

BFSS 2010



Image courtesy of Vanderbilt.edu

A Summary of the General and Affiliated Sessions of the Building FASD State Systems (BFSS) 2010 Conference

*Harmony and Collaboration: Working Together to
Keep FASD A Priority*

Nashville, Tennessee ● May 4-6, 2010

Report submitted: June 4, 2010
Revised August 2, 2010



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov



SAMHSA
Fetal Alcohol Spectrum Disorders
Center for Excellence

Table of Contents

BFSS 2010: Background and Planning	2
History.....	2
Attendees.....	2
Planning the Conference.....	3
Conference Overview	4
Registration, First-Time Attendees’ and FASD Overview Sessions, Poster and Exhibit Displays.....	4
BFSS Conference—Structure of the Sessions	4
Day 1 Plenary Sessions.....	4
Day 2 Plenary Sessions.....	6
Day 1 Breakout Sessions	10
Day 2 Breakout Sessions	13
Associated Meetings	18
The National Association of FASD State Coordinators (NAFSC).....	18
The Expert Panel.....	18
The FASD Subcontractors	19
The American Indian/Alaskan Native/Native Hawaiian Expert Panel.....	19
Conclusion	20
Action Steps.....	20
Outcomes	20
Appendix A: Meeting Evaluation	A-1
Appendix B: Evaluation Form	B-1

Electronic versions of the majority of the presentations summarized herein are available on the FASD Center for Excellence Web site (www.fasdcenter.samhsa.gov).

BFSS 2010: BACKGROUND AND PLANNING

History

The Substance Abuse and Mental Health Services Administration (SAMHSA) Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence convened the seventh Building FASD State Systems (BFSS) conference May 3–6, 2010 in Nashville, Tennessee. The annual BFSS event supports the Center’s legislative mandate to provide technical assistance (TA) to communities developing systems of care, and is designed to further specific Center goals, including:

- Advancing the field of FASD;
- Facilitating the development of comprehensive systems of care for FASD prevention and treatment;
- Building infrastructures to ensure that FASD gets critical resources required for lasting change;
- Identifying components of a comprehensive system of care for individuals who have an FASD; and
- Incorporating evidence-based interventions and prevention practices.

The weather did not stop the great city of Nashville, nor did it dampen the enthusiasm of the BFSS 2010 participants.

Despite the overwhelming weather conditions that impacted the Nashville region during the week of the BFSS conference, a large and committed group of health professionals and State officials from around the country braved the elements so they could learn about effective FASD approaches, interventions, and new science through plenary and breakout sessions, and through peer-sharing activities. In addition, as is increasingly the case with BFSS, participants seized the opportunity to share and coordinate efforts across the growing network of FASD-related service providers and organizations.

Attendees

A wide range of participants are invited to BFSS each year, with an emphasis on State and U.S. Territory government employees involved in issues related to FASD and policymaking. The sessions include voices from across the entire spectrum of support and services to people with

FASD, including representatives from primary care, the public and private sectors, criminal justice and social service, birth mothers and family members, advocates, counselors, educators, administrators, mental health and substance abuse treatment professionals, researchers, and scientists.

This year’s sessions feature representatives from 48 states (Nebraska and Rhode Island were not represented), two U.S. Territories (Guam and the Virgin Islands), Washington, D.C., and the Navajo Nation. Attendees included local, State, and juvenile court subcontractors implementing FASD intervention programs, as well as members of the Center’s Expert Panel, the National Association of

FASD State Coordinators (NAFSC), the Birth Mothers Network (BMN), and the American Indian/Alaskan Native/Native Hawaiian Expert Panel (Native Expert Panel). Other agencies represented included the National Organization on Fetal Alcohol Syndrome (NOFAS), the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS), the Arc of the United States, Children and Families First, Prevention First, and the Centers for Disease Control and Prevention (CDC), as well as 17 representatives from universities throughout the country.

BFSS 2010 Attendees at-a-Glance
189 participants from:
■ 48 States and the District of Columbia
■ 2 U.S. Territories (Guam and the Virgin Islands)
■ Representatives from multiple Native American communities, including the Arapaho, the Navajo Nation, the Northwest Portland Area Indian Health Board, the Salt River Pima-Maricopa Indian Community, the Central Council of the Tlingit & Haida, and the United South and Eastern Tribes

Planning the Conference

Each year, a BFSS Planning Committee helps formulate the conference agenda and activities. This Committee consists of no more than 10 individuals from the field, working with the Task Order Officer (TOO) and staff from the Center. The Committee meets by teleconference as often as necessary—this year there were three meetings—to accomplish the needed tasks. In selecting Planning Committee members, Center staff looks for representation from:

- Diverse geographic locations;
- States at all levels of development;
- Various organizations;
- States that have received a local community and/or State subcontract;
- Non-funded states;
- A mix of cultures and ethnicities;
- The meeting's host state; and
- Previous Planning Committee members.

The BFSS 2010 Planning Committee began working in November 2009. They developed the conference theme and recommended plenary and breakout session topics and potential speakers. Many Committee members also introduced speakers and served as session moderators and panelists at the conference.

BFSS 2010 Planning Committee

- Diane Casto (Alaska)
- Mary DeJoseph (Pennsylvania)
- Pamela Gillen (Colorado)
- Charlene Harmon (Tennessee)
- Muriel Kronowitz (Nevada)
- Michael Kudla (Louisiana)
- Meghan Louis (Minnesota)
- Paulette Romashko (Wisconsin)
- Margo Singer (New York)
- Ginny Wright (Hawaii)

Nashville, Tennessee was chosen as the site for BFSS 2010 because of its central location, adequate meeting space and accommodation availability, and competitive pricing. As the theme for this year's event, the Planning Committee chose *Harmony and Collaboration: Working Together to Keep FASD A Priority* to tie in the tremendous musical heritage of the location with the desire to both reflect on previous accomplishments and lay the groundwork for the continued growth of the FASD field.

CONFERENCE OVERVIEW

Registration, First-Time Attendees' and FASD Overview Sessions, Poster and Exhibit Displays—Tuesday, May 4, 2010

BFSS participants were able to register for the general sessions beginning at 3:30 PM (CST) on Tuesday, May 4. Later that afternoon, interested participants attended *A New Song: BFSS First Time Attendees' Session*, presented by the Center's Project Director, Callie B. Gass. Afterward, Dan Dubovsky, MSW, the Center's FASD Specialist, presented a well-attended session titled *Learning the Tune: FASD Mini-Training*. From 5:30 PM to 6:30 PM on May 4, the Center staged the annual Opening Poster and Exhibit Display Session, during which the 23 subcontractors shared posters and other materials about the FASD activities in their states. Joining the Poster Session this year were the members of the FASD Self-Advocates in Action (FSAA), a group of individuals with FASD, led by Rob Wybrecht. All attendees were able to use the session as a learning and networking opportunity.

BFSS Conference—Structure of the Sessions

The BFSS meeting began Wednesday, May 5 at 8:30 AM (CST). As in previous years, the meeting included general plenary sessions attended by all participants, followed by breakout sessions that allowed participants to select topics that suited their needs and interests. Four topic-specific breakout sessions were conducted on Wednesday, followed by five state working sessions that allowed representatives from states at similar levels of FASD capacity development to meet and discuss their activities. On Thursday, May 6, four topic-oriented breakout sessions were conducted. Brief descriptions of the plenary sessions are provided below. Listings of the breakout sessions offered on each of the two meeting days follow.

Day 1 Plenary Sessions—Wednesday, May 5, 2010

Opening Number: Welcome and Introduction

Patricia B. Getty, PhD, Task Order Officer, SAMHSA FASD Center for Excellence

Dr. Getty briefly welcomed participants and indicated how encouraged she is by the growth of the BFSS meetings and the expansion of the FASD field. She stressed the conference's overall themes of collaboration and partnership, as these will be the most important mechanisms for sustaining and growing the FASD field.

Latest Hits: Report from the SAMHSA FASD Center for Excellence

Callie B. Gass, Project Director, SAMHSA FASD Center for Excellence

Ms. Gass reviewed the Center's major activities since BFSS 2009. The expanding reach and influence of the Center is reflected in the continued growth of the Birth Mothers Network (BMN) and the National Association of FASD State Coordinators (NAFSC). Notably, discussions initiated by NAFSC led the National Association of State Alcohol and Drug Abuse Directors (NASADAD) to unanimously pass a resolution in April 2010 recommending that all members consider sending letters to the makers of home pregnancy tests, encouraging them to place warnings on their products about the dangers of using alcohol during pregnancy.

The expanding influence of the FASD Center for Excellence is reflected in the dynamic growth of both its activities and its ancillary organizations.

Moreover, both the Center's official Web site (www.fasdcenter.samhsa.gov) and toll-free hotline (866-STOPFAS) experienced all-time usage highs in early 2010, while Center staff delivered more trainings and technical assistance events in 2009 than in any previous year (55 events in 18 states).

As Ms. Gass noted, the Center also continues to foster a full-circle continuum of service-to-science and science-to-service, most notably through 1) the work of its 23 subcontractor sites, which are completing their second year of implementing FASD-related interventions and have begun to release significant outcomes data, and 2) the ongoing development of a Treatment Improvement Protocol (TIP) addressing FASD in substance abuse treatment settings.

