Substance Use Guideline 2
DISCHARGE PLANNING GUIDE FOR SUBSTANCE USING WOMEN AND THEIR NEWBORNS

INTRODUCTION

The *Discharge Planning Guide for Substance Using Women and their Newborns* is placed second in this section of the BCRCP Guidelines for Perinatal Care manual to emphasize the importance of initiating multidisciplinary discharge planning early in the prenatal period. This guideline outlines discharge planning relevant to mothers, infants, and families with exposure to perinatal substance use. The guideline is also designed to help plan discharge with other prospective caregivers of the infant. It is highly recommended that care providers refer also to BCRCP Obstetric Guideline 16: *Planned Maternity Discharge Following Term Birth*. While all mother/infant pairs discharged from hospital require coordinated care during the transition to the community, mothers with perinatal substance use present with a unique and complex mix of medical, social, and system–based issues that require a comprehensive Discharge Plan based on specific assessment parameters. The purpose of this guideline is to provide guidance to physicians, midwives, hospital nurses, hospital social workers, community health nurses, and other professionals involved in executing an effective Discharge Plan for women and infants with perinatal substance use.

PARAMETERS FOR DISCHARGE PLANNING

1) Preparation for discharge planning should be considered part of the normal prenatal education for all expectant mothers (and families).

2) It is recommended that the discharge planning team follow the process components of Integrated Case Management as outlined by the Ministry for Children and Families in this document.

3) Assignment of a case manager is necessary to best provide coordinated and consistent care during the discharge planning process.

4) It is recommended that the mother / caregiver, her support persons and key community resources be present and participate in the discharge planning process.

5) Postpartum and neonatal length of stay should be flexible and may extend beyond 7 days where appropriate because:
   - Withdrawal symptoms in the infant may not present for 7-9 days.
   - The mother-infant bond should remain intact while observing the infant for withdrawal. The mother should be kept close to her baby whenever possible (e.g. courtesy rooms).

- This allows time to address the special learning needs of the mother / caregiver.
- This allows time for preparing, planning, coordinating, and completing a viable Discharge Plan.

6) The day of the week impacts discharge. Discharge on weekends (Friday-Sunday) or holidays should be strongly discouraged due to the decreased availability of community health nurses and resources during these times.

7) The mother's and newborn's readiness for discharge should be determined by:
   - The medical and social stability of the mother and newborn.
   - Completion of a viable Discharge Plan that incorporates all aspects of the mother / caregiver and baby's transition back to the community, including placement for the infant.

8) The safety of the infant and the well being of the mother are of paramount consideration. Whenever a report is made to the Ministry for Children and Families, MCF have the ultimate responsibility to investigate and assess a child's safety.

MEMBERS OF THE INTERDISCIPLINARY DISCHARGE PLANNING TEAM

The discharge planning team members may include the mother / caregiver, perinatologists, obstetricians, gynecologists, neonatologists, pediatricians, addiction medicine specialists, family physicians, general practitioners, midwives, hospital nurses and social workers, community health nurses, substance use treatment service providers, family advocates, Ministry for Children & Families child protection workers and/or family services workers, Aboriginal Child Welfare Agencies (ACWA), Community Health Reps (CHR's), NADAP workers, lay home support workers, and/or other professionals and paraprofessionals.

The discharge planning team members include those key community resource workers who have been involved with the mother during her pregnancy and / or will be having ongoing contact with the mother / caregiver and infant after discharge.

INTEGRATED CASE MANAGEMENT

Optimal care is consistent with Integrated Case Management as outlined by the Ministry for Children and Families. This is defined as, "when the child…or adult has complex and often longer term needs that would require a formal and structured approach among service providers. This necessitates joint decision-making, development, implementation and monitoring of a single service plan and the clarification of their multiple roles and responsibilities. Each member of the integrated case management team must be clear about his/her part in the plan" (MCF, 1998). Integrated Case Management is a shared community process and should begin as soon as the pregnancy is known.

While the components and tasks for the successful implementation of Integrated Case Management are outlined below, it is recognized that these tasks may cross disciplinary

boundaries depending on the way each community defines and implements Integrated Case Management, and depending on the resources available in each community.

For clarification of roles for social workers working in hospital settings and for MCF child protection workers, see Appendix A.

