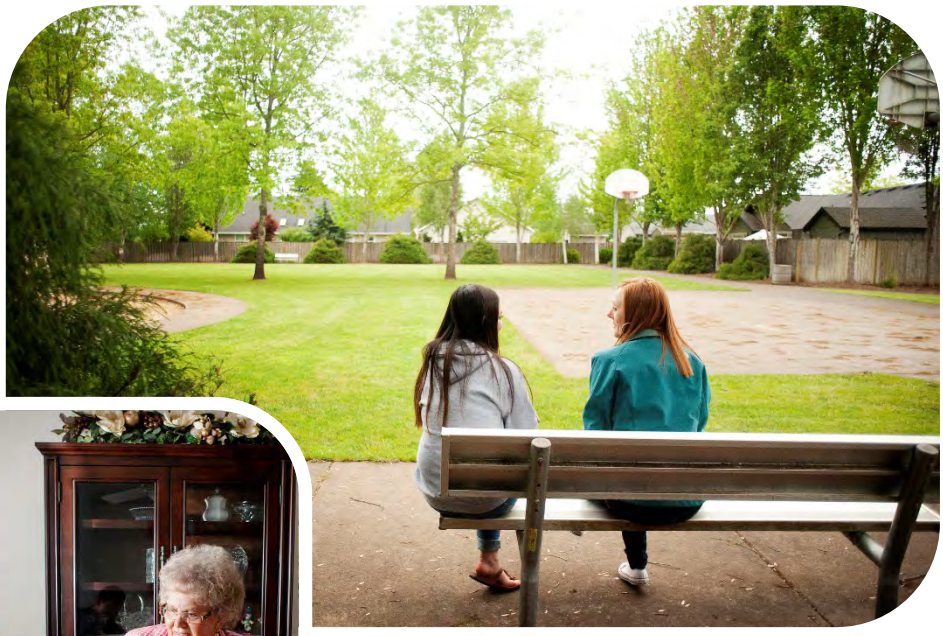
OYA Foster Care Pre-Service Training Manual



Welcome to the Pre-Service Training Manual for potential OYA foster parents. This manual is intended for foster parents to use individually by following the guidelines below. Please let your foster home certifier know if you are unable to access a computer to view the online training videos listed in the sessions below.

- Watch the video and read the articles for each session.
- Complete the competency worksheet attached to each article and/or session.
- Sign and date the competency worksheet when you have completed it.
- Meet with your certifier to review the worksheets, answer questions and sign off as completed.

Pre-Service Training Curriculum (25 hours)

Video - OYA Foster Care: Family Stories
bit.ly/2udu6Z9

Session One: Introduction to the Oregon Youth Authority – (2 hours)

➢ *"Introduction to the Oregon Youth Authority"* bit.ly/2pwzfGS	*Video*	*(30 min)*
➢ *OYA at a glance* Page 5-6	*Brochure*	*(30 min)*
Oregon Youth Authority and foster care bit.ly/2FVQ6gK	*Video*	*(30 min)*
➢ *OYA Quick Facts* Page 9-10	*Fact Sheet (1/18)*	*(informational)*

Session Two: Adolescent Development – (1 hour)

➢ *"The Teenage Brain"* bit.ly/2E1YdoK	*Video*	*(1 hour)*

Session Three: Adolescent Drug and Alcohol Issues – (5 hours)

- *Drug Facts – "Alcohol"* *Article (PDF)* *(1hour)*
  https://teens.drugabuse.gov/drug-facts/alcohol
- *Drug Facts – "Marijuana"* *Article (PDF)* *(1 hour)*
  https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/drugfacts-marijuana.pdf
- *Drug Facts – "Methamphetamine"* *Article (PDF)* *(1 hour)*
  https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/drugfacts-methamphetamine.pdf
- *Drug Facts – "Inhalants"* *Article (PDF)* *(1 hour)*
  https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/drugfacts-inhalants.pdf
- *Drug Facts – "Prescription over-the-counter medications"* *(1 hour)*

Session Four: Addressing the Mental Health of Youth – (4 hours)

- *"Helping Youth At Risk for Suicide"* *Article (PDF)* *(1 hour)*
  Page 59-65
- "*Understanding Anxiety Disorders: For Caregivers"* *Fact Sheet (PDF)* *(30 min)*
  Page 68-72
- "*Understanding Attention-Deficit/Hyperactivity Disorder: For Caregivers"* *Fact Sheet (PDF)* *(30 min)*
  Page 73-77
- "*Understanding Bipolar Disorder: For Caregivers"* *Fact Sheet (PDF)* *(30 min)*
  Page 78-82
- "*Understanding Depression: For Caregivers"* *Fact Sheet (PDF)* *(30 min)*
  Page 83-87
- *Complex Trauma - In Juvenile Justice System Involved Youth* *Article (PDF)* *(1 hour)*
  Page 91-97

Session Five: Working with Challenging Behaviors – (2 hours)

- *"Rethinking Challenging Kids-Where There's a Skill There's a Way"* *Video* *(1 hour)*
  bit.ly/2G5UkhQ
- *"Maintaining Appropriate Boundaries"* *Video* *(30 min)*
  bit.ly/2R7zPel
- *"Limiting Contraband"* *Video* *(30 min)*

bit.ly/2F5UZSE

Session Six: Cultural Competency – (1 hour)

- *"Building Cultural Competence"* *Video* *(1 hour)*
  bit.ly/26KBtuB

Session Seven: LGBTQ Youth – (1 hour)

- *Supporting Your LGBTQ Youth: A Guide for Foster Parents* *Article (PDF)* *(1 hour)*
  Page 112-122

Session Eight: Abuse, Neglect and Child Abuse Reporting – (1 hour)

- *"Mandatory Child Abuse Reporting"* *Video* *(1 hour)*
  bit.ly/2CMnm6J

Session Nine: Juveniles with Sexual Harming Behaviors – (1 hour)

- *Juveniles with Sexual Harming Behaviors - Debbi Martin* *Presentation* *(2 hours)*
  bit.ly/2aZh9iG

Session Ten: Positive Human Development – (2 hours)

- *Positive Human Development* *Video* *(2 hours)*
  bit.ly/2pzcoQ6

Session Eleven: OYA Foster Parent Handbook – (4 hours)

Oregon Youth Authority Foster Parent Handbook *Hardcopy or Electronic* *(4 hours)*

Page Intentionally left Blank for Printing

Thank you for choosing to work with the Oregon Youth Authority.
Together we will make a positive difference in the lives of Oregon's youth.

Session One:

Introduction to the Oregon Youth Authority

In this session you will learn about the Oregon Youth Authority and how youth move through the juvenile justice system. This section will also include an introduction to OYA's foster care program.

Page Intentionally left Blank for Printing

“Introduction to the Oregon Youth Authority”

Online Video

bit.ly/2pwzfGS

13 minutes 19 seconds

Page Intentionally left Blank for Printing

Session 1: Introduction to the Oregon Youth Authority

"Introduction to the Oregon Youth Authority"

Competency Worksheet

1. Name 3 of the agencies that are involved in the juvenile justice system.

   _____

   _____

   _____

2. How many of the youth actually get committed to OYA out of about 400,000?
   a. ☐ 100-200
   b. ☐ 500-700
   c. ☐ 200-300
   d. ☐ 900-1000
3. The Oregon Youth Authority's mission is to _____ and _____ by holding youth offenders accountable and providing opportunities for reformation in safe environments.
4. Where is Oak Creek located? Do they serve male or female youth?

   _____

   _____

5. OYA has contracted residential Treatment Programs.

   ☐ True

   ☐ False

6. Name 3 of youth offender's social characteristics:

   _____

7. Name 2 of the professional certifications that youth can achieve, while in OYA?

   _____

   _____

8. What does YRS stand for?

   _____

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

Community Partnerships
Working Together to Provide Services

How do partnerships help OYA youth?

Governmental Relationships
OYA works with many other justice-related agencies, state agencies, and governments to provide services. These include:

- County juvenile departments
- Courts and district attorneys
- Law enforcement agencies
- Oregon Department of Corrections
- Oregon Department of Education
- Oregon Department of Human Services
- Oregon Health Authority
- Oregon's Native American tribes
- Oregon Youth Development Council

Juvenile Justice Information System (JJIS)
The Juvenile Justice Information System (JJIS) is a statewide electronic database designed to support a continuum of services among all members of Oregon's juvenile justice community.

JJIS is a collaborative partnership between OYA and Oregon's county juvenile departments. Oregon is one of only three states in the nation with a statewide data system for youth in the justice system.

Advisory Committees
Advisory committee members include OYA leaders and staff, families of youth, victim advocacy groups, social service agencies, and representatives of communities of color, faith communities, and the LGBTQQI community.

- OYA Partnership Committee
- African American Advisory Committee
- Audit Committee
- Family Advisory Council
- Latino Advisory Committee
- LGBTQQI Advisory Committee
- Native American Advisory Committee

Volunteers
More than 500 volunteers provide supplemental programs at OYA facilities. Here are a few examples:

- Business professionals teaching skills for transition
- Professional athletes mentoring young runners
- Community members helping youth train dogs
- Master Gardeners teaching youth about plants
- Local churches donating holiday items and meals

530 Center Street NE, Suite 500
Salem, OR 97301-3777
Reception: 503-373-7205
En Español: 503-373-7205
www.oregon.gov/OYA

Oregon Youth Authority
At a Glance
January 2019

The business we are in

MISSION
OYA protects the public and reduces crime by holding youth accountable and providing opportunities for reformation in safe environments.

What we want to be known for

VISION
Youth who leave OYA go on to lead productive, crime-free lives.

What beliefs guide our actions

VALUES
Integrity
Professionalism
Accountability
Respect

Who we are

EMPLOYEES
OYA has 985 employees located throughout the state.

Where we serve youth

PROGRAMS
5 youth correctional facilities
4 youth transitional facilities
20 field offices
41 contracted residential programs
72 foster and proctor homes
1 administrative office

What is the Oregon Youth Authority?

We protect the public and keep communities safe.
As part of Oregon's juvenile justice system, we hold youth accountable and provide them with opportunities for reformation, either on parole or probation in the community, or inside secure facilities. We are responsible for youth ages 12 to 24 who commit crimes before age 18.

We serve youth who are unsuccessful at the county level, who need more services than the county can provide, or who commit very serious crimes.

We believe youth can change, and we provide them the means to do so.
Research shows the human brain continues developing until at least our mid-20s. This impacts judgment and decision-making for adolescents.

We provide youth with treatment, education, and other guidance to help them take responsibility for their behavior while learning how to act differently in the future. We do this in safe, positive, supportive environments that will help them become responsible, community-minded citizens.

We use commonsense approaches guided by research on what works.

YOUTH REFORMATION SYSTEM
We use research, predictive analytics, and professional judgment to inform decisions across the juvenile justice continuum to reduce crime, maximize effectiveness, and improve outcomes.

POSITIVE HUMAN DEVELOPMENT
Our culture aims for everyone to develop in safe, secure, respectful and supportive environments, where we all are held accountable, and where we are connected to our community.

Oregon's Juvenile Justice System
Using the Right Gears to Rehabilitate Youth

The justice system is like a bicycle — it works best when it can use different gears for different terrain. Luckily, Oregon has many gears available to rehabilitate youth, from county juvenile departments to community residential programs to OYA facilities. By using all of the gears, we can better reach our destination: youth who are crime-free, productive members of their communities.

Who are the youth in the system?

Most youth are served at the county level.

5,200 Youth supervised by county juvenile departments providing probation and detention services and connecting youth with treatment, education, and other services locally

730 Youth on parole or probation with OYA

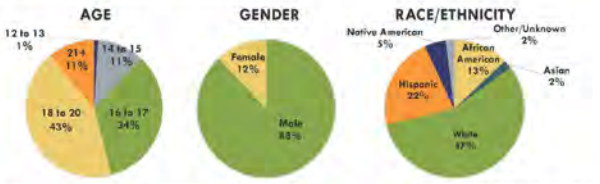
505 Youth in OYA's nine secure facilities

Youth come to OYA in two main ways.

1 **A juvenile court judge commits them to OYA** because they are not succeeding at the county level, or they need more services than the county can provide.

2 **They commit very serious crimes** and adult courts commit them to the Oregon Department of Corrections. Because of their younger age, they can live in OYA facilities until age 25.

Youth at OYA have diverse needs.



SOURCES: OYA Quick Facts, Jan 2019; OYA Biophysical Summary, 2018.

SOCIAL CHARACTERISTICS

- More than 75% have diagnosed **mental health disorders.**
- The majority have dealt with **substance abuse or dependence.**
- 43% of females and 16% of males are **victims of sexual abuse.**
- 29% of females and 12% of males have exhibited **past suicidal behavior.**

What gears does OYA use?

Community Supervision
The majority of our youth are in community settings. Supervised by juvenile parole and probation officers, these youth live at home or in a variety of placements, including:

- Residential treatment programs — OYA contracts with them for services
- Foster or proctor homes — OYA runs its own foster care program

Close-Custody Facilities

- 5 Youth Correctional Facilities
- 4 Youth Transitional Facilities

Services for Rehabilitation
We provide or connect youth with the services and support they need, including:

- Education and vocational training
- Treatment for negative or harmful behaviors
- Treatment for substance use disorders
- Medical and psychiatric care
- Mental health counseling and services
- Culturally responsive services
- Teaching positive social behaviors
- Teaching life skills and preparing for transition back to the community
- Recreational and enrichment activities

Page Intentionally left Blank for Printing

Session 1

OYA at a Glance

Competency Worksheet

1. Fill in the Blank: OYA is responsible for youth ages _____ to _____, who commit crimes before age 18.

2. OYA uses commonsense approaches guided by research on what works, such as the Youth Reformation System and Positive Human Development.

   ☐ True

   ☐ False

3. What are the core values that guide OYA?

   a. ☐ Relationships, Authority, Mentorships, Money
   b. ☐ Integrity, Professionalism, Accountability, Respect
   c. ☐ Environment, Food, Social Involvement, Events
   d. ☐ People, Community, Driving, Government

4. Most youth are served at the _____ level.

   a. ☐ State
   b. ☐ County
   c. ☐ City
   d. ☐ Local

5. Name the two main ways that youth come to OYA:

_____

_____

6. Youth at OYA do not have diverse needs.

   ☐ True

   ☐ False

7. Regarding social characteristics of OYA youth, more than _____ have diagnosed mental health disorders.
    a. ☐ 10%
    b. ☐ 40%
    c. ☐ 25%
    d. ☐ 75%

8. Name the three "gears" OYA uses to rehabilitate youth?

_____

_____

_____

9. The majority of OYA youth supervised by juvenile parole and probation officers are in community settings to include;

    a. ☐ Foster or Proctor Homes
    b. ☐ Residential Treatment Programs
    c. ☐ Home
    d. ☐ All of the above

10. The Oregon Youth Authority has a total of _____ Close-Custody Facilities throughout Oregon.

    a. ☐ 5
    b. ☐ 9
    c. ☐ 3
    d. ☐ 6

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

OYA Quick Facts

Oregon Youth Authority
January 2019

Total OYA Youth Population[1]	**1,235**	***100%***
Community Youth.....	**730**	***59%***
Juveniles on OYA Parole	330	*27%*
Juveniles on OYA Probation	400	*32%*
Close Custody Youth.....	**505**	***41%***
OYA Juvenile Commitments, Total	**280**	***23%***
Discretionary Beds	264	*21%*
Public Safety Reserve	16	*1%*
Dept. of Corrections (DOC), Total.....	**225**	***18%***
Mandatory Minimum Sentence	149	*12%*
Reduced Mandatory Minimum	2	*0%*
Waived	74	*6%*

Recidivism

A felony juvenile adjudication or adult conviction within 36 months of (a) commitment to OYA probation, (b) release to OYA parole, or (c) release to adult post-prison supervision (DOC PPS).

	Recidivism Rate
OYA Probation ..... (committed 7/1/14 - 6/30/15)	**20.5%**
OYA Parole ..... (released from OYA close custody 7/1/14 - 6/30/15)	**32.1%**
DOC PPS ..... (released from OYA close custody 7/1/14 - 6/30/15)	**24.1%**

Note: Comparing rates is misleading whenever there are differences in populations, definitions of recidivism, or methodology. Currently, there is no national standard.

Demographic Profile

	Community Youth						Close Custody Youth						All Youth	
	Parole		Probation		Total		Juvenile		DOC		Total		Total	
	330	***100%***	**400**	***100%***	**730**	***100%***	**280**	***100%***	**225**	***100%***	**505**	***100%***	**1,235**	***100%***
Sex														
Female	**42**	*13%*	**50**	*13%*	**92**	*13%*	**49**	*18%*	**13**	*6%*	**62**	*12%*	**154**	*12%*
Male	**288**	*87%*	**350**	*88%*	**638**	*87%*	**231**	*83%*	**212**	*94%*	**443**	*88%*	**1,081**	*88%*
Age														
12 thru 13	**1**	*0%*	**7**	*2%*	**8**	*1%*	**3**	*1%*	**0**	*0%*	**3**	*1%*	**11**	*1%*
14 thru 15	**17**	*5%*	**83**	*21%*	**100**	*14%*	**38**	*14%*	**1**	*0%*	**39**	*8%*	**139**	*11%*
16 thru 17	**83**	*25%*	**180**	*45%*	**263**	*36%*	**123**	*44%*	**34**	*15%*	**157**	*31%*	**420**	*34%*
18 thru 20	**180**	*55%*	**124**	*31%*	**304**	*42%*	**108**	*39%*	**121**	*54%*	**229**	*45%*	**533**	*43%*
21+	**49**	*15%*	**6**	*2%*	**55**	*8%*	**8**	*3%*	**69**	*31%*	**77**	*15%*	**132**	*11%*
Most Serious Crime														
Arson	**5**	*2%*	**2**	*1%*	**7**	*1%*	**4**	*1%*	**0**	*0%*	**4**	*1%*	**11**	*1%*
Criminal Other	**11**	*3%*	**15**	*4%*	**26**	*4%*	**11**	*4%*	**0**	*0%*	**11**	*2%*	**37**	*3%*
Drugs/Alcohol	**19**	*6%*	**11**	*3%*	**30**	*4%*	**16**	*6%*	**0**	*0%*	**16**	*3%*	**46**	*4%*
Homicide Related	**5**	*2%*	**0**	*0%*	**5**	*1%*	**3**	*1%*	**38**	*17%*	**41**	*8%*	**46**	*4%*
Person-to-Person	**54**	*16%*	**58**	*15%*	**112**	*15%*	**59**	*21%*	**51**	*23%*	**110**	*22%*	**222**	*18%*
Property	**103**	*31%*	**112**	*28%*	**215**	*29%*	**110**	*39%*	**1**	*0%*	**111**	*22%*	**326**	*26%*
Public Order	**3**	*1%*	**5**	*1%*	**8**	*1%*	**3**	*1%*	**0**	*0%*	**3**	*1%*	**11**	*1%*
Robbery	**21**	*6%*	**9**	*2%*	**30**	*4%*	**13**	*5%*	**59**	*26%*	**72**	*14%*	**102**	*8%*
Sex Offense	**92**	*28%*	**170**	*43%*	**262**	*36%*	**53**	*19%*	**75**	*33%*	**128**	*25%*	**390**	*32%*
Weapon	**17**	*5%*	**18**	*5%*	**35**	*5%*	**8**	*3%*	**1**	*0%*	**9**	*2%*	**44**	*4%*
Race/Ethnicity[2]														
African American	**59**	*18%*	**33**	*8%*	**92**	*13%*	**33**	*12%*	**37**	*16%*	**70**	*14%*	**162**	*13%*
Asian	**2**	*1%*	**6**	*2%*	**8**	*1%*	**4**	*1%*	**7**	*3%*	**11**	*2%*	**19**	*2%*
White	**177**	*54%*	**256**	*64%*	**433**	*59%*	**174**	*62%*	**91**	*40%*	**265**	*52%*	**698**	*57%*
Hispanic	**70**	*21%*	**67**	*17%*	**137**	*19%*	**53**	*19%*	**80**	*36%*	**133**	*26%*	**270**	*22%*
Native American	**17**	*5%*	**18**	*5%*	**35**	*5%*	**16**	*6%*	**8**	*4%*	**24**	*5%*	**59**	*5%*
Other/Unreported	**5**	*2%*	**20**	*5%*	**25**	*3%*	**0**	*0%*	**2**	*1%*	**2**	*0%*	**27**	*2%*

[1] Excludes 0 youth supervised on behalf of other states (Interstate Compact), 0 youth on escaped status, and 2 DOC youth with an open adult commitment but no longer in an OYA facility. Source: JJIS report 7a (01/07/2019).

[2] For comparison, the estimated breakouts of 2017 Oregon population age 10-17 by race/ethnicity from Puzzanchera, et.al. (2018) "Easy Access to Juvenile Populations" are African American 3%, Asian 6%, White 67%, Hispanic 22%, Native American 2%.

Average Length-of-Stay (LOS) in Close Custody

Releases from OYA Close Custody in 2018

Youth Status at Admission to OYA Close Custody	Overall			Male			Female		
	Number Released	LOS in Days		Number Released	LOS in Days		Number Released	LOS in Days	
		Mean	Median		Mean	Median		Mean	Median
All Close Custody Youth	**519**	**402**	**239**	**443**	**434**	**251**	**76**	**217**	**180**
Juveniles	**445**	**227**	**204**	**372**	**236**	**215**	**73**	**184**	**170**
First-Time Admissions	211	302	272	175	317	281	36	232	210
Discretionary Bed Allocation	202	297	273	166	311	284	36	232	210
Public Safety Reserve	9	422	268	9	422	268	0	0	0
Revoked to Close Custody	234	160	114	197	164	116	37	137	97
Department of Corrections	**74**	**1455**	**1168**	**71**	**1473**	**1173**	**3**	**1023**	**840**
Sentence Completed at OYA	52	1532	1367	50	1549	1367	2	1115	1115
Completing Sentence at DOC	22	1271	1030	21	1292	1052	1	840	840

Close Custody Beds 610

Youth Correctional Facilities, Total Beds	**521**
MacLaren YCF	271
Hillcrest YCF (Closed 9/1/2017)	0
Rogue Valley YCF	100
Oak Creek YCF	50
Eastern Oregon YCF	50
North Coast YCF (Closed 10/1/2017)	0
Tillamook YCF	50
Transition Programs, Total Beds	**89**
River Bend Facility	25
Camp Florence	25
Camp Tillamook	25
Young Women's Transition Program	14

Budget

2017-2019 Legislatively Adopted Budget

General Fund	$312.6 million
Total Funds	$411.0 million

Total Funds Distributed by Program

Facility Programs	41%
Community Programs	33%
Program Support	9%
Agency-wide	2%
Debt Service	3%
Capital Projects	12%

Social Characteristics of OYA Youth

	Female	Male
Biological Parent of a Child	10%	8%
Diagnosed Conduct Disorder	45%	50%
Diagnosed Mental Health Disorder (excluding Conduct Disorder)	90%	77%
Parents Used Alcohol or Drugs	82%	65%
Past Suicide Behavior	29%	12%
Sexually Abused	43%	16%
Special Education	19%	34%
Substance Abuse or Dependence	78%	62%

Source: OYA Biopsychosocial Summary, 2018

Number of Employees..... 985

Dec 31, 2018

Represented, Total	**845**
SEIU	757
AFSCME	88
Management/Unrepresented	**140**

Diversity Profile of Full-Time Staff

Dec 31, 2018

	People of Color	Female	Disabled
Overall	22.7%	29.7%	0.9%
Management	14.3%	45.7%	1.4%
Represented	24.1%	42.2%	0.8%

Oregon Youth Authority
530 Center Street NE, Suite 500
Salem, OR 97301-3765

503-373-7205
www.oregon.gov/OYA

Session Two:

Adolescent Development

In this session you will learn about the teenage brain and why teens make the decisions they do.

Page Intentionally left Blank for Printing

“The Teenage Brain”

Online Video

bit.ly/2E1YdoK

11 minutes 21 seconds

Page Intentionally left Blank for Printing

Session 2: Adolescent Development

"The Teenage Brain"
Competency Worksheet

1. What is one of the most common issues in a teenager's life?
    a. ☐ Peer pressure
    b. ☐ Parents
    c. ☐ Drugs/Alcohol
    d. ☐ Friends/School Change

2. Self-esteem is developed by what 2 interactions?

    _____

    _____

3. Name the 2 parts of the brain:

    _____

    _____

4. What is the definition of conformity?

    _____

5. Adolescence is a time for what 2 things:
    a. ☐ Attention and Drama
    b. ☐ Boyfriends and girlfriends
    c. ☐ Self-discovery and Self-identity
    d. ☐ Money and Friends

6. Tom wasn't able to apply himself or learn at school. The root of his problem is that he didn't feel the sense of and .

7. A persistent, compulsive dependence on a behavior or substance is known as an _____.

8. What does alcohol trigger?
    a. ☐ Excitement
    b. ☐ Jealousy
    c. ☐ Awesome dance moves
    d. ☐ Dopamine Rush

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

Session Three:

Adolescent Drug & Alcohol Issues

In this session you will learn about substance abuse issues to include how the substances are used, the short- and long-term effects of these substances, the potential for overdose and treatment options.

Page Intentionally left Blank for Printing

National Institute on Drug Abuse for Teens

Alcohol
Street names: *Booze, Brew, Liquor*
Provided by the National Institute on Alcohol Abuse and Alcoholism

What are alcohol use disorders?

Also known as: Booze, Brew, Liquor, and Sauce

Alcohol use disorders (AUDs) are medical conditions that doctors diagnose when someone's drinking causes them distress or harm.

What is a standard drink?

Many people are surprised to learn what counts as a drink. The amount of liquid in your glass, can, or bottle is not necessarily equal to how much alcohol is in your drink. A standard drink is:

- 12 ounces of beer (about 5% alcohol)
- 8 ounces of malt liquor – beer with a high alcohol content (about 7% alcohol)
- 5 ounces of table wine (about 12% alcohol)
- 1.5 ounces (a "shot") of liquor, like gin, rum, vodka, tequila, or whiskey (about 40% alcohol)

No level of drinking is safe or legal for anyone under age 21, but unfortunately many teens drink—and they often drink multiple drinks, which is very dangerous.

How does alcohol affect the teenage brain?

