The FASD (Fetal Alcohol Spectrum Disorder) Community of Practice (CoP) in Alberta Human Services:

Leading from Within Initiative

Final Report

Prepared for

The Alberta Centre for Child, Family and Community Research

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The FASD Community of Practice (CoP) Initiative, Leading From Within research evaluation project examined how an advanced model of training for casework supervisors, caseworkers and managers has supported and enhanced casework practice for children with FASD in care in the province of Alberta, whilst strategically building expertise within the Human Services Workforce. The FASD CoP was developed over the past ten years (2003-2013) through research beginning in Region 1 of Alberta Human Services that focused on the unique and specific needs of children with FASD, a lifelong disabling condition, who received child welfare supports and services. The history of the FASD CoP over the past decade is documented within this report. This project was funded by the Alberta Centre for Child, Family and Community Research and serves as a model for providing caseworkers, casework supervisors and managers with advanced training, case consultation, dialogues and discussions related to practice and policy on a provincial level on FASD.

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RESEARCH ABSTRACT

THE FASD (FETAL ALCOHOL SPECTRUM DISORDER) COMMUNITY OF PRACTICE IN ALBERTA HUMAN SERVICES - LEADING FROM WITHIN INITIATIVE

PURPOSE:
This project examined the implementation of advanced training specifically designed for caseworkers, casework supervisors and regional managers within Alberta Human Services and the Delegated First Nations Authorities from January to June 2013. Participants attended a 10 day course offered by Donna Debolt, FASD Consultant that included Fetal Alcohol Spectrum Disorder: Level One – Solutions Through Case Management including best practice approaches, case plan decisions, framework of practice, lifespan considerations and case management. Building on this learning, Fetal Alcohol Spectrum Disorder: Level Two - Advanced provided more in-depth training focused on the challenges of casework practice with children and families where FASD is a concern. There were 22 participants from nine Child and Family Service Authorities (CFSAs) regions. Participants were required to complete the Level One and Two courses, to move onto the next course Fetal Alcohol Spectrum Disorder: Team Competency and Screening. Subsequent to this training, 6 days of Fetal Alcohol Spectrum Disorder: Case Consultation that involved reviewing actual cases occurred in Region 6. The initiative is described in this report.

METHODS:
The training initiative, FASD CoP Leading from Within (FASD COP LFW) was evaluated through analysis and review of the training aspects of this project, that included a series of observations of training events, case consultations, field notes, a survey of participants via survey monkey, a focus group with three casework supervisors in one region and other communication with participants electronically and by phone. A qualitative approach was taken in terms of analyzing the responses to questions posed in relation to the training events, with qualitative software, Atlas Ti. The focus group with casework supervisors was recorded, transcribed and analyzed through Atlas Ti and evaluation of the training and case consultations included direct observation and extensive field note documentation. A review of the literature on FASD and child welfare and communities of practice was undertaken. The researcher participated in meetings of the Steering Committee for the duration of the project and remained in regular communication with the consultant and the FASD Cross Ministry committee.

FINDINGS:
This initiative took place in-house through a series of courses/training days through Workforce Development in collaboration with an FASD specialist/ training consultant, whose primary practice over the past two decades has focused on child welfare and supporting children and families living with FASD. Participants positively evaluated the FASD COP LFW workforce training. A key element of the success of this initiative was the recognition that child welfare practice in response to FASD requires a specialized approach and leadership on practice needs to originate and develop within the workforce. For the purposes of this report the term children is inclusive of both children and youth. Those working in child welfare are aware that the complex needs of children and families where addiction and family dysfunction are serious issues that often lead to the permanent removal of children from parental care. Children that are placed in care and live with FASD have high needs. Training on FASD specifically within a child welfare context is in essential in order to develop effective case management strategies and approaches. While awareness of FASD has developed more broadly, the challenges faced in child
welfare casework for children and families is not well understood. Through the FASD COP LFW training on casework practice, casework supervision, placement management including foster and group care, child development, recognizing brain based behaviors associated with FASD, and recognition that protection based decisions made for children have lifespan implications took place through processes of advanced training courses and live case consultations. The process included the lead consultant trainer, a representative from the Education system, caseworkers presenting the case, foster parents and other professionals. The case review itself collected information on FASD diagnosis, age, school status/grade, health, mental health/psychosocial concerns, placement history/stability including family history, legal issues, and the reason for consultation. These courses were highly interactive and provided a setting that allows for casework supervisors and regional managers to learn through participation in case consultations through listening, observation and the opportunity to participate “at the table” in a highly structured and confidential process. The findings from the FASD COP LFW were positive and reflect an important achievement in advancing child welfare practice for children and families living with the impact of FASD.

**DISCUSSION:**

The challenge of FASD as it is known in modern times is that children who experience prenatal alcohol exposure and who receive a diagnosis are at high risk of engagement with the child welfare system. As well, those prenatally exposed and NOT diagnosed are even higher risk for coming to CW attention because their disabilities are not identified and misunderstood or missed completely. Why? These children have vulnerabilities that emerge from their family of origin that include problems such as addictions, child neglect, poverty, social stigma and often, intergenerational cycles that are difficult to change. Children born into these circumstances are already at risk. Their parents may have had prior child welfare involvement themselves, perhaps have grown up in care and are now having children of their own, and may be significantly lacking in social support systems. These factors alone are a worry, and the birth of a child with a disability, in this case, FASD, is cause for concern. The training and education required to understand these circumstances include an understanding of the cycle of addictions from a psychological and physical perspective, intergenerational family problems, challenges associated with poverty, knowledge of disabilities, education and learning challenges, social circumstances that contribute to child neglect and abuse, and factors that cause children to be at risk and in need of child protection services. Children come into foster or group care when it is deemed safer for them to be in the system, than at home. The circumstances surrounding children placed in care in light of parents being unable to meet their needs is a complex phenomenon, worthy of study and understanding. The FASD COP LFW has advanced casework practice and supervision for children with FASD by unpacking some of the challenges faced by children and their families, by foster caregivers, through knowledge and education focused on the identification of a lifespan trajectory, appreciating developmental challenges and behaviors, and recognizing the complex needs that demand advanced practice skills. This work has led to the identification of a four point model of Protective Case Planning that includes, 1) training on FASD and child welfare practice, 2) children with FASD in need: critical supports, 3) placement stability support, and 4) intervention strategies: supporting connections, compliance and competencies. This work represents best practice as evaluated by the participants in the FASD COP LFW Initiative. The overarching goal of this project was to engage in training to support FASD informed casework practice, supervision and management in the Child and Family Services Authorities in the province of Alberta.

*Children in care with FASD are as good as we are. It’s our job to explain who they are to the world, not their job, to explain their world to everyone.*

*Quote from a casework supervisor*
Introduction

The FASD Community of Practice (FASD CoP) has a rich history in Alberta and has taken place in Alberta in three distinct iterations over the past decade (2003-2013). The needs of children with FASD were unique and multiple challenges related to supporting children and families emerged. The necessity to practice casework differently and more intensively for children with FASD engaged with child welfare was recognized by vigilant and concerned caseworkers, supervisors and managers in Region 1. To this end early training for caseworkers and casework supervisors in Alberta began to emerge largely through training offered by Donna Debolt and Mary Berube.

It is important to identify that the humble beginnings of the FASD CoP was a grassroots initiative within Region 1 that was truly ahead of its time. This region forged new practices and influenced responses to FASD in the Province of Alberta, and specifically within Alberta Human Services. In 2013 Alberta is recognized as leader through its’ FASD agenda that includes the FASD Cross Ministry Committee, 12 Service Networks across the province, the Parent Child Assistance Programs (P-CAP) that works with vulnerable children and families at risk for an FASD and a Learning Series that is broadcast internationally through webinars. Further information on these initiatives in Alberta can be found at www.fasd.alberta.ca

Course Description

CFSA – FASD Community of Practice Leading From Within Initiative

*The CFSA FASD Leadership Program was designed to enhance participant’s FASD knowledge and skills and to build capacity to serve those with FASD. With 24 participants at a time, the smaller group size optimizes individuals’ participation and learning, and the 10 day program infuses classroom training with real case consultation and post-Certificate strategies that aim to strengthen CFSA’s in the area of FASD screening and service delivery. Participants can go on to facilitate FASD training within and outside their organizations, provide consultation (e.g.*
colleagues, caregivers, professionals within their communities), and advocate for the needs of individuals affected by FASD (at individual, agency, and systems’ levels).

This report is focused on the work done by the Child and Family Services Authorities (CFSAs) in Alberta in relation to advanced training and case consultation course on FASD that took place from 2012-2013. The new initiative became known as Leading from Within as a means of acknowledging that practice on FASD requires training and leadership within the context of the delivery of child welfare services in Alberta. While many services are available to children in need, the delivery of child protection services occurs within a mandated framework. Knowledge on the particular needs of children with FASD have evolved over the past two decades when early training in FASD began in the 1990s largely through the efforts of Donna Debolt and Mary Berube. Training on Fetal Alcohol Syndrome (FAS) was offered in Region 1 beginning in 1992 and was delivered in other regions around the province. Training on FASD is a two-hour module in the CFSA delegation training for new child welfare caseworkers and that is not enough time to develop practice skills. While a basic introduction is helpful, this learning needs to be enhanced as many children in care live with FASD. There are many training opportunities on FASD provincially and nationally, but training specific to child welfare casework remains specialized. The development of advanced case consultation training offered through Human Services Workforce Development as a course accredited for competency credits through Human Services Workforce Development and the Alberta College of Social Workers attests to the commitment of the province to develop an FASD informed casework response for children in need.

Practice and Knowledge Development within CFSAs in Alberta: Setting the Stage
Alberta has been on the leading edge of practice and knowledge development related to child welfare service delivery since early innovations in the 1990s that saw the development of training, on FASD. Since these early days the response to FASD has become an international phenomenon. The Ten Year Strategic Plan developed within Alberta is at its midway point and remarkable progress has been made to date. While the FASD Community of Practice has demonstrated both leadership and innovation, the need exists to develop, from within the workforce of Children’s Services, knowledgeable leaders who can guide practice related to complex case management. Complex case management is an important construct in relation to responding to the needs of children, youth and families affected by FASD. Underlying social problems related to historical trauma, alcohol and substance abuse and chronic neglect are often factors in the care of children who come to attention of Children’s Services. How does the knowledge developed within the workforce through the FASD CoP project move forward?

This project represented a high standard of care being offered to some of the most vulnerable children and families engaged with child welfare. Practice for such families emerges from a need to shift practice for children with FASD who often have multiple, significant problems within their family of origin, leading to child welfare involvement. Anecdotally, we know through the voices of caseworkers, casework supervisors, regional managers, foster parents and other community caregivers, that children who live with a condition on the FASD spectrum often have severe social/environmental problems. Additionally, a strong response is required to tackle the problems associated with addictions, family violence, often fueled by substance abuse, child abuse and neglect, and the capacity of families to manage the care of children with FASD. The FASD Cross Ministry initiatives have been motivated and driven by
experience, knowledge and awareness of the challenges associated with high needs families. The need to work differently and engage in complex case management exists, along with the need to educate and train caseworkers on the front line to respond to the family where FASD is a concern. The National Outcome Indicators Matrix (NOM) has four core domains including safety, well-being, permanence and family support, while addressing the need to balance child protection/safety with the capacity of families to care and meet the child’s needs (Trocmé et al. 2009).

**Purpose of the Research and Key Research Questions**

The purpose of this research is to broaden and expand upon the concept of a Community of Practice that is specifically related to the needs of children in care who live with FASD and are viewed to need additional supports in care. A model for practice has been developing over the past decade in Alberta that has been informed most directly by caseworkers, casework supervisors and managers within the Child and Family Services Authority Regions under the auspices of Alberta Human Services. There are no clearly established frameworks and models for practice in response to the needs of children in care that is specific to FASD that has been published outside the FASD Community of Practice research in Alberta (Badry, Pelech and Norman, 2005; Badry, 2009; Badry & Pelech, 2011; Pelech, Badry & Daoust, 2012).

The key research questions are reflective and intended to provide a focus for hearing the voice and experiences of participants (key informants) in the evaluation framework:

1) What have you learned in the advanced training in the **FASD CoP Leading from Within Initiative** that impact your practice, knowledge and skill development and leadership capacity in your region in responding to the needs of children/youth with FASD on caseloads?

2) What difference has advanced training made directly in your practice with children with FASD? What practice will you change as a result of participation in this project/initiative?
3) What difference has the case consultation process made to informing your practice, knowledge and skill development
4) Other questions may emerge from this process and will be explored as needed. Anecdotal information reflective of the voice of participants will be utilized in this research.

This project involved working collaboratively with the **FASD CFSA Advisory Committee** and the **FASD Cross Ministry Committee** in developing a framework for evaluation of the proposed key areas: advanced training on FASD including knowledge development, practice skill development for caseworkers and supervisors; case consultation/case reviews and leadership development. This research utilizes a qualitative approach and has engaged with caseworkers and supervisors who are involved in this initiative from different regions across Alberta Human Services. Data was collected primarily through a survey sent to participants (Appendix IV & V), direct observation of training and case consultation, and a focus group with 3 regional participants, anecdotal information provided by participants, administrative team members and the lead consultant.

**The FASD Community of Practice Iterations in Alberta: A Brief History**

In order to understand the current project the history of The FASD Community of Practice (FASD CoP) is documented. The broad goals and key areas for training in the FASD CoP included a commitment to children/youth with FASD in care having permanent placements; transitional plans on record by 16th birthday; assessment for suspected cases of FASD; provision of 48 hours respite minimally per month per child/youth; collaborative support plans developed with caseworkers, foster care support workers and foster parents; minimal training of 12 hours required prior to placement and respite care; and case workers were required to meet at least
once a month with foster parents. These areas serve as the basic foundation for responding to the needs of children with FASD in care in Alberta.

**FASD CoP: Iteration I – Fetal Alcohol Spectrum Disorder Practice Standards**

*The FASD CoP Iteration I was known as the Fetal Alcohol Spectrum Disorder Practice Standards* and began in Region 1 of Alberta Human Services. This project focused on the unique and specific needs of children with FASD, a disabling condition, who received child welfare services (2003-2005) and included training for foster parents and caseworkers. With this in mind, Region 1 contacted the Faculty of Social Work, University of Calgary and engaged researchers in this project. The initial project was completed by Badry, Pelech and Norman (2005) and served as a foundation for ongoing work forthcoming in Alberta on the development of an FASD Community of Practice.

**FASD CoP: Iteration II – The FASD Community of Practice**

*The FASD CoP Iteration II emerged from a review of the initial report on Iteration I by Dr. Sandra Stoddard in 2008. As the initial project was considered successful in terms of supporting a population of children in care with high needs and high risks a review of the Region 1 activities led to a second project being developed in 2008 which concluded in 2011. Iteration II of the FASD CoP involved Regions 1, 6, 7, 9 and 10 and represented a concerted effort to provide training on FASD to caseworkers, casework supervisors and foster parents. While the Initial work on the FASD CoP became known as the Practice Standards, Iteration II offered a transition to the term Promising Practices and specifically became known as the FASD Community of Practice (FASD CoP). The term Promising Practices and the development of a Community of Practice signified a philosophical shift in child welfare caseload management. The FASD CoP was*
instrumental in identifying and bridging gaps in practice through a recognition that advanced knowledge and training would benefit children with FASD who face multiple struggles in their lives in care, and who have a lifelong disability.

**The FASD CoP Initiative - Iteration III Leading from Within – Advanced Case Consultation Training**

The FASD CoP Iteration III is known as *The FASD CoP: Leading from Within* initiative emerged in response to the identified need for advanced training in FASD for ministry staff. With experience in the previous two iterations of the FASD CoP, the stage was set to move in new directions. In this most recent iteration, the FASD CoP has committed to advanced training on FASD through Workforce Development in Human Services. The recent training involved specific courses for caseworkers, casework supervisors and managers on FASD within Human Services and Delegated First Nations Authorities. The rationale for providing advanced training on FASD prior to case consultations was to assure that there was consistency in the knowledge framework relating the needs of children in care with FASD. As an approved provider for social work continuing education by the Association of Social Work Boards (ASWB) through the Approved Continuing Education (ACE) program Workforce Development was able to provide these courses with “Category A” credits for participants who are Social Workers.