I PROCESS COMPONENTS OF INTEGRATED CASE MANAGEMENT

1) A holistic, culturally sensitive approach to working with clients
2) Advocacy
3) Respectful and consistent involvement of clients
4) The development of trusting relationships
5) Common goals
6) Clarity of roles
7) Information sharing and frank communication
8) Shared responsibility and accountability to other professionals and to clients
9) A mechanism for resolving conflict
10) Aboriginal involvement in planning services for their community. Aboriginal communities are increasingly involved in managing both child protection and family support services in their communities.

II GENERAL TASKS ASSOCIATED WITH INTEGRATED CASE MANAGEMENT

1) Assignment of a case manager
2) Multi-disciplinary case conferences
3) Proactive assessment, planning, review and implementation of case plans
4) Follow-through / follow-up

III SPECIFIC TASKS RELATED TO THE DISCHARGE PLAN

A case manager must be assigned (it could be the social worker, physician, community health nurse, or any working partnership with the mother/caregiver, depending on how the community has implemented Integrated Case Management).

The tasks that must be assumed by the assigned case manager include:

1) Coordinate family and team meetings.

2) Ensure discharge plans are done in collaboration with multi-disciplinary team members and representatives from community resources.

3) Ensure that each member of the discharge planning team has made arrangements for any referrals and medical or social follow-up needs identified.

4) Ensure that discharge planning team members have identified the process of planning and effective ongoing communication as necessary. This includes:
   - An Integrated Case Management Discharge meeting has been held which has included the community follow-up resources. It is recommended that the mother and family support persons be present.
   - Plans for community follow-up are well articulated prior to discharge.
   - Plans for community follow-up include the agencies involved (social work, mental health, etc.), and specific plans for follow-up including the planned date for visit following discharge.
   - Plans for community follow-up are clearly documented on the Community Liaison Record in hospital and the Community Liaison Record is shared with the Community Health Unit for continuity of information.
   - The discharge plan and list of recommendations are placed in the hospital chart and are given to the attending case manager, team members, and the mother / caregiver.

DISCHARGE PLAN FOR WOMEN AND NEWBORNS WITH PERINATAL SUBSTANCE EXPOSURE

I DISCHARGE PLAN FOR THE MOTHER

Clear discharge plans should be made which ensure that the needs of both the mother and infant are considered. With respect to the mother's Discharge Plan, please see Appendix B for specific questions to ask the mother when preparing her Discharge Plan, and Appendix C for a sample Discharge Planning Form. The Discharge Plan for the mother should consist of the following components:

A. Medical Assessment

Complete the comprehensive medical assessment and arrange for medical follow-up after discharge. (See Antenatal Record, Labour and Birth Summary Record, Maternal Postpartum Care Path, and Community Liaison Record).

B. Substance Use

The information concerning the mother's use of substances during her pregnancy is useful both for providing care for the baby and mother during their hospital stay, and in planning for their discharge. With proper documentation procedures, much of this information should be available from the patient's chart. If however, this information needs to be obtained directly from her, it is important to discuss with the mother at the start why she is being asked about her substance use during pregnancy, and what will be done with the information she provides.

1) Identify the mother's current plans regarding her use of substances (e.g. abstinence, maintenance, stabilization, or other).

2) Identify whether further withdrawal is noted or expected for the mother. If yes, then identify the management issues and the primary care provider monitoring her withdrawal.
3) The following topics should be discussed with the mother/caregiver and documented as part of the Discharge Plan:
   - Information on and / or referrals to substance use treatment resources and services as available in the community.
   - Harm reduction strategies.
   - The risks / benefits for mother and newborn of reducing or stopping smoking and / or other substances
   - Shaken Baby Syndrome and SIDS

C. Social and Psychological Assessment of the Mother / Caregiver

This assessment is to assist the mother / caregiver in identifying areas of need or concern with respect to herself and the care of her infant. In this assessment it is important to recognize the mother's / caregiver's strengths, and to be sensitive to cultural and spiritual issues. See Appendix B for a list of suggested questions to ask that effectively assess the life areas of the mother / caregiver. While completing the social and psychological assessment, it is important to:

1) Connect the mother / caregiver to available family, and community supports in the form of phone numbers, pamphlets, support groups and any programs in the community that may be of assistance, and provide follow-up.
2) Ensure that the mother / caregiver is aware of and understands the reason for follow-up appointments for themselves and their infant.
3) Assess the mental and emotional health of the mother / caregiver (See Maternal Postpartum Care Path and Community Liaison Record).

