Supporting the Prevention Conversation:

A Developmental Evaluation of an Innovative FASD Awareness and Prevention Initiative

Prepared by the Alberta Clinical and Community-Based Evaluation and Research Team (ACCERT)

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Executive Summary

Initiative Description

The FASD Prevention Conversation (FASD:PC) is an innovative, made-in-Alberta approach to FASD Prevention. It focuses on the unique role Healthcare Professionals and Social Service Providers can play in engaging women of childbearing age in supportive and non-judgemental conversations about alcohol and pregnancy. This initiative involved hiring Facilitators in each of the FASD Service Networks to train and prepare Service Providers for this role, while also engaging the larger community in discussions about alcohol and pregnancy, to increase awareness of FASD. In supporting these activities, the FASD:PC aligns with the FASD Cross Ministry Committee's (FASD-CMC) Strategic Pillars of Awareness and Prevention.

Evaluation Overview

This document presents findings from the developmental evaluation of this initiative, the purpose of which was to provide key information to stakeholders in order to inform their future decision-making regarding this FASD prevention initiative. The evaluation also served to track the development and implementation of the initiative, in order to assess its transferability to new contexts. This developmental evaluation employed a mixed-methods approach, collecting data from Facilitators, Service Providers, and key project team members to answer four key evaluation questions. Data collection took place between May 2013 and January 2015, during the period of development and the first year of the implementation (2014) of the initiative.

Key Findings

Overarching Theme of Connecting

A theme of Connecting permeated all findings from this evaluation. In short, the extent to which a Facilitator, and later a Service Provider, was "connected" to their colleagues, communities, and clients seemed the single greatest factor in their ability to do their job. Upon closer examination it became clear that this concept of *Connecting* could not be broken down into a single idea but rather was best examined in conjunction with the goals of the project – represented by the evaluation questions – in order to fully appreciate its foundational role.

Answering Evaluation Questions

1. What contributes to Facilitators' and Service Providers' preparation to engage in the FASD Prevention Conversation?

- Facilitators reported increased knowledge about FASD and confidence in delivering the initiative following training. Given the diverse backgrounds and previous experiences of Facilitators, it would be beneficial for training to be individualized to specific learning needs.

- Service Providers reported increased knowledge and changes in beliefs about FASD prevention following training. There was variability in their preparedness to discuss certain topics with their clients, suggesting further preparation in these areas might be warranted.

2. What are the experiences of those involved in the FASD Prevention Conversation?

- Facilitators reported varied experiences, seemingly as a function of how connected they were to their network and community. They experienced a number of challenges, but were able to identify ways in which they were addressing them, engaging with and adapting to the needs of their audiences. They also reported utilizing a number of unique approaches and activities as they customized the project to the needs of their network and noticed an increase in the demand for Network services as a result of their work.
- 73% of Service Providers reported incorporating the FASD:PC into their work. They reported overall positive experiences and that their conversations have increased in frequency and quality. Service Providers who are not engaging in the conversation reported believing that it was not important to their work and may be misinformed about the target audience for this initiative.

3. To what extent is the intended messaging being delivered and received by participants throughout the implementation of the FASD Prevention Conversation?

- Overall, there is consistency in the messaging reported by participants and service providers. This is especially encouraging, given the number of levels the message must travel through, however, messages heard by Service Providers do not always guide their conversations with women.
- Facilitators have differing views on the importance of message fidelity.

4. How was the FASD Prevention Conversation Developed and Implemented?

- Findings from Question 4 are presented in the companion document: *Capturing the Evolution of the Conversation: A Development Evaluation Process.*

Recommendations

These evaluation findings provide us with a number of key recommendations for continuing the conversation:

1. The Prevention Conversation should be Responsive
    - This includes being responsive to the needs of Facilitators, Service Providers, and the community-at large. For instance the creation of a community of practice to foster ongoing interactions and support, and the diversification of available training for Facilitators could allow for well-matched learning and supports. Similarly, opportunities for ongoing engagement with Service Providers may support capacity building that responds to diverse needs and contexts within communities. Finally, it will be important to continue to create and strengthen existing community partnerships to ensure the conversation stays relevant and responsive to the needs of unique communities.

2. Facilitators' Scope of Practice should be Prioritized
    - To eliminate any confusion surrounding the role of the Facilitator in FASD awareness and prevention, it is recommended that decision-makers prioritize a list of potential activities for Facilitators, with a focus on emphasizing those activities that promote relationship building with communities and between Facilitators. It is also recommended that Facilitators embed reflection into their practice, to reflect on their own strengths and limitations within their work, in order to better understand their role in the conversation and to continue to enhance and develop this role.

3. Project Materials should be Accessible
    - It is important that project materials continue to be easily accessible and relevant to all populations involved. This should involve consideration of opportunities to create an online presence or platform for the conversation, as well as a continued commitment to diversify printed materials to ensure easy access for all.

4. Long-term Funding should be Secured
    - Sustained and predictable funding will ensure that this initiative can continue to support awareness and prevention activities in the province of Alberta. It is therefore important to advocate the importance of prevention-focused initiatives such as this one, and engage key stakeholders in project updates, providing evaluative information on the success of the project.

Introduction & Acknowledgements

This document reports the findings of the developmental and formative evaluation of the first year (2014) of the FASD Prevention Conversation (FASD:PC) initiative. This evaluation was implemented between April 2013 and December 2014, by the Alberta Clinical and Community-Based Evaluation and Research Team (ACCERT, see Appendix A) and in collaboration with members of the FASD Awareness and Prevention Council (FASD-APC). The authors of this document would like to acknowledge the contributions of the collaborative efforts of the Prevention Conversation project manager, Hazel Mitchell, and members of the FASD Awareness and Prevention Council, during both the design and implementation phases of this evaluation. Particular thanks are sent to the Prevention Conversation Facilitators who were instrumental in collecting much of the data required to evaluate this initiative.

Abbreviations Used in this Document

FASD:PC → FASD Prevention Conversation

FASD-APC → FASD Awareness & Prevention Council

FASD-CMC → FASD Cross Ministry Committee

Project Overview

Organizational Context

To support FASD awareness and prevention efforts across Alberta, the FASD Cross Ministry Committee (FASD-CMC) established the FASD Awareness and Prevention Council (FASD-APC) in February, 2013. The FASD-APC was then tasked with developing, implementing, and evaluating an innovative approach to FASD awareness and prevention. The FASD-APC desired to create a hands-on, grassroots approach to address FASD awareness and prevention efforts in the province, and effectively lobbied the Government of Alberta for the opportunity to develop such an initiative: *The FASD Prevention Conversation* (FASD:PC). This innovative initiative addresses the need to take a relational approach to the prevention of FASD, by engaging women of childbearing age and their support networks (i.e., partners, families, and friends) in *conversations* about alcohol and pregnancy. At a broader level, this initiative is also intended to engage community members in similar discussions around how to best support women of child bearing age to make healthy decisions regarding alcohol and pregnancy.

Description of Initiative

The FASD Prevention Conversation addresses the first two levels of FASD prevention as outlined by the Public Health Agency of Canada's (PHAC) four-part model: Raising Awareness (Level 1) and Brief Counseling with Girls and Women of Childbearing Age (Level 2; Poole, 2008). Level 1 of this model, Raising Awareness, involves increasing the general public's knowledge of the risks of drinking during pregnancy, increasing awareness of alternatives to alcohol use during pregnancy, indicating where help can be accessed by those who need support for managing their alcohol consumption, and promoting involvement by community members in bringing awareness into action for FASD prevention (Poole, 2008). Level 2, Brief Counseling, involves engaging in collaborative and supportive discussions about alcohol use and related risks with women of childbearing age, as well as with their support networks (i.e., partners, families, and friends). This may also involve conversations about how to cope without alcohol, available prenatal supports, and contraception and pregnancy planning (Poole, 2008). These first two levels of prevention were the foundation of the development of the FASD Prevention Conversation, which focuses on the importance of engaging all women in these conversations, rather than specifically targeting at-risk groups.

The goal of the FASD Prevention Conversation (FASD:PC) is to support and facilitate non-judgmental, supportive conversations between Healthcare and Social Service Providers, and women of childbearing age and their families about alcohol and pregnancy. Specifically, this initiative responds to the need to engage and prepare Service Providers to take a comprehensive, preventative, and proactive approach in addressing FASD, recognizing they are in a unique position to have these meaningful conversations with women.

Aligning with the CMC's 2013-14 Strategic Pillars of (1) Awareness and (2) Prevention– levels 1 and 2, the FASD: PC addresses the identified need for the development and implementation of an innovative response to FASD awareness and prevention in Alberta. This need is addressed through the Prevention Conversation by engaging women of childbearing age and their support systems in supportive conversations about pregnancy, alcohol, and FASD prevention. Intended outcomes for the initiative, as outlined by the FASD-APC, include:

1. Health and social service providers across Alberta have increased knowledge, skills and confidence to effectively discuss alcohol use in pregnancy and intervene appropriately and effectively with women of child bearing age and their partners.
2. Health and social service providers create a safe environment for women to discuss alcohol consumption during early pregnancy.
3. Women of childbearing age are informed and aware of the risks associated with alcohol use in pregnancy in a non-judgemental way and of community resources and supports that are available to them.
4. Consistent messages are provided to women and their partners/families about the risks of alcohol consumption in pregnancy with a focus on early stages when pregnancy status may not be known.
5. These strategies will contribute to prevention and mitigate against the lifelong costs of FASD.

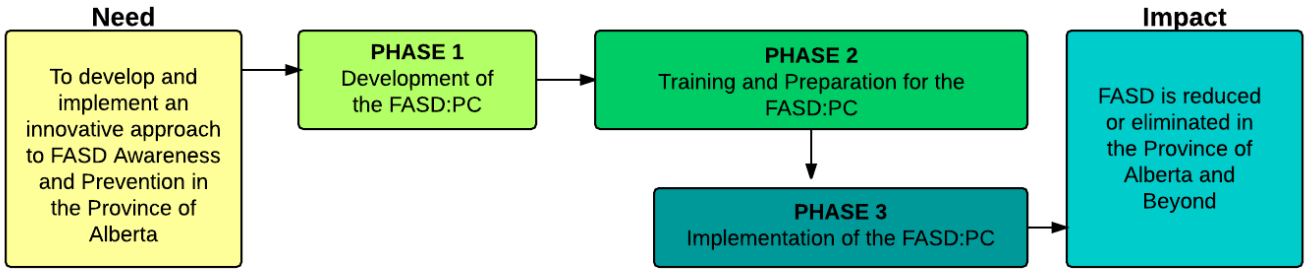
Six key prevention messages were developed by the FASD-APC as the foundation of the Prevention Conversation, with the primary message being: "*It is safest not to drink alcohol in pregnancy.*" This messaging is presented below in Table 1, and more details about the development and implementation of the messaging is provided in the Evaluation Findings section, in response to Evaluation Question 3.

Table 1. FASD Prevention Conversation Messaging

Audience	Prevention Messaging
General	*It is safest not to drink alcohol in pregnancy*
Women of Childbearing Age	*Drinking can be harmful at any point during pregnancy. The baby's brain and nervous system develops throughout the entire pregnancy and drinking may lead to a lifelong disability of FASD*
	Alcohol and pregnancy don't mix. If you drink alcohol and are sexually active, make sure you use effective contraception
	If you are pregnant or thinking about getting pregnant, consider talking to your health care provider or asking for help on learning more about support and services in your community
Community (Partners & Families)	*Friends, partners, and family members can support a pregnant woman by asking how they can help her to make healthy choices and healthy babies*
Healthcare and Social Service Providers	*Some women need support, care and treatment to help them stop drinking during pregnancy. Research points to the effectiveness of intervention. Engage them in The Prevention Conversation*

The FASD Prevention Conversation meets an identified need for an innovative approach to FASD awareness and prevention in the province of Alberta. It can be conceptualized in three distinct, yet overlapping phases that took place within an 18-month timeframe (from May 2013-December 2014). See Figure 1 for a visual description of these phases. Appendix B provides logic models and detailed descriptions of activities during each of the three phases.

Figure 1. A Visual Overview of the FASD:PC Initiative



The first phase involved the conceptualization of the project, and the development of conversation materials and training resources, and took place between May and November 2013. The second phase involved the training of Prevention Conversation Facilitators, who then engaged and trained healthcare and social service providers to have the prevention conversations with clients. Training of the Facilitators took place in December 2013 while training of the Service Providers occurred from January to December2014 and is ongoing as the project continues. The third and final phase involves healthcare and social service providers engaging in the prevention conversation with women of childbearing age, as well as their partners, families, friends, and communities. It is assumed that these conversations have been ongoing from the time the Services Providers receive their training, and thus began in January 2014. As Service Providers engage women of childbearing age in conversations surrounding alcohol and pregnancy, it is expected that the ultimate impact of this initiative will be a reduction in the prevalence of FASD in Alberta and potentially beyond.

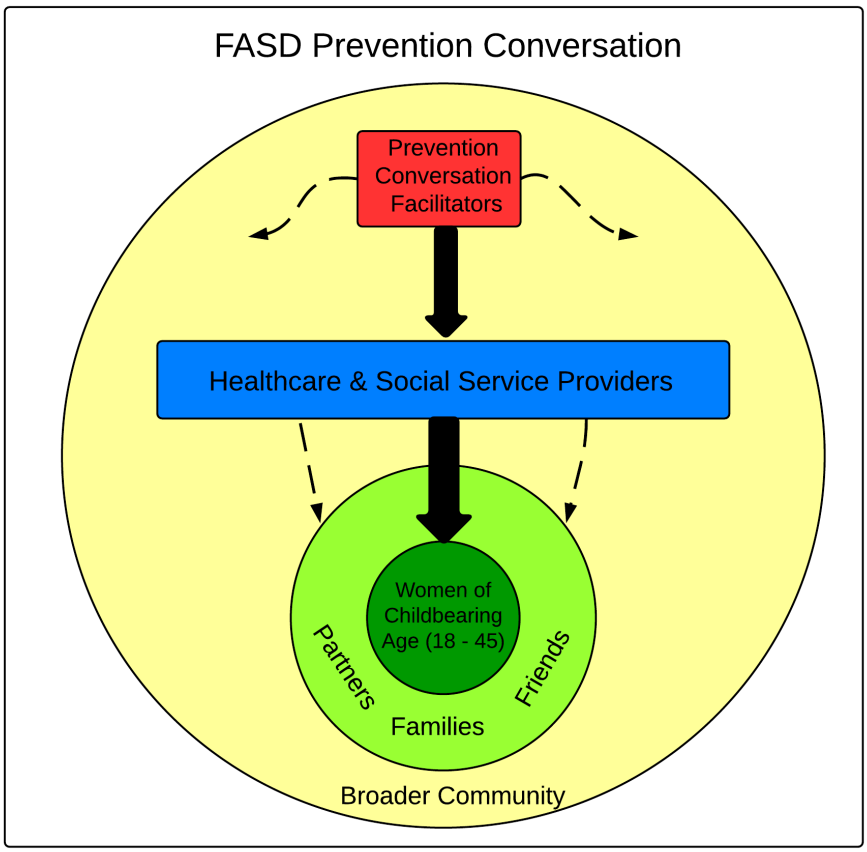
Initiative Stakeholders

Stakeholders in an evaluation are those individuals and organizations who have a vested interest in the program (i.e. program developers, funders, participants). For the purposes of this evaluation, identified stakeholders were organized into two groups based on their relationship to the Prevention Conversation:

- **Initiative Participants**: Facilitators, Service Providers, Women & Families, and the Broader Community.
- **Supporting Stakeholders**: The FASD Cross Ministry Committee (FASD-CMC), Alberta Center for Child, Family, and Community Research (ACCFCR), FASD Awareness & Prevention Council (FASD-APC), FASD Service Networks, Project Manager, TWIST Marketing, Expert Consultants, and the Evaluation Team.

For the sake of simplicity and clarity, we present descriptions of Stakeholders who are participants in the Prevention Conversation (i.e. Initiative Participants) in Figure 2. For a detailed description of the "Supporting Stakeholders" who supported the development and implementation of the FASD:PC (i.e. the FASD-CMC, the FASD-APC, ACCFCR, expert consultants, project manager, etc) see Appendix C.

Figure 2. Participants in the FASD Prevention Conversation Initiative



Initiative Participants

Stakeholders who are represented here are those for whom the Prevention Conversation is intended to support. In other words, they are the target audience for the project, and include the Prevention Conversation Facilitators, Health and Social Service Providers, and women of childbearing age (18 to 45 years old), their partners, families, and friends.

Prevention Conversation Facilitators

Facilitators were hired in the 11 geographical FASD Service Networks (see Appendix C for more information about the Service Networks). These Facilitators delivered presentations and training opportunities to Healthcare and Social Service Providers, with the goal of preparing them to engage women of childbearing age, and their support networks, in supportive and non-judgemental conversations about alcohol and pregnancy. Additionally, their role included engaging other community members (i.e. the general public) to raise awareness about FASD and its prevention. For demographic information about Facilitators hired for this initiative, see *Introduction to Facilitators & Service Providers.*

Service Providers

Healthcare and Social Service Providers received training from Facilitators, through formal presentations and/or more informal conversations, about FASD prevention strategies and how to engage their clients (i.e., women, partners, families, and friends) in the Prevention Conversation. For more information on the variety of Service Providers engaged in the Prevention Conversation, see *Introduction to Facilitators & Service Providers.*

Women of Childbearing Age

Women of childbearing age, both those who are pregnant and not currently pregnant, are the target audience of this initiative. The FASD Prevention Conversation is intended to engage these women in supportive discussions with healthcare and social service providers in order to increase their awareness of the risks of drinking alcohol while pregnant and its impact on fetal development. For women who are not yet pregnant, the conversation can also involve discussion of family planning and contraception as a means to prevent FASD. These women are members of the general public, from all socio-economic, educational, cultural, and ethnic backgrounds. Although the conversation may be tailored to suit the needs of various populations as needed, there is no focus on specific subgroups or "at risk" populations of women for this conversation. It is intended that all women of childbearing age in Alberta are engaged in the Prevention Conversation.

Partners, Families, and Friends

Partners, friends, and family play a crucial role in supporting women of child bearing age in their decision-making surrounding alcohol and pregnancy. They may be engaged in the Prevention Conversation directly with the women they support, through Service Providers, or though interaction with Prevention Conversation Facilitators to help support their partner/friend/family member. They may also be involved in supporting the Prevention Conversation by raising awareness about FASD prevention in their roles as members of the community.

The Broader Community

Community members play a role in the Prevention Conversation as they are the target of FASD awareness and prevention messaging. Although not the primary focus of the initiative, community members play a key role in working to change the overall perceptions of the general public in terms of FASD prevention, and in supporting women's healthy choices. By engaging the broader community in this initiative, Facilitators strive to create a safe and non-judgemental environment for conversations about alcohol and pregnancy, free from the stigma often associated with this topic. The exact scope of community engagement will be largely dependent on the needs of the area in which the Facilitators are working, their ability to engage community stakeholders, and community interest in the topic of FASD Prevention.

Supporting Stakeholders

For a full stakeholder map illustrating the relationships between the individuals and organizations who supported the development and implementation of the FASD:PC, as well as a more detailed description of the role that each played in this initiative, please refer to Appendix C.

Evaluation Overview

As the Prevention Conversation is the first initiative of its kind in Canada, documentation of its development and evaluation of its emerging outcomes was key to informing future implementation of the initiative and transferability to new contexts and jurisdictions. In this section we provide a brief description of the evaluation that was undertaken, including an introduction to developmental evaluation, an introduction to the key evaluation questions that guide our findings, and our evaluation procedures.

Evaluation Type, Purposes, and Approach

Given the complex needs of this systems-level, innovative initiative, this developmental evaluation was undertaken from a utilization-focused approach, embedding both developmental and formative purposes. A **Developmental Evaluation** is a way of collecting and using data for the development of programs or in contexts that require responsiveness to complex influences to remain innovative (Patton, 2010). This type of evaluation can help document how and why program decisions are made, which was one of the interests of the FASD-APC. Moreover, developmental evaluation is particularly well suited for exploring socially innovative programs. The developmental evaluation framework allows for adaptation of the evaluation design to the changing needs of the client(s), and as the initiative itself continues to develop. As our project was developed and implemented, this approach allowed the evaluation team to be responsive to changes, and to modify and update the evaluation design as appropriate.

As mentioned, there were two complimentary purposes for this developmental evaluation: one formative-focused purpose and one developmental-focused purpose. ***A formative-focused purpose*** provides a picture of how well a program is doing what it intends to do, in order to identify areas for improvement. The examination of the implementation of program activities allowed the evaluation team to provide an early estimate of the extent to which program goals were being achieved and allowed for changes and improvements to be made during implementation. ***A developmental-focused purpose*** is especially useful for tracking decision making throughout the development and implementation of a program. For the FASD:PC, such a purpose provides valuable information informing the transferability of the initiative to new contexts. With this purpose in mind, the evaluation team took on a role within the FASD-APC to track the development of the program and to identify key decision making points, while also assisting with the identification and operationalization of desired program outcomes. Findings and recommendations salient to the latter purpose can be found in the companion document *Capturing the Evolution of the Conversation: A Developmental Evaluation Process.*

Evaluation Questions

A series of key questions were developed, in collaboration with the FASD-APC, to encompass the Prevention Conversation's intended impacts on different groups of participants and its intended impact on FASD program delivery across contexts. These key questions focused on **Preparation** of individuals to engage in the FASD:PC, their **Experiences** of the initiative, the **Consistency** of message delivery, and the documentation of program decision-making in order to inform **Transferability**. Questions were designed to align with the initiatives' intended outcomes when possible, to ensure that data being collected would report the extent to which the Prevention Conversation was meeting desired goals. An outline of the four key questions and how they align to project outcomes is presented below in Table 2. Please note that findings from Question 4 are presented in a companion document: *Capturing the Evolution of the Conversation: A Development Evaluation Process.*

Table 2. Key Evaluation Questions Linked to Project Outcomes

Focus	Key Evaluation Questions	Outcome Alignment
Preparation	***1.*** *What contributes to Facilitators' and Service Providers' preparation to engage in the FASD Prevention Conversation?*	1. Health and social service providers across Alberta have increased knowledge, skills and confidence to effectively discuss alcohol use in pregnancy and intervene appropriately and effectively with women of child bearing age and their partners.
Experiences	***2.*** *What are the experiences of those involved in the FASD Prevention Conversation?*	2. Health and social service providers create a safe environment for women to discuss alcohol consumption during early pregnancy.
Consistency	***3.*** *To what extent is the intended messaging being consistently delivered and received by participants throughout the implementation of the FASD Prevention Conversation?*	4. Consistent messages are provided to women and their partners/families about the risks of alcohol consumption in pregnancy with a focus on early stages when pregnancy status may not be known.
Transferability	***4.*** *How was the FASD Prevention Conversation Developed and Implemented?*	These strategies will contribute to prevention and mitigate against the lifelong costs of FASD.

It is important to note that the outcomes presented by the FASD-APC are largely focused on how this initiative will impact **women of childbearing age**. However, data collection from women was outside the scope of the current evaluation. Therefore, some of the outcomes (i.e. "*Women of childbearing age are informed and aware of the risks associated with alcohol use in pregnancy in a non-judgmental way and of community resources and supports that are available to them*") are not addressed.

Evaluation Procedures

The evaluation was designed to collect data from multiple stakeholders, using several methods, at a number of time points to comprehensively answer the evaluation questions posed. Each question was designed to be answered by integrating both primary and complimentary data sources and collection methods to generate more comprehensive understandings than could be accessed using any single approach. We first review our participants and methodology.

Participants

Participants in the Prevention Conversation are Facilitators, Health and Social Service Providers, and ultimately, women of childbearing age. Although it was not deemed within the scope of this evaluation to collect data from women, Facilitators and Services Providers provided data to support findings for all evaluation questions.

- **Prevention Conversation Facilitators.** Facilitators played a large role in data collection efforts for this evaluation. They completed a number of surveys, participated in multiple interviews with the evaluation team, and were considered a key data source because of their direct involvement with the project. In addition, they also played a key role in collecting data from Service Providers by administering surveys. For more information about the Facilitators, please see *Introducing Facilitators and Service Providers*.

- **Health & Social Service Providers.** Service providers receive training from the Facilitators, and engage in conversation with the women. Because of their key role in the Prevention Conversation, Service Providers shared a wealth of valuable information with regards to key evaluation questions. Service Providers were asked to complete a number of surveys to document their experiences, beliefs, and intentions immediately before and after their training sessions with Facilitators. For more detailed information about the Service Providers involved, see *Introducing Facilitators and Service Providers.*

Methodology

This evaluation was undertaken from a Mixed Methods approach to data collection and analysis, where both quantitative and qualitative data were collected and integrated as appropriate to answer all four key evaluation questions. In the interest of keeping this section concise, detailed information regarding methodology, including data collection methods, data sources, and analyses, are presented in the following Appendices:

- Quantitative Methods: Appendix D
    - Facilitator Survey Question: Appendix E
    - Service Provider Survey Questions F
- Qualitative Methods: Appendix G
    - Qualitative Focus Group/Interview Questions: Appendix H
- Mixed Methods (Data Integration): Appendix I

Introducing Facilitators & Service Providers

Before presenting evaluation findings, we believe it is important to introduce you to the Prevention Conversation Facilitators and Service Providers who provided much of the data to support this evaluation. We provide demographic information about these two groups to help contextualize findings, and to help you visualize who this initiative has reached in its first year of implementation.

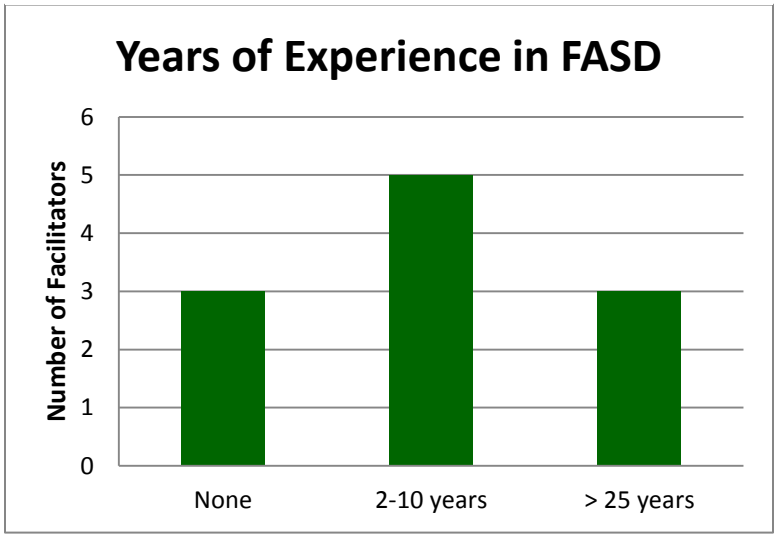
Who are the Prevention Conversation Facilitators?

A total of 13 Prevention Conversation Facilitators were hired in the 11 geographic FASD Service Networks. Each Network had one Facilitator, with the exception of the Calgary FASD Network which chose to hire three Facilitators for the position: one to focus on urban areas, and two to support the Prevention Conversation in rural communities. It should be noted that although there is a 12th FASD Service Network (i.e. the Metis Settlements Network), the decision was made not to hire a Facilitator specifically for this network. Rather, networks with Metis Settlements within their geographic boundaries were allocated additional funds to support delivering services to these populations. As demonstrated in Figure 3, the majority of Facilitators are women.

Figure 3. Visual Representation of Prevention Conversation Facilitators.

Eleven of the 13 Facilitators were able to attend Facilitator Training in December 2013. Demographic information presented in this section is based on data collected from those 11 attendees, and is supplemented with information from interviews with all 13 Facilitators throughout the first year of the initiative. Facilitators' backgrounds and previous experiences varied greatly coming into the project. Although the majority had some experience in the field of FASD (see Figure 4), three reported no experience or prior training in this area. Furthermore, there was also variability in those who reported previous experience in the field. Years of experience ranged from two to 40 years, with three Facilitators reporting working in the field for 25 or more years.

Figure 4. Facilitator Experience in FASD



Facilitators also brought skills and previous experience in a number of areas outside the field of FASD. They reported various professional degrees, areas of study, and educational experiences, as well as being previously employed in helping professions, education, and facilitation, among others. Their experiences were vast, unique, and were not easily collapsed into categories. Taking this into account, Figure 5 presents a visual depiction of some of the ways in which Facilitators described the previous professional experiences that prepared them for this role.

Figure 5. Facilitators' Pre-Initiative Professional Experiences

In terms of experiences relevant to the Prevention Conversation, approximately half (55%) of the Facilitators reported previously having a conversation with a pregnant woman, and 8 of the 11 (73%) reported having a conversation with a woman who was not pregnant, but of childbearing age. Further information about Facilitators' previous experiences relating to FASD, and their knowledge and beliefs about FASD prevention are presentedin Question 1.

Overall, Facilitators are a very diverse group of individuals who are all likely to bring a unique set of knowledge, skills, and previous experiences to guide them in their work as Prevention Facilitators.

Who are the Service Providers?

Those who received training from Prevention Conversation Facilitator have been labelled "Service Providers", for the purposes of this evaluation. The term "Service Provider" includes healthcare professionals, social service providers, and members of community agencies that provide services to the public. This section provides an introduction to the different Service Provider groups that were engaged in the Prevention Conversation (although limited to those who completed evaluation surveys). It also provides demographics regarding where these Service Providers work, as well as their previous training and previous engagement in conversations with clients about alcohol and pregnancy.

Service Providers who completed surveys reported their job titles, which were then divided into fourteen categories by the evaluation team, to allow for further comparisons between Service Provider groups as needed for this evaluation. Classifications and definitions of Service Provider groupings are presented in Appendix J.

Figure 6.Representation of Service Provider Groups

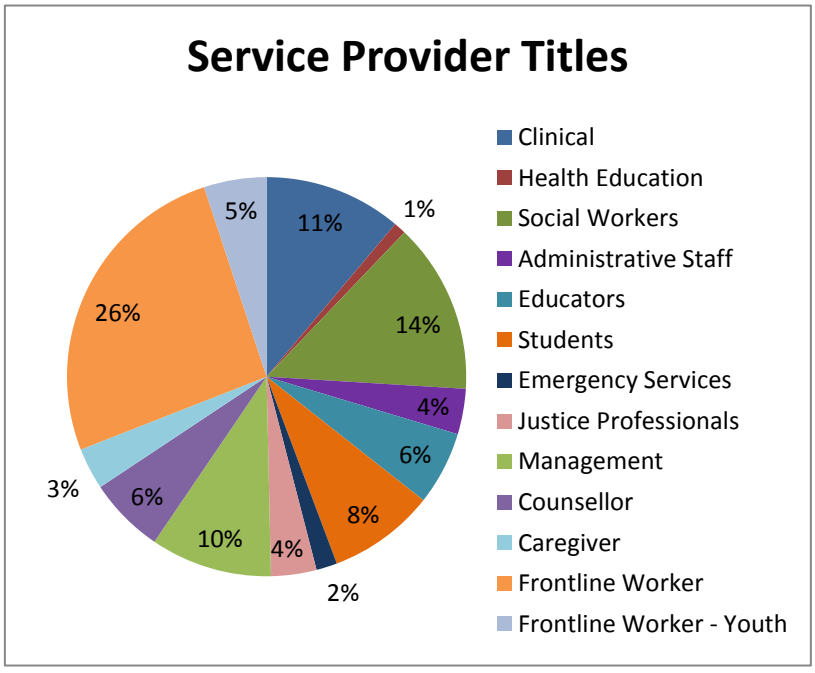
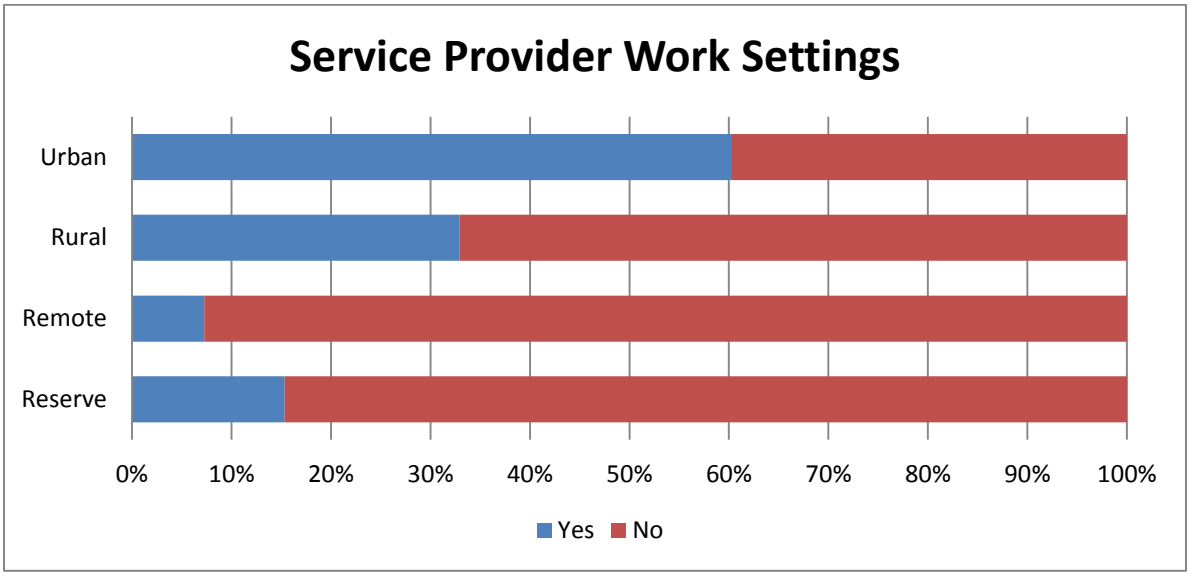


Figure 6 provides an illustration of the extent to which each of these Service Provider groups was engaged in the Prevention Conversation throughout the first year of its implementation. The most commonly engaged groups identified themselves as Frontline Workers, and Social Workers. In contrast, Health Educators, Emergency Services Personnel, and Caregivers are the least represented groups. Overall, a variety of Service Providers were engaged in the Prevention Conversation, which will be important to consider as we examine Service Provider beliefs and experiences of the initiative in the following sections. Finally, it should be noted that approximately 15% of Service Providers did not specify a job title, or entered a response that was not clear enough to classify (i.e. use of acronyms or vague terms).

