SAFE BABIES
Foster Parent Training Program

FACILITATOR REFERENCE GUIDE

An education program for families and caregivers of infants exposed prenatally to drugs and/or alcohol

Safe Babies Program
ROTMAN AWARD 2010 PROJECT
Foster Parent Support Services Society, BC Ministry of Children and Family Development, VI Health Authority, BC Safe Babies Programs, and SickKids Foundation

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INTRODUCTION

Welcome to the 2nd edition of the Safe Babies Foster Parent Education Curriculum. This revision is based on the original curriculum that was developed over the first four years of the Safe Babies Program (1997-2001), in consultation with many health and social services professionals and community members throughout British Columbia. Over the past twelve years of this program, agencies within communities across the province who provide care for infants and families have been continually open to sharing their knowledge, issues and experiences. Particular thanks are extended once again to the birth parents who shared their experiences, and to the dedicated group of foster parents who continue to focus on caring for this group of infants and children.

The Safe Babies Project was originally developed jointly in 1996 by the Capital Health Region (Victoria BC) and the BC Ministry of Children and Families Development (MCFD). It was subsequently adopted by many communities across the province. In 2008, a group of MCFD resource social workers, the Vancouver Island FPSS Foster Parent Support Services Society (FPSS), and specialized Safe Babies foster parents gathered to celebrate ten years of working together to support infants with substance exposure. At the same time, the Vancouver group was preparing for their tenth anniversary in 2011 and began preparing the third edition of the well-used caregiver's handbook. These groups and many others across the province have enthusiastically continued to meet to refresh the curriculum and program resources to reflect advances in research and knowledge, and to address shifts that have been noted in the population of infants and their families cared for within this program. For example, you will find new content on:

- crystal methamphetamine;
- methicillin resistant staphylococcus aureas (MRSA) infections;
- supporting caring for mothers and babies together;
- supporting mothers and father who have FASD themselves;
- trauma informed care;
- infant mental health;
- sensory integration;
- Aboriginal infant care considerations, and;
- Infant crying and Shaken Baby Syndrome

FORWARD

The care and nurturing of infants exposed prenatally to alcohol and/or drugs emerged a number of years ago as a major challenge to health care professionals, social workers, child and youth workers, and parents (natural, foster, and adoptive) (BC Children's Commission, 1998). Public awareness of this issue has been increasing over the past ten years, and also perceptions that the issue continues to grow in many communities across the province.

It continues to be difficult to find accurate information on levels of use, but the 2004 Canadian Addiction Study found that 78% of women in the country consumed alcohol, 39% reported trying cannabis, and 19% reported trying other illicit drugs (cocaine, speed, ecstasy, hallucinogens or heroin). Women in British Columbia were consistently the highest or almost the highest percentage of users in the country. Additionally, women continued to use prescription medications for anxiety and depression at record high rates. Health care and social service professionals and communities across Canada are much more aware of the impact of substance misuse on families and of the importance of prevention, early identification, coordination of services, and non-judgmental local support for positive outcomes for the infants and their families.

There has been a growing trend within the child welfare field to approach support of vulnerable families in a more comprehensive way. The recent Strong Safe and Supported framework developed by the BC Ministry of Children and Family Development (MCFD) includes prevention and early intervention strategies as well as intervention and support strategies. Even with increased prevention efforts by MCFD, health authorities and community agencies, there are still situations in which foster care is needed.

The Safe Babies education program is an attempt to outline what we believe to be the scope of knowledge and skills required of birth family members, foster families, professionals, and community members in providing the best care possible for infants and their families affected by prenatal substance misuse. The information is presented in an interdisciplinary format and is intended to provide you with a shared language and knowledge base, to promote the goal of consistency and currency in approaches and services throughout the community. Community-based collaborative training activities also offer the additional benefit of strengthening the networks that serve pregnant, substance-misusing women and their children.

CAREGIVER SELECTION CRITERIA GUIDELINES

Ministry for Children and Family Development (MCFD) staff selects participants for Safe Babies training and determines when a training event is needed in a particular community. The training is open to those foster parents who have been selected by the local Resource Team, Kith and Kin (family) caregivers who will be caring for a safe baby, MCFD staff, and community partners who work with Safe Babies. Whenever possible and space is available and with the approval of MCFD, Adoptive Parents may be included in the Safe Babies training. In order for the training to be most useful, foster parents who participate in the training and Safe Babies Foster Parent Training Program should have:

1. **Family Structure**

    - One adult should be a full-time primary caregiver
    - Must have a skilled support network or partner who, for regular periods of time, can take the place of the primary caregiver in providing care for the baby in all aspects of care
    - Other children in the home should be old enough to understand the demands the infant will make on their parent's time
    - All family members are supportive of having the infant within their family

2. **Physical Environment**

    - Infant should have his/her own room
    - Appropriate and CSA approved equipment must be used
    - Home should be large enough for caregivers to have a quiet place for the baby to ensure, when necessary, that a baby's needs for reduced noise and commotion are being met
    - Must meet the Standard of Smoke Free Environment as per BCFD Caregivers Standards
    - Pets in the home may hinder your ability to provide for some babies depending on their specific needs

3. **Education and Experience**

    - BCFCE – all training modules should be completed
    - Previous experience fostering children including infants and toddlers
    - Preferred outside-of-fostering experience with children with special needs, medically fragile or medically complex children
    - Preferred to have a minimum of 2 years fostering experience as an approved resource

- Degree or certificate in related field (i.e. nursing, child-care) or equivalent experience is recommended

4. Demonstrated Personal Characteristics

- Previous parenting experience
- Non-judgment and supportive attitude towards families with addiction issues
- Willing to work towards, and assist the family in gaining the skills required caring for their infant when re-unification is the plan
- Ability and commitment to work collaboratively with health care, community service providers, and MCFD staff
- Strong organization and record keeping skills
- Confidential and professional
- Ability to advocate for infant
- Ability to manage stress effectively
- Effective team member with the ability to take direction from team professionals to ensure care plan for infant
- Willingness to ensure self-care is maintain (use of relief, asking for help, breaks etc.)

5. Health Requirements

- Physically fit
- No limitations on physical self for caring for an infant i.e. lifting, holding infant for long periods of time or compromised back health
- Non-smoker
- Capacity to manage stressful situations and lack of sleep

6. Other

- Own reliable transportation suitable for safely transporting infants, equipped with appropriate infant car seat
- Commitment to stay current in the field of substance-exposed infants by reading and attending further training when available
- Availability and willingness to participate in local community support systems to remain connected

7. Final Approval

- A caregiver who has had the training must formally be designated and approved by MCFD as a Safe Babies Approved Home

PART A: GETTING STARTED

BACKGROUND OF THE PROJECT

Several high profile, tragic events involving high-risk infants in Victoria, BC, in the 1990's prompted a Children's Commission investigation and a Ministry of Children and Family Development (MCFD) review of high-risk infants and young children in foster care within the Capital Region. A key recommendation from both investigations was development of support and education services for drug and alcohol exposed infants, their parents and caregivers, and professionals.

In June 1997 representatives from the Capital Health Region (CHR) and MCFD met to discuss current services for substance-exposed infants and their families, and to raise issues surrounding practice in Victoria with this population. Drawing upon the varied experiences of the group (health care, child welfare, alcohol and drug services, infant development, foster care, and others) a pilot program was developed and initiated. The three primary goals of the program were to:

1. Develop and implement a "best practice" intervention model;
2. Provide education and support regarding the daily needs of the infants and their parents during the first year of life; and
3. Recruit new foster homes to care for high-risk infants.

The Safe Babies Education Program was developed as part of a pilot program in Victoria and was intended to be available for use by other communities throughout British Columbia and Canada. Over twelve years later, the program continues to provide education and support in different ways to communities across the province. In 2002, the Vancouver MCFD Safe Babies program received a Government of British Columbia Recognition Award in Innovative Practice for their program. Despite this work there continues to be a need to provide this information to communities. It is our hope that this revision will once again provide momentum for continued advancement in the support of infants in foster care, particularly those with health challenges due to prenatal substance exposure.

This document and the accompanying participant's manual were developed to provide education and training about the needs of the infants and their families and caregivers. To ensure the program would meet the needs of diverse communities, the following principles, based partly on the Child Protection Social Work Training Strategic Plan 1996-2000, were originally used to guide development:

- Training must be attainable and sustainable to ensure continuity;
- Training must be flexible to accommodate variations in geography, resources, and communities;
- Training must be based on the principles of adult learning; and
- Recognition and development of local expertise will support sustainability of the training.

Since development of the original Safe Babies curriculum, the BC Ministry of Children and Family Development and the BC Federation of Foster Parent Associations have developed the BC Foster Care Education Program. This program is the first of its kind in Canada developed by the BC community college system using the adult education

model. All new foster parents are required to attend this program. This Safe Babies revision was developed to build on what is learned in the general program (such as attachment, Aboriginal children in care, FASD/Neonatal withdrawal, and the effects of caregiving) and apply to the infant population generally and the substance-exposed infant population specifically.

The Safe Babies program is designed to improve the responsiveness of a community to the needs of substance-exposed infants and their families, caregivers, and professionals. As well as being an education program, the Safe Babies Foster Parent Training Program promotes a supportive philosophy of care that should be integrated into the practice and standards of professionals and related community services.

The program was designed to be adaptable to other communities. To develop and implement a successful program you will need:

- ✓ A community that is aware of, and accepting of, the need for increased education and improved coordination of services;
- ✓ Committed professionals, including physicians, nurses, social workers, administrators, and foster parents; and
- ✓ The ability within the community to develop a collaborative program that crosses traditional health care and child welfare boundaries.

This first section of the facilitator's guide includes information about work that needs to be done before any actual training. Remember that preparing education programs is a lot like an iceberg; nobody ever sees most of the work. The more thought that goes into planning and informing the community, the more successful the program.

STEP 1:

SETTING UP YOUR WORKING GROUP

Members of the working group are the people who "get the ball rolling", and often programs begin with a few interested people identifying a need within the community.

Here are some suggestions for getting started:

- ✓ Bring together a small group and begin thinking about your education needs. If you want your program to be supported locally, it is important to get ideas from people who represent a wide range of services. This small initial group would ideally include representatives from at least the following:
    - Health care (hospital and community)
    - Children's services
    - Foster parent support organizations

- ✓ Consider hosting a community information session to inform the community about the issue, to raise awareness about the need for education, and to recruit people interested in participating in the program.

  The responsibilities of this working group will include:

    - Community survey
    - Determination of community priorities for education
    - Formation of planning committee

- ✓ Once the working group has got the ball rolling, and you have some good ideas for your training program, it is important to convert the ***Working Group*** into a ***Planning Committee***. The *Planning Committee* will include members who will be responsible for all the activities associated with offering a program, such as:

    - Identifying a course facilitator
    - Obtaining necessary funding
    - Arranging course-related materials
    - Negotiating with speakers
    - Identifying participants

STEP 2:

SURVEY OF YOUR COMMUNITY

Implementation of a new philosophy of practice or a new program, or revision of an existing program, will be the most successful if it is based on detailed knowledge of the current services and skills present within your own community. This step provides you with the opportunity to survey what is available locally to support substance-exposed infants and their families and caregivers.

This step is presented in a series of worksheets which, when completed, will present a "snapshot" of the services. This snapshot will assist you with identification of the strengths and gaps in services, and provide a basis for developing a program that will fit the needs and abilities of your own community (refer to appendix). If you already have, or have had a Safe Babies program in your community, it is still a worthwhile exercise to revisit what resources are in your community. There are often changes in what is available in communities over the years with healthcare reorganization for example.

The worksheets survey three main areas:

1. Health care
2. Social services
3. Early childhood services

Using the following set of questions may assist you in your survey. They will provide you with a consistent set of information and make it easier to compile and compare the responses. Use the worksheets to identify the services, and then complete a community consultation sheet for each service.

Community Consultation Questions:

a) Please describe the services your agency currently offers, in particular to women and families with substance abuse issues.

b) What route do your clients have to take to access services at your agency?

c) Please describe the concerns you have regarding community services for the families and their children.

d) What recommendations would you have for improvement of local services?

Some examples of agencies to contact are:

- Primary care providers, including physicians, midwives and nurse practitioners
- Maternity nursing services in the hospital
- Public health nursing services
- Neonatal intensive care units

- Prenatal educators
- Mental health counselors
- Alcohol and drug counselors
- Children's ministry workers
- Foster parents
- Fetal Alcohol Spectrum Disorder (FASD Community Groups)
- Aboriginal health counselors and family workers
- Pregnancy Outreach Program staff
- Women's shelters
- Neighborhood house staff

You might find it helpful to hear what some of the consistent themes were that we heard from people working out in our communities on Vancouver Island – here was what we heard back in 1997 and also what we continue to hear today, despite lots of work by many people to address this:

- Communication between different services and agencies was often inadequate for a well-organized support plan (this was the comment that was heard most often);
- Services were often crisis-based instead of preventative and supportive;
- Caregivers and professionals needed up-to-date information on FASD and Neonatal withdrawal;
- The provincial child welfare and health care systems were difficult to navigate, especially for women and families in crisis;
- Professionals did not have a clear understanding of the practice mandates of other professionals and agencies;
- With current data collection methods it was difficult to obtain an accurate description and estimate of the number of babies exposed prenatally to drugs and alcohol in the community;
- Parents experienced difficulty in obtaining the diagnosis of FASD within the community;
- There were gaps in service noted between 18 months of age and 5 years of age; and
- These infants remained in the health and child welfare systems for longer periods of time.

The above information is related to collecting information from community agencies. It is also critical to hear from the mothers and families themselves. Here's what some of our birth mothers continue to say:

- Attitudes and judgments from professionals are usually negative;
- Mothers did not want to disclose their substance use because they were afraid their children would be taken away;
- There was lots of attention immediately after the baby was born but then everything fell away;
- Many professionals did not know enough about substance misuse; and

- There was lots of attention placed on their substance use but less on other things they were dealing with in their lives, such as violence, poverty, mental health concerns and no social support.

You may choose to do your information gathering in one of several ways. There are benefits and limitations to each method.

On an individual visit to each agency, with one person collecting the information.

- This method is the most personal and will provide you with the most detailed information. More consistent data will be gathered if the same person collects all the information. Another benefit is the opportunity to personally meet a wide range of local service providers.

On an individual visit to each agency, with several people sharing the work of data collection.

- The information gathered may not be as consistent, but still has the benefit of being collected on a personal basis. If the interview group met on a regular basis to compare notes, this would help to keep the focus clear. This method is more time-efficient. You could also have one person collecting information for each worksheet that has direct professional knowledge of that area to allow for more accurate direction for interviewing, for example, a health care professional could interview the health-related agencies.

At a community meeting.

- This method has the benefit of getting many community partners together at one time, which may be motivating. It helps to increase everyone's awareness of the range of agencies participating in the program development. Limitations of this method are the fact that it is difficult to get this many agency staff together at once and that the information gathered will not be as detailed and personal.

Telephone interview.

- This method is still slightly personal and allows for clarification of questions. It is also time-efficient.

On a mail out basis.

- This method may be time efficient on the part of the interviewer and the agency but has many drawbacks. Survey methods usually tend to have a low rate of response. Reminders may need to be sent. This method is not personal and there is limited opportunity for the service providers to clarify questions, ask questions, or experience the motivation of group discussion.

Once you have completed all your interviews, review all the information and ask yourself the following questions:

- To what degree is my community aware of the issues surrounding care of the substance-exposed infant and their family/caregiver?

- Are there any themes, or common threads, in the information that has been gathered?

- What are the strengths in the services within our community?

- What are the limitations in the services within our community?

- What are the priorities for improvement in services for our community?

- Who is the best person/agency to take on coordination of the training program?