In a situation where there is perceived to be a significant risk for the infant (See Discharge Plan for Infant on page 6) this part of the Discharge Plan needs to include acknowledgment of the child protection piece and how a mother might need to access support through this process. A home assessment needs to be completed by a MCF child protection worker or ACWA.

If the mother will not be the primary caregiver at the time of the neonate's discharge then whoever has the role of caregiver should be present at discharge planning and educated accordingly.

D. Community Follow -Up

1) A home visit / contact should be made within 24-48 hours of discharge. An assessment including breastfeeding and infant nutrition should be made at this time.
2) Medical follow-up visits should be provided.

3) Coordination and / or provision of referrals to other programs such as substance use treatment, breastfeeding and postpartum support groups and/or Aboriginal support workers should be done on an as needed basis.
4) Other issues arising from the psychological and social assessment completed by members of the discharge planning team should be addressed as well as any other issues as they present.
5) See Appendix D for a brief description of some of the community resources available.

E. Breastfeeding

Breastfeeding provides optimal infant nutrition however, in the context of substance use many other considerations are involved. There needs to be a discussion of the risks and benefits and the mother needs to make an informed choice. Breastfeeding is contraindicated if HIV +, or if active substance use of certain substances is present (e.g. heroin, cocaine, amphetamines) (Howard & Lawrence, 1998). There is still debate about breastfeeding if the mother has HCV. The ACOG Committee Opinion titled Breastfeeding and the Risk of Hepatitis C Virus Transmission (1999) states, "Studies to date evaluating the effect of breastfeeding on HCV transmission indicate that the average rate of infection is 4% in both breastfed and bottlefed infants. Therefore, it appears that breastfeeding does not appreciably increase the risk of transmitting HCV to a neonate."

If the mother and child are separated for medical or custody reasons, an electric breast pump should be provided and consideration should be given for breastfeeding visiting rights.

II DISCHARGE PLAN FOR THE INFANT

Given the complex mix of clinical, social and systems-based issues that is likely inherent to mothers and infants with prenatal substance exposure, each of these newborns should have a Discharge Plan based on a multi-dimensional risk model. Please ensure that the standard provincial form - Newborn Record, Part 2: Sections 13, 14, 15, and 16 regarding discharge is completed prior to discharge. The Discharge Plan should consist of the following components:

A. Newborn Length of Stay

Newborn length of stay should be flexible and may extend beyond 7 days because withdrawal symptoms may not show up until 7-9 days. The infant should not be discharged until it meets the SOGC / CPA guidelines for discharge (See BCRCP Obstetric Guideline 16 – Planned Maternity Discharge Following Birth), **plus**:

1) There are no signs or symptoms of withdrawal present or expected.
2) The infant is gaining weight.
3) Community follow-up: home assessment is complete and child protection issues have been addressed (see D and E below).

B. Physical, Neurological, and Behavioral Assessment and Documentation

1) Newborn growth parameters including length, weight, and head circumference are completed.
2) The newborn demonstrates good feeding behavior for 3 – 5 days prior to discharge (See Newborn Care Path)
3) **A documented weight gain of 20-30 grams/day for 3 - 5 days is recommended.**
   (Note: this may be lower if mother is breastfeeding – See Substance Use Guideline 4A p.10 – Perinatal Opioid Use, Care of the Mother).
4) Substance Effects
   - **The newborn should have been off morphine for at least 5 days prior to discharge.**
   - There are no signs and symptoms of withdrawal (See Substance Use Guideline 4B – Perinatal Opioid Exposure, Care of the Newborn, Appendix A – Neonatal Withdrawal Observation Sheet).
   - There is documentation on whether methadone withdrawal is expected.

