

# UTAH'S ADOPTION CONNECTION

CHILD AND FAMILY SERVICES

NOVEMBER 2008

*Sara, age 14 is waiting...*



# UTAH'S ADOPTION CONNECTION

CHILD AND FAMILY SERVICES

QUARTERLY DCFS NEWSLETTER



*Aria and Moses are waiting...*

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*If you are interested in any of the children you see in this publication, please contact The Adoption Exchange at 801-265-0444.*

November 2008  
Kathy Searle, Editor  
Lindsay Kaeding, Design Director

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# My Past

Written by Kelly K Owens

I was always afraid of facing my past.  
My past is okay because I ask for forgiveness.  
Now I smile about the ups and downs  
that I had to go through to get here.  
Sometimes I can't help but shed a tear.  
My past is blurry because I can only see it through my tears.

For more poetry by Kelly K. Owens visit Utah's Adoption Connection Lending Library at [www.utdcfsadopt.org](http://www.utdcfsadopt.org) and check out the book, "Can You Imagine" or visit his website at [www.canyouimaginebook.com](http://www.canyouimaginebook.com).



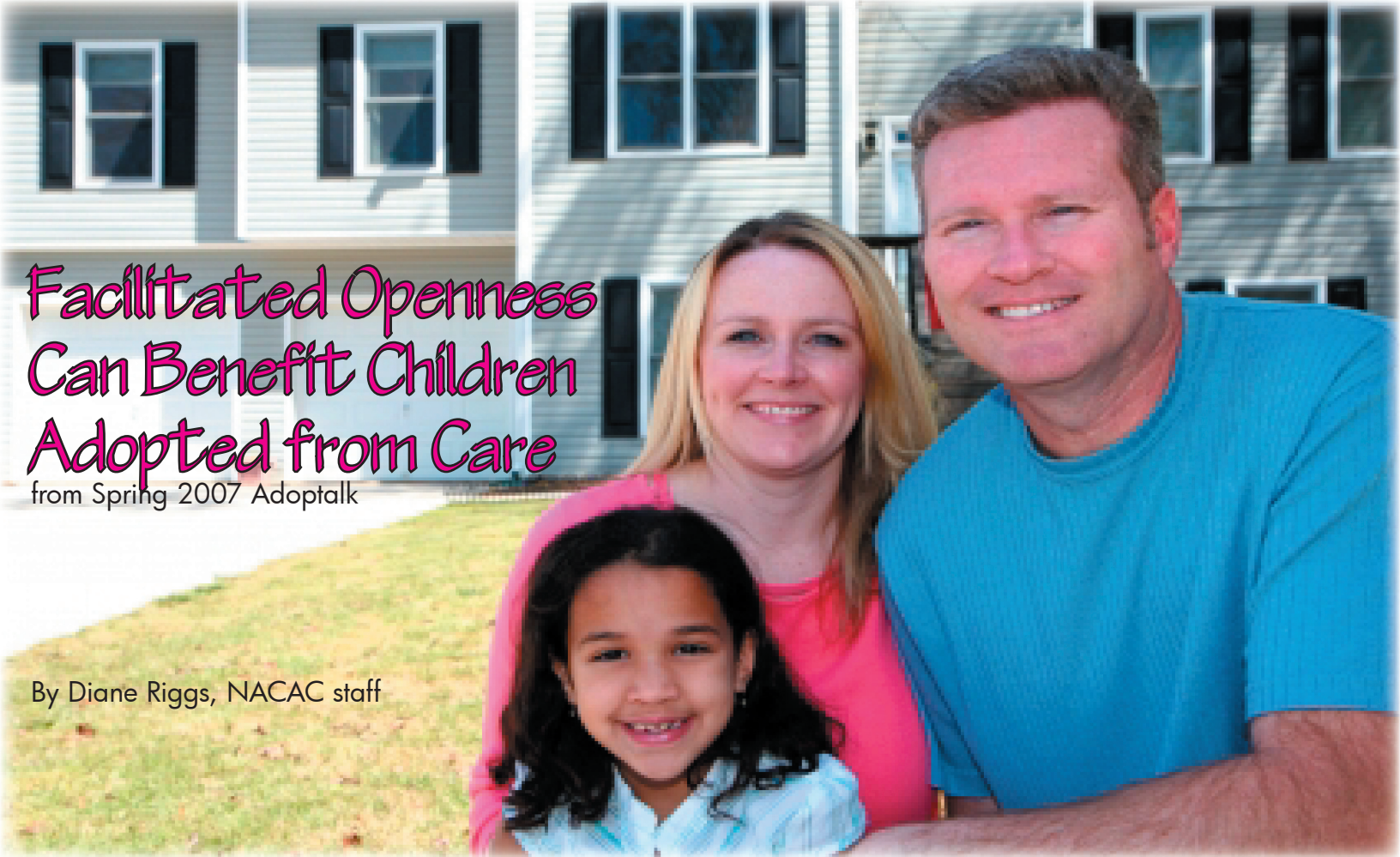
## Randy is waiting...