When teens drink, alcohol affects their brains in the short-term– but repeated drinking can also impact it down the road, especially as their brains grow and develop.

Short-Term Consequences of Intoxication (being "drunk"):

- An intoxicated person has a harder time making good decisions.
- A person is less aware that his/her behavior may be inappropriate or risky.
- A person may be more likely to engage in risky behavior, including drinking and driving, sexual activity (like unprotected sex) and aggressive or violent behavior.
- A person is less likely to recognize potential danger.

Long-Term Consequences as the Teen Brain Develops:

- Research shows that drinking during the teen years could interfere with normal brain development and change the brain in ways that:
    - Have negative effects on information processing and learning.
    - Increase the risk of developing an alcohol use disorder later in life.

How does alcohol affect your body?

People who drink are affected even before they show signs of being drunk, especially when it comes to decision-making abilities.

At first, alcohol causes people to feel upbeat and excited. But this is temporary and they shouldn't be fooled.

If drinking continues, the effects on the body—and the potential risks—multiply. Here's what can happen:

- **Inhibitions and memory**: People may say and do things that they will regret later, or possibly not remember at all. Inhibitions are lost - leading to poor decision making.
- **Decision-making skills:** When they drink, individuals are more likely to be impulsive. They may be at greater risk for having an alcohol-related traffic crash, getting into fights, or making unwise decisions about sex.
- **Coordination and physical control**: When drinking leads to loss of balance, slurred speech, and blurred vision, even normal activities can become more dangerous.
- **Death:** Drinking too much alcohol can also lead to death. If people drink too much, they will eventually get sleepy and pass out. Reflexes like gagging and breathing can be suppressed. That means they could vomit and choke, or stop breathing completely.

And finally, it's easy to misjudge how long alcohol's effects last. Alcohol continues to affect the brain and body long after the last drink has been finished. Even after someone stops drinking, alcohol in the stomach and intestine continues to enter the bloodstream, impairing judgment and coordination for hours.

What are the negative consequences of underage drinking?

There are increased risks and a range of negative consequences related to underage drinking. It is dangerous because it:

- **Causes many deaths.**
  On average, alcohol plays a role in the deaths of 4,358 young people under age 21 every year. These deaths include:
    - 1,580 deaths from car crashes
    - 1,269 from murders
    - 245 from alcohol poisoning, falls, burns, and drowning
    - 492 from suicides

- **Causes many injuries.**
  Drinking alcohol can cause young people to have accidents and get hurt. In 2011 alone, about 188,000 people under age 21 visited an emergency room for injuries related to drinking alcohol.

- **Increases the risk of physical and sexual assault.**
  Young people under age 21 who drink are more likely to carry out or be the victim of a physical or sexual assault after drinking than others their age who do not drink.

- **Can lead to other problems.**
  Drinking can cause teens to have trouble in school or with the law. Teens who drink are more likely to use other drugs than teens who don't.

- **Can lead to developing an alcohol use disorder.**
  Alcohol Use Disorders (AUDs) are medical conditions that doctors diagnose when someone's drinking causes them distress or harm. In 2014 about 679,000 young people ages 12-17 had an AUD. Even more important, the younger the use of alcohol the more likely one is to develop an AUD later in life.

- **Increases the risk of cancer.**
  Drinking alcohol increases your risk of developing various cancers, including cancers of the mouth, esophagus, pharynx, larynx, liver, and breast.

What is alcohol poisoning and how can I help someone who may be suffering from it?

Alcohol poisoning occurs when there is so much alcohol in a person's bloodstream that areas of the brain controlling basic life-support systems—such as breathing, heart rate, and temperature control—begin to shut down.

Symptoms of alcohol poisoning include:

- Confusion
- Difficulty remaining conscious
- Vomiting
- Seizures
- Trouble with breathing
- Slow heart rate
- Clammy skin
- Dulled responses, such as no gag reflex (which prevents choking)
- Extremely low body temperature
- Death.

If you suspect someone has alcohol poisoning, call 911 and get medical help immediately. Cold showers, hot coffee, or walking will NOT reverse the effects of alcohol overdose and could actually make things worse.

What is an alcohol blackout?

An alcohol blackout is a gap in a person's memory for events that took place while he or she was drinking. When a blackout happens, a person's brain does not create memories for these events as they are happening. For people who have had a blackout, it can be frightening to wake up the next day and not remember what they did the night before.

Is underage drinking a serious health problem?

Underage drinking is drinking alcohol before a person turns age 21, which is the minimum legal drinking age in the United States. Underage drinking is a serious problem, as you may have seen from your friends' or your own experiences. Alcohol is the most commonly used substance of abuse among young people in America, and drinking when you're underage puts your health and safety at risk.

Why do teens drink alcohol?

Teens drink for a variety of reasons. Some teens want to experience new things. Others feel pressured into drinking by peers. And some are looking for a way to cope with stress or other problems. Unfortunately, drinking will only make any problems a person has already worse, not better.

Session 3: Adolescent Drug and Alcohol Issues

"Alcohol"
Competency Worksheet

1. _____are medical conditions that doctors diagnose when someone's drinking causes them distress or harm.

2. Research indicates that drinking alcohol during the teen years could interfere with normal brain development.

   ☐ True
   ☐ False

3. Name four ways alcohol can affect your body:

_____

_____

_____

_____

4. Name at least four negative consequences of underage drinking:

_____

_____

_____

_____

5. On average, alcohol plays a role in the deaths of over 4,000 young people under the age of 21 every year.

   ☐ True
   ☐ False

6. Alcohol poisoning occurs when there is so much alcohol in a person's bloodstream that areas of the brain controlling basic life support systems begin to shut down.

   ☐ True
   ☐ False

7. You cannot die from alcohol poisoning.

   ☐ True
   ☐ False

8. Provide at least six symptoms of alcohol poisoning:

_____

_____

_____

_____

_____

_____

9. If you suspect someone has alcohol poisoning you should _____ .

10. What is an alcohol blackout?

_____

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

National Institute on Drug Abuse
DrugFacts
www.drugabuse.gov

Marijuana

What is marijuana?


Photo by NIDA

Marijuana refers to the dried leaves, flowers, stems, and seeds from the *Cannabis sativa* or *Cannabis indica* plant. The plant contains the mind-altering chemical THC and other similar compounds. Extracts can also be made from the cannabis plant (see "Marijuana Extracts," see page 2").

Marijuana is the most commonly used illicit drug in the United States.[1] Its use is widespread among young people. In 2015, more than 11 million young adults ages 18 to 25 used marijuana in the past year.[1] According to the Monitoring the Future survey, rates of marijuana use among middle and high school students have dropped or leveled off in the past few years after several years of increase. However, the number of young people who believe regular marijuana use is risky is decreasing.[2]

Legalization of marijuana for medical use or adult recreational use in a growing number of states may affect these views. Read more about marijuana as medicine in our *DrugFacts: Marijuana as Medicine.*

How do people use marijuana?

People smoke marijuana in hand-rolled cigarettes (*joints*) or in pipes or water pipes (*bongs*). They also smoke it in *blunts*—emptied cigars that have been partly or completely refilled with marijuana. To avoid inhaling smoke, some people are using vaporizers. These devices pull the active ingredients (including THC) from the marijuana and collect their vapor in a storage unit. A person then inhales the vapor, not the smoke. Some vaporizers use a liquid marijuana extract.


©Shutterstock/Stephen Orsillo

People can mix marijuana in food (*edibles*), such as brownies, cookies, or candy, or brew it as a tea. A newly popular method of use is smoking or eating different forms of THC-rich resins (see "Marijuana Extracts," see page 2).

Marijuana Extracts

Smoking THC-rich resins extracted from the marijuana plant is on the rise. People call this practice *dabbing.* These extracts come in various forms, such as:

- *hash oil* or *honey oil*—a gooey liquid
- *wax* or *budder*—a soft solid with a texture like lip balm
- *shatter*—a hard, amber-colored solid

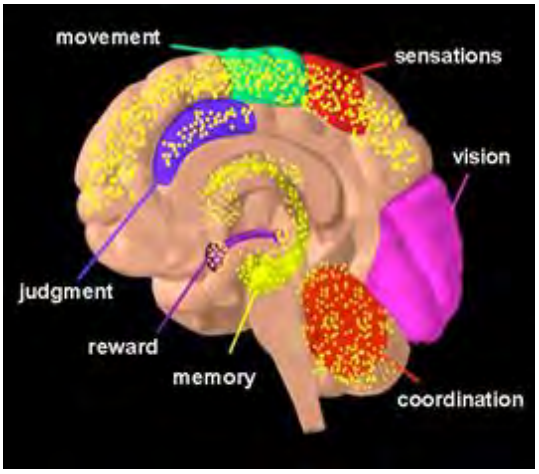
These extracts can deliver extremely large amounts of THC to the body, and their use has sent some people to the emergency room. Another danger is in preparing these extracts, which usually involves butane (lighter fluid). A number of people have caused fires and explosions and have been seriously burned from using butane to make extracts at home.[3,4]

How does marijuana affect the brain?

Marijuana has both short-and long-term effects on the brain.

Short-Term Effects

When a person smokes marijuana, THC quickly passes from the lungs into the bloodstream. The blood carries the chemical to the brain and other organs throughout the body. The body absorbs THC more slowly when the person eats or drinks it. In that case, they generally feel the effects after 30 minutes to 1 hour.



THC acts on numerous areas in the brain (in yellow).

Image by NIDA

THC acts on specific brain cell receptors that ordinarily react to natural THC-like chemicals. These natural chemicals play a role in normal brain development and function.

Marijuana overactivates parts of the brain that contain the highest number of these receptors. This causes the "high" that people feel. Other effects include:

- altered senses (for example, seeing brighter colors)
- altered sense of time
- changes in mood
- impaired body movement
- difficulty with thinking and problem-solving
- impaired memory
- hallucinations (when taken in high doses)
- delusions (when taken in high doses)
- psychosis (when taken in high doses)

Long-Term Effects

Marijuana also affects brain development. When people begin using marijuana as teenagers, the drug may impair thinking, memory, and learning functions and affect how the brain builds connections between the areas necessary for these functions. Researchers are still studying how long marijuana's effects last and whether some changes may be permanent.

For example, a study from New Zealand conducted in part by researchers at Duke University showed that people who started smoking marijuana heavily in their teens and had an ongoing marijuana use disorder lost an average of 8 IQ points between ages 13 and 38. The lost mental abilities didn't fully return in those who quit marijuana as adults. Those who started smoking marijuana as adults didn't show notable IQ declines.[5]

In another recent study on twins, those who used marijuana showed a significant decline in general knowledge and in verbal ability (equivalent to 4 IQ points) between the preteen years and early adulthood, but no predictable difference was found between twins when one used marijuana and the other didn't. This suggests that the IQ decline in marijuana users may be caused by something other than marijuana, such as shared familial factors (e.g., genetics, family environment).[6] NIDA's Adolescent Brain Cognitive Development (ABCD) study, a major longitudinal study, is tracking a large sample of young Americans from late childhood to early adulthood to help clarify how and to what extent marijuana and other substances, alone and in combination, affect adolescent brain development. Read more about the ABCD study on our Longitudinal Study of Adolescent Brain and Cognitive Development (ABCD Study) webpage.

A Rise in Marijuana's THC Levels

The amount of THC in marijuana has been increasing steadily over the past few decades.[7] For a person who's new to marijuana use, this may mean exposure to higher THC levels with a greater chance of a harmful reaction. Higher THC levels may explain the rise in emergency room visits involving marijuana use.

The popularity of edibles also increases the chance of harmful reactions. Edibles take longer to digest and produce a high. Therefore, people may consume more to feel the effects faster, leading to dangerous results.

Higher THC levels may also mean a greater risk for addiction if people are regularly exposing themselves to high doses.

What are the other health effects of marijuana?

Marijuana use may have a wide range of effects, both physical and mental.

Physical Effects

- **Breathing problems.** Marijuana smoke irritates the lungs, and people who smoke marijuana frequently can have the same breathing problems as those who smoke tobacco. These problems include daily cough and phlegm, more frequent lung illness, and a higher risk of lung infections. Researchers so far haven't found a higher risk for lung cancer in people who smoke marijuana.[8]

- **Increased heart rate.** Marijuana raises heart rate for up to 3 hours after smoking. This effect may increase the chance of heart attack. Older people and those with heart problems may be at higher risk.

- **Problems with child development during and after pregnancy.** One study found that about 20% of pregnant women 24-years-old and younger screened positive for marijuana. However, this study also found that women were about twice as likely to screen positive for marijuana use via a drug test than they state in self-reported measures.[9] This suggests that self-reported rates of marijuana use in pregnant females is not an accurate measure of marijuana use and may be underreporting their use. . Additionally, in one study of dispensaries, nonmedical personnel at marijuana dispensaries were recommending marijuana to pregnant women for nausea, but medical experts warn against it. This concerns medical experts because marijuana use during pregnancy is linked to lower birth weight[10] and increased risk of both brain and behavioral problems in babies. If a pregnant woman uses marijuana, the drug may affect certain developing parts of the fetus's brain. Children exposed to marijuana in the womb have an increased risk of problems with attention,[11] memory, and problem-solving compared to unexposed children.[12] Some research also suggests that moderate amounts of THC are excreted into the breast milk of nursing mothers.[13] With regular use, THC can reach amounts in breast milk that could affect the baby's developing brain. More research is needed. Read our *Marijuana Research Report* for more information about marijuana and pregnancy.
- **Intense Nausea and Vomiting.** Regular, long-term marijuana use can lead to some people to develop Cannabinoid Hyperemesis Syndrome. This causes users to experience regular cycles of severe nausea, vomiting, and dehydration, sometimes requiring emergency medical attention.[14]

Mental Effects

Long-term marijuana use has been linked to mental illness in some people, such as:

- temporary hallucinations
- temporary paranoia
- worsening symptoms in patients with *schizophrenia*—a severe mental disorder with symptoms such as hallucinations, paranoia, and disorganized thinking

Marijuana use has also been linked to other mental health problems, such as depression, anxiety, and suicidal thoughts among teens. However, study findings have been mixed.


©iStock/Adrian Hillman

Are there effects of inhaling secondhand marijuana smoke?

Failing a Drug Test?

While it's possible to fail a drug test after inhaling secondhand marijuana smoke, it's unlikely. Studies show that very little THC is released in the air when a person exhales. Research findings suggest that, unless people are in an enclosed room, breathing in lots of smoke for hours at close

range, they aren't likely to fail a drug test.[15,16] Even if some THC was found in the blood, it wouldn't be enough to fail a test.

Getting high from passive exposure?

Similarly, it's unlikely that secondhand marijuana smoke would give nonsmoking people in a confined space a high from passive exposure. Studies have shown that people who don't use marijuana report only mild effects of the drug from a nearby smoker, under extreme conditions (breathing in lots of marijuana smoke for hours in an enclosed room).[17]

Other Health Effects?

More research is needed to know if secondhand marijuana smoke has similar health risks as secondhand tobacco smoke. A recent study on rats suggests that secondhand marijuana smoke can do as much damage to the heart and blood vessels as secondhand tobacco smoke.[20] But researchers haven't fully explored the effect of secondhand marijuana smoke on humans. What they do know is that the toxins and tar found in marijuana smoke could affect vulnerable people, such as children or people with asthma.

How Does Marijuana Affect a Person's Life?

Compared to those who don't use marijuana, those who frequently use large amounts report the following:

- lower life satisfaction
- poorer mental health
- poorer physical health
- more relationship problems

People also report less academic and career success. For example, marijuana use is linked to a higher likelihood of dropping out of school.[18] It's also linked to more job absences, accidents, and injuries.[19]

Is marijuana a gateway drug?

Use of alcohol, tobacco, and marijuana are likely to come before use of other drugs.[21,22] Animal studies have shown that early exposure to addictive substances, including THC, may change how the brain responds to other drugs. For example, when rodents are repeatedly exposed to THC when they're young, they later show an enhanced response to other addictive substances—such as morphine or nicotine—in the areas of the brain that control reward, and they're more likely to show addiction-like behaviors.[23,24]

Although these findings support the idea of marijuana as a "gateway drug," the majority of people who use marijuana don't go on to use other "harder" drugs. It's also important to note that other factors besides biological mechanisms, such as a person's social environment, are also critical in a person's risk for drug use and addiction. Read more about marijuana as a gateway drug in our *Marijuana Research Report*.

Can a person overdose on marijuana?

An overdose occurs when a person uses enough of the drug to produce life-threatening symptoms or death. There are no reports of teens or adults dying from marijuana alone. However, some people who use marijuana can feel some very uncomfortable side effects, especially when using marijuana products with high THC levels. People have reported symptoms such as anxiety and paranoia, and in rare cases, an extreme psychotic reaction (which can include delusions and hallucinations) that can lead them to seek treatment in an emergency room.

While a psychotic reaction can occur following any method of use, emergency room responders have seen an increasing number of cases involving marijuana edibles. Some people (especially preteens and teens) who know very little about edibles don't realize that it takes longer for the

body to feel marijuana's effects when eaten rather than smoked. So they consume more of the edible, trying to get high faster or thinking they haven't taken enough. In addition, some babies and toddlers have been seriously ill after ingesting marijuana or marijuana edibles left around the house.

Is marijuana addictive?

Marijuana use can lead to the development of a *substance use disorder,* a medical illness in which the person is unable to stop using even though it's causing health and social problems in their life. Severe substance use disorders are also known as addiction. Research suggests that between 9 and 30 percent of those who use marijuana may develop some degree of marijuana use disorder.[25] People who begin using marijuana before age 18 are four to seven times more likely than adults to develop a marijuana use disorder.[26]

Many people who use marijuana long term and are trying to quit report mild withdrawal symptoms that make quitting difficult. These include:

- grouchiness
- sleeplessness
- decreased appetite
- anxiety
- cravings

What treatments are available for marijuana use disorder?

No medications are currently available to treat marijuana use disorder, but behavioral support has been shown to be effective. Examples include therapy and motivational incentives (providing rewards to patients who remain drug-free). Continuing research may lead to new medications that help ease withdrawal symptoms, block the effects of marijuana, and prevent relapse.

Points to Remember

- Marijuana refers to the dried leaves, flowers, stems, and seeds from the *Cannabis sativa* or *Cannabis indica* plant.
- The plant contains the mind-altering chemical THC and other related compounds.
- People use marijuana by smoking, eating, drinking, or inhaling it.
- Smoking and vaping THC-rich extracts from the marijuana plant (a practice called *dabbing*) is on the rise.
- THC overactivates certain brain cell receptors, resulting in effects such as:
    - altered senses
    - changes in mood
    - impaired body movement
    - difficulty with thinking and problem-solving
    - impaired memory and learning
- Marijuana use can have a wide range of health effects, including:
    - hallucinations and paranoia
    - breathing problems
    - possible harm to a fetus's brain in pregnant women
- The amount of THC in marijuana has been increasing steadily in recent decades, creating more harmful effects in some people.
- It's unlikely that a person will fail a drug test or get high from passive exposure by inhaling secondhand marijuana smoke.
- There aren't any reports of teens and adults dying from using marijuana alone, but marijuana use can cause some very uncomfortable side effects, such as anxiety and paranoia and, in rare cases, extreme psychotic reactions.
- Marijuana use can lead to a substance use disorder, which can develop into an addiction in severe cases.
- No medications are currently available to treat marijuana use disorder, but behavioral support can be effective.

Learn More

For more information about marijuana and marijuana use, visit our:

- Marijuana webpage
- *Drugged Driving DrugFacts*

Updated June 2018

References

1. Substance Abuse Center for Behavioral Health Statistics and Quality. Results from the 2015 National Survey on Drug Use and Health: Detailed Tables. SAMHSA. https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf. Published September 8, 2016. Accessed January 18, 2017.

2. Johnston L, O'Malley P, Miech R, Bachman J, Schulenberg J. *Monitoring the Future National Survey Results on Drug Use: 1975-2015: Overview: Key Findings on Adolescent Drug Use.* Ann Arbor, MI: Institute for Social Research, The University of Michigan; 2015.

3. Bell C, Slim J, Flaten HK, Lindberg G, Arek W, Monte AA. Butane Hash Oil Burns Associated with Marijuana Liberalization in Colorado. *J Med Toxicol Off J Am Coll Med Toxicol*. 2015;11(4):422-425. doi:10.1007/s13181-015-0501-0

4. Romanowski KS, Barsun A, Kwan P, et al. Butane Hash Oil Burns: A 7-Year Perspective on a Growing Problem. *J Burn Care Res Off Publ Am Burn Assoc*. 2017;38(1):e165-e171. doi:10.1097/BCR.0000000000000334

5. Meier MH, Caspi A, Ambler A, et al. Persistent cannabis users show neuropsychological decline from childhood to midlife. *Proc Natl Acad Sci U S A*. 2012;109(40):E2657-E2664. doi:10.1073/pnas.1206820109

6. Jackson NJ, Isen JD, Khoddam R, et al. Impact of adolescent marijuana use on intelligence: Results from two longitudinal twin studies. *Proc Natl Acad Sci U S A*. 2016;113(5):E500-E508. doi:10.1073/pnas.1516648113

7. Mehmedic Z, Chandra S, Slade D, et al. Potency trends of Δ9-THC and other cannabinoids in confiscated cannabis preparations from 1993 to 2008. *J Forensic Sci*. 2010;55(5):1209-1217. doi:10.1111/j.1556-4029.2010.01441.x

8. National Academies of Sciences, Engineering, and Medicine. *The Health Effects of Cannabis and Cannabinoids: Current State of Evidence and Recommendations for Research*. Washington, DC: The National Academies Press; 2017.

9. Young-Wolff KC, Tucker L-Y, Alexeeff S, et al. Trends in Self-reported and Biochemically Tested Marijuana Use Among Pregnant Females in California From 2009-2016. *JAMA*. 2017;318(24):2490. doi:10.1001/jama.2017.17225

10. The National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on the Health Effects of Marijuana: An Evidence Review and Research Agenda. *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*. http://nationalacademies.org/hmd/Reports/2017/health-effects-of-cannabis-and-cannabinoids.aspx. Accessed January 19, 2017.

11. Goldschmidt L, Day NL, Richardson GA. Effects of prenatal marijuana exposure on child behavior problems at age 10. *Neurotoxicol Teratol*. 2000;22(3):325-336.

12. Richardson GA, Ryan C, Willford J, Day NL, Goldschmidt L. Prenatal alcohol and marijuana exposure: effects on neuropsychological outcomes at 10 years. *Neurotoxicol Teratol*. 2002;24(3):309-320.

13. Perez-Reyes M, Wall ME. Presence of delta9-tetrahydrocannabinol in human milk. *N Engl J Med*. 1982;307(13):819-820. doi:10.1056/NEJM198209233071311

14. Galli JA, Sawaya RA, Friedenberg FK. Cannabinoid Hyperemesis Syndrome. *Curr Drug Abuse Rev*. 2011;4(4):241-249.

15. Röhrich J, Schimmel I, Zörntlein S, et al. Concentrations of delta9-tetrahydrocannabinol and 11-nor-9-carboxytetrahydrocannabinol in blood and urine after passive exposure to Cannabis smoke in a coffee shop. *J Anal Toxicol*. 2010;34(4):196-203.

16. Cone EJ, Bigelow GE, Herrmann ES, et al. Non-smoker exposure to secondhand cannabis smoke. I. Urine screening and confirmation results. *J Anal Toxicol*. 2015;39(1):1-12. doi:10.1093/jat/bku116

17. Herrmann ES, Cone EJ, Mitchell JM, et al. Non-smoker exposure to secondhand cannabis smoke II: Effect of room ventilation on the physiological, subjective, and behavioral/cognitive effects. *Drug Alcohol Depend*. 2015;151:194-202. doi:10.1016/j.drugalcdep.2015.03.019

18. McCaffrey DF, Pacula RL, Han B, Ellickson P. Marijuana Use and High School Dropout: The Influence of Unobservables. *Health Econ*. 2010;19(11):1281-1299. doi:10.1002/hec.1561

19. Zwerling C, Ryan J, Orav EJ. The efficacy of preemployment drug screening for marijuana and cocaine in predicting employment outcome. *JAMA*. 1990;264(20):2639-2643.

20. Wang X, Derakhshandeh R, Liu J, et al. One Minute of Marijuana Secondhand Smoke Exposure Substantially Impairs Vascular Endothelial Function. *J Am Heart Assoc*. 2016;5(8). doi:10.1161/JAHA.116.003858

21. Secades-Villa R, Garcia-Rodríguez O, Jin CJ, Wang S, Blanco C. Probability and predictors of the cannabis gateway effect: a national study. *Int J Drug Policy*. 2015;26(2):135-142. doi:10.1016/j.drugpo.2014.07.011

22. Levine A, Huang Y, Drisaldi B, et al. Molecular mechanism for a gateway drug: epigenetic changes initiated by nicotine prime gene expression by cocaine. *Sci Transl Med*. 2011;3(107):107ra109. doi:10.1126/scitranslmed.3003062

23. Panlilio LV, Zanettini C, Barnes C, Solinas M, Goldberg SR. Prior exposure to THC increases the addictive effects of nicotine in rats. *Neuropsychopharmacol Off Publ Am Coll Neuropsychopharmacol*. 2013;38(7):1198-1208. doi:10.1038/npp.2013.16

24. Cadoni C, Pisanu A, Solinas M, Acquas E, Di Chiara G. Behavioural sensitization after repeated exposure to Delta 9-tetrahydrocannabinol and cross-sensitization with morphine. *Psychopharmacology (Berl)*. 2001;158(3):259-266. doi:10.1007/s002130100875

25. Hasin DS, Saha TD, Kerridge BT, et al. Prevalence of Marijuana Use Disorders in the United States Between 2001-2002 and 2012-2013. *JAMA Psychiatry*. 2015;72(12):1235-1242. doi:10.1001/jamapsychiatry.2015.1858

26. Winters KC, Lee C-YS. Likelihood of developing an alcohol and cannabis use disorder during youth: association with recent use and age. *Drug Alcohol Depend*. 2008;92(1-3):239-247. doi:10.1016/j.drugalcdep.2007.08.005

Page Intentionally left Blank for Printing

Session 3: Adolescent Drug and Alcohol Issues

"Marijuana"
Competency Worksheet

1. Marijuana is the most commonly used illicit drug in the United States.

   ☐ True
   ☐ False

2. Name four ways marijuana can be used.

_____

_____

_____

_____

3. Name 4 types of edibles.

_____

_____

_____

_____

4. Short term effects of marijuana use on the brain include:
   ☐ A) Impaired memory & body movement
   ☐ B) Change in Mood
   ☐ C) Difficulty with Thinking and Problem Solving
   ☐ D) Altered Senses & Sense of Time
   ☐ E) All of the Above

5. When people begin using marijuana as teenagers, the drug may impair

   _____, _____, and _____

   and affect how the brain builds connections between the areas necessary for these functions.

