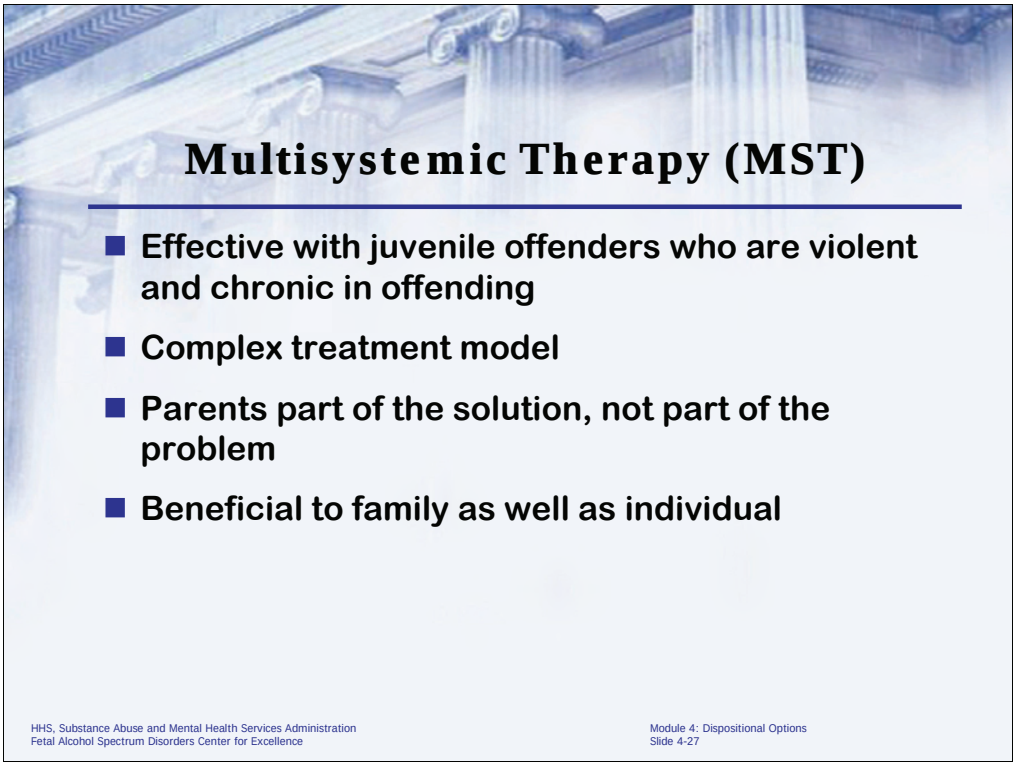
FACILITATOR'S TALKING POINTS:

- It is difficult to know what does not work for youth with an FASD and even more difficult to identify what "works." Information written on best practices typically does not indicate who does not do well. If something is not working, reassess the model and ask yourself, What if this youth has an FASD? The questions to ask next are, What does this youth need in order to be successful and how do we arrange that?
- As of now, there is no known, formalized, tested, evaluated, and validated treatment program specifically for youth with an FASD. Many youth will benefit from existing treatment programs in the areas of social and life skills, cognitive functioning, anger management, and substance abuse. However, it is important to tailor the program specifically to match the abilities of the individual. For those with an FASD, breaking everything into steps with much repetition is important.
- We cannot emphasize enough the importance of tailoring the program. Although there is research under way to identify successful interventions for those with an FASD, no validated treatment regimens have been implemented. There are many programs that have been found to work—for example, programs for chronic juvenile offenders. More research needs to be conducted to determine what works. In the meantime, professionals need to create individual programs for people with an FASD based on the knowledge we have of how prenatal alcohol exposure affects brain development.
- Because youth with an FASD face multiple problems, professionals need to consider more than just a single treatment program.



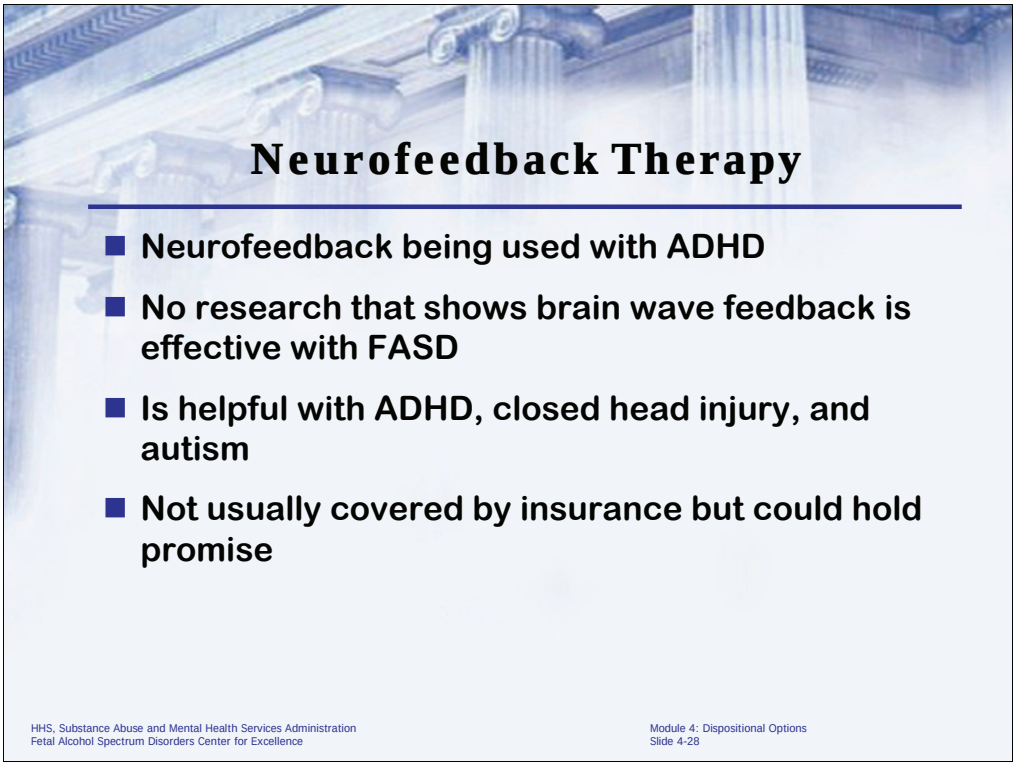
FACILITATOR'S TALKING POINTS:

- This is a type of individual or group therapy that focuses not on why a person feels or behaves a certain way but on what thoughts precede negative behavior and how to restructure those thought patterns in the future.
- Cognitive training, or "cog," is growing in jails and prisons across the country. It teaches problem solving, anger management, and conflict resolution. Studies show that cog can reduce recidivism and incarceration.
- Cognitive therapy is structured, strongly guided by the therapist, and skills-focused. Because it is structured and redundant, individuals with an FASD will have a greater chance of success with this type of program.
- However, cognitive-behavioral approaches may often need to be adapted for those with an FASD. For example, more role playing and less "talk" therapy may be needed.



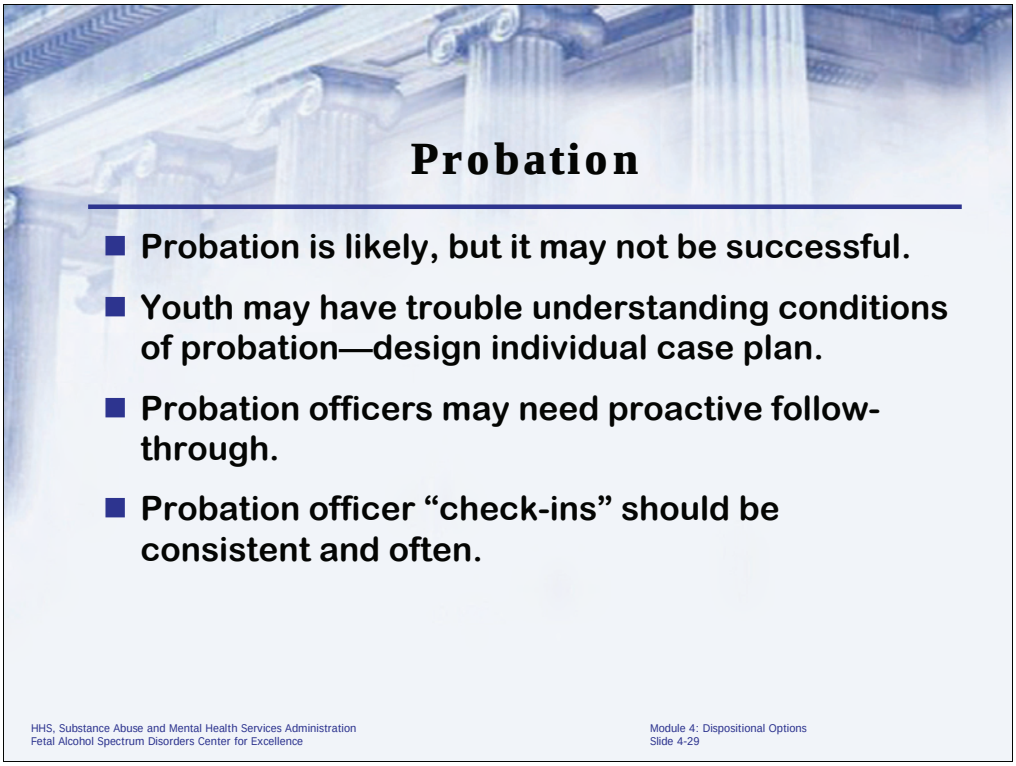
FACILITATOR'S TALKING POINTS:

- MST has proven effective in rigorous tests with violent and chronic juvenile offenders, as well as with youth who abuse substances and with juvenile sex offenders.
- MST is a family-based treatment that intensively addresses the known causes of delinquency directly in the home, school, and community. It is a complex treatment model that emphasizes provider accountability for engaging families in the treatment process.
- MST directly addresses the multiple factors that contribute to delinquency.
- MST sees parents as part of the solution rather than the problem.
- Therapists focus their energy to empower parents and families by using a strengths-based approach.
- MST also addresses barriers such as drug use and stress.
- MST is a potential therapy for juveniles with an FASD; however, it needs to be adapted for this population, and all parties need a good understanding of the youths' disabilities, including strengths and deficits.



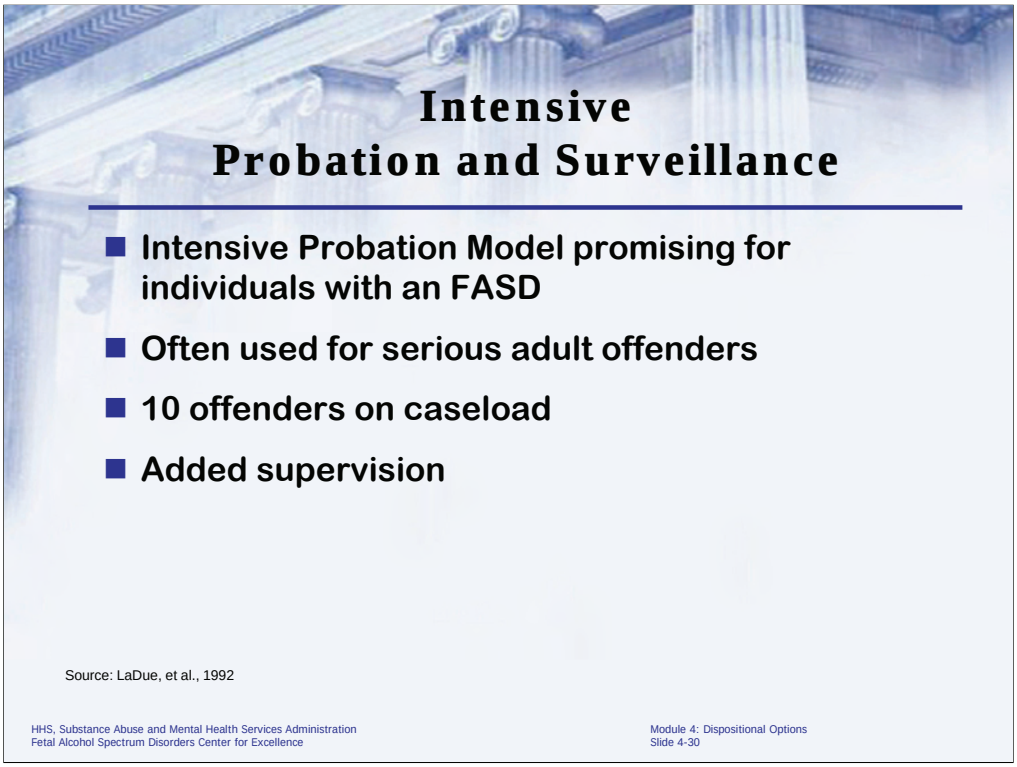
FACILITATOR'S TALKING POINTS:

- Neurofeedback is a painless, noninvasive treatment that allows individuals to gain information about their brain wave activity.
- Research shows that individuals with attention-deficit/hyperactivity disorder (ADHD) have elevated theta brain wave activity and low levels of beta brain wave activity.
- Neurofeedback has been reported to be helpful with disorders such as ADHD, closed head injury, and autism (Lubar, et al., 1995).
- Because there is no research that shows this treatment is effective for individuals with an FASD, insurance may or may not cover the costs. Since 40 to 60 sessions can be needed, this therapy can be quite expensive. Professionals need to consider this.
- Although anecdotal reports point to possible benefits, controlled research needs to be done to evaluate this approach.



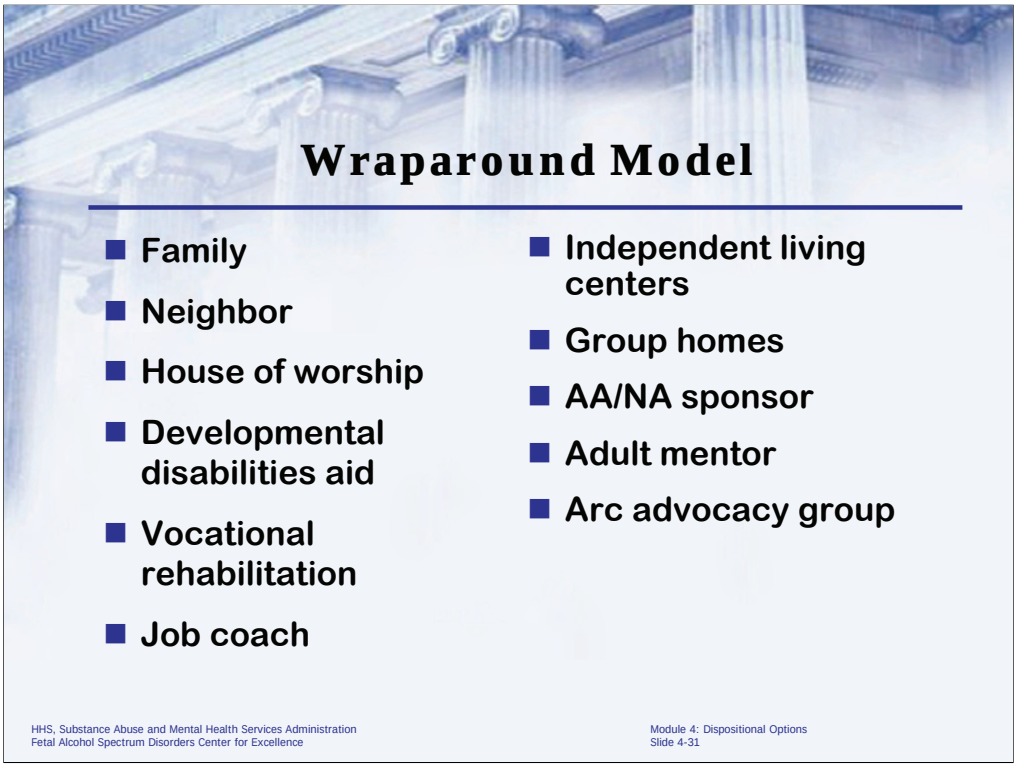
FACILITATOR'S TALKING POINTS:

- Most adjudicated youth will be placed on probation.
- Juveniles with an FASD on a general probation plan probably won't be successful. They will forget to call in and may miss appointments because of the disability.
- Juveniles with an FASD may forget what they are supposed to do and, as a result, violate probation.
- Juveniles with an FASD may not truly understand the multiple rules they have to follow in order to comply with a probation order.
- Case management of offenders with an FASD must take into consideration their inability to comprehend the conditions of the probation, and case plans must be designed to meet the youth's specific disabilities.
- Probation officers may need to be more proactive and make calls or aid in the follow-through with appointments.
- "Check-ins" with probation officers may be more successful if they are consistent and often (e.g., same time every day).
- Families and other supports need to be used to support the youth's success.
    - If family members have an FASD, tasks should be broken down and reviewed repeatedly, and support should be provided when needed.



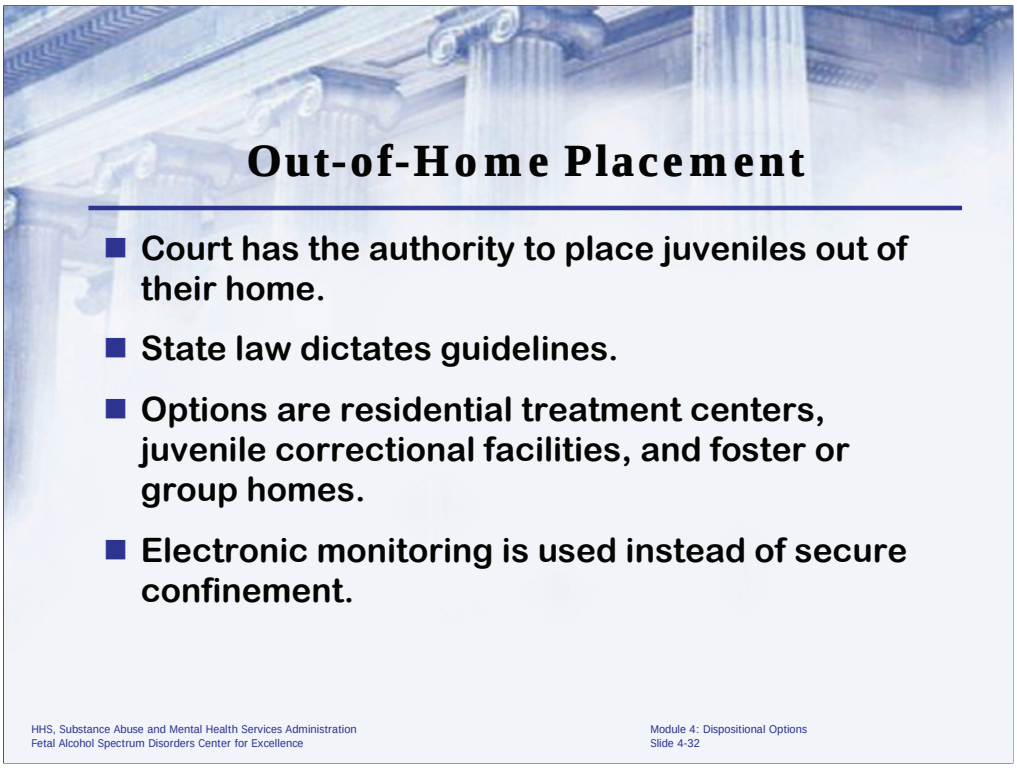
FACILITATOR'S TALKING POINTS:

- The Intensive Probation Model is offering some signs of hope for offenders with an FASD. It is typically used for adult offenders, and often the probation officer has only 10 people on the caseload.
- The focus is on continuity and frequent contact. Services are sought that specifically address the treatment needs of the offender, as well as provide the appropriate amount of supervision.
- It's important for probation officers to understand the child's disability and how it impacts his or her ability to follow through on conditions of probation.



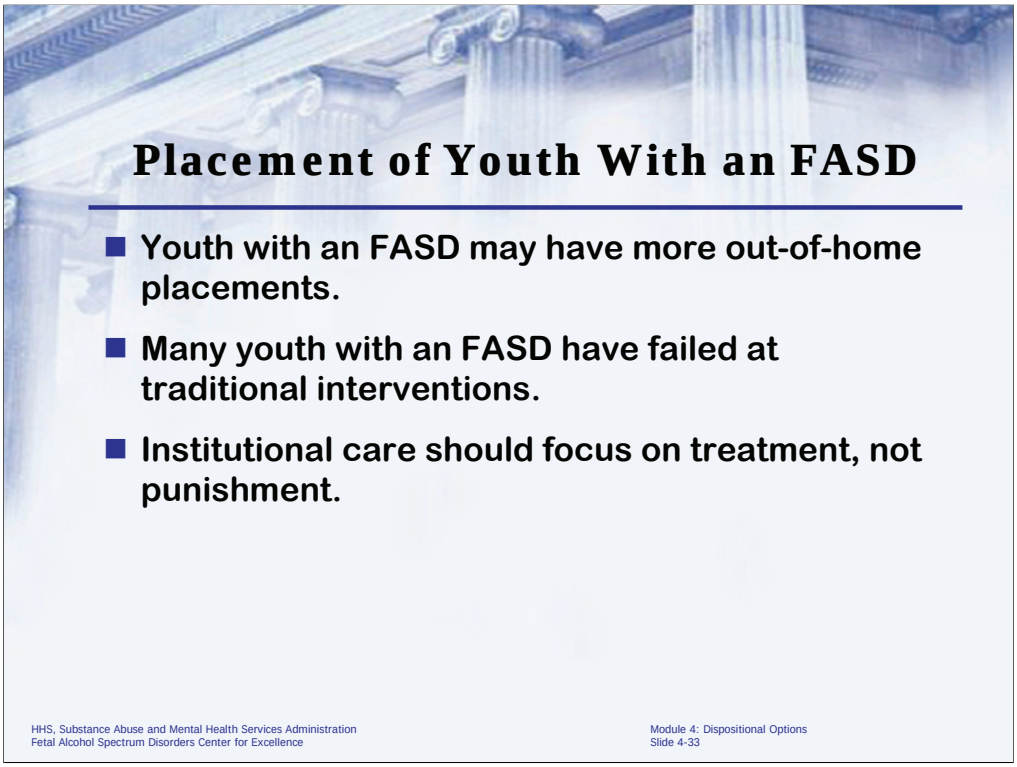
FACILITATOR'S TALKING POINTS:

- The wraparound system of care was developed by John VanDenBerg. At its core is a review of the youth and family to identify what resources are needed (e.g., services, providers) to keep the child at home (or at least in the community). This model focuses on the youth and family (VanDenBerg and Grealish, 1996).
- It may take 10 support persons for each individual with an FASD to be safe and successful. This is far less costly to society than prison and far more humane.
- Individuals with an FASD have a lifetime sentence before they are ever born, through no action or choice of their own.
- The wraparound concept strives to include multilevel services from a variety of disciplines. Community services for youth with an FASD will be more successful if agencies work together.



FACILITATOR'S TALKING POINTS:

- The court has the authority to place juveniles out of their home, and State law dictates the guidelines for such placements. Payment varies depending on the placement. The county or State may pay. In some cases the State or county will pay for the placement and may recoup the costs from the parents.
- Placements may occur in residential treatment centers, juvenile correctional or detention facilities, foster homes, and group homes.
- Juveniles who commit serious offenses, are repeat offenders, or fail to follow through with court orders or rules of probation are likely candidates for out-of-home placement.
- Juveniles who are arrested on a serious offense or taken into custody on a bench warrant for failing to comply with court orders or to appear for court hearings may be held in a secure detention facility until a detention hearing.
- Most courts use an electronic monitoring system as an alternative to secure confinement. The juvenile wears an electronic device that notifies probation if the youth is out of range of his or her house. This is a short-term option.
- According to the Office of Juvenile Justice and Delinquency Prevention (OJJDP), more than one in four adjudicated delinquency cases resulted in out-of-home placement in 1997. OJJDP also reports that the number of adjudicated delinquents placed outside the home grew 56 percent between 1988 and 1997 (Puzzanchera, 2000).
- When making the decision as to whether an out-of-home placement is appropriate, the court is guided by the "purpose clause" of the State's juvenile code. The code will direct the court to consider such factors as public safety, the juvenile's rehabilitative needs, the prevention of future delinquent activity, and the needs of the victim.



FACILITATOR'S TALKING POINTS:

- Youth with an FASD may face out-of-home placements more often than other juveniles because of their repetitive delinquent behavior and lack of follow-through with court orders and probation rules. Even if they don't commit a delinquent act, they are more likely to be at risk for dropping out of school and running away. Both of these activities will bring them before juvenile court and increase their chances of being placed out of the home.
- Traditional interventions have failed many youth with an FASD. Therefore, social service and probation often recommend out-of-home placements.
- If public safety is not an issue, then the professionals should consider a disposition that takes into account the youth's FASD disability instead of automatically recommending placement out of the home. This is particularly true if the FASD information is new to the court.
- If the court determines that institutional care is necessary and appropriate, professionals should consider facilities in which treatment, and not punishment, is emphasized. An advocate from the residential staff should be assigned to the juvenile as soon as he or she arrives at the facility.
- If a youth with an FASD is going to be placed out of the home, it is essential that people in that setting (e.g., staff, administrators, foster parents) have a sound understanding of FASD.

See Activity 2 in the Activities section.

Questions

Posttest!

Use this space for your notes.

Terms Used in Module 4

- Advocate: A person who promotes and supports the interests of another on his or her behalf
- Adjudicated: Given a judgment in a case
- Allegation: A claim of misconduct or illegal behavior made against a juvenile
- Disposition: Terms and type of punishment assigned in a juvenile case
- Juvenile delinquent: A youth who has been found guilty of breaking a law

Use this space for your notes.

Terms Used in Module 4 (cont'd)

- **Mitigating circumstances/mitigating factors:** Conditions that influenced or compelled the crime that do not excuse or justify the criminal conduct but are considered out of fairness in deciding the degree of the offense
- **Probation:** A period of supervision in which the juvenile's behavior and conduct are monitored under specific rules and instructions
- **Restitution:** An agreement to pay or make amends to a victim for damages caused by the juvenile's crime

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References

- See References for a complete list of all references in this module.

HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence

Module 4: Dispositional Options
Slide 4-38

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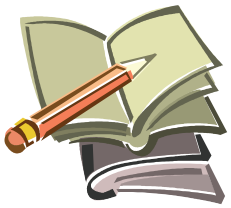
Pretest



ID # _____–pre

Please answer true or false to the following questions:

1. There are specific advocates trained to support juveniles with an FASD through the court process in every State.

   True ☐ or False ☐

2. Judges who are educated about FASD have shown more of a willingness to consider alternative sentencing.

   True ☐ or False ☐

3. "Disposition" is considered sentencing for youth who have been found guilty of a crime.

   True ☐ or False ☐

4. Although there is little research on "what works" for a youth with an FASD, there is a commonly held belief that programs that are short in duration are most effective.

   True ☐ or False ☐

5. When professionals understand that often the behavior of youth with an FASD is a result of brain damage, they are more effective in working with these youth.

   True ☐ or False ☐

6. Intensive probation and surveillance has shown some promise of being successful for youth with an FASD.

   True ☐ or False ☐

7. Cognitive-behavioral therapy may be more effective for youth with an FASD than insight-oriented therapy.

   True ☐ or False ☐

Posttest Facilitator's Notes

Please answer true or false to the following questions:

1. Disposition is considered sentencing for youth who have been found guilty of a crime.

   True ☐ or False ☐

   True: "Disposition" is defined as the order of a juvenile court that sets out the conditions a juvenile must comply with. It is similar to sentencing in an adult criminal case.

2. Judges who are educated about FASD have shown more of a willingness to consider alternative sentencing.

   True ☐ or False ☐

   True: Examples include combinations of community-based programs or mental health facilities for treatment instead of correctional punishment-based facilities. Some judges have been willing to suspend sentences if the individual with an FASD completes an appropriate treatment program.

3. Although there is little research on "what works" for a youth with an FASD, there is a commonly held belief that programs that are short in duration are most effective.

   True ☐ or False ☐

   False: Interventions that last between 7 months and 18 months improve outcomes for chronic juvenile offenders and youth with an FASD.

4. When professionals understand that often the behavior of youth with an FASD is a result of brain damage, they are more effective in working with these youth.

   True ☐ or False ☐

   True: When professionals understand the disability and the brain damage, and have insights into the behavior, they are able to do more effective case planning and management.

5. There are specific advocates trained to support juveniles with an FASD through the court process in every State.

   True ☐ or False ☐

   False: Specifically trained advocates for youth with an FASD are rare. However, understanding the system can often be very confusing for the youth and family. It is essential that a youth have an advocate assigned to him or her. This advocate can be a parent, caregiver, guardian ad litem, mentor, or another individual who has the time, expertise in FASD, and understanding of the youth's needs.

6. Cognitive-behavioral therapy may be more effective for youth with an FASD than insight-oriented therapy.

   True ☐ or False ☐

   True: There is no current research on how cognitive therapy works for individuals with an FASD, but because the therapy is more structured, it is more likely to be a success than insight-oriented therapy.

7. Intensive probation and surveillance has shown some promise of being successful for youth with an FASD.

   True ☐ or False ☐

   True: This model is often used for serious adult offenders. Probation officers have only 10 offenders on their caseload, which allows for more one-on-one attention and support.

