



Infant Adoption Training Initiative

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*Understanding Infant Adoption
By Spaulding For Children*

Trainer Guide

UNDERSTANDING INFANT ADOPTION (UIA 6)



Funded through the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #90CO1135. The contents of this material do not necessarily reflect the views or policies of the funders, nor does mention of trade names, commercial products or organizations imply endorsement by the U.S. Department of Health and Human Services. This information is in the public domain.

In Acknowledgement

Spaulding for Children would like to acknowledge and thank the many trainers, faculty members and other content experts who provided guidance and feedback about the revisions to the Understanding Infant Adoption (UIA) Curriculum. Special thanks to project partners Harmony Family Center and Public Research and Evaluation Services for their ongoing collaboration in the implementation and evaluation of the UIA curriculum.



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The Understanding Infant Adoption (UIA 6) Curriculum is comprised of six modules designed to educate health care and helping professionals and enhance their ability to provide adoption information and referrals to pregnant women, teens, and men, who are experiencing an unplanned/unintended pregnancy. The curriculum was revised and updated through a grant project funded by the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #90CO1135. Project partners included Spaulding for Children, Harmony Family Center and Public Research and Evaluation Services.

The intention of this training program is to ensure not only that expectant parents have adoption information presented with other options, but also to ensure that pregnant women who wish to place a child for adoption have access to well-trained staff and comprehensive supports in hospital settings throughout the adoption process.



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EXECUTIVE SUMMARY

The goal of the Understanding Infant Adoption (UIA) training is to enhance the ability of health care and helping professionals to provide adoption information and referrals to pregnant women, teens, and men, who are experiencing an unplanned/unintended pregnancy. The intention of this training program is to ensure not only that expectant parents have adoption information presented with other options, but also to ensure that pregnant women who wish to place a child for adoption have access to well-trained staff and comprehensive supports in hospital settings throughout the adoption process.

In July of 2001, a notice and request for proposal was issued by the U.S. Department of Health and Human Services (HHS) to develop and implement an “Infant Adoption Awareness Training Program” (IAATP). Spaulding for Children was awarded the grant for the 2001 to 2004 period. Over the 10+ years that followed, additional grants were awarded to Spaulding for Children and Understanding Infant Adoption curriculum was developed and refined over those years. Most recently, in July of 2017, a notice and request for proposal was issued by HHS to develop and implement a Hospital Based Adoption Support and Services (HBASS) program. Spaulding for Children partnered with Harmony Family Center and Public Research and Evaluation Services (PRES) on a proposal which was funded for a total of 33 months between October 2017 and September 2020.

The UIA curriculum was updated as part of the activities of the HBASS program to include current issues in infant adoption and trauma-informed care principles. In addition, a new module was added to provide more detailed information to help hospital staff and administration learn about best practices and policies relating to adoption. The new module contains a tool that hospitals can use to guide a review of their current policies, identify areas of strength, and highlight gaps that may exist.

A live pilot test of UIA 6 took place in October 2019 in Louisiana. Feedback was provided by the trainer regarding gaps or suggestions. The UIA 6 curriculum revision process also included triangulated data from a number of trainers and faculty members. To ensure that the revised UIA 6 curriculum is aligned with Best Practice Guidelines from the Infant Adoption Awareness Training Program (IAATP), a Best Practice Checklist was developed and then adapted into a form that was distributed to reviewers. Based on the feedback of both groups (faculty and trainers) it was determined that UIA 6 is well aligned with and is applicable to the needs of hospital-based staff.

INTRODUCTION

BACKGROUND INFORMATION

Unintended pregnancies are a significant occurrence in the United States. Around 45% of the 6 million annual U.S. pregnancies are unintended (Guttmacher, 2016). Research has shown that unintended pregnancies can have long-term implications for children and parents.

Births resulting from unintended pregnancies are associated with adverse maternal- and child- health outcomes such as delayed pre-natal care, premature birth, increases in the neonaticide rate (the killing of infants within 24 hours of birth) (Kaplan, 2014), and negative physical and mental health effects for children. In 2015, 65% of pregnancies nationwide resulted in live births (Center for Disease Control and Prevention, 2014). However, in 2014 only 0.5% of infants born were released and placed with adoptive families compared to an estimated 18.9% of pregnancies that ended in abortion, miscarriages excluded (Guttmacher Institute, 2016). This data suggests mothers may not be fully advised of the adoption option.

Hospital staff often serve as the first and only opportunity for expectant mothers to receive family planning information, making it critical for medical professionals to be aware of adoption information and agencies within their area so they can refer parents interested in learning more about adoption. Based on research done by the Guttmacher Institute (Guttmacher) and the Center for Disease Control and Prevention (CDC), unplanned pregnancy is one of the primary reasons women seek options counseling. However, hospital staff often do not have access to adoption information nor are they aware of resources that exist within their community. The sheer number of hospitals nationwide makes it difficult to ensure all staff are aware of adoption information. Currently, there are 6,146 registered hospitals in the U.S. (American Hospital Association, 2020). Some urban hospitals offer Centers for Family Planning, which provide an array of pregnancy services; however, most hospitals nationwide have no specialized family planning centers. Thus, it is critical that information about adoption be readily accessible to medical professionals and that connections with adoption experts are made so staff can continuously receive adoption information. This will help ensure that families experiencing unplanned pregnancies receive support and comprehensive information on the options available. While hospitals are where patients come for healing, they also present a perfect setting for learning. For these reasons, hospitals must cultivate trained staff who are knowledgeable on all options including adoption and who can present the information in a non-coercive and non-directive manner.

ISSUES FACED BY PREGNANT WOMEN AND EXPECTANT MOTHERS

Most expectant parents contemplating adoption find themselves responding to an unplanned pregnancy. Often, they are not in a committed/stable relationship and are unable to cope with the responsibility that comes with raising a child as a single parent. Some married couples consider adoption because they are unable to financially support the child. Many expectant parents considering relinquishing their child because they believe the child will have a better life in an adoptive home. Other reasons include family/societal pressure, personal goals, and socioeconomic situations.

Parents exploring options for their unborn child often experience a roller coaster of emotions including denial, anger, guilt, frustration, sadness, anxiety, shame, relief, and joy, which will not disappear after they decide to make an adoption plan. In fact, these emotions will likely continue and even intensify as

they work through the process. No matter how sure expectant parents may seem of their plan for adoption, they often struggle with the decision. They may receive lower levels of sympathy and support because their loss is viewed as a choice. Their complex emotions can be overwhelming to hospital staff, especially if staff do not have specific training on how to best support expectant parents and are not aware of the potential supportive resources that exist within their community. Navigating through these intense emotions requires training and knowledge of resources available to support the expectant parents' decision.

SPECIAL CONSIDERATIONS WITH TEENAGE PREGNANCY

Teenagers account for around 20% of unintended pregnancies in the U.S. (CDC, 2014). In 2014, 249,078 babies were born to adolescent females between the ages 15-19. That represents 24.2 births for every 1,000. In 2014, 1 in 6 births (17%) of those aged 15-19 were to females who already had one or more babies. Statistics reveal that women who became pregnant as teenagers are often at risk of economic and social disadvantages for the rest of their lives. Teen mothers are more vulnerable to health problems due to lack or delayed onset of prenatal care, poor nutrition, pre-term delivery fetal distress, low birth weight babies, and other problems associated with bearing children at an early age. Teens tend to have unrealistic views about how much help and support they will get from the baby's father, extended family, friends, and the welfare system. Research shows that pregnant teens present unique challenges to hospital staff because of their young age, developmental and maturity level, "minor" status, tendency to be easily influenced, family/friend pressures, and unrealistic expectations about parenting and extent of support needed.

TRAINING AND TECHNICAL NEEDS OF HOSPITAL-BASED STAFF

When expectant parents approach hospital staff regarding making an adoption plan, they believe staff are knowledgeable and capable of helping them make an informed decision. However, most hospitals specialize in treating acute/chronic illnesses and injuries, and staff are not equipped with the infant adoption information necessary to support families considering relinquishing their babies. Staff working in hospital settings typically have limited knowledge on adoption and minimal opportunities to examine their role in the complex issues of biases related to unplanned pregnancies. This puts staff at risk for providing incomplete or inaccurate information and making unintentional, insensitive missteps, which can inadvertently distress or alienate parents. Hospital staff play a critical role in providing support to expectant parents exploring options. These professionals are trained to consider the unique circumstances and perspectives of expectant parents, they are more likely to show empathy toward them and be better equipped to empower decision making based on accurate, fact-based, and unbiased information.

WHAT IS THE BENEFIT OF THIS CURRICULUM?

Women who find themselves with an unplanned pregnancy are under a great deal of stress (Guttmacher Institute, 2016). The hormonal changes and emotional rollercoaster they may feel about the pregnancy makes them vulnerable. Some women may not disclose the pregnancy to family/friends, making it more difficult to obtain support/assistance. They may turn to hospital staff for direction/assistance in understanding available options. Staff who have received training and are aware of adoption resources existing within their community will be more comfortable providing adoption information and referrals on an equal basis with all other courses of action included in nondirective counseling. This can help expectant parents consider all options so they can make informed decisions. Even if parents decide not to pursue adoption prior to delivery, it provides an option they can consider post-birth. Providing adoption information during pregnancy may prevent child abandonment, abuse, and neglect. If the circumstances post-birth are not working as planned, parents may consider an adoption plan for their infant after the child is born.

What did hospital professionals have to say after participating in the Understanding Infant Adoption Curriculum?

“
ADOPTION IS NOW
PART OF AN OPTION I
CAN HELP
PROSPECTIVE
PARENTS EXPLORE.
”

“
It helped me
BETTER EDUCATE
our patients on other
options.
”

“
I feel
**BETTER EQUIPPED
TO ANSWER THEIR
QUESTIONS**
and give them fact-based
information.
”

“
I have become more
knowledgeable about all the
options that are available for
pregnant women.
”

CLASSROOM TRAINING PRODUCTS

“

I'm excited about the incorporation of trauma-related information, the information on substance use/exposures, and the discussion of hospital policy. These are all excellent additions that are timely and important.

”

~Michael Hill
UIA Trainer
New York

As a trainer, you will have access to the following:

TRAINER GUIDE – This Guide will provide you with all of the content you will need to successfully facilitate the Understanding Infant Adoption training. It includes trainer preparation tips, the content that you will deliver with accompanying PowerPoint slides, the handouts you will need to support either discussion or activities throughout the training, and a pre/posttest that includes correct responses.

PARTICIPANT GUIDE – This Guide is for those who are attending the training as participants. The guide contains the handouts that will be used throughout the training. The Participant Guide also includes a copy of the pre/ posttest for their completion. Only the Trainer Guide has a copy that contains the correct responses.

STATE SPECIFIC RESOURCE GUIDE – This Guide provides state specific information about the laws that govern adoption. It also includes a listing of community-based adoption agencies, pregnancy counseling centers, and adoption attorneys to assist hospital-based professionals in making referrals.

“The resources we got during the session were full of great info.”

“I agree—now that I have a better understanding and knowledge of resources and the adoption process, I feel like I can be more helpful to patients.”



MODULES AT A GLANCE

Module	Method	Session Description
1 – Introduction	Lecture Activities	Provides an overview of the content of the curriculum, reviews professional standards, and offers an opportunity to begin to look at personal and professional values about adoption.
2 – Adoption as an Option	Lecture Activities	Focuses on the evolution of adoption practice, outlines standard adoption practice and defines the types of adoption. Reviews how both state and federal laws govern adoption to help participants better understand the legal implications of the adoption option.
3 – Presenting Adoption as an Option and Making Referrals	Lecture Activities	Provides guidance about how to present adoption as an option. Informed consent and the principles of non-directive and non-coercive counseling are discussed. Trauma-informed counseling principles are reviewed and making referrals is introduced.
4 – Influences on Decision Making	Lecture Activities Video Presentation	Explores the many influences that may impact a woman experiencing an unplanned/unintended pregnancy. The principles of culturally responsive services are reviewed. Special issues to consider when working with teens and approaches for engaging expectant fathers are also presented.
5 – Adoption Best Practices: Implications for Health Care Settings (Optional)	Lecture Activities	Best practice guidelines for adoption-related practice in hospital settings are reviewed. Participants are given an opportunity to reflect on their hospital's current policy in comparison to best practice guidelines
6 - Pulling it all Together	Lecture Activities Video Presentation	Participants watch a video depicting the story of Nicole and hear from experts about how to incorporate all of the information learned in previous modules into an approach that supports women, men and teens who are facing an unplanned/unintended pregnancy.

OVERVIEW OF TRAINING TECHNIQUES

TRAINER PRESENTATION

The trainer presents information by speaking to the whole group, sometimes using visuals such as slides, posters, pictures, or a flip chart. Presentations work well for introducing new information, but they should be short and accompanied by visuals and discussion.

TO DO A TRAINER PRESENTATION, WHAT SHOULD YOU DO?

- Prepare and organize your presentation ahead of time so that it is clear and easy to follow.
- Check any equipment (slide projector, flip chart) ahead of time to make sure it is working properly.
- Keep the presentation short, between 5 and 15 minutes if possible.
- Use simple, clear language that participants will understand.
- Use questions during the presentation to engage participants in the material you are presenting.
- Use open body language and a friendly, clear tone of voice.
- Watch participants during the presentation; if they look confused or bored, ask questions or move along more quickly.
- Move around the room as you present (if possible).
- Face participants when you are explaining a visual (do not face the visual).
- To wrap up your presentation, summarize and repeat the main points.

WHAT ARE THE BENEFITS OF USING TRAINER PRESENTATIONS?

- Presentations work well for introducing new information quickly and succinctly.
- Sometimes participants need to have new information presented before they can use or practice it.
- Most participants who went to school are familiar and comfortable with presentations.

WHAT ARE THE CHALLENGES OF USING TRAINER PRESENTATIONS?

- Presentations are not as active or engaging as small groups, role plays, or other more participatory activities.
- Sometimes participants stop paying attention.
- If the trainer is not well-organized, participants will not learn the information effectively.

SMALL GROUP ACTIVITY

The trainer divides participants into small groups to do an activity. Examples of small group activities include small group discussions, case studies, planning role plays, solving problems, and looking at picture stories. Small groups allow each person to participate more than they would in a large group activity. Small group activities also help participants get to know each other and experience working with different people.

TO FACILITATE A SMALL GROUP ACTIVITY, WHAT SHOULD YOU DO?

- Explain the small group activity clearly.
- Tell small groups how they will share their small group work with the large group. For example, will they write information on chart paper to share with the group, report information orally, or perform a role play?
- Divide participants into small groups. Small groups of 4–6 participants work best, but some activities may require groups of 3, or larger groups of 10–12.
- Divide participants into small groups according to the task to be completed. For example, for activities that require reflection on parenting strategies, divide participants in a way that ensures each group contains parents with varying levels of experience.
- If the topic does not require any particular kind of grouping, you can divide participants by asking them to count off, “1, 2, 3, 4, etc.” Then group 1’s together, 2’s together, etc.
- Group participants so that they are not always working with people they know well. Counting off is a good way to do this.
- If the small group activity requires reading or writing, make sure that at least one participant in each group has sufficient literacy skills.
- Tell groups how much time they will have to work. Then help groups manage time by giving periodic time warnings, for example, a half-time warning, 5-minute warning, and 1-minute warning. If you see that time is almost up and groups are not finished yet, you can allow groups more time to work if the schedule permits.
- While small groups are working, circulate around the room, observe the work to make sure that groups understand the task and are making progress, help, and answer questions as needed.
- Manage time during small group reports or presentations. For example, give each small group 5 minutes to present and a few minutes to respond to questions or comments.

WHAT ARE THE BENEFITS OF USING SMALL GROUPS?

- Small groups allow everyone to participate more than in a large group.
- Many people feel more comfortable speaking in small groups.
- Small groups often enable more in-depth learning and discussion because everyone is engaged.

WHAT ARE THE CHALLENGES OF USING SMALL GROUPS?

- Small group work takes more time than some other methods.
- Some small groups find it hard to work together or stay on task. If you observe a small group having difficulty, help them refocus, give examples, explain the task again, etc.

LARGE GROUP ACTIVITY

The trainer leads the whole group in an activity together. Examples of large group activities include voting, sorting pictures, learning songs, etc. Large group activities often work best for groups of 10–25 participants, but with good planning and organization, trainers can successfully lead large group activities with much larger groups.

TO FACILITATE A LARGE GROUP ACTIVITY, WHAT SHOULD YOU DO?

- Set a time limit and keep track of time.
- If participants need to move around the room during the activity, make sure that chairs and tables are moved away.
- Explain the activity clearly.
- Keep the activity moving along.
- Encourage everyone to participate.
- Highlight key points throughout the activity if appropriate.
- Wrap up the activity by repeating and summarizing main points.

WHAT ARE THE BENEFITS OF USING LARGE GROUP ACTIVITIES?

- Large group activities involve everyone and can be energizing.
- Large group activities require less intense participation than small group activities, and can be alternated with small group activities so that participants do not grow too tired.

WHAT ARE THE CHALLENGES OF LARGE GROUP ACTIVITIES?

- Some participants may not participate as actively as they would in a smaller group.
- Large group activities require lots of energy from the trainer.
- Large group activities can be challenging to manage if the group is very large.

CASE STUDY

A case study is a brief story or scenario that presents a realistic situation for participants to discuss and analyze. Case studies give participants the opportunity to use newly acquired knowledge to discuss, analyze, and solve problems related to the training topic. For example, a case study might describe a sick person's symptoms, and then ask participants to identify the symptoms and discuss what they would do for the sick person. Depending on the size of the group, case studies can be discussed and analyzed in pairs, small groups, or a large group. The goal of using case studies is to help participants generate possible solutions to issues that may arise in the course of their work.

TO FACILITATE A CASE STUDY, WHAT SHOULD YOU DO?

- Read the case study aloud (or ask a volunteer to read aloud) so that even participants with limited literacy skills will understand the details.
- Explain clearly what participants should do with the case study (discuss the case study questions, solve a problem represented in the case study, etc.).
- Provide questions to guide participants in analyzing the case study.

WHAT ARE THE BENEFITS OF USING CASE STUDIES?

- Case studies give participants the opportunity to use information that they have learned in a realistic way.
- Case studies give participants the opportunity to practice handling problems that they might encounter during their work.

WHAT ARE THE CHALLENGES OF USING CASE STUDIES?

- Case studies require problem-solving, which can be challenging and require more time than traditional presentations or simple discussions.
- Participants with limited literacy skills may be intimidated by case studies.

OPEN DISCUSSION

An open discussion is a dialogue between the trainer and the whole group of participants, with participants responding to questions the trainer has prepared ahead of time. During discussions, new questions may also surface. To start the discussion, the trainer must give clear instructions. During the discussion, the trainer must manage the discussion by keeping participants focused, eliciting participants' responses, and limiting participants who like to talk a lot.

TO FACILITATE A LARGE GROUP DISCUSSION, WHAT SHOULD YOU DO?

- Set a time limit and keep track of time.
- Explain that participants who want to speak should raise their hands.
- Keep the discussion on target.
- Keep the discussion moving and flowing.
- Encourage everyone to participate.
- Look around the room and make sure you call on everyone who raises her/his hand.
- Limit participants who like to talk a lot.
- Manage the flow of the discussion.
- If participants do not respond to a question, try asking the question a different way.
- Ask questions to encourage more responses to a question, for example: "What else?" "What other ideas do you have?"
- Wrap up the discussion; repeat and summarize main points.

WHAT ARE THE BENEFITS OF USING LARGE GROUP DISCUSSIONS?

- Everyone has the chance to participate.
- Everyone hears everyone else's ideas.
- Hearing many ideas can stimulate further discussion.
- Participants who do not feel comfortable speaking in a large group can participate by listening.

WHAT ARE THE CHALLENGES OF USING LARGE GROUP DISCUSSIONS?

- More talkative or assertive participants tend to dominate large group discussions.
- Shy or less-experienced participants may not feel comfortable speaking in a large group.
- Large group discussions can get off track if there are many competing ideas.

ROLE PLAY

A role play is a brief, informal performance where participants act roles in order to show a particular situation and feel what it is like to be in those roles and situation. Role playing is informal – participants do not need to memorize “lines” or perform perfectly. The point is to illustrate a problem, situation, or idea with acting. Role plays give participants the opportunity to act a real-life situation and practice handling it. Participants can use role plays to illustrate ideas and information for patients and community members. Role plays also help participants learn and practice communication and counseling skills, empathetic behavior, and proper ways to approach community members. Role plays can be improvised and informal, or more formal, and can be done in small or large groups.

TO FACILITATE A ROLE PLAY, WHAT SHOULD YOU DO?

- Plan enough time for participants to prepare and perform role plays.
- Explain clearly what the role play is, how participants will prepare, and what the role play should show.
- If participants are not familiar with role plays, model the role play to show how it is done.
- Set a time limit for role play performances and manage time well.
- Remind participants that role plays are not perfect performances, but rather an opportunity to practice handling situations that participants encounter in reality. It is okay to make mistakes during a role play.
- After a role play performance, lead a discussion about the ideas shown in the role play. Focus the discussion on the important issues raised by the role play, not participants’ acting skills.

WHAT ARE THE BENEFITS OF USING ROLE PLAYS?

- Role plays engage participants and give them the opportunity to think, feel, and act.
- Role plays give participants a chance to practice skills in a safe setting and get feedback.
- You can use 2 short role plays to show 1) the wrong way to handle a situation; and 2) the right way to handle a situation.
- Role plays can raise many issues and lead to useful discussions.

WHAT ARE THE CHALLENGES OF USING ROLE PLAYS?

- Role plays take a lot of time.
- Some participants may be uncomfortable performing in front of the group.
- Participants may not be familiar with doing role plays.

REFERENCES

- American Hospital Association. (2015). Teaching hospitals: Preparing tomorrow's physicians today. Fast facts on U.S. hospitals, 2020. <https://web.archive.org/web/20171006221939/http://www.aha.org/research/reports/tw/15june-tw-teachinghosp.pdf>
- Campbell, D. T., & Stanley, J. C. (1963). *Experimental and quasi-experimental design for research*. Hope-well, NJ: Houghton Mifflin Company.
- Center for Disease Control and Prevention. (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. *Morbidity and Mortality Weekly Report*. 63(RR04). 1-29. <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm>
- Guttmacher Institute. (2016). *On health of women and children report*. Accessed on August 27, 2020 from <https://www.guttmacher.org/>
- Kaplan, D. (2014). Who are the mothers who need safe haven laws? An empirical investigation of mothers who kill, abandon, or safely surrender their newborns. *The John Marshall Institutional Repository*. Accessed on August 27, 2020 from <https://repository.jmls.edu/cgi/viewcontent.cgi?article=1487&context=facpubs>
- Kirkpatrick, D.L. & Kirkpatrick, J.D. (2007). *Implementing the Four Levels: A Practical Guide for Effective Evaluation of Training Programs*. San Francisco: Berrett-Koehler Publishers, Inc.

UNDERSTANDING INFANT ADOPTION (UIA) 6 CURRICULUM



MODULE

1

TRAINER GUIDE



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MODULE 1: INTRODUCTION TO UNDERSTANDING INFANT ADOPTION

UIA Competency: Learn how to differentiate personal and professional attitudes, experiences, and possible biases related to adoption so that counseling, including the adoption option, is provided in an objective, non-biased way.

45 min

SEGMENTS

- I. Overview of Curriculum (15 MINUTES)
- II. Introduction (10 MINUTES)
- III. Professional Standards (10 MINUTES)
- IV. Personal Values (10 MINUTES)

Segment I. Overview of Curriculum

SLIDES 1-8
15 MINUTES

[PPT #1]: WELCOME

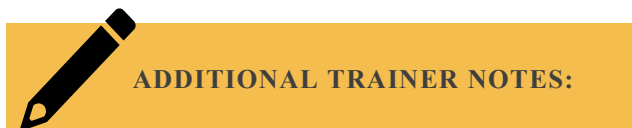


NOTE:

Allow approximately 45 minutes for introductory remarks and the content that is to be covered in Module One.

Display this slide as participants are getting seated and greet participants as they enter the room.

When it is time to begin, welcome participants to the training site and thank the agency hosting the training. Introduce yourself and identify your employer and role in adoption or options counseling.





STATE:

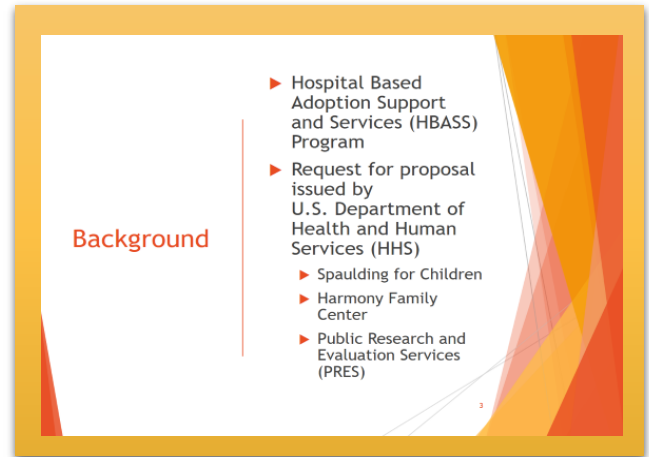
Let's review the purpose of bringing this information to you today. The goal of the Understanding Infant Adoption (UIA) training is to enhance the ability of health care and helping professionals to provide adoption information and referrals to pregnant women, teens, and men, who are experiencing an unplanned/unintended pregnancy. We hope to see the adoption option presented on an equal basis with all other courses of action in a non-directive, non-coercive manner.

While there is less stigma attached to circumstances such as being single and pregnant than there used to be, society still has a somewhat negative view of women who choose adoption, regardless of the reason for this choice. The stigma regarding adoption planning, coupled with the lack of adoption education amongst healthcare/helping professionals, causes a lot of women who are unsure they want to parent to feel like there is no one they can openly talk to about their thoughts. When they do talk to a healthcare/helping professional, the professionals are often unfamiliar with adoption, and therefore not able to have a wide-reaching conversation about it.

The intention of this training program is to ensure not only that expectant parents have adoption information presented with other options, but also to ensure that pregnant women who wish to place a child for adoption have access to well-trained staff and comprehensive supports in hospital settings throughout the adoption process.



ADDITIONAL TRAINER NOTES:



STATE:

In July of 2001, a notice and request for proposal was issued by the U.S. Department of Health and Human Services (HHS) to develop and implement an “Infant Adoption Awareness Training Program” (IAATP). Spaulding for Children was awarded the grant for the 2001 to 2004 period. Over the 10+ years that followed, additional grants were awarded to Spaulding for Children and the Understanding Infant Adoption curriculum was developed and refined over those years.

Most recently, in July of 2017, a notice and request for proposal was issued by HHS to develop and implement a Hospital Based Adoption Support and Services (HBASS) program. Spaulding for Children partnered with Harmony Family Center and Public Research and Evaluation Services (PRES) on a proposal which was funded for a total of 33 months between October 2017 and September 2020.



**NOTE:**

Share any necessary “housekeeping” details such as break times, restroom locations, lunch arrangements, etc. If continuing education credit hours are being offered, explain requirements to participants related to this process.

If a **Pre and Post Test** will be used, consider having participants complete the pre-test at this point. Provide Post-it notes that participants can use to write down the questions that they would like to have answered throughout the session. Remind participants to include legal questions as well which will be covered in Module Two.

Post and refer to the “Parking Lot” poster in the room and explain that participants should place their post-it notes in the parking lot so that the trainer can be sure to address them before the end of the day. Encourage participants to ask questions throughout the session, however, consider reserving the right to hold questions if you know that the question will be answered at a later point in the session.





STATE:

The Understanding Infant Adoption training consists of six modules. Each module builds on the information presented in the previous module.

► Module 1: Introduction

This module is the beginning of the six module UIA training series. It provides an overview of the content of the curriculum, reviews professional standards, and offers an opportunity to begin to look at personal and professional values about adoption.

► Module 2: Adoption As an Option

This module takes a deeper look at the option of adoption. It focuses on the evolution of adoption practice, outlines standard adoption practice and defines the types of adoption. The module reviews how both state and federal laws govern adoption to help participants better understand the legal implications of the adoption option.

