



ARKANSAS JUDICIARY

Pulaski County Juvenile Court FASD Project
**Annual Report for Screening, Diagnoses and
Intervention**

August 1, 2010 – July 31, 2011



Arkansas Department of Human Services

Division of Children and Family Services

*Together for Arkansas
Children and Families*

Table of Contents:

1. Executive Summary..... page 3-4

2. Key Client Results..... page 4-8

- a. Target Population
- b. Screening
- c. Diagnosis
- d. Intervention Services

3. Program Description..... page 9 -15

- a. Population Needs Identified and Addressed
- b. Service Delivery Process
- c. Staff Training
- d. Task force and Stakeholders
- e. Lessons Learned

4. Program Changes page 15-17

5. Appendix page 18

- a. Report Table page 18
- b. Additional Report Measure..... page 19

OY 3 Annual Report for Diagnosis and Intervention Subcontractors

1. Executive summary:

The Pulaski County Juvenile Court FASD project is a collaborative effort between the Arkansas Department of Human Services, Division of Children and Family Services (DCFS) and the Pulaski County Juvenile Court. In year one of the project, our target population was made of children ages 0-5 adjudicated dependant in Pulaski County. We soon realized that there are a large number of newborns entering into the state's custody due to of Garretts' Law. This law mandates that a report is made to the child abuse hotline if an infant or his/her mother test positive for illegal substances at birth. Our number of children to screen was high but our number of children diagnosed with and FASD was low. We learned over the course of the first year that diagnosing children with a FASD at this young age proved to be very challenging. In order to be able to monitor the newborns that screened positive for an FASD, we began to use the positive monitor category. For those children placed into a positive monitor category, not only will we monitor them closely, but we will also refer them to our local part C coordinator where they will receive further testing if needed along with their own part C case coordinator. If a child who is placed in positive monitor becomes symptomatic, he or she will be referred for an FASD diagnostic exam.

In year one, we were able to integrate the FASD diagnostic exam into the Pediatric and Adolescent Comprehensive Exam (PACE) which is a collaborative effort between the Division of Children and Family Services (DCFS) and the University of Arkansas for Medical Sciences (UAMS). In Arkansas all children who enter into the states' custody receive a PACE exam within 60 days of entering care. The PACE exams are conducted statewide and gives us excellent process for sustaining the project FASD diagnostic efforts after the project end date.

In year two we decided to modify our target population and screen all children for an FASD who enter into the states custody in Pulaski County between the ages of 2 and 7; and if a child screens positive for an FASD and has a sibling who is between the age of 0-2 with confirmed alcohol exposure, we will also screen the younger sibling. The decision was made to modify the age range in order to obtain better developmental testing, a key part of the diagnostic process. We also expanded our target population to include referrals for children ages 2-7 who came into custody prior to the start of the FASD initiative and have prenatal alcohol exposure, CNS abnormalities, developmental delays, and growth delays. Once we implemented our target population changes, we began to see an increase in the number of children diagnosed with an FASD through the project.

In year three we have continued with the target population changes made during year two and found them to be very effective in yielding more diagnosed cases. We also began receiving referrals from the adoption unit in Pulaski County for children who came into care prior to the start date of the project, are in the target age range, and are symptomatic of FASD. The project screens children whose adoptive placement has disrupted and they are in the states' custody and those who are in pre-adoptive placements and also in the states' custody. These children who have been in the states' custody and have already been through their Pediatric and Adolescent Comprehensive Exam

(PACE), where our project completes the FASD diagnostic exam, we have established a relationship with the genetics clinic at Arkansas Children's Hospital. The genetics clinic can and is willing to diagnose FASD's in children. However the wait to be seen at genetics remains a challenge to the project. As with most specialty clinics, the length of time to get in to the clinic can range from 6 to 9 months. This is the case with the genetics clinic in Arkansas.

From the start of the project a key part of the FASD project success has been the FASD task force. The group is comprised of key stakeholders who serve in an advisory capacity to the project to guide project planning, implementation, sustainability, and expansion of the Pulaski County Arkansas FASD project.

One of our key stakeholders and FASD task force member, the 0-3 Arkansas court team project for maltreated infants, brought Dr. Burd, a nationally known expert on FASD, to Arkansas this year. Dr. Burd conducted workshops on FASD for intervention providers, met with families who had a child or children diagnosed through the project, met with medical professionals in the community about screening and diagnosing FASD's, and spoke to our FASD task force.