6. Marijuana use has also been linked to other mental health problems such as depression, anxiety and suicidal thoughts among teens.
   ☐ True
   ☐ False

7. It's unlikely for a person to fail a drug test after inhaling second-hand marijuana smoke.
   - ☐ True
   - ☐ False

8. People who begin using marijuana before age 18 are 4 to 7 times more likely than adults to develop a marijuana use disorder.
   - ☐ True
   - ☐ False

9. Medications are currently available to treat marijuana use disorders.
   - ☐ True
   - ☐ False

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

National Institute on Drug Abuse
DrugFacts
www.drugabuse.gov

Methamphetamine

What is methamphetamine?

Methamphetamine is a stimulant drug usually used as a white, bitter-tasting powder or a pill. Crystal methamphetamine is a form of the drug that looks like glass fragments or shiny, bluish-white rocks. It is chemically similar to amphetamine [a drug used to treat attention-deficit hyperactivity disorder (ADHD) and narcolepsy, a sleep disorder].

Crystal methamphetamine
Photo by DEA/1.usa.gov/1WpNtno

Other common names for methamphetamine include *chalk, crank, crystal, ice, meth,* and *speed*.

How do people use methamphetamine?

People can take methamphetamine by:

- inhaling/smoking
- swallowing (pill)
- snorting
- injecting the powder that has been dissolved in water/alcohol

Because the "high" from the drug both starts and fades quickly, people often take repeated doses in a "binge and crash" pattern. In some cases, people take methamphetamine in a form of binging known as a "run," giving up food and sleep while continuing to take the drug every few hours for up to several days.

How does methamphetamine affect the brain?

Methamphetamine increases the amount of the natural chemical dopamine in the brain. Dopamine is involved in body movement, motivation, and reinforcement of rewarding behaviors. The drug's ability to rapidly release high levels of dopamine in reward areas of the brain strongly reinforces drug-taking behavior, making the user want to repeat the experience.

Short-Term Effects

Taking even small amounts of methamphetamine can result in many of the same health effects as those of other stimulants, such as cocaine or amphetamines. These include:

- increased wakefulness and physical activity
- decreased appetite
- faster breathing
- rapid and/or irregular heartbeat
- increased blood pressure and body temperature

How Do Manufacturers Make Methamphetamine?

Manufacturers make most of the methamphetamine found in the United States in "superlabs" here or, more often, in Mexico. But some also make the drug in small, secret labs with inexpensive over-the-counter ingredients such as pseudoephedrine, a common ingredient in cold medicines. To curb production, the law requires pharmacies and other retail stores to keep a purchase record of products containing pseudoephedrine. A person may only buy a limited amount of those products on a single day.

Methamphetamine production also involves a number of other very dangerous chemicals. Toxic effects from these chemicals can remain in the environment around a lab long after the lab has been shut down, causing a wide range of health problems for people living in the area. These chemicals can also result in deadly lab explosions and house fires.

What are other health effects of methamphetamine?

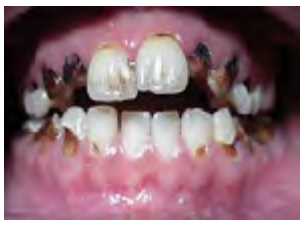
Long-Term Effects

People who inject methamphetamine are at increased risk of contracting infectious diseases such as HIV and hepatitis B and C. These diseases are transmitted through contact with blood or other bodily fluids. Methamphetamine use can also alter judgment and decision-making leading to risky behaviors, such as unprotected sex, which also increases risk for infection.

Methamphetamine use may worsen the progression of HIV/AIDS and its consequences. Studies indicate that HIV causes more injury to nerve cells and more cognitive problems in people who have HIV and use methamphetamine than it does in people who have HIV and don't use the drug.[1] Cognitive problems are those involved with thinking, understanding, learning, and remembering.

Long-term methamphetamine use has many other negative consequences, including:

- extreme weight loss
- severe dental problems ("meth mouth")
- intense itching, leading to skin sores from scratching
- anxiety
- confusion
- sleeping problems
- violent behavior
- *paranoia*—extreme and unreasonable distrust of others
- *hallucinations*—sensations and images that seem real though they aren't



"Meth mouth"
Photo by Dozenist/CC BY-SA/
bit.ly/1WCZhmr

In addition, continued methamphetamine use causes changes in the brain's dopamine system that are associated with reduced coordination and impaired verbal learning. In studies of people who used methamphetamine over the long term, severe changes also affected areas of the brain involved with emotion and memory.[2] This may explain many of the emotional and cognitive problems observed in those who use methamphetamine.

Although some of these brain changes may reverse after being off the drug for a year or more, other changes may not recover even after a long period of abstinence.[3] A recent study even suggests that people who used methamphetamine have an increased the risk of developing Parkinson's disease, a disorder of the nerves that affects movement.[4]

Are there health effects from exposure to secondhand methamphetamine smoke?

Researchers don't yet know whether people breathing in secondhand methamphetamine smoke can get high or have other health effects. What they do know is that people can test positive for methamphetamine after exposure to secondhand smoke.[5,6] More research is needed in this area.

Can a person overdose on methamphetamine?

Yes, a person can overdose on methamphetamine. An overdose occurs when the person uses too much of a drug and has a toxic reaction that results in serious, harmful symptoms or death.

Methamphetamine overdose can lead to stroke, heart attack, or organ problems—such as kidney failure—caused by overheating. These conditions can result in death.

How can a methamphetamine overdose be treated?

Because methamphetamine overdose often leads to a stroke, heart attack, or organ problems, first responders and emergency room doctors try to treat the overdose by treating these conditions, with the intent of:

- restoring blood flow to the affected part of the brain (stroke)
- restoring blood flow to the heart (heart attack)
- treating the organ problems

Is methamphetamine addictive?

Yes, methamphetamine is highly addictive. When people stop taking it, withdrawal symptoms can include:

- anxiety
- fatigue
- severe depression
- psychosis
- intense drug cravings

How can people get treatment for methamphetamine addiction?

The most effective treatments for methamphetamine addiction so far are behavioral therapies, such as:

- cognitive-behavioral therapy, which helps patients recognize, avoid, and cope with the situations in which they are most likely to use drugs
- motivational incentives, which uses vouchers or small cash rewards to encourage patients to remain drug-free

While research is under way, there are currently no government-approved medications to treat methamphetamine addiction.

Points to Remember

- Methamphetamine is usually a white, bitter-tasting powder or a pill. Crystal methamphetamine looks like glass fragments or shiny, bluish-white rocks.
- Methamphetamine is a stimulant drug that is chemically similar to amphetamine (a drug used to treat ADHD and narcolepsy).
- People can take methamphetamine by inhaling/smoking, swallowing, snorting, or injecting the drug.
- Methamphetamine increases the amount of dopamine in the brain, which is involved in movement, motivation, and reinforcement of rewarding behaviors.
- Short-term health effects include increased wakefulness and physical activity, decreased appetite, and increased blood pressure and body temperature.
- Long-term health effects include risk of contracting HIV and hepatitis; severe dental problems ("meth mouth"); intense itching, leading to skin sores from scratching; violent behavior; and paranoia.
- Researchers don't yet know whether people breathing in secondhand methamphetamine smoke can get high or have other health effects.
- A person can overdose on methamphetamine. Because methamphetamine overdose often leads to a stroke, heart attack, or organ problems, first responders and emergency room doctors try to treat the overdose by treating these conditions.
- Methamphetamine is highly addictive. When people stop taking it, withdrawal symptoms can include anxiety, fatigue, severe depression, psychosis, and intense drug cravings.
- The most effective treatments for methamphetamine addiction so far are behavioral therapies. There are currently no government-approved medications to treat methamphetamine addiction.

Learn More

For more information about methamphetamine, visit our:

- Methamphetamine webpage
- Commonly Abused Drugs chart

Updated June 2018

References

1. Chang L, Ernst T, Speck O, Grob CS. Additive effects of HIV and chronic methamphetamine use on brain metabolite abnormalities. *Am J Psychiatry*. 2005;162(2):361-369. doi:10.1176/appi.ajp.162.2.361.

2. Volkow ND, Chang L, Wang GJ, et al. Association of dopamine transporter reduction with psychomotor impairment in methamphetamine abusers. *Am J Psychiatry*. 2001;158(3):377-382. doi:10.1176/appi.ajp.158.3.377.

3. Wang G-J, Volkow ND, Chang L, et al. Partial recovery of brain metabolism in methamphetamine abusers after protracted abstinence. *Am J Psychiatry*. 2004;161(2):242-248. doi:10.1176/appi.ajp.161.2.242.

4. Curtin K, Fleckenstein AE, Robison RJ, Crookston MJ, Smith KR, Hanson GR. Methamphetamine/amphetamine abuse and risk of Parkinson's disease in Utah: a population-based assessment. *Drug Alcohol Depend*. 2015;146:30-38. doi:10.1016/j.drugalcdep.2014.10.027.

5. Bassindale T. Quantitative analysis of methamphetamine in hair of children removed from clandestine laboratories--evidence of passive exposure? *Forensic Sci Int*. 2012;219(1-3):179-182. doi:10.1016/j.forsciint.2012.01.003.

6. Farst K, Reading Meyer JA, Mac Bird T, James L, Robbins JM. Hair drug testing of children suspected of exposure to the manufacture of methamphetamine. *J Forensic Leg Med*. 2011;18(3):110-114. doi:10.1016/j.jflm.2011.01.013.

Page Intentionally left Blank for Printing

Session 3: Adolescent Drug and Alcohol Issues

"Methamphetamine"
Competency Worksheet

1. Methamphetamine is a _____ drug which is usually used as a white, bitter-tasting powder or pill.

2. Methamphetamine is chemically similar to a drug used to treat Attention Deficit Hyperactivity Disorder called amphetamine.
   - ☐ True
   - ☐ False

3. Common names for methamphetamine include:

   a) ☐ Powder, dust bunnies, sugar, splenda
   b) ☐ Speed, crystal, ice, chalk, crank
   c) ☐ Glass, blue bonnet, lightning
   d) ☐ Joker, skittles, rocks, pebbles

4. Name four ways methamphetamine can be used.

   _____

   _____

   _____

   _____

5. Methamphetamine decreases the amount of the natural chemical dopamine in the brain. Dopamine is involved in body movement, motivation, pleasure and reward.
   - ☐ True
   - ☐ False

6. Short term health effects of methamphetamine use include:

   a) ☐ Decreased appetite & faster breathing
   b) ☐ Irregular or rapid heart beat
   c) ☐ Increased wakefulness and physical activity
   d) ☐ Blood pressure and body temperature increase
   e) ☐ All of the above

7. Name six long term health effects of methamphetamine use:

   _____

   _____

   _____

   _____

   _____

   _____

8. Can a person overdose on methamphetamine? Please explain.

   _____

   _____

   _____

9. Check all that apply. When people stop taking methamphetamine, withdrawal symptoms include:

   ☐ Severe depression ☐ Loss of appetite ☐ Fatigue ☐ Aggressive behaviors

   ☐ Increased level of energy ☐ Anxiety ☐ Psychosis ☐ Wakefulness

   ☐ Impulsivity ☐ Intense drug cravings ☐ Truancy ☐ Overeating

10. The most effective treatments for methamphetamine addiction so far are behavioral therapies, such as cognitive-behavioral therapy and motivational incentives.
    ☐ True
    ☐ False

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

NIH National Institute on Drug Abuse
DrugFacts
www.drugabuse.gov

Inhalants

What are inhalants?

Although other substances that are misused can be inhaled, the term *inhalants* refers to the various substances that people typically take *only* by inhaling. These substances include:

- solvents (liquids that become gas at room temperature)
- aerosol sprays
- gases
- nitrites (prescription medicines for chest pain)

Photo by ©iStock.com/davidf/istockpho.to/2aW2uhd

Inhalants are various products easily bought and found in the home or workplace—such as spray paints, markers, glues, and cleaning fluids. They contain dangerous substances that have *psychoactive* (mind-altering) properties when inhaled. People don't typically think of these products as drugs because they're not intended for getting "high," but some people use them for that purpose. When these substances are used for getting high, they are called *inhalants*. Inhalants are mostly used by young kids and teens and are the only class of substance used more by younger than by older teens.

How do people use inhalants?

People who use inhalants breathe in the fumes through their nose or mouth, usually by "sniffing," "snorting," "bagging," or "huffing." It's called different names depending on the substance and equipment they use. For more information, read NIDA's *Research Report on Inhalants.*

Although the high that inhalants produce usually lasts just a few minutes, people often try to make it last by continuing to inhale again and again over several hours.

Products Used as Inhalants

Solvents

- industrial or household products, including:
  - paint thinners or removers
  - dry-cleaning fluids
  - gasoline
  - lighter fluid
- art or office supplies, including:
  - correction fluids
  - felt-tip marker fluid
  - electronic contact cleaners
  - glue

Aerosols

- household aerosol items, including:
  - spray paints
  - hair or deodorant sprays
  - aerosol computer cleaning products
  - vegetable oil sprays

Gases

- found in household or commercial products, including:
  - butane lighters
  - propane tanks
  - whipped cream aerosols or dispensers (*whippets*)
- used as anesthesia (to make patients lose sensation during surgery/procedures), including:
  - ether
  - chloroform
  - nitrous oxide

Nitrites

- often sold in small brown bottles labeled as:
  - *video head cleaner*
  - *room odorizer*
  - *leather cleaner*
  - *liquid aroma*

How do inhalants affect the brain?

Most inhalants affect the central nervous system and slow down brain activity. Short-term effects are similar to alcohol and include:

- slurred or distorted speech
- lack of coordination (control of body movement)
- euphoria (feeling "high")
- dizziness

People may also feel light-headed or have *hallucinations* (images/sensations that seem real but aren't) or *delusions* (false beliefs). With repeated inhalations, many people feel less self-conscious and less in control. Some may start vomiting, feel drowsy for several hours, or have a headache that lasts a while.

Unlike other types of inhalants, nitrites, which are often prescribed to treat chest pain, are misused in order to improve sexual pleasure by expanding and relaxing blood vessels.

What are the other health effects of inhalants?

Long-term effects of inhalant use may include:

- liver and kidney damage
- hearing loss
- bone marrow damage
- loss of coordination and limb spasms (from nerve damage)
- delayed behavioral development (from brain problems)
- brain damage (from cut-off oxygen flow to the brain)

In addition, because nitrites are misused for sexual pleasure and performance, they can lead to unsafe sexual practices or other risky behavior. This increases the chance of getting or spreading infectious diseases such as HIV/AIDS or hepatitis.

Read more about drug use and HIV/AIDS in *HIV/AIDS and Drug Abuse: Intertwined Epidemics DrugFacts*. Read more about drug use and hepatitis at our webpage about viral hepatitis.

Can a person overdose on inhalants?

Yes, a person can overdose on inhalants. An overdose occurs when a person uses too much of a drug and has a toxic reaction that results in serious, harmful symptoms or death.

Photo by ©iStock.com/ Photobalance/istockpho.to/2jtngoQ

These symptoms can cause seizures and coma. They can even be deadly. Many solvents and aerosol sprays are highly concentrated, meaning they contain a large amount of chemicals with a lot of active ingredients. Sniffing these products can cause the heart to stop within minutes. This condition, known as *sudden sniffing death*, can happen to an otherwise healthy young person the first time he or she uses an inhalant. Using inhalants with a paper or plastic bag or in a closed area may cause death from suffocation (being unable to breathe).

How can an inhalant overdose be treated?

Because inhalant overdose can lead to seizures or cause the heart to stop, first responders and emergency room doctors try to treat the overdose by treating these conditions. They will try to stop the seizure or restart the heart.

Can inhalants cause addiction, a form of substance use disorder?

Although it's not very common, repeated use of inhalants can lead to addiction, a form of substance use disorder (SUD). An SUD develops when continued use of the drug causes issues, such as health problems and failure to meet responsibilities at work, school, or home. An SUD can range from mild to severe, the most severe form being addiction.

Those who try to quit inhalants may have withdrawal symptoms that include:

- nausea
- loss of appetite
- sweating
- problems sleeping
- mood changes

How can people get treatment for addiction to inhalants?

Some people seeking treatment for use of inhalants have found behavioral therapy to be helpful:

- Cognitive-behavioral therapy helps patients recognize, avoid, and cope with the situations in which they are most likely to use drugs.
- Motivational incentives uses vouchers or small cash rewards for positive behaviors such as staying drug-free.

More research is needed to identify the most effective treatment options for addiction to inhalants.

Points to Remember

- Although other substances that are misused can be inhaled, the term *inhalants* refers to the various substances that people typically take *only* by inhaling.
- Inhalants are various products easily bought and found in the home or workplace—such as spray paints, markers, glues, and cleaning fluids. They contain dangerous substances that have *psychoactive* (mind-altering) properties when inhaled.
- People who use inhalants breathe them in through the mouth (*huffing*) or nose.
- Most inhalants affect the central nervous system and slow down brain activity.
- Short-term health effects include slurred or distorted speech, lack of coordination, euphoria (feeling "high"), dizziness, and hallucinations.
- Long-term health effects may include liver and kidney damage, loss of coordination and limb spasms, delayed behavioral development, and brain damage.
- A person can overdose on inhalants. Because inhalant overdose can lead to seizures or cause the heart to stop, first responders and emergency room doctors try to stop the seizure or restart the heart.
- Although it's not very common, repeated use of inhalants can lead to addiction, a form of substance use disorder. Withdrawal symptoms include nausea, sweating, problems sleeping, and mood changes.
- Some people seeking treatment for use of inhalants have found behavioral therapy to be helpful.

Learn More

For more information about inhalants, visit our:

- *Inhalants Research Report*
- Commonly Abused Drugs chart

Updated February 2017

Session 3: Adolescent Drug and Alcohol Issues

"Inhalants"
Competency Worksheet

1. The term inhalants refers to the various substances that people typically take only by inhaling.
   ☐ True
   ☐ False

2. Products that are used as inhalants include:
   ☐ a) Gasses
   ☐ b) Aerosol Sprays
   ☐ c) Nitrites (prescription medicines for chest pain)
   ☐ d) Solvents (liquids that become gas a room temperature)
   ☐ e) All of the above

3. Name four ways people use inhalants:

_____

_____

_____

_____

4. List 6 common household products currently in your home that are considered inhalants.

_____

_____

_____

_____

_____

_____

5. Most inhalants affect the central nervous system and speed up brain activity.
   ☐ True
   ☐ False

6. Short-term effects of inhalant use include:
   ☐ a) Dizziness
   ☐ b) Increased physical activity and energy level
   ☐ c) Euphoria (feeling "high")

☐ d) Slurred or distorted speech
☐ e) Lack of coordination
☐ f) A, C, D, & E
☐ g) All of the above

7. Name three long-term effects of inhalant use:

_____

_____

_____

8. A person cannot overdose on inhalants
   ☐ True
   ☐ False

9. Sudden sniffing death can happen to a healthy young person the first time he/she sniffs a product that is highly concentrated causing the heart to stop within minutes.
   ☐ True
   ☐ False

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

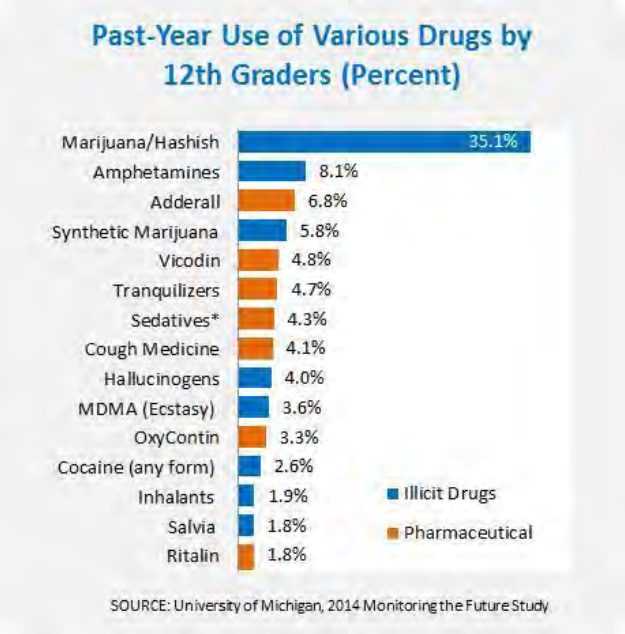
National Institute on Drug Abuse

DrugFacts

www.drugabuse.gov

Prescription and Over-the-Counter Medications

Some medications have psychoactive (mind-altering) properties and, because of that, are sometimes abused—that is, taken for reasons or in ways or amounts not intended by a doctor, or taken by someone other than the person for whom they are prescribed. In fact, prescription and over-the-counter (OTC) drugs are, after marijuana (and alcohol), the most commonly abused substances by Americans 14 and older.



The classes of prescription drugs most commonly abused are: opioid pain relievers, such as Vicodin® or Oxycontin®; stimulants for treating Attention Deficit Hyperactivity Disorder (ADHD), such as Adderall®, Concerta®, or Ritalin®; and central nervous system (CNS) depressants for relieving anxiety, such as Valium® or Xanax®.[1] The most commonly abused OTC drugs are cough and cold remedies containing dextromethorphan.

People often think that prescription and OTC drugs are safer than illicit drugs. But they can be as addictive and dangerous and put users at risk for other adverse health effects, including overdose—especially when taken along with other drugs or alcohol. Before prescribing drugs, a health care provider considers a patient's health conditions, current and prior drug use, and other medicines to assess the risks and benefits for a patient.

How Are Prescription Drugs Abused?

Prescription and OTC drugs may be abused in one or more of the following ways:

Taking a medication that has been prescribed for somebody else. Unaware of the dangers of sharing medications, people often unknowingly contribute to this form of abuse by sharing their unused pain relievers with their family members.

Most teenagers who abuse prescription drugs are given them for free by a friend or relative.

Taking a drug in a higher quantity or in another manner than prescribed. Most prescription drugs are dispensed orally in tablets, but abusers sometimes crush the tablets and snort or inject the powder. This hastens the entry of the drug into the bloodstream and the brain and amplifies its effects.

Taking a drug for another purpose than prescribed. All of the drug types mentioned can produce pleasurable effects at sufficient quantities, so taking them for the purpose of getting high is one of the main reasons people abuse them.

ADHD drugs like Adderall® are also often abused by students seeking to improve their academic performance. However, although they may boost alertness, there is little evidence they improve cognitive functioning for those without a medical condition.

How Do Prescription and OTC Drugs Affect the Brain?

Taken as intended, prescription and OTC drugs safely treat specific mental or physical symptoms. But when taken in different quantities or when such symptoms aren't present, they may affect the brain in ways very similar to illicit drugs.

For example, stimulants such as Ritalin® achieve their effects by acting on the same neurotransmitter systems as cocaine. Opioid pain relievers such as OxyContin® attach to the same cell receptors targeted by illegal opioids like heroin. Prescription depressants produce sedating or calming effects in the same manner as the club drugs GHB and Rohypnol®. And when taken in very high doses, dextromethorphan acts on the same cell receptors as PCP or ketamine, producing similar out-of-body experiences.

When abused, all of these classes of drugs directly or indirectly cause a pleasurable increase in the amount of dopamine in the brain's reward pathway. Repeatedly seeking to experience that feeling can lead to addiction.

What Are the Other Health Effects of Prescription and OTC Drugs?

Opioids can produce drowsiness, cause constipation, and—depending upon the amount taken—depress breathing. The latter effect makes opioids particularly dangerous, especially when they are snorted or injected or combined with other drugs or alcohol.

More people die from overdoses of prescription opioids than from all other drugs combined, including heroin and cocaine (see "The Prescription Opioid Overdose Epidemic").

Stimulants can have strong effects on the cardiovascular system. Taking high doses of a stimulant can dangerously raise body temperature and cause irregular heartbeat or even heart failure or seizures. Also, taking some stimulants in high doses or repeatedly can lead to hostility or feelings of paranoia.

CNS depressants slow down brain activity and can cause sleepiness and loss of coordination. Continued use can lead to physical dependence and withdrawal symptoms if discontinuing use.

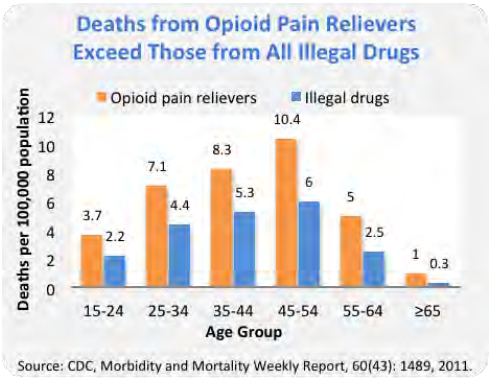
Opioids and Brain Damage

While the relationship between opioid overdose and depressed respiration (slowed breathing) has been confirmed, researchers are also studying the long-term effects on brain function. Depressed respiration can affect the amount of oxygen that reaches the brain, a condition called hypoxia. Hypoxia can have short- and long-term psychological and neurological effects, including coma and permanent brain damage.

Researchers are also investigating the long-term effects of opioid addiction on the brain. Studies have shown some deterioration of the brain's white matter due to heroin use, which may affect decision-making abilities, the ability to regulate behavior, and responses to stressful situations.

The Prescription Opioid Overdose Epidemic

More than 2 million people in the United States suffer from substance use disorders related to prescription opioid pain relievers. The terrible consequences of this trend include overdose deaths, which have more than quadrupled in the past decade and a half. The causes are complex, but they include overprescription of pain medications. In 2013, 207 million prescriptions were written for prescription opioid pain medications.



Dextromethorphan can cause impaired motor function, numbness, nausea or vomiting, and increased heart rate and blood pressure. On rare occasions, hypoxic brain damage—caused by severe respiratory depression and a lack of oxygen to the brain—has occurred due to the combination of dextromethorphan with decongestants often found in the medication.