Activity 1–Questions From the Bench–Activity Handout

Questions From the Bench

There seems to be a pattern to _____'s behaviors apart from getting into trouble. It appears that he does not truly understand why he is in trouble or how to avoid getting into trouble in the future. Would you agree?

- Does it also appear that sometimes when you talk to him, you are not sure he truly "gets it"?
- Does he have problems with memory? Does the school tell you that he has difficulty with math?
- What types of behaviors are you observing at home? Are there any issues that you are concerned about?

The learning problems and behaviors that we are seeing in _____ are often seen in children who were exposed to alcohol before birth.

- (To birth mom) Could you give me some history so we can compare it with what we are observing? What was your pregnancy like? Did you have prenatal care? Were there any complications with the birth? Was he full-term?
- Were there any childhood concerns that we should be aware of (immunizations up to date, any falls, high fevers, etc.)?
- (To birth mom) How much alcohol do you drink?
- (To birth mom) Is it at all possible that you drank alcohol before you knew you were pregnant? Could you give me an idea of how much you drank? Did you drink throughout the pregnancy?
- (To adoptive, foster, or other caregiver) Is it possible that _____was exposed to alcohol before birth?

We've learned some specific ways to help children if we know for sure that their brain has developed a little differently than usual. The sooner we know, the better it is for your child. Then we can all help him in the best possible way.

I am going to court-order a diagnostic evaluation for fetal alcohol syndrome at the comprehensive FAS diagnostic clinic at _____. In the meantime, I would also like to order you to attend a Parenting Differently class. You will learn a different parenting approach that will take into account the probability of brain damage from alcohol.

Used with permission from Barbara M. Wybrecht, RN

Activity 1–Questions From the Bench

To be conducted during Slide 4-11

Tools needed:

Handout: "Questions From the Bench"

Steps:

Slide 4-11

1. Ask for two volunteers to role-play the "Questions From the Bench." One will play the judge, and the other will play the parent/caregiver. Give each one a copy of the "Questions From the Bench" handout.
2. Take a 10-minute break for the volunteers to prepare the scene. Discuss the role-play and provide guidance to the two volunteers.
3. Ask the volunteers to role-play the scene.
4. Distribute the "Questions From the Bench" handout to all the participants and ask the group about the questions.
   a. Are the questions realistic?
   b. Will the judge or interviewer get accurate answers?
   c. Are these questions important in helping the court determine the best resolution of the case?
5. Have participants exchange ideas for other information the judge could provide and other questions the judge could ask.

Activity 2–What Would You Do Differently?

To be conducted during Slide 4-33

Tools needed:

Flip chart paper

Slide 4-33

Steps:

1. Break the participants into small groups of three to five people (depending on the size of the group). Have the participants count off to form groups (1, 2, 3, etc.).
2. Have the groups choose a recorder and a reporter.
3. Ask participants to think about a youth they work with. Then, ask them to discuss what they would do differently if they knew or suspected that this youth had an FASD. How would they help the family understand the FASD disability? How would they help the family provide structure in the child's life? In the home? The recorder should write ideas on flip chart paper, and the reporter should be prepared to present findings to the large group.
4. In the large group, ask reporters to share their group's ideas. Ask other small groups to give feedback.

Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

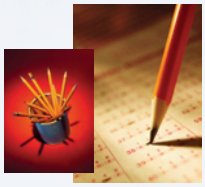
Module 4

Dispositional Options

Module 4: Dispositional Options

- Objectives: After completing this module, participants will be able to:
  - List issues to consider during disposition of youth with an FASD
  - Analyze dispositional options available for youth with an FASD
  - Describe dispositional options that could lead to better outcomes for repeat juvenile offenders with an FASD

Pencils Out



Pretest!

The Courts

- When a juvenile is found delinquent of an offense, the next step is what the court (judge) decides to do with the juvenile.
- Options may include consequences, treatment, probation, placement, and restitution.
- Juvenile courts use “disposition,” and adult courts use “sentencing.”

The Courts (cont'd)

- May be the most important player of the juvenile justice system for initiating assistance for youth with an FASD
- Judicial officers have the power to:
  - Make a difference in how youth with an FASD are treated
  - Change screening and assessment procedures systemwide

Choosing the Disposition

- Judges receive recommendations from probation officers, defense attorneys, and prosecutors.
- Lack of information and awareness leads to dispositions that are not helpful.
- Judges who are educated can make a powerful difference for youth with an FASD.

Canadian Decisions on FASD

- Two Canadian judges wrote decisions that provide guidelines to other courts in sentencing a person with an FASD.
  - Judge M.E. Turpel-Lafond, Youth Court of Saskatchewan
  - Judge C. Cunliffe Barnett, Provincial Court of British Columbia

Awareness

- Early intervention—the key
- Assessment at entry into system
- Parent, professional advocates needed

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Module 4: Dispositional Options
Slide 4-10

Awareness (cont'd)

- Youth with an FASD entering the system unrecognized
- Need staff education, case planning, and management
- Understanding of brain damage
- Realistic expectations
- Treatment or intervention likely to fail without understanding

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Module 4: Dispositional Options
Slide 4-11

Activity

Disposition Issues

- Special education services
- Disability or mental health evaluation
- Out-of-home placement
- IEP issues addressed
- Youth's ability to comprehend
- Youth's family and providers understand disability
- Teachers are being provided assistance

Issues When No Diagnosis Has Been Made

- Red flags for a disability (FASD) screening
  - Behavioral or learning problems
  - Issues addressed by school
  - History of protective services as a child
  - Biological parent with chemical dependency issues
  - Any siblings with an FASD
  - History of substance abuse

Issues for Defense Attorneys

- Little case law to draw upon
- FASD as a mitigating factor
- Proactive approach needed
- Offender's role in crime (FASD = patsy)
- Persons with an FASD easily victimized, particularly vulnerable
- Death penalty cases

Mistakes That I Have Made....

- Assumptions that clients with an FASD will understand:
  - Standard terms of probation
  - Telling the judge what happened
  - How to show remorse
  - Consequences
  - Time

Source: Boulding, 2001

Mistakes That I Have Made.... (cont'd)

- I failed my clients with an FASD by:
  - Never asking about drinking during pregnancy when the history was known
  - Not seeking a psychological or neurological assessment
  - Not asking social services for records on the family
  - Not seeing that jail had no effect on their behavior

Source: Boulding, 2001

Mistakes That I Have Made.... (cont'd)

- "I never put into place structures that would help my clients with follow-through…or put into place some type of support system to check on my clients in an ongoing way."

Source: Boulding, 2001

Advocacy

- A youth with an FASD in the juvenile justice system needs an advocate.
- Advocate can be a parent, family member, mentor, guardian ad litem, or other concerned person.
- Advocate should understand the system to be able to explain it to the youth and family.
- Advocate can assist in placement and planning.

Role of Advocates

- Learn the unique needs of youth with an FASD
- Help individuals maintain emotional control
- Help define strengths and limitations of youth with an FASD and develop realistic expectations

Best Practices for Serious and Chronic Juvenile Offenders

- Cognitive-behavioral techniques
- Interpersonal skills training
- In-home therapy
- Multisystemic and multimodal approach
- High level of contact with staff

Best Practices (cont'd)

- Community-based approaches
- Aftercare and transition services
- Responsive and flexible approaches
- Use of validated risk/needs assessments

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Module 4: Dispositional Options
Slide 4-22

Best Practices (cont'd)

- Approaches that decrease dynamic criminogenic risk factors
- Long-term interventions
- Behavior modification
- Continuum of graduated sanctions

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Module 4: Dispositional Options
Slide 4-23

Best Practices (cont'd)

- Case management
- Restitution and probation together
- Mentoring
- Educational/vocational treatment with other interventions

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Module 4: Dispositional Options
Slide 4-24

Community Treatment Interventions

- If it doesn't work, reassess the model
- No known, formalized treatment
- Tailor the program to the individual
- Consider multiple-treatment approach

Cognitive-Behavioral Therapy

- The focus is on what and how, not why.
- Most effective efforts have trained leaders and last 3 to 9 months.
- No research suggests this works for individuals with an FASD, but it has had better success than "insight" therapy.

Multisystemic Therapy (MST)

- Effective with juvenile offenders who are violent and chronic in offending
- Complex treatment model
- Parents part of the solution, not part of the problem
- Beneficial to family as well as individual

Neurofeedback Therapy

- Neurofeedback being used with ADHD
- No research that shows brain wave feedback is effective with FASD
- Is helpful with ADHD, closed head injury, and autism
- Not usually covered by insurance but could hold promise

Probation

- Probation is likely, but it may not be successful.
- Youth may have trouble understanding conditions of probation—design individual case plan.
- Probation officers may need proactive follow-through.
- Probation officer "check-ins" should be consistent and often.

Intensive Probation and Surveillance

- Intensive Probation Model promising for individuals with an FASD
- Often used for serious adult offenders
- 10 offenders on caseload
- Added supervision

Source: LaDue, et al., 1992

Wraparound Model

- Family
- Neighbor
- House of worship
- Developmental disabilities aid
- Vocational rehabilitation
- Job coach
- Independent living centers
- Group homes
- AA/NA sponsor
- Adult mentor
- Arc advocacy group

Out-of-Home Placement

- Court has the authority to place juveniles out of their home.
- State law dictates guidelines.
- Options are residential treatment centers, juvenile correctional facilities, and foster or group homes.
- Electronic monitoring is used instead of secure confinement.

Placement of Youth With an FASD

- Youth with an FASD may have more out-of-home placements.
- Many youth with an FASD have failed at traditional interventions.
- Institutional care should focus on treatment, not punishment.

Activity

Questions

Posttest!

Terms Used in Module 4

- Advocate: A person who promotes and supports the interests of another on his or her behalf
- Adjudicated: Given a judgment in a case
- Allegation: A claim of misconduct or illegal behavior made against a juvenile
- Disposition: Terms and type of punishment assigned in a juvenile case
- Juvenile delinquent: A youth who has been found guilty of breaking a law

Terms Used in Module 4 (cont'd)

- Mitigating circumstances/mitigating factors: Conditions that influenced or compelled the crime that do not excuse or justify the criminal conduct but are considered out of fairness in deciding the degree of the offense
- Probation: A period of supervision in which the juvenile's behavior and conduct are monitored under specific rules and instructions
- Restitution: An agreement to pay or make amends to a victim for damages caused by the juvenile's crime

References

- See References for a complete list of all references in this module.

Module 5: Special Education and Behavior Management

Description

Summary

The fifth module provides an overview of issues related to the special education rights of individuals with disabilities, including the Individualized Education Program (IEP) and Individuals With Disabilities Education Improvement Act (IDEA). The lesson plan also focuses on behavior management techniques that are appropriate for individuals with an FASD.

Objectives

After completing this module, participants will be able to:

- Discuss special education rights of individuals with disabilities
- Identify requirements of juvenile justice systems to provide special education for youth
- Describe effective behavior management techniques for individuals with an FASD

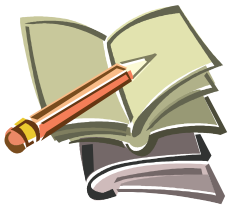
Facilitator's Outline

Step and Time	Tools Needed
One: Introduction—5 minutes	
You are presenting the *Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System*, a joint project of the Substance Abuse and Mental Health Services Administration (SAMHSA) Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence and the Minnesota Organization on Fetal Alcohol Syndrome. The FASD Center is a Federal initiative devoted to preventing and treating FASD. The Center's goals include advancing the field of FASD and promoting best practices. You may want to have participants introduce themselves, if time allows. Ask participants to state their backgrounds and interest in FASD. *Note: You do not need to do introductions if you combine modules—only conduct introductions at the beginning of a training session.*	
Two: Why We Are Here—5 minutes	
Discuss *Tools for Success*. *Tools for Success* focuses on assisting professionals who work with youth in the juvenile justice system who have an FASD to develop effective and appropriate interventions. It is designed for all correctional professionals, including advocates, attorneys, social workers, and social and human service providers who interact with children and families affected by FASD. *Tools for Success* contains seven modules: ■ Fetal Alcohol Spectrum Disorders (FASD): The Basics ■ FASD in the Juvenile Justice System ■ The Juvenile Justice System Response ■ Dispositional Options ■ Special Education and Behavior Management ■ Transition and Aftercare ■ Resources **2 minutes**	**PowerPoint Slide 5-1**

Step and Time	Tools Needed
Two: Why We Are Here (continued)	
Discuss Module 5: Special Education and Behavior Management. The fifth module provides an overview of issues related to the special education rights of individuals with disabilities, including IEP and IDEA. The lesson plan also focuses on behavior management techniques that are appropriate for individuals with an FASD. **2 minutes**	**PowerPoint Slide 5-2**
Discuss objectives for the module as indicated on PowerPoint Slide 5-3. **1 minute**	**PowerPoint Slide 5-3**
Three: Pretest—10 minutes	
Distribute the pretest and allow time for participants to complete it. After ensuring that each participant has provided a unique identifier on the pretest (see the Introduction), collect the tests. Do not review answers at this time.	**PowerPoint Slide 5-4** **Pretest** 
Four: PowerPoint Presentation—20 minutes	
Using PowerPoint presentation and facilitator talking points, provide introduction and background on the special education services, IEP, IDEA, 504 plan, and advocacy for clients with an FASD.	**PowerPoint Slides 5-5 through 5-23**
Five: Red Flags and Screening Questions Activity—20 minutes	
Follow directions for Activity 1—Red Flags and Screening Questions. Distribute Activity Handout: "Red Flags That Warrant Further Investigation." Distribute Activity Handout: "Screening Questions for Identifying Disabilities."	**PowerPoint Slide 5-24**  **Activity 1 sheets in curriculum** 

Step and Time	Tools Needed
Six: PowerPoint Presentation—30 minutes	
Using PowerPoint presentation and facilitator talking points, discuss behavior management for youth with an FASD, strategies that work, and eight magic keys.	**PowerPoint Slides 5-25 through 5-34**
Seven: Discussion—Change Is Good! Activity—15 minutes	
Follow directions for Activity 2—Change Is Good!	**PowerPoint Slide 5-35**  **Activity 2** **sheet in curriculum** 
Eight: Posttest—10 minutes	
Distribute the posttest and allow time for participants to complete it. Using the facilitator's notes in the curriculum, review the answers to the posttest. After ensuring that each participant has provided his or her unique identifier on the posttest, collect the tests.	**PowerPoint Slide 5-36**  **Posttest** **Posttest Facilitator's Notes**
Nine: Evaluation—5 minutes	
Total Time: 2 hours	

Pretest



ID # _____–pre

Please answer true or false to the following questions:

1. Role modeling is an effective method for teaching behavior to youth with an FASD.

   True ☐ or False ☐

2. IDEA (Individuals With Disabilities Education Improvement Act) does not require correctional facilities to provide eligible children with adequate special education and related services.

   True ☐ or False ☐

3. It is the legal responsibility of the correctional facility to request a transfer of youth's educational records from the most current educational setting.

   True ☐ or False ☐

4. FASD is a category authorized under Federal law for eligibility for special education services.

   True ☐ or False ☐

5. In working with youth with an FASD, there is one set of recommendations that works for behavior management for most kids.

   True ☐ or False ☐

6. Traditional behavior management techniques do not work for youth with an FASD.

   True ☐ or False ☐

7. Setting limits with youth with an FASD is not going to improve behavior.

   True ☐ or False ☐

Pretest Facilitator's Notes

Please answer true or false to the following questions:

1. Role modeling is an effective method for teaching behavior to youth with an FASD.

   True ☐ or False ☐

   True: Skills as well as attitudes can be modeled. Role modeling shows youth with an FASD what is expected in terms of healthy behavior.

2. IDEA (Individuals With Disabilities Education Improvement Act) does not require correctional facilities to provide eligible children with adequate special education and related services.

   True ☐ or False ☐

   False: IDEA does require correctional facilities to provide these services.

3. It is the legal responsibility of the correctional facility to request a transfer of youth's educational records from the most current educational setting.

   True ☐ or False ☐

   True: It is the legal responsibility of the facility; however, it does not automatically occur, and it is an issue parents, caregivers, and advocates should be aware of.

4. FASD is a category authorized under Federal law for eligibility for special education services.

   True ☐ or False ☐

   False: FASD is not a category authorized under Federal law; however, there are several categories under which a child with an FASD may qualify.

5. In working with youth with an FASD, there is one set of recommendations that works for behavior management for most kids.

   True ☐ or False ☐

   False: There is no recommended "cookbook" approach to working with youth with an FASD. Each child is unique and requires individual case plans that focus on the child's strengths and weaknesses.

6. Traditional behavior management techniques do not work for youth with an FASD.

   True ☐ or False ☐

   True: Because of their brain damage, these youth have difficulty connecting actions and consequences, generalizing and making associations, and retrieving information.

7. Setting limits with youth with an FASD is not going to improve behavior.

   True ☐ or False ☐

   False: Setting limits is crucial in helping a youth with an FASD understand boundaries and expectations. A limit must be clear, concise, enforceable, and doable.

Use this space for your notes.

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

Use this space for your notes.

Module 5

Special Education and Behavior Management

Use this space for your notes.

Module 5: Special Education and Behavior Management

- After completing this module, participants will be able to:
  - Discuss special education rights of individuals with disabilities
  - Identify requirements of juvenile justice systems to provide special education for youth
  - Describe effective behavior management techniques for individuals with an FASD

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Module 5: Special Education and Behavior Management
Slide 5-4

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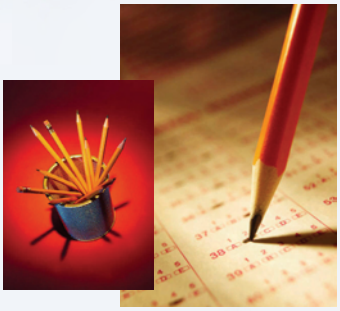
Pencils Out



Pretest!

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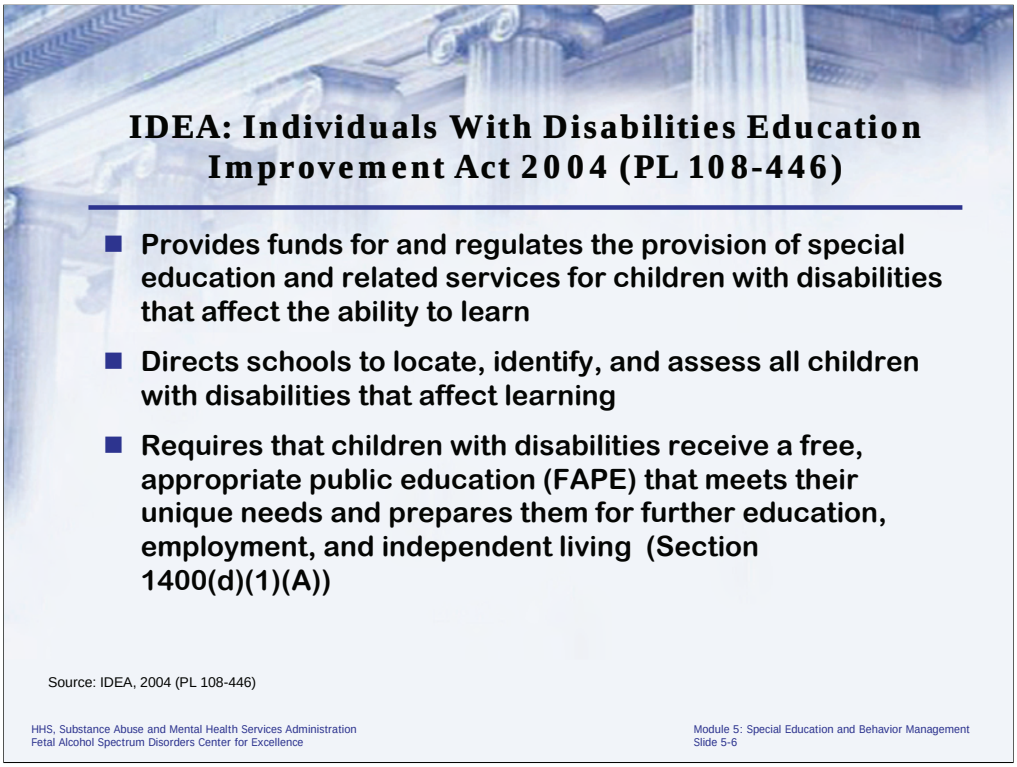
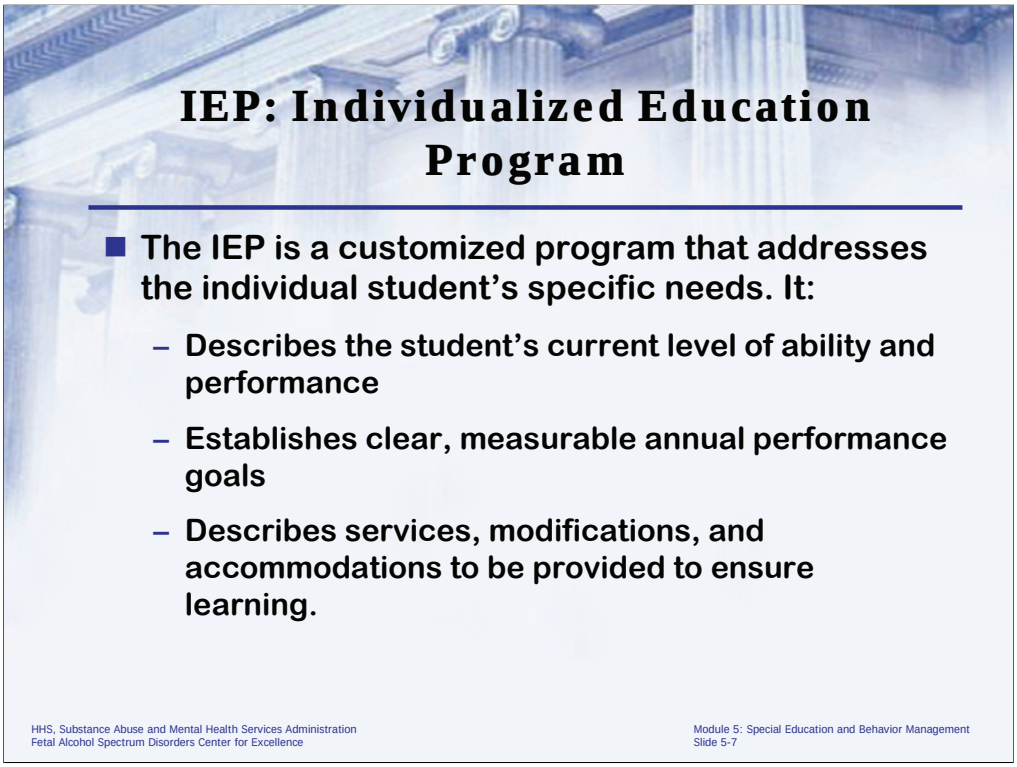


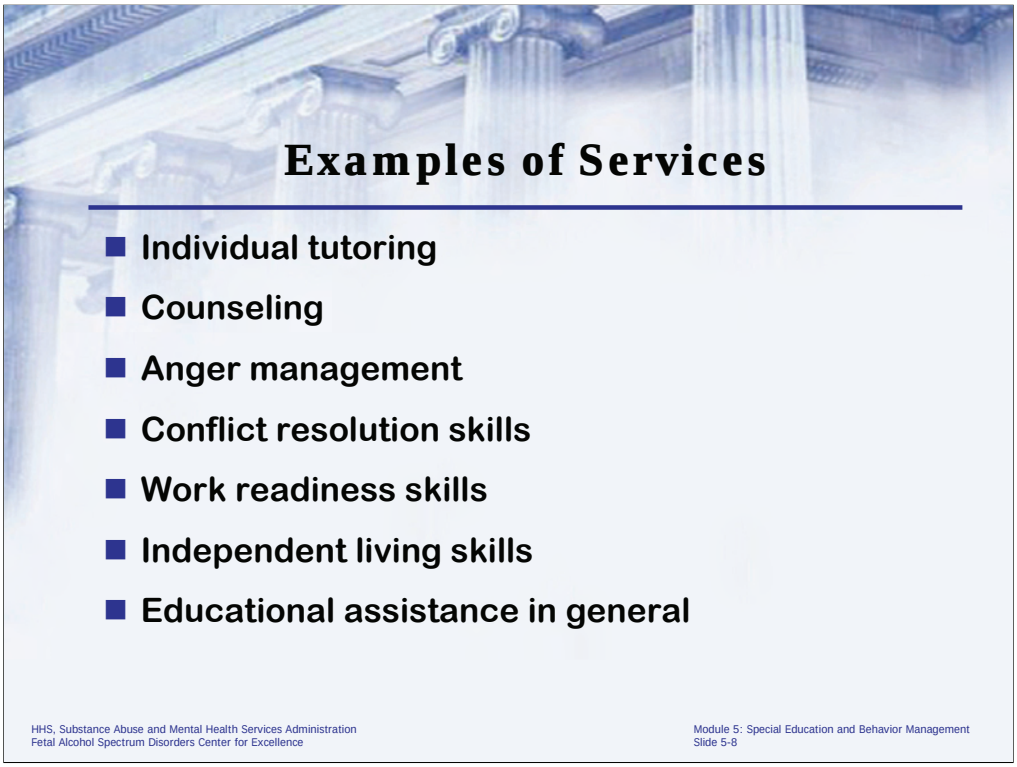
FACILITATOR'S TALKING POINTS:

- IDEA 2004 (PL 108-446) is a Federal public law that:
  - Provides funds to States, local school boards, and school districts to educate students with disabilities that affect their ability to learn.
  - Regulates the provision of those services and sets some standards.
  - Directs schools to locate, identify, and assess all children with disabilities that affect learning within their boundaries and to provide them with a free and appropriate public education in the least restrictive environment consistent with the child's needs.
- The "least restrictive environment" is not always the least restrictive environment available; it is the least restrictive environment in which the student can succeed.
- In order to qualify for services under IDEA, a student must be evaluated by the school district. (1) The student must have a disability, and (2) the disability must interfere with his or her ability to learn.



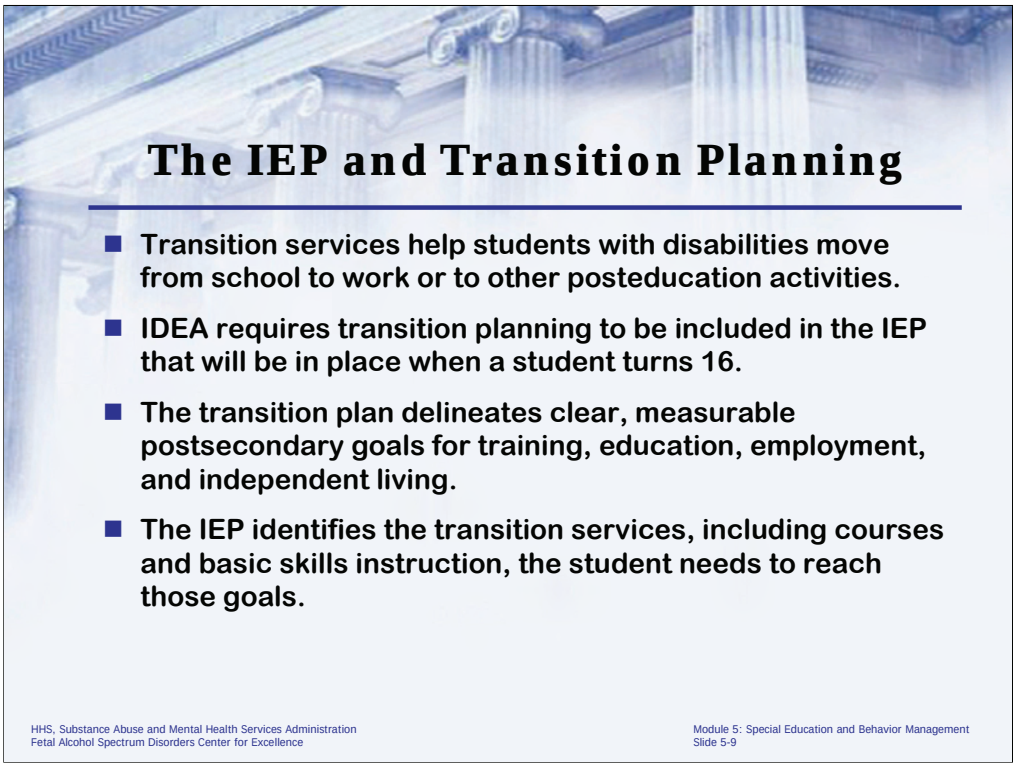
FACILITATOR'S TALKING POINTS:

- A guiding principle within IDEA is that special education services should be tailored to the unique needs of each student. All students who qualify for special education services are entitled to an IEP.
- A well-developed IEP:
  - Delineates the strengths and weaknesses of the student, the student's current performance level, and his or her educational abilities.
  - Includes annual educational and functional goals. The goals must be comprehensive, specific, and measurable.
  - Describes the services, interventions, modifications, and accommodations to be provided and indicates who will provide them and how frequently they will be provided.
  - Utilizes interventions and services that are "scientifically" or research-based—an IDEA requirement.