Peacemaker Randy, age 10, is a reader. He loves a good book but he also finds enjoyment from activities such as jumping on the trampoline, LEGOS and basketball. Randy really likes lasagna but if it's snack time, he can't pass up a king size Crunch bar. They are his favorite! Randy is an observant guy who likes to get along with others. He has decided that when he grows up, he wants most to be an "army guy."

Randy loves school. As a fourth grader he is working hard to catch up and is doing very well. He gets good grades in his classes but has expressed that he likes science and math the best.

Randy is currently attending counseling on a weekly basis. Counseling will need to continue after placement.

This young man is in need of a loving and stable home that will offer him support and security. If your family is interested in Randy, we urge you to inquire. Financial assistance may be available for adoption related costs.



# Facilitated Openness Can Benefit Children Adopted from Care

from Spring 2007 Adoptalk

By Diane Riggs, NACAC staff

When my parents adopted in the early '60s, society accepted adoption, but it was not something most adoptive parents (whose infants were matched with the family by skin, eye, and hair color) shared publicly. Today, parents who adopt children from foster care cannot pretend their children were always a part of the family, and most know that becoming a legal part of a new family does not erase a foster child's emotional ties to the past. As openness in infant adoption gains currency, it is worth considering how facilitated, safe contact with birth family members can benefit children adopted from care.

## Why Promote Contact?

Helping a foster or adopted child stay in contact with members of his birth family can be time-consuming and sometimes emotionally draining. Facilitated contact, however, can be valuable for children:

The promise of birth family contact can help some youth commit to adoption. A recently published adolescent adoption study [1] found that before they would accept an adoption plan, "adolescents needed to be told early that adoption would not preclude contact with their birth families." Youth also needed to clearly understand why they could not return to their birth parents, and why other family members could not assume custody. Once she realized her birth parents "weren't going to be there" for her, one youth in the study realized she belonged with her adoptive family.

Contact with birth family members and past caregivers can

ease the transition to adoption. As Nancy Umbach, an adoptive parent and professional in Ontario, asserts, "It is hard for kids to move on when they're still worrying about whether their birth family is okay or not." Fortunately a new provincial law, effective December 2006, allows foster children to be adopted and, when it serves their best interests, have contact with members of their birth family, previous caregivers, or members of their band or native community. Prior to the change, any foster children whose birth families were granted the right to visit them could not be adopted.

Prior foster families or birth family members can even aid the transition to adoption by assuring the child that they love him and that being adopted is okay. These important people need to let the child know they do not view the change as an act of disloyalty, but as an opportunity to be embraced.

By promoting contact with important figures from children's past, adoptive parents can show respect for their children. Showing respect for a child's birth family (and, by extension, the child) is important. When children feel respected and know that their adoptive parents are not trying to sever ties to their past, they are better able to open up about their experiences, and start healing old wounds. As one parent in the adolescent adoption study affirmed, "I'm not sure adolescent adoptions can succeed if...the adoptive family is not willing to be at least open to



some contact with the birth family.”

Helping children face family realities is better than allowing children to fantasize about the unknown. Faulty fantasies can grow when facts are absent. Realities, though they may be tough to handle, can be addressed and integrated into a child’s understanding of himself. Barb Fischer, a child welfare trainer and foster, kinship, and adoptive parent, puts it this way, “My preference is that my kids are able to know the answers to some of their questions and are allowed to start adjusting to some of their truths while they are still young, instead of [being forced to]...go through it all at once when they are adults.”

Keeping in touch can ease worries and promote the exchange of information. Even if a child’s birth parents are out of the picture, other members of the family or previous foster families may wonder and worry about the child. Contact with them can allow the child to see that other people still remember and care about her. Relatives and former foster families can also address the child’s anxieties, help fill gaps in her history, and offer adoptive parents insight about past experiences.

Contact can help youth reconcile more pieces of their identity. Questions of identity, particularly for teens adopted from foster care, can be deeply troubling. They were not born to their adoptive parents, so are they destined to replicate the missteps their birth parents may have made? Birth family members, neighbors, or past foster families may be able to address these concerns and share aspects of the family’s history—talents, accomplishments, stories—that are easier for the youth to own.

Post-adoption contact can help birth family members accept and support the adoption. In her study of parents who lost children to adoption, [2] Elsbeth Neil found that birth parents, burdened with feelings of shame and guilt, often required a great deal of emotional support. However, when adoptive parents initiated contact, indicated that the birth parents had value, and empathetically met with them face-to-face, adoption acceptance among birth parents rose substantially. As a result, they were able to be much more positive forces in their children’s lives

## Facilitating Contact

When considering contact, adoptive parents must put their children’s well-being first, and never force contact if the children are unwilling. With each interaction between her children and people from their past, Barb Fischer asks herself, “Whose best interest is served here?” The answer, says Barb, “has to be my child.”

Whether they know the birth family or not, adoptive parents should work with the placing agency to make certain they receive copies of all the information from the child’s file. Elements of the file can be incorporated into a lifebook for the child. The file might also include details about other members of the child’s birth family or previous foster families.

Cheryle Roberts, program director for Lilliput Children’s Services in California, suggests that workers might be able to

moderate a pre-adoption meeting where foster/adoptive parents and birth relatives can share information about and pictures of the child. The worker could even take a picture of the birth and adoptive parents together. “What better way is there to make a child feel comfortable with the adoption than having a picture of his birth and adoptive families together in his lifebook?” asks Cheryle.