► Module 3: Presenting Adoption as an Option and Making Referrals

This module provides guidance about how to present adoption as an option. Informed consent and the principles of non-directive and non-coercive counseling are discussed. Trauma-informed counseling principles are reviewed and making referrals is introduced.

► Module 4: Influences on Decision Making

This module explores the many influences that may impact a woman experiencing an unplanned/unintended pregnancy. The principles of culturally responsive services are reviewed. Special issues to consider when working with teens and approaches for engaging expectant fathers are also presented.

► **Module 5: Adoption Best Practices: Implications for Health Care Settings (Optional)**

In this module, best practice guidelines for adoption-related practice in hospital settings are reviewed. Participants are given an opportunity to reflect on their hospital's current policy in comparison to best practice guidelines.

► **Module 6: Pulling it all Together**

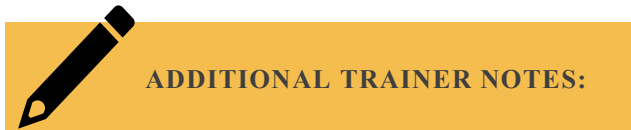
In this final module, participants watch a video depicting the story of Nicole and hear from experts about how to incorporate all of the information learned in previous modules into an approach that supports women, men and teens who are facing an unplanned/unintended pregnancy.

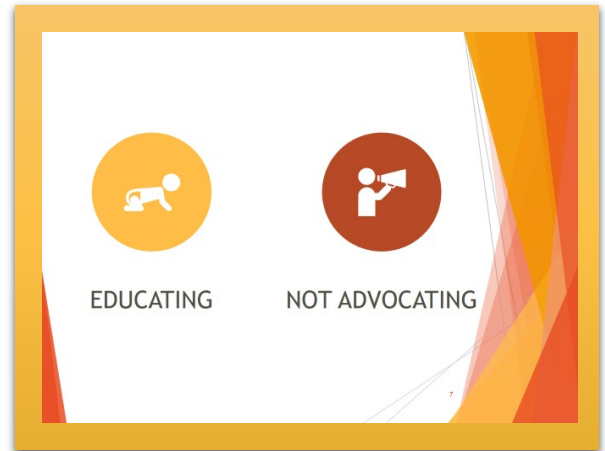




STATE:

The Understanding Infant Adoption training does not include information about international adoption, foster care adoption, or adoption of older children. This is not because these types of adoptions are not important to understand and support, but rather because our emphasis is on supporting those women and men who are experiencing an unplanned/unintended pregnancy.





STATE:

As was mentioned earlier, there is still a lot of shame and stigma associated with adoption.

Expectant parents have said things like, “I would rather terminate the pregnancy than place for adoption”, as if placing for adoption was public humiliation.

Expectant parents may have fears about what it will be like to give birth but not parent the child. You might hear, “I could never live with myself knowing I had a child out there somewhere”. While adoption is one of multiple options for an unplanned/unintended pregnancy, in some cases it seems to be dismissed before expectant parents can be educated on what adoption really is and how it can work.

As we go through the day please remember that Infant Adoption Awareness is about EDUCATING, NOT ADVOCATING for adoption. This training will focus on adoption, not the other options, because that is our area of expertise and the focus of this training. The content of this training raises some sensitive issues. If you are uncomfortable with any of the activities, feel free to limit your participation.



ADDITIONAL TRAINER NOTES:



STATE:

Let's take a few minutes to get to know who is in the room today.

NOTE:

You have 3 minutes for introductions. Keep in mind that time is limited. Even in a small group, it can take a lot of time if participants introduce themselves. Instead of having all participants introduce themselves individually, the trainer can give the group an idea of who is there with them by asking for a show of hands to the following questions:

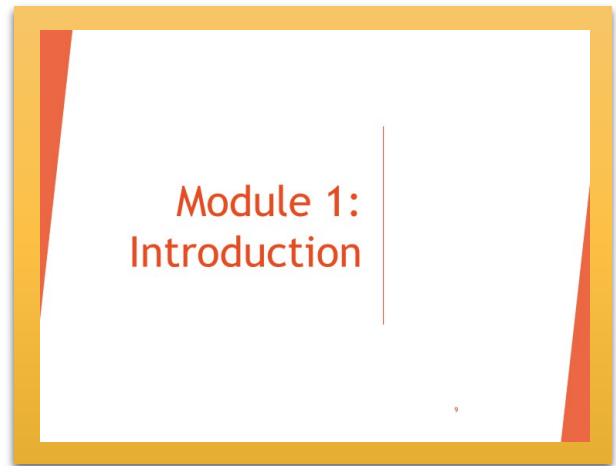
- ▶ How many of you work at a hospital in Labor and Delivery? Newborn Units?, NICU?, Postpartum Clinic/Unit? Other?
- ▶ How many of you are nurses? Social workers? Case managers? Others?
- ▶ How many of you work with pregnant teens on a regular basis?
- ▶ How many of you have more than 10 years of experience in working with pregnant women and teens?
- ▶ How many of you have less than 10 years of experience in working with pregnant women and teens?



Segment II. Introduction

SLIDES 9 - 11
10 MINUTES

[PPT #9]: INTRODUCTION



STATE:

This module is the beginning of the six module UIA training series. It provides an overview of the content of the curriculum, reviews professional standards, and offers an opportunity to begin to look at person and professional values about adoption.



ADDITIONAL TRAINER NOTES:

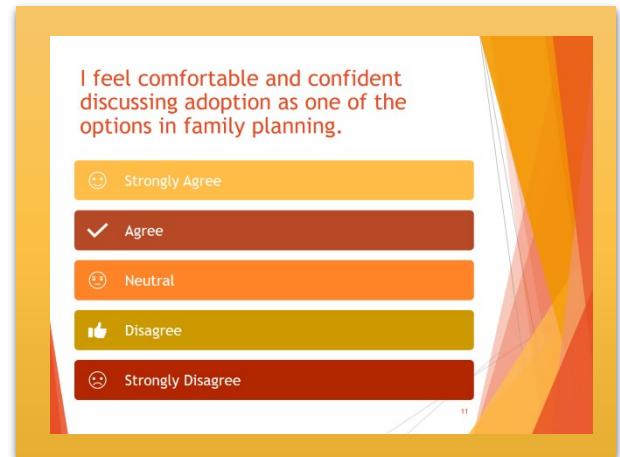


STATE:

The objective of our first module is to learn how to differentiate personal and professional attitudes, experiences, and possible biases related to adoption so that counseling, including the adoption option, is provided in an objective, non-biased way.



ADDITIONAL TRAINER NOTES:



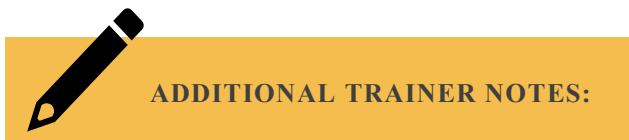
STATE:

Let's do a quick check-in before we move more deeply into the session. As a hospital-based health care professional (or student), how comfortable do you feel discussing adoption as one of the options in family planning?

Of course, our hope is that your comfort level will improve by the end of our time together.

NOTE:

Record of the number of responses in each category so that they can be compared to the number of responses in each category at the end of the day.



Segment III. Professional Standards

SLIDES 12-18
10 MINUTES

[PPT #12]: EXPERIENCES WITH ADOPTION



STATE:

As we begin the training, it is important for us to look at our own personal and professional experiences with adoption. Let's consider these questions.

In a Large Group Discussion format, facilitate a discussion using the following prompts:

- ▶ How might this training help you in your current role?
- ▶ As a hospital based professional, what has your experience been with adoption? Has it been positive or negative?
- ▶ What has your personal experience with adoption been like?

You may know someone impacted by adoption: a person who was adopted, parents who adopted a child, or someone who made an adoption plan. Let's look more at this now.



ADDITIONAL TRAINER NOTES:

Adoption by the Numbers

- 110,000 + adoptions annually
- 18,000 + infant adoptions each year
- Domestic adoptions represent:
 - 0.5% of all live births
 - 1.1% of births to single parents

Source: National Council For Adoption (NCFCA)

13

STATE:

Everyone is touched by adoption in one way or another. The National Council For Adoption is a non-profit, adoption advocacy organization that regularly produces statistical reports on adoption. The most recent report published in February 2017 showed that:

The total number of all adoptions taking place in the U.S. has fallen, from a count of 133,737 adoptions in 2007 to 110,373 (41,023 related adoptions and 69,350 unrelated adoptions) in 2014.

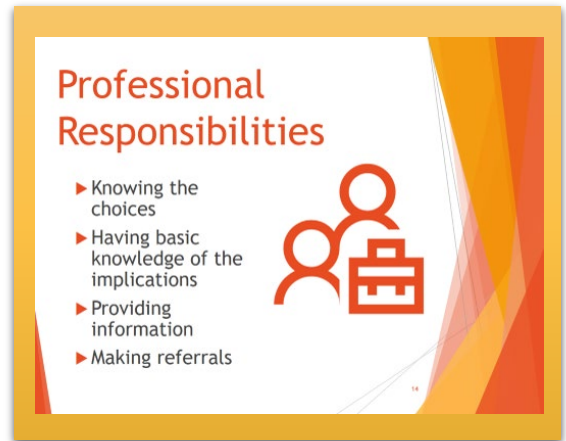
More than half of this decline can be attributed to the significant drop in the number of intercountry adoptions by Americans. There is also a significant decline in the number of kinship or relative adoptions.

The number of infant adoptions has remained mostly steady from 2007; there was a small increase from 18,078 in 2007 to 18,329 in 2014.

The number of domestic adoptions represents 0.5 percent of all live births and 1.1 percent of births to single parents.



ADDITIONAL TRAINER NOTES:



STATE:

The hospital and other health care provider's professional responsibilities in options counseling include:

- ▶ Knowing the choices available
- ▶ Having basic knowledge of the implications of the different choices
- ▶ Providing information on each choice
- ▶ Making referrals so that patient/clients can get the additional information they need before making their informed decisions about their pregnancies

Hospital and other health care providers have the professional responsibility of presenting all options to the client without providing their own opinion of what they would have done in the same situation or what they think the patient/client should do.



ADDITIONAL TRAINER NOTES:

Personal values must be recognized and controlled so that they do not interfere with professional responsibilities.

TRUE FALSE

STATE:

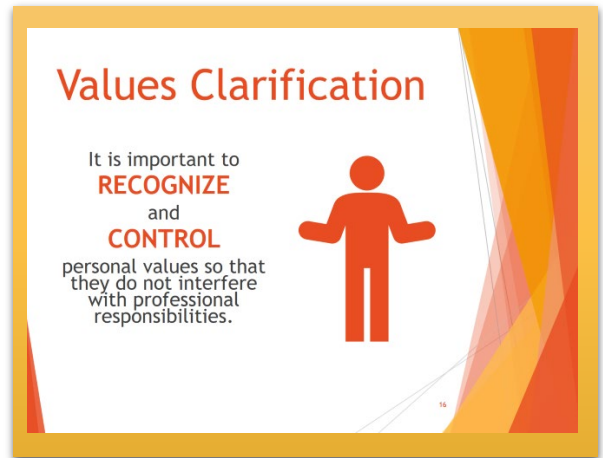
Let's take a look at this question. What do you think is the correct answer here?

NOTE:

Allow a few comments from participants about how they would answer this question. It is not necessary to reveal the correct response yet.



ADDITIONAL TRAINER NOTES:



STATE:

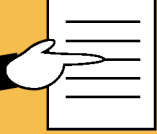
Value systems, individual and professional, are an organized set of beliefs that are important in guiding individual behavior. Individuals, as well as professions, are guided by multiple or changing clusters of values, rather than single or isolated values. Our values are influenced by our culture and by our experiences. Personal values must be recognized and controlled so that they do not interfere with professional responsibilities.

Values clarification is a process that helps to identify the personal and professional values that guide an individual's actions. It is an ongoing developmental process.

An article provided in your Participant Handbook, titled: *Legal and Ethical Considerations for Health Care Professionals in Pregnancy Counseling and Adoption* provides additional information on values and ethics.



ADDITIONAL TRAINER NOTES:



HANDOUT: LEGAL AND ETHICAL CONSIDERATIONS FOR HEALTH CARE PROFESSIONALS IN PREGNANCY COUNSELING AND ADOPTION

This article applies the law and accepted values and ethics of the health care profession to the practice of providing pregnancy options counseling. It describes conditions under which coercion can occur and defines noncoercive counseling. In addition, the article explores the concept of informed consent, as it applies to adoption. This information is intended to provide a legal and ethical framework in which to provide information and make effective referrals for pregnancy counseling and adoption services.

Background and the Law

In July of 2000, the Secretary of Health and Human Services issued regulations establishing requirements for recipients of family planning grants under section 1001 of the Public Health Service Act, 42 U.S.C. 300. The rules revoked the “gag rule” that restricted family planning grantees from providing abortion-related information in their grant-funded projects and reinforced a requirement that 1001 clinics provide information on all pregnancy options on an equal basis. Specifically, the law, as interpreted in the administrative rules, requires that the grantee:

- ▶ Provide services in a manner that protects the dignity of the individual.
- ▶ Provide services without regard to religion, race, color, national origin, handicap disabilities condition, age, sex, number of pregnancies or marital status.
- ▶ Provide neutral, factual information and nondirective counseling on any option the pregnant woman requests including:
 - prenatal care and delivery
 - infant care, foster care or adoption
 - pregnancy termination
- ▶ Provide for social services related to family planning, including counseling, referral to and from other social and medical services agencies and any ancillary services which may be necessary to facilitate clinic attendance.
- ▶ Provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies and health services projects supported by other Federal programs.

The Infant Adoption Awareness Training Program was funded by the Federal government to develop curricula that would help health care professionals provide information and support for the adoption option and make informed referrals for pregnancy counseling and adoption services for patient/clients who choose one or both of these options for further exploration.

The healthcare provider should make their opinion known to their patient/client and tell their patient/client what they would do in the situation.

TRUE FALSE

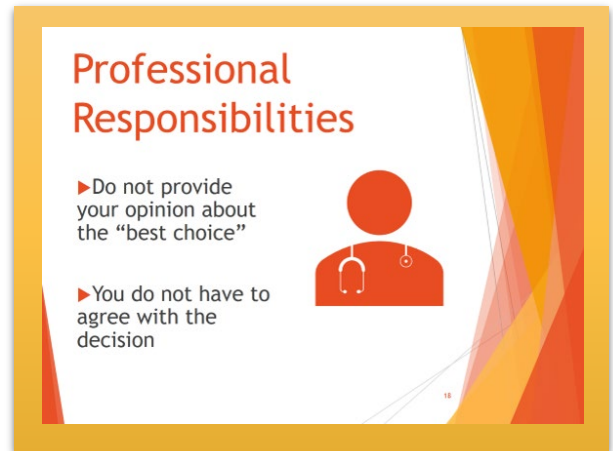
STATE:

What about this question? What are your thoughts here? Has anyone had an experience they would be willing to share about a time when a patient/client made a decision that you did not necessarily agree with? What was that like? How did you handle that situation?

NOTE:

Allow a few comments from participants about how they would answer this question. It is not necessary to reveal the correct response yet.





STATE:

In addition to what we have already talked about, the health care provider’s professional responsibilities in options counseling also include not providing their own opinion about what they feel is the “best choice” for any patient or client. As the health care provider, you do not have to agree with the patient/client’s decision.

It is important to separate personal values from professional values in providing options counseling. We should never make our opinion known or tell the patient/client what we would do in the situation.

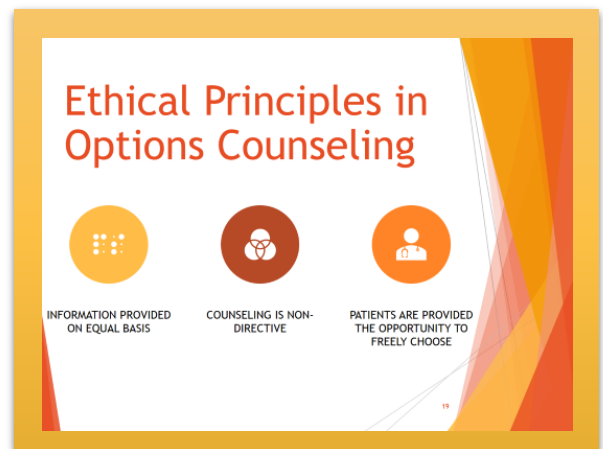


ADDITIONAL TRAINER NOTES:

Segment IV. Personal Values

SLIDES 19-21
10 MINUTES

[PPT #19]: ETHICAL PRINCIPLES



STATE:

Although professional organizations vary in the amount of detail they provide in their standards and code of ethics statements with regard to options counseling, they all share three important principles:

- ▶ Information is provided on an equal basis
- ▶ Counseling is provided in a non-directive manner
- ▶ Patients are provided the opportunity to freely choose the service or procedures they want

A chart entitled *Clinical Guidelines for Nondirective Counseling of Pregnant Women* is included in your Participant Handbook and summarizes the standards of various organizations.



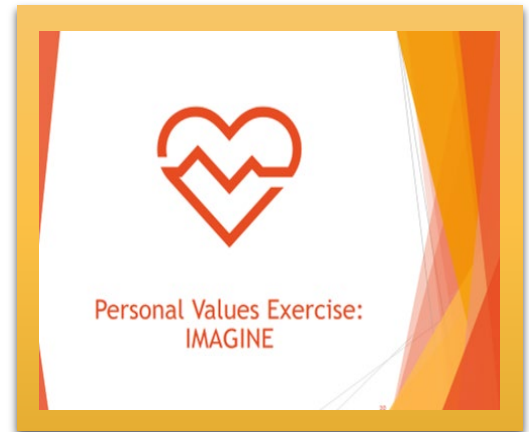
ADDITIONAL TRAINER NOTES:



HANDOUT: CLINICAL GUIDELINES FOR NONDIRECTIVE COUNSELING OF PREGNANT WOMEN

Organization	Guideline Type	Non directive	Language	Cite	Mention Adoption
Bureau of Primary Health Care	Policy Information Notice: 98-23	N/A	“...Health center clinic protocols should reflect the current guidelines established by health agencies or professional organizations such as the Agency for Health Care Policy and Research, the American College of Obstetrics and Gynecology...”	Part II.7.a	N/A
American College of Obstetricians and Gynecologists	Guideline for Women’s Health Care	Y	“In the event of an unwanted pregnancy, the patient should be counseled about her options: 1) continuing the pregnancy to term and keeping the infant, 2) continuing the pregnancy to term and offering the infant for legal adoption, or 3) terminating the pregnancy.”	Routine Assessments: Under 18 Years of Age	Y
Child Welfare League of America	Standard of Excellence: Services for Adolescent Pregnancy Prevention, Pregnant Adolescents, and Young Parents	Y	“The pregnant adolescent should be provided with individual and group counseling about her options: 1) continuing the pregnancy to term and keeping the infant, 2) continuing the pregnancy to term and offering the infant for legal adoption, or 3) terminating the pregnancy.”	Standard 4.10	Y

Organization	Guideline Type	Nondirective	Language	Cite	Mention Adoption
Council on Accreditation for Children and Families	Standard: Pregnancy Counseling and Supportive Services	Y	“The organization offers counseling to help expectant parents decide if they want to parent the child, plan for adoption, transfer custody of the child, or terminate the pregnancy.”	Standard S13.2.01	Y
American College of Nurse-Midwives	Code of Ethics for Certified Nurse-Midwives	Y	“Nurse-midwives share professional information with their clients that leads to informed participation and consent. This sharing is done without coercion, or deception.”	Code Four	N
National Association of Social Workers	Policy Statement: Family Planning and Reproductive Choice	Y	“The nature of the reproductive health services that a client receives should be a matter of client self-determination in consultation with the qualified health care provider furnishing them.”	“Social Work Speaks”: Page 113, Policy Four	N
American Medical Association	House of Delegates: Adoption Policy	Y	“It is the policy of the AMA to (1) support the provision of adoption information as an option to unintended pregnancies; and (2) support and encourage the counseling of women with unintended pregnancies as to the option of adoption.”	H-420.973	Y



STATE:

In order to proceed through the rest of the training recognizing our personal biases, we are going to engage in an individual values clarification activity. The activity will allow you to see how any experiences with adoption might affect your opinion about adoption. When you increase your awareness of your own values as they relate to adoption and how they can influence your work with patient/clients, you will better able to separate personal values from professional responsibilities.

This is a guided imagery technique. If you are comfortable doing so, you may close your eyes during the exercise. If participating makes you uncomfortable due to your personal background, you may choose to think about something else during this exercise.



ADDITIONAL TRAINER NOTES:

ACTIVITY

INSTRUCTIONS: Read the series of statements below to the participants, allowing sufficient time for participants to reflect on their responses to each question or statement. If male trainee is present, include male perspective as well.

- ▶ “Imagine when you were 18 years old, who were your friends? What type of music did you listen to? What was considered fashionable? Remember your favorite outfit and hairstyle. Put yourself back into that time. You just found out that you are pregnant. The father of the baby left town to attend college, and you have no relationship with him. Think about what you are feeling. Don’t speak, just think about it.”
- ▶ PAUSE “Who do you want to tell?” “Who are you afraid to tell?” “Were you planning on having a baby?” “What choice about the pregnancy are you thinking of making? (Parenting? Abortion? Adoption?)” “If you are the father of the baby, do you want to be involved in this decision or do you hope the mother will make the choice for you?”
- ▶ PAUSE “We will not be asking you to share this information with the group. With your eyes closed, raise your hand when you have decided what you will do.”
- ▶ PAUSE “Now let’s assume that option is no longer available to you. What is your second choice? With your eyes closed, raise your hand when you have decided what you will do.”
- ▶ PAUSE “Now imagine that your 18-year-old daughter is pregnant. What do you hope/want her to decide? With your eyes closed, raise your hand when you have decided.”
- ▶ PAUSE “It is okay to open your eyes now. The purpose of this exercise was to increase your awareness of your own values as they relate to adoption. We all have our biases and values and the more aware of them that we are, the more we can separate our own opinions from the process of helping a patient/client determine what is the best decision for them. Interestingly, sometimes what we think is best for us or for one person is not what we think is best for another person.”

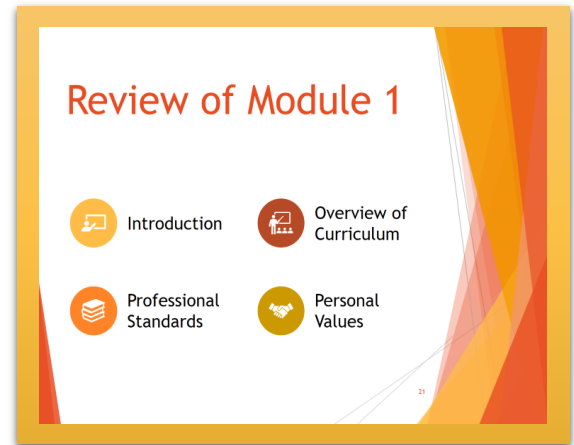
Invite participants to share thoughts about this difference and/or to share a personal scenario regarding adoption.

Participants could also be asked to share some of the values about adoption that they hold, or that they have heard about in terms of how others might view adoption.

Allow these discussions as time permits. If no one chooses to speak, point out who this illustrates that adoption can be a sensitive topic that some people may not be comfortable talking about. It is a constant challenge to keep our personal biases from influencing our professional responsibilities.

However, the first step in managing the influence of personal biases is to recognize that they exist and to actively monitor our conversations and actions with patient/clients to ensure that you give accurate information that does not reflect your personal biases.



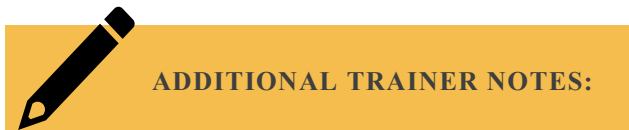


STATE:

Module One provided an overview of the content of the curriculum, reviewed the professional standards, and offered you an opportunity to begin to look at your own values about adoption. It is important to be aware that personal attitudes, experiences and possible biases may impact the work that you do with patient/clients.

Remember that the hospital and health care provider's professional responsibilities in options counseling includes knowing the choices available, having basic knowledge of the implications of the different choices, providing information on each choice, and making referrals so that patient/clients can get the additional information they need before making informed decisions about their pregnancies.

What questions or comments do you have about any of the material covered in this module?



APPENDIX

MODULE 1: PRE/POST TEST ANSWER KEY

Please choose the best answer for each item.

1. Which statement indicates a healthcare and/or helping professional who recognizes how to control his/her personal values in options counseling:
 - Research says that adopted babies of teens tend to have fewer behavior problems.
 - I would discuss adoption with my family before making a final decision.
 - You might refuse information, but I'm here to support your decision.**
 - I imagine parenting another child will not be too difficult.

2. What should a healthcare and/or helping professional say about grief and loss to a pregnant woman considering adoption:
 - Loss is part of the process that will ultimately be resolved.
 - Grief and loss is a part of every adoption.**
 - Adoption does not have to result in feelings of grief and loss.
 - Ongoing contact will reduce some of your anxieties about the child.

3. Birth Parents have the right to:
 - Determine adoption fees and expenses.
 - Develop adoption plans.**
 - Participate in the home study.
 - Terminate the adoption even after the adoption is finalized in court.

4. The Multi-Ethnic Placement Act as amended by the Interethnic Adoption Provision (IEP):
 - Mandates that federal agencies specify the race, color, or national origin of adoptive children.
 - Ensures that in federal agency adoptions and, if deemed best for the child, adoptions are delayed to ensure that adoptive families and children share race, color or national origin.
 - Monitors agencies that place too many children with families who share their culture.
 - Ensures that federally funded agency adoptions are not delayed based on the race, color or national origin of either the child or adoptive parent.**

5. With semi-open adoption:
 - The adoptive family receives identifying medical and social history on each birth parent and their family.
 - ✓ **Birth parents and adoptive parents may maintain contact through a third party.**
 - Members of the adoptive triad are required to participate in the child's life.
 - Birth parents and adoptive parents maintain contact with each other until the adoption is finalized.

6. With a fully disclosed or open adoption:
 - Contact between birth and adoptive families occur with an agency acting as intermediary.
 - ✓ **There is full disclosure of identifying information between adoptive and birth families.**
 - Adoptive parents are federally mandated to allow birth parents continued contact with the child.
 - Birth parents experience less severe grief and loss.

7. To engage birthfathers and to make them feel comfortable, healthcare and/or helping professionals should:
 - Call the father after the birth.
 - Invite him to the initial visits.
 - ✓ **Provide support for his emotional and psychological reactions.**
 - Talk to him face to face.

8. Adoption Laws:
 - Include guidelines at the federal level only.
 - ✓ **Are specific to each state and may change over time.**
 - Include guidelines at the state level only.
 - Should be presented by an adoption attorney or expert.

9. In cross cultural options counseling, the healthcare and/or helping professional:
 - Assists patient/clients from diverse backgrounds in seeing adoption as an appropriate option.
 - Includes the extended family in the decision-making process.
 - Should have an interpreter present.
 - ✓ **Recognizes that cultural factors influence the decision-making process.**

10. Choose the most appropriate way to refer to the process of adoption:

- Put up for adoption.
- Give the baby up for adoption.
- ✓ **Make an adoption plan.**
- Facilitate permanency and care.

11. Referral information works best when it is:

- Provided by the provider, who makes the initial contact.
- ✓ **Provided in multiple formats.**
- Provided by the contact person.
- Provided with testimonials.

12. The term “put up for adoption” originated from:

- The Child Protective Law.
- The Multi-Ethnic Placement Act.
- ✓ **Orphan Trains.**
- The Safe Haven/Safe Delivery Law.

Fill in the Blank.

13. What is the accurate and most neutral language to use to describe the biological parent(s)? They are the **Birth Parent(s)**.

14. Relative adoptions are also referred to as **Kinship Adoptions**.

15. The **Indian Child Welfare Act** is the law that governs the adoption of the Native American infants.

16. Nondirective, noncoercive counseling methods present information and options through the use of **Open Ended Questions**.

For each question please darken bubble either True or False.