Service Providers reported working in urban, rural, and remote settings, as well as working on reserves. Figure 7 demonstrates the percentage of Service Providers who reported spending at least some of their time in each of these four settings.

Figure 7. Settings in Which Service Providers Report Working



In terms of previous experiences related to FASD, more than half (55%) of Service Providers reported that they had received previous training in the area of FASD before their interactions with Facilitators. Additionally, the majority reported that they had previously engaged in conversations about alcohol and pregnancy with pregnant women (66%), as well as women who were of childbearing age but not pregnant (67%).

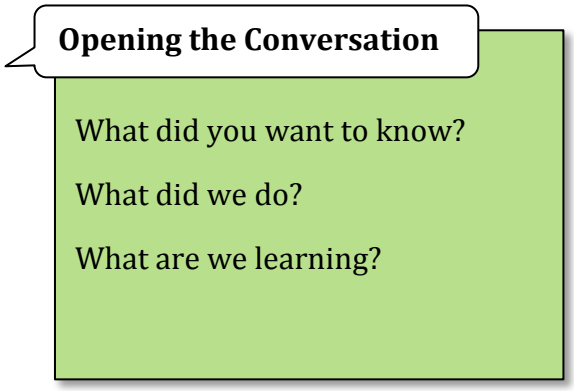
Overall, a diverse group of Service Providers, from a number of different fields and working in a variety of settings, have so far been engaged in the Prevention Conversation. Understanding who these Service Providers are will help us to better contextualize and interpret findings presented in the following sections for our four key evaluation questions.

Evaluation Findings

In this section we present key findings from the evaluation of the development and the first year of the implementation of the FASD Prevention Conversation. We begin by introducing a theme of Connectedness that guides our findings, and then we address each of the four evaluation questions, as they relate to preparing for the Conversation, experiences of the Conversation, consistency of prevention messaging, and considerations for the transferability of this initiative to other contexts.

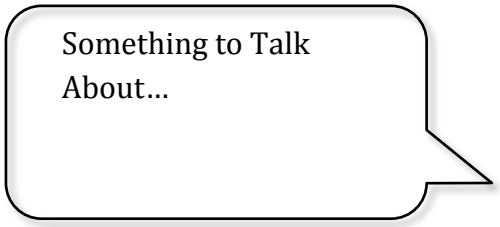
A Guide for Reading Findings

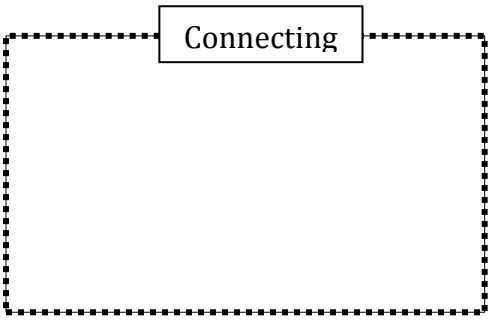
Given that this initiative is centered on the importance of promoting conversations about alcohol and pregnancy, we employ the theme of a conversation to help organize our findings. We hope the following legend will help guide your reading as you make your way through the findings sections.



Starting the Conversation. Presented at the beginning of each section, these boxes provide an overview of what is to come. First, "what did you (stakeholders) want to know?" reviews the questions answered in this section. Then, under the heading "what did we do?" you will find information about our evaluation procedures, data sources, and participants. Finally, "What are we learning" provides an overview of our key findings, which are further **bolded** throughout the text.

Something to Talk About… These conversation bubbles will pop up throughout the Findings section, and are used to present further questions we might have, or interesting things we are wondering about as we report and interpret the findings. Consider them discussion starters.





Connecting. These text boxes highlight instances where connectedness emerged as an important theme in the findings. The FASD:PC is a relational approach to FASD Prevention, emphasizing the importance of building relationships and making meaningful connections with women and their families that will ultimately impact decision making surrounding alcohol and pregnancy. It is not surprising then, that a theme of *Connecting* permeated all aspects of the findings from this evaluation. Emerging across interviews, surveys, and other interactions were discussions of the ways in which Facilitators' relationships were core to their ability to do their job, feel successful in their work, and support others (i.e. Service Providers) to connect and build important relationships.

Bolded Text. Finally, **bolded text** presented throughout this section is used to highlight key evaluation findings or "Take Home Messages" for the reader.

Preparing for the Prevention Conversation

Our first evaluation question, "*What contributes to Facilitators' and Service Providers' preparation to engage in the FASD Prevention Conversation?*" examines factors that are key to training and preparing diverse groups of Facilitators and Service Providers to engage in meaningful conversations about alcohol and pregnancy. We first examined Facilitators' experiences during their training sessions in December 2013, and how that training prepared them to fulfill their role in the Prevention Conversation. Secondly, we looked at how Service Providers are being prepared to engage in these conversations with their clients, through their interactions with the Prevention Conversation Facilitators.

Opening the Conversation

What did you want to know?

- *What contributes to preparing Facilitators and Service Providers to engage in the FASD:PC?*

What did we do?

- Post-training Focus Groups with Facilitators (See Appendix G)
- Pre- and Post-surveys with Facilitators & Service Providers (See Appendix D)

What are we learning?

- Facilitators reported:
  - Increases in knowledge about FASD and confidence in delivering the initiative.
  - The importance of opportunities for connecting and networking with each other.
  - Their diversity in background and experiences pointing to the benefits for individualized training tailored to specific learning needs.
- Service Providers described:
  - Increases in knowledge and beliefs about FASD prevention, as well as their beliefs about the power of a conversation and their own ability to have these important conversations with clients.
  - Feeling least prepared to discuss family planning and contraception with clients, and that they may benefit from additional support in this area.

Facilitator Preparation

Preparation for Facilitators to engage in the Prevention Conversation involved a two-day intensive training program in early December 2013. We examined the impact of this training in two ways. First, we explored their experiences of the Facilitator training sessions. Second, we examined factors the FASD-APC identified as important for Facilitator preparation (e.g. knowledge, beliefs, and confidence).

Experiences of Training

Following training, Facilitators participated in focus groups, the purpose of which was to reflect on their experiences during training and to look toward next steps in preparing for their prevention roles. We present the following focus group findings to answer the question *"What were the experiences of Facilitators during training?"*

The Highlights

Facilitators expressed appreciation for the opportunity to meet and interact with other Facilitators and Network Representatives from across the province. According to participants, this was valuable because it allowed Facilitators to learn from others' experiences during training and to network with people who could be a source of support in the future: *"Getting to meet all the others from across the province who will be doing the same work as me has been a wonderful opportunity."*

Connecting

The opportunity to build relationships was reported by Facilitators as a key element in preparing them to take on their roles in FASD Prevention.

Participants also communicated that the practical skills, tools, and resources provided during training were beneficial, although they were disappointed that the printed materials (i.e. training manual, posters, tip sheets) were not prepared, as they would have appreciated the opportunity to take these resources back to their networks to get started in a timely manner. The most valuable aspects of training were identified as the focus on motivational interviewing, non-judgmental communication, and tips for initiating conversations, as well as the role-playing exercises. Additionally, many Facilitators felt that training had affirmed their existing skills and accordingly boosted their confidence. One Facilitator reported: *"I was not very confident with the skills that I have…but as I went through…I learned yeah, I do have some skills that are transferable…and so it has given me the confidence to be able to tackle this."*

Moving it Forward

Facilitators provided suggestions for ways in which the training could be improved. Notably, a number of participants felt that a clarification of expectations prior to training would have been beneficial, as they described a mismatch between their expectations and the actual experience of training, particularly in regards to their role as Facilitators. As one participant explained, "*my understanding from the job description is that we're mainly going to be working with other professionals…but my understanding of the past two days…it was focused on us having direct contact with pregnant women."* This suggests that aspects of the training may have been misaligned with the overall goal of training Facilitators for working with service providers. Participants suggested that much of their confusion could have been avoided if training had been prefaced with a discussion about the context of the initiative and how the Facilitator role fits into the larger picture of FASD prevention in the province; *"Not everybody was totally clear about what the role of*

the Prevention Facilitator is…but I think if they had…just given some context around it, it might have helped." This confusion is not surprising given the variability in terms of the backgrounds and previous experiences of the Facilitators, some of whom were new to the field of FASD and lacked some of the background information that would have helped them to better situate themselves.

A clear outline of topics being covered, along with a discussion about the goals of training and the role of the facilitator would have likely helped to situate Facilitators' learning, and may have prevented the unease and uncertainty that Facilitators reported experiencing.

When asked about further supports and resources that Facilitators anticipated needing as they began their work, they spoke about their intentions to utilize their fellow Facilitators and Network Coordinators for resources and guidance, and also anticipated making use of online training opportunities and resources. Also, some participants felt the need to further clarify their understanding of their role as a Facilitator, and to generally become more educated about the role of the FASD Service Networks. According to one Facilitator, *"Although I know what the network does, I still need some clarification on the roles and the practice."* Facilitators reported that it would be difficult to know what additional training or resources they would require until they began their work, but that they intended to make the most of opportunities and that they felt comfortable seeking assistance from each other and from their Coordinators as needed.

Mountains to Climb

Facilitators identified a number of potential challenges, or "mountains" to keep in mind as they began their work. They expressed concern about the possibility of over-burdening busy service providers, both by engaging them in the Prevention Conversation and by expecting them to participate in the project's evaluation component. Similarly, concerns regarding timelines were raised, as participants felt that the yearlong timeframe could present a barrier to building meaningful relationships with service providers and achieving project goals. Participants also discussed how the topic of FASD itself presents a challenge, as it may be a difficult subject to broach with professionals. Furthermore, participants anticipated that working with service providers rather than directly with clients could present a challenge for them personally, as it would be a change from the client-centered work that many of them had focused on in the past. As one participant noted, *"it's going to be hard for some of us who've done this work before to remember what we're supposed to be doing…that's not our job to get in there now and intervene…this is about encouraging the conversations of others."*

Anticipating the Work Ahead

Finally, Facilitators explained that they were most excited by the chance to make a difference by being involved with this project. Facilitators were enthusiastic about the prospect of acting as a channel for consistent prevention messaging, and to begin collaborating with and supporting service providers. Participants expressed a hope that stakeholders (i.e. service providers) would be satisfied with their work and talk to others about it, hopefully leading to a demand for Facilitators' services. Further, participants anticipated that their work could provide momentum for community collaboration. In describing what success would look like for the FASD: PC, one

participant described that, *"we collectively, as a community, can deal with this a lot more effectively. And together, we're stronger. That's what it would look like for me."*

Facilitators reported looking forward to meaningful learning by gaining exposure to novel experiences and multiple perspectives through their work in the Prevention Conversation.

As one Facilitator described, "*each time you have these conversations, you're going to learn something new and have an experience that you've never had before."*

In summary, Facilitators reported being passionate about FASD Prevention, and they were eager to get started with their prevention work. While there was some confusion during the training session, Facilitators felt that overall it provided them with some basic information and resources. Perhaps more importantly, it provided them an opportunity to network with their counterparts around the province, creating relationships that they could continue to build and look to for support. By the end of training, they had acknowledged potential challenges and had started to generate ideas for ways in which to prepare themselves to meet and overcome those challenges in their new roles as Prevention Facilitators. Overall, there was an air of positivity and anticipation as Facilitators returned to their networks to start their prevention work.

Impacts of Training

In this next section, findings are presented to answer the question *"To what extent did the training prepare Facilitators to train Service Providers to engage in the Prevention Conversation?"* A number of factors were considered by the evaluation team as key to the successful preparation of Facilitators, including:

- Knowledge of the subject area (FASD Prevention)
- Comfort in engaging audiences & Confidence Preparing/Delivering Presentations
- Personal Beliefs Related to FASD Prevention
- Preparedness to Engage in this Initiative

To examine the effectiveness of the training in preparing the Prevention Conversation Facilitators to fulfill their role, these factors were measured pre- and post-training. Notable relationships and meaningful changes are presented in this section.

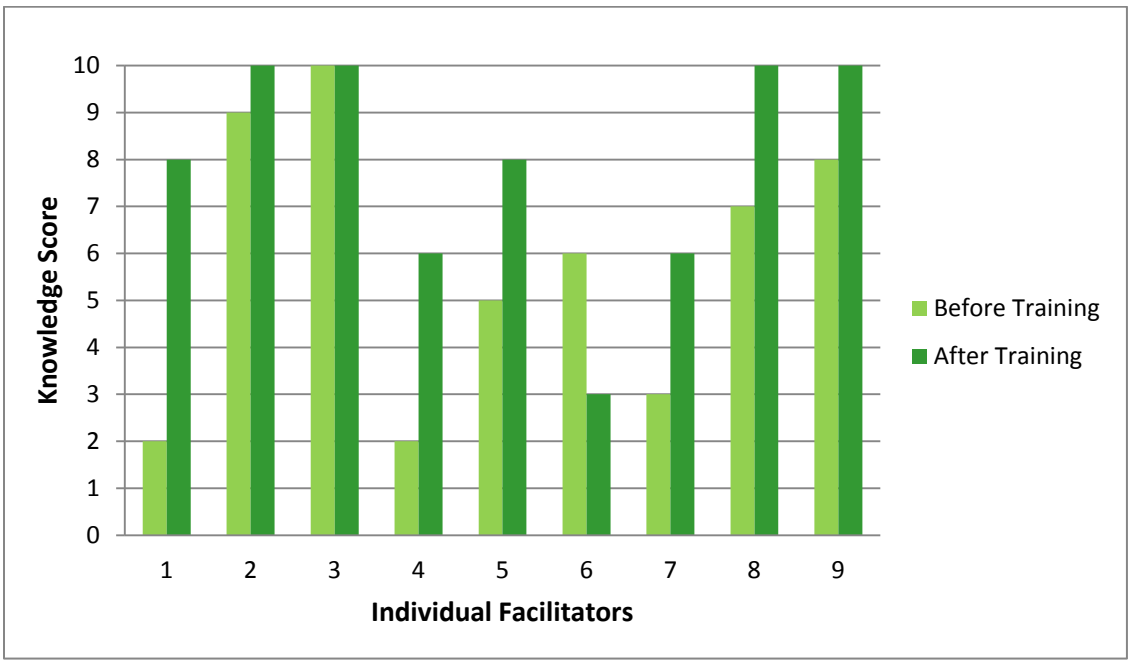
Facilitators' Knowledge of FASD Prevention

The role of a Facilitator involves engaging Service Providers in conversations about alcohol and pregnancy, and it is therefore important that they feel knowledgeable about this topic. We measured Facilitators' *perceived* knowledge in the area of FASD prevention, by asking them to respond to the question "*I consider myself to be knowledgeable about FASD Prevention*" on a 10-point scale, where higher ratings indicate higher perceived knowledge. As a group, Facilitators reported feeling more knowledgeable about FASD prevention following training (i.e. group mean score increased from 6.4 to 7.9 out of 10).

Training was successful at increasing Facilitator knowledge about FASD prevention.

However, the degree to which training had an impact on Facilitators' perceived knowledge varied between individuals, as illustrated in Figure 8. The variability in pre-training perceived knowledge is not surprising, given the different levels of experience Facilitators had in the area of FASD coming into this project (see Introducing Facilitators and Service Providers section). Although some Facilitators considered themselves very knowledgeable prior to training (e.g. 10 out of 10), many felt unknowledgeable in this area (e.g. 2 out of 10).

Figure 8. Facilitators' Knowledge of FASD Prevention Pre- and Post-Training



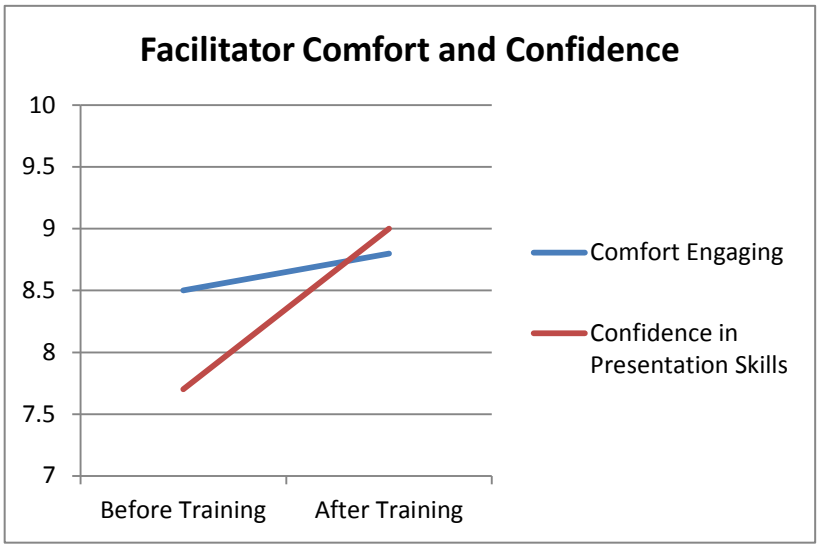
Perceived knowledge increased for all but one Facilitator (who's perceived knowledge actually decreased), suggesting that training was largely successful in making Facilitators feel knowledgeable in the area of FASD prevention. However, some Facilitators showed larger increases than others, and some came in already feeling quite knowledgeable, limiting how much they could gain from training. This suggests that individualized training that is responsive to Facilitators' unique needs may be warranted. For example, while a section of training devoted to "FASD Basics" was likely helpful for those without a background in FASD, it probably did not have a meaningful impact for those already working in the field, whose time may have been better spent on learnings in different areas.

Training such a diverse group of Facilitators' in one two-day training session may have limited Facilitators' learning in areas that were most important for their own individual preparation. Individualized training that is responsive to unique needs is warranted.

Facilitators' Comfort and Confidence

With the goal of connecting with a variety of Service Providers, Facilitators' ability to build relationships and to effectively deliver information is important to their success. In fact, the Prevention Conversation training focused specifically on the development of comfort in engaging audiences, and in preparing and delivering presentations.

Figure 9. Comfort & Confidence Pre- and Post-Training



To examine the impact of training in these areas, Facilitators responded to the statements "*I feel comfortable engaging professionals in discussion about FASD prevention*", and "*I feel confident in my ability to prepare and deliver effective presentations about FASD prevention*". Before training, Facilitators reported feeling slightly more comfortable engaging with professionals than with their ability to create and deliver meaningful presentations (means of 8.5 and 7.7, respectively). This pattern changed after training, with Facilitators reporting approximately even levels of comfort engaging professional and confidence in their presentation abilities (means of 8.8 and 9.0 respectively).

Overall, **training increased Facilitators' confidence in their ability to create and deliver effective presentations. Facilitators reported high levels of comfort engaging audiences prior to training, which may reflect why they applied and were successful in attaining this Facilitator position.**

Something to Talk About…

Which skills are most important for a Facilitator to bring to their role? Which skills can be taught?

Facilitators' Beliefs about FASD Prevention

Another key consideration in Facilitators' preparation is examining their beliefs about their role in FASD prevention. We asked Facilitators to respond to the statements "*FASD Prevention is an important aspect of my work*", *"I can play a role in helping to prevent FASD*", and "*I believe having a conversation with a woman can impact her decision-making about alcohol and pregnancy",* both before and after training.

Not surprisingly, Facilitators reported that they feel FASD Prevention is an important part of their work, that having a conversation with a woman can change her behaviour, and therefore that they can play a role in helping to prevent FASD. These beliefs seem to form the foundation for the desire Facilitators have for their work, as these beliefs were present both before and after training. This suggests that **in recruiting and training Facilitators, FASD Service Networks have effectively gathered professionals who are passionate about this area and the potential for this initiative.** Believing in what you do can be a crucial component to sustained success, as staff will persist through difficult times and work through challenges, invest more personal creativity, perform better, and be psychologically well when they are positively motivated and passionate (Deci & Ryan, 2008; Vallerand, 2008).

Facilitator Preparedness to Engage in the Prevention Conversation

Following training, Facilitators reported that they felt somewhat prepared to engage others in the Prevention Conversation (mean score of 6.4 out of 10), but that they would like to have access to additional resources to further support them in their prevention work. Facilitators suggested that the following resources would make them feel more prepared:

- Additional training in Motivational Interviewing
- Having access to resources beyond the printed materials (e.g. social media)
- Developing a "community of practice" for Facilitators

Connecting

A desire for connectedness is evident throughout these suggestions. Additional training may allow Facilitators to better connect with and meet the needs of their audiences. Social media and other materials might permit them to increase the scope of their work, allowing them to connect with more people. The creation of a community of practice could provide them with a means of connecting with each other, to share resources and ideas.

These findings are consistent with reports from the post-training focus groups, where Facilitators indicated that they will likely seek out additional resources and assistance within their networks in preparing themselves for this role. Again, this desire for additional resources may be reflective of the differing backgrounds of Facilitators prior to training. For those coming into this role with less experience in the field of FASD, it is unlikely that a 2-day training session would adequately prepare them for their role as a Prevention Conversation Facilitator.

Training that is responsive to the knowledge, skills, and beliefs of incoming Facilitators, will be key to ensuring that individual needs are met with regards to the work they will be doing in their own unique networks.

Service Provider Preparation

Preparation for Service Providers to engage in the Prevention Conversation involved formal and informal interactions with Prevention Conversation Facilitators. The content of these interactions was unique to each Service Network. We examined factors the FASD-APC identified as important for Service Provider preparation (e.g. knowledge, beliefs, and confidence).

Service Provider Training

Service Providers are led in training sessions and presentations surrounding alcohol, pregnancy, and FASD Prevention in order to prepare them to have FASD prevention conversations with their clients. Our examination of the factors that contribute to preparing Service Providers to engage in this initiative is guided by the question "*To what extent is Facilitator-led training preparing Service Providers to engage in the Prevention Conversation?*

A number of factors were considered as being key to the preparation of Service Providers:

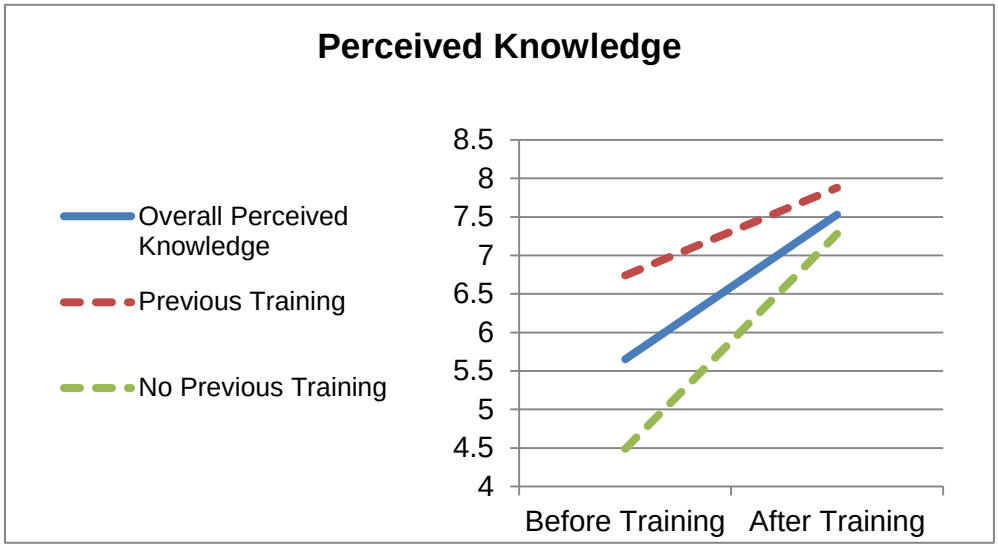
- Knowledge of FASD
- Beliefs about FASD Prevention
- Confidence to Engage in the Prevention Conversation
- Preparedness to Provide Support & Resources to Clients
- Intentions to Incorporate What They Learn into Their Work

To examine the effectiveness of Facilitator-led training in preparing Service Providers, these factors were measured pre- and post-training. Although these training sessions differ within and between networks, they typically involve a scheduled presentation with a group of Service Providers. We do not provide an example of what these training sessions look like, as they are intended to differ in length, content, and format, and to be individualized depending on the needs of the Service Provider audience and the context in which the training is taking place.

Service Provider Knowledge

One critical element in preparing Service Providers to engage in prevention conversations with their clients is to ensure that they feel knowledgeable about the subject that they will be discussing. Service Providers reported that their knowledge about FASD increased significantly following training. This increase is particularly notable, considering that 55% of Service Providers reported that they had already received some form of training in FASD prior to their engagement with the Facilitator.

Figure 10. Service Provider Pre- and Post-Training Knowledge of FASD



Although Service Providers who had not received previous training reported the greatest increases in levels of perceived knowledge (see Figure 10), those with previous FASD training also noted increases, suggesting that this training contributes to Service Provider education in a way that previous FASD training has not.

The Prevention Conversation training appears to be offering something unique to the professional development of Service Providers, as it increased their knowledge of FASD beyond previous training.

Something to Talk About…

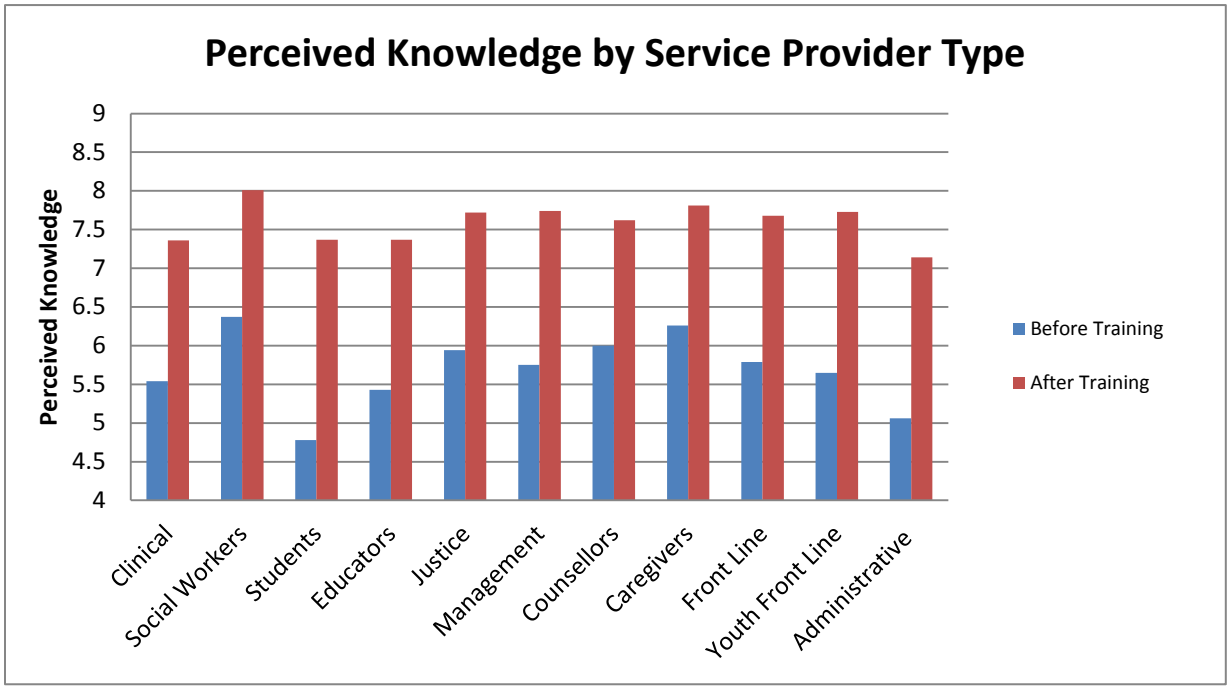
What are some aspects of the Prevention Conversation training that might make it a unique contribution to Service Provider learning?

Is it the relational approach taken by Facilitators?

Could it be that the focus on FASD Prevention provides something novel?

Examining our different groups of Service Providers, we see that regardless of where they start, their knowledge increases to a similar level following training. While Service Providers begin training with differing levels of perceived knowledge, Figure 11 demonstrates that all Service Provider groups leave Prevention Conversation training reporting that they know more about FASD than they did before, suggesting that this training is providing something above and beyond their previous training or job-related experiences, in terms of FASD information.

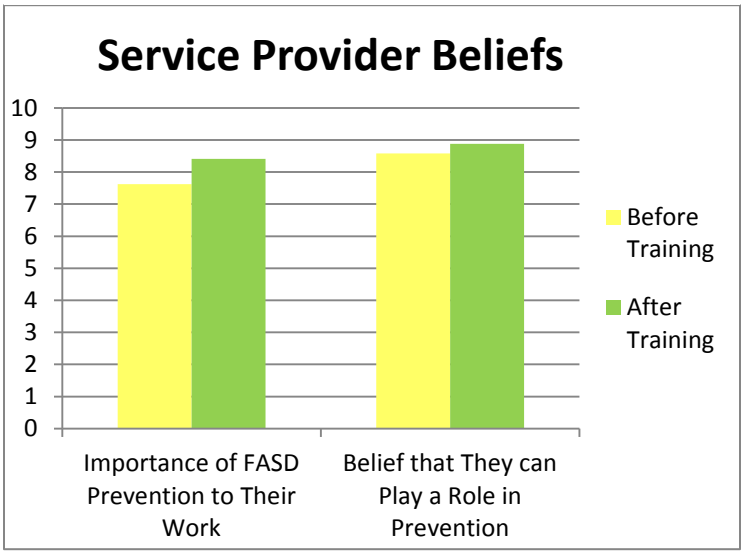
Figure 11. Service Provider Knowledge of FASD Before and After Training



Service Providers' Beliefs about FASD Prevention

Next, we examine Service Providers' beliefs about FASD prevention, including the importance they place on prevention as a part of their work, and their beliefs about their own role in the prevention of FASD. Service providers were asked to respond to the statements *"FASD Prevention is an important aspect of my work*", and "*I can play a role in helping to prevent FASD*", both before and after training. Findings are presented in Figure 12.

