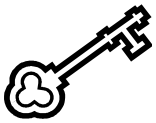
Chapter 2: Key concepts for planning effective education programs

This chapter presents a framework of key concepts for working with students with FASD. This framework gives teachers a starting point for thinking about and understanding the complex issues of students with FASD. Teachers can make an important difference in these students' lives, but to do so requires knowledge, understanding and the willingness to collaborate with others. It also requires a sense of hopefulness and a belief that, with support, patience and understanding, these students will be successful.

Students with FASD often have complex learning disabilities, behavioural difficulties, and problems expressing and understanding language. Many of these problems are the result of underlying neurological impairments. These students can and do learn, but they often learn in atypical ways.



Different levels and patterns of prenatal alcohol exposure lead to variable neurological impairments that are reflected in learning and behaviour.

Organic brain damage in individuals with FASD initially occurs prior to birth and is a result of exposure to alcohol.

The reason for the variability in brain damage in this population is that each child has experienced a unique pattern in the timing and level of alcohol exposure prenatally. So theoretically, each will have a distinct pattern of neurological impairment. The amount of alcohol the mother drank and when she consumed the alcohol influences the structures that were developing in the fetus at that specific period. Each fetus is susceptible to damage depending on stage of development and metabolic factors of the individual fetus. Each mother has her own factors that affect alcohol metabolism, including her food intake and overall physical health. In the moment of interaction between exposure to the toxic properties of alcohol and specific development in the fetus, damage to developing structures can occur.

Students with FASD often demonstrate subtle and complex difficulties in many areas of functioning. Their brain damage can affect how they perceive new information, how they memorize and learn new skills and ideas, and how they recall previously learned facts, concepts, procedures and skills.

Variability is a key feature in the FASD population of students. There are no defining characteristics, such as a reading disability, low level of intelligence or muscle weakness, that are always evident in this population. It is also difficult to identify which learning and behaviour issues are related to underlying neurological impairments, and which are related to other environmental, physical or social-emotional causes.

Students with FASD present a range of learning difficulties. Some have reading and written language difficulties, and many students have mathematical reasoning difficulties. Levels of intellectual functioning can range from severe mental disabilities to above average functioning. Many students have weak social communication skills. Some have speech articulation problems or difficulty learning simple, basic grammar and vocabulary.

Students' in-class and in-school behaviours vary, depending on age and social context. Most students with FASD perform better in structured learning environments and in smaller learning groups. When settings change and become more complex, such as moves to a junior high or high school, students who did well in the more structured environment may have difficulty coping with the new challenges of a larger, less-structured setting.

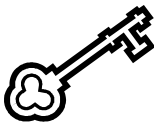
As teachers deal with the behavioural and learning challenges of students with FASD, they need to keep in mind that the daily learning and behaviours of students are related in part to neurological impairments caused by prenatal alcohol exposure. The learning needs of these students are variable; two different students diagnosed with FASD do not necessarily act or learn in similar ways.

Parents and professionals report a significant shift in their perceptions once they understand that individuals with FASD have a neurologically-based disability. The following chart of Paradigm Shifts and FASD, adapted from the work of Diane Malbin, indicates ways teachers can shift their interpretation of a particular behaviour to take into account underlying neurological impairment.[31]

Paradigm Shifts and FASD[31]

From seeing the child as…	**To understanding the child as…**
Won't	To Can't
Bad, annoying	Frustrated, challenged
Lazy, unmotivated	Trying hard, tired of failing
Lying	Story telling to compensate for memory, filling in the blanks
Fussy	Oversensitive
Acting young, babied	Being younger
Trying to get attention	Needing contact, support
Inappropriate	Displaying behaviours of young child
Doesn't try	Exhausted or can't get started
Mean	Defensive, hurt
Doesn't care	Can't show feeling
Refuses to sit still	Overstimulated
Resisting	Doesn't "get it"
Trying to annoy me	Can't remember
Showing off	Needing contact, support
From personal feelings of…	**To feelings of…**
Hopelessness	Hope
Fear	Understanding
Chaos, confusion	Organization, comprehension
Power struggles	Working with
Isolation	Networking, collaboration
Professional shifts from…	**To…**
Stopping behaviours	Preventing problems
Behaviour modification	Modelling, using visual cues
Changing people	Changing environments

31. Adapted with permission from Diane V. Malbin, "Paradigm Shifts and FAS/FAE" (Portland, OR: Fetal Alcohol Syndrome Consultation, Education and Training Services, Inc., 1994) AND from Diane V. Malbin, *Trying Differently Rather than Harder* (Portland, OR: Fetal Alcohol Syndrome Consultation, Education and Training Services, Inc., 1999), p. 42.