	True	False
17. To be culturally sensitive, a healthcare and/or helping professional should be aware that they probably lack complete knowledge about a patient/client's family and culture, even if they share their race/ethnicity.	✓	○
18. Open adoption is a cure for grief and loss.	○	✓
19. Relative adoptions are temporary, but legal arrangements.	○	✓
20. The purpose of the Multi-Ethnic Placement Act is to permit the adoption of Indian children by non-Indian parents so that they are not in the child welfare system too long.	○	✓
21. Federal legislation requires the delaying of a child's adoption on the basis of the race of the child or the foster/adoptive parents.	○	✓
22. Non-identifying information (medical and social history on each birthparent and their family) must be shared with adopting parents.	✓	○
23. Birthparents may be responsible for paying back legal, counseling or medical expenses if they change their mind about the adoption.	✓	○
24. A woman who places a baby for adoption is entitled to receive information about her child in the future, regardless to what the adoptive parents say.	○	✓
25. In the past, birth parents were often coerced into placing a child with someone else due to financial situations or social factors.	✓	○
26. If the father does not agree with the adoption, the mother can make the final decision herself if she judges him unfit.	○	✓
27. Pregnant adolescents often have realistic expectations about parenthood because of their prior experiences.	○	✓
28. Research shows that pregnant teens in early adolescence (11-14 years) are to make good decisions for themselves and their child.	○	✓
29. Pregnant teens are realistic about the challenges of parenting.	○	✓
30. Even if the birth mother refuses information, all pregnancy options should be discussed.	○	✓
31. Adoptive parents and birth parents have the option to negotiate an "open" adoption.	✓	○
32. It is important for staff who provide options counseling to agree with the patient/client's decision.	○	✓
33. A birth mother can change her mind before signing the legal consents/relinquishments to the adoption.	✓	○

34. Whether a birth mother can afford to pay adoption fees should be part of her pregnancy options decision.
35. An adoption agency that receives federal funds may steer a birth parent to adoptive parents by race, color, or national origin.
36. A birth mother cannot make her legal decisions about adoption until after the baby is born.

Match the description to the nondirective, noncoercive technique by filling in the correct bubble. There is only one technique for each description.

Description	Technique							
	Responding Nonjudgmentally	Rapport Building	Empowerment/ Strength-Based Comments	Defusing Anger	Open-ended Questions	Empathy	Reflective Listening	
Involves developing trust through verbal and non-verbal means.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assessing own values and beliefs so they don't interfere with their counseling.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Listening respectfully to the patient/client's concerns.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Identifying and complimenting strengths in order to help a patient/client take control of the situation.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Identifying and responding to the underlying issues and shifting the patient/client's perspective.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Paraphrasing patient/client's responses.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
			Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	
37. I feel knowledgeable enough to present adoption as an option in family planning/options counseling.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. I feel comfortable and confident enough to present adoption as an option in family planning/options counseling.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

UNDERSTANDING INFANT ADOPTION (UIA) 6 CURRICULUM



TRAINER GUIDE



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MODULE 2: ADOPTION AS AN OPTION

UIA Competency: Take a deeper look at the option of adoption. It focuses on the evolution of adoption practice, outlines standard adoption practice, and defines the types of adoption. The module reviews how both state and federal laws govern adoption to help participants better understand the legal implications of the adoption option.

60 min

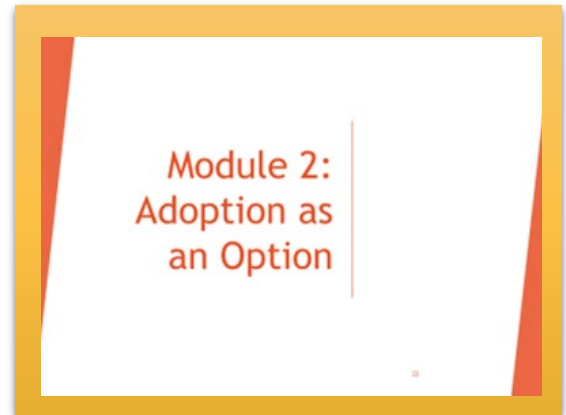
SEGMENTS

- I. Overview and Objectives (5 MINUTES)
- II. Adoption Evolution and Terminology (10 MINUTES)
- III. Relationship Continuum and Types of Adoption (15 MINUTES)
- IV. Adoption Law (30 MINUTES)

Segment I. Overview and Objectives

SLIDES 1-3
5 MINUTES

[PPT #1]: OVERVIEW



NOTE:

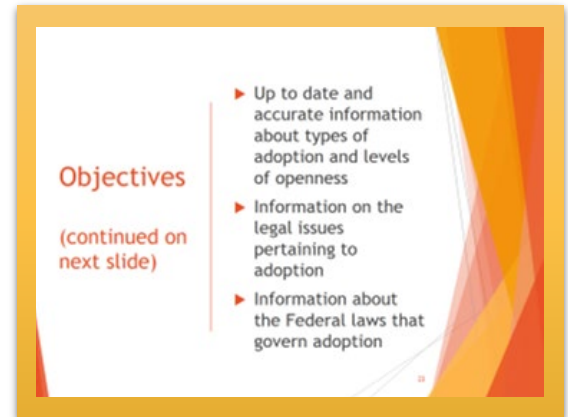
Allow approximately 60 minutes for the content that is to be covered in Module Two. Topics to be covered include:

- ▶ Definition of Adoption
- ▶ Adoption Triad
- ▶ The Relationship Continuum and Types of Adoption
- ▶ Kinship adoption
- ▶ Adoption Law
- ▶ Birth Parents Rights
- ▶ Child Protection Laws

This module takes a deeper look at the option of adoption. It focuses on the evolution of adoption practice, outlines standard adoption practice and defines the types of adoption. The module reviews how both state and federal laws govern adoption to help participants better understand the legal implications of the adoption option.



ADDITIONAL TRAINER NOTES:



STATE:

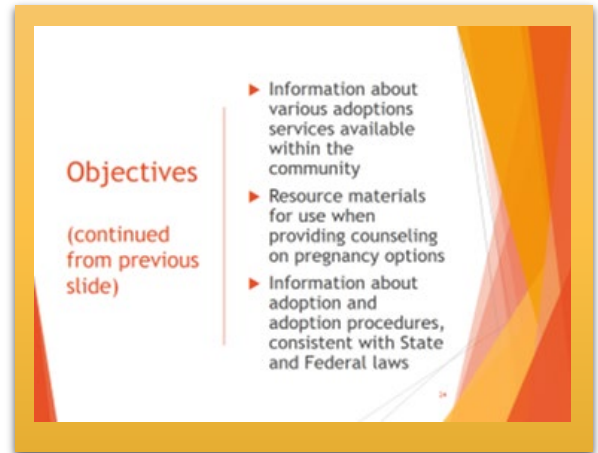
Now that we have introduced the format for the day, the modules we will be covering, talked a little about the Clinical Guidelines for Nondirective Counseling and discussed our personal feelings about adoption, we will move into adoption practices and how they have changed over time.

The objectives of this module are to provide:

- ▶ Up to date and accurate information about adoption, including the various types of adoptions such as closed adoptions and adoptions involving varying levels of openness with respect to the amount of contact or information exchanged between adoptive parents and birth parents.
- ▶ Information on the legal issues pertaining to adoption, including the rights of the birth mother and father, that is consistent with state law.
- ▶ Information to the trainees about Federal laws that govern adoption.



ADDITIONAL TRAINER NOTES:



STATE:

Additional objectives include providing:

- ▶ Information about various adoptions services available within the community including how to assess the quality of those services and their appropriateness for a particular woman.
- ▶ Resource materials that trainees can take with them to refer to when they are providing counseling on pregnancy options and to disseminate to the women they are caring for.
- ▶ Information about adoption and adoption procedures, that is consistent with State and Federal laws, so that trainees can present accurate and up to date information during options counseling.



Segment II. Adoption Evolution and Terminology

SLIDES 4-6
10 MINUTES

[PPT#4]: EVOLUTION OF ADOPTION



STATE:

As mentioned in Module One, as health care providers it is our responsibility to know the choices available and to have basic knowledge of the implications of the different choices. In Module Two, we will look at the option of adoption. We will focus first on standard adoption practice and then will look at the state and federal laws governing adoption so that you can better understand the legal implications of adoption.

Adoption has changed greatly over the last century, changing as our society has changed. Fewer infants are available for adoption. In the past birth parents were often coerced into placing a child for adoption due to financial and social factors. Today, adoption is governed by strict state laws that prohibit coercion. Additionally, adoption has moved toward a more open and transparent process.



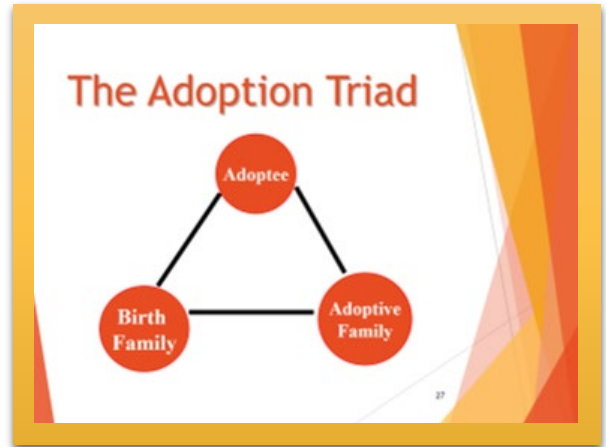


STATE:

Before discussing the adoption option in detail, it is important for us to begin with the basics. We will start by discussing a definition of adoption and the adoption triad.

Adoption is a legal process. The definition of adoption is shown on this slide. Let's review the definition together: a permanent parent and child relationship is formed by the transfer of parental rights from one set of parents to another individual or couple who is willing to assume those rights and responsibilities over the child.





STATE:

Adoption is a relationship between three parties who are central to the adoption process: the birth parents, the child/adoptee, and the adoptive parents. As a group, they are called “the triad” or are sometimes referred to as the “constellation” in adoption.

Also keep in mind that the birth family includes the mother and the father, as well as the grandparents, siblings and other family members. The same is true with regard to the adoptive family (mother, father, grandparents and siblings).

Decisions that impact one member of the triad will also likely impact the other members of the triad, as well as each of the member extended networks.



ADDITIONAL TRAINER NOTES:

Segment III. The Relationship Continuum and Types of Adoption

SLIDES 7-14
15 MINUTES

[PPT #7]: THE RELATIONSHIP CONTINUUM



STATE:

Let's focus now on the types of adoptions in the relationship continuum. In adoption today, there a variety of options available to the birth and adoptive families. As a health care provider providing information available options, it is important for you to be aware of these options and to understand the legal consequences of the adoption option.

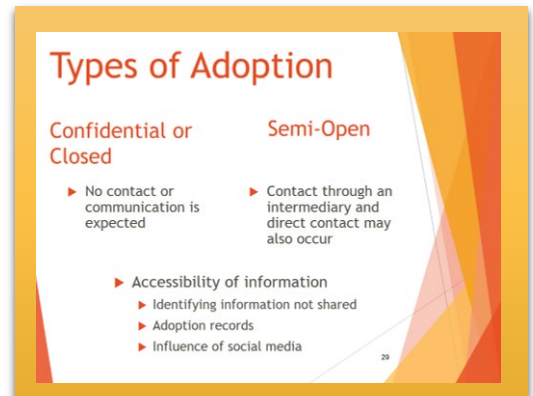
- ▶ Because of the varied requests and connections people make with one another in planning an adoption, there exists a continuum of approaches to the type of adoption. The terms that are most commonly recognized are: confidential/closed, semi-open, and fully disclosed/open. When speaking of an adoption being open, semi-open, or closed we are speaking of the relationship between the birth and adoptive families.
- ▶ Birth and adoptive families are asked to negotiate the amount of contact they wish to have with one another. All decisions should be made with the child's best interest at the heart of the dialogue. Adoption agencies attempt to bring families together who have similar wishes regarding contact. A birth mother who wants a fully disclosed or open adoption would not be shown the profile of an adoptive family who desires a confidential adoption. This is why when making adoption agreements, it is important for the parties to state their expectations clearly.

- ▶ In all types of adoption, the expectant parents may participate in selecting the adoptive family through adoptive family profiles, depending on the adoption agency the birth parents are working with.

Non identifying information (medical and social history on each of the birth parents and their families) must be shared with adopting parents. This is true for all adoptions.



ADDITIONAL TRAINER NOTES:



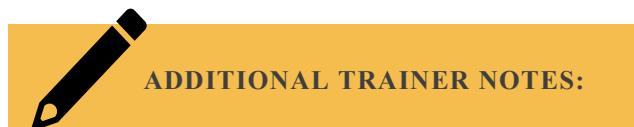
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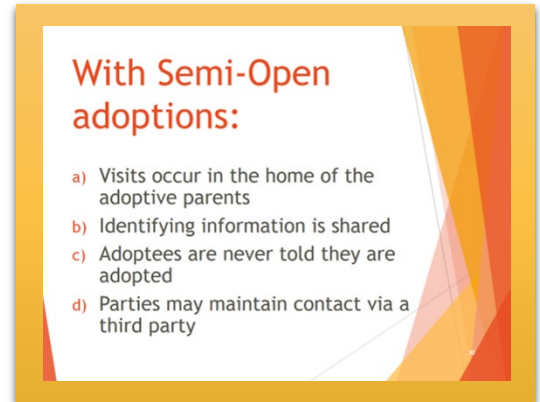
In a confidential or closed adoption, no communication or contact between the parties is expected.

In a semi-open adoption, birth parents and adoptive parents maintain contact with each other after the adoption finalizes, through a third party, such as an agency or attorney. In general, in semi-open adoptions, anonymity between the parties is maintained.

- ▶ This typically includes pictures and/or letters to each other sent on a previously agreed upon time schedule. For example, some people agree to send pictures of the child more frequently during the first year and then once or twice a year thereafter until the child reaches age 18. Some adoptive parents agree to accept birthday and/or holiday presents from the birth parents.
- ▶ The birth parents agree to maintain a current address with the agency and update the agency/adoptive family with any pertinent information, such as medical information.
- ▶ Direct in-person contact may occasionally occur, usually at the agency or pre-arranged meeting place. Other types of direct contact may also occur in a semi-open adoption, such as through the use of email.

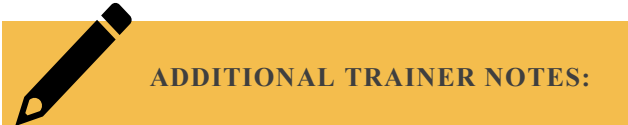
In terms of accessibility of information, in both closed and semi-open adoption, no identifying information is shared between the adopting and birth families. In some states, an adoptee can access the adoption file upon adulthood. This means that they will be able to learn their birth parents' identity. These states typically have a provision to address the issue of future contact. In the era of social media, it is important to remember how easy it is to find someone with very little information.





STATE:

The correct response is D. Let's take a closer look at response C for a moment. While there are still some cases of adoption where the adoptee is not told about their adoption, this is no longer as common as it was in the past. It is important not to confuse privacy with secrecy. Even in closed or confidential adoptions, it is more often the case that the adoptive parents share the details about the child's adoption with the child over the course of their life in a developmentally appropriate way. Referred to "late discovery adoptees", some adoptees who are not provided information about their adoption history can struggle with issues around identity development among other challenges.





STATE:

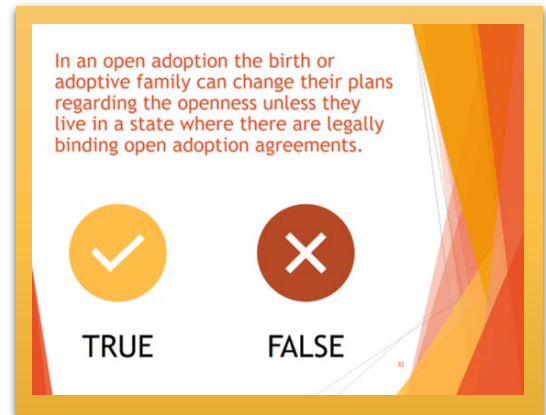
Let's review the characteristics of a fully disclosed or open adoption.

Contact between the birth and adoptive family is direct, without the agency as the intermediary.

- ▶ Full disclosure of identifying information between parties occurs. For instance, addresses and names are shared between the birth and adoptive parents.
- ▶ Some are flexible relationships where the birth parent(s) are considered part of the adoptive family's extended family, and vice versa; however, open adoption is not the same as co-parenting.
- ▶ No two open adoptions are the same. Contact between the members of the triad may be spontaneous and initiated by either party at any time. Some may be determined by a previously developed agreement of scheduled contact/visits and/or phone calls, and/or letters/pictures.
- ▶ Parties may renegotiate contact over time. Get-togethers are based on the lifestyle of the families; much like one would determine the extent of contact with in-laws.



ADDITIONAL TRAINER NOTES:



STATE:

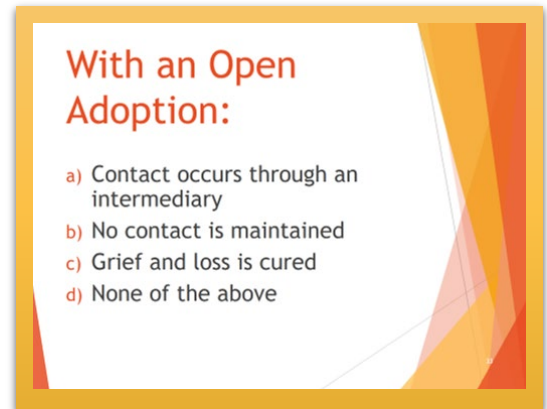
This is TRUE. Open adoptions most typically imply that there is a trusting relationship between the parties.

Having an “open adoption” does not imply anyone is legally obligated to continue to have contact. Adoption agreements in many states are good faith agreements and not legally binding contracts. In these informal agreements either birth or adoptive families may choose to change or stop previously agreed upon plans for visits and contact at any time.

While most states do not have legally binding agreements, some states do have enforceable agreements.

Adoptive parents maintain control over contact once the adoption is final. It is always the adoptive family’s responsibility to ensure their child’s safety and well-being and certain issues might make continued contact unwise.





STATE:

The correct response is D. We will talk more about the impact of grief and loss later.

Despite open adoptions become more of the “norm” in the last few decades, there are often many questions that families have about the benefits of open adoption. A report by the Evan B. Donaldson Adoption Institute outlines the benefits in their 2012 report: *Openness in Adoption: From Secrecy and Stigma to Knowledge and Openness* (pp.7-8):

- ▶ “The primary benefit of openness is access by adopted persons – as children and continuing later in life – to birth relatives, as well as to their own medical, genealogical and family histories. Adolescents with ongoing contact are more satisfied with the level of openness in their own adoptions than are those without such contact, and they identify the following benefits: coming to terms with the reasons for their adoption, physical touchstones to identify where personal traits came from, information that aids in identity formation, positive feelings toward birthmother, and others. Youth in open adoptions also have a better understanding of the meaning of adoption and more active communication about adoption with their adoptive parents (Berge, et al., 2006; Grotevant, et al., 2007; Wrobel, et al., 1996 & 1998).
- ▶ Adoptive parents as a group report positive experiences with open adoptions and high levels of comfort with contact. For them, greater openness is linked with reduced fear of and greater empathy toward birthparents, more open communication with their children about adoption, and other benefits in their relationships with their adopted children (Berry, et al., 1998; Grotevant & McRoy, 1998; Grotevant, Perry, & McRoy, 2005; Grotevant, et al., 1994; Siegel, 2008).”



ADDITIONAL TRAINER NOTES:



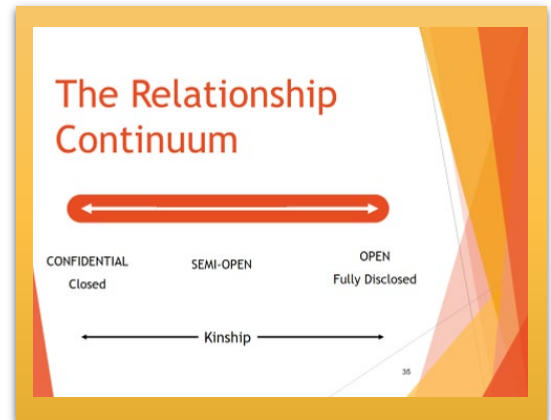
STATE:

In many states, a close relative (grandparents, aunts, uncles, brothers and sisters) can adopt utilizing a less intense procedure for the adoption. Culturally, many more relatives, and even non-biological relatives, may be considered kin by the parents; however, every state defines a relative adoption differently.

Kinship or relative adoptions are a permanent and legal arrangement that is intended to last forever, like all other adoptions. This is notably different from the more informal family care, where, for example, the grandmother does most of the parenting for a temporary time until the parent(s) is able to take over parenting responsibility.



ADDITIONAL TRAINER NOTES:



STATE:

Because of the varied requests and connections people make with one another in planning an adoption, there exists a continuum of approaches to the type of adoption. Kinship adoptions, for example, can fall anywhere along the relationship continuum.

It is recognized that a “one size” adoption does not fit all. People and relationships change over time. The adoption may start with specific agreements and arrangements, and later variations may occur as life stages change. It should be noted that it is normal for contact to ebb and flow throughout the lifespan of the adoption.



ADDITIONAL TRAINER NOTES:

Segment IV. Adoption Law

SLIDES 15-24
30 MINUTES

[PPT #15]: ADOPTION LAW



NOTE:

Review Post-it® notes that contain legal questions so that you can use them when you talk about state-specific laws.

STATE:

It is not expected for you to become an expert just by sitting in this session today. The intent is for you to obtain general knowledge regarding adoption law to share with a patient/client. Many health care professionals working in a hospital setting may feel that bringing up adoption is difficult as they feel the patient/client might have questions and emotions that they do not feel prepared to answer or handle. You should always feel comfortable saying, “I am not an expert in adoption law; but I can offer some general information and refer you to someone who can provide more complete information.

This module will provide information on Federal and State laws and answer questions about the adoption process in each state. Specific information about your state is provided in a resource guide that we will review during this module. Web-based resources for additional state specific information are provided in the Participant Handbook.



ADDITIONAL TRAINER NOTES:

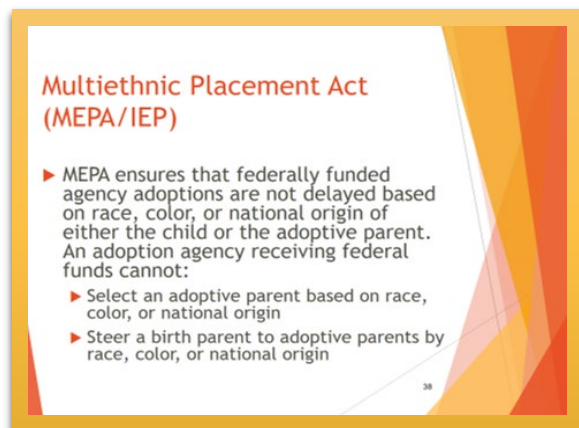


STATE:

Both Federal and State laws govern adoption in the United States. Federal law essentially regulates interstate adoption matters, adoption of Native American children, and issues of discrimination in the placement of children by agencies receiving federal funding. State law regulates all other processes affecting adoptions. Understanding the major provisions of Federal and State laws will provide useful background information when talking to patient/clients about the adoption option.

Let's begin with a discussion of the pertinent Federal laws. We will cover each of the Federal Laws listed here.





STATE:

The first federal law that we will cover is The Howard M. Metzenbaum/Multiethnic Placement Act (MEPA) of 1994, commonly referred to as MEPA. MEPA states “...Neither the State nor any other entity in the State that receives funds from the Federal Government and is involved in adoption or foster care placements may delay or deny the placement of a child for adoption or into foster care, on the basis of the race, color, or national origin of the adoptive or foster parent, or the child, involved.”

This means that an adoption agency receiving Federal funds may not steer a birth parent to adoptive parents by race, color, or national origin. MEPA ensures that federally funded agency adoptions are not delayed based on race, color, or national origin of either the child or adoptive parent. Note that not all adoption agencies receive Federal funding.

You can find more information about MEPA in the Participant Handbook under the Additional Reading section.





STATE:

Next we will cover the Indian Child Welfare Act, more commonly known as ICWA. ICWA was passed in 1978. Under the Act, Indian Tribes were granted extensive jurisdiction in child welfare cases involving Indian children, recognizing “that there is no resource that is more vital to the continued existence and integrity of Indian Tribes than their children.” The Act “established minimum standards for the removal of Indian children from their families and placement of such children in foster or adoptive homes which will reflect the unique values of Indian culture.”

- ▶ There are over 560 federally recognized Indian tribes in America. Federally recognized Indian tribes are considered by the American government to be sovereign nations. Placement and adoption of Native American children is governed by their tribe, whose authority is legislated by the U.S. Government. This means that tribes have the authority to intervene in court cases regarding adoption.
- ▶ If either parent has Native American heritage, a contact must be made to the appropriate tribe to determine if the child qualifies for tribal membership. Membership is not the same as enrollment, and each tribe sets its own membership criteria. Some tribes base membership on a specific blood quantum while other tribes only require proof of lineage from a tribal member. The only way to know for sure is to ask.
- ▶ If the child is eligible for tribal membership and the tribe chooses to intervene, the tribe will approve the placement. The tribe may decide to contact relatives for placement. If extended family members cannot adopt, the tribe has the authority to place the child for adoption with other tribal members. The third placement choice is a different tribe. The final placement choice is with a family outside the Native American community.

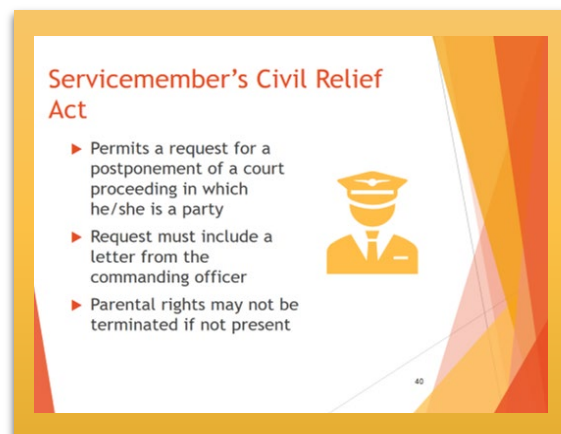
While many people are aware of the implications of ICWA in child welfare related placements, there are implications for Voluntary Infant Adoption as well. On June 14, 2016, the Bureau of Indian Affairs (BIA) released comprehensive guidelines on how to implement ICWA, which became legally enforceable in December 12, 2016. The 2016 ruling makes clear that ICWA applies in voluntary placements and that the court must require the parties involved to state as part of the record whether there is reason to believe

that the child is of Native American heritage. This ruling was upheld by a court in the Fifth Circuit in 2019.

You can find more information about ICWA in the Participant Handbook under the Additional Reading section.



ADDITIONAL TRAINER NOTES:



STATE:

The Servicemember's Civil Relief Act of 2003, formerly known as Soldiers' and Sailors' Civil Relief Act of 1940 is the next piece of federal legislation that we will review.

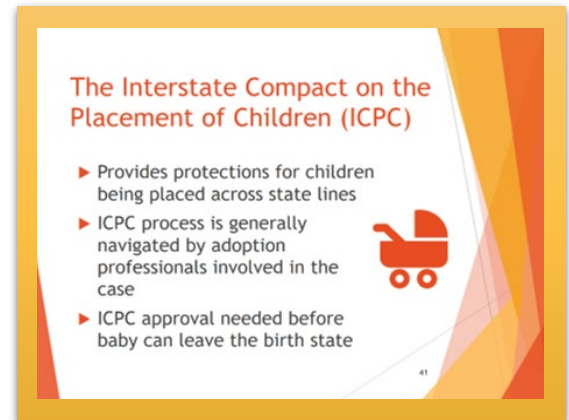
The Servicemember's Civil Relief Act protects service members who are either the plaintiff or the defendant in a civil lawsuit may request a postponement of a court proceeding in which he/she is a party. The postponement can be requested at any point in the proceedings. The provision applies to civil lawsuits, suits for paternity, child custody suits and bankruptcy debtor/creditor meetings.

In order to apply for these protections, the service member would have their commanding officer write a letter to the court and the opposing party's attorney stating that the service member is unable to attend the proceedings.