Figure 12. Service Provider Beliefs about FASD



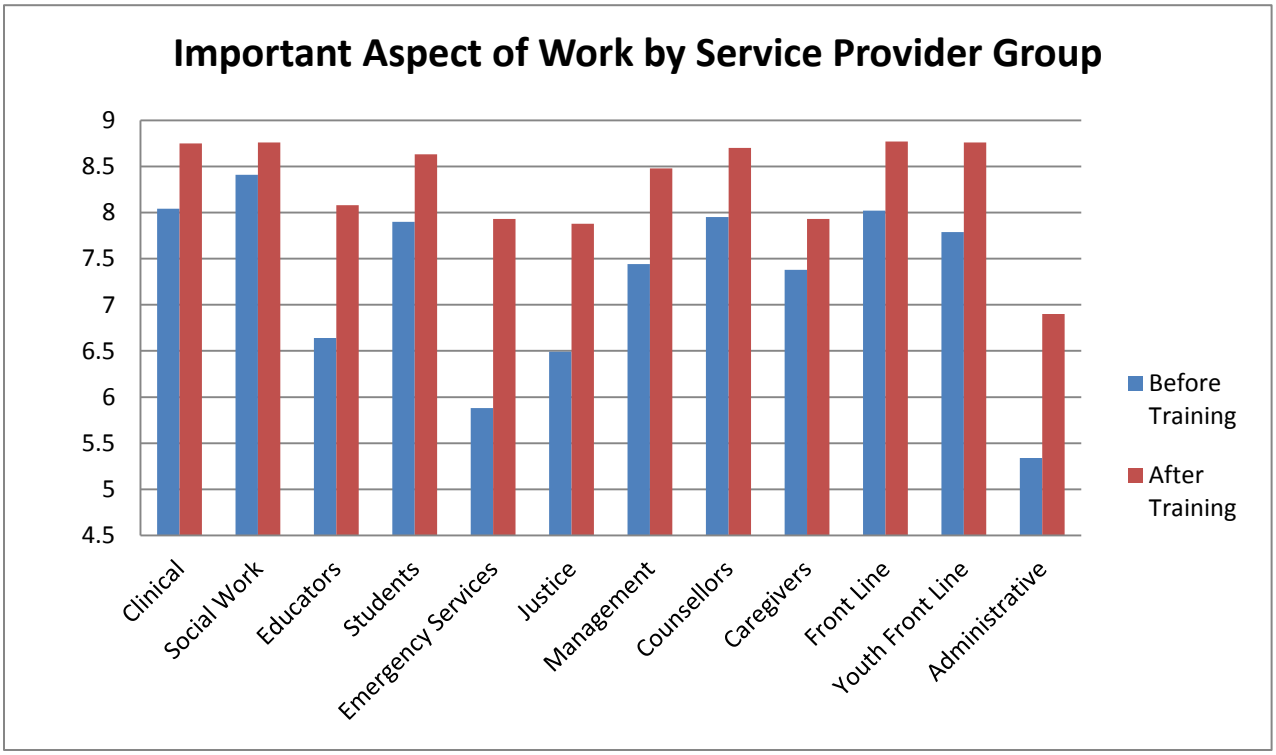
Service Providers came into training largely agreeing that they could play a role in the prevention of FASD, and this belief remained constant after training (from a mean of 8.58 to a mean of 8.88; not a meaningful increase). In contrast, Service Providers were less likely to believe that FASD prevention was an important aspect of their work before training, but this significantly changed after training (from a mean of 7.62 to 8.41out of 10).

These findings suggest two things. First,

given that Service Providers believed more in their own personal role in FASD prevention than the importance of FASD prevention in their work suggests that they may have been considering their role in FASD prevention more globally (i.e. in more than just their professional lives) when responding to survey items. Even though FASD prevention may not necessarily be part of the work they do, they believed they could play a role in prevention. Second, training was successful at positively increasing the belief that FASD prevention is an important aspect of the work these Service Providers do, suggesting that Facilitators are presenting information in a way that emphasizes the role that all Service Providers can play in preventing FASD.

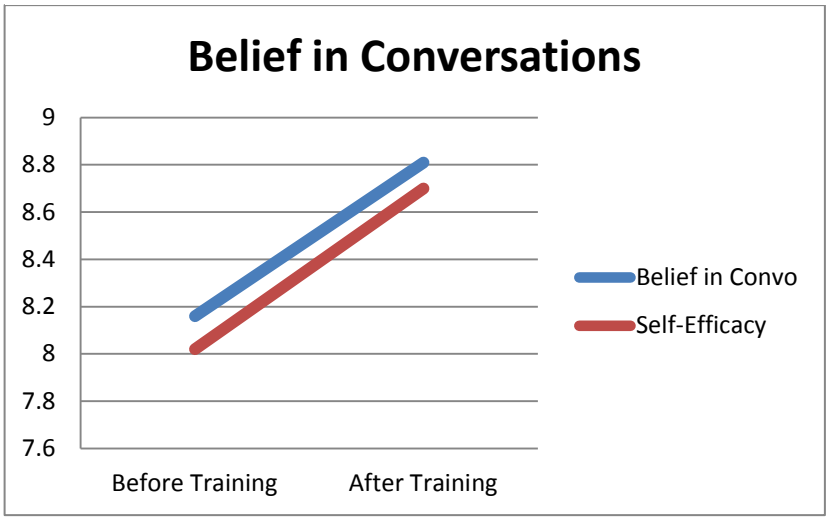
Examining Service Providers' beliefs about the importance of FASD prevention in their work in more detail, we see variability between groups both before and after training (see Figure 13). Understanding which groups of Service Providers are most likely to view FASD prevention as outside their scope of practice may be particularly important for Facilitators, as it would allow them to tailor their presentations and be prepared to work to get these Service Provider groups engaged with the topic if need be.

Figure 13. Service Providers Beliefs about the Importance of FASD in Their Work by Group



We also asked Service Providers to respond to the statements "*I believe that having a conversation with a woman may impact her decision-making about alcohol and pregnancy* " and, "*I believe that **I can** have a conversation with a woman that may impact her decision-making about alcohol and pregnancy."*

Figure 14. Service Providers' Beliefs in Conversations



The first question targets Service Providers' belief that the Prevention Conversation is a viable approach to FASD prevention, while the second question examines their self-efficacy. Self-efficacy refers to the belief that one has the ability to bring about a desired outcome, which in this case would be to impact decision-making surrounding alcohol and pregnancy (Bandura, 1977). Participation in training resulted in significant positive increases for each of the two beliefs (See Figure 14). However, after training, Service Providers' self-efficacy remained lower than their overall belief that conversations could be an effective method to prevent FASD.

Following training, Service Providers are largely in agreement that FASD Prevention in an important aspect of their work, and that caring, supportive, non-judgemental conversations can impact women's decision making and prevent FASD.

Service Providers' Confidence

It is critical that Service Providers feel confident in their ability to engage in the FASD Prevention Conversation with their clients. Following training, Service Providers reported feeling relatively confident in their ability to engage clients in conversations about alcohol and pregnancy (group means ranged from 7.54 to 8.60, with a mean score of 8.15 out of 10). Having the confidence to engage in these conversations is an important first step. Moving ahead , in a later section we look at the extent to which Service Providers have implemented what they've learned in their practice, as we examine their conversation experiences (See *Experiencing the Prevention Conversation*).

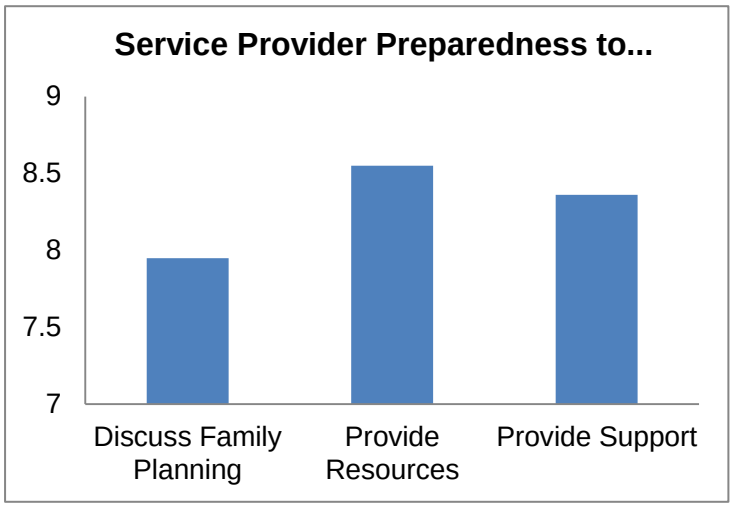
Following training, Service Providers are Confident in engaging in prevention conversations with their clients.

Service Providers' Preparedness

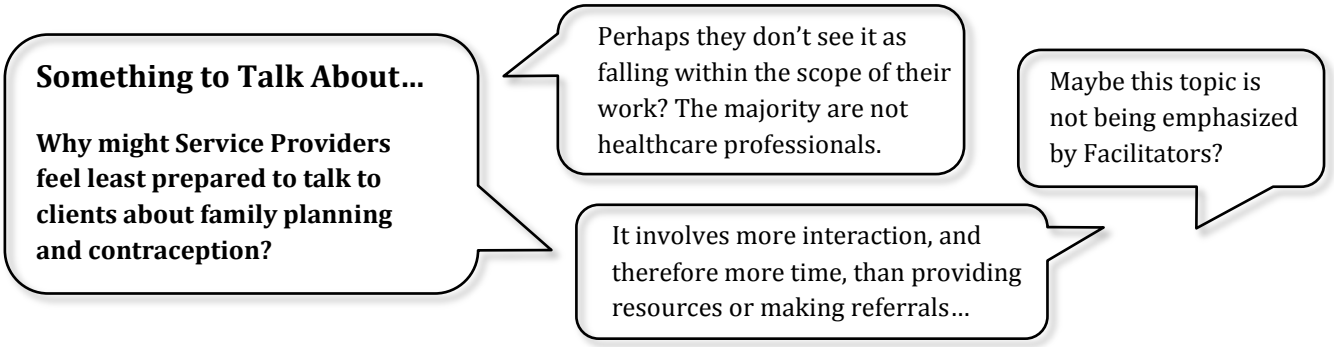
In addition to the factors examined above, we also examined how prepared Service Providers feel to engage in some of the more practical aspects of the conversations (See Figure 15). Based on the Prevention Conversation messaging, important aspects of the conversations that Service Providers must be prepared for include:

- Discussing family planning and contraception
- Providing relevant resources to clients
- Providing appropriate support and making referrals as necessary

Figure 15. Service Providers' Preparedness to Engage in Various Aspects of the FASD:PC



Following training, Service Providers reported feeling relatively prepared to incorporate all aspects into their conversations. However, Service Providers feel least prepared to engage in discussions surrounding family planning and contraceptive use with their clients (M=7.95). The same pattern holds for all groups: they feel least prepared to talk about family planning and most prepared to talk about resources.



Training from Facilitators is having a positive impact on Service Providers' (i) knowledge and beliefs about FASD and FASD prevention; (ii) beliefs about the power of a conversation; and (iii) beliefs about their own ability to be initiate these important conversations with their clients.

Service Providers' Intentions

Preparing Service Providers to engage in the Prevention Conversation will not directly result in the success of this project, unless Service Providers intend to incorporate what they have learned into their practice in order to engage clients in conversations about alcohol and pregnancy. We examined the extent to which Service Providers found this initiative useful to the work they do and asked them about their intentions to incorporate the Prevention Conversation into their work.

Service Providers reported that they found the Prevention Conversation to be both practical (M=8.32) and relevant (M=8.26) to their work, and that they do intend to engage clients in prevention conversations following training (M=8.41). Moreover, they intend to incorporate their learnings from the Prevention Conversation into their work (M=8.61). As expected, some service provider groups (i.e. Administrative Staff, M=7.16) indicated lower intentions to incorporate their learnings into their work than other groups. These groups are less likely to be working directly with clients and thus, may not see the Prevention Conversation as being important or easily incorporated into their work. Finally, we examined whether there were any specific beliefs that Service Providers hold that may make them more likely to engage in the Prevention Conversation.

The likelihood that a Service Provider would intend to engage in the prevention conversation was largely determined by combination of two factors:

a) the importance that Service Providers place on FASD prevention in their work and

b) their personal belief that they can have a conversation with a woman that impacts her decision making around alcohol and pregnancy

About 40% of the variance in Service Providers' intentions to engage can be explained by these two predictors. This suggests that these might be areas that Facilitators may want to focus on in training initiatives as they seem to be predicting intentions, which in turn often predict behaviour.

It is important to note that these findings indicate Service Providers intentions, rather than their actions, as data were collected immediately following training. More findings surrounding Service Providers' experiences of the Prevention Conversation initiative, including their engagement in conversations with clients, are provided in the next section.

Experiencing the Prevention Conversation

Our second evaluation question, *"What are the experiences of those involved in the Prevention Conversation?"* focuses on capturing the experiences of Facilitators and Service Providers who are directly involved in the implementation. We first examine the experiences of the Prevention Conversation Facilitators, followed by the experiences of the Service Providers in the following questions:

Opening the Conversation

What did you want to know?

- *To what extent are Facilitators & Service Providers engaging audiences in the FASD:PC?*
- *What are the experiences of Facilitators and Service Providers engaged in the FASD:PC?*

What did we do?

- Collected contact-log information from Facilitators
- Interviews with Facilitators (See Appendix G)
- Follow-up surveys with Service Providers (See Appendix D)

What are we learning?

Facilitators reported:

- Varied experiences, seemingly as a function of how connected they were to network and community. Connectedness facilitated access to audiences, resources, etc…
- Experiencing challenges in their work, but were able to identify ways in which they were addressing them, engaging with and adapting to the needs of their audiences.
- Customizing the project to the needs of their communities, and undertaking unique approaches to FASD prevention
- Prevention Conversation is leading to increased network visibility, and therefore increased demand for network services

Service Providers reported:

- Most (73%) are incorporating the FASD:PC into their work, engaging women in conversations about alcohol and pregnancy
- Overall positive experiences; conversations have increased in frequency and quality
- Reasons for not engaging in the Conversation included believing that it was not important to their work, or misinformation about the target audience

Please note: Examining the experiences of the "end clients" (i.e. women of childbearing age) was beyond the scope of the current evaluation. Therefore, the perspectives and experiences of women engaging in these conversations are not represented here, which is a significant limitation to the findings.

Facilitators' Experiences

In examining the experiences of Facilitators, we first looked at the extent to which they have engaged intended audiences in activities related to the Prevention Conversation. Facilitators were asked to monitor how many individuals they were engaging in the Prevention Conversation by recording both "informal" and "formal" contacts that they interacted with over the first year of the initiative. An informal contact was considered someone they may have had a conversation with about the initiative, either in person, over the phone, or via email, but who did not take part in a formal presentation or training session by the Facilitator. A formal contact is defined as a service provider or other community member who took part in a Prevention Conversation training session led by the Facilitator.

Facilitators were asked to keep a contact log recording all their informal contacts, and recorded attendance at their training sessions to document their number of "formal contacts." Although the evaluation team requested that contact logs be submitted on a monthly basis, the majority of Facilitators missed submissions during the year. Missing data varied greatly, from two Facilitators who failed to submit any contact logs, to Facilitators who submitted 9 out of 12 monthly contact logs. Because of the amount of missing data, a concrete number of individuals engaged in the Prevention Conversation cannot be calculated at this time. For the data that was reported, informal contacts ranged from 68 to 1006 between networks, and the number of individuals engaged in formal training sessions ranged from 45 to 1337. Keeping in mind that these numbers are underestimates, we can see that the number of formal and informal contacts varied greatly across the networks, with some Facilitators engaging more informal contacts, and some completing more formal training sessions. This speaks to the uniqueness of this initiative as it is implemented across networks.

Facilitators were invited to participate in individual interviews with a member of the Evaluation Team to recount their experiences of the Prevention Conversation initiative. Four key themes emerged from these interviews, related to:

- Connecting & Building Relationships
- Engaging Intended Audiences
- Accessing and Using Project Resources
- Emerging Project Impacts

An overview of these themes is presented below. Data is presented generally; differences in experiences between Facilitators are talked about in general terms to maintain the confidentiality of participants.

Connecting & Building Relationships

As mentioned previously, the Prevention Conversation is a relational approach to FASD prevention. As such, connecting and building relationships with Service Providers and other members of the community played a key role in Facilitators' experiences. Three sub-themes

encapsulate the overarching theme of connecting and building relationships: (a) the importance of relationships, (b) network visibility, and (c) connectedness among facilitators.

The Importance of Relationships. Facilitators emphasized the importance of building relationships, as well as utilizing pre-existing relationships when possible to spread the word about the initiative and to gain access to a number of important audiences. As one Facilitator said, *"I truly am a believer in 'it starts with relationship and ends with relationship,' so that's my number one, and I know that's our society as well, our [society's] philosophy. It needs to be embedded in a relationship."* It was also suggested that building relationships is the first step in this initiative, and must therefore be done before the Prevention Conversation can be successfully implemented: *"Really the first 6 months of this project are getting your feet wet, getting relationships established in the community, spreading the word, having people back you up because you can only be as good as the community connections you've got."*

Many Facilitators reported utilizing their own previously-established relationships, *"My previous work in the community and in the region really, is such that I already have a foundation of people and contacts.*" Those without these connections explained that much of their time was spent on relationship development: *"… my week is like beating down doors and sitting on my deck holding up the phone to my ear, sitting with my laptop just cold-calling people, getting out and meeting people".*

One Facilitator who expressed being well-connected in her network and community explained how this facilitated her work in engaging audiences:

> *It really has been as simple as 'hey I'd like to come in and I'd like to do training with you guys'. And I've had not a single one say no […] I can see that facilitators who do not have those connections, or networks themselves that don't maybe promote those connections as much, a lot of their work, and a lot of their time would have to be spent on building that, before they even engage in the prevention conversation.*

Connecting

Facilitators understand the importance of relationships, and acknowledge that those who came into this project from outside the field of FASD, or who are working in FASD Service Networks that are not as well established or connected to their respective communities may struggle with gaining access to key audiences.

Network Visibility. Based on Facilitators' reports, it appeared as though Networks differed in terms of their visibility in their communities. As one Facilitator described her experience, *"when people realize, wow you know what there's a network. They're like what? There's a network? Oh we've been here for [number removed for confidentiality] years, we aren't going anywhere. They go really? Wow. Really?"*

Many Facilitators reported that the relationship between their Network and the community it serves was strengthened through their work with the Prevention Conversation, and that some of the Networks were becoming a more visible presence in their communities. One Facilitator explained how her experience changed from the beginning of the project to now. In the beginning, *"I've really found,* [when I said] *I'm calling from the [Network name], no one knew who we were, they just didn't."* [and now] *"I feel like I've made some in-roads and people know a little more about who [Network name] is, and they know we offer this training about conversations and how they can be meaningful, and they kind of want to continue after I talk to these groups. They want to continue a relationship with us."* By acting as a "face" for the Networks, and engaging various Service Providers and community groups, Facilitators reported that they were increasing the visibility of their Networks, leading to more referrals and requests for services (see theme "Project Impacts", below for implications), and a better understanding from the community of what services were available to them in the area of FASD and FASD prevention.

Connectedness among Facilitators. Finally, many Facilitators spoke of their experiences connecting with other Facilitators from around the province. Facilitators explained the importance of being connected to those who are doing the same work, and the desire to engage with and learn from other Facilitators, both for the sake of ensuring the project is being implemented consistently across the province and to share learnings with the group so that others may benefit.

Although some Facilitators reported feeling connected to the rest of the group, crediting the monthly teleconference for keeping them connected, the majority of Facilitators reported being disappointed with the limited opportunities to connect. As one Facilitator explained:

> *The teleconferences are terrible. You don't really get to share during [them]. I hate the conferences […] there's no personal, we don't know each other. […] Your team is only as strong as its relationships. If people only meet over teleconference, no one really forms a relationship.*

Another Facilitator shared these views, reporting that *"we have our monthly check in […] but for the most part people just talk for 2 minutes about their successes and I don't feel like we really share a lot of information, or learning that way."* However, not all Facilitators agreed. One Facilitator in particular reported feeling connected with others:

> *I feel like the people are there for me and so if I ended up feeling all by myself that would just be my own fault because I wasn't reaching out […]that's another thing I feel is one of the strengths of the program because, whoever set it up that way (referring to the monthly teleconferences) […] it's a good way.*

As such, the Facilitators reported differing perceptions on their levels of connectedness, however, many facilitators remarked on wishing to find alternative ways to connect with one another beyond the teleconferences.

A prominent concern reported by Facilitators was that this lack of communication between Facilitators might threaten the consistency of the program being delivered: "*I really feel like for a campaign where they keep on saying, this is about [a] consistent message, I don't know how they can say that with confidence. I don't know what the other facilitators say when they present to a group."*

Connecting

In this initiative founded on the importance of relationships, Facilitators may benefit from feeling more supported by and connected to each other. This would allow them to learn from each other, to have more confidence in the work they are doing, and to understand how the initiative is unfolding across the province.

It is possible that increasing opportunities for connection and communication may lead to more information and resource sharing, and therefore to a more consistently-delivered project.

Facilitators shared a number of suggestions for increasing communication among the group. They suggested that the ability to meet more frequently in-person would allow them to connect with each other and develop stronger relationships. They also suggested reconceptualising the online forum, which was reportedly rarely used, as a means to share presentations, and reflections on experiences so that others are not needlessly duplicating resources that already exist, and so that others can learn from the challenging situations they had experienced.

Engaging Intended Audiences

Many of the key experiences Facilitators recounted surrounded their interactions with audiences for the Prevention Conversation, namely Service Providers and other community members. Five themes emerged related to Facilitators' experiences engaging intended audiences: (a) raising public awareness, (b) integrating the Prevention Conversation into other initiatives, (c) barriers to audience engagement, (d) adapting to the audience, and (e) creating a positive environment for the conversation.

Raising Public Awareness. A number of Prevention Conversation Facilitators discussed the various approaches they took to raise awareness about FASD prevention in their communities, which included speaking with local businesses (e.g., coffee shops, malls, liquor establishments), participating in trade fairs and other local events (e.g. parades, carnivals), using social media (e.g. various websites, blogs, Twitter, Facebook) to connect with a wider audience, writing articles for local newspapers and newsletters for professional groups, and creating t-shirts, decals, and other signage with prevention messaging to *"spread the word*". These initiatives were undertaken with the aim of reaching a larger audience than solely Service Providers, thereby increasing the scope of the initiative.

Facilitators engaged in these public awareness-raising activities with the goal of changing perceptions of FASD prevention, noted the importance of delivering prevention messaging in a way that generated public interest. One Facilitator's approach placed emphasis on repeated exposure to the messaging: *"So how I've approached everything has really been, with the*

understanding that people need to hear or see a message 5 times for it to stick." Facilitators also believed that these awareness activities were one way in which to develop relationships quickly, and to connect with potential audiences for the Prevention Conversation. One Facilitator commented: *"It's been really easy because they've already seen the messaging…they're not shocked when I contact them…at some point they would expect that I would be calling, and say, hey can we have a chat?"*

Although the majority of Facilitators were engaged to some extent in awareness-raising activities, not all shared the belief that raising public awareness about the dangers of alcohol and pregnancy was an important part of their role. Instead, there was a common belief among this group of facilitators that the initiative was intended to target Service Provider groups, and that the focus should be on training Service Providers. As one Facilitator expressed: "*our target really is health and social service providers, and yeah if you're going after [a] general public education approach, it's not really going to get you there".*

Something to Talk About…

Raising Public Awareness is listed by the Public Health Agency of Canada as Level 1 Prevention, and was originally conceptualized as a key part of the Prevention Conversation, along with Level 2: Brief Counselling with Women of Childbearing Age (PHAC, 2008).

Clarification of the goals and activities of the FASD:PC may be helpful to ensure all Facilitators are on the same page about the scope of their role.

Integrating the Prevention Conversation into Other Initiatives. Another way in which Facilitators connected with and engaged audiences was by integrating the Prevention Conversation and its messaging into other presentations and initiatives (e.g. "FASD Basics" presentations, community based programs, training sessions). This was done to reach audiences who may not have otherwise been interested in a presentation focusing only on FASD Prevention. One Facilitator commented, *"So we're pretty clever about getting the prevention message into everything we do, [if] it's standing alone, it isn't as effective, and [so] we sneak it in because we know our community."* In addition, Facilitators reported that they believed merging the FASD Prevention Conversation into other pre-existing initiatives helped to ensure the longevity of the prevention messaging, if for some reason the initiative is discontinued.

Challenges in Engaging Audiences. Facilitators discussed a number of challenges they encountered in connecting with and engaging audiences in the Prevention Conversation. Some of these barriers were inherent in the design of the initiative, while others were related to features of their audiences.

- **Topic Tension.** The complexity of the issue of FASD prevention can make it an uncomfortable subject to discuss, and Facilitators found that some Service Providers were reluctant to engage: *"…people are feeling like it's a taboo topic that they still can't openly talk about with people, and they're going to get in trouble or reprimanded or their supervisor will get mad at them… so there you go. See the topic is difficult for some of them."*

- **Scope of Practice.** Facilitators encountered Service Providers who did not believe that having these conversations was within the scope of their practice, or that it was a significant issue that warranted their attention. These reports from Facilitators were consistent with our findings related to Service Providers beliefs about FASD, and their role in FASD prevention. One facilitator stated:

  > *I met with a public health nurse out in one of the communities that I figured would have pretty easy buy-in and be concerned about the issue, and she wasn't, and that took me by surprise. It felt like I was making a sales pitch how it's important…*

  Facilitators also reported that some Service Providers did not believe they had the skills necessary to engage women in these conversations, as one Facilitator reported: *"[They] told us, that (a) they feel like they don't know how to do this well, (b), they're not sure they should be the ones to do it."* Facilitators further reported that some Service Providers (e.g. those in Child and Family Services) expressed concern that these conversations would even present a conflict of interest for them, as they were required to report behaviour that puts children at risk, making it difficult for them to take a non-judgemental approach to the conversation. Finally, although not occurring often, some Facilitators reported that some Service Providers were actually misinformed and had inaccurate and potentially harmful views about FASD and dangers of drinking alcohol during pregnancy. As a result, their presentations were not always received in a positive manner.

- **Feasibility.** Time also presented as a barrier in that some agencies and Service Provider groups reported that they did not have availability for the Prevention Conversation presentation; "*Some of the feedback, I always found was, 'it sounds lovely, it sounds like a great project but I never have a day when all my staff can do this".* Similarly, following presentations, Service Providers would sometimes indicate to Facilitators that they would not have the ability to incorporate such an initiative into their practice due to time constraints and the other responsibilities they had.

- **Uncertainty.** The uncertainty of the future of this initiative was challenging for some Facilitators who found it difficult to plan long term projects and activities. Since this initiative was originally designed as a one-year pilot, continued funding was not secured until well into the project. As a result, some Facilitators reported that they missed registering for time-limited opportunities (e.g. conventions and trade shows) because the future of the project was uncertain. Facilitators also expressed concerns over developing relationships with community

members and organizations given the uncertainty of the future of their position. As one Facilitator expressed:

> *[In this role] you actually are the face of the network for a period of time and so people develop a relationship with you and see you as the face of that network… then you could be gone, so now that relationship is 'oh who do I talk to in that agency now?'… If [the Facilitator] goes away, they'll stop thinking about it.*

Connecting

The uncertainty surrounding the future of the initiative was a source of stress for some Facilitators, and was perceived as a barrier to their ability to build relationships with some Service Provider groups based on their inability to make long-term commitments to ongoing training opportunities and relationships.

Additional challenges noted by Facilitators included the restriction of the initiative to audiences above the age of 18, since some Facilitators expressed receiving a demand for services for younger populations. Geographic factors also raised challenges for some Facilitators who were responsible for service delivery over a large area, leading to issues with time and resources for travelling. Finally, some Facilitators felt that a lack of overall focus on the project at a provincial level (rather than a network level) led to some challenges in engaging audiences. Some felt that a "top-down" approach to promoting the messaging may have facilitated their work, as one Facilitator explained: *"I think that it would be great if the Alberta government could do some top down promoting of the prevention conversation […] I think we could really get to a lot more people versus us having to do the legwork in that piece, like developing those relationships."*

Overall, although Facilitators discussed a number of challenges inherent in their work, they often included in these discussions ways in which they worked to overcome those challenges. In particular, Facilitators reported that having an understanding of their audience and being able to adapt their work accordingly was key to their success.

Adapting to the Audience. Facilitators discussed the importance of knowing their audience in order to ensure that the information presented is "*relevant for them*" to ensure that they can *"spin the conversation so that it makes sense for them."* Facilitators acknowledged that the Prevention Conversation is not one uniform presentation to be delivered over and over again to different Service Provider groups. Rather, the relational nature of the initiative necessitates flexibility and the ability to adapt to the different needs and expectations of various audiences. As one Facilitator explained, "*you have to know your audience. That's the first rule going in*."

Adapting to the audience meant tailoring their presentations to meet the needs of a variety of Service Provider groups. Facilitators reported making presentations more formal for certain groups who were likely to expect a more professional presentation (e.g., health care professionals, doctors, nurses) while making things less formal for other groups (e.g., Parentlink groups, other community groups) in order to ensure audiences were comfortable. Similarly, Facilitators

reported adapting their approach to take into account regional differences, as formal presentations seemed to be more expected of them in urban areas, while informal conversations were deemed more appropriate for rural engagements. As one Facilitator described her experience:

> *I do feel like there's a difference between what is required when you're talking to health professionals in [city] versus rural areas. I usually do a PowerPoint, and to be honest in [city] that's fully expected…Yeah it's assumed that I'm going to do [a formal presentation] whereas I find that in talking with my rural colleagues, that would be overkill if they came in with that.*

Furthermore, Facilitators emphasized that it was important to go into their presentations with an understanding of the beliefs and knowledge-base of their audience: "*every time we think about giving the message out about alcohol and pregnancy, we need to be sure who we're talking to, what their beliefs are around alcohol in general".* Thus, knowing the audience entailed learning about Service Providers' prior knowledge about FASD, what kind of information they were seeking, learning about the community, the client groups they would be serving, and the setting in which they work. Facilitators could then tweak their presentation as needed to make it more informative or interactive and to ensure that they would "*meet [the audience] where they're at."*

Understanding the audience's cultural background was also important, as Facilitators found that culture influenced their audience's beliefs about FASD, and alcohol use in general. One facilitator commented, *"Every sort of sub-culture that we deal with, there's a different need to understand their alcohol use before you can talk about their alcohol use and pregnancy, it's not that simple."* Another Facilitator explained:

> *Before you go into the rodeo community, you'd better know what they think about having rye in their coffee for breakfast. Before you go into the dentists' wives community, or the petroleum engineer's community, you need to know that the background to those women is that they have worked really, really hard to be equal to men. So the drinking for them has a different purpose. So every sort of sub-culture that we deal with, there's a different need to understand their alcohol use before you can talk about their alcohol use and pregnancy. It's not that simple.*

When possible, Facilitators reported that they would meet with a contact person from the Service Provider or community group before their presentation to gather background information to inform their presentations.

Facilitators also reported adapting the use of visuals, video clips, PowerPoint presentations, and using role play scenarios depending on the needs of the audience. For example, one facilitator commented:

> *I've developed a bibliography of video clips and then I make notes to myself under each one about what it's about, so then depending on the group I'm going to I can select and insert videos that I think will be most appreciated by them, or pertinent to their work.*

Finally, many Facilitators gave examples of times when they made changes to their presentations while presenting, based on the reactions of their audiences. One Facilitator commented on reading the audience for feelings of guilt and shame, and as a consequence, she "*tried to fine-tune the presentations so that there was no shame and blame factors involved."* This emphasized the importance of flexibility and preparedness on the part of the Facilitator for dealing with unexpected situations as they arise.