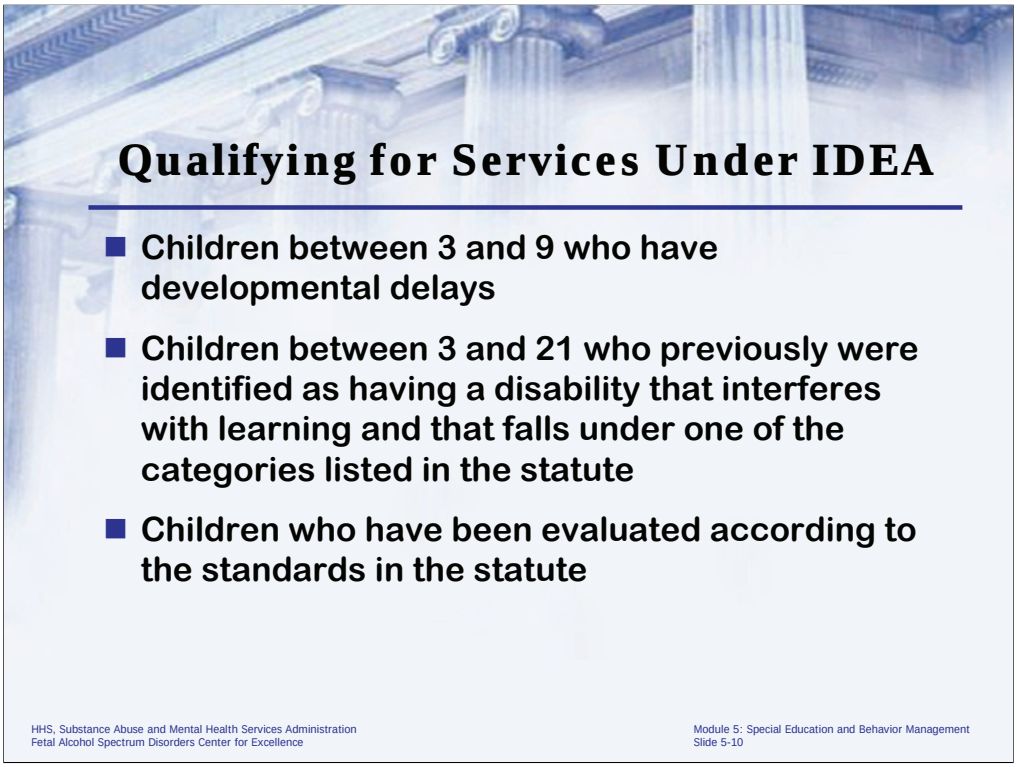
FACILITATOR'S TALKING POINTS:

- "Services," "modifications," and "accommodations" are all very important components of an effective IEP for students with an FASD.
- "Services" can include classroom aides, tutoring, speech/language therapy, counseling, anger management and conflict resolution skills training, social skills groups, work readiness or work experience training, and independent living skills.
- "Modifications" are changes to the curriculum or instruction to assist the student in mastering the same work as a student without a disability. Examples of modifications include reduced amount of homework assigned, reduced reading loads, use of easy-to-read texts that simplify material, a spelling list on a different grade level or with fewer words, and arithmetic instruction that focuses on basic skills.
- "Accommodations" are changes to how the student completes the work. They do not affect the content or level of expectations for subject mastery or tests. Accommodations can include priority classroom seating, extended time for tests or assignments, a duplicate set of textbooks to leave at home, and assistive technology—such as a computer, verbal and visual prompts, and prompts for transitions.
- Parents or caregivers may have to advocate strongly to obtain all the necessary services, modifications, and accommodations for their child.



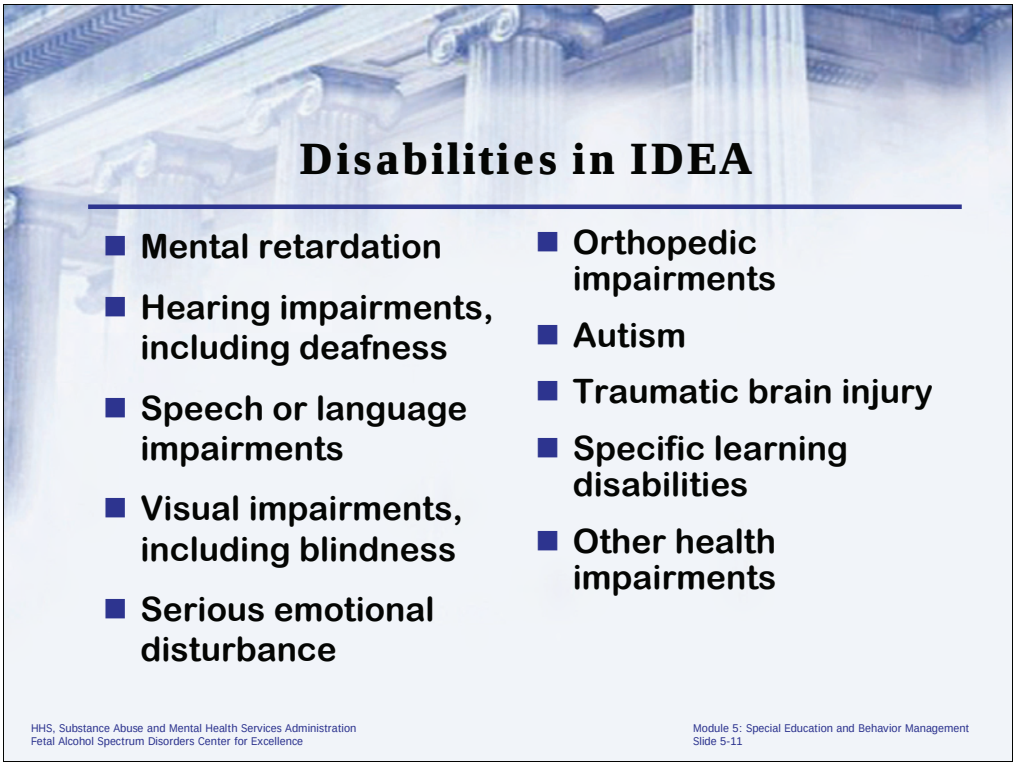
FACILITATOR'S TALKING POINTS:

- Schools may include transition planning in IEPs for students as young as 14.
- The transition plan is a required component of the student's IEP. It is not a supplement to an IEP or a separate plan.
- The plan mirrors a student's previous IEPs. It should establish clear, measurable postsecondary goals. It should be based on a thorough student assessment.
- It should identify the services and courses the student will need to meet the goals.
- While it is not required, parents should ask for regular reports on the child's progress in meeting the plan goals.



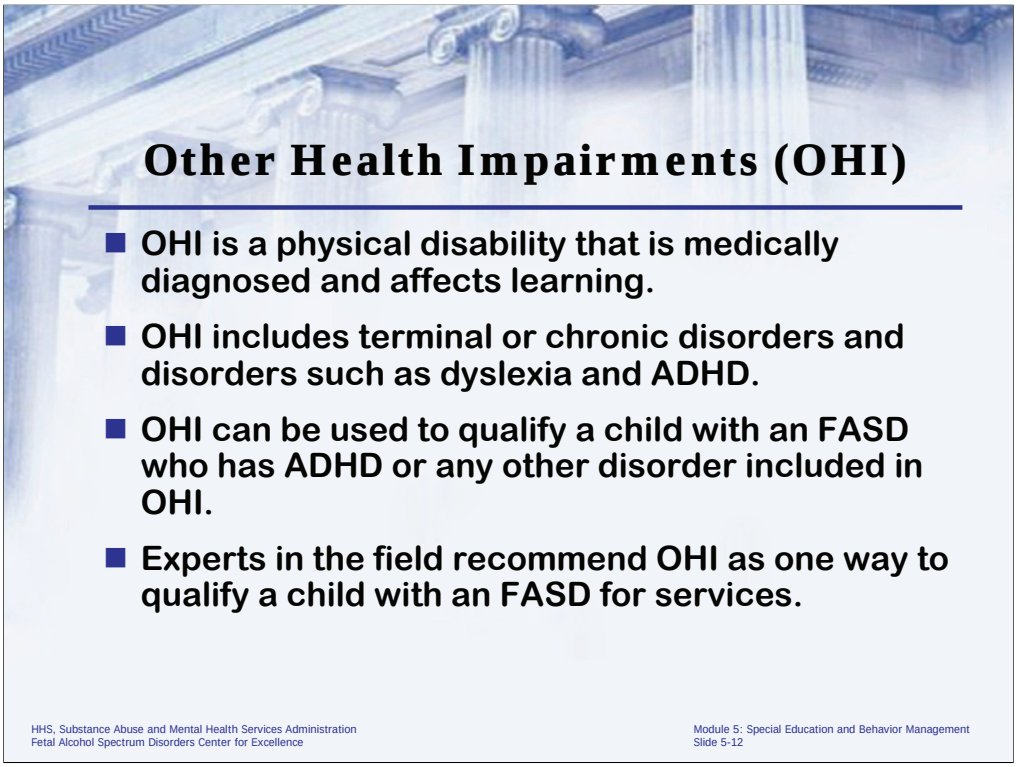
FACILITATOR'S TALKING POINTS:

- "Identified" means that the child has been assessed or evaluated and that the disability and its affect on learning has been documented.
- A child may be qualified for services by having a disability, but if the child is not assessed and identified, no services will be provided.
- Every student who has an IEP is eligible for and should have a transition plan.



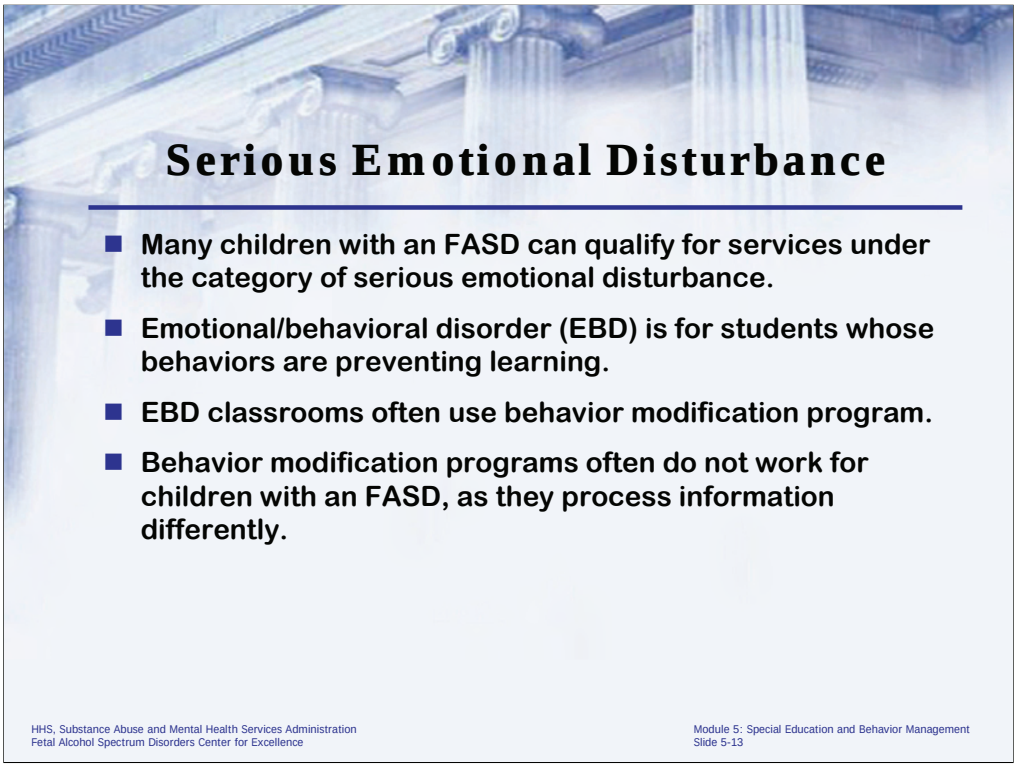
FACILITATOR'S TALKING POINTS:

- Federal law requires schools to provide special education services to children who are assessed and identified as having one or more of the listed disabilities.
- Children who do not fall into one of these categories often cannot receive services under IDEA.
- FAS and FASD are not listed disabilities, but children with an FASD can often qualify under "other health impairments" and/or "specific learning disabilities," which encompass a wide variety of learning problems.



FACILITATOR'S TALKING POINTS:

- Meeting eligibility requirements can be tricky for children or youth with an FASD. There is, however, hope for getting services.
- Children with an FASD often have another diagnosis, such as attention-deficit/hyperactivity disorder (ADHD), which can qualify them for services under OHI.
- Student with OHIs often receive accommodations, modifications, and services, where necessary, to address the learning differences that result from the diagnosed disability.
- Parents and professionals in the field often recommend that we work to have children with an FASD receive a diagnosis, such as ADHD, that will allow them to qualify for services under the OHI category.

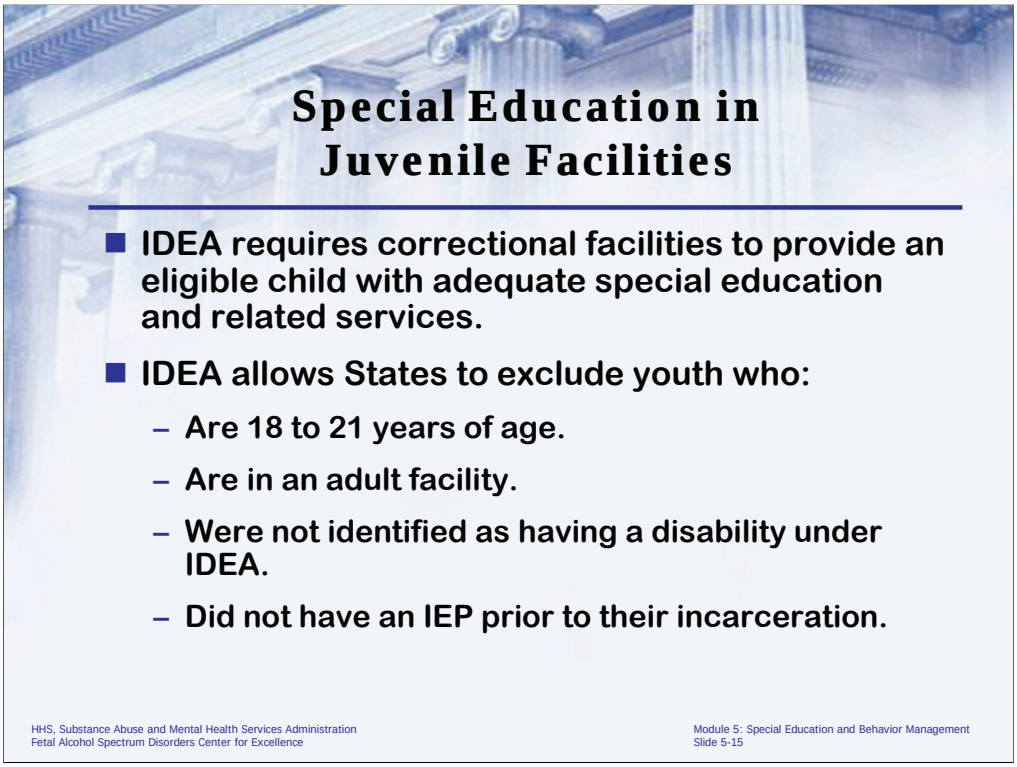


FACILITATOR'S TALKING POINTS:

- "Serious emotional disturbance" can include the following conditions (if they are serious, long-term, and/or interfere with the child's educational performance):
  - Inability to maintain satisfactory interpersonal relationships with teachers or peers.
  - Inappropriate behaviors or feelings under normal circumstances.
  - Depression.
  - Physical symptoms or fears associated with school or personal problems (Part 300/A/300.8/c/4/i).
- EBD programs are based on the needs of students whose emotions or behaviors are getting in the way of their learning, not that they have differences in the way their brains process information.
- The programs for students with EBD are based on behavior modification techniques and require a student to know what is required (the abstract meaning behind the rules), understand consequences, and remember the rules and apply them to other settings.
- Behavior modification often is not successful for children and youth with an FASD, as their brain damage causes them to process information differently, often interfering with their ability to understand cause and effect, or consequences, or to generalize rules to different settings.

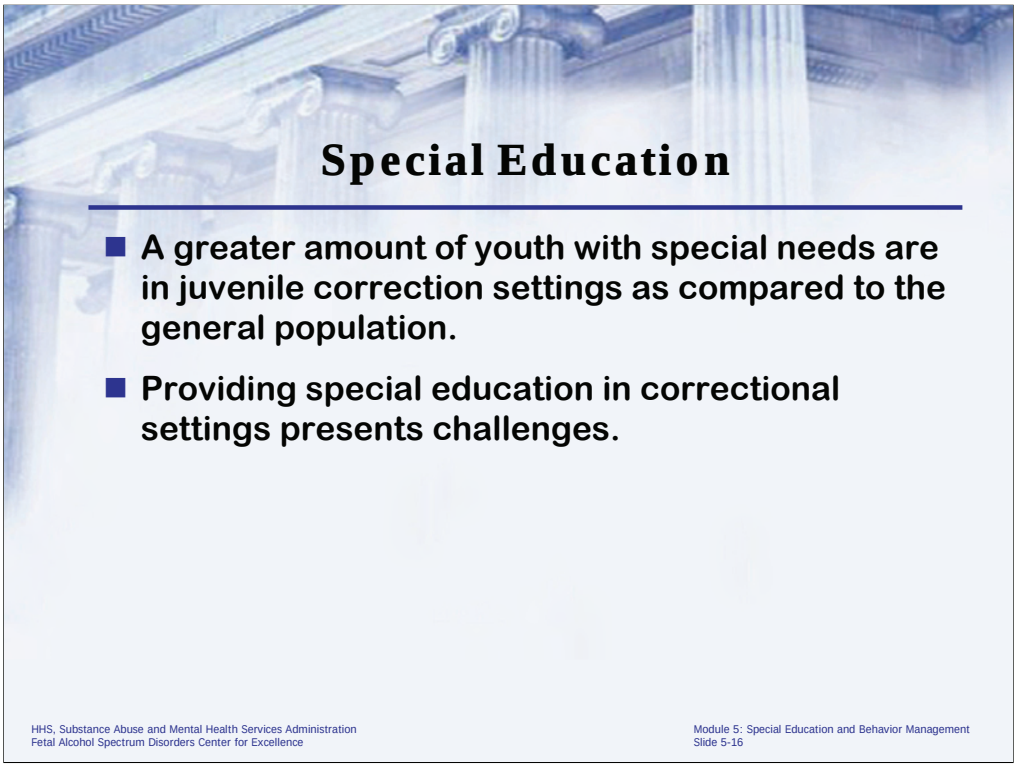
FACILITATOR'S TALKING POINTS:

- Specific learning disabilities are usually diagnosed through extensive testing by educational psychologists or other specialists.
- Under IDEA, specific learning disabilities exist when a child does not achieve adequately for his or her age or meet State-approved, grade-level standards in one or more of the following areas: oral expression; listening comprehension; written expression; basic reading skill, fluency, or comprehension; and/or mathematics calculation or problem solving— provided those problems are not caused by mental retardation, emotional disturbance, or a vision or hearing disability (Part 300/D/300.309/a).
- Children with an FASD often have one or more specific learning disabilities in the areas associated with mathematics and reading comprehension and qualify for interventions under this category.



FACILITATOR'S TALKING POINTS:

- If a juvenile offender has a current IEP upon entering a correctional or other residential facility, the IEP team should convene as soon as possible to determine what modifications, if any, will be needed. The local school district does not "automatically" or routinely provide facilities with special education records or an IEP when a youth enters the facility. It is important that a parent, case manager, defense attorney, probation officer, previous special education teacher, or any other professional familiar with the youth make special education information available in writing to the director of the facility following the placement. However, it is the legal responsibility of the facility to request a transfer of a youth's educational records from the most current educational setting.
- The probation or parole officer needs to educate the parents or caregivers on laws related to special education.

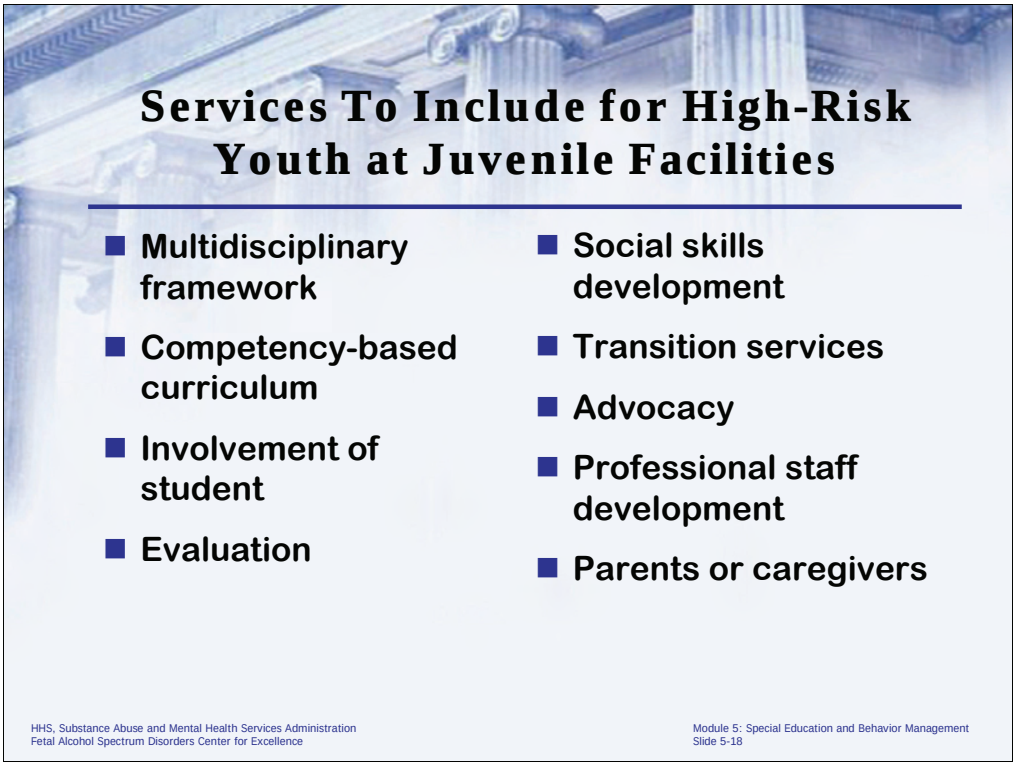


FACILITATOR'S TALKING POINTS:

- 28 to 42% of youth who are incarcerated are educationally handicapped (Krisberg, 1992).
- 34% of youth who are incarcerated are functionally illiterate (Gerry and Certo, 1991).
- More than half of youth who are incarcerated have substance abuse problems (McPherson, 1993).
- Substantial problems with both access *and* equity remain unresolved. Special education programs for youth who are incarcerated often fail to meet legal requirements and currently accepted professional standards. As a result, youth with disabilities in correctional settings often do not participate in education programs to which they are entitled and that can prepare them to reenter their schools and communities (Meisel, et al., 1998).
- Challenges to be dealt with include length of stay, physical layout of the facility, and need for heightened security (Burrell and Warboys, 2000).
- Challenges also include collaboration among education and treatment professionals and the family.

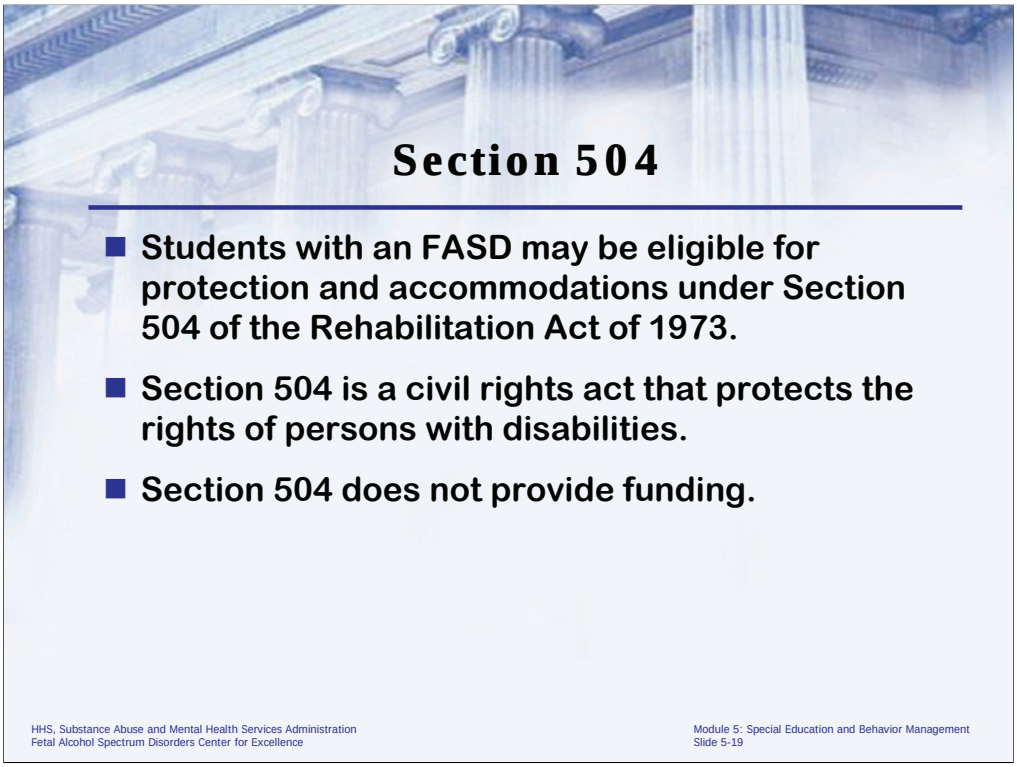
FACILITATOR'S TALKING POINTS:

- Appropriate resources for education and treatment services have not kept pace with the percentage of youth entering correctional facilities. Overpopulation and lack of funding contribute to a one-size-fits-all mentality for services and results in reduced teaching time and lack of space for educational activities.
- Few States coordinate services between schools and correctional facilities. Several reasons for this include:
  - Lack of trained staff and adequate funding
  - Poor coordination between the correctional/residential facility and the youth's school
  - Frequent turnover and transfer of clients
  - No IEP available
  - Comprehensive assessments not performed
  - Lack of involvement of parents



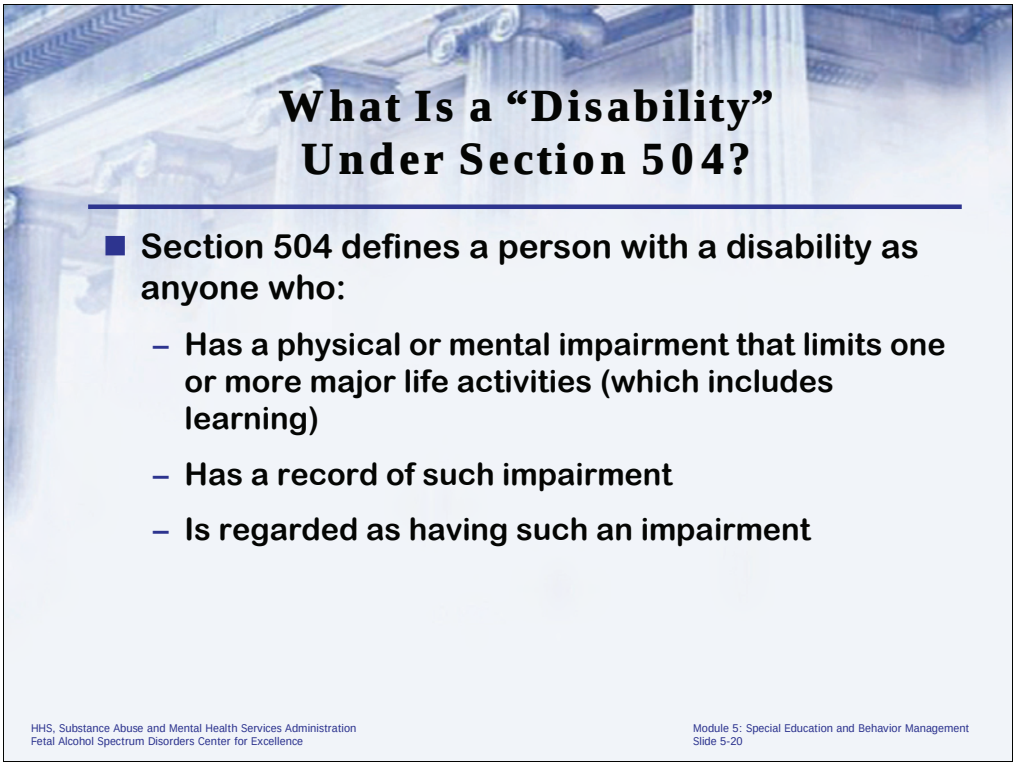
FACILITATOR'S TALKING POINTS:

- Effective educational services for high-risk youth within juvenile facilities should include:
  - A multidisciplinary framework providing quality referral, educational services, treatment, and rehabilitative services.
  - A competency-based curriculum that includes options for addressing academic, vocational, social, emotional, recreational, and behavioral skills of youth.
  - Instructional strategies that involve students in curriculum development.
  - Evaluation of the effectiveness of the curriculum focusing on its responsiveness to the needs of the student.
  - Training in social competency for youth.
  - Transition services—In order to have effective transition services, staff need to develop relationships within business and community programs to increase understanding of youth with disabilities and to nurture successful transition services.
  - Leadership and advocacy—These are essential in the development of appropriate educational services for high-risk youth to ensure that the mandates under IDEA are incorporated.
  - Professional development for staff to provide the most appropriate educational services for youth.
  - The involvement of parents or caregivers, as they know the youth's behavior best.