Opening Notes: SAMHSA Updates with a Focus on Partnerships

Moderator: Virginia Mackay-Smith, MPH, Director, Division of Systems Development (DSD), Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Services Administration (SAMHSA)

Additional Speakers:

- Rebecca M. Buchanan, PhD, Senior Study Director, Westat
- Helen S. Weinstein, CPP, Fetal Alcohol Program Coordinator, Erie County Council for the Prevention of Alcohol and Substance Abuse; Co-Chair, New York's FASD Prevention Task Force
- Trisha Hinson, MEd, CMHT, FASD State Coordinator/Project Director, Mississippi Department of Mental Health Division of Children and Youth; SAMHSA FASD Center for Excellence National Association of FASD State Coordinators (NAFSC) Member

Ms. Mackay-Smith moderated a panel session which began with her discussion of the evolving priorities at SAMHSA. In the last two years she, CSAP Director Frances M. Harding, and SAMHSA Administrator Pamela S. Hyde have joined the agency. Ms. Hyde's leadership has brought a renewed set of programmatic imperatives, outlined in SAMHSA's recently announced ten Strategic Initiatives (more information about these initiatives is available at <http://www.samhsa.gov/about/strategy.aspx>). The ten initiatives promote SAMHSA's public health vision, which Ms. Mackay-Smith described as "national in scope, local in focus." She indicated that the goals of the BFSS participants and the field of FASD are in line with SAMHSA's objectives; integrating substance abuse and mental health treatment, strengthening state leadership on these public health issues, linking systems and services, and building workforce skills. She added that the recently passed health reform is an encouraging sign for the FASD field, as the legislation stresses prevention and integration of services.

Ms. Mackay-Smith then introduced the other panel speakers:

- Dr. Buchanan reviewed the activities of the five pilot sites that served as the basis for material published as the *Partnership to Prevent Fetal Alcohol Spectrum Disorders Public Education Program Manual*.
- Ms. Weinstein discussed the Erie County Council's Fetal Alcohol and Drug Effects (FADE) program, which grew out of the pilot activities that Dr. Buchanan summarized. FADE promotes positive prevention messages and provides credible information to women of childbearing age and their significant others concerning the risks of consuming alcohol during pregnancy. Ms. Weinstein stressed the important role that partnerships play in sustaining efforts like FADE, and indicated that partners can be found in any sector of your area, including community centers, youth programs, parenting organizations, educators, politicians, and other healthcare providers.

- Ms. Hinson related the factors that led to the development of a State Task Force on FASD in Mississippi in 2003. The work of this Task Force has been sustained not only through extensive partnerships but also through a focus on making sure that FASD-related priorities (screening & diagnosis, expanded services for children, etc.) are formally included in legislation and in state policy language.

Singing-Out: The Self Advocacy Network for Individuals with an FASD

Introduction: Rob Wybrecht, Lifelong Expert on FASD; SAMHSA FASD Center for Excellence Expert Panel Member

Rob Wybrecht, a member of the Center’s Expert Panel who also has an FASD, introduced members of FASD Self-Advocates in Action (FSAA). Each offered a musical performance and then spoke about their own struggles with FASD. Performances included:

- Amanda Oliver Blane of Nevada (dance)
- Brandan Gelo of Washington (Elvis impersonation)
- Morgan F. Strang of California (Native American flute)

Day 2 Plenary Sessions—Thursday, May 6, 2010

Reports from State Working Groups

Moderator: Callie B. Gass, Project Director, FASD Center for Excellence

Ms. Gass moderated a session in which designated speakers from each of the five state working sessions on Day 1 reported on their group’s findings.

State Working Groups
<ul style="list-style-type: none"> ■ Group A: Establishing A Designated State Coordinator (this page) ■ Group B: Creating and Sustaining a Statewide Task Force (page 7) ■ Group C: Develop a State Plan (page 7) ■ Group D: Working Across State Lines to Increase Regional and State-to-State Efforts (page 8) ■ Group E: Jump-Starting State Efforts – Developing State Systems 101 (page 8)

A. Establishing a Designated State Coordinator

Group Facilitators:

- Mary D. Johnson, Maryland FASD State Coordinator, Center for Maternal and Child Health, Family Health Administration, Maryland Department of Health and Mental Hygiene
- Joseph E. Kotsch, RN, MS, Maternal and Child Health Perinatal Consultant, Kansas Department of Health and Environment; NAFSC Member
- Janice K. White, MEd, TBI/FASD Program Coordinator, State of North Carolina Division of Mental Health/Developmental Disabilities/ Substance Abuse Services; NAFSC Member

Group A noted that even states without a designated State Coordinator for FASD may still have a coalition related to the issue, or a state Task Force. These bodies need to find an FASD champion within the state government and/or legislature (a women’s legislative group is a great place to start). Funding is a matter of persistence, and needs to be backed up with data. Participants were urged to utilize the resources available (e.g., Block Grant dollars [in any field], the training and TA offered by the Center). A sample job description can be very helpful. NAFSC will post one on their Web site.

B. Creating and Sustaining a Statewide Task Force

Group Facilitators:

- Dan Dubovsky, MSW, FASD Specialist, SAMHSA FASD Center for Excellence
- Kathy Jo Stence, CAC, Program Analyst, Bureau of Drug and Alcohol Program, Pennsylvania Department of Health; NAFSC Member

Group B identified the following critical steps to developing a statewide Task Force:

- Create awareness of the need
- Identify a core group of members committed to FASD who can determine who to invite to participate from both the state and private sectors
- Determine the tasks to be completed and establish a timeline
- Complete a Needs Assessment to identify FASD prevention and diagnosis and intervention needs, resources, and gaps
- Ensure that meetings are task-oriented, with action plans (using a facilitator is recommended)
- Identify the issues and needs of members and ensure that they are addressed so that all participants feel as if their voice is being heard
- Think “outside the box” on funding
- Utilize university interns for assistance in analyzing data and universities for advanced technological capabilities
- Learn from other states’ experiences (no need to re-invent the wheel)

The group also identified key barriers:

- Funding
- Staff turnover
- Lack of systems and capacity (i.e. diagnostic capacity)
- Lack of key players at the table
- The existence of agency ‘silos,’ with each only focused on their own issue

C. Developing a State Plan

Group Facilitator: Sharon L. Dorfman, ScM, CHES, President/Consultant, SPECTRA

Group C identified the following elements of state plan development:

- Conducting a needs and resource assessment
- Forming partnerships focused on addressing common goals
- Collaboratively developing a data-driven multi-year plan that incorporates evidence-based programs
- Implementing the plan using one-year action plans as guides
- Monitoring progress toward goal achievement by tracking measurable outcome objectives

It was noted that a state FASD plan can be stand-alone or part of a broader state plan. Challenges noted included lack of funding, lack of organization and collaboration, an overflow of needs, cultural issues, and lack of resources. Participants were encouraged to utilize the resources of the FASD Center for Excellence in developing their state plans and to request TA from the Center if needed. Participants suggested including a document listing the benefits of developing a state FASD plan and a workshop at the 2011 BFSS conference on community-based evaluation.

D. Working Across State Lines To Increase Regional and State-to-State Efforts

Group Facilitators:

- Georgiana Wilton, PhD, Associate Scientist, Department of Family Medicine, University of Wisconsin; Co-Principal Investigator and Project Director, Great Lakes FASD Regional Training Center
- Pamela Gillen, ND, RN, CACIII, Assistant Professor of Research; Project Director, COFAS Prevention Program/Colorado AHEC System; Expert Panel Co-Chairman; NAFSC Member

Group D provided the following suggestions for increasing state-to-state and collaborative regional efforts around FASD:

- Use conferences as a way to get the word out
- Identify funding streams: You may be able to access grant funding even from other subject areas
- Know the key players and each government's structure, and identify turf and political issues
- Use the resources of the Addiction Technology Transfer Centers (ATTCs) and the CDC's Regional Training Centers (RTCs)
- Don't forget to involve the affected individuals: They can be a tremendous resource!

Every state working group noted funding as a major obstacle, and stressed the need for creative thinking. Minnesota got funding for their FASD State Task Force from a brewery!

The group identified lack of a common language and timing issues as barriers to collaboration. Participants suggested that the Center provide a live feed of BFSS 2011, and also create a resource & name list (who is doing what in various states; perhaps even provide a map on the Web site).

E. Jump Starting State Efforts - Developing State Systems 101

Group Facilitators:

- Rebecca M. Buchanan, PhD, Senior Study Director, Westat
- Susan L. Doctor, MEd, PhD, FASD Specialist, University of Nevada, Reno

Group E brainstormed the necessary components of an effective State FASD system:

- A common vocabulary: Terminology that will allow for effective communication within and across public agencies and private entities, and even State-to-State
- Better coordination of local, State and Federal law and guidelines pertaining to FASD-related issues
- Recognizing and taking advantage of "teachable moments," among small and large agencies, private and public meetings, and with individuals (e.g. foster parents)

Barriers noted include:

- Competition among agencies for limited dollars and "penalties" for collaborating across groups (if groups work together and pool resources, dollars often are cut from one group's budget)
- Lack of public and professional awareness on FASD

This group also recommended greater sharing of State and regional experiences between BFSS conferences, and also suggested a live feed from the BFSS 2011 conference (not just to the primary State FASD representatives).