All of these drugs have the potential for addiction, and this risk is amplified when they are abused. Also, as with other drugs, abuse of prescription and OTC drugs can alter a person's judgment and decision making, leading to dangerous behaviors such as unsafe sex and drugged driving.

Prescription Opioid Abuse: A First Step to Heroin Use?

Prescription opioid pain medications such as Oxycontin® and Vicodin® can have effects similar to heroin when taken in doses or in ways other than prescribed, and research now suggests that abuse of these drugs may actually open the door to heroin abuse.

Nearly half of young people who inject heroin surveyed in three recent studies reported abusing prescription opioids before starting to use heroin. Some individuals reported taking up heroin because it is cheaper and easier to obtain than prescription opioids.

Many of these young people also report that crushing prescription opioid pills to snort or inject the powder provided their initiation into these methods of drug administration.

Learn More

For more information on prescription and OTC drugs, visit: www.drugabuse.gov/publications/research-reports/prescription-drugs

Updated November 2015

References

[1] These are proprietary names of particular drug products. Generic versions may also exist.

Session 3: Adolescent Drug and Alcohol Issues

"Prescription and Over-the-Counter Medications"
Competency Worksheet

1. Prescription and Over-the Counter (OTC) drugs, after marijuana and alcohol are the most commonly abused substances by Americans 14 and older.

☐ True
☐ False

2. Name at least 3 of the most commonly abused prescription drugs:

_____

_____

_____

3. Name two ways prescription and OTC drugs may be abused:

_____

_____

4. Most teenagers who abuse prescription drugs steal them from friends or relatives

☐ True
☐ False

5. When abused, prescription and OTC drugs directly and indirectly increase the amount of dopamine in the brain's reward pathway. Repeatedly seeking to experience that feeling can lead to addiction

☐ True
☐ False

6. More people die from overdoses of prescription opioid pain relievers (such as Vicodin or Oxycontin) than from all other drugs combined to include heroin and cocaine.

☐ True
☐ False

7. Abuse of prescription and OTC drugs can alter a person's _____ and _____, leading to dangerous behaviors such as unsafe sex and drugged driving.

8. More than _____ people in the United States suffer from substance use disorders related to prescription opioid pain relievers.

9. Nearly _____ of young people who inject heroin surveyed in three recent studies reported abusing prescription opioids before starting to use heroin.

Important Reminder: As an OYA foster parent and per Oregon Administrative Rules (Division 530), it is your duty and responsibility to ensure all medications are stored in locked storage sufficient to prevent unauthorized access.

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

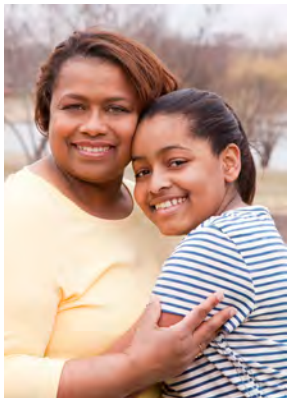
Session Four:

Addressing the Mental Health of Youth

In this session you will learn about different mental health disorders, what they are, the treatment approaches and how you can better help and support the youth in your home

Page Intentionally left Blank for Printing

Foster Care Providers:
Helping Youth at Risk for Suicide



This information sheet addresses suicide prevention among youth in foster care. It is written for professionals and volunteers who interact with foster children or work with their caregivers.

Every year in the United States, more than 4,800 children, teens, and young adults ages 0–24 die by suicide (CDC, 2010). Approximately 175,800 others are treated in emergency departments for injuries from self-harm (CDC, 2012). Although suicide can occur in any family, youth in foster care are at higher risk for attempting or seriously considering suicide (Pilowsky & Wu, 2006).

Fortunately, there are steps that foster caregivers can take to identify and get help for youth who are at risk. Many young people who are thinking of killing themselves show warning signs. Knowing the warning signs and risk factors can help foster caregivers intervene and get the young person connected with assistance. Foster caregivers can also help address underlying mental health issues and strengthen the factors that protect against suicide.

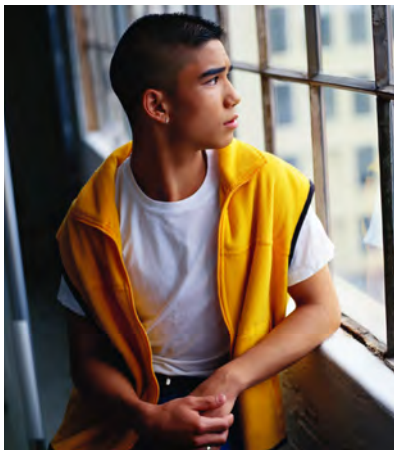
Suicidal Behavior and Youth in Foster Care

Most youth who die by suicide have a mental disorder, such as depression, or a substance use disorder. Youth in foster care are more likely to have a mental disorder or substance use disorder than those who were never in foster care (Pilowsky & Wu, 2006; Pecora et al., 2009). They are also about two and a half times more likely to have seriously considered suicide and almost four times more likely to have attempted suicide than other youth (Pilowsky & Wu, 2006).

Many youth are placed in foster care because they have experienced trauma, abuse, and/or neglect by their families. According to one study, 54 percent of foster children had been sexually abused before they were placed with foster families, while another 28 percent had been physically abused or neglected (Pecora et al., 2005). Their families may have been affected by violence, mental disorders, and/or substance abuse. Another study found that having adverse childhood experiences, including emotional, physical, or sexual abuse, increased the risk of suicide attempts by two to five times (Dube et al., 2001).

Once in foster care, youth may struggle with separation from their parents and other caregivers, further maltreatment in care, and frequent moves. Almost all children in foster care, whether or not they come from families who have abused or neglected them, experience a deep sense of loss and sometimes shame when placed in foster care. In addition to losing their families, frequent moves mean that they often lose their other natural support systems, including their friends, school, and neighbors. They may find themselves in a completely new environment with few established supports. These experiences of loss, isolation, and lack of social support are all risk factors for suicide.

Warning Signs of Suicide



It is important that foster caregivers and other people in support roles are familiar with the following warning signs of suicide and know how to help.

Some behaviors may mean a person is at immediate risk for suicide. These three should prompt action right away:

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Talking about feeling hopeless or having no reason to live

If the child is in imminent danger of suicide, the foster caregiver should stay with him or her until help has been obtained. The child needs to be kept safe until a mental health professional can conduct an assessment. If there is immediate potential for self-harm, 911 should be called. While this step can be difficult for the caregiver and frightening for the child, it may be necessary to ensure the child's safety. The caregiver should go with the child to a hospital emergency department.

It may also help to call the National Suicide Prevention Lifeline (see box). Trained staff provide crisis counseling, suicide intervention, and information about local resources to suicidal youth and adults as well as support to family and friends who are concerned.

Other behaviors may also indicate a serious risk for suicide—especially if the behavior is new; has increased; and/or seems related to a painful event, loss, or change:

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

NATIONAL SUICIDE PREVENTION LIFELINE

1-800-273-TALK (8255)

- Open 24 hours, toll-free, confidential
- Available in English and Spanish
- For a wallet-sized card with the warning signs of suicide, go to: http://www.suicidepreventionlifeline.org/getinvolved/materials.aspx

(Adapted from National Suicide Prevention Lifeline, [n.d.])

It may be difficult for foster caregivers to distinguish between warning signs of suicide and a child's emotional reaction to being placed in foster care. The unfamiliarity of a new living situation as well as the uncertainty of the future can affect a child's moods, schoolwork, and relationships. It is important, however, to pay attention to and try to explore any indication that something is bothering a child. These warning signs can be used as a starting point to talk with the foster child about what he or she is feeling. Foster caregivers should regularly report their observations of their foster child's moods and behaviors to the child's social worker or a staff member at the foster care agency.

Risk for and Protection against Suicide

Youth with more risk factors and fewer protective factors are more likely to attempt or die by suicide than other children. Understanding a foster child's risk and protective factors can help determine whether there is a need to contact a mental health professional for a full assessment.

Protective factors are characteristics and conditions that reduce the likelihood of suicide. Strong self-esteem, a supportive family, caring adults, safe schools, and helpful friends are protective factors that can help youth through the challenges of adolescence and buffer them against the impact of risk factors. Foster caregivers can play a key role in ensuring their foster child's well-being by listening to him or her, being emotionally supportive, having fun together, and getting health and mental health care if needed. Feeling connected with parents or caregivers may be the most influential protective factor for youth.

Risk factors increase the likelihood of suicide. The following are the most common risk factors for foster children:

- **Depression.** Most people with depression do not attempt or die by suicide. However, depression significantly increases the risk for suicide deaths and attempts.
- **Previous suicide attempts.** A previous attempt is one of the strongest risk factors for suicide. Youth who have made previous suicide attempts should be carefully watched for recurring behaviors.
- **Other mental disorders,** especially mood disorders, substance use disorders, conduct disorders (especially aggressive behavior), and anxiety disorders (especially posttraumatic stress disorder).
- **Child abuse and neglect,** including emotional, physical, and sexual abuse.
- **Mental disorder or substance abuse in a parent or other household member.** This risk factor may lead to increased child abuse and neglect, trauma, and other family dysfunction.
- **Access to lethal means.** Lethal means are items that a person can use to end his or her life. They include firearms, prescription and over-the-counter medications, and alcohol. An at-risk youth with access to lethal means is at even greater risk for suicide. A youth in crisis can act impulsively, but if lethal means are not readily available, the delay created may allow the crisis to resolve itself. Reducing access to lethal means is an important strategy for foster caregivers to keep youth safe.
- **Self-injury.** Some youth injure themselves (e.g., by cutting or burning) to relieve intense feelings such as pain, anger, or tension. Self-injury is a sign that a young person needs help developing alternative ways for dealing with emotions. Learn more about self-injury at http://www.sprc.org/search/library/self-injury?filters=type%3Alibrary_resource.
- **Other risk-taking behaviors**. Risk-taking behaviors can be symptoms of emotional or social problems. Behaviors such as unprotected or promiscuous sex, drug or alcohol use, driving recklessly or without a license, petty theft, or vandalism can indicate that something deeper is wrong, especially if these behaviors begin suddenly or represent a change.

- **Losses.** If the foster child has recently experienced the loss of a relationship or a decrease in status (whether real or anticipated), he or she may have feelings of humiliation, shame, or despair, which can increase suicide risk. The loss of a friend, an expected poor grade at school, or getting into trouble with the law can feel earth-shattering to a young person.
- **Minority sexual orientation or gender identity.** Gay, lesbian, bisexual, and transgender youth are at higher risk for suicidal thoughts and attempts than their peers.
- **Bullying.** Youth who are bullied, as well as those who bully, are at increased risk for depression and suicidal thinking.

Responding to Suicide Risk and Promoting Mental Health

A foster caregiver may be reluctant to explore a foster child's emotional or behavioral issues. It is difficult to know where to draw the boundaries when caring for a child who is your responsibility but who may have been with you only a short time. Talking directly with the foster child, increasing family connectedness, getting access to effective care, providing supervision by caring adults, and restricting access to lethal means can help decrease the foster child's risk for suicide.

Foster caregivers should be encouraged to use the following strategies to reduce their child's risk of suicide and promote his or her mental health:

- Encourage your foster child to talk with you. Although many caregivers are afraid to ask their foster children if they have considered suicide or other self-destructive acts, asking youth if they have thought about suicide does ***not*** increase their risk. In fact, a child may feel relief and reassurance knowing that in this foster home it is okay to talk about these feelings. The caregiver's interest can counter the child's feeling that no one cares or understands.
- Remind your foster child that you or another caring adult will be there to listen when the child is ready to talk. A child might want to open up to you but be afraid to do so unless asked. He or she may feel threatened by your concern and may become upset or deny having problems.
- If you are concerned that your foster child may be considering suicide, ask some specific questions in a way that does not judge or threaten the child. You may want to be very direct and simply ask the question: "Are you thinking about killing yourself?" Or you can start the conversation indirectly by asking one of the following questions:
  - ◊ "Do you ever wish you could go to sleep and never wake up?"
  - ◊ "Sometimes when people feel sad, they think about hurting or killing themselves. Do you ever have thoughts like that?"

The caregiver's comfort level in talking with the foster child about suicide (and the child's willingness to talk with the caregiver about these issues) may depend on many issues: the foster caregiver's experience in that role, how long the child has been with the caregiver, the cultural background of the child's family, and whether the child is used to talking with adults about difficult topics.

Another factor unique to foster children is the possible fear that sharing their suicidal thoughts will result in being removed from the foster home. This may influence whether a foster child will admit to feeling

suicidal. It is important to let foster children know that they can talk with their caregiver about their problems and that the caregiver will make every effort to keep the child in the foster home.

Most individuals who are suicidal can safely stay in their homes or in a community setting and are not hospitalized. If foster caregivers work with the social worker or placement agency and a mental health professional to get a thorough assessment and follow-up plan, they are often able to keep the child in their home. Experiencing the disruption of another placement could increase the level of risk for the child.

If the caregiver feels that he or she cannot talk with the foster child about these issues or the child refuses to talk with the caregiver directly, the caregiver needs to find someone who can build the needed rapport. The National Suicide Prevention Lifeline at 1-800-273-TALK (8255) is a good place to call for support. It is also important for the caregiver to know the policy of the foster care agency in regard to seeking emergency help, as well as the procedures for notifying the agency and the child's caseworker about an emergency.

Foster caregivers need to provide a safe environment for their foster child, especially if the child is in crisis or is emotionally distressed. This means reducing access to lethal means for suicide. Here are some ways to do that (HSPH, n.d.):

- Remove firearms from the home. Give them away or have a relative or friend (who is not accessible to the foster child) hold them for safekeeping.
- Lock up firearms and ammunition. If removal is not an option, the second best option is to store firearms in a gun-safe or tamper-proof storage box with the ammunition locked in a separate location, preferably not in the home.
- Keep medications secure. Depending on the age of the child, keep them out of reach or lock them up. Also, do not stockpile medications. Have only the amount needed at home.
- Keep alcohol out of reach and/or locked up. Only keep small quantities of alcohol at home. Excessive alcohol use can increase impulsivity and reduce an individual's ability to restrain from making a suicide attempt. It can also increase the lethality of a medication or drug overdose.

Foster caregivers can also learn more about preventing suicide by receiving training on how to recognize the signs of suicide and access support services or treatment for a foster child. The state child welfare agency, foster care organizations, or the state office on suicide prevention may be able to provide information about training on youth suicide prevention. For more information, see the links in the Resources section of this sheet. For state-specific contacts, go to http://www.sprc.org/states/all/contacts.

Getting Professional Help

The emotional problems associated with suicide require professional intervention. One of the most important things a foster caregiver can do for a foster child who is considering suicide is to get professional help. This may require overcoming the foster child's reluctance to go to a mental health practitioner. Foster caregivers may have to advocate with the child's caseworker to ensure that this help is found quickly and that a full risk assessment is done by a trained mental health professional.

To find mental health help in their local area, foster caregivers can contact their health insurance provider; the National Suicide Prevention Lifeline; local crisis and information hotlines; community mental health organizations; or the Behavioral Health Treatment Services Locator, a national online directory of mental health and substance abuse services that can be searched by location and type of service.

Resources

Materials

National Center for the Prevention of Youth Suicide. (2012). Preventing suicidal behavior among youth in foster care. Washington, DC: American Association of Suicidology. Retrieved from http://www.suicidology.org/c/document_library/get_file?folderId=261&name=DLFE-557.pdf

Suicide Prevention Resource Center. (2013). Suicide prevention resources for parents/guardians/families. Waltham, MA: Education Development Center, Inc. Retrieved from http://www.sprc.org/sites/sprc.org/files/Families.pdf

Suicide Prevention Resource Center. (2013). Suicide prevention resources for teens. Waltham, MA: Education Development Center, Inc. Retrieved from http://www.sprc.org/sites/sprc.org/files/Teens.pdf

Organizations

American Academy of Pediatrics (AAP) – Healthy Foster Care America

http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Issues.aspx

Healthy Foster Care America is an initiative of the AAP and its partners to improve the health and well-being of children and teens in foster care. This special section is designed to help foster children and caregivers learn about the health and mental health issues and needs of children and teens in foster care.

Casey Family Programs – Foster parent resources

http://www.casey.org/Families/FosterParents/Resources.htm

Casey Family Programs is the nation's largest operating foundation focused entirely on foster care. The website has information on mental health issues related to foster care.

Child Welfare Information Gateway

http://www.childwelfare.gov

This website provides access to information and resources to help protect children and strengthen families. It covers a wide range of topics including mental health issues and child abuse and neglect. It is a service of the Administration for Children and Families, U.S. Department of Health and Human Services.

Child Welfare League of America (CWLA)

http://www.cwla.org/programs/bhd/mhdefault.htm

Child Welfare League of America is the nation's oldest and largest membership-based child welfare organization. It offers information and resources on various topics, including mental health issues.

National Foster Parent Association

http://nfpaonline.org/

The National Foster Parent Association is a nonprofit organization established to meet the needs of foster families. Its website includes resources for foster parents and links to state foster care associations.

National Indian Child Welfare Association (NICWA)

http://www.nicwa.org/resources/

NICWA is dedicated to improving the lives of American Indian children and families, which includes addressing the issues of child abuse and neglect. Its publication *Ensuring the Seventh Generation: A Youth Suicide Prevention Toolkit for Tribal Child Welfare Programs* is available at http://www.nicwa.org/YouthSuicidePreventionToolkit/documents/YSPToolkit.pdf

References

Centers for Disease Control and Prevention (CDC). (2010). *Web-based injury statistics query and reporting system* (WISQARS). Retrieved February 3, 2014, from http://www.cdc.gov/injury/wisqars/fatal.html

Centers for Disease Control and Prevention (CDC). (2012). *Web-based injury statistics query and reporting system* (WISQARS). Retrieved February 3, 2014, from http://www.cdc.gov/injury/wisqars/nonfatal.html

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association 286*(24), 3089–3096. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=194504

Harvard School of Public Health (HSPH). (n.d.). Means Matter website. Retrieved from http://www.hsph.harvard.edu/means-matter/

National Suicide Prevention Lifeline. (n.d.). *What are the warning signs for suicide?* Retrieved from http://www.suicidepreventionlifeline.org/Learn/WarningSigns

Pecora, P. J., Kessler, R. C., Williams, J., O'Brien, K., Downs, A. C., English, D., . . . Holmes, K. (2005). *Improving family foster care: Findings from the Northwest Foster Care Alumni Study.* Seattle, WA: Casey Family Programs. Retrieved from http://www.casey.org/Resources/Publications/pdf/ImprovingFamilyFosterCare_FR.pdf

Pecora, P. J., White, C. R., Jackson, L. J., & Wiggins, T. (2009). Mental health of current and former recipients of foster care: A review of recent studies in the USA. *Child & Family Social Work, 14,* 132–146. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2206.2009.00618.x/abstract

Pilowsky, D. J., & Wu, L. (2006). Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved with foster care, *Journal of Adolescent Health, 38*(4), 351–358. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1472845/

Revised March 2014

The Suicide Prevention Resource Center is supported by a grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 5U79SM059945.

Suicide Prevention Resource Center

Web: http://www.sprc.org • E-mail: info@sprc.org • Phone: 877-GET-SPRC (438-7772)

Page Intentionally left Blank for Printing

Session 4: Addressing the Mental Health of Youth

"Helping Youth at Risk for Suicide"
Competency Worksheet

1. Many young people who are thinking of killing themselves show warning signs.
   - ☐ True
   - ☐ False

2. Foster Parents should regularly report their observations of their youth's mood and behaviors to the youth's social worker, (Certifier, JPPO) or staff member at the foster care agency. (Especially if the behavior is new, has increased and/or seems related to a painful event, loss or change.)
   - ☐ True
   - ☐ False

3. If you are unsure about whether or not a youth should be referred to a mental health professional for evaluation of suicidal risk, then you should refer.
   - ☐ True
   - ☐ False

4. Name three behaviors that should prompt immediate action:

   _____

   _____

   _____

5. If a youth is in imminent danger of suicide, the foster parent should_____.
If there is immediate potential for self-harm then_____ should be called.

6. Name 5 of the most common risk factors for youth in foster care.

   _____

   _____

   _____

   _____

   _____

7. Asking youth if they have thought about suicide increases their risk.
   - ☐ True
   - ☐ False

8. Which of the following strategies can help reduce the risk of suicide and promote a Youth's mental health?

    a) ☐ Encourage youth to talk with you
    b) ☐ Be available and remind the youth you are there to listen when he/she is ready
    c) ☐ Ask specific questions in a way that does not judge or threaten the youth
    d) ☐ All of the above

Important Reminder: It is not up to the foster parent to decide whether or not a youth is at risk, let the professionals make the call.

As an OYA foster parent and per Oregon Administrative Rules (Division 530), foster parents must understand and implement suicide prevention techniques and reporting requirements.

In regards to foster parents providing a safe environment and also per Oregon Administrative Rules (Division 530):

- Firearms must remain unloaded and stored in a locked gun safe or behind double locks that prohibit access and visibility to youth offenders. For purposes of this rule, a double lock may be a locked compartment within a locked room. Ammunition must be stored in a separate locked compartment, separate from any firearm. Trigger locks and glass front display cabinets are not adequate.
- All medications must be stored in locked storage sufficient to prevent unauthorized access.
- All alcoholic beverages, marijuana, and marijuana paraphernalia must be stored and locked in a manner sufficient to prevent access by youth offenders.
- Foster parents and members of the household may not provide any form of tobacco, inhalant delivery system, alcohol, marijuana, drug paraphernalia, or illicit drugs to youth offenders, or allow youth offenders to consume or use such items or products.

Foster Parent Signature: Date:

Foster Parent Signature: Date:

Certifier Signature: _____ Date: _____

UNDERSTANDING ANXIETY DISORDERS

Caregiver: Get the Facts

What does it mean when a health care professional says "anxiety disorder"?

"When I learned my daughter was diagnosed with anxiety I felt relief. I was relieved because I now better understood the behaviors she exhibited as a child. I have learned to recognize the signs and can assist her better."

—Regina, Parent

Anxiety Disorders

Hearing a health care professional say your youth or young adult has an anxiety disorder can be confusing. The good news is that the emotions and behaviors you have been concerned about are actually symptoms of a treatable disorder. By engaging in treatment and entering recovery, people with an anxiety disorder can manage their symptoms and feel better. Recovery does not necessarily mean a cure. It does mean people are actively moving towards wellness.

It is important to talk with a health care provider about treatment options and additional information. Your provider may be a child and adolescent psychiatrist, general psychiatrist, psychologist, pediatrician, social worker, or other health care provider. If you are concerned that your youth or young adult may have an anxiety disorder, it is important to seek a thorough evaluation. The evaluation includes talking about their symptoms, and conducting blood and urine tests, and perhaps other tests to ensure that there is no underlying medical condition that could be causing the symptoms. It is also important to ensure that your youth or young adult can tolerate medication, if recommended as part of a treatment plan.

What do we mean by recovery?

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.[1]

Recovery focuses on wellness and resilience, encouraging [people] to participate actively in their own care.[2]

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

What is an anxiety disorder?

People with anxiety disorders worry excessively. These feelings go well beyond the typical kind of worry that is appropriate to life situations and can help people focus and be alert. The apprehensiveness that your youth or young adult feels with an anxiety disorder occurs almost daily and may be overwhelming. Symptoms of an anxiety disorder include restlessness, a heart-pounding sensation, muscle tension and fatigue, irritability, difficulty concentrating, and/or sleep disturbances. These feelings are severe enough to interfere with day-to-day functioning in school, at work, or in social situations.

There are 3 types of anxiety disorders: generalized anxiety disorder (GAD), phobias, and panic disorders. Some youth and young adults have milder forms of anxiety disorders that do not last forever and respond well to treatment. Others with more severe forms of anxiety disorders may experience lifelong symptoms, with the specific type of anxiety changing over time or including mood symptoms. However, treatments for an anxiety disorder that involve medications, psychotherapy, and other elements of an individualized treatment program can help your youth or young adult to be more resilient, manage symptoms, improve everyday functioning, and help them to lead a full, meaningful life. An individualized treatment program can include positive family and peer support.

What caused this?

Researchers and health care professionals do not completely understand what causes anxiety disorders. It is unlikely that a single factor causes an anxiety disorder. It is most likely caused by a combination of things such as genetics (i.e. family history of anxiety disorders), chemical or other changes in the brain, and/or environmental factors. Traumatic experiences can also contribute to the development of psychiatric disorders. If your child has experienced a traumatic incident, it is critical to share that information with their mental health specialist and pediatrician.

Should I have known?

It is very difficult for parents and caregivers to know if their youth or young adult is acting like a typical youth or young adult or if their moods and behaviors are actually symptoms of an anxiety disorder. Teenagers may be moody or withdrawn at times and are sometimes reluctant to talk openly about emotions or behaviors. Perhaps you tried to ask questions but were not able to get answers. Working with a trained health care professional is important to help you and your youth or young adult understand whether or not they have an anxiety disorder and how to start moving forward.[4]

What do we mean by resilience?

Resilience is the ability to respond to stress, anxiety, trauma, crisis, or disaster. It is critical in recovery [from mental disorders].[3]

What are the treatment approaches?

An anxiety disorder can be managed in many ways. This includes the use of psychotherapy or a combination of medication(s) and therapy. You should discuss treatment options with your youth or young adult and their health care provider, and make decisions based on individual health goals and priorities. Youth or young adults of consenting age may need to provide written consent for parents or caregivers to participate on the treatment team. Decisions may be made based on many factors, including the severity of symptoms, but should always account for your youth or young adult's health goals, priorities, and ambitions. It is important to talk to your health care providers about other types of treatment, such as complementary medicine, as well as programs that can provide additional support related to education, employment, housing, and vocation and career development. It is also important to encourage good self-care, such as a healthy diet, exercise, sleep, and abstinence from illicit drugs. Understanding how treatment works will help you to play an active role in your youth or young adult's recovery.