When considering contact resources, adoptive parents should cast a wide net. Parents and teens in the adolescent adoption study included the following as family: birth parents, step-parents, siblings, past foster siblings, godparents, fictive kin, grandparents, aunts and uncles, and other previous caregivers. Since sibling loss is often felt most acutely, it is not surprising that 73 percent of study families were in contact with siblings.

## Promoting Safety

Lilliput Children’s Services, reports Cheryle, likes to “promote openness as a continuum from no contact at all to open regular contact.” Most families, she says, fall somewhere in the middle. After deciding upon contact, families must set parameters around the amount and kind of contact, the degree of supervision needed, and strategies for avoiding uncomfortable situations. Parents must also be prepared to help their children through any acting out that can result from contact. If any contact gets negative, parents should limit or stop it.

To help prevent problems, adoptive parents should instruct youth how to assess danger, extricate themselves from unhealthy situations, and address uncomfortable questions. One youth in the adolescent adoption study whose birth mother makes him feel guilty has a pat response: “I tell her that I love her and that there is a place in my heart for her, but I have moved on.” Another youth reports, “I call my mom if I feel uncomfortable, and she will be right there.” Just knowing her parents would not sanction contact with a drug-addicted uncle helped another youth leave her grandparents’ house after her uncle showed up.

Although it can be difficult for adoptive parents to reach out to their child’s first family, many former foster children know and may someday seek out members of their birth family. When it is safe to do so, adoptive parents can help their children explore the past—and prepare for the future—by making or maintaining connections with birth families and former caregivers. These connections can help children and youth gain a better sense of who they are and more readily accept their place in the adoptive family.

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[1] Lois Wright, Cynthia C. Flynn, and Wendy Welch, “Adolescent Adoption and the Birth Family,” *Journal of Public Child Welfare* 1, no. 1 (2007): 35–63.

[2] Elsbeth Neil, “Coming to Terms with the Loss of a Child: The Feelings of Birth Parents and Grandparents about Adoption and Post-Adoption Contact,” *Adoption Quarterly* 10, no. 1 (2006): 1–23.

# Post Adoption Support:

Report by: Susan Egbert, MSW, PhD, Independent Researcher

The following is a brief summary of a report on the Post Adoption Support Needs Assessment 2008. The survey was mailed in May 2008 to parents who have adopted children through Utah's Division of Child and Family Services. The researcher appreciates the time and energy adoptive parents shared to complete the survey! The full report of results and conclusions based on the input provided by adoptive parents is available on-line at: [www.utdcfsadopt.org/2008%20post%20adoption%20assessment.pdf](http://www.utdcfsadopt.org/2008%20post%20adoption%20assessment.pdf). The on-line report contains detailed summaries of parents' responses with regard to their children's maltreatment histories; post adoption needs experiences; and post adoption service awareness, access, use and ratings of quality. Quotes from parents are included in the report.

## Executive Summary

Last year in Utah, 392 children were adopted from foster care. Children who are adopted from foster care experience a significant set of special needs. The availability of services to help address these special needs after adoption is crucial to securing permanent committed families for children leaving foster care. These services are also critical to strengthening and maintaining adoptive families over time.

Many post adoption services have been developed and are funded, or in some way administrated by the Division of Child and Family Services to support families adopting children from Utah's foster care system. These services focus on:

1. Information and referral
2. Education and training
3. Family support and respite care
4. Treatment and crisis intervention.

Services may meet multiple needs at once.

This needs assessment follows previous surveys of Utah's DCFS post adoptive families (Egbert, 2001, 2002, 2003). These initial studies provided a vehicle for parents' ideas and suggestions about their needs for services to directly inform the development of post adoption programs as they were created and implemented.

The number of post adoptive families (currently over 2,700) has almost doubled since the previous research was completed and many DCFS funded services have now been in place for five years. A follow-up survey of adoptive families at this juncture provides data and consumer feedback so resources and services are used and developed effectively and efficiently. This study was completed by an independent researcher, Dr. Susan Egbert, at the request of Child and Family Services.

This report summarizes the responses of 804 parents who provided data on 975 children adopted from foster care through DCFS. Data was collected via surveys mailed by DCFS to all adoptive parents who receive adoption assistance. Surveys were returned anonymously and opened and analyzed by the researcher.

Parents reported that 60.1% of their children have current emotional or behavioral concerns and that 9.8% of their children have had emotional or behavioral concerns that have resulted in placement outside of their home at some point since adoption finalization. When asked about post adoption crisis, 28.4% of parents indicated that they have experienced what they would consider a post adoption crisis since finalization. They described a variety of "points of contact" for crisis help and a variety of feelings about the response and support they received.

### Objective One: Adoptive Families Level of Awareness

The solid increase, from previous surveys, in the percentage of families aware of services, and the percentage of families who know how to access services, indicates that the delivery of service information is continually improving. This is especially relevant in light of the fact that so many of these families are "new" to adoption in the last few years.

### Objective Two: Adoptive Families Access to, Use of, and Satisfaction with Services

# Needs Assessment 2008

Despite the increase in service awareness and in service access knowledge, the rate of families' use of post adoption services has remained fairly stable for most services. These data also indicate that satisfaction with the quality of services has increased and exhibits a positive trend for all services.