In the case of a Voluntary Infant Adoption, if the child's parent is a service member, the adoption process may be affected by this act. If the parent wants to plan for his/her child but cannot be available for hearings, his/her rights to the child may not be terminated just because he/she is not present. Parents need to be located and heard before an adoption plan can be made.



ADDITIONAL TRAINER NOTES:



STATE:

The Interstate Compact on the Placement of Children (ICPC) is the mandatory legal process the Agency uses to place a child from one state to another for purposes of foster care and/or adoption. ICPC is a legal agreement that facilitates cooperation among all 50 states, the District of Columbia, and the U.S. Virgin Islands in interstate adoption placements. ICPC allows the birth mother’s current state of residence (the “sending state”) and the adoptive family’s state of residence (the “receiving state”) each to review adoption paperwork to ensure the placement follows all state adoption laws and regulations. Each state must approve the ICPC paperwork and adoption placement before the baby can be taken out of the sending state to the adoptive family’s home. The compact applies to all non-relative interstate adoption placements.

The majority of the ICPC process is completed by the adoption professional and does not actively involve the adoptive parents. However, it is very important for the adoptive family to comply with ICPC and wait for approval before leaving the baby’s state. Otherwise, the adoption may be jeopardized and the baby may be returned to his or her birth state.

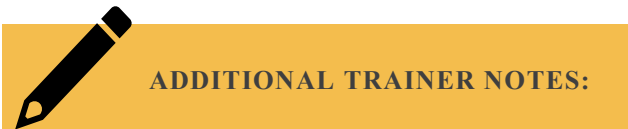


ADDITIONAL TRAINER NOTES:



STATE:

The correct response is B. States must follow both state and federal law, and state law does not supersede federal law. While you are not expected to be an expert in adoption law, it can be very helpful for you to have a basic understanding of the law governing adoption so that you can share this information with your patients. Because adoption law, especially at the state level, tends to evolve and change over time, referrals for more specific questions about adoption are appropriate to ensure your patient has the most accurate and up to date information to consider as part of their decision-making.





NOTE:

Orient participants to the state specific Resource Booklet for the state you are in. Point out that time will not permit you to cover all of the information related to state laws, but note that the resource provided is easy to use as a quick reference guide. Start with the questions collected from participants at the beginning of the module, use any remaining time to review additional content using the Resource Booklet.



ADDITIONAL TRAINER NOTES:



STATE:

Turn now to your Participant Handbook where you will find a list of birth parent rights.

From 1996 to 2018, the Evan B. Donaldson Adoption Institute was a national research, education and advocacy organization that focused on issues of domestic adoption.

In their publication: *Safeguarding the Rights and Well-Being of Birthparents in the Adoption Process*, the following were identified as rights that all birth parents should have:

- ▶ To make the placement decision in a fully informed manner devoid of pressure or concern.
- ▶ To reconsider an adoption plan at any point prior to the legal finalizing of the relinquishment.
- ▶ To be informed from the start of any monetary expectations – such as repayment of financial assistance – if she changes her mind about placement.
- ▶ To exercise all parental rights he/she wishes prior to placing a child for adoption.
- ▶ To be treated with dignity, respect, and honesty.
- ▶ To have independent legal counsel to protect her/his best interests in the process.
- ▶ To receive nondirective counseling to help her/him understand all of the options and resources available and the implications of the decision.
- ▶ To be legally assured that promises and agreements regarding ongoing information or contact made as a part of the process will be adhered to.

The rights of birth parents are protected primarily by state law, which can vary state to state. It is important that you are aware of the laws that impact birth parent rights in your state.



ADDITIONAL TRAINER NOTES:



STATE:

Another issue that health care professionals may face when working with pregnant adolescents is the need to report incidents of abuse, neglect or exploitation to the proper state child protection agency. Reporting concerns about threats to a child's safety is one way that society protects the rights of children.

A referral to Child Protective Services (CPS) is required in the following situations:

- ▶ When the parent or other person responsible for the pregnant teen's care refuses to have her in the home, threatens to harm the teen and/or the child or refuses to consent to medical care required to prevent death or a serious long-term disabling condition for the teen and/or child.
- ▶ When the pregnancy resulted from incest.
- ▶ When the pregnancy resulted from rape by a person having regular and substantial contact with the teen and who has a close personal relationship with the teen's mother.
- ▶ A child is born to a mother who has had previous children removed from her care due to abuse or neglect.
- ▶ A child is born to a mother and has symptoms of drug withdrawal.
- ▶ A child is born to a mother who states that she does not want to take the child home, has no one to care for the child, and does not want to release the child for adoption at this time.
- ▶ A child is born to a mother who exhibits abusive/neglectful behaviors to the child while in the hospital or who abandons the child in the hospital.
- ▶ A child is 12 years of age or less and is pregnant.

Remember that all states have laws that govern child protective services. It is important to have an understanding of the Child Protection Law in your state. Health care professionals are mandated reporters and as such must report suspected incidents of abuse, neglect or exploitation to the proper state child protection agency.



ADDITIONAL TRAINER NOTES:



STATE:

Let's do a quick review of the highlights of the information presented in Module Two.

- ▶ Adoption is a legal process.
- ▶ Individuals central to the adoption process are the birth family, adoptive family and the adoptee known as the adoption triad.
- ▶ It is important to be able to identify and describe current adoption practice, the different types of adoption, and the relationship continuum.
- ▶ Non-identifying information, social and medical history for each birth parent and their families must be shared with the adoptive family.
- ▶ Kinship or relative adoptions are lifelong and legal arrangements.
- ▶ Remember, you are not expected to be legal experts. However, you do have references for the laws discussed should you desire further information.
- ▶ It is important to have knowledge and understanding of the rights of birth mothers and birth fathers.
- ▶ Make sure you know the requirements for mandating reporting to child protection services in your state.



ADDITIONAL TRAINER NOTES:

UNDERSTANDING INFANT ADOPTION (UIA) 6 CURRICULUM



MODULE

3

TRAINER GUIDE



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MODULE 3: PRESENTING ADOPTION AS AN OPTION AND MAKING REFERRALS

UIA Competency: We will discuss how to present adoption as an option. We will also discuss the principles of non-directive and non-coercive counseling.

60 min

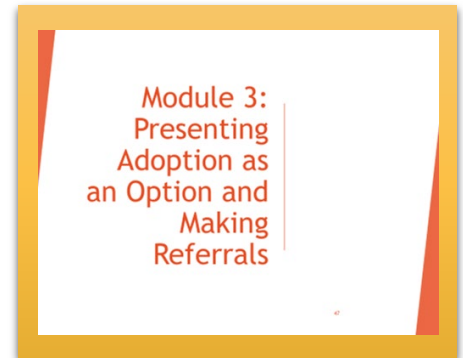
SEGMENTS

- I. Overview and Objectives (5 MINUTES)
- II. Accurate and Neutral Adoption Language (10 MINUTES)
- III. Non-Directive, Non-Coercive Counseling and Techniques (20 MINUTES)
- IV. Impact of Trauma on Pregnancy Counseling (15 MINUTES)
- V. Making Referrals (10 MINUTES)

Segment I. Overview and Objectives

SLIDES 1-2
5 MINUTES

[PPT #1]: OVERVIEW



NOTE:

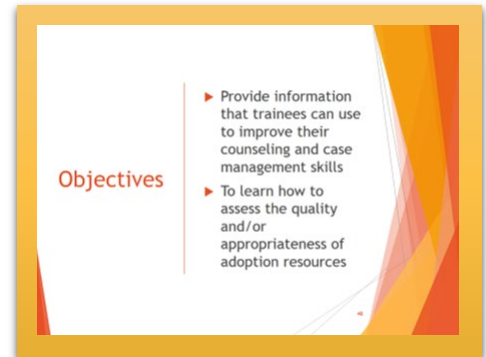
Allow approximately 60 minutes for the content that is to be covered in Module 3. Topics include:

- ▶ Accurate and Neutral Adoption Language
- ▶ Non-Directive, Non-Coercive Counseling and Techniques
- ▶ Informed Consent
- ▶ Impact of Trauma on Pregnancy Counseling
- ▶ How to Make Referrals

This module provides guidance about how to present adoption as an option. Informed consent and the principles of non-directive and non-coercive counseling are discussed. Trauma-informed counseling principles are reviewed and making referrals is introduced.



ADDITIONAL TRAINER NOTES:



In Module Two, we discussed options in adoption and the legal impact of adoption. In Module Three, we will discuss how to present adoption as an option. We will also discuss the principles of non-directive and non-coercive counseling.

The objectives of this module include:

- ▶ Providing information so that you can improve your counseling and case management skills, including cultural humility, listening, building rapport, recognizing someone in crisis, being empathetic, treating clients with respect and assessing service needs and making appropriate referrals. All of these skills are important to helping to ensure that adoption, and information about other pregnancy options, is presented objectively and without bias or judgement.
- ▶ Learning about various adoption services available within the community and how to assess the quality of those services and their appropriateness for a particular woman.



Segment II. Accurate and Neutral Adoption Language

SLIDES 3-4
10 MINUTES

[PPT #3]: LANGUAGE EXERCISE

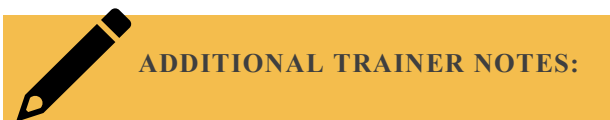


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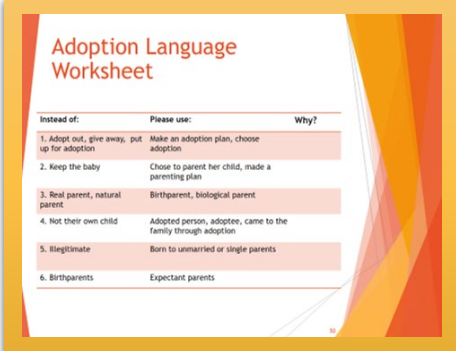
In some people’s eyes, making an adoption plan still comes with a certain stigma attached. Certain terms have the effect of closing doors and serving as barriers to having an open discussion about adoption. Insensitive comments like, “How could you give your baby away?”, can make it even more difficult for expectant parents to seek support. Over time, the language of adoption has changed as practices have changed. Adoption is a process, not a label. When speaking about adoption, it is important to use accurate and neutral adoption language.

Let’s take a few moments to look at some terms. Look now at the Adoption Language Worksheet in the Participant Handbook. These are some common words or phrases associated with adoption.

Using the *Adoption Language Worksheet*, discuss with your tablemates why the “Please Use” language is preferred.



[PPT #4]: ADOPTION LANGUAGE WORKSHEET

A graphic titled "Adoption Language Worksheet" with a table of language alternatives. The table has three columns: "Instead of:", "Please use:", and "Why?".

Instead of:	Please use:	Why?
1. Adopt out, give away, put up for adoption	Make an adoption plan, choose adoption	
2. Keep the baby	Chose to parent her child, made a parenting plan	
3. Real parent, natural parent	Birthparent, biological parent	
4. Not their own child	Adopted person, adoptee, came to the family through adoption	
5. Illegitimate	Born to unmarried or single parents	
6. Birthparents	Expectant parents	

NOTE:

Conduct a Large Group Discussion by having participants share their “Why” answers for the first item. This can be done by having one table share their answers and then asking if others have anything to add. After all the answers have been exhausted, make sure that each of the points are covered. Repeat this process for the remaining items. Preferred responses for the “Why” responses are below.

1. *“Make an adoption plan” conveys that adoption is a decision that has been thought through. “Adopt out, give away, put up for adoption” conveys that the event is done casually or without thought and also conveys the belief that the child is an object. The term “put up for adoption” originated from a time when children from the urban parts of the northeastern United States were taken by train to the western parts of the United States, placed on railroad platforms to be viewed and selected by prospective families who chose the child or children they wanted to adopt.*
2. *Keeping the baby denotes a passive decision-making process. Parenting indicates that raising a child is an active process. We keep and give away things not people. Also infers that child will always be a baby; that adoption is not a lifelong decision.*
3. *“Real parent” conveys that adoptive parents are not real, natural or entitled to parent. “Birthparent” is an accurate description of the relationship between a child and the person who gave birth to them.*
4. *By differentiating own versus adopted, the speaker invalidates the adoptive relationship.*
5. *Illegitimate has a lot of negative connotations. Is the person illegal, fake, or not real?*
6. *Use “expectant parent” until expecting parent chooses adoption; “birth parent” implies that the parent has already chosen the adoption option.*

If time permits, ask participants to share other terms or phrases that may insensitive or inaccurate.

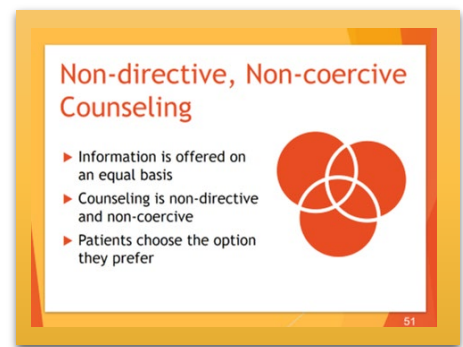


ADDITIONAL TRAINER NOTES:

Segment III. Non-Directive and Non-Coercive Counseling and Techniques

SLIDES 5-13
20 MINUTES

[PPT #5]: NON-DIRECTIVE AND NON-COERCIVE COUNSELING



STATE:

Just as the words and phrases used to present adoption as an option are important, how we present information to our patients and clients is equally important. Next, we will discuss non-directive counseling and non-directive counseling and technique.

Health care and mental health literature uses a variety of terms to describe empowerment-based approaches to treatment, including: solution-focused brief therapy; nondirective interventions; client-centered treatment; and strengths-based treatment. All of these refer to a basic premise that patient/clients have the ability to solve their own problems with adequate access to nonjudgmental, supportive resources and supports.

In the 1960s many societal values were being challenged, and new ways of thinking were being developed. One major change that occurred in the health and mental health fields was that patient/clients were empowered to take a more active role in their own care. They were no longer “acted upon,” but were partners in the decision-making and events of their lives.

Around the same time, medications were identified that helped to control the symptoms of many mental illnesses. In many cases, these medications helped people gain more control of their lives. They could return to their communities and exercise self-determination to make decisions on their own behalf.

These factors, along with the desire to curb spiraling health care costs, gave rise to the notion of brief mental health interventions. It was no longer conventional wisdom for an individual to undergo years of psychotherapy. Instead, a short, focused relationship with a health care or mental health professional was thought to be best to facilitate growth and change.

The focus was no longer on telling someone the right thing to do, but rather helping him/her discover the answers within him/herself. This marked another change in thinking that departed from the notion that the experts know best, to the belief that individuals know what is best for them and with guidance and social support, will make decisions that serve them well.

Another major change was the blurring of the divisions between physical and mental health services. Many professional roles overlapped, and each group began to develop strategies for learning about the other and working together. What resulted was of benefit to both areas. Better-trained professionals, and higher quality patient/client care.

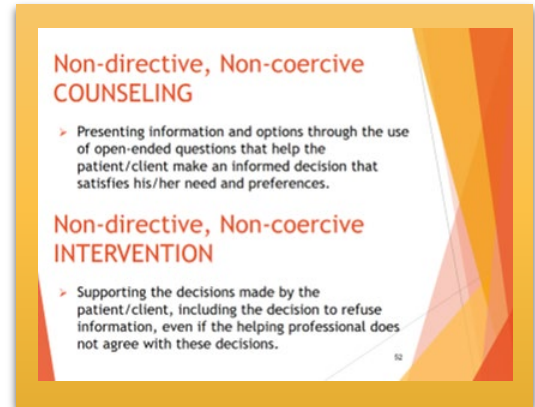
These shifts are embodied in the three principles of non-directive counseling:

- ▶ Information is offered on an equal basis
- ▶ Counseling is non-directive and non-coercive
- ▶ Patients choose the option they prefer



ADDITIONAL TRAINER NOTES:

[PPT#6]: NON-DIRECTIVE AND NON-COERCIVE COUNSELING



STATE:

Non-directive, non-coercive counseling methods present information and options through the use of open-ended questions. These questions are designed to help the patient/client make an informed decision that satisfies his/her needs and preferences.

A non-directive, non-coercive intervention requires that the helping professional support the decisions made by the patient/client, including the decisions to refuse information, even if the helping professional does not agree with these decisions.



ADDITIONAL TRAINER NOTES:

[PPT #7]: NON-DIRECTIVE AND NON-COERCIVE COUNSELING



STATE:

Are there any ethical considerations in working with mothers who present at the hospital without an adoption plan but are undecided about parenting?

Possible responses include:

- ▶ There may be concerns about having the time for her to make an informed decision.
- ▶ If there has been drug exposure there may be concerns about the mother reaching out to a private agency and making an adoption plan or working with child protective services on a parenting plan.

As a health care provider, what are some of the things that you can do to ensure your client's rights are maintained even in situations where a mother presents at your hospital without an adoption plan and undecided about parenting?

Preferred response:

- ▶ Remind her that she doesn't have to make a decision right away.

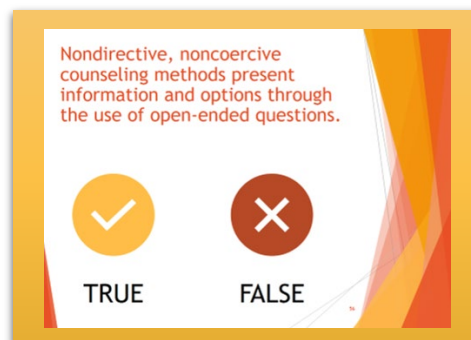
Many agencies have interim care where the child can be care for while the mother makes a decision about adoption planning or parenting. Interim care is short term foster care provided by families that have been approved to care for infants whose adoption plans are still being finalized. An interim care provider cares for the infant 24 hours per day (no daycare permitted). Interim care providers take the baby to pediatrician appointments and communicate with social workers about the baby's development. The average length of a stay in interim care is 2-24 days.

Source: <https://www.adoptionstogether.org/blog/2017/05/04/become-interim-care-provider-adoptions-together/>



ADDITIONAL TRAINER NOTES:

[PPT #8]: NON-DIRECTIVE AND NON-COERCIVE COUNSELING



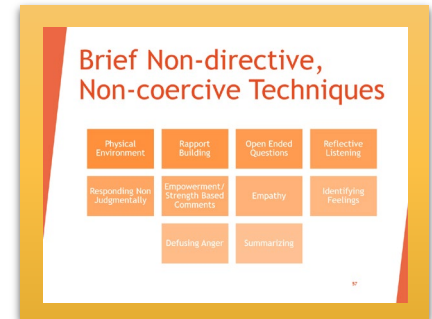
STATE:

Let's now turn to the topic of nondirective, noncoercive counseling methods. What are your thoughts in this question? The correct response is TRUE.

In addition to open-ended questions, there are many other useful techniques that you can use when supporting a patient/client experiencing an unplanned, unintended pregnancy. Let's take a look of them now.



ADDITIONAL TRAINER NOTES:



NOTE:

Ask participants to refer to the Participant Handbook to follow along. Review the definitions of each technique and provide examples.

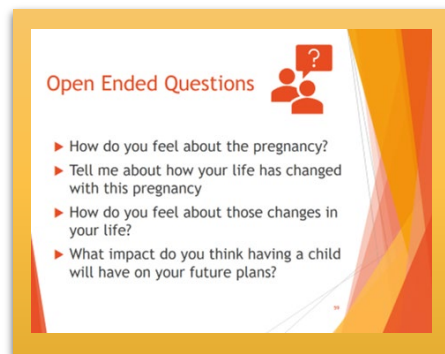
STATE:

- ▶ **Physical Environment:** It is important to ensure that the physical environment of your office, waiting room, or other areas of your organization reflect your clientele. Do the pictures on your wall or the magazines in the lobby match the diversity of your patient/clients? If you are working in a hospital setting, what are some of things that can be done to make sure that the environment is a safe place?
- ▶ **Rapport Building:** This involves developing trust through verbal and non-verbal means. Verbal rapport building can include the use of compliments, expressions of caring, such as asking, “How would you feel most comfortable?”, self-disclosure and humor. Non-verbal rapport building can include touch, eye contact, nodding, and smiling.
- ▶ **Open-Ended Questions:** These questions allow the patient/client to tell his/her story. Open-ended questions cannot be answered by a yes or no. We will talk more about open-ended questions more in a bit.
- ▶ **Reflective Listening:** This technique lets the patient/client know that the health care provider is listening to what he/she is saying. This technique is often referred to as paraphrasing and/or reflective or active listening.
- ▶ **Responding Nonjudgmentally:** Responding Nonjudgmentally requires the health care provider to continually assess their own values and beliefs so that they do not interfere with their work with patient/clients.
- ▶ **Empowerment/Strength-Based Comments:** Identifying and complimenting strengths helps an individual take control of a situation. When responding to the patient/client communication, it is helpful to notice the strengths you can identify, not just the problems and concerns.

- ▶ Empathy: Involves listening respectfully to the patient/client’s concerns and relating to the patient/client’s situation.
- ▶ Identifying Feelings: Occurs when the health care professional puts words to the emotions that are being expressed and then checks with the patient/client to make sure that his/her interpretation is correct.
- ▶ Defusing Anger: Defusing anger can be accomplished by several techniques including identifying and responding to the issues underlying the person’s anger, such as fear, acknowledging that fear, and shifting the person’s perspective.
- ▶ Summarizing: This is a technique in which the health care provider highlights key points of the conversation with the patient/client and checks back to make sure that his/her interpretation is correct.
- ▶ The resource section of the Participant Handbook contains an article titled, Brief Nondirective, Noncoercive Interventions, and a checklist titled, Effective Communication, which provides more information about techniques that can be considered helpful when interacting with patients/clients.



ADDITIONAL TRAINER NOTES:



STATE:

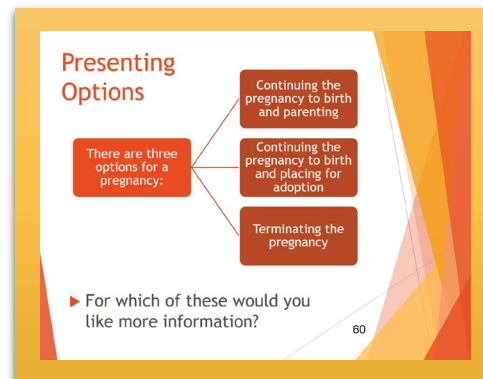
Here are some examples:

- ▶ How do you feel about the pregnancy?
- ▶ Tell me about how your life has changed with this pregnancy.
- ▶ What impact do you think having this child will have on your future plans?
- ▶ Tell me what concerns you have about this pregnancy.
- ▶ Who will be helping you as you go through this pregnancy and how do you feel about their helping?

Ask participants to share their experiences using open ended questions. Ask participants to share other open-ended questions that might be helpful when talking to a pregnant woman



ADDITIONAL TRAINER NOTES:



STATE:

As a health care provider, you can bring together open-ended questions and providing information about the options by saying something like: There are basically three options available to you:

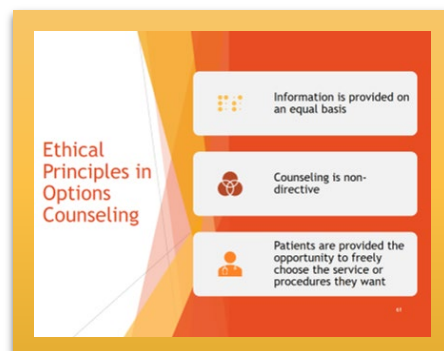
- ▶ continuing the pregnancy to birth and placing him/her for adoption by relatives or non-relatives;
- ▶ continuing the pregnancy to birth and parenting;
- ▶ or terminating the pregnancy.

For which of these would you like more information?

You will find an article in the Participant Handbook in the resource section titled, Introducing Pregnancy Options in Fifteen Minutes or Less. This script provides suggested language that can be used when informing a patient/client of a positive pregnancy test result. The resource section of the Participant Guide includes two examples of literature that can be provided to patients/clients who are experiencing an unplanned, unintended pregnancy.



ADDITIONAL TRAINER NOTES:



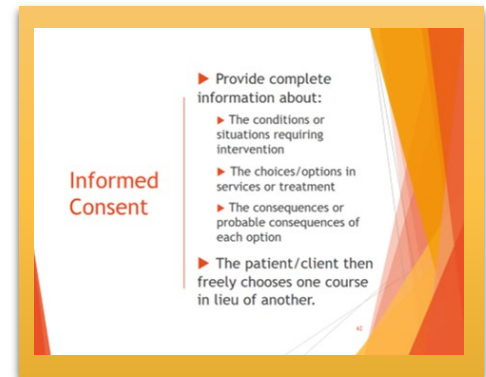
STATE:

As mentioned in Module One, the practice and clinical standards of many health care organizations guide professionals in their work in Options Counseling. Although organizations vary in the amount of detail they provide in their standards and code of ethics statements, they all share three important principles:

- ▶ Information is provided on an equal basis
- ▶ Counseling is provided in a non-directive manner.
- ▶ Patients are provided the opportunity to freely choose the service or procedures they want.



ADDITIONAL TRAINER NOTES:



STATE:

Informed consent is given after the patient/client or patient/client’s legal representative has been provided with complete information as to:

- ▶ The conditions or situation requiring intervention.
- ▶ The choices/options in services or treatment.
- ▶ The consequences or probable consequences of each option.
- ▶ Then the patient/client freely chooses one course in lieu of another.

Although the roles of various helping professionals may differ, the goal of informed consent in adoption is to assure that a patient/client fully understands the present and future consequences of an adoption decision, and options other than adoption, that may be available to resolve their situation.

Informed consent by the patient/client makes them responsible for the final decision and all of its consequences. Using this method of intervention is consistent with the health care practice of supporting the patient/client while he/she has the responsibility for the final decision-making.

Some adoption agencies have reported seeing declines in the numbers of expectant parents inquiring about services for adoption with fewer numbers following through with options counseling. Although best practice would be that all expectant parents receive options counseling, it is equally important to meet the individual needs of each patient/client. In some cases this will mean finding ways to engage in shorter interactions, while still providing the information that is needed to help expectant parents make informed decisions.

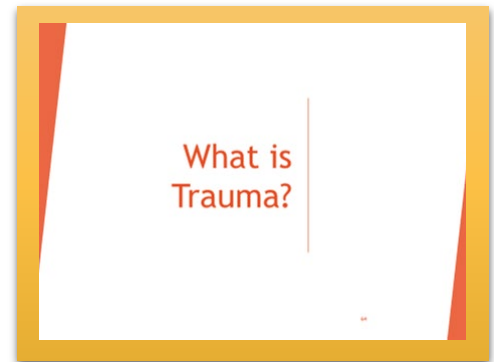


ADDITIONAL TRAINER NOTES:

Segment IV. The Impact of Trauma in Pregnancy Counseling

SLIDES 14-16
15 MINUTES

[PPT #14]: WHAT IS TRAUMA?



STATE:

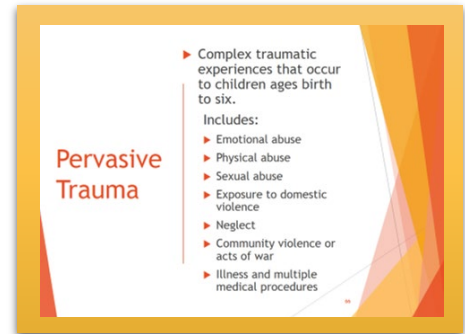
So far in this module we have discussed non-coercive, non-directive counseling and informed consent. Now let's switch gears and talk about the impact of trauma in pregnancy counseling.

What is trauma? Working in the helping profession, you have probably heard all of the buzz around "trauma." The word "trauma" can mean a lot of different things to different people. In the medical field, trauma is most often associated with a physical injury. But trauma is not just physical harm.

In the social services and mental health field, the word trauma is associated with psychological harm that occurs as the result of an event, or a series of events that is experienced by an individual. More recently we have come to understand that traumatic experiences can in fact impact all aspects of well-being including physical health, cognitive development, emotional, and relationships. An important aspect of trauma is the issue of safety. People who have experienced trauma experience the world around them to as being unsafe.