Both prenatal and postnatal factors contribute to learning and behavioural difficulties.

Students with FASD may demonstrate not only central nervous system problems caused by prenatal alcohol exposure, but may also have other prenatal and postnatal factors that have negatively influenced brain development, and subsequent social adjustment and learning.

In addition to prenatal alcohol exposure, a variety of other genetic and prenatal factors may influence the learning and behaviour of children. Children can inherit genetic tendencies, such as the likelihood to develop diseases, as well as their cognitive and behaviour strengths and disabilities. A child's level of intelligence or tendency to have a reading disability may be related to an inherited pattern. Also, certain behavioural disorders, such as attention-deficit/hyperactivity disorder, are inheritable.

Children may also have experienced other toxic factors, such as nicotine, prenatally. In follow-up studies of children with FASD, many birth mothers report smoking and using other drugs during pregnancy.[32] Tobacco use in pregnancy can lead to smaller newborns and childhood respiratory problems. Exposure to drugs, such as cocaine and heroin, can have negative effects on behavioural regulation.[33] However, compared to other drugs studied, alcohol seems to have the most pronounced and long-term effects on cognitive functioning, learning and behaviour.[34]

Postnatal exposure to alcohol can also play a role in neurological development. Significant brain development occurs in the first two years of life. Some children continue to have postnatal exposure to alcohol through their mothers' breast-milk.[35]

An important influence on overall cognitive, social and emotional adjustment is the nature of the caregiving situation. When children with FASD are raised in homes that provide nurturing, love, appropriate stimulation, resources and family bonding, there are immense benefits. A positive and stable early home life is one of the prime protective factors against developing secondary disabilities. It is important that families understand that children with prenatal exposure to alcohol may need long-term supports as a result of this brain damage.

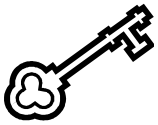
Children can experience the protective factor of a stable, understanding, nurturing home and family environment in a variety of ways. Biological parents can work to become sober and learn the skills they need to parent and provide a positive home environment. Children can be placed soon after birth in nurturing, supportive foster or adoptive homes. Stable placements, and appropriate support and love, can give children the family experience they need for optimum growth and development. Most families want to work with school and community personnel to improve the lives of children with FASD.

Educators need to be aware of the risks to children who live in negative, disrupted home environments and experience inappropriate parenting. Some children with FASD live with family instability, neglect, abuse and multiple changes in caregivers. When parents continue to abuse substances and lead negative lifestyles, their children experience many threats and difficulties to their development. Such family factors should be considered when addressing the needs of these children at school.

32. Astley et al. 2000.
33. Fried 2002.
34. Streissguth et al. 1991.
35. Little et al. 1989.

Another factor that puts children with FASD at risk is lack of understanding of the reasons for their problems and difficult behaviours. This can be an issue in all kinds of family settings. Adoptive and foster parents may not be informed of the possibility of prenatal exposure. Even if the adoptive or birth family is aware that the biological mother drank during pregnancy, they may not understand that brain damage and other consequences may result from prenatal alcohol exposure.

When parents don't have a clear understanding of these children's complex needs, many frustrations, conflicts and problems occur. Typical child-rearing approaches may be unsuccessful with children with FASD. These children's failures can lead to disappointment and guilt for all family members. It is important that school staff understand the nature of these children's difficulties and ensure appropriate programming is in place.



A medical diagnosis creates an opportunity for understanding and is a protective factor against developing secondary disabilities.

Parents and teachers often require assistance and support to understand the needs of children with FASD, and adapt expectations for present and future performance. Often it is when children start school that their learning disabilities, and social and behavioural difficulties become obvious. In some cases, parents may have suspected problems from an early age. Diagnosis may be the first step on the path to understanding and accepting a student's limitations and special needs.

Teachers may be called upon to help in the diagnostic process. Teachers may be the first to note the learning and behaviour problems students are having. After trying the usual approaches to adapting instruction and modifying behaviour, it may become evident that a student is not responding like most others his or her age. At this point teachers can:

- document concerns in writing
- ensure all necessary academic and psychological testing is conducted in order to obtain a complete picture of the student's strengths and needs
- meet with parents to share test results and concerns
- arrange for a designated person from the school, either the psychologist or counsellor, to meet with parents to suggest a follow-up medical evaluation to obtain more information
- assist with the diagnostic medical evaluation by completing informal interviews, behavioural rating forms, and sharing school records and performance information.