**Objective Three:** Current and or Additional Needs of Adoptive Families and **Objective Four:** Prioritization of Current Needs  
Current needs of adoptive families were assessed by observing the number of parents who commented on a given service. Education, mental health, information about their children's special needs, respite care, and DCFS post adoption services received the most focus from adoptive parents, indicating the importance of quality support in these areas to meet the needs of the children and families they serve.

## Recommendations

This project represents an immediate opportunity for research findings to guide state and local policy and program development. This information is intended for utilization by those who are tasked with improving the state's ability to keep adoptive children and their families safe and thriving. The following study-derived recommendations are directed at strengthening the connection between the needs of adoptive families and service providers' ability to meet those needs at any level from strengthening families, to treatments that promote healing and reaching potential, to crisis support.

- Continue the use of the Newsletter, the Resource Booklet, and other available universal information delivery systems to provide all adoptive parents upfront, ongoing, and repeated education about post adoption resources.
- Maintain continual focus on the arduous task of keeping information about services constantly present so that the nearly 400 parents added to the ranks of adoptive families each year will be immediately informed about services; and so that the many families who may not have needed services last year, but who experience a crisis this year, know exactly where to turn for immediate, responsive help.
- Educate community partners about post adoption services. Many families in crisis do not approach the Division of Child and Family Services initially and schools, police, private mental health providers, etc. are their first point of contact. Inform these agencies of available services to promote appropriate referrals to adoption competent services.
- Advocate for and facilitate adoption competent education and mental health service provision for children and families. Mental health services and education were defined as post adoption services for the purpose of this survey because on previous surveys, parents' voices were so strong in presenting the critical role both of these systems play in their families' ability to meet their children's special needs. Partnership and communication with these systems has been improved on many fronts. However, the sheer numbers of foster adoptive families needing and using these services, along with the turnover rates for professionals working in these taxing professions, makes ongoing training and education in these systems a vital focus.
  - o Continue to support the mental health system's efforts to increase its adoption competency.
  - o Support the education system's understanding of and responsiveness to the needs of special needs adoptive children and their families.
- Continue to promote unencumbered accessibility to an array of post adoption services to meet families' information and referral, education and training, family support and respite care, and treatment and crisis intervention needs on an as needed basis.
- Recognize that the Division of Child and Family Services will always remain a point of contact and support for adoptive families, especially during times of crisis. This remains a fact when families have moved outside of the region in which their adoption occurred, or even out of state. Return phone calls in a timely manner and point families in a direction of hope and healing, even if the services are not available through Child and Family Services.

# WHAT ARE FETAL ALCOHOL SPECTRUM DISORDERS

BY LYNN TANNER

## EFFECTS OF ALCOHOL ON A FETUS

Alcohol is one of the most dangerous teratogens, which are substances that can damage a developing fetus. Every time a pregnant woman has a drink, her unborn child has one, too. Alcohol, like carbon monoxide from cigarettes, passes easily through the placenta from the mother's bloodstream into her baby's blood and puts her fetus at risk of having a fetal alcohol spectrum disorder (FASD). Prenatal exposure to alcohol can damage a fetus at any time, causing problems that persist through the individual's life. There is no known safe level of alcohol use in pregnancy. Drinking alcohol while pregnant can result in cognitive, social and motor deficiencies and other lifelong problems. Prenatal exposure to alcohol can cause permanent brain damage. <sup>(1)</sup> The good news is that FASD is 100% preventable if a woman does not drink alcohol while she is pregnant.

## WHAT ARE FETAL ALCOHOL SPECTRUM DISORDERS?

The term fetal alcohol spectrum disorders (FASDs) has emerged to address the need to describe the spectrum of disorders related to fetal alcohol exposure. It is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects can include physical, mental, behavioral, learning disabilities, or a combination of these, with possible lifelong implications. Fetal Alcohol Syndrome (FAS) represents the severe end of a spectrum of effects that can occur when a woman drinks alcohol during pregnancy and is a medical diagnosis. FAS is characterized by abnormal facial features, growth deficiency and central nervous system problems (CNS). The term FASDs is not intended for use as a clinical diagnosis. Unlike people with FAS, those with other prenatal alco-

hol-related conditions under the umbrella of FASDs do not show the identifying physical characteristics of FAS and, as a result, they often go undiagnosed. <sup>(2)</sup>

## DIAGNOSIS

For information about the diagnostic criteria for FAS, visit: [http://www.cdc.gov/ncbddd/fas/documents/FAS\\_guidelines\\_accessible.pdf](http://www.cdc.gov/ncbddd/fas/documents/FAS_guidelines_accessible.pdf).

Children with FAS have evidence of growth deficiency, CNS problems, and a distinct pattern of facial characteristics such as a thin upper lip, smooth philtrum (the groove running vertically between the nose and lips), and small eye openings. <sup>(3)</sup>

## GETTING A DIAGNOSIS

Only trained professionals can make a diagnosis. Teachers or relatives may identify a problem, but they cannot diagnose an FASD.