A Little Background Music: Current Science and Research Trends in the Field

Moderator: Pamela Gillen, ND, RN, CACIII, Assistant Professor of Research; Project Director, COFAS Prevention Program/Colorado AHEC System; Expert Panel Co-Chairman; NAFSC Member

Speaker: Cynthia J.M. Kane, PhD, President, FASD Study Group; Professor, Neurobiology and Developmental Sciences, University of Arkansas for Medical Sciences

Dr. Kane opened by noting that, while there has historically been a lack of hard scientific information on the subject of FASD, much new work is being done in this area. There were 300 scientific papers published on FASD in 2009, while there had been only 160 in the nine preceding years. She then discussed the teratogenic effects of pre-natal alcohol exposure, and spotlighted procedures such as Magnetic Resonance Imaging (MRI), Functional MRI (fMRI), and Magnetic Resonance Microscopy (MRM) that are making it possible to more specifically identify not only the impact of alcohol on the brain of a fetus, but also at what stage of development the impact occurs.

Dr. Kane also provided an overview of developments in neo-natal analysis (e.g., hair sampling) that may make it easier to identify pre-natal alcohol exposure, as well as advancements in chemical treatment (e.g., the use of anti-oxidants, nutritional metabolites, or neurotrophic peptides) that may soon make it possible to offset or block some negative impacts.

Invigorating the Field: A Working Lunch: Tuning into Policies that Address Drinking Among Women of Child-Bearing Age

Moderator: Deborah E. Cohen, PhD, Executive Director, New Jersey Office for Prevention of Developmental Disabilities; Expert Panel Member

Speaker: Raul Caetano, MD, MPH, PhD, Regional Dean and Professor, University of Texas School of Public Health and University of Texas Southwestern Medical Center at Dallas

Dr. Caetano began by reviewing Census-based and epidemiological information about women of childbearing age and births and pregnancies in the U.S. He noted that, in the 2006 Census, there were nearly 62 million women in America in the traditional child-bearing age range (15-to-44 years old). He also noted that, of the 4.3 million births that occur on average each year in this country, nearly half are unplanned, and that both the highest drinking rates and the highest unplanned pregnancy rates are among women 18-29. This establishes a very large core audience for the FASD prevention message.

Dr. Caetano also discussed three levels of prevention when alcohol is a risk factor:

- Universal: Directed at all members of a population (e.g., all women, all pregnant women)
- Selective: Directed at subgroups of individuals with a risk higher than average (e.g., drinkers, pregnant women who drink, partners)
- Indicated: Directed at groups at highest risk (e.g., high risk drinkers, those who are dependent)

Each of these levels calls for different types of intervention:

- Universal: Reduce alcohol consumption in the population, support abstinence, FAS risk awareness in routine health care
- Selective: Screen, identify those at risk, and provide more intense interventions than at the Universal level
- Indicated: Most intense interventions, for those at highest risk (e.g., treatment)

Dr. Caetano indicated that universal interventions have the best chance of preventing women from moving into higher risk, although he plotted their efficacy along a continuum of high (e.g., alcohol taxation), moderate (e.g., community mobilization, limiting the times and/or outlets of

permissible sales), limited (e.g., advertising bans), and lacking (e.g., public messages, warning labels). He recommended expanding and testing methodological approaches for assessing the effects of universal prevention strategies.

Day 1 Breakout Sessions

On Day 1, participants chose one of four breakout sessions:

Harmonizing Chords: Strategies for Developing and Sustaining Effective Partnerships

Moderator: Dan Dubovsky, MSW, FASD Specialist, SAMHSA FASD Center for Excellence

Speakers:

- Sharon L. Dorfman, ScM, CHES, President/Consultant, SPECTRA
- Rebecca M. Buchanan, PhD, Senior Study Director, Westat
- Helen Weinstein, CPP, Fetal Alcohol Program Coordinator, Erie County Council for the Prevention of Alcohol and Substance Abuse; Co-Chair, New York's FASD Prevention Task Force

Day 1 Breakout Sessions

- Harmonizing Chords: Strategies for Developing and Sustaining Effective Partnerships (this page)
- Setting the Stage: Identification and Diagnosis of Adolescents and Adults with an FASD; Establishing Diagnostic Centers and Building Capacity (this page)
- Not the Same Ole Song and Dance: Innovative Communication Strategies for Supporting Families and Creating Change (page 11)
- Tuning into Prevention: Binge Drinking Among Pregnant Women and Policy-based Prevention Strategies to Address the Issue (page 11)

All three panelists focused on the importance of communications in the work of FASD organizations.

- Ms. Dorfman gave specific tips on how to maintain the involvement of Task Force members, such as sending out regular program updates, meeting summaries, and 'thank you' messages, especially to members who miss meetings so that they continue to feel part of the group. She also suggested that allowing members to speak about their organizations during FASD sessions and pairing new people with experienced members will help sustain and increase participation.
- Dr. Buchanan stressed the importance of testing public information materials to ensure that they will be effective rather than being a waste of resources.
- Ms. Weinstein spoke about successful information campaigns that her organization has employed. She encouraged participants to carefully select their target audience, select and use the medium that will best reach that group, and tailor positive, consistent messages to the local population. Asking potential community partners what they need can lead to collaboration that benefits both parties.

Setting the Stage: Identification and Diagnosis of Adolescents and Adults with an FASD; Establishing Diagnostic Centers and Building Capacity

Moderator: Paulette Romashko, MSW, LCSW, Director of Correctional Services, ARC Smart Start Program Director, ARC Community Services, Inc, 2010 BFSS Planning Committee Member

Speakers:

- Susan Buttross, MD, Behavioral Pediatrician, University of Mississippi Medical Center; Member, FASD Diagnostic Learning Community-Children/Adolescents
- David Wargowski, MD, Associate Professor, University of Wisconsin School of Medicine and Public Health-Adolescents/Adults

Dr. Wargowski, a pediatric geneticist, reviewed the criteria for FAS, and identified some of the challenges and unanswered questions in the diagnostic process. The diagnostic assessment includes a review of records; birth, growth, medical, IQ tests, and neuropsychological, behavioral, or physical assessments. Dr. Wargowski reviewed two diagnostic approaches; the Revised Institute of Medicine (“Hoyme”) criteria and the University of Washington Diagnostic and Prevention Network 4-Digit Code. General challenges to the diagnosis of FASD include lack of awareness among physicians and service providers, lack of willingness to refer children and youth for an assessment, lack of reliable information regarding prenatal alcohol exposure, bias and stigma in providing information regarding alcohol exposure, and variables that affect phenotype. The essential elements for a framework for FAS diagnosis and services include initial identification, referral, diagnosis, and services. Ideal team members for a multidisciplinary diagnostic team will include a physician, occupational therapist, physical therapist, nutritionist, psychologist, audiologist, speech and language pathologist, and social worker.

Dr. Buttross discussed the problems that a child may encounter when the mother uses alcohol during pregnancy, which can range from subtle issues to profound problems. She also provided information about the effects of maternal smoking and use of cocaine on the development of children. She concluded with a case presentation which illustrated the efficacy of early intervention with appropriate services and a loving home.

Not the Same Ole Song and Dance: Innovative Communication Strategies for Supporting Families and Creating Change

Moderator: Ginny Wright, Co-Chair, Hawaii FASD Task Force; SAMHSA FASD Center for Excellence American Indian/Alaska Native/Native Hawaiian Expert Panel Member; 2010 BFSS Planning Committee Member

Speakers:

- Emily A. Gunderson, Director of Communications, Minnesota Organization on Fetal Alcohol Syndrome (MOFAS)
- Nancy A. Beyer, Parent Liaison, Virtual Family Center, MOFAS

Ms Gunderson presented on the MOFAS Virtual Family Center, which serves families living in Minnesota who are foster, adoptive, or biological parents of a child or children affected by FASD. Since it was incorporated in 1998 as a 501(c)(3), MOFAS has worked to eliminate disability caused by alcohol consumption during pregnancy and improve the quality of life for those living with FASD throughout Minnesota. The Virtual Family Center is a place where families can find meaningful connections and helpful information about FASD. Once online, families can view welcome videos, view FASD picture scrapbooks, stories, and blogs, and can share their own stories and interact with other families.

Tuning into Prevention: Binge Drinking Among Pregnant Women and Policy-based Prevention Strategies to Address the Issue

Moderator: Melinda M. Ohlemiller, MA, Chief Executive Officer, Nurses for Newborns Foundation; Expert Panel Co-Chairman

Speakers:

- Joseph C. Gfroerer, Director, Division of Population Surveys, Office of Applied Studies, SAMHSA
- Mary Kate Weber, MPH, Behavioral Scientist, Fetal Alcohol Syndrome Prevention, Centers for Disease Control and Prevention

Mr. Gfroerer discussed data from National Survey on Drug Use and Health (NSDUH) self-administered questionnaire. Substance use questions asked about drinking patterns at the

beginning, middle, and end of pregnancy. Most of the data presented was from 2002-2008.