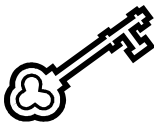
FAS is a medical diagnosis and requires the expertise of a multidisciplinary team. The role of teachers is NOT to diagnose, but to communicate with parents and let them know that additional information is required to better understand and support the learning needs of their children. School psychologists or family physicians may suggest local clinics and/or multidisciplinary teams that can make a medical diagnosis of FAS.

Although a FAS diagnosis points to conditions with lifelong consequences, there is hope for the future. Diagnosis before the age of six is a universal protective factor reducing the likelihood of mental health problems, disrupted school experience, trouble with the law and confinement.[36]

36. Streissguth and Kanter 1997.

Clear diagnoses lead to greater appreciation of children's needs and are a protective factor as children go through school. Eventually, adolescents and adults may receive special work status and social services based on their diagnoses. With appropriate training and support, the emotional and social problems (secondary disabilities) often seen in adolescence are less likely to occur.

Another advantage of a medical diagnosis is that it creates opportunities to offer support to birth mothers. Effective intervention with birth mothers helps ensure that future children are not at risk of FASD.



Students need early intervention and continual educational support.

Early intervention provides a crucial foundation for the development of skills, enhancement of relationships and prevention or minimization of secondary disabilities.

Early identification has a direct impact on parents' perception of their children and provides a context for understanding their skill and behavioural development. Early intervention programs through health regions and home visit programs emphasize an interactive approach to developing skills and relationships. By providing support, information and strategies to parents, challenges that can be frustrating and distressing are placed in the context of the disability rather than attributed to poor parenting or the motivational characteristics of children. Parental understanding and involvement provide the basis for effective family and school relationships.

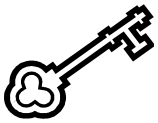
Multidisciplinary teams can provide strategies for skill development. Speech-language pathologists, occupational therapists and psychologists can suggest developmental experiences that may have substantial impact during the first six years of life when the brain experiences significant growth. These consultants can continue to assess and provide valuable suggestions to address the unique learning patterns, strengths and needs of students throughout their life spans.

Early education programs maximize the effectiveness of learning experiences during the developing years. Strategies that emphasize providing support, reframing perceptions, developing environmental modifications and ensuring that successes are celebrated can be implemented early with the intention of maintaining such approaches throughout individuals' lives.

Early intervention is more than just working with children through their early years. It also emphasizes putting supports in place when transitions are about to occur or early on when challenges are first recognized. Involving parents, teachers and support personnel helps ensure individualized program plans (IPPs) are developed and implemented, and fosters communication and support between home and school. To learn most effectively, students with FASD require a creative combination of strategies, approaches and techniques tailored to their individual needs and strengths. To ensure generalization, skills taught in school may also need to be taught at home.

Learning for students with FASD, as for all students, continues throughout the life span. However, the developmental levels of functioning of students with FASD are often substantially below their chronological age expectations. Additional planning, training and support is warranted during the transition years from school into the workplace. Many students with FASD demonstrate lifelong disabilities that require ongoing support, education and management strategies. With appropriate education and support, these individuals will continue to learn. Many go on to live independently and contribute to their communities while others may need supportive family or group home settings.

Working with students with FASD can be challenging, however teaching these students can also be a rewarding experience. Through working with these children, teachers can learn more about how all children think and learn, and how to modify instruction for all students with special needs. Teachers can model the importance of seeing children with FASD as children first, looking for and identifying their strengths, and understanding and responding to the diversity of their needs.



Identifying and understanding individual strengths and needs is the starting point of effective programming.

Finding successful interventions for each student begins with understanding that individual and the world in which he or she lives. As teachers understand their students better, they can begin to program more effectively for them.

One helpful strategy might be having a consultant observe the student with FASD in the classroom setting while the teacher works with the class. This process can help the teacher and consultant work collaboratively to develop intervention strategies to use in the classroom and at home.

To start an analysis of students' strengths and needs, begin with classroom observation.[37] At the same time, ask parents about behaviour at home and conditions that affect behaviour. Formal assessments can be initiated at this point to determine cognitive, language and motor abilities, adaptive skills functioning and basic academic skills. Use this information to identify students' developmental levels. The developmental level should be the starting point for instructional planning. The developmental level is the equivalent functioning age level at which a student understands information, plays, speaks and completes tasks independently. Knowing the developmental age establishes appropriate expectations and levels of support. Even though skills and concepts need to match the levels of functioning of students, instructional strategies and materials used to teach these skills and concepts should be as age-appropriate as possible.