ADDITIONAL TRAINER NOTES:



STATE:

Pervasive developmental trauma generally refers to complex traumatic experiences that occur to children ages 0-6. Children may experience various types of trauma including:

- ▶ Emotional abuse
- ▶ Physical abuse
- ▶ Sexual abuse
- ▶ Exposure to domestic violence
- ▶ Neglect
- ▶ Community violence or acts of war
- ▶ Illness and multiple medical procedures

Neglect is often thought to be the most impactful form of childhood trauma.

In addition to concerns about early childhood experiences, new research shows that pre-birth exposure to violence, malnutrition, substance exposure and chronic stress also impacts well-being.

The current thinking in the field is that early childhood trauma has the most profound impact on overall wellbeing than do other types of trauma. In Module Four, will cover the impact of trauma on sexual health and in more detail.



ADDITIONAL TRAINER NOTES:

[PPT #16]: IMPACT OF TRAUMA ON INFORMED CONSENT



STATE:

Let's consider these questions for a few minutes.

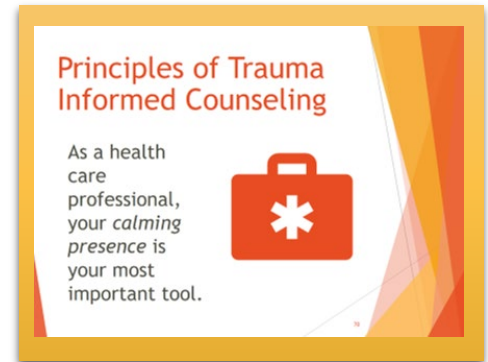
As a health care provider, how have you seen the trauma (acute or complex) affect your patients' ability to process their feelings and/or information?

As a health care provider, how have you seen the trauma (acute or complex) affect your patients' ability to make decisions about their options?

As a health care provider, what have you found to be helpful when working with a patient who is in crisis and struggling to process their emotions?



ADDITIONAL TRAINER NOTES:



STATE:

When dealing with a person who has a trauma history or who is dealing with the crises of an unintended pregnancy or a traumatic birth experience, patients can benefit from health care providers who can listen and hear their concerns. Most importantly, patients need our help to regulate their emotions. Until our patients are in a calm state, they cannot really process anything that we say to them.

It is easy for health care providers to feel anxious about saying the wrong thing or doing the wrong thing. As a health care provider, your calming presence is your greatest tool. When you're dealing with a person in crisis, it is fitting for us to remember a quote by poet, Mayo Angelou: "I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."



ADDITIONAL TRAINER NOTES:

Regulate	
Give	Give patient time and space
Suggest	Suggest sensory-based techniques
Be	Be calm yourself

STATE:

The importance of relationships is key to most forms of counseling. The same is true for trauma informed counseling. After the patient is regulated, then the health care provider can work on building rapport with the patient. You will remember we covered building rapport in more detail earlier. This includes the use of compliments, expressions of caring, self-disclosure and humor. You can also connect with your patient through non-verbal rapport building techniques such as touch, eye contact, nodding, and smiling.

It is only after your patients are in a calm regulated state that you complete the next step in options counseling which is providing information about options and referrals for more information and support.

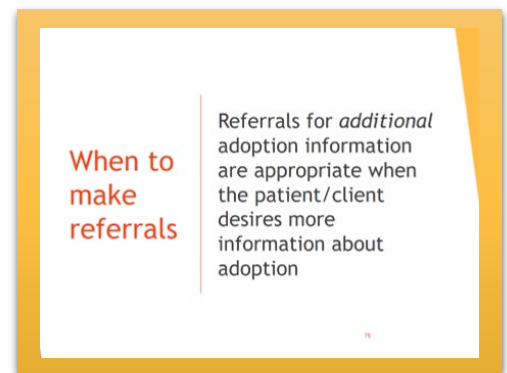


ADDITIONAL TRAINER NOTES:

Segment V. Making Referrals

SLIDES 19-22
10 MINUTES

[PPT #19]: WHEN TO MAKE REFERRALS



STATE:

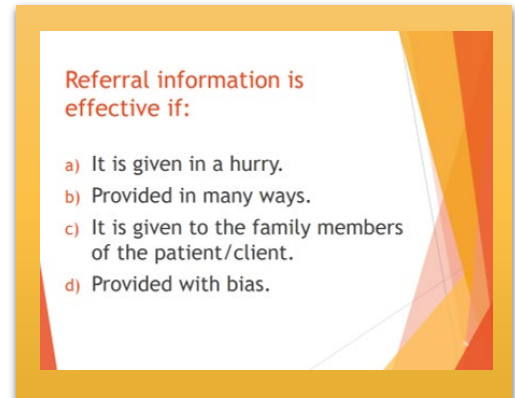
Referrals for further adoption information are appropriate when the patient/client desires more information about adoption. It might also be appropriate to make a referral when the pregnant woman may be undecided and wants more information.

Patient/clients who are pregnant require information about all of their available options.

Often there is more than one resource for a service in which case you can be helpful by identifying questions the clients might ask before deciding which resource best meets their needs. They may want referrals to additional resources including pregnancy counseling and adoption services, or Public Health Department programs such as Women Infants and Children (WIC). They also might need help with housing or shelter care.



ADDITIONAL TRAINER NOTES:

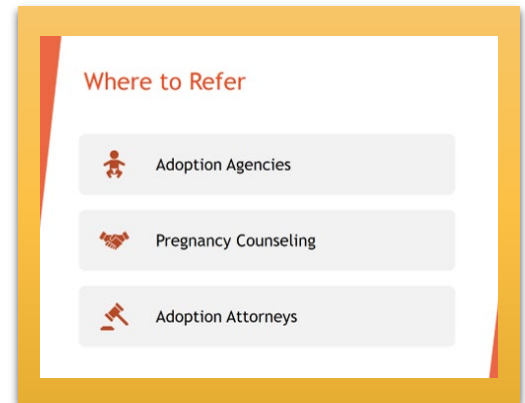


STATE:

The correct response is B. Referral information works best when it is provided orally, written and /or in brochures.



ADDITIONAL TRAINER NOTES:



STATE:

Let's review the types of agencies and professionals that support those who are experiencing an unplanned/unintended pregnancy.

- ▶ Typically, adoption agencies are licensed by the state to provide pregnancy counseling and adoption services. The role of the agency is to assure that not only the legal issues are handled correctly, but that the social and emotional issues are addressed through counseling as well. Many birth parents are now considering agencies as they want the post-placement counseling for as long as they need it.
- ▶ Some organizations provide pregnancy and options counseling, though they do not provide adoption services. They often have partnerships with adoption agencies that they refer to. Some may also provide related services such as pregnancy testing, maternity clothes and assistance, or referrals to meet other needs during pregnancy and postpartum if the decision is to parent.
- ▶ In most states, attorneys can provide the legal services required for an adoption. The attorney often has profiles of approved adoptive families to consider if the birth parents do not already have someone in mind. Some attorneys have resources they refer to for services such as counseling.

Generally, adoption agencies have no fees for pregnancy counseling or adoption services for birth parents. Qualified birth parent expenses are covered by the agency or passed on to the adoptive family. The attorney fees for both the birth and adopting family are usually paid for by the adopting family.

Refer participants to the State Specific Booklet which includes a listing of adoption agencies that provide pregnancy counseling and adoption counseling and attorneys that specialize in adoption.



ADDITIONAL TRAINER NOTES:



STATE:

Unfortunately, there are some situations that expectant parents and adoptive families can find themselves in when navigating the adoption process without the right agency and legal supports in place.

Expectant parents may be working with an out-of-state agency (not licensed in the placing state) and as a result will most likely receive no post-placement support. Other expectant parents are responding to ads from consultants and attorneys who are advertising illegally. Families who desire a liaison after placement often don't find out until later in the process that facilitators can't provide these services. Education of attorneys who facilitate private adoptions is also important. Some facilitate these placements with no understanding of the long-term challenges that they are creating and are not following best practice when it comes to adoption, for example, circumstances where attorneys are having the expectant mother waive counseling.

When expectant parents and prospective adoptive families locate each other on their own without the support and guidance of an adoption agency, they can quickly find themselves in legally complex adoption situations. There are many private providers/facilitators that do more online but may have less follow through.

- ▶ Expectant mothers are using the Internet more frequently to find adoptive families who have created social media pages about their desire to be matched. Matching in this way can result in circumventing laws that many states have that require parties to work with the guidance of an agency. Without this guidance, birth mothers may not have access to the support and legal protection that they need during their decision-making process.
- ▶ Adoptive families may arrive at the hospital to receive placement with no guidance. Often the facts of an expectant mother are not disclosed, such as substance exposure, so the adoptive parents walk into situations they are unprepared for. In some cases, families have some concerns a few years after their adoption and the agency or person they worked with are no longer available to help.

For these reasons, it is very important that you connect your patient/client to support who are reputable and have the appropriate expertise. For example, attorneys who are members of the Academy of Adoption and Assisted Reproduction Attorneys are those who commit to ethical practices in adoption.

The Participant Handbook contains a list of questions, *“Questions for Health Care Practitioners to Ask Agencies and/or Attorneys.”* These are some questions you might use when attempting to identify appropriate referrals. Another resource, Questions for Patient/Clients to ask Agencies and Attorneys can be given to patients/clients as a guide for them to use when accessing additional support. Openness education is critical for families entering this adoption process. Demonstrating based on research that openness is a helpful and healthy approach is an area that needs more attention.



ADDITIONAL TRAINER NOTES:

UNDERSTANDING INFANT ADOPTION (UIA) 6 CURRICULUM



MODULE

4

TRAINER GUIDE



Funded through the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #90CO1135. The contents of this material do not necessarily reflect the views or policies of the funders, nor does mention of trade names, commercial products or organizations imply endorsement by the U.S. Department of Health and Human Services. This information is in the public domain.

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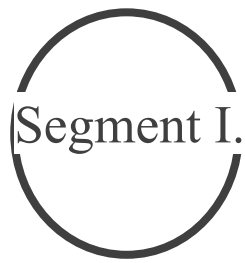
MODULE 4: INFLUENCES ON DECISION MAKING

UIA Competency: Explore some of the other considerations with adoption. Specifically, we will look at the influences on a woman's decision making such as culture, family, community, the expectant father, adolescence, substance use, domestic violence and trauma, and grief and loss.

75 min

SEGMENTS

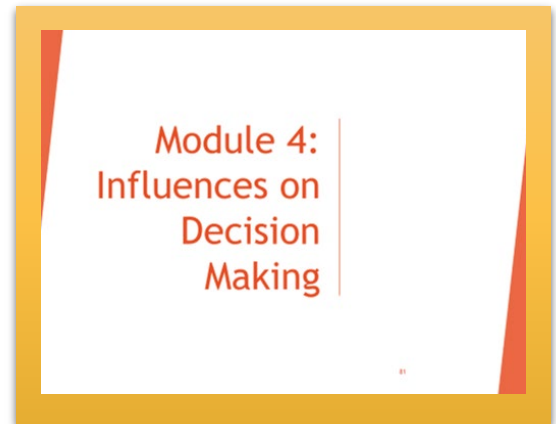
- I. Objectives and Introduction to Influences (10 MINUTES)
- II. Culture (10 MINUTES)
- III. Birth Fathers (10 MINUTES)
- IV. Adolescent Decision Making (10 MINUTES)
- V. Substance Use (10 MINUTES)
- VI. Impact of Trauma (15 MINUTES)
- VII. Grief and Loss (10 MINUTES)



Segment I. Objectives and Introduction to Influences

SLIDES 1-5
10 MINUTES

[PPT #1]: OVERVIEW



NOTE:

Allow approximately 75 minutes for the content that is to be covered in Module Four. Topics include the influences on a woman's decision, including:

- ▶ Culture
- ▶ Birth Father
- ▶ Adolescent Pregnancy
- ▶ Substance Use
- ▶ Impact of Trauma
- ▶ Domestic / Inter-Partner Violence
- ▶ Grief and Loss



ADDITIONAL TRAINER NOTES:

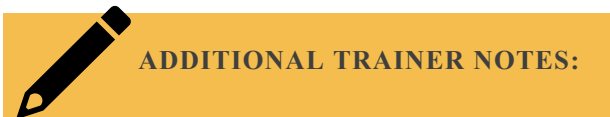


STATE:

In Module Two, we explored the option of adoption and the legal ramifications of making an adoption plan. In Module Three, we discussed how to present adoption as an option using non-directive counseling. Now, in Module Four, we will explore some of the other considerations with adoption. Specifically, we will look at the influences on a woman’s decision making such as culture, family, community, the expectant father, adolescence, substance use, domestic violence and trauma, and grief and loss.

Our objectives for this module include:

- ▶ Increasing sensitivity, understanding and skills regarding the influences that expectant parents may experience from family, peers, and community.
- ▶ Understanding how culture, the expectant father, substances, trauma and grief and loss impact woman’s decision-making process.
- ▶ Learning how adolescent development impacts options counseling.
- ▶ Exploring psychological and emotional reactions, such as shame, grief, loss, guilt, and depression that expectant parents are likely to experience throughout the decision-making process as various pregnancy options are considered.



[PPT #3]: HOW DO PEOPLE MAKE DECISIONS



STATE:

Let's first consider this question. How do people make decisions?



ADDITIONAL TRAINER NOTES:

ACTIVITY

NOTE:

Divide participants into small groups with the 1-2 people around them for a team activity. Set a timer for three minutes once teams are in their groups and have them work quickly to generate a list.

STATE:

Now that you are in small groups, work together for three minutes to come up with a list of some of the influences on woman's decision making related to an unplanned, unintended pregnancy.

After three minutes have each team share one item at a time from their lists without repeating something that another group has already identified. Record the list on a flip chart or white board so that participants can see the responses. Add any from the list below that were not mentioned.

Possible answers are:

- ▶ Culture—more adoptive families are adopting transracially; women from some cultures may make adoption plans more secretly because of stigmas attached or fear of being judged and they may choose closed adoptions which is not always best for the child as they age as closed adoptions limit the ability for the child to know their birth family
- ▶ Age—teenagers are not the only population who experience unplanned/unintended pregnancies
- ▶ Family and friends—family members may oppose adoption; this pressure can be greater on expectant parents who may still be living with their own parents
- ▶ Religion/Spirituality—beliefs about the preferred ways to develop families; views about termination of pregnancy
- ▶ Society—more LGTBQ families are adopting; numbers of prospective adoptive parents with infertility issues continues to increase; more adoptive families are open to adopting children from the foster care system through private agencies
- ▶ Media—fears continue to be part of the process from both the expectant parent perspective and the adoptive parent perspective due to how adoption in past and currently is shown through media (TV, movies, social media)
- ▶ Child Protective Services—some expectant parents may be influenced by current of past involvement with the child welfare system





NOTE:

Now that we have generated this list, let's take a look at how some of these influences may play out. Influences is a three-minute video featuring Stephanie, a young pregnant woman who repeats in her head all the advice and comments she has received from everyone she knows, including friends, family, and the birth father.

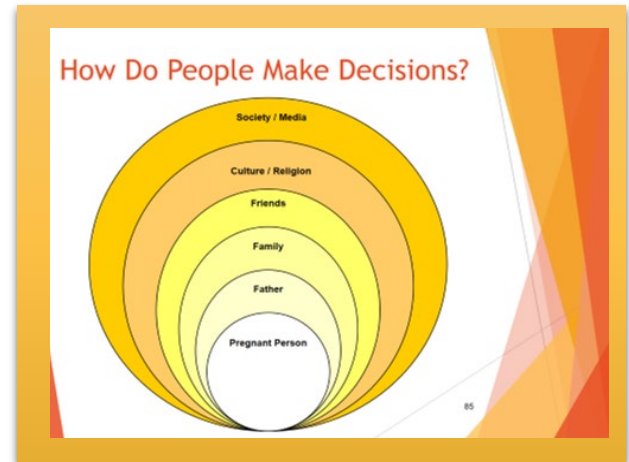
Play the Influences video: <https://cdn.jwplayer.com/players/yZD1j8kX-BQWrJxa9.html>

Let's talk about what we saw in this video.

- ▶ What would it feel like to have so many people telling you what to do?
- ▶ Please list the helpful things you heard during the video.
- ▶ How would this input affect your decision-making?



[PPT #4]: HOW DO PEOPLE MAKE DECISIONS?



STATE:

As highlighted in the influences video, there can be many influences on a woman decision related to an unplanned/unintended pregnancy. We don't live in a vacuum. We have all kinds of people, opinions and messages coming at us telling us the "right" thing to do. It can seem like everyone we know has an opinion.

We listen to some opinions more than others depending on our relationship to that person. We may listen more to someone we know well, or someone we trust, and we may disregard the opinions of those who we are not close to or we believe do not have our best interests in mind. We may consider the expertise of the person giving the advice when we decide how much weight to give their opinions.



ADDITIONAL TRAINER NOTES:

Segment II. Culture

SLIDES 6 - 12
10 MINUTES

[PPT #6]: CULTURE & VALUES




STATE:

Throughout this module we will take a closer look at some of the key “influencers” on decision making. Let’s start by looking at the role, of culture, family and community. What do we mean when we talk about culture? Culture is the values, traditions, the social behavior of certain groups of people. Culture is a way of life that is transmitted generationally. Culture impacts decision-making.



ADDITIONAL TRAINER NOTES:

When working with someone of a culture different than your own, remember the patient/client:



- ▶ May have a different *perspective* on the situation
- ▶ May have a different *priority* in the situation

▶ The patient/client's perspective is *more important* than yours, and they have *the right* to make their own decisions about their life.

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STATE:

When working with someone of a culture different than your own, it is imperative that you remember that the patient/client may have a different perspective on the situation, and they may have a different priority in the situation. Ultimately, the patient/client's perspective is more important than yours and they have the right to make their own decisions about their life.



ADDITIONAL TRAINER NOTES:

Culturally Responsive Health Care Providers:

- a) Are aware that there is little diversity within a culture.
- b) Recognize that cultural factors influence the decision-making process.
- c) Are not concerned about the power differential.
- d) Always include family members in the process.

STATE:

Let's take a look at this question. What would you say is the best response? The correct response is B. Let's look more closely at Culturally Responsive Services.



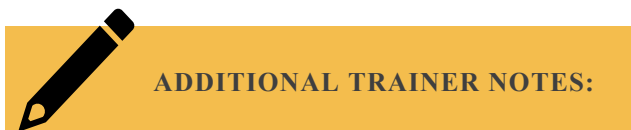
ADDITIONAL TRAINER NOTES:



STATE:

Cultural responsiveness requires that the health care provider be aware and respectful of the cultural norms held by the patient/client that may influence his/her decision-making or his/her perception of the available options. We need to be aware and respectful of commonly held culturally held beliefs, yet not stereotype or make assumptions.

More information about culturally responsive services can be found in Participant Guide in the article titled: Cultural Responsiveness in Providing Options Counseling. Also provided are a Cross-Cultural Skills Checklist and Cultural Background Self-Assessment Worksheet to help you consider the influences of your own culture.





STATE:

As a health care provider, being aware of the influence that culture, community, and family play in decision making is very important in helping guide your patient through the decision-making process. Cultural humility describes the ability to maintain a position of being open to the experiences of others.



ADDITIONAL TRAINER NOTES:



STATE:

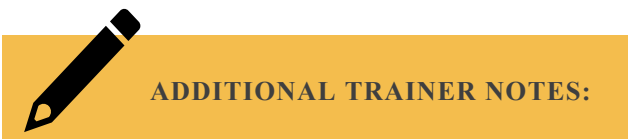
Next, let's do an exercise that will allow you to discuss a scenario where culture, family, and community are possible influences.

Read the Lillian Scenario: (See Module 4 in the Participant Handbook)

Lillian is a 26-year-old Hispanic, Catholic woman who has come to your hospital-based clinic seeking prenatal care. She has recently moved back to the community where she was raised after losing her sales job and breaking up with her boyfriend, the baby's father. For the last year, she had been living in a major metropolitan area in another state with her boyfriend and her 5-year-old daughter from a previous relationship. Following the dissolution of her relationship with the boyfriend, Lillian moved back to her hometown to be near her mother. She is now five months pregnant. The ultrasound reveals that she is carrying a boy.

Despite the fact that she has been very successful raising her daughter, shortly after you became her health care provider, Lillian has begun to express doubts about her ability to raise another child on her own. She indicates that her father is deceased, and her mother has had to go back to work to support herself, and Lillian's two younger siblings are still in high school. Lillian would like to continue working toward her bachelor's degree in marketing so that she can provide a better life for her daughter, but she does not know how she can do this and take care of another child. She indicates that the baby's father is involved in another relationship and has let her know that he is not interested in being a father at this point in his life and that he has no intention of being involved in the baby's life.

Lillian's aunt and her husband have approached her regarding adopting the baby. They have been married for several years, are in their forties and have not been able to have children. Lillian seems ambivalent about the whole issue of placing her baby for adoption. She does not know how she can go on with her life if she gives her baby to someone else to raise.





STATE:

What are the influences impacting Lillian? Possible responses are:

- ▶ Her family
- ▶ Her mom having to go back to work
- ▶ Her faith/religious background
- ▶ Being Latina
- ▶ Her father's death

As a health care provider, how can you be respectful of her culture?

- ▶ Understand that her mother may be a big influence
- ▶ Understand that her Catholic faith may be an influence
- ▶ Understand that her community may be an influence

What other issues will be important to consider when working with Lillian?

- ▶ Grief and Loss of boyfriend and father
- ▶ Employment
- ▶ Bilingual services
- ▶ Church relationships/religious issues
- ▶ Child care
- ▶ Familial relationships (mother, aunt and uncle)
- ▶ Neighbors and friends



ADDITIONAL TRAINER NOTES:

Segment III. Birth Father

SLIDES 13-18
10 MINUTES

[PPT #13]: EXPERIENCES WITH ADOPTION



STATE:

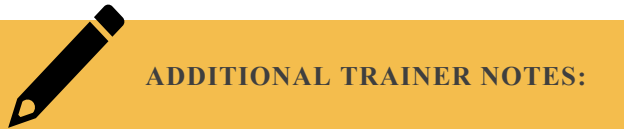
Someone who may bear a great deal of influence on the decision to be made is the expectant father. Engagement with him must start with the pregnant woman. It is the pregnant woman's decision to determine how she wants the birth father engaged in the process of discussing pregnancy options with the health care professional. Once she makes the decision to include him in the discussion with the health care professional, it is that professional's responsibility to engage him in the process. It is important for health care professionals to engage interested expectant fathers using the same techniques used to engage others: treating them with dignity and respect; actively listening to their concerns and being nonjudgmental.

Remember that:

- ▶ Legally many states demand that expectant fathers be contacted regarding a pregnancy and offered counseling and services. When indicated, health care professionals can be welcoming and helpful in encouraging him to support the pregnant woman by attending prenatal and perinatal visits, if that is what the pregnant woman chooses or wants. Health care professionals can facilitate informed decision-making by identifying strengths and building on those in making referrals.
- ▶ Without exception, expectant fathers who release their parental rights experience a range of feelings, including a sense of loss. Even the most seemingly disinterested expectant father – despite his relief, despite his eagerness to sign the papers, despite his apparent urge to flee – still experiences a loss. Many expectant fathers find it helpful to talk about this sense of loss, either

in a professional or peer support setting. Expectant fathers who release their parental rights will experience loss and may find it helpful to talk about this with others, either in a professional or peer support setting.

- ▶ Birth fathers can be encouraged to provide information about themselves, their medical history, and their interest in contact with their child when he/she is an adult. This information needs to be given to the attorney and/or agency completing the adoption. In open adoptions, birth fathers may be able to maintain on-going contact with their child and update any personal or medical information for the adoptive family.
- ▶ Birth fathers can become custodial parents.



In engaging birth fathers, it is the healthcare providers responsibility to:

- a) Contact him when the child is born.
- b) Make sure he doesn't come to the appointments.
- c) Let him know that if he stays involved, he can avoid child support.
- d) Be supportive toward his feelings and reactions.

STATE:

Consider this question. How would you answer this? The correct response is D. It is important to talk with the expectant mother about the importance of the expectant father's involvement. The ultimate decision is hers. If she chooses to involve him on the process, he should be treated with dignity and respect. Let's talk about engagement strategies when working with birth fathers a bit more.



ADDITIONAL TRAINER NOTES:

**STATE:**

If the birth father is at all involved with the pregnant woman, he will play a significant role in her pregnancy option decision. Therefore, he should have as much information as possible to help him support her decision-making process. Should the decision be to parent a child, the birth fathers' involvement may be beneficial to the life and well-being of that child. This underscores why it is so important for him to be engaged in the process from the beginning. If the pregnant woman chooses to involve the birth father, the health care professional can facilitate this engagement. Let's look at some ideas to help us consider how we can best engage the birth father.

Have male-oriented items in the office including décor, magazines, information about fathering and fatherhood programs, information in grief and loss and support groups for men. Make sure he feels welcomed by all staff. Discuss honestly with staff what their feelings are about the birth father and men in general.

Talk to the birth father directly, ask him specifically what he wants to know or talk about. Don't assume that what you have heard from the pregnant woman represents how he feels. Attending to his questions and concerns using non-directive, non-coercive techniques. Acknowledge this is a difficult decision for him as well. Point out how important he is to the decision-making process.

Have resource information available about the role of the birth father in pregnancy care, birth, and parenting. Provide ideas about how he can be a positive support to the pregnant woman.

If both the pregnant woman and the birth father agree, it would be beneficial if the paternal relatives are also encouraged to be part of the process. For so long, birth fathers have not been encouraged to participate, much less the paternal relatives. Extended family support can be very important during these times.

Are there any questions that you have regarding birth fathers and the role they can play in a woman's decision-making process when faced with an unintended pregnancy?

More information about working with birth fathers can be found in the Participant Handbook in the articles titled: Common Myths and Facts for Birth Fathers, Stages of Birth Father Grief, and Techniques to Engage Birth Fathers.



ADDITIONAL TRAINER NOTES:

[PPT #16]: INFLUENCES OF THE BIRTH FATHER



STATE:

This exercise allows participants to discuss a scenario where the birth father status plays a role in a woman's decision.

Read the Jazmine Scenario: (See Module 4 in the Participant Handbook)

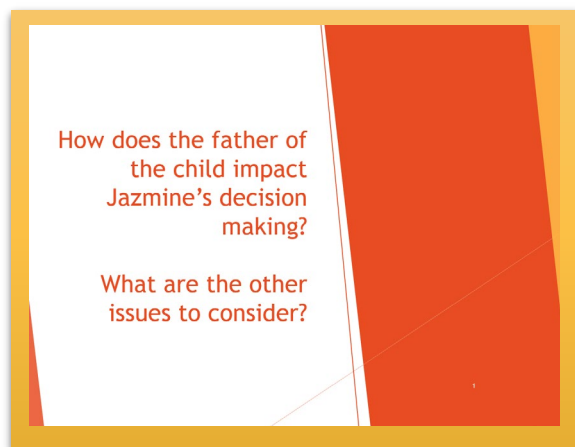
Jazmine is a 27-year-old woman who has presented at the emergency room with acute stomach and back pain. Upon physical examination and ultrasound, it is discovered that she is approximately 38 weeks pregnant and is in labor. Jazmine is understandably in shock that she is about to have a baby. After a few moments to digest this information, Jazmine tells the ER staff that she has never had regular periods due to a “hormone disorder” and she thought her recent weight gain was due to “stress eating.”

Jazmine has recently moved to the area to start “a new life” with a new job as a “buyer” for a major department store chain. She is unsure of who the father of the baby is. It could be her ex-boyfriend. Jazmine relates that she went through a tumultuous period for several months last year when she and her boyfriend broke up. They were “on again, off again” and during this time she was partying a lot and admits to “having a one-night stand.”

Jazmine is obviously overwhelmed with the news that she is about to give birth to a child. She expresses her concern that she is not in any way prepared to raise a baby at this time. Jazmine states that she has never really had the desire to have children because she did “not have the best childhood” and is not close to either of her parents who are divorced, remarried and have “new families of their own.”



ADDITIONAL TRAINER NOTES:



STATE:

Large Group Discussion: Jazmine Scenario

How does the father of the child possibly impact Jazmine's decision making?