- What should we do with this information? Some applications for this information include:
  - *Developing community descriptions*
  - *Obtaining program funding*
  - *For local presentations when describing the needs of the community*
  - *As a comparison point for future evaluation of programs*

- What are the particular needs of our community?

Only you and the members of your community can determine what the priority needs of your community are and what is achievable depending on the resources and skills available. Also, keep in mind that a few smaller communities in a geographically close area may want to get together and combine resources and information. It is also helpful to check out what regional or provincial resources are available to come out to your area.

It is important to note that your goals may change over time. For example, your primary goal might be to increase public awareness of the issues. A higher level of awareness may then lead to motivation of the community to do more for this group of infants and their families and caregivers. Here is a selection of possible goals to get you thinking. You may choose several of these, adapt some, or determine your own:

- ✓ Basic education of professionals and the community
- ✓ Recruiting and training specialized foster homes
- ✓ Developing supportive services for pregnant and/or early parenting substance-using women
- ✓ Developing services not just for infants, but also children/adults affected by prenatal substance use
- ✓ Improving case management
- ✓ Health promotion activities

No community is too large or too small to begin work on this. Larger centers may have more services available, but the drawback is that it gets difficult to coordinate all the services. Smaller centers may have less service, but it is usually easier to get everyone sitting together at the same table.

STEP 3:

DETERMINING YOUR CURRICULUM

The information that you gathered in your community survey will be helpful as you begin to plan your curriculum. Various community members will be able to provide you with helpful direction for content. For example, infant development consultants who visit infants in their homes for the first few years of life will be able to provide information on the types of developmental issues that are commonly seen.

The next section in the facilitator's guide includes a sample of course goals and outlines. They were originally based on the needs of the communities that were involved with development of this program. They have been further refined and updated for this revision by our Vancouver Island Safe Babies Working Group. You will be able to compare them to the needs of your own community. For example, if your community does not have a lot of identified drug-exposed infants, but you do have more alcohol-exposed children, you may want to expand the content to cover issues related to older children and condense the information related to infants.

The way that your content is presented will also be dependent on your timeline and whom you have identified as your local experts. The objectives within each class may be adapted or moved around so that they meet the schedule you have set and match the abilities and availability of the speakers.

STEP 4:

IDENTIFYING YOUR PARTICIPANTS

Most of the content is targeted toward foster parents who are caring for substance-exposed infants. The curriculum has also been found to be helpful for a wide range of audiences, including:

- Birth family members who are considering caring for the infant;
- Special needs adoption workers;
- Families who are considering adopting infants or children who are prenatally substance-exposed;
- Social workers;
- Family support workers;
- Health care professionals; and
- Day care staff.

Most communities who have implemented this program have found that it is helpful to offer the program to a wider range of community members when resources permit. This provides an opportunity to share consistent information and bring together community partners with a common goal. It is also helpful in each program to have a mix of participants. This encourages diverse discussion and sharing of information and ideas.

It is also helpful to have a mix of experienced and new foster parents so that the new foster parents may benefit from the knowledge of the experienced foster parents. Other roles for experienced foster parents are that of facilitators or panel members in the program, as they have personal knowledge of much of the material.

As much of the content is designed for foster parents, the full training program usually does not meet the needs of birth parents. Communities have been working at designing ways to adapt the infant-specific material into parent education programs. The information has been shared in one-to-one sessions, in small group sessions at Pregnancy Outreach Programs, and during hospital stays before and after birth, for example. Because the program has also been designed to align with MCFD processes related to foster parent education and support, there will most likely also be a need to adapt the material for emerging delegated Aboriginal child welfare agencies and foster family organizations across the province.

STEP 5:

PLANNING THE PROGRAM

Now you know about potential participants and the information you want to include. The next step is to put all the practical pieces into place. Here are some of the most important pieces. At this point, your community will need to identify a course facilitator. The facilitator will have the primary responsibility for doing the program planning. It is important that there is one point of contact for all communication related to the program, to ensure consistency and continuity. Here is an example of a timeline for you to consider.

THREE MONTHS BEFORE THE PROGRAM:	**STATUS/NOTES**
Choose your dates and times. ☐ Consider the needs of your participants (for example, if they have to travel in from outlying communities or if child care is needed). ☐ Communities offering the program have used a variety of schedules, including week night sessions, all day sessions, and weekends. Before setting the dates, take other events into considerations, including statutory holidays, school start dates, etc.	
Book a room. Do this well ahead of time to ensure that you get a good room. *Look for the following features:* ☐ Better too large than too small ☐ Audio visual equipment is available ☐ Chairs are comfortable ☐ Tables are available if possible ☐ Bathrooms are close by ☐ Available parking, preferably with no cost ☐ Space for refreshments ☐ No cost for the room if possible. If you have the right people on your committee, you should be able to arrange access to rooms in locations such as health units, hospitals, or social services offices. ☐ Central location for participants ☐ Phone available	
Agree on course materials. ☐ The participant manual that accompanies this guide has sample handouts and powerpoints for each topic. You do not have do use all these handouts and powerpoints – they were included to give you an idea of what is available through health organizations or internet sites and to save you a bit of leg work. Some are generic and some were developed specifically for this course. ☐ For this revision, we have included an increased number of web links. There is some great material on the web that is geared towards parents that is updated regularly by sponsoring agencies such as the BC Ministry of Health, the Canadian Pediatric Society, the Centre for Addiction and Mental Health, and the Sick Kids Infant Mental Health	

THREE MONTHS BEFORE THE PROGRAM:	**STATUS/NOTES**
Promotion coalition. Some are also specific to the community where the course was developed. ☐ Each speaker may also want to provide you with readings or their own Power Point, and you may want to include some handouts that have local information for your community. ☐ The *Safe Babies "toolkit"* – in the resources section you will find recommendations for a toolkit which provides you with some additional basic resources to support the work of your coordinators and providers. It includes a range of texts and DVDs that augment and complement the web resources provided throughout the facilitator's guide.	
Remember the following points when you are looking for handouts: ☐ Consider copyright permission. Try to find material where it says that it is acceptable to distribute copies. ☐ Make sure that the copy is good quality for readability. Try to use handouts that are mostly black and white as they copy more easily (and cheaply) and are more readable ☐ Consider reading comprehension level and the literacy abilities of your group. ☐ Make sure that the information is from a reputable source and is current (with the date on the resource if possible). ☐ Make every attempt to use information from Canadian sources. There are significant differences in the way information is presented and in health care practices between Canada and the U.S. for example. ☐ If you have your handout package prepared ahead of time, perhaps one of the supporting agencies would arrange photocopying services. This is a big time and cost saver. ☐ Consider electronic possibilities if your community members prefer.	
There are sample Power Points for each module included with this toolkit. Feel free to adapt and reorganize to meet the learning needs of your group and your community. *Remember the following points when you are preparing Power Point presentations:* ☐ Try to keep slides simple and not too full of content. ☐ Use 1 to 2 slides per minute of your presentation at the most. ☐ Include 4 to 5 points on each slide. ☐ Avoid wordiness, use key words and phrases only. ☐ Do not go overboard with the animation. ☐ Use an easy to read font and don't capitalize unless necessary. ☐ Avoid colors that are hard to read and remember that lots of different colors can be distracting. ☐ Remember that the Power Point is simply a tool to guide your discussion.	
For interest, incorporate teaching strategies other than lecturing, such as: ☐ Group discussion ☐ Take home activities ☐ DVDs – good sources for DVDs include your local public health office, hospital, foster parent resource center, or the provincial Ministry for Children and Family Development library. Book well ahead of time to ensure availability. Refer to the resource list at the end of the guide for some recommendations. ☐ On line visual resources ☐ Demonstrations ☐ Panel discussions	

Confirm your speakers. Do this early to give them lots of time to prepare. You may have to juggle your schedule a bit to meet the needs of all your speakers. Some people have tighter schedules than others – book these speakers first.

When you are planning a session with the speaker, share the objectives and readings with them, and negotiate what will be included in the session. This will help with avoiding missing some content or doing some content more than once. There will naturally be a bit of overlap in material – in your introduction you can let the participants know that this will happen, and that they will get to hear a few different perspectives on the material.

The course facilitator and others helping with planning should review the facilitators guide and the participant manual so that they are familiar with the content that will be presented throughout the program. This way all the speakers can help reinforce key messages throughout the curriculum.

ONE MONTH BEFORE THE PROGRAM:	**STATUS/NOTES**
Choose your dates and times.	
☐ Prepare a mail-out (paper or electronic) for participants. Suggestions for a mailout include a program schedule and an introduction letter.	
☐ Confirm audiovisual equipment needs with speakers.	
☐ Confirm the room booking.	
☐ Circulate the schedule. It is helpful to let community professionals know that they are welcome to drop in to sessions. Often it is difficult for them to find the time to do the whole program, but they are able to attend one or two. Some information is better than none!	

ONE WEEK BEFORE THE PROGRAM:	**STATUS/NOTES**
Choose your dates and times.	
☐ Arrange refreshments. ☐ Ensure participant manuals are ready.	

Related Activities:

- ☐ Have a registration sheet prepared.
- ☐ Make sure you have direction signs up for the first class or two so that the location is not difficult to find.
- ☐ Obtain name tags if you want to use them.

PART B:

TOPIC OUTLINES

Topic Outlines

This section of the facilitator's guide presents module outlines for eight major subject areas and includes the following:

- Goals and objectives
- Learning outcomes
- Recommended speaker
- Approximate recommended time frame
- Essential concepts
- Instructor's notes
- Instructional strategies
- Learning materials and resources
- Suggested handouts (located in participants manual)
- Summary remarks/reflections

Remember that the objectives were designed to be flexible, so adapt them as you feel necessary to meet the needs of your participants and your speakers. Much of the class content may be added together in different ways, so that eight separate sessions may not be needed. For example, acute withdrawal and related health issues may be presented together when you have a health professional as your guest speaker. The objectives and content may also be rearranged into shorter presentations appropriate for various professional and community groups and for workshops.

The **major goal** of this program is to provide participants with the knowledge and skills they will require to begin caring for substance-exposed infants, as family members, foster parents, or community professionals. It is acknowledged that information and research in this field is rapidly changing. Participants are encouraged to continue to attend educational opportunities related to this topic to maintain a current knowledge base.

Education Framework

Module 1: Introduction

- Understanding the community experience emphasizes the need for specialized training and services. This session provides a broad overview of the issues for infants, families, and communities related to substance use during pregnancy, and provides an opportunity to provide information on the history of the program and local information about the extent of the issue in the community and its impact on the foster care system. The overview will introduce key concepts, which will be addressed during the education program. The first session also provides an opportunity for us to begin the process of group building.

Module 2: Understanding Women and Addictions

- In general, the public has a negative perception of women who have a problem with alcohol and drugs, particularly if they are pregnant. This issue is complex and requires us to look beyond the substance use to the context of women's lives. Many people focus on the substance use and are not aware of the significant impact of social issues such as abuse, violence and poverty on women's health and well-being. This session will provide an opportunity to look at some of these factors and also to consider our own feelings and attitudes about the issue.

Module 3: The Impact of Substance Abuse During Pregnancy

- In this session we will review basic information about the effects of commonly abused substances on development of and function in the fetus, infant, child, adolescent, and adult. We will also look at developmental influences such as nutrition, genetics and stress. Understanding the effects of drugs and alcohol provides a context for interpretation and effective support of behaviors.

Module 4: Partnership with Birth Families

- A key skill for foster families is developing the ability to work effectively and compassionately with birth families and to maintain connection between infants and their birth families. This session will present information that will help you develop or advance this skill and also increase your confidence and comfort in developing appropriate relationships with families. Information learned within Module 2 (Women and Addictions) will be brought forward into this session. Issues specific to foster care will be discussed, including visitation, access, and mentoring. We will also address how our care can incorporate and support Aboriginal cultural infant care and parenting practices. We will also discuss how we can support parents who have FASD themselves.

Module 5: Withdrawal in the Newborn and Related Health Issues For Infants

- The purpose of this session is to describe the experience of withdrawal for the infant during the first few weeks and months of life and provide information about the medical, environmental, and social support of the infant and their family during this stage. We will also review other health-related concerns that are seen more frequently with this population.

Module 6: Neurodevelopmental Support for the Substance-Exposed Infant

- Healthy development of an infant is influenced by the interactions between the infant, the caregiver, and the environment. Each infant is unique and requires individualized care to meet their own needs. Infants change dramatically in the first few months and there are numerous opportunities to influence and support positive development. This session will review early brain development, provide strategies to support development of successful interactions, and present information on available local support services.

Module 7: Caring for Substance-Exposed Infants: A Foster Parent's Perspective

- Infants in foster care present with a wide range of needs. Foster parents must work effectively with not only the infant, but also their family, and numerous professionals. This session will provide you with an overview of key issues in the daily care of infants, including feeding, supporting development of sleep/wake cycles, managing symptoms related to substance exposure, and working with multiple health professionals. Being the foster family for infants with increased care needs places many demands on families. We will also address how you can keep your own family healthy and strong during the time you do this work.

Module 8: Infant Cardiopulmonary Resuscitation (CPR)

- Substance-exposed infants have a higher incidence of Sudden Infant Death Syndrome (SIDS) than the general infant population. They may also have other related health issues, which place them at further risk of SIDS, including prematurity. Caregivers within the Safe Babies program are required to maintain current certification in infant CPR.

Module 1:

Introduction

PURPOSE:

Understanding the community experience emphasizes the need for specialized training and services. This session provides a broad overview of the issues for infants, families, and communities related to substance use during pregnancy, and provides an opportunity to provide information on the history of the program and local information about the extent of the issue in the community and its impact on the foster care system. The overview will introduce key concepts, which will be addressed during the training. The first session also provides an opportunity for us to begin the process of group building.

TIME:

- 1 hour – introductions and program review
- 1 hour – overview of issues

RECOMMENDED SPEAKER:

The introductions and course review should be done by the course facilitator(s) to provide a beginning to development of the group. The overview may be done by the course facilitator(s) or by a guest speaker with knowledge of the topic, such as a registered nurse, social worker, physician, or experienced foster parent.

ESSENTIAL CONCEPTS:

Effective work between group members

- Foster parents consistently identify other foster parents as their primary source of support. Relationships may begin in this group that will continue as participants begin or continue their fostering service.

Principles of adult learning

- Effective learning implies that the learner is receiving information they find helpful in a way that respects their experiences and knowledge. Teaching will occur in a manner that is flexible, adaptable, and individualized to the needs of each different group and group members. The principles of adult learning include:
    1. Teaching strategies are inclusive and respectful of participants' experiences and knowledge.
    2. The education framework is learner-centered.
    3. A climate is created that encourages and supports learning.

Society's response to substance use during pregnancy

- The conflict between the rights of the woman to control of her own body and the rights of the infant to physical and emotional well being presents a difficult social issue. To be truly supportive, programs and communities need to recognize the combined interests of women and their infants.

Health and social challenges during pregnancy

- Drug and alcohol use during pregnancy are not the only indicators of risk for pregnancy. There are many other factors that contribute to the well being of the fetus, including maternal nutrition, prenatal care, maternal personal safety, and health. These factors are often called "social determinants of health".

Limitations of current information

- A great deal of the information available to the general public in the past 20 years was sensationalized and based on research that did not take into account the many environmental and social variables that also affected the well-being of the mother and infant. There has also been little research available on the long-term outcomes of the infants and children. It is difficult to conduct research in this field for many reasons; however, researchers are increasingly taking multiple factors into account when looking at health and developmental outcomes.