Findings included:

- The highest rates were among women in their first trimester, at 18.2 percent (8.4 percent during 2nd trimester and 7 percent in their 3rd trimester). A likely explanation for higher rates in the first trimester is that many women do not yet know they're pregnant.
- Binge alcohol use among pregnant women was at a rate of 3.7 percent. The definition of binge drinking used by NSDUH was 5 or more drinks, differing from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) definition of 4 or more drinks.
- Drinking rates during pregnancy are highest among those under 21. After 21, the rates begin to decline and flatten out after 30.
- There is a tremendous variation in rates by state, with the Northern Plain States and Northeastern States having the highest rates of binge drinking for women ages 15-44.
- Among non-pregnant women, the highest rates of alcohol use are among Caucasian women, at 60 percent (African American at 43 percent, Hispanic women at 39 percent).
- There is a correlation between higher income and higher alcohol use rates, with the highest rates among non-pregnant women with a household income of \$75,000.
- There has been no significant change in alcohol use rates among pregnant women and non-pregnant women in the last seven years.

Ms. Weber discussed the National Task Force on FASD's recent review of universal strategies used to raise awareness of FAS. Strategies reviewed included:

- Bottle Labeling: Studies revealed that the labeling that came about from the Alcoholic Beverage Warning Label Act of 1988 mostly affected light drinkers.
- Point of Purchase Warning Posters/Signs: Placed in bars, liquor stores, and restaurants, these posters may not change alcohol-related behaviors but do raise awareness and reinforce the beverage warning labels. As of January 2009, 23 states have implemented the mandatory warning signs.
- Communication Campaigns: There is insufficient evidence to indicate that these strategies are effective in reducing alcohol-exposed pregnancies, but they are important for increasing public awareness.
- Limiting Alcohol Outlet Density: The National Task Force recommends the use of regulatory authority to limit alcohol outlet density.
- Increased Taxation: These taxes are imposed at the State and Federal level, and vary from state-to-state and by the type of alcohol. Seventy-five studies have looked at the relationship between either tax rates or total price on measures related to excessive alcohol consumption and its related harms. Increasing the price of alcohol by 10 percent would reduce alcohol consumption by 7 percent. The National Task Force on FASD recommends increasing the unit price of alcohol by raising taxes.
- Enhanced Enforcement of Sales-to-Minors Laws: These interventions are typically done through sting operations. The National Task Force recommends enhanced enforcement of laws prohibiting sale to alcohol to minors.

The National Task Force on FASD recommends limiting alcohol outlet density, increasing taxation on alcohol products, and enhancing the enforcement of laws prohibiting the sale of alcohol to minors.

Meeting participants also provided strategic suggestions:

- **Kentucky:** Volunteers delivered FASD information to every obstetrics office in Kentucky on FASD Awareness Day (September 9, 2009). This was the first statewide FASD Awareness Day program that the State recognized.
- **North Carolina:** Task Force members are working closely with the Alcohol and Beverage Commission (ABC) and putting warning signs in liquor stores. In the western part of the state they are partnering with ABC in including slides on FASD in their server training. In addition, they are collaborating on writing a policy statement to prevent FASD.

State Working Sessions

Five state working sessions were offered for Day 1. Participants were encouraged to select the session that most closely paralleled where their state is in the FASD systems development process (e.g., just getting started, or designating a State FASD Coordinator, or further along). Report-outs from these groups were offered during the general plenary on Day 2, and are summarized above (pages 6-8).

Day 2 Breakout Sessions

On Day 2, participants chose from one of four breakout sessions:

Sounds of Success: Implementing Evidence-Based Programs

Moderator: Margo B. Singer, MPA, Addictions Program Specialist II, New York State Office of Alcoholism and Substance Abuse Services; 2010 BFSS Planning Committee Member; NAFSC Member

Speakers:

- Patricia Bailey, Project Director, Project CHOICES, Texas Office for Prevention of Developmental Disabilities
- Sara Rumann, MA, Program Manager, Screening and Brief Intervention, Arizona Department of Health Services
- Joyce L. Washburn, MPA, Substance Abuse Treatment Specialist, Parent–Child Assistance Program, Michigan Office of Drug Control Policy
- Trisha Hinson, MEd, CMHT, FASD State Coordinator/Project Director, Mississippi Department of Mental Health Division of Children and Youth; NAFSC Member

This breakout featured four subcontractors funded to implement FASD prevention and treatment:

- Ms. Bailey opened the session with a brief description of the Texas Office for Prevention of Developmental Disabilities, the department receiving funding to implement Project CHOICES. She then gave an overview of CHOICES, stating that the goal is to lower rates of alcohol-exposed pregnancies by encouraging behavior change in women who are able to become pregnant and who are sexually active, using alcohol, and not using effective contraception. Seven sites have screened 803 women through March 2010, and 337 have entered the program.
- Ms. Rumann, began her session with an overview of the Arizona Health Start Program, and described the Alcohol Screening and Brief Intervention (SBI)

Day 2 Breakout Sessions

- Sounds of Success: Implementing Evidence-Based Programs (this page)
- A Sound Investment: Connecting with Tribes and Native American Populations (page 14)
- Instruments of Success: Reaching Out to and Working With Primary Care Providers (page 15)
- Marching Together: Steps Juvenile Courts Have Taken to Address FASD Screening, Evaluation, and Sentencing Modifications (page 16)

project. Project findings, challenges, and implementation successes were also discussed. Arizona started off with two pilot sites, adding six more sites in 2010. They plan to add an additional six sites by the end of the project, giving them 14 implementation sites in ten counties. Through March of 2010, 758 women have been screened, and 100 have received a brief intervention.

- Ms. Washburn gave a brief history of the Parent Child Assistance Program (PCAP). The primary goal of PCAP is to prevent subsequent alcohol and drug-exposed births. To achieve that goal, Michigan has implemented PCAP in three counties; Berrien, Kent, and Muskegon. Ms. Washburn explained that PCAP is an evidenced-based program founded on a relational model. Unlike other interventions, PCAP is a lengthy (three-year) home-based intervention where advocates provide peer support and focus on prevention of FASD by either reducing alcohol use or getting women to use effective contraception. Advocates help the mothers build and maintain healthy independent family lives. They also ensure that children are in safe and stable homes. Michigan has enrolled 78 women in their PCAP program through March of 2010.
- Ms. Hinson explained that the goal of the FASD Diagnosis and Intervention project is to improve the functioning and quality of life of children and youth and their families by identifying and diagnosing those who have an FASD and providing interventions tailored to the diagnosis. The current target population being screened for FASD in Mississippi is children ages 0-to-7 who are served by one of 15 Community Mental Health Centers in the State. She explained that in the future, the age group will expand to 0-to-21. Mississippi's system of care for children incorporates Community Mental Health Centers with Making A Plan (MAP) teams. MAP Teams help ensure that services are "wrapped around" each child, and that children who screen positive are referred for a diagnostic evaluation. Each child with an FASD diagnosis receives an individualized treatment plan. In 2010, the Mississippi Department of Mental Health developed and implemented the first comprehensive ten-year strategic plan for mental health services in Mississippi. There are at least two objectives in the plan that are specific to FASD awareness or services.

A Sound Investment: Connecting with Tribes and Native American Populations

Moderator: Kendra King Bowes, MPA, Native American Specialist, Native American Management Services, Inc.; 2010 BFSS Planning committee Member

Speakers:

- Alaska—Jeri Museth, MSW, Wellness Coordinator, Central Council of the Tlingit and Haida Indian Tribes of Alaska; American Indian/Alaska Native/Native Hawaiian Expert Panel Member and Genevieve Casey, MSW, Project Coordinator, Prevention and Early Intervention Services, Department of Health and Social Services Division of Behavioral Health, State of Alaska
- Arizona/Navajo Nation—Louise S. Ashkie, Program and Project Specialist, Navajo Nation FASD Project, Department of Behavioral Health Services; American Indian/Alaska Native/Native Hawaiian Expert Panel Member; NAFSC Member and Cynthia D. Beckett, MS, PhD, Director-Pediatrics, Flagstaff Medical Center
- Oregon—Carolyn Hartness, FASD Educator/Consultant, Northwest Portland Area Indian Health Board; American Indian/Alaska Native/Native Hawaiian Expert Panel Member and Suzie Kuerschner, MEd, FASD consultant and child development specialist; Northwest Portland Area Indian Health Board FASD Tribal Project; American Indian/Alaska Native/Native Hawaiian Expert Panel Member

The speakers in this session highlighted the geographic and community diversity that can exist within a single state or tribe, and how it affects the ability to offer and deliver services to their populations.