Creating a Positive Environment for the Conversation. Facilitators discussed their efforts to create a positive, safe, and non-judgmental atmosphere in which to engage Service Providers in the Prevention Conversation. They accomplished this by ensuring the audience had the opportunity to ask questions and make comments, and created opportunities for audience participation and open dialogue. For some audiences, this meant making the presentation less formal, using humor and metaphors, as appropriate, to deliver the messaging. The goal was to make the Prevention Conversation personal and relatable to Service Providers, and to reduce some of the stigma that seems to exist around discussing alcohol and pregnancy.

One facilitator commented on attempting to reduce stigma by reframing drinking during pregnancy using a metaphor:

> *I want people to begin to see this isn't a moral issue…I'm not talking about should we or shouldn't we drink. I'm not talking about should we or shouldn't we be sexually active. This is a matter of, just like you're not going to smoke while you're at a gas station. I want people in Alberta to get to the point that if you choose to be sexually active, then be aware of your drinking habits… You know, you'd be shocked if you saw someone smoking while filling up their car at a gas station.*

Facilitators spoke about the importance of approaching the topic with a certain amount of humor balanced with sensitivity, in order to create a relaxed environment and to reduce feelings of judgment around the topic. As one Facilitator summarized: "*so there's certainly a different level of sensitivity that goes around with those conversations, and I've found that humor and just making it personal[ly] related to my own experience has allowed me to connect."* Another Facilitator described using humor to approach an otherwise difficult topic: "*I try to use humor to make it not all doom and gloom. I mean, come on, it's a pretty sobering topic…and I recognize that…but really, it's pretty serious stuff and the way to really influence the people who we need to change their behaviour, we need to make it be really reinforcing…"*

Facilitators reported striving to create a positive and collaborative environment as a way to model how to interact with clients and to get their audiences excited about and engaged with the topic of FASD prevention: *"I get them excited and involved, and I think that the biggest thing is saying, 'I need your help. I need you.' This is a one year project, so I need your help to help you know, prevent FASD and to help me spread the messaging."*

Accessing & Using Project Resources

In reflecting on the work they've done during the first year of the Prevention Conversation, Facilitators discussed various materials and resources that were available to them, and the extent to which having access to these resources facilitated their work. We've divided these resources into three categories: (a) official project materials, (b) support, and (c) ongoing training.

Official Project Materials. A number of project materials were designed by TWIST Marketing to support Facilitators in their work on this project, including training manuals, business cards, bookmarks, posters, and tip sheets to use as they engaged with various audiences. Facilitators' feedback on the quality, relevance, and timeliness of the materials provided differed. Many of the facilitators were content with the materials, stating that they "loved" the project materials and they were very happy with them: "*I thought the resources that have been developed for us are above and beyond,*" and *"I really like the resources that they have. I do. Especially for the service providers, they're good resources".*

Other Facilitators were a bit more critical of the provided materials. Some suggested the materials were too high-level and academic, and therefore of limited relevance to some of the audiences they worked with:

> *I find that part of the issue with the materials that we've been given is the materials are academic materials. They're not layperson materials, so they're harder to use. And they're great with the medical staff and stuff, but they're harder to use with social services, with education, with justice.*

Similarly, there were concerns about the cultural relevance of the materials, especially for Facilitators who were working with First Nations' communities. One Facilitator described her experience speaking to an elder in an aboriginal community: *"He said that when I see a poster in my community and it's got a blonde white person on it telling them you know, don't do something. They don't relate to that. They want to see an aboriginal person on that."* Therefore more diversity in printed materials may help to alleviate some of these concerns.

One Facilitator reported being concerned with the credibility of some of the information provided in the printed materials, as sources and citations were not included:

> *They would give something like, 40% of pregnancies are unplanned…it wouldn't have a source. Or the source would be really old or like if you actually traced back to the source, I couldn't really find, the source didn't match up with number. Things like that kind of concern me.*

Facilitators would have appreciated a greater diversity of available materials, rather than just printed information, to support them in their work. Specific suggestions included having small models of the brain (i.e., brain stress balls), bookmarks that were more visually appealing and durable, pens and pencils, or other "fidgets" that could be branded with Prevention Conversation

logos and contact information. They thought such materials would add interest and be something that individuals would be more likely to keep for future reference.

Finally, nearly all Facilitators spoke of the significant delay in receiving the printed project materials (i.e. materials arrived in May as opposed to January, at the start of the project). Given the delay, some Networks took initiative to design and print their own materials:

> *Even though we didn't get the printed resources until I don't even know when, that wasn't a barrier for us. As a network, we printed off resources. Like the bookmarks and such, just so that there wasn't a gap and we weren't waiting for things from the project and we were able to get started right away.*

The creation of the network-specific materials led Facilitators to get creative and put their own "spin" on the project. However, not all Networks created their own materials, leading to some very different experiences by Facilitators within the first four months of the project. While some were creating their own materials, others were feeling frustrated at the lack of resources they were provided with to do their work, feeling as though they were expected to *"mak[e] it up as [they] went along".*

Facilitators generally reported being at least somewhat satisfied with the project materials, but desired greater variability in printed resources. Limited access to these materials in the beginning was challenging for Facilitators, at a critical time when they were perhaps in need of the most support and resources.

Support. A number of Facilitators also reported personal support, in the form of mentorship, leadership, and administrative help, was important to their work. Several facilitators talked about leadership and the important role that the Network Coordinator and other personnel played in mentoring them, particularly those who started the project with less of a background in FASD. One Facilitator expressed appreciation for the support of her Coordinator in this process:

> *I'm very fortunate that I'm being mentored by [Coordinator name] in the network activity business… She's been able to give me contact names and provide just a really, really good mentoring process for me because of course she knows a lot about this.*

Facilitators also spoke about the administrative part of their work and how support in this area was helpful in completing projects that would have otherwise been very time consuming, such as putting together information packages and printing materials for presentations:

> *I also think you know, one thing that's been really good is that I do have staff… I did the health expo in which there was going to be 1200 health employees come through the expo, and so we made packages… I was able to get 10 staff on board with helping me put these together… That could be really time-consuming if you're working by yourself.*

In contrast, Facilitators without access to help in this area reported that taking care of all the administrative work took away from their time that they believed would be better spent preparing presentations and networking with Service Providers:

> *An administrative assistant in some part of this would be so helpful because when I'm down at [local business] spending 2 hours with the person there explaining how I want posters blown up […] Now I'm going to go to [office supply store] and look at getting easels to support them all. I look on that as really an administrative assistant kind of work. If I had somebody that I could delegate that to, that would be so helpful because it's very time consuming.*

Some Facilitators also spoke about having other Network staff accompany them to their presentations to help with logistics, such as managing large groups of people, distributing surveys and materials, and answering questions, and sometimes acting as a co-facilitator.

Connecting

This initiative is difficult to deliver in isolation, without the help of support staff and those who can offer mentorship and guidance, which is consistent with the focus of the Prevention Conversation as being a relational approach to FASD Prevention.

Ongoing Training & Development. Facilitators also discussed their desire for ongoing and additional training opportunities to ensure they are prepared to meet the demands of their work. Some Facilitators sought out additional training and shared their experiences with that, while others made suggestions for training opportunities they would appreciate receiving through the initiative itself.

Motivational Interviewing (MI) was by-far the most talked about training opportunity that Facilitators desired, most likely because MI was emphasized in Facilitator training as an important aspect of the Prevention Conversation, particularly as it relates to having conversation with women, but Facilitators were not trained in how to engage in it (for a review of Facilitator training, see Question 1.1). As one Facilitator explained:

> *[It] was hard to go into a meeting and encourage them to use motivational interviewing, and they want to do some troubleshooting, and I'm like ahhhh I don't really know how to help you [use Motivational Interviewing] cause I don't really…I mean I understand the premise of it…but…*

In fact, MI was seen as such an important aspect of their work, that some Facilitators took it upon themselves to seek out additional training in this area. One Facilitator explained:

> *We were never offered like the full 2 day motivational interviewing training, or anything like that, yet we're supposed to be going out and talking to people about concepts that are hugely based on motivational interviewing, right? […] And so I know myself, my network, we paid for me to go take motivational interviewing training.*

Secondly, a number of Facilitators also expressed interest in more in-depth training in FASD, beyond just FASD prevention. Some Facilitators expressed that it took them quite some time to acquire enough information to feel comfortable developing and presenting a presentation. Some Facilitators explained that they were still occasionally presented with questions, or put in situations where they did not feel adequately knowledgeable enough to answer. In the experience of one Facilitator:

> *Somebody asked me before, because on some charts it says first two weeks [the fetus] is not affected by alcohol and then other charts say it is, but they're different kinds of charts…so making sure I kind of do a quick 'bio crash' to understand what the difference is between the two charts and what they're saying so that I can explain it to people.*

In particular, the importance of having more information about some of the more complex or scientific aspects of FASD, such as fetal development, was brought up by many. Some stated they had spent countless hours researching, reading, and watching online learning series presentations to gather information. Other Facilitators expressed a desire for more training focused on trauma-informed practice, or for additional workshops to develop facilitation skills. The diversity in desired training is not surprising given the variability of backgrounds of the Facilitators (see *Introducing Facilitators and Service Providers*); it also serves to further highlight the need for training that is tailored to the needs of the individual Facilitator.

Finally, Facilitators who were able to attend the Alberta FASD Conference spoke about the importance of such a professional development opportunity. They expressed appreciation for the opportunity to connect with other FASD professionals and to learn from some of the experts in the field of FASD. Some reported that hearing others speak at FASD events was invaluable to improving their own presentations, allowing them to incorporate more personal stories and knowledge of FASD work. One Facilitator spoke about her experience:

> *…so that experience in Edmonton was just critical for me, is where I met people, I heard stories, I saw birth mothers sharing their stories and crying, and the emotion attached to that and me being able to share that with other people, and you just don't get that from reading it on the internet. It's something you need to experience in order to share that and those stories are impactful for people, those are what they remember.*

Overall, because of the variety of Facilitator backgrounds, there was a wide variety of requests in terms of further training opportunities. While some may benefit from more training in FASD or MI, others have more than 15 years of experience in FASD, or have already take a course in MI and thus would not benefit from these opportunities. This makes it difficult to tailor general group training sessions to the needs of such a diverse group; further training opportunities thus need to be responsive to the needs of individual facilitators.

Although Facilitators differ in the areas in which they would like more training, all were similar in their desire for continued training and development opportunities, which would improve their ability to implement this initiative.

Emerging Project Impacts

Although still early in the project, Facilitators' discussed what they believed to be some initial impacts that they could see emerging as the project was implemented. Facilitators reported witnessing changes in audience perceptions relating to FASD prevention, seeing an increase in capacity in their Networks, and initiating some unique approaches to FASD awareness and prevention that have the potential for far-reaching impacts.

Changing Audience Perceptions. A number of Facilitators spoke about watching the beliefs and perceptions of audience members change during or soon after their presentations. They talked about how rewarding it was to see that people were "*getting the message at a deeper level*" and seeing that the prevention messaging was "*making sense to them*". Facilitators described these "*light bulb moments*" as critical points in the project for them and identified these experiences as some of the successes they were most proud of in their work so far.

Facilitators saw their audiences take new perspectives by challenging their beliefs and debunking myths, de-stigmatizing alcohol, and acting as a "change agent" to encourage Service Providers to see both clients and situations from a different perspective. Many Facilitators remarked on their surprise and excitement at how well many Service Providers had received the prevention messaging. One facilitator commented:

> *Seeing them actually get excited you know, and not only their body language, kind of leaning forward, but the interaction that you know, the questions they were starting to ask. Intuitive questions, which you know tells me that not only were they hearing the information but they were processing it.*

Another commented:

> *[Service providers] said you know… I feel very comfortable talking to a young person about birth control, but I never thought about tying alcohol into that conversation about how alcohol can affect the developing baby, and they all kind of said yeah, I can do this now. This makes sense. So yeah I liked that.*

Overall, seeing the changes they were making first-hand was rewarding to Facilitators. One Facilitator remarked: "*I feel it's important the audience get the message. When I see they really are and I'm getting tangible feedback, that wow, they really are getting this, I find it really rewarding.*" Witnessing these changes brought them excitement, reaffirmed they were on the right track, and occasionally provided them with renewed purpose in the face of challenges or setbacks: *"[In those moments] I feel like, 'yes, I'm doing what I'm supposed to do."*

Increasing Capacity. Facilitators discussed their beliefs that this initiative led to an increase in capacity in their networks, communities, and in themselves. In terms of Network capacity, the position of Prevention Conversation Facilitator allowed networks to offer services to the community that they may not have otherwise been able to. Many Facilitators also reported being involved in Network initiatives other than the Prevention Conversation. Their ability to connect with and build relationships with the community and Service Provider groups led to increased Network visibility in the community and therefore an increase in requests for services. One Facilitator explained: *"You know, the worry from network coordinators, how is this going to increase our workload? It's a really good worry, it should increase your workload. If you're doing a good job of this, your phone should be ringing off the hook."*

While many see the addition of their position to the network as a positive, some Networks have struggled with the demand for services that has been created by increased community awareness of FASD. One Facilitator expressed difficulties accommodating the new referrals, as wait lists for Network services lengthened:

> *The difficulty is getting 50 referrals in a week. Our waitlists are still really long. So we're increasing viewership within the community for prevention and FASD, but our program can't accommodate that increase. The increase that we see for requests for services based on us getting out into the communities and having these conversations.*

As Facilitators increase the capacity of their Networks to offer services to the community, increased demand for related services, as a result of the Prevention Conversation, must be taken into account so that Networks are prepared to meet the needs of their communities.

Some Facilitators also commented on their own personal development, reporting that they believed being involved in this initiative increased their own capacity in certain areas. For example, some reported developing better time management skills, learning more about FASD, and gaining a better appreciation for some of the programming offered by the FASD Networks. Key learnings described by many Facilitators were:

- Personally reflecting on their own beliefs about alcohol use by pregnant women
- Understanding the different aspects of prevention, including cultural significance
- Realizing that FASD is not specific to any person, social or cultural group; recognizing that we are all at risk.

Facilitators saw these learnings as key to their continued success in the Prevention Conversation.

Unique and Creative Projects. As previously mentioned, the Prevention Conversation initiative was meant to be adopted and customized based on the needs of the individual Networks and communities in which the Facilitators work. To some extent, this flexibility led to the emergence of some unique and creative approaches to FASD awareness and prevention, many of which have the potential for far-reaching impacts beyond what was originally conceptualized for this project.

First, one Facilitator in particular took to the internet, specifically social media (e.g. Facebook, Twitter) to spread messaging related to FASD Prevention, exposing this initiative to a global audience. She explained that social media allowed her flexibility and variety in reaching a number of different audiences and allowed her to play with what the focus of her messaging might be: *"What kind of theme or focus for twitter this week? What do we want to put on the Facebook site to kind of connect different users for each of them? So what's going on the Facebook site, and then within the week it's looking at, so what particular group have I not focused on?"*

For this Facilitator and a number of others, the fact that a provincial web presence was not conceptualized as a part of this initiative was disappointing and was seen as a missed opportunity to connect with a broader audience. One Facilitator reported, *"I think that's maybe been one of the downfalls with this project that [social media] has not been a focus."* While this social media presence was developed in one Network in an attempt to fill in this gap, a consistent approach across the province, with a central website to refer audiences to, is seen by Facilitators as being an important next step for this initiative.

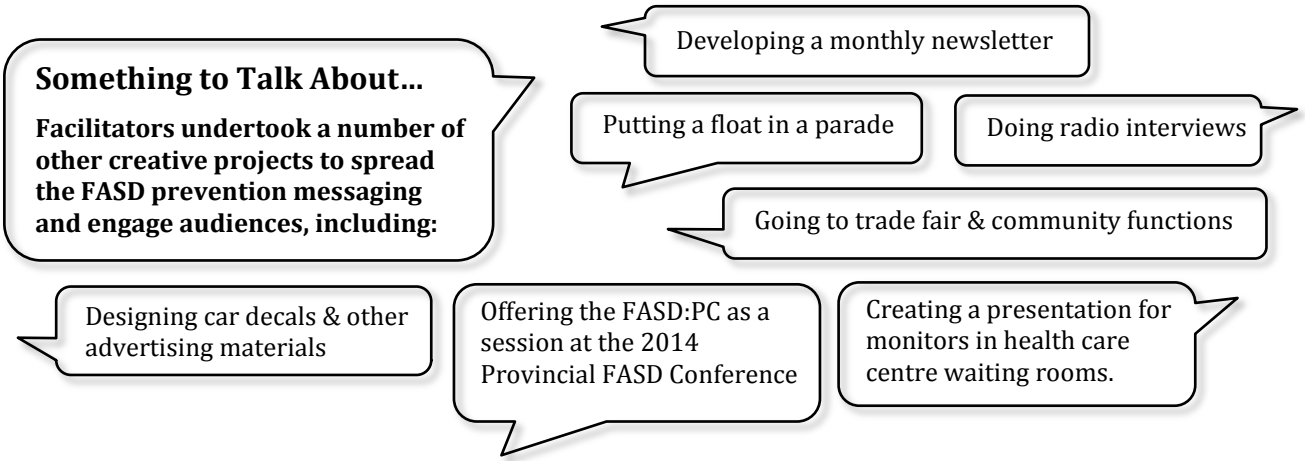
In a second example of a unique project, one Facilitator took the initiative to create an online learning series which health professionals from across the province, and beyond, could complete to learn more about FASD prevention. She remarked:

> *I'm trying to go after audiences where it has a lasting impact. For example, I'm trying to line up an online learning series that's run through Healthy Minds Healthy Children…and sort of do an online training course in FASD prevention. It will stay in their archives for 2 years, so even if I don't have my job in 2 years, whatever health professional that goes on their website will have access to it.*

This learning series continues to provide access to the prevention messaging to Service Providers, and to the general public, thereby extending the reach of the project beyond those individuals that this Facilitator may have been able to reach alone:

> *It took about a month to create the presentation and record it, and now it's available to a massive network. It has huge potential for the next 2 years… their information is available to all health professionals across Alberta, and specifically targeted to mental health professionals.*

Other Facilitators engaged in a number of creative projects. While many of these projects fall within what would be expected, some go above and beyond what was originally conceptualized, further expanding the reach of this innovative initiative.



Service Providers' Experiences

Next, we examine the experiences of Service Providers involved in the Prevention Conversation, including both those who have incorporated the FASD:PC into their work by engaging clients in conversations about alcohol and pregnancy and those who have not.

During a follow-up survey 3-6 months following their training with Facilitators, Service Providers were asked whether or not they had engaged in a conversation with a client (i.e. woman of childbearing age) related to alcohol and pregnancy in the time since their training with the Prevention Conversation Facilitator. The majority of Service Providers (73%) have engaged in prevention conversations with their clients since their training.

For Service Providers Who Did Not Engage…

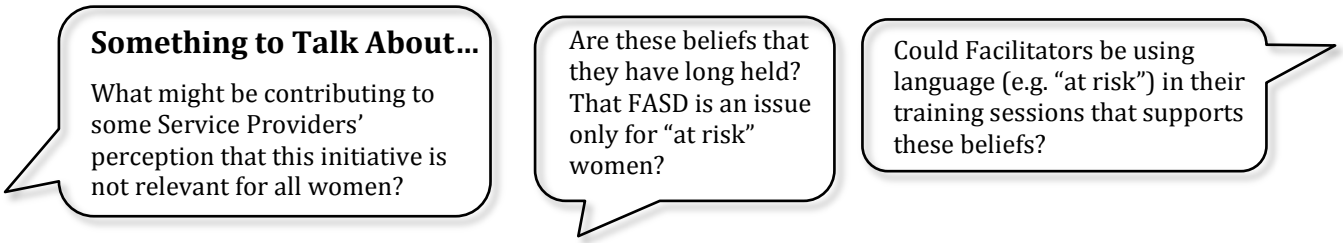
The 27% of Service Providers who had not engaged reported that a number of barriers may have prevented them from doing so. Most commonly (71%), they reported that they had not yet had the opportunity to engage in a prevention conversation with their clients. Furthermore, approximately 14% indicated that they had not engaged because they did not believe it was within the scope of their practice to do so. Fewer Service Providers indicated that they had not engaged in conversation because:

- They worried the woman would feel judged (6%)
- They were not confident in the state of FASD research (6%)
- They did not feel comfortable approaching the topic (3%)
- They were not sure what to do if alcohol consumption was confirmed by a pregnant woman (3%)

These Service Providers also provided a variety of suggestions for what might increase the likelihood of engaging in prevention conversation with their clients. General themes that emerged from the data included issues related to the type of clientele served by the Service Providers, issues related to additional training and the availability of resources, and issues related to workplace policies.

A number of Service Providers responded that there were issues relating to their clientele that prevented them from engaging, suggesting that they were not currently working with women who they considered "at risk", or who were in need of having these discussions. As one Service Provider explained, s/he would engage if s/he "*worked with clients of childbearing age who consume alcohol or, who may be at risk".* Similarly, one Service Provider reported that s/he would only engage "*if women who were presenting to my program had the need to discuss it or required referral regarding the same."*

Some Service Providers may have misconceptions about the purpose of the FASD:PC, as it is meant to encourage conversations with all women of childbearing age and their families/friends, not solely those who would traditionally be considered "at risk".



Additionally, some Service Providers requested additional training or resources, suggesting that these additional tools would encourage them to have the conversation. One Service Provider reported that they would like to engage in these conversations, but that additional training would make them feel much more confident in doing so. Similarly, one Service Provider reported a desire for related materials, specifically expressing that having access to educational videos with example conversations would be helpful. The desire for more training is not surprising given the variability in FASD knowledge that Service Providers reported before training. Since the Prevention Conversation training sessions are relatively brief, Facilitators could offer suggestions for additional training as part of their presentations to ensure Service Providers have the resources they need to engage in this initiative.

A number of Service Providers also indicated issues surrounding workplace policies, suggesting that if the prevention messaging was included in workplace policies mandating them to have the conversation, or if it was included in the development of new programs, they would be much more

Something to Talk About…

Service Providers who believed FASD Prevention was an important aspect of their work were more likely to report intending to engage in the FASD:PC.

Service Providers who are not engaging may be those who have not internalized beliefs surrounding the importance of FASD prevention to their work.

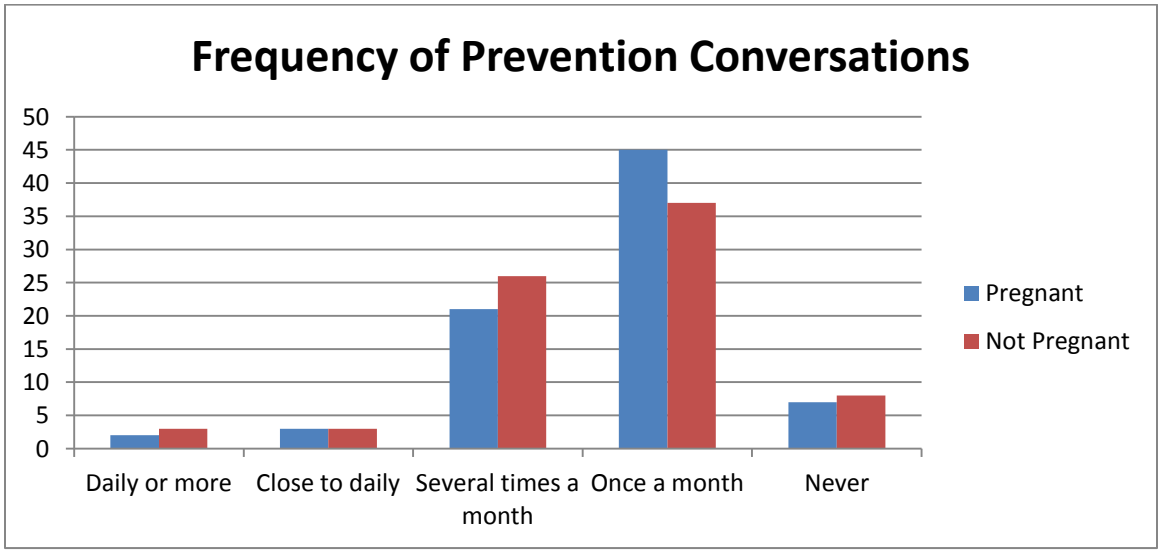
likely to engage. Another Service Provider suggested, *"a shelter policy that stated every woman who came to the shelter must be spoken to about the damage caused by using alcohol during pregnancy and what the damage to the fetus might look like."* For these Service Providers, it appears that engaging in the Prevention Conversation is something they would do if it became part of their job description, but not something that they are interested in engaging in above and beyond the work they currently do.

For Service Providers Who Did Engage…

The 73% of Service Providers who reported that they had engaged in at least one prevention conversation were asked to provide further information about their experiences. Specifically, we were interested in learning more about how often they engaged, what topics were included, and in what ways their conversations with women have changed since training.

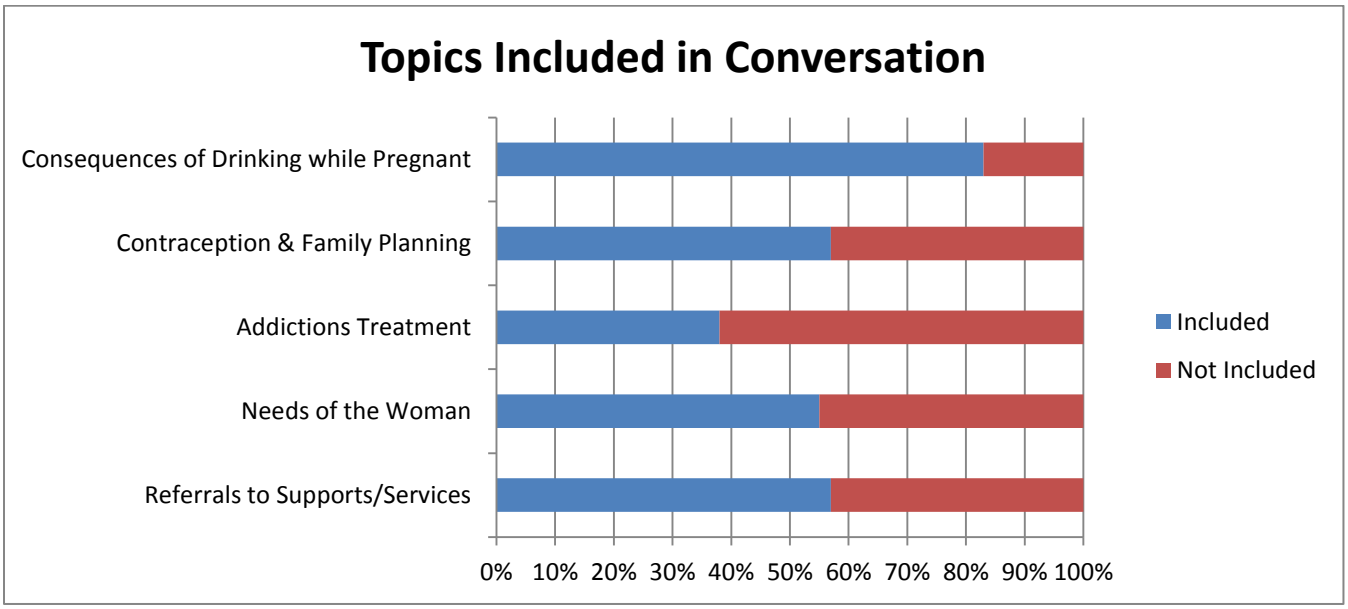
As demonstrated in Figure 16, findings suggest that Service Providers are most commonly engaging in these conversations between once and a few times per month, while very few are engaging on a daily basis. In addition, the frequency of conversations with both pregnant and non-pregnant women appears to be similar, suggesting that Service Providers understand the importance of having this conversation with all women, regardless of pregnancy status.

Figure 16. Frequency of Engagement in Prevention Conversations



Service Providers were also asked to indicate what topics were included in their conversations with women, from a list of common topics. They reported that topics related to the consequences of drinking while pregnant are the most often included, while addictions treatments are least likely to be included (potentially because those services are likely to be required by a more "at-risk" group of women, rather than the more general public). Service Providers reported including a number of the topics that would be considered important to the foundation of the initiative in their conversations with clients (see Figure 17).

Figure 17. Topics Included in Service Providers' Conversations with Women



Finally, Service Providers reported on ways in which their conversations with women have changed since their interactions with Facilitators. In examining their responses, we see a number of common themes, including:

- Increased Conversation Frequency
- Increase in Quality of Conversations
- Increased Knowledge & Comfort
- Consistent Messaging

Service Providers reported that their conversations have changed in frequency; they are engaging women of childbearing age in conversations about alcohol and pregnancy more often than they were prior to training. The increase in conversation frequency may be due to a shift in thinking, as some Service Providers reported that they now believe it is a conversation that is worth having.

Service Providers also reported a change in the quality of their conversations with women. Examples of ways in which they attempted to increase quality included adjusting their tone to sound less judgemental, conveying more empathy, and striving to be more supportive and to build stronger relationships with their clients. In fact, an increase in focus on relationship-building was

mentioned by a number of Service Providers. For example, rather than immediately launching into a conversation about risk-factors without knowing the client well, Service Providers explained that they now ensure they have taken steps to establish a relationship with the woman. As one Service Provider reported, *"I find it effective to first build a relationship of respect and understanding before I would ever engage a client in conversation about prevention".* They also reported focusing on identifying and helping women focus on the relationships in their own lives as a way to seek support. For instance, one Service Provider stated, *"I think one of the biggest changes has been the focus on women's support system and their role in supporting her to have a healthy pregnancy."*

Connecting

Service Providers appear to be grasping one of the key elements of the Prevention Conversation: the focus on a relational approach to FASD prevention.

Service Providers also reported feeling more knowledgeable and comfortable about the topic of FASD, and believing that they now have more information to share with their clients. For instance, they reported knowing more facts about FASD, and having the proper vocabulary to discuss FASD in general. As one Service Provider reported, "*I just have a better vocabulary for beginning the conversations now*". They also reported having a better understanding of how to direct the conversation, they believed they were better able to speak to the complexity of the issue, and they reported being more knowledgeable about FASD resources and referral options. In relation to comfort, Service Providers reported feeling more comfortable approaching the subject and initiating conversations, and that they also felt more confident in speaking with their clients about this issue in general. In the words of one Service Provider, *"my biggest change would be my confidence about engaging in the conversation".*

Finally, Service Providers reported that their conversations with women have benefitted from the focus on consistent prevention messaging that is core to the Prevention Conversation. They express appreciation that the Prevention Conversation is leading to a common understanding among Service Providers, and are encouraged by the idea that all professionals are "*talking the same talk*" when it comes to FASD prevention. Some Service Providers are embracing the messaging, explaining that they now focus their conversation more on prevention, and that they bring up issues relating to the needs of pregnant women. They also report being more likely to follow-up with women to make FASD prevention an ongoing discussion rather than just a one-time conversation.

Service Providers reported that their conversations with women of childbearing age have changed in a number of positive ways following the Prevention Conversation training. Conversations have increased in frequency and quality, and the tone of discussions has changed.

Consistency of Message Delivery

Our third evaluation question, *"To what extent is the intended messaging consistently being delivered and received by participants throughout the implementation of the Prevention Conversation?"* examines how the prevention messaging is traveling throughout the Prevention Conversation. Because there are multiple levels through which these messages must travel (e.g. from Facilitators, to Service Providers, to women and families), evaluating the messages received at each level will help to ensure that the Prevention Conversation's intended audiences are being provided with clear and consistent messaging regarding alcohol, pregnancy, and FASD prevention.

Opening the Conversation

What did you want to know?

- *What messages are intended to be delivered through the Prevention Conversation?*
- *What messages are being received at each level?*

What did we do?

- Facilitator Post-Training Surveys (See Appendix D)
- Facilitator Interviews (See Appendix G)
- Service Provider Post-Training, and Follow-Up Surveys (See Appendix D)

What are we learning?

- Overall consistency in messaging considering how many levels it travels through.
- Messages heard by service providers do not always guide their conversations with women; some are emphasized more than others.
- Facilitators have differing views on the importance of message fidelity.