Signs that may indicate the need for assessment include:

- Sleeping, breathing, or feeding problems
- Small head or face or dental anomalies
- Heart defects or other organ dysfunction
- Deformities of joints, limbs, and fingers
- Slow physical growth before or after birth
- Vision or hearing problems
- Mental retardation or delayed development
- Behavior problems
- Maternal alcohol use <sup>(3)</sup>

## WHY IS DIAGNOSIS IMPORTANT?

Because most people with FASD have no visible signs of alcohol exposure, their problems may be wrongly blamed on poor parenting or on other disorders. Early diagnosis and intervention contribute to positive long-term outcomes.



Accurate diagnosis can:

- Help the person receive appropriate services.
- Aid communication among clinicians, caregivers, educators, and families.
- Provide better self-awareness and understanding by family members. (4)

In Utah for diagnosis contact: The University of Utah, Division of Medical Genetics: 801-581-8943 (Drs. Viskochil, Carey and Rope)

You will need a referral from your Family Practice Physician or Pediatrician. The referral needs to be faxed to 801-581-8986. They will send you a packet to complete prior to your appointment. They usually are booked out at least six months.

## **MEETING THE CHALLENGES ASSOCIATED WITH FASD**

Brain damage and physical defects are the primary disabilities associated with FASD. Lifelong behavioral or cognitive problems may include:

- Mental retardation
- Learning disabilities
- Hyperactivity
- Attention deficits
- Problems with impulse control, social skills, language, and memory

These problems can lead to other problems called secondary disabilities, which may include:

- Disrupted school experience
- Alcohol and substance abuse
- Mental illness
- Dependent living
- Problems with employment
- Inappropriate sexual behavior
- Involvement in the criminal or juvenile system
- Confinement (prison or inpatient treatment for mental health or substance abuse problems) (5)

A child with an FASD is likely to need services throughout his or her life and may never be able to live independently. The lifetime cost for one child with FAS can be \$2 million. (6) Despite their challenges, children with an FASD have a number of strengths. For example, they tend to be caring, creative, determined, and eager to please. (7) They also respond well to structure, consistency, concrete communication, and close supervision. With a supportive home, and early diagnosis, and appropriate services, many children with an FASD can avoid secondary disabilities and reach their full potential. (8)

## **ADVOCACY TIPS FROM THE EXPERTS**

Once the problem has been defined you have a better road map and will have more realistic expectations. Par-

ents know their children better than anyone and your voice should be heard. Below are listed some advocacy tips from experts.

Education is often an area where families struggle to get appropriate services – the following suggestions are by Victoria McKinny from her article in the FAS Times in the Winter 2003/2004.

- **Early Intervention:** Get young children affected by prenatal exposure into early intervention programs and fight for all the services that are available, including occupational therapy, physical therapy, speech, etc.
- **School Personnel:** You may need to educate the school personnel yourself. Don't think it ends with the teacher—all school personnel need to be educated (even the bus driver). Because of confidentiality laws, many of the para-professionals are not allowed this information. Everyone should be involved in the IEP process and a special invitation for the non-classified employee to attend it will promote more success in the educational program.

**Special Education Services:**

Students can qualify for Special Education under the category of "Health Impaired" with a diagnosis of neurological damage from prenatal alcohol exposure. The Health Impaired category recognizes neurological disabilities or impairments. It is critical that the individual with an FASD be in this category, so their disability is understood as organic brain dysfunction instead of willful disobedience.

A website which may help you understand your rights and education law is: [www.wrightslaw.com](http://www.wrightslaw.com)

## **MENTAL HEALTH**

Ask for an Independent Evaluation and a Neuro-Psychological Evaluation. Not many mental health providers are educated on issues of prenatal alcohol exposures, so it is imperative you find someone who has had a background or training in this area. A neuro-psych evaluation will pick up the discrepancy between their verbal ability and their functional ability and will highlight areas of strength and weakness.

In Utah for clinical neuropsychological testing contact: Mary K. Hales, PhD at 801-359-6069 [mary.hales@neurodynamics.biz](mailto:mary.hales@neurodynamics.biz)

## **DEVELOPMENTAL DISABILITIES (DD)**

**Eligibility Door:** Unfortunately the system of care most appropriate to take care of individuals with an FASD has eligibility criteria that require an IQ below 70, so most do not qualify. This is where the appeal process and the exception to policy might help. It is also beneficial to start working with your state policy makers today and get this criteria changed.

Qualifying criteria should depend on functional abilities rather than IQ: Seek testing and records that highlight

functional inabilities rather than relying on IQ.

Traumatic Brain Injury: We have found some great successes using the basics of programs developed for traumatic brain injuries. We don't need to reinvent the wheel. Get involved with DD community advocacy groups. They can give you some wonderful insights.

This advocacy information is from Victoria McKinney's article and is not a complete list of her suggestions for more information go to: Family Resource Institute <http://www.fetalalcoholsyndrome.org/publications.html>

## **STRATEGIES FOR WORKING WITH CHILDREN WITH A FASD**

It is important to remember that no two children with an FASD will exhibit the same behaviors. A strategy that has worked with one child will not necessarily work with another child; in other words, there is no "cookbook approach" that works with all children with an FASD. That said there are some strategies that are worth trying that may be beneficial. You may even want to try a new approach or technique several times or at different times of the day, and as a general rule if the child is tired, hungry or having a hard day, wait until another day.