37. Hartness 2001.

The following chart compares standard behavioural expectations for chronological ages and contrasts them with actual developmental age abilities often seen in children with FASD.[38]

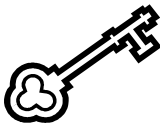
Chronological age-appropriate expectations	Developmental age-appropriate expectations
Age 5	**Age 5 going on 2 developmentally**
Go to school	Take naps
Follow three instructions	Follow one instruction
Sit still for 20 minutes	Active, sit still for 5–10 minutes
Interactive, cooperative play, share	Parallel play
Take turns	My way or no way
Age 6	**Age 6 going on 3 developmentally**
Listen, pay attention for an hour	Pay attention for about 10 minutes
Read and write	Scribble
Line up on their own	Need to be shown and reminded
Wait their turn	Don't wait gracefully, act impulsively
Remember events and requests	Require reminders about tasks
Age 10	**Age 10 going on 6 developmentally**
Read books without pictures	Beginning to read, with pictures
Learn from worksheets	Learn experientially
Answer abstract questions	Mirror and echo words, behaviours
Structure their own recess	Require supervised play, structured play
Get along and solve problems	Learn from modelled problem solving
Learn inferentially, academic and social	Learn by doing, experiential
Know right from wrong	Developing sense of fairness
Have physical stamina	Easily fatigued by mental work
Age 13	**Age 13 going on 8 developmentally**
Act responsibly	Need reminding
Organize themselves, plan ahead, follow through	Need visual cues, modelling
Meet deadlines after being told once	Comply with simple expectations
Initiate, follow through	Need prompting
Have appropriate social boundaries	Kinesthetic, tactile, lots of touching
Understand body space	In your space
Establish and maintain friendships	Forming early friendships
Age 18	**Age 18 going on 10 developmentally**
On the verge of independence	Need structure and guidance
Maintain a job and graduate from school	Limited choices of activities
Have a plan for their lives	Live in the "now," little projection
Relationships, safe sexual behaviour	Giggles, curiosity, frustration
Budget their money	Need an allowance
Organize, accomplish tasks at home, school, job	Need to be organized by adults

38. Adapted with permission from Diane Malbin, *Fetal Alcohol Syndrome/Alcohol-Related Neurodevelopmental Disorder: A Five-part Set of Information for Parents and Professionals; Set Five: Master Set: Collection of Set One Through Four* (Portland, OR: FASCETS, Inc., 1999), pp. 33–34.

Understanding students and their levels of performance helps teachers plan initial programming strategies. As teachers observe the effects of new strategies on students' daily learning, additional strategies can be introduced gradually. Build in an appropriate observation period to see if students improve with the new interventions before adding additional strategies.

Make adjustments to students' programs as needed. It may be necessary to take a step back and observe students once again to decide what strategies should be modified, discontinued or added.

Each student is a unique person with his or her own talents and gifts. It is important that educators help students with FASD develop and use their strengths and talents, and support them as they cope with their difficulties. Include positive activities in the daily routine of each school day. Many students have talents in music or art. Encourage athletics and create opportunities for them to help others. These students need opportunities to build their feelings of self-worth and experience success.



Collaborative planning and programming help teachers meet the complex needs of students.

A team approach can help classroom teachers better meet the complex needs of students with FASD. Perspectives and programming ideas from various education professionals, as well as from parents, can be helpful in planning comprehensive programs that address student needs. See Appendix A1, page 111, for sample questions to discuss during meetings with parents.

No single individual has all the knowledge and expertise required to understand and meet the complex learning needs of students with FASD. Collaboration, planning and programming are key to successful instruction. Collaborative teaming can take many forms.

A problem-solving approach is the core of effective collaboration, whether the team is large or small, formal or informal. The problem-solving cycle begins with identifying and clarifying the problem. The team works together to generate solutions and develop a plan of action. Timelines for implementation and a method for evaluation encourage team members to come back together to evaluate the plan and see if it is working. If necessary, the team can revisit the problem-solving cycle and address new or outstanding issues.

There are a number of guidelines for facilitating successful collaboration.

- Involve other teachers. Create opportunities for all teachers involved to raise concerns about student progress and engage in problem solving before there is a formal referral. Provide opportunities for every teacher to participate and receive support.