Message Development

In a meeting of the FASD-APC on May 7, 2013, a series of messages to be used to guide the Prevention Conversation were discussed and subsequently decided on. These messages were designed to be comprised of both primary and secondary messaging (see Table 3); and to be consistent with messaging approved elsewhere in the FASD community (i.e. Canada FASD Research Network, 2013), and currently being used throughout the 12 FASD Service Networks for awareness and prevention activities. The following messages were finalized by members of the FASD-APC to guide the Prevention Conversation.

Table 3. Key Messaging for the FASD Prevention Conversation

#	Priority	Audience	Messaging
1	Primary	General	It is safest not to drink alcohol during pregnancy.
2	Secondary	Women	Drinking can be harmful at any point during pregnancy and can result in lifelong disabilities. The baby's brain and nervous system develop (and are vulnerable to damage from alcohol) throughout pregnancy.
3	Secondary	Women	Alcohol and pregnancy don't mix. If you drink alcohol and are sexually active, make sure you use effective contraception.
4	Secondary	Women	If you're pregnant or thinking about getting pregnant, consider talking to your healthcare provider or asking for help to learn more about support and services in your community.
5	Secondary	Community Members	Friends, partners and family members can support a pregnant woman by asking how they can help her make healthy choices and healthy babies.
6	Secondary	Service Providers	Some women need support, care and treatment to help them stop drinking during pregnancy. Research points to the effectiveness of intervention. Engage them in The Prevention Conversation.

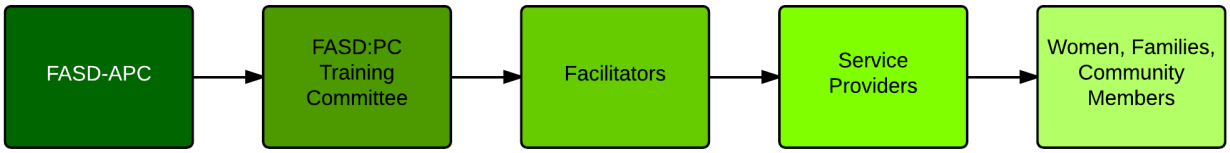
The primary prevention message, "*it is safest not to drink alcohol during pregnancy*" is considered a universal message, relevant to everyone, upon which the foundation of the Prevention Conversation was built. This message was chosen and refined to be a clear, simple message, which could be easily delivered and included in marketing for the Prevention Conversation materials. Secondary messages were further individualized for specific target audiences, including women of childbearing age (i.e. messages 2, 3, and 4), community members (i.e. partners, families, and friends of women; message 5), and Service Providers (i.e. message 6) to ensure that all parties involved in this initiative received specific messaging that was relevant to them, and that emphasized the role they could play in the prevention of FASD.

Wording of the messages was reviewed and discussed by members of the FASD-APC to ensure that the prevention messaging was as clear, concise, and consistent with other prevention initiatives as possible. Although the possibility of including messaging for youth was briefly discussed, it was decided that youth would not be targeted for the Prevention Conversation initiative, as programing designed for this age group required special considerations that were beyond the scope and feasibility of the project at that time.

Message Delivery

Prevention messaging must be transferred through multiple levels, as demonstrated below in Figure 18.

Figure 18. Message Transfer in the FASD:PC

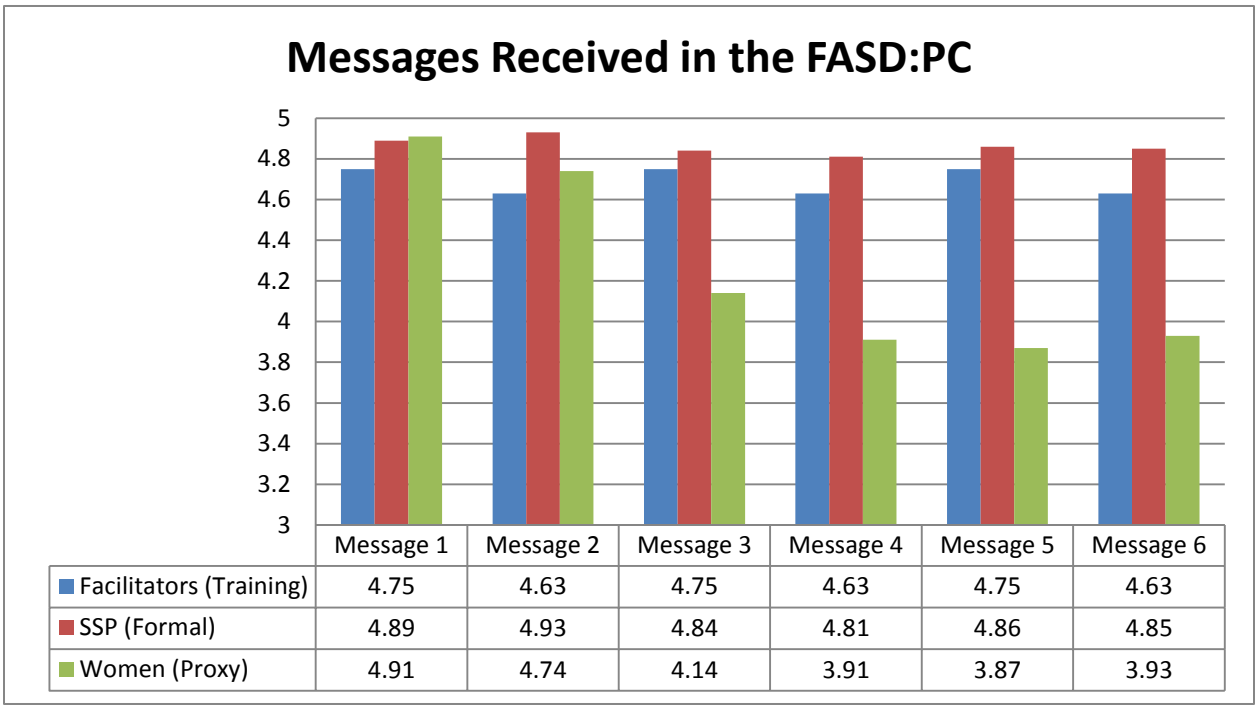


After the FASD-APC develop the prevention messaging, and it is incorporated into Facilitator training, it is then delivered to the Facilitators, who deliver is to the Service Providers, who will then incorporate it into their conversations with women. An examination of the messages being received at each level can provide insight into what individuals at each level have learned or taken away from the Prevention Conversation. It is critical to examine whether and to what extent the prevention messages are maintaining integrity as they are received at each of the different levels, to ensure the intent of the messaging is not lost or changed.

Note: Since collecting data from women was beyond the scope of this evaluation, we employed a proxy measure to estimate the messaging women were receiving by asking Service Providers to what extent each of the messages guided their conversations.

We examined the extent to which each of the prevention messages was received by (1) Facilitators during training; (2) Service Providers during training sessions with Facilitators; and (3) women (via proxy measure). Figure 19 depicts the extent to which each group reported hearing each of the six prevention messages (1= message not heard at all, 5= message heard exactly as written).

Figure 19. Messaging Received by Participants in the FASD:PC



	Message 1	Message 2	Message 3	Message 4	Message 5	Message 6
Facilitators (Training)	4.75	4.63	4.75	4.63	4.75	4.63
SSP (Formal)	4.89	4.93	4.84	4.81	4.86	4.85
Women (Proxy)	4.91	4.74	4.14	3.91	3.87	3.93

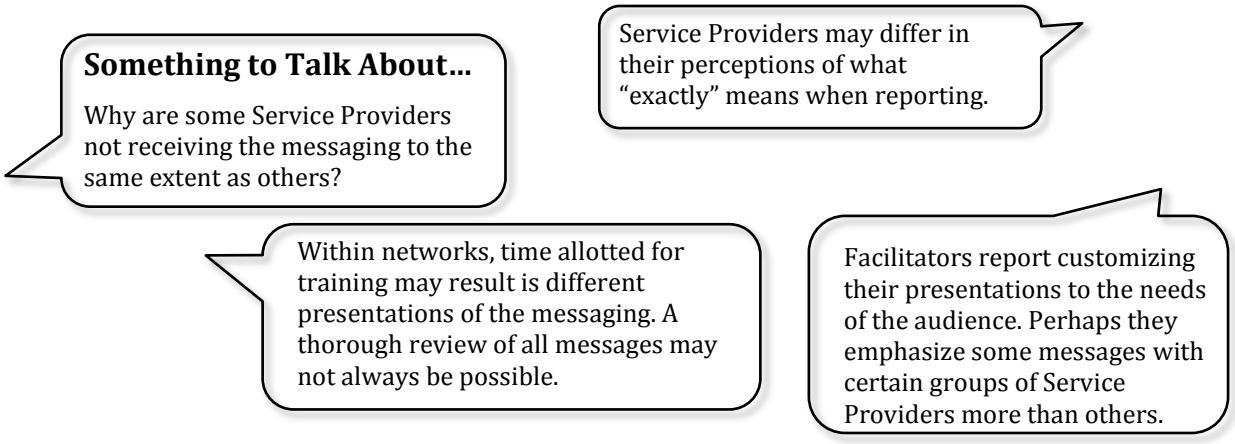
Messaging Received by Facilitators

The extent to which Facilitators reported hearing the various prevention messages during training ranged from 3 (somewhat) to 5 (exactly). In examining the responses of individual Facilitators, it can be seen that one Facilitator consistently responded that they had heard each of the messages only "somewhat", while the rest reported mostly scores of 5, and occasionally 4. This is potentially concerning, given that this represents the beginning stage of message transfer. If messages are not heard exactly at the point of Facilitator training, this may prevent messages from being translated to Service Providers and the rest of the community as the FASD-APC intended them to. However, Facilitators were provided with Prevention Conversation materials that emphasized all six of the prevention messages. As such, they had the opportunity to further familiarize themselves with any messaging they may have missed during training.

Messaging Received by Service Providers

We examined the messaging received by Service Providers both during formal training sessions and during informal interactions with Facilitators. As a group, Service Providers who participated in formal training sessions reported hearing all messages approximately to the same extent (see Figure 19). However, individual reports from Service Providers varied from 1(not at all) to 5 (exactly), indicating that at least some Service Providers who are participating in Prevention Conversation training are "not at all" receiving the various prevention messages.

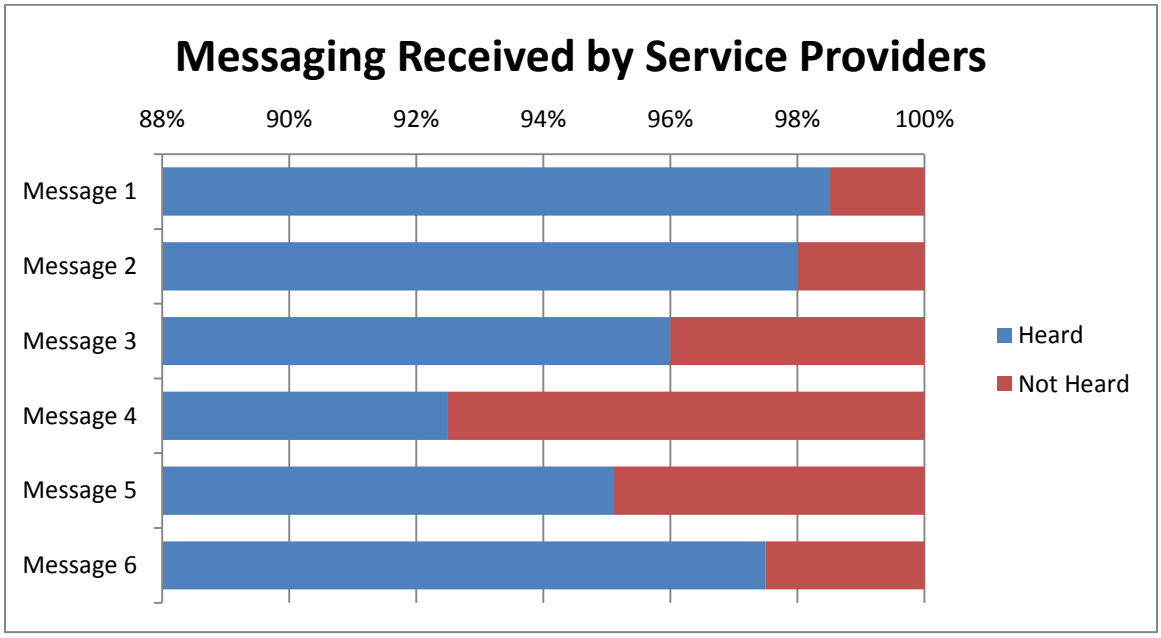
We examined whether there were possible differences between Networks (i.e. that perhaps some Facilitators were consistently leaving out certain messaging during their training and informal interactions with Service Providers). However, no notable differences in Service Provider responses between Networks were found. Responses from Service Providers across all Networks ranged from 1-5, and means were similar for all 6 messages.



Prevention Messaging is being communicated clearly and is reaching the vast majority of Service Providers as it was intended.

We also examined the messages heard by Service Providers during *informal* interactions with Facilitators (i.e. calls, emails, quick discussions). Figure 20 depicts the percentage of Service Provider survey respondents that indicated hearing each of the prevention messages during their informal interactions with Facilitators.

Figure 20. Messaging Received by Service Providers during Informal Interactions.



Over 90% of Service Providers indicated that they had heard all six messages during informal interactions with Facilitators. Message 4 was the least likely to be heard by Service Providers. This message, which is intended for women as a target audience, focuses on speaking to a healthcare provider if one is pregnant or considering becoming pregnant in order to learn about community supports and resources. Given that this message is relatively general, it is possible that Facilitators may have embedded this message throughout their training rather than focusing specifically on this message separately from the others.

Service Providers also reported differences between intended and received messages, as well as additional messages they received during their interactions with Facilitators via open-ended survey responses. Service Providers indicated that some Facilitator interactions did not focus on the role of partners, friends, and/or family members in prevention conversation, but rather focused largely on the women's role, and how to support them in decision-making. In addition, some survey respondents indicated that contraception was not fully discussed during their interactions with Facilitators. Where contraception was covered, some respondents suggested that the discussion of contraception was relatively brief and glossed over the depth of the issue. Similarly, some Service Providers indicated that the messages received during Facilitator interactions did not necessarily *differ* from intended messages, but that the messaging was sometimes presented without being elaborated upon or discussed, seemingly due to time constraints. Therefore, it is possible that although many Service Providers responded that they had heard all of the prevention messaging during training, they may differ in the extent to which they understood the purpose of the messaging and the importance of translating this messaging to women and their support systems.

In addition to the six core prevention messages, Service Providers also indicated a number of other topics or messages were included in their interactions with Facilitators. Service Providers reported that they had learned (1) general principles and specific strategies for working with people impacted by an FASD; (2) specific strategies and principles for interacting with and supporting pregnant women and mothers; and (3) that prevention efforts are needed for all women and should not only be directed to women from populations typically considered at-risk.

Messaging Received by Women (Proxy)

Messaging that Service Providers report as guiding their conversations with women was used as a proxy measure to estimate what messaging women are likely receiving. In examining these messages that Service Providers are delivering to women as part of the Prevention Conversation, we start to see a more pronounced downward trend in a number of the messages (represented by the green bars on the graph in Figure 19).

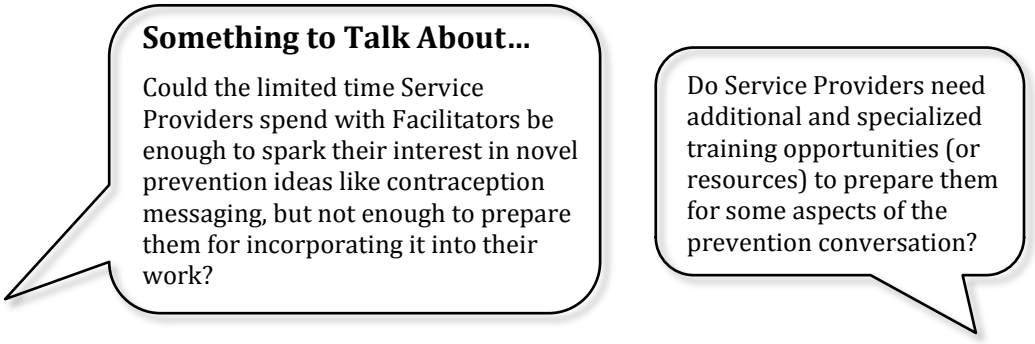
Overall, reception of each of the messages was relatively high (i.e. means from 3.9 - 4.9 out of 5), considering they have been passed through a number of messengers by this point. However, it is clear that some messages are being emphasized to a greater extent than others in conversations with women. Messages one and two appear to be emphasized most strongly, while messages three, four, five, and six are less emphasized. As you may recall, prevention messaging is targeted toward a variety of audiences (see Table 3), which may explain why some messages are not being emphasized as strongly with women. For example, messages 5 and 6 are targeted toward other audiences (i.e. family and friends as well as Service Providers); these messages provide suggestions for how to support women of childbearing age in making healthy decisions. It is thus reasonable that these messages are less often discussed during conversations with women themselves. Message 4, although directed at women, refers to the importance of consulting with a healthcare provider about appropriate supports and services when pregnant or planning to become pregnant. Since these conversations are happening between Service Providers and women, message 4 is likely assumed (i.e. women are already seeking services), and therefore may be less likely to be included in the conversation.

It is perhaps most interesting that prevention message 3 is among those less commonly emphasized in conversations between Service Providers and women. This finding is supported by both the quantitative survey data as well as Service Providers' responses to qualitative survey questions, as noted above. Message 3 is targeted toward women, and emphasizes the importance of contraception and family planning in the prevention of FASD. In contrast to the other messages that are less often being discussed, it is a reasonable expectation for Service Providers to be emphasizing the importance of contraception and family planning in their conversations with women, as it is a key aspect of FASD prevention. The finding that this message is least emphasized is consistent with post-training Service Provider reports of feeling the least comfortable and least prepared to discuss this topic with their clients (See Question 1b).

However, Facilitator reports suggest that they believe Service Providers have overall been very receptive to the contraception messaging. As one Facilitator reported:

> *Everybody loves the birth control, you know, 'if you're having sex and you're drinking alcohol, don't get pregnant. Make sure you're on birth control' […] By far that's been the messaging that people are really onboard with and they really want to spread because for the last 20 years we've really focused on when you're pregnant, don't drink. So now it's a complete shift in talking about, don't get pregnant.*

As Facilitators suggest, audiences seem to be particularly receptive to this message because it characterizes a more novel approach to the issue of FASD prevention. In particular, this message shifts the focus from "don't drink when you're pregnant" to "don't get pregnant if you're drinking", which presents an alternative for women. However, being interested or excited about a message is different than feeling prepared to deliver that message and engage in conversations on a topic that some Service Providers may not feel prepared to cover.



Although many of the messages are received by Facilitators, and then by Service Providers during their training, these messages are not always evenly translated into Service Providers' conversations with women. Given that all messages are important in the prevention of FASD, further examination of how to prepare Service Providers to engage in these discussions is warranted to ensure that women are getting access to a complete list of prevention messaging.

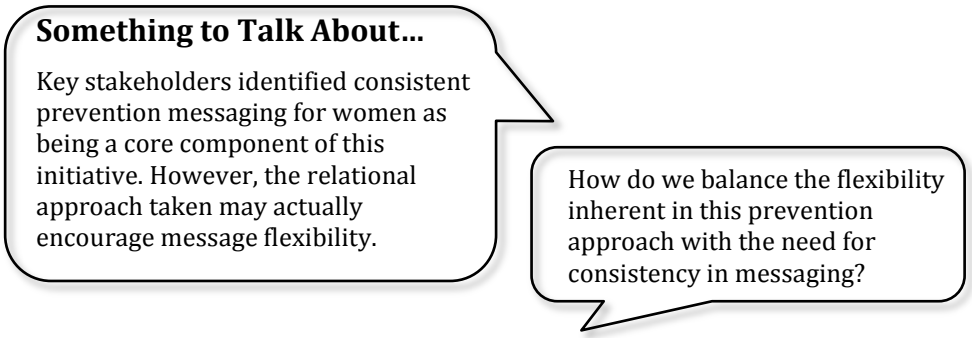
Facilitators Perceptions of Message Fidelity

Understanding Facilitator perspectives on prevention message fidelity may help to contextualize and interpret some of the above findings appropriately. In particular, we looked at the role that messaging plays in Facilitators' presentations to Service Providers. Facilitators expressed different views on message fidelity, and the extent to which maintaining the integrity of the prevention messaging was key to the Prevention Conversation. Some Facilitators have taken the delivery of key messaging very seriously, reciting it verbatim to audiences, as one reported:

> *How I talk to new people may look a little bit different just in presentation style and format, but the messaging is staying the same regardless of whom I'm chatting with […] For me, every community is different, but I change…really we want the messaging to be the same, so really it's just style that changes depending on who you're talking to.*

However, for the majority of Facilitators, the "spirit" of the messaging was key, rather than reciting prevention messaging verbatim to Service Providers during their presentations. For example, one Facilitator explained: *"You know, my approach has been that the words don't have to stay the same, it's the meaning behind the messages that we want to get out to the community as a whole".* Another seconded, *"There are 12 people across the province doing the same thing. We have these general key messages that we want you to understand the spirit of them, but it's not like you need to memorize it or anything."*

These differences in views could explain the variability in Service Provider responses, as some Service Providers indicated that they did not hear the messaging exactly as stated. It also suggests the possibility of variability within the delivery of the Prevention Conversation across the province, based on the role that messaging plays within individual Facilitators' presentations.



Continuing the Conversation

The findings from this evaluation inform a number of key recommendations to support continued implementation of the Prevention Conversation initiative. These recommendations are outlined below and operationalized when possible to provide examples of how to move forward and "continue the conversation".

1. The Prevention Conversation should be Responsive

Key to the ongoing success of this initiative is that the Prevention Conversation be responsive to the diverse needs of all its participants, including Facilitators, Service Providers, and the broader community (i.e. women, friends, families, partners).

Responsive to Facilitators

- **Establish a community of practice**. This is congruent with the relational approach of the overall FASD:PC and needs to be embedded in training and supports provided to Facilitators.
    - For example, organize two face-to-face meetings per year, incorporate a mentoring or peer partnership for Facilitators, and shift teleconference exchanges from being report-based to being theme-oriented should support solution-seeking conversations.
- **Diversify Training.** In recognition of the contextual responsivity of the FASD:PC, use of a variety of training mechanisms would enhance future training opportunities.
    - For example, a leveled training program (ideally online) comprised of different content modules could be created to respond to diverse needs, ongoing training needs, and geographic dispersion. This could permit opportunities for either preparatory training or follow up work, to support the in-person components.

Responsive to Service Providers

- **Be Attentive to Diverse Needs**. The FASD:PC needs to be responsive to its audience, which comprises many different subgroups of Service Providers.
    - It would be prudent for Facilitators to complete a needs assessment prior to their formal training sessions to ensure that content delivered meets the need of that group. Although some Facilitators report they are already doing this, a formalized process for needs assessments would increase consistency and capacity and set a standard for training delivery.
- **Build Capacity**. Service Providers report feeling unprepared in some areas (e.g. discussing family planning with clients), suggesting that one-time interactions with Facilitators may not be enough to prepare them for the FASD:PC. Access to ongoing supports after their interactions with Facilitators will be important for building Service Provider capacity.

- For example, providing mentoring and building ongoing relationships with service providers to support them as they experience challenges or struggle to initiate conversation in certain content areas. Also, it will be important to connect Service Providers with access to ongoing training and resources, to support their professional development.

Responsive to the Community

- **Create Community Partnerships.** The FASD:PC needs to be responsive to community needs, which will differ between Service Networks and geographical locations. This requires Facilitators to develop an in-depth understanding of the needs of their respective communities, through the establishment of community partnerships and communications with key community stakeholders.
    - For example, Facilitators can engage key community stakeholders in discussions about the best-fit for the conversation in their communities. They can hold broad-based presentations to introduce themselves and the services they offer on a large-scale, inviting feedback from and encouraging collaboration with community members.

2. Facilitators' Scope of Practice should be Prioritized.

- **Define Priorities of Role.** Our findings suggest that Facilitators are currently engaged in a wide variety of activities within their networks and communities, and that there is some confusion surrounding the priorities of their role when it comes to FASD awareness and prevention. The scope of practice of the FASD Prevention Conversation Facilitators therefore needs to be more clearly defined.
    - Decisions need to be made as to the priorities given to each task expected of a Facilitator. Decision makers need to prioritize Facilitators' time spent on presentations, awareness-raising activities, engaging community stakeholders, and in direct contact with Service Providers, ensuring that sufficient time is allotted for these activities.
    - It is recommended that high priority be assigned to all tasks that involve building relationships within communities and between Facilitators, and that Facilitators be consulted in this process for their views on effective use of their time.
- **Encourage Reflective Practice.** Facilitators would benefit from an emphasis on reflective practice, by taking time to reflect on the work they have done, and specifically how to identify and capitalize on their strengths in the work they do. As mentioned, there is great diversity in the backgrounds and skill sets of current Facilitators. It is therefore important that each individual understand his or her strengths and areas of limitation to ensure they are delivering the FASD:PC in a way that fits with their skills.
    - This could involve asking Facilitators to reflect on their work on a regular basis, perhaps weekly. Ideally Facilitators would be provided with a number of questions

to guide their reflections, and would have the opportunity to share their reflections with each other if they desire to do so.

3. Project Materials should be Accessible.

- **Accessible Materials.** It is important that Facilitators have timely access to materials, provided in multiple formats to support them in their prevention work with various Service Provider and community groups.
    - For example, the development of an online presence for this initiative would increase access to prevention messaging across the province. Providing online (digital) materials, in addition to currently existing materials, will ensure that there is a variety of mediums for Facilitators to choose from, further enhancing the customizability of their work to specific audiences. It will be important to maintain both online and printed resources to respond to the challenges involved in serving Alberta's remote communities, who often have inconsistent access to the Internet.
    - Having an online presence will also allow for the documents and materials that support the FASD:PC to be "living documents" – easily editable and readily updated without worrying about reprinting costs.
- **Relevant Materials.** In reviewing materials, it will be important to consider the audience materials are intended for and the relevance of these materials, in order to ensure that the needs of various populations across the province are being met in a sensitive manner.
    - For example, consideration of materials to support the delivery of the Prevention Conversation to Aboriginal populations, linguistically diverse populations, new immigrant populations, etc.

4. Long-term Funding should be Secured

- **Sustained and Predictable Funding.** The FASD:PC is a coordinated provincial initiative that is uniquely situated to respond to preventing FASD across Alberta. Securing long-term, sustainable funding will allow the FASD Service Networks to maintain this strong focus on FASD Awareness and Prevention (two of the FASD-CMC's strategic pillars). It will also encourage retaining staff, and allow Facilitators to more fully immerse themselves in the community, creating stronger relationships with Service Provider and community groups, and planning for long-term partnerships focused on prevention. The uncertainty of current funding makes this difficult and is a source of stress for Facilitators.
    - Advocate for the importance of prevention activities, and the long-term benefits of investing resources in this area to various project and provincial stakeholder.
    - Embed the Facilitator role and associated funding into the Service Networks' operating budgets, creating a more permanent position focused on community awareness and prevention activities.

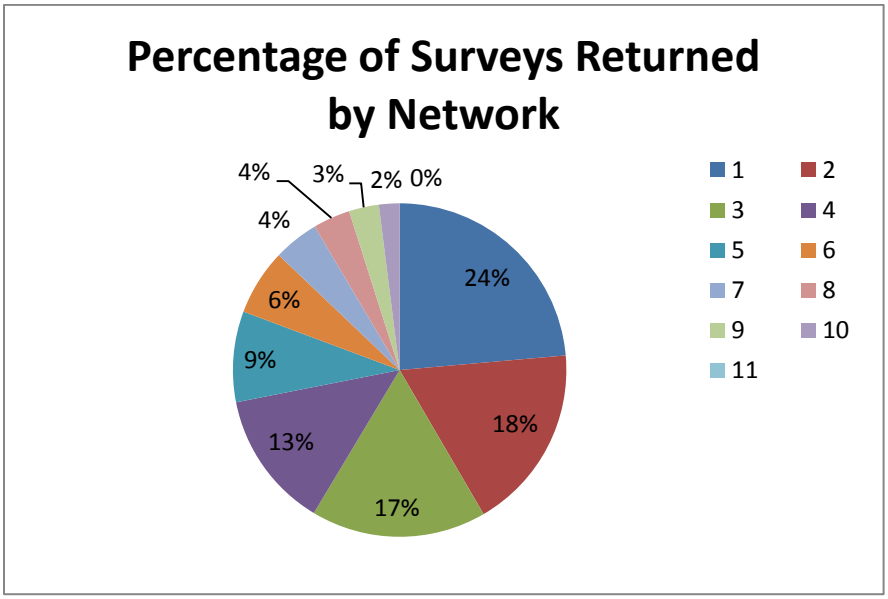
- Continue collecting evaluative data to provide evidence of the initiative's intended outcomes and impacts as it proceeds (see next section for recommendations for continued evaluation.

Current Limitations & Future Evaluation

Evaluation findings presented in this document must be understood in context, based on a number of limitations that were encountered. We present these limitations below, along with actions taken to mitigate these issues whenever possible and recommendations for overcoming them in the future. Limitations presented surround the representativeness of data collected, the exclusion of women as participants, potential selection bias for surveys, limited sample sizes for some analyses, and the time frame of the project.

Limited Generalizability of Findings

One of the chief limitations of this evaluation is the limited representativeness of the data presented and thus our limited ability to generalize findings across the entire province. This is based on the number of evaluation materials (i.e. contact logs, training summaries, completed surveys from Service Providers) returned from each of the FASD Service Networks. Unfortunately, Facilitators' engagement in the evaluation varied between Networks, and more than 70% of the surveys returned were from Facilitators in only 4 of the 11 Networks. One Facilitator failed to return any surveys.



A similar pattern holds for contact logs, where some Facilitators did not submit any of the requested materials. This means that the data presented may not accurately reflect the scope of the initiative across the entire province. While we expected to see some variability between Networks, based on the fact that the initiative was designed to look different across the province, this was beyond what was anticipated. We must therefore take caution in making statements about the state of the Prevention Conversation across the entire province of Alberta, as data from some regions is very limited.

Actions Taken. Frequent reminders were sent to Facilitators via email to encourage them to submit their materials on a monthly basis. When materials were not submitted, a member of the evaluation team followed up with individual Facilitators to discuss potential barriers and make a plan for submitting materials. Surveys were also revised two months into the initiative, to make them more feasible to administer for Facilitators and to encourage buy-in. Facilitators were also encouraged to contact the evaluation coordinator with any questions or concerns regarding evaluation materials. Despite these strategies, the representativeness of the data remains the main limitation of this Evaluation.

Moving Forward. The physical nature of the materials (i.e. printed surveys) may have presented a barrier for Facilitators, who were asked to submit completed surveys through the mail. In the future, consideration could be made for creating as many opportunities as possible for participants to provide data online, to minimize the workload of the Facilitator. The focus of data collection could also shift for ongoing evaluation, after this original pilot year, eliminating the need for such thorough data collection procedures.

Limited Inclusion of Perspectives

Another limitation lies in the fact that collecting data from women of childbearing age was outside the scope of the current evaluation. We were therefore unable to explore their perceptions of the initiative and the experiences they have had engaging with Service Providers. This is a key limitation, as one of the intended project outcomes in particular relates to the knowledge and perceptions of women (i.e. *Women of childbearing age are informed and aware of the risks associated with alcohol use in pregnancy in a non-judgemental way and of community resources and supports that are available to them*). Without speaking to this population, we are limited in our ability to provide evidence toward these outcomes.

Actions Taken. In order to mitigate this limitation, we have used a proxy measure for women's experiences. This means we have used what Service Providers report they discuss with women when they engage in the Prevention Conversation as a measure for what women are experiencing. While this is not an optimal way to assess these outcomes, it provides us with an estimate of how women are experiencing the Prevention Conversation until we can formally assess these outcomes.