Many children who were prenatally exposed to alcohol are oversensitive to sensory stimuli. Their disorganized brain may have difficulty prioritizing and filtering stimuli. Normal environments may be overwhelming. They many have heightened sensitivity to light, sound, touch, smell or taste. When a child experiences sensory overload you might see them begin to repeat words and thoughts, exhibit frustration, or have temper tantrums. If you watch for these behaviors you may be able to stem the tide and avoid a melt down. Below are calming techniques parents have shared with me – keep in mind they will work for some children but not all children.

- Reduce stimulation for a period of time
- Take steps to avoid sensory triggers
- Provide space with no distractions
- Allow them time to sit in a bean bag type chair
- Listen to quiet music with a headset
- Provide loose comfortable clothing
- Sunglasses to reduce glare – indoors as well
- Dim lighting – especially in classroom
- Desk facing away from peers
- Avoid crowded situations
- Cocooning – sleeping bag in a tent
- Weighted blankets or vests

Deb Evensen and Jan Lutke developed: Eight Magic Keys: Developing Successful Interventions for Students with FAS. Even though these were developed for the classroom they of course can be used effectively at home.

1. Concrete
2. Consistency
3. Repetition
4. Routine
5. Simplicity
6. Specific
7. Structure
8. Supervision

There is a brochure that has more detail about these interventions which can be found at: [www.fasstar.com](http://www.fasstar.com)

As with every child, it is important to develop a strengths based approach to improve outcomes, and as parents it is our job to help identify those strengths and desires in our children. What do they do well? What do they like to do? What are their best qualities? They may love to work with their hands, enjoy art work, or like working with animals. If you have not already identified your child's strengths spend time observing and then help them develop those areas.

You may also need to redefine success. Success is different for different people. Being safe and happy should be seen as a life success for anyone. (9) Dan Dubovsky an adoptive father and national lecturer on Fetal Alcohol Spectrum Disorders said: "Prenatal alcohol exposure causes brain damage. While this brain damage can't be undone, people can grow, improve and be successful."

The Utah Fetal Alcohol Coalition has a new website which is still being developed, if you have good resources and would like to add them to the site please email information to: [lynnt@dbutah.org](mailto:lynnt@dbutah.org) and visit the website: [www.utahfetalalcohol.org](http://www.utahfetalalcohol.org)

### **NATIONAL WEBSITES:**

[www.cdc.gov/ncbddd/fas](http://www.cdc.gov/ncbddd/fas)  
[www.niaaa.nih.gov](http://www.niaaa.nih.gov)  
<http://fasdcenter.samhsa.gov>  
[www.nofas.org](http://www.nofas.org)  
[www.thearc.org](http://www.thearc.org)  
[www.come-over.to/FASCRC](http://www.come-over.to/FASCRC)  
[www.fetalalcoholsyndrome.org](http://www.fetalalcoholsyndrome.org)  
[www.marchofdimes.com](http://www.marchofdimes.com)  
[www.depts.washington.edu/fadu](http://www.depts.washington.edu/fadu)

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2. Centers for Disease Control and Prevention: Frequently Asked Questions [www.cdc.gov/ncbddd/fas/faqs.htm](http://www.cdc.gov/ncbddd/fas/faqs.htm)
3. & 4. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Fetal Alcohol Spectrum Disorders Center for Excellence Fact Sheet: Understanding Fetal Alcohol Spectrum Disorders, Getting a Diagnosis. [www.samhsa.gov](http://www.samhsa.gov)
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9. FASD 201: Trainer's Manual, University of Alaska Anchorage, Family and Youth Services Training Academy, The State of Alaska, Department of Health and Social Services, Office of FAS.

**CELEBRATE NATIONAL ADOPTION AWARENESS MONTH**

WITH



**SATURDAY, NOVEMBER 15TH, 2008**

11:00 A.M.- 1:00 P.M.

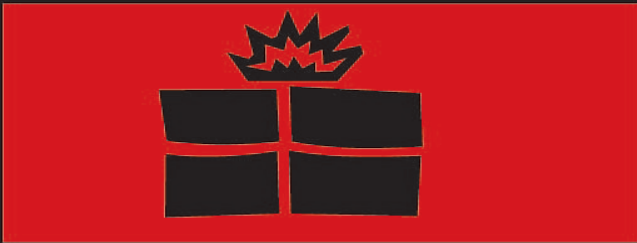
**BOONDOCKS FUN CENTER**

ENJOY UNLIMITED MINIATURE GOLF

10 ARCADE TOKENS AND 1 PASS VALID TO CHOOSE FROM ONE MAJOR ATTRACTION.



**BRANDON, AGE 10**



AARON AGE 17, RYAN AGE 16, FELICIA AGE 14, JOE AGE 16

**HELP GIVE  
CHRISTMAS  
TO A  
FOSTER CHILD  
IN NEED**



**ARIA & MOSES, AGES 7, 9**

BRITTANI AGE 15, TRISTAN AGE 11, AUSTIN AGE 13, PAUL AGE 13

- UNDERWEAR \*
- TOYS \*
- SKATEBOARD \*
- JACKET \*
- ART SUPPLIES \*
- MATCH BOX CARS \*
- STUFFED ANIMALS \*
- PUZZLES \*
- WALKIE TALKIE \*
- GLOVES \*
- WALKMAN \*
- TEDDY BEAR \*
- ACTION FIGURES \*
- CD \*
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# Is There a Connection between Adoption and AD/HD?