FACILITATOR'S TALKING POINTS:

- Section 504 is a Federal law designed to protect the rights of individuals with disabilities in programs and activities that receive Federal funds from the U.S. Department of Education.
- It requires school districts to provide students with disabilities appropriate educational services designed to meet the individual needs of the student—to the same extent that the needs of students without disabilities are met.
- An appropriate education for a student with a disability can consist of education in regular classrooms, education in regular classes with supplementary services, and/or special education and related services (U.S. Department of Education, Office of Civil Rights).



FACILITATOR'S TALKING POINTS:

- Not all youth with disabilities will be eligible for special education services under IDEA; however, they may be eligible for services under Section 504. Persons with handicaps under Section 504 are defined as having an impairment (physical or mental) that limits one or more major life activities, having a record of an impairment, or being regarded as having an impairment.
- Learning is considered a major life activity that is protected under Section 504 for eligible youth. Juvenile justice professionals should be knowledgeable about academic and behavioral problems that may meet the eligibility criteria for services under 504. Section 504 requires that eligible youth receive the means to succeed in the classroom and to participate in school activities. Services can include speech, occupational therapy, etc.
- In order to be protected under Section 504, a student must be determined to be disabled.
- Each State, and often school district, has its own process and requirements for establishing eligibility. These are often the same or similar to the process used under IDEA.
- A medical or other diagnosis does not automatically qualify a student.
- Section 504 requires that students be reevaluated periodically for eligibility.

Possible Provisions of a Section 504 Plan

- Dispensing of medications
- Special diets
- Early dismissal for appointments
- Change in the number of allowable absences for health reasons
- Individualized assignments
- More time to complete assignments

HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence

Module 5: Special Education and Behavior Management
Slide 5-21

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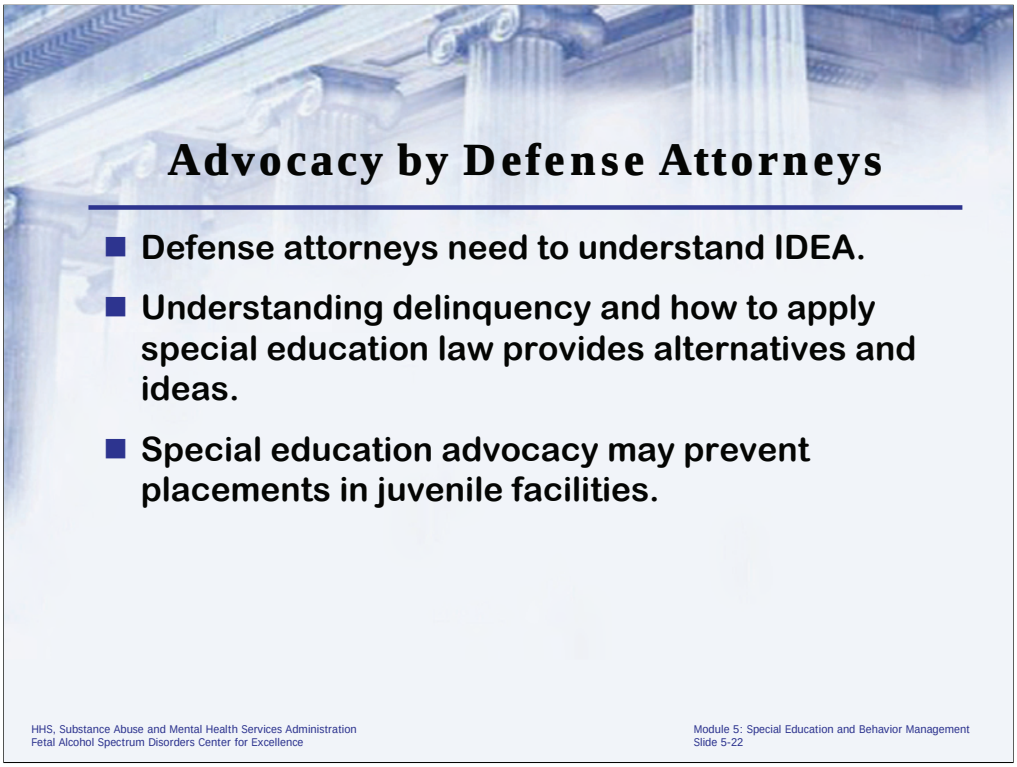
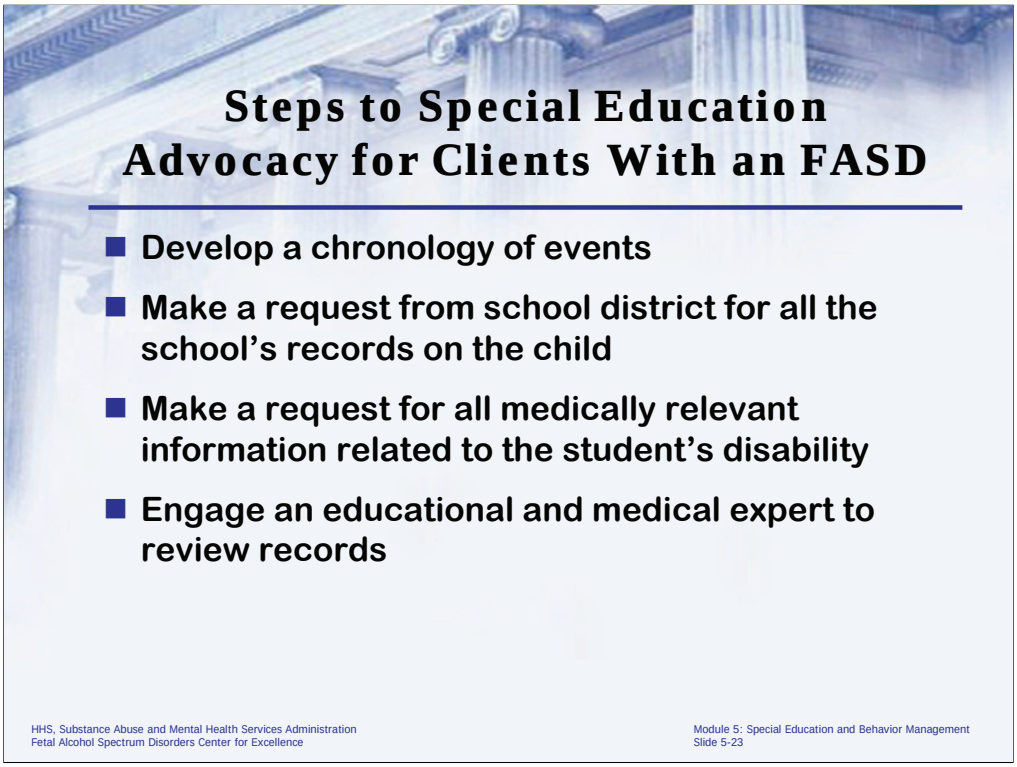


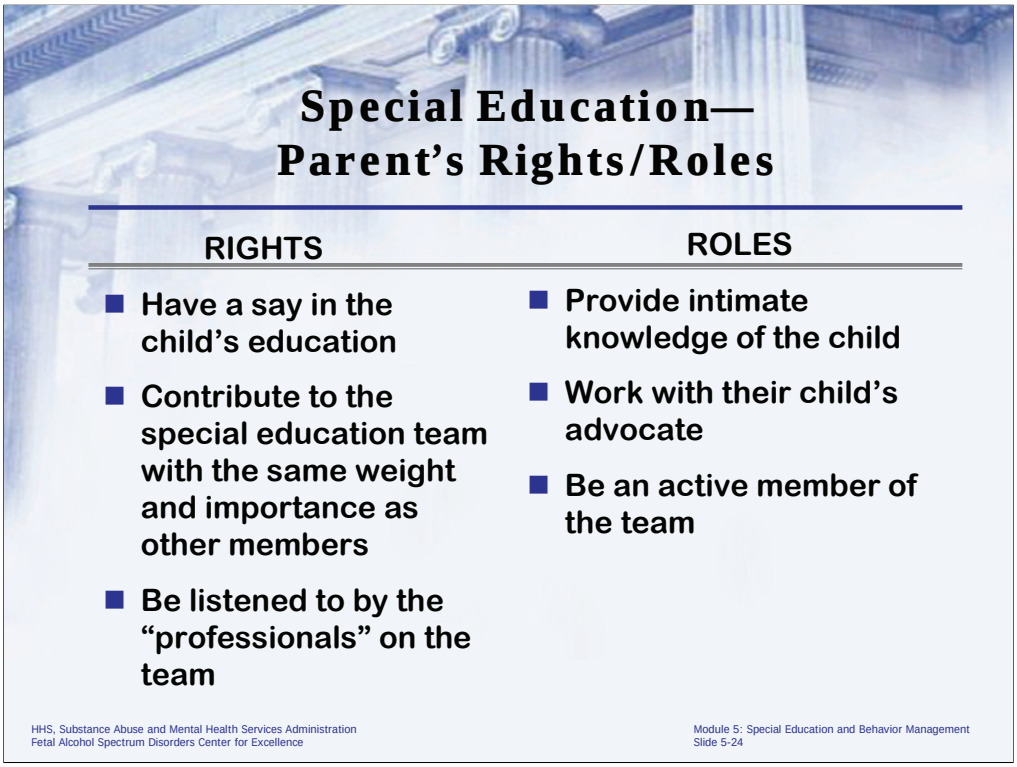
FACILITATOR'S TALKING POINTS:

- Knowing IDEA legislation will benefit clients.
- Understanding this type of legislation and law (special education law) provides alternative solutions and strategies that would not otherwise be available.
- Special education advocacy may prevent placements in juvenile facilities.
- Counsel may convince the court in a truancy case, for example, that lack of attention to appropriate special education is at least part of the problem and that the solution should be requiring the school to meet the child's special education needs.
- Schools must provide materials to district attorneys, public defenders, and prosecuting attorneys.



FACILITATOR'S TALKING POINTS:

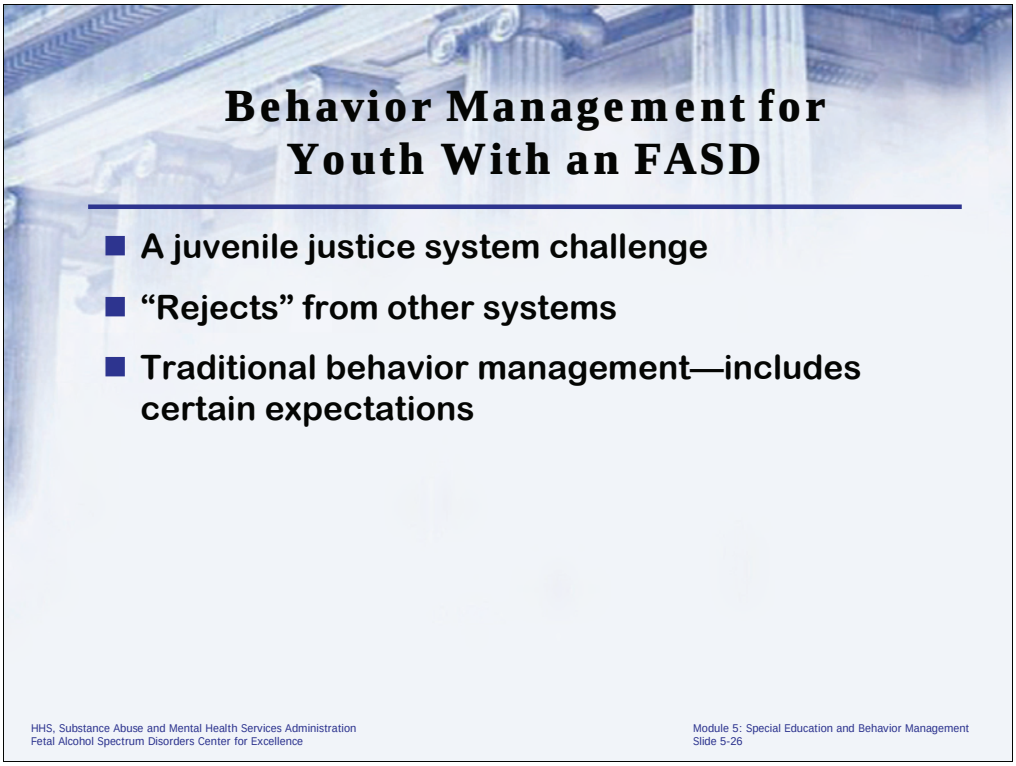
- Some concrete steps can be taken for clients who may have an FASD. For attorneys and advocates, the following steps can be taken:
  - Develop a chronology of events, including the student's dates of evaluation, identification as disabled, disciplinary records, and school performance history. Family chemical dependency history is also important in determining prenatal alcohol exposure.
  - Make a request from the school district for all the school's records on the child and prepare those documents so that they are in chronological order. It may help to graph each document, its relevant data, and where it falls in the chronology of events in order to gain an historical perspective on the student's educational career.
  - Make a request for all medically relevant information related to the student's disability. This may often include psychological or psychiatric sources. If FASD is suspected, seek referral for FASD evaluation.
  - Engage an educational or medical expert early on to review the records and consider the services and placement that could have or should have been provided to the student in the past and that may be necessary to address the student's current needs.



FACILITATOR'S TALKING POINTS:

- Attorneys for youth with disabilities need to enlist the help of parents in their special education advocacy defense. Often in the juvenile justice system, parents feel powerless. Many parents of youth with an FASD in the system have tried but failed to find appropriate services for their child in the community. They feel they have no choice but to go through the delinquency process. The special education advocacy process will help parents deal with their frustration and helplessness by getting them involved in advocating for special education services.
- By law, public juvenile facilities must provide appropriate educational services, even if they lack funding or do not routinely provide these services. Parents, when armed with this knowledge, can be strong advocates for their child. The parent has a key role. Parents can:
  - Provide intimate knowledge of the child and help design an IEP that best meets that child's needs
  - Work with their child's advocate to introduce meaningful treatment options into the special education program and into the delinquency proceedings
  - Work with the special education team to identify comprehensive services that provide the child with an opportunity to succeed

See Activity 1 in the Activities section.

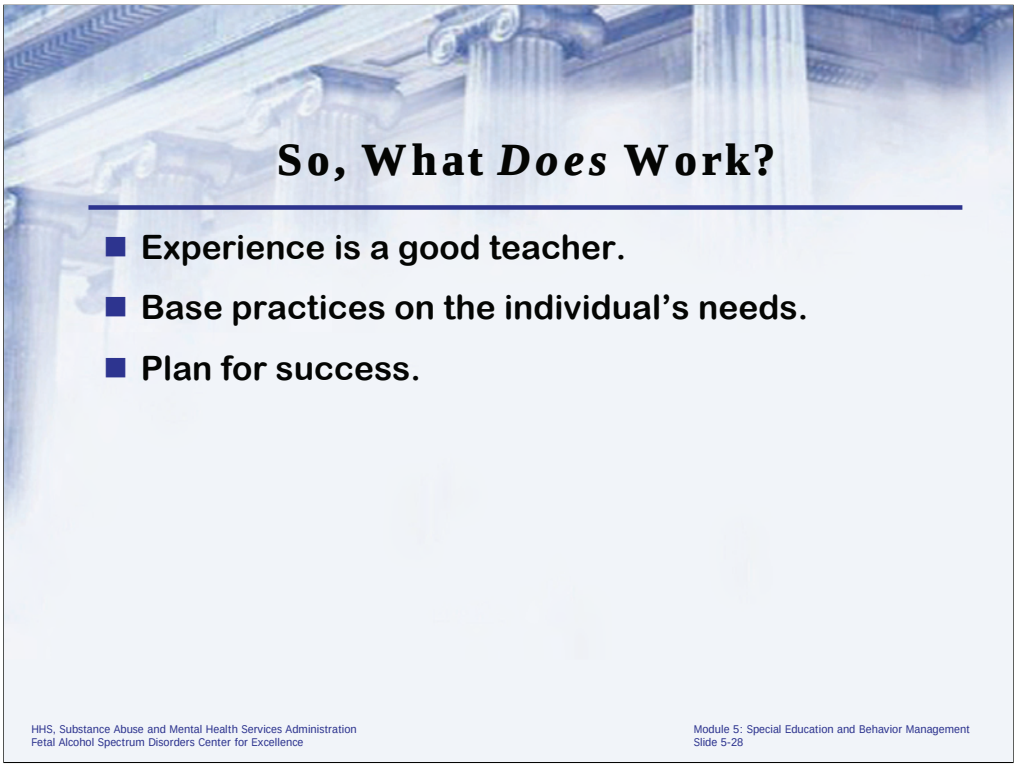


FACILITATOR'S TALKING POINTS:

- Addressing the needs of youth with an FASD is a challenge for those in the juvenile justice system.
- Many of these youth have been rejected from other programs because their needs could not be met.
- To effectively manage the behavior of youth with an FASD, professionals need to first understand that traditional behavior management techniques imply certain expectations about how people behave.

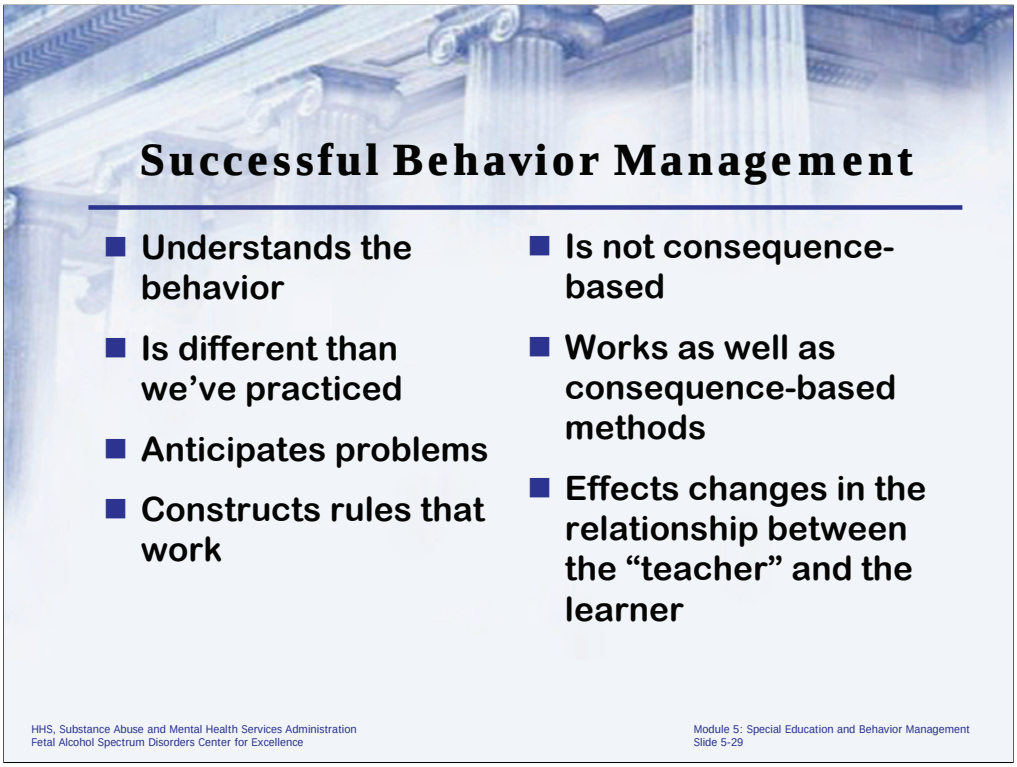
FACILITATOR'S TALKING POINTS:

- With traditional behavior management techniques, we expect that youth:
  - Hear and understand the consequences and link the consequence with a behavior that may have occurred some time in the past or in some other context
  - Associate the consequence with the behavior
  - Integrate the meaning of the consequence with future behaviors
  - Predict different outcomes based on anticipated future behaviors
  - Retrieve this information in other, different circumstances at some other time
  - Recall other consequences of past behaviors, perceive that there are various choices available, and anticipate potential negative consequences that could be imposed on current events
  - Integrate the recollections and predictions automatically
- *These expectations generally do not work for youth with an FASD.* Because of their brain damage, these youth have difficulty connecting actions and consequences, generalizing and making associations, and retrieving information.
- Organic brain damage is a form of physical disability. No one would punish a resident who is blind for not being able to see. We need to modify our expectations to meet their capabilities. Otherwise, our expectations will far exceed the best possible results and the youth will be destined to fail.



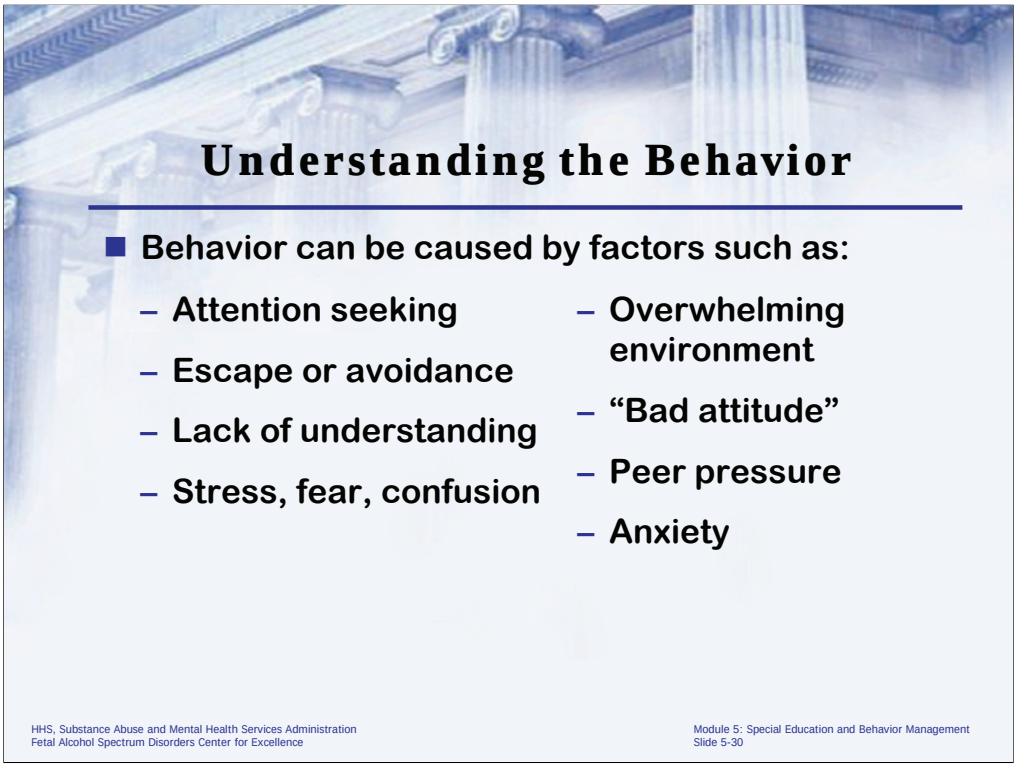
FACILITATOR'S TALKING POINTS:

- This would be a good time to share your examples of successful interventions based on your experience.



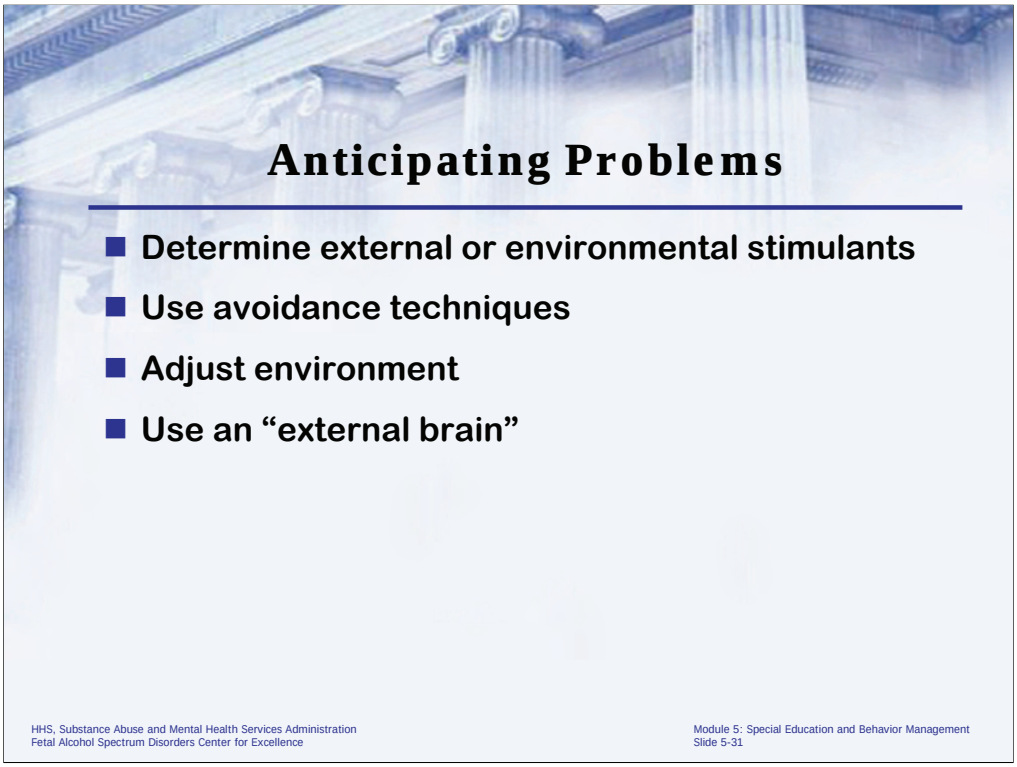
FACILITATOR'S TALKING POINTS:

- Understands the behavior.
- Is different from what we're used to.
- Is not consequence-based. When youth "make up" stories, it is perceived that they are lying when, in fact, they are not thinking ahead of the consequence or they are lying because they are trying to fill in the gaps.
    - The consequence model would be to punish the youth for the lie (time-out, etc.); this will typically not work for youth with an FASD.
    - The better route would be to lead them to the truth by asking questions. Don't ask why. Ask, "What happened?" Give choices for answers.
    - Try to determine what happened, and again, don't ask why. Don't let the "lying" affect you personally; the "lying" can be part of the FASD disability.
- Works equally well as consequence-based methods.
- Changes the relationship between the adult and the learner in a positive manner, shifting the role of the adult from "enforcer" to "teacher/helper."
- Incorporates the important element of recognizing the reason for the behavior. Understanding the underlying causes is crucial to successful behavior management.
- It is important to recognize reasons for the behaviors to determine what may have caused an outburst in behavior. However, do not ask why the youth behaved a certain way; the youth will not be able to tell you. Rather, ask, "What happened?"