- ▶ She has no support
- ▶ The embarrassment of not knowing who he is
- ▶ Jazmine does not know who the father is
- ▶ Jazmine doesn't have a relationship with ex-boyfriend

What are other influences may impact Jazmine's decision making?

- ▶ New job
- ▶ No family support
- ▶ No time to prepare
- ▶ She may be traumatized by the news
- ▶ She may have a trauma history based on what she said about her family
- ▶ She may be worried about not having pre-natal care and partying early in job

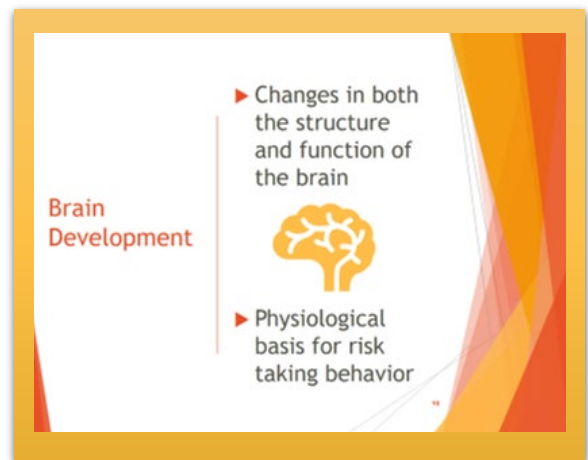


ADDITIONAL TRAINER NOTES:

Segment IV. Adolescent Decision Making

SLIDES 18-26
10 MINUTES

[PPT #18]: BRAIN DEVELOPMENT



STATE:

Let's look now at how adolescent development influences the teen's ability to cope with an unplanned pregnancy. Adolescents can be mature one moment and frustratingly immature the next. The adolescent brain is not fully developed. Knowing this may help us understand some adolescent behavior. Adolescence is a time of important changes in both the structure and the function of the brain. In fact, maturation of the prefrontal cortex is not complete until the mid 20's. At the same time the prefrontal cortex is maturing there are other changes going on in the brain including increased release of dopamine, the chemical substance that is responsible for the feeling of pleasure.



ADDITIONAL TRAINER NOTES:



STATE:

Let's look at some key elements of typical adolescent development.

Cognitively, adolescents are still formulating their own points of view. They do this by trying out different ways of doing things and adjusting what they do based on the reactions of others or their demands and expectations. Emotionally, adolescents are often egocentric in nature, operating in a self-centered manner. They can be moody and have coping skills that are not fully developed.

Socially, adolescents look primarily to the peer group for information and guidance. While this group may be one of the largest influences on a patient/client the information they provide may not always be accurate. Remember that it is part of adolescent development to separate from caregivers and reject parental input.

Adolescents this age may not understand the reality and impact of caring for a baby until months after the baby is born. Early (12 to 15 years old) and middle adolescents (16 to 18 years old) have difficulty anticipating the needs of others and putting them above their own, particularly the unborn child. Research has shown that younger adolescents possess less sophisticated decision-making skills than do 16 to 18-year-olds.



For pregnant teens this normal stage of development can make them appear to be undecided, unpredictable and non-compliant



ADDITIONAL TRAINER NOTES:

[PPT #20]: QUESTIONS ON ADOLESCENT DEVELOPMENT

Research shows that pregnant teens in middle (16-18) adolescence are able to make good decisions for themselves and their child.

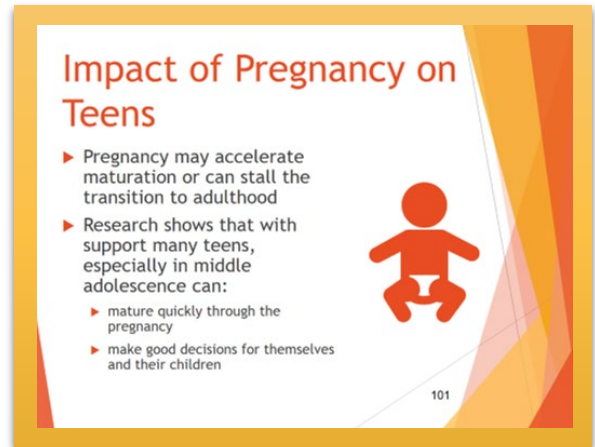
TRUE FALSE

STATE:

The correct response is TRUE. What is your reaction this question? Does it surprise you at all? Let's talk more about the impact of a pregnancy on teens.



ADDITIONAL TRAINER NOTES:

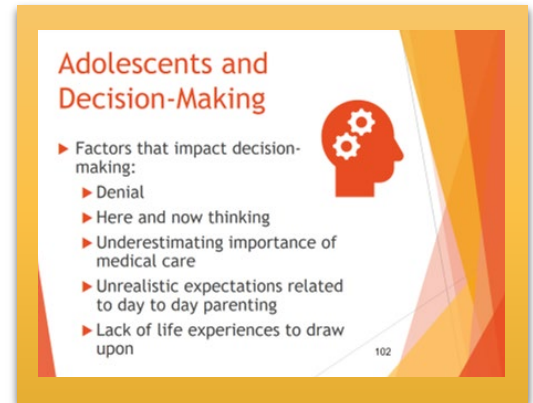


STATE:

Pregnancy may impact teens differently. Pregnancy may accelerate maturation or stall the transition to adulthood. Research shows that many pregnant teens, especially those in middle adolescence, mature quickly throughout their pregnancy and are able to make good decisions for themselves and their child.



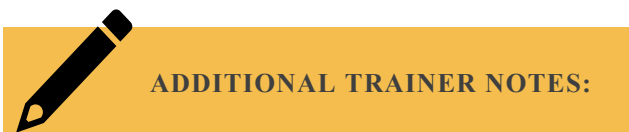
ADDITIONAL TRAINER NOTES:



STATE:

There are many factors that are likely to impact a teen’s decision-making. It is important not to underestimate these factors.

- ▶ Denial may be a reaction for teens, though this may be true for any age. Teens may pretend they are not pregnant for as long as they can. Sometimes later in the pregnancy when they can feel the baby moving is when it becomes more “real” to them. Sometimes it is not until the baby is born that it becomes “real.”
- ▶ Intellectually, adolescents may be very concrete, using here and now thinking. When they do consider the future, they often have idealistic or unrealistic expectations due to lack of experience.
- ▶ Some pregnant teens may not follow through on medical advice or keep medical appointments, because these activities may set them aside from the peer group and/or they underestimate its importance.
- ▶ Teens often underestimate the task of parenting until they face the day to day challenges of raising a child.
- ▶ Adolescents may be less skillful than adults in identifying options because they lack sufficient knowledge alternatives and relevant life experiences to draw from.




Adolescence is a time of change in the brain. In working with teens the health care provider can:

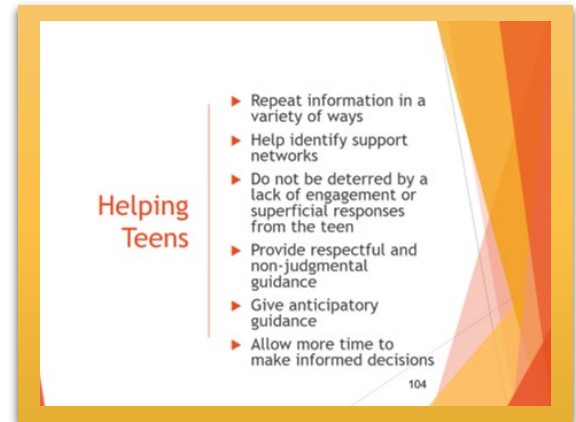
- a) Provide information multiple times in multiple formats
- b) Help them with anticipatory guidance
- c) Offer neutral, factual, information on the options
- d) All of the above

STATE:

The correct response is D. Remember that teens often need more time to make decisions about their pregnancies. Let's look now at some other pointers for helping teenagers facing an unplanned, unintended pregnancy.



ADDITIONAL TRAINER NOTES:

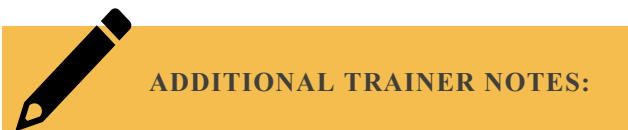


STATE:

Given all that we have covered about adolescent development, let's focus on some concrete ways that was can help pregnant teens.

- ▶ Because adolescents are experiencing a time of great change that is heightened by the crisis of an unintended pregnancy, they may need information to be repeated and presented in different ways. This information may be provided by any of the helping professionals that the pregnant teen may have contact with. Handouts may be helpful as the teen may review this information later.
- ▶ Relationships with both parents and peers have been shown to influence the adolescent's ability to reflect upon and develop a strategy for the future. Adolescents who do best with unintended pregnancies have the help and support of the adults in their lives.
- ▶ Teen communication styles may include not being very verbal, not being very engaging, and avoiding eye contact. Despite that teens tend to not be verbal and tend to give superficial answers when initially dealing with authority figures, they still need to be provided with information.
- ▶ Treating teens with dignity and respect and listening non-judgmentally will be most helpful. Choosing matching language can be helpful, though not to the extreme that it is no longer genuine. Teens can usually tell when someone is trying too hard to be "cool".
- ▶ Because teens have difficulty with future thinking, anticipatory guidance and problem-solving support will be helpful until they are faced with the day to day challenges of parenting a child.
- ▶ Overall it is critical that we understand that adolescents tend to need more time to make informed decisions.

Additional information regarding adolescents and decision making can be found in the Participant Guide in the articles titled: Adolescence and the Adoption Option, Pregnant Teens: Discussing Family Involvement, and Helping Teens with Future Planning.





STATE:

Let's review a scenario now that will allow you to discuss a scenario involving adolescence and develop a plan to assist the parents. Please turn to the Kaelyn Scenario in the Module Four section of the Participant Handbook.

Kaelyn is a 17-year-old, Caucasian female. She will graduate from high school in three months. She is a smart girl though her grades have not always reflected her intelligence. Fortunately, her test scores were high enough for her to be admitted to a university that is about two hours from her mother and step-father's house. A talented artist, Kaelyn is planning on studying Studio Art.

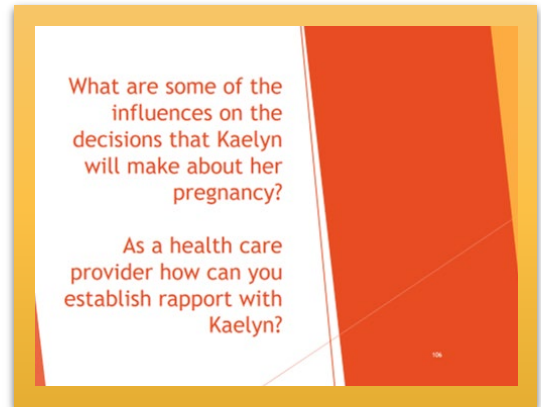
Kaelyn has a conflictual relationship with her mother, Stephanie. Stephanie was also a teen mother. Stephanie has worked very hard to better herself while raising Kaelyn as a single mom. Stephanie worked full time and went back to school to get her nursing degree. She met Robert at the hospital where they work. They got married when Kaelyn was twelve. Robert and Kaelyn have a good relationship. He tries his best to respect his role as step-dad. Kaelyn gets along well with most adults but tends to be very sensitive to any feedback or suggestions made by her mother.

Robert and Stephanie did not know that Kaelyn was sexually active so finding out that Kaelyn was 12 weeks pregnant came as a shock. Stephanie has tried very hard over the years to talk with Kaelyn about sexual health and taking precautions. Kaelyn has always denied any interest in boys and has been adamant that she was not sexually active. Extremely concerned, Stephanie and Robert have tried very hard to talk with Kaelyn about her options. Kaelyn reacts by running to her room in tears or leaving the house abruptly to hang out with friends.



ADDITIONAL TRAINER NOTES:

[PPT #26]: INFLUENCE OF ADOLESCENCE: KAELYN SCENARIO



STATE:

What are some of the influences on the decisions that Kaelyn will make about her pregnancy?

- ▶ Her age
- ▶ Relations with the birth father
- ▶ Relationship with her mother and step-father
- ▶ Going to college
- ▶ Mother was a teen mother
- ▶ Being in denial about pregnancy

As a health care provider, how can you establish rapport with Kaelyn?

- ▶ Being non-judgmental
- ▶ Don't talk down to her
- ▶ Explaining her options
- ▶ Acknowledge the difficulty of this situation

Remember that an unplanned/unintended pregnancy can create a crisis for the family—a stressful and disruptive event that comes without warning and disturbs the equilibrium of the family. The article titled: Families in Crisis is included in the Participant Handbook in the Resources section that includes some helpful information about working with families experiencing a crisis.



ADDITIONAL TRAINER NOTES:

Segment V. Substance Abuse

SLIDES 27 - 29
10 MINUTES

[PPT #27]: THE INFLUENCE OF SUBSTANCE ABUSE ON DECISION MAKING



STATE:

Some adoption agencies have seen an increase in the number of infants placed for adoption that are at risk for having special needs in the future due to in utero opioid exposure. Nationally, rates of opioid use disorder at delivery hospitalization more than quadrupled during 1999–2014. According to 2016 data from the Healthcare Cost and Utilization Project, managed by the U.S. Agency for Healthcare Research and Quality, seven newborns were diagnosed with NAS for every 1,000 newborn hospital stays. That is approximately one baby diagnosed with NAS every 19 minutes in the United States, or nearly 80 newborns diagnosed every day. Research continues to be needed on the short-term and long-term impact of various substances during pregnancy.

Substance abuse can influence a woman’s decision-making process about her pregnancy. It is incredibly important that health care workers provide a safe, nurturing space for parents in active substance abuse patterns. These individuals may be less than truthful about their substance use and may seek to leave the hospital as quickly as possible after the child is born. Providing accurate and neutral information on their options is crucial to working with this population.

Parents struggling with substance abuse should still be given non-directive, non-coercive options counseling at every opportunity which includes the consequences of their actions. When working with this population, timing is of the essence. You do not know when you will see them again or whether they’ll remember the information you provided. So the best advice is to repeat, repeat, repeat.

It can also be helpful to find out how old the patient was when they started using. Often, they present as emotionally around that age, especially when stressed.

Acknowledging their love for their child and their desire to do the best they can for their child can be an effective tool to connect with a substance abusing patient and avoid defensiveness.



ADDITIONAL TRAINER NOTES:

[PPT #28]: THE INFLUENCE OF SUBSTANCE USE/ABUSE: ANNA SCENARIO



STATE:

This exercise will allow you to discuss a scenario involving substance use and develop a plan to assist the parents.

Read the Anna and Luke Scenario: (See Module 4 in the Participant Handbook)

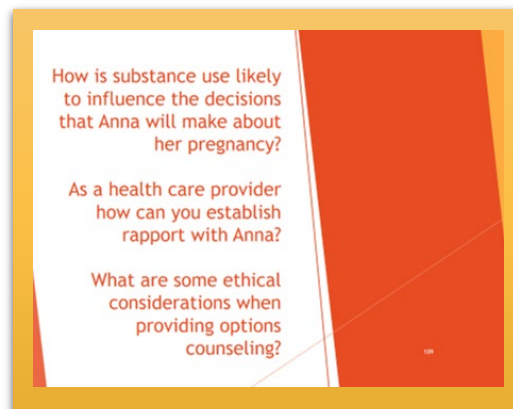
- ▶ Anna and Luke arrive at the hospital appearing disheveled, dirty and wearing many layers of clothing. Initially, ER staff dismissed Anna's pleas thinking she was med seeking but an exam showed she is 32 weeks pregnant and in active labor. Anna states that she did not know she was pregnant until arriving at the emergency room in serious pain and has not had any prenatal care. Anna has a very difficult time with labor and gets angry with staff because she says the meds given aren't touching her pain. Luke keeps saying he is going out to smoke every hour or so and is gone for an extended period of time and then comes back and seems to be nodding off in the corner. Anna gets really agitated every time he leaves and seems worried that he won't come back.
- ▶ After the baby is born, he is rushed to the NICU due to prematurity and suspicion of substance exposure. She denies any substance use initially but after being confronted with test results admits to the hospital social worker that she and Luke live in a tent not far from the hospital and have been using heroin for the last 10 years. Anna seems primarily focused on getting out of the hospital. She says that she has to go soon, or all of their belongings will be stolen. Anna reports that she lost her three children from a previous marriage to foster care about 4 years ago due to domestic violence and substance abuse allegations. She is still very angry about that situation and does not want this baby to go to the foster care system.

- ▶ Anna asks to have baby brought to her room and doesn't seem to understand that the baby is in the NICU for specialized care. After visiting baby for 10 minutes in NICU, Anna returns to her room very upset about the baby's condition. She is inconsolable and vacillates between starting to gather her things into a bag and sobbing on the bed. Luke gets frustrated and leaves. You are worried that Anna will leave the hospital AMA without making any decisions for baby.



ADDITIONAL TRAINER NOTES:

[PPT #29]: THE INFLUENCE OF SUBSTANCE USE/ABUSE: ANNA SCENARIO



STATE:

Large Group Discussion: Anna Scenario

How is Anna's substance use likely to influence her decision making?

- ▶ Denial
- ▶ Delayed entry to prenatal care
- ▶ The influence of drug seeking behavior
- ▶ Fear of going into withdrawal

What are the other influences impacting Anna?

- ▶ Homelessness,
- ▶ Relationship with Luke
- ▶ Previous experience with CPS

As a health care provider, how can you establish rapport with Anna while acknowledging her challenges?

- ▶ Tell her the facts in a respectful way
- ▶ Acknowledge her feelings

What are some of the ethical considerations in providing options counseling with substance using parents?

- ▶ Making sure that you follow hospital policy
- ▶ Accepting patients right to make decisions that you think may not be the best for the child

Thinking back when we discussed child protection laws, what are some reality-based statements you could make without shaming Anna?

- ▶ "Hospital policy requires that when babies test positive we have to notify CPS. Do you want to be part of that phone call so that you can tell them what you need/want for your baby?"

How might you present options to Anna?

- ▶ “Would you be interested in talking with someone from an adoption agency? I know you said you don’t want this baby to be in state foster care. Their counselor will be able to discuss some of your options in more depth.”

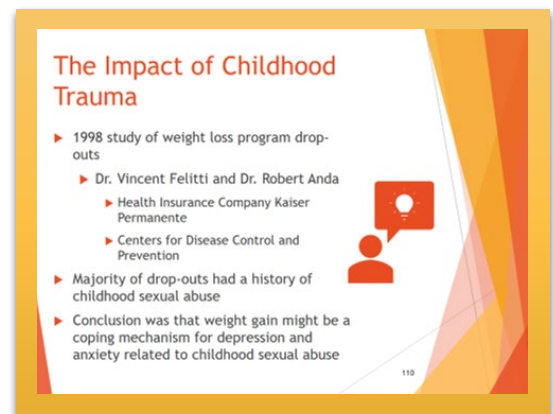


ADDITIONAL TRAINER NOTES:

Segment VI. Impact of Trauma

SLIDES 30 - 39
15 MINUTES

[PPT #30]: THE IMPACT OF CHILDHOOD TRAUMA



STATE:

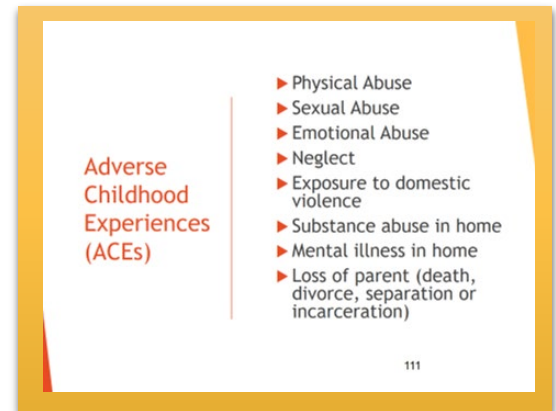
Over the last two decades, more and more experts have been talking about childhood trauma. You may have heard pediatrician Dr. Nadine Burke Harris who was appointed in 2019 as California's first Surgeon General of California talk about the link between adverse childhood experiences and toxic stress. Other advocates like Oprah Winfrey have brought attention to the long-term impacts of childhood trauma.

The buzz about trauma can really be traced back to a long-term study based on research conducted by Dr. Vincent Felitti (head of Kaiser Permanente's Department of Preventive Medicine) and Dr. Robert Anda (Centers for Disease Control). The 1998 Adverse Childhood Experience Study was based on interviews with participants who left Kaiser Permanente's obesity clinic without successfully completing the program. Through these interviews, Dr. Felitti discovered the majority of the program drop-outs had a history of childhood sexual abuse. Dr. Felitti surmised that weight gain might be a coping mechanism for depression and anxiety related to childhood sexual abuse.



ADDITIONAL TRAINER NOTES:

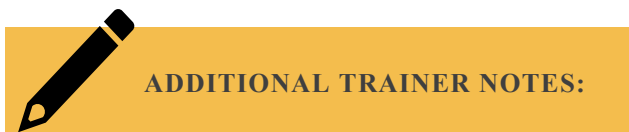
[PPT #31]: ADVERSE CHILDHOOD EXPERIENCES (ACES)

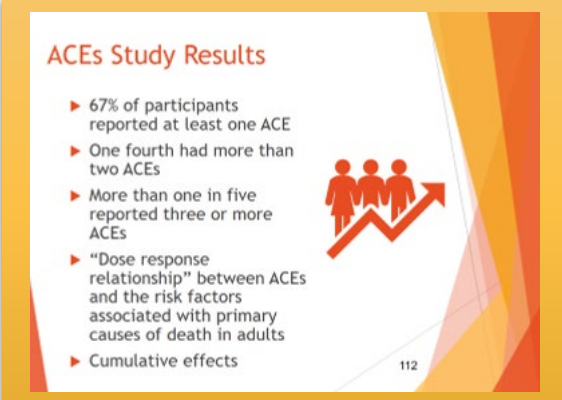


STATE:

Dr. Felitti and Dr. Anda went on to conduct another study of more than 17,000 Kaiser Permanente Health Maintenance Patients. The participants received physical exams and were asked to complete surveys regarding their childhood experiences, current health status, and current behaviors. Specifically, they were asked about different types of adverse childhood experiences including:

- ▶ Physical abuse
- ▶ Sexual abuse
- ▶ Emotional abuse
- ▶ Physical neglect
- ▶ Emotional neglect
- ▶ Exposure to domestic violence
- ▶ Household substance abuse
- ▶ Household mental illness
- ▶ Loss of parent through death, separation, or divorce
- ▶ Incarcerated household member





ACES Study Results

- ▶ 67% of participants reported at least one ACE
- ▶ One fourth had more than two ACEs
- ▶ More than one in five reported three or more ACEs
- ▶ “Dose response relationship” between ACEs and the risk factors associated with primary causes of death in adults
- ▶ Cumulative effects

112

The slide features a graphic of three stylized human figures in red, with a red line graph showing an upward trend to the right, symbolizing cumulative effects or a dose-response relationship.

STATE:

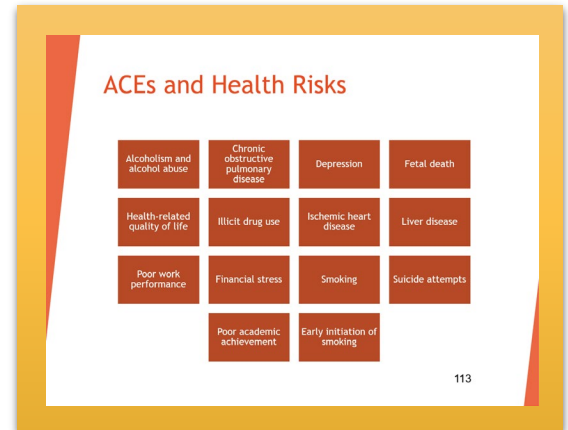
The results were astounding. The study found that Adverse Childhood Experiences (ACEs) are common. Nearly 67% of the participants reported at least one ACE. One fourth had more than two ACEs and more than one in five reported three or more ACEs.

The study found that there is a “dose response relationship” between the extent of childhood abuse and family dysfunction and the risk factors associated with the primary causes of death in adults indicating that the effects of stress are cumulative.

Early childhood experiences matter and have the potential to impact the trajectory of a person’s life.



ADDITIONAL TRAINER NOTES:



STATE:

In short, the higher the ACE score (which is the total sum of the different types of childhood trauma experienced) the greater the risk for the health risks noted on the slide.

- ▶ Alcoholism and alcohol abuse
- ▶ Chronic obstructive pulmonary disease
- ▶ Depression
- ▶ Fetal death
- ▶ Health-related quality of life
- ▶ Illicit drug use
- ▶ Ischemic heart disease
- ▶ Liver disease
- ▶ Poor work performance
- ▶ Financial stress
- ▶ Smoking
- ▶ Suicide attempts
- ▶ Poor academic achievement
- ▶ Early initiation of smoking



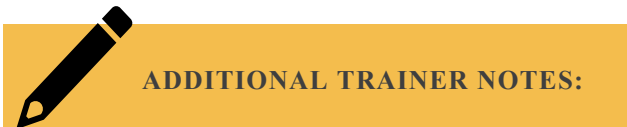
ADDITIONAL TRAINER NOTES:

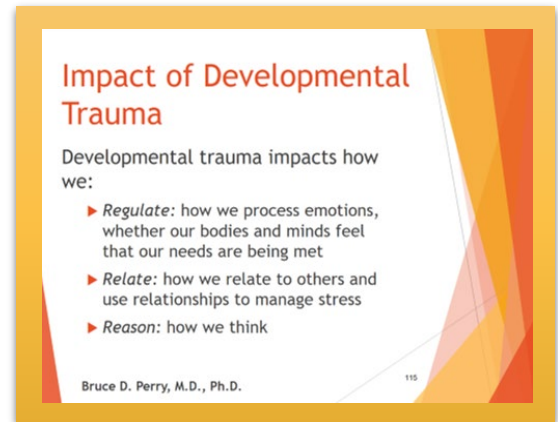


STATE:

We also learned in the ACEs study early childhood trauma is associated with an increased with the following indicators of sexual health:

- ▶ Intimate partner violence
- ▶ Multiple sexual partners
- ▶ Sexually transmitted diseases
- ▶ Early initiation of sexual activity
- ▶ Adolescent pregnancy
- ▶ Sexual violence
- ▶ Unintended pregnancies





STATE:

We also know that early childhood trauma impacts decision making. As mentioned in Module Three, trauma impacts how we REGULATE (how we process emotions, whether our bodies and minds feel that our needs are being met), how we RELATE to caregivers as a child and others as we get older and how we think (REASON).

Let’s look more closely at the word “regulate”. Exposure to unpredictable and severe levels of fear in childhood leads to what is known as “sensitized stress response” which means that even the minor events can cause an individual to experience a severe stress response. Dr. Perry states that “Once a tolerance to a chronically stressful environment is built up, only a tiny dose, the theoretical “straw that breaks the camel’s back” can raise stress levels significantly”. (Perry 2014, Niehoff 1999)

Now let’s look first at the word “relate.” Dr. Perry states “the most important property of humankind is the capacity to form and maintain relationships.” (Perry, n.d.). Sadly, trauma impacts a child’s ability to use relationships to help regulate physiological responses to stress which can lead to reliance on unhealthy ways of managing stress such as involvement in unhealthy relationships, multiple sexual partners, and substance use in adulthood.

Lastly, let’s look at the word “reason.” Dr. Perry describes who decision making is impacted by early childhood trauma, “People with developmental trauma can start to feel so threatened that they get into a fight-flight alarm state, and the higher parts of the brain shut down...first, the stress chemicals shut down their frontal cortex (thinking brain). Now they physically cannot think. Ask them to think and you only make them more anxious.” (Perry, 2014).



ADDITIONAL TRAINER NOTES:

[PPT #36]: THE IMPACT OF TRAUMA ON DECISION MAKING



STATE:

This next exercise will provide you with an opportunity to discuss a scenario involving the influence of trauma and provide ideas about how to develop a plan to assist expectant parents impacted by trauma. Turn now to the Neveah Scenario in the Module Four section of your Participant Handbook.