AGENDA:

1. Introduction of facilitator (s)
2. Distribution of course materials, including course outline with discussion of main objectives
3. Review of course ground rules – the group may also want to add their own:

   Confidentiality

   Respect

   Participatory
4. Arrange for refreshment breaks
5. Distribution of course/class evaluation form – participants are encouraged to complete on an ongoing basis while class content is still fresh in their minds. Provide reminders to participants at intervals throughout the course. Ensure participants are aware that their comments are anonymous, and will be used to improve the program and make it more relevant for future participants.

LEARNING OUTCOMES:

By the end of Module 1, participants will be able to:

1. Personally begin the process of group interaction and participation;
2. Understand the purpose and origins of the Safe Babies program;

3. Understand the local experience of drug and alcohol use during pregnancy and its impact on the foster care system;
4. Develop an awareness of the range of health and social issues for infants and their parents related to substance use during pregnancy;
5. Define the following terms: fetal alcohol syndrome, partial fetal alcohol syndrome, fetal alcohol spectrum disorder, neonatal withdrawal, alcohol related neurodevelopmental disorders, and alcohol related birth defects; and
6. Understand the limitations of current knowledge and research.

LEARNING OUTCOMES WITH INSTRUCTOR NOTES

Learning Outcome 1:

- ***Personally begin the process of group participation and interaction***

Encourage each participant to introduce him or herself and provide the group with a bit of their background. A good icebreaker is to have the facilitator introduce him or herself first and provide some personal information. Some participants have included:

- *Why they are interested in fostering this group of infants*
- *Family composition*
- *What they hope to get out of the class*
- *Brief personal background*

Some facilitators have incorporated other icebreaker activities into their introductions.

Learning Outcome 2:

- ***Understand the purpose and origins of the Safe Babies program***
    - Present the main recommendations from the BC Children's Commission and the Capital Region MCFD review (refer to powerpoint)
    - Briefly describe how the program was developed in your own community

Learning Outcome 3:

- ***Understand the local experience of drug and alcohol use during pregnancy***

Data may be obtained from agencies such as local hospitals, public health units, child welfare agencies, Pregnancy Outreach programs, and police services.

Some facts that participants have found helpful include:

- Local birth rate with number of estimated and identified cases of births of substance-exposed infants
- Outcomes for substance-exposed infants in the community
- Issues for birth families
- How many infants are placed per year in foster care
- How many of these infants have a history of prenatal substance exposure
- What the frequently used substances are in your community

Learning Outcome 4:

- ***Define the following terms that relate to effects of prenatal substance exposure on the infant:***
  - Fetal alcohol syndrome
  - Partial fetal alcohol syndrome (formerly called fetal alcohol effects)
  - Fetal alcohol spectrum disorder
  - Neonatal withdrawal
  - Alcohol related neurodevelopmental disorders
  - Alcohol related birth defects

Most participants will have completed the initial foster parent education program, which includes a module on FASD and neonatal withdrawal. This content should be a refresher for them and provides an opportunity for the program coordinator to ensure there is a common ground of understanding for participants.

It is important to introduce participants to frequently used language and to alert them to the fact that in the past there were are range of terms used to describe these health conditions. They will be exposed to a variety of terms when reading resources.

It is also important to consider using respectful language. Calling an infant a “crack baby” is sensationalizing the issue and placing the drugs before the infant. It is more accurate to state that the baby was exposed prenatally to cocaine.

Learning Outcome 5:

- ***Understand the limitations of current knowledge and research***

It is challenging to predict or determine outcomes for infants based on their prenatal history as there is a great deal of variation within individuals. There is even less research into the effects of other substances. The first generation of research had many flaws in design. Some concerns with early research included:

- The study groups were too small;
- The effects of lifestyle and other substances were not factored out;
- This is a difficult group to stay in touch with over a long period of time and many infants were lost to follow-up;

- There were different reporting requirements between provinces, states, and agencies; and
- Reporting of levels of substance use relies on mothers self-reporting, which may over or under estimate the level of use.

Another concern has been about the bias that exists within the literature itself. Twenty years ago Dr. Gideon Koren and his research Motherisk Team at the Toronto Hospital for Sick Kids (1989) found that studies that reported negative outcomes associated with prenatal substance use were more likely to get published that studies which reported no effects. There has not been a recent study to look at this to see if this still holds true today.

In summary, research in general supports a continuum of potential outcomes for newborns exposed prenatally to substances, ranging from no effects at all to long-term severe effects. Researchers agree that it is difficult to isolate the specific cause of the adverse effect from other risk factors associated with a drug-using lifestyle. It is important to note that researchers agree that a supportive environment during the first three years of life can have a positive impact on long-term outcomes of the children. Some researchers also suggest that the social environment is just as important, if not more important, in infant development as prenatal exposure to drugs.

LEARNING MATERIALS AND RESOURCES

WEB-LINKS:

Health Link BC
https://www.healthlinkbc.ca/

REFERENCES/MATERIALS:

General FASD DVD (most foster parent support groups have a general DVD. Check in the FASD toolkit for choices)

Health Link BC FASD fact sheet
https://www.healthlinkbc.ca/hlbc/files/documents/healthfiles/hfile38e.pdf

SUGGESTED HANDOUTS

Ministry of Health FASD Health File
https://www.healthlinkbc.ca/hlbc/files/documents/healthfiles/hfile38e.pdf

Participants should have the basic information on FASD from their initial foster parent education program

SUMMARY OF MODULE

Debrief:

- Important in this program as there may be participants in the class who are dealing with similar issues within their own families. It is important to be aware of resources for participants (such as the foster parent resources line) if they are in need of additional supports.
- Tie back to overall goals and objectives.

EVALUATION

- Provide class evaluation to group.

Module 2:

Understanding women and addictions

In general, the public has a negative perception of women who have a problem with alcohol and drugs, particularly if they are pregnant. This issue is complex and requires us to look beyond the substance use to the context of women's lives. Many people focus on the substance use and are not aware of the significant impact of social issues such as culture, abuse, violence and poverty on women's health and well-being. This session will provide an opportunity for us to look at some of these factors and also to consider our own feelings and attitudes about the issue.

TIME:

- 2 hours

RECOMMENDED SPEAKERS:

- Part A: Alcohol and Drug Counsellor, Transition House or violence against women counsellor
- Part B: Birth Parent

LEARNING OUTCOMES:

- ***By the end of Module 2, participants will be able to:***

1. Reflect on their personal attitudes and judgments toward pregnant women with a substance abuse issue.
2. Understand how the addiction experience for women may differ from the addiction experience of men.
3. Be aware of many other factors that influence the health and well being of mother and baby.
4. Understand the impact of a history of trauma on women's current circumstances.
5. Identify ways in which foster parents can support women who are experiencing addiction, mental health challenges and trauma/violence.

ESSENTIAL CONCEPTS:

Cycle of dependence

- Women's substance misuse is often a way of coping which initially facilitates coping, but over time takes away their power, choices, and abilities (BC FAS Community Action Guide, 1999). The cyclical nature of this developing dependency is diagrammed in a handout for you to share with participants.

Stages of change theory

- Each individual is in a different state of readiness to attempt the work of stopping or cutting back on substance use. Our interventions and support need to match the readiness of the woman. The Prochaska and DiClemente (1992) model has been a popular model for practitioners for many years; it presents 6 stages of change, each with their own strategies for action. For example, the practitioner's task when women are contemplating (or thinking about) change is to not move right into action strategies but to help women think about where they are in relation to being ready to make a change. Important to note is that often the agenda of recovery does not fit well with the agenda of those looking at the needs of the infant.

Harm reduction

- Harm reduction complements approaches that seek to prevent or reduce the overall level of substance use. This approach acknowledges the reality that many people are unable or unwilling to stop using drugs at any given time. It involves the provision of information, skills, and resources so that the consequences of drug use for the users, the community, and the culture have minimum impact (International Harm Reduction Association, 2009). For example, a needle exchange program is a harm reduction strategy that helps reduce harms associated with injection drug use such as Hepatitis C and HIV.

Trauma-informed care

- Trauma is related to early abuse and/or neglect and is seen frequently in women who are involved in the child welfare system and addictions recovery/mental health programs. When we are supporting women with mental health and addictions issues, we need to consider that they have most likely experienced significant trauma in their backgrounds.

Barriers to treatment

- Women experience many difficulties in obtaining treatment, including lack of childcare, fear of losing children, guilt and shame, opposition by family and friends, and lack of financial resources. The challenge in providing services to women is to treat their direct recovery issues and also their possible coexisting issues, such as mental illness, violence, poverty, isolation, and low self-esteem (Poole & Isaac, 2001).

LEARNING OUTCOMES WITH INSTRUCTOR NOTES

Learning Outcome 1:

- ***Reflect on their personal attitudes and judgments toward pregnant women with substance abuse issues***

This is an important piece of work for the participants to begin working on as foster parents need to be able to work with birth families in a supportive, empathetic manner. Most studies of substance-abusing mothers found that what they appreciate most of all is others being respectful, non-judgmental, and honest with them. Studies of professionals usually find them to be negative and judgmental in attitudes toward the mothers.

The PowerPoint slides ***"Truth or Myth"*** provide some points to provoke discussion in the group and to start the process of self-reflection on personal attitudes and judgments regarding drug use during pregnancy. You may want to use them all or just choose a few that you find most thought provoking.

Having a birth parent come to present to the class is invaluable. Some of the comments from participants who have had the opportunity to hear a birth parent's story include:

- Helpful to hear the other side of the story – so often we base our assumptions on what we hear and see in the media, which is negative.
- Puts a face to the issue, brings it closer.
- Takes away some of the fear and negative images we have of the mothers.
- Helps us to hear what the parents found helpful in professionals and foster families.

If you have guest parents, be sure to give them enough time as the group always has many questions. Consider arranging transportation and an honorarium to acknowledge their contribution. Guest parents may benefit from attending with a support person who can bring them to the class, help them prepare, support them after if they need some debriefing, and take them home.

If it is difficult for you to arrange a birth parent as a speaker, consider arranging for a DVD that has a birth mother talking about her experiences. Your local public health office, Ministry for Children and Family Development, foster parent association, or hospital may be able to help you arrange this. Refer to the resources section for some available titles.

Be sure to include a debriefing time after the guest has left to see how people are doing. The content is often very emotional and often there are a few participants who are dealing personally or within their family/social circle with addiction.

Learning Outcome 2:

- ***Understand how the addiction experience for women may differ from the addiction experiences of men***

Information that your speaker may want to review for this objective include:

  - The differences in physiologic responses to use between men and women
  - Why women use versus why men use
  - Barriers to treatment

- What specific services women require – for example, women are often the primary caregivers for their children – there are limited programs which supply childcare or where you can take your children

The differences in physiologic responses to use between men and women:

- Women metabolize alcohol and other psychoactive substances more slowly than men, allowing harmful metabolites to stay in the body longer.
- Women progress more quickly into problematic substance use than men.
- Women suffer more severe health consequences from drinking, smoking and illegal drug use, including lung damage, brain damage, cardiac problems, liver disease and reproductive health problems.

Why women use substances:

Women use alcohol and other substances because they believe it benefits them in some way. The following is a list of reasons why women commonly use alcohol and other substances (Seymour & Payne, 2006):

- To experience pleasure
- To cope with feelings and pain
- To cope with situations
- Out of habit
- To cope with interpersonal and community situations
- Living in poverty
- Sexual orientation
- Physical and sexual violence

Substance dependence requires at least three of the following:

- Tolerance
- Withdrawal problems
- Use more than intended
- Reduced involvement
- Inability to stop
- Excessive spending or effort to obtain
- Continued use

A useful exercise for this learning outcome is to present a scenario to the group that includes many common elements for women and families with which participants may be working. This scenario can be developed based on your local experience, but here are several examples:

- The group activity can be to discuss (in one large group or several small ones where they report back to the larger group) possible outcomes for mother and baby at different stages of the story, opportunities for support, what challenges they see arising, and what their own personal feelings or perceptions of the situation may be.
- Scenarios for group discussion are available from the Canadian PRIMA Project website (Pregnancy-Related Issues in the Management of Addiction).
- The Woman Abuse Response Program at BC Women's Hospital has developed a "Barriers Exercise" which demonstrates the challenges women have to deal with on a daily basis to manage their lives. A copy of this exercise is included in each Safe Babies Toolkit. If you need to order additional copies, call 1(604) 875-3717.
- A You Tube video called "From Stilettos to Moccasins" has been developed that portrays the healing experiences of Aboriginal women who have struggled with drug abuse and addiction. Here is the link if you have internet access while you are teaching (a DVD is also available to order): http://www.nnapf.org/stilettos-moccasins-song-violet-naytowhow-and-unique-group-aboriginal-women

Learning Outcome 3:

- ***Be aware of many other factors that influence the health and well being of mother and baby***

There are many public misperceptions and judgments about women who are pregnant and using substances. Building awareness of the many other factors that are influencing the situation will hopefully contribute to development of empathy and a deeper understanding of the circumstances. For example, most women themselves and the providers who support them would identify a lack of safe affordable housing as one of the most challenging issues they are dealing with.

Learning Outcome 4:

- ***Understand the impact of a history of violence and trauma on women's current circumstances***

A more recent shift in the addiction and mental health field is the growing awareness of violence and trauma on children, women, their families and communities. Because of the very strong connection, it is important that trauma always be considered when working in situations where addiction and mental health challenges are present. The guest speakers for this topic will be able to address trauma-informed care, practices and services. This will have implications not only for how we support mothers at this moment, but also long-term implications for how she will parent her children and their long term development.

Learning Outcome 5:

- ***Identify ways in which foster parents can support women who are experiencing addiction, mental health challenges and trauma/violence***

It will be important for foster families to appreciate the many challenges a woman may be dealing with in addition to her substance use and consider how their care, routines and practices and relationships will support or challenge her.

LEARNING MATERIALS AND RESOURCES

WEBSITES:

Health Gov BC
https://www2.gov.bc.ca/gov/content/health

Center of Excellence for Women's Health
http://bccewh.bc.ca/

BC Gov
https://www2.gov.bc.ca/

National Film Board
https://www.nfb.ca/

Center of Addictions and Mental Health
https://www.camh.ca/en/hospital/Pages/home.aspx

Canadian Women's Health Network
http://www.cwhn.ca/

CanFASD
https://canfasd.ca/

REFERENCES/MATERIALS:

Women and Alcohol: A Women's Health Resource
http://www.health.gov.bc.ca/library/publications/year/2010/bcstats-hcip-report.pdf

Apprehensions: Barriers to treatment for substance using mothers – Nancy Poole and Barbara Isaac (2001)
http://www.bccewh.bc.ca/publications-resources/documents/apprehensions.pdf

Barriers Exercise
BC Women's Hospital Abuse Response Program

Best practices approaches: Child protection and violence against women: A curriculum for child protection workers, prepared for Ministry of Children and Family Development
https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/public-safety/protecting-children/best_practice_approaches_policy.pdf

Centre for Addiction and Mental Health – Addiction: An information guide (2007)
http://www.camh.net/About_Addiction_Mental_Health/Drug_and_Addiction_Information/Addiction_Information_Guide/index.html

DVD: ActNow BC Healthy Choices in Pregnancy DVD
Supporting change: Preventing fetal alcohol spectrum disorder

Highs and Lows: Canadian Perspectives on Women and Substance Use (N. Poole and L. Greaves, Eds). http://www.cwhn.ca/en/node/39425

With Child: Substance Use During Pregnancy, A Woman-Centred Approach (S. Boyd and L. Marcellus, Eds.). 2007.
http://www.cwhn.ca/en/node/40301

HANDOUTS:

BCCEWH Coalescing on women and substance use: Linking research, practice and policy.

Relational Approach: The Importance of Supportive and Timely Connections (2010). FASD Prevention from a Women's Health Determinants Perspective-
http://www.cwhn.ca/en/node/40301

SUMMARY OF MODULE:

- Debrief
- Tie back to overall goals and objectives

EVALUATION

Provide class evaluation to group.