- Involve parents. Welcome parents as important team members. Recognize and respect both the information they can provide about their children and their contribution to children's programs.

- Involve students. Students can provide important information about their learning and will be more actively involved in their programs if they participate in setting goals. This is an opportunity for older students to learn valuable self-advocacy skills. The age and level of functioning of students will determine their level of participation.

- Involve administrators. School administrators' support is essential to success. School-wide acceptance of shared responsibility for the success of all students depends on strong leadership. Organizing a systematic process for collaborative program planning and ensuring that there is time for collaboration require the kind of supportive structure that only school administrators can create.

- Designate one school-based person to facilitate the process, seek out additional expertise, and organize and coordinate resources.

- Keep team membership flexible and draw on expertise available in the school. Do not limit the collaboration to formal interactions of a designated team. Encourage regular collaborative problem-solving meetings for smaller teams that are implementing and monitoring education plans.

To be successful, collaborative teams need:
- willingness to share and exchange expertise and resources
- acceptance of mutual responsibility and accountability for key decisions
- clearly established roles and responsibilities
- all members to contribute and all contributions to be valued
- training and supervision for teaching assistants, volunteers and peer tutors
- procedures for sharing observations and monitoring progress
- support from school administrators
- regular scheduled time for planning and communication. This is especially important if some programming is delivered outside the regular classroom. Team meetings can address issues, such as transition and generalization, links to classroom instruction, and common language and cueing systems for students.

Use a collaborative team approach in the development of individualized program plans (IPPs). IPPs are written commitments of intent by education teams to ensure appropriate planning for students with special needs. They are working documents and records of student progress.

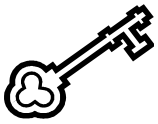
There are a number of guidelines for collaborative development of IPPs.
- Actively involve parents in the IPP process.
  - Seek parental input prior to IPP conferences, e.g., send home a form seeking information about their goals, their children's preferences, etc.
  - Give parents the opportunity to specify how they would like to be involved in their children's education programs and keep them informed.
  - Assist parents in preparing for IPP meetings.
  - Discuss a draft IPP and invite meaningful input from the parents. Make changes and additions with their input. (Putting a signature on a finalized IPP with no opportunity for input may be discouraging to some parents.)
  - Provide parents with a copy of IPPs so they can support the goals at home.

  See Appendix A2, page 112 for more strategies to enhance parent involvement in the IPP process, and Appendix A3, page 113 for a tip sheet for parents on participation in the IPP process.

- Actively involve students in the IPP process, increasing participation as they mature.
  - Involve students in setting goals and evaluating progress to increase ownership and motivation, as appropriate.
  - Involve students in IPP conferences, as appropriate.
  - Support students in taking responsibility for describing needs and seeking appropriate support.
  - Help students develop self-advocacy skills.

- Involve appropriate school personnel in developing IPPs.
  - All school personnel involved in providing instruction for students with FASD should be involved in developing IPPs. Regular classroom teachers are better able to use IPPs as instructional guides when they are involved in developing them.
  - IPPs are most effective when viewed in the context of an active problem-solving process, which can be facilitated by an organizational structure, e.g., Student Support Team model, that provides a forum for ongoing team planning.
  - Provide professional development and guidance for teachers to increase understanding of the purpose and structure of IPPs.
  - The culture and organization of the school should support the IPP process, e.g., time for involvement, communication, access to additional expertise.

For more information, see *Individualized Program Plans* (Alberta Education, 1995), Book 3 of the *Programming for Students with Special Needs* series.



Establish strong home-school partnerships.

Parents are important and essential partners in creating and carrying out effective education programs. They play a critical role in their children's daily lives and can help school personnel understand their children's behaviours and needs. Parents can help develop individualized program plans, and can continue the learning and behavioural strategies at home, reinforcing the school program. Children supported at home and at school in similar ways maximize their learning and have better opportunities to meet their potential.

Many families are eager to participate in partnership with school staff. They often know and use many effective ways to help their children learn, and have information and observations to share about their children's strengths and weaknesses. Some parents already have medical diagnoses of FASD for their children. Others have knowledge of FASD and are aware their children were exposed prenatally to alcohol. They may have previous evaluations and a range of resources to bring to school. These parents may be actively seeking out services and interventions, and will readily work with the school learning team to organize and collaborate. See Appendix A4, page 114 for tips on working with parents.