Neveah is a 20-year-old college student attending community college. Neveah is participating in a program that supports former foster youth who have graduated from high school and are enrolled in college or technical school. Neveah and her boyfriend, Zeb, have been dating for six months. Like Neveah, Zeb spent most of his youth in foster care.

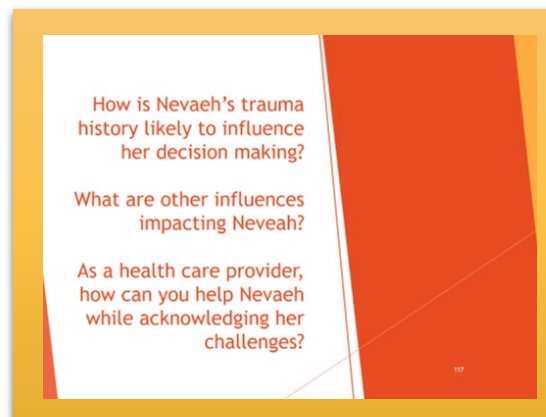
The caseworkers who have known Neveah most of her life describe her as an incredibly bright and resilient kid. They are impressed that she has done so well for herself considering the abuse and neglect that she experienced as a child. These same caseworkers are extremely disappointed that she is pregnant. They are also very worried that she has partnered with someone who was also in foster care.

One of the conditions of Neveah's program is that she stay in school. She will lose the funding that pays for her apartment and college if she drops out of school. Neveah and Zeb just found out that she is five months pregnant. They both want to raise the baby together and are adamant that they do not want to see her end up in foster care.



ADDITIONAL TRAINER NOTES:

[PPT #37]: LARGE GROUP DISCUSSION: NEVEAH SCENARIO



STATE:

How is Nevaeh's trauma history likely to influence her decision making?

- ▶ May be distrustful of people who are trying to help
- ▶ May struggle processing information given to her
- ▶ Want better for their child
- ▶ No role models for good parenting
- ▶ May want a baby to so they have someone to love them

What are the other influences impacting Nevaeh?

- ▶ Fear of losing funding
- ▶ Relationship with Zeb
- ▶ Relationship with caseworkers
- ▶ Previous experience with CPS

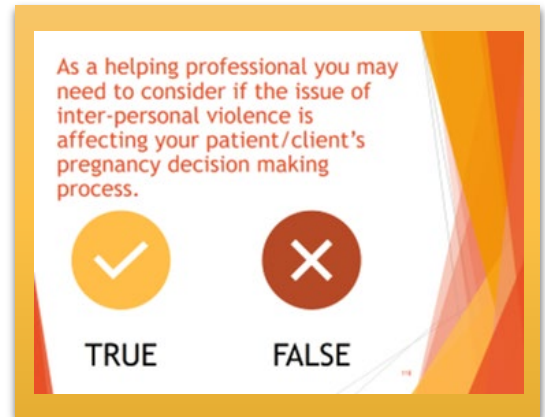
As a health care provider, how can you help Nevaeh while acknowledging her challenges?

- ▶ Help her regulate/calm down so that she can process information
- ▶ Give her time and space



ADDITIONAL TRAINER NOTES:

[PPT #38]: LARGE GROUP DISCUSSION: NEVEAH SCENARIO



STATE:

The correct response is TRUE. This is another form of trauma that can be experienced by women facing an unplanned, unintended pregnancy and something that helping professionals should be prepared to respond to.



ADDITIONAL TRAINER NOTES:



STATE:

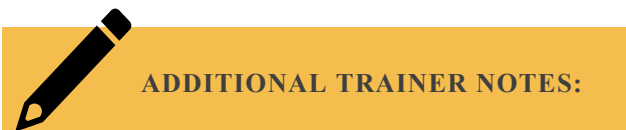
According to the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, nearly 1 in 6 pregnant women in the U.S. have been abused by a partner.

Women who experience intimate partner violence prior to and during pregnancy are at increased risk of low maternal weight gains, infections, high blood pressure and are more likely to deliver pre-term or low birth weight babies.

Women who received prenatal counseling for IPV had fewer recurrent episodes of IPV during and post pregnancy, as well as better birth outcomes such as lower rates of preterm birth and low birth weight.

American Congress of Obstetricians and Gynecologists (ACOG), the U.S. United States Department of Health and Human Services (HHS) and the Institute of Medicine (IOM) all recommend that IPV screening and counseling be a core part of women's preventive health visits and at periodic intervals, including obstetric care (at first prenatal visit, at least once per trimester, and at the postpartum checkup, as disclosure may not occur at the first attempt). Source: Thee American Congress of Obstetricians and Gynecologists (ACOG). (2012). Committee Opinion: Intimate Partner Violence.

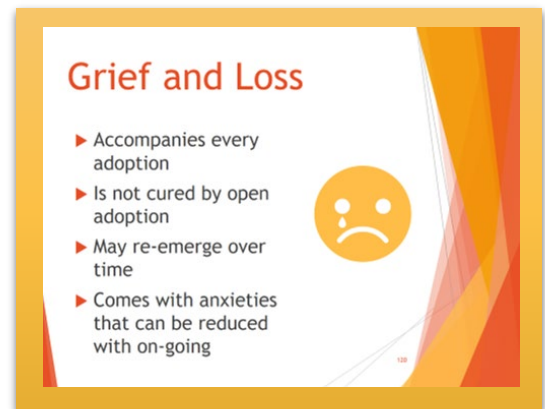
There are several resources on Inter-personal Violence, including assessment guidelines, provided on the Additional Reading section of the Participant Handbook.



Segment VII. Grief and Loss

SLIDES 40 - 46
10 MINUTES

[PPT #40]: GRIEF AND LOSS



STATE:

Understating the impact of grief and loss is important when supporting expectant parents who are considering their options. Grief and loss accompany every adoption, no matter which type is selected, in fact it is often said that adoption can only happen as a result of loss. All members of the adoption triad experience loss. Birth parents will experience the loss of their child and the loss of the opportunity to parent. A person who was adopted may experience the loss of birth parents, extended relatives, community, culture and sometimes language. For some adoptive parents, there may be the loss of the experience of pregnancy and of having a biological child. In the hospital setting they may present as fearful around the process.

Ongoing contact may reduce some anxieties, such as birth parents and the child not knowing whether or not the other is alive. However, some birth families will say the idea of having an ongoing relationship makes it more difficult for them to handle the grief of not raising the child.

Grief and loss is a process, it changes over time, and it is triggered by new losses. Different people handle the grief and loss process in various ways. It is not something that should be minimized. Birth parents may accept the loss and work through the grief, but feelings of loss may re-emerge over time and at perceived significant occasions i.e. birthdays, placement date, and/or holidays.

Birth parents never forget their child. The goal is for birth parents to integrate the loss into their ongoing lives and gain feelings of control so that they can move forward. Those who have a history of prior losses may find it more difficult to consider another loss of this nature.

For birth parents, pre and post adoption counseling and supports are typically available to address the issues associated with grief and loss.



ADDITIONAL TRAINER NOTES:

Birth Parents	Adoptive Parents
Early Labor: Nervous, fearful, sometimes anxious for privacy, bonds to nurses	Nervous, fearful, fearful of being "unchosen." Worried about medical view
Mid Labor: If epidural, often wants adoptive parent included.	Thrilled to be included, some deep feelings of unexpressed envy, anticipatory, fluctuating between empathic and needed, unspoken.
Postpartum - First few hours: Elated birth is over, eager to share the beauty of the child, on somewhat of a "high."	Elated to see the child in the flesh, flooded with feelings of gratitude, also on a bit of a "high."
First night alone in the hospital: Often wants rooming in, has quiet, private time with child.	Beginning some anxiousness about "if she's with the baby all this time... she might change her mind." Wanting to spend time with baby, not wanting to interfere, feeling envy and displaced
Second day: Often flooded with intense mother child feelings that have perhaps not been expected. Feeling singularly capable of a bond that "no one else" can have like "I do."	Aware and observing of increasing connection c mother and child. Terrified mother will claim th child. Ashamed of some of their "ownership" competitiveness.


STATE:

Let’s take a few minutes to look at a chart in your Participant Handbook titled: Stages of Grief Following Delivery for Parents Planning Adoption. Please turn to your Participant Handbook to follow along.

This chart, developed by Gayle Ward, MA Education Institute, Kinship Center, summarizes the stages of grief both birth and adoptive families may experience after the child is born and while all remain in the hospital. As a health care provider, it is important for you to be aware that both the birth and adoptive family are experiencing complex emotions and that these emotions are normal and healthy.

As a health care provider, it is important to remember that grief and sadness expressed during the adoption does not mean that the parents who are in the process of placing a child for adoption are having second thoughts. Pain is not an indication of a bad choice or regret. Grief and pain are normal part of the process. As a health care provider, your natural instinct to alleviate pain can make the process of sitting with your patient’s grief very hard.

You might consider placing a discrete symbol on the door of a patient who is planning adoption. This will keep staff mindful that the patient may have complex needs and desire extra empathy.



ADDITIONAL TRAINER NOTES:

[PPT #42]: INFLUENCE OF GRIEF, LOSS, AND GUILT: HELEN SCENARIO



STATE:

Just as a trauma history can impact decision making, grief, loss and guilt are likely to impact pregnancy decision making. This exercise allows participants to discuss a scenario involving the impact of grief and loss in the decision-making process. Let's turn now to the Helen Scenario found in the Module Four section of the Participant Handbook.

Helen is a 29-year-old woman living with her three-year-old son, Aidan, in a two-bedroom apartment. Helen works at the local utility board and makes a decent salary but still struggles to make ends meet at times. Helen has been officially divorced for a year. Her ex-husband, Ray, pays his child support but has already remarried and has a new baby on the way. Ray and his new wife maintain a different lifestyle than Helen and Aidan. Both have good jobs and are quick to criticize Helen's lifestyle and parenting.

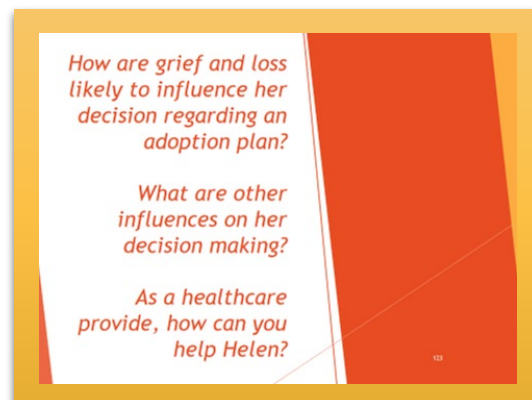
Helen has a complicated relationship with her mother, Suzanne. Her father, Dan, passed away two years ago. Dan was the glue that held their family together. His death of a heart attack devastated the family. Suzanne and Dan adopted Helen as a newborn after years of unsuccessful infertility treatment. Helen grew up knowing that she was adopted but has never met her birth family. Now pregnant, Helen is making an adoption plan and is working with a licensed adoption agency. She has chosen a closed adoption like her own adoption. The birth father of the child has already met with the adoption agency and has agreed to consent to the adoption.

Helen has recently given birth at your hospital. The baby is doing well and is being cared for by her adoptive parents on another floor in your hospital. Initially Helen appeared to be handling the adoption very well until you began to talk with her about her discharge from the hospital tomorrow. She is now crying uncontrollably and expressing fears that her daughter will grow up thinking that she was not loved or wanted. She is also worried that Aidan will think she is going to give him away as well. You have notified the hospital social worker who has called the adoption agency representative who left the hospital a few hours ago thinking all was well.



ADDITIONAL TRAINER NOTES:

[PPT #43]: INFLUENCE OF GRIEF, LOSS, AND GUILT: HELEN SCENARIO



STATE:

How are grief and loss likely to influence her decision making regarding the adoption plan?

- ▶ She chose a closed adoption like her own
- ▶ She may be projecting her own feelings onto the child
- ▶ She may have been in denial until the nurse brought up discharge
- ▶ Unresolved feelings from her own adoption

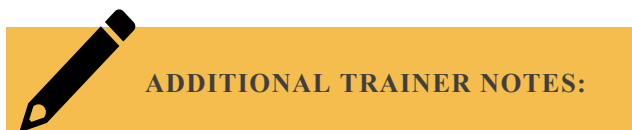
What are the other influences on Helen's decision making?

- ▶ Strained relationship with mother and ex-husband
- ▶ Negative judgments
- ▶ Financial strain
- ▶ Work
- ▶ She has not prepared to parent and may be worried to ask her mom for help

As a health care provider, how can you help Helen?

- ▶ Relate, Regulate, and Reason
- ▶ Non-directive counseling
- ▶ Help her identify options
- ▶ Just be with her
- ▶ Listen

As a hospital based professional how have you seen the stages of grief and loss play out when you are working with birth and adoptive families who are in the process of an adoption plan? How has this impacted you personally? What have you done that you have found to be helpful? What have you seen that is not helpful?



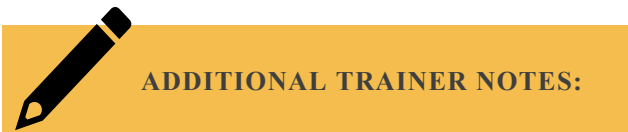


STATE:

We have discussed options counseling for pregnant or recently delivered women. Now we are going to discuss how to support women who are making an adoption plan in your hospital. Those of you who have worked with women making an adoption plan recognize how significant the interval in the hospital, when labor and deliver occurs, is in the adoption process. The woman who is giving birth may reconsider, which is her right. The amount of planning for this interval is variable, and staff will have to adapt to any changing situations as they occur. This interval is likely to have a lasting impact for the birth mothers.

Let's take a few moments to look at Participant Handbook, where you will find an article titled, The Hospital Interval. The article addresses potential discomfort in knowing the "right thing to say" to the mother of the child. Here is a quote from the article:

“The art of nursing, presence and caring take place within an atmosphere of interpersonal sensitivity and intimacy, which is characterized by open and honest interactions. Personal insights are disclosed in verbal and non-verbal ways, and the nurse unobtrusively grasps the patient's needs and responds in a kind and compassionate way. Empathy is expressed through words and actions, and a supportive nurse-patient partnership is cultivated.”



[PPT #45]: SUPPORTING WOMEN MAKING AN ADOPTION PLAN



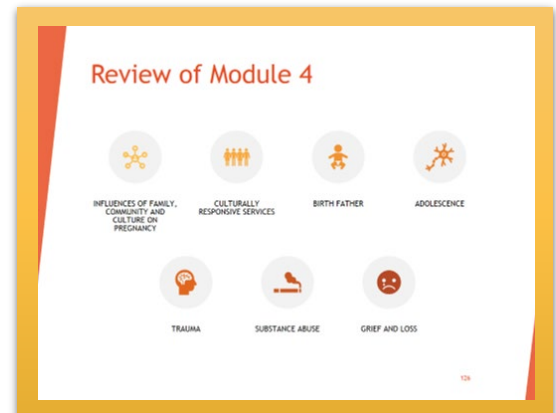
STATE:

For those of you who have worked with women making an adoption plan, what are some of the things that you have found to be helpful?

Let's look at the sample Adoption Plan in the Participant Handbook. This sample provides some ideas about what elements should be considered as part of the planning process.



ADDITIONAL TRAINER NOTES:



STATE:

Let's do a quick review of the highlights of what was covered in Module Four.

- ▶ As a health care provider, being aware of the influence that culture, community, and family play in decision making is very important in helping guide your patient through the decision-making process.
- ▶ Cultural responsiveness requires that the health care provider be aware and respectful of the cultural norms held by the patient/client that may influence his/her decision-making or his/her perception of the available options. We need to be aware and respectful of commonly held culturally held beliefs, yet not stereotype or make assumptions.
- ▶ Someone who may bear a great deal of influence on the decision to be made is the expectant father. Engagement with him must start with the pregnant woman. It is the pregnant woman's decision to determine how she wants the birth father engaged in the process of discussing pregnancy options with the health care professional. Once she makes the decision to include him in the discussion with the health care professional, it is that professional's responsibility to engage him in the process. It is important for health care professionals to engage interested expectant fathers using the same techniques used to engage others: treating them with dignity and respect; actively listening to their concerns and being nonjudgmental.
- ▶ Understanding adolescent development can help be better able to support teens who are experiencing an unplanned, unintended pregnancy. Overall it is critical that we understand that adolescents tend to need more time to make informed decisions.
- ▶ Parents struggling with substance abuse should still be given non-directive, non-coercive options counseling at every opportunity which includes the consequences of their actions. When working with this population, timing is of the essence. You do not know when you will see them again or whether they'll remember the information you provided. So the best advice is to repeat, repeat, repeat.

- ▶ Trauma impacts how we REGULATE (how we process emotions, whether our bodies and minds feel that our needs are being met), how we RELATE to caregivers as a child and others as we get older and how we think (REASON).
- ▶ Grief and loss accompany every adoption. For birth parents, pre and post adoption counseling and supports are typically available to address the issue associated with grief and loss.



ADDITIONAL TRAINER NOTES:

UNDERSTANDING INFANT ADOPTION (UIA) 6 CURRICULUM



MODULE

5

TRAINER GUIDE



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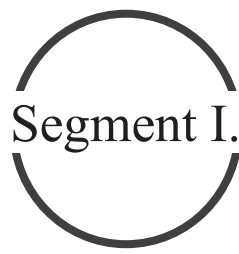
MODULE 5: ADOPTION BEST PRACTICES— IMPLICATIONS FOR HEALTH CARE SETTINGS

UIA Competency: Acknowledge the challenges that participants may raise and focus on the importance of best practice in terms of the benefits for not only the patient/client, but for the entire adoption triad.

60 min

SEGMENTS

- I. Adoption Statistics & the Hospital Experience (10 MINUTES)
- II. Issues that Impact Adoption Work Within Hospitals (10 MINUTES)
- III. Adoption Best Practices in Hospital Settings (30 MINUTES)
- IV. The Hospital Experience for the Adoption Triad (10 MINUTES)



Segment I. Current Adoption Data/Statistics

SLIDES 1-3
10 MINUTES

[PPT #1]: ADOPTION BEST PRACTICES—IMPLICATIONS FOR HEALTH CARE SETTINGS



NOTE:

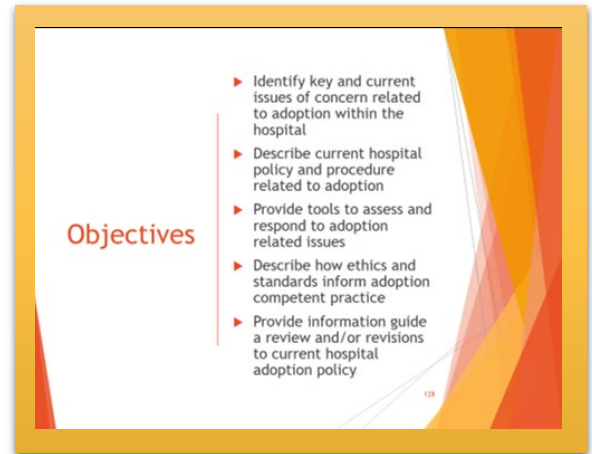
Module Five is an optional module. In order to be the most effective, participants should be familiar with their current hospital policy and bring a copy of the hospital policy for their own use during the session. Even if attendees have not reviewed their existing policies prior to the session, the information presented about best practices can help hospital professionals evaluate the strength of their current practices.

Keep in mind that typically nurses and social workers are not the ones who create hospital policy and the protocols for creating or amending hospital policy differs across various hospital settings. Some hospitals may be reluctant about sharing their policies or talking about the lack thereof. Trainers should be clear that they are not asking the hospital to share any of their internal documents. Instead, participants can be encouraged to use the time during the module to reflect on their current policies and to share the resources provided in this module with their risk management teams. Be prepared for some attendees to be guarded about their opinions about existing policies during the session. It is not necessary for attendees to share policy information as much as it is important for them to be exposed to best practices.

While facilitating this module, recognize that it may be challenging implement best practices in a hospital environment where there are many competing demands and politics to navigate. Acknowledge the challenges that participants may raise and focus on the importance of best practice in terms of the benefits for not only the patient/client, but for the entire adoption triad.



ADDITIONAL TRAINER NOTES:



STATE:

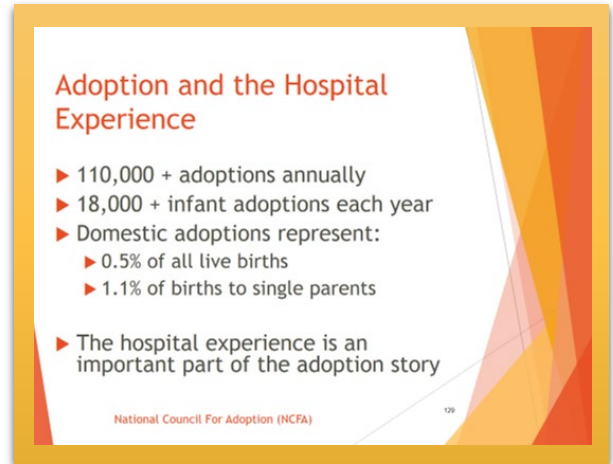
The objectives of this module are to:

- ▶ Identify key and current issues of concern related to adoption within the hospital
- ▶ Describe current hospital policy and procedure related to adoption
- ▶ Impart information so that trainees can assess and respond to adoption related issues
- ▶ Describe how ethics and standards inform adoption competent practice
- ▶ Provide information so that trainees know how to review and/or revise your current hospital adoption policy



ADDITIONAL TRAINER NOTES:

[PPT #3]: ADOPTION AND THE HOSPITAL EXPERIENCE



STATE:

Remember the statistics we shared earlier from the National Council For Adoption:

- ▶ The total number of all adoptions taking place in the U.S. has fallen, from a count of 133,737 adoptions in 2007 to 110,373 (41,023 related adoptions and 69,350 unrelated adoptions) in 2014.
- ▶ More than half of this decline can be attributed to the significant drop in the number of intercountry adoptions by Americans. There is also a significant decline in the number of kinship or related adoptions.
- ▶ The number of infant adoptions has remained mostly steady from 2007; there was even a small increase from 18,078 in 2007 to 18,329 in 2014.
- ▶ The number of domestic adoptions represents 0.5 percent of all live births and 1.1 percent of births to single parents.

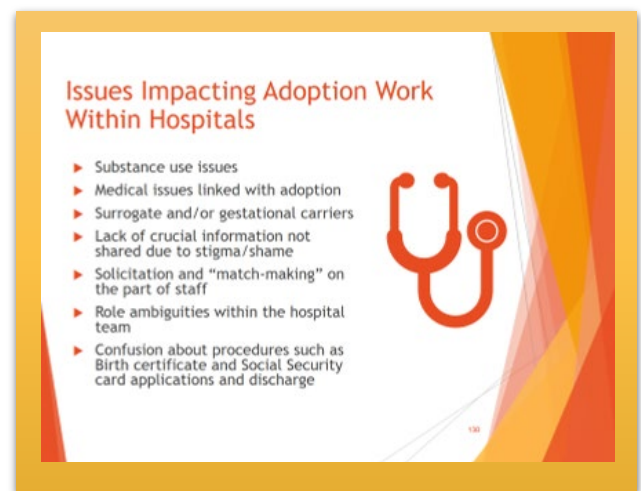
When parents adopt domestically, their family's beginning is often at a hospital — where they meet their newborn son or daughter for the first time. This hospital experience is an important part of the family's adoption story. Careful planning and preparation will ensure that the wishes of all those involved, birth parents as well as adoptive parents, are respected and carried out — and that time spent together at the hospital will be remembered fondly, as with any birth.



Segment II. Issues that Impact Adoption Work within Hospitals

SLIDES 4 - 5
10 MINUTES

[PPT#4]: ISSUES IMPACTING ADOPTION WORK WITHIN HOSPITALS



STATE:

There are many issues that impact the work of adoption in the hospital setting.

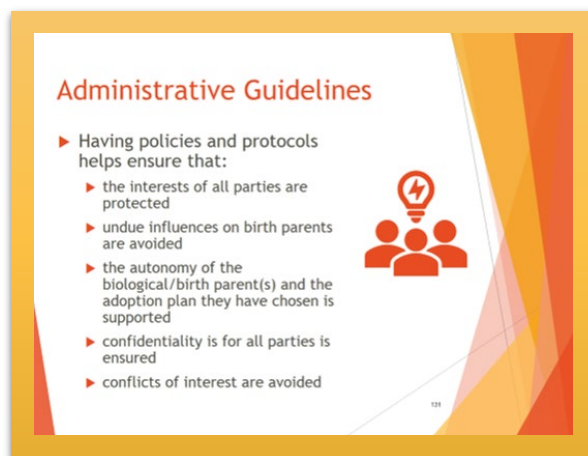
- ▶ We talked earlier about how substance use/abuse issues may impact decision-making and care in the hospital setting.
- ▶ Medical issues can be linked with adoption. For example, in Safe Haven or international adoptions, medical information may not be known or disclosed. Questions related to decisions for the infant such as consents for circumcision or consent for emergent medical care before and after parental rights relinquished or before an adoption finalized can be confusing for hospital professionals.
- ▶ Surrogate and/or gestational carriers may present unique issues.
- ▶ Sometimes information about STIs, Substance Use, or Behavioral/Mental Health related issues is not shared because of stigma/shame
- ▶ The American College of Obstetricians and Gynecologists Committee Opinion on Adoption written in 2012 and reaffirmed in 2018 states, "When physicians are also prospective parents, there may be a temptation to adopt an infant from one of their own patients. This arrangement is

ethically problematic. It takes advantage of the physician-patient relationship and the power differential inherently built into this relationship.” Solicitation and “match-making” on the part of staff continues to be an on-going occurrence within some hospitals, especially in hospitals with weak or non-existent policy regarding conflict of interest.

- ▶ There are sometimes role ambiguities within the hospital team. What is the role of the physician, nurse, social worker, and case manager? Who handles what? What about nights and weekends? In some cases nurses may simply refer to the social worker for adoption-related issues, but it is important that all hospital professionals interacting with the members of the adoption triad be aware of the basics of good adoption practice.
- ▶ A lack of awareness about current adoption policy (or a lack of policy altogether) within the hospital setting can contribute to an environment where best practice is harder to achieve. Procedures around discharge, such as reviewing discharge paperwork and referrals for the infant to a pediatrician may be different when there is an adoption plan. Even something as seemingly simple as the procedures related to birth certificate and Social Security card applications can be confusing if hospital staff make assumptions about the process. For example, birth certificates are to be issued with the names of the birth parents, then revised once the adoption is final.

What are other issues have you found to be important to identify?





STATE:

Let's review the purpose for policy, procedure and guidelines.

Incorrect assumptions and misconceptions remain common regarding adoption practices in the hospital setting. Confusing language and definitions of terms in adoption practice, such as “intended parent”, “natural parent”, “original parent”, “putative father”, “legal father”, etc. can create more confusion. It is critical that hospital administrators establish guidelines to protect the interests of all who are involved in the adoption of an infant delivered in a hospital-affiliated facility.

These guidelines are meant to prevent undue or inappropriate influence of birthparents considering adoption and ensure that the best interest of the child (adoptee) be upheld.

It is important that hospital administrators, in providing guidance to hospital professionals providing care and support to pregnant women and their families, have a thorough understanding of the current issues related to adoption.

It is recommended that hospitals develop facility-specific policy be adopted to address such issues. Having policies and protocols in place can help ensure that each adoption proceeds smoothly during the adoption stay. Administrative guidelines help ensure that:

- ▶ Hospital professionals respect and support the autonomy of the biological/birth parent(s) and support the adoption plan they have chosen. Engagement of the birth father, his influence and legal standing has been previously discussed and should be protected. Core emotional issues such as grief, loss and/or shame should be addressed. Respect for the dignity of all involved is important.
- ▶ Confidentiality is maintained for all parties involved in the adoption process. It is extremely important to safeguard the privacy of the birth parents and infant in closed or confidential adoptions.

- ▶ Conflict of interest which may arise between the adoptive parties and hospital staff are avoided. Professional boundaries should be adhered to with self-disclosure of any personal relationships or potential conflict of interests.