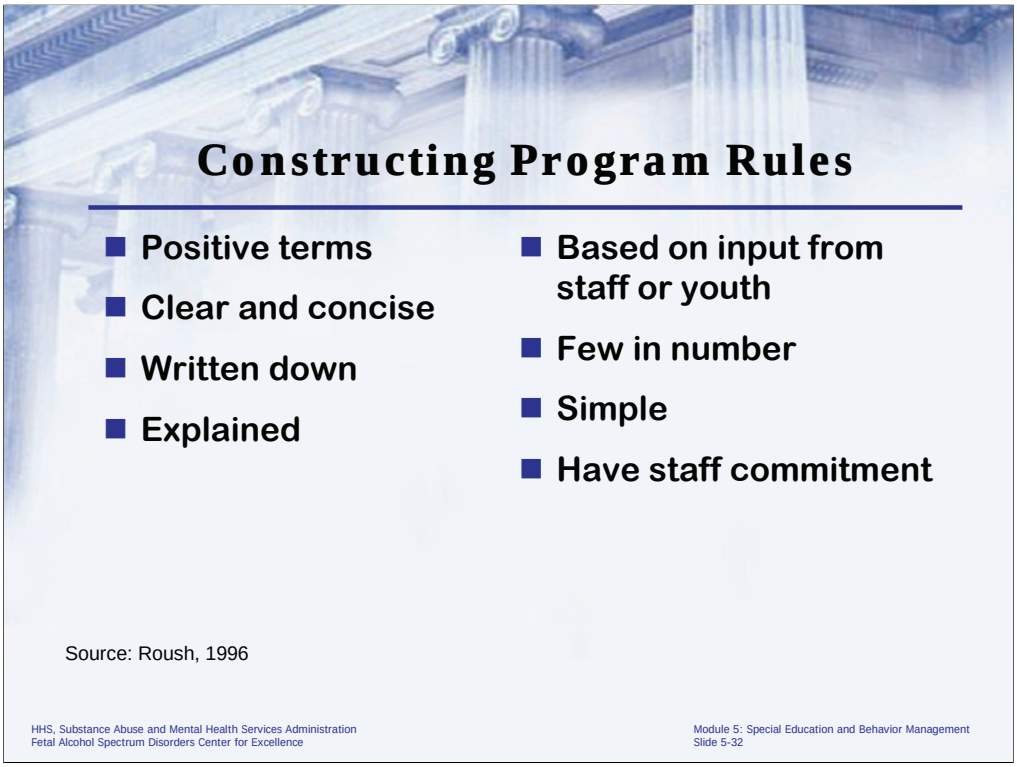
FACILITATOR'S TALKING POINTS:

- Youth with an FASD often have many diagnoses, such as ADHD, EBD, or learning disability. It is important to focus on the primary disability of FASD. Staff should examine any behavior issue or mental health issues through the "lens" of FASD. To effectively manage the behavior of youth, we need to know what causes their behavior. The behavior may be caused by many different factors, including:
  - Attention seeking
  - Escape or avoidance
  - Lack of understanding
  - Stress, fear, or confusion
  - Overwhelming or overstimulating environment
  - Bad attitude—wants to be adversarial (not all behaviors are "misunderstood")
  - Peer pressure or doing what others tell them
  - Anxiety



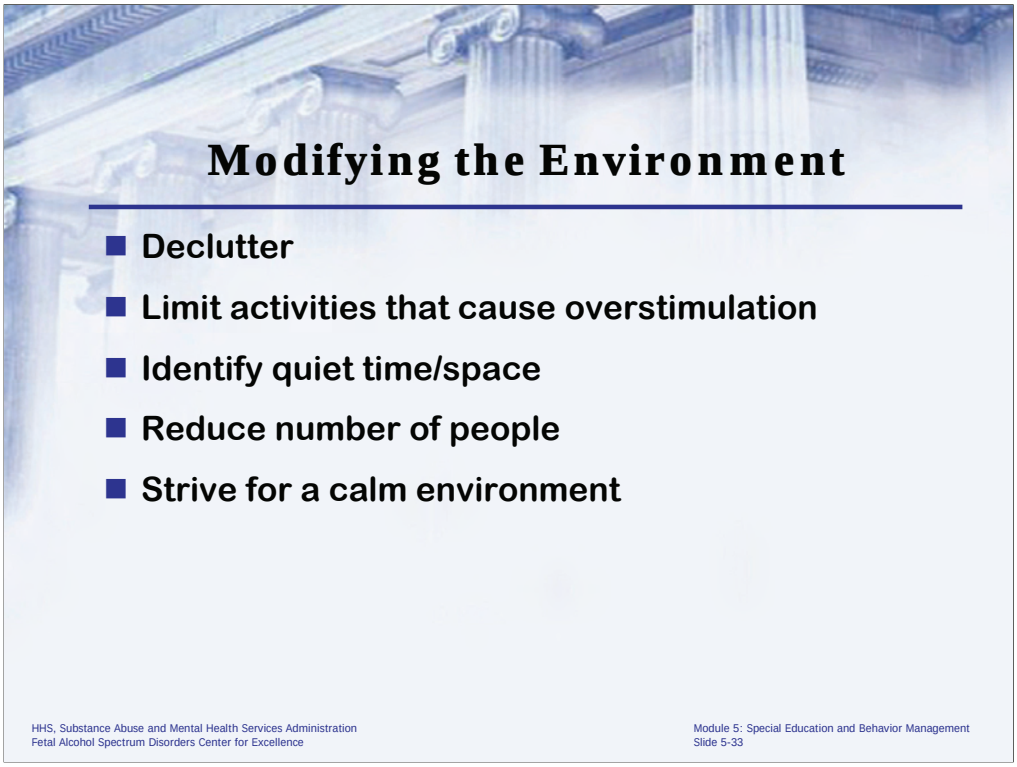
FACILITATOR'S TALKING POINTS:

- A key strategy to behavior management is anticipating problems. Many youth with an FASD are often overstimulated by their environment, which can lead to uncontrolled responses. Staff should try to determine what external or environmental stimuli increase the likelihood of the symptom or undesirable behavior. They can then simply use an avoidance technique. Examples of an avoidance technique include diverting the person to another activity or limiting those situations that are consistent triggers. Environment can include attitude, perceptions, physical layout, sensory stimuli, timelines, expectations, and processes.
- Review the room that the youth sleeps in, the classroom, and the work environment. Many places within the youth's environment will be overwhelming and can lead to an outburst in behavior.
- Often youth with an FASD need reminders of what they are supposed to be doing, where they are supposed to be, and the steps they need to take to accomplish a task. This is often referred to having an "external brain" (another person) to help guide them.



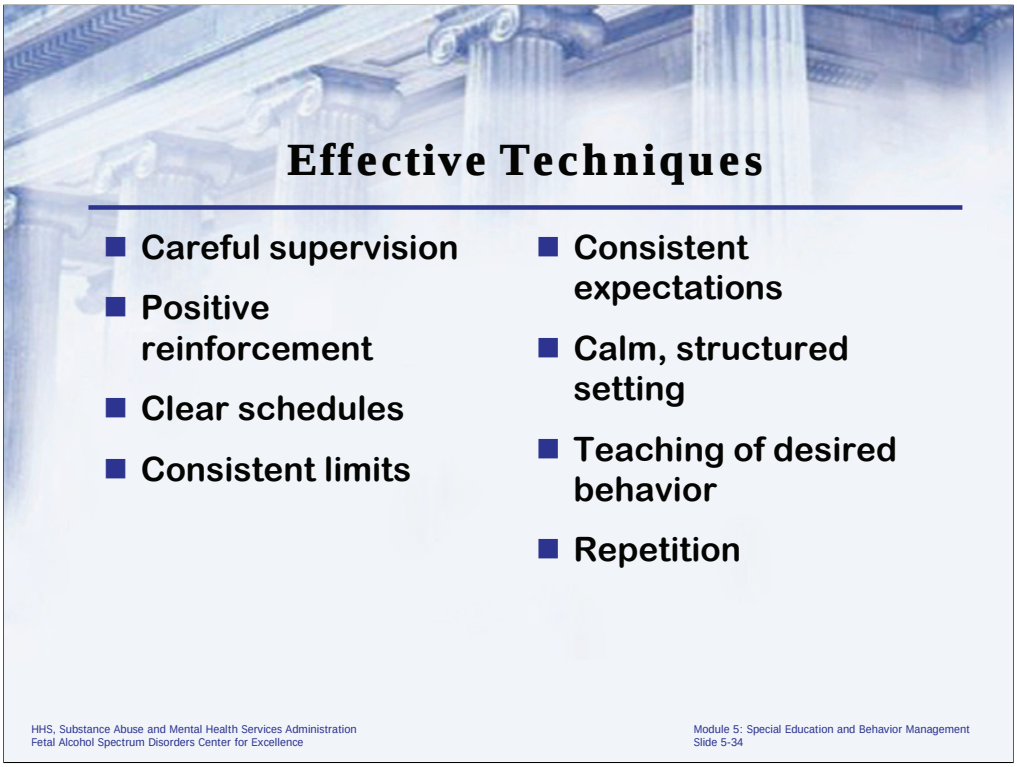
FACILITATOR'S TALKING POINTS:

- Rules establish expected standard behavior. This process should take into account that juveniles with an FASD have a brain-based physical disability with behavioral symptoms. Their developmental ability will not be consistent with the expected ability for their chronological age (Malbin, 2004).
- Staff should write the rules in the following manner to achieve the desired behavior (Roush, 1996):
  - State the rules in positive terms. Tell them what you want them to do, not what you do not want them to do.
  - State the rule clearly and concisely. Give a series of directions one step at a time. Try to avoid long lists of expectations of behavior. All rules should be stated in only one or two sentences.
  - Write rules down. The rules are a contract.
  - Explain the rules.
  - Seek input from staff and youth for the rules. Staff should have input into the meaning of rules so there will be no misunderstandings.
  - Keep rules to a minimum.
  - Keep rules simple.
  - Get staff commitment to the rules. Enforce in a consistent manner. Repeat the rules in a positive, supportive manner frequently.



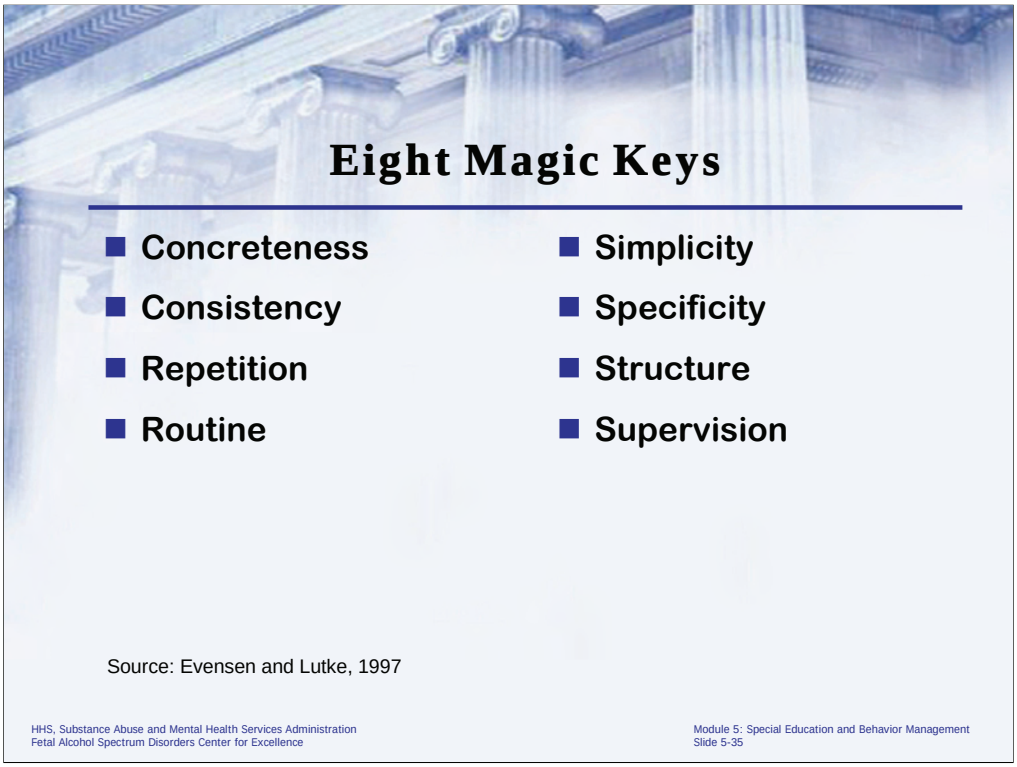
FACILITATOR'S TALKING POINTS:

- Keep rooms and walls free from clutter.
- Limit activities that cause overstimulation, such as TV, video games, or loud music.
- Identify a quiet time-out place that youth can go to voluntarily when they feel overstimulated or overwhelmed.
- Reduce the number of people in the youth's space.
- Strive for a calm, quiet environment.
- Include these modifications in an IEP or 504 plan.



FACILITATOR'S TALKING POINTS:

- Those who work with youth with an FASD have found the following components to be most effective and helpful in any program or setting:
  - Careful supervision. Youth with an FASD need careful supervision so they do not place themselves or others in dangerous situations. Close supervision helps avoid problems.
  - Positive reinforcement. Rewards to reinforce positive behavior may be used for youth with an FASD. It needs to be *immediate*!
  - Clear schedules with a structured environment. Minimize transitions—the number, the frequency, and the speed—and give lots of warnings for transitions.
  - Consistent limits that are clear, concise, enforceable, and doable for the client.
  - Consistent expectations by all staff.
  - A calm structured setting is imperative to avoid behavior issues.
  - Teaching of behavior through role modeling, compliance training, contingency management, and simple time-out procedures.
  - Repetition, especially of schedules, limits, and expectations.



FACILITATOR'S TALKING POINTS:

- There is no recommended "cookbook" approach to working with youth with an FASD, as each child is unique. Parents, caregivers, and providers must change their expectations and work on the following guidelines:
  - Concreteness—Youth with an FASD do well when parents and others talk to them in concrete terms and don't use words with double meanings, idioms, etc. Think younger when giving instructions, etc.
  - Consistency—Because of the difficulty these youth experience in trying to generalize learning from one situation to another, they do best in an environment with few changes.
  - Repetition—Youth with an FASD have chronic short-term memory problems. They forget things they want to remember as well as information that has been learned and retained for a longer period of time.
  - Routine—Stable routines that don't change from day to day will make it easier for youth with an FASD to know what to expect next and decrease their anxiety.
  - Simplicity—Remember to KISS, Keep It Short and Simple.
  - Specificity—Say exactly what you mean. Youth with an FASD can have difficulty with abstractions or generalizations and are not able to fill in the blank when given directions.
  - Structure—Structure is the glue that makes the world make sense for youth with an FASD.
  - Supervision—Youth with an FASD often need constant supervision to develop appropriate behavior.
- Give an example of how an outcome could be different with the use of special education or section 504 services.
- Characterize how we might react in the current consequence-based model and how we could apply things differently.
- Refer to handouts of scenarios you may use with possible discussion questions and points you may want to cover during the open discussion period.

See Activity 2 in the Activities section.

Questions

Posttest!

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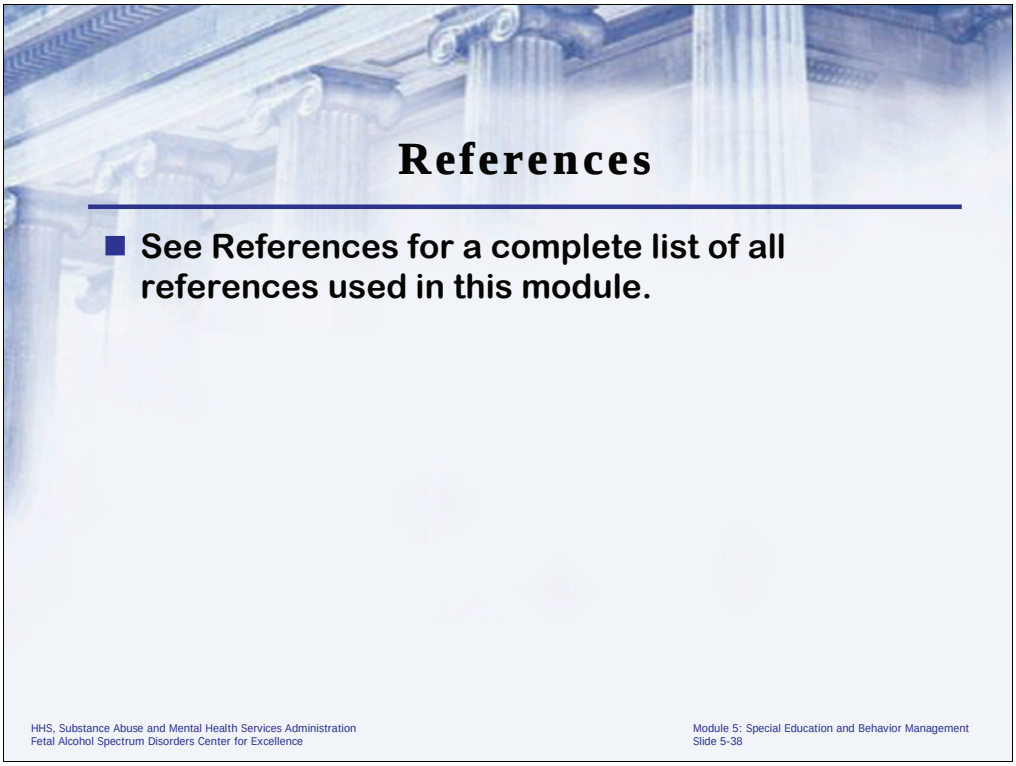

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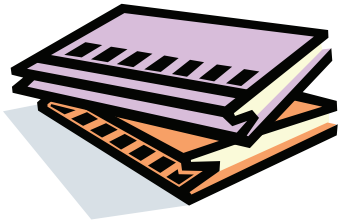
Posttest



ID # _____–post

Please answer true or false to the following questions:

1. FASD is a category authorized under Federal law for eligibility for special education services.

   True ☐ or False ☐

2. IDEA (Individuals With Disabilities Education Improvement Act) does not require correctional facilities to provide eligible children with adequate special education and related services.

   True ☐ or False ☐

3. It is the legal responsibility of the correctional facility to request a transfer of youth's educational records from the most current educational setting.

   True ☐ or False ☐

4. Traditional behavior management techniques do not work for youth with an FASD.

   True ☐ or False ☐

5. Setting limits with youth with an FASD is not going to improve behavior.

   True ☐ or False ☐

6. Role modeling is an effective method for teaching behavior to youth with an FASD.

   True ☐ or False ☐

7. In working with youth with an FASD, there is one set of recommendations that works for behavior management for most kids.

   True ☐ or False ☐

Posttest Facilitator's Notes

Please answer true or false to the following questions:

1. FASD is a category authorized under Federal law for eligibility for special education services.

   True ☐ or False ☐

   False: FASD is not a category authorized under Federal law; however, there are several categories under which a child with an FASD may qualify.

2. IDEA (Individuals With Disabilities Education Improvement Act) does not require correctional facilities to provide eligible children with adequate special education and related services.

   True ☐ or False ☐

   False: IDEA does require correctional facilities to provide these services.

3. It is the legal responsibility of the correctional facility to request a transfer of youth's educational records from the most current educational setting.

   True ☐ or False ☐

   True: It is the legal responsibility of the facility; however, it does not automatically occur, and it is an issue parents, caregivers, and advocates should be aware of.

4. Traditional behavior management techniques do not work for youth with an FASD.

   True ☐ or False ☐

   True: Because of their brain damage, these youth have difficulty connecting actions and consequences, generalizing and making associations, and retrieving information.

5. Setting limits with youth with an FASD is not going to improve behavior.

   True ☐ or False ☐

   False: Setting limits is crucial in helping a youth with an FASD understand boundaries and expectations. A limit must be clear, concise, enforceable, and doable.

6. Role modeling is an effective method for teaching behavior to youth with an FASD.

   True ☐ or False ☐

   True: Skills as well as attitudes can be modeled. Role modeling shows youth with an FASD what is expected in terms of healthy behavior.

7. In working with youth with an FASD, there is one set of recommendations that works for behavior management for most kids.

   True ☐ or False ☐

   False: There is no recommended "cookbook" approach to working with youth with an FASD. Each child is unique and requires individual case plans that focus on the child's strengths and weaknesses.

Activity 1–Red Flags and Screening Questions

To be conducted during Slide 5-24

Tools needed:

Handouts: "Red Flags That Warrant Further Investigation" and "Screening Questions for Identifying Disabilities"
Flip chart paper

Slide 5-24

Steps:

1. Break the participants into small groups of three to five people (depending on the size of the group). Have the participants count off to form groups (1, 2, 3, etc.).
2. Have the groups choose a recorder and a reporter.
3. Distribute the "Red Flags" and "Screening Questions" handouts.
4. Have the small groups discuss three to four red flags and determine the best screening questions for each. (If needed, assign different red flags per group.) The recorder should write ideas on flip chart paper, and the reporter should be prepared to present findings to the large group.
5. Have the small groups refer to the "Kattina" scenario in Module 3, Activity 3—Develop Case Plan. What are some red flags in this scenario?
6. In the large group, ask reporters to share their group's ideas

Activity 1–Red Flags and Screening Questions–Activity Handout

Red Flags That Warrant Further Investigation

- History of child protection involvement
- Family history of chemical dependency
- Learning disabilities
- In foster care or has been raised in an adoptive home
- Small in stature
- Significant history of delinquent behavior, starting at a young age
- Does not seem affected by past punishments
- Immature and has poor social behavior
- Adaptive behaviors lower than IQ should indicate
- May seem unaware of what they have done or why they are in trouble
- Pattern of repetitive crime
- History of running away, alcohol/drug use, prostitution, living on the streets
- Involvement with a gang
- Inconsistent answers to questions
- Resisting physical restraints when “typical” juvenile would not
- Easily distracted, hyperactive, inattentive
- May demonstrate impulsive behavior, have little common sense
- Unable to connect their actions with consequences
- Crime of opportunity rather than planned
- May be a “patsy” for others
- Family history of being sexually or physically abused
- Easily influenced by others

Used with permission from Susan Carlson, JD (2001)

Activity 1–Red Flags and Screening Questions–Activity Handout

Screening Questions for Identifying Disabilities

Academic Deficits (poor or failing school grades)

Does the child:

- Have a record of poor to failing grades despite adequate school attendance?
- Not read or write well?
- Have a school record of low yearly achievement scores?
- Have a "flat," subaverage academic profile (shows no areas of strength)?
- Have a "spiky" profile (showing both high and low levels of skill across subjects)?

Intellectual Abilities (appears unintelligent or slow)

Does the child:

- Lack general, age-appropriate information?
- Have a history of late development in walking/talking?
- Exhibit low IQ scores?

Attention Deficits (doesn't pay attention to what is said or what is going on)

Does the child:

- Get easily distracted from the task at hand?
- Have trouble focusing/paying attention?
- Have a high level of physical activity?
- Have a need for constant redirection or prompting to complete tasks?
- Exhibit self-stimulating behaviors while working, such as tapping, rocking, noise making?
- Take (or took at one time) Ritalin or Cylert?

Screening Questions for Identifying Disabilities (continued)

Language Deficits (difficult to understand and/or communicate with the child)

Does the child:

- Need constant restatement or simplification of questions and directions?
- Have a limited vocabulary to express thoughts?
- Talk a lot while making little sense?
- Lack correct labels for nouns/verbs or use incorrect ones?

Physical Disabilities

Does the child:

- Have speech/articulation problems?
- Have brain damage/head injury?
- Have a biological mother who used alcohol and/or drugs during pregnancy?
- Have history of premature birth and/or low birth weight?
- Have family members with similar disabilities?
- Have a history of birth trauma/injury?
- Have a chromosomal disorder?

Adaptive Skill Deficits

Does the child need assistance from others to do the following:

- Communicate information?
- Accomplish self-care tasks (e.g., grooming, hygiene, dressing)?
- Behave appropriately for his/her age level?
- Clean house and cook?
- Find out about and use community resources?
- Make appropriate choices for self?
- Maintain responsible health and safety practices?
- Apply academic skills to daily living?
- Engage in work/leisure activities?

Screening Questions for Identifying Disabilities (continued)

Social/Behavioral Deficits

Does the child exhibit any of the following behaviors:

- Tendency to misinterpret facial expressions, social gestures, and environmental cues?
- Impulsivity (i.e., rapid, poorly thought-out decisions/actions)?
- Difficulty planning and/or completing and executing plans?
- Emotional mood swings?
- A need for outside direction in a crisis?
- Use by peers as a scapegoat or "go-for"?
- Being easily led by others to get into trouble?
- Lack of confidence?
- Signs of feeling unpopular, friendless, rejected by peers?

Source: Cowardin, 1998. Used with permission from Nancy Cowardin.

Activity 2–Change Is Good!

To be conducted during Slide 5-35

Tools needed:
Flip chart paper

Slide 5-35

Steps:

1. Break the participants into small groups of three to five people (depending on the size of the group). Have the participants count off to form groups (1, 2, 3, etc.).
2. Have groups choose a recorder and a reporter.
3. Have groups review Slides 5-27 through 5-34 on strategies for working with youth with an FASD.
4. Ask the small groups to discuss their work and how they would adapt to provide the most appropriate services for youth with an FASD.
5. Have the small groups report their ideas to the large group.
6. Write the participants' ideas on flip chart paper.

Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

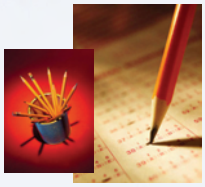
Module 5

Special Education and Behavior Management

Module 5: Special Education and Behavior Management

- After completing this module, participants will be able to:
  - Discuss special education rights of individuals with disabilities
  - Identify requirements of juvenile justice systems to provide special education for youth
  - Describe effective behavior management techniques for individuals with an FASD

Pencils Out



Pretest!

IDEA: Individuals With Disabilities Education Improvement Act 2004 (PL 108-446)

- Provides funds for and regulates the provision of special education and related services for children with disabilities that affect the ability to learn
- Directs schools to locate, identify, and assess all children with disabilities that affect learning
- Requires that children with disabilities receive a free, appropriate public education (FAPE) that meets their unique needs and prepares them for further education, employment, and independent living (Section 1400(d)(1)(A))

Source: IDEA, 2004 (PL 108-446)

IEP: Individualized Education Program

- The IEP is a customized program that addresses the individual student's specific needs. It:
  - Describes the student's current level of ability and performance
  - Establishes clear, measurable annual performance goals
  - Describes services, modifications, and accommodations to be provided to ensure learning.

Examples of Services

- Individual tutoring
- Counseling
- Anger management
- Conflict resolution skills
- Work readiness skills
- Independent living skills
- Educational assistance in general

The IEP and Transition Planning

- Transition services help students with disabilities move from school to work or to other posteducation activities.
- IDEA requires transition planning to be included in the IEP that will be in place when a student turns 16.
- The transition plan delineates clear, measurable postsecondary goals for training, education, employment, and independent living.
- The IEP identifies the transition services, including courses and basic skills instruction, the student needs to reach those goals.

Qualifying for Services Under IDEA

- Children between 3 and 9 who have developmental delays
- Children between 3 and 21 who previously were identified as having a disability that interferes with learning and that falls under one of the categories listed in the statute
- Children who have been evaluated according to the standards in the statute

Disabilities in IDEA

- Mental retardation
- Hearing impairments, including deafness
- Speech or language impairments
- Visual impairments, including blindness
- Serious emotional disturbance
- Orthopedic impairments
- Autism
- Traumatic brain injury
- Specific learning disabilities
- Other health impairments

Other Health Impairments (OHI)

- OHI is a physical disability that is medically diagnosed and affects learning.
- OHI includes terminal or chronic disorders and disorders such as dyslexia and ADHD.
- OHI can be used to qualify a child with an FASD who has ADHD or any other disorder included in OHI.
- Experts in the field recommend OHI as one way to qualify a child with an FASD for services.

Serious Emotional Disturbance

- Many children with an FASD can qualify for services under the category of serious emotional disturbance.
- Emotional/behavioral disorder (EBD) is for students whose behaviors are preventing learning.
- EBD classrooms often use behavior modification program.
- Behavior modification programs often do not work for children with an FASD, as they process information differently.

Specific Learning Disabilities

- Many children with an FASD can also qualify for services under the category "specific learning disabilities."
- Specific learning disabilities can include problems with mathematical calculations and/or reading skills or disorders of written expression.
- Specific learning disabilities are often addressed by providing modifications to the curriculum and accommodations.

Special Education in Juvenile Facilities

- IDEA requires correctional facilities to provide an eligible child with adequate special education and related services.
- IDEA allows States to exclude youth who:
  - Are 18 to 21 years of age.
  - Are in an adult facility.
  - Were not identified as having a disability under IDEA.
  - Did not have an IEP prior to their incarceration.

Special Education

- A greater amount of youth with special needs are in juvenile correction settings as compared to the general population.
- Providing special education in correctional settings presents challenges.

Barriers to Special Education Services

- Lack of trained staff and funding
- No partnerships between education and judicial systems
- Frequent transfer of clients
- No IEP available
- Assessments not performed
- Lack of involvement from parents

Services To Include for High-Risk Youth at Juvenile Facilities

- Multidisciplinary framework
- Competency-based curriculum
- Involvement of student
- Evaluation
- Social skills development
- Transition services
- Advocacy
- Professional staff development
- Parents or caregivers

Section 504

- Students with an FASD may be eligible for protection and accommodations under Section 504 of the Rehabilitation Act of 1973.
- Section 504 is a civil rights act that protects the rights of persons with disabilities.
- Section 504 does not provide funding.

What Is a "Disability" Under Section 504?

- Section 504 defines a person with a disability as anyone who:
  - Has a physical or mental impairment that limits one or more major life activities (which includes learning)
  - Has a record of such impairment
  - Is regarded as having such an impairment

Possible Provisions of a Section 504 Plan

- Dispensing of medications
- Special diets
- Early dismissal for appointments
- Change in the number of allowable absences for health reasons
- Individualized assignments
- More time to complete assignments

Advocacy by Defense Attorneys

- Defense attorneys need to understand IDEA.
- Understanding delinquency and how to apply special education law provides alternatives and ideas.
- Special education advocacy may prevent placements in juvenile facilities.

Steps to Special Education Advocacy for Clients With an FASD

- Develop a chronology of events
- Make a request from school district for all the school's records on the child
- Make a request for all medically relevant information related to the student's disability
- Engage an educational and medical expert to review records

Special Education— Parent's Rights/Roles

RIGHTS	ROLES
■ Have a say in the child's education	■ Provide intimate knowledge of the child
■ Contribute to the special education team with the same weight and importance as other members	■ Work with their child's advocate
■ Be listened to by the "professionals" on the team	■ Be an active member of the team

Activity

Behavior Management for Youth With an FASD

- A juvenile justice system challenge
- "Rejects" from other systems
- Traditional behavior management—includes certain expectations

Expectations of "Consequence-Based Behavior Modification"

- Hear and understand consequences
- Link consequence with behavior
- Apply to future behaviors
- Predict outcomes
- Retrieve previous information
- Recall all possible consequences
- Integrate the recollections and predictions automatically and adjust behavior accordingly

So, What *Does* Work?