- Ms. Museth spoke to Alaska which, unlike nearly every other state, had funding in place for FASD *before* programs were developed. Using a 5-year, \$5.5 million Federal grant, nine diagnostic teams were trained, then deployed in communities across the State. Even with the State's financial ongoing commitment, the initiative still needs funds and support from private sources. It relies on its volunteer task force to help raise funds and awareness. Each family that enters a program is assigned someone who helps them through the process until they are handed off to a clinician/caseworker. Because of Alaska's size and terrain, FASD diagnostic teams only come together and receive training once a year; they rely on teleconferences and videoconferences in between. In February 2010, using funds gleaned from the State and by volunteers, a regional FASD conference was held in Anchorage.
- While the Alaska project serves populations concentrated around urban centers, Ms. Ashkie outlined the challenges of serving the Navajo Nation, which consists of 250,000 people spread across 200,000 square miles in Arizona. The Navajo program began as a four-year initiative in which two teenage girls were trained to disseminate information on sexually transmitted diseases, contraceptives, and FASD. It was adopted by the Navajo Nation 20 years ago. Their approach: Train anybody who will listen.
- Ms. Hartness and Ms. Kuerschner indicated that Oregon's FASD initiative has become a vehicle for creating and building trust with local Native communities. Services are delivered to families living in semi-urban areas, and to families in a large, rural, land-based reservation model. Cultural competency is key. The urban model formed a countywide task force and has successfully integrated with local and State governments, United Way, and other private agencies. In the rural area, where 80 percent of their clients are family referrals, the public school system wants to pay to use the clinic's FASD evaluation services. In both instances, the concern is how to integrate community members and volunteers into the process in a way that does not diminish their value.

Instruments of Success: Reaching Out to and Working With Primary Care Providers

Moderator: Jerome A. Romero, Director, New Mexico Statewide Prevention Project, University of New Mexico; NAFSC Chairman; Expert Panel Member

Speakers:

- Georgiana Wilton, PhD, Associate Scientist, Department of Family Medicine, University of Wisconsin; Co-Principal Investigator and Project Director, Great Lakes FASD Regional Training Center
- Roger J. Zoorob, MD, MPH, FAFP, Professor and Chair, Meharry Medical College Family and Community Medicine; Principal Investigator, FASD Southeast Regional Training Center
- Charlene Harmon, Family Counselor, Tennessee Disabilities Resource Center; 2010 BFSS Planning Committee Member

Dr. Wilton discussed the work of the Great Lakes FASD Regional Training Center (RTC). The overarching purpose of the Great Lakes RTC, as with all RTCs, is to increase the FASD knowledge and clinical skills of medical and allied health professionals. This is accomplished by:

- Convening an advisory committee and subcommittees to oversee the development and implementation of project activities;
- Developing and implementing a menu of training and awareness opportunities addressing the prevention, identification, and treatment of FAS;

- Utilizing standardized pre- and post-training evaluation tools that assess knowledge and skills, with a 3- and 6-month post-training follow-up;
- Developing and implementing a plan to include core competencies in licensure and credentialing standards in medical and allied health professions; and
- Developing a sustainability plan for the RTC.

Training approaches include an FASD Training-of-Trainers certificate program, sponsored trainings, the option to participate in local, regional and national conferences, one-on-one clinical skills development ('shadowing' along on actual FAS assessments), online learning, and information dissemination (e.g., Awareness Day activities, the work of a Regional Speakers Bureau). Results to date indicate that the Great Lakes RTC has trained over 1,300 individuals through sponsored trainings, and that 55 professionals have completed the FASD Train-the-Trainers curriculum. These individuals have in turn trained 483 people.

Dr. Zoorob presented an overview of the Southeast FASD RTC, which initially worked with five collaborating sites but expanded through a train-the-trainer program. The Southeast RTC is also developing a Regional FAS Speakers Bureau, as well as culturally appropriate approaches to address the needs of women at risk for FASD. Training approaches include clerkships, residencies, CME and CEU programs, and short didactics and workshops. The site is seeking to pilot new learning methods such as case-based/problem-based FAS learning. Between October 2008 and September 2009, the Southeast RTC trained over 1,700 healthcare professionals.

FASD Regional Training Centers (RTCs), funded by the Centers for Disease Control and Prevention (CDC), are providing thousands of healthcare professionals with added knowledge and clinical skills to assist those affected by FASD.

Ms. Harmon was a recipient of FASD Train-the-Trainer learning in Wisconsin, and spoke to the importance and efficacy of these efforts. She is frequently invited to do trainings within the school system and in faith-based programs. She indicated that it is critical to be culturally sensitive to different communities and to approach people in a non-judgmental way. She stressed the importance of finding and engaging a person well-respected by the community. Once that person is engaged, doors to different systems will open up. In her own area, Ms. Harmon became close with an obstetrician who frequently invites her to speak with pregnant clients.

Marching Together: Steps Juvenile Courts Have Taken to Address FASD Screening, Evaluation, and Sentencing Modifications

Moderator: Catherine E. Hargrove, MSW, JD, Technical Assistance Liaison, SAMHSA FASD Center for Excellence

Speakers:

- Allen O. Battle, PhD, ADPP, Professor of Psychiatry, Chief of the Division of Clinical Psychology, University of Tennessee College of Medicine
- Meghan Louis, Program Director, FASD Juvenile Court Program; 2010 BFSS Planning Committee Member

Dr. Battle discussed his experiences as a psychological forensic specialist for the courts in Tennessee. He has screened many thousands of juveniles within the court system. When he became aware of FASD, he added maternal drinking to the screening process. He has found juvenile courts to be more flexible in their sentencing, particularly if the judge has an interest in mental health and rehabilitation. He closed by stressing that the real solution lies in prevention.

Ms. Louis has worked with the FASD Juvenile Court Program for five years. The target population is 12- to 16-year-old adjudicated delinquents who reside in Hennepin County (Minnesota). The goals of the program are to reduce involvement in the justice system, maintain stability and placement, increase school success, and improve overall functioning for participants. The program partners with court officials, probation officers, school systems, and community providers, offering them education and assistance in providing services to youth with an FASD. A task force that includes court, probation, and community stakeholders oversees the program. Ms. Louis noted that some lessons learned include the need to obtain diagnostic slots specifically for Court Program clients, to circumvent long waits, to maintain and improve communication among systems, to understand that youth with an FASD on probation take up a lot of their probation officers' time, and to help families and court officials better understand FASD evaluation reports by making them more reader friendly.

ASSOCIATED MEETINGS

Feeding into the comprehensive national system supported by the FASD Center for Excellence is the work accomplished by:

- The National Association of FASD State Coordinators;
- The Birth Mothers Network;
- The Expert Panel;
- The FASD Subcontractors; and
- The American Indian/Alaskan Native/Native Hawaiian Expert Panel.

Weather conditions affected travel for a number of Birth Mothers Network members, forcing the cancellation of their meeting. However, each of the other groups proceeded with their meetings in Nashville, though times needed to be adjusted. Below are brief synopses of the work accomplished at their meetings.

National Association of FASD State Coordinators—Tuesday, May 4, 2010

Representatives from 20 States, Washington DC, and the Navajo Nation attended the NAFSC meeting. There are currently 24 States represented in the Center's NAFSC group, in addition to Washington, DC and the Navajo Nation. The meeting opened with a group pronouncement of appreciation for Chair Jerome A. Romero, who has led NAFSC since its inception and was recently inducted into the Tom and Linda Daschle FASD Hall of Fame. Their half-day agenda also included:

- Remarks by Patricia B. Getty, PhD, Task Order Officer for the SAMHSA FASD Center for Excellence.
- Updates on activities from each State.
- Report-outs from the subcommittees, including:
 - ✓ Airlines: Tasked with engaging US-based airlines to include a prominent statement about alcohol use and pregnancy anywhere in-flight alcoholic beverages are discussed. The group drafted and sent a NAFSC-approved letter to 14 airlines. As a follow-up activity, the group is considering asking for the support of the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and other relevant groups/organizations in this campaign.
 - ✓ Primary Care: Tasked with formulating an effective method for approaching primary care providers and making them more aware of and responsive to FASD-related issues. Potential next steps for this group include: (1) Encouraging groups with an outreach-to-providers component to give information on FASD to providers and (2) Sending a letter to medical schools to encourage inclusion of FASD education in their curricula.
- Nomination of Vice Chair Margo B. Singer, the NAFSC representative from New York, who accepted the nomination.

Congratulations to NAFSC Chair Jerome A. Romero on his induction into the Tom and Linda Daschle FASD Hall of Fame.

The NAFSC group meets quarterly and will meet again via teleconference in August 2010.

The Expert Panel—Tuesday, May 4, 2010

The Center's Expert Panel convened a quorum of 13 voting members and three ex-officio members. The agenda included an update on the work of the FASD Center for Excellence and the Native Expert Panel, as well as updates from the Self Advocacy Network for Individuals with an FASD, the National Prevention Network, the Indian Health Service (IHS), the CDC, and NIAAA. In addition:

- Edward P. Riley, PhD, Distinguished Professor and Director from the Center for Behavioral Teratology at San Diego State University, provided an update on the development of the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, or DSM. At present, the issue of whether ARND/FASD will be included in the DSM-V is still under deliberation. They are not in the DSM-IV.
- Sterling K. Clarren, MD, FAAP, Chief Executive Officer and Scientific Director of the Canadian NW FASD Research Network, discussed recent activities of the Canadian Institutes of Health Research, including the funding and formation of NeuroDevNet, the first trans-Canada initiative dedicated to studying children's brain development from both basic and clinical perspectives. Dr. Clarren also shared findings of a Canadian study which measured palpebral fissures in school children who were considered as "normally developing." Of those, 40 percent were determined to have short palpebral fissures, more commonly associated with children with FASD.