Our task force members also play a major role in establishing and maintaining the FASD family support group, which began in year two of the project and continues to meet monthly. The support group is open to the foster parents, biological parents, grandparents and adoptive parents and has been very well received by the families. One of the project goals is to insure that parents, foster parents, caregivers, and teachers have the knowledge and skills needed to meet the needs of children who are diagnosed with an FASD.

The project remains committed to recognizing the special needs of children diagnosed with an FASD and providing early interventions for those children. At the same time we are committed to the belief that placement stability in homes, schools, or child care settings are key to success for children living with an FASD.

2. Key Client Results:

Target Population

When the project first began, our target population was children ages 0-5 in the custody of the State of Arkansas. In year 2, we decided to change our target population to children ages 2-7, younger siblings of these children who screen positive, and referrals of children ages 2-7 who came into care prior to the start of the project and were symptomatic of FASD. From August 1, 2010-July 31, 2011, 93 children entered the State's care in the project target age range and were screened for FASD.

Demographic Data

Gender of children screened was almost equally distributed, with 46% of children female, and 54% male. Also well distributed was child race, with 43% of those screened Caucasian, and 47% African-American. An additional 10% of children were multi-racial or of other ethnic backgrounds. Most

children served (52%) were between the ages of 2-4 years old, though a large portion of 5-7 year olds were also screened (44%).

Of the 93 children who were screened during OY3, most (44%) were placed in single parent foster homes. Those placed in 'non-relative' placements were in emergency shelters until an appropriate foster home could be found. Only 1 of the 6 children who were diagnosed with FASD during OY3 had any placement moves during their time in custody of the State (83% with zero placement moves).