- Experience is a good teacher.
- Base practices on the individual's needs.
- Plan for success.

Successful Behavior Management

- Understands the behavior
- Is different than we've practiced
- Anticipates problems
- Constructs rules that work
- Is not consequence-based
- Works as well as consequence-based methods
- Effects changes in the relationship between the "teacher" and the learner

Understanding the Behavior

- Behavior can be caused by factors such as:
  - Attention seeking
  - Escape or avoidance
  - Lack of understanding
  - Stress, fear, confusion
  - Overwhelming environment
  - "Bad attitude"
  - Peer pressure
  - Anxiety

Anticipating Problems

- Determine external or environmental stimulants
- Use avoidance techniques
- Adjust environment
- Use an "external brain"

Constructing Program Rules

- Positive terms
- Clear and concise
- Written down
- Explained
- Based on input from staff or youth
- Few in number
- Simple
- Have staff commitment

Source: Roush, 1996

Modifying the Environment

- Declutter
- Limit activities that cause overstimulation
- Identify quiet time/space
- Reduce number of people
- Strive for a calm environment

Effective Techniques

- Careful supervision
- Positive reinforcement
- Clear schedules
- Consistent limits
- Consistent expectations
- Calm, structured setting
- Teaching of desired behavior
- Repetition

Eight Magic Keys

- Concreteness
- Consistency
- Repetition
- Routine
- Simplicity
- Specificity
- Structure
- Supervision

Source: Evensen and Lutke, 1997

Activity

Questions

Posttest!

References

- See References for a complete list of all references used in this module.

Module 6:
Transition and Aftercare

Description

Summary

The sixth module discusses what juvenile justice system professionals need to do when planning for the release of offenders from juvenile facilities into their communities. It also focuses on the aftercare services needed for youth with an FASD after their release and as they enter into adulthood.

Objectives

After completing this module, participants will be able to:

- Demonstrate an understanding of the need for transition and aftercare services for juveniles with an FASD who are leaving correctional or other residential placements and transitioning into adulthood
- Identify particular aftercare needs of youth with an FASD in the juvenile justice system
- Examine employment-related issues for youth with an FASD

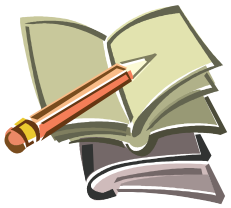
Facilitator's Outline

Step and Time	Tools Needed
One: Introduction—5 minutes	
You are presenting the *Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System*, a joint project of the Substance Abuse and Mental Health Services Administration (SAMHSA) Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence and the Minnesota Organization on Fetal Alcohol Syndrome. The FASD Center is a Federal initiative devoted to preventing and treating FASD. The Center's goals include advancing the field of FASD and promoting best practices. You may want to have participants introduce themselves, if time allows. Ask participants to state their backgrounds and interest in FASD. *Note: You do not need to do introductions if you combine modules—only conduct introductions at the beginning of a training session.*	
Two: Why We Are Here—5 minutes	
Discuss *Tools for Success*. *Tools for Success* focuses on assisting professionals who work with youth in the juvenile justice system who have an FASD to develop effective and appropriate interventions. It is designed for all correctional professionals, including advocates, attorneys, social workers, and social and human service providers who interact with children and families affected by FASD. *Tools for Success* contains seven modules: ■ Fetal Alcohol Spectrum Disorders (FASD): The Basics ■ FASD in the Juvenile Justice System ■ The Juvenile Justice System Response ■ Dispositional Options ■ Special Education and Behavior Management ■ Transition and Aftercare ■ Resources **2 minutes**	**PowerPoint Slide 6-1**

Step and Time	Tools Needed
Two: Why We Are Here (continued)	
Discuss Module 6: Transition and Aftercare. The sixth module discusses what juvenile justice system professionals need to do when planning for the release of offenders from juvenile facilities into their communities. It also focuses on the aftercare services needed for youth with an FASD after their release and as they enter into adulthood. **2 minutes**	**PowerPoint Slide 6-2**
Discuss objectives for the module as indicated on PowerPoint Slide 6-3. **1 minute**	**PowerPoint Slide 6-3**
Three: Pretest—10 minutes	
Distribute the pretest and allow time for participants to complete it. After ensuring that each participant has provided a unique identifier on the pretest (see the Introduction), collect the tests. Do not review answers at this time.	**PowerPoint Slide 6-4** **Pretest** 
Four: PowerPoint Presentation—10 minutes	
Using PowerPoint presentation and facilitator talking points, provide introduction and background on transition and aftercare, transition services defined, and strategies for a smooth transition.	**PowerPoint Slides 6-5 and 6-6**
Five: Transition to the Community: Youth Needs Activity—15 minutes	
Follow directions for Activity 1—Transition to the Community: Youth Needs. Distribute Activity Handout: "Considerations When Planning for Youth Leaving Juvenile Facilities"	**PowerPoint Slide 6-7**  **Activity 1 sheets in curriculum** 
Six: PowerPoint Presentation—15 minutes	
Using PowerPoint presentation and facilitator talking points, discuss aftercare programs.	**PowerPoint Slides 6-8 through 6-10**

Step and Time	Tools Needed
Seven: Aftercare Activity—15 minutes	
Follow directions for Activity 2—Aftercare. Distribute Activity Handout: "Aftercare." Distribute Activity Handout: "Intensive Aftercare Program."	**PowerPoint Slide 6-11**  **Activity 2** **sheets in curriculum** 
Eight: PowerPoint Presentation—15 minutes	
Using PowerPoint presentation and facilitator talking points, discuss employment issues as they relate to youth and adults with an FASD.	**PowerPoint Slides 6-12 through 6-21**
Nine: Employment Activity—15 minutes	
Follow directions for Activity 3—Employment. Distribute Activity Handout: "Advice for Employers of Youth With an FASD." Distribute Activity Handout: "Vocational Rehabilitation." Distribute Activity Handout: "Vocational Rehabilitation—Potential Limitations." Distribute Activity Handout: "What Works for John's Employment Program."	**PowerPoint Slide 6-22**  **Activity 3** **sheets in curriculum** 
Ten: Posttest—10 minutes	
Distribute the posttest and allow time for participants to complete it. Using the facilitator's notes in the curriculum, review the answers to the posttest. After ensuring that each participant has provided his or her unique identifier on the posttest, collect the tests.	**PowerPoint Slide 6-23**  **Posttest** **Posttest Facilitator's Notes**
Eleven: Evaluation—5 minutes	
Total Time: 2 hours	

Pretest



ID # _____–pre

Please answer true or false to the following questions:

1. The IEP (Individualized Education Program) requires transition planning for higher education or vocational education needs when a youth reaches the age of 17.

   True ☐ or False ☐

2. Aftercare programming is not as crucial for success as primary programming.

   True ☐ or False ☐

3. Vocational rehabilitation services are not usually appropriate for individuals with an FASD.

   True ☐ or False ☐

4. Individuals with an FASD tend to have problems with employment.

   True ☐ or False ☐

5. The aftercare planning and implementation begins upon release from the primary program or facility.

   True ☐ or False ☐

6. Individuals who receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits are presumed to be eligible for vocational rehabilitation services.

   True ☐ or False ☐

7. Whether a youth with an FASD will be eligible for vocational rehabilitation services depends on the type and magnitude of the youth's functional limitations.

   True ☐ or False ☐

Pretest Facilitator's Notes

Please answer true or false to the following questions:

1. The IEP (Individualized Education Program) requires transition planning for higher education or vocational education needs when a youth reaches the age of 17.

   True ☐ or False ☐

   False: Federal legislation requires transition planning in all States for students 16 and older and encourages planning as early as 14 years old.

2. Aftercare programming is not as crucial for success as primary programming.

   True ☐ or False ☐

   False: Aftercare is as important as, or even more important than, primary programming. Coordinated aftercare is necessary to maximize the likelihood of success for a youth with an FASD.

3. Vocational rehabilitation services are not usually appropriate for individuals with an FASD.

   True ☐ or False ☐

   False: Individuals with an FASD can benefit greatly from vocational rehabilitation services. Under these programs, individuals are entitled to services to help them get ready for work or to find and keep a job.

4. Individuals with an FASD tend to have problems with employment.

   True ☐ or False ☐

   True: According to the secondary disabilities study (Streissguth, et al., 1996), 79 percent of women and men affected by prenatal alcohol use in the study had problems with employment.

5. The aftercare planning and implementation begins upon release from the primary program or facility.

   True ☐ or False ☐

   False: Aftercare planning actually begins early in the process of treatment. There are four phases of aftercare, including the predisposition phase, facility phase, prerelease phase, and postrelease phase.

6. Individuals who receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits are presumed to be eligible for vocational rehabilitation services.

   True ☐ or False ☐

   True: This is the case unless there is clear and convincing evidence that they are too severely disabled to benefit from vocational rehabilitation services.

7. Whether a youth with an FASD will be eligible for vocational rehabilitation services depends on the type and magnitude of the youth's functional limitations.

   True ☐ or False ☐

   True: Functional limitations are barriers or deficits that interfere with some predetermined standard of functioning. States vary on their definition of this term.

Use this space for your notes.

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

Use this space for your notes.

Module 6

Transition and Aftercare

Use this space for your notes.

Module 6: Transition and Aftercare

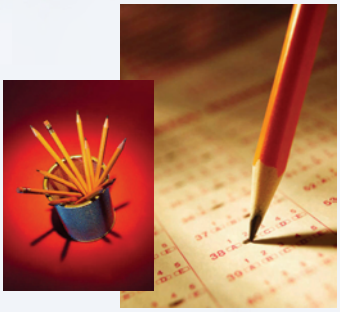
- After completing this module, participants will be able to:
  - Demonstrate an understanding of the need for transition and aftercare services for juveniles with an FASD who are leaving correctional or other residential placements and transitioning into adulthood
  - Identify particular aftercare needs of youth with an FASD in the juvenile justice system
  - Examine employment-related issues for youth with an FASD

HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence

Module 6: Transition and Aftercare
Slide 6-4

Use this space for your notes.

Pencils Out



Pretest!

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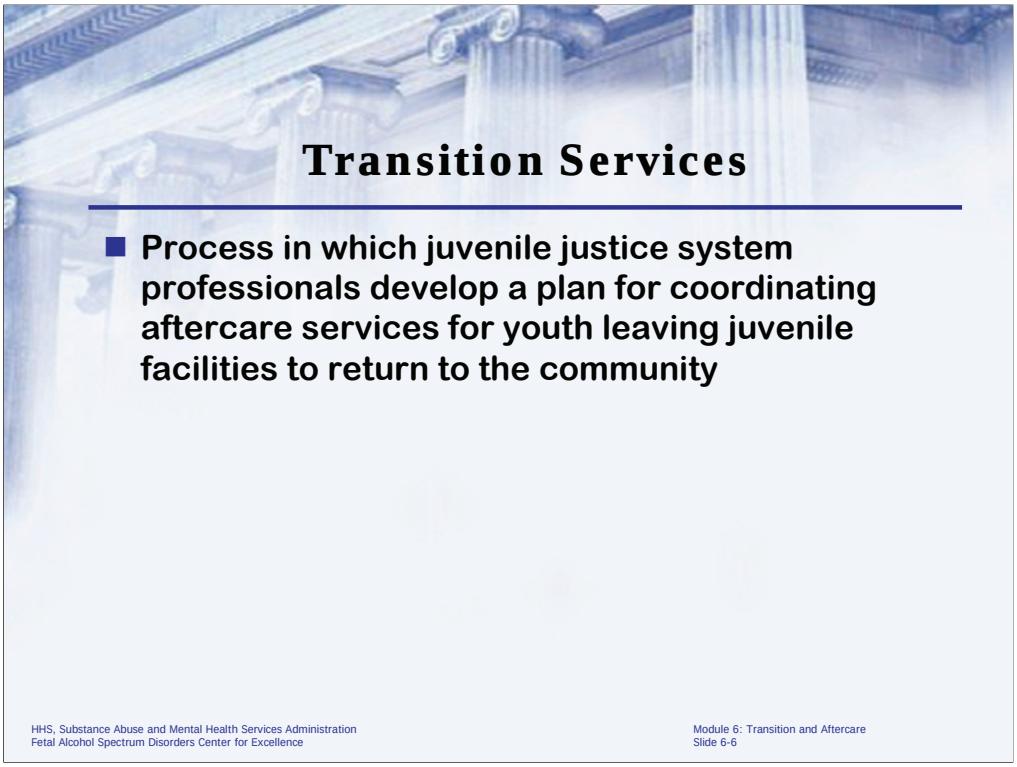


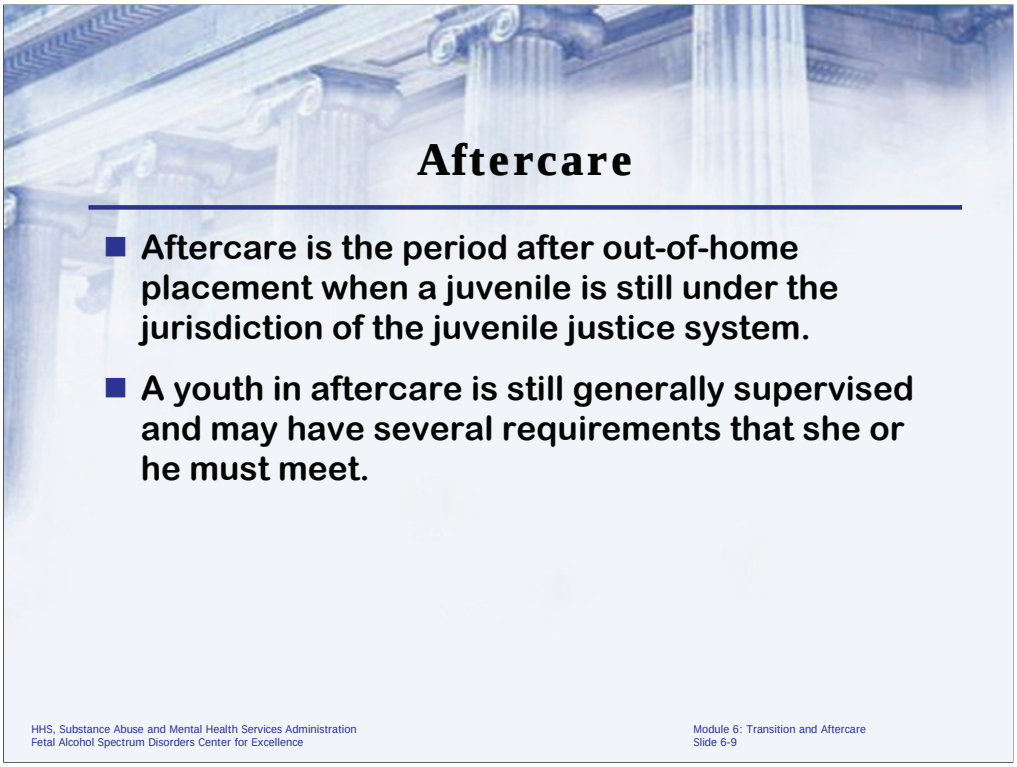
FACILITATOR'S TALKING POINTS:

- When juvenile offenders are sent out of the community to correctional or other residential placement, they often make great progress. But if juvenile offenders return home to the same environment in which their delinquency flourished, they may repeat their behavior. Because of their permanent neurological deficits and the many secondary problems these deficits generate, youth with an FASD will face many obstacles, requiring extensive planning prior to their release.
- All youth with an FASD reentering the community need these services, but often this fails to occur for various reasons. Youth who receive appropriate transition services will have a better chance of adjusting socially and seeking successful educational and employment opportunities. Transition services should be provided for a minimum of 6 months.

FACILITATOR'S TALKING POINTS:

- It is challenging to put together and implement a strong transition plan for a youth with an FASD, but these strategies support a smooth transition:
  - Establish relationships within the community for potential employment.
  - Utilize the concept of wraparound in all transition planning. This entails taking a look at the individual and family and identifying what they need. From that, identify how to and who will provide services.
  - Provide training in social skills, on-the-job skills, and independent living skills prior to release.
  - Provide services that support the entire family.
  - Begin early and review the plan often. Especially for youth with an FASD, planning for transition is essential, and revisiting the plan repeatedly will help prepare the individual and family for the transition. Ideally, transition planning should start as soon as the youth enters the facility.

See Activity 1 in the Activities section.



FACILITATOR'S TALKING POINTS:

- Many experts in juvenile justice recommend establishing a continuum of graduated sanctions and interventions. Aftercare is a vital step in that continuum. Just as juveniles are ideally "stepped up" toward a serious residential placement, they must be "stepped down" from such placements through furlough, transition, and aftercare services.
- Establishing intensive aftercare requires collaboration across geographical and organizational boundaries, changes in facility culture, and sufficient funding.

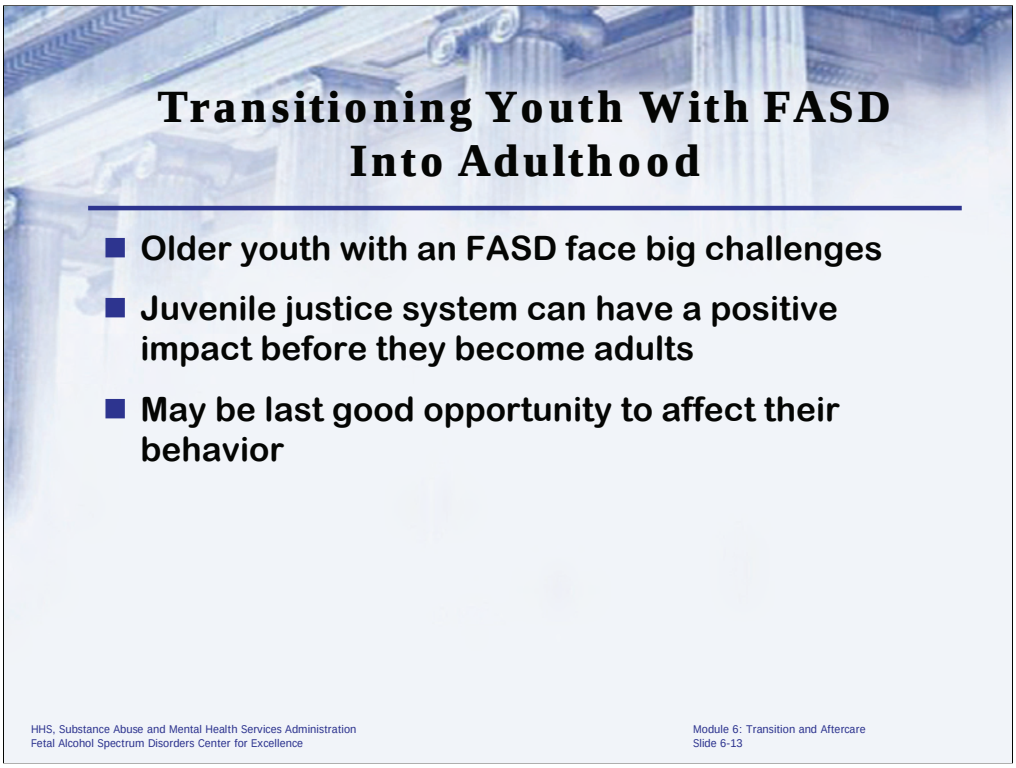
FACILITATOR'S TALKING POINTS:

- Aftercare is as important as, or even more important than, primary programming. Coordinated aftercare is necessary to maximize the likelihood of success for a youth with an FASD. Any out-of-home treatment should have a coordinated aftercare program to:
  - Assist youth in maintaining skills and strategies learned while in placement. When these youth return to their community, they may have difficulty remembering and using the skills they learned in placement if they do not have a lot of support and repetition. Youth with an FASD tend not to generalize what they've learned in one setting to other settings.
  - Provide supports to the youth and his or her family.
  - Assist the family in understanding the youth's disability.
  - Assist the youth in responding to the influence of problematic peers or temptations.
  - Assist the school in integrating the youth and providing special education, vocational planning, or job training. Explore other appropriate educational opportunities and situations—options such as GED and Job Corps.
  - Assist the youth in accessing social and psychological services that may include chemical dependency treatment.

FACILITATOR'S TALKING POINTS:

- This is a promising program for youth with an FASD. Under the program, youth with special needs receive the services listed here.
- The overall goal of this model is to improve the transition and aftercare services available to juvenile offenders by providing structure, accountability, and guidance. To be optimally effective, this process must begin even before a juvenile is committed to a facility and continue for up to a full year after release.
- The program integrates individual case planning and is based upon the risk levels of the youth.

See Activity 2 in the Activities section.



FACILITATOR'S TALKING POINTS:

- As youth with an FASD enter into their late teens and leave their childhood behind, they face huge challenges and continue to struggle with mental health problems, alcohol and drug problems, confinement, trouble with the law, employment, and independent living.
- The juvenile justice system has the opportunity to intervene and have a positive impact on these youth with an FASD during their adolescent years and before they become adults.
- Many of these youth are placed out of the home in correctional or other residential placements, and this may be the last time that the juvenile justice system can have a positive impact before they become adults.

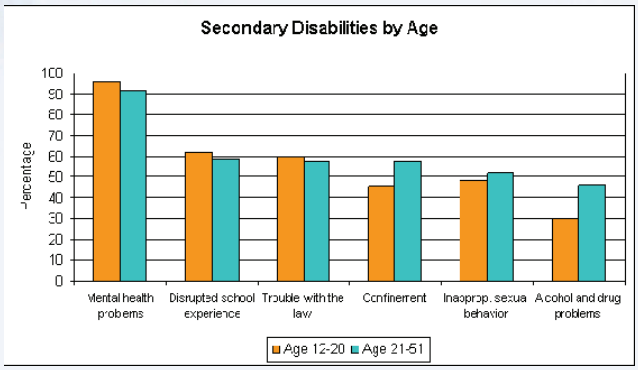
Juvenile Age by State

AGE	STATES
<18	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Virginia, Washington, West Virginia, Wisconsin, Wyoming
<17	Georgia, Illinois, Louisiana, Massachusetts, Michigan, Missouri, South Carolina, Texas
<16	Connecticut, New York, North Carolina, Vermont

FACILITATOR'S TALKING POINTS:

- Compared with adult courts, juvenile courts have more limited sanctions that can be imposed, even for the most violent offenders. Sanctions by juvenile courts are limited by the juvenile's age.
- States vary in their age limits for juvenile court jurisdiction. This table shows the age for juvenile court jurisdiction by State.

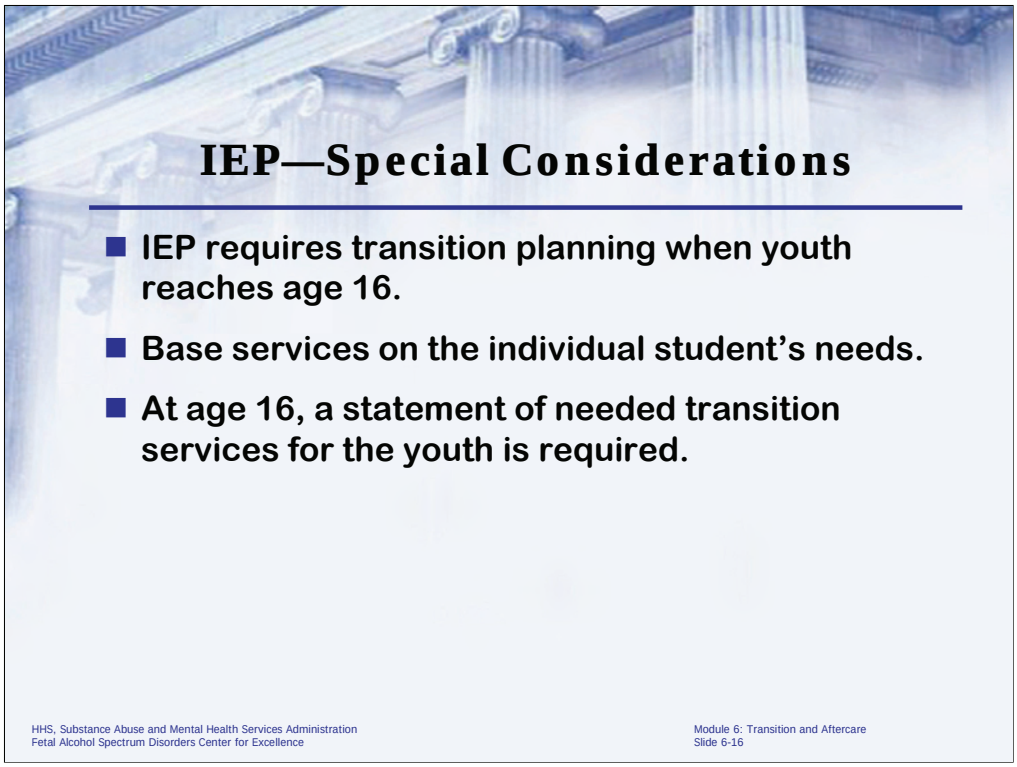
Secondary Disabilities by Age



Source: Streissguth, et al., 1996

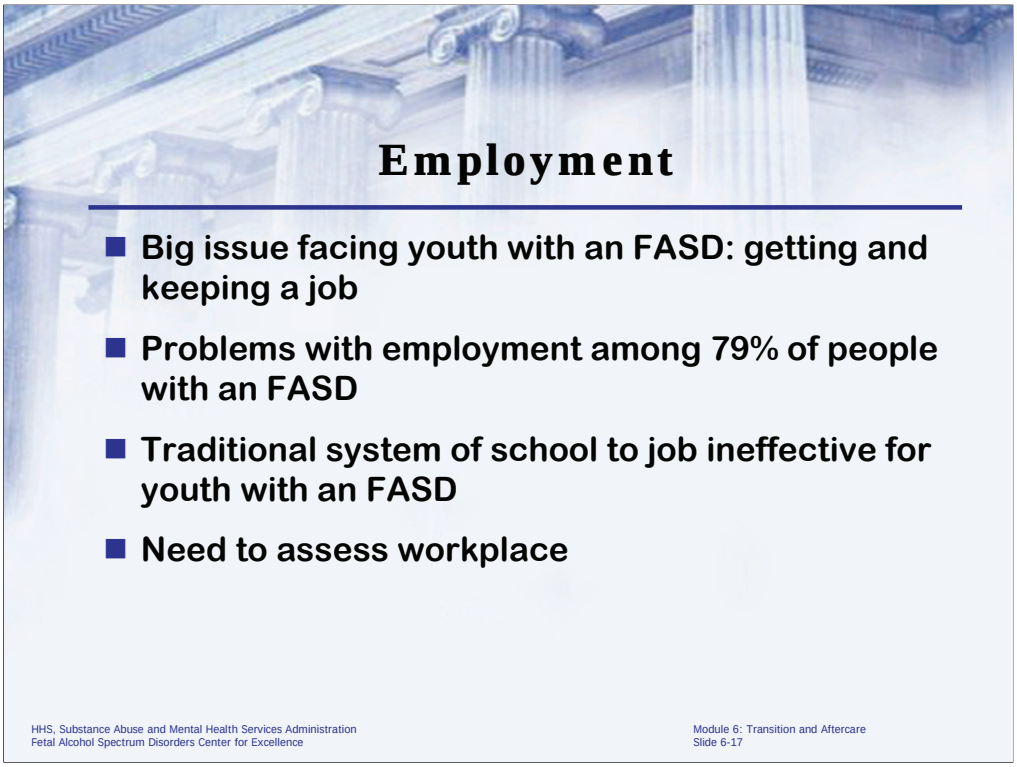
FACILITATOR'S TALKING POINTS:

- This figure shows the secondary disabilities for adolescents and adults from the 1996 secondary disabilities study (Streissguth, et al., 1996) and shows very little change for individuals with FAS/FAE as they become adults.
- According to Streissguth, many of these people had received community intervention services and out-of-home placement services, which failed to prevent their continuing secondary disabilities.
- This module will focus on what juvenile justice professionals need to consider in planning for the employment and independent living needs of these youth.