Module 3:

The impact of substance abuse during pregnancy

PURPOSE:

In this session we will review basic information about the effects of commonly abused substances on development of and function in the fetus, infant, child, adolescent, and adult. We will also look at developmental influences such as nutrition, genetics and stress. Understanding the effects of drugs and alcohol provides a context for interpretation and effective support of behaviors.

TIME:

- 2 hours

RECOMMENDED SPEAKER:

- Physician or registered nurse with addictions background, alcohol and drug counsellor.

ESSENTIAL CONCEPTS:

Fetal vulnerability

- Most substances readily cross the placenta to the fetus. Environmental agents may cause direct effects or teratogenic (see below) effects. These effects are dependent on the frequency, timing, type, and variety of drugs used. The fetus is affected not only by substance use, but also by a range of maternal environmental factors such as nutrition, stress, pollution, and exposure to chemicals.

Continuum of substance use

- A person's involvement with alcohol or other drugs can be placed on a continuum of use, ranging from no use (abstinence) to addiction (dependence). A person's involvement can move in either direction, and is affected by many factors.

Polydrug use

- Polydrug use is defined as use of more than one substance, often with the intention of enhancing or countering the effects of another drug. It also may occur simply because the user's preferred drug is not available or is too expensive at the time. Research shows that most substance users use more than one

drug. Polydrug use has a greater risk for mother and fetus because the drugs influence each other and may result in a greater overall impact.

Teratogen

- A teratogen is defined as any factor associated with the production of physical or mental abnormalities in the developing embryo or fetus. It is estimated that 10% of all birth defects are caused by a teratogen. These exposures include, but are not limited to, medication or drug exposures, maternal infections and diseases, and environmental and occupational exposures (such as radiation). Alcohol and a number of prescription medications are classified as teratogens.

LEARNING OUTCOMES:

By the end of Module 3, participants will be able to:

1. Understand the pharmacological action of the following commonly abused substances:
    - tobacco
    - alcohol
    - marijuana
    - stimulants, including cocaine and crystal methamphetamine
    - opioids, including heroin and methadone
    - other substances used locally
2. Describe the physical effects of the substance on the biological systems of the adult body.
3. Describe the effects of the substance on the developing fetus and the infant.
4. List the benefits of methadone maintenance programs during pregnancy.

LEARNING OUTCOMES WITH INSTRUCTOR NOTES:

Learning Outcome 1:

- ***Understand the pharmacological action of the following commonly used substances:***
    - Tobacco
    - Alcohol
    - Marijuana
    - Stimulants, including cocaine and crystal methamphetamine
    - Opioids, including heroin and methadone
    - Other substances used locally

Participants find it helpful to know how the drug actually works, as you can connect the physical effects with the pharmacological action. For example, when you know that cocaine causes blood vessels to narrow, it is easier to understand that this may mean fewer nutrients for the developing fetus.

It is also helpful to include drug-specific information on:

- How it is used (i.e. smoked, injected)
- Patterns of use
- What withdrawal or craving is like for the adult
- The process of recovery

Learning Outcome 2:

- ***Describe the physical effects of the substance on the biological systems of the adult body***

Each drug has effects on major body systems such as the nervous system, the liver, stomach, and intestine, and the cardiovascular system. It is also important to talk about how long it takes the body to recover from chronic alcohol or drug use. The parents that foster families will be supporting may be still actively using or recovering from use and it will be helpful for them to be aware of what the parents are experiencing. The handouts for this section are from the Alberta Alcohol and Drug Abuse Commission (AADAC) which is now a part of Alberta Health Services if you are looking for their website.

Learning Outcome 3:

- ***Describe the effects of the substance on the developing fetus and infant.***

The content for this objective may be discussed in several different ways. You may choose to present some of the information in the introduction session, this class, or the session on acute withdrawal, depending on the expertise of your speakers.

It is important to discuss the fact that substances can cause changes in two main ways:

1. **Teratogenic changes** or birth defects, such as cardiac malformations, cleft palates, and facial abnormalities.
2. **Neurological effects,** such as withdrawal.

An excellent resource (*Exposure to psychotrophic medications and other substances during pregnancy and lactation: A handbook for health care providers*) is available on line through the Centre for Addiction and Mental Health.

In addition to information specific to each substance, some general comments to share with the group are:

- You cannot accurately predict outcomes based on pregnancy and birth history. Each pregnancy and infant is unique.
- Effects cannot be clearly attributed to one specific drug because there are many other factors that influence outcomes.
- Reducing or stopping substance use at any point during pregnancy still has clear benefits for both mother and baby.
- The brain continues to develop long after birth. There are many opportunities to support neurodevelopment in the first years of life.
- A supportive parent/caregiver and environment is just as critical to positive outcomes as the substance exposure itself.

Learning Outcome 4:

- ***List the benefits of methadone maintenance during pregnancy***

One recommended strategy to help women with a heroin addiction have a healthier pregnancy is to place them on methadone maintenance therapy. It is often confusing for people to understand why pregnant women are maintained on methadone when withdrawal for the infant is known to be difficult (on higher doses). It is helpful for participants to understand the benefits of methadone treatment on the long-term outcomes for the infants and also the mothers.

Benefits of using stabilized methadone:

- Decreases risks associated with injection use
- Provides opportunity to regularly connect with health care providers
- Smoothes swings in blood level of drug; avoids sudden drop that can contribute to fetal stress.

LEARNING MATERIALS AND RESOURCES

WEBSITES:

Perinatal Services BC
http://www.perinatalservicesbc.ca/

Western Health
http://westernhealth.nl.ca/

REFERENCE MATERIALS/RESOURCES:

Perinatal Services BC Clinical Guidelines
http://www.perinatalservicesbc.ca/health-professionals/guidelines-standards

Caring for women with problematic substance use, their newborns & families: A self-directed learning module / Seymour, Laurie; Payne, Sarah; BC Women's Hospital & Health Centre / 2006

HANDOUTS:

Is it Safe For My Baby? (2003)
Centre for Addiction and Mental Health (also available free from Healthy Choices in Pregnancy)
http://westernhealth.nl.ca/uploads/Addictions%20Prevention%20and%20Mental%20Health%20Promotion/Is%20It%20Safe%20for%20My%20Baby.pdf

Information on Toll-Free Motherisk Alcohol and Substance Use Helpline. Available online at:
www.motherisk.org/alcohol/index.php3

Effect Series (Alcohol, Amphetamines, Cannabis, Cocaine, Hallucinogens, Opiods, Tobacco)
Health Services

SUMMARY OF MODULE:

- Debrief
- Tie back to overall goals and objectives

EVALUATION:

Provide session evaluation to participants.

Module 4:

Partnership with birth families

PURPOSE:

A key skill for foster families is developing the ability to work effectively and compassionately with birth families and to maintain connection between infants and their birth families. This class will present information that will help you develop or advance this skill and also increase your confidence and comfort in developing appropriate relationships with families. Information learned within Module 2 (Women and Addictions) will be brought forward into this class. Issues specific to foster care will be discussed, including visitation, access, and mentoring. We will also address how our care can incorporate and support Aboriginal cultural infant care and parenting practices.

TIME:

- 2 hours

RECOMMENDED SPEAKER:

- Infant development consultant, social worker, Aboriginal family support or social agency consultant, Elder, family support agency staff

ESSENTIAL CONCEPTS:

Relational practice:

- Women who are pregnant and newly parenting with substance use issues are more likely to connect with people (ie. doctors, public health nurses, social workers, foster families) who are welcoming, respectful and non-judgmental. Honoring women's self-determination and capacity for change, building on strengths, and supporting women to address shame and guilt, the loss of control over their lives, and their mistrust of systems are beneficial in establishing a trust-based connection (Canada Northwest FASD Research Network, 2010).

Cultural safety:

- The concept of cultural safety originated in New Zealand in response to the lobbying by the Maori people for a change in health and social service delivery that more appropriately met their needs and was delivered in a way that acknowledged the cultural and social barriers that exist between Aboriginal people and contemporary society (Gerlach, 2007). Aboriginal families of children with special health care needs have identified cultural knowledge, respect and sensitivity as essential for all health professionals working with their children.

FASD informed practice:

- Parents need care and support that fit with what we know about the spectrum of disabilities related to FASD.

LEARNING OUTCOMES:

- ***By the end of Module 4 participants will be able to:***

1. Discuss strategies that are helpful in developing and maintaining communication with birth families of infants;
2. To understand the experiences of grief and loss for parents whose infants are in foster care;
3. Discuss visitation and access considerations that are recommended for infants;
4. Increase awareness of Aboriginal views of children and cultural care and parenting practices specific to infancy; and
5. Be aware of local community resources for birth families, including alcohol and drug counseling, parenting classes and parenting support.
6. Discuss what an approach to supporting parents with FASD will look like.

LEARNING OUTCOMES WITH INSTRUCTOR NOTES:

Learning Outcome 1:

- ***Discuss strategies that are helpful in developing and maintaining communication with birth families***

This information is best presented within a group discussion where experienced foster parents can share what has worked for them as they interact with birth families. Topics may include:

- Use of a communication book that goes between birth and foster parents on visits.
- Acknowledgement of the birth parents, for example a card on Mother's Day, providing frequent photographs, keeping them up to date on milestones.
- Including them in IDP visits, visits to the physician, public health nurse.
- Setting up a phone contact schedule.
- Assisting in arranging visits. It is ideal if the visits can occur in the home of the foster parents. If not, try to arrange visits that are in a "family atmosphere".
- Asking for parents' opinions on parenting issues concerning their child, especially if the plan is reunification.

Learning Outcome 2:

- ***To understand grief and loss for parents whose infants are in foster care***

Foster parents usually learn about how to support children who are experiencing grief and loss when they enter foster care. We are not always however taught that birth parents experience their own grief and loss. Foster parents need to be aware that what may initially come across as anger, exhaustion, and frustration often emerge in response to the trauma of losing of their infant.

Learning Outcome 3:

- ***Discuss visitation and access considerations that are recommended for infants.***

Special consideration of visiting is needed for the infant population in general as they are at the stage of establishing trust and attachment in parents and caregivers. There are additional considerations related to sensitivity for infants with prenatal substance exposure specifically, such as making sure the visit space and logistics are planned around their routine and sensitivities.

Visits are best done in the foster home (as long as there is no risk to the family) as the home environment is more conducive to helping the parents feel more comfortable and in helping them develop parenting skills. If an office needs to be used, try to find one that is welcoming with enough space for parents to cuddle, feed, change and play with their baby. The more time that parents have with their infant, the more they will be able to develop their parenting skills, or conversely, it will help them decide if they are able to continue with parenting.

Learning Outcome 4:

- ***Increase awareness of Aboriginal views of children and of cultural care and parenting practices specific to infancy*.**

Important note: For this part of the session it is valuable to partner with your local Aboriginal community to share stories and practices related to ways of parenting, and to develop a way of sharing information that works for your community.

From "*A sense of belonging: Supporting healthy child development in Aboriginal families*" (Best Start, 2006): There is great diversity within each community, even within each family, and a single or uniform Aboriginal culture should not be presumed (Gerlach, 2007). Aboriginal people believe that children do not belong to us but are gifts sent from the Creator. It is our job to nurture and guide the children through their childhood so they will grow to fulfill their purpose while on this earth. Every child, regardless of age or disability has gifts and teaches us lessons. They are all unique and should be respected.

Children learn from conception that they are never alone. A large interconnected circle of family and community relationships constantly nurture their spirits. Within Aboriginal concepts of family and community, the spirit is always being affirmed and validated by support, guidance, love and a sense of belonging.

Aboriginal child wellness results from the balance of the physical, emotional, spiritual and mental dimensions of the individual, family and community. Aboriginal parents have shared that the main areas they feel front line workers should consider when supporting them in raising happy, healthy children are:

- The need for knowledge of traditional Aboriginal parenting
- Inclusion of the extended family in family planning
- Using a holistic approach to supporting their children
- Understanding the challenges Aboriginal children face
- Inclusion of strategies for parent or caregiver health

Learning Outcome 5:

- ***Be aware of local community resources for birth families, including alcohol and drug counseling, parenting classes, and parenting support.***

You may want to include a list of your local resources and any relevant pamphlets for reference. Birth parents often will obtain this information from other sources such as public health nurses, IDP, or their physician, but you never know if you will be talking to parents when they are in a state of readiness to move on one of their issues. It is helpful to have this information available.

It is also helpful to have a group discussion for this learning outcome as there are often participants with knowledge of additional resources.

Learning outcome 6:

- **Discuss what an approach to supporting parents with FASD will look like.**

In addition to coping with the challenges of substance use, mental health issues, trauma and violence, and other social issues such as poverty and lack of safe housing, it is most likely that a number of parents may have some degree of FASD themselves (Rutman, in press; Rutman, La Berge & Wheway, 2005). Foster parents will find it useful to reflect on their knowledge of strategies that support success in individuals with success and apply them to the parenting process. For example:

- Modifying our expectations of parents in line with their developmental age
- Reframing our interpretation of behaviors
- Using concrete language and visual cues
- Making accommodations in parent teaching

LEARNING MATERIALS AND RESOURCES

WEBSITES:

Best Start
https://www.beststart.org/

Unicef
https://www.unicef.ca/en

REFERENCE MATERIALS/RESOURCES:

A Sense of Belonging: Supporting Healthy Child Development in Aboriginal Families
Best Start: Ontario's Maternal, Newborn and Early Child Development Centre (2006)
https://www.beststart.org/resources/hlthy_chld_dev/pdf/aboriginal_manual.pdf

Aboriginal children's health: Leaving no child behind
http://www.unicef.ca/sites/default/files/imce_uploads/DISCOVER/OUR%20WORK/ADVOCACY/DOMESTIC/POLICY%20ADVOCACY/DOCS/Leaving%20no%20child%20behind%2009.pdf

Cultural safety in practice with children, families and communities (Ball, UVIC)
http://www.ecdip.org/culturalsafety

Ensuring the healthy development of infants in foster care: A guide for judges, advocates and child welfare professionals. Zero to Three Policy Center (2004)
http://www.courts.state.ny.us/ip/justiceforchildren/PDF/Infant%20Booklet.pdf

Infants in the child welfare system: A developmental framework for policy and practice. Brenda Jones Harden (2007). Zero to Three

Parenting with FASD: Challenges, strategies and supports. Rutman, La Berge & Wheway (2005)

Substance exposed infants: State responses to the problem (2009)
U.S. Substance Abuse and Mental Health Services Administration
http://www.ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf

Visitation with infants and toddlers in foster care: What judges and attorneys need to know. Zero to Three Policy Center (2007)
http://www.abanet.org/child/policy-brief2.pdf

SUGGESTED HANDOUTS:

Visitation for Infants and Toddlers
http://www.abanet.org/child/cw/07_08aug.pdf

"A Sense of Belonging: Supporting Healthy Child Development in Aboriginal Families". (pages 31, 32, 38, and 39)
This book is in the Safe Baby Toolkit.
https://www.beststart.org/resources/hlthy_chld_dev/pdf/aboriginal_manual.pdf

EVALUATION:

Provide session evaluation to participants.

Module 5:

Withdrawal in the newborn and related health issues for infants

PURPOSE:

- The purpose of this class is to describe the experience of withdrawal for the infant during the first few weeks and months of life and provide information about the medical, environmental, and social support of the infant and their family during this stage.
- We will also review other health-related concerns that are seen more frequently with this population.

TIME:

- 2 hours

RECOMMENDED SPEAKER:

- Registered nurse or physician with related clinical experience.

LEARNING OUTCOMES:

- ***By the end of Module 5, participants will be able to:***

1. Identify the signs and symptoms of neonatal withdrawal.
2. Describe the onset and duration of withdrawal in infants exposed to commonly used substances.
3. Describe the characteristics of a supportive physical environment for an infant experiencing withdrawal and discuss how these characteristics may be adapted for home environments.
4. Describe and demonstrate effective strategies for the following issues:
    - Feeding difficulty
    - Inconsolability and irritability
    - Sleeping irregularities
    - Increased or decreased muscle tone
5. Be aware of current trends in the care and support of infants and mothers related to withdrawal.
6. Be aware of best practice recommendations for infant care and infant safety in general.

ESSENTIAL CONCEPTS:

Environmental support

- Substance-exposed infants may have difficulty controlling their responses to the environment. Our job as caregivers is to provide the infants with an environment that protects and supports them as they recover from withdrawal and begin to move toward meeting developmental milestones. It is important to consider factors such as physical space, noise, sight, movement, temperature, and handling.
- Providing a protective environment does not mean placing the infant in a completely dark, restricted environment. It means adjusting the surroundings so that the baby can get on with their tasks of daily living, like feeding and sleeping.

Infant cues

- Infant cues are the body language of infancy that convey the infants need for interaction or the need for a break (Seymour & Payne, 2006). Every infant is unique and requires individual attention and intervention.
- The most important feature of effective parenting is the direct interaction between the parent and the infant and the communication that is established. The parent/caregiver must be able to interpret the cues that the baby is demonstrating so that they can consistently and accurately meet their needs.

INTERACTION (Engagement) CUES	BREAK (Disengagement) CUES
Tremors, startles, twitches	Grasping
Yawning	Hand to mouth activity
Gagging, spitting up	Suck/suck searching
Hiccoughing	Hand holding
Straining	Clear sleep states
Sneezing, coughing	Rhythmic, robust crying
Sighing	Active self-quieting
Facial grimace	Attentional smiling
Hand on face, fisting	Cooing
Fussing or irritability	
Staring or gaze averting	
Panic or worried alertness	
Glassy-eyed alertness	

Transition

- Transition is change. Transition for an infant may be a change in caregiver, environment, routine, or expectations. Transitions are necessary for developmental progression. A critical skill in working successfully with substance-exposed infants is being able to: a) support the infant during the transition, and b) control transitions so that they do not exceed the capabilities of the infant.

Self-Calming

- Self-calming skills are a set of skills developed by the infants to settle themselves down and stop crying on their own. Some of these skills include sucking, movement of extremities, and certain body positions. Development of these skills shows that the infant is able to assert control over their reactions that used to make them distressed.

LEARNING OUTCOMES WITH INSTRUCTOR NOTES

Learning Outcome 1:

- ***Identify the signs and symptoms of neonatal withdrawal***

Not all babies exposed to substances experience withdrawal symptoms. There are a number of symptoms that are commonly seen in the newborn in many of the newborn's body systems (for example respiratory, central nervous system, gastrointestinal system, musculoskeletal, immune, and skin).

A helpful acronym to remember the most common signs and symptoms of withdrawal is "WITHDRAW":

W Wakefulness, problems with waking/sleeping

I Irritability, difficult self-calming, high pitched cry

T Tremors, twitching (seizures are rare)

H Hypertonia (high tone), hyperactive reflexes

D Diarrhea, diaphoresis (sweating)

R Regurgitation and/or poor/weak/frantic suck

A Apnea

W Weight loss, failure to gain

It is also important to point out that many of the symptoms of withdrawal, such as jitteriness and sneezing, are commonly seen in the newborn population for a variety of reasons.

Learning Outcome 2:

- ***Describe the onset and duration of withdrawal in infants exposed to commonly used substances***

The signs and symptoms shown by infants vary a great deal depending on the substance exposure, the timing of the use prior to birth, the gestation and weight of the infant, the renal and liver function of the infant, the overall health of mother, and other factors. It is important to remember that each infant will metabolize and respond to substances in their own way.

Withdrawal symptoms in infants and may be evident minutes after birth or not for up to two weeks. Typically symptoms are apparent within 72 hours. There is no predictable course and symptoms may be brief, delayed in

onset, intermittent or have a gradual progression. The greatest risks to the infant during withdrawal come from the possibility of dehydration and electrolyte imbalance due to loose stools, poor intake, and regurgitation (spitting up).

Most hospitals use an assessment tool to monitor the signs and symptoms of infant withdrawal. The importance of using an assessment tool is to assess the pattern of symptoms over a period of time. It is helpful for caregivers to know the assessment process as it will make them more familiar with the symptoms and also the severity of withdrawal.

The additional impact of early discharge from the hospital after birth means that many babies may leave the hospital before the symptoms present. These babies may experience their withdrawal in the community with little or no support for the baby or the birth parents. If the infant is in foster care, substance exposure may be unknown and the foster parent is suddenly dealing with an infant experiencing withdrawal. The information presented in this course is helpful for anyone who receives infants into their homes, as often the substance use histories of the mother may not be known at the time of placement.

There are differences in withdrawal experiences depending on which substances mother used. The differences are related to the different pharmacological actions of the drugs, which were covered in Module 3. At this point it is important to discuss the fact that rarely does a woman use one substance, for example cocaine and heroin may both be used during a pregnancy, so withdrawal signs may be mixed. Polydrug use may result in compounded (even greater) withdrawal symptoms. However, researchers suggest that the symptoms seen in infants exposed to cocaine after birth are not related to withdrawal, but are more consistent with cocaine exposure.

Learning Outcome 3:

- ***Describe the characteristics of a supportive physical environment for an infant experiencing withdrawal and discuss how these characteristics may be adapted for home environments***

Two factors which are of great importance in caring for substance-exposed infants are: a) a skilled caregiver, and b) a supportive physical environment. Review the Power Point slide **"*Characteristics of an effective environment*"** with the group and give them the following take-home exercise:

Look at the characteristics on the slide and then examine your own home. Imagine yourself to be a stressed infant and then look at your own space and see what will be most supportive. Ask yourself the following questions:

Where will the baby sleep?

Where will the baby feed?

Where will you settle the baby when he/she is irritable?

How will you manage your daily routine with a sensitive infant?

Learning Outcome 4:

- ***Describe and demonstrate effective strategies for the following common behaviors:***
    - Feeding difficulty
    - Irritability and difficulty settling
    - Sleeping irregularities
    - Increased or decreased muscle tone

The information for caregivers regarding the daily care of the substance-exposed infant is in the accompanying document "*Safe Babies: A caregiver's guide to daily care for infants exposed prenatally to alcohol and drugs" (3rd edition, 2010).* The handbook contains the practical information necessary for hands on care. These topics will be revisited in later modules. As you will note, much of the information in the handbook is helpful to caregivers of infants in general, not just those with special needs.

Please encourage participants to review the key concepts for caregivers in the handbook. Once again, the concepts of individuality and a continuum of effects are presented. It is critical that caregivers are aware that many infants do well, and only some infants are more impacted. Participants have requested that visual tools be used when presenting caregiving techniques.

Here are some suggestions:

- Bring along a doll and some props such as blankets and bottles to demonstrate skills such as swaddling, settling and positioning techniques, and feeding methods.
- Use DVDs if you have them. The resource section includes some listings.

Learning Outcome 5:

- ***Be aware of current trends in support of infants and mothers related to withdrawal***

Over the past few years there has been more attention toward support of infant and mother during the period of time surrounding pregnancy, birth, and the first year of life. Care is continuing to shift away from medicalized withdrawal support to that of normalizing care.

Here are some examples of this shift:

- Babies are usually not routinely moved away from their mother into a neonatal intensive care unit, but are kept in the room with their mothers.
- Breastfeeding is considered appropriate in many cases.
- Communities that focus on intensive support for the infant, mother and family during pregnancy and after birth are reporting a decrease in the number of infants placed in foster care.
- Low dose methadone support is more frequently used for mothers with heroin addiction.

Learning Outcome 6:

- ***Be aware of best practice recommendations for infant care and infant safety in general***

Over the past twenty years, there have been significant changes in recommendations for infant care related to health, development and safety. It is important that foster parents are up to date on what the current recommendations are for infant care. Your local public health nurse will be an excellent resource for this information. Some areas of focus may be:

- Positioning for safe sleep
- Car seat safety
- Crib safety
- Feeding and nutrition
- Immunization
- Prevention of Shaken Baby Syndrome – Period of PURPLE Crying education program (see website section)
- Home safety

LEARNING MATERIALS AND RESOURCES

WEBSITES:

BC gov Health
https://www2.gov.bc.ca/gov/content/health

Period of PURPLE crying
http://www.purplecrying.info/

BC Hospital
http://www.bcchildrens.ca/

Canadian Pediatric Society
https://www.cps.ca/en/

REFERENCE MATERIALS/RESOURCES:

Baby's Best Chance (2017)
BC Ministry of Health
http://www.health.gov.bc.ca/library/publications/year/2017/BabysBestChance-Sept2017.pdf

Toddler's First Steps (2008)
http://www.llbc.leg.bc.ca/public/PubDocs/bcdocs/437200/TFS_Intro.pdf

SUGGESTED HANDOUTS:

Safe Babies: A caregiver's guide to daily care for infants exposed prenatally to alcohol and drugs.

Prevent Shaken Baby Syndrome BC

Home safety checklist from Safe Start BC
http://www.bcchildrens.ca/Child-Safety-Site/Documents/homesafetychecklist.pdf

An Infant with Seizures, Rash, and Hepatosplenomegaly
https://academic.oup.com/cid/article/46/3/451/392025

CPT1 Deficiency
http://www.bcchildrens.ca/Resource-Centre-site/Documents/C/BCCH1547_CPT1Deficiency.pdf

Congenital Syphilis: No Longer Just of Historical Significance
https://www.cps.ca/en/documents/position/congenital-syphilis

The Syphilis Outbreak in Alberta

Syphilis is on a comeback
http://www.macleans.ca/news/canada/a-scourge-on-a-comeback/

BC Health Files – there is a large selection of health files available at the following site. Your local public health nurse will be able to assist you in selecting the ones that are most relevant for your group and also provide you with additional printed resources used in your area, such as information on hearing screening for infants. Here are a few examples:

http://www.healthlinkbc.ca/healthfiles/index.stm

- Hepatitis B
- HIV
- Hepatitis C
- Safe sleeping
- Baby's first foods
- Infant dental care
- Formula feeding

EVALUATION:

Provide session evaluation to participants.

Module 6:

Neurodevelopmental support for the substance-exposed infant

PURPOSE:

Healthy development of an infant is influenced by the interactions between the infant, the caregiver, and the environment. Each infant is unique and requires individualized care to meet their needs. Infants change dramatically in the first few months and there are numerous opportunities to influence and support positive development. Knowledge in this field is developing rapidly and it will be important for us to keep up to date over the next few years. In this session we will review early brain development, provide strategies to support development of successful early interactions and relationships, and present information on available local support services.

TIME:

- 2 hours

RECOMMENDED SPEAKER:

- Depending on the resources in your community, this topic may be presented by one speaker or two. Suggestions for speakers include a physiotherapist or occupational therapist with knowledge of the neonatal and infancy periods, infant development consultant, infant/child mental health therapist, and pediatrician.

LEARNING OUTCOMES:

- ***By the end of Module 6, participants will be able to:***

1. Review basic development of the brain. Discuss effects of prenatal alcohol use on the developing brain.
2. Appreciate the many variables other than prenatal substance exposure that contribute to brain growth and development in the infant.
3. Review progression of basic growth and development milestones from infancy through toddlerhood.
4. Discuss the impact of FASD on growth and development from infancy through toddlerhood.
5. Identify signs of engagement and stress in the infant.
6. Describe the importance of the development of early relationships on the future emotional and social health of the infant.
7. Identify local supports in the community for infant development
8. Describe the role of the infant development consultant.

ESSENTIAL CONCEPTS:

Early intervention

- Early intervention programs assist in offsetting the potentially negative impact of medical, biological, and environmental conditions associated with developmental disabilities. For children with FASD, key factors that prevent development of secondary disabilities (ie. school disruptions, mental health problems, trouble with the law) are a diagnosis before the age of six, a stable and nurturing home, and a knowledgeable community.

Family-centered services

- Services that have a guiding philosophy and emphasis on responding to the needs and strengths of not just the infant, but of the whole family. The rights of both the family and the children are recognized and balanced.

Sensory integration

- Sensory regulation is the capacity to control the nature and intensity of one's responses to stimuli by regulating levels of arousal, attention, affect and action.

Self regulation

- Capacities that move the infant and child toward greater self-control, organization of behavior, and engagement with the environment. Some of the earliest signs of self-regulation are development of sleep-wake cycles, hunger-satiety cycles, and development of self-calming skills.

Resiliency

- Resiliency is the power of recovery, and reflects the ability of the infant to rebound from stressful circumstances. Infants and young children have a tremendous capacity for resilience.

Attachment

- Attachment is the deep and enduring connection established between a child and a caregiver in the first few years of life. Attachment is a basic human need and something that children and caregivers create together. A positive attachment – one of trust and security – results from the primary caregiver's consistent and satisfactory responses to the child's physical and emotional needs.

LEARNING OUTCOMES WITH SPEAKER NOTES

NOTE: Because of the speed of advancement of knowledge in this field, the information here may change quickly. Your guest speakers for this topic will be able to provide much more information that what is provided here. Consider this the basics and then work with your community speaker to enhance this topic with the latest advances in research. The accompanying PowerPoint has some beginning slides – your speaker will most likely bring some more detailed content for you.

Learning Outcome 1:

- ***Review basic development of the brain***
- ***Discuss effects of prenatal alcohol use on the developing brain***

The brain develops in a hierarchical order, from the most primitive to the most high-functioning. There are five main areas of the brain:

Brainstem – at the base of the skull and it controls most basic life activities including body temperature, heart rate, and blood pressure

Midbrain – at top of brainstem and controls "drives", including sleep, appetite, arousal, and motor regulation

Cerebellum – behind the brainstem and it coordinates movement and balance

Limbic – in the central part of the brain and it controls relationships, including attachment, memory, and emotional reactivity

Cortical – top layer of the brain and is the "executive branch" of the brain that regulates decision making and controls abstract and concrete thought, reasoning and language.

Most babies are born with more than 100 billion brain cells that are not yet all connected with each other and some of which will not be used and will die off. There are two forces working together to influence how the baby's brain develops: human genes and the environment. Optimal brain development in infants and young children is guided by experience. Infant-initiated interactions are necessary for optimal neurological development, including: crying, eye contact, touch, smile, movement, feeding, the heart connection, and in-arms holding.

Brain development occurs in waves, with different parts of the brain becoming active "construction sites" at different times. While learning continues throughout the life cycle, there are prime times or windows of opportunity when the brain absorbs new information more easily than other times in life.

For participants wanting more information on brain development, refer them to the following websites:

Zero to Three
http://www.zerotothree.org/site/PageServer?pagename=key_brain
http://www.zerotothree.org/baby-brain-map.html

Society for Neuroscience: Brain facts: A primer on the brain and nervous system (6th edition, 2008)
http://www.sfn.org/index.aspx?pagename=brainfacts

Prenatal alcohol use may lead to permanent damage to the brain. Alcohol affects the developing brain in three main ways:

- Structural – microcephaly (small brain size), other abnormalities in brain structure (such as agenesis of the corpus callosum)
- Neurological – two ways – diagnosable disorders (ie. seizure disorders) and non-specific impairments (ie. impaired motor skills, neurosensory hearing loss, sensory integration dysfunction)
- Functional – developmental disabilities – behavioral and cognitive expressions

Learning Outcome 2:

- ***Appreciate the many variables other than prenatal substance exposure that contribute to compromised brain growth and development in the infant***

There are many factors that may contribute to compromised brain development in the infant. Some of these factors are:

- Health issues, for example prematurity, infections, genetic/metabolic disorders
- Neglect
- Trauma (violence, abuse)
- Poor nutrition
- Lack of stimulation
- Consistent relationships
- Chronic or acute stress

Enriching experiences and relationships are necessary to create connections. Compromised brain development may also occur with stress, abuse, and neglect. The higher functioning areas of the brain do not develop as well and the brain reverts to survival functioning, which includes behavior that is more reactive and impulsive. There is a great emphasis now in foster parent education on trauma and brain development (Bruce Perry, Child Trauma Academy). Most organizations now have additional resources available on stress/trauma and brain development for you to use with this session.

Infant behaviors such as irritability, poor feeding and poor sleeping should not be automatically attributed to prenatal substance exposure. If the infant is experiencing many changes in their life, such as changes in caregivers and frequent visits with family members, they may be expressing that they are stressed. These signs are also associated with attachment difficulties.

Learning Outcome 3:

- ***Review progression of basic growth and development from infancy through toddlerhood***

Participants need to have a basic understanding of typical growth and development patterns as they begin to care for infants. This will provide them with a context for following the progress of the infant. Participants then need to understand that it is important to set aside their knowledge and pre-set expectations and match their care to the abilities of each individual infant. It is important to share the following points with participants:

- There is a wide range of normal for infants when it comes to achieving milestones
- Do not always assume certain behaviors are due to the substance exposure – there are many other reasons for an infant to have those symptoms.

Learning Outcome 4:

- ***Discuss the impact of FASD on growth and development from infancy through toddlerhood***

You can link back to information presented in the first class and to the content foster parents would have received in their MCFD training when they started. Content from that class can be reinforced.

Learning Outcome 5:

- ***Identify signs of engagement and stress in the infant***

Infants are capable of telling us a great deal about how they are feeling. Our job as caregivers is to be able to pick up on the infant's cues (signals), interpret them correctly, and meet their needs.

Engagement is when the baby gives you signs that they want to be with you. Signs include looking at your face, reaching out to you, relaxed tone, smiling, and cooing.

Disengagement presents as stress and means that the baby is telling you they need a break or a rest from what you are doing. Signs include fussiness, pulling away, squirming, or pale skin.

It is important to realize that any baby may experience stress, due to reasons such as overstimulation, insecurity, unmet needs, or discomfort. Sometimes substance-exposed infants give us cues that are subtle – it is helpful to spend lots of time getting to know the individual signs of your infant so you can respond appropriately and consistently.

Learning Outcome 6:

- ***Describe the importance of the development of early relationships on the future emotional and social development of the infant***

Infant mental health researchers have made great strides in linking attachment with other psychological processes. For example, we now know that secure attachment is related to caregiver responsivity and sensitivity.

Secure attachment enhances young children's capacity to cope with and adapt to stressful experiences. In the long term, it also influences later relationships, including how these children will parent their own children. Caregivers play a profound role as partner in an infant's mental health development.

Infants with prenatal substance exposure face additional challenges to attachment, including:

- They may experience frequent changes in caregiver in the early years
- They may experience erratic caregiving (support of hunger, crying, sleeping etc)
- Birth mothers may also be coping with a mental health issue such as postpartum depression
- The effect of the substance exposure and other health challenges (ie. prematurity) on their ability to manage social and relational interactions

Learning Outcome 7:

- ***Identify local supports in the community for infant development***

In your community assessment prior to planning the program, you had the opportunity to talk to agencies or professionals who offer developmental support and services.

You may want to prepare a handout that lists services for the parents and caregivers.

Learning Outcome 8:

- ***Describe the role of the infant development consultant***

The Infant Development Program, offered through the Ministry of Children and Family Development, is an excellent resource to provide information, home support, and referrals for parents and caregivers of infants.

Participants find it helpful to hear the following:

  - How will they be linked to the service?
  - What is a home visit is like and how often do visits occur?
  - What are common difficulties for the infants (i.e. hypotonia, feeding difficulties, speech delays)?
  - Who are the staff?

LEARNING MATERIALS AND RESOURCES

WEBSITES:

Sick Kids
https://www.sickkids.ca/

Canadian Child Welfare Research Portal

Child Welfare Information Gateway
https://www.childwelfare.gov/

REFERENCE MATERIALS/RESOURCES:

A Simple Gift: Comforting Your Baby (2008): Summary for caregivers after viewing and discussing on line video from Sick Kids Infant Mental Health Program
https://www.sickkids.ca/pdfs/IMP/16099-IMPComfortingBabySummary08.pdf

Handbook on Infant Mental Health (2009). Charles Zeanah, Ed. Guilford Press.

I Am Your Child DVD and Parent Educator Manual
https://www.parentsaction.org/wp-content/uploads/2017/04/IAYC_FirstYears-bklt-Eng.pdf

The Out-Of-Sync Child: Recognizing and coping with sensory processing disorder (2005). Carol Stock Kranowitz

The Out-Of-Sync Child Has Fun: Activities for kids with Sensory Processing Disorder (2006) Carol Stock Kranowitz

Infants in the Child Welfare System: A developmental framework for policy and practice.
Brenda Jones Harden, 2007, Zero to Three

Young Children and Foster Care: A guide for professionals
Judith A Silver, Barbara J. Amster, Trude Haecker (1999)

Steps in the Right Direction: Connection and collaborating in early intervention therapy with Aboriginal families and communities in British Columbia (2007). Alison Gerlach

CECW Assessing Emotional Neglect in Infants
http://cwrp.ca/sites/default/files/publications/en/EmotionalNeglectInfants59E.pdf

CECW- Attachment disorder
http://cwrp.ca/sites/default/files/publications/en/AttachmentDisorder37E.pdf

CECW Emotional Trauma in Infancy
http://cwrp.ca/sites/default/files/publications/en/InfantTrauma75E.pdf

CECW Supporting healthy attachment: An overview for child welfare practitioners
http://cwrp.ca/sites/default/files/publications/en/Healthyattachment56E.pdf

CECW supporting the social-emotional development of infants and toddlers in foster care
http://cwrp.ca/sites/default/files/publications/en/EmoNeedsFoster60E.pdf

Understanding the Effects of Maltreatment on Brain Development
https://www.childwelfare.gov/pubPDFs/brain_development.pdf

HANDOUTS:

The First Years Last Forever pamphlet from the Canadian Institute for Child Health
https://www.parentsaction.org/wp-content/uploads/2017/04/IAYC_FirstYears-bklt-Eng.pdf

Centre of Excellence for Child Welfare information sheets:
Assessing emotional neglect in infants (2008)
http://cwrp.ca/sites/default/files/publications/en/EmotionalNeglectInfants59E.pdf

Attachment Disorder (2006)
http://cwrp.ca/sites/default/files/publications/en/AttachmentDisorder37E.pdf

Emotional Trauma in Infancy (2009)
http://cwrp.ca/sites/default/files/publications/en/InfantTrauma75E.pdf

Supporting Healthy Attachment: An Overview for Child Welfare Practitioners (2007)
http://cwrp.ca/sites/default/files/publications/en/Healthyattachment56E.pdf

Supporting the Social-Emotional Development of Infants and Toddlers in Foster Care (2008)
http://cwrp.ca/sites/default/files/publications/en/EmoNeedsFoster60E.pdf

Child Welfare Information Gateway
Understanding the effects of maltreatment on brain development (2009)
http://www.childwelfare.gov/pubs/issue_briefs/brain_development/brain_development.pdf

EVALUATION:

Provide session evaluation to group.

Module 7:

Caring for substance-exposed infants: A Foster Parent's Perspective

PURPOSE:

Infants in foster care present with a wide range of needs. Foster parents must work effectively with not only the infant, but also their family, and numerous professionals.

This session will provide you with an overview of key issues in the daily care of infants, including feeding, supporting development of sleep/wake cycles, managing symptoms related to substance exposure, and working with multiple health professionals. Being the foster family for infants with increased care needs places many demands on families.

We will also address how you can keep your own family healthy and strong during the time you do this work.

TIME:

- 2 hours

RECOMMENDED SPEAKERS:

- Experienced foster parent and social worker.
- It is important for this session that the foster parent guest speaker be experienced and be able to present an honest, open picture of the skills needed to successfully care for this group of infants. If you do not have an experienced foster parent in your community, there are many throughout the province and you may be able to arrange for someone to visit you from another community.
- The social worker can provide general support, build partnership and information around supports and caregiver expectations, limitations and self-care.

ESSENTIAL CONCEPTS:

Self care

- Researchers have found that parents and caregivers of special needs infants focus so much on the needs of the infants that they neglect their own well-being.

- Caregivers need to look after themselves as carefully as they look after the infant and their own family.

Access to support

- Foster parents consistently identify the feeling of being supported as key to their success and satisfaction with fostering.
- They also consistently identify this as an area where they do not often get their needs met. Foster parents need to maintain confidence in their parenting abilities and have the ability to manage the wide range of challenging situations that come their way.
- Parents need to be aware of their own strengths and limitations and know what they need to keep themselves, their family and their foster children happy and healthy.

Secondary trauma

- Foster parents are at risk of being impacted by the trauma they see being experienced by the children in their care and their families. The ability to help the children depends on our ability to stay emotionally healthy and motivated in difficult and often very frustrating situations.
- Traumatic stress is sometimes confused with burnout and should not be.

LEARNING OUTCOMES:

- ***By the end of Module 7, participants will:***

1. Develop an awareness of the commitment, knowledge and skills required to effectively care for infants.
2. Identify care strategies to deal with the discomforts and behaviors commonly experienced and demonstrated by infants in with prenatal substance exposure.
3. Understand practice issues for foster parents working with MCFD, including documentation, reporting requirements, supporting birth parent visitation and transition from foster home to birth or adoptive home.
4. Understand the stressors experienced by foster parents and discuss strategies of maintaining well-being personally and within the family.

LEARNING OUTCOMES WITH INSTRUCTOR NOTES:

Learning Outcome 1:

- ***Develop an awareness of the commitment, knowledge and skills required to effectively care for infants***

This class is most effectively taught if a variety of learning methods are used, including:

- Group discussion
- Panel presentation by foster parents
- DVD
- Demonstrations with doll, including practice opportunities, for example with swaddling, chin support during feeding.

A handout with a number of practical scenarios for discussion is provided. These scenarios were developed by experienced foster parents and social workers to reflect situations that are commonly seen.

Learning Outcome 2:

- ***Identify care strategies to deal with the discomforts and behaviors commonly experienced and demonstrated by infants in with prenatal substance exposure***

It is important to preface this objective by once again ensuring participants know that not all babies will demonstrate signs of withdrawal. Use the daily care handbook to work your way through this discussion. Once again, it is helpful to disperse alternate teaching methods throughout this talk, such as demonstrations and visual tools. Of course, the best way to learn these techniques is with an actual baby, so some of this information will need to be covered again with new foster parents after they have infants in their homes and have been practicing the techniques. The Safe Babies training checklist provides a way of tracking which areas have or have not been covered.

Learning Outcome 3:

- ***Understand practice issues for foster parents working with MCFD, including documentation, reporting requirements, supporting birth parent visitation and transition from foster home to birth or adoptive home***

The document “Standards for Foster Parents (1998)” states that children need to have accurate, individual, secure, and confidential records of their relevant history and progress in the home (p. 40). These records are important for the history of the child, for legal reasons, and for monitoring of the child’s health.

It is also helpful to review the topic of reportable incidents. This information is found on page 6 of the standards document. All information of significance to the safety and well-being of children are promptly reported to a social worker. *Some examples of reportable incidents include:*

- Accidents requiring medical treatment
- Plans, not previously authorized, for the child to be cared for overnight by another person
- Allegation of abuse, neglect, or mistreatment of a child or youth

When considering whether to access treatment or report an incident for something that may seem minor, for example a bump on the head, it is usually more prudent to be more cautious in your approach because (a) the potential exists for accusations of abuse and (b) your are covered legally if something more significant emerges develops health-wise.

Learning Outcome 4:

- ***Understand the stressors experienced by foster parents and discuss strategies of maintaining well-being personally and within the family***

There is only a small amount of research available that looks specifically at the stressors experienced by foster parents caring for substance-exposed infants. Most of what we know comes from learning from our experienced families. Group discussion works well for this topic. The Power Point contains a few slides that act as discussion points.

Secondary trauma also provides a good framework to organize discussion around stress and managing the work.

It is helpful to have participants also have a look at their own systems of support and their own ways of identifying and dealing with personal and family stress. The speaker that you use for this module may want to use some group or individual exercises that provide participants with the opportunity to look at individual triggers for stress, how stress presents itself, and what strategies they can develop to deal with it. It is also helpful to know that this may look different for each member of the family.

An important point to share with participants is that it is not a weakness to admit to stress; it is a strength to recognize stress and seek support.

It is helpful for participants to examine their own systems of support. One effective strategy is to have participants draw an "eco-map". Have them draw themselves in a circle in the middle of a piece of paper and then all around them identify who their supports are. Once they have identified their supports, they then need to "qualify" them. In other words, ask questions such as:

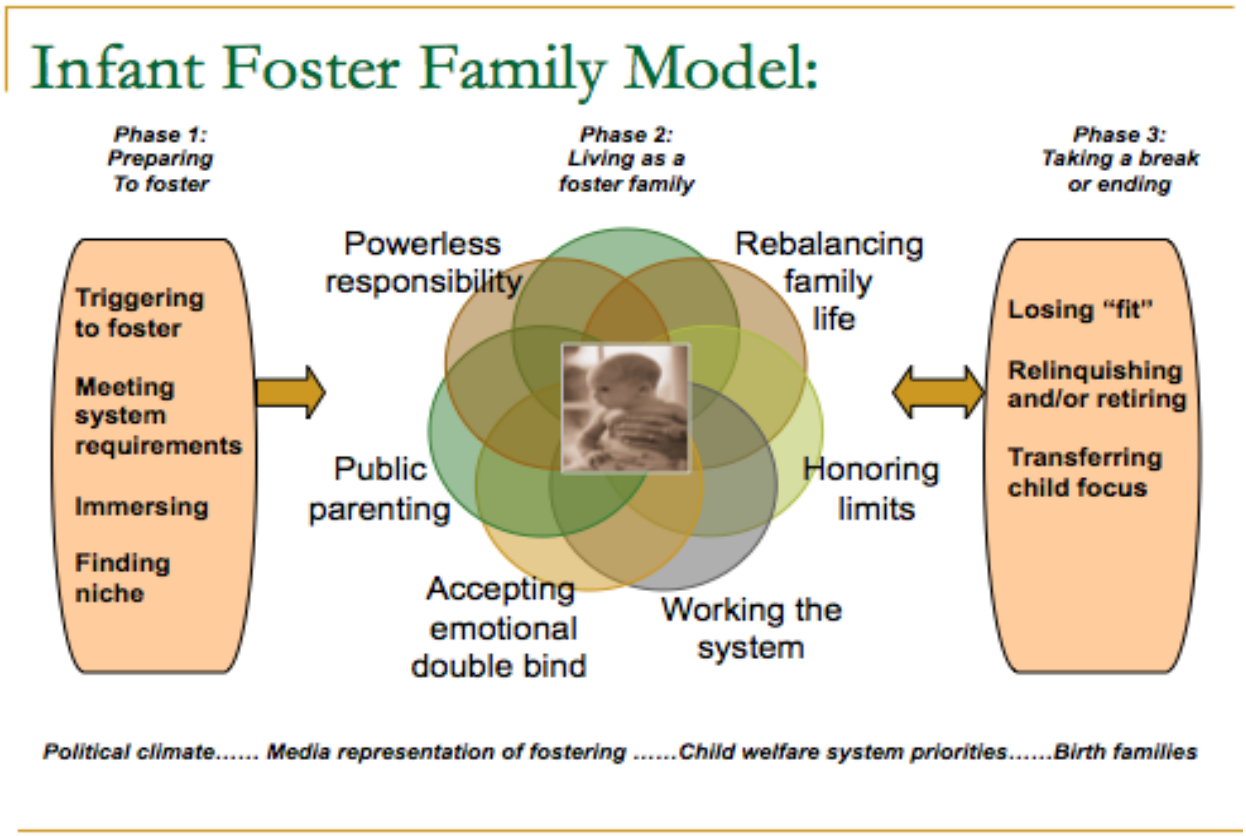
- *Who can you count on to help you with activities with your other children?*
- *Who can you count on to come over for an hour or two so you can have a nap?*
- *Who can you count on at 3 am when you phone them and tell them you need someone to come over right away to help?*

Have the participants identify any gaps they might have in their support and look at ways they can develop support to fill in the gaps.