**Course Structure/Training Process**

**Course 1:** *Fetal Alcohol Spectrum Disorder – Level One: Solutions through Case Management* (January 21-22, 2013)

**Course 2:** *Fetal Alcohol Spectrum Disorder- Level Two Advanced* (February 4, 2013)

Course 3: FASD Team Competency and Screening (February 5, 2013)

**Course 4:** *FASD Consultation: Six Days* (February 25 & 26, March 11 & 12 and April 4 & 5, 2013)

(See Appendix VIII)
Case Consultations

These courses, offered through the FASD COP LFW were structured in such a way that Course 1 (2 days) was a prerequisite for Course 2 and 3 (2 days). Completing Courses 1, 2 and 3 were required to move forward into the Course 4: FASD Consultation was scheduled for February, March and April, two days each month. **Course 1** focused on recognizing FASD within practice, understanding of intersections of child interventions that occur within practice and across systems, while considering complexities such as a life span approach, case management challenges such as placement disruptions and best practice. **Course 2 and 3** focused on creating practice frameworks working from an FASD informed perspective that considers the linkage between behavior and brain based function, understanding systemic collaboration, appreciating the developmental challenges and impact on placement stability, and examining effective interventions for working with children and families. Courses 1, 2 and 3 provided the foundation for moving forward to actual case consultation. **Course 4** - Case consultations were offered in Region 6 as this was the first time this course has been offered and it was determined that the training would take place in Edmonton. Caseworkers, casework supervisors and managers were invited to bring cases forward for consultation that would benefit from a structured review. The case consultation process offered such a perspective.

**Course 4** included six full case consultation days that reviewed 3 cases a day for a total of 18 case reviews. All case consultations occurred in Edmonton with families from Region 6, referred to the *FASD CoP Leading from Within Project*. Referral sources included caseworkers and casework supervisors who were engaged with foster parents (caregivers), biological families of children involved with child welfare but not necessarily in care, schools and
community partners such as agencies involved with children or youth. The topics for case consultation included personal vulnerability for children/youth, school related concerns around supporting the child in the school setting, issues related to families (i.e. a parent that has an FASD), placement stability, crisis planning, developing a deeper understanding of FASD and the particular needs of a child/youth, behavioral concerns, foster parent needs such as respite, working with schools, financial concerns, and executive functioning concerns in activities of daily living. The focus of the case consultation for children with FASD centered on the recognition of life vulnerabilities and risk factors over time, ages and stages of development, and engaging in planning for meeting complex needs. Additionally, Suzanne Rosko, an educator was part of the consulting team. Mary Berube, Regional Manager for Service Enhancement, Edmonton and Area, Child and Family Services Authority also participated at the consultation table. Providing case consultation that included the child’s team, the FASD COP LFW project participants as both consultants and advisors supported a model of direct learning. The cases of Helen (16) Jim (8) and Karen (17) will be profiled as examples reviewed in the case consultations.

**Case Example 1 - Case Consultation on Helen (16 years old)**

1. **Why are we here today? Case presentation.**

Helen is turning 16 and came into care at age 6. The process of transition planning needs to occur. Helen and her brother are both in care, and have experienced sexual abuse and severe neglect. The biological mother has a history of being in care as well as her siblings and their children indicating a multigenerational family involvement with child welfare. Helen and her brothers are both suspected to have FASD. There has never been confirmation of prenatal
alcohol exposure but Helen is being supported from the perspective of having FASD based on her history and challenges. Helen is the focus of this case consultation. It was indicated that behavioral challenges have resulted in at least six placement changes since age 13. Prior to age 13, Helen was in a stable foster home placement for six years. It was not possible for Helen and her brother to stay together in a group placement and it was stated: “Together – they are too much for one caregiver.” A kinship care placement was established for Helen and this broke down quickly. Helen has now been with the current foster parent for about a year. The foster parent described her as a child who is “one of the best kids you want to know”, followed by a comment that “Her eyes light up and then it’s gone. There’s a lot going on in her brain.” Helen, although not diagnosed, knows she has challenges. Helen’s needs are demanding within the foster home and this has impacted the foster parent’s relationship with her own adolescent daughter. Helen has been bringing her boyfriend home when no one else is there and there are concerns about sexuality and vulnerability including possibility of pregnancy. Helen has told her foster parent that she is going to work and has left the home and never arrived at work. She was away for several days, staying at friends, contacting her biological mother who provided her with alcohol and then called her foster parent for help.

2. What do we know about this child? What are the challenges, concerns and diagnostic status of the child?

It is known that Helen likely has FASD and is also reaching an age where transition from care is evident. She has had enough adverse life experiences and we have reason to believe she was traumatized – sexualized long before she needed to be. Assessment of her neurological challenges has indicated that she has numerous functional issues and as a consequence is very dismature. She also experiences grief and loss related to her family issues and she does see a
therapist. Although she looks age 16 she is not socially or emotionally functioning at that age, and this is not going to change.

School is a challenge. Helen needs to take courses and programs that she can handle and can support her being successful. Helen has memory problems and is missing the skills necessary to manage the expectations normally placed on a child her age. Helen gets easily stressed and needs information in small bits as she becomes overwhelmed quickly when given too much information at once. Her foster parent recognizes this challenge and she adapts the amount of information provided to Helen. The concerns are related to sexuality, placement stability, transition planning, running away behavior, unpredictability at times, and immaturity, particularly when stressed. Helen’s disability is invisible and her lack of functional skills is a challenge that places her at risk.

3. What do we need to do to support this child from an FASD informed lens? Recommendations for case planning, and identification of case management strategies/supports.

To provide the support required for Helen we need four things:

1. Training for FP
2. Coaching
3. Respite (reliable and consistent)
4. The ability to give up what is not working (be realistic about goals).

At age 16 Helen needs support in relation to sexual/reproductive health and has been identified as sexually vulnerable. She is not on any form of reliable family planning and it was recommended that she be seen at a sexual health clinic with her foster mother to get support in this area. One of the concerns for Helen is that she has run away before and she is at risk. The role of the caseworker is to “get in front of Helen”, and anticipate some of the challenges forthcoming based on history and behavior. Helen struggles at school and has asked for a tutor
to “make it easier”. Chudley, Kilgour, Cranston & Edwards (2007) have indicated that most non-compliance with individuals with FASD is non competence, and addressing supports with that philosophy in mind will support a better understanding of what contributes to success for each individual. Having a school coach is a recommendation that is supported. This is a solid recommendation and supports her goals of going to college. Helen is quickly overwhelmed with too much information and needs to be protected from being in this position. Part of her challenge is a “disability of thinking” and it is difficult to fully appreciate this perspective in a child who appears developmentally mature but this is incongruent with the assessment information regarding her function.

It will be important to remember that there is strong likelihood that Helen’s dependency needs will continue to be evident through transition to adulthood. It is also crucial to maintain placement stability and taking respite is an important recommendation emerging from this case consultation. It was also recommended that a neuropsychological assessment take place to help inform the professionals on the challenges Helen faces and to inform casework practice. One of the important focuses of an assessment is to become informed of Helen’s strengths and to support those strengths. For example, Helen has been working part time at a store but has had some problems in the workplace. It was identified that she should be supported in her job in a position that she has the capacity to do well and not to overwhelm her with a position that is beyond her skill level and capacity as this contributes to the potential of failure in the workplace or losing her job. Supporting Helen from this perspective indicates there is an understanding of her needs and those involved in her life are not just responding to challenges, but anticipating areas of need and support and creating supports as required. This is important
in maintaining stability in all areas of her life. It was emphasized that the people around the
table have a deep appreciation of Helen’s challenges and this is a protective factor because
these are the people that will advocate and support Helen.

Case Example 2 - Case Consultation on Jim (8 years old)

1. Why are we here today? Case presentation.

Jim came into care as an infant. This foster family has cared for Jim his whole life and this has
been a stable placement with a shared co-foster parent placement with his foster mother and
foster grandmother. He received a diagnosis on the FASD spectrum in November of 2011 when
he was six years old. He has problems with eating and usually eats best in the evening. Some of
the struggles and behavior identified around food are that he wants to be fed rather than
eating himself. Around 6:30 – 7PM he has a bedtime snack. Jim is described as having “no
instinct for survival” and has had challenges with thriving over the years. He is easily distracted
and doesn’t eat, and likes to read menu but does not follow-through. He also experiences
anxiety in social settings and fear about eating around strangers. He sees a child mental health
therapist for these concerns. He lives in a rural community. One major concern is his
distractibility that was described by his foster mother as follows: *His brain is like a pinball
machine and things ping all over the place. Not the same every day. I want him to be successful.*

*We want a pathway for him.* Jim’ foster mother believes that he will succeed in life. This
placement is considered to be permanent for Jim as he is well supported and in a long-term
placement with foster parents who are highly committed to Jim.

2. What do we know about this child? What are the challenges, concerns and diagnostic
status of the child?
Jim has already been identified as complex and has been medically diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), Obsessive Compulsive Disorder (OCD), a Fetal Alcohol Spectrum Disorder (FASD), and has a lot of behavior challenges. For example, in relation to eating he states: “I just don’t want to.” Perhaps this will change over time and it is important to recognize that Jim has his own personality (quirkiness) and unique nature. The pediatrician is engaged with this family, and is an important support given Jim complexity.

“Jim, at age 8, is at a fairly good level with his peers but it will fall off from here. He’s starting to feel the difference between him and his peers. Jim will need to be treated in many ways as a much younger child, without measuring him against others. So we don’t let it get away from us. A perfect moment to create what 12, 15 and 18 will look like.”

Jim’s caseworker indicated that the better he feels about his skills, the better he feels about himself. The caseworker knows this child and this is important. What is the best outcome for Jim based on the current knowledge that we have about him? For Jim, at 15 everyone’s happy and Jim is still in this placement.

Education consultant perspective: Jim is already overwhelmed with his day in school and ideally he would not be given homework. The school needs to understand his needs and concerns to provide supportive programs to him. At 8 years old we want him going to school on time – that’s a goal. Jim is also reliant on his foster mother to explain his needs to his teacher and school. For example, when Jim needs to say something he has an urgency about him that requires an immediate response. The foster mother adapts the environment and tells people “When Jim needs to tell me something he needs to tell me now.” Often it’s something important and he needs to be included right away in the conversation. His challenges in the education system will continue to grow as more demands are placed on him.
3. What do we need to do to support this child from an FASD informed lens?
Recommendations for case planning, and identification of case management strategies/supports.

In relation to supports for Jim in school, in the foster home and the community:

We need to help the school to understand FASD – he will likely have trouble with math, money and time. Understanding what he can’t do and helping the school to understand this is as important as sharing his strengths. He can learn a lot of really good habits. Kids with FASD don’t know what to do what they cannot do. Building good habits will be very helpful. Maybe he can be employed at stuff he’s good at. Simple example – it’s a disability of thinking – processing and thinking. We like our habits that provide structure and routine. A protective factor for Jim in that he doesn’t have to think too much in new situations – having good habits in place reduces the need for adaptive thinking within environments where children do not know what to do. Give the kids really good habits – he has some really good things going for him. He may look better than he really does [in relation to skill level]. The risk is if you give Jim too much credit for things he can’t do, the risk increases for providing unrealistic expectations [not recognizing that it’s too much for him to handle]. The child is doing well because of the Foster Parents consistency, love and care. This is a permanent placement and the child has been there since he was 30 hours old. We need to recognize that not everyone understands FASD and we cannot assume they understand the particular needs of this child and we have to explain it in terms that are helpful and protective of the child. (Donna Debolt)

How do we create stability in Jim life?

The foster home has a practice philosophy for Jim: We love you forever and always and no matter what.

Critical Question: Is this Foster Home permanent? Knowing that Jim is best served in this home how do we address this issue? We’ve often spoken about permanency. Are foster homes asking to be private guardianship or adoption? The question is about the strong push for permanency or the prevailing belief that “the best kind of permanency looks like adoption but this is not always the case.” The best place may be a long term foster home with supports. The caseworker has to put it in place that the child welfare system perhaps that we do not need to
push for someone to adopt him. It’s not better for him to be adopted by someone else knowing what we know. The best outcome for this child is to stay with this family and receive the supports he needs. Is this sustainable through changes in caseworkers over time? This information is important to put on the table by the casework supervisor in terms of changes down the road and examine what is in the best interests of Jim in terms of a long term, stable and loving home, and that is the foster home he has been in, his whole life. This plan also needs to be well document in the child’s file. The joint fostering by the mother and grandmother is part of what makes this work for Jim. Several suggestions were made at the table in relation to supporting Jim placement.

1) Foster parents could do advanced training.

2) Coaching – what should we do – support in school. Let’s give him lots of things to do that make him feel competent. A coach can intervene and support as needed.

3) Respite – accepting supports is a good thing. This is a protective factor.

4) Grief and loss work – may not sound great right now or perceived as important but it can be anticipated there will be concerns. Part of the process is accepting what the challenges are that are unique to this child and do case planning from that perspective.

**Key Messages from the consultation process in relation to placement stability for Jim.**

- The more knowledge the foster parent has about FASD – the more empowered they are to explain Jim to the world, not the world to Jim.
- Anything that jeopardizes this child’s placement where he is now would be a problem. His best outcome is in the current placement and caseworker should support the FP to maintain the placement. Jim is not going to be flexible with this issue.
- Advocate for the child with the permanency planning leads now and get a record of this commitment on file.
- Do not jeopardize the permanency of this foster child who needs a “permanent” foster home. This is something that needs to get organized by the “guardian” to ensure that a plan is in place to protect the current placement as his home. The family is committed and needs to be assured that the system accepts that they are his permanent foster home and this status will not be “threatened” in the future.
Summary by Consultant: What do we know going forward?

Much of what is highlighted for Jim relating to permanency is that he is best where he is, for the long term, with the foster parent and foster grandmother and protective case planning and intervention for Jim would be to maintain his current placement for the long term. As each child is unique and children with FASD have complex needs, the notion of permanency and what looks best for each child may be different. Permanent placement may not always be found in adoption and long term stable, loving nurturing foster homes become substitutionary parents to children. This foster home stopped taking other placements as it was recognized that Jim has really high needs and requires lots of attention. A potential concern for the foster home is if mom became a single parent with Jim and did not have the back up support from the grandmother this would be a concern. They truly are a team. The foster family needs to anticipate the developmental trajectory of FASD – they need to get ready for the demands that are coming for supervision and care with the support of the caseworker and the foster care support worker. To support stability in the placement a team is required over the long term.

Case Example 3 - Case Consultation on Karen (17 years old)

1. Why are we here today? Case presentation.

The current caseworker has known this family since 2009 and she is part of a sibling group of four, all of whom are in care. The focus is on Karen, who turns 17 in 2013. There is a concern that Karen has a history of sexual abuse but this has not been disclosed. Her most recent placement broke down. At age 13 when Karen came into care she had a stable placement between 2003-2008. Since then she has been in other foster homes, a group home, a supported independent living situation. Risk behaviors at the group home included drinking
alcohol, running away and missing school. Karen has fears about going to another foster home. The biological family has struggled with alcohol and all four children came into care at the same time in 2003. An older sibling has aged out care. There are challenges in the school system and Karen is not doing well and finds school stressful. It was recommended in 2008 that Karen be assessed for FASD as Karen has a lot of behavioral issues and there is evidence of some facial dysmorphology. Karen also has memory problems and struggles to express herself. She is described as impulsive, moody, and overly focused on the negative. She is also described as a follower and the first in line to get into trouble. She has no sense of consequence and continues to act out.

Karen can also be aggressive towards other and there is a risk she could get into trouble with the law. There are challenges in her relationship with one sister and they care for each other but also can’t live together. Karen is not good at following direction and is very impulsive. Things “fall apart” quickly for Karen. She has sleeping issues, eating issues, memory issues, struggles in school, steals and doesn’t like, and is resistant to help. These are all signals to indicate that there are many challenges ahead for Karen, and for those who provide support and care.

2. What do we know about this child? What are the challenges, concerns and diagnostic status of the child?

Question by consultant: When you see Karen, what worries you the most about her?

The major concern for Karen is being taken advantage of by others and that her life will be in a spiral that she can’t get out of. Karen’s already engaged in substance use, alcohol use and those activities that will impact her and carry forward into a pregnancy. She is not on any
reliable family planning program and this needs to be addressed. Karen can only take so much stress and then she “loses it”, was stated as a description.