> "Connect with a family support organization because you will need that peer-to-peer support. Do not feel ashamed or blame yourself for your child's mental health diagnosis."
>
> *—Muriel, Parent*

Medications

Medications (particularly a class of medications called selective serotonin reuptake inhibitors or SSRIs) can help manage many of the symptoms of an anxiety disorder. Each person reacts differently to these medications. For that reason, the prescribing health care professional may try different doses and different kinds of medication before finding the most effective approach for your youth or young adult. Finding the best medication and the most effective dose for your youth or young adult may take time. In milder cases of anxiety disorders, medication may not be necessary. Therapy or lifestyle changes (e.g., smoking cessation, decreased caffeine intake, regular exercise, or mindfulness exercises) may be sufficient to manage symptoms.

Therapy

Health care professionals may recommend behavioral therapy, cognitive behavioral therapy, or other forms of psychotherapy as stand alone treatment or in combination with medications depending on severity of symptoms. Psychotherapy helps your youth or young adult develop behaviors and daily routines that can protect them from experiencing frequent, severe, or prolonged symptoms.

Support

Peer and family support is also an important part of treatment for an anxiety disorder. Positive family members, caregivers, and peers can be part of a comprehensive treatment team. As a partner on this team, you can provide important support and encouragement to help your youth or young adult stay focused on reaching their treatment and recovery goals. Additionally, talking with other caregivers who also have a child diagnosed with an anxiety disorder can help you to learn more and know what to expect. You may benefit from having someone further along in the process with whom to discuss your own questions, thoughts, and feelings.

Is this my fault?

No, it is not. Decades of medical research provide evidence that anxiety disorders and other mental disorders can be the result of a complex interaction of genetics and biological, environmental, social, physical, and emotional influences. None of the contributing factors alone are sufficient to cause a mental disorder. Your youth or young adult is not to blame and neither are you.

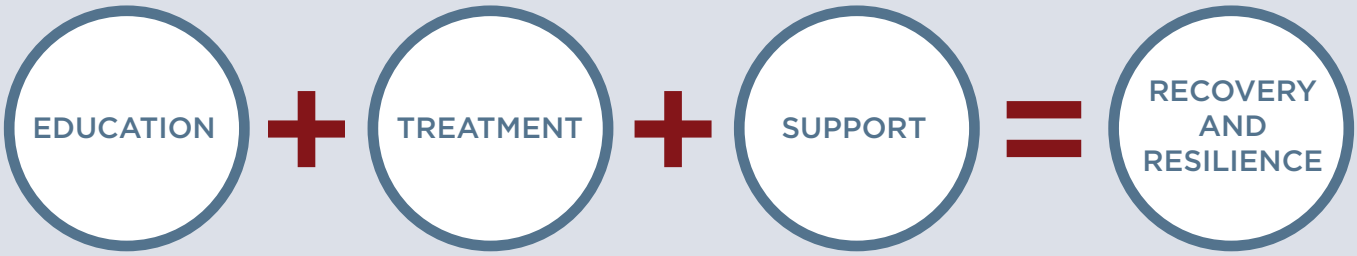
How common is this disorder?

Anxiety disorders represent one of the most common forms of mental disorders among children and adolescents, but they often go undetected or untreated. Data from the Centers for Disease Control and Prevention show that the rate of anxiety disorders among 3-17-year-olds is in the range of 3 percent (current symptoms) to 4.7 percent (ever reported having anxiety).[4]

How can I help?

Parents, caregivers, and family members can be important partners in treatment and recovery from an anxiety disorder. You can play a major role by monitoring symptoms and responses to medication changes and encouraging your youth or young adult to stick with their treatment and treatment plan. Alert your health care providers about your youth or young adult's symptoms, such as any particular fears or phobias, including social situations, insomnia, or persistent low mood, as well as if he or she uses drugs, excessive caffeine, nicotine, or alcohol. Seek help immediately if your youth or young adult has thoughts or plans of harming themselves or others (For more information, see the hotline and website below*). There is significant evidence that your involvement can improve treatment outcomes. Your own self-care is also an important part of caring for a child with a mental health disorder. Self-care may include talking to your own mental health professional, friends, or family, as well as joining a local support group through the National Federation of Families for Children's Mental Health or the National Alliance on Mental Illness, exercising, getting a good night's sleep, or meditation.

*** National Suicide Prevention Lifeline: 1-800-273-TALK (8255). http://www.suicidepreventionlifeline.org**



Where can I learn more and get support?

American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Anxiety_Disorder_Resource_Center/Home.aspx

Anxiety and Depression Association of America (ADAA)
http://adaa.org

Find Youth Info
http://www.findyouthinfo.gov

Mental Health America
http://www.mentalhealthamerica.net

National Alliance on Mental Illness
http://www.nami.org/Learn-More/Mental-Health-Conditions/Anxiety-Disorders

National Institute of Mental Health
http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

National Center for Complementary & Integrative Health
https://nccih.nih.gov/health/integrative-health

National Federation of Families for Children's Mental Health
http://www.ffcmh.org/

National Suicide Prevention Lifeline
http://www.suicidepreventionlifeline.org
1-800-273-TALK (8255)

Ok2Talk
http://ok2talk.org

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/disorders/mental

Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline
http://www.samhsa.gov/find-help/national-helpline

The Family Run Executive Director Leadership Association
http://www.fredla.org

SAMHSA would like to thank the American Academy of Child and Adolescent Psychiatry, the American Psychological Association, the American Psychiatric Association, and the Caring for Every Child's Mental Health Campaign Family and Young Adult Councils for their collaboration in developing and disseminating this fact sheet. This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number HHSS280201500007C, with SAMHSA, U.S. Department of Health and Human Services. Lisa Rubenstein served as the Project Manager and Eric Lulow served as the Government Project Officer.

REFERENCES:

[1] (2012). *SAMHSA's Working Definition of Recovery.* SAMHSA.

[2] American Psychiatric Association. (2005). *Position Statement on Use of the Concept of Recovery.*

[3] (2013). *SAMHSA Annotated Bibliography.*

[4] Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., et al. (2013). *Mental Health Surveillance Among Children – United States, 2005-2011.* Retrieved from: http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm?s_cid=su6202a1_w

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

HHS Publication No. (SMA) 16-5009

UNDERSTANDING ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER

Caregiver: Get the Facts

What does it mean when a health care professional says "attention-deficit/ hyperactivity disorder"?

Hearing a health care professional say your youth or young adult has attention-deficit/hyperactivity disorder (ADHD) can be confusing. The good news is that the emotions and behaviors you have been concerned about are actually symptoms of a treatable disorder. By engaging in treatment and entering recovery, people with ADHD can manage their symptoms, concentrate better, and be more successful in their everyday lives. Recovery does not necessarily mean a cure. It does mean that people are actively moving toward wellness.

Getting information about your child's diagnosis is one of the most critical tools you will need for the journey that you are going to embark upon. Far too many parents depend on the "experts" to tell them everything about their child's diagnosis, but your own research will help you and your family better understand the diagnosis.

—Regina, Parent

It is important to talk with a health care provider about treatment options and additional information. Your provider may be a child and adolescent psychiatrist, general psychiatrist, psychologist, pediatrician, social worker, or other health care provider. If you are concerned that your youth or young adult may have ADHD, it is important to seek a thorough evaluation. The evaluation includes talking about their symptoms, blood and urine tests, and perhaps other tests to ensure that there is no underlying medical condition that could be causing the symptoms. Additionally, neuropsychological and/or psychosocial testing of ADHD can be helpful in determining a diagnosis. It is also important to ensure that your youth or young adult can tolerate medication, if recommended as part of a treatment plan.

What do we mean by recovery?

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.[1]

Recovery focuses on wellness and resilience, encouraging [people] to participate actively in their own care.[2]

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

What is ADHD?

ADHD involves a persistent pattern of inattentive and/or hyperactive and impulsive behavior. These behaviors interfere with day-to-day activities in school, at work, or in social situations. A person with ADHD has a hard time paying attention, following instructions, and organizing and carrying out activities. People with ADHD often lose things, are forgetful, and are easily distracted. Hyperactive behavior includes things like difficulty waiting or taking turns, fidgeting or squirming, always feeling "on the go," and not being able to sit still. People with ADHD may interrupt others, talk excessively, and express feelings of being "driven." The diagnosis of ADHD can be made in older youth and adults. However, for the diagnosis of ADHD, symptoms must have appeared prior to age 12. Youth and young adults who develop ADHD may not be hyperactive initially. Rather, they have trouble managing behavior, paying attention, and following instructions.

ADHD is typically an ongoing disorder. In adolescence and adulthood, the hyperactive symptoms will diminish but the organizational and attentional challenges will persist. However, treatments that involve medications and other elements of an individualized treatment program can help your youth or young adult improve their coping skills (become more resilient), manage symptoms, improve everyday functioning, and lead a productive and meaningful life. An individualized treatment program can include positive family and peer support or specialized educational programming.

What caused this?

Researchers and health care professionals do not completely understand what causes ADHD. It is unlikely that a single factor causes ADHD. It is most likely caused by a combination of things such as genetics (i.e., family history of ADHD), chemical or other changes in the brain, and/or environmental factors. Traumatic experiences can also contribute to the development of psychiatric disorders. If your child has experienced a traumatic incident, it is critical to share that information with their mental health specialist and pediatrician.

Should I have known?

It is very difficult for parents and caregivers to know if their youth or young adult have behaviors that are consistent with ADHD. Working with trained health care professionals is important to help assess your youth or young adult and to discuss how to best approach treatment.

What do we mean by resilience?

Resilience is the ability to respond to stress, anxiety, trauma, crisis, or disaster. It is critical in recovery [from mental disorders].[3]

What are the treatment approaches?

ADHD can be managed in many ways. This includes the use of behavioral therapy or a combination of medication and behavioral therapy. You should discuss treatment options with your youth or young adult and their health care provider, and make decisions based on individual health goals and priorities. Youth or young adults of consenting age may need to provide written consent for parents or caregivers to participate on the treatment team. It is important to talk to your child's health care providers about other types of treatment, such as complementary medicine, as well as programs that can provide additional support related to education, employment, housing, and vocation and career development. It is also important to encourage good self-care, such as a healthy diet, exercise, sleep, and abstinence from illicit drugs. Understanding the treatment for ADHD will help you play an active role in your youth or young adult's recovery.

I found that working with my child's health care professionals, reassuring my child they will get better, and taking care of myself were the best ways to keep our family moving forward.

—Jane, Parent

Medications

Medications can help manage many of the symptoms of ADHD. Stimulant medications are the primary treatment for ADHD. Each person reacts differently to these medications. For that reason, the prescribing health care professional may try different doses and different kinds of medication before finding the most effective approach. Finding the best medication and the most effective dose may take time. For some people with mild symptoms of ADHD, the health care professional may not need to prescribe medication.

Therapy

Health care professionals may recommend behavioral therapy and parent management training as stand alone treatment or in combination with medications. Therapy may help your youth or young adult develop behaviors and daily routines that can reduce the symptoms of ADHD. It can also help you develop strategies to support your youth with ADHD.

Support

Peer and family support are also important for people with ADHD. Family members and caregivers with positive attitudes, and peers who are recovering from similar disorders, can be great assets to the team or your youth or young adult with ADHD. As a partner on this team, you can help to identify problems early and provide important support and encouragement to help your youth or young adult comply with recommended medications. You can also help them stay focused on their recovery goals. Additionally, talking with other caregivers who also have a child diagnosed with ADHD can help you to learn more and know what to expect. You may benefit from having someone further along in the process with whom to discuss your own questions, thoughts, and feelings.

Is this my fault?

No, it is not. Decades of medical research provide evidence that ADHD and other mental disorders can be the result of a complex interaction of genetics and biological, environmental, social, physical, and emotion-al influences. None of the contributing factors alone are sufficient to cause a mental illness. Your youth or young adult is not to blame and neither are you.

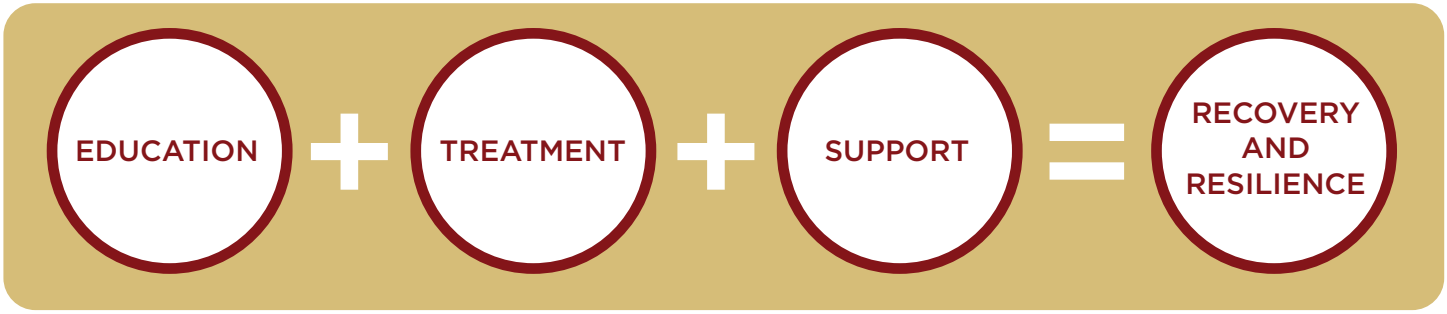
How common is this disorder?

Data from the Centers for Disease Control and Prevention show that the rate of ADHD among 3-17 year-olds is in the range of 6.8 percent to 8.9 percent.[4]

How can I help?

Parents, caregivers, and family members can be important partners in treatment and recovery from ADHD. You can play a major role by monitoring symptoms and response to medication changes and encouraging your youth or young adult to stick with their treatment and treatment plan. It is also important to alert health care providers if your youth or young adult uses drugs, excessive caffeine, nicotine, or alcohol. Seek immediate help if your youth or young adult has thoughts or plans of harming themselves or others. (For more information, see the hotline and website below*). The health care professionals and counselors working with your youth or young adult value your role in treatment. Please monitor for, and encourage youth to share information about any other health conditions or attempts to self-medicate symptoms. There is significant evidence that your involvement can improve treatment outcomes. Your own self-care is also an important part of caring for a child with a mental health disorder. Self-care may include talking to your own mental health professional, friends, or family, as well as joining a local support group through the National Federation of Families for Children's Mental Health or the National Alliance on Mental Illness, exercising, getting a good night's sleep, or meditation.

*** National Suicide Prevention Lifeline: 1-800-273-TALK (8255). http://www.suicidepreventionlifeline.org**



Where can I learn more and get support?

American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Anxiety_Disorder_Resource_Center/Home.aspx

Children and Adults with Attention-Deficit/Hyperactivity Disorder
http://www.chadd.org

Find Youth Info
http://www.findyouthinfo.gov

Mental Health America
http://www.mentalhealthamerica.net

National Alliance on Mental Illness
http://www.nami.org/Learn-More/Mental-Health-Conditions/ADHD

National Center for Complementary & Integrative Health
https://nccih.nih.gov/health/integrative-health

National Institute of Mental Health
http://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml

National Suicide Prevention Lifeline
http://www.suicidepreventionlifeline.org
1-800-273-TALK (8255)

Ok2Talk
http://ok2talk.org

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/disorders/mental

Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline:
http://www.samhsa.gov/find-help/national-helpline

Teen Mental Health
http://teenmentalhealth.org/learn/mental-disorders/adhd

Youth Motivating Others through Voices of Experience
http://www.youthmovenational.org

SAMHSA would like to thank the American Academy of Child and Adolescent Psychiatry, the American Psychological Association, the American Psychiatric Association, and the Caring for Every Child's Mental Health Campaign Family and Young Adult Councils for their collaboration in developing and disseminating this fact sheet. This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number HHSS280201500007C, with SAMHSA, U.S. Department of Health and Human Services. Lisa Rubenstein served as the Project Manager and Eric Lulow served as the Government Project Officer.

REFERENCES:

[1] (2012). *SAMHSA's Working Definition of Recovery.* SAMHSA.

[2] American Psychiatric Association. (2005). *Position Statement on Use of the Concept of Recovery.*

[3] (2013). *SAMHSA Annotated Bibliography.*

[4] Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., et al. (2013). *Mental Health Surveillance Among Children – United States, 2005-2011.* Retrieved from: http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm?s_cid=su6202a1_w

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

HHS Publication No. (SMA) 16-5011

UNDERSTANDING BIPOLAR DISORDER

Caregiver: Get the Facts

What does it mean when a health care professional says "bipolar disorder"?

Hearing a health care professional say your youth or young adult has bipolar disorder can be confusing. The good news for you and your young adult is that the feelings and behaviors you have been concerned about are actually symptoms of a treatable disorder. By engaging in treatment and recovery, people with bipolar disorder can feel better and lead full, meaningful lives. Recovery does not necessarily mean a cure. It does mean that people are actively moving toward wellness.

> "As a parent, learning that my child has a mental disorder brought a mixture of relief that I finally understand my child's behavior and also questions about how to help my child."
>
> *—Jane, Parent*

It is important to talk with a health care provider about treatment options and additional information. Your provider may be a child and adolescent psychiatrist, general psychiatrist, psychologist, pediatrician, social worker, or other health care provider. If you are concerned that your youth or young adult may have bipolar disorder, it is important to seek a thorough evaluation. The evaluation includes talking about their symptoms, blood and urine tests, and perhaps other tests to ensure that there is no underlying medical condition that could be causing the symptoms. It is also important to ensure that your youth or young adult can tolerate medication, if recommended as part of the treatment plan.

What do we mean by recovery?

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.[1]

Recovery focuses on wellness and resilience, encouraging [people] to participate actively in their own care.[2]

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

What is bipolar disorder?

Bipolar disorder refers to a spectrum of disorders that involve unusual changes in mood, activity, and energy. These changes in mood or behavior are different than the typical "highs" and "lows" that all youth and young adults experience.

In bipolar disorder, the "highs" (sometimes called manic episodes or, in less severe cases, hypomanic episodes) are marked by a combination of symptoms. This may include:

- restlessness,
- irritability,
- excessive energy and activity,
- decreased need for sleep,
- rapid talking and racing thoughts,
- poor judgment and risky behavior,
- and a feeling that nothing can go wrong.

The "lows" (sometimes called depressive episodes) may involve feelings of:

- constant sadness or anxiety,
- changes in appetite or sleep patterns,
- low energy,
- restlessness,
- irritability,
- thoughts about death,
- and loss of interest in favorite or pleasurable activities.

A diagnosis of bipolar disorder means that the manic or depressive moods last at least a week, are present most of the day nearly every day, and seriously interfere with regular activities in school, at work, or in social situations. In between episodes, people return to their usual thoughts and behaviors.

Bipolar disorder is typically an ongoing and recurrent disorder. However, treatments that involve medications and other elements of an individualized treatment program can help your youth or young adult to be more resilient, manage symptoms, improve daily functioning, and help them to lead a full, meaningful life. An individualized treatment program can include positive family and peer support.

What caused this?

Researchers and health care professionals do not completely understand what causes bipolar disorder. It is unlikely that a single factor causes bipolar disorder. It is most likely caused by a combination of things such as genetics, changes in the brain, and environmental factors. Traumatic experiences can also contribute to the development of psychiatric disorders. If your youth or young adult has experienced a traumatic incident, it is critical to share that information with their health care provider.

Should I have known?

It is very difficult for parents and caregivers to know if their youth or young adult is acting like a typical youth or young adult, or if his or her moods and behaviors are symptoms of a disorder like bipolar disorder. Typical teenagers may be moody, and are reluctant sometimes to talk openly about emotions or behaviors. Perhaps you tried to ask questions, but were not able to get answers. Working with a trained health care professional is important to help your youth or young adult—and you—understand how to start moving forward.

What do we mean by resilience?

Resilience is the ability to respond to stress, anxiety, trauma, crisis, or disaster. It is critical in recovery [from mental disorders].[3]

What are the treatment approaches?

Bipolar disorder can be managed with a combination of medications, behavioral therapy, and family or peer support. You should discuss treatment options with your youth or young adult and their health care provider, and make decisions based on individual health goals and priorities. Youth or young adults of consenting age may need to provide written consent for parents or caregivers to participate on the treatment team. It is important to talk to your child's health care providers about other types of treatment, such as complementary medicine, as well as programs that can provide additional support related to education, employment, housing, and vocation and career development. It is also important to encourage good self-care, such as a healthy diet, exercise, sleep, and abstinence from illicit drugs. Understanding how treatment works will help you play an active role in your youth or young adult's recovery.

> "Educate yourself. Learn about the diagnosis so you can make informed decisions when it comes to the treatment of your children. Find someone, a support group, a family organization, some kind of support that understands the feelings you are having."
>
> *—Andrea, Parent*

Medications

Medications that regulate levels of chemical messengers in the brain can help manage many of the symptoms of bipolar disorder. Each person reacts differently to these medications. For that reason, the prescribing health care professional may try different doses and different kinds of medication before finding the most effective approach. It is important to note that medications must be taken every day. Finding the best medication and the most effective dose may take time. In mild or moderate cases of bipolar disorder, the health care professional may not need to prescribe medication.

Therapy

Behavioral therapy, cognitive behavioral therapy, or other forms of psychotherapy, (e.g., dialectical behavioral therapy, or DBT, has shown evidence of being effective for some of the symptoms associated with bipolar disorder) may be used alone or in combination with medications. Therapy also helps your youth or young adult develop behaviors and daily routines that can protect them from experiencing severe or prolonged symptoms.

Support

Peer and family support are also important for people with bipolar disorder. Family members and caregivers with positive attitudes, and peers who are recovering from similar disorders, can be great assets to a comprehensive treatment team. As a partner on this team, you can help to identify problems early and provide important support and encouragement to help your youth or young adult comply with recommended medications. You can also help them stay focused on their recovery goals. Additionally, talking with other caregivers who also have a child diagnosed with bipolar disorder can help you to learn more and know what to expect. You may benefit from having someone further along in the process with whom to discuss your own questions, thoughts, and feelings.

Is this my fault?

No, it is not. Decades of medical research provide evidence that bipolar and other mental disorders can be the result of a complex interaction of genetics and biological, environmental, social, physical, and emotional influences. None of the contributing factors alone are sufficient to cause a mental disorder. Your youth or young adult is not to blame and neither are you.

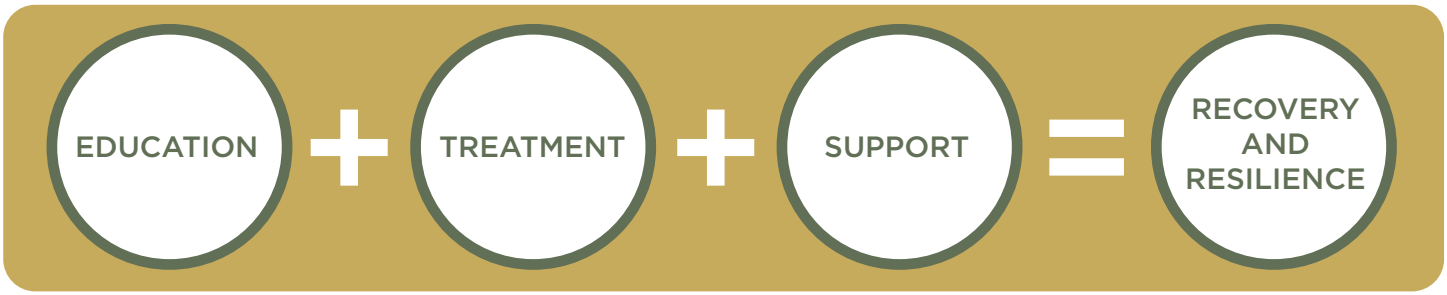
How common is this disorder?

Data from the National Comorbidity Survey show that the rate of bipolar disorder among 15- to 29-year-olds is in the range of 3.1 percent to 7.0 percent.[4]

How can I help?

Parents, caregivers, and family members can be important partners in treatment and recovery from bipolar disorder. You can play a major role by monitoring symptoms and responses to medication changes and encouraging your youth or young adult to stick with their treatment plan. Alert your health care providers about your youth or young adult's symptoms, such as any particular fears or phobias, including social situations, insomnia, or persistent low mood, as well as if they use drugs, excessive caffeine, nicotine, or alcohol. Seek help immediately if your youth or young adult has thoughts or plans of harming themselves or others (For more information, see the hotline and website below*). There is significant evidence that your involvement can improve treatment outcomes. Your own self-care is also an important part of caring for a child with a mental health disorder. Self-care may include talking to your own mental health professional, friends, or family, as well as joining a local support group through the National Federation of Families for Children's Mental Health or the National Alliance on Mental Illness, exercising, getting a good night's sleep, or meditation.

*** National Suicide Prevention Lifeline: 1-800-273-TALK (8255). http://www.suicidepreventionlifeline.org**



Where can I learn more and get support?

American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Bipolar_Disorder_Resource_Center/Home.aspx

Depression and Bipolar Support Alliance
http://www.dbsalliance.org

Find Youth Info
http://www.findyouthinfo.gov

Mental Health America
http://www.mentalhealthamerica.net

National Alliance on Mental Illness
http://www2.nami.org/Content/NavigationMenu/Mental_Illnesses/Bipolar1/Home_-_What_is_Bipolar_Disorder_.htm

National Center for Complementary & Integrative Health
https://nccih.nih.gov/health/integrative-health

National Federation of Families for Children's Mental Health
http://www.ffcmh.org/

National Institute of Mental Health
http://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml
http://www.nimh.nih.gov

National Suicide Prevention Lifeline
http://www.suicidepreventionlifeline.org
1-800-273-TALK (8255)

Ok2Talk
http://ok2talk.org

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/disorders/mental

Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline
http://www.samhsa.gov/find-help/national-helpline

The Family Run Executive Director Leadership Association
http://www.fredla.org

Teen Mental Health
http://teenmentalhealth.org/learn/mental-disorders/bipolar-disorder-2

The Storm in My Brain
http://www.dbsalliance.org/pdfs/storm.pdf

Youth Motivating Others through Voices of Experience:
http://www.youthmovenational.org

SAMHSA would like to thank the American Academy of Child and Adolescent Psychiatry, the American Psychological Association, the American Psychiatric Association, and the Caring for Every Child's Mental Health Campaign Family and Young Adult Councils for their collaboration in developing and disseminating this fact sheet. This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number HHSS280201500007C, with SAMHSA, U.S. Department of Health and Human Services. Lisa Rubenstein served as the Project Manager and Eric Lulow served as the Government Project Officer.