C. Laboratory Studies

If indicated from mother's history and if medically necessary for the baby, lab studies should be done with informed consent from the mother. If the mother cannot or will not give consent, these tests can be ordered by a pediatrician or the newborn's family physician, but only if the infant's health is at risk. The tests should be done prior to discharge and the reports should be sent to the medical practitioner following the baby in the community, mother / caregiver, and the MCF worker if the baby has been taken into care. Tests may include:

1) Drug screen – urine, meconium, and/or hair
2) HIV
3) Anti-HbsAg
4) Anti-HCV
5) Renal ultrasound if cocaine exposed and indicated

D. Preparation and Assessment of Home Environment

1) There has been a home assessment conducted by the MCF / ACWA (whether the infant will be placed with it's natural parents or a foster family).
2) The mother / care provider for the infant has been informed about:
   - Potential withdrawal symptoms and their management
   - Shaken Baby Syndrome
   - SIDS risk reduction recommendations
   - Other relevant medical recommendations

E. Community Follow –Up

1) Arrange Community Health Nurse visit within 24 hours of discharge, and subsequent visits daily as indicated.
2) Arrange Medical Practitioner appointment within 48 – 72 hours of discharge. Ensure continuity of care if possible.
3) Ensure reassessment by family physician or pediatrician if withdrawal symptoms appear after discharge.
4) Indicate MCF / ACWA or community support worker's name on the Community Liaison Record.
5) Ensure there is timely developmental follow-up by a family physician / pediatrician or an Infant Development Program (IDP).
6) Infants should not be discharged to motels or hotels unless in transit.
7) The infant's caregivers must be present at discharge and discharge should only occur if a suitable infant car seat is available for use.

F. Child Protection Issues

It is everyone's responsibility to report infants considered at risk, and to share information in a timely and comprehensive manner. It is the mandate of the MCF child protection worker to assess and, where appropriate, to investigate reports where a child may need protection. If the result of the investigation is that the child is in need of protection, the social worker will take whatever steps are necessary to keep the child safe. Children are only removed from their parents when they are in immediate danger and nothing less disruptive can protect them. The social worker must conduct a comprehensive risk assessment for every child who may be in need of protection, and develop a plan to reduce the highest risk factors. The plan will include specific steps to be taken and services to be provided to family members. The process of decision making for children at risk is a complex one and benefits from a team approach. The removal of a newborn is one of the most difficult experiences for women and their partners. MCF social workers and contracted service providers can work with the hospital social workers and health care providers to incorporate supportive services into the plan for the family. Considerable support is needed for the woman and an ongoing support plan needs to be developed on a case by case basis.

REFERENCES

American College of Obstetricians and Gynecologists (1999). Committee Opinion Number 220. Breastfeeding and the Risk of Hepatitis C Virus Transmission. August. Authors.

Howard, L. & Lawrence, R. (1998). Breastfeeding and Drug Exposure. Obstetric and Gynecologic Clinics of North America (25). NO.1, 99-118.

Ministry for Children and Families. (1998). Draft document. Integrated Case Management.

APPENDIX A

I HOSPITAL SOCIAL WORKER

1) Completes an assessment of psychological and social issues in the woman's life to determine her needs and goals for the perinatal period. The assessment should explore the following areas as they are related to the woman's use of substances:

   A) Current and past history of substance use and recovery experience
   B) Current and past family functioning (including extended family)
   C) Relationship with partner and father of the baby
   D) Parenting issues and needs
   E) Survival needs such as housing, transportation and financial issues
   F) Issues of violence including both domestic and safety issues of her environment
   G) Cultural issues as they impact on her needs and goals
   H) Legal issues as they impact on her needs and goals
   I) Mental health issues and need for psychiatric assessment
   J) Coping abilities and social skills
   K) Recommendations regarding readiness for discharge.

2) Coordinates hospital team response to the Ministry for Children and Families Child Protection Involvement. Works in collaboration with the MCF social Worker and communicates MCF plan to the hospital team. Plays a supportive role to women and their families during the child investigation process.

3) Counsels the woman and her family until baby's discharge from hospital

   A) Provides emotional support, crisis, problem-focused, resource and/or psychotherapeutic counseling on a range of issues as identified with the woman through the assessment process.
   B) Considers a continuum of harm reduction to abstinence strategies.

4) Discharge Planning

   A) Refers, advocates, and liaisons with a wide range of appropriate community agencies from alcohol and drug treatment services, income assistance, and parenting support programs as required.
   B) Facilitates care planning conferences in collaboration with both community and hospital caregivers.
   C) Ensures coordinated proactive post-discharge plan has been communicated to all caregivers prior to discharge.