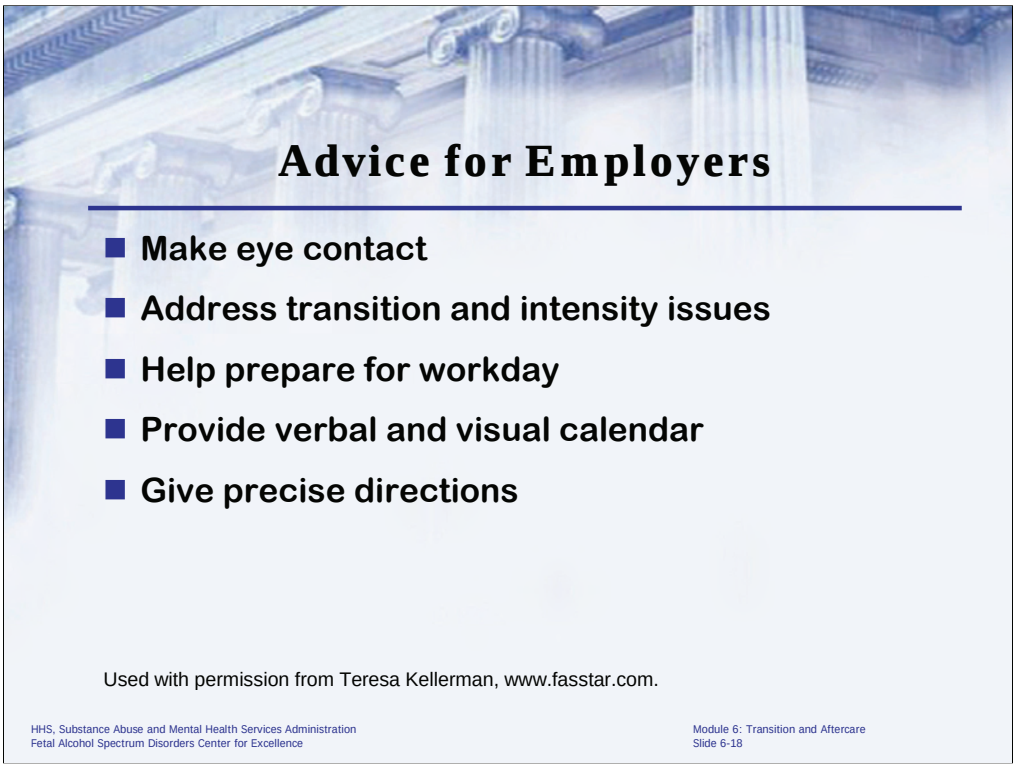
FACILITATOR'S TALKING POINTS:

- "Transition" is also a term used in an educational context.
- Transition services must be based on the student's needs, taking into consideration his or her preferences and interests. The services should include instruction, community experiences, development of employment and other postschool adult living objectives, and, if needed, training in daily living skills and access to functional vocational evaluations. For youth 16 years or older, the Individualized Education Program (IEP) *must* include a statement of the transition needs of the youth that focuses on the course of study.
- Beginning at age 16, a statement is required of needed transition goals and services for the youth, including courses of study needed to assist the child in reaching those goals. This is the maximum age to begin transition services for a youth with an IEP. However, it can, and often should, be started at age 14.



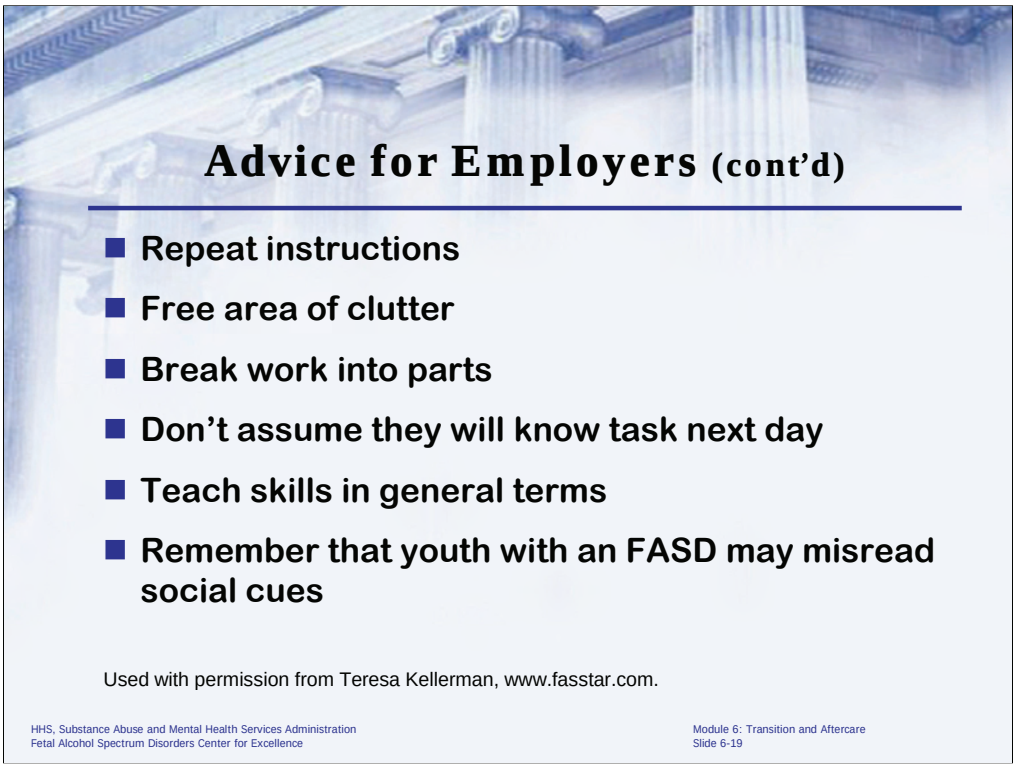
FACILITATOR'S TALKING POINTS:

- One of the greatest issues facing youth with an FASD is getting and keeping a job. According to the 1996 secondary disabilities study (Streissguth, et al., 1996), 79% of adults in the study had problems with employment (PWE). The researchers defined PWE as:
  - Having financial support other than their own earnings
  - Earning less than $280 a week
  - Being in a sheltered workshop
  - Working halftime or less
  - Having more than three jobs over the past 2 years
- These were considered red flags indicating PWE. The most common on-the-job problem was being easily frustrated (65%), followed by poor task comprehension (57%), poor judgment (55%), and social problems (54%).
- Juvenile justice staff need to consider many issues when preparing juveniles for employment after their release. It is recommended that these youth need an apprenticeship with a supportive trainer who individually trains and supervises one trainee at a time. Other suggestions will follow in the presentation.
- Youth with an FASD benefit from structured environments, repetition, and visual cues that reinforce verbal instructions.



FACILITATOR'S TALKING POINTS:

- Youth with an FASD can be successful and committed employees given the right support. Some suggestions for employers when working with youth:
  - Position yourself with the worker so that eye contact is maintained during discussion, taking into account cultural views of eye contact.
  - Youth with an FASD have a difficult time with transition, and often their desire to complete a task is intense. It is important that youth understand when a transition is going to take place.
  - Teach youth to prepare for the workday the night before by picking out clothes and getting lunch money ready.
  - Verbally and visually use the calendar. Use the calendar or datebook to write down the written work schedule and go over the schedule with them.
  - Use well-defined and precise directions. Youth with an FASD take instructions literally.

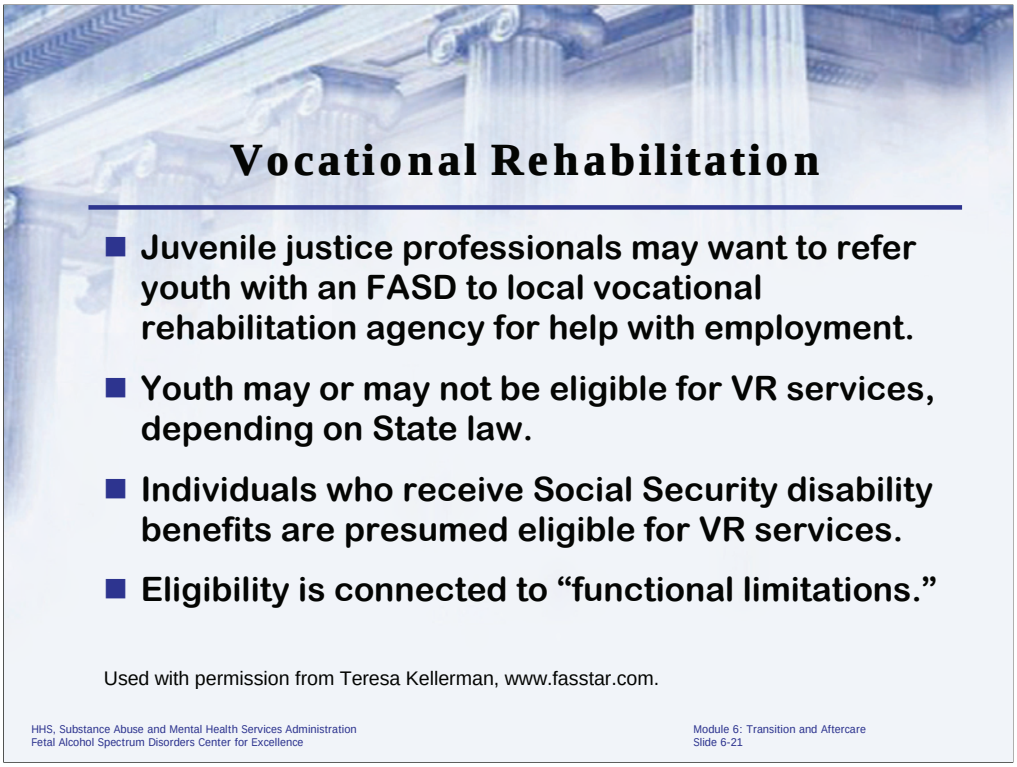


FACILITATOR'S TALKING POINTS:

- Here are some additional suggestions for employers when working with youth with an FASD:
  - When giving instructions, ask youth to repeat them and explain what they mean. Remember that youth may be able to repeat word for word what was said. However, they really may not understand the directive. Use verbal and visual instructions.
  - Free the work area of material that will not be needed by the youth.
  - Break the work into parts. When a task is completed, give the next piece to be done.
  - Repeatedly describe a task to be completed; use the same words over and over. Demonstrate each task. Do not assume that when a task is taught it will be remembered the next day; repetition is imperative.
  - Teach skills in general terms so that youth can adapt a skill to a different situation. Recognize that youth with an FASD often have difficulty adapting skills to different situations and need much support and role-playing in this area.
  - Remember that youth with an FASD often misread social cues. For example, a customer may come in a bad mood and be angry or argumentative or even just have a "mean" expression. Youth with an FASD may misinterpret that as the customer being angry at them. These misinterpretations need to be addressed when they occur.

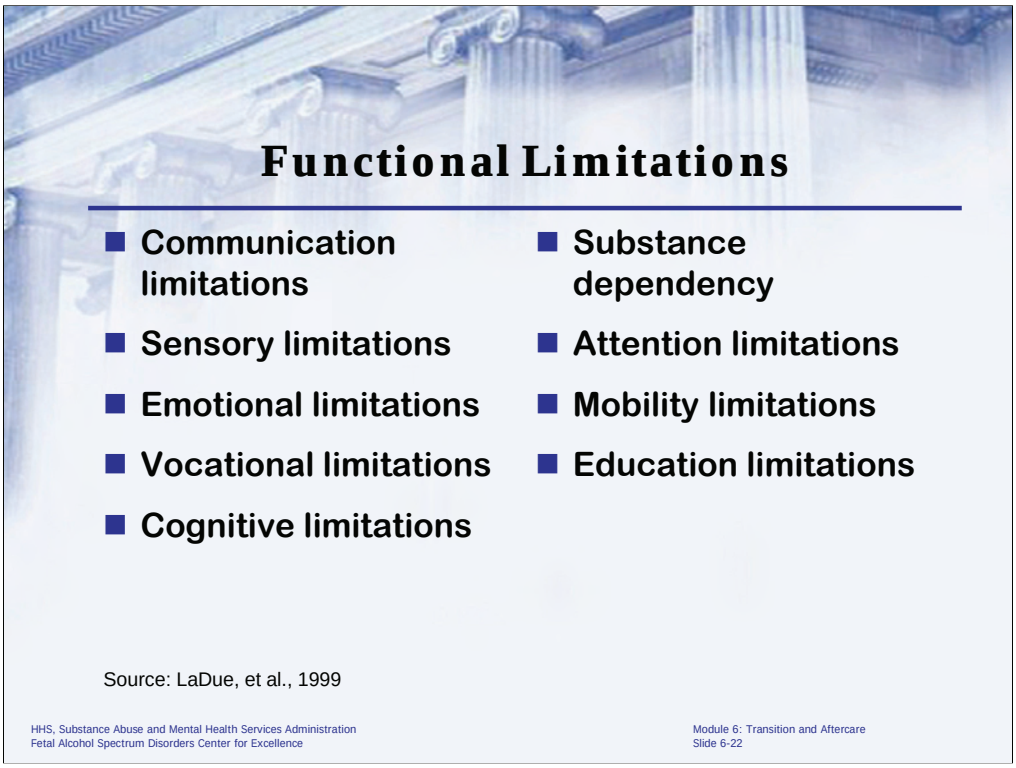
FACILITATOR'S TALKING POINTS:

- Each State may vary as to the type of vocational rehabilitation (VR) services offered, but generally they will include the following:
  - Counseling in understanding the disability and how it can affect employment, explanation of the Americans With Disabilities Act, and an assessment of a person's abilities for employment
  - Assessment of abilities and interests
  - Training in obtaining skills for employment and in adjusting to working
  - Help in finding a job, such as job accommodations, explanation of disability to an employer, information on where to apply for a job, and information on exploring and developing self-employment
  - Help in keeping a job, such as getting along with others, learning job duties, improving quality and quantity of work, and solving problems
  - Assistive technology, which is equipment to help if a person's disability makes it hard to do some tasks
  - Supportive services, including help with extra costs of other services necessary to help a disabled person achieve his or her job goal, such as transportation, books, or supplies



FACILITATOR'S TALKING POINTS:

- Juvenile justice professionals may want to consider referring youth with an FASD to their local vocational rehabilitation agency to obtain help with employment-related issues. Under VR law, individuals with disabilities are entitled to services to help them get ready for work or to find or keep a job.
- Eligibility is dependent on State's VR laws and the Federal law requirements. Individuals who receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits are presumed to be eligible for VR services leading to employment.
- Federal act requires States to serve individuals with the most severe disabilities first when there are not enough resources to serve everyone who is eligible.
- Whether a youth with an FASD will be eligible for VR services will depend on the type and magnitude of his or her functional limitations. Functional limitations are barriers or deficits that interfere with some predetermined standard of functioning. States may vary as to their definition of "functional limitation." Functional limitations are a key concept in vocational rehabilitation, because the services provided are directed explicitly at remediating these limitations.
- Youth with an FASD will need extra help in getting to their VR appointments. Recognizing this can avoid unnecessary closing of cases for lack of follow-through. VR often assumes the person can get to services on his or her own if motivated. However, those with an FASD need extra help to do so.



FACILITATOR'S TALKING POINTS:

- According to LaDue, et al. (1999), functional limitations that are common among people with an FASD include:
  - Communication limitations, including the ability to understand and process information
  - Sensory limitations, such as inability to tolerate loud noises
  - Emotional limitations, such as lack of confidence in ability to work, difficulty controlling their temper, inability to relate normally with people, and low self-esteem
  - Vocational limitations, such as lack of vocational skills or work habits
  - Cognitive limitations, such as impaired ability to learn or understand in one or more areas, impaired reasoning, difficulty processing new information, inability to count money, inability to learn basic social or survival skills, and need for ongoing and supportive supervision
  - Physical or psychological dependence on drugs
  - Attention deficits
  - Mobility limitations, lack of ability to sit still, and impaired motor functions due to medications
  - Educational limitations, such as limited ability to read, write, add, and subtract
- Other conditions that may adversely affect an individual's employability include unstable or nonexistent work history, criminal record, minority group identification, socioeconomic identification, and socially unacceptable appearance.
- Clearly, these issues are often seen in individuals with an FASD. Eligibility for VR services cannot be based on these conditions, but these limitations may require special counseling or intervention and placement assistance.

See Activity 3 in the Activities section.

Questions

Posttest!

Use this space for your notes.

References

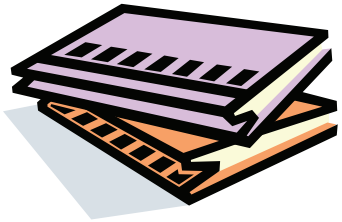
- See References for a complete list of all references used in this module.

HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence

Module 6: Transition and Aftercare
Slide 6-25

Use this space for your notes.

Posttest



ID # _____–post

Please answer true or false to the following questions:

1. The IEP (Individualized Education Program) requires transition planning for higher education or vocational education needs when a youth reaches the age of 17.

   True ☐ or False ☐

2. Individuals with an FASD tend to have problems with employment.

   True ☐ or False ☐

3. Vocational rehabilitation services are not usually appropriate for individuals with an FASD.

   True ☐ or False ☐

4. Individuals who receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits are presumed to be eligible for vocational rehabilitation services.

   True ☐ or False ☐

5. Whether a youth with an FASD will be eligible for vocational rehabilitation services depends on the type and magnitude of the youth's functional limitations.

   True ☐ or False ☐

6. Aftercare programming is not as crucial for success as primary programming.

   True ☐ or False ☐

7. The aftercare planning and implementation begins upon release from the primary program or facility.

   True ☐ or False ☐

Posttest Facilitator's Notes

Please answer true or false to the following questions:

1. The IEP (Individualized Education Program) requires transition planning for higher education or vocational education needs when a youth reaches the age of 17.

   True ☐ or False ☐

   False: Federal legislation requires transition planning in all States for students 16 and older and encourages planning as early as 14 years old.

2. Individuals with an FASD tend to have problems with employment.

   True ☐ or False ☐

   True: According to the secondary disabilities study (Streissguth, et al., 1996), 79 percent of women and men affected by prenatal alcohol use in the study had problems with employment.

3. Vocational rehabilitation services are not usually appropriate for individuals with an FASD.

   True ☐ or False ☐

   False: Individuals with an FASD can benefit greatly from vocational rehabilitation services. Under these programs, individuals are entitled to services to help them get ready for work or to find and keep a job.

4. Individuals who receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits are presumed to be eligible for vocational rehabilitation services.

   True ☐ or False ☐

   True: This is the case unless there is clear and convincing evidence that they are too severely disabled to benefit from vocational rehabilitation services.

5. Whether a youth with an FASD will be eligible for vocational rehabilitation services depends on the type and magnitude of the youth's functional limitations.

   True ☐ or False ☐

   True: Functional limitations are barriers or deficits that interfere with some predetermined standard of functioning. States vary on their definition of this term.

6. Aftercare programming is not as crucial for success as primary programming.

   True ☐ or False ☐

   False: Aftercare is as important as, or even more important than, primary programming. Coordinated aftercare is necessary to maximize the likelihood of success for a youth with an FASD.

7. The aftercare planning and implementation begins upon release from the primary program or facility.

   True ☐ or False ☐

   False: Aftercare planning actually begins early in the process of treatment. There are four phases of aftercare, including the predisposition phase, facility phase, prerelease phase, and postrelease phase.

Activity 1–Transition to the Community: Youth Needs–Activity Handout

Considerations When Planning for Youth Leaving Juvenile Facilities

- A safe and supportive placement
- Family-based services with counseling and training in effective parenting
- Enrollment in school, GED, or appropriate vocational programming
- Substance abuse support if necessary with a strong and appropriate relapse prevention plan
- Identified mentors
- Community support
- Procurement of necessary personal identification (Social Security card, birth certificate, etc.)
- Mental health services, including securing medications and aligning community-based mental health services with home county social service agencies
- Restorative justice programming
- Spiritual needs and the utilization of the existing faith community
- Youth's home in a metro or rural area
- Peer-related pressures upon return to the community
- Focus on building upon the strengths of the youth and family
- Any health-related issues and careful monitoring of medications
- The willingness of the youth to be involved in the transition plan in a cooperative manner
- Any suspected disabilities that require further testing for identification and remediation

Activity 1–Transition to the Community: Youth Needs

To be conducted during Slide 6-7

Tools needed:

Handout: "Considerations When Planning for Youth Leaving Juvenile Facilities"
Flip chart paper

Slide 6-7

Steps:

1. Lead a discussion with all the participants on what youth need for a smooth transition into the community.
2. Write the participants' ideas on flip chart paper.
3. Distribute the "Considerations When Planning for Youth Leaving Juvenile Facilities" handout. Go over each consideration listed and determine whether any points were missed or there are items to be added. Encourage participants to write notes on their copies of the handout.

Activity 2–Aftercare–Activity Handout

Aftercare

Coordinated aftercare is necessary to maximize the likelihood of success for youth with an FASD. Any extensive (3 months or longer) out-of-home placement should have a coordinated aftercare program to:

- Assist the youth in maintaining skills and strategies learned while in placement.
- Provide supports to the youth and his or her family.
- Assist the family in understanding the youth's disability.
- Assist the school in reintegrating the youth and providing appropriate special education, vocational planning, or job training.
- Assist the youth in responding to the influence of problematic peers or temptations.
- Assist the youth in accessing social and psychological services that may include chemical dependency treatment.

Activity 2–Aftercare

To be conducted during Slide 6-11

Tools needed:

Handouts: "Aftercare" and "Intensive Aftercare Program"
Flip chart paper

Slide 6-11

Steps:

1. Lead a discussion with all the participants on what aftercare youth with an FASD may need for a smooth transition into the community.
2. Write the participants' ideas on flip chart paper.
3. Distribute the "Aftercare" handout and go over each item listed to determine whether any points were missed or there are items to be added. Encourage participants to write notes on their copies of the handout.
4. Lead a discussion with all the participants on what intensive aftercare some youth may need for a smooth transition into the community.
5. Write the participants' ideas on flip chart paper.
6. Distribute the "Intensive Aftercare Program" handout and go over each item listed to determine whether any points were missed or there are items to be added. Encourage participants to write notes on their copies of the handout.

Activity 2–Aftercare–Activity Handout

Intensive Aftercare Program

When determining levels of intervention (services or programs) needed, the following information should be taken into consideration:

- Prior and current offense/disposition
- Family/parenting
- Education/employment
- Peer relations
- Substance abuse
- Leisure/recreation
- Personality/behavior
- Attitudes/orientation

Key principles of the model are:

- Begin assessment and transition processes prior to commitment to the facility.
- Develop transition agency partnerships.
- Overcome obstacles to information sharing among involved agencies.
- Involve residents and families in the transition process.
- Help the youth to envision and establish a meaningful, positive role as a valued member of the community.
- Surround the youth with positive, reliable persons.
- Draw on the restorative justice philosophy.
- Measure outcomes and evaluate transition and aftercare services.

A transition and aftercare planning team guides the entire process for each youth. The entire aftercare process maintains a tight focus on providing services that are tailored to each youth and that provide the desired "ecological validity" of promoting success in the community environment. This is especially important for youth with an FASD.

For further discussion, more on the aftercare phases can be found on page 157 of the *Tools for Success: Working With Youth With Fetal Alcohol Syndrome and Effects in the Juvenile Justice System Resource Guide* (Carlson and Holl, 2001).

Activity 3–Employment–Activity Handout

Advice for Employers of Youth With an FASD

- Position yourself with the worker so that eye contact is maintained during discussions.
- Youth with an FASD have a difficult time with transition, and their desire to complete a task is intense. It is important that youth understand when a transition is going to take place. Telling the youth they will take a break in 5 minutes would be an example.
- Teach the youth to prepare for the workday the night before by picking out their wardrobe and getting lunch money ready.
- Verbally and visually use the calendar. Use the calendar or datebook to write down the written work schedule and go over the schedule with them.
- Use well-defined, precise directions. Youth with an FASD take instructions literally. Telling a youth to "throw in the towel" will cause confusion. Do you really want him or her to "throw in a towel"?
- When giving instructions, ask the youth to repeat the directions.
- Remember that they may be able to repeat word for word what was said, but they really may not understand the directive. Use verbal instruction while showing the task to be completed.
- Free the work area of material that will not be needed by the youth.
- Break the work into parts. When a task is completed, give the next piece to be done.
- Repeatedly describe a task to be completed; use the same words over and over again.
- Do not assume that when a task is taught it will be remembered the next day; repetition is imperative.
- Teach skills in general terms so that youth can adapt the skills to different situations.

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Activity 3–Employment

To be conducted during Slide 6-22

Tools needed:

Handouts: "Advice for Employers of Youth With an FASD," "Vocational Rehabilitation," "Vocational Rehabilitation—Potential Limitations," and "What Works for John's Employment Program"
Flip chart paper

Slide 6-22

Steps:

1. Distribute the "Advice for Employers of Youth With an FASD" handout.
2. Use the handout as a guide to continue the discussion on transition and aftercare. Encourage participants to write notes on their copies of the handout.
3. Write the participants' ideas on flip chart paper.
4. Distribute the "Vocational Rehabilitation" and "Vocational Rehabilitation—Potential Limitations" handouts.
5. Use the handouts as guides for continuing the discussion on transition and aftercare. Encourage participants to write notes on their copies of the handouts.
6. Write the participants' ideas on flip chart paper.
7. Distribute the "What Works for John's Employment Program" handout.
8. Use the handout as a guide for continuing the discussion on transition and aftercare. Encourage participants to write notes on their copies of the handout.
9. Write the participants' ideas on flip chart paper.

Activity 3–Employment–Activity Handout

Vocational Rehabilitation–Potential Limitations

According to LaDue, et al. (1999), functional limitations that are common among people with an FASD include:

- **Communication Limitations—**Lack communication skills, including the ability to understand and process information.
- **Sensory Limitations—**Cannot tolerate loud noises.
- **Dysfunctional Behavior (Emotional)—**Lack confidence in ability to work, have difficulty controlling their temper, do not relate appropriately with people (poor social and interpersonal skills), have low self-esteem, are awkward in social situations, and cannot handle stress as it relates to everyday living.
- **Invisible Limitations—**Lack vocational skills or work habits.
- **Restricted Environment—**Need to be in a controlled environment.
- **Mental Limitations—**Have impaired ability to learn or understand in one or more areas, impaired reasoning ability, difficulty processing new information, inability to count money, inability to learn basic social or survival skills, and need for ongoing and supportive supervision.
- **Substance Dependency—**Have a physical or psychological dependence on drugs.
- **Attentive Limitations—**Have periods of involuntary inattentiveness.
- **Debilitation or Exertion Limitations—**Lack ability to work independently.
- **Mobility Limitations—**Lack ability to sit still; have impaired motor functions (may be due to medication).
- **Educational Limitations—**Lack ability to read, write, add, or subtract beyond second or third grade levels.
- **Other conditions that may adversely affect an individual's employability include** unstable or nonexistent work history; criminal record; minority group identification; socioeconomic identification; and socially unacceptable appearance, such as poor hygiene. These are often seen in individuals with an FASD. Eligibility for VR services cannot be based on these conditions, but these limitations may require special counseling or intervention and placement assistance.

Activity 3–Employment–Activity Handout

Vocational Rehabilitation

Under vocational rehabilitation (VR) law, individuals with disabilities are entitled to services to help them get ready for work or to find or keep a job. Each State may vary as to the type of services offered, but generally they will include the following:

- **Counseling** in understanding the disability and how it can affect employment, explanation of the Americans With Disabilities Act, and an assessment of a person's abilities for employment.
- **Training** in obtaining skills for employment and in adjusting to working.
- **Help in finding a job**, such as job accommodations, explanation of disability to an employer, information on where to apply for a job, and information on exploring and developing self-employment.
- **Help in keeping a job**, such as getting along with others, learning job duties, improving quality and quantity of work, and solving problems.
- **Assistive technology**, which is equipment to help if a person's disability makes it hard to do some job tasks.
- **Supportive services**, including help with the extra costs of other services necessary to help a person with a disability achieve his or her job goal, such as transportation, books, or supplies.

Additional issues include:

- **Eligibility:** Whether a youth is eligible for VR services will depend on each State's VR laws and the Federal requirements. Under Federal law, the term "disability" means a physical or mental impairment that constitutes or results in a substantial impediment to employment.
- **Income:** Individuals who receive Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI) benefits are presumed to be eligible for VR services leading to employment, unless there is clear and convincing evidence that they are too severely disabled to benefit from VR services.
- **Priority:** The Federal act requires States to serve individuals with the most severe disabilities first when there are not enough resources to serve everyone who is eligible. After serving these individuals, States can then serve others.

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Activity 3–Employment–Activity Handout

What Works for John's Employment Program

- **Awareness** by the employer/staff of the general nature of FASD.
- **Acceptance** of the person's limitations and/or deficits.
- **Small work group.** Vocational rehabilitation provides for a 1:6 ratio, but there are only 3 or 4 workers in John's group.
- **An outside environment** that provides a sense of freedom but is fenced off for safety, well away from the public.
- **Medications** that work all day long.
- **Communication book** that is written in everyday, by his mother and by the job coach, to keep informed of what's working, what's not working, alerts, and unusual circumstances.
- **Daily reinforcement** for appropriate behavior and/or cooperation at work.
- **Redirection** when needed using positive phrases.
- **"What if"** situations played out in advance, such as "What if you get angry at your boss?"
- **FASD** education and reeducation for all staff.

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Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

Module 6

Transition and Aftercare

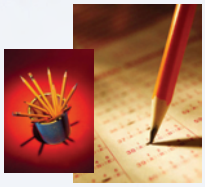
Module 6: Transition and Aftercare

- After completing this module, participants will be able to:
  - Demonstrate an understanding of the need for transition and aftercare services for juveniles with an FASD who are leaving correctional or other residential placements and transitioning into adulthood
  - Identify particular aftercare needs of youth with an FASD in the juvenile justice system
  - Examine employment-related issues for youth with an FASD

HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence

Module 6: Transition and Aftercare
Slide 6-4

Pencils Out



Pretest!