How can we help Karen to be successful when we know that she is immature, has behaviors that are brain based and it often feels with Karen that one is working in quicksand? The foster care situation is not working well and placement needs to be determined and stabilized. Given she has had lots of adverse child events, including trauma, she needs support in translating her experiences in the world and supporting her from a position that understands she is dismature and does not always comprehend and fully understand the information given to her. The challenges that Karen faces are unique to her, as children with FASD have unique neurological challenges. What is common in relation to behavior is that it is often reactive and out of proportion to the event or incident. From an FASD informed lens, this is where understanding behavior as reflective of a child not feeling competent, or confident and this is important to keep in mind. Karen does seem to have some of the neurological (brain based behaviors) and challenges cognitively. It would be great to have a diagnosis to help refer for supports.

Who is around Karen? Who are her friends? “She has “user friends”. A concern was expressed because Karen is a follower that she can easily get into trouble. Karen has a relationship with her Dad who has a serious illness. One of the reasons the children were removed is due to family violence and concerns about sexual abuse. The sexual abuse was never confirmed. Karen is asking to go back to Dad’s house as she is having problems staying in a placement. She does have a good relationship with her sister who is two years younger and
trying to build in a relationship with the sister that is supportive may be helpful. Karen is seen as highly vulnerable and we need to work to fit the program around her needs.

3. What do we need to do to support this child from an FASD informed lens? Recommendations for case planning, and identification of case management strategies/supports.

Placement issues for Karen are a primary concern. Given her age and lack of stability this will be a challenge. Placements are often inflexible at time due to the need to meet the needs of many children and she doesn’t get along well with others. Perhaps a supportive roommate type of situation will work with her in the future. A modified school program from 9-3 is recommended as well as pre-prepared meals, someone to tell her to remind her to eat her snack, do her homework, increase supervision and increase social activities. Someone has to plan this for her. She needs to participate in “academic” settings with supervision. Consider a future orientation – she needs a useful future. What types of skills does Karen need to develop in relation to a potential work placement after school is complete? Who’s out there that could do this? Where is the best fit for Karen?

It is important for Karen to have support to make a long-term decision in terms of reliable family planning. Karen will need lifelong supports and help to not become a young parent. Becoming a young parent puts Karen at risk down the road and contributes to the potential of an intergenerational cycle. It is important to intervene and prevent this from occurring if possible.

What will be helpful In the future? If, at age 25, Karen has meaningful work and her living/placement is stable, and doesn’t have the challenge of parenting at a young age, then, we have supported a healthier developmental trajectory than the one she is currently on. The
challenge here is the limited time to plan for Karen’s transition to adulthood and designing a program tailored to her needs. Karen lives in a small, rural community and it is recommended that she stay in this community due to concerns for her safety in a larger city. This young woman is at risk and will remain at risk. We do the best we can do to support her, build skills, and help develop a solid plan for transition to adulthood.

Introduction to the Literature Review

The purpose of this literature review is to examine existing literature relevant to the key focus of this research, on FASD and child welfare practice. It is evident that there is a dearth of literature on this topic and the forthcoming review of the literature will highlight existing literature related to key words utilized in the search including child welfare, disability, FASD, child vulnerability, social work, casework and best practice. It is important to examine what literature exists that is reflective of best practice for children with FASD as much of the learning is applied in practice, anecdotal – based on experience and not necessarily published, contained in events such as case conferences or consultations that are generally held privately with the support network of a child, and within the domains of assessment and diagnosis. Although much information is recorded within a child’s file, the practice framework in response to FASD generally rests with responding to challenging behavioral concerns, caregiver/foster care support, placement stability and clinical assessment and diagnosis of FASD. The literature on best practice remains relatively thin in contrast to biomedical related research.

Scope and Limitation of the Literature Review

In scoping the literature, the initial literature search through Ebsco host and the Summon search feature revealed no results on the key words “child welfare” and “disability”. Adding the
term “FASD” (Fetal Alcohol Spectrum Disorder [in full]) and “child welfare” yielded four results. A search on the terms “child welfare” and “vulnerability” returned 24 results and further filters were applied and ten articles from 2007 onwards have been selected for review. While a search on the terms “Fetal Alcohol Spectrum Disorder” and “children” yielded 399 results there is very little found in this literature that is related to child welfare practice. The terms “Fetal Alcohol Spectrum Disorder” and “best practice” returned 22 results with ten articles that are relevant and generally focused on neurobehavioral and neurocognitive issues with some articles emerging in the area of education. A search of the terms “Fetal Alcohol Spectrum Disorder” and “intervention” with a filter applied for Social Sciences yielded 248 articles of which 12 relevant articles were selected. Much of the literature is medically based and not relevant to the current topic. Literature emerged from the fields of nursing; psychology/ neurodevelopmental issues and interventions; medicine including neurology, psychiatry, pediatrics and epidemiology; social work/child welfare/child and youth care; justice/law enforcement; economics; education/learning disabilities/ speech and language pathology with a small body of literature emerging on overall social policy and systemic responses.

A search on the terms Fetal Alcohol Spectrum Disorder and foster care returned 160 articles that were filtered and reduced based on relevance to 10 articles that are presently under review. A search on “FASD” and “fostering” returned 55 articles that were reviewed from 2013 and approximately 10 articles considered for review. Utilizing the keywords “youth”, “fetal alcohol” and “child welfare” in the specialized Family & Society Studies Worldwide databases yielded 2 results (Pelech, Badry & Daoust, 2012) and another article excluded from 1991. The SocINDEX with the terms “youth” and “child welfare” and FASD (full) yielded no
The terms “child” and “child welfare” and “FASD” (in full) yielded 2 articles (Potter, 2013 and Badry, 2009) that were selected for inclusion. Potter focused on the role of the state in collecting alcohol histories from women and the implications of this practice in government intervention in framing alcohol use during pregnancy as child abuse. Badry (2009) reviewed the first child welfare related study in Alberta (2003-2005) on the application of specific practice standards for children in care with FASD, indicating that applying more rigorous standards/practices had positive benefits in casework. The documents that were selected for inclusion in the literature review primarily focus on key areas of research relevant to child welfare practice, education, disability, foster care, placement stability and placement breakdown factors, behaviour, justice and some limited public policy articles.

**Review of the Literature**

This literature search is indicative that child welfare practice for children with FASD is not a highly published topic as it relates to casework practice, child welfare and systemic responses for a highly vulnerable population. The literature presented here has a general focus on the social sciences including social work. A pivotal study was conducted by Premji, Benzies, Serrett & Hayden (2006). They engaged in a substantial review of the literature using the keywords: children, Fetal Alcohol Spectrum Disorder, intervention, systematic review and youth. Premji et al. concluded that there was limited literature grounded in intervention for the specific population of children with FASD. Although the literature has evolved since 2006 with some new articles emerging, research that is specifically related to practice for children with FASD is severely limited. Ryan, Bohjanen and Humphrey (2009) examined the literature for evidence based practice on intervention and education for children with FASD and indicated...
finding three studies. Fuchs, Burnside, Marchenski & Mudry (2010) produced a hallmark study on children with FASD in child welfare care in Manitoba and provided insight into the need to respond to FASD from a disability informed lens. The key point made in this research is that limited intervention research exists that supports improvement in outcomes for children with FASD in contrast to other disabilities such as autism which is often aimed at family support, while highlighting that a strong body of literature in describing the neurodevelopmental disabilities associated with alcohol exposed pregnancies. Diagnosis remains a hallmark for establishing good practice. Astley (2011) states:

A diagnosis reflects the condition of a patient; however, because a diagnosis serves many purposes (e.g., treatment, prevention, communication among specialists, and qualification for services), the process of rendering a diagnosis can sometimes be influenced by those different purposes. The only diagnosis that serves all purposes most effectively is a correct diagnosis. Access to services should be based on an individual’s disabilities and not on what caused their disabilities. Therefore services should be available for individuals across the full continuum of FASD and not just those with FAS (p. 25).

Intervention based studies are published on child welfare casework practice on placement stability (Pelech et al. 2012) and child welfare practice in Alberta (Badry, 2009); language and literacy work related to community based interventions with women/families at risk for FASD (Leenaars, Denys, Henneveld & Rasmussen, 2012); neurodevelopmental issues and child behavioral intervention (Davis, Desrocher and Moore, 2011) and Pei, Job, Kully-Martens and Rasmussen (2011) who focus on executive function and memory issues for children with FASD. In relation to behavior concerns/phenotype some evidence exists to support diminished intellectual functioning, particularly in the complex task of information processing (Kodituwakku, 2007 and Paley & O’Connor, 2011), foster care and placement (Brown, Sigvaldason and Bednar, 2005).
A small body of literature also exists that focuses on the topic of diagnosis as an intervention, particularly in relation to supporting early intervention and mediating the challenges associated with FASD (Carmichael Olson, Jirikowic, Kartin & Astley 2007). Rasmussen and Bisanz (2009) have done critical research on executive functioning that contributes to a deeper understanding of the neurological challenges children face and potential remediation strategies to support children in their environments. Kotria and Martin (2009) wrote on social work practice in response to FASD and identified screening tools primarily focused on substance abuse with women and brief interventions. The role of the social worker they suggest is help families in providing stable and healthy environments and supporting a family to have “realistic expectations of their child, create home environments that support their child’s unique needs” (p. 502). They indicate that social workers have a role in screening with pregnant women who come to attention of social services. Further, they indicate that social work is well positioned to provide referrals, to support accessing community services and facilitate and activate processes to support the family.

Children with disabilities in Canada have faced adversity while in the care of child welfare since the nineteenth century (Strong-Boag, 2007). While institutions may have largely given way to foster homes, the challenge of finding stable, permanent and/or adoptive placements for children with disabilities remains. At the beginning of Canada’s child welfare history, adoptive parents sought children “of perfect health”, free from “hereditary blemishes” with specific physical characteristics (similar to those of the adoptive parent). By the late 1940s, a movement pushed for an elimination of the criteria for adoptable vs. unadoptable children and encouraged placement of previously ‘unadoptable’ into homes. While this shift ultimately
benefitted children in care, it has since introduced challenges in providing appropriate supports to foster and adoptive parents as they care for children with challenges. Today, providing support networks and strategies to foster and adoptive parents on raising children with disabilities must remain a priority.

One study on *Parenting with an FASD* (Rutman & Van Bibber, 2010) was discovered that examined the needs of parents who had a suspected FASD. Badry & Bradshaw (2011) in a systematic review of assessment and diagnosis of FASD in adults indicated that diagnostic resources are limited and infrastructure for such clinics is limited in Canada. Rutman & Van Bibber highlighted in their qualitative study that parents recognized that their challenges with addictions factored in to losing their children to child welfare care. Other important factors highlighted included lack of “positive role models in parenting” (p. 356) and challenges in understanding healthy parenting practices. This article also presents some of the interactions of parents living themselves, with FASD who had with child welfare interventions, and expressed fears around stigma, lack of understanding, and raises the voices of parents. For example, the statement of one parent highlights a personal perspective on workers: “Workers make me really frustrated; they don’t know who I am really...They don’t know me personally...things that I’ve accomplished and overcome; you know what my life’s been like” (p. 357).

Further, policy barriers such as lack of meeting criteria for disability supports, challenges accessing parenting supports, and financial struggles were all identified. Rutman & Van Bibber (2010) highlight the need to deeply examine and shift thinking about FASD that embraces values such as non-judgmental practice and providing parenting support and education for families. Appreciating and understanding “FASD as a neuro-behavioural disability” (p. 361) is
paramount in shifting practice and policy. Supporting families is also relevant to prevention. In the findings of the FASD COP LFW research one caseworker noted that the inclusion of family planning should be an essential part of casework. The efforts made on the ground, at the front line with families merit further examination in terms of their benefit and utility in compassionate, supportive practice. In hearing the voices of parents we are a step closer to comprehending their reality, which in turn, deepens an understanding of children and families who struggle with FASD. The need to continue to support families was also highlighted in this study of parenting with an FASD and challenges families face in the child welfare system. Interviews were completed with 59 individuals across a diverse array of backgrounds including adults with suspected FASD, service providers and client support people. Emerging themes included: Parenting – Hopes & goals, accomplishments & strategies and challenges & barriers.

Challenges with Society – Attitudes & expectations, policy-related barriers for parents with FASD. In examining outcomes, there was a profound lack of knowledge noted, regarding the day-to-day support needs of those with FASD that must be addressed, when providing interventions for those parenting with a FASD.

Leenaars, Denys, Henneveld & Rasmussen (2012) highlight the need to focus on practice issues with families and to examine the benefit of such practices in intervention and prevention. In this evaluation of the Coaching Families (CF) program, significant reductions in caregiver stress, family and marital conflict, health issues and family neglect (significant changes were seen across 21 measures in all). While parents did express some concerns, such as mentors not understanding the complexities of living with a child with FASD, 98% of participating parents were satisfied with the program and 99% stated they would return to the
program if needed. Results also called attention to the need for longer-term programs to support and mentor caregivers living with a child with FASD and the importance of collaboration between program mentors and other professionals (teachers etc.) involved with the child. To this end, the PCAP (Parent Child Assistance Programs) programs are offered in Alberta as well as other locations in Canada and the United States. Leenaars et al. (2012) highlight the importance of mentors working with families through the Coaching Families program. Support for caregivers and parents of children with FASD is the focus of this intervention and helps families to highlight their strengths, need for supports, identifying grief and loss issues and required supports as well as providing supports for families that decrease crisis oriented interventions. The greatest challenge remains mental health support. Efforts at educating, advocating and supporting families in meeting their children’s needs showed positive results and family stress was decreased through such interventions.

Bertrand (2009) completed an overview of five projects and found that, in all cases, participants showed improvement in behaviors and skills and four programs produced statistically significant results. In evaluating the interventions provided it was noted that a key component of program success was the provision of parental education and training as a built-in component of the program as a whole. Strategic targeting of specific behaviors and skills for each child with FASD was also noted as important. Programs that directly taught skills and behaviors that would normally be learned by observation alone were found particularly effective. Finally, it was noted that provision of a variety of interventions would be essential to success in the treatment of FASD due to the wide breadth of symptoms and concerns seen across and between children diagnosed with FASD.
From a philosophical perspective on prevention and intervention in social work practice, and Holleran Steiker (2012) highlight the issue of prevention and intervention in social work as a dichotomy and suggest the era of evidence-based research while indicating that few publications exist in this regard. In moving from practice to research this team “have analyzed prevention as an integral part of the care continuum... in the area of adolescents and substance abuse and women who at risk of having a child with FASDs (p. 103)”. Their work proposes that research on the effectiveness of interventions be included at the outset of projects and social work engaged in reducing the distance between prevention and intervention as both are critical features in responding to addictions and FASD. The FASD COP LFW as well as previous projects in the FASD CoP within Alberta has included such an approach, as there remains limited evidence based social work literature on responding to the challenges family’s face when FASD is a concern.

Paley and O’ Connor (2009) indicate that while knowledge about FASD has been well established for over three decades studies on intervention remain thin. Burd (2007) suggests the same in his pivotal message that we must do better in interventions for children and families where FASD is a concern. Paley et al. offer a very detailed overview of interventions that includes treatment needs and consideration, interventions for FASD, educational and cognitive interventions, parenting intervention, adaptive skills training, pharmacological interventions and case management that are briefly reviewed in this paper. Paley et al., provide a key review of interventions relevant to education and cognitive function, parenting interventions and highlight concerns found in the literature of the high needs and challenges in caring for children with FASD. Research focused on reducing caregiver stress and behavioral
consultation drawing on the work of Carmichael Olson et al. (2007) highlighted concerns related to child attachment, and the need to intervene as this issue was considered important. Direct teaching of parents and modeling is considered to be worthwhile. In terms of social skills Paley et al. indicate positive findings for Children’s Friendship Training [CFT; Frankel and Myatt, 2003 in Paley et al. 2009). Other concerns identified are around safety and the need to provide skills training due to “impulsivity, difficulties in behavioral inhibition, and poor judgment often exhibited by child with FASDs place them in the high risk group” (p. 262). In terms of using medication it is suggested from their review that there may be some benefit to stimulants associated with concerns of FASD but generally indicate that a great deal of research is needed to understand the efficacy of such an intervention due to concern of potential side effects. Finally, case management identifies concerns relating to mental health and draws on some of the early work of Streissguth et al. (1996) and Huggins et al. (2008). A critical point raised on the value of interventions by Paley et al. suggests,

“It is not uncommon for individuals with FASDs to be viewed as resistant to or uncooperative with treatment, when in fact they are being provided with interventions that are unsuitable or have been inappropriately adapted to accommodate their cognitive and behavioral deficits” (p. 263).

Other concerns raised include substance use, sexuality, legal problems and medical issues. Of great importance to this research is the recommendation that,

“It is imperative that professionals working in health care, education, social services, and the criminal justice system are properly trained in how to recognize individuals with PAE (prenatal alcohol exposure) and educated regarding appropriate interventions for this population” (p. 264).