By Linda Smith

As co-founder of CHADD's Parent to Parent: Family Training on AD/HD class series, I have taught workshops on AD/HD to many families around the country. I have observed that a large number of the families attending the classes have children with AD/HD who are adopted. I have a special interest in this observation because several of my children are adopted and they deal with AD/HD in their lives.

Recently, Beth Kaplanek, also a co-founder for the classes, put together an article about AD/HD and adoption for our program materials. The first segment of her information is included in the material below. The second segment will be included in the next issue of the Utah's Adoption Connection.

## Adoption and AD/HD -- Is There a Connection?

Beth Kaplanek, R.N.

In preparation for a speech on AD/HD for the regional office of Planned Parenthood; I started thinking about high risk populations and teenage pregnancy. Is there an increased risk in youth with AD/HD for teenage pregnancy that could lead to adoption? Is there a higher prevalence rate of AD/HD among youth that are adopted?

In order to attempt to answer these questions, I reviewed some of the available literature related to adoption. Listed below are some of my thoughts that pose many questions and again reinforce the importance of early intervention and AD/HD education for families because "knowledge is power and prevention".

- AD/HD tends to run in families. It is highly inheritable, almost as inheritable as 'height'. Parenting can influence the characteristics of AD/HD but does not cause AD/HD. Low birth weight babies full term or pre-mature due to poor prenatal care, excessive alcohol consumption, nicotine addiction, substance abuse account for a smaller percentage of AD/HD. Environmentally, high lead and mercury have been implicated in a very small percentage of cases.
- The national prevalence rate of AD/HD is 5-8% of school age children. Up to two-thirds carry the symptoms of AD/HD into adolescence and up to 60% into adulthood.
- AD/HD is a chronic (pervasive and on-going) disorder characterized by developmentally inappropriate levels of inattention, hyperactivity and impulsivity that significantly impair one's life in more than one setting: home, school, work, or social.
- Impulsive children "live in the moment" and do what is on their radar screen at that moment and have great difficulty stopping, thinking and reasoning before making decisions.
- Left untreated, AD/HD can cause low self-esteem and academic underachievement increase in degree over time leading to academic failure, school dropout, early tobacco smoking, potential substance abuse, trouble with relationships, family stress, an inability to cope, getting in trouble with the law, depression, anxiety etc.
- Teens are going to find something to make themselves feel good even if that something is not good for them. Hanging with the wrong crowds, substance abuse, early smoking behaviors are coping mechanisms for teens. They often look for love in all the wrong places and often engage in unprotected sex. This can lead to sexually transmitted diseases as well as teen pregnancy.
- Teen pregnancy could lead to adoption of the child by a caring family who can provide a nurturing environment.

I started this article by posing a question; is the prevalence rate of AD/HD higher in families with adopted children? By the very nature of AD/HD, its inheritable features and impulsive characteristics, the rate of AD/HD and co-existing conditions could be higher in families with adopted children but does the literature demonstrate that fact?

(A brief look at a few studies on adoption that will help answer the question posed above will be included in the next issue of the Adoption Connection.)

CHADD of Utah AD/HD Support Group Contact: Julie Kinsey 801-209-1336

1. Salt Lake Branch Support Group  
2nd Wednesday of each month from 7-8:30 p.m.  
Valley Mental Health Children's Outpatient Services Building,  
Parkview building, Suite A170  
1141 East 3900 South
2. Davis County Branch Support Group  
First Thursday of each month from 7-8:30 p.m.  
Bountiful Community Church  
150 North 400 East in Bountiful  
Contact: Tammy Naylor 801-292-6233



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Cost: \$60/couple (\$50/couple for CHADD members) for the entire series to cover the cost of materials. Limited scholarships are available based on financial need. Pre-registration is required.

Check CHADD of Utah website for updated class schedules: [www.chaddofutah.com](http://www.chaddofutah.com)

(For classes taught in Spanish please contact Julie Moreno at 272-1051 or at 867-2375)