Moving Forward. Although collecting data from women was originally conceptualized as part of this evaluation during the design phase, it was later deemed not feasible due to current resources. It is therefore recommended that future evaluation of the Prevention Conversation build on those original plans to include women. This could involve creating a simple online survey for members of the general public to complete or partnering with specific groups of Service Providers to recruit a sample of women to take part in a focus group to recount their experiences. Including women of childbearing age as participants will help to ensure the Prevention Conversation is moving toward accomplishing all of its intended outcomes.

Limited Ability to Compare among Groups

The overall sample size for the Service Providers who participated in the Prevention Conversation formal training was large (N≈880 matched pairs). However, within this large sample, the size for many of the subgroups of service providers were uneven (e.g. Emergency Services N=16, Front line workers = 260). These uneven sample sizes limited what we were able to do with the data, and made it impossible to analyze much of the data using inferential statistics in order to look at the significance of any differences that may have existed between groups. We are therefore limited in many instances to reporting aggregate data and descriptive statistics.

Actions Taken. We present findings largely using descriptive statistics, accompanied with visuals. Aggregate data is presented for items of interest, and differences between groups are noted, but are not implied to be significant. Additionally, we eliminated very small Service Provider groups from all analyses, to avoid presenting potentially misleading information (e.g. Government category had 2 members, so the means for items were not presented).

Moving Forward. With continued evaluation, survey collection from specific Service Provider groups could be emphasized in an attempt to even out sample sizes. Further consideration for how else Service Provider groups could be divided (e.g. by work setting instead of by professional title), may also allow for the creation of meaningful groups that are more balanced.

Limited by Voluntary Participation

It must be noted that we are limited in this evaluation by participants' willingness to participate, particularly in relation to the Follow-Up Survey for Service Providers. Service Providers who agreed to be contacted were emailed an invitation approximately 3-6 months following their training session. First, there could be something noteworthy about the group of Service Providers who refused to be further contacted. Second, the Service Providers who accepted the email invitation to participate may have in some way been different from those who chose not to.

Actions Taken. To encourage as many Service Providers to complete the surveys as possible, two follow-up reminders were sent, and participants were encouraged to respond with any questions or concerns.

Moving Forward. Unfortunately, this will always be a limitation inherent in data collection using surveys. In future evaluation efforts, additional data collection methods (e.g. focus groups) could be explored to gain a richer sense of Service Providers' experiences, and care could be taken to specifically select participants with varying experiences in an attempt to get a more detailed picture.

Limited by Time Constraints

As a final note, it is important to keep in mind that all of the data for this evaluation was collected within one year from the initiative start date. The findings presented in this document are therefore preliminary, as evidence toward intended program outcomes is just starting to emerge. Typically, we would only expect to see more long term outcomes after a program has been implemented for three to five years. As a result, we have only begun to capture some of the potential outcomes of this initiative.

Moving Forward. Continued evaluation of the Prevention Conversation will allow for monitoring and examining of emergent outcomes and short and long term outcomes as the initiative evolves and increases in scope.

Knowledge Mobilization

Due to the innovative nature of this FASD Prevention initiative, sharing findings from this evaluation is considered key to supporting ongoing Awareness and Prevention of FASD in Alberta and beyond. A number of activities have already been undertaken to disseminate findings to stakeholder groups, and there is opportunity for findings to be prepared and shared in a number of ways following completion of this evaluation.

Activities Completed to Date

- **Progress Updates:** Updates were routinely provided by members of the Evaluation Team during the monthly FASD-APC monthly meetings, and during the monthly Facilitator teleconference meetings. These updates included an overview of where the evaluation was currently at, any issues or concerns, and reminders to participants to submit surveys and other evaluation materials.
- **Interim Report:** A report was prepared for ACCFCR in April, 2014, to be included in the findings for the Year 7 Evaluation of the FASD-CMC 10-Year Strategic plan. Because this was early in the implementation of the project, the report included a review of activities completed to date, preliminary findings from Facilitator training, and an overview of the next steps in the evaluation.
- **Presentation at the 2014 Alberta FASD Conference:** Preliminary data were presented during a session at the Alberta FASD Conference on October 26, 2014. The presentation included an introduction to the initiative and the evaluation participants. Findings presented included a summary of Facilitators' experiences of their training, of their work in the Prevention Conversation, and an overview of next steps in the evaluation.
- **Final Report:** This document is the Final Evaluation Report. It was prepared to be submitted to ACCFCR and then to any other interested stakeholders as required.

Potential Future Activities

- **Presentations to Stakeholder Groups**: The opportunity exists for evaluation findings to be presented to various stakeholder groups, including the FASD-APC and other key project team members, and to the Facilitators, some of whom have expressed interest in learning more about the evaluation and its outcomes.
- **Conference Presentations:** Conference presentations will be developed and submitted to a variety of local, provincial, national, and international conferences, both FASD-specific and otherwise, to share the findings with other researchers, professionals, and the larger community, including individuals affected by FASD.
- **Academic Publications:** As this program is an innovative approach to FASD awareness and prevention, and there has been a wealth of information collected for this evaluation, there is the opportunity to publish the findings in academic journals to contribute to the literature in this area. Publication outlets for consideration include those with a focus on FASD research and prevention, program evaluation, mixed-methods research, and applied psychology journals.

The above knowledge mobilization strategies will create ongoing connection and discussion around FASD Awareness and Prevention in Alberta and would support the efforts of the FASD Prevention Conversation moving forward.

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Appendix A: The ACCERT team

The **A**lberta **C**linical and **C**ommunity-based **E**valuation **R**esearch **T**eam (ACCERT) was co-founded in 2009 by Drs. Cheryl Poth and Jacqueline Pei. The University of Alberta-based team involves faculty and graduate students (referred therein as associates) from the Department of Educational Psychology within the Faculty of Education. We specialize in community-involved program evaluation and applied social research with a focus on building capacity both within our University-based team and with the clients and stakeholder organizations we work with. Since our inception, the team has been involved in small, single-site evaluation and research projects (e.g., not-for-profit organizations) as well as several large-system level projects involving provincial governments. Capitalizing on the diverse expertise across team members, we have worked in a wide variety of sectors, such as education, justice, social services, health care, mental health, and early childhood development. We have also worked with programs for traditionally marginalized populations and communities, including youth, women, Aboriginal groups, and people with disabilities.

ACCERT's faculty and associates are recognized experts within the evaluation field, research methods, and content areas ranging from Fetal Alcohol Spectrum Disorders (FASD) to classroom assessment. In addition to more traditional summative (i.e., outcomes-oriented) evaluations we also offer expertise in formative (i.e., improvement-oriented) evaluations and developmental (i.e., innovative-oriented) evaluations. The faculty regularly deliver presentations and workshops to other evaluators, practitioners, and scholars at conferences focused on evaluation (e.g., American Evaluation Society, Canadian Evaluation Society), research methods (e.g., International Institute for Qualitative Methods, American Educational Research Association) and content areas (e.g., Canadian Society for Studies in Education, International Conferences on FASD). Finally, faculty teach graduate level methods and evaluation-focused courses.

Cheryl Poth, PhD, is a faculty member of the Center for Research in Applied Measurement and Evaluation within the Department of Educational Psychology at the University of Alberta. She teaches the doctoral level program evaluation course within the graduate program and coordinates the undergraduate classroom assessment course in the pre-service teacher education program. Cheryl brings over a decade of evaluation experience including working with school boards, post-secondary institutions, and Federal organizations in the areas of Educational programs and Health Services. She has expertise in qualitative, quantitative, and mixed methodologies. She is an active member on committees associated with the Canadian and American Evaluation Associations (CES and AEA) and a regular contributor to their annual conferences and publications. She is the current National Council member for Alberta-NWT Chapter for CES and is a member of the professional development committee within this Council. Among several professional memberships, she holds a CES "credentialed evaluator" designation. Her research interests include evaluation use with particular emphasis on developmental and participatory evaluation approaches.

Jacqueline Pei, PhD, contributes her strong background in clinical and collaborative practice with multiple community organizations. Operating from a scientist-practitioner perspective, Jacqueline has extensive experience working with community and research teams to examine ways in which evaluative information may be translated to effective practice. She has been principal investigator for community (e.g., Fetal Alcohol Syndrome Society Yukon), clinical (e.g., BC Provincial Health Authority), and research (e.g., Alberta Centre for Child, Family, & Community Research) based grants, and is skilled at translating key information between these varied stakeholders in a way that leads to positive program impacts. Jacqueline began her career as a criminologist and forensic counselor working with incarcerated youth. Motivated by this early work, she returned to academia to study youth at risk, child development, and neuropsychology, leading to her current focus on intervention programs and strategies for youth and adolescents at-risk. Continuing with her clinical practice, Jacqueline joined the University as an assistant professor in the department of Educational Psychology. In this role she provides clinical training for graduate level students, emphasizing the role of evaluation within applied practice. Dissemination of research findings is pursued in research and community settings, as well as publicly accessible venues (e.g. FASD Learning Series, available online at http://www.fasd-cmc.alberta.ca/).

Erin Atkinson is a third year doctoral student in the School and Clinical Child Psychology (SCCP) program at the University of Alberta, and project coordinator of the evaluation for the Prevention Conversation. She developed an interest in program evaluation after taking a course with Dr. Cheryl Poth, and has since been involved in designing and implementing a number of program evaluations, including the 5-year evaluation of the FASD-CMC 10-Year Strategic Plan, in 2012. She has experience in both quantitative and qualitative data collection and analysis, and has a specific interest in mixed methods research design. Erin is very interested in the area of FASD prevention and the education of children with FASD. Her doctoral research focuses on preparing pre-service teachers to work with students with FASD in their future classrooms, through the use of attributional retraining interventions.

Amanda Radil brings over 6 years of experience in a variety of research and applied settings, including academic and community-based contexts, to her work on the FASD Prevention Conversation. Amanda is currently a doctoral student in School and Clinical Child Psychology at the University of Alberta, where her research focuses on developing an instrument to explore the motivational practices that teachers use in the classroom. She sees evaluation as a valuable and integral part of her overall strengths-based clinical practice and is interested in using empowerment evaluation as an approach to help build capacity in organizations. Amanda brings specialized skills in research design, survey design and quantitative data collection and analysis to the current evaluation as well as content area knowledge in social psychology and educational psychology. Additional areas of interest include neurodevelopmental disorders (e.g. ADHD, FASD), mixed methods research and positive psychology.

Erin Buhr is a second year doctoral student in the Counselling Psychology program at the University of Alberta. Much of her experience comes from direct work in counselling, where she has worked primarily with individuals with depression, anxiety, and a history of trauma. Previous to her degree, she worked one-on-one with individuals with FASD to determine realistic lifestyle opportunities in order to assist them in living as healthily and independently as possible. She has graduate training in Program Evaluation, and has also assisted with numerous research projects involving qualitative data collection methods and analyses. Erin is a strong believer in education in order to reduce the probability individuals will develop mental health issues and concerns, and works from a harm-reduction and prevention-based philosophy.

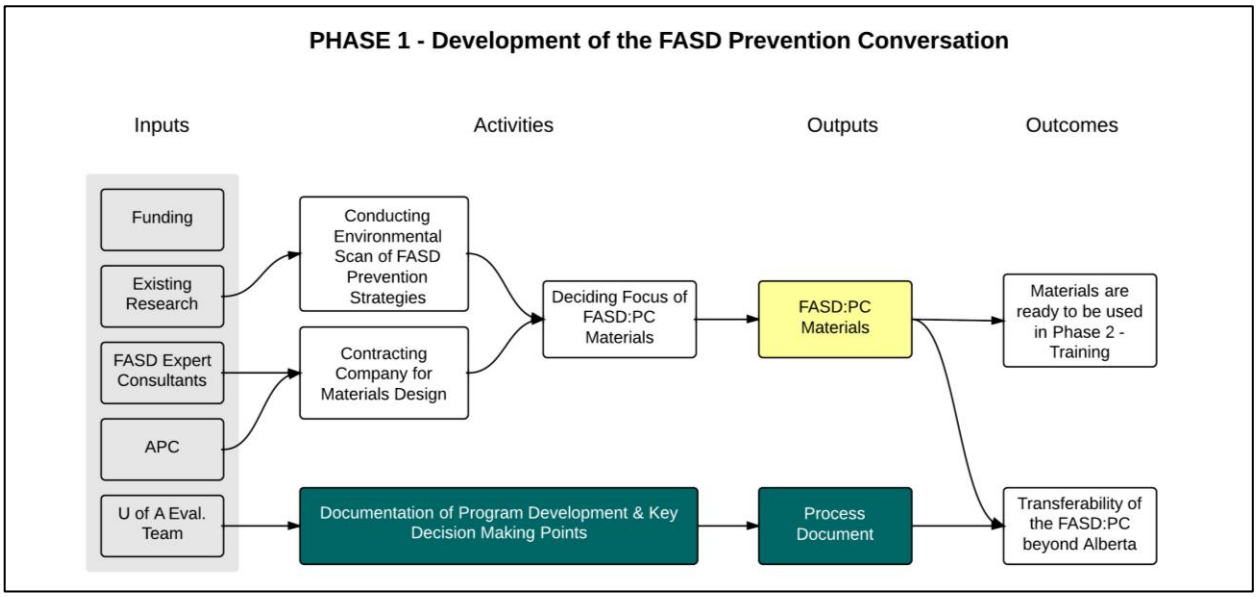
Melissa Tremblay is a first year doctoral student in the School and Clinical Child Psychology (SCCP) program at the University of Alberta. Melissa brings a strong background in participatory evaluation methods to her work on the Prevention Conversation. Previously, Melissa worked for two years as a lead evaluator in the Alberta Health Services Edmonton zone for the Alberta Children's Mental Health Action Plan. Melissa is currently a lead evaluator for community-based substance abuse prevention programs in Indigenous communities, and works as an evaluation consultant for a number of community-based programs and agencies. Melissa also brings graduate-level training and extensive experience in qualitative research methods and evaluation, having participated in data collection, analysis, and the preparation of manuscripts for a number of qualitative and mixed-method projects. In addition, Melissa brings applied experience in working with vulnerable youth in community and hospital settings.

Helena Dayal is a second year doctoral student in the Counselling Psychology program at the University of Alberta. Helena's academic background is in counsellor education and training, and the mental health and wellness of counsellors and counsellors-in-training. Helena has worked extensively in the area of qualitative research across disciplines (i.e., educational psychology, nursing, medicine) and has graduate training in program evaluation. Previously, Helena has worked on a community-based level with individuals who have eating disorders. She has run psycho-educational groups, and advocates for awareness and improved services for individuals with eating disorders in her work as a board member of the Eating Disorder Council of New Brunswick. In her counselling practice, Helena has worked primarily with the university student population to address both mental health and career needs.

Appendix B: Program Logic Models

Logic models were developed to visualize the inputs, activities, outputs and outcomes of each of the three phases of the FASD Prevention Conversation: Development, Training & Preparation, and Implementation.

Phase 1 – Development of the FASD Prevention Conversation



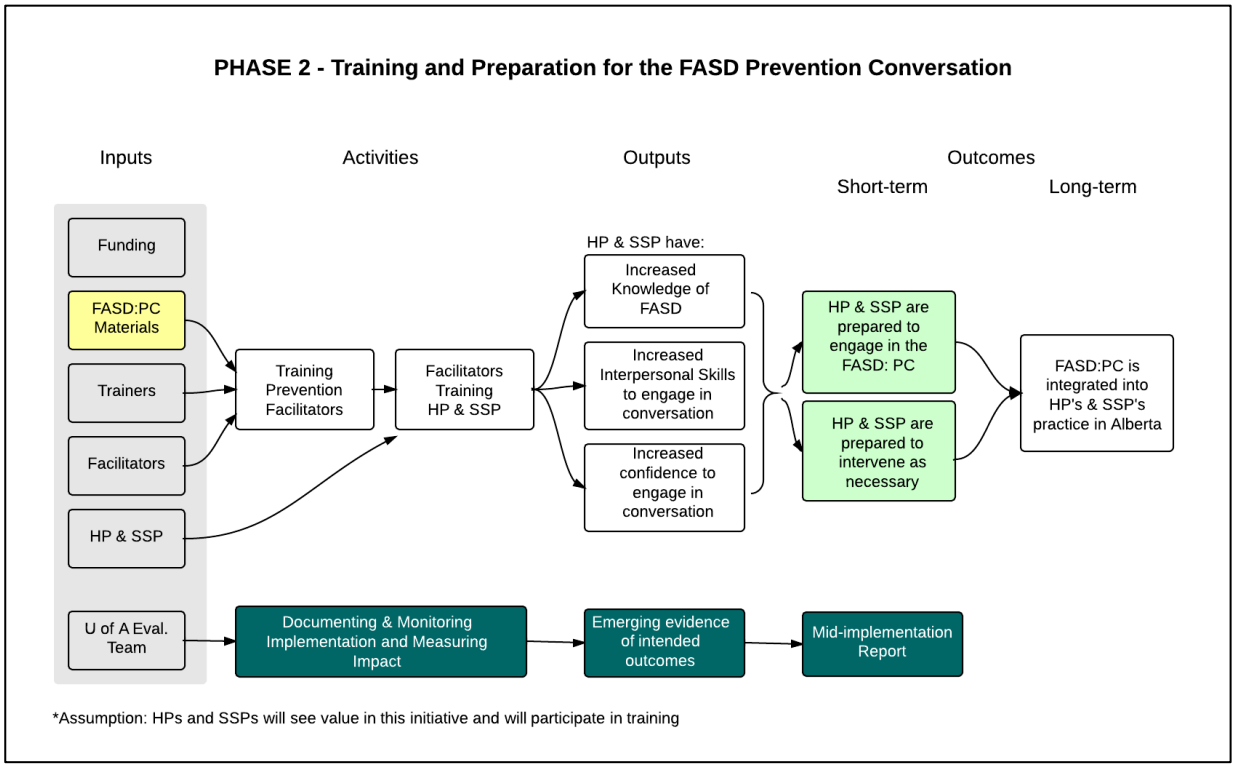
Inputs. Resources invested in the development of the FASD:PC include funding provided by the FASD-CMC, existing FASD prevention research, and human resources. The funding supports the hiring of the Evaluation Team (ACCERT), and supports the FASD-APC and its consultants in completing a number of program activities, such as reviewing existing research and in hiring a marketing firm (TWIST Marketing) to develop FASD: PC materials, which are discussed more thoroughly in the next section.

Activities. Two key activities are involved in the development of the FASD:PC. First, a comprehensive environmental scan of existing FASD prevention strategies was conducted to determine best practices and to identify key requirements and recommendations for developing the FASD:PC to ensure it is strongly rooted in research and is evidence-based. Secondly, the FASD-APC contracted a marketing firm (TWIST Marketing) to design the FASD:PC materials and training. Working in partnership, the FASD-APC, and Twist Marketing determined the focus and scope of the FASD: PC. Throughout this process, ACCERT will document key decision making points and aid in embedding evaluation principles into the design and development of the program.

Outputs. The project activities (environmental scan and contracting TWIST) lead to the development of the FASD:PC materials and training resources. The marketing firm, TWIST, will produce materials to train the Prevention Conversation Facilitators, including the training session itself. They will also produce materials and resources to be used by health-care and social service providers in the conversations with women of childbearing age. Throughout this process, ACCERT will provide the FASD-APC with a process document detailing the development of the FASD:PC,

with a focus on key decision-making points and things to consider to inform transferability of the program.

Outcomes. The direct outputs of Phase 1 of the FASD: PC will contribute to the intended project outcomes. First and foremost, the developmental of the materials will lead to them being available for the training and implementation phases of the project, detailed below. In terms of the process documentation, as with any innovative program, it is expected that the development of the FASD: PC will serve as a model for other programs, organizations, and areas that want to integrate FASD awareness and prevention into their mandate. It is expected that the transferability of the FASD: PC to other geographical areas and jurisdictions will be facilitated as a result of having an embedded developmental evaluation completed with project documentation from the beginning.



Phase 2: Training of Facilitators and Health & Social Service Providers

Inputs. Training healthcare and social service providers to engage in the FASD: PC will require funding, the conversation materials, and human resources. Funding to support the training will be provided by the FASD-CMC. This funding will cover the costs of FASD: PC materials, training events for facilitators and healthcare and social service providers. Funding will also support the ACCERT evaluation team who will continue to document the program development and measure emerging outcomes of training. Human resources for the training will include the trainers (TWIST Marketing), the Prevention Conversation Facilitators (12 total), and Health and Social Service Providers.

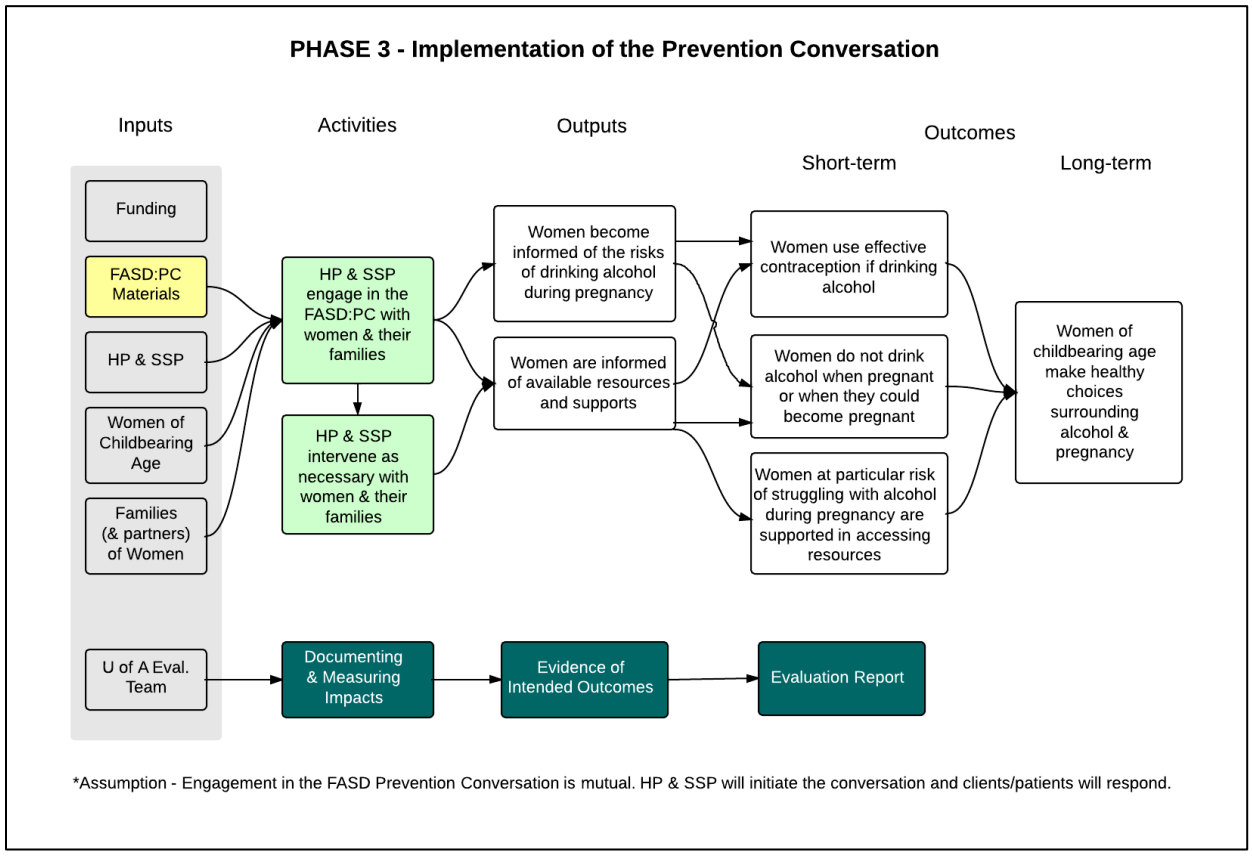
Activities. There are two main activities in Phase II of the FASD: PC program. First, TWIST Marketing will engage the 12 Prevention Conversation Facilitators in training for the FASD:PC. This training will take place across two days and will include information on FASD, a review of conversation materials, and training in community engagement, among other things. Secondly, upon completion of this training, the Prevention Conversation Facilitators will be responsible for working with and training healthcare and social service providers to engage in the FASD: PC with women of child-bearing age and their partners/families. Throughout the training process, ACCERT will be monitoring the implementation of the FASD:PC and collecting data to measure intended outcomes.

Assumption. In order for the activities listed above to lead to the Phase 2 intended outcomes, an assumption must be met. It is assumed that healthcare and social service providers will see value in the FASD: PC and will participate in training events. As this training is not mandatory, a lack of interest in the FASD:PC on the part of health and social-service providers would severely limit this project's ability to achieve intended outcomes and longer term impacts.

Outputs. There are three expect outputs of the training phase. After training, healthcare and social service providers will have: (1) increased knowledge of FASD, (2) increased interpersonal skills to engage in the FASD: PC, and (3) increased confidence to engage in the FASD: PC. Moreover, during this phase emerging evidence of intended outcomes related to training will be gathered by ACCERT.

Outcomes. The direct outputs within Phase 2 of the FASD: PC will lead to the intended outcomes. As with the implementation of many new programs, it is expected that certain outcomes will be more immediate, or short term, while others may take longer to emerge. For short-term outcomes, it is expected that upon completion of training, healthcare and social service providers will be (1) prepared to engage in the FASD: PC with women of child-bearing age, and (2) prepared to intervene as necessary to provide resources and supports to their clients/patients as needed. In terms of long-term outcomes, it is expected that the FASD: PC will be integrated into healthcare and social service providers' regular practice in Alberta. At this point in the evaluation process, ACCERT will complete their evaluation of the training component and provide stakeholders with a mid-implementation report detailing findings related to the emerging outcomes.

Phase 3: Implementation of the FASD Prevention Conversation



Inputs. The implementation of the FASD: PC will continue to require the same elements as Phase 2 (i.e., funding, FASD:PC materials, and human resources), with the addition of women of childbearing age and their support systems (i.e., partners, families, friends). The FASD-CMC will continue to provide funding for FASD: PC materials to be used by healthcare and social service providers during the prevention conversation with women of child-bearing age and their families/partners, as well as for ongoing evaluation services provided by the Evaluation Team (ACCERT).

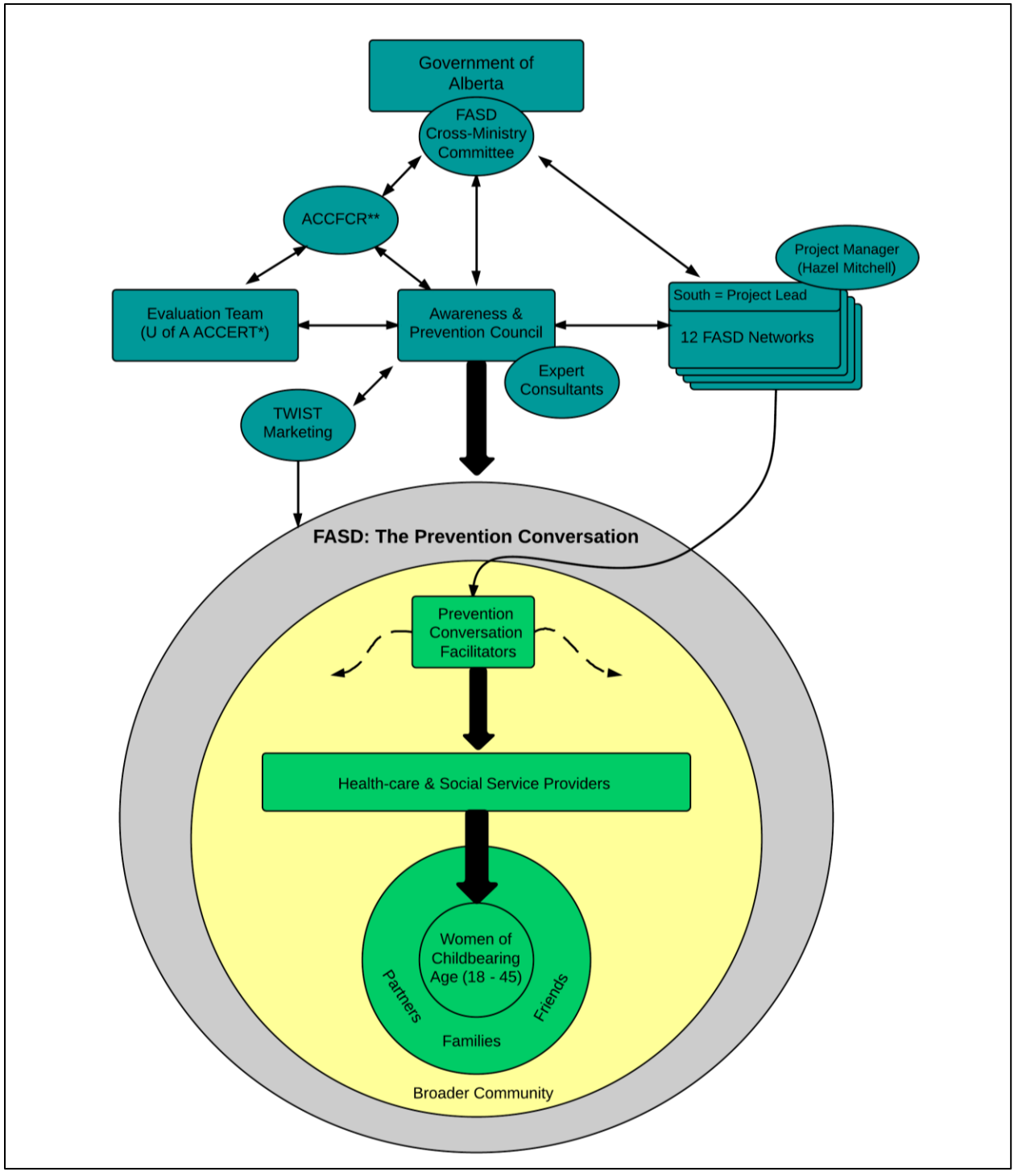
Activities. There are two main activities in Phase 3 of the FASD:PC. First, healthcare and social service providers will engage in the prevention conversation with women of child-bearing age and their families/partners. Second, healthcare and social service providers will intervene as necessary to provide women with resources and supports related to alcohol and pregnancy as needed. As in previous phases, ACCERT will continue documenting and measuring impacts of the FASD: PC by collecting data from all parties involved. This will include the Prevention Conversation Facilitators, health and social service providers, and women of childbearing age.

Assumption. An effective conversation is one in which both parties are engaged. It is therefore important that both health and social service providers, as well as their clients, are mutually engaged in the Prevention Conversation. It is assumed that health and social service providers will initiate the conversation and that the clients will respond. If one or both parties is not engaged, the FASD:PC will be severely limited in its ability to reach intended outcomes and longer term impacts. This assumption will be tested as part of the evaluation.

Outputs. Given that service providers and clients are mutually engaged in the conversation, two direct outputs can be expected from the activities discussed above. After engaging in the FASD: PC with healthcare and/or social service providers, women of child-bearing age will be: (1) informed of the risks associated with drinking alcohol during pregnancy, and (2) informed of available resources and supports should they require assistance with alcohol and pregnancy. During this phase, ACCERT will continue to collect data as evidence of intended outcomes emerges.

Outcomes. As women become informed about FASD and available supports and resources, it is expected that this will lead to both short- and long-term outcomes, similar to Phase 2. In terms of short-term outcomes, it is expected that after engaging in the FASD: PC women of child-bearing age: (1) will use effective contraception if drinking alcohol to prevent alcohol-exposed pregnancies, (2) will not drink alcohol when pregnant or when they could become pregnant, and (3) that women at particular risk of struggling with alcohol use during pregnancy will be supported in accessing the resources they need. In time, it is expected that these short-term outcomes will lead to women of child-bearing age generally making healthy choices surrounding alcohol and pregnancy.

Appendix C: Stakeholder Map & Descriptions



Initiative Participants

Stakeholders who are of primary focus in this evaluation are those for whom the Prevention Conversation is being developed to directly support. In other words, they are the target audience for the project; they include the Prevention Conversation Facilitators, Health and Social Service Providers, and women of childbearing age (18 to 45 years old), their partners, families, and friends.