REFERENCES:

[1] (2012). *SAMHSA's Working Definition of Recovery.* SAMHSA.

[2] American Psychiatric Association. (2005). *Position Statement on Use of the Concept of Recovery.*

[3] (2013). *SAMHSA Annotated Bibliography.*

[4] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 593-602.

[5] Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime Prevalence of Mental Disorders in US Adolescents: Results from the National Comorbidity Study - Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry 49*(10), 980-989.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

HHS Publication No. (SMA) 16-5007

UNDERSTANDING DEPRESSION

Caregiver: Get the Facts

What does it mean when a heath care professional says "depression"?

Hearing a health care professional say your youth or young adult has depression can be confusing. The good news is that the emotions and behaviors you have been concerned about are actually symptoms of a treatable disorder. By engaging in treatment and entering recovery, people with depression can feel better and lead full, meaningful lives. Recovery does not necessarily mean a cure. It does mean that people are actively moving toward wellness.

> "Once we knew what it was, we were able to educate ourselves and work toward supporting him to live a happy, healthy life."
>
> *— Malisa, Parent*

It is important to talk with a health care provider about treatment options and additional information. Your provider may be a child and adolescent psychiatrist, general psychiatrist, psychologist, pediatrician, social worker, or other health care provider. If you are concerned that your youth or young adult may have depression, it is important to seek a thorough evaluation. The evaluation includes talking about their symptoms, blood and urine tests, and perhaps other tests to ensure that there is no underlying medical condition that could be causing the symptoms. It is also important to ensure that your youth or young adult can tolerate medication, if recommended as part of a treatment plan.

What do we mean by recovery?

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.[1]

Recovery focuses on wellness and resilience, encouraging [people] to participate actively in their own care.[2]

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

What is depression?

Depression is a mental disorder that is marked by a sad, empty, hopeless, or helpless mood that is present almost every day and lasts most of the day for at least two weeks. Everyone feels sad or anxious from time to time; however, the feelings associated with depression are far more intense and long lasting than the "ups and downs" of everyday life. The feelings interfere with day-to-day activities in families, school, at work, or in other social situations. Sometimes depression involves irritability. Depression may also involve physical symptoms such as fatigue, sleep difficulties, and weight changes. It can also be the cause of hopelessness, guilt, and suicidal thoughts.

Depression may happen in a single episode or be a recurrent condition. An individual could be diagnosed with major depression (which can be mild, moderate or severe) or persistent depression. However, youth and young adults can be resilient. Treatments that involve medications, psychotherapy, and other elements of an individualized treatment program can help your youth or young adult improve their coping skills, manage symptoms, improve daily functioning, and go on to lead a full and meaningful life. An individualized treatment program can include positive family or peer support.

What caused this?

Researchers and health care professionals do not completely understand what causes depression. It is unlikely that a single factor causes depression. It is most likely caused by a combination of things such as genetics (i.e., family history of someone having depression), chemical changes in the brain, and/or environmental factors. Traumatic experiences can also contribute to the development of psychiatric disorders. If your child has experienced a traumatic incident, it is critical to share that information with their mental health specialist and pediatrician.

Should I have known?

It is very difficult for parents and caregivers to know if their youth or young adult is acting like a typical youth or young adult or if their moods and behaviors are actually symptoms of depression. Teenagers may be moody and are reluctant sometimes to talk openly about emotions or behaviors. Perhaps you tried to ask questions but were not able to get answers. Working with a trained health care professional is important to help assess your youth or young adult's situation and understand how to start moving forward.

What do we mean by resilience?

Resilience is the ability to respond to stress, anxiety, trauma, crisis, or disaster. It is critical in recovery [from mental disorders].[3]

What are the treatment approaches?

Depression can be best managed by one or more of the following interventions: medication(s), behavioral therapy, and family or peer support, depending on the level of impairment. You should discuss treatment options with your youth or young adult and their health care provider, and make decisions based on individual health goals and priorities. Youth or young adults of consenting age may need to provide written consent for parents or caregivers to participate on the treatment team. Decisions should be made based on several factors and should always include your youth or young adult's health goals and ambitions. It is important to talk to your child's health care providers about other types of treatment, such as complementary medicine, as well as programs that can provide additional support related to education, employment, housing, and vocation and career development. It is also important to encourage good self-care, such as a healthy diet, exercise, sleep, and abstinence, from illicit drugs. Understanding how treatment works will help you to play an active role in your youth or young adult's recovery.

Medications

Medications can help manage many of the symptoms of depression. Each person reacts differently to these medications. For that reason, the prescribing health care professional may try different doses and different kinds of medication before finding the most effective approach for your youth or young adult. To find the most effective approach with the least side-effects for your youth or young adult may take time and patience. For some people with mild symptoms of depression, their health care professional may not prescribe medication. They may suggest initial treatment with therapy.

Therapy

Health care professionals may recommend behavioral therapy, cognitive behavioral therapy (CBT), or other forms of psychotherapy as stand alone treatments or in combination with medications. This kind of treatment helps your youth or young adult to enhance their resiliency skills and develop behaviors and routines that can protect them from experiencing frequent, severe, or prolonged symptoms. The good news is that there are many evidence-based therapies that are effective for treating depression in youth including cognitive behavioral therapy and interpersonal psychotherapy.

Support

Peer and family support are also important for youth or young adults with depression. Family members with positive attitudes, caregivers, and peers who are recovering from similar disorders, can be great assets to a treatment team. As a partner on this team, you can help to identify problems early and provide important support and encouragement to help your youth or young adult to stay focused on reaching their treatment and recovery goals. Additionally, talking with other caregivers who also have a child with depression can help you to learn more and know what to expect. You may benefit from having someone further along in the process with whom to discuss your own questions, thoughts, and feelings.

> **"Find others who have been through what you are going through. Find someone who can walk with you and help navigate the helping systems. Find those who support the idea that there is hope and a brighter future despite the diagnosis."**
>
> *—Shannon, Parent*

Is this my fault?

No, it's not. Decades of medical research provide evidence that depression and other mental health disorders can be the result of a complex interaction of genetics and biological, environmental, social, physical, and emotional influences. None of the contributing factors alone are sufficient to cause depression. Your youth or young adult is not to blame and neither are you.

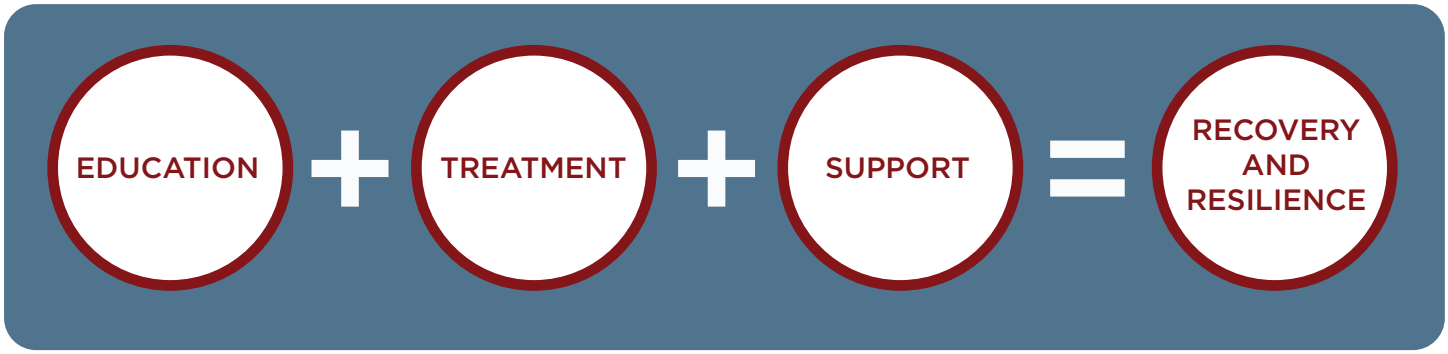
How common is this disorder?

Data from the Substance Abuse and Mental Health Services Administration show that 11.4% of youth, ages 12-17, had at least one major depressive episode in the past year.[4]

How can I help?

Parents, caregivers, and family members can be important partners in treatment and recovery from depression. You can play a major role by monitoring your youth or young adult's symptoms and responses to medication changes, and encouraging them to stick with their treatment and treatment plan. Alert healthcare providers promptly if your youth or young adult uses drugs, excessive caffeine, nicotine, or alcohol—these are frequently an attempt to self-medicate symptoms of depression. Seek help immediately if your youth or young adult has thoughts or plans of harming themselves or others (For more information, see hotline and website below*). There is significant evidence that your involvement can improve treatment outcomes. Your own self-care is also an important part of caring for a child with a mental health disorder. Self-care may include talking to your own mental health professional, friends, or family, as well as joining a local support group through the National Federation of Families for Children's Mental Health or the National Alliance on Mental Illness, exercising, getting a good night's sleep, or meditation.

*** National Suicide Prevention Lifeline: 1-800-273-TALK (8255). http://www.suicidepreventionlifeline.org**



Where can I learn more and get support?

SAMHSA would like to thank the American Academy of Child and Adolescent Psychiatry, the American Psychological Association, the American Psychiatric Association, and the Caring for Every Child's Mental Health Campaign Family and Young Adult Councils for their collaboration in developing and disseminating this fact sheet. This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number HHSS280201500007C, with SAMHSA, U.S. Department of Health and Human Services. Lisa Rubenstein served as the Project Manager and Eric Lulow served as the Government Project Officer.

REFERENCES:

[1] (2012). *SAMHSA's Working Definition of Recovery.* SAMHSA.

[2] American Psychiatric Association. (2005). *Position Statement on Use of the Concept of Recovery.*

[3] (2013). *SAMHSA Annotated Bibliography.*

[4] Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, & RTI International (2015). Results from the 2014 National Survey on Drug Use and Health: Mental Health Detailed Table. Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUH-MHDetTabs2014/NSDUH-MHDetTabs2014.htm

American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Anxiety_Disorder_Resource_Center/Home.aspx

American Academy of Pediatrics—Information for Parents
http://www.healthychildren.org/English/health-issues/conditions/emotional-problems/Pages/Childhood-Depression-What-Parents-Can-Do-To-Help.aspx

American Psychiatric Association
http://www.psychiatry.org/depression

American Psychological Association
http://www.apa.org/topics/depress/index.aspx

Anxiety and Depression Association of America
http://adaa.org

Depression and Bipolar Support Alliance
http://www.dbsalliance.org

Families for Depression Awareness
http://familyaware.org

HelpGuide.Org
http://www.helpguide.org/home-pages/depression.htm

Kids Health-Information for Parents
http://kidshealth.org/parent/emotions/feelings/understanding_depression.html

National Alliance on Mental Illness
http://www.nami.org/Learn-More/Mental-Health-Conditions/Depression

National Center for Complementary & Integrative Health
https://nccih.nih.gov/health/integrative-health

National Federation of Families for Children's Mental Health
https://www.ffcmh.org

National Institute of Mental Health
http://www.nimh.nih.gov

National Suicide Prevention Lifeline
http://www.suicidepreventionlifeline.org
1-800-273-TALK (8255)

Ok2Talk
http://ok2talk.org

Parents Med. Guide: http://www.parentsmedguide.org

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/disorders/mental

Substance Abuse and Mental Health Services Administration (SAMHSA)
National Helpline: http://www.samhsa.gov/find-help/national-helpline

The Family Run Executive Director Leadership Association
http://www.fredla.org

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

HHS Publication No. (SMA) 16-5003

Session 4: Addressing the Mental Health of Youth

"Understanding Anxiety, ADHD, Bipolar Disorders & Depression for Caregivers"
Competency Worksheet

1. Name 3 types of health care providers.

_____

_____

_____

2. What does recovery focus on?

_____

_____

_____

3. Which one is not a symptom of an anxiety disorder?

   ☐ a) Restlessness

   ☐ b) Heart-pounding Sensations

   ☐ c) Depressed Mood

   ☐ d) Muscle Tension

4. Anxiety disorders represent one of the most common forms of mental disorders among children and adolescents, but they often go undetected or untreated.

   ☐ True
   ☐ False

5. Getting information about your child's diagnosis is one of the most critical tools you will need.

   ☐ True

   ☐ False

6. Name 3 things that a youth diagnosed with ADHD, has a hard time with:

_____

_____

_____

7. _____ _____ are the primary treatment for ADHD.

8. Bipolar disorder refers to a spectrum of disorders that involve unusual changes in which three things:

_____

_____

_____

9. Which one is not a symptom of bipolar disorder “high”?

   ☐ a) Restlessness

   ☐ b) Irritability

   ☐ c) Decrease in energy and activity

   ☐ d) Poor judgement and risky behavior

10. Which one is a symptom of bipolar disorder “low”?

   ☐ a) High Energy

   ☐ b) Good Mood

   ☐ c) Thoughts about death

   ☐ d) Increased interest in activities

11. Depression is a mental disorder that is marked by a _____, _____, _____, or _____ mood that is present almost every day and lasts most of the day for at least two weeks.

12. Depression can happen in a single episode or be a recurrent condition?

   ☐ True

   ☐ False

13. The only cause for depression is genetics.

   ☐ True

   ☐ False

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

NCTSN The National Child Traumatic Stress Network

Complex Trauma:

In Juvenile Justice System-Involved Youth

Elizabeth is a 17-year-old Hispanic female whose father was murdered by a drug dealer when she was three years old. After his death, she, her mother, stepfather, and two older sisters lived together in an economically disadvantaged neighborhood. Her stepfather, who left when she turned 12, physically and verbally abused Elizabeth and her other family members. Elizabeth's mother was also verbally and physically abusive toward her.

Elizabeth also remembers being bullied in elementary school. In addition to the direct maltreatment she experienced, she has known several female family members and friends – including her sister and her best friend from preschool – who were sexually assaulted.

Elizabeth first began affiliating with gangs when she was 12 years old and considered them her "real family." She started smoking marijuana heavily after joining the gang and used multiple other substances to get high. At age 13, she assaulted another teen and received 18 months of house arrest. She reports that she "blacked out" during this incident and doesn't remember much of it. She later discovered that she had broken the youth's nose and arm. Despite her lack of recall about that assault, however, she reports that she is haunted by the image of seeing someone shot in the head and watching him die. At the age of 16, she was convicted of drug- and weapons-related offenses and was sentenced to a youth detention center for a year. At the time, she reported that beating people up was part of her gang's expectations for belonging.

As Elizabeth's story illustrates, youth who come to the attention of law enforcement and become involved in the juvenile justice system are often experiencing the after-effects of years of exposure to complex interpersonal trauma. These youth have faced repeated threats to their lives or the lives of people closest to them. Losing key people in their lives, and experiencing betrayals of trust and abandonment from caregivers, compound the violations of the basic social contract that every youth should have an equal opportunity to have a successful life as a valued member of society.

These survival threats and painful emotional (and often also physical) injuries are a part of daily life and second nature for too many youth who become involved with law enforcement and juvenile justice. They also are forms of complex trauma that can have lifelong adverse effects.

More than two-thirds of youth involved with law enforcement or juvenile justice have complex histories of interpersonal trauma, including exposure to neglect, emotional, physical, and sexual abuse, family and community violence, traumatic losses, and disrupted relationships with primary caregivers (Ford, et al., 2013). Many also come from families in which caregivers and siblings are coping with other adversities such as substance abuse, mental health problems, unemployment, or discrimination based on race, ethnicity, sexual identity, or disability, legal problems, or incarceration). Youth from ethnic and racial minorities and those from low-income backgrounds are disproportionately involved in the juvenile justice system and subject to these additional adversities.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

WHAT IS COMPLEX TRAUMA?

The term complex trauma describes both children's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure. These events are severe and pervasive, such as abuse or profound neglect. They usually begin early in life and can disrupt many aspects of the child's development, including the formation of a self. Since these adversities frequently occur in the context of the child's relationship with a caregiver, they can interfere with the child's ability to form a secure attachment bond. Many aspects of a child's healthy physical and mental development rely on this primary source of safety and stability.

PATHWAYS FROM COMPLEX TRAUMA TO INVOLVEMENT IN JUVENILE JUSTICE AND RECIDIVISM

The pathways from complex trauma exposure to involvement in juvenile justice and recidivism are correspondingly complex and variable. **One common denominator is the adoption of an unstated code of behavior.** This "survival code" differs from the established rules of the majority society, and is a direct consequence of traumatic stress on emotional, physiological, and behavioral factors which place youth at increased risk of committing offenses. The experience of complex trauma violates the social contract that lies at the heart of societal laws and structures: the unspoken contract that says that good deeds and behavior are rewarded, that perpetrating harm should and will be punished, and that maintaining order is mutually beneficial. For youth who have experienced repeated violence, violation, exploitation, rejection, and abandonment in their homes, schools, and communities, safety and justice seem impossible to obtain. As a result, the rubric of survival ("What do I have to do to survive?") is likely to trump legality ("Is this behavior appropriate within the laws of my community and society?").

A second common denominator for youth with complex trauma histories who are involved with law enforcement or juvenile justice is difficulty in effectively managing emotions, physical reactions, impulses, attention, consequential thinking (i.e., problem-solving and decision-making based on an awareness of and accurate evaluation of consequences), and involvement in interpersonal relationships (i.e., ranging from extreme isolation to enmeshment in dangerous or exploitive relationships). These are the building blocks for self-regulation, the ability to draw on one's own inner strengths and genuinely supportive relationships in order to channel motivation, manage distress, and think effectively. The development in childhood of these self-regulation capacities is severely undermined by complex trauma.

As a result, these youth often have problems in school, family relationships, and with substance abuse, sexualized behaviors, risky or reckless behavior, delinquency, and running away. On the surface, these behaviors may appear to be motivated by disregard for their own or others' safety and well-being and the law, but actually they are attempts to cope with or prevent further traumatization. Seen from the perspective of these youths' internal realities, their excessive suspiciousness, hostility, defiance, and disconnection from relationships with others may be necessary adaptations in order to prevent further vulnerability, betrayal, and victimization.

COMPLEX TRAUMA AND GIRLS IN THE JUSTICE SYSTEM

Girls now account for approximately 30 percent of the estimated 2.11 million juvenile arrests made each year. On any given day, more than 7,800 girls reside in detention or juvenile corrections facilities in the US (Kerig & Ford, 2014). Girls' arrest rates for violent offenses—including physical assault, sexual assault, and homicide—have increased 78 percent while declining 6 percent for boys. Girls in the justice system also report higher levels of exposure to traumatic experiences, interpersonal victimization (particularly forms of abuse that occur in the context of close personal relationships such as family violence and sexual assault), and mental health problems, including PTSD, than their male peers. Among traumatized girls, researchers have found heightened stress-reactivity, developmental lags, and adverse effects of traumatic maltreatment. These effects increase the risk for "intra- and inter-relational chaos" and lead to volatile and conflictual relationships, as well as involvement with antisocial romantic partners. These relationship choices, in turn, increase the risk not only of justice-involvement but of subsequent intimate partner violence and re-victimization (Chamberlain & Leve, 2004). Experiences of trauma, maltreatment, and victimization play a role in placing girls on the pathway toward delinquency, re-traumatization, and chronic exposure to complex trauma. Other researchers observe that many girls in the justice system have endured their most traumatic experiences in the context of close personal relationships, and that involvement in those relationships also increases the risk of their perpetrating violence themselves. Fostering positive relationships may play a significant role in helping girls both to heal from trauma and avoid furthering a course leading to more involvement with the juvenile justice system.

HOW YOUTH IN THE JUVENILE JUSTICE SYSTEM ARE AFFECTED BY COMPLEX TRAUMA

Survival-oriented coping, although necessary for self-protection when complex trauma is occurring (or could re-occur, even during periods of apparent safety), may compromise the functioning of three key systems in the brain and body:

- The reward/motivation system that is essential for attention, learning, initiating and completing tasks, and social and moral judgment;
- The distress tolerance system that is crucial to coping with frustration, boredom, unhappiness, worry, sadness, fear, guilt, shame, and depression; and
- The executive system that is necessary for proactive problem-solving, sustained and focused attention, setting goals and making and carrying out plans to achieve them, and recognizing and utilizing emotions as a guide to personal decisions and relationships.

Thus, youth with complex trauma histories tend to have extremely high "survival IQs," but due to operating in survival mode they often experience serious difficulties in several areas:

- stopping to think before reacting
- setting and achieving goals that involve positive outcomes
- handling intense feelings of frustration/anger without resorting to aggression
- handling intense feelings of disappointment/hopelessness without becoming isolative, reckless, self-harming, or suicidal
- using alcohol and drugs to cope with frustration, boredom, and hopelessness
- developing and maintaining relationships based on mutual trust and well-being
- following social and legal rules and expectations
- recognizing their own self-worth and positive accomplishments

Often youth who have had to survive complex trauma and have become involved in the juvenile justice system appear defiant, unmotivated, and "incorrigible" as a result of attempting to deny and conceal distress, disillusionment, and self-blame through a façade of indifference or aggression. In order to gain a sense of personal control, relief from distress, social inclusion, and self-esteem, they may turn to self-medication, avoidance and isolation, or choose peer relationships based on detachment from or rejection of mainstream values, norms, and cultural practices.

RECOMMENDATIONS

Although complex trauma leads youth to be suspicious or even defiant toward adults who offer help, these youth are very resilient and can be reached by adults who are willing to support them patiently – not by endorsing actions that are illegal, dangerous, or harmful, but by aligning with these youths' core goals, values, and personal strengths, and offering guidance that empowers rather than judges them.

For Judges and Juvenile Justice Program Administrators

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides practical guidance for leaders such as judges and administrators who are seeking to implement a trauma-informed approach in their systems.

- Ensure that all staff as well as all youth and families have the knowledge, tools and resources needed in order to realize the impact of trauma in youths' daily lives.
- Recognize the role that trauma-related reactions and survival coping play in youths' behavioral, emotional, and legal problems.
- Respond in a manner that enhances the safety of the youth as well as the community and the youth's ability to achieve her/his full potential through developing a healthy lifestyle, skills, and relationships. And,
- Prevent re-traumatization or the triggering of trauma-related memories.

Adding to SAMHSA's "4 Rs," as this guidance is known, the National Child Traumatic Stress Network (NCTSN) has identified eight essential elements of trauma-informed practice to support youth in the juvenile justice system who have been complexly traumatized. These are:

1. Ensure the physical and psychological safety of all youth, family members, and staff through the development of trauma-informed policies and procedures.

2. Identify youth who have experienced complex trauma through carefully timed screening.

3. Offer clinical assessment and trauma-focused intervention for complexly traumatized youth who have been identified as impaired in the screening process.

4. Provide trauma-informed programming and staff education on complex trauma for staff across all components of the juvenile justice system.

5. Recognize and respond to the adverse effects of secondary traumatic stress in the workplace in order to support workforce safety, effectiveness, and resilience.

6. Engage youth and their families as partners in all juvenile justice programming and therapeutic services.

7. Through cross-system collaboration, ensure the provision of continuous integrated services to justice-involved youth who have experienced complex trauma.

8. Review practices and policies to ensure that they address the diverse and unique needs of all groups of youth and do not result in disparities related to race, ethnicity, gender, gender-identity, sexual orientation, age, intellectual and developmental level, or socioeconomic background.

Other steps the juvenile justice system can take to help youth recover from complex trauma while pursuing the mission of ensuring public safety have been outlined in the Report of the Attorney General's National Task Force on Children Exposed to Violence and include:

- Limit laws and policies that have unintended negative consequences for youth with complex trauma (e.g., seclusion, restraints, shackling, pepper spray, and other potentially traumatizing sanctions, crisis interventions, and behavioral management strategies).
- Foster the social and emotional development of youth as a co-equal goal to preserving public safety. This is because public safety depends upon having youth who are able to develop into productive and responsible citizens.
- Provide services that increase the safety of youth who are being traumatized by abuse, sexual exploitation/trafficking, and stigma due to their racial/ethnic background, gender or sexual identity, or disabilities.

For Parents, Family Members, and Adults Who Supervise Youth

- Take time to build trust with youth with complex trauma. Each has a personal story to share with only a few people who have earned his or her trust. Knowing the youth's story is the crucial first step to helping that youth build a good life.
- It takes a community: everyone in the youth's family and other supportive relationships must join together in order to heal their lives and make the community safe and healing.
- Strive to make every interaction with youth an honest and respectful dialogue by setting a model for how everyone—not just the youth—can and must "walk the walk" by taking responsibility for their emotions and actions and striving to achieve social justice.
- Be open to alternative ways of understanding the youths' motivations that highlight their core values, goals, and competencies instead of stigmatizing them as "incorrigible," "unmotivated," or "delinquent."
- When conflict or disagreements occur, remember that it is developmentally appropriate for adolescents to be on an emotional rollercoaster and to assert their independence by debating everything others say. When adults are able to model being emotionally regulated and respectful this shows the adolescent that it's possible to work out disagreements without anyone being disrespected or being forced to be the "loser."
- Remember there is no "one size fits all" formula that can be applied to all complexly traumatized youth—each youth is an individual who needs to be known and understood as the person that she/he is capable of being, rather than being treated as "just another bad kid" or "just another victim."

SOURCES

Chamberlain, P., & Leve, L. D. (2004). Female juvenile offenders: Defining an early-onset pathway for delinquency. *Journal of Child & Family Studies, 13,* 439-452.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., & van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35,* 390-398.

Ford, J. D., & Blaustein, M. (2012). Systemic self-regulation: A framework for trauma-informed services in residential juvenile justice programs. *Journal of Family Violence, 28,* 655-677.

Ford, J. D., Chapman, J., Mack, M., & Pearson, G. (2006). Pathway from traumatic child victimization to delinquency: Implications for juvenile and permanency court proceedings and decisions. *Juvenile and Family Court Journal, 57(1)*, 13-26.

Ford, J. D., Chapman, J. C., Connor, D. F., & Cruise, K. C. (2012). Complex trauma and aggression in secure juvenile justice settings. *Criminal Justice & Behavior, 39(5),* 695-724.

Ford, J. D., Grasso, D. J., Hawke, J., & Chapman, J. F. (2013). Poly-victimization among juvenile justice-involved youths. *Child Abuse and Neglect, 37,* 788-800. doi: 10.1016/j.chiabu.2013.01.005

Kerig, P. K., & Ford, J. D. (2015). *Trauma among girls in the juvenile justice system*. http://www.nctsn.org/sites/default/files/assets/pdfs/trauma_among_girls_in_the_jj_system_2014.pdf

Recommended Citation: Complex Trauma Treatment Network of the National Child Traumatic Stress Network. (2016). *Complex trauma: In juvenile justice-system involved youth.* Los Angeles, CA, & Durham, NC: National Center for Child Traumatic Stress.