The Expert Panel meets face-to-face twice annually, and will meet again in December 2010 in McLean, Virginia.

The FASD Subcontractors—Tuesday, May 4, 2010

The Coordinating Center of the FASD Center for Excellence oversees 23 subcontracts that are implementing prevention and diagnosis and intervention programs. The programs include states, tribal courts, juvenile dependency and delinquency courts, and local providers.

The subcontractor meeting at BFSS was structured around two sets of breakout sessions, three in the morning and two before lunch. The three early breakouts centered on how 1) local, 2) State, or 3) juvenile court settings can successfully integrate screening, intervention, and data strategies into existing systems. The two later breakouts were divided into the 15 prevention subcontractors (SBI, CHOICES, and P-CAP) and the eight diagnosis and intervention subcontractors. Each group discussed the completion of annual reports for their second-year activities, and the development of implementation plans for Year Three.

After a working lunch, the group heard from Sharon L. Dorfman, ScM, CHES, President of SPECTRA and a subcontractor. Ms. Dorfman provided strategies for sustainable systems change, whereby a site is able to integrate the essential components of a program and can continue after the conclusion of the subcontract.

The American Indian/Alaskan Native/Native Hawaiian Expert Panel—Tuesday, May 4, 2010

The American Indian/Alaskan Native/Native Hawaiian Expert Panel (Native Panel) met with ten members present, as well as a representative from the United South and Eastern Tribes. In addition to comments from SAMHSA and an update on the FASD Center for Excellence's activities, the agenda included a review of the panel's revised protocols, and planning sessions for the Panel's upcoming activities, including the development of Tribal FASD Task Forces, the delivery of trainings, and the coordination of regional meetings of tribal leaders. The group also shared success stories from the field, and considered nominations for subcommittees.

CONCLUSION

Action Steps

As with each BFSS event, the Center will pursue certain action steps in the wake of BFSS 2010:

- Follow up with states who are seeking to establish a State Coordinator position;
- Follow up with states who have not submitted their FASD plans;
- Check with states regularly throughout the year to see how they are progressing with their FASD plans;
- Pull together lessons learned from the planning process and meeting evaluations to refine and improve next year's process;
- Hold a staff debriefing session on lessons learned from BFSS 2010 to ensure that next year's conference is equally if not more successful; and
- Update the Center's Web site with information from the conference, including the meeting summary, presentations, speaker biographies, photographs, and participant lists.

In addition, a number of specific suggestions emerged, including the need for an updated FASD resource guide and the desire for a live feed of BFSS 2011 for those who cannot physically attend. As always, the Center will incorporate this and all participant feedback in upcoming planning sessions and product development in an effort to continue to meet the needs of the field.

Outcomes

Each BFSS conference is evaluated by participants to gather their thoughts on the agenda, the speakers, the site, and the usefulness of the information shared, and also to elicit recommendations for the next event. In addition to formal evaluation findings (beginning on the following page), positive trends emerge each year. For 2010, these include:

- **High participation despite very difficult conditions**—Actual attendance at this year's BFSS conference was down from 2009, but by less than 9 percent, and initial registration figures indicate that the event would have been even larger than BFSS 2009 had it not been for disastrous weather conditions. By and large, attendance and participation reflected not a decrease in interest but rather the tremendous resolve of the committed professionals in this field.
- **The continued growth of FASD-related organizations**—The NAFSC and the BMN both increased in size since BFSS 2009, the scope and vision of the Native Expert Panel continues to expand, and late 2009 saw the development of the Diagnostic Learning Community among the Center's subcontractors.
- **Increased collaboration**—Collaboration and networking were unofficial 'guidelines' at BFSS 2009. For 2010 they were official themes, and the field has clearly taken these themes to heart. The members of NAFSC, the BMN, the Expert Panels, and the subcontractors have all found creative ways to grow their efforts and collaborate with each other. Increasingly, the Center's 'offshoots' are becoming just what was envisioned when the Center was established nearly ten years ago; a vibrant, collaborative, and growing infrastructure.

Ultimately, it rained hard in Nashville, but it did not wash away the spirit of the city, and it did not rain on the spirit of BFSS. If we borrow the cliché that SAMHSA planted a tree by establishing the FASD Center for Excellence, then BFSS 2010 was clear evidence that a forest is growing. As Ms. Dorfman put it so well at the subcontractors meeting, "Never stop making partnering a rewarding experience." BFSS 2010 was yet another rewarding experience for everyone involved, and those words can be our collective theme as we work toward 2011.

APPENDIX A: MEETING EVALUATION

Introduction

The evaluation component for the 2010 BFSS meeting focused on determining the attendees' overall level of experience of certain attributes of the meeting, such as quality and clarity, information sharing, networking opportunities, and applying lessons learned to work situations. In addition, attendees were asked to provide feedback on the usefulness of each of the sessions.

Methods

An evaluation form was designed to elicit feedback from meeting attendees (Appendix A). Evaluation forms were provided to all attendees and filled out and turned in to Center staff at the end of the meeting. Completed evaluation forms were checked for data accuracy, followed by data entry and analysis. Responses were compiled as a frequency for the close-ended questions and a content analysis was performed for the open-ended responses.

Evaluation Questionnaire

The questionnaire was designed to include both close-ended and open-ended questions. The first question was designed to get respondents' ratings on general aspects of the meeting. The second question was regarding the usefulness of the general and breakout sessions.

Attendees were asked to respond to open-ended questions on the following topics:

- The most useful part of the meeting;
- Plans to use what they learned at the meeting in their work; and
- Topics or speakers for future BFSS meetings.

Evaluation Results

A total of 130 respondents submitted completed evaluation forms. Quantitative and qualitative results are presented below.

Quantitative Results

Respondents' ratings of the meeting overall, and of the sessions held during this event, are presented in Tables 1 and 2 below. The percentages of respondents shown in these tables are based on the actual numbers of those who answered a particular question, as shown in the last column of Table 1 and Table 2.

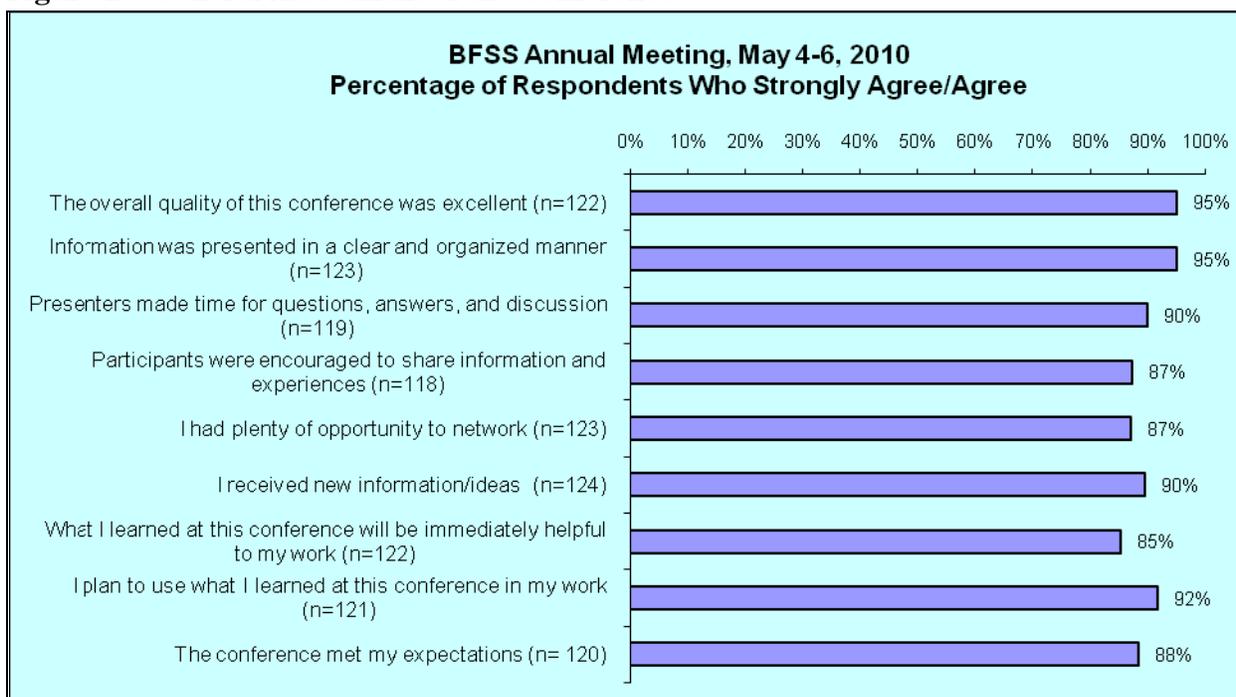
Table 1—General Assessment of the Conference

Item	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree	Total
The overall quality of this conference was excellent.	0 (0%)	2 (2%)	4 (3%)	56 (46%)	60 (49%)	122 (100%)
Information was presented in a clear and organized manner.	0 (0%)	3 (2%)	3 (2%)	59 (48%)	58 (47%)	123 (100%)
Presenters made time for questions, answers, and discussion.	0 (0%)	6 (5%)	6 (5%)	45 (38%)	62 (52%)	119 (100%)
Participants were encouraged to share information and experiences.	0 (0%)	7 (6%)	8 (7%)	48 (41%)	55 (47%)	118 (100%)
I had plenty of opportunity to network.	0 (0%)	9 (7%)	7 (6%)	57 (46%)	50 (41%)	123 (100%)

I received new information/ideas.	1 (1%)	3 (2%)	9 (7%)	39 (31%)	72 (58%)	124 (100%)
What I learned at this conference will be immediately helpful to my work.	0 (0%)	7 (6%)	11 (9%)	48 (39%)	56 (46%)	122 (100%)
I plan to use what I learned at this conference in my work.	0 (0%)	2 (2%)	8 (7%)	38 (31%)	73 (60%)	121 (100%)
The conference met my expectations.	0 (0%)	7 (6%)	7 (6%)	48 (40%)	58 (48%)	120 (100%)

Note: Due to rounding, sum may not add to 100 percent.

