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Fetal Alcohol Spectrum Disorder

Diagnostic & Assessment Clinic Teams Training Needs Summary

• March 31, 2011

Completed by:
Lakeland Centre for Fetal Alcohol Spectrum Disorder

The Lakeland Centre for FASD would like to thank Alberta Health & Wellness for providing the funds to complete this project.

March 31, 2011

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Executive Summary

Executive Summary

Fetal Alcohol Spectrum Disorder (FASD) is a serious social and health issue and includes a range of disabilities caused by prenatal exposure to alcohol. People affected by FASD may require supports across their lifespan to help them meet their potential. Through the Alberta Provincial FASD Service Networks, diagnostic and assessment services provide organized and centralized resources that can assist individuals who are suspected of having FASD.

In February and March 2011, Lakeland Centre for Fetal Alcohol Spectrum Disorder (LCFASD) undertook an independent review to provide an overview of current and future FASD diagnostic and assessment training content needs, key modes of delivery for training to be most effective, and existing barriers or challenges in accessing team training.

Information was obtained through a qualitative interview process with team members represented by the following professions and team affiliations: clinic team coordinators, network coordinators or directors, diagnostic clinic follow-up support workers, team physicians, paediatricians, team nurses, speech language pathologists, occupational therapists, psychologists, social workers, and correctional services workers. This list is representative of the core or primary team members who participate on the various multi-disciplinary diagnostic and assessment teams throughout Alberta. Although interview questions focused on the current and future training content and needs of clinics, useful information was forthcoming with regards to ways clinics have adapted and fine-tuned processes to meet unique circumstances of their regions.

Findings

FASD clinic training and the provision of support or mentorship of team members is essential for providing a base of knowledge and confidence prior to a clinic becoming operational. Prior FASD diagnostic and assessment training that was identified by team members included assessment and clinic training delivered by LCFASD; individuals or teams travelling to University of Washington, Seattle for 1-2 days of Diagnostic and Prevention (DPN) training; completion of the University of Washington's 4-digit Code on-line training, and Lethbridge Community College's FASD certificate program. Some interviewees reported that diagnostic team training was obtained by either shadowing other clinics or being trained by outgoing or current clinic members.

Other FASD related training enhanced participants' skills and provided useful and relevant information, but was not categorized as being specific to FASD assessment and diagnosis. Reference FASD related training included conferences, workshops, professional development and the provincial FASD learning series, which uses videoconference sessions to interact with the presenters and access a variety of FASD related topics.

Current and future training needs varied according to team members' roles. Common themes around training included:

- Information about *Freedom of Information and Protection of Privacy Act (FOIP), Health Information Act* requirements regarding consents for release and sharing

information; guardianship and other legal issues that clinics should be aware of;

- Cultural competency training, reflecting service delivery within diverse demographic areas;
- 4-digit diagnostic code and Canadian guidelines for diagnosis—training for all team members;
- Additional information on Speech Language Pathologist (S.L.P.), Occupational Therapy (O.T.) and Psychology test instruments required and used to assess domains;
- Understanding assessment results from SLP, OT, and Psychologist and translating data and scores to common layman language when developing interventions and interpreting results to caregivers;
- Obtaining pre-natal alcohol exposure information and other pre and post- natal information; case scenarios that deal with referrals that are not straight forward;
- Skill development for post-clinic, continuum of care strategies and supports that are identified in the diagnostic report's recommendations.

All respondents highlighted the importance for current, consistent diagnostic and assessments training across the province, simultaneously allowing teams to remain autonomous and able to develop best practices around process, without compromising the Canadian guidelines for diagnosis (Chudley, Albert E, *et al.* 2005). Ongoing team support and provision of necessary resources would be best managed within a mechanism that is easy to access and where updates and new information is posted for team members.

Team mentorship that is delivered face to face and on-site, by use of telehealth or by shadowing other teams, was identified as being important.

Respondents indicated that the most desirable mode of training is face- face delivery; however the majority of interview participants understood the cost effectiveness of certain training components that could be accessed by telehealth, video conference, on-line learning or through the use of updated team manuals. There was consensus amongst the respondents that profession-specific and peer delivered training by those with expertise in FASD clinic assessment and diagnosis was a beneficial mode of training.

All clinic coordinators interviewed underscored the importance of being able to connect, in person, with other coordinators across Alberta. They identified that a minimum of one face-face meeting a year with their peers would be optimal. The clinic coordinators unanimously agreed that a venue to communicate with other coordinators is essential. To be able to share information, discuss strategies and case scenarios, with the possibility of accessing targeted coordinator based training at either end of the meeting is of immense value.

Introduction

In February 2011, Alberta Health and Wellness commissioned Lakeland Centre for FASD (LCFASD) to complete an independent assessment for the purpose of collecting information regarding the current and future training needs of community and institution based FASD diagnostic and assessment clinics in Alberta. Clinics operating in Alberta have confidence that their standards of practice are consistent with the Canadian guidelines for diagnosis (Chudley A.E., Conry,J., Loock, C., Rosales, T., & LeBlanc, N. , 2005) and team members have an adequate working knowledge of the guidelines, including the 4-digit diagnostic code and how it is applied to an FASD diagnosis; however, interview results provided sufficient information to prompt the investigation of current and future training needs of teams, recommended modes of training delivery, and suggestions as to how training can be sustained over the long term. Discussion will also focus on issues of how team members can keep current with best- practices and latest research in the field.

LCFASD has extensive experience in training delivery and has trained many of the existing teams currently operating throughout Alberta. LCFASD, centered in Cold Lake, AB, opened in 2001 to support a local group of hard working and dedicated professionals who were contributing to a community-based diagnostic team serving children. The team had been trained at the Fetal Alcohol Syndrome Diagnostic and Prevention Network at the University of Washington, Seattle, WA. The training prepared the LCFASD team to provide clear diagnoses for those prenatally exposed to alcohol. The local team worked together to adapt the diagnostic model to meet a rural need. They were able to develop and deliver this service with the support of the Lakeland Fetal Alcohol Syndrome Committee, which began in 1994. The LCFASD presently provides services to the Lakeland region, which is an area in north eastern Alberta that includes 1 small city, 25 small towns or villages, 7 First Nations communities, 4 Métis settlements (land-based Métis peoples, unique to Alberta) and 1 military base, with a total population of about 80 000. From Edmonton, the closest community served by the LCFASD is a 1-hour drive while the farthest is a 3.5-hour drive. All communities are accessible by road. The LCFASD is based in Cold Lake, AB, but provides its services to the region's communities through mobile diagnostic and assessment teams and follow-up support personnel (McFarlane, A., 2011).

The Alberta FASD Cross Ministry Committee (FASD-CMC) was formed in 2002 and includes representation from nine provincial government ministries. Prior to 2002, there were a limited number of FASD diagnostic and assessment clinics that were either institution-based (Glenrose, Alberta Children's Hospital), private clinics or operated by not-for-profit societies or agencies. Since 2007, the development of the FASD-CMC, and the allocation of money to support the initial implementation of the FASD 10-year strategic plan, numerous FASD diagnostic and assessment teams have been developed across Alberta.

> *"It is more important to understand what level of understanding you are at and to know what level you should be or want to be at. Access whatever training you need, and use whatever avenue is available. For some, that might be e-learning, peer delivered or face to face."*

Initially, seven FASD Networks were established across the province and in 2008, five additional FASD Service Networks were established. The Government of Alberta has invested nearly $37 million since 2007 for FASD programs and services.

These funds support FASD-related initiatives across Alberta, including awareness and prevention, assessment and diagnosis, and research and support for individuals and caregivers. The FASD 10-year Strategic Plan provides an overview of the scope and impact of FASD on

individuals and families in Alberta. It identifies a vision, mission statement, guiding principles and a broad framework for the coordination, planning and delivery of FASD services across Alberta (www.fasd-cmc.alberta.ca).

Methodology

A list of diagnostic and assessment clinics that operate within each Network was used as the starting point for the key informant interviewee list. A letter **(Appendix A)** sent to all team and network coordinators outlined the intent of the project, the time frame for completion of interviews, and contact information for anyone with questions around the interview and project. Attempts were made to interview all team coordinators or, in their absence, network coordinators or team support workers. The interviewee list also included team physicians or paediatricians, psychologists, nurses, speech-language pathologists, occupational therapists, social workers, and correctional services staff. Some interviewees had personal, face to face interviews, however due to the short time frame for completion and the inclement time of year (winter), most interviews were completed over the telephone. Interview appointments were scheduled in advance to ensure that sufficient time to conduct an uninterrupted interview was allotted. The interview format was qualitative and focussed on listening and obtaining the most relevant information from the interview participant. This format was meant to explore elements being investigated, to allow the participants to describe their experiences, and to obtain useful, directive feedback. Qualitative interviews are a more personal form of research than questionnaires or rating scales and the interviewer must have the ability to probe or ask follow up questions. This type of interview format can be more time consuming than a quantitative method of data collection and may pose logistical difficulties, given the short time lines established to examine the data and complete the final report. Qualitative interviews do provide clear, descriptive senses of stakeholders' current training experiences and information where attention and further development is needed.

A general interview guide approach was used, with standardized, open-end questions **(Appendix B**). This method is intended to ensure that the focus of questions is the same for each participant, while allowing for flexibility and modification of the question to get sufficient information from each individual. There were 13 clear, easy- to- understand questions, with opportunities for participants to add or provide further information and impressions of the interview. Consents outlining the purpose of the interview and the intended use of the responses were provided to each participant to sign and return **(Appendix C).** The findings of this investigation are described in the subsequent sections of this report.

Strengths and Challenges of Diagnostic Teams

Newly developed teams are to be commended for their multiple successes which have enabled families to obtain a timely and necessary diagnosis and a post-diagnostic continuum of care services. There are positive outcomes with each clinic, however there are also challenges faced by emerging clinics.

Strengths

The creation of 11 FASD –CMC Networks has allowed regional FASD diagnostic teams to access funding which supports multi-disciplinary assessment, targeted prevention campaigns and follow up support for those affected by an FASD. This level of funding support has done much to allow teams to advance their diagnostic capacity and to focus their energy on developing strong teams.

Emerging strengths in the diagnostic and assessment field include:

- A diverse level of skills, abilities and knowledge that exists collectively among provincial clinics;
- Advances in community capacity to support multi-disciplinary team involvement and stakeholder participation in FASD service delivery, in part due to the level of agency involvement with their respective network leadership teams;
- Best-Practices in areas of diagnostic and assessment clinic services are evolving to provide unique service delivery models that meet the needs of each region and are respectful of those accessing the services, while upholding the FASD Canadian Guidelines for Diagnosis;
- Development of consistent and accountable clinic practices that encourage the integrity of the diagnostic process throughout all regions of the province;
- Ability of team members to participate in projects such as this one and to provide useful feedback for program developers;
- Alberta is seen as a leader in areas of Assessment and Diagnosis and is a model for many other regions in Canada.

Challenges

Despite the rapid expansion of clinics throughout Alberta, there continues to be no standard for the training of FASD diagnostic and assessment teams in the province, nor is there a national standard for those existing or emerging clinics throughout the other provinces of Canada. As an example, and not to undermine the commitment to excellence of new network agencies, there are clinics operating within agencies which have no prior experience in either the coordination or delivery of FASD services. Challenges faced by new teams include, but are not limited to the following:

- Team coordinator and other team member attrition;
- New agencies with little or no prior diagnostic clinic background are administering the contract for services, which involves a learning curve and policy development around clinic services;
- For new coordinators with no prior clinic experience, there is a strong, underlying

theme of "where do we begin the process of team development and coordination for clinics", especially for new teams with no mentorship experience with FASD assessment and diagnosis within the organization;

- In some rural, remote communities, there is an absence or shortage of trained professionals who are able to administer the required assessments;
- Lack of infrastructure to keep clinics current or advise of best practices, or policy changes that might impact clinic operations;
- Difficulties in accessing opportunities that would allow meetings with other clinics and colleagues who are involved with FASD assessment and diagnosis;
- Teams relying on in-house training for coordinators by other team members with limited clinic coordination experience;
- Geographical, work-load and budget restraints are barriers for accessing team training;
- Confusion and a lack of consistency when it comes to legal and consent documents required for the collection of medical and other confidential material for the clinical process. Understanding the parameters of the Health Authority Act, FOIP and how it impacts the diagnostic clinics' process is time consuming and misunderstood by many;
- Lack of funding to support training for team members.

For the most part, these issues are not answered by the Canadian FASD Diagnostic Guidelines, and the information is not contained in a manual or other retrievable format that coordinators can readily access and have assurances that it is accurate and current.

Themes Arising During Interviews

During the course of 31 interviews, it became clear that the clinics are to be commended for successes that have enabled them to provide professional and client centred services for those seeking FASD assessment and diagnosis.

Current Levels of Training

There were limited responses which identified training specific to FASD assessment and diagnosis or targeted team coordinator training. This reflects the finite number of resources that are known to provide specific diagnostic team training and targeted team coordinator training.

Identified FASD Diagnostic & Assessment Training

- Lakeland Centre for FASD—1 or 3 day clinical training for teams; onsite, Cold Lake, AB;
- Clinic training that is delivered to teams in their own region—trainers travel to these communities. Often the training is delivered by a physician, psychologist and a coordinator or individual with extensive coordination experience;
- Teams supported by telehealth to access mentorship and affiliation with an institution-based team. This model provides confidence to new teams and increases transference of skills and knowledge from those with expertise to newly developed teams.
- University of Washington-FAS Diagnostic and Prevention (DPN) 1 or 2 day training;
- University of Washington-4 digit code on-line course;
- Lethbridge Community College FASD—1 year certificate program; online delivery. Some course content has diagnostic and assessment information;
- Training of coordinators completed in-house by other team members or overlap with previous coordinator when first employed;
- Shadowing clinic coordinators or team members who have prior experience;
- On-site diagnostic clinic coordinator training offered by LCFASD.

"Everything is useful—even the small points. Nothing is redundant if it is a good reminder of why you are doing this work. It's so important to come back from training and share information with other team members."

"The training is only as good as the passion an individual has for wanting to expand their knowledge and make it relevant for the team role or position."

Identified Training that Supports FASD Knowledge and Skill Sets

Interviewees reported that while an abundance of the current training received was not specific to FASD assessment or diagnosis, the training was still considered as being valuable for team members. These types of training opportunities were described as being essential for keeping current with best practices, emerging research in the field and to establish and to provide networking opportunities with peers and colleagues in the field.

- Alberta Provincial FASD conference;
- National and International FASD Conferences;
- Workshops and professional development through employers or affiliations;

> *"The impact of being able to observe an actual clinic, as offered at LCFASD, was very relevant for all who took the 1 or 3 day training in Cold Lake. It gave me the confidence and knowledge to begin the coordination piece of the puzzle."*

- Organic Brain Disorder Training- (OBD);
- The Provincial FASD videoconference series was identified by many as a useful training tool and many took advantage of the sessions that held interest for them. For some, these series were identified as the only FASD related training they had accessed;
- Presenters delivering specific information around FASD intervention, support, working with youth and adults affected with FASD, continuum of care strategies and other content that is specific to the audience attending. Some of this training was open to community stakeholders, as well as FASD team members;
- Independent research that is self-directed and shared between team members;
- In-house training delivered by professionals within their team: i.e. team Psychologist, SLP, OT and Physician. This training was often concurrent with team meetings or delivered on clinic day.

Impact of Training

All interviewed participants unanimously stated that any FASD diagnostic and assessment training prior to clinic was a valuable, necessary and an ongoing process. Training seemed more relevant after some clinic experience, but all coordinators reiterated that no training prior to clinic would have been very difficult. Although this response was underscored by team coordinators, it was also expressed by speech language pathologists and occupational therapists.

The following responses explain the impact past training had on the interviewees' role with FASD diagnostic and assessment teams:

- Team coordinators appreciated any overlap with previous coordinators; however, when the sole mode of training is left to the out-going coordinator or other staff, there is the sense that training consistency across the province might be compromised. This is more apparent with teams who have been operational for a short time, and are facing attrition of network staff. Face to face training and the ability to observe an actual clinic, paired with mentorship from other teams, was recognized as being valuable;
- All previous training is useful—even training that isn't targeted specifically as FASD training (e.g. motivational interviewing techniques; training around working with women with addictions);
- Sharing information with others in same profession has value and is one way to keep current with latest research;
- The University of Washington 4-digit code and diagnostic training

increased knowledge level and confidence to participate in the clinic with a better sense of clinical terminology and understanding of diagnostic coding;

- Training that is individualized for the team and their unique demographics and circumstances are valuable and make it more relevant (i.e. team coordinator training);
- Mentorship with other teams is an important part of training for many—especially if they haven't been able to access other diagnostic training;
- For professionals on the team, orientation prior to clinic makes a difference and "more is better". Profession-specific material, especially around testing materials made a difference to their orientation;
- The video-conference series are useful for "FASD 101" material and has relevancy;
- The OBD training gave insight into interviewing birth moms for prenatal history;
- Face to face observation of more than 1 clinic model gave the team some direction in choosing their team model;
- Training is useful when it helps to break down the diagnostic process and language into understandable pieces.

"Training set the stage for our team to begin clinic coordination. The task of starting from scratch would have been very difficult had there been no chance of observing an actual clinic."

How do Team Members Keep Current?

When asked how they keep current in their field of expertise as it pertains to FASD assessment and diagnosis and how they are informed of any emerging information that would impact their role on the multi-disciplinary team, the interviewees had varied responses. The following ways of keeping current were identified, in addition to suggested methods of information sharing:

" Have Coordinator be the "receiver of information" and gate-keeper and pass on relevant and current information to team—most team members are full time employees somewhere else and would like to see a centralized method of keeping current and then be informed by team coordinator".

- Alberta Videoconference series —accessible and no cost to clinics;
- List serves that could be accessed by team members through a log-in system;
- Networking between clinic members—this would be a formalized and scheduled

event(s);

- Link to University of Washington e-mailing list or other links to sites that are evidence based;
- Coordinator's meetings—face to face has more value;
- Peer delivered training to keep current and journal articles within professionals' specific field;
- Attendance at INAT or DiagnosticNAT meetings—good chance to network with others from out-of-province;
- Participation with diagnostic and assessment clinics to keep current and connected with local team;

"The provincial conferences were good opportunities to hear from families who have been impacted by FASD and to associate real people, with real stories to the work we do".

- Take advantage of any professional development that is offered.

The responses to this question highlighted the need for a coordinated and enhanced response to the dissemination of relevant, current information for all teams. Many stated that email links sent by CMC, team coordinators or other team members are good ways to keep current; however an effective infrastructure where this is managed outside the networks would be better. This recommended system would ensure all clinics are receiving the same information and that no one clinic would be left out or be responsible to forward information to the other networks.

Current Training Needs of Teams, Content, Delivery Modes

When an organization supports training, future productivity and retention are invested. As with any other organization, human resources are the most valuable asset for any FASD diagnostic and assessment team. They are also one of the most dynamic and changing aspects for some teams. In order for team members to reach or maintain their full potential, issues such as motivation, leadership, communication and training must receive attention. This report focused on the training needs of the teams, the content of training and the delivery format of training.

"Teaching each other on the team is challenging, as professionals are already being pulled together for the clinic dates and it is expensive to attend training and pay for expenses over and above clinics. There needs to be a lead organization to have a provincial-wide resource to log in and access articles and other resources."

The interview had 4 questions which focused on:

- Current training needs of the teams;
- Content and information which would be most useful for any future team diagnostic training;

- Modes of delivery for future training.

Current Training Needs Identified

Interviewees identified training opportunities they have accessed. They also stressed the need for additional training and resources that would provide relevant, practical information or training around current FASD diagnostic and assessment research, and any information that impacts their role with the team, whether it is linked to pre or post clinic involvement. Common themes emerged regarding training needs of teams:

- There is a desire to develop more relevant training for team development and processes. Some teams are experiencing difficulties with recruitment and retention of team members and would like training to focus on team roles and process;
- The current training needs are dependent on team representation and the expertise level of members. This is not static, so training needs to adapt to current and future members' needs;
- Effective training should be consistent throughout the province to enhance credibility of all teams;
- The understanding by all levels of agencies and government that ongoing training is essential to keep current and connected with others in the field. Training and education is an important part of diagnostic clinic development and sustainability;
- Training should be accessible by all teams and cost factors need to be recognized as an important variable for teams to keep current.

Identified Training Content

Individual team members identified training content they thought was essential and foundational for those participating on the teams as well as information regarded as useful and informative, but not conditional for team development. Essential training should include the following content:

- Criterion for diagnosis, knowledge of the Canadian Guidelines for Diagnosis and understanding of the 4-digit code and terminology;
- Background knowledge of assessment tools for those team members who do not administer or score the tests—this gives foundation for understanding the domains tested;
- Clinic day process, which provides a context of what background information is needed, team roles and responsibilities;
- Legal issues or questions that could arise from use of consents to release confidential information and release of reports;
- Guidelines for professions, such as O.T. and S.L.P., to determine when a screening tool might be appropriate rather than a full assessment in terms of being able to look at indicators where pre-natal alcohol exposure may have impacted function. This does not eliminate the need for further full or further testing, but might clarify

when a screening function would or would not suffice;

- Specific team coordinator training. Content identified as being essential for coordinators includes:

  - ✓ *Referral, Screening and Intake Process;*
  - ✓ *Information about Legal Guardianship Orders, Health Information Act, Freedom of information and Privacy Act, Privacy Impact Assessments and any other legislature or policy that would impact the intake process and information retrieval for clinic;*
  - ✓ *Case scenario approach in training to prepare and anticipate difficult referrals;*
  - ✓ *Cultural competency training;*
  - ✓ *Obtaining maternal alcohol confirmation and history—all coordinators wanted information and appropriate tools;*
  - ✓ *Coordinating logistics, such as timelines pre, during and post clinic; preparation of clinic agenda and any other planning process leading up to and including clinic date;*
  - ✓ *Motivational interviewing skills, which is essential for person completing birth mother or caretaker interviews.*

- Training that would be useful for team members to access, and is broader based than just diagnostic and assessment content was identified:

  - ✓ *Background on how to transfer the assessment results from O.T., SLP and Psychology to practical interventions when developing support plan for individuals and families;*
  - ✓ *FASD 101 content for new team members who have the commitment and enthusiasm for team participation, but may be lacking foundational knowledge around FASD diagnostic processes and post-clinic follow up planning;*
  - ✓ *Adult specfic diagnostic information;*
  - ✓ *Profession-specific and peer delivered was seen as important, especially for core professionals on the team.*

Training Delivery Format

- Hands-on observations of other clinics to gain better understanding of different processes and best practices and provide mentorship;

- Policy and process training manual would be helpful, DVD's and other resources that could assist in keeping current;
- Provincial FASD video-conference series and on-line modes are considerations for team members who cannot access training delivered from larger centres or are financially restricted;
- E-learning or on-line course delivery;
- Emailed articles that keep current with latest research, best practices;
- Face to face delivery for clinic observations for new staff and for coordinator meetings;
- Provincial FASD conferences are a good way to network with other teams and obtain a more generalist base of training;
- Websites that provide links for individuals to pursue specific topics;
- Opportunities for coordinators to have break-out sessions and ability to ask questions, especially those who are new to positions;
- Peer delivered;
- Training that allows for discipline- to- discipline dialogue and mentorship;
- Training that provides accreditation or credits for designated professions.

Barriers and Challenges

Common themes emerged when participants were asked:

> "Are there any barriers or challenges you see for yourself or other members of your team in accessing training?"

- **Workloads and time commitments from team members**

Most members of community based FASD multi-disciplinary diagnostic and assessment teams are core team professionals who have other full time commitments in their field or government/ agency representatives and are employees of those organizations. Those interviewed listed a common barrier as not having the time to attend training due to commitments with their full-time jobs and the difficulties for some to obtain approval. Training is often a juggling act for many professionals, who are committed to the clinic, but cannot take time from other obligations. An exception is the team coordinator or those affiliated with facility-based teams, when they are often paid employees of the agency or society responsible for the diagnostic component.

- **Financial restrictions of accessing training**

Participants representing many teams identified costs of attending training as prohibitive

thus preventing them from accessing a continuum of valuable and useful information. Some interviewees cited the lack of awareness or knowledge by their managers or employers regarding the necessity and value of diagnostic training by their representatives on the team.

For many rural based teams or those not operating under an institution-based model, there is no set budget for training team members on an ongoing or even initial basis; however, it was stated that the expectation remains that these clinics operate at the same level as those who have been afforded full staff training. Professionals interviewed stated that time away from their practices to attend training was usually not covered.

- **Location of training and delivery format**

A common theme emerged around locations of training events and the current format of training delivery. This barrier intersects the findings on financial restriction to access training, however its focus is more on the time and energy spent to attend a training session: i.e. 2 days travel to attend a one-day training session. This is the case for many rural and remote teams located outside the Edmonton/Calgary regions. The use of telehealth and videoconferences are suitable for some training but targeted training for new teams and new team members is most desirable using a face to face or onsite training mode of delivery. The option of e-learning or on-line course delivery would increase accessibility of core training.

- **Lack of awareness of available training**

Currently, there is no centralized mechanism to inform teams of training opportunities or provide them with websites or links to obtain up-to-date training information. The most common method of receiving any training news is when network coordinators, team members, or individuals access resources, share and forward this information or they receive email notices from organizations or list serves.

Several new team members highlighted, “not being aware of training opportunities”, and this is a valid response regardless of the duration they had served as a team member. The Canada Northwest FASD Research Network has an excellent website that posts current training opportunities however, it was noted that not all team members are aware of its existence and usefulness as a resource.

Proposed Training

Throughout the course of these interviews, importance of investing in team members’ training was underscored as an area that is vital to organizations’ ongoing capacity to deliver quality and consistent services in the area of FASD assessment and diagnosis. Currently there are no standards of training in place, and this has resulted in an inconsistent approach and one that has obvious shortfalls. The additional section of this report focuses on the proposed training plan and offers a broader prospective of suggested training and its formats. Capacity development in this area could include:

Education—usually intended to mean basic instruction in knowledge and skill set. This can be broadly based;

Training—opportunities to gain specific skills;

Development—suggests a broader view of knowledge, understanding skills and values to be able to adapt to challenging work scenarios;

Competence—putting learning into practice; the difference between "knowing how" and "doing". (adapted from Cole, 2004)

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www.fasd-cmc.alberta.ca

Appendix A

Letter of Introduction

Lakeland Centre for FASD Fetal Alcohol Spectrum Disorder
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January 14, 2011

Dear Alberta FASD Diagnostic/Assessment Clinic

RE: Alberta Diagnostic/Assessment Training Project

As you are aware, over the past 3 to 4 years, there have been numerous FASD assessment and diagnostic teams developed across Alberta. For many current teams, this rapid expansion of assessment and diagnostic services was largely due to the funding assistance from the FASD Cross Ministry Committee (CMC). Newly developed teams are commended for multiple successes that have enabled families to obtain timely and necessary diagnosis and post-diagnostic continuum of care services. There are positive outcomes with each clinic, however there are also expected challenges faced by emerging clinics.

Currently, there are no standards for training of FASD assessment and diagnostic teams in Canada. Some new clinics are operated within community agencies with no prior experience in the field of coordination of FASD service delivery (not to undermine the commitment of these agencies to providing excellent services). Many of the challenges faced by new teams include: team coordinator attrition, new agencies administering the contract for services and a strong, underlying theme of "where do we begin the process of team development and coordination for clinics". These issues are not answered by the Canadian FASD diagnostic guidelines or any available resource material.

Alberta Health & Wellness, through the FASD-CMC, (a contract is pending) has asked the Lakeland Centre for FASD (LCFASD) to make recommendations regarding the training needs for FASD assessment/diagnostic clinics in Alberta and to develop a comprehensive clinic manual with common forms and applications. The LCFASD has trained FASD Diagnostic and Assessment teams within Alberta and the rest of Canada since 2002, has participated in numerous clinic development projects, written clinic resource materials and has participated in clinic research practices.

In order to develop a comprehensive manual and identify a training plan for clinics, it is optimum for a meeting (either face-face or video conference) to be held with as many teams as possible. Coordination of this project will be launched over the next few weeks and someone will be contacting you to make arrangements for a meeting of your convenience. The meetings would focus on the current training needs of the clinic coordinator and team member and to discuss future training you feel would be necessary (mentoring, other resources, face-face meetings with other clinics, e-modules). Information will also be sought as to the types of training that would have been useful when your teams initially developed and prior to any assessment or diagnosis being completed.

It is recognized that there will be different needs for community based or facility based teams, as each region is unique, with unique challenges and strengths. Your input and participation will greatly assist in completion of meaningful training recommendations for the FASD-CMC. For those clinic members who would like to attend the face-face or video conference meetings, but are unable, an electronic survey is a possible solution.

There are many clinics using common forms and some teams have developed creative, innovative and practical tools to assist with team development, policy and practice. These may be team manuals, checklists or other materials that are individualized and adapted to your clinic's unique needs. It is hoped that by clinics sharing these valuable tools, we will be able to develop common forms/processes that can be utilized for the benefit of all clinics. If you are able to share these documents electronically, in advance of the meetings, please email them to: Audrey.mcfarlane@lcfasd.com

The timeline for providing feedback and reporting to CMC is short—by March 31, 2010. Thank you for the support and guidance with this project. Please feel free to contact me with any questions or concerns you might have or if another contact other than yourself should be added.

Sincerely,

Audrey McFarlane
Executive Director

Appendix B

Interview Guide
Clinic Training Alberta Teams

Introduction:

The aim of this qualitative interview is to provide a scan of current and future training needs of FASD diagnostic and assessment clinics in Alberta, and ascertain what training might have been useful to emerging or new teams.

Participant information

Participant I.D. _______________ Date of Interview___________________________

Site:_________________________ Name of organization_________________________

Consent ____Y ____N Name of Interviewer__________________________

Role____(Coordinator, profession, etc.)

Time: start____ End_____

Participant background:

1. Could you please describe any prior training related to FASD assessment and diagnosis you have completed? (What format, type , delivery mode, length, when?)

2. Can you explain the impact of any past FASD training you have and the extent if there is differences this training has made to your work with the FASD team. (positive, useful, not related to or relevant to current role with team)

3. Please explain how you keep current with any latest development, research or best practices in the field of FASD assessment, diagnosis? (courses, peer articles, papers, etc., conferences/workshops, mentoring, face-face meetings)

Current Training Needs:

4. Please elaborate on the current training needs of the FASD diagnostic and assessment team you are involved with? (extent of training needed, necessary, adequately addressed, ongoing, are not aware of needs)

5. What do you consider to be key method of delivery criteria for any FASD assessment/ diagnostic clinic training to be effective? (peer-delivered for professionals, face-face, back-ground and knowledge base of participants to be similar, participatory, available as on-line, flexible format)

6. Please describe some of the content or information that would be most useful for you in the course of any FASD diagnostic and assessment clinic training? (theory, Canadian guidelines, clinic process, specific to coordination)

7. What resources would be helpful to yourself or your team that might address some current training needs of your clinic? (manuals, video-conference, mentors, on-line resources, follow-up training, on-site clinic observations, feedback)

8. What advice could you give to anyone considering the training needs of new or emerging FASD clinics in the province? (delivery-mode, tailored to unique team demographics and regions)

9. Are there any barriers or challenges you see for yourself or other members of your team in accessing training (costs, work-load, scheduling or other logistics?)

Ongoing training and future needs:

10. How would you see any newly acquired skills or training maintained long-term for your team? (refreshers, one-one mentoring, manual updates)

11. If you could have accessed specific training prior to any FASD assessment or diagnosis clinic occurring, please describe what this training would cover (FASD 101, coordination, team roles, policy, Canadian standards)

12. What type of follow up or support do you think is necessary for diagnostic and assessment teams following any type of team or coordinator training? (mentors, manual updates, one-one)

13. Please describe any training needs of your team that you anticipate would be helpful over the next year.

Wrap up questions:

Do you have anything to add?

Is there anything else I should have asked with respect to training needs, current or future?

Appendix C

Consent for Interview

I ____, _____________________________ (role) do consent to the following interview conducted on behalf of Lakeland Centre for FASD for the purpose of collecting information to guide the current and future training needs for FASD diagnostic and assessment teams in Alberta and to undertake the development of a comprehensive diagnostic training manual. I understand that any information I give will not be identifiable as to the individual or team represented and that none of the information will be given to anyone for any other intent.

____

Signature of interviewee

Date

____