A Special Thanks to: Julian Ford, PhD, Rocio Chang, PsyD at the University of Connecticut & Rachel Liebman, PhD, Joseph Spinazzola, PhD at The Trauma Center at Justice Resource Institute.

Page Intentionally left Blank for Printing

Session 4: Addressing the Mental Health of Youth

"Complex Trauma"
Competency Worksheet

1. More than two-thirds of youth involved with law enforcement or juvenile justice have complex histories of interpersonal trauma.

☐ True
☐ False

2. Fill in the blank: The term complex trauma describes both children's exposure to _____, often of an invasive, _____ nature, and the wide-ranging, _____ impact of this exposure.

3. For youth who have experienced repeated violence, violation, exploitation, rejection and abandonment in their homes, schools and communities, safety and justice seem impossible to obtain.

☐ True
☐ False

4. A second common denominator for youth with complex trauma histories who are involved with law enforcement or juvenile justice has difficulty in effectively manage their emotions.

☐ True
☐ False

5. Males in the justice system report higher exposure to traumatic experiences, interpersonal victimization and mental health problems, including PTSD, than their female peers.

☐ True
☐ False

6. Survival-oriented coping compromises the functioning of three key systems in the brain and body. Name those three key systems.

_____

_____

_____

7. What are some of the difficulties youth experience from complex trauma when operating in survival mode? Name at least four.

_____

_____

_____

_____

8. Which one of these is the recommendations for Parents (Foster Parents), Family Members, and Adults Who Supervise Youth?

a. ☐ Take time to build trust with youth.
b. ☐ Strive to make every interaction with youth an honest and respectful dialogue.
c. ☐ Be open to alternative ways of understanding the youths' motivations.
d. ☐ Remember that it is developmentally appropriate for adolescents to be on an emotional rollercoaster.
e. ☐ Remember there is no "one size fits all" formula.
f. ☐ All of the Above

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

Session Five:

Working with Challenging Behaviors

In this session, Dr. Stuart Ablon will suggest a revolutionary way of thinking about challenging behavior and a corresponding process by which kids of all kinds can be taught skill of flexibility, frustration tolerance and problem solving. In addition, you will also learn the importance of maintaining appropriate boundaries as a foster parent and how to limit contraband in the foster home.

Page Intentionally left Blank for Printing

“Rethinking Challenging Kids - Where There's a Skill There's a Way”

Online Video

bit.ly/2G5UkhQ

19 minutes 25 seconds

Page Intentionally left Blank for Printing

Session 5: Working with Challenging Behaviors

"Rethinking Challenging Kids-Where There's a Skill There's a Way"
Competency Worksheet

1. Kids do well if they can!

   ☐ True

   ☐ False

2. Name 2 examples of skills youth may lack.

   _____

   _____

3. How can adults help children to develop skills, which one is correct?
   a. ☐ Collaborative Problem Solving
   b. ☐ Reading to them
   c. ☐ Going to each class with them
   d. ☐ Telling them all the answers

4. Name 3 common predictable problems.

   _____

   _____

   _____

5. In your own words: How do you think that you will be able to implement Collaborative Problem Solving?

   _____

   _____

   _____

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

Page Intentionally left Blank for Printing

“Maintaining Appropriate Boundaries”

Online Video

bit.ly/2R7zPel

15 min

“Limiting Contraband”

Online Video

bit.ly/2F5UZSE

15min

Session Six:

Cultural Competency

In this session you will learn about what it means to be culturally competent and the importance of building cultural competence. The video also discusses how there can be multiple interpretations of a single event, interaction or situation based on one's own cultural beliefs, values, attitudes and assumptions.

Page Intentionally left Blank for Printing

“Building Cultural Competence”

Online Video

bit.ly/26KBtuB

24 minutes 59 seconds

Page Intentionally left Blank for Printing

Session 6: Cultural Competency

"Building Cultural Competence"
Competency Worksheet

1. What is the key to living in our world?
    a. ☐ Building better schools
    b. ☐ Building Cultural Competence
    c. ☐ Love everybody
    d. ☐ Be overbearing

2. _____ is the willingness and ability to effectively interact with people from diverse cultures and backgrounds.
3. Name 3 factors to consider when talking about diversity?

    _____

    _____

    _____

4. Everybody has a culture.

    ☐ True

    ☐ False

5. What is culture compared to?
    a. ☐ Ice cream
    b. ☐ Hamburger
    c. ☐ French Fries
    d. ☐ Iceberg

6. What is the first step to becoming cultural competent?

    _____

7. Name 2 visible cultural characteristic.

    _____

    _____

8. In your own words: How do you think that you can and be open and accepting to other cultures?

_____

_____

_____

_____

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

Session Seven:

LGBTQ Youth

In this session you will learn about LGBTQ (Lesbian, Gay, Bisexual, Transgender or Questioning) youth in the child welfare system, the unique risks they face and the important role that foster parents can play in reducing those risks.

Page Intentionally left Blank for Printing

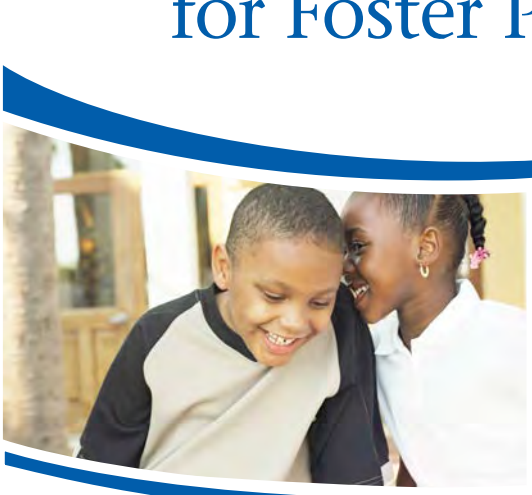
Child Welfare Information Gateway

PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

FACTSHEET FOR FAMILIES

May 2013

Supporting Your LGBTQ Youth: A Guide for Foster Parents



There are approximately 175,000 youth ages 10–18 in foster care in the United States.[1] Of these youth, an estimated 5–10 percent—and likely more—are lesbian, gay, bisexual, transgender, or questioning (LGBTQ).[2]

[1] The total number of youth in care comes from *The AFCARS Report* (http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport19.pdf). It is based on the number of youth ages 10–18 in care on September 30, 2011.

[2] The estimate comes from the assumption that 5–10 percent of the general population is LGBT. John C. Gonsiorek & James D. Weinrich, "The Definition and Scope of Sexual Orientation," in *Homosexuality: Research Implications for Public Policy* (Newbury Park, CA: Sage Publications, 1991); Courtney, Dworsky, Lee, and Raap, (2009) found a much higher percentage of youth in foster care who identified as something other than fully heterosexual (see http://www.chapinhall.org/research/report/midwest-evaluation-adult-functioning-former-foster-youth).

What's Inside:

Use your smartphone to access this factsheet online.

Children's Bureau

Child Welfare Information Gateway
Children's Bureau/ACYF/ACF/HHS
1250 Maryland Avenue, SW
Eighth Floor
Washington, DC 20024
800.394.3366
Email: info@childwelfare.gov
https://www.childwelfare.gov

Like all young people, LGBTQ youth in foster care need the support of a nurturing family to help them negotiate adolescence and grow into healthy adults. However, LGBTQ youth in foster care face additional challenges. These include the losses that brought them into care in the first place, as well as traumas they may have suffered while in foster care. They also include stressors unique to LGBTQ youth, including homophobia or transphobia[3] and the need to evaluate (often with little or no support) the safety of their communities, schools, social networks, and homes in order to decide whether to disclose their LGBTQ identity, when, and to whom.

Despite these challenges, LGBTQ youth—like all youth in the child welfare system—can heal and thrive when families commit to accepting, loving, and supporting them as they grow into their potential as adults. This factsheet was written to help families like yours understand what they need to know to provide a safe, supportive, and welcoming home for an LGBTQ youth in foster care.

In this factsheet, you will learn about LGBTQ youth in the child welfare system, the unique risks they face, and the important role that foster parents can play in reducing those risks. You will discover specific actions that you can take to create a welcoming home for all youth in your care and to promote your youth's health and well-being in the community. At the end of this factsheet are links to many resources for more information and support.

[3] *Transphobia* refers to fear of people who are transgender.

About LGBTQ Youth

The acronym *LGBTQ* is a general term used to describe people who are lesbian, gay, bisexual, transgender, or questioning their gender identity or sexual orientation.

Definitions

Lesbian, *gay*, and *bisexual* describe a person's *sexual orientation*—emotional, romantic, or sexual feelings toward other people. *Lesbian* refers specifically to women who love women, while gay can refer to any person who is attracted to people of the same sex. (The term *homosexual* is considered outdated and offensive by many gay people.) Bisexual people are attracted to men or women regardless of their anatomy. People do not need to have any particular sexual experience (or any sexual experience at all) to identify as bisexual, gay, or lesbian, because sexual orientation and sexual behavior are not the same thing.

Transgender refers to a person's *gender identity*—an internal understanding of one's own gender. A transgender person's gender identity does not match the sex (a biological characteristic) assigned to him or her at birth. Many, but not all, transgender people choose to alter their bodies hormonally and/or surgically to match their gender identity. Some people's experience, perception, or expression of their gender evolves and changes over time. Gender identity and sexual orientation are separate aspects of a person's identity: A transgender person may be bisexual, gay, or straight (or may identify in some other way).

Some youth (and adults) identify as *questioning* when they start to recognize that they may be part of the LGBT community. This does not mean that sexual orientation or gender identity is a choice. These youth may need time to process what being LGBT means for them; to reconcile any anti-LGBT stereotypes they have internalized; and to decide if, when, and how they should identify themselves as lesbian, gay, bisexual, or transgender to others.

Some people's *gender expression* (meaning, the ways in which they express their gender identity to others) does not conform to society's expectations for their sex. This might include choices in clothing, mannerisms, names, hairstyles, friends, and hobbies. It is important to understand that society's gender expectations are cultural, not biological, and they change over time (for example, women used to be expected to wear only dresses; now teens of both genders wear jeans, sweatshirts, and tennis shoes). In any case, not all *gender-variant* (or *gender nonconforming*) youth will continue to express themselves this way into adulthood, and many will never identify as gay, lesbian, bisexual, or transgender.

In other words, it is best not to make assumptions. Respecting your youth's self-identification is very important. As youth grow to trust their foster families, many will eventually share their feelings about gender identity or sexuality more openly.

> "Gaining that trust takes time, patience, and consistency. That's what [my foster mother] gave me."
> — *LGBTQ youth in foster care*

Addressing Common Misconceptions

There is a lot of misinformation about sexual orientation and gender identity. Here are some things that are important for you to know about LGBTQ youth in your home:

LGBTQ youth are a lot like other youth. In fact, the similarities that LGBTQ youth in foster care share with other youth in care far outweigh their differences. Most, if not all, youth in foster care have been affected by trauma and loss; they require acceptance and understanding. Making sure your home is welcoming to all differences, including race, ethnicity, disability, religion, gender, and sexual orientation, will help ensure that all youth in your home feel safe and that the youth in your care grow into adults who embrace diversity in all of its forms.

This is not "just a phase." LGBTQ people are coming out (acknowledging their sexual orientation/gender identity to themselves and others) at younger and younger ages. Studies by the Family Acceptance Project have found that most people report being attracted to another person around age 10 and identifying as lesbian, gay, or bisexual (on average) at age 13. Gender identity may begin to form as early as ages 2 to 4.[4] Someone who has reached the point of telling a foster parent that he or she is LGBTQ has likely given a great deal of thought to his or her own identity and the decision to share it.

No one caused your youth's LGBTQ identity. Sexual orientation and gender

[4] Ryan, C. (2009). *Helping families support their lesbian, gay, bisexual, and transgender (LGBT) children.* Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

identity are the result of complex genetic, biological, and environmental factors. Your youth's LGBTQ identity is not the result of anything you (or a birth parent, or any other person) did. LGBTQ people come from families of all religious, political, ethnic, and economic backgrounds. Experiencing childhood trauma or reading about, hearing about, or being friends with other LGBTQ people did not "make" the youth become LGBTQ.

LGBTQ youth are no more likely than other youth to be mentally ill or dangerous. These unfortunate myths and stereotypes have no basis in truth. Gay or transgender people are not more likely than heterosexuals or gender-conforming people to molest or otherwise pose a threat to children. And although it is true that LGBTQ people experience higher rates of anxiety, depression, and related behaviors (including alcohol and drug abuse) than the general population, studies show that this is a result of the stress of being LGBTQ in an often-hostile environment, rather than a factor of a person's LGBTQ identity itself.[5] Professional mental health organizations agree that homosexuality is not a mental disorder and is a natural part of the human condition.

Your youth's LGBTQ identity cannot be changed. Medical and psychological experts agree that attempting to change someone's sexual orientation or gender identity does not work and often causes harm.

Many religious groups embrace LGBTQ people. Some people fear that they will have to choose between their faith and supporting their youth's LGBTQ identity—but this is not always the case. Many religious communities welcome LGBTQ youth, adults, and their families. It may be important to know that there are other options if your family does not feel welcomed or comfortable at your place of worship.

LGBTQ Youth and the Child Welfare System

LGBTQ youth are overrepresented in the child welfare system: While approximately 5 to 10 percent of the general population is estimated to be gay, a study conducted in three Midwestern States found that a greater percentage of those aging out of the child welfare system reported a sexual orientation other than heterosexual (24 percent of females and 10 percent of males). These numbers are likely to be underreported because youth who come out often risk harassment and abuse.

Some LGBTQ youth enter the child welfare system for the same reasons that other children and youth enter care: Their birth families are unable to provide a safe, stable, and nurturing home for them due to a parent's incarceration, drug or alcohol abuse, mental illness, or other reasons unrelated to the youth's LGBTQ identity. Others, however, are rejected (and in some cases, neglected or abused) by their families of origin when their families learn that they identify as LGBTQ. Some youth experience

[5] Schlatter, E., & Steinback, R. (2010). 10 anti-gay myths debunked. *Intelligence Report, no. 140.* Retrieved from http://www.splcenter.org/get-informed/intelligence-report/browse-all-issues/2010/winter

repeated losses—originally adopted as babies or toddlers, they are returned to the system by their adoptive families when they come out.

Youth who are rejected by their families may experience greater risks than other youth in care. Studies show that these youth have lower self-esteem and a much greater chance of health and mental health problems as adults. Compared to other LGBTQ youth, those who are highly rejected by their families because of their sexual orientation or gender identity are:

- More than three times as likely to use illegal drugs or be at high risk for contracting HIV and other STDs
- Nearly six times as likely to experience high levels of depression
- More than eight times as likely to attempt suicide[6]

Unfortunately, a high percentage of LGBTQ youth in foster care experience further verbal harassment or even physical violence after they are placed in out-of-home care. As a result, many of these youth experience multiple disrupted placements, compounding the trauma associated with leaving their families of origin. In one study, as many as 56 percent of LGBTQ youth in care spent some time homeless because they felt safer on the streets than in their group or foster home.[7] This maltreatment is partially responsible for the fact that LGBTQ youth make up as many as 40 percent of homeless teens.[8] Homelessness, in turn, increases the youth's risk of substance abuse, risky sexual behavior, victimization, and contact with the criminal justice system.

The good news is that these risks can be mitigated by foster and adoptive families who are willing to nurture and protect the health, safety, and well-being of these young people. It is essential for child welfare agencies to identify and ensure access to family foster homes that can provide stable, supportive, and welcoming families for LGBTQ adolescents, where youth can develop the strength and self-confidence they need to become successful adults.

Creating a Welcoming Home for Youth

All youth in care need nurturing homes that provide them with a safe place to process their feelings of grief and loss, freedom to express who they are, and structure to support them in becoming responsible, healthy adults. Creating a welcoming foster home for LGBTQ youth is not much

[6] Ryan, C. (2009). *Helping families support their lesbian, gay, bisexual, and transgender (LGBT) children.* Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

[7] Mallon, G. P. (1998). *We don't exactly get the welcome wagon: The experience of gay and lesbian adolescents in North America's child welfare system.* New York: Columbia University Press. Cited in Wilber, S., Ryan, C., & Marksamer, J. (2006). *CWLA Best Practice Guidelines: Serving LGBT Youth in Out of Home Care.* Washington, DC: Child Welfare League of America. http://www.nclrights.org/site/DocServer/bestpracticeslgbtyouth.pdf?docID=1322

[8] Administration on Children, Youth and Families. (2011). *Information memorandum: Lesbian, gay, bisexual, transgender and questioning youth in foster care.* Washington, DC: U.S. Department of Health and Human Services.

different from creating a safe and supportive home for any youth.

> "The most important thing is to allow any youth to feel safe enough to blossom into whoever they are meant to be."
> — *Foster parent*

In fact, youth in care may have difficulty trusting adults (many with good reason), so you may not know a youth's gender identity or sexual orientation until he or she has spent some time in your home and has grown to trust you. Avoid making assumptions about gender identity or sexual orientation. Any steps you take to make your home welcoming to LGBTQ youth will benefit all children and youth in your care—both by giving LGBTQ youth the freedom to express themselves and by helping heterosexual and gender-conforming youth learn to respect and embrace diversity.

Behaviors that openly reject a youth's LGBTQ identity must be avoided and not tolerated. This includes slurs or jokes about gender or sexuality and forcing youth to attend activities (including religious activities) that are openly hostile or unsupportive of LGBTQ people. Well-meaning attempts to protect youth from potential harassment, such as "steering" them toward hobbies more typical for their sex (football for boys, for example) or isolating them for the sake of safety, also are experienced as rejection by LGBTQ youth and can have devastating consequences for their self-esteem and well-being.

Consider the following suggestions to make your home a welcoming one,

whether or not a youth in your care openly identifies as LGBTQ:

- Make it clear that slurs or jokes based on gender, gender identity, or sexual orientation are not tolerated in your house. Express your disapproval of these types of jokes or slurs when you encounter them in the community or media.
- Display "hate-free zone" signs or other symbols indicating an LGBTQ-friendly environment (pink triangle, rainbow flag).
- Use gender-neutral language when asking about relationships. For example, instead of, "Do you have a girlfriend?" ask, "Is there anyone special in your life?"
- Celebrate diversity in all forms. Provide access to a variety of books, movies, and materials—including those that positively represent same-sex relationships. Point out LGBTQ celebrities, role models who stand up for the LGBTQ community, and people who demonstrate bravery in the face of social stigma.
- Let youth in your care know that you are willing to listen and talk about anything.
- Support your youth's self-expression through choices of clothing, jewelry, hairstyle, friends, and room decoration.
- Insist that other family members include and respect all youth in your home.
- Allow youth to participate in activities that interest them, regardless of whether these activities are stereotypically male or female.
- Educate yourself about LGBTQ history, issues, and resources.

> "At [my foster mother's] house, I was able to feel safe and focus on being who I was."
> — *LGBTQ youth in foster care*

If a youth in your care discloses his or her LGBTQ identity, you can show your support in the following ways:

- When a youth discloses his or her LGBTQ identity to you, respond in an affirming, supportive way.
- Understand that the way people identify their sexual orientation or gender identity may change over time.
- Use the name and pronoun (he/she) your youth prefers. (If unclear, ask how he or she prefers to be addressed.)
- Respect your youth's privacy. Allow him or her to decide when to come out and to whom.
- Avoid double standards: Allow your LGBTQ youth to discuss feelings of attraction and engage in age-appropriate romantic relationships, just as you would a heterosexual youth.
- Welcome your youth's LGBTQ friends or partner at family get-togethers.
- Connect your youth with LGBTQ organizations, resources, and events. Consider seeking an LGBTQ adult role model for your youth, if possible.
- Reach out for education, resources, and support if you feel the need to deepen your understanding of LGBTQ youth experiences.
- Stand up for your youth when he or she is mistreated.

LGBTQ youth in foster care need permanent homes; they do not need additional disrupted placements. If you are being asked to consider providing foster care to an LGBTQ youth and you feel—for any reason—that you are not able to provide a safe and supportive environment, be honest with your child welfare worker for the sake of both the youth and your family. If you are able to provide an affirming environment, remember that you can talk with your child welfare worker about any questions you may have or support you may need.

Supporting Your Youth in the Community

The support your LGBTQ youth receives in your home is important. However, you also must be prepared to advocate for your youth when needed to ensure that she or he receives appropriate child welfare, health care, mental health, and education services to promote healthy development and self-esteem.

Working With the Child Welfare System

The overwhelming majority of child welfare workers, like foster parents, have the best interest of the children and youth they serve at heart. However, workers are human, and they have their own feelings and biases. While there is no need to assume problems

will arise, it is important to be aware of your youth's rights.[9] For example:

- **Your youth has the right to confidentiality.** Agencies should not disclose information regarding his or her sexual orientation or gender identity without good reason (e.g., development of a service plan) and the youth's permission.
- **Your youth has the right to an appropriate service plan.** This should include the same permanency planning services provided to heterosexual or gender-conforming youth: The youth's sexual orientation or gender identity alone should not be a reason for a worker to forego attempts to reunite the youth with his or her birth family or seek a permanent adoptive placement. It also includes helping the youth access LGBTQ community programs, if desired.
- **Your youth should be supported in expressing his or her gender identity.** The child welfare agency should respect your youth's preferred pronoun and name.
- **Your youth has the right to request that a new caseworker be assigned,** if the current worker is not addressing his or her needs appropriately.

Health Care and Mental Health Providers

Your youth, like all youth in foster care, has the right to health care and mental health services that address his or her individual needs. In the case of a lesbian, gay, bisexual, or transgender youth, finding a competent, supportive provider may require some additional research. Consider the following:

- **Check with your youth to see whether he or she feels comfortable at agency-recommended service providers.** Although your agency may have preferred providers, you can inquire about other options that work better for your youth. Begin with those who accept Medicaid; however, if the provider your youth needs does not accept Medicaid, the child welfare agency may be able to authorize additional funding for necessary services.
- **Sexual health should be part of every youth's wellness exam.** Competent health-care providers will be able to offer frank, nonjudgmental, and comprehensive education about sexual health that is relevant to LGBTQ youth.
- **Transgender youth need health-care providers who are appropriately trained to address their health concerns.** This includes the ability to discuss, provide, and obtain authorization for medically necessary transition-related treatment, if desired.
- **Be aware of the possibility that your youth might benefit from mental health counseling** about issues that may or may not be related to sexual orientation or gender identity. In addition to typical adolescent concerns, many LBGTQ youth struggle with depression or anxiety as a result of experiencing stigma, discrimination, or harassment. If that is the case, seek a provider who is experienced and

[9] For more information, see Wilber, Ryan, & Marksamer, 2006, in note on page 5.

competent in helping LGBTQ youth cope with trauma.

- **Under no circumstances should your LGBTQ youth be forced or encouraged to undergo "conversion therapy."** Practices intended to change a person's sexual orientation or gender identity have been condemned by every major medical and mental health association.

Your Youth at School

Unfortunately, bullying and harassment at school are everyday experiences for many LGBTQ youth. In many schools, negative remarks about sexual orientation or gender identity are common from other students, and even faculty or staff. A 2011 survey of more than 8,500 students between the ages of 13 and 20 found that nearly two-thirds of students felt unsafe at school because of their sexual orientation, and 44 percent felt unsafe because of their gender expression.[10] School harassment can have devastating consequences for youth's education and general well-being. Absenteeism and dropout rates are higher and grade point averages lower among LGBTQ youth experiencing harassment at school.[11]

If your youth is being bullied or harassed, you may need to work with his or her caseworker, school administrators, school board, and/or PTSA to address the problem.

The following practices have proven effective for preventing anti-gay harassment and improving school climate for LGBTQ youth:

- **Gay-straight alliances (GSAs).** Students at schools with GSAs hear fewer homophobic remarks, experience less harassment, feel safer at school, and are more likely to receive help when reporting bullying to school personnel.[12]
- **Anti-bullying policies that specifically reference sexual orientation and gender identity.** Students in States with comprehensive safe school laws report fewer suicide attempts.[13]
- **LGBTQ-friendly teachers, curriculum, and resources.** Students in schools with an inclusive curriculum were about twice as likely to report that classmates were somewhat or very accepting of LGBTQ people.[14]

Conclusion

The evidence shows that LGBTQ youth are overrepresented in the foster care system and that these youth face serious risks and challenges beyond those experienced by other youth. Rejection by their families and other caregivers exacerbates these risks. If LGBTQ youth are to reach their full

[10] The Gay, Lesbian & Straight Education Network [GLSEN]. (2012). *The 2011 national school climate survey: Executive summary.* New York: Author.

[11] Ibid. Also see, for example, Lambda Legal. (n.d.) *Facts: Gay and lesbian youth in schools*. New York: Author; and Mental Health America (2012). Bullying and Gay Youth [webpage]. http://www.nmha.org/index.cfm?objectid=CA866DCF-1372-4D20-C8EB26EEB30B9982

[12] GLSEN, 2012.

[13] Espelage, D. L. (2011). Bullying & the lesbian, gay, bisexual, transgender, questioning (LGBTQ) community. Proceedings of the White House Conference on Bullying Prevention. Retrieved from: http://www.stopbullying.gov/at-risk/groups/lgbt/white_house_conference_materials.pdf

[14] GLSEN, 2012.

potential and become healthy, happy adults, they—like all youth in care—need families who can provide permanent, supportive homes during their critical adolescent years. With a little additional education and training, your family can successfully provide a welcoming home to LGBTQ youth in need.