Figure 1—General Assessment of the Conference



As shown in Figure 1, respondents gave the meeting a highly favorable assessment, with the vast majority (95 percent) rating it as excellent in quality and indicating that they planned to use what they learned in their work (92 percent). Almost all respondents also felt that the information presented was clear and well organized (95 percent) and most agreed that presenters made time for questions, answers, and discussion (90 percent).

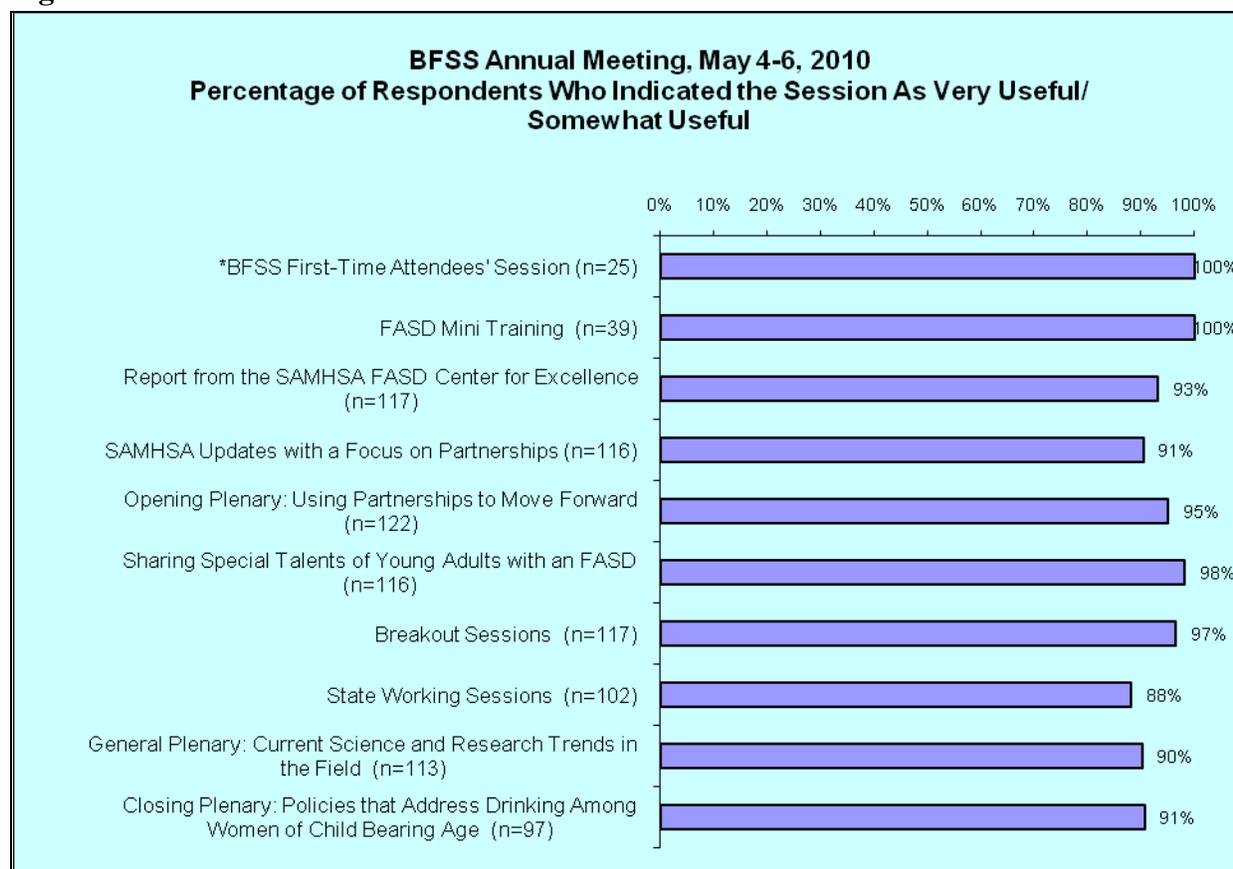
When comparing the rating of this meeting to the 2009 BFSS meeting in Albuquerque, NM, the scores were similar. Changes in ratings ranged from an increase of two percent to a decrease of two percent. Compared to 2009, three items increased by two percent including; the overall quality of the conference, opportunity to network, and planning to use what they learned in their work. Only one item decreased by two percent; the rating of presenters making time for questions, answers and discussion. The other five items either stayed the same or increased/decreased by one percent.

Table 2—Assessment of the Sessions

Please circle the number that matches your answer.	Not at All Useful	Not Very Useful	Somewhat Useful	Very Useful	Total
*BFSS First Time Attendees' Session	0 (0%)	0 (0%)	8 (32%)	17 (68%)	25 (100%)
FASD Mini Training	0 (0%)	0 (0%)	5 (13%)	34 (87%)	39 (100%)
Report from the SAMHSA FASD Center for Excellence	1 (1%)	7 (6%)	46 (40%)	63 (54%)	117 (100%)
SAMHSA Updates with a Focus on Partnerships	3 (3%)	8 (7%)	44 (38%)	61 (53%)	116 (100%)
Opening Plenary: Using Partnerships to Move Forward	0 (0%)	6 (5%)	44 (36%)	72 (59%)	122 (100%)
Sharing Special Talents of Young Adults with an FASD	0 (0%)	2 (2%)	13 (11%)	101 (87%)	116 (100%)
Breakout Sessions	0 (0%)	4 (3%)	44 (38%)	69 (59%)	117 (100%)
State Working Sessions	1 (1%)	11 (11%)	39 (38%)	51 (50%)	102 (100%)
General Plenary: Current Science and Research Trends in the Field	1 (1%)	10 (9%)	26 (23%)	76 (67%)	113 (100%)
Closing Plenary: Policies that Address Drinking Among Women of Child Bearing Age	1 (1%)	8 (8%)	32 (33%)	56 (58%)	97 (100%)

*Session was only required for BFSS first timers.
 Note: Due to rounding, sum may not add to 100 percent.

Figure 2—Assessment of the Sessions



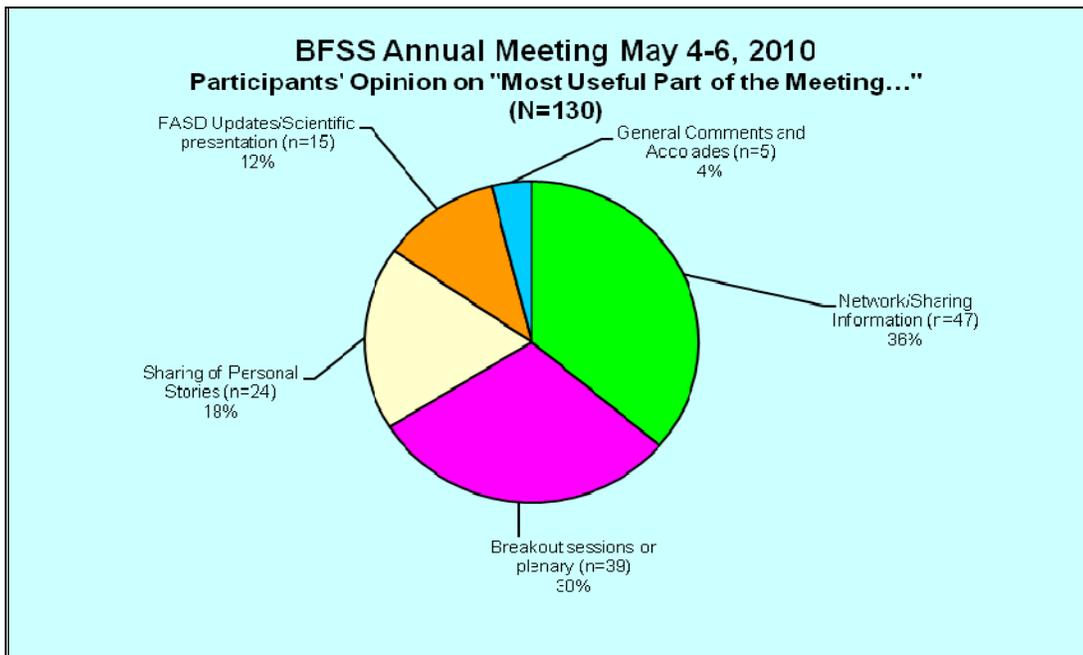
*BFSS First Time Attendees' and FASD Overview for Individuals New to the Field was for the BFSS first timers.