When developing an educational partnership with parents, keep the lines of communication open by:
- giving parents opportunities to identify goals for their children
- identifying and clarifying specific parental concerns and helping parents assess their family needs
- being aware of and discussing the parent-child relationship and interactions
- discussing current interventions parents are using.

For parents who are ready to examine the issue of FASD, school staff may be able to offer support and assistance in one or more of the following areas:

- providing ways to learn about the signs, symptoms, medical, social and behavioural consequences of FASD through brochures, videos, conferences
- supporting parents in setting realistic goals and expectations for their children and themselves
- keeping a positive focus on their children's strengths, talents and accomplishments
- facilitating referrals to other agencies, such as health and social services
- finding parent support groups and/or counselling with knowledgeable individuals
- encouraging parents to participate in parent education classes for parents of children with special needs. Typical childrearing practices may not be effective, however specialized parenting courses, such as those dealing with the parenting of difficult children, may be helpful.

A variety of techniques can be used for home-school communication. Communication books can be valuable tools for supporting students, and keeping both parents and teachers up-to-date on relevant issues. Completing checklists of agreed-upon behaviours is time efficient and may ensure more objective reporting. Phone contact and e-mails also work for many families. See Appendix A5, page 115 for an example of a home-school communication book.

Some parents may initially seem less willing to engage with the school or appear uncooperative. Usually there are reasons for these parents' reticence and resistance. One issue may be the parents' own history of negative school experiences. Parents may want to avoid school because they lack confidence in their own ability to deal with teachers. Other parents may have overwhelming health, economic and social difficulties, and limited energy to engage. They may feel that school staff cannot understand their current life circumstances. Cultural and language differences may also influence parental reactions. Some parents may be angry about their children's previous school experiences. They may have lost hope that their children will obtain the education they need. For such parents, it is essential that school staff continue to encourage participation.

School staff may use these strategies to try to involve parents who seem reluctant to participate.

- Continue to invite parents to come to school. Try a range of ways to contact them. In addition to letters or phone calls, see if there is a school staff member who could visit the home, such as a liaison worker.

- Ask for the assistance of a parent advocate, family service agency worker or group already involved with the family, such as a health agency or Child and Family Services.

- Offer to meet parents either at their homes or neutral locations, such as community centres or restaurants.

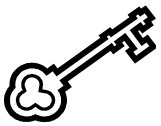
- Suggest parents invite a family member, friend or neighbour to come to meetings with them for support.

- Maintain a positive, understanding approach even when the response is negative.

Resources for parents:

- *The Parent Advantage* (Alberta Education 1998)
- *A Handbook for Aboriginal Parents of Children with Special Needs* (a video and guide for First Nations parents) (Alberta Learning, 2000)
- *The Learning Team: A Handbook for Parents of Children with Special Needs* (Alberta Learning, 2003)

Home-school partnerships provide initial support that will facilitate learning for students with FASD and set the stage for working with other community agencies.



Coordinating services ensures everyone works toward common goals.

Meeting the needs of students with FASD requires a coordinated effort, not only between home and school, but also among community organizations that serve students and their families. Many issues that require intervention in the classroom may also need to be addressed in day care, community mental health programs, recreational settings, job settings and possibly the legal system. The multiple needs of students with FASD often require multiple fronts of intervention and interagency cooperation.

Efforts in the greater community need to be two-fold—supporting individuals with FASD and educating the community about the prevention of this disability. There are a number of people, groups and agencies throughout the province that offer services related to FASD.

In recent years, resources have been developed in Canada to help members of the judicial system and police better understand the issues for individuals with FASD. These materials, written by Conry and Fast (2000), and Laporte et al. (2003) can be a helpful way for groups to educate themselves about legal issues related to working with individuals with FASD.

Ideas for successful community partnerships include:

- working collaboratively with parents to identify, plan and deliver appropriate programming and services
- establishing education programs to inform the community of the dangers of alcohol consumption by expectant mothers
- networking with external agencies to provide support to students, parents and school staff
- collaboratively developing transition plans with specified supports and services that will enable students to be successful.[39]

Fetal Alcohol Spectrum Disorder: FASD Guidebook for Police Officers (2003) by Annette Laporte et al. is available from the following Web site: www.asantecentre.org/pdf/latestfasguide.pdf.

Fetal Alcohol Syndrome and the Criminal Justice System (2000) by Julianne Conry and Diane K. Fast, is available from the BC FAS Resource Society, P.O. Box 525, Maple Ridge, BC, V2X 3P2; fax 604–467–7102.

39. Streissguth 1997.