## Class Location & Registration Contact Information:

- (1) Salt Lake City -- classes are held each Fall, Winter and Spring from 6:30 to 8:30 P.M. on a rotating basis at Valley Mental Health Children's Outpatient Services Building, Suite A170, 1141 East 3900 South, in Salt Lake City. Contact: Susan McDonald—467-8553.
- (2) Davis County -- classes are held each Fall, Winter and Spring 6:30-8:30 P.M. at the Davis School District, Kendall Building, Personal Development Center, 75 East 100 North, Farmington. Contact: Tammy Naylor 801-292-6233.
- (3) Weber/Box Elder—Classes are held each Fall, Winter and Spring from 6:30 – 8:30 P.M. at different schools in the Ogden area. Check CHADD of Utah website for current location. Contact: Ed Williams 801-452-4589
- (4) Utah Valley – classes are held from 7:00-9:00 P.M. at American Fork High School, 510 N. 600 E., American Fork. Contact: Melanie Hatch at 801-789-3952.
- (5) Cache County -- Contact: [bsteiner.therapy@gmail.com](mailto:bsteiner.therapy@gmail.com) 435-232-8419
- (6) Heber – Contact: Lindsey Knight [lindsey.knight@hotmail.com](mailto:lindsey.knight@hotmail.com) 435-654-8060
- (7) Price – Contact: Debbie Henrie [henrie130@emerytelcom.net](mailto:henrie130@emerytelcom.net) 435-637-0824
- (8) Vernal – Contact: Shanna Wheeler [fishwheeler@ubtanet.com](mailto:fishwheeler@ubtanet.com) 435-790-5658
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- (11) St. George – Contact: Jenni Heiner [jheiner@infowest.com](mailto:jheiner@infowest.com) 435-986-9001

Contact Linda Smith, Director of Education for CHADD of Utah at [klsmith9134@comcast.net](mailto:klsmith9134@comcast.net) 801-292-2816 for information.



# **A Shade of White**

By: Anonymous Author



"Oreo, a black cookie with white filling, but that's not what they mean when they call me that". My sister told me one night as she was helping me clean my room. "They said I don't act black" she started hanging up some of my clean laundry. "Personally I don't think you can act a color. You are who you are" I said as I threw a shirt at her to hang up. I hesitated a moment to look at her and see if she was serious. She had no emotion on her face. Usually her dark brown eyes could tell a story in one look and her smile could make a 50 year old man stop in his tracks but at this moment there was nothing. She changed the subject quickly to "what should I wear tomorrow?" Looks were everything to my sister.

The next day I'm sitting in the kitchen eating lunch. All I hear is "ugh, I'm so mad!" The front door slammed shut, I look up to see my sister throwing all her stuff on the kitchen counter. "What's going on?" I asked. She glared at me saying, "I was at MacDonald's with Ali and I'm waiting in line to order and this guy just gets in front of me and I was thinking well this is weird. But I didn't really care; he turned around and asked me if I knew why he got in front of me. I didn't know what to say so I just stood there and then he had the guts to say because you're black and you deserve to be at the back of the line." And when I heard this it really took me a second to register. No, this didn't happen 50 years ago it was June 14, 2007.

My sister and I for a month straight went on long exasperating runs around our neighborhood every night. We always stopped at the 7 eleven on the corner of our street to get some ice. It felt so good after running your guts out for 45 min. I never really stopped to notice how other people treated her until all this commotion on she's black and she acts white. But as we went to go get ice the man watched her every move and when we went to buy the ice he then never looked at her, even when she gave him the money.

In school you talk about racism, you talk about the hangings, the wild fires that engulfed the houses, the horses that dragged the lifeless bodies around town, racism that happened a long time ago. People think racism is dead because no one commits these hateful, inhumane acts of murder anymore. But racism lives on in the looks that people give, and the jokes about ones identity.

We judge others, and most certainly tease others for not acting like they look. Or for that matter acting like they look. You have to do drugs, talk with attitude and have sex to be black. You have be uneducated, poor and an alien to be Latin/Mexican. These stereotypes look at my brothers and sisters in the mirror each night. Can you really act a color? Barrack Obama the first African American president of the United States? Maybe, maybe not, but he is one man that has been called too white to be black but not white enough to actually be white. We have people voting for Obama just because he is black, so Americans can feel better and say we are not racist. But what does the ignorance of this statement mean? People are still judging him by the color of his skin not by what he has actually done while in senate. Webster's dictionary tells us that racism is a belief that race is the primary determinant of human traits and capacities. Which basically says you're judging by appearance and not by any other factor positive or not. Being white I never have really looked at color this way before. I see it, I acknowledge it, and then it's gone. But for my sister color is everywhere. She complains about wearing band aides because they are for light skin, and about never being able to experience a tanning bed. She sees my blonde hair and blue eyes as something that's customary and sought after. Looks are everything to my sister.

Growing up I was related to all the African American people in my school. They would go to school and be the minority, when they came home I would be. When I tell people my story there eyes get real big like they've just won the lottery "you live with all black people?" After that million dollar question the next question always followed, "are you black?" Always produced with a huge smile, for them having a black friend is extraordinary. This happened a lot to my sister. The first week of school freshman year she was having a blast. Everyone talked to her and loved her, but 2nd week came, 3rd week past and the kids all moved on. The black friend position had been filled. She was left wondering who her true friends were.

She graduated last summer; she had changed so much from her 1st freshman week. She came home drunk, she swore and yelled all the time while at home. Her A's turned to C's but most importantly she was no longer an "Oreo" she was now officially the black girl.

Racism, judgments, stereotypes changed my sister from what she was to what she is now. She might be happy, she might not. But because looks were everything to sister, she had to change how she looked, who she was, to fit everyone else's mirror of what a black girl should be. So the basis of my story is to acknowledge the fact you can't act a color no matter what others say, think, or believe. The question of can you act a color was a mere statement in the mind of a girl who should know who she is, was, and will be tomorrow. And she won't have to look in the mirror and see the face of a stereotype conjugated out of mistakes and false hopes.



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