These points are highlighted as they emerge from a comprehensive review of the literature that takes best practice into consideration from key researchers and leaders in the field. Further, Paley et al. propose the value in further research that examines service approaches and interventions on multiple levels that includes collaboration between clinicians and researchers
to move forward and translate knowledge on best practice for use in the community and by professionals. This research highlights many of the concerns identified through the FASD COP LFW in relation to effective interventions that support children and families.

A Community of Practice Approach

The identification of a Community of Practice (CoP) approach in the CFSAs was initially proposed by Dr. Sandra Stoddard (2008) from Research and Innovation in 2008. Stoddard worked in government and had a background in education, where CoP was a familiar model. It was proposed that a CoP model in response to practice for children in care with FASD and their families supported best practice. As such, the findings of the first study in Alberta (2003-2005) as outlined in the history of the FASD CoP within Alberta Human Services (formerly Alberta Children Services) were considered to be of benefit and Promising Practices were drafted for the FASD Cop in 2008 and the project took place from 2009-2011. It was determined that a CoP approach was innovative and could support innovation and improvement regarding decision making and allocation of resources to support the needs of children with FASD in care.

The value of the FASD CoP was demonstrating through research that such interventions were successful and one of the strongest areas of benefit was placement stability, which showed a marked increase during the project period (Badry, Pelech & Stoddard, 2012; Pelech, et al., 2013). Through this research it was also noted that casework, supervision, FASD specific training for foster parents (caregivers) and caseworkers was essential for effectively supporting and meeting the complex needs of children and families.

A critical feature of the current FASD COP LFW is that consistent training is offered to casework supervisors, foster care supervisors and regional managers meeting in one location
for the purpose of consistency and developing a shared knowledge framework that can be applied in practice. The leadership offered within the province of Alberta through the FASD COP LFW building on previous success of the FASD CoP represents leading edge innovation in child welfare practice nationally and internationally, and warrants further exploration.

A small body of research on communities of practice (CoP) was reviewed and indicated that while this approach has merit, the scope must expand from learning to action in practice (Gau, 2013; Gray, Parker, Rutter & Williams, 2010; Wenger, 2006). They identify characteristics such as mutual relationships, common forms of practice engagement and other features shared such as common language, tools, communication and style that occurs in groups, supporting an identity and purpose. While there is value in moving knowledge to practice, the distinct possibility of resistance to such change can provide a barrier. While embracing innovation change always require time, effort and new ways to look at practice and intervention. The notion of “making space” for change occurs at the organizational level and it is clear that shifting practice, growing knowledge and applying new models of examining complex social problems for children with FASD is a pivotal point of the FASD CoP Leading from Within work. This work has grown from the original FASD CoP that served as a foundation to move further into the work and to align practice with understood high needs children and families. Such organizational change takes shifting perspectives, time, and courage, particularly in learning activities in a group such as that offered in this project. Gau (2013) suggest that communities of practice support knowledge and resource exchange, supports and enables social networks, promotes learning through reflection while focused on tasks and suggest that “shared practices become a leverage that not only sharpens individuals’ understandings, but also increases
cooperation to strengthen interpersonal networks” (p. 1529). The capacity of a community of practice in learning together is reflected in work that aims at changing and improving practice. In the FASD COP LFW bringing regional representatives together from across Alberta supported a shared, common learning experience that is highlighted as positive in the results of this project.

From a social work perspective Gray, et al. (2010), discuss learning cultures and organizational learning and the impact of enabling work based practice learning. The interest of maintaining a culture that retains social work values while being effective and efficient presents a challenge. Establishing a learning culture that is embedded within social work practice (and allied health professions) calls for leadership. In drawing upon the work of Wenger (2006), Gray et al. suggest that a community of practice should have room to grow and to provide access to learning opportunities through resources such as time for learning. Differences exist between professional learning competencies culture and the workplace culture that often presents a challenging dichotomy.

While prescribed learning in child welfare exists, opportunities beyond mandated training need to be included as a means of developing the individual worker, the team and in supporting goals of delivering best practice approaches. It also needs to be recognized that the demands of child protection work, staff shortages, or supporting new staff in training can impede training activities, particular in periods of caseload crises. Some flexibility is required in these circumstances. Providing training to regional managers and casework supervisors through the FASD COP LFW project embraced a complex model of learning through engaging the leadership directly into practice via the case consultation process.
Supervision is a critical part of social work practice and the greater the knowledge of the supervisory and management team, the higher the applied benefit is likely to be for caseworkers on the frontline and children and families served. Learning in the FASD COP LFW was professional and personal as evidenced in the evaluations offered through the courses and case consultation as described in this project. Gray et al. (2010) suggest that a community of practice model is well suited to social workers whose value base focuses on empowerment of children and families (clients) within the system. Supervisory training in child welfare practice was examined by Snyder & Babins Wagner (2013) by conducting an extensive review of the literature and key informant interviews. Training on different aspects of supervision was highlighted including effective supervision/management skills as well as applied practice knowledge and prior experience as an element of supervision. They indicate that it should not be assumed that supervisors had acquired these skills when promoted to supervisor. This report suggests that tensions exist between different levels of the organization and one key area of relevance to the FASD COP LFW project relates to developing the clinical competency levels of supervisors, and recognizing the differences between rural and urban locations. As FASD is a complex social phenomenon the value of training casework and foster care supervisors, as well as regional managers is the engagement of leaders within child welfare to participate in “evidenced informed approaches to practice in their areas of service delivery” (Snyder & Babins-Wagner, p. 72). Ongoing concerns in child welfare supervision are risk management and crises and these factors can affect the availability of supervisors and managers in training courses.
In summary, this review of the literature, while offering perspectives on relevant research, also highlights the limited body of child welfare/child protection/intervention based literature. While highlighting that published research on interventions is limited in relation on casework practice, child welfare and systemic responses grounded in front line practice, as first identified by Premji et al. (2006). However, promising research and review of intervention literature has developed and the notion of a community of practice approach supports the need for innovative practice in responding to the problems for children and families in relation to FASD. Interventions that focus on the family, such as the PCAP programs are important, as well as supporting stress reduction factors for families and caregivers. The emergence of literature that focuses on leadership within organizations through a community of practice model informs this research. While much innovative case planning occurs for children with FASD in care, the need exists to promote the publication of such strategies and to share this work nationally and internationally. Models of excellence in practice need to be shared amongst child welfare authorities that work with highly vulnerable children and families.

Methodology
This evaluation project is qualitative in nature and will focus on the experiences of participants in the current FASD COP Leading from Within Advanced Training Initiative (FASD COP LFW). Engaging in qualitative research and analysis supports the understanding of the experiences of individuals engaged in a research project and ultimately leads to transforming findings into units of meaning (Patton, 1990). Patton further states that no exact formula exists as each researcher will approach the analysis from their frame of knowledge, experience and engagement with the topic. It is important in qualitative research to analyze data and to
develop understanding of experiences and events, and to share these findings with others through various descriptions. Qualitative research is compelling in terms of a project such as the FASD COP LFW as it directly engages participants in sharing and voicing their experience. Sharing these experiences helps to develop a depth understanding of the meaning, interpretation and significance of such experiences. The phenomenon of study in this research is the experience of caseworkers, casework supervisors and managers who have participated in the current training initiative (2012-2013). This group included 1 manager, 10 supervisors, 11 caseworkers and 2 specialists.

While caseworkers across the province have received training over the years in FASD primarily through the contracted training provided by Donna Debolt over the past decade, the inclusion of supervisors and managers has enhanced the practice model further. A key recommendation of the FASD CoP report (Badry and Pelech, 2011) was to work towards the inclusion of casework supervisors and management teams in relation to training on FASD. The rationale for this approach was recognizing that while caseworkers received training on FASD, a gap existed for casework supervisors and management staff. Casework supervisors and regional managers are frequently called upon to support and direct casework decisions for children with FASD. While coverage and time was afforded for caseworkers and foster care workers, time for management staff was difficult to find. This was particularly the case for more rural and remote communities who often have limited coverage in the absence of staff. The FASD CoP as a reality in the landscape of casework practice in Alberta has been emerging since 2003 and has consistently over the past decade remained a consideration in planning and responding to the needs of children in care with FASD.
The evaluation methods for this project consist of a review of the literature, interviews with key informants – participants in the FASD CoP LFW, findings of a focus group with two casework supervisors and a foster care supervisor in one region, transcripts and field notes from case consultations, a survey that 30% of participants responded to on the FASD COP LFW as well as discussions and meetings with the project team and the lead consultant/trainer, Donna Debolt.

**Qualitative Data Findings Emerging from Participants in the FASD CoP Leading from Within**

This section provides a few anecdotal quotes that have emerged from participants engaged in the FASD CoP training from different regions in Alberta. The quotes are presented anonymously and regions and names are confidential. These quotes are utilized to illustrate the impact of the FASD CoP activities. All responses from the survey monkey on FASD COP LFW are recorded and discussed below. When combined, responses to the survey instrument, discussions with participants on three training/case consultation days in 2013, the focus group with foster care and casework supervisors as well as phone calls with some participants, serve to inform the qualitative data that is presented in this report. A key purpose of this initiative is training as well as developing capacity and expertise within the Alberta Human Services Workforce. While a model of training in Alberta on FASD has been enriched by considerable experience in child welfare and longevity through members of the FASD CoP that have remained engaged in this work since its inception in 2003; the need exists to develop expertise broadly within the province.
Survey Results

A survey was sent to participants in the FASD COP LFW project and a 30% response rate occurred. The results of the survey were reviewed and are presented below. The responses below are original and taken directly from the survey. Further analysis of the responses took place through qualitative analysis and research memos, notes and discussion is included for each question from the survey and qualitative analysis.

FASD COP LFW Survey results – Survey Monkey

Q. 1 What have you learned in the advanced training in the FASD Community of Practice Leading from Within (LFW) Initiative in relation to your knowledge and skill development with clients with FASD?

The biggest 'take home' was clearly identified values and best practice that can be generalized across individuals with FASD. These values include; -understanding FASD as an organic brain disorder -understanding the developmental trajectory of the disability -understanding the dismaturity of FASD -best-practice around ensuring residential stability (the need for caregivers to have coaching/training, respite/relief, and grief and loss work) -the understanding that often non-compliance is non-competence -the need to foster supported dependency with individuals with FASD so they will accept support rather than focus on greater independence -the need to focus on environmental modifications that will set individuals with FASD up for success (and where that onus is placed).

This training has solidified my ability to apply knowledge into practice with confidence and consistency and be able to influence the practice of those who are working with clients with this disability. I have learned to more effectively describe the disability and help people understand "behaviors" they are seeing from a disabilities perspective. I have also learned how to break down the complex presentation of FASD to more foundational philosophies and approaches.

I have learned that we need to focus from the beginning on having conversations with caregivers about the trajectory of this disability and work to prevent placement breakdowns for the life span of these people

Building relationships with caregivers to offer the supports is paramount to a successful child.

I have learned more effective ways to practice when the client is affected, and I finally have an understanding of affected individuals' behavior.
[I have] increased [knowledge] and new outlook on case planning strategies - increased support to shift to more brain focus vs. behavioral - importance of collaboration with partners - focus on environment and supports rather than expectations from child - increase placement stability and permanency - decrease burnout and increase hope.

Q 1. Discussion/Memo

Understanding FASD differently was a key point highlighted by participants. This new understanding influences case planning strategies, an appreciation of FASD as a disability and acknowledgement that children with FASD have unique high needs, are difficult to care for, and are at increased risk for placement breakdown. Recognizing the needs that children have for support within the community where they live and in different social environments underscores the need for proactive case planning. Case planning that is anticipatory and recognizes that even though a child may not currently be experiencing problems, the need to plan interventions and additional supports exists. Ongoing monitoring of the child's needs behaviors and challenges in environments, such as school should take place. This type of monitoring can occur in several ways including regular visits with the child and foster parents, contact as needed with the school at least twice a term, and responding quickly to foster parents when they ask for help.

Q.2 Do you feel more confident in your leadership in responding to casework scenarios about clients with FASD?

Yes – 100%

Q. 3 If yes, can you explain how this training has been helpful in developing your leadership and confidence in response to the needs of children in care with FASD?

I speak out now when I hear others adopting strategies that will not work with affected peoples. I advocate for others to get more training in the area. When I do speak, I do so with confidence from a solid foundation of understanding
It has improved my leadership because I now “get it” and can apply it to practice. I am able to influence people’s perspective, understanding and expectations for themselves and for the client they are working with.

Provided appropriate vocabulary and materials to explain the rational to caregivers, professionals and managers.

The training has provided me with a foundation of values and best practice to draw from -a clear idea of where energy and priorities should be placed (i.e. on caregiver stability, environmental modifications, on ensuring that all stakeholders have the same understanding of FASD, transition planning, redefining success...rather than focusing on strategies) -a stronger ability to identify when people/support staff/professionals don’t have a good understanding of FASD and how I can better support them -a clearer idea of how to bring support teams together, to focus and set priorities, and develop an action plan.

This training modeled good casework consultations and allowed for me to participate in consultations with caseworkers with support. This gave me the opportunity to practice my skills/knowledge and gain more experience and confidence.

I feel more confident in recommendations, case planning, consults with caseworkers and caregivers, schools -less emphasis on child’s responses and more attention to supports in placement, planning for positive outcomes -new frame of mind, changed my views on ‘behaviours’ even more -able to give rationale for directions, recommendations, planning, supports -I feel confident in making decisions regarding files - I have been able to provide an explanation for my reasoning with confidence, knowing and believing what I say. [I have a] mindset change in FASD as disability vs. behavior.

Q. 3 – Discussion/Memo

Responses focused on feeling confident in advocating for clients by recognition of approaches that are not effective, and speaking out about this. Confidence is increased through deeper understanding the expression of “getting it”, and further increasing advocacy through describing client needs to other professionals and managers. Another participant highlighted that the training provided “foundational values“ and “best practice“ which both relate to social work and child welfare casework. Confidence was increased through “redefining success”, an important point as it speaks to being realistic while having a clearer understanding of what works, and setting aside approaches that do not work. This was expressed through being clear
in relation to support and action plans, both crucial functions in supporting children and families living with FASD. These comments also reflect a shift in casework practice with this population.

Q. 4 What will you change in your practice as a result of participating in the FASD CoP LFW training initiative?

I will stop having unreasonable expectations of affected people, and work towards shaping a better environment for them. I will actively support those individuals who care-give affected children, and advocate for them to receive respite, training and counseling as needed.

Ensuring all the stakeholders meet on a regular basis without including the child.

I will more actively participate and organize case consultations regarding individuals with FASD -when 'complex' children with FASD are brought to the triage table to consult I will incorporate the 'values' and best practices learned into support plans -I will work with service providers to more accurately operationalize their support outcomes for individuals with FASD -I will support service providers to have a better understanding of best-practice around supporting individuals with FASD -I will work with caseworkers to initiate transition planning as early as possible -I will be more active in ensuring the recommendations and consultations will be more disability focused and focused on the supports to the environment, 'stability' of caregivers (training/coaching, relief/respite, grief and loss work).

Consults with caseworkers address FASD impact, brain damage, disability and need to plan for lifelong supports -advocacy for caregivers and children is different in my understanding of FASD as a disability.

Q. 4 Discussion/Memo

The voices of the participants were clear as noted above on what they would change in practice through new understanding.

Q. 5 Has the case consultation process enhanced your learning?

In response to this question the majority of respondents strongly agreed that their learning was enhanced through the case consultation and a small number of participants indicated they disagreed that this process enhanced their learning.

Q. 5 Discussion/Memo
**Case planning and case consultation.** This process is critical to informing everyone working with a child or youth with FASD about what the challenges are for the particular child, what the problems are that the child is experiencing, the environments where problems occur, and supports the foundational need for communication on an ongoing basis. Communication about the child across different environments supports appreciating the complexity of the needs and the types of effective supports required. Communication between caseworkers and casework supervisors is an essential part of casework planning. Providing training to casework supervisors and managers who support frontline case management has been a hallmark of the FASD CoP Leading from Within Initiative.

Appreciating that casework planning and management for children with FASD requires all involved to have a common understanding of needs facilitates more effective case management. One of the common threads identified by this group of casework supervisors and regional managers was advocacy. The participants in this training appreciated advocacy in new ways through a deeper understanding of the challenges in care faced by children, youth and caregivers. Shifting practice and gaining a deeper understanding of children with FASD in care has served to re-focus practice and approaches to this vulnerable population. The vulnerability of children is constant and occurs across different environments.