II MINISTRY FOR CHILDREN AND FAMILIES CHILD PROTECTION WORKER

1) Ensures there is an integrated case management approach.
2) Ensures appropriate support services are available for the needs of mother and infant.
3) Assesses child protection issues.
4) Conducts investigation if appropriate.
5) Conducts a risk assessment.
6) Consults with medical staff in conducting the risk assessment.
7) Arranges alternative care if necessary.
8) Ensures alternative care giver has received appropriate training.
9) If infant will be discharged to an alternative care giver, MCF will ensure they have received the appropriate information and training prior to the infant's discharge.
10) Arranges alternate care during residential treatment for mother if necessary.
11) Assists with referral of mother to residential treatment.
12) Monitors the home if appropriate.
13) Functions as a member of the multidisciplinary team.

APPENDIX B

ASSESSING LIFE AREAS OF THE MOTHER

Under each of the following topic headings are things to consider and/or suggested questions to ask to effectively assess life areas of the mother.

I RELATIONSHIPS AND INFORMAL SUPPORTS

Briefly describe mom and baby's social network & supports, strengths and stresses e.g. father of child, extended family, friends, siblings of new baby.

1) Are mom and baby safe within these relationships? (universal screening for violence can be done by physician, midwife, nurse, or hospital social worker – See Obstetric Guideline 13 – Domestic Violence in Pregnancy & Postpartum)
2) How can these relationships be enhanced or supported? (e.g. hospital visitation policies, rooming in, supports, etc).

II SPIRITUAL AND/OR CULTURAL

1) Does mom have any beliefs or practices (e.g. spiritual or cultural affiliations) about healing, birth, pregnancy or health that she would like taken into account during her hospital stay and discharge planning process?
2) What are these, and how will they influence her stay in hospital and her discharge plans?

III LEGAL ISSUES

Briefly describe any legal concerns mom may have, (e.g. custody issues, outstanding warrants, probation requirements, immigration, etc.).

IV PARENTING NEEDS (listen carefully-this is often the place where she may ask for help.)

Have the woman (and partner) briefly describe their parenting needs, concerns and strengths. Ensure information has been given to the mother (written, verbal and/or demonstrated) regarding specific skills and information she will need if her baby has any special requirements (e.g. SIDS education, child development stages, warning signs re: withdrawal, comforting techniques, infant cues, feeding, bonding and attachment, etc.).

1) Are there any specific issues regarding mother/baby attachment?
2) **What has been her experience with prior pregnancies, placements, etc?**
3) Do mom and baby need some specific parenting supports?
4) Has mom experienced previous losses of children (due to death, custody or child protection issues)? Does she have any residual fears from these losses?
5) Does mom have specific parenting or treatment needs around her use of substances? (e.g. transportation and childcare needs while in treatment, respite care when parenting children with high needs, etc.).

V EMOTIONAL HEALTH

Briefly describe mom's emotional health (e.g. fears, anxieties, depression etc.).

VI MENTAL HEALTH

Briefly describe mom's mental health status.

1) Has patient been diagnosed previously with a dual or multiple diagnosis?
2) Does she require assessment and/or follow-up by the hospital, community psychiatric team or a mental health care worker?

VII FINANCES

1) Are mother’s needs in place e.g. housing, breast pump rental?
2) Are baby needs in place? (e.g. crib, bedding, clothing, diapers, car seat etc.).
3) Does she qualify for ministry support to get these things in place?
4) When will finances be in place?
5) Does mother have a telephone, or ready access to one?
6) Does mother have money to feed herself and baby?

VIII HOUSING

1) Is mom and baby's housing safe, affordable and adequate?
2) Is temporary housing needed?
3) Do mom and baby have available to them a housing environment that supports a harm reduction approach?

IX TRANSPORTATION

1) How will mom and baby get home from the hospital?
2) Do they have access to on-going transportation? (e.g. bus pass, access to a vehicle etc.)
3) Has transportation been arranged for medical follow-up?

X FORMAL SUPPORTS

1) What arrangements have been made for routine medical follow-up for mom and baby?
2) What other follow-ups should be arranged? (e.g. regarding late withdrawal assessment for mom and/or baby, paediatrician follow-up, C.H.N, I.D.P, Pregnancy Outreach program or Building Blocks program etc.).
3) Does mom require follow-up with MCF? e.g. child protection or support services
4) Does mom need to be linked up to any alcohol and drug treatment programs or services?
5) Does mom need to be linked up to any personal counselling services?
6) Does mom need to be linked up to any mental health services?
7) Does mom need or would she like, any help connecting with these services or any others?