Prevention Conversation Facilitators. Facilitators were hired of the 11 geographical FASD Service Networks. These Facilitators delivered presentations and training opportunities to Healthcare and Social Service Providers, with the goal of preparing them to engage women of childbearing age, and their support networks, in supportive and non-judgemental conversations about alcohol and pregnancy. Additionally, their role included engaging other community members (i.e. the general public) to raise awareness about FASD and its prevention. For demographic information about Facilitators hired for this initiative, see *Introduction to Facilitators & Service Providers.*

Service Providers. Healthcare and Social Service Providers received training from Facilitators, through formal presentations and/or more informal conversations, about FASD prevention strategies and how to engage their clients (i.e., women, partners, families, and friends) in the Prevention Conversation. For more information on the variety of Service |Providers engaged in the Prevention Conversation, see *Introduction to Facilitators & Service Providers.*

Women of Childbearing Age. Women of childbearing age, both those who are pregnant and not currently pregnant, are the target audience of this initiative. The FASD Prevention Conversation is intended to engage these women in supportive discussions with healthcare and social service providers to increase their awareness of the risks of drinking alcohol while pregnant and its impact on fetal development. For women who are not yet pregnant, the conversation can also involve discussion of family planning and contraception as a means to prevent FASD. These women are members of the general public, from all socio-economic, educational, cultural, and ethnic backgrounds. Although the conversation may be tailored to suit the needs of various populations as needed, there is no focus on specific subgroups or "at risk" populations of women for this conversation. It is intended that all women of childbearing age in Alberta are engaged in the Prevention Conversation.

Partners, Families, and Friends. Partners, friends, and family are recognized as playing a crucial role in supporting women of child bearing age in their decision-making surrounding alcohol and pregnancy. They may be engaged in the Prevention Conversation directly with the women they support, through healthcare and social service providers, or directly by Prevention Conversation Facilitators to help support their partner/friend/family member. They may also be involved in supporting the Prevention Conversation by raising awareness about FASD prevention, as they are members of the community.

The Broader Community. Community members, and the community-at-large, play a role in the Prevention Conversation as they are the target of FASD awareness and prevention messaging. Although not the primary focus of the initiative, community members play a key role in working to change the overall perceptions of the general public in terms of FASD prevention, and the role they can play in supporting women. By engaging the broader community in this initiative, Facilitators strive to create a safe and non-judgemental environment for conversations about alcohol and pregnancy without the stigma often associated with this topic. The exact scope of community engagement will be largely dependent on the needs of the area in which the Facilitators are working, their ability to engage community stakeholders, and community interest in the topic of FASD Prevention.

Supporting Stakeholders

The stakeholders who support the program are responsible for funding, developing, implementing, and evaluating the program. These stakeholders have made a commitment to the FASD Prevention Conversation and have an interest in FASD awareness and prevention efforts across the province. They include the Government of Alberta through the FASD-CMC, the Alberta Centre for Child, Family, and Community Research (ACCFCR), the FASD-APC, Expert Consultants, the 12 FASD Service Networks, Twist Marketing, and the Evaluation Team (ACCERT).

The FASD-CMC. The FASD-CMC represents the funders (i.e., the government), and is comprised of representatives from different government ministries and was established in 2002 to oversee FASD prevention and support programs throughout Alberta; it is responsible for making funding and program development decisions for all FASD Service Networks in Alberta in accordance with the FASD 10-Year Strategic Plan (see Program Context section). The FASD-CMC addresses the need to provide a coordinated approach to FASD service delivery and prevention across the province and focuses on developing and delivering community-based programs that are supported by government policy and funding.

The ACCFCR. The Alberta Centre for Child, Family, and Community Research (ACCFCR) is a not-for-profit organization established in 2003, as a partnership between Alberta's universities, communities, and the Government of Alberta. The purpose of the Centre is to support and disseminate research knowledge and evidence related to improving the well-being and health of children in Alberta. For this project, the ACCFCR is involved as the funding managers for the evaluation component of the project. They are responsible for overseeing the funding distribution and completion of evaluation deliverables.

The FASD-APC. The FASD-APC is comprised of representatives from government ministries, the FASD Service Networks, and expert consultants. Their vision is to proactively support FASD prevention in the province of Alberta by establishing it as a shared responsibility among many stakeholder groups. They support the 12 FASD Service Networks in their prevention efforts through the development of common messaging, education, and training opportunities. Prevention of FASD is approached with a strategy that is women-centered, harm-reduction

oriented, and focuses on collaborating and walking with women to prevent FASD, rather than placing blame. Currently, the FASD Prevention Conversation initiative is their primary focus, with plans to take on new and innovative projects in the near future.

Expert Consultants. As noted above, expert consultants who have significant expertise in the areas of FASD awareness and prevention from throughout Alberta and across the country have been invited to sit on the FASD-APC. These individuals are an important resource for the FASD:PC, as they provided input and feedback on the Prevention Conversation training and materials, and helped ensure that FASD best practices were incorporated into the FASD:PC framework.

The 12 FASD Service Networks. The FASD Service Networks support and coordinate access to services for Albertans affected by FASD. They are comprised of a network coordinator and service providers who fill various roles (e.g. mentor, educators, and advocates). Each network was responsible for hiring one Prevention Conversation Facilitator to engage Service Providers in a dialogue about integrating FASD prevention into their practice and provide training for the FASD:PC. The South FASD Service Network (in Lethbridge) coordinated the development and implementation project under the leadership of Hazel Mitchell, **Project Manager** for the FASD:PC. The South Network also acted as a 'Banker' for the development and implementation elements of project, ensuring that funding was delegated and used as intended.

TWIST Marketing. TWIST Marketing is a Calgary-based marketing firm that specializes in branding, destination marketing, online marketing, and marketing research. TWIST was contracted by the FASD-APC to brand, design, and create the materials for the Prevention Conversation to ensure the FASD:PC has a unique, consistent, and visually appealing look and feel. They worked closely with a number of the FASD-APC members to establish a vision for the conversation and developed materials for the conversation itself, as well as supporting materials and resources for training the prevention conversation facilitators. TWIST also led the training of the facilitators.

Evaluation Team. The Alberta Clinical and Community-based Evaluation and Research Team (ACCERT) is a University of Alberta based team composed of faculty and graduate students from the Department of Educational Psychology within the Faculty of Education. They specialize in community-involved program evaluation and applied social research, and focus on building capacity both within the University-based team and with the clients and stakeholder organizations with whom they work. They were contracted to design and undertake an evaluation of the FASD:PC as it is developed and implemented. This included documenting the development of the initiative by noting key decision-making points, identifying and operationalizing outcomes, and collecting and analyzing data as the project was implemented to measure intended outcomes.

Appendix D: Quantitative Methods

Quantitative methods were employed due to their feasibility and cost-effectiveness in reaching a large amount of participants in a short amount of time. In addition these methods produce information that is most commonly represented by numbers and statistics which is an effective way of communicating outcomes to key stakeholder groups, such as project funders who are interested in results-based budgeting (Government of Alberta, 2012).

Quantitative Data Sources

Survey Responses. Survey use is commonly used in evaluation due to its efficiency in gathering large amounts of information within in a short period of time for generating information related to patterns and trends related to selected populations (Vogt, 2007). For the purposes of this evaluation, multiple surveys were developed to be delivered to two participant groups (i.e. Facilitators and Service Providers) at various points in time throughout the first year of the implementation of the FASD:PC. A combination of rating scales and demographic items provided quantitative data for analysis. Surveys also occasionally included questions with open-ended responses, which collected qualitative data from participants. Responses to these questions are further discussed in Qualitative Methods. Surveys were designed to take no longer than 10 minutes to complete and were written in simple language to make them accessible to multiple audiences and to encourage a high response rate. A summary of which surveys were administered to which participants at various time points is provided below in Table 21, and copies of all survey items are included.

It is important to note that the Pre-Training and Post-Training Surveys for use with Service Providers were redrafted in February 2014 to respond to Facilitator concerns that these questionnaires were taking too long for Service Providers to complete; questionnaires were shortened by removing items that were related to satisfaction with training, some demographic variables, and other non-essential items.

Table 21. Overview of Survey Participants and Time Points

Data Sources	Pre-Training Survey	Post-Training Survey	Informal Survey (Online)	Follow-Up Survey (Online)
Facilitators	**N=11** (Dec 2013)	**N=8** (Dec 2013)		**N=10** (Jan 2015)
Service Providers	**N=1073*** (Jan-Dec 2014)	**N=1033*** (Jan-Dec 2014)	**N=211** (Jan-Dec 2014)	**N=116** (June-Dec 2014)

*Note: Of these Service Provider surveys, approximately 880 are matched pairs (i.e. the same individual completed both pre- and post-surveys).

Pre-Training Surveys were administered to both Facilitators and Service Providers who were engaged in formal training, either by the Training Team or a Facilitator, to gather baseline information about the knowledge, beliefs, and previous experiences of individuals coming into the FASD:PC training.

Post-Training Surveys, with similar questions to the Pre-Training Surveys, were administered to Facilitators and Service Providers immediately following training sessions to measure potential change in knowledge and beliefs. In addition, the Facilitator version of this post-measure included a section for general feedback about the training. This section regarding satisfaction with training was originally included on Service Provider surveys, but was removed when surveys were redrafted in February 2014.

An Informal Survey was made available online for Service Providers to complete after more "informal" interactions with a Facilitator, or when the completion of pre- and post-surveys was not possible due to time constraints. Service Providers were provided with a link to an online survey in their follow up contact with the Facilitator, where they were invited to answer questions that were similar to, but somewhat more general than, the Post-Training survey.

Follow-Up Surveys were administered to both Facilitators and Service Providers who agreed to be contacted. Facilitators completed their follow-up surveys in January 2015, after delivering the Prevention Conversation for one year. Service Providers received a link to an online follow-up survey approximately 3-6 months after their original interactions with a Facilitator. The purpose of the follow-up Service Provider survey was to see if Service Providers were incorporating aspects of the Prevention Conversation in their practice, and what barriers existed to doing so.

Quantitative Analyses

Descriptive Statistics were the most effective way to analyze much of the quantitative data, and include means, ranges, frequency counts, etc. These are often presented in visual formats within the evaluation report. For example, a bar graph visually communicates how much experience FASD:PC facilitators had with the topic of FASD prior to their training. These visuals are helpful in communicating results back to all stakeholder groups, including the general public. Moreover, within this descriptive analysis, stakeholder groups were further divided into subgroups based on their answers to the demographic questions, as it was meaningful to do so. For example, similar analyses can be completed for clinicians, nurses, and social workers to compare items of interest between groups. This allowed for comparisons to be made both within and across groups of participants in the FASD:PC in order to develop an understanding of the impact that it is having in multiple areas.

Inferential Statistics were also used to draw inferences from the data, as was appropriate. These statistics included correlations, regression analyses and ANOVAS, and allow us to compare our measures between various groups of Prevention Conversation participants (e.g. differences between clinical individuals and social workers on variables of interest) as well as participants to themselves. Moreover, these procedures also allow us to examine the relationships between variables. Correlations are a statistical technique used for examining the associations between constructs or variables of interest (only two). An Analysis of Variance (ANOVA) is a set of statistical techniques that are used to compare the differences between group means and thus enable us to see whether or not a difference between groups is meaningful. Finally, Regression is a statistical process for examining the relationships between multiple variables or constructs and is often used to help with the prediction of a specified outcome.

Quantitative Results

Statistics are not provided within the write-up for evaluation findings, to ensure the readability and accessibility of the findings for a variety of audiences. Key statistical information is therefore presented below, for your reference.

Descriptive Statistics

The following tables present the descriptive statistics for the items that are reported in the body of this evaluation report. A mean represents the average score for this item across all participants. The Standard Deviation is a measure of the amount of variation within a set of responses. Minimum and maximum values are the smallest and largest reported values for each item, respectively. Finally, "n" represents the number of participants whose data was used in these calculations and possibly included in inferential statistical analyses. For example, in Table 5 below, 11 Facilitators completed all pre-measures, while only 8 completed the post-measures.

Table 5. Facilitator Descriptives

Item		Mean	Standard Deviation	Minimum	Maximum	n
Pre	Knowledge	6.36	3.01	2.00	10.00	11
	Comfort	8.18	2.56	2.00	10.00	11
	Preparation to Engage	7.36	2.94	2.00	10.00	11
	Confidence	7.73	2.28	3.00	10.00	11
	Belief in Convo	8.82	1.33	6.00	10.00	11
Post	Knowledge	7.88	2.64	3.00	10.00	8
	Comfort	8.88	1.72	5.00	10.00	8
	Preparation to Engage	7.75	1.91	5.00	10.00	8
	Confidence	9.00	.76	8.00	10.00	8
	Belief in Convo	9.00	1.07	7.00	10.00	8

Table 6. Service Provider Descriptives

Item		Mean	Standard Deviation	Minimum	Maximum	n
Pre	Knowledge	5.65	2.21	1.00	10.00	963
	Belief in Role	8.56	1.92	1.00	10.00	1073
	Important Aspect of Work	7.62	2.53	1.00	10.00	1070
	Belief in Convo	8.17	1.91	1.00	10.00	1077
	Self-Efficacy	8.03	2.13	1.00	10.00	1075
Post	Knowledge	7.53	1.66	1.00	10.00	917

	Belief in Role	8.88	1.64	1.00	10.00	1033
	Important Aspect of Work	8.41	2.04	1.00	10.00	1028
	Belief in Convo	8.82	1.53	1.00	10.00	1031
	Self-Efficacy	8.70	1.60	1.00	10.00	1033
	Confidence	8.15	1.67	1.00	10.00	1034
	Prepared to discuss family planning	7.95	2.09	1.00	10.00	1008
	Prepared to discuss resources	8.55	1.70	1.00	10.00	1020
	Prepared to Intervene	8.36	1.73	1.00	10.00	1027
	Practical	8.32	1.99	1.00	10.00	1021
	Relevant	8.26	2.11	1.00	10.00	1015
	Intentions to Incorporate	8.61	1.68	1.00	10.00	1020
	Intentions to Engage	8.41	1.81	1.00	10.00	1018

Repeated Measures ANOVA Results

Findings from the following Repeated Measures ANOVA tests were reported on in the *Preparing for the Conversation* section. These tests assess the differences between individuals' own scores on the items of interest prior to training and post-training and allow us to speak to whether or not there are statistical and/or meaningful differences between these beliefs. In order for their data to be included in these analyses, participants' data had to be matched between pre and post surveys based on a personalized code. Some participants did not provide a code, did not complete both pre and post measures, or had codes that were unable to be matched; their data is thus not included in these analyses. Statistics are presented in Table 7.

Table 7. ANOVA Results for Findings Related to Preparing for the Conversation.

Question		df	*F*	*P*	η^2
Facilitators	Knowledge	7	4.12	.08	.37
	Comfort	7	.57	.48	.08
	Confidence	7	5.64	.05	.45
Service Providers	Knowledge	799	793.91	< .05	.50
	Belief in Role	884	38.80	< .05	.04
	Important Aspect of Work	879	186.58	< .05	.18
	Belief in Convo	883	133.73	< .05	.13
	Self-Efficacy	883	133.82	< .05	.13

Regression Results

A regression analysis was completed to examine potential predictors of Service Providers' intentions to engage in the Prevention Conversation following training. The importance that Service Providers place on FASD prevention in their work and their personal belief that they can have a conversation with a woman that impacts her decision making around alcohol and pregnancy emerged as predictors of their intentions to engage. About 40% of the variance in SSPs intentions to engage can be explained by these two predictors (See Table 8).

Table 8. Regression Results for Intentions to Engage in the FASD:PC

Variable	*B*	SE *B*	*β*	*t*	*p*	Regression
Step 1						
Constant	2.20	.27		8.08	.00	
Important Aspect of Work	.338	.03	.38	11.37	.00	R = .63 R^2 = .40
Belief in Role	-.03	.04	-.02	-.67	.50	Adj. R^2=.40
Self-Efficacy	.42	.04	.37	11.92	.00	

Appendix E: Facilitator Surveys

FASD Prevention Conversation Pre-Training Survey (December 2013)

Tell us about yourself and your previous experience

Please Note: The following demographic information will be used for matching purposes to collect data within your service network for the evaluation of the FASD Prevention Conversation. This data will only be viewed by the evaluation team – your network will not receive specific information about your answers. Data in the evaluation report will be provided in general, and will not name results or statistics for specific networks. In this way, your responses here are confidential.

A. Your FASD Service Network: _____

B. Position:
___ Prevention Conversation Facilitator
___ Network Coordinator
___ Other Network Representative (please specify): _____

C. Gender: ___Female ___Male ___Other

D. Prior to being hired as a Prevention Conversation Facilitator, what positions have you held? Please list.

E. Have you previously received any training in FASD? ___Yes ___No

If yes, in which of the following areas? (check all that apply)

a. __ FASD prevention
b. __ FASD diagnosis
c. __ FASD Intervention
d. __ Other: _____.

F. Have you ever worked with an individual who was identified or suspected of having FASD?
____Yes ____No

If yes, approximately how many people? _____

If yes, for how many years? _____

If yes, primarily with: ___Children ___Adults ____Both

If yes, what services have you provided? (Check all that apply)

___ Clinical (e.g. Counseling, assessment)
___ Advocacy (e.g. mediation, support services)
___ Referrals (e.g. point of contact)
___ Program delivery (e.g. support groups, mentoring. If so, which program?
___ Education
___ Other (please specify): _____

G. Have you previously engaged in conversations related to alcohol and pregnancy with pregnant women?
___Yes ___No

H. Have you previously engaged in conversations related to alcohol and pregnancy with women who are of childbearing age (i.e., 18 to 45) but not pregnant? ___Yes ___No

I. If yes to G or H above, which of the following was included in the conversation (Check all that apply):

___ Consequences of drinking during pregnancy
___ Contraception and family planning
___ Addiction treatments

___ Needs of the woman (e.g. safety, housing, employment, etc)
___ Other (please specify): _____

Your Beliefs about and Knowledge of FASD

Please indicate the extent to which you agree with the following statements:

		Strongly Disagree									Strongly Agree
1.	I consider myself to be knowledgeable about FASD prevention	1	2	3	4	5	6	7	8	9	10
2.	I consider myself to be knowledgeable about supporting individuals with FASD and their families.	1	2	3	4	5	6	7	8	9	10
3.	I consider myself to be knowledgeable about FASD diagnosis	1	2	3	4	5	6	7	8	9	10
4.	FASD is easily recognizable	1	2	3	4	5	6	7	8	9	10
5.	FASD is 100% preventable	1	2	3	4	5	6	7	8	9	10
6.	FASD is an incurable, life-long disorder	1	2	3	4	5	6	7	8	9	10
7.	FASD is multi-factorial	1	2	3	4	5	6	7	8	9	10
8.	It is impossible to be diagnosed with "FASD"	1	2	3	4	5	6	7	8	9	10

What are your beliefs about FASD prevention?

Your Beliefs about FASD Prevention

Please indicate the extent to which you agree with the following statements.

		Strongly Disagree									Strongly Agree
1.	I can play a role in helping to prevent FASD	1	2	3	4	5	6	7	8	9	10
2.	I feel that FASD prevention is an important aspect of my practice	1	2	3	4	5	6	7	8	9	10
3.	I feel comfortable engaging professionals in conversations about FASD prevention	1	2	3	4	5	6	7	8	9	10
4.	I feel prepared to engage professionals in conversations about FASD prevention	1	2	3	4	5	6	7	8	9	10
5.	I feel confident in my ability to prepare and deliver effective presentations about FASD Prevention	1	2	3	4	5	6	7	8	9	10
6.	I believe that having a conversation with a woman may impact her decision-making about alcohol and pregnancy.	1	2	3	4	5	6	7	8	9	10

Please indicate the extent to which you agree with the following messages.

		Strongly Disagree									Strongly Agree
1.	It is safest not to drink alcohol during pregnancy	1	2	3	4	5	6	7	8	9	10
2.	Drinking can be harmful at any point during pregnancy and can result in lifelong disabilities. The baby's brain and nervous system develop (and are vulnerable to damage from alcohol) throughout pregnancy.	1	2	3	4	5	6	7	8	9	10
3.	Alcohol and pregnancy don't mix. If you drink alcohol and are sexually active, make sure you use effective contraception.	1	2	3	4	5	6	7	8	9	10
4.	If you're pregnant or thinking about getting pregnant, consider talking to your healthcare provider or asking for help to learn more about support and services in your community.	1	2	3	4	5	6	7	8	9	10
5.	Friends, partners and family members can support a pregnant woman by asking how they can help her make healthy choices and healthy babies.	1	2	3	4	5	6	7	8	9	10
6.	Some women need support, care and treatment to help them stop drinking during pregnancy. Research points to the effectiveness of intervention. Engage them in The Prevention Conversation.	1	2	3	4	5	6	7	8	9	10

Thank you for taking the time to complete this survey! Enjoy your training ☺

Facilitator Online Post-Training Survey (December 2013)

The following demographic information will be used for matching purposes to collect data within your service network for the evaluation of the FASD Prevention Conversation. This data will only be viewed by the evaluation team – your network will not receive specific information about your answers. Data in the evaluation report will be provided in general, and will not name results or statistics for specific networks. In this way, your responses here are confidential.

1. What was your role at the FASD Prevention Conversation (FASD PC) Training?

_____Prevention Conversation Facilitator
_____Network Coordinator/Representative
Other (please specify)_____

2. In what FASD Service Network will you be providing prevention services?

_____

We are interested in learning more about the prevention messaging you heard during your training. For each of the following messages, please indicate the extent to which heard that message. If not exactly, please indicate how the message you heard differed from the one presented.

3. What did you hear?

	Not at all		Somewhat		Exactly
	1	2	3	4	5

a) It is safest not to drink alcohol during pregnancy

If not exactly, how did the message you heard differ?

_____

b) Drinking can be harmful at any point during pregnancy and can result in lifelong disabilities. The baby's brain and nervous system develop (and are vulnerable to damage from alcohol) throughout pregnancy.

If not exactly, how did the message you heard differ?

_____

c) Alcohol and pregnancy don't mix. If you drink alcohol and are sexually active, make sure you use effective contraception.

If not exactly, how did the message you heard differ?

_____

d) If you're pregnant or thinking about getting pregnant, consider talking to your healthcare provider or asking for help to learn more about support and services in your community.

If not exactly, how did the message you heard differ?

_____

e) Some women need support, care and treatment to help them stop drinking during pregnancy. Research points to the effectiveness of intervention. Engage them in The Prevention Conversation.

If not exactly, how did the message you heard differ?

_____

f) Friends, partners and family members can support a pregnant woman by asking how they can help her make healthy choices and healthy babies.

If not exactly, how did the message you heard differ?

_____

4. Please list any other messages you heard during your Prevention Conversation training that were not listed on the previous page:

_____

_____

5. Your Beliefs about and Knowledge of FASD

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7 8 9 10

a) I consider myself to be knowledgeable about FASD Prevention
b) I consider myself to be knowledgeable about supporting individuals with FASD and their families
c) I consider myself to be knowledgeable about FASD diagnosis
d) FASD is easily recognizable
e) FASD is 100% preventable
f) FASD is an incurable, lifelong disorder
g) FASD is multifactorial
h) It is safest not to drink alcohol during pregnancy
i) It is impossible to be diagnosed with "FASD"

6. **What are your beliefs about FASD Prevention?**

_____

_____

7. **Your beliefs about FASD Prevention:**

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7 8 9 10

a) can play a role in helping to prevent FASD
b) feel that FASD Prevention is an important aspect of my practice
c) feel comfortable engaging professionals in conversations about FASD Prevention
d) feel prepared to engage professionals in conversations about FASD Prevention
e) feel confident in my ability to prepare and deliver effective presentations about FASD Prevention
f) believe that having a conversation with a woman may impact her decision-making about alcohol and pregnancy

8. **Your FASD Prevention Conversation training:**

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7 8 9 10

a) I enjoyed the FASD PC training
b) The FASD PC training was a good use of my time
c) I found the training venue appropriate
d) I found the trainers to be very well prepared
e) The FASD PC training content was consistent with what I expected
f) The FASD PC training process was consistent with what I expected
g) I learned new information about FASD Prevention today that I did not know coming into training
h) This training has prepared me to engage professionals in the FASD Prevention
i) Conversation
j) I feel that I will need additional training and/or resources in specific areas before I am ready to engage in the Prevention Conversation

9. If you feel you need additional training/resources, please describe what you think would be helpful.

_____

_____

10. If you have any other thoughts or experiences regarding your training that you would like to share with the evaluation team, please use the space below to do so.

_____

Facilitator Post Implementation Survey (January 2015)

The following demographic information will be used for matching purposes to collect data within your service network for the evaluation of the FASD Prevention Conversation. This data will only be viewed by the evaluation team – your network will not receive specific information about your answers. Data in the evaluation report will be provided in general, and will not name results or statistics for specific networks. In this way, your responses here are confidential.

***1. In what FASD Service Network do you work?**

_____

2. We are interested in learning more about how the prevention messaging was incorporated into your work. To what extent did the following messages guide your conversations and training sessions with service providers?

	Not at all		Somewhat		Very Much
	1	2	3	4	5

a) It is safest not to drink alcohol during pregnancy
b) Drinking can be harmful at any point during pregnancy and can result in lifelong disabilities. The baby's brain and nervous system develop (and are vulnerable to damage from alcohol) throughout pregnancy.
c) Alcohol and pregnancy don't mix. If you drink alcohol and are sexually active, make sure you use effective contraception.
d) If you're pregnant or thinking about getting pregnant, consider talking to your healthcare provider or asking for help to learn more about support and services in your community.
e) Some women need support, care and treatment to help them stop drinking during pregnancy. Research points to the effectiveness of intervention. Engage them in The Prevention Conversation.
f) Friends, partners and family members can support a pregnant woman by asking how they can help her make healthy choices and healthy babies.

3. What other messages and topics were included in your conversations with service providers?

_____
_____
_____

4. Your beliefs about FASD Prevention:

	Strongly Disagree									Strongly Agree
	1	2	3	4	5	6	7	8	9	10

a) am knowledgeable about FASD prevention
b) can play a role in helping to prevent FASD
c) feel that FASD Prevention is an important aspect of my work
d) feel comfortable engaging professionals in conversations about FASD Prevention
e) feel prepared to engage professionals in conversations about FASD Prevention
f) feel confident in my ability to prepare and deliver effective presentations about FASD Prevention
g) believe that having a conversation with a woman may impact her decision-making about alcohol and pregnancy

5. In your opinion, which of the following are most important for the work you do as a prevention facilitator? (Please rank in order of importance: 1 = most important)

____ *Knowledge about FASD Prevention*
____ *Confidence in your facilitation skills*
____ *Seeing value in FASD Prevention*

6.What else (in addition to knowledge, confidence, and valuing the subject matter) is important for the work you do? And would you rate this as more or less important than the areas listed above?

_____

_____
_____

7. Your FASD Prevention Conversation training:

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7 8 9 10

a. believe that the training I received adequately prepared me to engage professionals in the FASD Prevention Conversation
b. believe that I need additional training and/or resources in specific areas in order to continue my work as a Prevention Conversation Facilitator

8. If you feel you need additional training/resources, please describe what you think would be helpful.

_____
_____
_____

9. As you continue your work as a prevention facilitator, what are your hopes/goals for this initiative over the next year?

_____
_____
_____

Appendix F: Service Provider Surveys

Service Provider Pre-Survey (Version 1)

Before you begin, please create (and remember!) a 4 digit code using letters and/or numbers. You will use this code on the post-survey following this session, so that your responses can be matched while maintaining your anonymity.

Code: ___ ___ ___ ____

Tell us about yourself and your previous experience

A. Gender: ___Female ___Male ___Other

B. What is your professional title? (e.g. social worker, physician, counsellor, etc) _____

C. How many years have you been in this profession? _____

D. Have you been in any other positions throughout your career? ____Yes ____No

If yes, which positions have you held? _____

_____

E. In what setting do you work?
   a. primary care
   b. hospital
   c. private practice
   d. mental health
   e. child protection
   f. addictions services
   g. outpatient services
   h. community organization
   i. school/university setting
   j. Other (please specify):_____

F. What are the first 3 digits of your postal code? _____

G. Approximately what percentage of your work is spent in the following areas? (Should add up to 100%)

____Urban _____Rural _____Remote _____Reserve/Settlement

H. Have you previously received any training in FASD? ___Yes ___No

If yes, in which of the following areas? (check all that apply)
   e. __ FASD prevention
   f. __ FASD diagnosis
   g. __ FASD Intervention
   h. __ Other: _____.

I. Have you ever worked with an individual who was identified or suspected of having FASD?

____Yes ____No

If yes, approximately how many people? _____

If yes, for how many years? _____

If yes, primarily with: ___Children ___Adults ____Both

If yes, what services have you provided? (Check all that apply)

___ Clinical (e.g. Counseling, assessment)
___ Advocacy (e.g. mediation, support services)
___ Referrals (e.g. point of contact)
___ Program delivery (e.g. support groups, mentoring. If so, which program? _____)
___ Education
___ Other (please specify): _____

J. Have you previously engaged in conversations related to alcohol and pregnancy with pregnant women?
___Yes ___No

K. Have you previously engaged in conversations related to alcohol and pregnancy with women who are of childbearing age (i.e., 18 to 45) but not pregnant?
___Yes ___No

L. If yes to I or J above, which of the following was included in the conversation? (Check all that apply):

___ Consequences of drinking during pregnancy
___ Contraception and family planning
___ Addiction treatments
___ Needs of the woman (e.g. safety, housing, employment, etc)
___ Other (please specify): _____

M. If no to I or J above, what has prevented you from engaging in these conversations? Check all that apply.

a. I do not believe it is in my scope of practice
b. I feel uncomfortable approaching the topic
c. I worry my patient will think I am judging them
d. I am unsure of what to do if alcohol consumption during pregnancy is confirmed
e. I am not aware of what the research says about FASD
f. I am not confident in the state of current research on FASD
g. I have not had training in this area
h. I do not have the time
i. Other: _____

Your Beliefs about FASD and FASD Prevention

Please indicate the extent to which you agree with the following statements:

	Strongly Disagree									Strongly Agree
9. I consider myself to be knowledgeable about FASD prevention	1	2	3	4	5	6	7	8	9	10
10. I consider myself to be knowledgeable about supporting individuals with FASD and their families.	1	2	3	4	5	6	7	8	9	10
11. I consider myself to be knowledgeable about FASD diagnosis	1	2	3	4	5	6	7	8	9	10
12. FASD is easily recognizable	1	2	3	4	5	6	7	8	9	10
13. FASD is 100% preventable	1	2	3	4	5	6	7	8	9	10
14. FASD is an incurable, life-long disorder	1	2	3	4	5	6	7	8	9	10
15. I feel that FASD prevention is an important aspect of my practice	1	2	3	4	5	6	7	8	9	10
16. I can play a role in helping to prevent FASD	1	2	3	4	5	6	7	8	9	10
17. I believe that having a conversation with a woman may impact her decision-making about alcohol and pregnancy.	1	2	3	4	5	6	7	8	9	10
18. I believe that ***I can*** have a conversation with a woman that may impact her decision-making about alcohol and pregnancy.	1	2	3	4	5	6	7	8	9	10

Why have you chosen to take part in this session on FASD Prevention at this point in your career? Please list all reasons.

_____

_____

_____

_____

_____

Service Provider Pre-Survey (Version 2)

Before you begin, please create (and remember!) a 4 digit code using letters and/or numbers. You will use this code on the post-survey following this session, so that your responses can be matched while maintaining your anonymity.

Code: ___ ___ ___ ____

Tell us about yourself and your previous experience

N. What is your professional title? (e.g. social worker, physician, counsellor, etc) _____

O. In what setting do you work?
   a. primary care
   b. hospital
   c. private practice
   d. mental health
   e. child protection
   f. addictions services
   g. outpatient services
   h. community organization
   i. school/university setting
   j. Other (please specify):_____

P. What are the first 3 digits of your postal code? _____

Q. Approximately what percentage of your work is spent in the following areas? (Should add up to 100%)

____Urban _____Rural _____Remote _____Reserve/Settlement

R. Have you previously received any training in FASD? ___Yes ___No

If yes, in which of the following areas? (check all that apply)
   i. __ FASD prevention
   j. __ FASD diagnosis
   k. __ FASD Intervention
   l. __ Other: _____.