ADDITIONAL TRAINER NOTES:

Segment III. Adoption Best Practices in Hospital Settings

SLIDES 6 - 11
30 MINUTES

[PPT #6]: ADOPTION-FRIENDLY BEST PRACTICE



STATE:

We have considered the importance of hospital guidelines for adoption related issues that may arise. We will now focus on best practices for adoption friendly-competent care related to those issues. First, you need to identify who will make up your hospital adoption support services team. This may include: social workers, nurses, case managers, nurse administrators, hospital administrators, health information managers, obstetricians, adoption agency professionals, attorneys, hospital risk managers/legal counsel, chaplains or others. Do these individuals have any input into decisions regarding adoption policy?

Next, identify what team members will be responsible for. Consider being specific here. Some members of the team may have minimal interaction with the patient, and others will have more complex involvement. Consider protections that may be needed to protect the patient but that also minimize litigation risk. You may need to consider assigning levels of responsibility based on the level of training or based on licensure of staff for example.

Finally, plan for when you will to consider review and revisions to policy. Like many areas of healthcare, in adoption, practices may evolve and change as more is learned in the field.



ADDITIONAL TRAINER NOTES:

[PPT #7]: ADOPTION-FRIENDLY BEST PRACTICE

Which group of professionals may serve on a hospital adoption support services team:

- a) Social workers
- b) Case managers
- c) Perinatal nurses
- d) All of the above

STATE:

The correct response is D, all of the above. Think about the mechanisms you may have in place already or that you may need to create to help you build or strengthen adoption-friendly practices in your healthcare setting.



ADDITIONAL TRAINER NOTES:



STATE:

In this section, we will discuss items to include in hospital policies and procedures related to adoption. Please refer to the Adoption Policy and Procedure Assessment Tool for Hospitals in the Participant Handbook. Take a few minutes now and review the tool. In a few minutes, we will use the tool as a guide to help you review your hospital's adoption-related policies.



ADDITIONAL TRAINER NOTES:



HANDOUT: ADOPTION POLICY AND PROCEDURE ASSESSMENT TOOL

The following policy areas are suggested as important to protecting the interests of pregnant women considering adoption or making an adoption plan. Review the items below to determine the Policies and Procedures in place at your facility. Indicate for each item whether the policy exists and is sufficient or needs improvement or whether the policy does not exist. Recommendations for each policy area are included to provide additional guidance.

	YES		NO	
	Sufficient	Needs Improvement		
PREGNANCY DECISION MAKING				
Procedures exist to refer a pregnant woman considering adoption as soon as possible to the appropriate hospital staff.				
<i>Recommendations: Consider requiring that a facility representative (e.g., social worker or case manager) be notified immediately when a birth parent(s) indicates an interest in pursuing or discussing adoption. Determine if and/or how other hospital employees or physicians with hospital privileges should discuss adoption with the patient or participate in adoption arrangements. Consider having a designated staff member who is an “expert” in adoption and who can be a point of contact when other staff members are uncertain how to proceed in a situation with a particular parent or family. Consider having this staff member build relationships with adoption and other social services providers, and advise on updating policies as needed to reflect current laws, trends, and best practices in adoption.</i>				
Protocols are in place to prevent undue or inappropriate influence of birthparents considering adoption.				
<i>Recommendations: Consider prohibiting facility personnel and medical staff members from initiating, discussing or imposing their personal beliefs or suggestions to a birth parent(s) in order to avoid any undue influence or a potential conflict of interest.</i>				
Direction is provided with regard to the prohibition of hospital personnel and medical staff members engaging in placing children either for adoption or for temporary foster care.				
<i>Recommendations: Consider prohibiting facility personnel from making referrals or suggestions regarding possible adoption for their personal benefit or the benefit of family members or friends. Be clear that hospital staff are not permitted to mention potential adoptive parents to patients, show profiles of prospective adoptive parents, or to refer a patient to “someone they know” who wishes to adopt.</i>				
A protocol clearly defines the importance of confidentiality of the mother.				
<i>Recommendations: Consider prohibiting disclosure of the mother’s adoption plan with other hospital personnel unless it has a direct connection to care. Outline that information should not be provided to individuals who call or visit the hospital without the express permission of the mother.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
A policy is in place that outlines the referral process that is to be used when additional support outside of the hospital setting is indicated.				
<i>Recommendations: Include procedures to ensure that referrals are made to competent and/or licensed professionals, including adoption agencies and pregnancy counseling agencies. Consider developing a list of providers to which hospital staff can refer.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
LABOR AND CHILDBIRTH				
A policy is in place that guides hospital staff in supporting the expectant mother’s labor and childbirth plan. The policy includes the procedures to be followed when changes to the plan are made.				
<i>Recommendations: Consider who must be familiar with the plan. Ensure the following elements are included:</i>				
<ul style="list-style-type: none"> • Who will be in the room during labor and childbirth? Will the prospective adoptive parent(s) be present? • Are there other spaces for adoptive parents at the facility (e.g., another hospital room) where they may wait during labor and spend time with the infant after birth? • When would the birth mother like to invite the prospective adoptive parents to meet the infant? • Are the birth and adoptive parents in agreement on any routine healthcare procedures that the infant may face soon after birth (e.g., vaccinations, circumcision)? • Do the birth and adoptive parents have a plan for the child’s name? Birth mothers sign the original birth certificate and can name the infant, although adoptive parents have the right to re-name the infant once the adoption is finalized and the adoption birth certificate is issued. • Have the birth and adoptive parents discussed whether the infant will be breastfed following birth? 				

	YES		NO	
	Sufficient	Needs Improvement		
CONTACT WITH THE BABY				
Procedures are in place that support following the mother’s wishes regarding contact with the baby during the hospital stay and protect her parental rights and responsibilities.				
<i>Recommendations: Birth mothers making an adoption plan should be permitted see the baby, hold the baby, feed the baby (either bottle or breast), name the baby, and room-in if desired. Support should be provided to mothers who wish to supply the infant with expressed breast milk, either before or after the adoption, including the provision of counseling about pumping and resources for how to maintain and manage a supply of breast milk.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
THE ROLE OF PROSPECTIVE ADOPTIVE PARENTS				
Protocols surrounding the prospective adoptive parents' involvement are clear. The policy assures that the birth mother is provided with the opportunities to spend as much time as desired with the infant after birth.				
<p><i>Recommendations: Prospective adoptive parents should attend the baby's delivery only at the birth mother's request. Visits and participation in the infant's care by the prospective adoptive parents should be in accordance with the birth mother's wishes and be facilitated so that the birth mother does not feel inadvertently pressured in her in making her final plans. Consider whether adoptive parents should receive a wristband, ID, or other designation indicating to staff that the mother has allowed them to be there.</i></p>				

	YES		NO	
	Sufficient	Needs Improvement		
BIRTH ANNOUNCEMENTS				
A protocol exists for the release of birth data to newspapers, new baby websites affiliated with the hospital, or other similar platforms.				
<p><i>Recommendations: Birth data should not be made available for publication on babies whose mothers are planning adoption.</i></p>				

	YES		NO	
	Sufficient	Needs Improvement		
DISCHARGE				
Discharge guidance is adequate for situations where the infant is being discharged to someone other than the birth mother or birth father. Documentation requirements related to discharge of an infant to anyone other than the mother are sufficient.				
<p><i>Recommendations: With the birth mother's written permission, permit discharge of the infant to a relative, the birth father, or an adoption agency/attorney. Discharge of an infant to anyone other than the mother should be accompanied by a written release signed by the birth mother authorizing the hospital to discharge the baby to the adoption agency representative and to release all child medical information. A photocopy of the identification card of the designated agency representative who received the baby at the time of discharge is advised.</i></p>				
Protocols are in place pertaining to the delivery of complimentary gifts for new parents.				

	YES		NO	
	Sufficient	Needs Improvement		
<i>Recommendations: Ensure that complimentary gifts are given separately as needed to both birth parents and prospective adoptive parents.</i>				
Policies are in place that support screening of the birth mother for postpartum depression before discharge, since this screening may not be as available as it would typically be during well-child visits for the infant.				
<i>Recommendations: Consider protocols that inform birth mothers about the range of normal emotional responses, to recognize if they are struggling beyond that threshold, and to know when and where to seek help.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
RELEASE OF INFANT'S MEDICAL INFORMATION				
Protocols around the release of the child's medical information are outlined, including details with regard to what specific types of information is to be released.				
<i>Recommendations: Consider providing this information to the party assuming physical custody of the child at discharge to ensure continuity of medical care.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
INFANTS DELIVERED BY A SURROGATE				
Guidance is provided regarding situations involving the birth of a child delivered by a surrogate, including the discharge of infants in gestational carrier situations.				
<i>Recommendations: Consider state specific laws or other requirements that the hospital must follow. Include specific documentation requirements.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
OTHER				
State-specific legal considerations are incorporated into policies surrounding adoption.				
<i>Recommendations: Include how and when parental rights are ended, who is legally eligible to adopt, and which legal rights all participants will have post-adoption as well as general state policies regarding adoption.</i>				
Procedures are in place for receiving infants surrendered via Safe Haven.				
<i>Recommendations: Safe haven providers are required to accept emergency protective custody of the infant and to provide any immediate medical care that the infant may require. The provider is also required to notify the local child welfare department that an infant has been relinquished.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
ADOPTION EDUCATION				
Expectations regarding training on adoption related issues for hospital staff are clearly defined.				
<i>Recommendations: Consider training for hospital staff who may come into contact with pregnant women or women who have given birth that includes adoption agency professionals. Ensure that training includes being ready to discuss all options—parenting, abortion, and adoption— in a productive, unbiased, non-judgmental way. Ensure that hospital staff are at least somewhat familiar with their state’s policies regarding adoption, to include:</i>				
<ul style="list-style-type: none"> • <i>Are open adoption agreements legally enforceable in their state or are they courtesy agreements?</i> • <i>When is the termination of parental rights document signed?</i> • <i>Does the state have an adoption revocation period during which birth parents can change their minds and regain their parental rights?</i> • <i>What are birth fathers’ rights as far as notification and relinquishment?</i> • <i>What is the status of open records?</i> 				

References:

Model Adoption Protocol For Hospitals: Developed by the Health Care Provider and Social Work Committees of Adoption STAR, Retrieved from: [https://adoptionstar.com/wp-content/uploads/2013/09/Model Adoption Protocol.pdf](https://adoptionstar.com/wp-content/uploads/2013/09/Model_Adoption_Protocol.pdf)

The American College of Obstetricians and Gynecologists Committee Opinion on Adoption, Retrieved from: <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2012/06/adoption.pdf>

Best-practice recommendations for adoption planning and placement in the healthcare setting, Retrieved from: <https://npwomenshealthcare.com/best-practice-recommendations-adoption-planning-placement-healthcare-setting/>

Infant Safe Haven Laws, <https://www.childwelfare.gov/resources/infant-safe-haven-laws/>

Educating Hospitals About Adoption: How Hospital Staff Can Support Parents Considering an Adoption Plan, <https://web.archive.org/web/20130214145451/https://www.adoptioncouncil.org/publications/adoption-advocate-no-52.html>

Resources

Adoption STAR. (n.d.). Model Adoption Protocol For Hospitals. Retrieved from: [https://adoptionstar.com/wp-content/uploads/2013/09/Model Adoption Protocol.pdf](https://adoptionstar.com/wp-content/uploads/2013/09/Model_Adoption_Protocol.pdf)

Family to Family Support Network®
<https://www.familytofamilysupport.org/>

HCA Healthcare. (2020). Adoption and Surrogacy. Ethics and Compliance Policy Committee. Retrieved from: <https://hcahealthcare.com/util/forms/ethics/policies/ethics-and-compliance/EC022.doc>



ADDITIONAL TRAINER NOTES:

STATE:

Hospital professionals may find themselves at the center of adoption issues because of their expertise in the assessment and management of infertility, pregnancy, and childbirth. The lack of clarity about both ethical issues and legal consequences may create challenges for hospital professionals regarding adoption. Professional groups, such as the Committee on Ethics of the American College of Obstetricians and Gynecologists encourage rigorous discussion about ethical issues, proposing safeguards, and making recommendations regarding the role of the hospital professional in adoption.

Group Activity:

If participants have a hospital adoption policy, have them begin to compare their policy with what is being recommended. Should the participants be from a hospital without a policy or another type of agency, they can review this as a template.

Ask participants to identify areas of strength as well as areas where improvements could be made. Remember not to press attendees to share more than they are comfortable sharing about their existing policies. The intention of the activity is for the participants to increase their own awareness about the strengths and improvements needs, not for the trainer to review or comment about existing policy.

- ▶ What is in the policy? Is there a checklist?
- ▶ What is included in the checklist?
- ▶ What is in the birth plan? Who gets the plan? When?
- ▶ Are all parties included? Identified? Signatures?
- ▶ Is the policy child focused?
- ▶ How does the policy compare to current state and federal laws?
- ▶ Other forms –
- ▶ Permission to release
- ▶ Agency acknowledgement of infant release
- ▶ Medical reports
- ▶ Birth verification
- ▶ Power of attorney for health care decisions



ACTIVITY



- ▶ Process to receive medical information, etc
- ▶ Delivery notification
- ▶ Visitation plan
- ▶ Mother-Infant ID bracelets/cards (Are adoptive parents included?)
- ▶ Discharge plan – Consider each party: Infant with adoptive family, visitation (identify who), and care of the infant
- ▶ Protocol when the process does not follow the plan or “it hits the fan”
- ▶ Open and Closed Adoption plans – different protocols need to be established
- ▶ Rooming in (birth and adoptive families)
- ▶ Preparing and orienting new staff (what do they need to know)
- ▶ Birth certificate issues
- ▶ Cross department roles clearly identified and understood
- ▶ Safe Haven fit
- ▶ Substance exposure for infant
- ▶ Medical complications during birth (Prematurity)
- ▶ Social service/CPS notification procedure
- ▶ Special considerations for incarcerated birth mothers
- ▶ Adoption specific training provided to staff
- ▶ Birth mother relinquishment of rights (State specific, i.e. Louisiana birth mom cannot sign relinquishment papers until after 3 days after birth with an adoption agency or 5 days after birth if handled by attorney, Floridian mothers cannot have any narcotic or sedative medications within four hours before the signing)
- ▶ How do you handle unexpected complications?

[PPT #10]: STANDARDS FOR ADOPTIONS IN A HOSPITAL SETTING



STATE:

As you reflect on the activity we just completed, remember it is your values, principles, ethics and standards that inform your best efforts at formulating and following policy. Let's take a look at some of the ethics and standards that can create an environment for adoption- friendly practice within hospitals.

The National Association of Perinatal Social Workers has created a set of standards that we will refer to now. These are found in your Participant Handbook. Let's review them together now.

- ▶ Standard 1: Services are provided to all individuals involved in the creation of an adoption plan and all will be considered clients whose needs and rights will be respected.
- ▶ Standard 2: A written plan shall be maintained pertaining to adoption planning and will comply with current state and federal adoption law.
- ▶ Standard 3: An initial assessment shall be completed for a woman interested in relinquishing her infant for adoption and, following hospital guidelines, shall provide the expectant mother with referrals to state-licensed adoption agencies or attorneys of her choice.
- ▶ Standard 4: The hospital staff and agency/attorney shall coordinate services and documentation in accordance with policy and the adoption plan.
- ▶ Standard 5: The designated hospital professional such as the perinatal social worker or case manager will maintain contact, communication and documentation with all parties involved.
- ▶ Standard 6: Communication facilitated by the designated hospital professional includes ongoing medical information regarding the infant's status, including discharge teaching with adoptive parents.
- ▶ Standard 7: There is to be no solicitation on behalf, no identification of, or referral of an infant to any specific adoptive family, nor the procurement of an infant for adoption for a specific adoptive family by any member of the hospital staff.

- ▶ Standard 8: The perinatal social worker will provide support and teaching to staff regarding psycho-social and legal aspects of adoption.
- ▶ Standard 9: The identified hospital professional functioning as an integral member of the health care delivery team, shall be included in policy formulation and decision making related to the issue of adoption.



ADDITIONAL TRAINER NOTES:

[PPT #11]: STANDARDS FOR ADOPTIONS IN A HOSPITAL SETTING



STATE:

The correct response is FALSE. Let's take a closer look at this and some additional situations that you may encounter in your facility.



Segment IV. The Hospital Experience for the Adoption Triad

SLIDES 12-13
10 MINUTES

[PPT #12]: SCENARIOS AND DISCUSSION INVOLVING THE ADOPTION TRIAD



STATE:

Let's look now at some common scenarios that play out in the hospital setting. For each scenario, identify next steps according to your policy:

Hospital Employee Match-Making

An obstetrician or nurse midwife providing prenatal care for the delivery, suggests one of their infertility patients or friends as potential adoptive parents with their pregnant patients who are considering adoption. There are ethical standards for nurses, midwives and physicians. All need to be held to these standards.

Emergency Procedures

If it becomes necessary for the birth mother or newborn to undergo an emergency procedure, how will that alter the birth plan? The adoptive mother planned to be present in the delivery room, but an emergency C-Section is needed for fetal distress.

Substance Abuse

(Refer to “Annie” scenario in earlier module)

Substance abuse/use situations can be very tricky and sticky. Especially if the adoptive parents have not been told about the abuse or have been told the abuse had stopped and it had not. Some adoptive parents may rethink their decision to adopt this infant and/or become very angry. Withdrawal can be a very difficult beginning for the infant.

Birth Mother Rethinks Adoption Decision

A college student in her sophomore year, already has an 18 month old child at home. She decides to make an adoption plan with the consent of the father of the baby but without confiding in her parents. She delivers safely. The adoptive parents arrive and begin bonding with baby. The birth mother’s mother arrives to visit her daughter and new grandson in the hospital and learns of the adoption plan which greatly upsets her. She offers kinship adoption which her daughter rejects because she feels obligated to carry out her original adoption plan and cannot face telling the adoptive parents that she has changed her mind. A perinatal nurse advocates for her, asking everyone to leave so the patient can rest and then offers counseling with the hospital chaplain which the birthmother accepts. After counseling and a good night’s sleep, she decides to parent. The adoption agency’s social worker is present to support her when she tells the adoptive parents.

Hospital Employee Interested in Adopting Infant

A nurse manager of Women’s Services, is often approached by a hospital employee interested in adopting a baby, especially in the case of a newborn relinquished under the Safe Haven law. A standard answer is to proceed through an adoption agency or attorney for a future adoption. A referral list of agencies and attorneys who handle adoptions in the region can be offered. There are usually emotional background stories involved in these requests, so the same non-judgmental, therapeutic approach to communication should be used with them as with any individuals or couples interested in adopting.

Neonatal Complications

When a baby requires a higher level of care and the adoption is open, with the birth mother’s consent, the Pediatrician/Neonatologist should speak with both the birth and adoptive parents. It is important they all hear the same information which helps them to support each other and make whatever decisions need to be made regarding care of the infant.



ADDITIONAL TRAINER NOTES:



STATE:

Let's review. In this module, we discussed adoption statistics, common adoption issues within the hospital setting, current hospital adoption policy and procedure, ethics and standards for adoption practice and reviewed samples of hospital adoption policies.

Honest, clear communication with both the birth and the adoptive parents is critical. A perinatal nurse can meet with both as soon as possible after their arrival at the hospital. Having the adoption plan or birth plan in advance helps clarify everyone's expectations.

It is important to communicate hospital policies, what they can expect from the hospital and when including: rooming-in, meals, restaurants that deliver, procedures for mother and baby, physician rounds, the process of relinquishing parental rights, registering the adoption attorney or agency as guarantor, etc. Daily rounds, or more frequently if needed are suggested by the designated adoption liaison. The team should ensure clear communication, concern and compassion.

Infant adoption-specific training should be a part of any "new hire" orientation in healthcare/helping facilities in which the employees are going to regularly interact with pregnant people. A commitment on the part of hospital administrators to have their staff go through the UIA 6 or other training related to current adoption practice will be helpful to ensure the best possible experience for birth and adoptive families.

Do you have any questions or comments about any of the material presented in this module?



ADDITIONAL TRAINER NOTES:

UNDERSTANDING INFANT ADOPTION (UIA) 6 CURRICULUM



MODULE

6

TRAINER GUIDE



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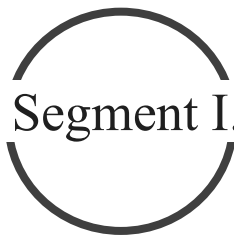
MODULE 6: PULLING IT ALL TOGETHER

UIA Competency: The objective of this module is to present a component in which the birth parent experience can be understood.

45 min

SEGMENTS

- I. Nicole Video, and Discussion (30) MINUTES)
- II. Wrap-up/Adjourn (5 MINUTES)
- III. Post-test/Evaluations (10 MINUTES)



Segment I. Nicole Video, and Discussion

SLIDES 1-5
5 MINUTES

[PPT #1]: PULLING IT ALL TOGETHER



NOTE:

Allow approximately 45 minutes for the content that is to be covered in Module Six. Topics include the viewing of the Nicole video that pulls together concepts from previous modules as well as Post Test and Evaluation activities if they are being utilized.



ADDITIONAL TRAINER NOTES:

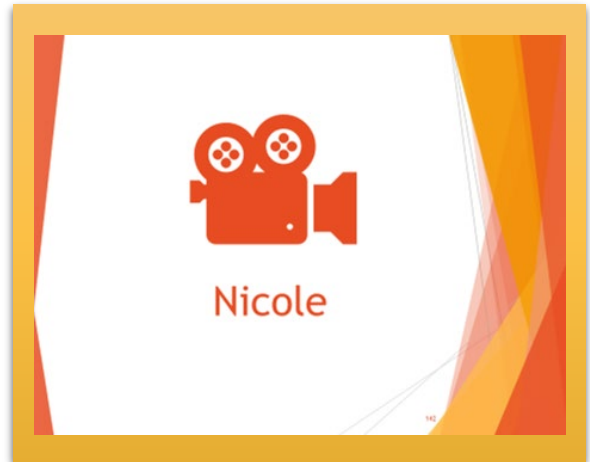


STATE:

The objective of this module is to present a component in which the birth parent experience can be understood.



ADDITIONAL TRAINER NOTES:



STATE:

The video “*Nicole*” is a 28-minute drama that features a single woman who is a senior in college. She has been accepted into a master’s program at the University. She is entering the hospital in labor, accompanied by her mother. We then see Nicole and a friend entering a clinic 8 months earlier. At that visit she learned she was pregnant. We see how her options are presented to her, and what her decision is regarding a plan for her child. She is not in a relationship with the birth father, Kevin, also a college student, but he has been somewhat involved in the process. Finally, we see the birth parents, birth grandmother, baby and adopting parents (Jeff and Lori) together in the hospital.

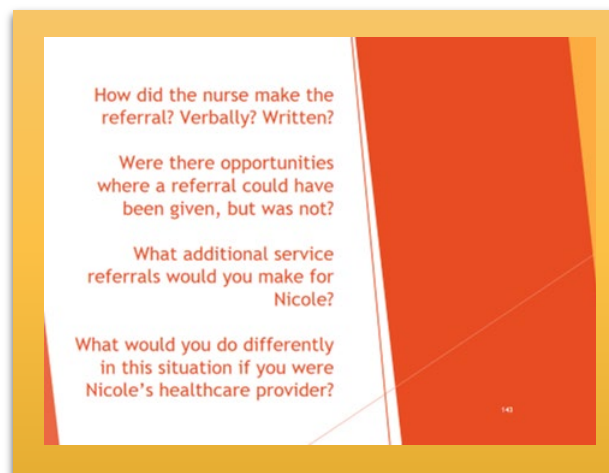
As you watch the video, consider the following:

- ▶ How did the nurse make the referral? Verbally? Written?
- ▶ What other referrals could have been offered to Nicole?
- ▶ Were there opportunities where a referral could have been given, but was not?
- ▶ What additional service referrals would you make for Nicole?
- ▶ Remember to watch for the non-directive, non-coercive counseling techniques discussed previously.

Play the *Nicole* video: <https://cdn.jwplayer.com/players/o1gqRg7Q-BQWrJxa9.html>



ADDITIONAL TRAINER NOTES:



STATE:

Let's talk for a few minutes about what you saw in the video. Before we look at the questions on this slide, let's consider your thoughts about the nurse's interaction with Nicole after the baby was born. What stood out to you? Did you see any of the non-directive, non-coercive techniques that we have talked about today? What specifically did you notice? Now let's consider some of the questions on the slide.

NOTE:

As part of the discussion, you may want to be prepared to talk about some of the specific resources from your local community to which Nicole might be referred.

STATE:

Let's review some key points:

- ▶ As previously mentioned, it is important to discuss options with a patient/client to help her make an informed decision.
- ▶ When making referrals, it is important to match resources and supports with the identified needs and preferences of the patient/client.
- ▶ Remember, patient/clients have the right to refuse services and supports.
- ▶ Patient/clients may want information to review before making a decision about using community resources and supports.
- ▶ It may be helpful to encourage a patient/client to talk with friends, family and the birth father before making a decision that will have long-term effects on her life.
- ▶ It is important to tell your patient/client that the child's birth father will need to be involved if her decision is to release her child for adoption.

- ▶ The Participant Handbook includes the article, Accessing Community Resources. The article contains some helpful techniques that can be used to assess whether a resource is a good match for a particular patient/client.



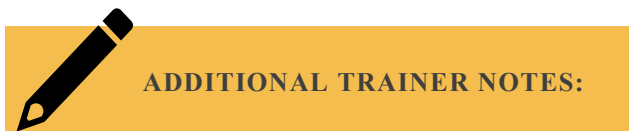


STATE:

The Nicole video highlights a young woman’s process of making an adoption plan and the health care providers providing ethical options counseling. Her health care providers fulfilled their responsibility to her by:

- ▶ Knowing the options available and providing basic information about the implications of each option
- ▶ Providing counseling non-directive, non-coercive manner
- ▶ Making referrals so that Nicole could get the additional information she needed before making an informed decision about her pregnancy

It is our hope that you now feel better equipped to provide options counseling by and that you feel confident in your ability to support patients who are facing an unplanned, unintended pregnancy.



Segment II. Wrap-up/Adjourn

SLIDE 6
5 MINUTES

[PPT #6]: COURSE REVIEW



STATE:

Now let's summarize what we have learned today.

Module 1: Introduction

This module is the beginning of the six module UIA training series. It provides an overview of the content of the curriculum, reviews professional standards, and offers an opportunity to begin to look at person and professional values about adoption.

Module 2: Adoption As an Option

This module takes a deeper look at the option of adoption. It focuses on the evolution of adoption practice, outlines standard adoption practice and defines the types of adoption. The module reviews how both state and federal laws govern adoption to help participants better understand the legal implications of the adoption option.

Module 3: Presenting Adoption as an Option and Making Referrals

This module provides guidance about how to present adoption as an option. Informed consent and the principles of non-directive and non-coercive counseling are discussed. Trauma-informed counseling principles are reviewed and making referrals is introduced.

Module 4: Influences on Decision Making

This module explores the many influences that may impact a woman when experiences an unplanned/unintended pregnancy. The principles of culturally responsive services are reviewed. Special issues to consider when working with teens and approaches for engaging expectant fathers are also presented.

Module 5: Adoption Best Practices: Implications for Health Care Settings (Optional)

In this module, best practices guidelines for adoption-related practice in hospital settings are reviewed. Participants are given an opportunity to reflect on their hospital's current policy in comparison to best practice guidelines.

Module 6: Pulling it all Together

In this final module, participants watch video depicting the story of Nicole and hear from experts about how to incorporate all of the information learned in previous modules into an approach that supports women, men and teens in facing an unplanned, unintended pregnancy.



ADDITIONAL TRAINER NOTES:

Segment III. Post-Test/Evaluations

SLIDES 7 - 8
10 MINUTES

[PPT #7]: CLOSURE



NOTE:

Review the Parking Lot and answer any questions that have not been covered during the training.

If a pre and post test is being used, consider administering the post test at this point.

Revisit the list of expectations (if used) from the start of the training. Go over these to make sure the participants had their expectations met.

Depending on the size of the group and the time remaining, consider asking participants to share three take-aways from the training and/or one or two things they plan to share with a colleague who was not able to attend the session.



ADDITIONAL TRAINER NOTES:



STATE:

Thank participants for attending and thank the host agency, if applicable.



ADDITIONAL TRAINER NOTES: