

Parent-Child
Assistance Program
(PCAP) in Alberta First
Nation Communities
Evaluation Report

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Report Prepared by
the Alberta
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THANK YOU

We extend our sincere thanks to the PCAP participants, mentors, and supervisors, as well as all FASD Network staff, who took the time to openly share their stories and experiences.

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FOREWORD

In this report, our evaluation team presents findings from an evaluation of the Parent-Child Assistance Program (PCAP), as implemented in First Nation communities. Our report begins with an introduction to the PCAP, including organizational context and alignment with the Truth and Reconciliation Commission of Canada principles. Next, we detail our evaluation methods, with a description of our approach, purpose, and questions, as well as qualitative and quantitative data collection and analysis. Our evaluation findings are subsequently shared and organized according to data source. Finally, we summarize the data that addresses our evaluation questions and end with recommendations and conclusions. Throughout our report, the analogy of a journey is used.

EXECUTIVE SUMMARY

INITIATIVE DESCRIPTION

Our evaluation was undertaken to provide key information about how the Parent–Child Assistance Program (PCAP) was being implemented in order to identify areas for improvement, and to provide outcome information to stakeholders to inform decision-making regarding ongoing implementation of PCAP in First Nation communities.

PCAP is an evidence-based three-year home visitation program aimed at preventing future alcohol- and drug-exposed births. PCAP serves women who are at risk of abusing substances and who are pregnant, at risk of becoming pregnant, and/or up to six months postpartum. PCAP mentors assist clients to avoid drinking before and during their pregnancy, and to avoid becoming pregnant if they are unable to achieve sobriety. In 2014, the Alberta Ministry of Health provided funds to Alberta Community and Social Services to fund six FASD Service Networks to establish or expand PCAP in First Nation communities in Alberta. The work of PCAP aligns with the Truth and Reconciliation Commission's (TRC) Calls to Action, including Call to Action number 33 regarding addressing and preventing Fetal Alcohol Spectrum Disorder (FASD).

EVALUATION OVERVIEW

Our evaluation used a participatory approach. Participatory evaluation involves local people and evaluators deciding together how progress should be measured, and often requires the adaptation of methods to local circumstances. Our approach was responsive in that we adapted our methods to meet the needs of the communities that we worked with. As a result, we conducted a significant proportion of this evaluation in person. As decided upon during an early evaluation-planning meeting involving community representatives, both qualitative and quantitative data sources were used for the evaluation.

KEY FINDINGS

Qualitative findings were organized according to six themes that aligned with the analogy of a journey. Themes included (1) rooting the program, (2) growing the program, (3) landmarks of success, (4) bumps in the road, (5) walking with First Nation communities, and (6) moving forward together. Qualitative and

quantitative data were combined to address three evaluation questions, as follows.

1. How has PCAP been implemented in First Nation communities?

a. To what extent are services delivered in alignment with the PCAP model?

PCAP staff generally reported a high degree of fidelity to the PCAP model by describing how their work aligned closely with PCAP principles, goals, and protocols. Thus, there was no indication of a need to change the core principles of the PCAP model in order to provide adaptive and appropriate services in Alberta First Nation communities. There was some reported leniency regarding client enrollment criteria and the timeframe of services, which may reflect responsiveness to community needs. There was also some variation in responses regarding staff qualifications and mentor supervision, which may be related to the limitations of small communities. Overall, however, our findings suggest that the PCAP model works well in First Nation communities, and that mentors are able to deliver respectful, culturally respectful services through the model.

b. What key considerations are important for working with First Nation communities?

Along with a high degree of fidelity to the PCAP model, our findings shed light on key considerations important for working with First Nation communities. In particular, a significant investment of time and effort was required to establish PCAP roots, and community approval had to be obtained before the program could begin. It was also important for program staff to have community knowledge, as well as an attitude of respect and a desire to learn about the community. With community approval and knowledge, as well as sufficient time, relationship building could occur, and mentors could begin to carry out work with clients, which involved addressing challenges unique to working in rural, remote, and isolated First Nation communities. To work with these challenges, mentors reported engaging in work that was outside of their job descriptions, such as attending community events outside of typical business hours. Mentors were also required to demonstrate high levels of flexibility and

responsivity, for example, by prioritizing a holistic, collective, and community-based orientation to service provision. All of these considerations aligned with the spirit of the TRC work. These findings highlight how PCAP staff have made adjustments to the ways that they implement the PCAP model in order to demonstrate cultural sensitivity and respect for the people and settings in which they are carrying out their work.

2. In what ways has PCAP impacted participants and their families?

Overall, mentors observed a number of impacts on clients and families across domains of well-being. The majority of clients reported strong relationships with mentors, supported by powerful quotes. To obtain a more complete picture of client outcomes and impacts, we attempted to access information from the Penelope and FASD-ORS databases. However, it was not possible to obtain this data. Therefore, our evaluation of client and family impacts is limited, and further evaluation is recommended.

a. What impacts have mentors observed?

Mentors observed a number of emerging impacts on clients and their families, including improved client social and emotional wellbeing, clients' increased positive community experiences and independence, reduced stigmatization and isolation, and reduced stress levels. Impacts were also observed in the domain of addictions and mental health. While engaged with PCAP, women accessed health and addictions services, and some were able to complete addictions treatment. At the familial level, women had healthy births, regained custody of their children, and evidenced improved parenting practices.

b. What impacts have clients experienced?

Clients reported strong relationships with mentors, as well as high perceptions of the quality of support received. Clients reported that mentors had helped them with such areas as developing a positive outlook and building on their strengths, while demonstrating understanding and respect. Overall, clients reported that their mentors had made a difference in their lives.

3. In what ways has PCAP impacted communities?

Communities were observed to become increasingly informed, with a growing awareness about the work of PCAP, an increased community-level awareness of FASD, and reduced stigmatization of clients.

RECOMMENDATIONS

1. Continued investment in working with First Nation communities

A primary recommendation is for continued investment in relationship-based, trauma-informed programs that are responsive to First Nation communities. Programs such as PCAP can contribute to positive outcomes for individuals, families, and communities, and it is strongly recommended that efforts to move forward continue to be explored based on our evaluation findings, which suggest that PCAP is an appropriate fit for many First Nation communities.

2. Changing the ways that services are provided in First Nation communities

A movement away from short-term program funding within communities is suggested. This model of service can be viewed by community members as harmful to the individuals most in need of services, and detrimental to actions towards reconciliation and change. Our findings clearly indicated that extensive work is required for staff to establish program roots in partnership with First Nation communities and that three-year program funding cycles do not provide this time. Sufficient time needs to be allocated for partnerships to develop between programs and communities – before clients can be seen. This requires adaptable and sustainable long-term funding models.

We suggest that all levels of program planning for First Nation communities should be adaptive and interactive, with clear, common goals, benefits, and expectations for all involved. Partnership, consultation, cooperation, mutual respect, and collaborative development are integral to program success and are signals that governing bodies are committed to actively involving Indigenous peoples. A new service provision model may include developing long-term co-administered funding partnerships that take a shared approach to planning, keep all involved parties accountable to shared goals, and allow change to occur within respectful professional relationships. In addition, a new approach might also be taken to the way that service training occurs for health or other employees. In particular, training sessions could occur within the smaller, more rural communities, or be offered in more easily accessible locales.

3. Improvements to Data Collection and Dissemination

Currently, a consistent method of data collection is not being implemented by all programs and Networks. A clear procedure needs to be put in place for collecting data and ensuring data quality. A protocol to guide data collection and entry would be of significant benefit. Building staff capacity and resources to consistently complete data collection and entry would need to accompany this protocol. It is recommended that infrastructure be developed in order for site-level data to be pulled and made available within each of the FASD Networks.

Standard PCAP reporting forms, such as the biannual reporting forms, may need to be adapted for culturally appropriate and respectful use in First Nation communities. Adaptation of these materials would need to be done in consultation with First Nation community members and Elders, and may address some of the barriers that exist related to completing these forms and thus obtaining important evaluative data.

In addition, data dissemination methods should be improved. Sharing outcomes could provide staff the opportunity to identify program strengths and challenges and to adapt accordingly. Community-level benefits could result from a wider dissemination of PCAP information in an accessible format. A collaborative decision-making process involving key community stakeholders should guide decisions around community dissemination. This will assist in developing trust, accountability, and transparency with community partners.

4. Ongoing evaluation and measurement

Evaluation and measurement are key to identifying program strengths and weaknesses, and understanding whether desired outcomes are being achieved. In order to implement continual evaluation of PCAP in First Nation communities, it will be critical for evaluators to have ongoing involvement with each of the communities participating in the evaluation. It is recommended that future evaluation should involve more face-to-face data collection and increased resources allocated to allowing deeper immersion into each of the communities involved in the evaluation.

5. Increased communication among stakeholders

All levels of PCAP (i.e., mentors, supervisors, funders) would benefit from increased communication. With multiple levels of stakeholders involved in PCAP, there are multiple opportunities for communication breakdown. We suggest that increased communication between organizational levels of PCAP (e.g., information technology and frontline staff) and between the Networks could be of significant benefit (e.g., by sharing advice regarding the coding of data and production of reports). Implementing a means for communication between sites and across Networks could allow staff to benefit from the opportunity to learn from those who have navigated similar challenges, and from the opportunity to share their stories. Introductions between sites and Networks will be important for opening the doors to communication and increasing the probability that staff will be comfortable reaching out. Aside from these suggestions, it is recommended that community input should strongly guide methods and strategies for improving communication.



INTRODUCTION

Description of the Program

The Parent–Child Assistance Program (PCAP) is an evidence-based three-year home visitation program initiated in 1991 by a research team at the University of Washington (Ernst, Grant, Streissguth, & Sampson, 1999). The goal of PCAP is to prevent future alcohol- and drug-exposed births. PCAP serves women who are at risk of abusing substances (e.g., alcohol and/or drugs) and who are pregnant, at risk of becoming pregnant, and/or up to six months postpartum. PCAP clients have commonly experienced early life adversity such as sexual abuse, unstable home environments, and parental substance abuse (Grant et al., 2014). These early life experiences are often associated with significant challenges later in life, including poverty, social isolation, housing instability, and involvement with the criminal justice system. To address these challenges, PCAP mentors use a case management model with the objectives of assisting clients to avoid drinking before and during their pregnancy, and to avoid becoming pregnant if they are unable to achieve sobriety.

PCAP work is guided by three theoretical frameworks (Figure 1). These include relational theory (Amaro & Hardy-Fanta, 1995), whereby the client–mentor relationship is regarded as critical to the program’s success; the transtheoretical model of change (Prochaska & Velicer, 1997), requiring mentors to tailor their work to clients’ differing levels of readiness to change; and harm reduction theory (Wodak, 1999), in that clients and mentors set goals to reduce the type or amount of abused substances until clients are prepared to work towards complete abstinence.

To achieve these goals, mentors’ work with clients centers around home visitation and intensive case management. In this way, mentors connect clients with other community supports relevant to such areas as their physical and mental health care, addictions, parenting, legal issues, and employment. Services are tailored to clients’ individual needs and are based on client-driven goals.

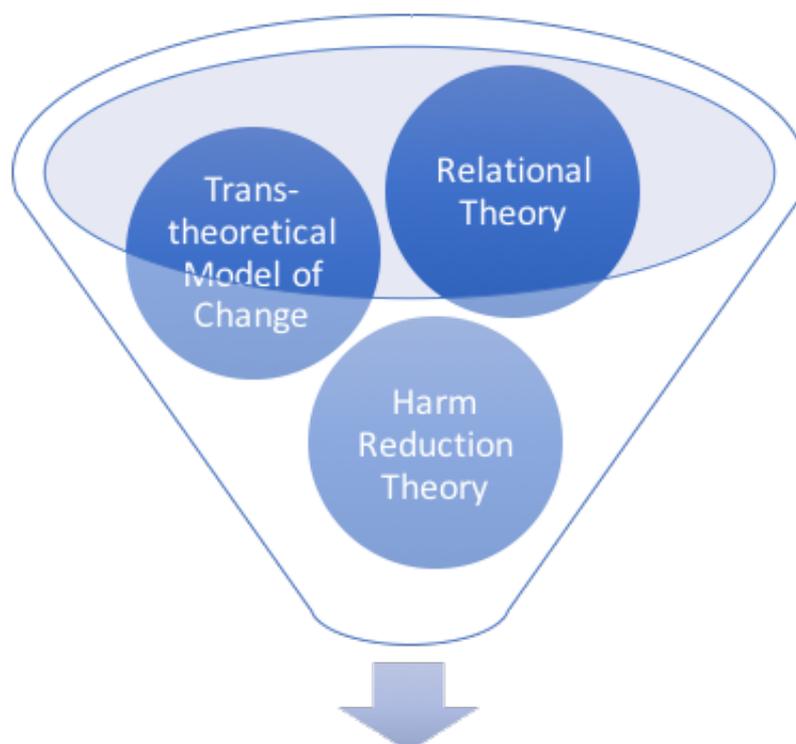


Figure 1. Theoretical basis of PCAP model

Organizational Context

In Alberta, PCAP has been in place since 1999, with 30 current Alberta PCAP sites providing services to approximately 500 women. The Alberta PCAP Council is in place to support quality assurance, promote program fidelity, and represent PCAP provincially.

In 2014, the Alberta Ministry of Health provided funds to Alberta Community and Social Services to fund six FASD Service Networks to establish or expand PCAP in First Nation communities in Alberta (see Figure 2). These consisted of South, Northwest, Prairie Central, Northwest Central, Mackenzie, and

Lakeland FASD Networks. Based on community consultations, decisions were made regarding the selection of First Nation communities in which PCAP would be implemented. Grant conditions included a requirement for an evaluation of PCAP in these communities. PolicyWise for Children and Families was required to manage this evaluation project. In turn, PolicyWise contracted the Alberta Clinical and Community-based Evaluation and Research Team (ACCERT), led by University of Alberta researchers Dr. Jacqueline Pei and Dr. Cheryl Poth, to design and conduct the evaluation.

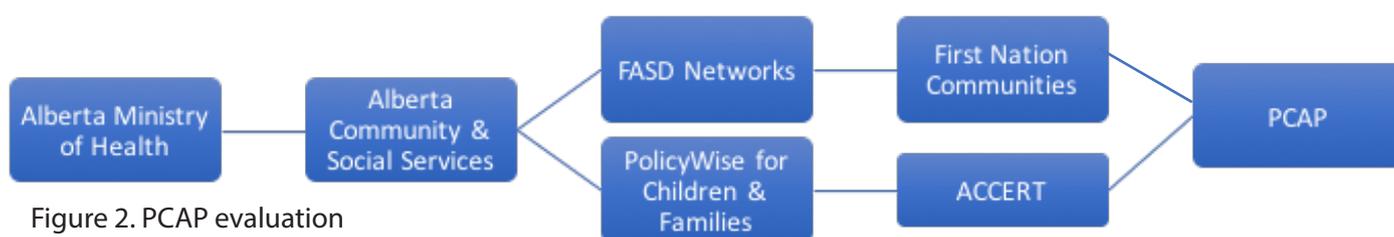


Figure 2. PCAP evaluation organizational context

Truth and Reconciliation

In recognition of the historic and ongoing impacts of colonialism on Aboriginal peoples, it is critical for programs providing services in First Nation communities to consider alignment with the Truth and Reconciliation Commission of Canada (TRC). The TRC was created to receive information about and recognize the unique experiences of former residential school students. The TRC has made a number of calls to action with the goal of establishing and maintaining respectful relationships to move forward on initiatives that will improve the well-being of Aboriginal Canadians (TRC, 2015). The work of PCAP aligns with the TRC's calls to action. Primarily, delivering PCAP in First Nation communities and evaluating its effectiveness and cultural appropriateness responds to TRC Call to Action #33:

We call upon the federal, provincial, and territorial governments to recognize as a high priority the need to address and prevent Fetal Alcohol Spectrum Disorder (FASD), and to develop, in collaboration with Aboriginal people, FASD preventive programs that can be delivered in a culturally appropriate manner.

The TRC has acknowledged that residential school experiences and ongoing colonialism have had detrimental intergenerational impacts on Aboriginal peoples, leaving many families without strong role models for parenting skills (TRC, 2012). To heal disruptions in parenting, the TRC has acknowledged the importance of providing culturally appropriate programs in Aboriginal communities, and providing resources for Aboriginal communities to keep families together where safe to do so. By accompanying women on their journeys towards healing, and with the goals of supporting women to give birth to healthy children and develop their capacity to raise healthy children, PCAP corresponds to the TRC.

The TRC has also called for creating a more equitable society by closing the gaps in outcomes between Aboriginal and non-Aboriginal Canadians (2015). Constructive action is required to address the ongoing legacies of colonialism, in part by attending to the distinct health needs of Aboriginal peoples, and in part through respectful relationships that will facilitate healing. (TRC, 2012). The relationship-based PCAP model certainly has the potential to contribute to closing gaps between Aboriginal and non-Aboriginal Canadians through relationship building.

EVALUATION METHODS

Evaluation Approach

Our evaluation used a participatory approach. Participatory evaluation involves local people and evaluators deciding together how progress should be measured, and often requires the adaptation of methods to local circumstances (Chambers, 2009; Guijt & Gaventa, 1998). Active engagement and participation of Aboriginal peoples has become an ethical imperative for Canadian researchers and is in keeping with the relational goals of the TRC (TCPS, 2010); thus, this approach was deemed most appropriate for our project.

We received ethical approval to use a participatory approach to work closely with communities on collecting information. Working with communities was important to our approach. This allowed us to maximize opportunities for engagement and participation from community members who were involved in implementing PCAP, thereby potentially enhancing the quality of our data. The participatory relationship with PCAP programs, and the responsive flexibility inherent to that relationship, also allowed for our evaluation team to be responsive to community circumstances by adapting our evaluation procedures accordingly.

As depicted in Figure 3, there were four overarching ways in which we enacted a participatory approach. In particular, we began designing the current evaluation in September 2015, when PolicyWise hosted an evaluation-planning gathering. Invitees included directors from each of the six FASD Networks that received Health funding. Directors had the opportunity to invite five members of their PCAP community who were interested in contributing to planning the evaluation. At this meeting, members of our evaluation team worked with community attendees to formulate evaluation questions and ideas for data collection, after which we circulated an evaluation plan to all attendees. In anticipation of the challenges faced by many PCAP clients, including limited access to cell phones and ongoing transience, collecting information from clients over the phone was not feasible. Therefore, we adjusted our data collection methods by visiting communities in order to collect information from clients in person. We also established in-person relationships with PCAP staff. Our evaluation team met in person with PCAP staff from four out of the six FASD Networks involved in the evaluation to discuss the purpose of the evaluation, conduct interviews and focus groups, and to attend community events.

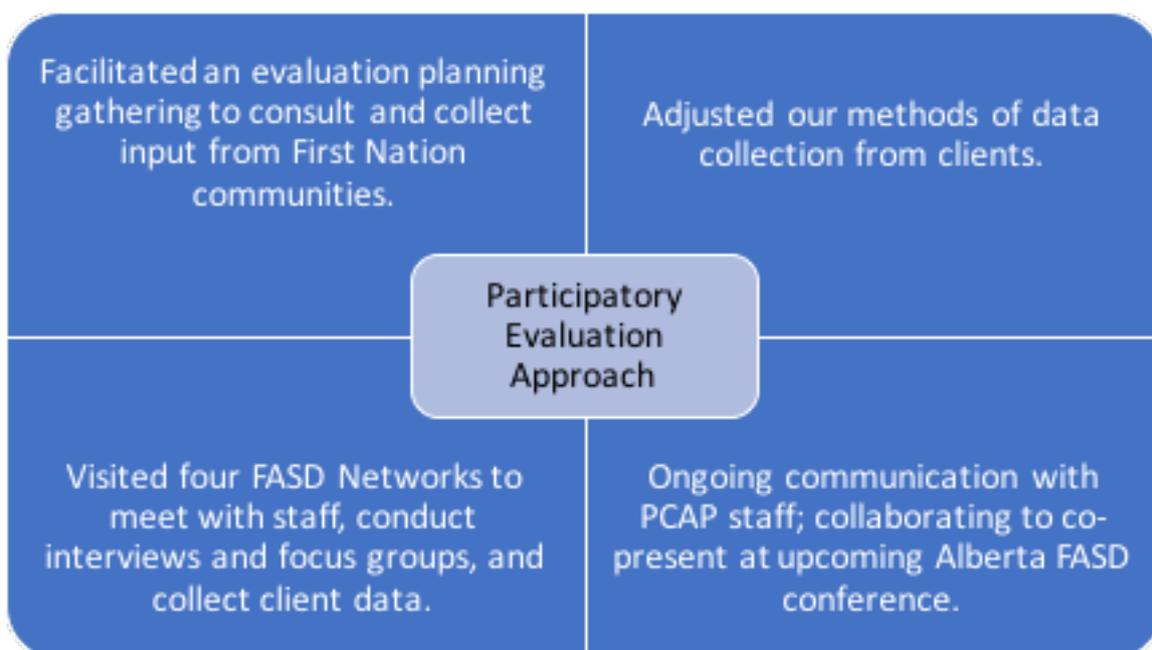


Figure 3. Our participatory evaluation approach

In one community, an evaluation team member brought her two-month old baby to a community baby fair, where information was collected from clients. As another example, one of our evaluation team members travelled to the Mackenzie Network with two staff members from the Northwest Central Network. This not only allowed for relationship building between our evaluation team and PCAP staff members, but also facilitated relationship building and information sharing between Networks. Feedback from PCAP staff indicated that this was an outstanding and worthwhile experience. Moreover, our evaluation team maintained contact with PCAP staff through

frequent email and phone communication, which further contributed to building and maintaining relationships. The benefits of our relationship building efforts continue to emerge; our evaluation team will collaborate to deliver a presentation at the upcoming Alberta FASD Conference in Calgary in October, 2017. Throughout all of our interactions with PCAP staff, whether in person, on the phone, or through email, our evaluation team carefully and intentionally demonstrated respect, responsiveness, and collaboration, working with PCAP staff to gather information in a way that honored their realities as well as those of their communities.

Evaluation Purpose and Questions

Our evaluation was undertaken with two overarching purposes. Our *formative-focused* purpose was to provide key information about how PCAP was being implemented, in order to identify areas for improvement. Our *summative-focused* purpose was to provide outcome information to stakeholders to inform decision-making regarding ongoing implementation of PCAP in First Nation communities. With these purposes in mind, we sought to address the following three evaluation questions:

1. How has the PCAP model been implemented in First Nation communities?
 - a. To what extent are services delivered in alignment with the PCAP model?
 - b. What key considerations are important for working with First Nation communities?
2. In what ways has PCAP impacted participants and their families?
 - a. What impacts have mentors observed?
 - b. What impacts have clients experienced?
3. In what ways has PCAP impacted communities?

Qualitative and Quantitative Data Collection and Analysis

Figure 4 provides an overview of each of our data sources. In particular, our evaluation used two sources of qualitative data, including interviews and focus groups as well as narrative reports. Two sources of

quantitative data were also used, consisting of the PCAP Fidelity Assessment and the Advocate-Client Relationship Inventory.

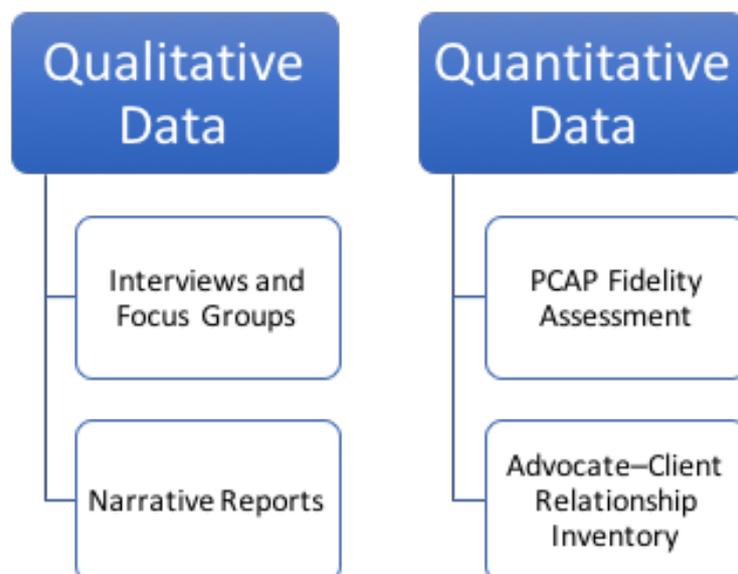


Figure 4. Qualitative and quantitative data sources

Table 1 describes how our evaluation questions relate to our data sources.

EVALUATION QUESTIONS	DATA SOURCES
1. How has the PCAP model been implemented in First Nation communities?	
a. To what extent are services being delivered in alignment with the PCAP model?	<ul style="list-style-type: none"> • PCAP Fidelity Assessment • Interviews and focus groups • Narrative reports
b. What key considerations are important for working with First Nation communities?	<ul style="list-style-type: none"> • Interviews and focus groups • Narrative reports
2. In what ways has PCAP impacted participants and their families?	
a. What impacts have mentors observed?	<ul style="list-style-type: none"> • Interviews and focus groups • Narrative reports
b. What impacts have clients experienced?	<ul style="list-style-type: none"> • Advocate-Client Relationship Inventory • Interviews and focus groups
3. In what ways has PCAP impacted communities?	
	<ul style="list-style-type: none"> • Interviews and focus groups • Narrative reports

Table 1. Evaluation questions and data sources

Interviews and focus groups

Semi-structured individual interviews were conducted with 24 PCAP mentors and supervisors, and six other community service providers (e.g., community nurses from other organizations who worked with PCAP) either over the phone or in person. Two in-person focus groups (with 6 and 22 staff, respectively) were also held with PCAP staff. At one of these focus groups, PCAP staff created collages to describe PCAP successes and challenges. Pictures of these collages are included throughout this report. Where consent was granted by participants, interviews and focus groups were audio-recorded and transcribed verbatim. Where it was not possible to audio-record interviews, detailed notes were taken. Questions were asked regarding how the PCAP site began, program successes and challenges, as well as how the program had contributed to improved community and client outcomes. To supplement interview and focus group data, some mentors captured photos that represented their experiences with PCAP. Photos are included in the findings section of this report.

Interview and focus group transcripts and notes were analyzed in alignment with the process of thematic analysis described by Braun and Clarke (2007). The goal of thematic analysis is to identify and report patterns or themes within data. This is carried out by

1. becoming familiar with the depth and breadth of the data through active immersion (in this case, reviewing transcripts and notes);
2. producing initial codes to meaningfully group the data;
3. looking for overarching themes and sub-themes among the codes;
4. reviewing and refining themes;
5. defining and naming themes; and
6. completing the final analysis (Braun & Clarke, 2007).

Descriptions of interview and focus group data therefore represent the results of each of these stages of data analysis.

Narrative reports

PCAP sites have various reporting requirements. Most sites provide quarterly and/or annual reports to their Networks and to funders. PCAP mentors, supervisors, and/or FASD Network coordinators were contacted and asked to provide these reports to the evaluation team, retrospective to the date that Health funding

was received. Reports were received from five out of the six FASD Networks. The content of narrative reports was reviewed by members of the evaluation team and subsequently mapped onto our existing data from interviews and focus groups.

PCAP Fidelity Assessment

PCAP is an evidence-based program, with researchers demonstrating high rates of substance abuse treatment completion and abstinence from substance abuse, fewer substance exposed births, reduced dependence on child welfare, and reduced dependence on public assistance among women completing PCAP as compared to similar women who did not complete the program (Grant & Ernst, 2017). Measuring fidelity to the original PCAP model represents one method for determining if positive outcomes can be expected based on that evidence.

The PCAP Fidelity Assessment was developed at the University of Washington. Although it is recognized that communities will need to adapt programs to suit their sites, PCAP has core characteristics that are evidence-based and integral to successful outcomes. The Fidelity Assessment was designed to evaluate alignment with the evidence-based PCAP model, and is comprised of 40 questions that cover nine domains: Characteristics of the Person Completing the Survey, Client Characteristics, Client Intervention Setting, Characteristics of Staff, Training, Conducting the Intervention, Clinical Supervision to Case Managers, Clinical Supervisor in the Community, and Program Evaluation.

Responses are provided on a five-point Likert scale, and each item corresponds to a different characteristic of the PCAP model, as follows:

Advocate-Client Relationship Inventory (ACI)

The ACI was also developed at the University of Washington. It is designed to examine how clients feel about their experience with their PCAP advocate. Participants indicated how they felt about each statement on a five-point Likert scale, where 1 = disagree strongly, and 5 = agree strongly. Three open-ended questions were included: a) Do you think being in PCAP made a difference in your life, or changed you? How? b) What did you like the best about PCAP? and c) What did you like least about PCAP?

- A score of five on any given item indicates that the PCAP site fully meets the characteristic (and therefore, reflects ideal PCAP model replication).
- A score of four indicates that a site is fairly close to meeting the characteristic.
- A three indicates that a site is midway between the two extremes.
- A two indicates that there is a small amount of similarity between the site and the PCAP model characteristic.
- A score of one indicates that a PCAP site does not meet the core characteristic of the PCAP model.
- Respondents could also choose a “don’t know” option, which indicates that the characteristic cannot be scored for their site.

A link to complete the Fidelity Assessment anonymously was sent to key PCAP contacts from each of the six FASD Networks via Survey Monkey, with instructions to distribute the link to others involved in the Network. These included mentors, supervisors, coordinators, directors, and program managers. Across Networks, sixteen staff responded to the Fidelity Assessment.

Results of the PCAP Fidelity Assessment were analyzed using descriptive statistics, and are presented in graph form throughout this evaluation report for a simple visual depiction of alignment with the PCAP model.

For three of the Networks that the evaluators visited in person (Prairie Central, Mackenzie, and Lakeland), clients completed the ACI in person. Other ACIs were completed over the phone. Informed consent was obtained from all clients before they completed the ACI. In total, 19 clients completed the ACI.

ACI results were analyzed using descriptive statistics and are presented with bar graphs, which depict overall ratings of advocate–client relationships. 14

Penelope and FASD Online Reporting System (FASD-ORS)

Reports were requested from the standard PCAP reporting databases (Penelope and FASD-ORS) from each of the six FASD Networks. Data were requested in relation to the following outcomes: number of clients served, client demographics, substance use, social support, birth control, pregnancy, income source/employment status, use of mental health counseling, and use of physician health care. As of August 2017,

it was not possible to obtain data from the Penelope or FASD-ORS databases. This is because site-level reporting was not possible at the time. Instead, data from Penelope and FASD-ORS are amalgamated across sites. According to the Alberta PCAP Council, developing the capability to pull and report data from specific PCAP sites will be a primary goal for the Alberta PCAP Council in the coming months.

Photovoice

An invitation was extended to PCAP staff to participate in the photovoice component of our evaluation. PCAP staff were invited to send the evaluation team photos that represented their experiences with PCAP, and that depicted the program's successes and challenges. However, our evaluation team learned that sharing information through photographs was not a comfortable exercise for PCAP staff members or their clients. As with the program itself, relationships and face-to-face contact were incredibly important to facilitate trust and information sharing. Thus, our evaluation team found that PCAP staff members were very engaged with us when we were able to visit them in person, and in many cases, when we conducted interviews over the phone, but sending photos through electronic means was not an effective data collection method for this population of service providers and their clients. Thus, we received

insufficient photovoice submissions to formally analyze. This revealed the importance of ongoing relationships with communities to determine the best approaches to exchanging information and gaining understandings. Moreover, although an approach may have been used successfully in the past with a given community, each community is different and requires negotiation and respectful consideration of the appropriate ways of "knowing" within that community.

Although formal analysis was not possible, the photos that were shared by mentors have been incorporated throughout this report and have been used in awareness raising and relationship based materials that were developed for distribution back to communities.



FINDINGS

Our evaluation project was undertaken to understand how PCAP was being implemented in First Nation communities, and to inform decision-making about the program's ongoing implementation. In line with this purpose, and in the interest of preserving confidentiality, information from participating First Nation communities is presented in aggregate form.

Findings from Qualitative Data

Analysis of data from interviews, annual reports, and focus groups resulted in six broad themes that provide the organizing structure depicted in Figure 5.

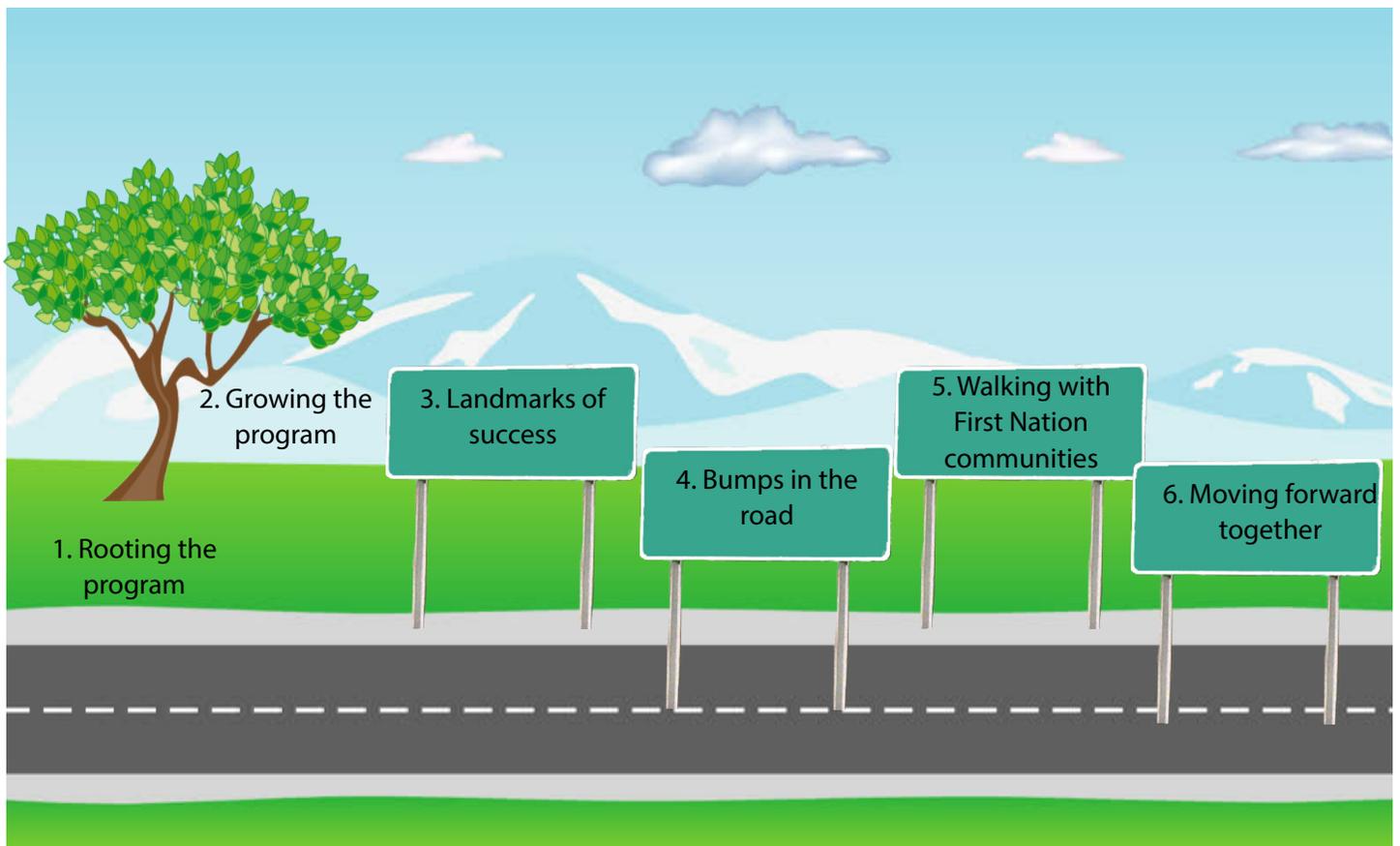


Figure 5. Qualitative evaluation findings

Rooting the Program

Staff spoke about the importance of being well rooted in communities before beginning to implement PCAP. This foundational work was seen as critical to the growth of the program. Program roots are discussed in terms of four core components, consisting of

1. community knowledge;
2. community approval;
3. time; and
4. relationship building.

Community knowledge

According to mentors, rooting the program required gaining knowledge and understanding of the community and its unique history before program implementation could occur. This knowledge guided hiring decisions so that the individuals selected to fill mentor positions could be an appropriate fit for each unique community. It was critical for program staff to have a sense for whether mentors should be members of the community that they were working in, or whether mentors should come from outside of the community. In some remote communities, logistics related to travel necessitated that mentors came from inside of the community. In other cases, however, clients were not comfortable working with mentors who were part of their community and preferred to work with mentors who were not community members. As one mentor described, *“It’s better to come from outside the community because...I’m not related to any of the families.”* In other communities, it was reported that being a community member facilitated the establishment of trust and relationship. Having knowledge of these dynamics was important in order to hire mentors appropriately. In some Networks, this meant that community members needed to be actively involved in recruiting mentors, and that hiring decisions needed to be community driven.

In addition, it was necessary for PCAP staff to consider both family and community dynamics as they moved towards program establishment and implementation. Rich familial histories can be found in many First Nation communities; it was described as imperative for staff to be aware of unique community

and family dynamics as they moved forward. As an example, one community was described as *“quite a political community, and a provincial organization is recommended to tread lightly.”* As another mentor shared, *“a lot of times too is there’s a history with families and last names in our communities and we need to recognize that.”*

Similarly, mentors commented that providing services in small rural communities led clients to suspect that there would be a lack of privacy and confidentiality. Mentors noted that, in small communities, many people were related, which led to hesitancy from clients to access services due to family members working at various agencies and the risk of others becoming aware of their personal information. Where services were available on reserve, some clients preferred to access services outside of their community so that other community members would not know that they were seeking help. One mentor commented that, *“When clients do reach out and want to talk to someone, there’s a lot of gossip.”* It was important to be aware of these community-specific factors when considering how the program would be delivered.

Knowledge of the community’s past experiences with other services was indicated as imperative to establishing strong program roots. Some communities had negative prior experiences with other programs, the knowledge of which helped mentors tailor their approach accordingly. As one mentor explained, *“some of the clients were burnt a little bit, so they won’t go near the community services.”* Knowledge of current community services external to PCAP was also important to avoid *“stepping on toes,”* and to facilitate collaboration with other service providers.





Furthermore, awareness of recent community events, particularly those related to community challenges and social problems, was noted as essential in guiding staff towards rooting the program in a culturally sensitive and appropriate way. As an example, a mentor described how one of the communities she worked in experienced frequent suicides. Entering the community to conduct PCAP-related work after a recent tragedy was described as being inappropriate and potentially harmful: “You have to be very respectful of the culture. It’s huge. Within the community, if there is a death, some communities will completely shut down. I tried to go out, do some work; no, you cannot. I would be seen as disrespecting.”

Many mentors voiced the strong message that it was necessary to demonstrate cultural sensitivity and respect at all stages of the PCAP, from initial meetings where the program was introduced to community leaders to frontline service provision. According to one staff member, “... the first couple little steps to know the community are, I think, very, very important for success.” This included an attitude of respect characterized by humility and openness as well as a desire to learn about the community and its members. This attitude allowed mentors to recognize that it was necessary for them to continue learning about and adapting to different community circumstances. As one mentor noted, “How can we get into these communities? It depends on the community. Depends on the trauma they’ve been through, depends on what’s going on right now, in the here and now for that community. I don’t think there’s a one-size-fits-all.”

Community approval

Program acceptability often hinged upon approval from community elders and other leaders. According to PCAP staff, building relationships and possessing community knowledge made it possible to gain community approval for the program, which was required before program implementation. Yet this did not remove the formal responsibility of seeking permission from community leaders. As one mentor described, “We’re there by the grace of chief and council.”

This approval was dependent on the development of a partnership between the community and the PCAP organization and program staff. As one mentor described, “The importance of community engagement with First Nations before initiating proposals and services cannot be overstated.” Such a partnership was built upon a reciprocal pathway where information was sought from the community, decisions were informed by community members, and program providers were willing to learn from community members. A staff member commented that, “if [the community] is playing a part in the process, it’s a lot easier for the community acceptance and trust for your mentors coming in.”





Another mentor described how, “if I’m trying to do something, I want to speak with one of the council members for advice because that’s their community.” In this way, “a bottom-up, rather than a top-down approach” was recommended, where community members could make decisions about the program in early implementation. Mentors recommended that, “you need to include the community right off the bat.” In this way, demonstrating a willingness to learn from the community was important for gaining community approval: “Don’t ever think that you know the community. You’re there to learn about the community. You’re not there to change them. I’m not there to tell them that they’re doing things wrong.”

Overall, learning rather than telling, was a theme that defined this process of partnership building. This created the conditions that made it possible for PCAP to be invited into the community. According to mentors, they much preferred “being invited in rather than just barging in.” Invitations from the community were often facilitated by “community champions”—namely, those community members who recognized a community need for PCAP, believed in the potential success of the program, and were willing to advocate for the program to be introduced to the community.

Time

It takes time to establish healthy roots. Given the unique and challenging role of mentors, some Networks reported spending a significant amount of time finding and retaining appropriate mentors. Thus, it was important for Networks to be prepared to invest time in planning before program implementation. One Network reported that, “hiring continues to be the biggest challenge to delivering this program. It can be quite a challenge to find the right fit.” Another staff member explained that, “Finding skilled workers in their area is not always easy given lower population numbers.”

Even where mentors were successfully hired, building relationships, gaining community knowledge, and acquiring community approval required a significant time investment. PCAP staff also discussed how it took time for communities to be ready for PCAP to be introduced to their communities: “The Network needed to slow down, adjust expectations, and allow the community to establish their own state of readiness for the PCAP position.” Staff also emphasized that adequate time was required before they were accepted by the community, and thus before program implementation could begin. As one mentor shared, “Two years, it took, for them to start accepting me and bringing me in.” Linked closely with the concept of relationship building, mentors reported that adequate time needed to pass in order for community members to trust that the program would be present in the community over the long term: “You need to establish that you’re not just going to be there six months and then leave.” Similarly, “when you’re bringing resources into the communities, you have to prove yourself. It could take six months or one year to get there.”

Relationship building

PCAP staff spoke about the importance of building relationships in order to establish trust with clients and the wider community. As one staff member explained, “relationship building is so important because it’s that journey of trust.” Upon first entry and as they established their presence, some mentors described experiencing limited trust on a community level, noting that a significant challenge was “sometimes being shut out by the community when you don’t yet have their trust. It’s intimidating to push yourself to go out there and do what you need to do.”



However, when PCAP staff could demonstrate that they were invested in the community over the long term, they spoke of trust and relationship building being facilitated: “you’ve got to be able to prove that, ‘I’m not going anywhere, and I’m going to stay here, and this is what we do.’” To this end, PCAP staff described the importance of being present in the community on a regular basis, particularly during the initial stages of program implementation. They felt it was necessary for mentors to become familiar faces in the community in order to become well-known. It was also important for mentors to be involved in the community. Some PCAP staff found it helpful to sit on advisory boards or community councils in order to build relationships with other organizations. One PCAP mentor noted that, “if they start seeing me on a regular basis, I’ll have referrals just from being there, just being present.”

Similarly, establishing connections with other community organizations was necessary to carry out work with clients: “You have to work at getting trust of the services that they do have because you want to partner with them. I can’t just walk in there and do women’s empowerment. I need to be able to work with the resources that they have and sometimes that takes a long time.” The time spent building community partnerships was a vital step towards receiving referrals from other service providers. One staff member shared that it took “a year, if not more, for [other organizations] to start sending referrals and recommending the program.”

At the individual level, many staff shared that it was important to form relationships with clients before attempting to meet program needs (e.g., capturing baseline information for reporting purposes). One



mentor described this by stating, “The isolation and challenge of getting into the communities to do intakes is being addressed by more frequent community visits by the supervisor. As the PCAP program becomes entrenched in the communities, we are finding that the individuals are more willing to take part in the intake process prior to receiving services.” Clients were described as presenting with a lack of trust, a state that mentors associated with clients’ personal histories and prior experiences with service providers. One staff member described a PCAP client who was meeting a mentor for the first time: “There was a concern that [the mentor] was there to take their kids.” This underscored the need for extensive time spent on relationship building when making contact with some clients. Even as relationships grew, mentors were required to continually work on building trust with these women: “Our clients have trust issues and think you’re never coming back. It’s difficult not to be there for them 24/7. But with a trusting relationship you can reassure them you’ll be back Monday.” Interview participants reported that relationship building was paramount to the program’s success, and needed to occur before meaningful work could be undertaken with clients. As one staff member described: “It’s really challenging for the PCAP worker who’s just starting to develop a relationship to be looking at getting really personal information—asking about the addictions. It’s after that relationship has been built when you’ll be able to get some baseline information without being too intrusive. Because the women are very vulnerable, and they have trust issues.” Similarly, “Moms really need support with addictions. Only income support was available to the mothers previously but [those programs] made no real connection with the ladies.”



Growing the Program

In continuing to describe the PCAP journey, staff described how the program was implemented in First Nation communities, with a focus on aspects of program implementation that they attributed to the program's success. These are discussed according to four themes, consisting of

1. a shared, trauma-informed approach;
2. a shared attitude;
3. walking with clients; and
4. community responsiveness.

A shared, trauma-informed approach

In order to assist clients towards preventing substance use during pregnancy, mentors became involved in very personal aspects of clients' lives, making trusting relationships critical. To develop trusting relationships with PCAP clients, a trauma-informed approach was necessary. There was a strong shared understanding of these overarching program components. Several key aspects of relationship building using a trauma-informed approach were described.

In particular, staff reported a need to work with clients using an approach that demonstrated unconditional support, where relapse or ongoing challenges did not mark the end of the relationship. In this way, harm reduction practices were applied, consistent with a trauma-informed perspective. For many clients, this was a unique experience: "Many of the women haven't had an experience of acceptance—that positive relationship, somebody



that's going to be in their corner and back them up." Mentors reported that, because services were not terminated due to client relapse, "women are not falling through the gaps like in other programs." One mentor appreciated the flexible and accommodating harm reduction approach which permitted her to continue working with clients even if they had been out of contact for an extended period: "If [the client] has some struggles and she ends up drinking, it's not like she'd be kicked out of the program. It's someone to walk with women on their journey. Saying, 'You stumbled, now let's take the next step. Today is a new day.'" The absence of a strict chronological three-year service agreement allowed mentors to count only the time women actually spent in the program towards their three-year service total. One mentor described how clients would phone her from jail after months with no contact because "building that trust, they remember you and have held on to that contact info and will talk with you when they need that support."

From a trauma-informed perspective, mentors' work is strengths-based and client-driven, a powerful means to "meeting clients where they're at." Mentors thus facilitated a sense of agency within these women "because the PCAP worker works with the client in identifying success and where she wants to go." To focus on a hopeful pathway forward, one mentor suggested that, "Instead of asking them 'why do you drink?' I ask them, 'what you would be doing if you weren't drinking?'" Another critical step identified by mentors was to "affirm their abilities and remind them they're capable of looking after their children."



A shared attitude

Mentors' attitudes were described by PCAP staff as critical given the relational foundation of the program. Although mentor attitudes aligned closely with many of the PCAP principles described above, PCAP principles were attributed to the program, and mentor attitudes were attributed to mentors themselves.

Primarily, it was emphasized that PCAP mentors must have a passion for and investment in working with people who have complex needs. As one staff member described, "It's doing things from the heart. It's heart work." Many characteristics were described as helpful in doing this work. For instance, it was reported that it was necessary for mentors to demonstrate persistence, particularly with a population that could be ambivalent about change. A number of mentors reported telling their clients that they would not give up on them. As one mentor shared, "just being there is so important. Persistence. Other agencies give up when they can't reach them." Enacting persistence, some FASD Network staff described choosing particular First Nation communities to work with because these communities were challenging to engage. It was additionally important for mentors to demonstrate consistency and reliability: "They come to depend on us to be there for them." Other mentor attitudes and characteristics deemed important included being non-judgmental, collaborative, patient, committed, trustworthy, knowledgeable, and open-minded.

A collaborative, team-oriented attitude was also described as a prominent characteristic necessary for mentors to support successful program implementation. Working as a team with other PCAP staff allowed mentors to provide the most effective services to clients by covering for one another during especially busy times. Collaboration also facilitated the development of respect for mentors in the community. On this note, mentors indicated the importance of conducting themselves in a professional and trustworthy way: "if someone sees that you're being professional and you're not gossiping, then that's going to travel around the community, 'we can maybe trust her,' or whatever the case may be."

Walking with clients

In addition to discussing their overall approach and attitudes, PCAP staff described their work with clients. Much of the work between mentors and clients centered around goal setting. Goals often included supporting clients towards independence, while recognizing that clients had different capacities in this area. This could include working with clients to learn general life skills such as budgeting, self-care, or grocery shopping. As one staff member described: "Their mentors are teaching them how to be successful, how to advocate for themselves, how to be able to stabilize their lives. To the point where gradually, over time, they're not really calling their PCAP mentor. And then they're calling their mentor to tell them, how awesome! They just found a ride to town. They did shopping on their own."

Mentors additionally described working together with clients to help themselves meet their own basic needs. For many clients, this involved receiving assistance with accessing emergency food services off-reserve. This was often difficult for clients to do on their own since most First Nation communities did not offer food bank services. PCAP mentors also transported clients to important appointments that were off reserve and not accessible without a vehicle, such as those involving medical treatment, mental health care, and visits with their children, as well as court and probation meetings.



Housing was put forth as a significant challenge that mentors observed for most PCAP clients living on-reserve. Consequently, they described walking alongside clients to access stable living situations as a frequent part of their work.

Guiding clients in the domain of medication management for themselves and their children was also perceived as important by mentors. Relatedly, mentors often worked to help clients experiencing mental health issues to stabilize until they could access formal mental health care. This was routinely necessary given the long waiting lists for mental health services in many communities. Similarly, mentors facilitated client access to FASD clinics for assessment and diagnosis. This could be seen as a significant step in securing additional services and support for clients.

Another primary aspect of mentors' work involved helping clients to address their addictions. In many cases, this consisted of linking clients with treatment services and supporting clients to complete treatment and manage their addictions. As one mentor described, this "works to get clients to the best possible place they can be with their addictions." Other mentors used a calendar with clients to mark days involving alcohol use in order to talk about triggers that may have been present on those days and how future use could be reduced and/or prevented by anticipating and dealing with triggers. As another mentor shared, "clients have applied for and attended school, rehab services and counselling with the support of the PCAP program. While most programs help a client for a limited time, this program allows the client a period of three years to grow and achieve."

Supporting clients' sexual and reproductive health was another focus for mentors. With regard to clients experiencing ongoing addictions, staff deemed it particularly important to have conversations about birth control with women at their first meeting. Mentors collaborated with clients to obtain and track their birth control, and they reminded clients to attend appointments for birth control treatment. Mentors also described educating clients about boundaries, sexual assault, and sexually transmitted infections (STIs).

Working with clients to enhance their parenting skills was described by mentors as another focus of their work. This could consist of group classes or modeling calm ways of disciplining children, and



acknowledging when clients were parenting in a positive way. In many cases, mentors attended client visits with their children. As one mentor mentioned, "Something I work on quite a bit is how to talk to your children. If their kids are acting out, they'll let me show them how to speak to the kids, how to calm them down. And they try. And I acknowledge that."

Community responsiveness

In addition to working directly with clients, establishing and maintaining collaborative efforts with other community organizations represented a substantial part of the work carried out by PCAP staff. In order to appropriately respond to unique communities, mentors took on a variety of roles related to program delivery, facilitating client access to community programs, and advocating for clients in their communities.

In particular, many PCAP staff members worked with other service providers such as local health nurses to deliver group programs to women. Partnerships with other organizations helped mentors to effectively refer and connect their clients to other services and resources as needed. Mentors noted that it was often necessary to accompany clients to initial meetings with new service providers rather than simply referring them and expecting them to meet new service providers without support: "Our PCAP workers aren't going to be everything to everybody. For certain counselling and supports, that's where they're connecting to other supports. But I think it's so important that our women have somebody that's going to be there walking alongside them. Because a lot of times that's where our women have not been successful. A lot of times, it's go talk to this person over there. Well they're not going to do that on their own."

With consent from clients, some mentors connected with other service providers to streamline service delivery. This allowed mentors to enhance their understanding of the services being provided to their clients, as well as service gaps. Illustrating this point, one PCAP staff member mentioned how “The opportunities to partner and collaborate with local agencies and supports have strengthened the work being done by the PCAP program. With the understanding of the role of the PCAP, agencies are able to better support shared clients, as the communication and recognition of various services available is clarified and utilized by all agencies. Case conferencing has increased and has provided for opportunities to identify duplication in services and reallocate responsibilities as per program objectives.”

In some communities, PCAP mentors were the only PCAP staff in the area. In these instances, it was vital for mentors to collaborate with staff from external organizations. Beyond establishing community connections to strengthen support for clients, doing so established a web of self-care support for mentors when, due to logistical considerations, supervision and/or peer consultation opportunities were not readily available. As noted by one staff member, “Supervision and support of satellite offices is difficult to maintain when the supervisor is based [in another town].” Therefore, a support network was described as helpful to prevent mentors’ feelings of isolation. As one staff member described, “They might be working with different clients but they’re all coming from the same heart work with individuals who are struggling with complex needs. That’s why we think it’s so important to have people working and collaborating together.” Without addressing widespread stigma and misconceptions, the program’s growth may be stunted from the get-go.

Mentors also discussed a lack of FASD awareness in communities as representing a challenge to service provision. As a result, mentors noted that it was vital to spend time raising awareness by spreading the word about PCAP and having open, non-judgmental conversations about FASD. In some communities, PCAP staff held training and formal events, whereas more informal strategies were used in other communities: “It’s not like we’ve done a great big community presentation but having those one-on-one conversations has been huge.”

Along these lines, PCAP staff also worked to raise awareness regarding some of the barriers that their clients face: “informing the community, the services

that are there, about challenges. And being able to be that bridge in between.” Raising awareness often involved advocacy work. For example, one mentor described how she often advocated with the RCMP to use alternative measures for her clients, and another mentor described having conversations with justice and probation regarding repeat offenses. In addition, mentors worked with community service providers to enhance understanding of the complexities of FASD: “...get them to understand that clients may appear to understand what you’re saying but they really don’t. In many cases, it’s an invisible disability and they don’t have the capacity to make sound decisions.” As one mentor noted, “Other agencies don’t understand that the decision-making part of the brain did not develop with these clients that have FASD. The community, as well, not understanding the invisible disability part of it. There’s a lot of discrimination and judgment.”

Addressing FASD stigma was another focus of mentors’ work. Mentors described how initial perceptions of the wider community often posed challenges for the program and clients due to stigma that had been attached to the work of PCAP because of the program’s association with FASD. In response, staff members from some Networks intentionally avoided labelling clients as being affiliated with an FASD-focused program. Instead, they provided “an emphasis on what the program can provide , which proved to dissolve barriers for clients.” The presence of stigma also reinforced mentors’ drive to actively engage the community in conversations about FASD. This was important because many PCAP clients had FASD themselves. One mentor described challenges with “reaching out and trying to educate people on this disability and they don’t want to know anything about it. All they see is a bunch of criminals. That’s how people with FASD are seen and it’s very, very unfortunate.” In most communities, FASD was viewed as a highly sensitive issue that led to reluctance from many women to admit to using substances, which posed a barrier to service access and continuation.



Landmarks of Success

Following from rooting and growing the program, PCAP staff discussed ways in which PCAP was successful in First Nation communities. Importantly, PCAP staff acknowledged that achieving long-term, measurable success would conceivably take longer than three years to achieve. However, they described a number of emerging successes in terms of

1. improved client well-being;
2. enhanced family functioning; and
3. informed communities.

Improved client well-being

PCAP staff described positive social and emotional impacts on clients, which primarily involved the formation of mentor-client relationships. Mentors indicated that they were often the first person who clients contacted when they were experiencing challenges, such as being picked up by an ambulance or police officer. Many mentors were present for the births of clients' children, waited in hospital emergency rooms with clients, and negotiated with police to visit clients when they were in jail. As another mentor shared, "They feel secure; that they have somebody that they can call. And they feel great knowing that they don't have to do it alone."

In this vein, mentors described observing how strong mentor-client relationships allowed clients to demonstrate an increasing openness to trusting other service providers. This likely augmented the probability that clients would consider accessing other services in the future—an important step forward in preparing these women for the transition out of PCAP services in three years' time. One mentor gave an example of a client who "took a long time to warm up. And then she wouldn't go to the doctor or see any other professionals without me. Now she's going to some appointments on her own and she has another worker she trusts."

Forming relationships with other women was identified as another positive step forward for many clients. One mentor described how she had partnered with another organization to offer a group to her clients, which evolved into a space for connections between women: "when they all get together and realize that they all have the same issues, then it's a comradeship." Other mentors described that through group programs, women were able to make meaningful connections. These connections were particularly impactful for clients as

they were provided the opportunity to meet others "whose children are also impacted, and that really know what they're going through." As another mentor observed with regard to group programs, "now they know how to play with their kids, they know how to do crafting that is child appropriate, they learned all of those skills but they learned them together and can have playdates."

Mentors also offered examples of clients' pride in their improved ability to access services independently. As one mentor commented, "Ladies are growing as moms and wives, and see they can do programs and finish them. Before, they didn't even want to come to the band office to do programs because of judgement. Now they do."

Mentors also spoke about clients learning to address their addictions and physical health. Staff perceived that some clients lacked understanding of basic physical health needs such as seeing a doctor during pregnancy. As a result, linking clients with medical services represented a step towards achieving the overall PCAP goal of healthy births. Mentors observed some clients take positive steps along the path towards personal health and the health of their babies when they decided to attend addictions treatment through their involvement with PCAP. Clients accepting help for their addictions was described by mentors as a monumental step forward, which was often followed by clients completing treatment.

Enhanced family functioning

Related to successes in client well-being, PCAP staff spoke about impacts of the program on clients' children and families. Some mentors described clients having healthy births since being involved with PCAP, which represented a major success for women who had not abstained from substances during previous pregnancies.

PCAP staff also described impacts on entire families. Some mentors talked about indirect impacts on clients' children, where clients' improved stability translated to their improved parenting practices such as children attending school, eating healthy meals, and following a healthy routine. Other mentors shared more direct impacts on families; for example, working with a woman and her partner to successfully develop and implement a plan that allowed them to regain custody of their children.



Informed communities

Beyond the positive changes observed at the individual and family levels, PCAP staff identified growing community awareness of PCAP itself as a significant indicator that PCAP was impacting the community as intended. One mentor described how, “Because the clients themselves are so happy with the program, they speak with other people within the community. So I see that this program is really helping everybody that could be or has FASD.” A mentor from another community shared similar observations about the impacts on women not involved in PCAP: “Before, it was all hush hush, you don’t tell anybody about your problems. And if you have a problem, you keep it under wraps. But now they are seeking us out. If they see our vehicles in the community, they are coming to us. They are doing self-referrals.” Receiving referrals from other community agencies also provided evidence of mentors’ success in raising awareness about the program, as did mentors being invited to sit on committees with other community service providers. One mentor described how, “if I left in, say, a year’s time, these communities will know FASD resources will stay there and that, to me, is a big part.”

In addition to observing communities becoming more informed about PCAP, mentors observed increased community-level awareness of FASD: “Before, they didn’t have a name for [FASD]. Now,

being able to go to community meetings and have it discussed openly, it’s really changed the way we talk about [FASD] now. It isn’t an ugly dirty word. We are still instrumental in getting that out there.” Mentors spoke about engaging in extensive work to reduce the stigma around FASD, and to enhance community members’ knowledge about the disability.

A fully informed community means that care providers are aware of the services offered by each agency, so that they may collaborate to fill gaps in community services. Mentors described the ability to fill service gaps and the importance of avoiding redundancy in programming as essential to impactful service provision. Many community organizations reportedly struggled to adequately support clients. And mentors’ presence in communities helped to “ease the burden” experienced by other service providers. One mentor described how PCAP programming filled service gaps: “The PCAP ladies, they don’t have anybody that will come to their home and be able to help them keep their children and address their addiction issues—whether its stresses or housing or finding food. Nobody ever had that one person before.” Other mentors similarly explained that, “A lot of our communities have no other supports except for us. And it’s important for them to have somebody that cares about whether or not they have healthy babies.” Similarly, “We are the only agency in this community that works with FASD and impacted persons.” The unique, relationship-based nature of PCAP also functioned to fill a gap in services provided in First Nation communities: “Moms really need support with addictions, especially teen and young moms. Only income support was available to the mothers previously, but they made no real connection with the ladies. This programming allows the opportunity for understanding and support.”



Bumps in the Road

Along with the significant successes of PCAP in the relatively brief time since its inception in many First Nation communities, PCAP staff reported a number of challenges that required responsiveness. These related to

1. access to resources; and
2. the complex needs of clients served by PCAP.

Access to Resources

PCAP staff reported a number of challenges related to providing services in rural, remote, and isolated communities. A core challenge was that of traveling long distances. Mentors noted that they frequently drove for more than an hour to remote communities, and that upon arrival, they sometimes had difficulty locating clients. In many cases, mentors' ability to reach clients was impeded by limited cell phone service in the more isolated communities. Thus, mentors were often unable to confirm appointment times and client availability before travelling to their homes. As a result, mentors described spending a significant amount of time searching for their clients before making the long trip back to the office at the end of the day. A lack of transportation was described as a related challenge. To provide an example, in one network, a community served by PCAP was only accessible by barge or plane, the cost of which was prohibitive for clients. This community was 2.5 hours' travel from the nearest town. It would cost those women approximately \$300 to get to a grocery store. Limited groceries were available in this isolated community for inflated prices (e.g., \$12 for one jug of milk).

The lack of services in remote and isolated communities was another challenge to which mentors needed to respond. In this way, transportation factored heavily into service accessibility for many PCAP clients. As one mentor described, "We don't have a Parent Link. We don't have mental health that we can just walk in and talk to somebody, like in the city." In describing clients in crisis, another mentor commented that, "People need services, and they need them now. They can't wait or they don't want to wait for someone to drive an hour and a half to get them and an hour and a half back." Even where clients were able to access services off reserve: "Those that do succeed and can finish the [addictions] program come back to the community where nothing else has changed but them. There are no addictions supports, so they're right back to square one and that is the biggest challenge that I see."

Aside from a lack of other services in general, mentors also pointed to the specific need for child care services to accompany programming: "Being so remote is a

challenge for my clients. Most are single moms who were raised in abusive situations, end up in abusive situations, and are raising kids on their own. It would be so monumental for them if they had child care in their community or some kind of program to give them a break because for FASD individuals, stress levels elevate and they can just explode."

Severe housing shortages were also universally mentioned as a challenge to PCAP mentors' work. Homelessness was common among women who accessed PCAP services. Where clients did have access to housing, their housing situations were often described as unsafe, or they lived with family members who were actively abusing substances. In these cases, it was "hard for them to make progress even if they wanted to." This could be frustrating, as one mentor noted, "They shouldn't have to leave their community in order to get good housing." Another staff member explained that, "In some instances, clients have no choice but to leave their community and family supports to find a women's shelter. As there is limited space, limited shelters, no financial aid and no transportation, many women resign to stay in unsafe situations. They are asked to find a stable home in order to have their children but there is nothing available to them." Food insecurity and poverty were noted as related challenges.

Complex needs of clients served by PCAP

PCAP clients had complex needs, and mentors reported challenges in helping clients navigate their circumstances. In particular, mentors reported that PCAP clients were frequently in crisis, were often impacted by FASD themselves, and were prone to dependence on mentors: "Trying to teach them that I'm here, I can teach you, but I can't do everything for you. Some confusion about doing it for themselves. Hand holding. Expecting me to do everything for them." Clients were described as having complex webs of trauma histories, mental health issues, and addictions: "Trauma goes hand in hand with addictions. Which do you help with first? In treatment centres, the main focus is addictions but most of my clients have so much trauma. It's not easy watching them." Transience of clients was perceived to lead to bumps in the service road, and mentors felt that they needed to be responsive to the living style in which clients found themselves. As one mentor shared, "It's a matter of building that relationship so they can stay in one spot long enough for me to help them."

PCAP staff discussed how they had walked with First Nation communities in delivering the program. In other words, they described the program's transferability to First Nation contexts with two general categories of ideas:

1. work outside of mentor job descriptions;
2. adapting to community circumstances; and
3. a collective orientation to service provision.

Work outside of mentor job descriptions

Primarily, PCAP staff reported feeling that it was important for mentors to engage in work outside of formal job descriptions. Some mentors described going fishing, and mint and berry picking with their clients. Another mentor shared how, "I go to almost every event that they have there, whether on the weekend or in the evenings." Another mentor similarly described how, "The Network has met with community members off-reserve, on weekends and evenings out of respect for the cultural customs and protocols. These are viewed as opportunities for showing of respect and enhancing flexibility."

Mentors also highlighted how, during community events, they contributed to tasks such as helping in the kitchen or roadside cleanup, because "in the Aboriginal communities you have to be seen. You have to be part of the community." Carrying out work that was outside of mentors' job descriptions reportedly "paid off" by resulting in increased referrals from other community organizations as well as building trust and relationships.

Similarly, many mentors facilitated client access to community cultural events and took part in events themselves: "It is their culture. So having their client with them when they go [participate in a cultural event], it's just reinforcing that. Giving them that opportunity, being that role model to show them that they're not letting go of who they are." It was also incredibly important for mentors and other PCAP staff to follow cultural protocols and to conduct themselves in a culturally appropriate way, including offering tobacco, providing appropriate honorariums to Elders, participating in events such as feasts and pipe ceremonies, as well as opening and closing all meetings in prayer. As one mentor shared, "Consistent and ongoing engagement with community agencies and members, attending community ceremonies and meetings when invited to do so is imperative to building trust and relationships."

When the communities that they worked in experienced losses, many mentors participated in grieving processes alongside the community. Referring to the loss from suicides that many First Nation communities experienced, one mentor commented: "We've got to be part of that— grieving, and loss, and self-care. We go through everything with the community. It's not a matter of, 'oh, that's not my client.' First and foremost, it's community."

Adapting to community circumstances

Adapting to the circumstances of the communities they worked in was described as a key component of PCAP implementation. As one mentor shared: "It's a home visitation program, but if a client is out in camp, you go out to that camp. You have to be very flexible. You never know if you're going to be sitting in the back of a tailgate doing paperwork because the driveways are so muddy that you can't even get in their driveway. You have to be flexible to drop your tailgate and [say] 'alright then, let's do some paperwork.'" Relatedly, mentors described the challenges that accompanied working with clients who were intergenerationally impacted by residential schools and ongoing colonialism. Intergenerational impacts were highlighted as amplifying clients' stress levels, particularly where clients' own parents continued to abuse substances. As one mentor observed, "the PCAP clients experience rejection or no support from family members, especially as they work towards sobriety."

Collective orientation to service provision

Prioritizing community and adopting a collective orientation to service provision were important aspects of program transferability described by mentors. Similarly, PCAP mentors described working from a holistic perspective: "It's a very holistic program that takes into account the health of the entire family from the mom to the dad, to extended family." Along with a holistic approach, many mentors described an integrated service provision approach: "We're located in the health centre and there are other services within. PCAP is integrated as a part of the other programs. Someone receiving PCAP may receive another [service] in conjunction with PCAP. I think we see that more in this community than other PCAP programs." Overall, one mentor summarized the work of PCAP in First Nation communities by stating that, "No adjustments have been made to how we deliver the PCAP itself. However, the workers do much more community engagement than other mentors." 28

Moving Forward Together

In light of the journey described by PCAP staff, including rooting and growing the program, positive steps forward, bumps in the road, and program transferability, staff provided recommendations for moving forward along the PCAP path to enhance service delivery, and, ultimately, to improve client outcomes. These included

1. a different approach to providing services;
2. data collection and entry improvements;
3. coordinated systems;
4. supportive work environments.

A different approach to providing services

Primarily, staff members discussed the need for a different approach to providing services in First Nation communities. Given the foundational work required prior to program implementation, and the extensive time required to build relationships, PCAP staff reported that three-year funding cycles were insufficient and should be extended. One staff member referred to “the importance of relationship building and how long that takes. So we need longer funding cycles so there’s not that expectation that workers can jump in on day one and have clients for the full three years.” PCAP staff felt that, with longer funding cycles, programs could avoid perpetuating the cycle often experienced by First Nation communities where programs are implemented and quickly terminated. As one staff member noted, “We are worried about continued funding and how our relationship will be managed with the rest of [Network] services if we cannot continue to provide the same level of support.” Extended time for community integration would allow PCAP to establish its presence, or roots, and relay to community members that the program will avoid this cycle. This new approach to service provision would likely also allow programs to “demonstrate the outcomes and numbers that funders want to see, which takes longer than three years.”

Data collection and entry improvements

Another recommendation mentioned across networks was for improvements to current data collection and entry processes to lessen the time spent on data collection and entry, improve the quality of data, and avoid re-traumatizing clients by asking them personal questions prior to forming a relationship. As one staff member explained, “Being able to get the data that we need is a challenge. Even getting back information for business planning is a challenge. Not that work isn’t happening, just getting

information to show it—[it is hard to get] the concrete data to justify to funders what’s going on.”

Collective orientation to service provision

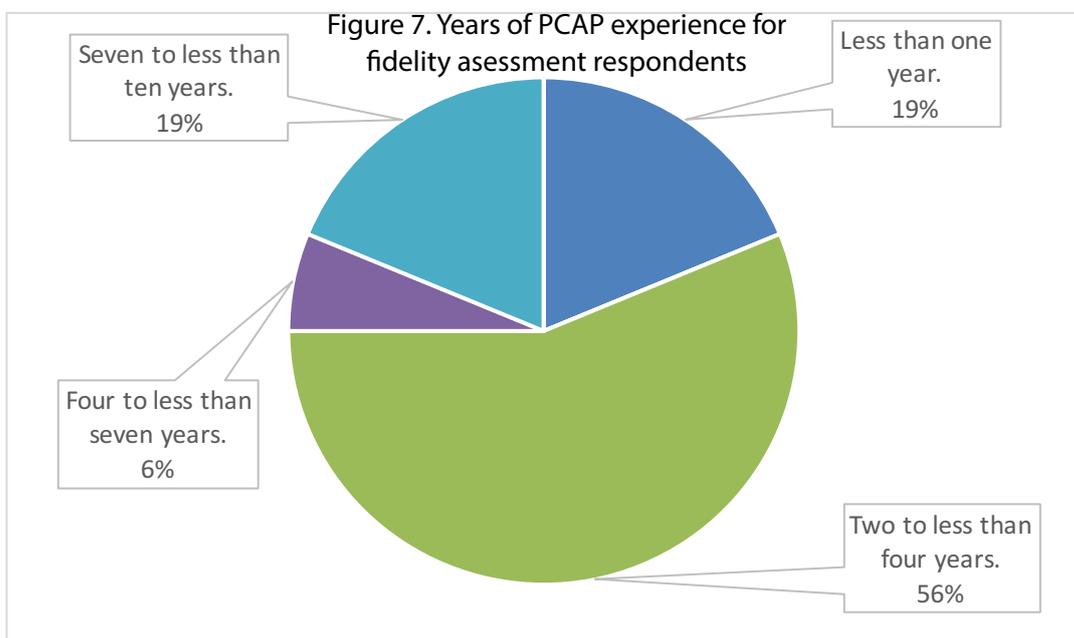
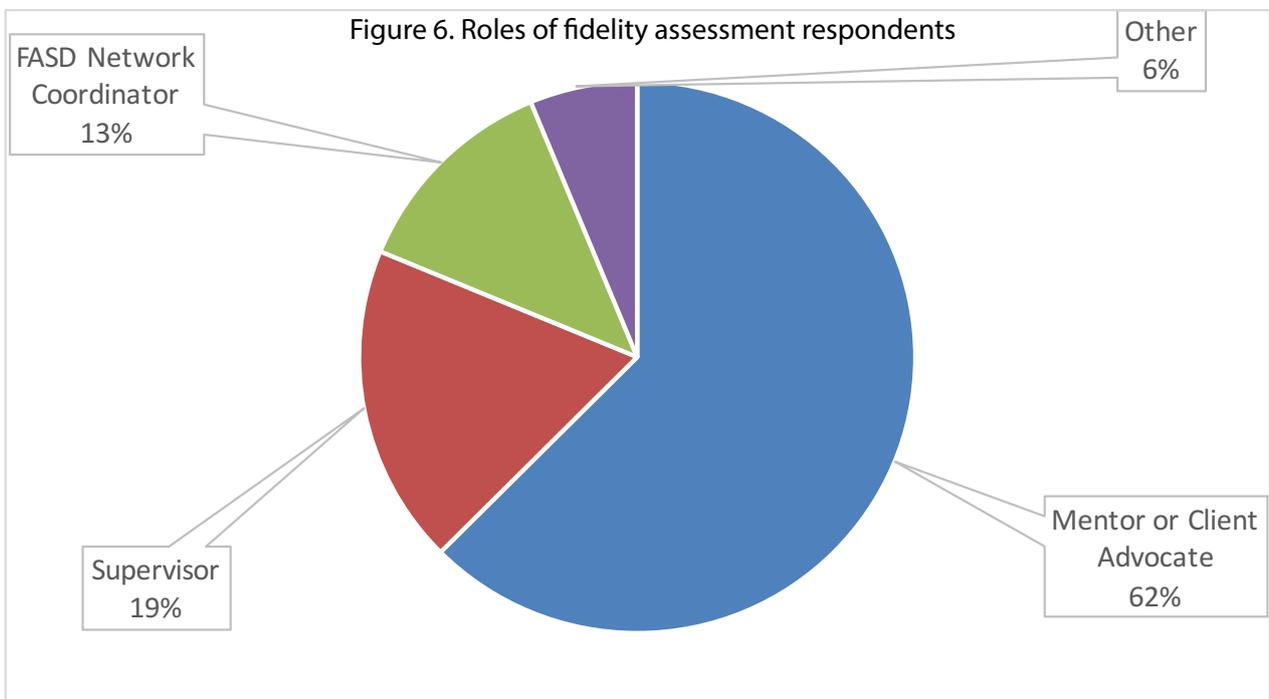
Although in some communities, collaboration with other organizations represented significant successes and some PCAP programs were integrated with other services, mentors struggled with the fractured nature of many systems and services. For this reason, staff members spoke about the need for coordinated systems to simplify client access to services. For example, one mentor suggested “a common referral form so our women don’t have to tell their story over and over again. Every time they want to access a service, it’s another application.” In addition, PCAP staff recommended improvements to clients’ access to transportation in First Nation communities, as this could significantly free time up for PCAP staff to focus on educating and supporting clients in other ways. Similarly, “as the numbers for the PCAP increase, more staff will need to be hired or those referred will have to be waitlisted, as all of the frontline PCAP workers in these communities except for [one] are at capacity.” Along these lines, many mentors described feeling overwhelmed with full caseloads. With challenges in such areas as transportation, travelling long distances, and the necessity of increased community engagement activities in First Nation communities, some staff members considered that it might be appropriate to reduce caseload sizes. However, in each of the Networks, this would require additional staff, as staff members described full client waiting lists.

As a result, mentors recommended that PCAP should continue emphasizing supportive work environments to deal with the complex demands of the program. PCAP staff were aware that staff retention and well-being were critical to their work. Being part of a cohesive team reportedly enhanced mentors’ ability to effectively serve clients, as mentors filled in for one another when client demands were high (e.g., when two clients had appointments at the same time and both requested the mentor’s support and presence). Mentors also pointed to the importance of having supportive co-workers with whom they could debrief and share resources and knowledge. The benefits of having supportive supervisors who provided ongoing guidance and direction was also mentioned. As one mentor described, “We’re really close in the network. We’re very supportive of one another. That makes an enormous difference.”

Findings from Quantitative Data

Fidelity Assessment

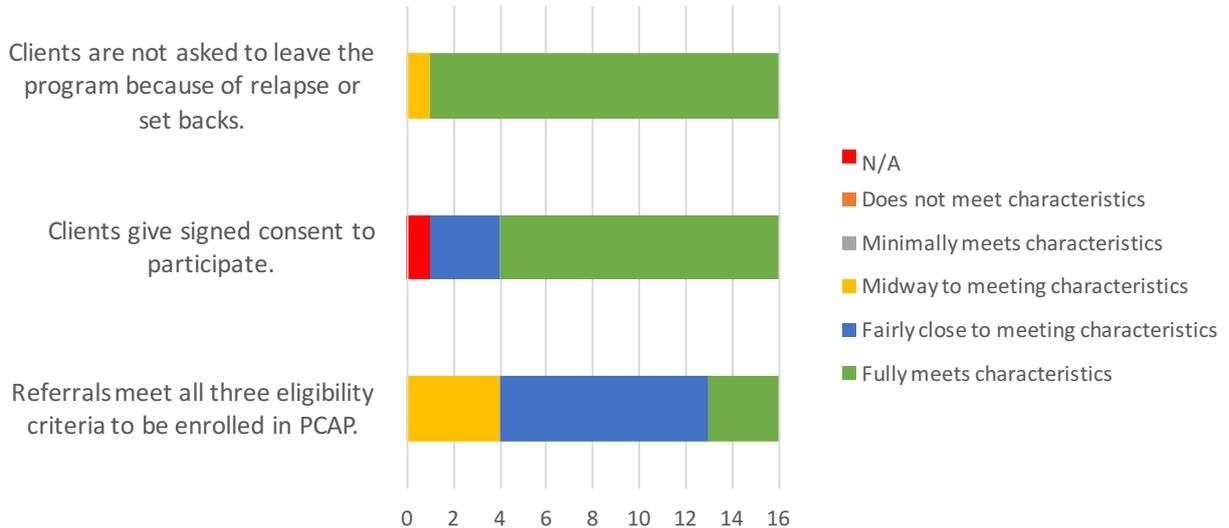
Sixteen respondents completed the PCAP Fidelity Assessment, which was administered to determine the extent to which PCAP was implemented in the way it was designed. The largest number of respondents came from the Lakeland FASD Network (n = 7), although there was at least one respondent from each Network. Responses to the survey are presented by domain. Two respondents from each of the Mackenzie, South, Northwest, and Northwest Central Networks participated, as well as one respondent from the Prairie Central Network. The breakdown of respondents' roles and the number of years they were involved with PCAP are depicted in Figures 6 and 7 below, respectively. In Figures 8 through 15 higher numbers denote greater adherence to the PCAP model. Importantly, although the Lakeland FASD Network was disproportionately represented in responses to the Fidelity Assessment, other data (i.e., focus groups, interviews, narrative reports, Advocate-Client Relationship Inventories) were more balanced in terms of Network representation.



Client characteristics

Overall, findings showed that programs are generally following PCAP protocols regarding program initiation and continued enrollment (see Figure 8; overall client characteristic mean = 4.53). It appears that some leniency exists regarding enrollment criteria (mean = 3.94) which may speak to staff members’ responses to communities’ needs for services (i.e., very limited options for service exist in smaller and/or more remote communities).

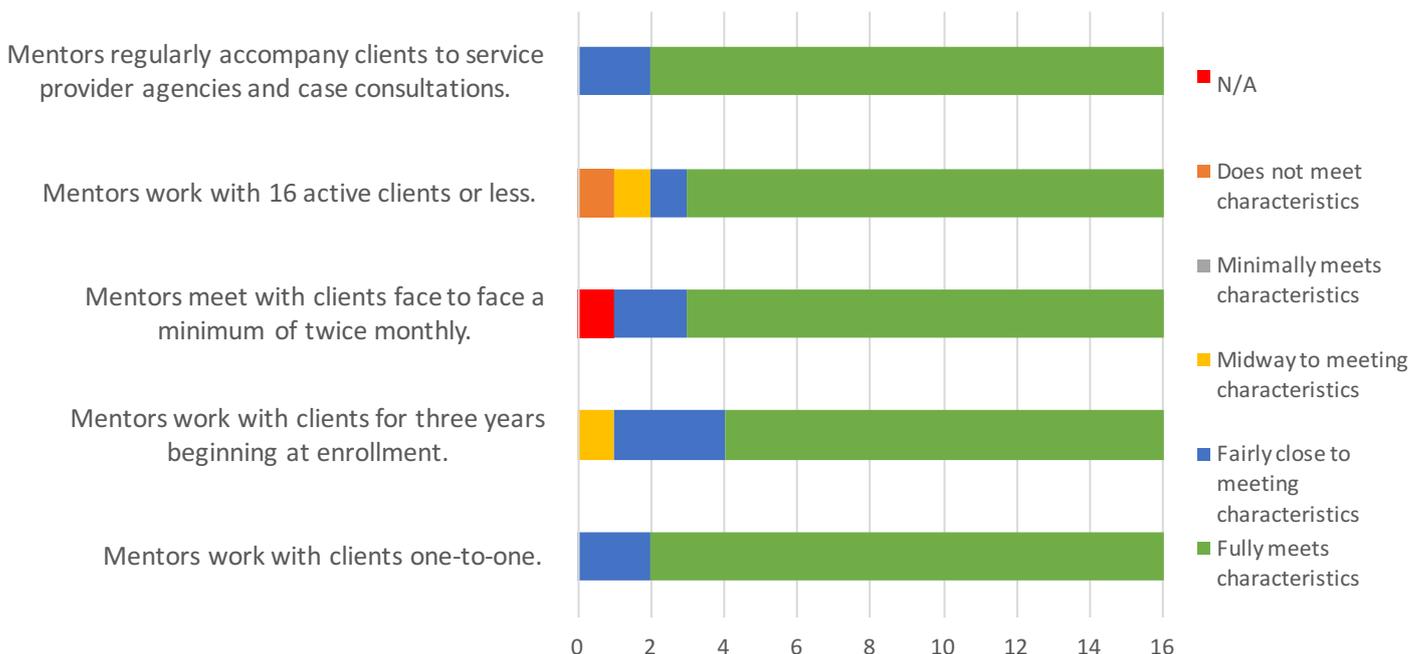
Figure 8. PCAP client initiation and continued enrollment: Fidelity assessment responses



Client intervention setting

As reported by mentors, the time spent with clients and the style of service delivery closely match PCAP guidelines (see Figure 9; overall client intervention setting mean = 4.77). One quarter of respondents indicated that their sites were fairly close to working with clients for three years. Our qualitative data suggests that, because of the time required for program start-up, high client needs, and limited community resources, mentors may work with some clients for longer than three years. Some mentors spoke of clients coming and going from PCAP, and mentioned that they often put the three-year time limit on hold while clients were out of touch with their mentors, and therefore, not engaged in PCAP services. Overall, findings suggest strong alignment with the PCAP model in terms of client characteristics.

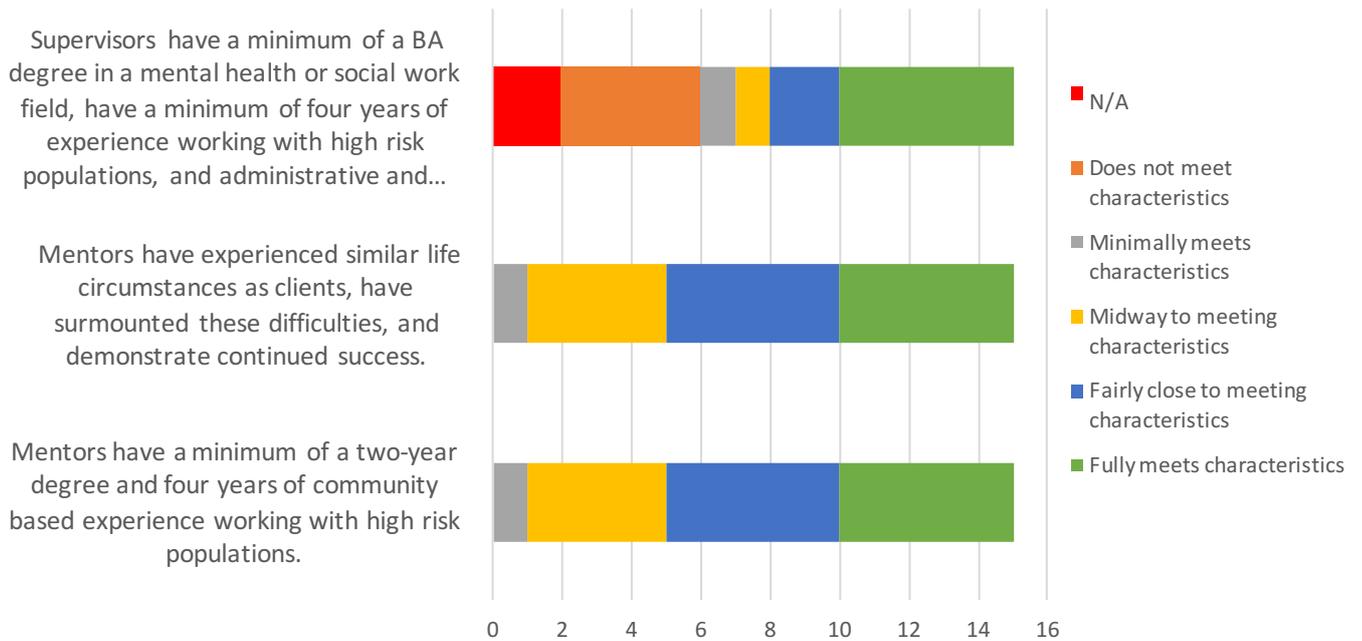
Figure 9. Client intervention setting: Fidelity assessment responses



Staff qualifications and experience

In this domain, increased response variability was observed (see Figure 10; overall characteristics of staff mean = 3.72). Staffing challenges were mentioned several times throughout our qualitative data. In particular, comments were made about difficulties finding qualified employees who would remain in and be accepted by the community, and who would share attitudes of respect, collaboration, persistence, and investment in the program. Many spoke of the importance of having a mentor that is accepted by the community. This may speak to the need for additional training to develop mentors who have community connections but lack full training requirements. Supervisory experience was the lowest-rated staff characteristic (mean = 3.23).

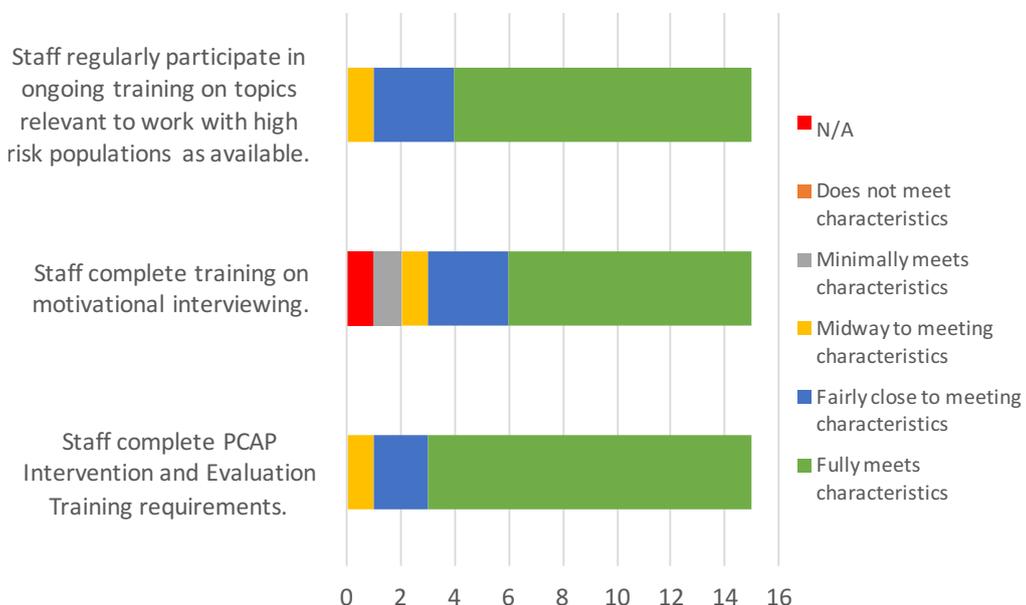
Figure 10. Staff qualifications and experience: Fidelity assessment responses



Training

Overall, staff reported strong to fairly strong PCAP training (see Figure 11; overall training mean = 3.72). Motivational interviewing training was one area with variability in responses, indicating that this might be an area of future focus.

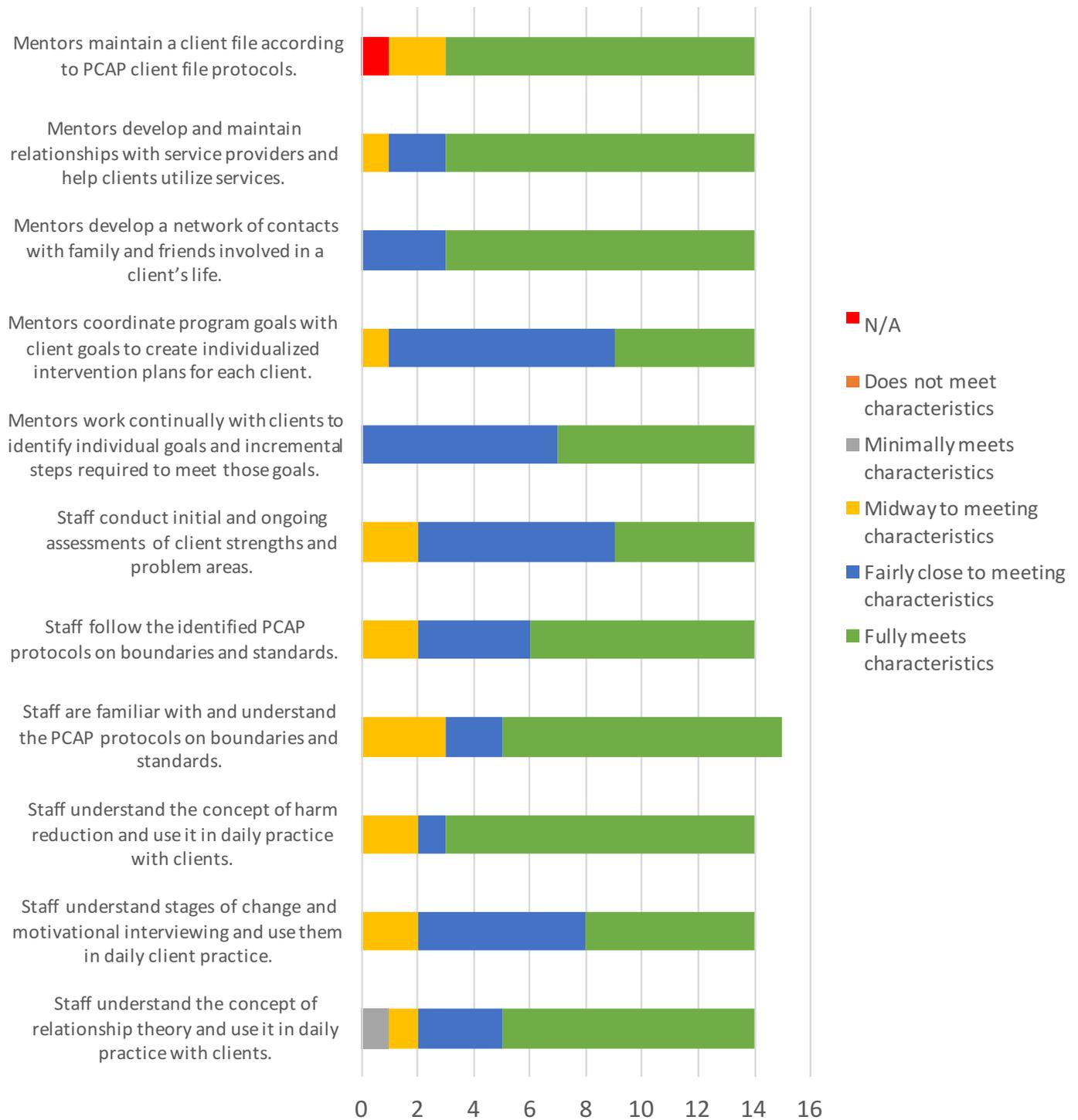
Figure 11. Training received as a PCAP employee: Fidelity assessment responses



Conducting the intervention: Fidelity to the PCAP model

The majority of respondents indicated that they were following PCAP protocols regarding program delivery (see Figure 12; overall intervention mean = 3.44).

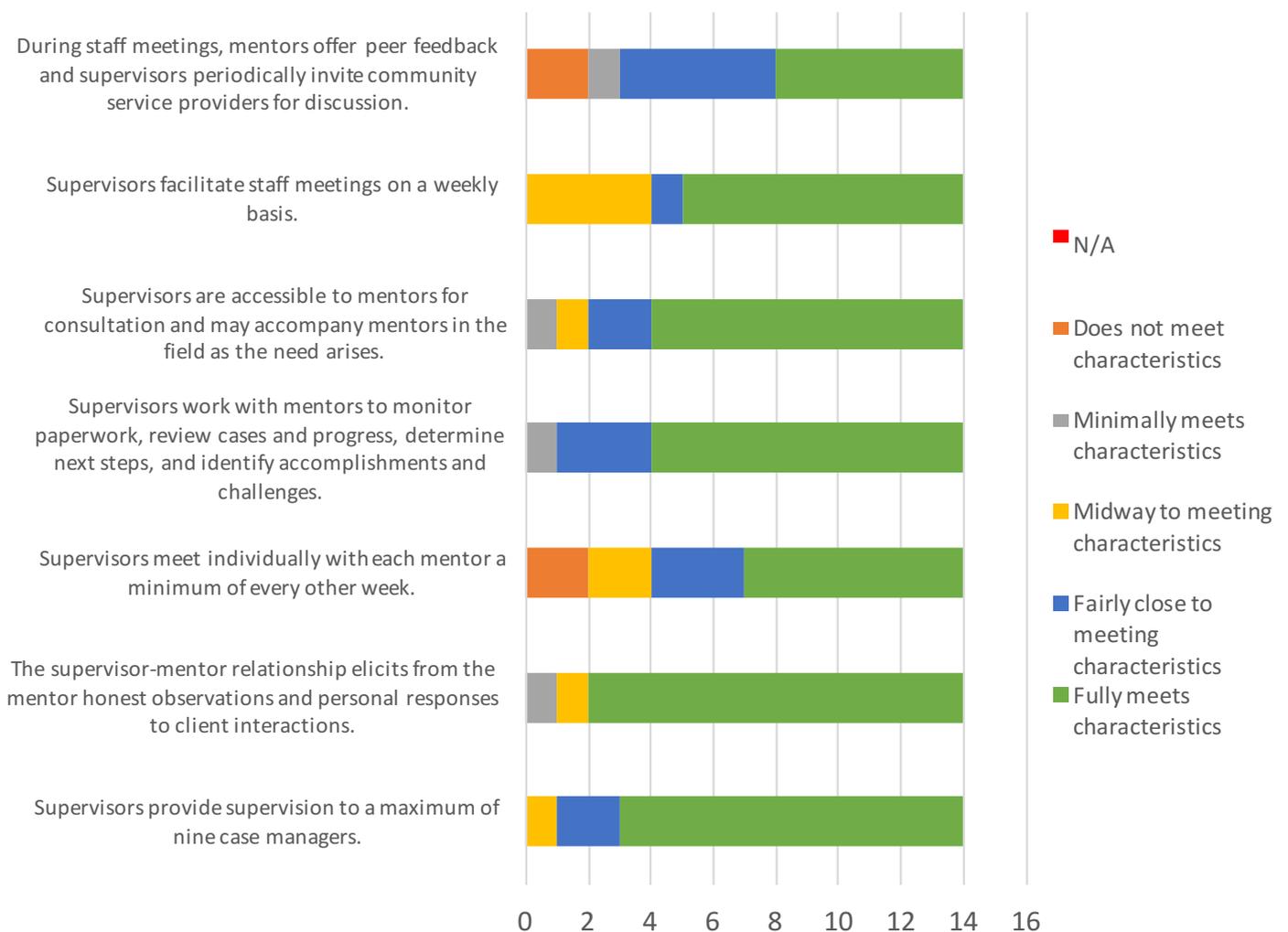
Figure 12. Adherence to the PCAP model: Fidelity assessment responses



Clinical supervision to mentors

The majority of respondents reported strong supervisory practices (see Figure 13; overall supervision mean = 4.37). However, we see that mentors either are not offering peer feedback at all staff meetings or that external community service providers are not joining these meetings. This may align with interview findings that demonstrate slow start-up and community integration in some communities. Some respondents also indicated that mentor supervision is not meeting the minimum requirements. This may be the case in more remote locations where internet and phone connection difficulties exist. Some interviewees and reports mentioned attempting to remedy these situations by establishing satellite offices.

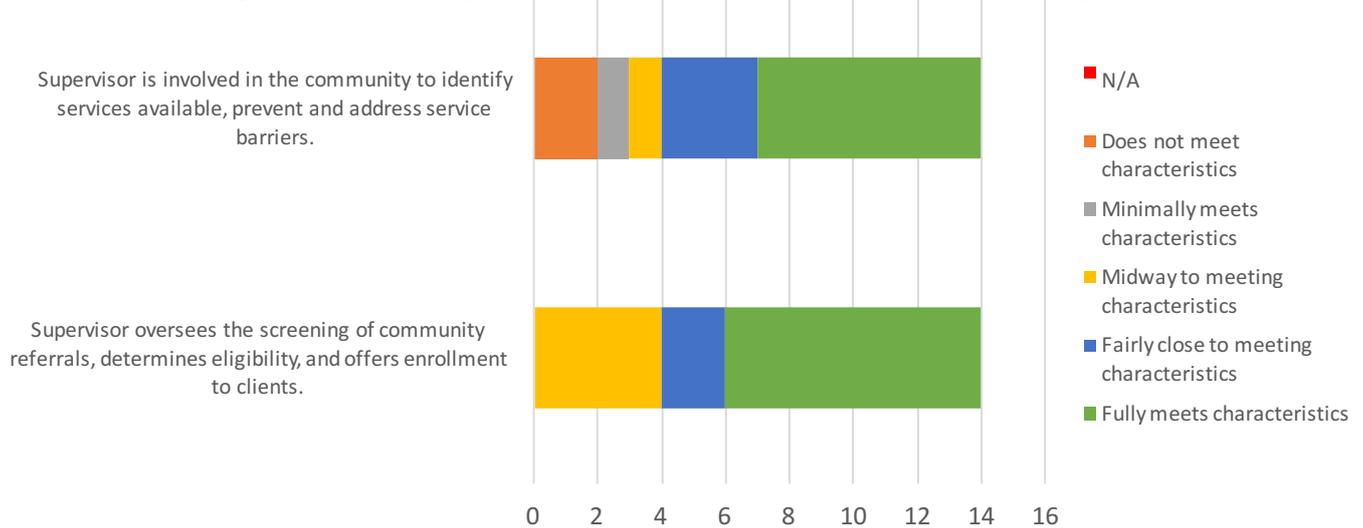
Figure 13. Clinical supervision to mentors: Fidelity assessment responses



Clinical supervisor in the community

While most respondents were happy with the community and screening/enrollment involvement of supervisors, some saw room for improvement (see Figure 14; overall clinical supervisor in the community mean = 4.07). Particularly, some respondents indicated that supervisors were not, or were minimally, involved with the community as a support. It is possible that geographical limitations prevent some supervisors from frequenting the communities that their mentors work in.

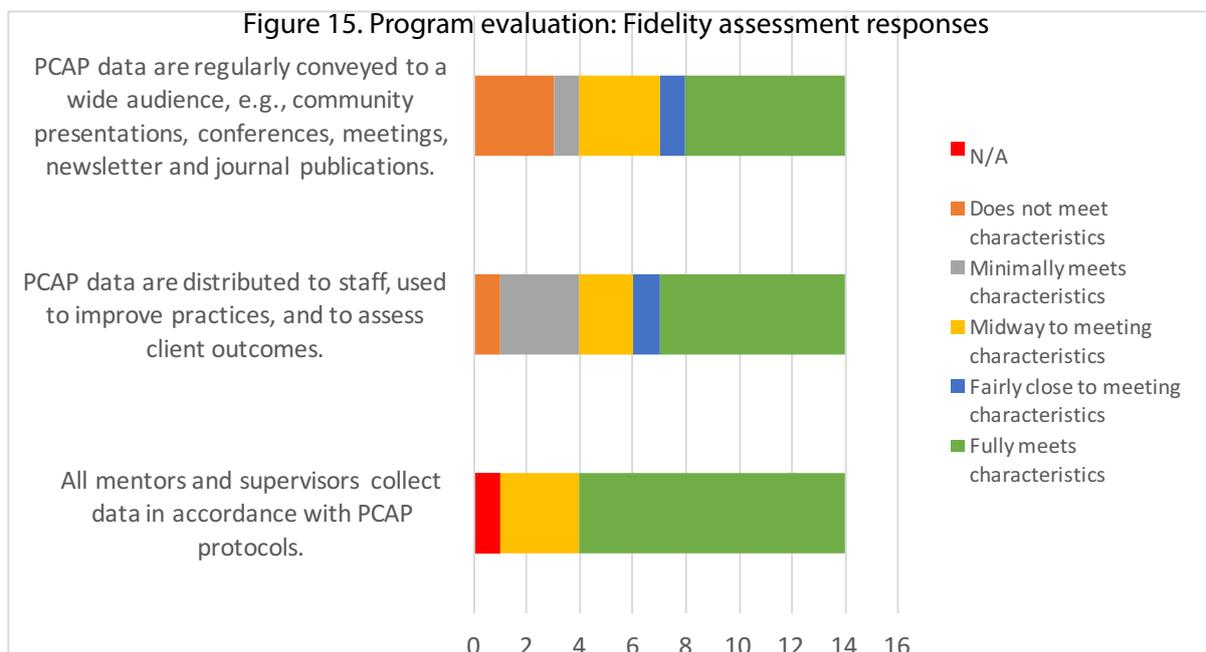
Figure 14. Clinical supervisor in the community: Fidelity assessment responses



Program evaluation

We see good alignment with PCAP protocols regarding the collection of data, a finding that aligns well with our qualitative data (see Figure 15; overall program evaluation mean = 3.80). However, several respondents rated the dissemination of PCAP data to both staff and wider audiences quite poorly. This aligns with interviewees' comments regarding data collection, as well as with the evaluation team's experiences. While several Networks provided detailed annual narrative reports describing their experiences implementing PCAP, they were ultimately unable to provide quantitative data reports to track site-level or First Nation-specific progress. Inevitably, this has interfered with data dissemination.

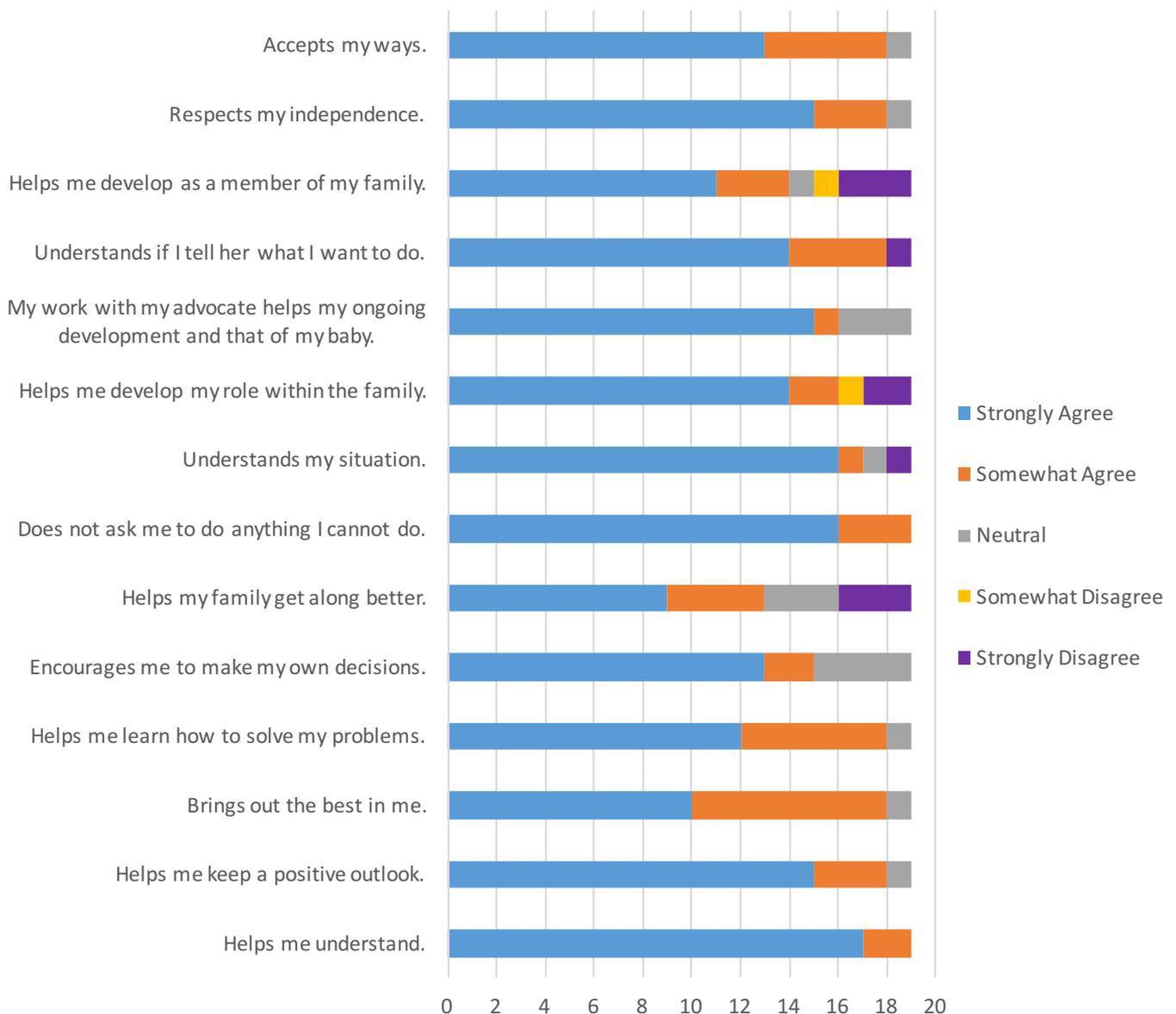
Figure 15. Program evaluation: Fidelity assessment responses



Advocate-Client Relationship Inventory

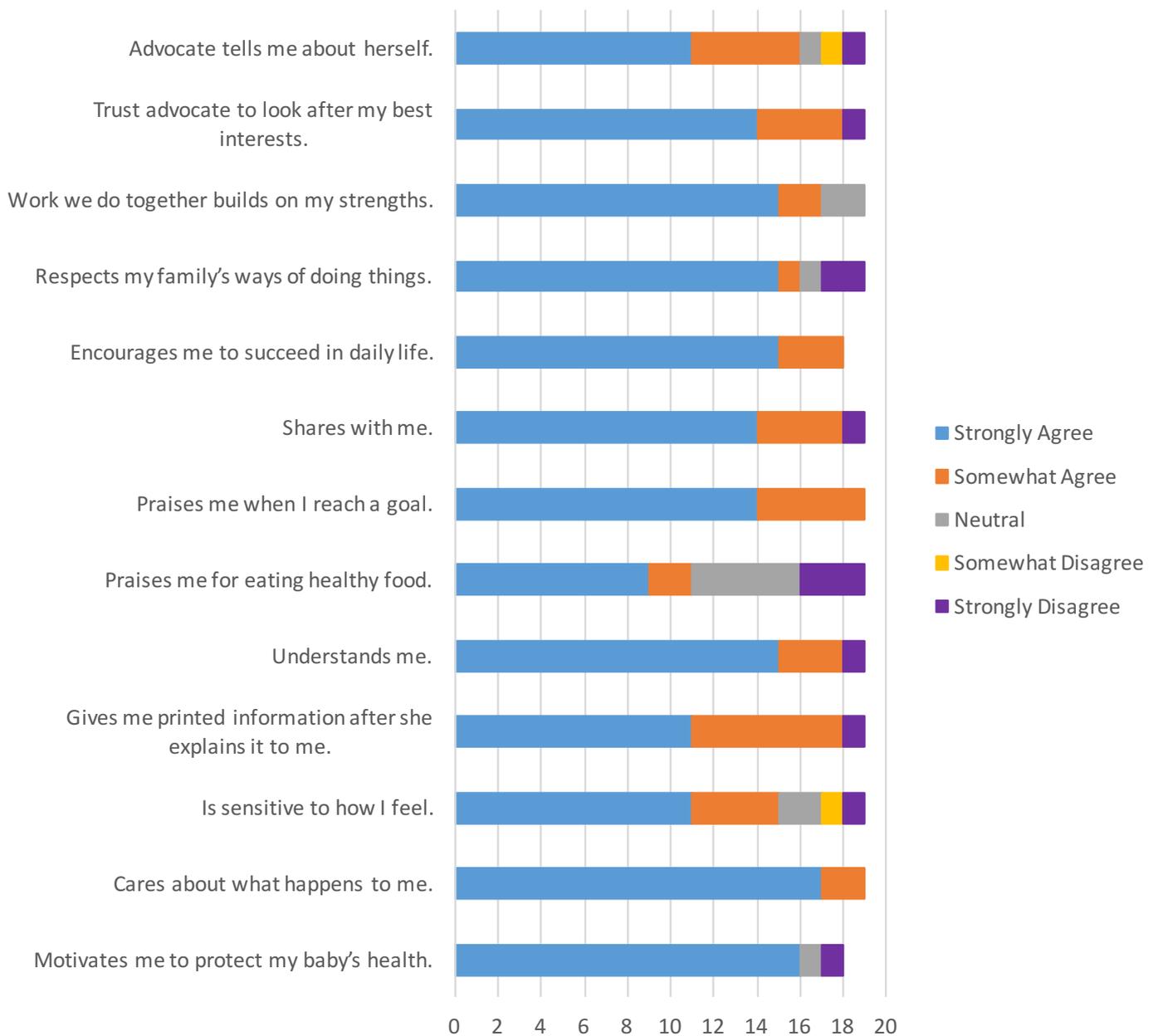
Nineteen respondents completed the Advocate-Client Relationship Inventory (ACI; (Figures 16a and b; n = 17; mean total = 120.53, minimum = 68, maximum = 135), with representatives from Lakeland (n = 9), Prairie Central (n = 3), and Mackenzie Networks (n = 7). Members of the evaluation team travelled to three communities to collect ACI data from clients.

Figure 16a. Advocate-Client Relationship Inventory responses



Overall, clients in these three Networks reported positive relationships with their mentors. Again, higher scores indicate positive relationships. Select items showed some variability. Two family-specific items received more negative ratings (helps me develop as a member of my family, mean = 3.95; helps my family get along better, mean = 3.84). This may indicate that mentors tend to focus more heavily on individual rather than familial aspects of service, or, as mentioned during some interviews, this may reflect mentors providing responsive service to their clients. Specifically, when clients are often in crisis or the majority of mentor time is spent transporting clients to meet their basic needs (e.g., food shopping), less time may be spent working on what may be perceived as less urgent issues (e.g., family relationships). This may also be why the item praises me for eating healthy food showed less positive ratings (mean = 3.74).

Figure 16b. Advocate-Client Relationship Inventory responses



Open-ended ACI responses

In addition to rating the items above, clients provided responses to open-ended questions on the ACI. In response to an item asking how PCAP had made a difference in their lives or changed them, clients responded positively. Many spoke of changes in their lives since participating:

"It helped me when I was pregnant and drinking. I shared with her about if I were struggling. She was supportive. I stopped drinking two months after pregnancy."

"I changed my life around. I am drug free now."

"Gave me self-confidence."

"I needed more structure and they provide that. They helped me be more outgoing. They helped me be more mature and make mature decisions."

In addition, many clients described positive experiences with their mentor:

"Have confidence to come to the health centre, check it out. I was shy. We talk about how I feel, what's going on in my life."

"I left my abusive relationship, went through treatment. She supported me."

"It helped me be a better person. I'm happy she supported me."

"When I'm down, I talk to [my mentor] and she lifts me up again. Gives me info about FAS, how it affects me and my kids. I blamed myself for FAS, she helps me not blame myself."

In the case of an exception, one woman felt safe sharing her negative experience with PCAP:

"No. Mentor's never there to be supportive. Was supposed to take me to appointments, then doesn't answer calls or texts, stopped relying on her to help me."

When asked about their favourite part of PCAP, many clients mentioned the activities that they engaged in with their mentors, the provision of transportation, and their appreciation for the opportunity to get out of the house: In addition:

"My mentor checks in with me to see how I'm doing."

"Not a place that I have to go to, but a person that I can talk to and get the information through her."

"My mentor never judged me."

When asked what they liked least about PCAP, clients responded that there was nothing they did not like about the program. Some suggestions for improvement included more women's groups, time with their mentor, and transportation. In addition:

"Another helper is needed, for rides, transport, to get ladies to appointments. [My mentor] really needs help. Sometimes she's so busy to take on all clients."

"Certain days I need my worker and they're always busy on those days with meetings."

Finally, clients were asked if there was anything else that they wished to share about the mentor or their experiences in PCAP. Clients responded as follows:

"I like this program. My worker helped me lots to get my girl back."

"Keep it going for other mothers in the future. It helped me a lot."



LESSONS LEARNED ALONG THE EVALUATION JOURNEY: ADDRESSING OUR EVALUATION QUESTIONS

1. How has the PCAP model been implemented in First Nation communities?

a. To what extent are services being delivered in alignment with the PCAP model?

Our evaluation revealed that PCAP mentors in Alberta First Nation communities are generally following the PCAP model. In particular, during interviews and focus groups, PCAP staff described working in a way that closely aligned with core PCAP principles, including a shared, trauma-informed approach, as well as a shared attitude that demonstrated collaboration and a passion for working with people who have complex needs. Mentors also described carrying out work with clients that was consistent with core PCAP goals, including goal setting and helping clients to meet their basic needs, access stable living situations, address their addictions, support their sexual and reproductive health, and enhance their parenting skills towards preventing future FASD-affected births. Overall, responses to the PCAP Fidelity Assessment also indicated strong adherence to the PCAP model. Mentors reported close alignment with PCAP protocols regarding program initiation and continued enrollment, the style of service delivery, and activities involved in the intervention.

Despite indication that programs are generally following the PCAP model, there was variance in responses to some Fidelity Assessment items which are worth noting. In particular, there appeared to be some leniency regarding client enrollment criteria, which may indicate mentors' responsiveness to communities' needs for services (i.e., very limited options for service exist in smaller and/or remote communities). In addition, there was some variance in responses regarding the timeframe of services. Specifically, some respondents reported that they were fairly close to working with clients for three years; however, given the time require to establish

program roots, high needs, and limited community resources, some mentors worked with clients for longer than the standard three-year timeframe.

There was also variance in responses regarding staff characteristics. Some mentors and supervisors did not have the qualifications stipulated by PCAP criteria. This was reflected in our qualitative data, which suggested challenges with hiring and retaining staff in small and remote communities. Thus, it is likely that Networks are working with the most suitable candidates that they have available though they may not be ideally qualified in terms of educational background. On a related note, findings indicated that mentor supervision is not meeting minimum PCAP requirements in some areas. However, given our small sample size, this finding cannot be generalized to all PCAP sites. Rather, it is likely that some sites struggle with supervisory requirements due to staffing shortages and remote locations. Many sites have addressed these challenges with the use of satellite offices and phone supervision. Some mentors also reported that supervisors are minimally involved in PCAP communities.

In sum, PCAP staff generally reported that they were delivering services in alignment with the PCAP model. Thus, there was no indication of a need to change the core principles of the PCAP model in order to provide adaptive and appropriate services in Alberta First Nation communities. Overall, our findings suggest that the PCAP model works well in First Nation communities, and that mentors are able to deliver respectful, culturally respectful services through the model.

b. What key considerations are important for working with First Nation communities?

Along with a high degree of adherence to the PCAP model, our findings shed light on key considerations important for working with First Nation communities. In particular, a significant investment of time and effort was required to establish program roots. In communities where there had been previous negative experiences with external programs and services, introduction of the program had to be carried out with great sensitivity. Community approval had to be obtained before the program could begin, which was facilitated by partnerships between the community, the program, and program staff members. It was also important for program staff to have community knowledge, including awareness of recent community events, community experiences with other programs, and unique community and family dynamics. This not only assisted in introducing the program to the community, but also guided hiring decisions which were reported as a challenge in many communities. In addition, it was necessary for staff members to demonstrate an attitude of respect, characterized by humility and openness, as well as a desire to learn about the community. With community approval and knowledge, as well as sufficient time, relationship building could occur. Mentors worked to establish a community presence in order to build trust on both the client and community level, become well-known in the community (including by other community organizations), and to demonstrate that the program would serve the community over the long-term.

Thereafter, mentors could begin to carry out work with clients, which involved addressing challenges unique to working in rural, remote, and isolated First Nation communities. These included travelling long distances, dealing with limited cell phone service, a lack of transportation, a lack of other services, severe housing insecurity, food insecurity, and poverty, all while walking alongside women with complex trauma, mental health, and addictions.

To work with these challenges, mentors engaged in work outside of their job descriptions, such as attending community events outside of typical business hours. This was described as necessary for working successfully in First Nation communities. In addition, mentors facilitated client access to

community cultural events and took part in such events themselves, engaged in grieving processes alongside the community, and demonstrated high levels of flexibility and responsiveness by adapting to community circumstances. In addition, PCAP staff prioritized a holistic, collective, and community-based orientation to service provision. Together, these considerations were identified as key to working with First Nation communities.

These key considerations are in keeping with the spirit of the TRC work, as well as specific recommendations made by the TRC. In particular, the TRC has acknowledged that in order for healing and reconciliation to occur, a foundation of trust and respectful relationships must be built (TRC, 2015). This is in line with our findings that it is not possible to jump into core work before this foundation has been laid, or in our case, before program roots have been established. Also aligned with our findings related to time, the TRC has noted that it is important for foundational work to take shape at a pace that is comfortable for Aboriginal peoples, and to acknowledge the significant time investment required for successful relationship building (TRC, 2015). Moreover, the TRC has drawn attention to the need to integrate communities and larger systems into their work by stating that, “reconciliation is not an Aboriginal problem. It is a Canadian one.” Our findings similarly highlight the central importance of communities in contributing to the PCAP goal of preventing future FASD-affected births.

QUESTION 1 TAKE AWAY

The PCAP model appears well-suited for work in First Nation communities. However, PCAP staff have made adjustments to the ways that they implement this model in order to demonstrate cultural sensitivity and respect for the people and settings in which they are carrying out their work. These findings have informed an important recommendation for providing services in First Nation communities (see page 44).

2. In what ways has PCAP impacted participants and their families?

a. What impacts have mentors observed?

Although mentors felt that three years represented a relatively short time period to establish program roots, grow relationships with complex clients, and carry out their work, they observed a number of emerging impacts on clients and their families. Primarily social and emotional impacts were observed, including the formation of relationships with mentors, other women, and other service providers. Mentors also observed clients having positive community experiences, which some clients had never previously enjoyed. As a result, mentors reported that clients were experiencing reduced stigmatization and isolation, reduced stress levels, and increased pride in their improved independence. Following from forming strong relationships and enhancing clients' social and emotional well-being, mentors observed impacts in terms of clients' addictions and mental health. Mentors facilitated access to health and addictions services, and witnessed clients completing addictions treatment. Relatedly, mentors observed clients having healthy births since reducing or stopping their substance abuse. Some clients regained custody of their children with the support of their mentors, and some children began attending school, eating healthy meals, and following a healthy routine.

b. What impacts have clients experienced?

Drawing from findings of the Advocate–Client Relationship Inventory completed by 19 clients, strong relationships with mentors were reported, as well as high perceptions of the quality of support received. Clients reported that mentors had helped them with such areas as developing a positive outlook and building on their strengths, while demonstrating understanding and respect. Overall, clients reported that their mentors had made a difference in their lives. Areas that were scored lower tended to focus on family, which may indicate that mentors tend to focus more heavily on individual rather than familial aspects of service. This may also reflect mentors' providing services to clients who are often in crisis or who require time spent on meeting their basic needs (e.g., food shopping), such that less mentor time may be spent working on what may be perceived as less urgent areas (e.g., family relationships).

QUESTION 2 TAKE AWAY

Overall, mentors observed a number of impacts on clients and families across domains of well-being. The majority of clients reported strong relationships with mentors, supported by powerful quotes. Of note, as observed by the evaluation team as well as some program supervisors, many mentors were hesitant to report on the impacts that they had observed. In line with an attitude of humility described as critical for working with First Nation communities, mentors were often modest in reporting on client successes, and preferred to attribute successes to clients themselves rather than their work with clients. To obtain a more complete picture of client outcomes and impacts, we attempted to access information from the Penelope and FASD-ORS databases. However, as described in the methods section above, it was not possible to obtain this data. Therefore, our evaluation of client and family impacts is limited, and further evaluation is recommended below (see page 46).



THE PATH FORWARD: RECOMMENDATIONS

Findings from our evaluation inform five key recommendations related to continuing implementation of PCAP in First Nation communities:

1. continued investment in working with First Nation communities
2. changing the ways that services are provided in First Nation communities;
3. data collection and dissemination;
4. ongoing evaluation and measurement; and
5. increased communication among stakeholders.

1. Continued Investment in Working with First Nation communities

A primary recommendation is for continued investment in relationship-based, trauma-informed programs that are responsive to First Nation communities. Programs such as PCAP can contribute to significant, positive outcomes for individuals, families, and communities, and it is strongly recommended that efforts to move forward continue to be explored based upon our evaluation findings which suggest that PCAP is an appropriate fit for many First Nation communities. At its foundation, the PCAP mentorship model is based upon the successful formation and maintenance of deeply meaningful relationships. The strong presence and central importance of relationships and connections between mentors and clients, among mentors, and between PCAP staff and communities was exemplified in the stories shared by the mentors. Due to the consistent emphasis of the importance of relationships, we recommend that relationship building and maintenance continue to be emphasized at all stages of the PCAP journey.

2. Changing the Ways that Services are Provided in First Nation communities

Through our qualitative evaluation findings, we have demonstrated that PCAP was positively received by many communities, yet this was not the case for all. Several communities were reluctant to accept and welcome PCAP services into their communities because of negative experiences with previous service providers. Many of these communities have had resources brought in only to see the resources taken away at the whim of others. Through focus groups and interviews, PCAP staff shared that this has left community members, Elders, and other leaders distrustful of service providers and program longevity. Perpetuating this cycle of relatively short-term program provision to communities can be viewed by community members as harmful to the individuals most in need of services, and detrimental to actions towards reconciliation and change. Our findings clearly indicated that extensive work is required for staff to establish program roots in partnership with First Nation communities and that three-year program funding cycles do not provide this time. Sufficient time needs to be allocated for partnerships to develop between programs and

communities- before clients can be seen. This requires adaptable and sustainable long-term funding models.

We suggest that all levels of program planning for First Nation communities should be adaptive and interactive, with clear, common goals, benefits, and expectations for all involved parties from the beginning. Taking this approach shows responsive movement towards the realization of at least one of the Truth and Reconciliation Commission Calls to Action. For instance, Call number 33:

We call upon the federal, provincial, and territorial governments to recognize as a high priority the need to address and prevent FASD, and to develop, in collaboration with Aboriginal people, FASD preventive programs that can be delivered in a culturally appropriate manner.

The Calls to Action refer to the implementation of the UN Declaration of Rights of Indigenous Peoples. Throughout this document, reference is made to concepts such as partnership, consultation, cooperation, mutual respect, and collaboration. Taking steps towards a new model of service delivery responds to Article 23 of the Declaration in that it signifies that governing bodies are committed to actively involving Indigenous peoples "...in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer[ing] such programmes through their own institutions."

Movement towards a new service delivery model may include developing long-term co-administered funding partnerships that take a shared approach to planning, keep all involved parties accountable to shared goals, and allow change to occur within a respectful professional relationship. Beyond the

funding aspect of the professional relationship, a new approach might also be taken to the way that service training occurs for health or other employees. For current or potential employees, we discovered that it can be a personal and a service barrier to commute long distances to major city centres for training. A more feasible approach might be to have training sessions occur within the smaller, more rural communities, or to have training offered in more easily accessible locales. PCAP is a great program to facilitate such training opportunities, as workers can become certified as PCAP trainers. Short-term investments to have First Nation PCAP workers trained as trainers may build community capacity, lessen the travel burden, and facilitate more rapid training of new employees. For those communities that would like to hire from within, but that may be struggling to find women who are qualified for the mentor position, having local training opportunities may ease this burden, create jobs, and benefit women waiting to access PCAP services.

3. Data Collection and Dissemination

As described above, it was not possible for our team to access Penelope or ORS data for the purpose of this evaluation because site-level data is currently unavailable. This, in combination with information from PCAP staff as described in our qualitative findings section, suggests that improvements should be made to PCAP data collection and dissemination processes in First Nation communities. This aligned with findings reported by evaluators who examined use of the Penelope database in 2014 (Hassar, Pei, Poth, & Heudes).

Currently, a consistent method of data collection is not being implemented by all programs and Networks. The recommendation from the 2014 report remains applicable in 2017:

A clear procedure needs to be put in place for collecting data and ensuring data quality. Specific instructions should be established, implemented, and monitored with explicit accountability measures. It is critical for all data to be collected in the same way and in the presence of clients, especially given that most variables are of a highly personal nature (e.g., frequency of birth control use, drug use).

Sites reported varying levels of knowledge about expectations for data collection and entry, and sites varied in the extent to which they reported following these expectations. A protocol to guide data collection and entry would be of significant benefit. Building staff capacity and resources to consistently complete data collection and entry would need to accompany this protocol.

Issues with data collection and entry may be related to concerns that mentors voiced about the collection of baseline data upon first meetings with PCAP clients, due to what mentors perceived as the traumatizing nature of the Zero-Month Biannual intake questionnaire. Without the collection of baseline data, however, we cannot clearly track client progress and demonstrate the full impact of the program. Therefore, standard PCAP reporting forms, such as the biannual reporting forms, may need to be adapted for culturally appropriate and respectful use in First Nation communities. Adaptation of these materials would need to be done in consultation with First Nation community members and Elders, and may address some of the barriers that exist related to completing these forms and thus obtaining important evaluative data. A redesign of these instruments could also improve efficiency by reducing the number of items. This would require involvement of the PCAP Council, PCAP supervisors, and PCAP mentors in order to maintain alignment with PCAP goals.

Data dissemination is another important consideration. Many staff were frustrated with their inability to see the outcomes for their programs after spending hours entering data. Sharing outcomes could provide staff the opportunity to identify strengths and weaknesses within their programs and to adapt accordingly. It could also provide motivating reinforcement to staff to continue collecting and entering quality data. Furthermore, wider dissemination of this information could have community-level benefits in that members could recognize positive changes that PCAP is contributing to, and thus be more receptive to the program.

Accordingly, it is recommended that infrastructure be developed in order for site-level data to be pulled and made available within each of the FASD Networks.

A collaborative process involving key community stakeholders should guide dissemination decisions. A plan should then be set in place regarding how these reports will be shared within Networks, sites, and communities. This will assist in developing trust, accountability, and transparency with community partners. Existing PCAP Council methods for communicating data to staff should be continued and augmented with input from community members.

4. Ongoing Evaluation and Measurement

Ongoing evaluation and measurement is suggested. Evaluation and measurement are key to identifying program strengths and weaknesses, and understanding whether desired outcomes are being achieved. Ongoing evaluation based upon reliable data sources can be a critical source of information for evidence-based decision-making by communities, funders, and policymakers.

In order to carry out ongoing evaluation of PCAP in First Nation communities, it will be critical for evaluators to have ongoing involvement with each

of the communities participating in the evaluation. In our experience, it was immensely beneficial to visit communities in person. We feel that our efforts to form relationships with PCAP staff, observe community settings firsthand, and employ responsive, participatory methods enriched our data and the story that we can tell through our evaluation. In order to build on these methods, it is recommended that future evaluation should involve more face-to-face data collection and increased resources for deeper involvement with each of the communities involved.

5. Increased Communication Among Stakeholders

All levels of PCAP (i.e., mentors, supervisors, funders) would benefit from increased communication. Our findings clearly indicate that relationships between mentors and clients are key to PCAP's success. We suggest that communication and relationship-building between all stakeholders are similarly critical. With multiple levels of stakeholders, including funders at the government level, PolicyWise, the PCAP Council, FASD Networks, PCAP sites beyond the Networks, as well as staff and supervisors themselves, there are multiple opportunities for communication breakdown. We suggest that the evidence compiled reveals that increased communication between organizational levels of PCAP (e.g., information technology and frontline staff) and between the Networks could be of significant benefit (e.g., by sharing advice regarding coding data and producing reports).

Challenges to establishing and implementing PCAP were mentioned across Networks, with some sites currently facing bumps in the road, and some sites

having successfully navigated them. Implementing a means for communication between sites and across Networks could allow staff to benefit from the opportunity to learn from those who have navigated similar challenges, and from the opportunity to share their stories. Increased communication could function as an additional form of support for program staff. Realization of this recommendation might include the creation of online forums for discussion and posted materials, quarterly or biannual meetings for First Nation PCAP service providers, and/or the encouragement of open contact between Networks via conference and/or personal calls. The latter suggestion might be facilitated by having an initial meeting during which staff members from across Networks could, importantly, introduce themselves and create a contact list. Introductions will be important for opening the doors to communication and increasing the probability that staff will be comfortable reaching out. Aside from these suggestions, it is recommended that community input should strongly guide methods and strategies for improving communication.

CONCLUDING THE JOURNEY: SUMMARY

Inspired by the descriptions of PCAP staff, our findings align well with the metaphor of a journey where mentors and other PCAP staff act as travellers. When embarking on their journeys, PCAP staff found that they needed to do some groundwork to root themselves and the program. Like travellers on a journey, staff were required to understand the area that they were venturing to. Knowledge had to be gained regarding local customs, historical factors, and appropriate timing to be respectful of local circumstances and cultural norms. Travellers might investigate the mode of dress of local peoples, how they will be expected to address members of the community, and what is expected of them as a newcomer. PCAP staff were no different in this respect. Community integration is often key to the success of a journey, as building relationships with community members and leaders can provide travellers with different experiences than they would have by remaining outsiders. To facilitate travellers' integration, it is often desirable to seek out the services of a tour guide. Mentors formed relationships with community members who helped them navigate along their journeys and spread word that they were in town. Relationship building and community knowledge facilitated community approval, and mentors who understood that these processes took time were well-positioned for success on their journeys.

After planting roots, PCAP staff, like travellers, could experience growth. Importantly, travellers to any area will find that some community members experience their presence as positive; as a result, word of mouth can open the door for the community to be more welcoming and trustful of newcomers and other travellers (i.e., other service providers). Depending on community history and circumstances, however, community members may hesitate to welcome travellers and may distrust travellers and their tour guide. In this case, travellers must demonstrate a respectful attitude and approach that fits with local norms, and demonstrate community responsiveness. This allows travellers (i.e., mentors) to walk alongside community members (i.e., clients) on their journey, and to make a difference in the community.

With strong roots, a responsive approach, and a willingness to walk alongside community members, travellers can see beautiful landmarks along their journeys, and contribute to protecting and enhancing these landmarks themselves. Landmarks can be likened to the successes that PCAP mentors contribute to. However, all travellers experience bumps in the road. Accessing certain areas in a new locale can be tricky for travellers, and many of the things that travellers take for granted at home (e.g., cell phone access, year-round navigable roads, food security, and affordable housing) may not be readily available in other locations. However, bumps in the road can be navigated by planting strong roots and relationships, prioritizing community needs, and adapting a collective orientation. Bumps in the road also lend themselves to recognizing areas that would benefit from improvement. Thus, travellers can make recommendations for next steps, and can share their experiences so that others can move forward with the knowledge gained along the journey. This includes understanding what they can expect if they wish to embark on their own journeys into these areas.

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