Figure 1. Gender of Children Screened by Project

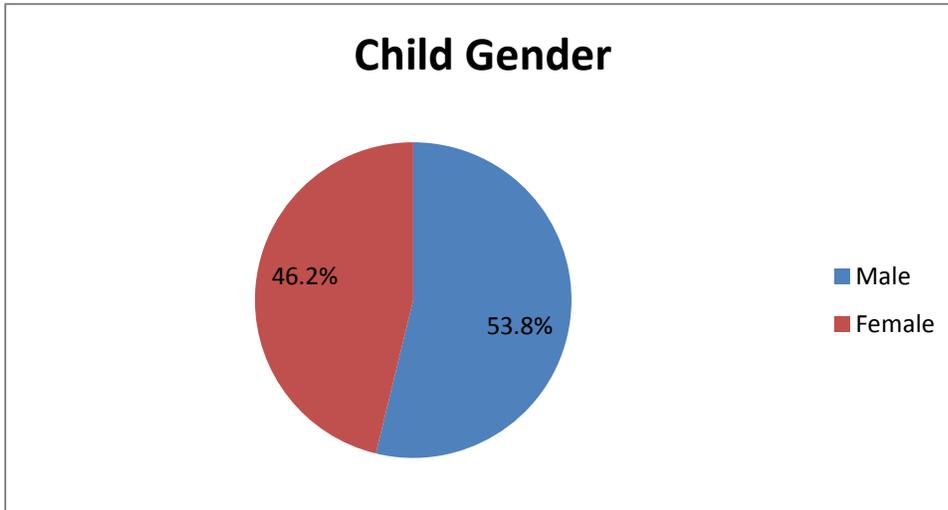


Figure 2. Race of Children Screened by Project

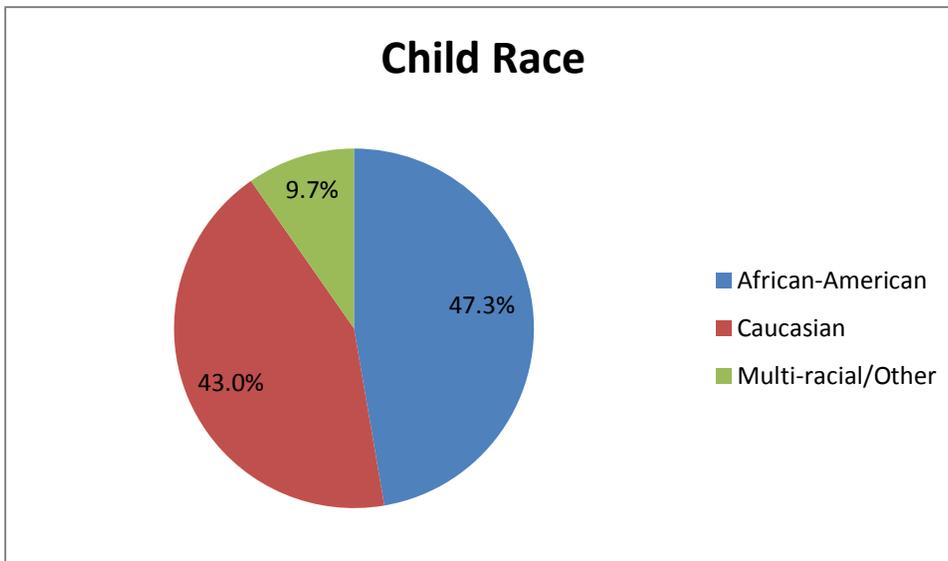


Figure 3. Age by Year of Children Screened by Project

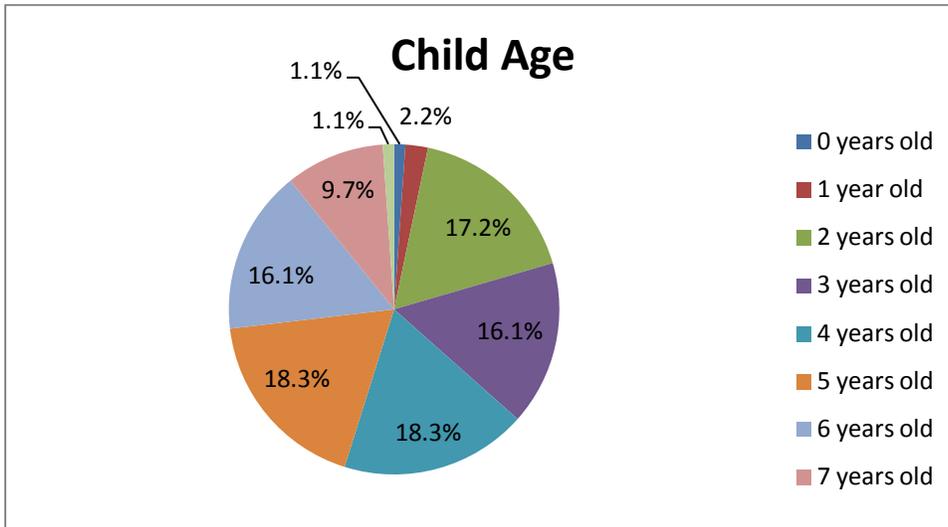


Figure 4. Residential Status of Children Screened by Project

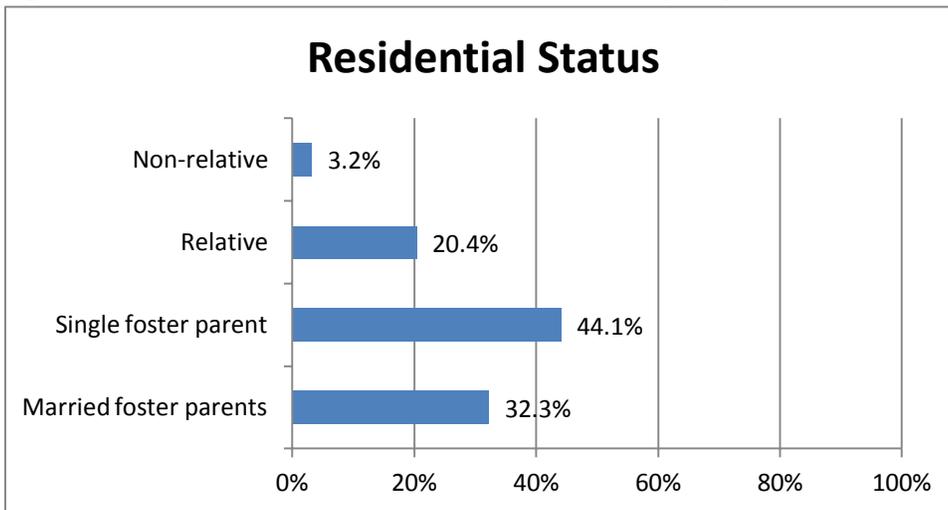
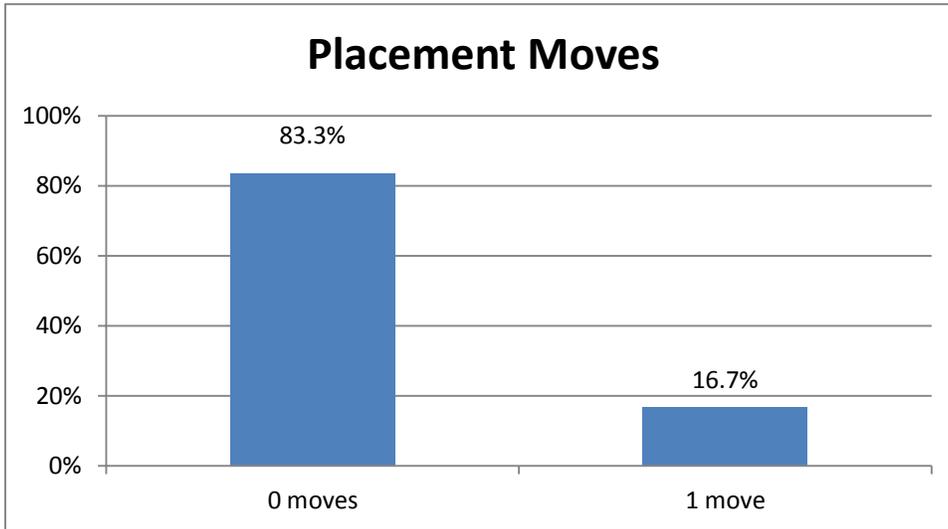