Transition Services

- Process in which juvenile justice system professionals develop a plan for coordinating aftercare services for youth leaving juvenile facilities to return to the community

HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence

Module 6: Transition and Aftercare
Slide 6-6

Strategies for a Smooth Transition

- Community relationships for employment
- Training in social skills, on-the-job skills, and independent living skills
- Services that support the entire family
- Plan that begins early and is reviewed often

Activity

Aftercare

- Aftercare is the period after out-of-home placement when a juvenile is still under the jurisdiction of the juvenile justice system.
- A youth in aftercare is still generally supervised and may have several requirements that she or he must meet.

Coordinated Aftercare Program

- Maintain skills learned in placement
- Support youth and family
- Help family understand the disability
- Help youth deal with peers and temptations
- Help school integrate youth
- Help youth access social and psychological services

Intensive Aftercare Program

- Education
- Vocational and job readiness preparation
- Emotional and health services
- Counseling
- Social skill development
- Family involvement/ counseling
- Recreation activities

Activity

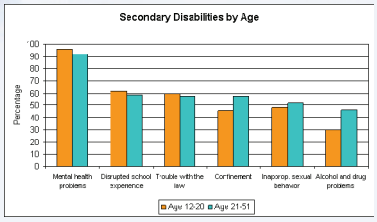
Transitioning Youth With FASD Into Adulthood

- Older youth with an FASD face big challenges
- Juvenile justice system can have a positive impact before they become adults
- May be last good opportunity to affect their behavior

Juvenile Age by State

AGE	STATES
<18	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Virginia, Washington, West Virginia, Wisconsin, Wyoming
<17	Georgia, Illinois, Louisiana, Massachusetts, Michigan, Missouri, South Carolina, Texas
<16	Connecticut, New York, North Carolina, Vermont

Secondary Disabilities by Age



Source: Streissguth, et al., 1996

IEP—Special Considerations

- IEP requires transition planning when youth reaches age 16.
- Base services on the individual student's needs.
- At age 16, a statement of needed transition services for the youth is required.

Employment

- Big issue facing youth with an FASD: getting and keeping a job
- Problems with employment among 79% of people with an FASD
- Traditional system of school to job ineffective for youth with an FASD
- Need to assess workplace

Advice for Employers

- Make eye contact
- Address transition and intensity issues
- Help prepare for workday
- Provide verbal and visual calendar
- Give precise directions

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Advice for Employers (cont'd)

- Repeat instructions
- Free area of clutter
- Break work into parts
- Don't assume they will know task next day
- Teach skills in general terms
- Remember that youth with an FASD may misread social cues

Used with permission from Teresa Kellerman, www.fasstar.com.

Vocational Rehabilitation (VR) Services

- Counseling
- Assessment
- Training
- Help in finding a job
- Help in keeping a job
- Assistive technology
- Supportive services

Used with permission from Teresa Kellerman, www.fasstar.com.

Vocational Rehabilitation

- Juvenile justice professionals may want to refer youth with an FASD to local vocational rehabilitation agency for help with employment.
- Youth may or may not be eligible for VR services, depending on State law.
- Individuals who receive Social Security disability benefits are presumed eligible for VR services.
- Eligibility is connected to "functional limitations."

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Functional Limitations

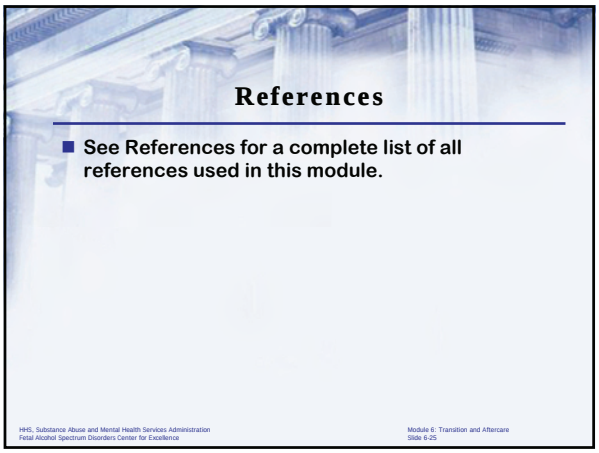
- Communication limitations
- Sensory limitations
- Emotional limitations
- Vocational limitations
- Cognitive limitations
- Substance dependency
- Attention limitations
- Mobility limitations
- Education limitations

Source: LaDue, et al., 1999

Activity

Questions

Posttest!


References
See References for a complete list of all references used in this module.
HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence
Module 6: Transition and Aftercare
Slide 6-25

Module 7: Resources

Description

Summary

The seventh module focuses on a rationale and an approach to begin to identify national and community resources for juveniles with an FASD and their families. The lesson plan focuses on identifying national, local agency, and system resources.

Objectives

After completing this module, participants will be able to:

- Identify national resources for information on FASD
- List systems that can be used as resources for youth with an FASD who are involved in the juvenile justice system
- Describe methods to identify local resources

Facilitator's Outline

Step and Time	Tools Needed
One: Introduction—5 minutes	
You are presenting the *Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System*, a joint project of the Substance Abuse and Mental Health Services Administration (SAMHSA) Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence and the Minnesota Organization on Fetal Alcohol Syndrome. The FASD Center is a Federal initiative devoted to preventing and treating FASD. The Center's goals include advancing the field of FASD and promoting best practices. You may want to have participants introduce themselves, if time allows. Ask participants to state their backgrounds and interest in FASD. *Note: You do not need to do introductions if you combine modules—only conduct introductions at the beginning of a training session.*	
Two: Why We Are Here—5 minutes	
Discuss *Tools for Success*. *Tools for Success* focuses on assisting professionals who work with youth in the juvenile justice system who have an FASD to develop effective and appropriate interventions. It is designed for all correctional professionals, including advocates, attorneys, social workers, and social and human service providers who interact with children and families affected by FASD. *Tools for Success* contains seven modules: ■ Fetal Alcohol Spectrum Disorders (FASD): The Basics ■ FASD in the Juvenile Justice System ■ The Juvenile Justice System Response ■ Dispositional Options ■ Special Education and Behavior Management ■ Transition and Aftercare ■ Resources **2 minutes**	**PowerPoint Slide 7-1**

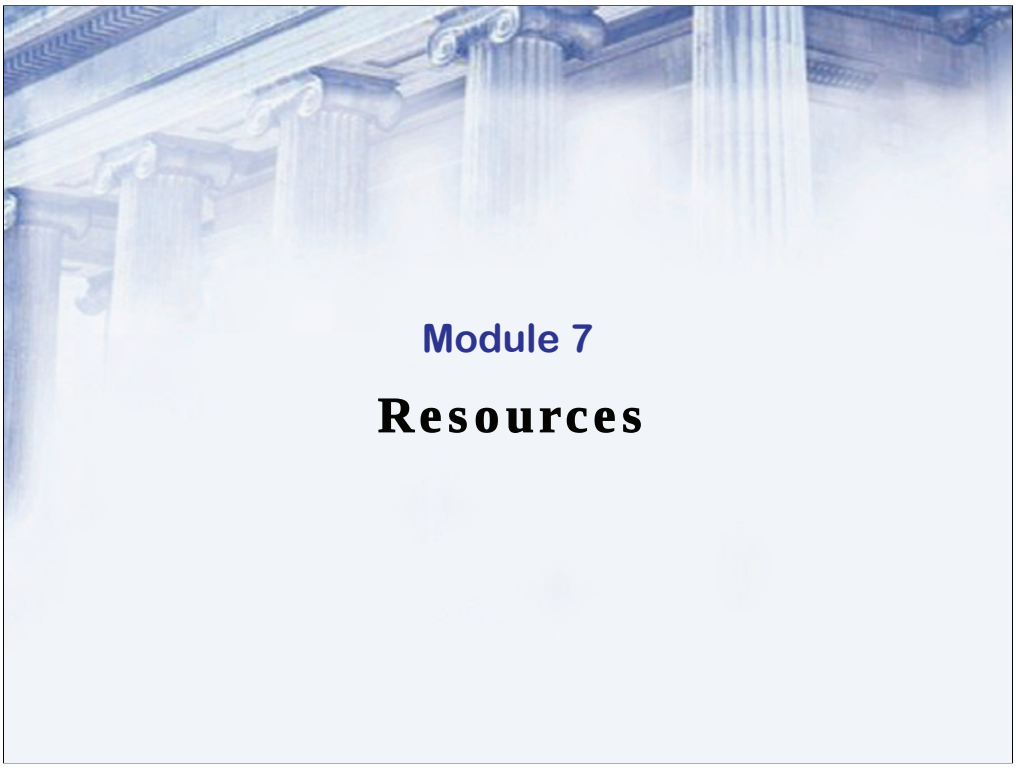
Step and Time	Tools Needed
Two: Why We Are Here (continued)	
Discuss Module 7: Resources. The seventh module focuses on a rationale and an approach to begin to identify national and community resources for juveniles with an FASD and their families. The lesson plan focuses on identifying national, local agency, and system resources. The hope is that participants will return to their settings and begin to partner with systems that can provide comprehensive and ongoing support to juveniles with an FASD. Although information on identifying resources and developing partnerships is woven into other modules, it is highly recommended that this module or a modified version of this module be included in each training. The new knowledge and information that participants gain from the other modules will have a greater impact if they are able to identify both local and national resources. **2 minutes**	**PowerPoint Slide 7-2**
Discuss objectives for the module as indicated on PowerPoint Slide 7-3. **1 minute**	**PowerPoint Slide 7-3**
Three: PowerPoint Presentation—15 minutes	
Using PowerPoint presentation and facilitator talking points, provide overview of national resources for information on FASD.	**PowerPoint Slides 7-4 and 7-5**
Four: Systems Activity—20 minutes	
Follow directions for Activity 1—Systems. Distribute Activity Handout: "Systems as Resources."	**PowerPoint Slide 7-6**  **Activity 1 sheet in curriculum** 

Step and Time	Tools Needed
Five: PowerPoint Presentation—20 minutes	
Using the PowerPoint presentation and facilitator talking points, provide information on identifying local resources.	**PowerPoint Slides 7-7 and 7-8**
Six: Local Resources Activity—20 minutes	
Follow directions for Activity 2—Local Resources. Distribute Resource Handout: "National Resources."	**PowerPoint Slide 7-9**  **Activity 2 sheet in curriculum** 
Seven: Evaluation—5 minutes	
Total Time: 1.5 hours	

Use this space for your notes.

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

Use this space for your notes.



FACILITATOR'S TALKING POINTS:

- The seventh module focuses on a rationale and an approach to begin to identify national and community resources for juveniles with an FASD and their families. The lesson plan focuses on identifying national, local agency, and system resources. The hope is that participants will return to their settings and begin to partner with systems that can provide comprehensive and ongoing support to juveniles with an FASD.
- Although information on identifying resources and developing partnerships is woven into other modules, it is highly recommended that this module or a modified version of this module be included in each training. The new knowledge and information that participants gain from the other modules will have a greater impact if they are able to identify both local and national resources.

Module 7: Resources

- After attending this session, participants will be able to:
  - Identify national resources for information on FASD
  - List systems that can be used as resources for youth with an FASD who are involved in the juvenile justice system
  - Describe methods to identify local resources

HHS, Substance Abuse and Mental Health Services Administration
Fetal Alcohol Spectrum Disorders Center for Excellence

Module 7: Resources
Slide 7-4

Use this space for your notes.

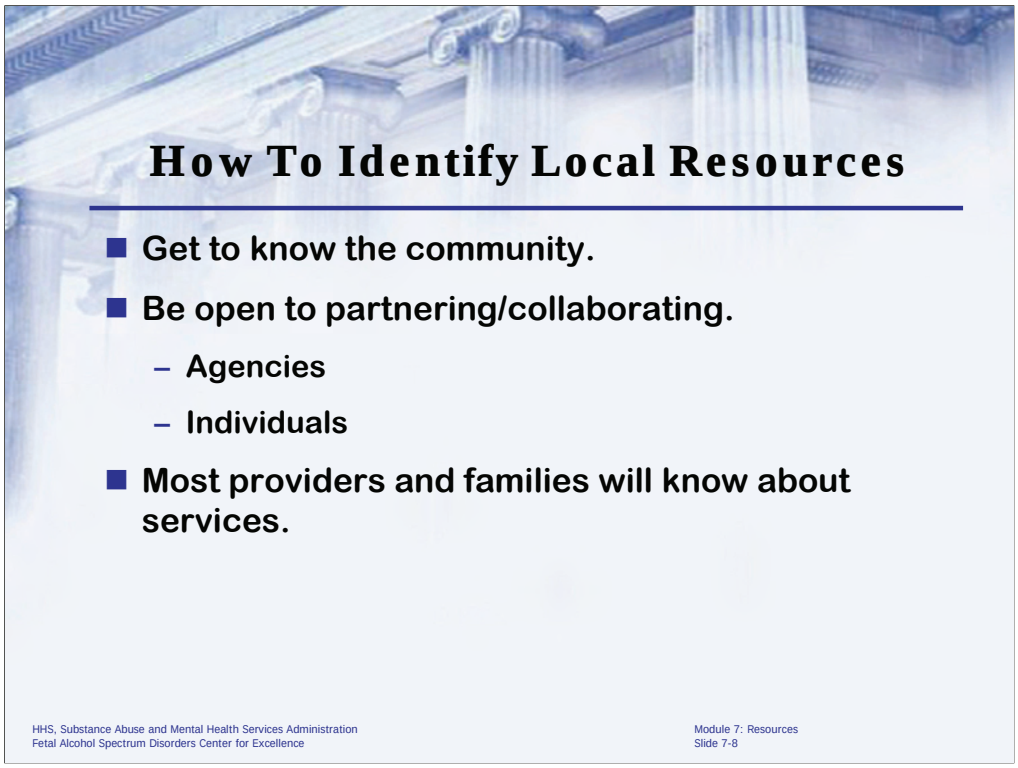
FACILITATOR'S TALKING POINTS:

- CDC addresses FAS through its National Center on Birth Defects and Developmental Disabilities (NCBDDD). CDC also hosts the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effects.
- The IHS Behavioral Health Program strives to eliminate alcoholism and other drug dependencies and improve the health care of American Indians and Alaska Natives. The program supports Native communities in achieving excellence in holistic substance abuse treatment, rehabilitation, and preven-tion services; promotes self-determination and self-governance; and advocates for American Indians, Alaska Natives, and service providers.
- ICCFAS is hosted by the National Institute on Alcohol Abuse and Alcoholism. ICCFAS includes represen-tatives from various branches of the U.S. Department of Health and Human Services (DHHS). ICCFAS members exchange information and coordinate Federal FASD strategies and programs.
- NIAAA supports research to improve diagnosis and assessment of impairment and disability and to develop tools to enhance academic and daily living skills. Areas of research include prenatal diagnostic and screening methods to identify fetuses affected by alcohol; assessment methods; skill-building, therapeutic, and educational products for individuals with an FASD; measures of the responsiveness of children with an FASD to stress and risk factors for alcohol use or psychopathology; and educational and training programs to enhance the skills of nonprofessional caregivers in dealing with FASD.
- Many individuals with an FASD become involved with the criminal justice system. OJJDP was created in 1974 to provide national coordination, resources, and leadership on juvenile justice. A member of the OJJDP staff sits on the FASD Center for Excellence Steering Committee.
- SAMHSA aims to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness. The agency administers grants and programs that target various priority areas in the substance abuse and mental health fields. SAMHSA's FASD Center for Excellence conducts training and other events, provides resources, and leads several initiatives to reduce the number of infants born prenatally exposed to alcohol, increase functioning of persons who have an FASD, and improve quality of life for individuals and families affected by FASD. NCADI is the Nation's one-stop resource for infor-mation about substance abuse prevention and addiction treatment. SAMHSA established ICCPUD to develop a coordinated plan to combat underage drinking. The group includes representatives from the Departments of Health, Education, Defense, Justice, and Transportation.

FACILITATOR'S TALKING POINTS:

- March of Dimes researchers, volunteers, educators, outreach workers, and advocates work together to address prematurity, birth defects, and low birth weight. Activities include parent education, genetic research, and health care advocacy.
- MOFAS, a nonprofit organization founded in 1998, is the first State affiliate of NOFAS. Its board of directors includes parents and family members of affected individuals, individuals diagnosed with an FASD, social workers, medical doctors, therapists, and people involved in adoption. *Although the focus of MOFAS is to provide FASD information and education in Minnesota, the organization also serves as a resource on a national level.*
- NOFAS is a nonprofit organization dedicated to eliminating alcohol-related birth defects and improving the quality of life for individuals with an FASD and their families. NOFAS is committed to raising public awareness of FASD. NOFAS works to develop and implement innovative ideas in prevention, intervention, education, and advocacy in communities throughout the Nation.
- Teratology is the study of the effects that drugs, medications, chemicals, and other exposures may have on the fetus. Teratology Information Services (TIS) are comprehensive and multidisciplinary resources for medical consultation on prenatal exposures. They interpret information regarding known and potential reproductive risks into risk assessments that are communicated to individuals of reproductive age and health care providers. Member programs of OTIS are located throughout the United States and Canada. Each TIS is designed to serve a specific population.
- The Arc is the national organization of and for people with mental retardation and related developmental disabilities and their families. It is devoted to promoting and improving supports and services for people with mental retardation and their families. The association also fosters research and education regarding the prevention of mental retardation. The Arc has an FAS Web page.
- Web sites for Federal agencies and national organizations can be found in the Activity 2 resource handout.

See Activity 1 in the Activities section.



FACILITATOR'S TALKING POINTS:

- One of the most important ways to impact systems change is to begin to identify local resources and partners.
- To do that, each professional needs to reflect on potential local partners and be open to collaborating with a variety of agencies and individuals.
- Most providers and families are already very adept at partnering with agencies and organizations to make changes and access services needed.

FACILITATOR'S TALKING POINTS:

- To begin to develop new relationships, here are some simple ideas to think about:
  - Start with local affiliates from those national and Federal organizations previously discussed. Have you met the local or State Arc representative? Are they involved in FASD issues at all? How could they collaborate with you and your work?
  - It is vital that, when developing systems of support for an individual with an FASD, we look at that person's natural supports. Often a person's extended family or faith community is the most effective system to work with.
  - Keep an open mind to new partners. Sometimes a group that you would not think would be a partner is the most productive. This can be especially true when it comes to work and vocational programs.
  - Reach out to people in the community and offer education and training to help raise awareness. Engage people and organizations in the process and ask them how they can be involved and make a difference. You will be amazed at the response you may get.

See Activity 2 in the Activities section.

Questions

Use this space for your notes.

Activity 1–Systems

To be conducted during Slide 7-6

Tools needed:

Handout: "Systems as Resources"
Flip chart paper

Slide 7-6

Steps:

1. Break the participants into small groups of three to five people (depending on the size of the group). Have the participants count off to form groups (1, 2, 3, etc.). If you prefer, keep them in a large group.
2. Have groups choose a recorder and a reporter.
3. Distribute the "Systems as Resources" handout.
4. Have participants review the handout and work together to draw up a list of systems that can be used as resources for youth with an FASD. Start the brainstorm by reminding individuals to "think outside the box" and seek to identify systems beyond the most obvious ones that offer programs.
5. On flip chart paper, list a selection of the following systems to get the discussion started:
   a. Juvenile corrections system
   b. Job training/vocational rehabilitation
   c. Substance abuse treatment
   d. Child protective services
   e. Developmental disabilities
   f. Health care
   g. Schools/education
   h. Mental health
   i. Family systems
   j. Respite/supported living
   k. Public safety
6. If small groups are used, have them report their ideas to the large group.
7. Write the participants' ideas on flip chart paper.

Activity 1–Systems–Activity Handout

Systems as Resources

A great variety of systems can be used as resources for youth with an FASD. It is often challenging for individuals with an FASD, their families, and the professionals who work with them to access the support and services that systems can provide. This sometimes may be due to the lack of understanding and awareness of the disability.

For professionals working in the juvenile justice system, one of the first steps toward accessing needed services and support is to identify the systems that can be impacted by individuals with an FASD.

It is important to consider the informal supports and systems that exist in the community. Often these “natural supports” are the most effective ones to assist a family in dealing with this challenge.

Many existing systems potentially can be impacted by an individual with an FASD. When professionals in the systems identified have insight and understanding of FASD, they are better able to respond to the needs of individuals and families, as well as provide appropriate supports.

Activity 2–Local Resources

To be conducted during Slide 7-9

Tools needed:

Handout: "National Resources"
Flip chart paper

Slide 7-9

Steps:

1. As a large group, spend 15 minutes discussing the following questions:
   a. What are names of agencies, organizations, or individuals who have a local presence in your community? List as many as you can. (5 minutes)
   b. Of these people and agencies, which do you think are the most supportive of individuals with an FASD and their families? Why are they supportive? (5 minutes)
   c. How can these agencies and individuals become more supportive? List specific strategies. (5 minutes)
2. Write the participants' ideas on flip chart paper.
3. Distribute the "National Resources" handout.

Activity 2–Local Resources–Resource Handout

National Resources

Federal Agencies

- Substance Abuse and Mental Health Services Administration (SAMHSA)
  www.samhsa.gov
- SAMHSA FASD Center for Excellence
  www.fasdcenter.samhsa.gov, 866-786-7327
- Centers for Disease Control and Prevention (CDC)
  www.cdc.gov, 800-311-3435 or 404-639-3534
- Indian Health Service (IHS)
  www.ihs.gov, 201-443-3024
- Interagency Coordinating Committee on Fetal Alcohol Syndrome (ICCFAS)
  www.niaaa.nih.gov/AboutNIAAA/Interagency
- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
  www.niaaa.nih.gov, 301-443-3860
- Office of Juvenile Justice and Delinquency Prevention (OJJDP)
  www.ojjdp.ncjrs.org, 202-307-591
- National Clearinghouse for Alcohol and Drug Information (NCADI)
  ncadi.samhsa.gov, 800-729-6686
- Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), www.stopalcoholabuse.gov

National Organizations

- March of Dimes Birth Defects Foundation
  www.modimes.org, 888-663-4637
- Minnesota Organization on Fetal Alcohol Syndrome (MOFAS)
  www.mofas.org, 866-90-MOFAS
- National Organization on Fetal Alcohol Syndrome (NOFAS)
  www.nofas.org, 800-66NOFAS
- Organization of Teratology Information Services (OTIS)
  www.otispregnancy.org, 866-626-OTIS
- The Arc of the United States
  www.thearc.org, 301-565-3842

Tools for Success Curriculum: Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System

The information in this curriculum was developed from materials created by the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). The Substance Abuse and Mental Health Services Administration (SAMHSA) appreciates the collaboration.

Module 7

Resources

Module 7: Resources

- After attending this session, participants will be able to:
  - Identify national resources for information on FASD
  - List systems that can be used as resources for youth with an FASD who are involved in the juvenile justice system
  - Describe methods to identify local resources

Federal Agencies

- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - FASD Center for Excellence
  - National Clearinghouse for Alcohol and Drug Information (NCADI)
  - Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) Centers for Disease Control and Prevention (CDC)
- Indian Health Service (IHS)
- Interagency Coordinating Committee on Fetal Alcohol Syndrome (ICCFAS)
- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- Office of Juvenile Justice and Delinquency Prevention (OJJDP)

National Organizations

- March of Dimes Birth Defects Foundation
- Minnesota Organization on Fetal Alcohol Syndrome (MOFAS)
- National Organization on Fetal Alcohol Syndrome (NOFAS)
- Organization of Teratology Information Services (OTIS)
- The Arc of the United States

Activity

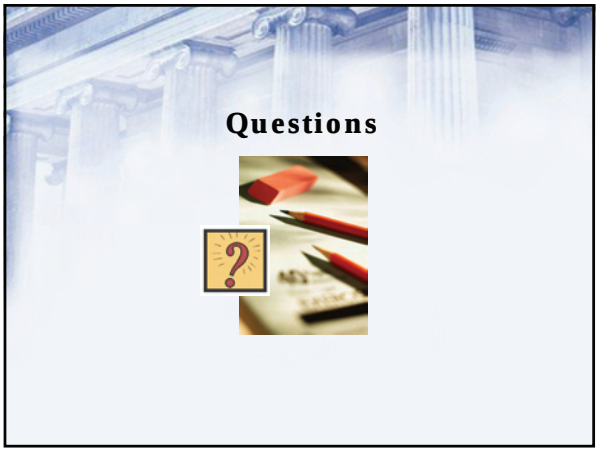
How To Identify Local Resources

- Get to know the community.
- Be open to partnering/collaborating.
  - Agencies
  - Individuals
- Most providers and families will know about services.

How To Develop Relationships

- Contact local arm of national/State organizations
- Remember natural support systems
- Keep an open mind to new partners
- Take the first step and offer education


Activity


Questions



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Module 7: Resources

No references

Evaluation Form

Tools for Success Curriculum

Working With Youth With Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System

Evaluation Form

Date: _____ **Site Location:** _____

I. Race/ethnicity and gender. This list uses Federal racial and ethnic classifications as defined by the Office of Management and Budget. Your voluntary cooperation in providing the following information is greatly appreciated. Please indicate:

- ☐ Female
- ☐ Male
- ☐ American Indian or Alaska Native
- ☐ Hispanic
- ☐ Asian or Pacific Islander
- ☐ White (not of Hispanic Origin)
- ☐ Black (not of Hispanic Origin)
- ☐ Other (specify):_____

II. Highest educational level/degree (choose highest level only):

- ☐ Doctorate
- ☐ Master's
- ☐ Bachelor's
- ☐ Associate
- ☐ High school or equivalency
- ☐ Other post-doctorate

III. I am (check all that apply):

- ☐ Person with an FASD (such as FAS/FAE)
- ☐ Service provider (specify):_____
- ☐ Government personnel (specify):_____
- ☐ Parent/caregiver of a person with an FASD (such as FAS/FAE)
- ☐ Other (specify):_____

IV. Module completed:

- ☐ Module 1
- ☐ Module 2
- ☐ Module 3
- ☐ Module 4
- ☐ Module 5
- ☐ Module 6
- ☐ Module 7
- ☐ All

Rating Key: N/A = Not Applicable; 1 = Poor; 2 = Satisfactory; 3 = Good; 4 = Excellent

V. On a 4-point scale, please rate the following:

Content of the information	1	2	3	4
Competence of the presenter(s)	1	2	3	4
Course objectives support the course description	1	2	3	4
Physical environment was conducive to learning	1	2	3	4
Opportunity for discussion with others	1	2	3	4

Comments: _____

_____

_____

VI. Please rate the following items regarding the course content:

Overall course quality	N/A	1	2	3	4
Written handouts	N/A	1	2	3	4
Use of audiovisual equipment	N/A	1	2	3	4
Content sequence	N/A	1	2	3	4
Individual/group exercises	N/A	1	2	3	4

Rating Key: N/A = Not Applicable; 1 = Poor; 2 = Satisfactory; 3 = Good; 4 = Excellent

VII. Please rate this presenter (Insert name) _____ regarding:

Overall quality of presenter	N/A	1	2	3	4
Knowledge of subject matter	N/A	1	2	3	4
Enthusiasm for subject	N/A	1	2	3	4
Use of examples/clarifying techniques	N/A	1	2	3	4
Willingness/capacity to respond to questions	N/A	1	2	3	4

VIII. Please rate this presenter (Insert name) _____ regarding:

Overall quality of presenter	N/A	1	2	3	4
Knowledge of subject matter	N/A	1	2	3	4
Enthusiasm for subject	N/A	1	2	3	4
Use of examples/clarifying techniques	N/A	1	2	3	4
Willingness/capacity to respond to questions	N/A	1	2	3	4

IX. Please indicate how well the training met each of the following training objectives:
(Trainer: Add objectives based on presentation)

_____	1	2	3	4
_____	1	2	3	4
_____	1	2	3	4

X. What did you like best about this presentation? _____

_____

_____

XI. What could be improved? _____

_____

_____

XII. What other topics related to FASD would be of most interest to you? _____

_____

_____

Please write any additional comments or suggestions in the space below. Thank you.

_____

_____

_____

_____

_____

Instructions for Participant Materials

Each *Tools for Success* participant should receive a package at the training that contains materials relevant to the modules being presented. Trainers should order a folder to give to each participant. The folder has a cover showing the *Tools for Success* title and image, as well as inside pockets for inserting materials. Because the trainer will be customizing the training and may be presenting only some modules, he or she needs to prepare the materials to insert into the folder. Suggestions for developing the contents are listed below:

Left inside pocket:

- Training agenda, created by the facilitator.
- Participant list, created by the facilitator. A participant list can be developed from registration data and should include contact information such as name, degrees, title, organization, address, phone number, fax number, and e-mail address.
- A brief biography of each facilitator, if needed.

Right inside pocket:

- The Description page for each of the modules being presented.
- Handouts of PowerPoint slides for each of the modules being presented. These can be printed in the PowerPoint format that allows three slides to a page and space for notes. It may be best to print or copy the handouts double sided to conserve space in the folder.
- A copy of "A Guide for Parents and Caregivers."
- The evaluation form, modified by the facilitator from the generic version included in the *Tools for Success* curriculum.

Participants also should receive pre- and posttests and activity handouts. These can be copied prior to the training and distributed to participants during the training as they are needed.

To order free copies of this Participant Materials Folder for your trainings, please call SAMHSA's National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686 or 1-800-487-4889 (TDD).