APPENDIX C
SUGGESTED DISCHARGE PLANNING FORM FOR PERINATAL SUBSTANCE USING MOTHERS AND THEIR INFANTS

1. Who is the assigned community case manager?

Name:______________________________ Contact Number:__________________________

2. **Who is the baby going home with?** ***(parent (s), foster parent(s))***

Name:______________________________ Contact Number:__________________________

3. Follow-up visits have been booked for:
Mother's Medical Needs: Yes No

Physician Name:____________________ Contact Number:__________________________

Baby's Medical Needs: Yes No

Physician Name:____________________ Contact Number:__________________________

3. Have the baby's developmental needs been addressed (e.g. Infant Development Program referral)?

Yes No

4. Have the mother's /caregiver's following needs been addressed: Referral Name & Number

			Referral Name & Number
A) Home environment	Yes	No	____________________
B) Psychosocial and Mental Health	Yes	No	____________________
C) Substance use issues	Yes	No	____________________

6. Has there been the need for MCF involvement: Yes No
If yes, Social Worker Name & Number ____

7. Has mother/caregiver received information / guidance on:

A) Withdrawal symptoms for mother and baby	Yes	No
B) Behavioral and safety needs of high risk infants	Yes	No
C) SIDS & Shaken Baby Syndrome	Yes	No
D) When and whom to ask for help	Yes	No

Signed By:

Mother / Caregiver:____

Hospital Case Manager:____

Community Case Manager:_______________________________________

Date:____________________________

APPENDIX D

COMMUNITY RESOURCES

There are many community resources for clients to access and they may vary from community to community. It may be beneficial to list the names and phone numbers of resources available in your community for reference purposes. In this appendix 3 common community resources are explained.

I Pregnancy Outreach Programs (POPs)

Pregnancy Outreach Programs offer health counseling and peer support to high-risk pregnant women who do not typically access traditional prenatal health services. The goal of the program is to promote positive health practices that contribute to the health of the mothers and newborns. The specific objectives are to:

- Improve nutrition
- Decrease smoking
- Decrease alcohol and drug use
- Raise self-esteem
- Encourage breastfeeding
- Promote dental health
- Encourage physical activity
- Encourage early and continuing physician care
- Promote social/community support

A. Client Eligibility

The Pregnancy Outreach Program service begins with a referral (most commonly self-referral) from government or non-government agencies (e.g. Health units, Alcohol and Drug Programs, Social Services, or by a physician referral).

- The Individual Prenatal risk Identification Tool and the T-ACE (screening tool for substance misuse) are used to establish client eligibility
- The Coordinator reviews all client assessments before the person is accepted into the program
- Priority is given to clients at less than 28 weeks gestation so there is sufficient time for the intervention to be effective
- Client assessment is completed within 24 hours of receipt of the referral

B. Client Services

- Group Sessions to encourage peer support/counseling and to involve clients' families are offered a minimum of once every two weeks. A healthy snack/meal is provided.

- Individual Counseling based on the client's need. Clients receive a minimum of 5 counseling sessions.
- Vitamin/Mineral Supplements are provided for clients in financial need.
- Food Supplements are provided for clients in financial need.
- Referrals are made to local Health Units or Medical Services Health Centers prior to the client's expected delivery date.

II The Ministry for Children and Families Building Blocks Initiatives Lay Home Support Visitors Component

Lay Home Support Visitors are experienced parents who are trained to provide early home-based support and education to first time parents of higher risk children from before birth to age five. These parents may require assistance to achieve the optimal growth and development for them and their children. The program will assist in the areas of family interaction and development of their child through a combination of individualized and group services with an emphasis on home visiting format.

Lay Home Programs are currently available in four sites in British Columbia:

- Burns Lake
- 100 Mile House
- New Westminster
- Richmond / Vancouver

III Infant Development Programs

Infant Development Programs provide parents of developmentally delayed children from birth to three years of age, and at-risk infants with support through home visits, workshops and opportunities to meet other parents. They assist families in planning a program of activities, which encourages development in physical, intellectual and self-help skills. For information on the location of an Infant Development Program in your region, phone the office of the Provincial Advisor at (604) 822-4014.

IV Resources Specific to Your Community

	Name	Phone
1.		
2.		
3.		
4.		
5.		