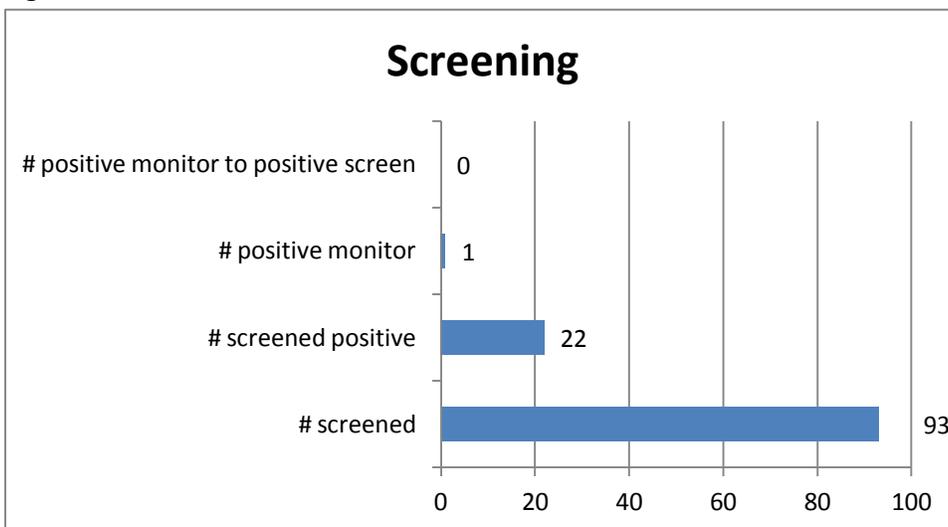
Figure 5. Placement Moves of Children Screened by Project



Screening

From August 1, 2010-July 31, 2011, 93 children were screened as part of the Pulaski County Juvenile Court FASD project. Of those 93 assessed, 22 screened positive for FASD, with 1 additional child being placed in positive monitor. No children were moved from positive monitor to positive screening during this time.

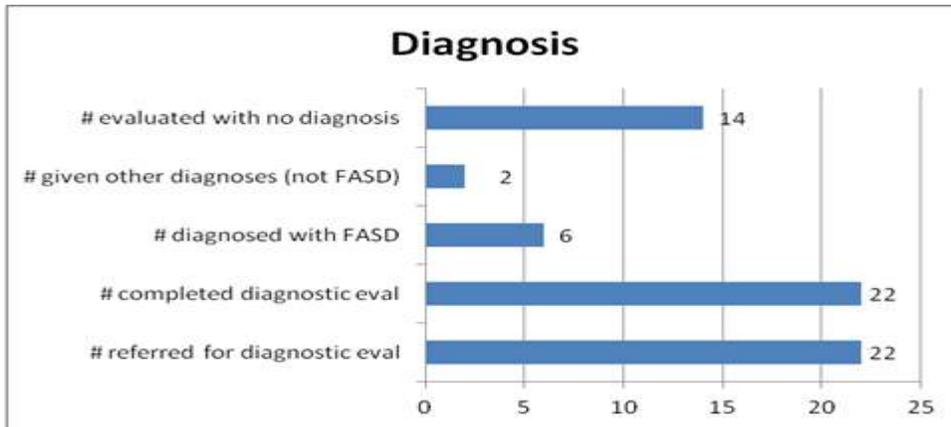
Figure 6. Number of Children Screened and Results in OY3



Diagnosis

Of the 22 children who screened positive for FASD, all were *referred for* and *completed* their diagnostic evaluation. Six of these children were diagnosed with FASD. During OY3, 3 of these children were diagnosed with FASD *and* additional diagnoses. Two children were given a diagnosis other than FASD. Additionally, 14 children were evaluated with no diagnosis given.

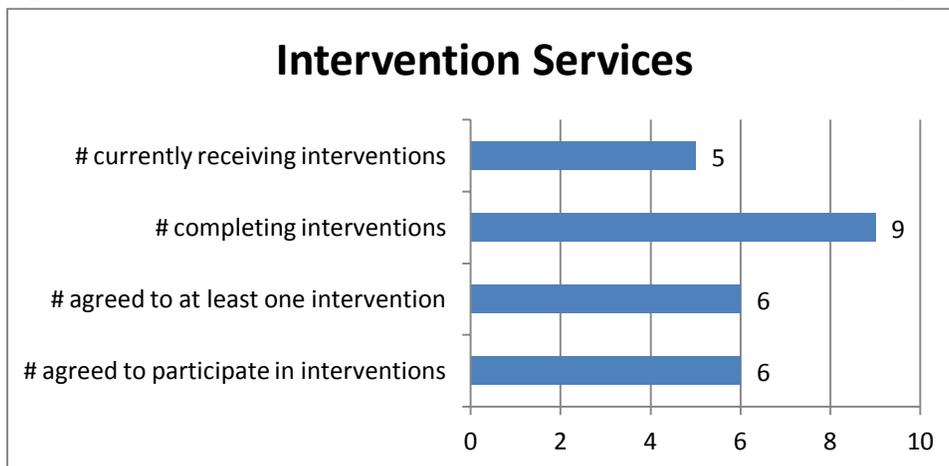
Figure 7. Number and Results of Children Screened Positive for FASD



Intervention Services

Six children have been diagnosed with FASD from August 1, 2010 to July 31, 2011. All six children agreed to participate in interventions provided by the State as part of the FASD contract. Of those 6 children, 5 are currently receiving interventions. The other child was adopted before services could be planned or provided and is not longer in the care of the state. Additionally, during OY3, 9 children have completed the intervention services they were receiving.

Figure 8. Number and Status of Intervention Services of Children Diagnosed with FASD



3. Service Delivery Process:

i. We are Juvenile court project that works with children who have entered into the states custody, we screen children in our target population once they have been adjudicated dependant/neglect and are placed in foster care. For project staff the process begins at the probable cause hearing when the judge decides if the Division of Children and Family Services (DCFS) had probable cause to remove the child from his/her home and if probable cause continues to exit. If the child remains in the states custody, the judge includes in the court orders to the parents to participate in the FASD assessment. In year two of the project we began to accept referrals on children who were in the states' custody prior to the start date of the project and were symptomatic of an FASD. These referrals usually come from DCFS case managers who are concerned about children on their caseload. During option year three of the project we continued receiving referrals from DCFS case managers and began to receive referrals from DCFS adoption specialist who were experiencing disruptions in adoptions and had children coming back into the states' custody. These referrals come to the FASD project director who determines if the child is eligible for the project.

ii. & iii. & iv. The FASD case manager attends the probable cause hearing whenever possible and at the end of the hearing will introduce herself to the parents and explain the screening process. Arrangements are then made to conduct the maternal drug and alcohol history interview. The court sends the FASD project director a copy of the court orders, which states that the mother will participate in the project. The FASD case manager is assigned by the DCFS supervisor or FASD project director as the secondary case manager on the case.