Children with FASD come into care with a history that has clearly assessed they are at risk and in need of a placement outside of the family of origin. These children are at social risk for harm including being taken advantage of, being bullied, being isolated, being a scapegoat, being harmed, and being blamed often for their behavior. These factors contribute to a complex portrait of life with an FASD. Offering advanced case consultation on children with
FASD with the child/youth’s “team” around the table provided an opportunity to learn, to analyze, to engage in meaningful conversations and dialogue and a place to grapple with the intersections of ethics and challenges in practice. If we know that children with FASD have an existing predisposition to vulnerability and we have some knowledge about the trajectory of challenges they face, we have a responsibility to mediate wherever possible.

The FASD CoP Leading from Within Initiative was offered as a course through Workforce Development and provided direct training through directly conferencing current cases with those most closely involved with a child or youth. Caseworkers, foster parents, educators and support workers all came to the table for consultations on children/youth in their care, to participate in a highly structured case consultation. The setting included a central table for the consultation and participant casework supervisors and regional managers were located around the room. These consultations occurred in strict confidence and the cases that were reviewed all had complex elements. Donna Debolt acted as the lead consultant and up to two participants in the course were invited to be at the table and engage themselves as consultants reviewing the case.

Q. 6 Was the inclusion of a consultant from the Education system helpful?
In response to this question the majority of respondents strongly agreed or agreed this was helpful. One respondent was unsure and one disagreed.

Q. 7 How would you rate your experience of sitting at the table and directly participating in the case consultation process?
In response to this question the result was Excellent – 100%.

Q. 8 How would you rank the experience of observing the case consultation process?
In response to this question the result was Excellent – 100%.

Q. 8 Comments:
This was an amazing experience and would recommend it definitely be part of the process. This offered and opportunities to observe, process, assess and listen to the info and consult unfold. This was actually an exhausting time as I found myself very engaged with the entire process, listening, observing, assessing, trying to apply all of the data received from Donna and attempting to apply it. The first couple of conferences were rather difficult and scattered to pull together, however after a couple I was quite delighted to find I was coming up with recommendations and plans that were confirmed by what Donna recommended to the family or caseworker. Absolutely one of the best teaching tools I have been part of. I believe those conferences are what solidify the information. I have been able to bring back the tools Donna provided and apply them many times outside of a full consultation.

Observing case conferences allowed to see how the training material could be generalized across different situations and also reduced my post - training recidivism.

This experience allows workers to observe how the theory is applied consistently. It also allows you to start recognizing themes in the various case presentations that helps to simplify the intervention approach.

Q. 8 Discussion/Memo

Observing the case consultation process turned out to be a highly engaged process for participants and represented a learning curve. Initially participants were somewhat reluctant to engage in the process but this changed over time. As one worker stated;

This was an amazing experience and would recommend it definitely be part of the process. This offered and opportunities to observe, process, assess and listen to the info and consult unfold. This was actually an exhausting time as I found myself very engaged with the entire process, listening, observing, assessing, trying to apply all of the data received from Donna and attempting to apply it. The first couple of conferences were rather difficult and scattered to pull together, however after a couple I was quite delighted to find I was coming up with recommendations and plans that were confirmed by what Donna recommended to the family or caseworker. Absolutely one of the best teaching tools I have been part of. I believe those conferences are what solidify the information. I have been able to bring back the tools Donna provided and apply them many times outside of a full consultation.

In the words of two other participants:

Observing case conferences allowed to see how the training material could be generalized across different situations and also reduced my post - training recidivism.
This experience supported participants to observe how practice theory on FASD is applied consistently. It also allowed participants to start recognizing themes in the various case presentations that help to simplify the intervention approach. This process represented, in many ways, an unfolding of knowledge through direct engagement. While case consultations are not new in child welfare practice, the need to examine the way that we help others through sitting at the table, and observing the process of a case conference supported direct learning. Involvement in this process required attention, active listening, and engagement with the experiences being described by those involved with the child. This was a real case, within a region, and the primary reason for being at the case consultation was because there were challenges and problems occurring for this child or youth. The participants had to take the risk to step up and participate at the table through volunteering - a new process for learning in courses on child welfare practice and FASD.

The complexity of the lives of children, youth and families where FASD is a concern provides a rationale for such training. Concerns about poor outcomes and life trajectories for youth once they leave care are real and the need to provide as solid a foundation in life as is possible rests with the resources of the ministry. By creating and offering this course, the capacity to engage in advanced learning increased, as did expectations around learning by participants. Participants consistently identified this learning opportunity as highly valued and indicated that this course has influenced their practice. One key learning that participants identified was gaining a deeper understanding of FASD. This raises an important point about training and learning about FASD that is discipline specific and relates to the need for learning opportunities grounded in best practice for children with complex, high needs.
Q. 9 What key training needs about FASD would you identify as important in supporting your practice for children, youth and their caregivers?

To be able to have access to a mentor that has a solid foundation, to be able to consult with peers to keep my perspective fresh and to have the latest good research available.

FASD training should be delivered in this format as a mandatory approach if we truly want "training" to be incorporated into our case practice.

This training needs to be part of Delegation training. It also needs to be mandatory for all workers, supervisors and managers.

I think the reiteration of key values is the most significant training need. Values such as; - focus on supported dependency rather than independence - factors that foster greater caregiver stability - understand the dismaturity and developmental trajectory of FASD - plan - redefine success - have appropriate expectations - understand non-compliance as non-competency and often unrealistic expectations.

The need for all supervisors, managers and collaborative partners to have training together, to understand the best way to work with persons with FASD.

Training should be mandatory, and repeated every year or two years to refresh. Video training may be an option. Caregiver training on the 'how to', rather than just facts, about FASD offers an opportunity for caseworkers to apply their knowledge with support from management. This is a change of thinking so meets with dismissal sometimes or a general disinterest. The mandates [for children living] in group- care focuses a great deal on behaviours, which usually is a big impact on many of our children. Education here is a must and quite a crucial place to have this knowledge.

Q. 9 Discussion/Memo

A clear message is identified in these responses about the need for mandatory training on FASD and disability that takes place in delegation training as well as through ongoing professional development or workforce learning opportunities. Another clear message is a strong desire to engage in learning opportunities that are focused on the “how to” do this work. This type of learning that is practical needs to take place. This comment is important: The need for all supervisors, managers and collaborative partners to have training together to understand the best way to work with persons with FASD. This comment offers a reflection of what constitutes a community of practice. The construct of Leading from Within is critical to child welfare.
practice. Much of the work done by child welfare workers is misunderstood and because of confidentiality, the details of such work are not released to the public. While both criticism and praise of child welfare practice has emerged in social media, the value of this work is not well understood by those who do not have insider knowledge of how the system works. What generally gets reported in the media is when something goes wrong. Every day casework practice that makes a positive difference in the lives of children takes place. This project represents innovation in practice by integrating casework supervisors and managers into cases where additional support is needed due to the complex factor of FASD. Appreciating the complexity of FASD and engaging with peers in this process is highlighted in this comment:

To be able to have access to a mentor that has a solid foundation, to be able to consult with peers to keep my perspective fresh and to have the latest good research available.

Q. 10 Please share any specific learning or take away message from this process that you think is important to share with others in engaging in practice with children/youth and caregivers in relation to FASD.

You don't get it until you get it, and then when you do, you will never be the same again...regarding understanding FASD and practicing as a caseworker.

Disability First Language when describing the needs/presentation of a person with FASD. Behavior needs to be interpreted through the understanding of the cognitive functioning/disability not as stand-alone and stop listening to the child, find permanent stable placements and support them well as soon as possible, encourage them to keep up with training descriptors.

One of the most profound comments made during the training was; “Would you ever get mad at a deaf child for not listening?” This statement reiterated for me the responsibility we have to better understand how these children need to be supported. The need for us to make environmental modifications, have appropriate expectations, ensure caregiver stability, build habits and competencies within them, ensure that others understand their needs...these are ways that we can ensure that we stop being 'mad' at these children. The onus is ours.

FASD cannot be just a diagnosis. The understanding of how to work with the child with a diagnosis of FASD [who] is not generally receiving the care suitable for their needs. The
caseworker, supervisor etc. need to be educated. Cannot be sporadic, if all do not speak the same language it will continue to be a challenge to offer the service the child needs. Placement breakdowns are in a crisis state, children who have FASD disability continue to be moved and disengaged from a permanent home due to lack of understanding and incorrect supports.

**Q. 10 Discussion/Memo**

The comment, “Would you get mad at a deaf child for not listening?” had an impact. This participant highlighted this comment and described it as having a profound impact on her understanding and response to children with FASD in care. It also reflects an honest response in terms of indicating children are difficult to manage, and indicated there are ways to “stop being mad” at children with FASD. Where does this come from – being frustrated with casework with children with FASD? This was identified in one of the case consultations as the *mad factor* and suggests that there are frustrating and challenging experiences with children, who are frequently blamed for their behavior. Underpinning this notion is a lack of understanding on the roots of challenging behavior, the capacity of the child, and further, raises the question about whether the interventions being used to support the child are effective, or needs to change.

**List of Codes Generated from Qualitative Analysis of the FASD COP LFW Training**

The list of codes presented here in alphabetical order was generated through an in-depth analysis of all the responses to the FASD COP LFW survey monkey questions presented in the following section. The coding process involved reading and re-reading the text to develop a deeper understanding of the experience of participants in this workforce course. Codes are generally used to highlight meaning and are reflective of experiences. Evaluating experience within new training frameworks is crucial in relation to FASD, as limited intervention based research is published as highlighted in the review of the literature. Reviewing this information
contributes to a deeper rigor in the process and provides a means to cross check that the code is reflective of the experience. The higher usage of the code supports the development of themes emerging from the research. The highest used codes are indicated in the words in this chart that are bolded but are not necessarily reflective of an important “finding”. Rather, they represent areas to reflect upon in understanding more deeply the experience of the participants and insights they have shared through responding to questions asked about the FASD COP LFW. These responses when combined with other parts of this evaluation, in many ways highlight learning and reflect a new understandings of the complex phenomenon of caring for children with FASD, responding to families, engaging in casework supervision and learning.

**Table 1: List of Codes**

<table>
<thead>
<tr>
<th>Advocacy</th>
<th>Disability awareness and understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior (understanding)</td>
<td>Engaged learning</td>
</tr>
<tr>
<td>Beyond the diagnosis</td>
<td>I get it now (insight into FASD)</td>
</tr>
<tr>
<td>Caregiver relationships</td>
<td>Interdependence</td>
</tr>
<tr>
<td>Case consultation</td>
<td>Lifespan</td>
</tr>
<tr>
<td>Case reviews</td>
<td>Mentor</td>
</tr>
<tr>
<td>Case planning</td>
<td>Peer consultation</td>
</tr>
<tr>
<td>Casework supervision</td>
<td>Placement support</td>
</tr>
<tr>
<td>Collaborative training</td>
<td>Prevent placement breakdowns</td>
</tr>
<tr>
<td>Commitment</td>
<td>Research awareness</td>
</tr>
<tr>
<td>Communication about practice</td>
<td>Skill and knowledge development</td>
</tr>
<tr>
<td><strong>Confidence in practice</strong></td>
<td>Understanding FASD differently</td>
</tr>
<tr>
<td>Disability</td>
<td>Value of training</td>
</tr>
</tbody>
</table>

Table 2 below identifies the primary codes identified through the analysis as well as a list of related codes. Codes and related codes support developing a concept or constructs that have some relationship or mesh together. For example, advocacy is related to commitment related to ensuring a child gets needed services through this activity. Advocacy can also be supported through mentorship by casework supervisors at the next level and regional managers as well.
Table 2 – Primary Codes and Related Codes

<table>
<thead>
<tr>
<th>Codes</th>
<th>Related Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>Commitment, mentor</td>
</tr>
<tr>
<td>Confidence in practice</td>
<td>Casework supervision</td>
</tr>
<tr>
<td>Disability awareness and understanding</td>
<td>Interdependence, disability awareness, lifespan (implications)</td>
</tr>
<tr>
<td>Skill and knowledge development</td>
<td>Behavior (understanding), case reviews, caregiver relationships, case planning, research awareness</td>
</tr>
<tr>
<td>Understanding FASD differently</td>
<td>Placement support, prevent placement breakdown,</td>
</tr>
<tr>
<td>Value (of the training)</td>
<td>Collaborative training, engaged learning, peer consultation, communication about practice</td>
</tr>
</tbody>
</table>

Discussion on Codes: Upon review of the codes further grouping of the codes can support a broader category reflective of similar experiences in this instance, through the FASD COP LFW project. As viewed together a relationship between experience and outcomes of the Workforce Development course that contribute to outcomes/actions identified in response to the training. Such outcomes include advocacy, confidence in practice, an increased understanding of FASD as a disability, skill knowledge and development, understanding FASD differently (allied with the increase in disability awareness) and the value of the training that was highlighted as collaborative, peer based consultation and an opportunity to communicate and talk about practice. Participation in being at the case consultation and observing the case consultation were interpreted to support the value attributed to this training. Understanding FASD differently contributes to engaging in practice in new ways and supports creating pathways for children that are realistic. The training also contributed to a sense of confidence in the casework supervisors and managers in responding to supervision from an FASD informed practice lens. When considering the application of this training to day-to-day practice the participants also completed a brief survey on key practice areas for children with FASD.

Brief Survey: Evaluation Comments on Key Practice Areas Emerging from Case Consultation – What works?

A brief survey was provided to participants at a training session that took place prior to the case consultations (Appendix V) on what works with children and families. Table 3 below provides a summary of these comments in key practice areas. Field notes from the discussion on Creating Placement Stability follow in Table 3 and serve to highlight key points of the discussions.
Table 3: Comments from Participants on Areas of Practice – What Works?

<table>
<thead>
<tr>
<th>Key Practice Area</th>
<th>Comments from Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement stability:</td>
<td>Implementation of 1-1 support for the child, change the environment; Value the four pillars to placement stability: respite, grief and loss, training, coaching; paying attention to the number of placements in the home; stability is the goal for children with FASD</td>
</tr>
<tr>
<td>Transition Plans:</td>
<td>We continue to use support and transition plans; to value and identify dependence not independence; Goals look different – decisions made “around child”;</td>
</tr>
<tr>
<td>Relationships with Caregivers:</td>
<td>Monthly face-to-face contact with caregivers is important and we strive maintain this standard.</td>
</tr>
<tr>
<td>Use of Respite:</td>
<td>Regular respite and more active application of respite support [provided] for a minimum of 48 hours a month; Normalize respite rather than use in time of crisis and explain how relationships work in FASD – connection, compliance and competence; Encourage and coach caregivers, encourage respite as vital</td>
</tr>
<tr>
<td>Case coordination and consultation, case conferences:</td>
<td>All important and necessary to guide good case practice and strong surrounding supports; Change the environment, not the child; The FASD Coordinating Committee and the region continue to bring Donna Debolt in for consultations; useful for information sharing, very valuable.</td>
</tr>
<tr>
<td>Training on FASD</td>
<td>All should have [this] yearly – both workers and caregivers and other professionals; Educate through example, absolutely! A mandatory training in the region is highly valued. Yearly reminders or refreshers.</td>
</tr>
<tr>
<td>Other areas of practice</td>
<td>The use of assessments to determine functioning and aid in diagnosis and to help explain the disability; the importance of reliable family planning as a standard for good case practice and viewing Mom’s and children as our clients. Continue to challenge and advocate for children with FASD</td>
</tr>
<tr>
<td>Additional Comments:</td>
<td>The CoP FASD COP LFW has been invaluable. The knowledge and skills will contribute to strong case practice and better outcomes for children What’s new (in the training) from the “Certificate Program” (FASD COP LFW)?</td>
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<tr>
<td></td>
<td>• Disability first language when writing or explaining a youth</td>
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<td></td>
<td>• Don’t talk about behaviour – redirect to describe functioning/disability</td>
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<tr>
<td></td>
<td>• Small dose training – solid FASD education training through consultation and discussion</td>
</tr>
<tr>
<td></td>
<td>• Through solid explanation of disability the “strategies” reveal themselves</td>
</tr>
<tr>
<td></td>
<td>• Solid core values and philosophical approach</td>
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</table>
Field Notes – Training Focus: Creating Placement Stability for Children with FASD: Reflections from a discussion/debriefing in a training day in February 2013 with participants and the trainer/consultant. Question of the day: So if we know the trajectory for children with FASD, how do we practice differently?

Dali Lama Logic of intervention: If we know this, then this influences what we do next.

Placement stability conference issues: These are hard kids to look after. We need to put this on the table and acknowledge this aspect of caring for children with FASD. Placement crisis is always a concern. Have FP establish a plan for when things get too stressful. Building placement stability is as crucial workplace turnover and stability is. You can make change: “If you think you are too small to make a difference try sleeping with a mosquito.” Knowledge and experience can both be used to identify and adopt strategies that work best for children and their caregivers. For children with FASD it’s about the brain and not the behaviour.

Intellectual Disabilities issues: When considering the issue of intellectual disability it is important to recognize that concerns can be situational, cognitively based, related to personality and affect state. The older the youth gets, the greater the exposure to risk. Personality can sometime be more passive. The weight on the home literally can be too much when much of the disability is cognitive and related to thinking things through. This process requires support. The value of professional training is that it increases identification of risk and works towards a goal of intervention that appreciates and understands that some behavioral deterioration can occur and is often predictable based on past experience. If a caseworker knows this they can proactively develop behavioral strategies and hopefully reduce the occurrence.

School issues: School can be very stressful. Issues related to age and expectations need to be reviewed for children with FASD. As we know children with FASD face challenges in the education system in learning and in social relationships, strategies need to consider the gap that is experienced for children with FASD in contrast with their peers. With children with FASD
grow up, expectations change and generally increase with age. What happens to children when caregivers fail to cope?

**Differential diagnoses issues:** Comorbid risk factors exist such as placement disruption and expectations increase when support is framed as "treating" children. The issue of moving a young person into supported or supervised independent living is a concern, as this may not be the best option for youth with FASD as the need for support is lifelong. Too many disconnects eventually cause the system to fail. It's difficult to reboot the system. Where is this going? While relationships and consistency are important, contrary to popular belief, a good relationship is not enough to support the child in their day-to-day living skill development. This needs to be an intentional, structured and deliberate activity that focuses on skill development that will support the child feeling competent. Decreased levels of attachment can occur with children if there is a disconnection between needs, and an adequate response to their needs.

**Caregiver issues:** The first placement for children in care, are usually the longest. Symptoms of grief and loss are common. Caseworkers need to understand what works for the culture of a family. Sometimes families put the help on the run. “Caregivers need training on the challenges”. Strategies not solutions as we continually need to adapt responses as required while maintaining structure, routine and consistency.

**On substitutionary caregivers:** Children with FASD often end up in care and we often look to parents/caregivers to understand children's behaviour. Key issues supporting care include respite, training and more training. Grief and loss work needs to be included. Grief issues exist including losses, self-esteem, competence, enjoyment, balanced family system, social network, privacy, freedom, ability to share in accomplishments, and life challenges for children with
FASD. Work around the needs of caregivers for respite and training – this requires differential options be made available dependent on need. Unrealistic expectations set children up for failure. This is a caution underpinning good practice for children with FASD

**Focus group with casework supervisors in May 2013**

A focus group with two casework supervisors and one foster care worker took place in one region. The focus group was recorded and transcribed and the text below reflects the essence of the conversation with some quotes, points of discussion and interpretive descriptions.

Quotes from participants are in italics.

> The child is conditionally safe but chronically at risk. We had to think from a disability first perspective and disability first language and explain the disability while keeping all the complicating factors out of it.

This quote from a casework supervisor speaks volumes. Children that are placed may be safe but having an FASD indicates that the child is chronically at risk. The perception of at risk and risk are critical constructs from an FASD informed perspective. The need to manage, contain and engage in casework practice that considers the risks to children across different environments is sound, as risk remains constant. Appreciating the challenges faced by children developmentally and factoring their social vulnerabilities into an equation of support is essential for children with FASD. If we consider what a potential equation looks like for care of children with FASD it would include developmental knowledge of ages and stages, understanding the brain injury and subsequent disabilities associated with alcohol exposed pregnancies, assessment of the strengths and challenges for children, environmental adaption to mediate against the struggles children with face in the family or foster home, in the community, in the education system and in other locations and recognition that decisions made
for children with FASD have lifespan implications. An FASD informed casework model also appreciates that children are not predictable, yet some of the common behavioral challenges are known and can inform practice.

Further, for children in care with FASD a model that supports increased contact between the caseworker, child and caregiver supports stronger communication.

*Increased contact between caseworker, child and caregiver supports stronger communication and the opportunity to more regularly "coach and support understanding of FASD through a disabilities lens", which will subsequently inform more effective intervention/management by the caregiver." This supports consistency with key training principles on creating placement stability and is congruent with the Signs of Safety approach to case practice developed by Turnell and Edwards (1999).*

The need for training that goes well beyond a basic understanding of FASD and examines day-to-day living for children in care should be mandatory, and ongoing. One casework supervisor who suggested that not everyone who claims to understand FASD truly appreciates the complexity of the problem brought the concern forth. Through *active communication* with the caregiver and child a deeper relationship evolves and everyone benefits. Training must be available to all involved in the care of the child as this offers a consistent approach to meeting the needs of a particular child.

Clearing the path for children with FASD is largely about having realistic expectations and ensuring that the environment is responsive and adaptive to the child's needs. Donna Debolt refers to this as snowplowing. One example relates to employment for a youth with FASD. She had a part time job in the community stocking shelves in a store. Things were going well in the job because the level of the work was within her capacity. As the disabilities of youth with FASD are not apparently visible, expectations within environments can shift and increase without recognizing potential pitfalls or challenges. In this case the youth was promoted from
stocking shelves to cashier and the job fell apart. Communication regarding skill and capacity within the workplace could support the youth to maintain her position rather than have expectations placed on her that were too much. Proactive planning in these types of circumstances and practice/support from an FASD informed perspective could support maintaining realistic expectations and goals.

Comments about the advanced training and case consultation

[FASD] Training [in this new course] talked about predictable trajectory. The other thing about written reports, when we have kids that are affected I am far more diligent as a supervisor about how they are writing about these kids because a lot of times you even get new babies out of hospital. New workers say the baby is happy and healthy and I say, let’s dial that back a bit. The child was prenatally exposed to alcohol, here was the withdrawal they experienced and we can predict now that this child will be diagnosed with an FASD, that there will be developmental dismaturity that we will be watching for and paying attention for. Documenting issues such as prenatal exposure to alcohol and issues is important.

Comment about a youth who is employed:

I am thinking I did such a good job of snowplowing, supported her getting a job, did all these things for her and she did so good, was successful for so long and going through this has educated me more about where you need to keep going, and take into consideration. You can’t just stop at snowplowing.

This casework supervisor played an active role in working with the youth and the employer, collaboratively with the foster parent has helped maintain employment and also offers recognition of the need for sustained support for this youth. Snowplowing was explained as getting ahead of the child and anticipating their needs prior to running into problems.

The voice of a foster care worker

The issue of foster care training on FASD is important to caseworkers. As a result of the case consultation process a foster care supervisor shifted her training to a different track when only 3 of 15 participants signed up for the session in a small, rural community. The process supported foster parents to speak more about the challenges they were facing with children in
their care and felt supported through a small group process. The influence of the case consultation training was clear. The worker also expressed that the training session was:

*Meaningful, relevant and helpful. The foster parents left feeling they got what they needed and that case-by-case training was helpful. They could leave feeling confident in their abilities. The case consultation training has me keyed up to think how I adapt information to take into practice with a disability first model.*

These quotes were included to illustrate briefly the progress to date on the FASD CoP Leading from Within Initiative and project engagement. The voice of participants in the project including caseworkers, casework supervisors, regional managers and participants in the case consultation process such as foster parents and educators from urban and rural settings are represented.

**One word about what this project has meant to you**

In the final case consultation day participants were asked to summarize in one word what the training has meant to them. This was represented at the outset of the report in the Word Cloud presented on page 5 of this report. It was great to see the willingness of course participants to engage in a circle and briefly survey the impact on the project. The questions leading to the one word response were framed as follows:

*How has this course/training impacted you? What has it meant professionally? Use one word to describe what being part of the Leading from Within Initiative has meant. What is one word you would use to describe the experience?*

Key terms reflected in the responses focus on impact, Professional Practice, learning on FASD, and usefulness of the training and case consultation process. The responses:

*Invaluable, Useful, Practical, Relief, Inspiring, Competent, Inspiring, Enlightening, Validating, Change, Changing, Hopeful, Impactful, Game-changer, Practice, Knowledge, Leadership*
The information presented in this report supports a model of casework practice, supervision and management that is FASD informed. Transformational learning occurred within these courses and supports new directions in practice based training and learning that emerges from within the CFSA workforce.

**Conclusion: Discussion on Findings**

A critical need to engage in child welfare practice for children in care from an FASD informed lens is essential. This is a key finding from this research. Training on FASD serves an important function through conferences and other venues as this activity inform professionals about a variety of topics related to FASD such as prevention, best practice with birth mothers, issues for adolescents and adults, biomedical research and international concerns amongst many other topics. However, training on specific child welfare practice approaches and responses to FASD, in all its’ complexity in casework requires new training approaches. Training that is practice based, grounded in a disability context, and from an FASD informed perspective is an essential tool for the front lines of the child welfare system that intervenes on a daily basis with families where children and even parents, live with an FASD. These families are complex and often, intergenerational issues are a concern. The multi-dimensional challenges, Interprofessional collaboration and systems that are involved with children and families, often through referral and advocacy by caseworkers and their supervisors, need well trained professionals that have a deep level of knowledge on FASD. In many ways, the following quote from a casework supervisor in the focus group provides a critical summary and underlines the benefits of this training initiative.

*The stronger people are in explaining the disability of FASD, the greater the difference it makes in providing supports and establishing the structure and services we are using to support these kids. We*
started this process on FASD because we had to. We struggle with FASD and disability. I’m doing disabilities work - misunderstood disabilities and disabilities not served well contribute to protection issues.

Appreciating FASD from a disability context became a consistent theme throughout this research in training and case consultations. This quote is a critical statement and is supported by the work of Koponen, Kalland & Autti-Ramo (2009) in their research with 38 children in care, and note that children who remain undiagnosed show significantly more behavioral problems when compared with children diagnosed with an FASD. This is a critical contribution to the research literature in terms of the need for not only FASD informed practice, but also, disability informed practice. FASD must be framed from a disability lens to be fully understood and appreciated. While practice responses in developmental disability are well established and integrated, the response for FASD has taken its’ own trajectory for many reasons. The need to integrate disability theory with FASD is a critical part of the advanced, competency based, case consultation training within the FASD CoP Leading from Within Initiative that has taken place in 2012 and 2013 across the CFSAs in the Province of Alberta. The opportunity to engage in advanced training case consultations has been a rich experience for participants.

**Returning to the key research questions**

1) What have you learned in the advanced training in the *FASD CoP Leading from Within Initiative* that impact your practice, knowledge and skill development and leadership capacity in your region in responding to the needs of children/youth with FASD on caseloads?

2) What difference has advanced training made directly in your practice with children with FASD? What practice will you change as a result of participation in this project/initiative?

3) What difference has the case consultation process made to informing your practice, knowledge and skill development

4) Other questions may emerge from this process and will be explored as needed. Anecdotal information reflective of the voice of participants will be utilized in this research.
The responses to these questions have guided the writing of this report through documenting and demonstrating learning acquired through the voices of the participants (caseworkers, casework supervisors and regional managers). Their voice is strong in relation to the positive experiences gained from this course as well as identification of key challenges faced by children and foster homes. Many comments reflected a new understanding of FASD as a disability and the disabling conditions faced by children, and the need for structure and stability in the child’s life. Understanding behavior and the types of interventions utilized supports a shift in thinking around practice, and should lead to evaluating responses to the child and thinking about effective environmental adaptations are required to meet the needs of the child. This understanding provides a route to a deeper understanding of FASD as a disability and suggests that there are other ways to respond to the needs and demands when children with FASD are in care. Appreciating that behavior is not purposeful, manipulative or necessarily intentional as indicated through the LWI training positions caseworkers and casework supervisors to practice differently and respond to foster parents with deeper understanding.

The other key area of focus was on understanding FASD in new ways from a disability lens and focus. While the literature on interventions for children with developmental disabilities is substantially rich, much of this work has not been translated effectively in response to FASD. Understanding of FASD as a brain-based disability that is not necessarily visible, but identifiable often through behavior, and deconstructing the contributing factors as took place in the case consultations, shifts thinking. Other areas identified through the case consultations included concerns about social experiences and vulnerabilities, and deepening understanding of the neurological challenges faced by the child that, upon examination, are
identified as learning and memory problems. The discussions emerging from the case consultations has deepened the understanding of the complexity around the needs of children with FASD in care through the combined experience of advanced training and direct engagement in case consultations. This training contributed to the development of critical thinking skills relevant to examining concerns, engagement in case analysis, challenging assumptions and considering the implications and consequences, outcomes for children, both positive and negative in relation to casework practice, supervision and intervention.

Common discussion threads in the case consultations included the challenges in foster homes related to the demand on foster parents, maintaining placement stability over the long term, understanding different needs as children grow older, increasing behavior problems as children move into adolescence including being taken advantage of, sexuality, vulnerabilities, social skills development, transportation, protection and safety, emotional challenges, exposure to substance abuse, comprehension and processing information – particularly abstract concepts, problems/challenges in the education system, behavior escalations and frustrations, understanding the capacity of the child or youth, and appreciating what a good day looks like for a child with FASD. The notion of taking life one day at a time was commonly mentioned by foster parents participating in the case consultations. This learning also supported a deeper understanding of the needs for advocacy for the child across different environments.

**Key Messages**

*FASD, if understood as a disability,* and offering training/advanced training on casework practice through case consultations as applied in the FASD COP LFW project; supports and
promotes a deeper understanding of the complex needs facing children in care, their families, the community and in care placements.

Understanding that the trajectory for children in care with FASD can be problematic without putting interventions and supports in place as early as possible is important. FASD informed practice appreciates the trajectory and the need for planning prior to challenging problems that spiral downward. This concept was identified as snowplowing or getting ahead of children with high needs.

By understanding FASD as a disability, a different appreciation of the needs for ongoing and consistent communication in relation to expectations of the child was highlighted. Understand children with FASD have vulnerabilities emerging from experiences in their family of origin. Problems that have contributed to these vulnerabilities include addictions, child neglect, poverty, social stigma and often, intergenerational cycles of family problems that are difficult to change. Children born into these circumstances are already at risk. To recap the vulnerabilities highlighted for the case consultations earlier, they include, personal vulnerability for children/youth, school related concerns around supporting the child in the school setting, issues related to families, i.e. a parent that has an FASD, parent with a substance abuse problem, placement stability, crisis planning, developing a deeper understanding of FASD and the particular needs of a child/youth, behavioral concerns, foster parent needs such as respite, working with schools, financial concerns, and executive functioning concerns in activities of daily living. The focus of the case consultation for children with FASD centered on the recognition of life vulnerabilities and risk factors over time, ages and stages of development, and engaging in planning for meeting complex needs.
The question at the outset of the training was: **What does it mean to truly understand this child?** What do we need to change to support this child in their goals and what are the barriers to achieving those goals? As was often said, *change the environment, not the child.* A new construct is emerging that is focused on **protective case planning for children in care with FASD.**

**Practice and Knowledge Development within the CFSAs in Alberta**

Alberta has been on the leading edge of practice and knowledge development related to child welfare service delivery since early innovations in the 1990s that saw the development of training on FASD. Since these early days the response to FASD has become an international phenomenon. The Ten Year Strategic Plan developed within Alberta is at its midway point and remarkable progress has been made to date. While the FASD Community of Practice has demonstrated both leadership and innovation, the need exists to develop, from within the workforce of Children’s Services, knowledgeable leaders who can guide practice related to complex case management. Complex case management is an important construct in relation to responding to the needs of children, youth and families affected by FASD. Underlying social problems related to historical trauma, alcohol and substance abuse and chronic neglect are often factors in the care of children who come to attention of Children’s Services. How does the knowledge developed within the workforce through the FASD CoP project move forward?

Strategically it makes sense to move the response to FASD within Children’s Services from the inside. The concept of *Leading from Within* shows incredible promise in response to the application of skills and knowledge related to complex case management and shifting practice to effectively meet the needs of children in care living with FASD. It is clear that specific
training and knowledge about FASD is required in addition to adequate resourcing to respond to the needs of children, youth and families. While the outcome that children remain at home is desirable, this is frequently not the case and many of the children served by the province are unable to be returned to familial care. This reality positions the province to offer leadership through excellence in care. This work has been taken seriously as demonstrated by the commitment and positive outcomes of the FASD CoP (2009-2011) in terms of placement stability and development of a standard of practice including regular home visitation, enhanced training and case conferencing (Badry et al., 2011).

The FASD: CoP Leading from Within represents a logical and critical step forward in response to FASD and the development of the workforce in the Child and Family Services Authorities (CFSAs) within the Province of Alberta. The opportunity to provide enhanced leadership training, skill development and complex case management makes sense. This model holds both promise and possibility and as identified by the participants, has been of great benefit. There are leaders in the workforce who are engaging in opportunities for training on FASD and they have the capacity to offer leadership from within. A culture that enhances learning and practice knowledge specialization as required, in this instance, on FASD, can only enhance supports for children. An FASD informed caseworkers, supervisors and regional managers who receive advanced training are critical within workforce development. This small group representative of different CFSAs can act as a somewhat of a specialized support within teams, offices and regions in the CFSAs, share their knowledge and provide consultation. Training in complex case management and developing knowledge of strategies, techniques and
interventions that work for children is crucial in relation to FASD because of the unique presentation of children, the underlying neurodevelopmental disorders, and related disabilities.

**Children with FASD have unique needs from children who do not have FASD.** While it could be argued that all children in care have some form of special needs, the investment the province has made in terms of training, funding and strategic planning in response to FASD continues to move forward through initiatives such as the FASD CoP: Leading from Within. This initiative positions the development of leadership on FASD strategically as emerging from within. The skills, knowledge foundations and understanding advanced through the training and the case consultations has provided a form of structured learning that is directly relevant to frontline practice, to casework supervision and to working differently as needed with children who have complex needs. Investing in the development of the Children’s Services workforce in term of specialized knowledge on case management in FASD and sharing this knowledge within and amongst regions promotes innovation and excellence in practice.

A graphic representation of the different activities that took place in the FASD CoP Leading from Within Initiative is reflected in the following model identified as: *Protective Case Planning for Children in Care with FASD Through Advanced Training and Case Consultation: A Four Point Model.* The need to engage in casework that is FASD informed, proactive and preventative, can help mitigate against the barriers, obstacles and challenges faced by children their caregivers and families. This model has four components that include 1) training on FASD, 2) Children with FASD in Need: Critical Supports, 3) Placement Stability, and 4) Intervention Strategies – Support Connections, Compliance & Competencies.
Protective Case Planning for Children in Care with FASD Through Advanced Training and Case Consultation: A Four-Point Model

Model 1: Training on FASD and Child Welfare Practice

Key Points on Supporting Case Planning through Advanced Training and Case Consultation

- Learning occurs on a continuum and the three key points in the left hand column, basic training, advanced training and case consultation are the foundations to casework responses in practice responses to children and families living with FASD.
- The expectation in this type of training model is that learning on challenges and complexities for children and families is grounded in real casework scenarios. Providing a foundation and then adding layers of complexity supports a deeper understanding of the needs of children, families, caregivers/foster parents and other systems such as education. Awareness of advocacy as an intrinsic component of casework practice for children with FASD is highlighted.
- With each training activity, moving from basic to advanced; the learning is translated to knowledge, and a framework for FASD informed practice is developing. An FASD informed practice perspective is transformational and shifts casework practice and supervision.
Model 2: Children with FASD in Need: Critical Supports

Key Points on Critical Supports

- A child in care with FASD is a child that requires structured, intentional case planning to meet their needs and challenges at home, at school and in the community.
- The child with FASD is at the centre and different systems are wrapped around the child. For children in care, all professionals involved from different systems should agree on common goals and interventions, with consistency across environments from an FASD informed perspective. Foster care placements require ongoing support, contact and respite in order to support the placement.
- Children with FASD are socially vulnerable and proactive planning and the child's supervision needs must be worked out through communications and strategic planning that includes everyone. The support system for this child must adapt their practice to respond to the needs of the child.
Model 3 – Placement Stability Supports

Key Points on Placement Stability

- A child in care with FASD requires a structured and caring foster home. A primary goal is supporting placement stability. It is important from an FASD informed perspective to keep placements to a minimum with no more than two children with FASD placed in one home.

- Placement stability where the child lives is the essential foundation for building a support system and caring framework for a child. Anecdotally, it was discussed at the advanced training that the child’s first placement is often the longest. In the case scenarios it appears that once a placement breaks down, the risk of a series of breakdowns may follow.

- Supporting the foster home through proactive/preventative planning aimed at placement stability. Such stability has an impact on the life trajectory of the child.

- Communication, respite and training activities that create support in a foster home placement. Placement stability is created through supporting the needs of the foster parents in caring for children with FASD.

- Supporting placements from a disability and FASD informed perspective, recognizing and appreciating the challenges of day-to-day life at home for foster parents, is an important facet of placement stability.
Key Points on Connection, Compliance and Competencies

- A child in care with FASD has multiple challenges related to their neurological (brain based) problems that often present as behavior problems. From an FASD informed perspective these constructs are inter-related. Making a connection helps to create compliance with children through relationships in the home and with the caseworker. Compliance is about responding to requests, follow-through and requires support. If a child is supported to follow through on a request, a sense of competency develops. While this seems like a basic construct, it provides a critical foundation in relationships within a home. When a child develops and feels a sense of competence (with support) this leads to greater compliance. Compliance supports developing relationships as it is grounded in getting along with others.

- Participants in this training identified the three C’s – compliance, competency and connections as a helpful model to understand basic relationship dynamics for children with FASD.

Discussion on a Four Point Model Supporting Children in Care with FASD

**Model 1** presents *Training on FASD and Child Welfare Practice*, **Model 2** presents *Child with FASD in Need and Critical Supports* and **Model 3** presents *Placement Stability* and **Model 4** presents *Intervention Strategies – Support Connections* that focuses on competencies and compliance. These four models were developed from research on the training model delivered
through the initiative, *FASD CoP: Leading from Within* that took place in 2012 - 2013 and was developed by Donna Debolt, an FASD consultant and trainer. Model 4 that Donna proposed offers some insight into working with children in relation to intervention strategies and were highlight by participants in their responses relation to *Connection, Compliance and Competencies*.

The reason that creating competencies through utilizing supports and strategies with children with FASD is that they face multiple challenges. When children do not have a connection they are far less likely to be compliant with the foster parent, the teacher and others. Children who feel like they have mastered a skill have far more confidence when they feel competent and can share this success with others. A critical piece of support and casework is to support creating environments that are structured and contribute to children building confidence and feeling competent across different environments. Given the high stigma and challenges faced by children and their families living with FASD, this is a critical part of support. Ongoing engagement, communication and involvement with the child by the caseworker help provide a deeper understanding of the needs of the child and the caregivers. Training for casework supervisors and regional managers supports the notion that everyone working with this child, one way or another, is working from the same page in terms of developing, engaging and maintaining supports.

Training on FASD needs to evolve as we learn more from biomedical science as well as through social science. The most basic need that all caseworkers have is an understanding of the population they work with, and to receive training that provides understanding of the characteristics and needs of children involved with the child welfare system, and to receive
casework supervision. Those activities offer a basic place to begin. What is known about working with children and families where FASD is a concern, is that there are often intergenerational issues, challenges with substance abuse, addictions, family violence and often, children from these homes end up in care. When children with FASD come into care, they need a workforce that is FASD informed and understands, how best to meet their needs. In child welfare casework practice for children with FASD, appreciating a disability context is crucial to planning and intervention.

Recognizing that FASD is a disability that stays with a child for their lifetime, and an appreciation that decisions made early in the child’s life when in care, requires engaging the supports, resources and services to support placement stability. A stable, caring supportive foster home is often the best resource a child with FASD will have over their lifetime. As the high needs of children with FASD become more deeply understood, casework practice begins to shift to a perspective that is FASD informed, a key construct emerging from this initiative. In accordance with the Year Five Evaluation of the FASD 10 Year Strategic Plan in Alberta (Government of Alberta, 2013), Outcome 3 directly indicates that individuals living with FASD and their caregivers need to be part of coordinated services that support their needs. Having an FASD informed workforce in the CFSAs directly supports the connections between systems and provides linkages to the community in new ways. The FASD CoP Leading from Within courses are directly aligned with the FASD 10 Year Strategic Plan in Alberta. The need for Protective Case Planning for Children in Care with FASD emerged from an innovative course offered by Workforce Development, and serves as a model for excellence in practice with vulnerable children and families.
Recommendations from the FASD CoP Leading from Within Initiative

• Provide training opportunities on FASD for Human Services staff delivering child welfare services using the FASD CoP Leading from Within Initiative that are directly practice focused and based on a model of protective case planning.

• Include case consultation as an essential component of training as this serves to identify needs, complexities, identify trajectories, benefits of interventions, and facilitates planning from a comprehensive perspective.

• Create a compendium of emerging research on complex case management, challenges in foster care and best practice in order to support the creation of brief knowledge translation products for the Children and Family Service Authorities about current research and best practice on a quarterly basis.

• Engage in knowledge dissemination and mobilization about this model of learning across inter-provincial child welfare authorities and systems to support best practice for children and youth in care with FASD.

• This initiative is in alignment with the Year Five Evaluation of the FASD 10 Year Strategic Plan in Alberta, Outcome 4: Service providers and families/caregivers have knowledge of and access to training and educational resources that are based on research and leading practices. Access to training for services providers as defined in the FASD COP Leading from Within Initiative included casework supervisors and regional managers. Similar training should be available across the sector and training opportunities offered to foster parents and caregivers. Further, create opportunities for dialogues between foster parents and caseworkers about day-to-day life with a child with FASD.

• Through strategic planning, a list of competencies that contribute to FASD and disability informed practice in child welfare must be developed, designed and utilized as a training platform for ministry staff. Levels of training and opportunities for frontline, supervisory and management staff are important to identify that relate to best practice, case management and the critical function of supporting placement stability in foster and group care.

• While much innovative case planning occurs for children with FASD in care, the need exists to promote the publication of such strategies and to share this work nationally and internationally. Models of excellence in practice need to be shared amongst child welfare authorities that work with highly vulnerable children and families to promote best practice.
References


Appendices
### Appendix I

**Project Timeline and Deliverables**

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<th>Activity</th>
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<tr>
<td><strong>FASD CoP Meetings</strong></td>
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<tr>
<td>January 23, 2013 – FASD-CMC Strategic and Operational Planning</td>
</tr>
<tr>
<td>March 25, 2013</td>
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<tr>
<td>May 23, 2013 - FASD-CMC Strategic and Operational Planning</td>
</tr>
<tr>
<td><strong>Training Events with Donna Debolt</strong></td>
</tr>
<tr>
<td>Course 1: <em>Fetal Alcohol Spectrum Disorder – Level One: Solutions through Case Management</em> (January 21-22, 2013)</td>
</tr>
<tr>
<td>Course 2: <em>Fetal Alcohol Spectrum Disorder- Level Two Advanced</em> (February 4, 2013)</td>
</tr>
<tr>
<td>Course 3: <em>Fetal Alcohol Spectrum Disorder: Team Competency and Screening</em> (February 5, 2013)</td>
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<tr>
<td>Other activities within the FASD CoP Iteration III included additional case consultation days</td>
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<tr>
<td><strong>Case Consultation Training Days with Donna Debolt</strong></td>
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<tr>
<td>Feb 25/26th</td>
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<tr>
<td>March 11/12</td>
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<tr>
<td>April 4/5th</td>
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<tr>
<td>Six days were designated in this project for case consultation to review cases and provide opportunities for the FASD CoP team members (participants in the project) to observe, participate at the consultation table and engage in discussions including a debriefing after each day on the three cases reviewed that day. A total of 18 cases were set for review/case consultation. The case consultations included FASD CoP team members (observers), foster parents (caregivers), schools/educators, community partners such as mental health practitioners, community based organizations/agencies working with child or youth, and probation workers. The case plan review had a specific focus on understanding the developmental needs of the child/youth that were being reviewed.</td>
</tr>
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</table>
Appendix II

Terms of Reference
TERMS OF REFERENCE

CFSA FASD Community of Practice (CoP): Leading from Within

Purpose:
To integrate findings from research/evaluations in the area of Fetal Alcohol Spectrum Disorder (FASD) into child intervention practice.

Background:
- FASD describes a cluster of birth defects caused by prenatal exposure to alcohol. FASD is a life-long disability and those affected by FASD may require supports at all life-stages.
- Since 1996, various provincial government departments and agencies have been actively involved in the prevention of alcohol-related birth defects and support of individuals affected by pre-natal exposure to alcohol.
- In 2003, the Alberta FASD Cross-Ministry Committee (FASD CMC) was formed with the mandate to act as the primary vehicle to support a collaborative approach to plan and deliver provincial government programs and services associated with FASD.
- The FASD CMC developed a 10-Year FASD Strategic Plan that was signed by the 10 partnering Ministers and approved by the Standing Policy Committee on Health and Community Living in September 2006.
- In 2007/08, $4 million in funding was secured to begin implementation of the Strategic Plan. This funding was used to develop the FASD Services Network Program across the province. Since 2008/09, $16.5 million has been allocated annually to further support the implementation of the Strategic Plan.
- In addition to provincial FASD initiatives and programs, partnering Ministries have used proportioned funding received under the Strategic Plan to implement a number of Ministry-specific FASD initiatives. Beginning in 2009/10, there has been $600,000 allocated to the Ministry of Human Services for Ministry-specific initiatives.
- Beginning in 2009, the CFSA FASD CoP project was undertaken in order to bring together stakeholders (caseworkers, foster families, community agencies and partners, etc.) to improve outcomes and placement stability for children in care who are diagnosed or suspected of having FASD.
- Alberta is also a member of the Canada Northwest FASD Partnership (CNFASDP). In the fall of 2004, the CNFASDP established the Canada Northwest FASD Research Network to foster an evidence base that would inform the rapid expansion of policy and program development in this field.
**Membership:**

**Chairs:**
- Denise Milne, FASD Program
- Sharon Long, Child and Family Services Division

**Members:**
- Brenda Burton, Region 1
- Vacant, Region 2
- Val Naslund, Region 3
- Brent Ochsner, Region 4
- Larry Gazzola, Region 5
- Mary Berube, Region 6
- Bonda Thompson, Region 7
- Tina Hackett-Miles, Region 8
- Trudy Cockerill, Region 9
- Shannon Ballas, Region 10

**Ad hoc:**
- Donna Debolt, Consultant
- Carol Arnold-Schutta/Troy Cunningham, Workforce Development

**Mandate:**
1. The CoP, to determine how best to integrate the key findings from research/evaluations into child intervention practice.
2. To make recommendations and forward for approval.
3. To oversee the implementation of the approved recommendations.
4. To evaluate the strategies implemented to ensure alignment with identified outcomes.
5. To share information with the FASD CMC regarding decisions made by the CoP in order to explore opportunities to leverage/integrate with other initiatives and provide required reporting.
6. To provide advice on any proposed new FASD initiatives related to children, youth and families involved with Child Intervention Services.

**Reporting Relationship:**
The CFSA FASD CoP reports to the Assistant Deputy Ministers of Disability Services and Child and Family Services Division. The CFSA FASD CoP also has a reporting relationship to the FASD CMC and is required to provide a report each year.

**Decision Making:**
Decisions on recommendations will be made by consensus. Approval will be sought at the appropriate level as determined by the Chairs in consultation with the ADMs.

**Frequency of Meetings:**
Meetings will be arranged as required.
Appendix III

Training Process of the FASD CoP Leading from Within (2012-2013)
Appendix III - Training Process of the FASD CoP Leading from Within (2012-2013)

CFSA – FASD Community of Practice Initiative: Leading from Within

The CFSA FASD Leadership Program is being designed to enhance participants’ FASD knowledge and skills and to build capacity to serve those with FASD. With only 16-18 participants at a time, the smaller group size optimizes individuals’ participation and learning. The 10-day program infuses classroom training with real case consultation and post-Certificate strategies that aim to strengthen relevant CFSA staff in the areas of FASD screening and service delivery. Participants can go on to facilitate FASD training within and outside their organizations, provide consultation (e.g. colleagues, caregivers, professionals within their communities), and advocate for the needs of individuals affected by FASD (at individual, agency, and systems levels).
Appendix IV

Key Informants Survey on the FASD CoP Initiative: Leading from Within
Appendix IV

Key Informant Survey: FASD COP Initiative: Leading from Within Initiative

Instructions: Please fill out your responses with as much detail as possible at the end of training and return to the presenter. Please put an x beside other responses. Please return these forms to the project researcher, Dr. Dorothy Badry, 2500 University Drive NW, Calgary, AB T2N 1N4 or by e-mail: badry@ucalgary.ca. Please identify the subject line as 2013 FP survey if you send by e-mail.