Another good point for discussion is the importance of regular relief. Regular relief is a good way to avoid getting burned out. Breaks need to be taken before someone feels overwhelmed. Often foster parents (any parents) don't realize what intense work they are doing until something falls apart, such as their health. Taking breaks will help keep caregivers and their families healthy, both physically and mentally.

The Infant Foster Family Care Model

The model below represents the process foster families move through as they learn to care for infants with prenatal substance exposure. Development of this model was based on the experiences of foster families and social workers on Vancouver Island.



PHASE 1:

Preparing to Begin Fostering

Potential foster families were *triggered to look into fostering* in many ways, including exposure in their own family or social circle, reading about fostering or seeing a commercial. Other parents were internally motivated by reasons such as personal experience with a challenging childhood, a spiritual calling, or an altruistic desire to contribute to a community need. It is important at this point that all members of the family, including children, have the opportunity to contribute to the final decision to proceed with the steps needed to become licensed or approved as a foster family.

Once potential foster families are linked initially into the child welfare recruitment system, there are a number of steps that they need to complete to *meet the system requirements*, including a home study, orientation and education programs, criminal record checks, and establishment of contracts. These steps, particularly the home study, are time consuming and intrusive for the families. At this time, foster families are also expected to specify if they have a preference for an age group or gender for placement.

Once approval is received, families experience *an immersion* into the world of fostering with their first placement. For some families, this goes more smoothly than others. For the majority of families it is an eye opener into the scope and depth of the impact of this new role on their family life.

The first few placements provide opportunities for families to *find their niche* as far as the age and gender of foster children that work with the structures and strengths of their own family. Families that specialize in fostering infants are usually passionate about providing the intense 24/7 care and love that infants with challenges needed to develop and thrive.

PHASE 2:

Living as a Foster Family

Rebalancing family life is a challenge for families as they manage the ongoing cyclical rhythm of bringing infants and children into their life and letting them go. Family routines, roles and activities and even the environment of the home are all impacted by the presence of infants and young children with substance exposure who need interventions such as routines and decreased stimulation to manage their sensitivities.

This ongoing rebalancing requires a commitment on the part of all family members to *honor the limits* of everyone within the family. Knowing when patience levels are reached or when a break is needed was important to keeping the family healthy and positive with energy to keep fostering. It is also acknowledged that there are limits that affected the family's well being on a number of levels, including individual, family, and systems.

A double bind is a situation where a person receives two conflicting or contradictory messages. Foster families caring for infants experience an *emotional double bind* as they are expected to fully invest emotionally with each infant to provide an environment that promoted attachment, yet they also have to be able to release the infant on short notice to another birth or adoptive family. Although not usually

presented within the terms of grief and loss, all family members have to learn how to deal with loving and letting go with each infant.

An unanticipated component of fostering is *tolerating the child welfare system,* including its rules and regulations and its political underpinnings. Foster families have identified that often the most challenging part of the role is not providing care for an infant with special needs, but dealing with the expectations and parameters of a complex government system.

Foster families also consistently report that their role within the child welfare system is one that was structured as having a *powerless responsibility*; despite having sole responsibility over the day-to-day decisions related to care of the infant, they have little control over decisions that affected the long-term future of the infant.

Foster families conduct their work not only under the scrutiny of the child welfare system but also in the eye of the public. Being a *public parent* comes with heightened expectations of parenting skill and family life that are not necessarily supported with resources.

PHASE 3:

Ending Fostering

The goodness of fit between the infant in care and the foster family caring for them is key to success. *Losing fit* happens for a number of reasons, including within the family itself and within the family/system relationship. A major change in family composition and role, such as adoption, birth of another child, major family illness, aging, loss of partner, and employment changes places may alter the balance that kept the family healthy in the past. Increasing dissatisfaction of the family with expectations and restrictions of the system can contribute to an imbalance between the benefits members of the family feel they receive from fostering in comparison to the stressors with which they are dealing.

Most foster families who discontinue their formal relationship with a child welfare agency do not suddenly end their mission or goal of helping children in need. Rather, they *transfer their child focus* to another form of volunteerism or community support of children. For example, they provide care to children of family or friends, continue to parent their adopted child, or volunteer with programs that care for vulnerable infants and children.

LEARNING RESOURCES AND MATERIALS:

WEBSITES:

Child Trauma Academy
http://childtrauma.org/

Fostering Perspectives
http://fosteringperspectives.org/

REFERENCE MATERIALS/RESOURCES:

Dozier, M., Higley, E., Albus, K., & Nutter, A. (2002). Intervening With Foster Infants' Caregivers: Targeting Three Critical Needs. *Infant Mental Health Journal, 23*(5), 541-554.

Marcellus, L. (2008). (Ad)ministering Love: Foster Families Caring for Infants with Prenatal Substance Exposure. *Qualitative Health Research, 18*(9), 1220-1230.
https://www.researchgate.net/publication/23158294_Administering_Love_Providing_Family_Foster_Care_to_Infants_With_Prenatal_Substance_Exposure

Marcellus, L. (2006). Foster Care Services for Infants with Prenatal Substance Exposure: Developing Capacity in the Care-Giving Environment. *Promoting Resilient Development in Children Receiving Care Conference Proceedings.* Ottawa: Child Welfare League of Canada.

Marcellus, L. (in press). Supporting Resilience in Foster Families: A model for program design that supports recruitment, retention and satisfaction of foster families who care for infants with prenatal substance exposure. Child Welfare.

Miedema, B. (1999). Mothering for the State: The Paradox of Fostering. Halifax: Fernwood Publishing.

Silver, J., Amster, B., & Haecker, T. (1999a). *Young Children and Foster Care: A Guide for Professionals.* New York: Brookes.

Stages of Greif
http://fosteringperspectives.org/fp_vol1no2/articles/stages_of_grief.htm

The Cost of Caring: Secondary traumatic stress and the impact of working with high risk children and families (Bruce Perry, 2003)
https://childtrauma.org/wp-content/uploads/2014/01/Cost_of_Caring_Secondary_Traumatic_Stress_Perry_s.pdf

HANDOUTS:

Marcellus, L. (2004). Infants with Prenatal Substance Exposure: Supporting transition from foster to adoptive home. The Source: Newsletter for the U.S. National Abandoned Infants Assistance Resource Center. Berkeley, CA: University of California (Invited), 13(2), 9-13.

The Cost of Caring: Secondary traumatic stress and the impact of working with high risk children and families (Bruce Perry, 2003)
https://childtrauma.org/wp-content/uploads/2014/01/Cost_of_Caring_Secondary_Traumatic_Stress_Perry_s.pdf

Stages of Grief and Ways to Work through the Stages
http://fosteringperspectives.org/fp_vol1no2/articles/stages_of_grief.htm

EVALUATION:

Provide session evaluations to participants.

Module 8:

Infant Cardiopulmonary Resuscitation (CPR)

PURPOSE:

- Substance-exposed infants have a higher incidence of Sudden Infant Death Syndrome (SIDS) than the general infant population.
- They may also have other related health issues, which place them at further risk of SIDS, including prematurity.
- Caregivers within the Safe Babies program are required to maintain current certification in infant CPR.

PART C:

EVALUATION

Safe Babies Foster Parent Training Program

Sample of an Evaluation and Feedback Form

OPEN QUESTION: Please respond, at least briefly, to each of the following:

1. Do you have additional training needs in the area of substance-exposed infants? If so, please list

2. How will this training influence your understanding of, or interactions with, substance-exposed infants and their families?

3. What do you think were the best and worst aspects of this training experience? What would you change about the curriculum or its presentation?

SAFE BABIES FOSTER PARENT TRAINING PROGRAM

SAMPLE EVALUATION AND FEEDBACK FORM

RATING	Quality of Class					Clarity & Importance of Learning Objectives					Handout/Reading					Overall Organization				
Scale	5 = Excellent • • • 1 = Poor																			
Module 1: Introduction	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
Module 2: Understanding women and addictions	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
Module 3: The impact of substance use during pregnancy	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
Module 4: Partnership with birth families	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
Module 5: Withdrawal in the newborn	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
Module 6: Neurodevelopmental support	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
Module 7: Caring for substance-exposed infants	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
Module 8: Infant CPR	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
COMMENTS:																				

Name (Optional): _____ Contact Number (Optional): _____

Please provide us with feedback about this training course. On the grid below, please rate characteristics of the modules you experienced by using a scale from 1 to 5 (with 1= poor, 3 = fair, 5 = excellent). Just fill in your rating in each box. Then please also provide additional thoughts as requested on the next page. Thank you.

PART D: RESOURCES

RESOURCES

1. Catalogue of Handouts
2. References
3. Catalogue of Websites
4. Agencies
5. DVDs/Videos

Catalogue of Handouts:

Module 1: Introduction

Ministry of Health FASD health file-
https://www.healthlinkbc.ca/hlbc/files/documents/healthfiles/hfile38e.pdf

Module 2: Understanding Women and Addictions

BCCEWH Coalescing on women and substance use: Linking research, practice and policy.

Relational Approach: The Importance of Supportive and Timely Connections (2010). FASD Prevention from a Women's Health Determinants Perspective-
http://www.cwhn.ca/en/node/40301

Module 3: The Impact of Substance Abuse During Pregnancy

Is it safe for my baby? (2003)
Centre for Addiction and Mental Health (also available free from Healthy Choices in Pregnancy)
http://westernhealth.nl.ca/uploads/Addictions%20Prevention%20and%20Mental%20Health%20Promotion/Is%20It%20Safe%20for%20My%20Baby.pdf

Information on toll-free Motherisk Alcohol and Substance Use Helpline. Available online at:
www.motherisk.org/alcohol/index.php3

Effect Series (Alcohol, Amphetamines, Cannabis, Cocaine, Hallucinogens, Opiods, Tobacco)
Health Services

Module 4: Partnership with Birth Families

Visitation for infants and toddlers
http://www.abanet.org/child/cw/07_08aug.pdf

"A Sense of Belonging: Supporting Healthy Child Development in Aboriginal Families". (pages 31, 32, 38, and 39)
This book is in the Safe Baby Toolkit.
https://www.beststart.org/resources/hlthy_chld_dev/pdf/aboriginal_manual.pdf

Module 5: Withdrawal in the Newborn and Related Health Issues for Infants

Safe Babies: A caregiver's guide to daily care for infants exposed prenatally to alcohol and drugs.

Prevent Shaken Baby Syndrome BC

Home safety checklist from Safe Start BC
http://www.bcchildrens.ca/Child-Safety-Site/Documents/homesafetychecklist.pdf

BC Health Files – there is a large selection of health files available at the following site. Your local public health nurse will be able to assist you in selection the ones that are most relevant for your group and also provide you with additional printed resources used in your area, such as information on hearing screening for infants. Here are a few examples:

An Infant with Seizures, Rash, and Hepatosplenomegaly
https://academic.oup.com/cid/article/46/3/451/392025

CPT1 Deficiency
http://www.bcchildrens.ca/Resource-Centre-site/Documents/C/BCCH1547_CPT1Deficiency.pdf

Congenital Syphilis: No Longer Just of Historical Significance
https://www.cps.ca/en/documents/position/congenital-syphilis

The Syphilis Outbreak in Alberta

Syphilis is on a comeback
http://www.macleans.ca/news/canada/a-scourge-on-a-comeback/

Module 6: Neurodevelopmental Support for the Substance-exposed Infant

The First Years Last Forever pamphlet from the Canadian Institute for Child Health
https://www.parentsaction.org/wp-content/uploads/2017/04/IAYC_FirstYears-bklt-Eng.pdf

Centre of Excellence for Child Welfare information sheets:
Assessing emotional neglect in infants (2008)
http://cwrp.ca/sites/default/files/publications/en/EmotionalNeglectInfants59E.pdf

Attachment Disorder (2006)
http://cwrp.ca/sites/default/files/publications/en/AttachmentDisorder37E.pdf

Emotional Trauma in Infancy (2009)
http://cwrp.ca/sites/default/files/publications/en/InfantTrauma75E.pdf

Supporting Healthy Attachment: An Overview for Child Welfare Practitioners (2007)
http://cwrp.ca/sites/default/files/publications/en/Healthyattachment56E.pdf

Supporting the Social-Emotional Development of Infants and Toddlers in Foster Care (2008)
http://cwrp.ca/sites/default/files/publications/en/EmoNeedsFoster60E.pdf

Child Welfare Information Gateway
Understanding the effects of maltreatment on brain development (2009)
http://www.childwelfare.gov/pubs/issue_briefs/brain_development/brain_development.pdf

Module 7: Caring for Substance-exposed Infants: A Foster Parent's Perspective

Marcellus, L. (2004). Infants with Prenatal Substance Exposure: Supporting transition from foster to adoptive home. The Source: Newsletter for the U.S. National Abandoned Infants Assistance Resource Center. Berkeley, CA: University of California (Invited), 13(2), 9-13.