Resources

For Families

- **Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children.** Research showing that families have a major impact on their LGBT children's health, mental health, and well-being. http://www11.georgetown.edu/research/gucchd/nccc/documents/LGBT_Brief.pdf
- **Family Acceptance Project.** A research-based, culturally grounded approach to help ethnically, socially, and religiously diverse families increase support for their LGBT children. http://familyproject.sfsu.edu
- **PFLAG.** A national nonprofit organization that supports families through more than 350 chapters in major urban centers, small cities, and rural areas in all 50 States. Selected resources include:
  - **Coming Out Help for Families, Friends, and Allies** http://community.pflag.org/page.aspx?pid=539
  - **Our Trans Children.** Answers to frequently asked questions and support for family members just learning of their loved one's gender differences. http://www.pflag.org/fileadmin/user_upload/Publications/OTC_5thedition.pdf
  - **Be Not Afraid: Help Is on the Way!** A faith-based resource from PFLAG's Straight for Equality program. http://community.pflag.org/sfe-test/document.doc?id=649
- **Advocates for Youth: GLBTQ Issues Info for Parents.** Tips for parents of LGBTQ youth, including resources on talking about sexuality. http://www.advocatesforyouth.org/glbtq-issues-info-for-parents
- **LGBTQ Youth Resources for Families.** Resource list from the Maternal & Child Health Library at Georgetown University. http://www.mchlibrary.info/families/frb_LGBTQ.html
- **Centers for Disease Control and Prevention.** Education, information, resources, and health services for LGBTQ youth and adults. http://www.cdc.gov/lgbthealth/
- **American Psychological Association.** Answers to questions about…
  - **Transgender People, Gender Identity, and Gender Expression.** http://www.apa.org/topics/sexuality/transgender.aspx
  - **Sexual Orientation and Homosexuality.** http://www.apa.org/topics/sexuality/orientation.aspx

- **LGBTQ Youth in the Foster Care System and Legal Rights of Lesbian, Gay, Bisexual, and Transgender Youth in the Child Welfare System.** Factsheets from the National Center for Lesbian Rights. http://www.nclrights.org/site/DocServer/LGBTQ_Youth_In_Foster_Care_System.pdf?docID=1341 and http://www.nclrights.org/site/DocServer/LGBTQ_Youth_In_Child_Welfare_System.pdf?docID=1581
- **Getting Down to Basics.** Toolkit from Lambda Legal with resources for those supporting LGBTQ youth in foster care. http://www.lambdalegal.org/publications/getting-down-to-basics

For LGBTQ Youth

- **Be Yourself: Questions & Answers for Gay, Lesbian, Bisexual & Transgender Youth.** Clear, straightforward answers for LGBTQ youth. http://www.pflag.org/fileadmin/user_upload/Publications/Be_Yourself.pdf
- **Represent and *YCteen* Stories.** Personal stories from youth in foster care. http://www.representmag.org/topics/gay+slash+lesbian.html
- **The Trevor Project.** Crisis intervention and suicide prevention services for LGBTQ youth. http://www.thetrevorproject.org
- **It Gets Better Project.** Videos created to show LGBTQ youth that they are not alone and that they have the potential for happy, positive futures, if they can just get through their teen years. http://www.itgetsbetter.org
- **Get Busy. Get Equal.** ACLU resources for LBGT youth about their rights at school and how to advocate for themselves effectively. http://www.aclu.org/lgbt-rights
- **Know Your Rights: Youth.** Legal resources regarding out-of-home care and school issues for LGBTQ youth (from Lambda Legal). http://www.lambdalegal.org/issues/teens
- **Gay, Lesbian, and Straight Education Network.** The leading national education organization focused on ensuring safe schools for all students. http://www.glsen.org/cgi-bin/iowa/all/student/index.html

Acknowledgment: This factsheet was developed by Child Welfare Information Gateway, in partnership with Jill Rivera Greene.

Suggested citation: Child Welfare Information Gateway. (2013). *Supporting your LGBTQ youth: A guide for foster parents*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Page Intentionally left Blank for Printing

Session 7: LGBTQ Youth

"Supporting Your LGBTQ Youth: A Guide for Foster Parents"
Competency Worksheet

1. Despite a lot of challenges, LGBTQ youth can thrive when families commit to accepting, loving and supporting them as they grow into their potential as adults.

   ☐ True

   ☐ False

2. What does LGBTQ stand for?

   _____

3. The term *homosexual* is accepted and liked by many gay people.

   ☐ True

   ☐ False

4. A transgender youth may be bisexual, gay, or straight, or may identify in some other way.

   ☐ True

   ☐ False

5. Which one of these is not considered gender expression?
   a. ☐ Mannerisms
   b. ☐ Hairstyles
   c. ☐ Food
   d. ☐ Hobbies
6. As youth grow to trust their foster families, many will eventually share their feelings about gender identity or sexuality more openly.

   ☐ True

   ☐ False

7. Fill in the blank: LGBTQ youth are no more likely to be _____ ill or _____ than other youth.

8. Fill in the blanks: Compared to other LGBTQ youth, those who are highly rejected by their families because of their sexual orientation or gender identity are:
    a. More than_____ times as likely to use illegal drugs or be at high risk for contracting HIV and other STDs
    b. Nearly _____times as likely to experience high levels of depression
    c. More than _____times as likely to attempt suicide.

9. Which one is a good example of gender-neutral language?
    a. ☐ Let's go buy you some girly clothes.
    b. ☐ Hey dude, let's go check out some girls.
    c. ☐ Do you have a boyfriend?
    d. ☐ Is there anyone special in your life?
10. Name 3 different types of support a youth might need while in your home:

_____

_____

_____

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

Session Eight:

Abuse, Neglect & Child Abuse Reporting

In this session you will learn about Oregon's Child Abuse Reporting Law, the different types of abuse, how to make a report, the importance of reporting and what your role is as a mandatory reporter.

Page Intentionally left Blank for Printing

“Mandatory Child Abuse Reporting”

Online Video

bit.ly/2CMnm6J

25 minutes 24 Seconds

Page Intentionally left Blank for Printing

Session 8: The Role of Mandatory Reports in Child Abuse Cases- QUIZ

Name: _____ Date: _____

1. List three professions specifically mentioned in Oregon's Child Abuse Reporting law:
   a. _____ b. _____ c. _____

(Circle One)

2. **True** or **False**: Nearly 75% of all child abuse cases are reported by mandatory reporters.
3. **True** or **False**: As OYA staff, you only report suspected abuse while you are on duty.
4. **True** or **False**: You must call both CPS and your local law enforcement agency.

5. List three useful pieces of information you should gather about the suspected abuse:
   a. _____ b. _____ c. _____

6. You should keep a record of your call to CPS; what information should you record?
   a. _____ b. _____ c. _____

7. Should you inform the parent or the suspect that you have made a mandatory report?
   ☐ Yes ☐ No ☐ Maybe sometimes

8. Sex abuse is one type of abuse: name the three others you are required to report:
   a. _____ b. _____ c. _____
9. List three things you should keep in mind when questioning a child abuse abuse:
   a. _____ b. _____ c. _____

10. Can you be sued for reporting suspected child abuse in good faith? ☐ Yes ☐ No

11. Can you be sued for **NOT** reporting suspected child abuse? ☐ Yes ☐ No

12. How long is the statue of limitations for <u>reporting</u> child abuse? _____

13. If you report to your supervisor, your obligation is fulfilled. ☐ Yes ☐ No

14. Under the present child abuse laws, is it legal to buy or sell a child in Oregon?

    ☐ Yes ☐ No ☐ Maybe sometimes

Page Intentionally left Blank for Printing

Session Nine:

Juveniles with Sexual Harming Behaviors

In this session you will learn about the prevalence of sexually harming behaviors by juveniles, the key differences between adult sex offenders and juveniles, the various treatment goals and targets for juveniles in treatment, as well as your role as a foster parent.

Page Intentionally left Blank for Printing

“Juveniles with Sexual Harming Behaviors”

Power Point

bit.ly/2aZh9iG

Approx. 25min

Page Intentionally left Blank for Printing

Juveniles with Sexually Harming Behaviors

OYA Foster Parent Training

2017

A Few Definitions

- **Sex Offense** – any crime that involves sexual behavior as defined by criminal statutes in Oregon (e.g. Rape, Sexual Abuse, etc…)
- **Sexually Harming Behavior** – sexual behavior which is inappropriate and/or physically or psychologically harmful to others.
- **Referral** – criminal behavior for which a juvenile is referred to a county juvenile department, similar to an arrest for an adult.
- **Adjudication** – process by which a juvenile is found responsible for criminal behavior in juvenile court, similar to a conviction in adult court.

Key Points

For the purposes of this training, the youth we will be discussing:

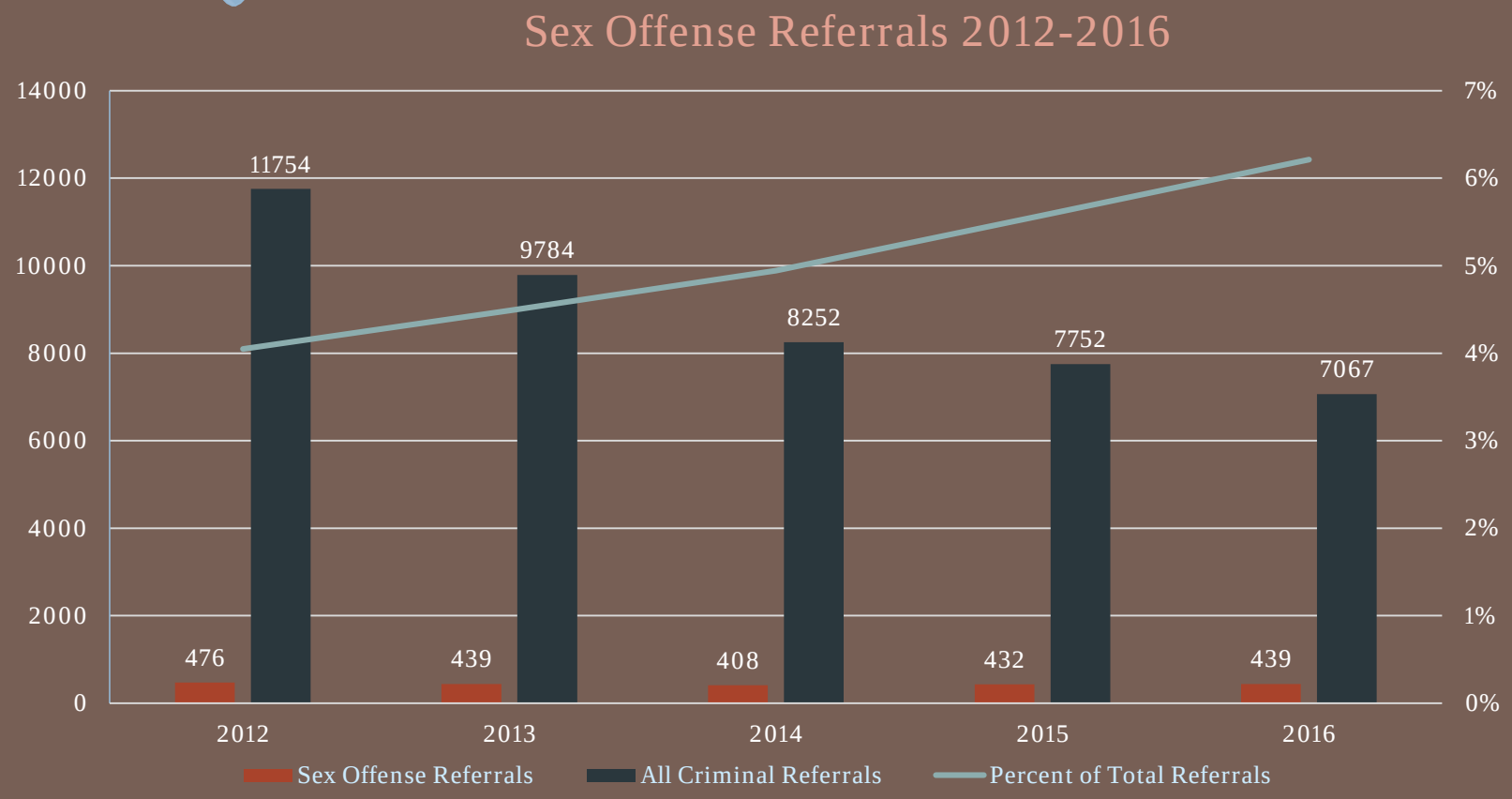
- Are adolescents, generally between the ages of 12 and 17. We will not address the special population of young children with sexual behavior problems.
- Are male. Although we know that females engage in sexually harming behavior, the majority of juveniles with sexually harming behavior appear to be male.
- Are adjudicated youth. The information presented is designed for youth have been referred to and adjudicated by the juvenile courts.

Goals of the Training

- The goals of this training are to help you to understand:
  - What is known about the incidence and prevalence of sexually harming behaviors by juveniles;
  - The key differences between adult sex offenders and juvenile with sexually harming behavior;
  - Treatment goals and targets for youth in treatment for sexually harming behaviors.
  - The role of foster parents with juveniles with sexually harming behaviors.

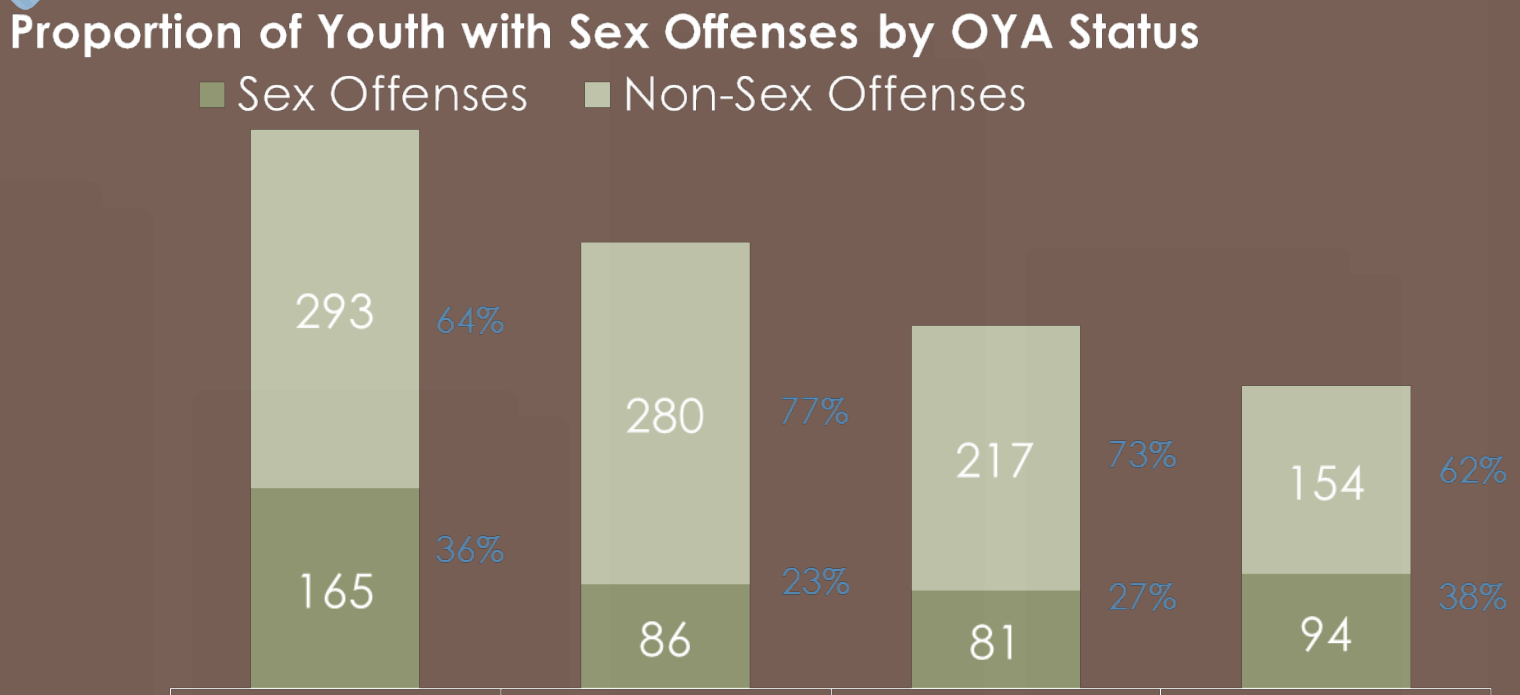
What Do We Know?

Sex Offense Referrals in Oregon



Source: JJIS Report 56s

Proportion of Youth with Sex Offenses by OYA Status



	Probation	Parole	Juvenile	DOC
Non-Sex Offenses	293	280	217	154
Sex Offenses	165	86	81	94

Source: OYA Quick Facts, July 2017

Juveniles vs. Adults

There are some similarities between juveniles with sexually harming behaviors and adults who sexually offend, but also many important differences.

Key Similarities (between juveniles and adults)

- Harm to victims is the same.
- Most adults and juveniles who sexually harm are more likely to harm people they know vs. strangers
- Most are done in secret, are under reported, and there is hardly ever physical evidence.
- It does not "just happen" – there is usually some planning.
- Thinking errors such as justifying and minimizing are common.
- Struggle in areas of self care such as poor hygiene, and have lagging social skills.
- There is no one type of person that has sexually harming behaviors, there is diversity in background, demographics, personalities, etc…
- They are not just "sex offenders" – they are whole people with many different aspects to their life and behaviors.

Suggested Differences (between juveniles and adults)

- Adults have more deviant interests or arousal
- Psychopathy is more common in adults, but even then it is quite rare.
- Juveniles have more "normative" impulsivity than adults.
- Juveniles are often not in control of their environment and it has a huge impact.
- The trauma experienced by juveniles is often times more recent and there is a potential link between child sex abuse and sexually harming behaviors in juveniles.
- Recidivism and positive outcomes tend to be better for juveniles than adults.

What Do We Do?

Assessment & Treatment

Risk Factors: General Criminal Recidivism

- Age at first referral or adjudication
- Prior referrals or adjudications
- Nature of current charge
- Prior aggression
- Association with delinquent peers
- Social isolation
- History of running away
- Substance abuse
- Family instability, poor parent-child relations
- History of maltreatment
- School problems

(see, e.g., Cottle et al., 2001; Lipsey & Derzon, 1998)

Suggested Risk Factors for Juveniles: Sexual Recidivism

- Family instability, poor parent-child relations
- Association with delinquent peers
- Social isolation
- Antisocial orientation, psychopathy
- Past offenses against two or more known victims
- Deviant arousal
- Sexual preoccupation, compulsivity
- Non-familiar victims
- Attitudes supportive of offending
- Impulsivity
- Treatment non-compliance, termination

(see, e.g., Prescott, 2006; Worling & Langstrom, 2006)

OYA Recidivism Rates

36-Month Felony Conviction/Adjudication Recidivism Rates for All Youth Placed on OYA Probation* or Released from Close Custody**

	Adjudicated for Sexual Offense		Adjudicated for Non-Sex Offense	
Disposition	Any Felony	Sex Offense Felony Only	Any Felony	Sex Offense Felony Only
Probation*	4.6%	2.7%	28.8%	.9%
YCF***	11.9%	3.3%	36.7%	1.4%
DOC**	18.8%	5.1%	23.2%	.4%

* Tracking starts at disposition
** Tracking starts at release
***First-time releases only, does not include revoked youth

FY06 thru FY10 by Disposition, Crime Type, and Type of Recidivism Crime

Examples of Evidence-Based Interventions

- Wraparound Services
- Functional Family Therapy
- Multisystemic Therapy
- Cognitive Behavioral Treatment

Common Treatment Goals

- Accept responsibility for behaviors
- Identify contributing factors
- Explore and use effective coping strategies
- Develop prosocial skills and competencies
- Establish positive peer relationships
- Promote healthy family functioning
- Clarification and Reunification

Common Treatment Targets

- Taking responsibility
- Cognitive distortions or risky thinking (thinking errors)
- Victim empathy
- Intrapersonal and interpersonal skills
- Healthy Sexuality
- Relationship skills
- Healthy masculinity
- Arousal control
- Trauma resolution
- Pornography use
- Family functioning

Clarification and Reunification

- Gradual and deliberate
  - Out of home placement
  - Treatment interventions
  - Readiness assessments (for both juvenile and victim)
  - Supervised contacts in clinical settings
  - Clarification
  - Supervised contacts in natural environments
  - Transition to family supervision
  - Return home possible

How Do We Supervise?

Supervision

A Balanced Supervision Approach

- Beyond surveillance, monitoring, deterrence, and sanctioning.
- Emphasize rehabilitation.
- Successful, productive youth translate into safer communities.
- Treatment team approach – includes youth, foster parent, treatment provider, foster care certifier, parent, Juvenile Parole/Probation Officer (JPPO), and ???

Examples of Success-Oriented Goals

- Participate in prosocial recreational and leisure activities
  - Think about available options in your community.
- Achieve and maintain positive school engagement
- Establish positive peer groups
- Obtain appropriate employment

Supervising Youth in the Community

Guided by:

- Current case/treatment plan and direction of JPPO
- Risk and needs
- Strengths and assets
- Environmental factors
- Needs of victims and vulnerable parties

Supervising Youth in the Community (cont)

- Special considerations
  - Restrictions on contact with victims or other vulnerable individuals (e.g. young kids, low functioning individuals)
  - Follow all treatment recommendations
- Every day decisions
  - Free time in the community
  - Extracurricular and employment activities
  - Supervision level
  - School safety planning

Specialized Conditions

- Internet or computer restrictions
  - Internet accessible devices (i.e. X Box, iPod, Netflix, cell phones)
  - No internet in the bedrooms
  - Internet blocks & monitoring programs (i.e. Net Nanny, Covenant Eyes)
  - Be aware of Social Media (i.e. Facebook, Instagram, Snapchat)
- Limits on TV programming and video games
  - In consultation with treatment team

Behaviors to Notice

- Juveniles may set-up potential victims to gain trust so they will go along with abuse and not tell.
  - Paying special attention to someone.
  - Crossing small boundaries (e.g. wrestling, non-sexual touching)
  - Using tricks, traps, bribes, or threats to gain the "upper hand" and eventual compliance.
- Caution: Juveniles are still juveniles – not all behavior is a potential set-up.
  - It is good to always be aware and know how this may look different for every youth

Foster Parent Role

- Serve as role models
- Engage juveniles in positive social interactions and activities
- Provide positive reinforcement
- Help youth to use skills learned in treatment
- Monitor and respond to high risk behaviors and situations
- Communicate openly with probation/parole officers, treatment providers, and certifiers about progress and problems

SO Registration Basics

- No juveniles will be required to complete sex offense registration while in OYA custody.
- Juveniles will have a hearing in the six months prior to termination of OYA supervision to determine if they will register as a sexual offender.

Page Intentionally left Blank for Printing

The Wrap-Up

Summary

Page Intentionally left Blank for Printing

Take Home Messages

- Juveniles with sexually harming behavior are different in many ways from adult sex offenders.
- Treatment for juvenile's with sexually harming behavior is **effective** and includes many treatment targets and goals.
- Coordination between foster parents, treatment providers, foster care certifiers, and JPPOs is **critical** for success.

Contact Us

- Please call your OYA Foster Care Certifier with any questions.

- If your certifier cannot be reached, you can call the Foster Care Support Direct Line at 503-373-7595.

Session 9: Juveniles with Sexual Harming Behaviors

"Juveniles with Sexual Harming Behaviors"
Competency Worksheet

1. Name 3 key similarities between juveniles with sexual harming behaviors and adult sex offenders.

_____

_____

_____

2. Name 3 suggested differences between juveniles with sexually harming behaviors and adult sex offenders.

_____

_____

_____

3. Recidivism and positive outcomes tend to better for juveniles than adults.

☐ True
☐ False

4. Name at least six of the recidivism risk factors for juveniles with sexually harming behaviors.

_____

_____

_____

_____

_____

_____

5. Name four common treatment targets used when working with juveniles with sexually harming behaviors:

_____

_____

_____

_____

6. Supervision of youth with sexual harming behaviors goes beyond monitoring and sanctioning their behavior, the focus is on treatment and rehabilitation.

☐ True

☐ False

7. Behaviors to notice when working with juveniles with sexually harming behaviors include:

a) ☐ Crossing small boundaries (e.g. wrestling, non-sexual touching).

b) ☐ Uses tricks, traps, bribes, or threats to gain the "upperhand" and eventual compliance.

c) ☐ Paying special attention to someone.

d) ☐ All of the above.

8. Foster parent role in supervision and success of youth.

a) ☐ Serve as a role model

b) ☐ Engage juveniles in positive social interactions and activities

c) ☐ Provide positive reinforcement

d) ☐ Help youth to use skills learned in treatment

e) ☐ All of the above

9. OYA youth do not have to register while on OYA supervision.

☐ True

☐ False

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

Session Ten:

Positive Human Development

In this session you will learn the meaning of positive human development, the culture of success pyramid and how you can promote this strength-based approach with the youth in your home.

Page Intentionally left Blank for Printing

“Positive Human Development”

Online Video

bit.ly/2pzcoQ6

2 hours

Page Intentionally left Blank for Printing

Session 10: Positive Human Development (PHD)

"Positive Human Development"
Competency Worksheet

1. Positive Human Development is not _____ we do, it is _____ we do it.

2. Check all that are true.

   a. ☐ The Amygdala is the emotional command center of the brain.
   b. ☐ The prefrontal cortex is the part of the brain that is responsible for reasoning, decision-making, and self-control.
   c. ☐ The prefrontal cortex is fully developed by the age of 15.

3. Match the lens to its definition:
   a. Villian Lens
   b. Victim Lens
   c. Resource Lens

   _____ Sees an individual as a whole person, recognizing that they have challenges but they also have strengths

   _____ Sees an individual in a negative way (i.e. focuses on a youth's criminal history, substance abuse issues, antisocial behavior, etc.)

   _____ Sees an individual as a problem to be fixed (i.e. focuses on things like trauma, mental health issues, dysfunctional families)

4. What are the 3 types of safety and security?

   _____

   _____

   _____

5. Caring is defined as a sense of being _____ or _____.

6. Expectations should be exactly the same for every youth no matter what skills and abilities they may have.

   ☐ True

   ☐ False

7. Providing only external accountability (i.e. rewards and consequences) will lead to crime-free, productive citizens.

   ☐ True

   ☐ False

8. Foster Parents and staff need to provide skill building opportunities and role modeling in order for a youth to develop an internal sense of accountability.

   ☐ True

   ☐ False

9. Meaningful participation happens when we believe we are taking an _____ role in a partnership or collaboration.

10. Give three examples of a type of community:

    _____

    _____

    _____

Foster Parent Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____

Certifier Signature: _____ Date: _____

Session Eleven:

OYA
Foster Parent
Handbook

Page Intentionally left Blank for Printing