Survey Questions

1. What have you learned in the advanced training in the FASD Community of Practice Leading from Within Initiative (LWI) in relation to your knowledge and skill development with clients with FASD?

2. What have you learned in the advanced training in the FASD Community of Practice Leading from Within (LFW) Initiative in relation to your knowledge and skill development with clients with FASD?

3. Do you feel more confident in your leadership in responding to casework scenarios about clients with FASD? ___ Yes ___ No

4. If yes, can you explain how this training has been helpful in developing your leadership and confidence in response to the needs of children in care with FASD?

5. What will you change in your practice as a result of participating in the FASD CoP LFW training initiative?

6. Has the case consultation process enhanced your learning?
   ___ Strongly Agree
   ___ Agree
   ___ Not sure
   ___ Disagree
   ___ Strongly Disagree

7. Was the inclusion of a consultant from the Education system helpful?
   ___ Strongly Agree
   ___ Agree
   ___ Not sure
   ___ Disagree
   ___ Strongly Disagree

8. How would you rate the experience of sitting at the table and participating in the case conference process directly?
9. What aspects of the case conference process were most helpful to you?

10. What key training needs about FASD would you identify as important in supporting your practice for children in care? Please share any specific learning or take away message from this process that you think is important to share with others in engaging in practice with children/youth and caregivers in relation to FASD.
Appendix V

Brief Survey with Key Informants on the FASD CoP Initiative: Leading from Within
Appendix V

Brief Survey with Key Informants on the FASD CoP Initiative: Leading from Within

The focus of this open-ended questionnaire is on the following three activities:

1. FASD Team Competency and Screening
2. Level One FASD - Solutions Through Case Management
3. Level Two Advanced – FASD - Solutions Through Case Management

Evaluation Questionnaire

Introduction

As a participant in the FASD Community of Practice (CoP) your input is important in developing an understanding how this experience (training and case consultation) has informed your current practice for children you support in your region. Please answer the following questions as comprehensively as you can. This is a qualitative survey and the questions are open ended.

Please identify the training that you attended by placing an x in the box before each activity.

1. What difference has advanced training made in your practice with children with FASD?
2. What have you learned through participation in this project? Please identify and explain the impact of advanced training on leadership.
3. How do caseworkers and supervisors define leadership in responding to the needs of children/youth with FASD on caseloads?
Appendix VI

Case Consultation/Case Plan Review Purpose, Process and Sharing Information
Appendix VI

Case Consultation/Case Plan Review

Prepared by Donna Debolt

Purpose of the case conference review:
1. Reporting to the Case Review Committee is simply a meeting of the team responsible for the care of the child. This team consists of all key players and invited “specialists”.
2. The draft case plan is presented with a clear picture of the assessment and the agreed upon plans designed to minimize risk and enhance permanency planning.
3. Case Plan Review increases the circle of influence, provides “training” and advocacy and expands skills and knowledge beyond the case manager’s capacity.
4. Case Plan Review understands the concept of “collective wisdom” and can support the “trends” of resource issues/needs.

In finalizing the plan we hope to:
1. Ensure that the plan is based on current research and effective practice.
2. Include a variety of approaches in intervention that are geared to the specific needs of the child/family.
3. Base all recommendations on a comprehensive assessment.
4. Guarantee that the case plans are supported by a multidisciplinary team that includes caregivers.
5. Ensure that it is reflective of the person with FASD’s individual needs.
6. Provide outcome-based information to our funders and community and government partners.
7. Support the concepts of “cross training” and shared “work”.

Case Consultation Process
1. There will be 1.25 hours allotted, for each consultation unless more time is anticipated and arranged for. The session will be chaired and co-chaired by the Social Work Consultant and the child’s social worker.
2. The participants will include all individuals responsible for the care of the child and will always include but not be limited to: the child’s social worker, the parents/caregivers, the school, respite care providers, program personnel and potential service providers.
3. The format will include summarizing what we know about the child, what that information means within the context of the disability and how that influences what we do or what we need to do.
4. A report will be prepared to summarize the activities and outcomes of the case plan review process.

Sharing Information appropriately means
- Improved assessment of client’s needs
• Shared goals and objectives
• Progress and case goals are shared
• Agencies do not work at cross purposes
• Agencies do not make conflicting demands
• Agencies do not undermine each other’s efforts
• Resources are used efficiently
• There is no duplication of service
Appendix VII

Knowledge Dissemination
Appendix VII

Knowledge Dissemination

It is important to share findings on projects that support translating knowledge to practice. This abstract submitted and accepted to the Alberta FASD Conference – November 19 & 20, 2013 in Calgary, AB.

Website Address for the Alberta FASD Conference 2013:


The implementation of advanced case consultations as a means of training casework supervisors, caseworkers, foster care supervisors and regional management is a recent innovative course offered by Workforce Development of Alberta Human Service in 2013. Each region that provides services in Child and Family Services Authorities (CFSAs) has engaged in specific training that is accredited by the ministry, as well as the Alberta College of Social Workers (ACSW). Formal case consultations on complex cases of children in care with a Fetal Alcohol Spectrum Disorder (FASD) include the caseworker as primary presenter, community partners, educational system representative, caregivers and regional representatives who formally participate around a table. This approach involves a learning circle, is structured in such a way to provide immediate learning and offers collective wisdom in advanced case management. This presentation will highlight the process, benefits of training and will offer encouraging research evaluation results.
Appendix VIII

Workforce Development: Fetal Alcohol Spectrum Disorder Course Descriptions
FETAL ALCOHOL SPECTRUM DISORDER - LEVEL ONE SOLUTIONS THROUGH CASE MANAGEMENT

Overview
Fetal Alcohol Syndrome and its related effects are disproportionately over represented in children and families needing service from Child Welfare. Critical case management errors can happen when the system fails to consider the possibility of FASD in the child, its long-term ramifications and also fails to consider the possibility that the parent(s) may be compromised by this birth defect as well. Even minimal, hard to diagnose brain damage can cause significant problems due to adaptive handicaps. Traditional case management practices and beliefs are often unsuccessful and measured outcomes inappropriate. This training will examine the case management needs of affected children and their families and will propose a framework for practice.

Target Audience / Human Services and DFNA Child Intervention Staff / Intermediate Level

Content Level

Course Objectives: Participants will learn to:
1. Recognize the presentation of Fetal Alcohol Spectrum Disorder in their practice.
2. Understand how children, adolescents, and adults with Fetal Alcohol Spectrum Disorder interface with the child intervention services system.
3. Make case plan decisions, within the framework of “best practice” with Fetal Alcohol Spectrum Disorder.
5. Create performance through concurrent planning and management placement disruptions

Note: Human Services, Workforce Development, provider #1132 is approved as a provider for social work continuing education by the Association of Social Work Boards (ASWB) www.aswb.org through the Approved Continuing Education (ACE) program. Human Services, Workforce Development maintains responsibility for the program. ASWB approval period: May 19, 2013

Social Workers participating in this training will receive a certificate noting 12 continuing education clock hours that can be used for Alberta College of Social Workers, Category A credit.

Time: 2 day course from 8:30 a.m. to 4:30p.m

Dates & Locations: January 21-22, 2013 Edmonton

Facilitator: Donna Debolt, B.S.W., R.S.W.

Cost: Human Services and DFNA Employees – No Cost

Registration Info: Participants will be manually enrolled into each session by Workforce Development

Inquiries: If you have a concern or disability please contact Workforce Development by email: cs.training@gov.ab.ca or Phone: (780) 427-7754

Certificates: Upon successful completion of the classroom training, attendance record verification and confirmation on the participant’s OLE account the certificate will be available from the My Training Records page of your OLE account.
FETAL ALCOHOL SPECTRUM DISORDER - LEVEL TWO ADVANCED

Overview

This is an advanced workshop for those staff who have completed the FASD One-Intermediary workshop. Participants will be given an opportunity to learn how to plan for children and youth with FASD and to recognize the impacts that the development trajectory of FASD has on case planning.

Target Audience / Human Services and DFNA Child Intervention Staff / Intermediate Level

Content Level

Prerequisite This is a follow up to FASD Level One and cannot be taken without completing the FASD – Level One course first.

Course Objectives: Participants will learn to:
1. Create a framework for practice through case planning strategies specific to FASD.
2. Shift thinking from a behavioral to a brain-based focus for intervention.
3. Recognize the importance of collaboration in influencing systemic change.
4. Case manage the developmental trajectory of this disability which often compromises placement stability.
5. Increase short term effectiveness of interventions through reduced frustration, decreased professional burnout and improved outcomes for children and families.

Note:
Human Services, Workforce Development, provider #1132 is approved as a provider for social work continuing education by the Association of Social Work Boards (ASWB) www.aswb.org, through the Approved Continuing Education (ACE) program. Human Services, Workforce Development maintains responsibility for the program. ASWB approval period: May 19, 2013. Social Workers participating in this training will receive a certificate noting 6.5 continuing education clock hours that can be used for Alberta College of Social Workers, Category A credit.

Time:
1 day course from 8:30 a.m. to 4:30p.m

Dates & Locations: February 4, 2013 Edmonton

Facilitator: Donna Debolt, B.S.W., R.S.W.*

Cost: Human Services and DFNA Employees – No Cost

Registration Info: Participants will be manually enrolled into each session by Workforce Development

Inquiries: If you have a concern or disability, please contact Workforce Development by email: cs.training@gov.ab.ca or Phone: (780) 427-7754

Certificates: Upon successful completion of the classroom training, attendance record verification and confirmation on the participant’s OLE account the certificate will be available from the My Training Records page of your OLE account.
FETAL ALCOHOL SPECTRUM DISORDER
Team Competency and Screening

Overview
The FASD (Fetal Alcohol Spectrum Disorder) Community of Practice Initiative (Leading from Within) is a 10-day classroom series designed to enhance participants’ knowledge and skills regarding FASD and to build capacity to serve those living with FASD. The FASD Team Competency and Screening training is the fourth day of the FASD Community of Practice Initiative (Leading from Within) training. It is preceded by FASD Level 1 Solutions through Case Management and FASD Level 2 Advanced training and builds upon the learning completed in these trainings. This one-day classroom training focuses on creating team competency and screening for FASD in Child Intervention practice. Children, adolescents and adults with FASD have multi-faceted medical, psychological and social needs. The Team Competency portion of this session will explore the techniques and tools used to collaborate with and coordinate a team approach that is user friendly and promotes stability for children and adults affected by FASD. This portion will also challenge participants to move from a behaviourist approach to a neurobehavioral perspective of FASD in order to reduce frustration, expand options, and establish informed networks of care with congruent application of the brain-based approach. The diagnosis of an alcohol related disability requires confirmation of prenatal alcohol and substance exposure. The screening portion of this session will explore techniques and tools that will assist in becoming an efficient and effective professional partner in this important diagnostic step.

Target Audience / Human Services and DFNA Child Intervention Staff / Intermediate Level
Content Level

Prerequisite
This is a follow up to FASD - Level One and FASD - Level Two.
This course CANNOT be taken without completing FASD - Level One and FASD - Level Two first.

Course Objectives:
The participant will:
1. Learn to create plans as a multidisciplinary team that are based on current research and effective practice including a variety of approaches in intervention with recommendations based on a comprehensive assessment.
2. Be able to provide outcome-based information to Human Services and partners.
3. Understand the complexity of the diagnostic process and how to effectively evaluate and consolidate file history in order to gather the information that is needed by the physician to support the diagnostic standard for FASD.
4. Understand that other diagnosed conditions can mislead good “promising practice” within the intervention framework for alcohol related disabilities and explore patterns of learning and behavioural problems which may be related to alcohol exposure.
5. Learn the use of specific tools and techniques to facilitate the best outcomes for the assessment of risk process.

Note:
Human Services, Workforce Development, provider #1132 is approved as a provider for social work continuing education by the Association of Social Work Boards (ASWB) www.aswb.org, through the Approved Continuing Education (ACE) program. Human Services, Workforce Development maintains responsibility for the program. ASWB approval period: May 19, 2013. Social Workers participating in this training will receive a certificate noting 6.5 continuing education clock hours that can be used for Alberta College of Social Workers, Category A credit.
Social Workers participating in this training will receive a certificate noting 6.5 continuing education clock hours that can be used for Alberta College of Social Workers, Category A credit.

**Time:**
1 day course from 8:30 a.m. to 4:30 p.m.

**Dates & Locations:**
February 5, 2013

**Facilitator:**
Donna Debolt, B.S.W., R.S.W.*

**Cost:**
Human Services and DFNA Employees – No Cost

**Registration Info:**
Participants will be manually enrolled into each session by Workforce Development

**Inquiries:**
If you have a concern or disability please contact Workforce Development by email: cs.training@gov.ab.ca or Phone: (780) 427-7754

**Certificates:**
Upon successful completion of the classroom training, attendance record verification and confirmation on the participant’s OLE account the certificate will be available from the My Training Records page of your OLE account.
FETAL ALCOHOL SPECTRUM DISORDER
Consultation - Days One through Six Overview

The FASD (Fetal Alcohol Spectrum Disorder) Community of Practice Initiative (Leading from Within) is a 10-day classroom series designed to enhance participants’ knowledge and skills regarding FASD and to build capacity to serve those living with FASD. The FASD Consultation days are the fifth through tenth days of the FASD Community of Practice Initiative (Leading from Within) training. It is preceded by FASD Level 1 Solutions through Case Management, FASD Level 2 Advanced training and FASD Team Competency and Screening and builds upon the learning completed in these trainings.

In the 6 days of FASD Consultation training participants will observe the facilitator lead consultations on real cases followed by the participants leading consultations with the facilitator’s support. Each day will be structured to include 3 real case consultation and time for reflecting and discussion of skill development. The themes of collaboration, coordination and effective intervention will be foundational to this training. Collaboration allows for service providers to meet a broader range of family needs. The case planning process allows participating stakeholders to better coordinate their efforts and ensure that they neither overwhelm individuals and family with requirements nor impose conflicting demands. The learning will enable a more effective use of limited resources and help prevent inefficient parallel program development.

**Target Audience / Content Level**

Human Services and DFNA Child Intervention Staff / Intermediate Level

**Prerequisite**

This is a follow up to FASD - Level One, FASD - Level Two and FASD Team Competency and Screening. This course CANNOT be taken without completing the courses listed above first.

**Course Objectives:**

Through observation, participation and the mentorship provided by the facilitator the participants’ skills and understanding will be developed in the following:

1. In the context of case consultation the participants will be able to utilize a variety of approaches for interventions and supports that are geared to the specific needs of the child/family.
2. Participants will be able to develop recommendations that are based upon a comprehensive assessment, current research and effective practice.
3. Participants will learn how to effectively coordinate and collaborate within consultations to create plans that are supported by a multidisciplinary team that includes caregivers.
4. Participants will be able to ensure that plans are reflective of the affective Individual’s needs.
5. Participants will be able to provide outcome-based information can be provided to community and government partners and support the concepts of “cross training” and shared work.

**Note:**

Human Services, Workforce Development, provider #1132 is approved as a provider for social work continuing education by the Association of Social Work Boards (ASWB) www.aswb.org, through the Approved Continuing Education (ACE) program. Human Services, Workforce Development maintains responsibility for the program. ASWB approval period: May 19, 2013. Social Workers participating in this training will receive a certificate noting 6.5 continuing education clock hours that can be used for Alberta College of Social Workers, Category A credit.
Social Workers participating in this training will receive a certificate noting 6.5 continuing education clock hours that can be used for Alberta College of Social Workers, Category A credit.

**Time:**
6 day course from 8:30 a.m. to 4:30 p.m.

**Dates & Locations:**
Day 1 & 2 – February 25-26, 2013  
Day 3 & 4 – March 11-12, 2013  
Day 5 & 6 – April 4-5, 2013

**Facilitator:**
Donna Debolt, B.S.W., R.S.W.*

**Cost:**
Human Services and DFNA Employees – No Cost

**Registration Info:**
Participants will be manually enrolled into each session by Workforce Development

**Inquiries:**
If you have a concern or disability please contact Workforce Development by email: cs.training@gov.ab.ca or Phone: (780) 427-7754

**Certificates:**
Upon successful completion of the classroom training, attendance record verification and confirmation on the participant’s OLE account the certificate will be available from the My Training Records page of your OLE account.