As illustrated in Figure 2, the sessions that were rated as “very useful/somewhat useful” by the highest percentages of respondents were *BFSS First-Time Attendees’ Session* (100 percent), *FASD Mini Training* (100 percent), *Sharing Special Talents of Young Adults with an FASD* (98 percent), and the “Breakout Sessions” (97 percent).

Qualitative Results

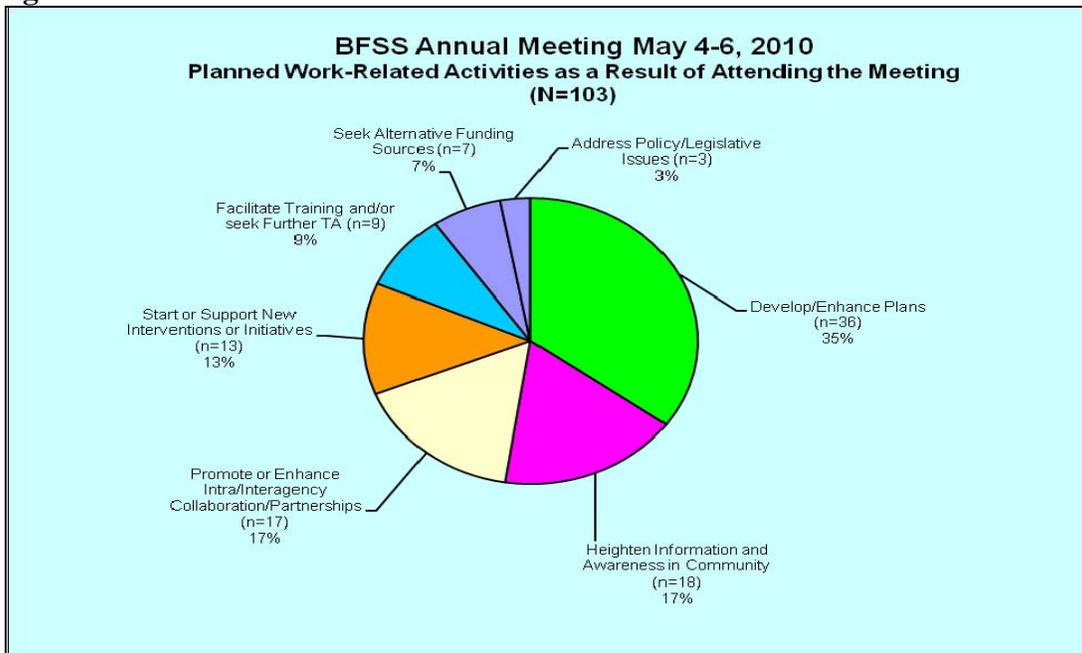
Respondents provided written comments about this meeting to three open-ended questions. For each of the open-ended questions, responses were grouped under specific topic areas. The total number of responses within each topic area for each of the questions is represented in the pie charts on the following pages.

Figure 3—Most Useful Part of the Meeting



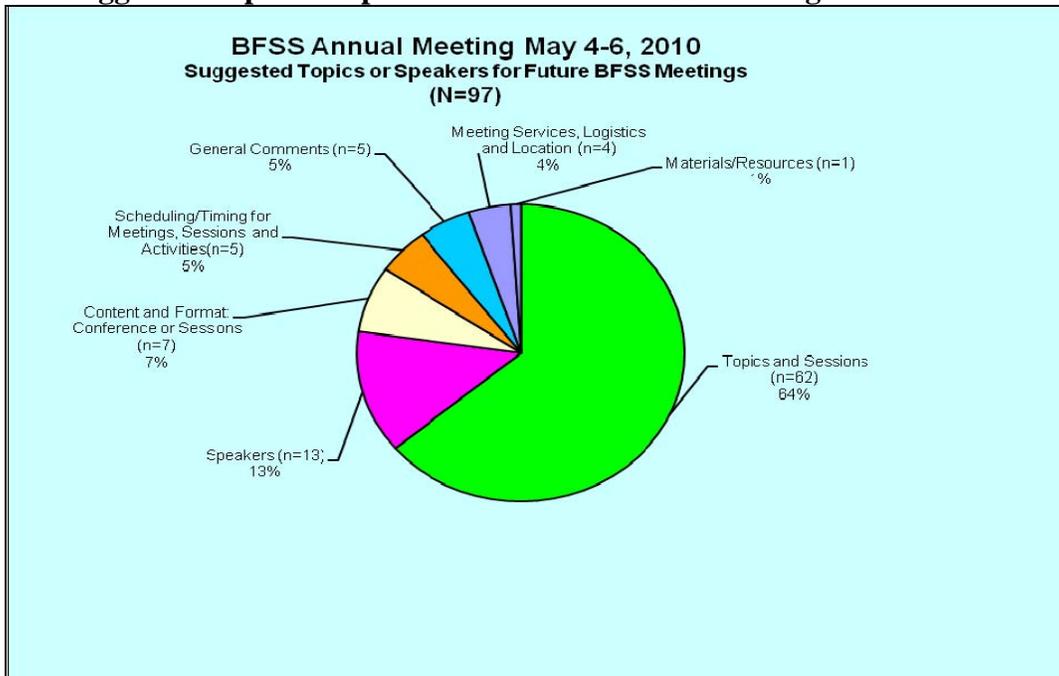
As presented in Figure 3, the majority (36 percent) of the responses indicate that participants found networking and information sharing to be the most useful. Thirty percent of the responses indicated the breakout or plenary sessions were the most useful part of the conference.

Figure 4—Respondents’ Planned Work-Related Activities as a Result of Attending the Meeting



Among the 103 responses received to this question, the most frequently reported priorities were to develop or enhance State plans (35 percent).

Figure 5—Suggested Topics or Speakers for Future BFSS Meetings



Of the 97 responses for suggestions for topics or speakers for future BFSS meetings, the majority (64 percent), provided suggestions on new ideas for topics and sessions.

Evaluation Conclusions

Evaluation results presented above indicate that this meeting was a success. Significant findings from the quantitative and qualitative data presented in Tables 1 and 2 and responses to the open-ended questions are as follows:

- Overall, 95 percent of the respondents rated the quality of this meeting as excellent, and 95 percent also agreed that the information presented was clear and well organized.
- The vast majority of respondents (90 percent) agreed that presenters made time for questions, answers, and discussion, and that they intended to use this information when they got back to work (92 percent).
- The FASD Mini Training and First-Time Attendees' sessions were viewed as the most useful (100 percent). Sharing Special Talents of Young Adults with an FASD (98 percent), and the "Breakout Sessions" (97 percent), were also viewed as highly useful.
- Thirty-six percent of the responses indicated that networking was the most useful part of the meeting.
- The most frequently reported work-related plans were to develop or enhance State plans (35 percent).
- The majority of the responses (64 percent), on topics/speakers for future meetings, were new ideas for topics and sessions.

APPENDIX B: EVALUATION FORM

SAMHSA Fetal Alcohol Spectrum Disorders Center for Excellence

BUILDING FASD STATE SYSTEMS (BFSS) CONFERENCE

NASHVILLE, TENNESSEE

May 4–6, 2010

Evaluation Form



Date Completed: _____

Title/Position: _____

1. Have you attended a BFSS conference in the past? _____

2. To what extent do you agree with the following general statements about this conference:

Please circle the number that matches your answer.	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
The overall quality of this conference was excellent.	5	4	3	2	1
Information was presented in a clear and organized manner.	5	4	3	2	1
Presenters made time for questions, answers, and discussion.	5	4	3	2	1
Participants were encouraged to share information and experiences.	5	4	3	2	1
I had plenty of opportunity to network.	5	4	3	2	1
I received new information/ideas.	5	4	3	2	1
What I learned at this conference will be immediately helpful to my work.	5	4	3	2	1
I plan to use what I learned at this conference in my work.	5	4	3	2	1
The conference met my expectations.	5	4	3	2	1

3. How useful were the following sessions:

Please circle the number that matches your answer.	Very Useful	Somewhat Useful	Not Very Useful	Not At All Useful	Attended Session (Circle Yes or No)	
					Yes	No
BFSS First Time Attendees' Session	4	3	2	1	Yes	No
FASD Mini Training	4	3	2	1	Yes	No
Report from the SAMHSA FASD Center for Excellence	4	3	2	1	Yes	No
SAMHSA Updates with a Focus on Partnerships	4	3	2	1	Yes	No

Opening Plenary: Using Partnerships to Move Forward	4	3	2	1	Yes	No
Sharing Special Talents of Young Adults with an FASD	4	3	2	1	Yes	No
Breakout Sessions	4	3	2	1	Yes	No
State Working Sessions	4	3	2	1	Yes	No
General Plenary: Current Science and Research Trends in the Field	4	3	2	1	Yes	No
Closing Plenary: Policies that Address Drinking Among Women of Child Bearing Age	4	3	2	1	Yes	No

4. What was the most useful part of this conference for you? Please explain.

5. What are one or two things you plan to do in your work, based on what you learned at this conference?

6. What topics or speakers would you suggest for future BFSS conferences?

Thank you for your feedback. Please drop in the evaluation box.