S. Have you previously engaged in conversations related to alcohol and pregnancy with pregnant women?
___Yes ___No

T. Have you previously engaged in conversations related to alcohol and pregnancy with women who are of childbearing age (i.e., 18 to 45) but not pregnant?
___Yes ___No

U. If you said yes to F or G, which of the following was included in the conversation? (Check all that apply):

___ Consequences of drinking during pregnancy
___ Contraception and family planning

___ Addiction treatments
___ Needs of the woman (e.g. safety, housing, employment, etc)
___ Other (please specify): _____

V. If you said no to F or G, what has prevented you from engaging in these conversations? Check all that apply.

j. ___ I do not believe it is in my scope of practice
k. ___ I feel uncomfortable approaching the topic
l. ___ I worry my patient will think I am judging them
m. ___ I am unsure of what to do if alcohol consumption during pregnancy is confirmed
n. ___ I am not aware of what the research says about FASD
o. ___ I am not confident in the state of current research on FASD
p. ___ I have not had training in this area
q. ___ I do not have the time
r. ___ Other: _____

Tell us About Your Beliefs about FASD and FASD Prevention

Please indicate the extent to which you agree with the following statements:

	Strongly Disagree									Strongly Agree
19. I consider myself to be knowledgeable about FASD	1	2	3	4	5	6	7	8	9	10
20. FASD is easily recognizable	1	2	3	4	5	6	7	8	9	10
21. FASD is 100% preventable	1	2	3	4	5	6	7	8	9	10
22. FASD is an incurable, life-long disorder	1	2	3	4	5	6	7	8	9	10
23. I can play a role in helping to prevent FASD	1	2	3	4	5	6	7	8	9	10
24. I feel that FASD prevention is an important part of my work	1	2	3	4	5	6	7	8	9	10
25. I believe that having a conversation with a woman may impact her decision-making about alcohol and pregnancy.	1	2	3	4	5	6	7	8	9	10
26. I believe that ***I can*** have a conversation with a woman that may impact her decision-making about alcohol and pregnancy.	1	2	3	4	5	6	7	8	9	10

Why have you chosen to take part in this session on FASD Prevention at this point in your career? Please list all reasons.

_____

_____

_____

_____

Service Provider Post-Survey (Version 1)

Please record the 4-digit code that you created on your pre-survey. **Code: ___ ___ ___ ___**

Tell us About Your Beliefs about FASD and FASD Prevention

Please indicate the extent to which you agree with the following statements:

	Strongly Disagree									Strongly Agree
27. I consider myself to be knowledgeable about FASD	1	2	3	4	5	6	7	8	9	10
28. FASD is easily recognizable	1	2	3	4	5	6	7	8	9	10
29. FASD is 100% preventable	1	2	3	4	5	6	7	8	9	10
30. FASD is an incurable, life-long disorder	1	2	3	4	5	6	7	8	9	10
31. I can play a role in helping to prevent FASD	1	2	3	4	5	6	7	8	9	10
32. I feel that FASD prevention is an important aspect of my work	1	2	3	4	5	6	7	8	9	10

Your Beliefs about the FASD Prevention Conversation

	Strongly Disagree									Strongly Agree
8. I can use the information discussed today to benefit my work and my clients	1	2	3	4	5	6	7	8	9	10
9. I feel confident in my ability to engage in the FASD prevention conversation	1	2	3	4	5	6	7	8	9	10
10. I am prepared to discuss family planning and contraception with my clients/patients	1	2	3	4	5	6	7	8	9	10
11. I am prepared to provide my clients with resources about FASD prevention as necessary	1	2	3	4	5	6	7	8	9	10
12. I am prepared to intervene (to provide support) to women who confirm drinking alcohol while pregnant	1	2	3	4	5	6	7	8	9	10
13. The FASD Prevention Conversation is practical to incorporate into my work	1	2	3	4	5	6	7	8	9	10
14. The FASD Prevention Conversation is relevant to my work	1	2	3	4	5	6	7	8	9	10
15. I believe that having a conversation with a woman may impact her decision-making about alcohol and pregnancy.	1	2	3	4	5	6	7	8	9	10
16. I believe that ***I can*** have a conversation with a woman that may impact her decision-making about alcohol and pregnancy.	1	2	3	4	5	6	7	8	9	10

In your session today, to what extent did you hear the following messages?

	Not at all	Somewhat			Exact
1. *It is safest not to drink alcohol in pregnancy*	1	2	3	4	5
2. *Drinking can be harmful at any point during pregnancy and can result in lifelong disabilities. The baby's brain and nervous system develop (and are vulnerable to damage from alcohol) throughout pregnancy.*	1	2	3	4	5
3. *Alcohol and pregnancy don't mix. If you drink alcohol and are sexually active, make sure you use effective contraception.*	1	2	3	4	5
4. *If you're pregnant or thinking about getting pregnant, consider talking to your healthcare provider or asking for help to learn more about support and services in your community.*	1	2	3	4	5
5. *Friends, partners and family members can support a pregnant woman by asking how they can help her make healthy choices and healthy babies.*	1	2	3	4	5
6. *Some women need support, care and treatment to help them stop drinking during pregnancy. Research points to the effectiveness of intervention. Engage them in The Prevention Conversation.*	1	2	3	4	5

If you answered "somewhat" to any of the items above, how did the messages you heard differ?

_____

_____

_____

Please list any other messages that you heard today that are not listed above:

_____

_____

_____

After this session:	Very Unlikely									Very Likely
1. How likely are you to incorporate what you have learned today into your practice/work?	1	2	3	4	5	6	7	8	9	10
2. How likely are you to engage women of childbearing age in an FASD Prevention Conversation?	1	2	3	4	5	6	7	8	9	10

Thank you for your time. Your feedback is critical to our evaluation of the impact of this initiative. Are you willing to be invited to complete one more short survey about your experiences with the FASD Prevention Conversation?

You will be emailed a link to an online survey with no obligation to participate. ___Yes ___No

Please provide your email address: _____

Satisfaction with your FASD Prevention Conversation Session

	Strongly Disagree									Strongly Agree
1. I enjoyed this FASD Prevention Conversation session	1	2	3	4	5	6	7	8	9	10
2. This session was a good use of my time	1	2	3	4	5	6	7	8	9	10
3. The Prevention Conversation Facilitator was engaging	1	2	3	4	5	6	7	8	9	10
4. The Prevention Conversation Facilitator was knowledgeable	1	2	3	4	5	6	7	8	9	10
5. The Prevention Conversation Facilitator was well prepared	1	2	3	4	5	6	7	8	9	10
6. This session was consistent with what I expected	1	2	3	4	5	6	7	8	9	10

After this session:	Very Unlikely									Very Likely
3. How likely are you to incorporate what you have learned today into your practice/work?	1	2	3	4	5	6	7	8	9	10
4. How likely are you to engage women of childbearing age in an FASD Prevention Conversation?	1	2	3	4	5	6	7	8	9	10

Thank you for your time. Your feedback is critical in our ongoing evaluation of the impact of this initiative. Are you willing to be contacted in the future to complete one more short (10 min) survey about your experiences with the FASD Prevention Conversation? You will be emailed a link to an online survey with no obligation to participate should you choose not to.

___Yes ___No

If yes, please provide your email address: _____

Service Provider Post-Survey (Version 2)

Please record the 4-digit code that you created on your pre-survey. **Code: ___ ___ ___ ___**

Your Beliefs about FASD and FASD Prevention

Please indicate the extent to which you agree with the following statements:

	Strongly Disagree									Strongly Agree
33. I consider myself to be knowledgeable about FASD prevention	1	2	3	4	5	6	7	8	9	10
34. I consider myself to be knowledgeable about supporting individuals with FASD and their families.	1	2	3	4	5	6	7	8	9	10
35. I consider myself to be knowledgeable about FASD diagnosis	1	2	3	4	5	6	7	8	9	10
36. FASD is easily recognizable	1	2	3	4	5	6	7	8	9	10
37. FASD is 100% preventable	1	2	3	4	5	6	7	8	9	10
38. FASD is an incurable, life-long disorder	1	2	3	4	5	6	7	8	9	10
39. I feel that FASD prevention is an important aspect of my practice	1	2	3	4	5	6	7	8	9	10
40. I can play a role in helping to prevent FASD	1	2	3	4	5	6	7	8	9	10
41. I believe that having a conversation with a woman may impact her decision-making about alcohol and pregnancy.	1	2	3	4	5	6	7	8	9	10
42. I believe that ***I can*** have a conversation with a woman that may impact her decision-making about alcohol and pregnancy.	1	2	3	4	5	6	7	8	9	10

Your Beliefs about the FASD Prevention Conversation

	Strongly Disagree									Strongly Agree
17. I can use the information discussed today to benefit my practice and my clients	1	2	3	4	5	6	7	8	9	10
18. I feel confident in my ability to engage in the FASD prevention conversation	1	2	3	4	5	6	7	8	9	10
19. I am prepared to discuss family planning and contraception with my clients/patients	1	2	3	4	5	6	7	8	9	10
20. I am prepared to provide my clients with resources about FASD prevention as necessary	1	2	3	4	5	6	7	8	9	10
21. I am prepared to intervene (to provide support) to women who confirm drinking alcohol while pregnant	1	2	3	4	5	6	7	8	9	10
22. The FASD Prevention Conversation is practical to incorporate into my work	1	2	3	4	5	6	7	8	9	10
23. The FASD Prevention Conversation is relevant to my work	1	2	3	4	5	6	7	8	9	10

In your session today, to what extent did you hear the following messages?

	Not at all		Somewhat		Exact
7. *It is safest not to drink alcohol in pregnancy* If somewhat, how did the message you heard differ?	1	2	3	4	5
8. *Drinking can be harmful at any point during pregnancy and can result in lifelong disabilities. The baby's brain and nervous system develop (and are vulnerable to damage from alcohol) throughout pregnancy.* If somewhat, how did the message you heard differ?	1	2	3	4	5
9. *Alcohol and pregnancy don't mix. If you drink alcohol and are sexually active, make sure you use effective contraception.* If somewhat, how did the message you heard differ?	1	2	3	4	5
10. *If you're pregnant or thinking about getting pregnant, consider talking to your healthcare provider or asking for help to learn more about support and services in your community.* If somewhat, how did the message you heard differ?	1	2	3	4	5
11. *Friends, partners and family members can support a pregnant woman by asking how they can help her make healthy choices and healthy babies.* If somewhat, how did the message you heard differ?	1	2	3	4	5
12. *Some women need support, care and treatment to help them stop drinking during pregnancy. Research points to the effectiveness of intervention. Engage them in The Prevention Conversation.* If somewhat, how did the message you heard differ?	1	2	3	4	5

Service Provider Informal Post-Survey (Online)

Tell us a bit about yourself:

1. **What is your professional title or designation? (e.g. social worker, physician, counsellor, etc)**
_____

2. **In what setting do you primarily work?**
    a. primary care
    b. hospital
    c. private practice
    d. mental health
    e. child protection
    f. addictions services
    g. community organization
    h. school/university setting
    i. Other (please specify) _____

3. **What are the first 3 digits of your postal code?** _____

4. **Approximately what percentage of your work is spent in the following areas? (Should add up to 100%)**
    Urban _____ Rural _____ Remote _____ Reserve/Settlement _____

5. **Have you previously received any training in FASD?**
    Yes____ No____

6. **If yes above, in which areas did you receive training? (check all that apply)**
    FASD Prevention _____ FASD Diagnosis ____ FASD Intervention ____ Other (please specify)
_____

Tell us about your previous experiences with FASD Prevention:

7. **Have you previously engaged in a conversation related to alcohol and pregnancy with a pregnant woman?** Yes____ No____

8. **Have you previously engaged in a conversation related to alcohol and pregnancy with a woman who was of childbearing age (i.e., 18 to 45) but not pregnant?**
    Yes____ No____

9. **If you have engaged in a conversation, what was included in that conversation? (check all that apply)**
    a) Consequences of drinking during pregnancy_____
    b) Contraception and family planning_____
    c) Addiction treatments_____
    d) Needs of the woman (e.g. safety, housing, employment, etc)_____
    e) Other (please specify) _____

10. **If you have not engaged in a conversation in the past, what has prevented you from**

doing so? (Check all that apply.)

a) did not believe it is in my scope of practice/work_____
b) felt uncomfortable approaching the topic_____
c) worried the woman would think I am judging them_____
d) was unsure of what to do if alcohol consumption during pregnancy was confirmed_____
e) was not aware of what the research says about FASD_____
f) was not confident in the state of current research on FASD_____
g) have not had training in this area_____
h) I do not have the time_____
i) Other (please specify) _____

Tell us about your beliefs about FASD and FASD Prevention:

11. Your Beliefs about FASD Strongly Disagree
Strongly Agree

1 2 3 4 5 6 7 8 9 10

a) I consider myself to be knowledgeable about FASD
b) FASD is easily recognizable
c) FASD is 100% preventable
d) FASD is an incurable, lifelong disorder

12. Your beliefs about FASD Prevention: Strongly Disagree
Strongly Agree

1 2 3 4 5 6 7 8 9 10

a) can play a role in helping to prevent FASD
feel that FASD Prevention is an important part of my work
c) can use the information discussed with the Prevention Facilitator to benefit my work
d) feel confident in my ability to engage in the FASD prevention conversation
e) am prepared to discuss family planning and contraception with clients/patients/women
f) am prepared to provide my clients with resources about FASD prevention as necessary
g) am prepared to intervene (to provide support) to women who confirm drinking alcohol while pregnant
h) The FASD Prevention Conversation is practical to incorporate into my work
i) The FASD Prevention Conversation is relevant to my work
j) believe that having a conversation with a woman may impact her decision-making about alcohol and pregnancy
k) believe that I am capable of having a conversation with a woman that may impact her decision-making about alcohol and pregnancy

Tell us about your conversation with the Prevention Facilitator:

13. Were the following topics related to FASD prevention discussed during your conversation with the Prevention Facilitator?

a) It is safest not to drink alcohol in pregnancy Yes_____ No_____
b) Drinking can be harmful at any point during pregnancy and can result in lifelong disabilities. The baby's brain and nervous system develop (and are vulnerable to damage from alcohol) throughout pregnancy. Yes___No____

c) *Alcohol and pregnancy don't mix. If you drink alcohol and are sexually active, make sure you use effective contraception.* Yes_____ No_____

d) *If you're pregnant or thinking about getting pregnant, consider talking to your healthcare provider or asking for help to learn more about support and services in your community.* Yes_____ No_____

e) *Friends, partners and family members can support a pregnant woman by asking how they can help her make healthy choices and healthy babies.* Yes_____ No_____

f) *Some women need support, care and treatment to help them stop drinking during pregnancy. Research points to the effectiveness of intervention. Engage them in The Prevention Conversation.* Yes_____ No_____

13. What other topics, if any, were discussed in your conversation with the FASD Prevention Conversation Facilitator?

_____
_____
_____
_____

14. Following your interactions with the FASD Prevention Facilitator, how likely are you to:

a) *Incorporate the information discussed into your work?* Extremely Unlikely Extremely Likely

1 2 3 4 5 6 7 8 9 10

b) *Engage women of childbearing age in an FASD Prevention Conversation?*

Extremely Unlikely Extremely Likely

1 2 3 4 5 6 7 8 9 10

16. Thank you for taking the time to complete this survey. Your feedback is key to our evaluation of the impact of this initiative. Are you willing to be invited to complete one more short (10 min) online survey about your experiences with the FASD Prevention Conversation within the next 6 months?

Yes_____ No_____

17. If Yes, please provide your email address: _____

Survey Complete!
Thank you for taking the time to respond to this survey and share your experiences of the FASD Prevention Conversation training. Your feedback will provide important information for the evaluation of the Prevention Conversation initiative.

If you have any questions related to this survey or the evaluation of this initiative, please do not hesitate to contact the evaluation team:

Dr. Jacqueline Pei jacqueline.pei@ualberta.ca
Erin Atkinson ematkins@ualberta.ca

18. If you have any other comments or experiences about the FASD Prevention Conversation or about this survey that you would like to share, please use the space below to do so.

_____

_____

_____

_____

Service Provider Follow Up Survey (3-6 months post-training)

Tell us a bit about yourself:

1. **What is your professional title or designation? (e.g. social worker, physician, counsellor, etc)**

_____

2. **In what setting do you primarily work?**
   j. primary care
   k. hospital
   l. private practice
   m. mental health
   n. child protection
   o. addictions services
   p. community organization
   q. school/university setting
   r. Other (please specify) _____

3. **What are the first 3 digits of your postal code?** _____

4. **Approximately what percentage of your work is spent in the following areas? (Should add up to 100%)**
   Urban _____ Rural _____ Remote _____ Reserve/Settlement _____

5. **Since your interactions with the FASD Prevention Facilitator, have you engaged in conversations related to alcohol and pregnancy with women?** Yes____
   No____

(If yes to question 5) You indicated you have engaged in prevention conversations with women.

6. **Since your interactions with the FASD Prevention Facilitator, how often do you engage in conversations related to alcohol and pregnancy with pregnant women in a typical month?**
_____Daily or more _____Close to daily _____Several times a month _____Once a month _____Never

7. **Since your interactions with the FASD Prevention Facilitator, how often do you engage in conversations related to alcohol and pregnancy with women who are of childbearing age (i.e., 18 to 45) but not pregnant?**
_____Daily or more _____Close to daily _____Several times a month _____Once a month _____Never

8. **Which of the following have been included in your conversations? (check all that apply)**
   _____Consequences of drinking during pregnancy
   _____Contraception and family planning
   _____Addiction treatments

_____Needs of the woman (e.g. safety, housing, employment, etc)
_____Referrals to supports/services
Other (please specify)_____

9. To what extent do the following prevention messages typically guide your conversations with women?

1-Not at all 2-Somewhat 3-Very much

a) *It is safest not to drink alcohol in pregnancy*
b) *Drinking can be harmful at any point during pregnancy and can result in lifelong disabilities. The baby's brain and nervous system develop (and are vulnerable to damage from alcohol) throughout pregnancy.*
c) *Alcohol and pregnancy don't mix. If you drink alcohol and are sexually active, make sure you use effective contraception.*
d) *If you're pregnant or thinking about getting pregnant, consider talking to your healthcare provider or asking for help to learn more about support and services in your community.*
e) *Friends, partners and family members can support a pregnant woman by asking how they can help her make healthy choices and healthy babies.*
f) *Some women need support, care and treatment to help them stop drinking during pregnancy. Research points to the effectiveness of intervention. Engage them in The Prevention Conversation.*

10. Since your interactions with the FASD Prevention Facilitator, in what ways have your conversations changed? (e.g. frequency, quality, tone, comfort, etc)

_____
_____
_____

(If no to question 5) You responded that you have not engaged women in prevention conversations since interacting with the FASD Prevention Facilitator. We are interested in learning more about your experience.

11. What has prevented you from engaging women in conversation related to alcohol and pregnancy? (Check all that apply.)

_____I do not believe it is in my scope of practice/work
_____I feel uncomfortable approaching the topic
_____I worry the woman will think I am judging her
_____I am unsure of what to do if alcohol consumption during pregnancy is confirmed
_____I am not aware of what the research says about FASD
_____I am not confident in the state of current research on FASD
_____I have not had the opportunity (i.e. I have not worked with women)
_____I do not have the time
Other (please specify)_____

12. If anything was possible, what would most likely increase your chances of engaging with women of childbearing age in conversations about alcohol and pregnancy?

_____

_____

_____

13. Your Beliefs about FASD Strongly Disagree
Strongly Agree

1 2 3 4 5 6 7 8 9 10

a) consider myself to be knowledgeable about FASD
b) FASD is easily recognizable
c) FASD is 100% preventable
d) FASD is an incurable, lifelong disorder

14. Your beliefs about FASD Prevention: Strongly Disagree
Strongly Agree

1 2 3 4 5 6 7 8 9 10

a) can play a role in helping to prevent FASD
b) feel that FASD Prevention is an important part of my work
c) feel confident in my ability to engage in the FASD prevention conversation
d) believe that having a conversation with a woman may impact her decision-making about alcohol and pregnancy
e) believe the FASD Prevention Conversation is practical to incorporate into my work
f) believe the FASD Prevention Conversation is relevant to my work
g) believe the FASD Prevention Conversation has positively impacted my work

15. Since my interactions with the FASD Prevention Facilitator:

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7 8 9 10

a) have incorporated the FASD Prevention Conversation into my work
b) have sought out additional information or training in the area of FASD or FASD Prevention.
c) have engaged in conversations with other professionals about FASD prevention.

Survey Complete!
Thank you for taking the time to respond to this survey and share your experiences of the FASD Prevention Conversation training. Your feedback will provide important information for the evaluation of the Prevention Conversation initiative.

If you have any questions related to this survey or the evaluation of this initiative, please do not hesitate to contact the evaluation team:
Dr. Jacqueline Pei jacqueline.pei@ualberta.ca
Erin Atkinson ematkins@ualberta.ca

Appendix G: Qualitative Methods

Qualitative methods were employed to capture participant experiences of the Prevention Conversation initiative, allowing for a more in-depth person-centered approach to the evaluation.

Qualitative Data Sources

Interviews & Focus Groups

Semi-structured interviews and focus groups were completed with Facilitators, at the following time points:

Pre-Implementation	Mid Implementation	Post-Implementation
2 Focus Groups (Dec 2013)	11 Interviews (Aug 2014)	10 Interviews (Dec 2014)

Interviews and focus groups were semi-structured, meaning protocols including key questions were developed, with an understanding that there is room for either the interviewer or the interviewee to expand on their answers or to ask questions as necessary. See Appendix H for a list of interview and focus group questions. Interviews are limited by what participants are able to, or desire to articulate, and so ensuring participants feel comfortable and free to express themselves was critical (Creswell, 2009). Care was taken to ensure participant confidentiality in presenting the findings.

Facilitator Focus Groups were conducted for the purpose of exploring Facilitators' experiences of their training session in December, 2013. Two focus groups of 4-5 Facilitators in each were completed. Confidentiality and consent were reviewed with Facilitators, and all signed consent forms. Focus groups were audio recorded and transcribed. A summary of key themes was then generated and sent to Facilitators to review for accuracy. Data collected was used to inform findings for Question 1.

Facilitators Interviews were conducted for the purposes of capturing Facilitators' experiences of the Prevention Conversation. One-hour interviews were conducted at two time points with Facilitators. Eleven Facilitators participated in an interview close to the midpoint of the project, in July-August 2014. Ten Facilitators participated in interviews at the end of the first year of the project, in December 2014. In all cases, Facilitators were emailed questions (for example interview questions, see Appendix H) prior to their interview.

Open-Ended Survey Questions

A number of our surveys for both Facilitators and Service Providers (see Appendices E and F) included open-ended questions, which encouraged participants to write about their experiences. The purpose of these questions was to gain insight on participant experiences when interviews/focus groups were not feasible. For example, Service Providers were invited to explain how their conversation with women has changed since training, using their own words rather than selecting items from a list.

Qualitative Analyses

Focus Groups & Interviews

A **Thematic Analysis** (see Creswell, 2013) was undertaken, using an inductive approach, in which the data was analyzed without pre-conceived ideas or questions, in an effort to understand Facilitators' experiences. A constant comparison method was employed, as it is designed to compare between multiple data sources (Onwuegbuzie, Dickinson, Leech, & Zoran, 2009).This process began with two evaluation team members open-coding three interview transcripts. The codes were then compared, consolidated, and organized into themes. A code chart was created (i.e. code name, definition, and example quotes) that was used by three members of the evaluation team to deductively code the remaining transcripts, allowing for new codes and themes to be added as necessary. After all transcripts were coded, themes were then re-organized based on which evaluation question they were most relevant to, and findings were reported where appropriate.

Open-Ended Questions

Due to limited data provided in these questions, a formal thematic analysis was not completed on open-ended responses. Rather, responses were summarized and presented as they relate to each of the evaluation questions.

Appendix H: Focus Group & Interview Questions

Facilitator Focus Group Questions (December 2013)

1. Can you share with us what led to you to be interested in becoming a prevention conversation facilitator?
    a. What past experiences have led you to being interested in this area?

2. In what ways has the training prepared you to engage in the prevention conversation?
    a. Can you provide an example of something you heard or learned in the past two days that might be most useful for you?
    b. Can you provide an example of something you heard or learned in the past two days that appear at this point in time to be the least useful to you?

3. As you begin working with this project what additional supports, resources, and/or training might you be interested in seeking out?
    a. What might you be looking for to supplement your learning here?
    b. How will you go about seeking these supports, resources, and training?

4. As you begin your work in the prevention conversation, what kinds of barriers do you anticipate experiencing within your networks or communities?
    a. How might you proactively plan to address those barriers?

5. What aspects of your role in the prevention conversation are you most looking forward to? Most excited about?
    a. What do you think you could experience in your job that would be most satisfying?

6. If you could step into a time machine and be transported a year into the future, what would you most like to see looking back on this project?
    a. What would the future look like if the prevention conversation is successful?

Facilitator Interview Questions (August & December 2014)

1. How did you come to be involved in this project?
    a. What was your background coming into this project?
    b. What makes you a good fit (qualified) for this position? What did you bring to this project?

2. What have been the most critical moments in your work with the project so far?
    a. Is this what you anticipated?
    b. Why/why not?
    c. Do you feel your background prepared you for the work you're doing?

3. What would you say have been your greatest learning from the project thus far?
    a. Are there things that you now know that you wish you were aware of at the beginning of the project? If so, what?

b. Is there anything on this project you would have done differently?
c. What advice or tips would you give to someone starting work on this project?

4. Talk to us a little bit about how a typical day for you working on the Prevention Conversation.
    a. What is your favourite part of the day?
    b. What kinds of challenges might you face on a day?
    c. Do all days look similar? If they are different, how do they vary?

5. What have been the most challenging aspects of this project so far?
    a. Could any of these challenges have been anticipated? Or were they unexpected?
    b. Examples?
    c. At this point, have these challenges been overcome? How?

6. What supports and/or resources (e.g. people, money, information) do you currently have assisting you in this process?
    a. What additional supports would you like to have available to you? How would that help?

7. If you could have unlimited resources and supports to help you do your job better, what would you like?

8. Has anything gone significantly better or easier than you anticipated?
    a. Was there anything that facilitated that? What comes to mind?

9. When people ask you to describe your successes what do you think of?
    a. What are you most proud of?

Sample Interview Questions for Team Members (Sept. 2013 – Jan. 2015)

*Questions were modified slightly to make then appropriate for the different roles that each of the key project team members play. Below are a sample of interview questions that provide an overview of areas examined.

1. Please describe your role in the Prevention Conversation initiative.
    a. Has it changed since the start of the program? If so, how?

2. What have been the critical moments in this project since we last spoke in August?
    a. What did you learn from them?
    b. Prompt for specific decision-making points & experiences
        i. Completing materials
        ii. Training

3. What have you learned during your time working on this project?
    a. Are there things that you now know that you wish you were aware of at the beginning of the project? If so, what?

        i. When did you become aware that these things were important to this project?
        ii. What would you have done differently had you known?
    b. What advice would you give to someone starting this project?

4. Talk to us a little bit about how your team has changed/evolved over time.
    a. Who have the key contributors been?
        i. How have they enabled the process?
    b. Have the right people been involved throughout the project?
        i. If anyone was missing, how & when was it determined that they also needed to be involved?
    c. Are there people involved who have slowed down or hindered the process?

5. What have been the most challenging aspects of this project so far?
    a. Could any of these challenges have been anticipated? Or were they unexpected?
    b. Examples?
    c. At this point, have these challenges been overcome?
        i. If so, how?
        ii. If not, what is preventing them from being overcome?
        iii. If you could go back and make any changes, would you? What would you change?

6. With unlimited supports and resources (if anything was possible), what would this project look like?
    a. What additional supports would be available to you?
    b. How would that help?

7. When people ask you to describe your successes what do you think of?
    a. What are you most proud of?
    b. Is there anything that was easier than you anticipated?

8. What are your hopes/goals for this initiative as it continues over the next year and possibly beyond?

Appendix I: Mixed Methods Integration

This evaluation employed a mixed-methods design to collect the data necessary to answer four key evaluation questions. Data collected using quantitative and qualitative methods were analyzed separately (see Appendices D and G), and then findings were integrated where appropriate to triangulate, explain, and interpret evaluation findings related to each of the four key evaluation questions.

Integrated Data Analysis

Quantitative data analysis procedures included descriptive statistics, correlation analysis and inferential procedures (e.g. Regression Analysis). For more details on specific quantitative data analyses performed, please refer to Appendix D. Qualitative data analysis procedures include a thematic analysis (see Appendix G). Following separate analyses of the quantitative and qualitative data, data were integrated and interpreted together where appropriate, since stronger conclusions can be drawn when multiple methods are analyzed jointly, leading to a more comprehensive, rich understanding of the Prevention Conversation initiative. Although each of the four evaluation questions presented in the next section could have largely been answered using a single data collection method (e.g., pre- and post-training surveys for question 1), adding information collected from complementary methods (e.g., Focus Groups) strengthened inferences we were able to draw from the data. Care was taken to focus both on instances where findings converged (i.e. were similar) and diverged (i.e. were different) across methods.

Primary and Complementary Data Sources Mapped onto Enabling Questions

	Quantitative	Qualitative	
Data Sources	**Surveys**	**Focus Groups & Interviews**	**Open-ended Survey Responses**
Question 1 (Preparation)	P	P	C
Question 2 (Experiences)	P	P	C
Question 3 (Messaging)	P	C	C

Note. P = Primary Data Source; C = Complementary Data Source

Appendix J: Service Provider Classifications

Service Providers	Definition	Examples
Clinical Service Providers	Service Providers with advanced training and professional designation in a health-related field.	Nurses, physicians (including psychiatrists), dieticians, psychologists, therapists (e.g. occupational, speech and language, mental health), pharmacists, and clinical counsellors.
Educators	Service Providers whose work involves education others, in a variety of settings.	Teachers, educational assistants, early childhood educators, and university/college instructors.
Health Educators	Service Providers whose work falls between the areas of health and education.	Health promotions facilitators, community educators with Alberta Health Services, and Aboriginal liaison workers.
Social Workers	Service Providers in this category identified themselves as social workers, and reported working in a variety of settings.	Work settings include community organizations (e.g. non-profits, women's shelters), child protection and family service, addictions and mental health services, schools, and legal settings.
Frontline Workers	Service Providers who provide direct services to primarily adult clients, in a variety of different settings.	Support workers, mentors, success coaches, advocates, personal care aids, and addiction workers, among others.
Frontline Youth Workers	Service Providers who provide direct services primarily to children and youth, in a variety of settings.	Youth care workers, childcare workers, and early intervention workers.
Counsellors	Service Providers who provide counselling services to clients. Although similar to Frontline Workers, counselling was a large enough group to consider separately.	Work in a variety of settings, including crisis intervention, women's shelters, and addictions.
Service Providers in Justice	Service Providers who work in the justice system, and are likely to be working with clients and populations who are mandated, and therefore not voluntarily receiving services.	Probation officers, justice workers, prison liaison workers, lawyers.
Management	Service Providers who described management as a key aspect of their title, which implies less direct client contact, and supervision or coordination of other employees.	Coordinators, managers, program supervisors.
Administrative Assistants	This category includes individuals who do office administration, reception, and clerical work in a variety of settings.	Secretary, receptionist, clerical staff, office administrator.
Students	This category encompasses students in post-secondary institutions; those who are in training to become service providers but have yet to enter their area of practice.	All students
Emergency Services	Service Providers often involved in working with the public in emergent situations.	Firefighters, emergency medical technicians, and police officers,
Caregivers	Individuals whose job title implies that their primary role is caring for others.	Foster parents, caregivers in group homes, respite workers.
Miscellaneous	Members of the broader community, whose job titles do not fit within the previously listed categories.	Social media specialists, artists, graphic designers, professional drivers, and custodian.