The Cost of Caring: Secondary traumatic stress and the impact of working with high risk children and families (Bruce Perry, 2003)
https://childtrauma.org/wp-content/uploads/2014/01/Cost_of_Caring_Secondary_Traumatic_Stress_Perry_s.pdf

Stages of Grief and Ways to Work through the Stages
http://fosteringperspectives.org/fp_vol1no2/articles/stages_of_grief.htm

References:

Module 1: Introduction

General FASD DVD (most foster parent support groups have a general DVD. Check in the FASD toolkit for choices)

Health Link BC FASD fact sheet
https://www.healthlinkbc.ca/hlbc/files/documents/healthfiles/hfile38e.pdf

Module 2: Understanding Women and Addictions

ActNow BC Healthy Choices in Pregnancy
Women and Alcohol: A women's health resource
http://www.health.gov.bc.ca/library/publications/year/2010/bcstats-hcip-report.pdf

Apprehensions: Barriers to treatment for substance using mothers – Nancy Poole and Barbara Isaac (2001)
http://www.bccewh.bc.ca/publications-resources/documents/apprehensions.pdf

Barriers exercise
BC Women's Hospital Abuse Response Program

Best practices approaches: Child protection and violence against women: A curriculum for child protection workers, prepared for Ministry of Children and Family Development
https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/public-safety/protecting-children/best_practice_approaches_policy.pdf

Centre for Addiction and Mental Health – Addiction: An information guide (2007)
http://www.camh.net/About_Addiction_Mental_Health/Drug_and_Addiction_Information/Addiction_Information_Guide/index.html

DVD: ActNow BC Healthy Choices in Pregnancy DVD
Supporting change: Preventing fetal alcohol spectrum disorder

Highs and Lows: Canadian Perspectives on Women and Substance Use (N. Poole and L. Greaves, Eds).
http://www.cwhn.ca/en/node/39425

With Child: Substance Use During Pregnancy, A Woman-Centred Approach (S. Boyd and L. Marcellus, Eds.). 2007.
http://www.cwhn.ca/en/node/40301

Module 3: The Impact of Substance Abuse During Pregnancy

Perinatal Services BC clinical guidelines
http://www.perinatalservicesbc.ca/health-professionals/guidelines-standards

Caring for women with problematic substance use, their newborns & families: A self-directed learning module / Seymour, Laurie; Payne, Sarah; BC Women's Hospital & Health Centre / 2006

Module 4: Partnership with Birth Families

A Sense of Belonging: Supporting Healthy Child Development in Aboriginal Families
Best Start: Ontario's Maternal, Newborn and Early Child Development Centre (2006)
https://www.beststart.org/resources/hlthy_chld_dev/pdf/aboriginal_manual.pdf

Aboriginal children's health: Leaving no child behind
http://www.unicef.ca/sites/default/files/imce_uploads/DISCOVER/OUR%20WORK/ADVOCACY/DOMESTIC/POLICY%20ADVOCACY/DOCS/Leaving%20no%20child%20behind%2009.pdf

Cultural safety in practice with children, families and communities (Ball, UVIC)
http://www.ecdip.org/culturalsafety

Ensuring the healthy development of infants in foster care: A guide for judges, advocates and child welfare professionals. Zero to Three Policy Center (2004)
http://www.courts.state.ny.us/ip/justiceforchildren/PDF/Infant%20Booklet.pdf

Infants in the child welfare system: A developmental framework for policy and practice. Brenda Jones Harden (2007). Zero to Three

Parenting with FASD: Challenges, strategies and supports. Rutman, La Berge & Wheway (2005)

Substance exposed infants: State responses to the problem (2009)
U.S. Substance Abuse and Mental Health Services Administration
http://www.ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf

Visitation with infants and toddlers in foster care: What judges and attorneys need to know. Zero to Three Policy Center (2007)
http://www.abanet.org/child/policy-brief2.pdf

Module 5: Withdrawal in the Newborn and Related Health Issues for Infants

Baby's Best Chance (2017)
BC Ministry of Health
http://www.health.gov.bc.ca/library/publications/year/2017/BabysBestChance-Sept2017.pdf

Toddler's First Steps (2008)
http://www.llbc.leg.bc.ca/public/PubDocs/bcdocs/437200/TFS_Intro.pdf

Module 6: Neurodevelopmental Support for the Substance-exposed Infant

A Simple Gift: Comforting Your Baby (2008): Summary for caregivers after viewing and discussing on line video from Sick Kids Infant Mental Health Program
https://www.sickkids.ca/pdfs/IMP/16099-IMPComfortingBabySummary08.pdf

Handbook on Infant Mental Health (2009). Charles Zeanah, Ed. Guilford Press.

I Am Your Child DVD and Parent Educator Manual
https://www.parentsaction.org/wp-content/uploads/2017/04/IAYC_FirstYears-bklt-Eng.pdf

The Out-Of-Sync Child: Recognizing and coping with sensory processing disorder (2005). Carol Stock Kranowitz

The Out-Of-Sync Child Has Fun: Activities for kids with Sensory Processing Disorder (2006) Carol Stock Kranowitz

Infants in the child welfare system: A developmental framework for policy and practice.
Brenda Jones Harden, 2007, Zero to Three

Young children and foster care: A guide for professionals
Judith A Silver, Barbara J. Amster, Trude Haecker (1999)

Steps in the right direction: Connection and collaborating in early intervention therapy with Aboriginal families and communities in British Columbia (2007). Alison Gerlach

CECW Assessing Emotional Neglect in Infants-
http://cwrp.ca/sites/default/files/publications/en/EmotionalNeglectInfants59E.pdf

CECW- Attachment disorder -
http://cwrp.ca/sites/default/files/publications/en/AttachmentDisorder37E.pdf

CECW Emotional Trauma in Infancy-
http://cwrp.ca/sites/default/files/publications/en/InfantTrauma75E.pdf

CECW Supporting healthy attachment: An overview for child welfare practitioners-
http://cwrp.ca/sites/default/files/publications/en/Healthyattachment56E.pdf

CECW supporting the social-emotional development of infants and toddlers in foster care-
http://cwrp.ca/sites/default/files/publications/en/EmoNeedsFoster60E.pdf

Understanding the Effects of Maltreatment on Brain Development-
https://www.childwelfare.gov/pubPDFs/brain_development.pdf

Module 7: Caring for Substance-exposed Infants: A Foster Parent's Perspective

Dozier, M., Higley, E., Albus, K., & Nutter, A. (2002). Intervening With Foster Infants' Caregivers: Targeting Three Critical Needs. *Infant Mental Health Journal, 23*(5), 541-554.

Marcellus, L. (2008). (Ad)ministering Love: Foster Families Caring for Infants with Prenatal Substance Exposure. *Qualitative Health Research, 18*(9), 1220-1230.
https://www.researchgate.net/publication/23158294_Administering_Love_Providing_Family_Foster_Care_to_Infants_With_Prenatal_Substance_Exposure

Marcellus, L. (2006). Foster Care Services for Infants with Prenatal Substance Exposure: Developing Capacity in the Care-Giving Environment. *Promoting Resilient Development in Children Receiving Care Conference Proceedings.* Ottawa: Child Welfare League of Canada.

Marcellus, L. (in press). Supporting Resilience in Foster Families: A model for program design that supports recruitment, retention and satisfaction of foster families who care for infants with prenatal substance exposure. Child Welfare.

Miedema, B. (1999). Mothering for the State: The Paradox of Fostering. Halifax: Fernwood Publishing.

Silver, J., Amster, B., & Haecker, T. (1999a). *Young Children and Foster Care: A Guide for Professionals.* New York: Brookes.

Stages of Greif
http://fosteringperspectives.org/fp_vol1no2/articles/stages_of_grief.htm

The Cost of Caring: Secondary traumatic stress and the impact of working with high risk children and families (Bruce Perry, 2003)
https://childtrauma.org/wp-content/uploads/2014/01/Cost_of_Caring_Secondary_Traumatic_Stress_Perry_s.pdf

Catalogue of Websites

Module 1: Introduction

Health link BC
https://www.healthlinkbc.ca/

Module 2: Understanding Women and Addictions

Health Gov BC
https://www2.gov.bc.ca/gov/content/health

Center of Excellence for Women's Health
http://bccewh.bc.ca/

BC Gov
https://www2.gov.bc.ca/

National Film Board
https://www.nfb.ca/

Center of Addictions and Mental Health
https://www.camh.ca/en/hospital/Pages/home.aspx

Canadian Women's Health Network
http://www.cwhn.ca/

CanFASD
https://canfasd.ca/

Module 3: The Impact of Substance Abuse During Pregnancy

Perinatal Services BC
http://www.perinatalservicesbc.ca/

Western Health
http://westernhealth.nl.ca/

Module 4: Partnership with Birth Families

Best Start
https://www.beststart.org/

Unicef
https://www.unicef.ca/en

Module 5: Withdrawal in the Newborn and Related Health Issues for Infants

BC gov Health
https://www2.gov.bc.ca/gov/content/health

Period of PURPLE crying
http://www.purplecrying.info/

BC Hospital
http://www.bcchildrens.ca/

Canadian Pediatric Society
https://www.cps.ca/en/

Module 6: Neurodevelopment Support for the Substance-Exposed Infant

Sick Kids
https://www.sickkids.ca/

Canadian Child Welfare Research Portal
http://cwrp.ca/sites/default/files/publications/en/

Child Welfare Information Gateway
https://www.childwelfare.gov/

Module 7: Caring for Substance-Exposed Infants: A Foster Parent's Perspective

Child Trauma Academy
http://childtrauma.org/

Fostering Perspectives
http://fosteringperspectives.org/

Agencies

Abbotsford Community Services
https://www.abbotsfordcommunityservices.com/

Adoptive Family Association of BC
https://www.bcadoption.com/

Axis Family Recourses
http://axis.bc.ca/

BC Center for Disease Control
http://www.bccdc.ca/

BC Center for Excellence for Women's Health
http://bccewh.bc.ca/

BC Federation of Foster Parent Associations
https://bcfosterparents.ca/

BC MCFD- Ministry of Child and Family Development
https://www2.gov.bc.ca/gov/content/governments/organizational-structure/ministries-organizations/ministries/children-and-family-development

Canadian Institute of Child Health
https://cich.ca/

Canadian Pediatric Society
https://www.cps.ca/en/

Community Bridge
http://communitybridge.ca/

Federation of BC Youth in Care Networks
http://fbcyicn.ca/

Foster Parent Support Service Society
http://fpsss.com/

Grandparents Raising Grandchildren
http://www.parentsupportbc.ca/for-grandparents/

Hollyburn Family Services
https://www.hollyburn.ca/

Indigenous Perspectives Society
http://ipsociety.ca/

Interior Community Services
http://www.interiorcommunityservices.bc.ca/

Okanagan Foster Parent Association
http://www.okfosterparents.ca/

PRIMA- Pregnancy Related Issues in the Management of Addictions
http://www.addictionpregnancy.ca/

Surrounded by Cedar
http://www.surroundedbycedar.com/

DVDs/Videos

Bevel Up
https://www.nfb.ca/film/bevel_up_drugs_users_and_outreach_nursing/

Child Development Media
http://www.childdevelopmentmedia.com/

I am your Child Video
https://www.parentsaction.org/videos/

A Simple Gift
http://www.childdevelopmentmedia.com/home-visiting/a-simple-gift-comforting-your-baby-video/

Period of PURPLE Crying
https://www.dontshake.org/purple-crying

SAFE BABIES FOSTER PARENT TRAINING PROGRAM

Caregiving Scenarios

These scenarios were developed by a group of experienced foster parents and foster parent educators. They represent some of the more frequently seen situations that foster parents face and are intended to prompt discussion. The discussion session brings up some points but your participants will most likely bring up many more.

Linda and Rick

Linda and her husband Rick, who is the pastor of a small community church, have been foster parents for four years. Typically, they have taken children six years and older. They have three children of their own ranging in age from nine to sixteen. Their two oldest daughters are heavily involved with soccer and the youth group at their church while the youngest son is an upcoming hockey player. He has daily early morning practices and games on the weekend. Rick coaches the girls' soccer team and Linda gets up early to get their son to his hockey practices. The whole family likes to attend the games and support each other.

Linda has decided she would like to foster infants and has attended the required Safe baby training. She was thrilled when she got a call from MCFD saying they had a newborn waiting for release from hospital. This baby was born a month premature and had been exposed to crystal meth during pregnancy. The birth father has not been identified and the birth mother will be having daily two hour supervised visits five days per week.

How will Linda and Rick balance the demands of their household and with the caregiving requirements of this baby?

Discussion:

- Is this busy home a good match for this baby?
- How can Linda and Rick make this work...or should they?
- Linda and Rick need to reflect on their family life workload and the needs of an infant with some health challenges and be thoughtful about what is realistic and safe.

Nancy

Nancy was called to take four-day old baby boy David who had prenatal exposure to alcohol and cocaine. David was due to be released from the hospital the following day. His mother Sharon had been released the day before. When Nancy inquired as to what formula she should buy, she was told by the social worker that David was being breastfed by Sharon who was visiting every day. The plan was for Sharon to have supervised visits every day, and

that she would be provided with a breast pump so that David would have a steady supply of breast milk for the days when there were no visits. Nancy immediately felt concerned because Sharon had a long history of alcoholism and had already had five previous children removed from her care. She thought to herself "Why isn't the social worker telling mom she can't breastfeed when chances were she's still drinking and using cocaine?"

Discussion:

- This has been a challenging debate for years. Presently research evidence shows that for many medications the benefits of breastfeeding outweigh the risks. Check with your health care providers or programs like Motherisk to find out the latest evidence on substance use and breastfeeding and recommendations specific to the substances Sharon is using. It is best to have this decision made collaboratively between Sharon, her health care providers and MCFD before baby leaves the hospital.
- Other conditions to consider are how much Sharon is currently using and if she has any other health issues such as HIV where breastfeeding is not recommended.
- Consider the positive mother and baby bonding that happens when nursing.
- An additional consideration related to the health of the infant is to make sure that the milk was pumped, stored and transported safely. Your public health nurse will be able to work with you to assess this situation.

Helen and Steve:

Helen and Steve received a call from their social worker to take a three-month-old seven-pound baby boy Bryan. Bryan had a disorganized suck and was easily over stimulated. He required constant care and feeding. Helen and Steve were beginning to feel that they could get nothing done in the day but try to get an adequate amount of formula into Bryan. They took him to public health to be weighed weekly. He was slowly gaining weight but only because of Helen and Steve's persistence.

Six weeks later they took Bryan for a follow up visit with the pediatrician. From her perspective, she saw an infant who presented as doing well and seemed content in Helen's arms for the half hour appointment. Helen and Steven found themselves increasingly frustrated by her attitude of "What's the problem here?" she seemed to be missing the point that Bryan was having a hard time coping with his symptoms and that perhaps additional supports for both Bryan his caregivers were needed.

Discussion:

- Helen and Steve need to put into practice some self-care strategies. What would help?
- What can Helen and Steve do to better advocate for Bryan? How can they provide the pediatrician with an accurate picture of their struggles?
- Provide documentation – daily log book – can be used to show symptoms and to educate the pediatrician.
- Access relief and support
- Work with public health nurse and infant development program to manage symptoms. Also, you could arrange to have the public health nurse come and weigh the baby in your home to reduce stress.
- Helen and Steve have each other for support but it is still important for them to take breaks on their own and together as a couple.

Bonnie and Bruce:

Baby boy Lance was discharged from the neonatal intensive care unit at ten days of age. He was heavily exposed to cocaine right up until the time of birth. The nurses reported that he did well and gained weight in the NICU. Bonnie and Bruce, his foster parents, found him to be sleepy for the first several weeks in their care. All that changed quickly and Lance began to wake up. He became very irritable and hypersensitive to stimulation. Bonnie and Bruce found that they had to put all their therapeutic skills into practice. Lance seemed to function fairly well at his visits with his birth parents Stacey and Damien, which was confirmed by the visit supervisor. The supervisor reported that Stacey and Damien interacted well with Lance. Bonnie and Bruce were beginning to feel increasingly frustrated when after each visit, they would hear how well Lance did. However, at home he was not doing so well after visits and would cry relentlessly and was difficult to feed. Bonnie and Bruce were beginning to have self-doubts about their own parenting skills.

Discussion:

- The timing of maternal cocaine use related to the appearance of symptoms initially.
- The delayed response to overstimulation. Foster parents need to communicate the importance of low stimulation during visits to the visit supervisor also.
- What other strategies could be put into place to help the baby cope with visits? For example, visits could take place in the foster home, foster parents could teach about reading baby cues and effective ways of interacting with Lance. Could the visit schedule be adjusted?

Randy:

Social worker Randy was called to the hospital when Laura, a young woman with FASD, gave birth to seemingly healthy baby girl Charlotte. Laura and her husband Don were low functioning plus Don had a history of alcohol abuse and at present was unemployed. Laura and Don also have a four-year-old boy who was removed from their care by MCFD for neglect, and had been adopted by extended family. Randy organized a meeting at the hospital with Laura and Don, a Safe Babies caregiver and the maternity unit manager to discuss planning options for Charlotte. The Safe Babies caregiver was concerned for the well being of the baby when she met the parents. Although she felt sympathy for them as they were in tears at the thought of losing another baby to foster care, she was concerned about their ability to care for Charlotte. Later in the afternoon Randy met with extended family members who rallied around the young parents to support them in their effort to keep their baby. The following day Randy developed what he felt was the best plan for Charlotte. What would you have decided if you were Randy?

Discussion:

- Randy decided to have Charlotte go home with Laura and Don, with a firm plan of support from extended family members in place, additional supports provided from community social support agencies, and a more detailed follow up assessment process.

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