Screening is conducted by the FASD case manager. This includes the parent interview, obtaining a copy of the child's birth records, taking a photo of the child and run it through the FASD facial screening software. Then a determination is made based on our screening criteria if the child screens positive or negative for an FASD.

If the child screens negative the information is recorded in the children's reporting and information system (CHRIS) used by DCFS, a report is sent to the attorneys on the case to be entered into the court records, a report is sent to the PACE 48 hours prior to the PACE team notifying them of the results and that a FASD diagnostic exam is not needed, and the secondary assignment for the FASD case manager ends. If the screening results are positive for FASD, the information obtained by the FASD case manager is then sent to the PACE team at least 48 hours prior to the PACE/FASD diagnostic exam. The results of the FASD screening are documented in CHRIS. The FASD case manager also sends a court report to all attorneys involved in the case detailing the results of the FASD screening. This report is entered into the court record.

Our project has integrated our FASD diagnostic exam into the Project for Adolescent and Child Evaluation (PACE). This is a collaborative effort between DCFS and the University of Arkansas for Medical Sciences (UAMS). All children entering the foster care system in Arkansas receive a PACE evaluation which is a comprehensive exam with a multidisciplinary team. This exam is to take place within 30 to 60 days of a child entering into foster care. With the 30 to 60 day timeframe in mind, the FASD project staff must complete the FASD screening prior to the PACE exam date. A monthly log of PACE exams scheduled is sent to the FASD project director and FASD case manager from the

PACE clinic. The FASD case manager must have all screening completed and results in to the PACE team 48 hours prior to the scheduled PACE exam.

One of the FASD project procedures that works well with the DCFS practice model is that the project makes sure the birth mother, whenever possible, attends the FASD diagnostic exam so that she can be interviewed by the diagnostic staff to provide any information that might be helpful during the diagnostic exam. The FASD case manager will notify the mother of the exam date and assist with transportation if needed. The FASD case manager or FASD project director will attend the PACE/FASD diagnostic exams on children who screen positive to provide any other information requested by the diagnostic team.

The PACE clinic provides a complete report to the DCFS staff and recommendations for any special services the child might need regardless of FASD diagnosis. If the child is diagnosed with an FASD the FASD project staff are notified. The PACE team prepares a PACE report and the results and recommendations are recorded in the CHRIS system. This report is a guide for the case managers to make referrals for intervention services that meet the child's needs. If the child is diagnosed with an FASD, the FASD case manager will remain as the secondary case manager and will notify the primary case manager of the diagnosis.

The FASD exam results will also be entered into CHRIS by the FASD case manager. Within two to four weeks of diagnosis the FASD case manager will schedule a family team meeting with the primary case manager, biological parents, foster parents, attorneys involved in the case, and a special team from UAMS Partners for Inclusive Communities with knowledge and skills in the area of FASD to review and discuss the FASD diagnosis and recommended interventions. The goal of the meeting is to decide on the best and appropriate interventions for the child. The family is also invited to participate in the monthly FASD family support group. The FASD case manager oversees the necessary referrals for services. If needed, the FASD case manager will schedule a FASD knowledge and skill building meeting between the UAMS partner's team and pre-school or child care staff in order to develop some classroom strategies for children with FASD.

For children ages 0-3 who are diagnosed with FASD, the FASD case manager will make a referral to the local part c coordinator who oversees education interventions required to be in place by the department of early childhood education. For children ages 3-5 the FASD case manager will refer to the Pulaski County tri-district office our local part b coordinator. They will begin to provide the intervention services recommended at the PACE/FASD diagnostic exam and if needed, they will conduct additional testing. This ensures that children will be identified prior to starting school and will be continually monitored by the school system.

If a child is placed into a positive monitor category the FASD case manager will remain as a secondary case worker on the case. The primary case worker is notified of the positive monitor status and it is also recorded in CHRIS. The FASD case manager checks with the primary case manager every three months to see if the child is displaying signs of FASD and needs to be referred for a FASD diagnostic exam. The primary case manager is aware that if he/she feels at any time the child is displaying symptoms that might be related to FASD, they can contact the FASD case manager and request a FASD diagnostic exam.

If a FASD diagnostic exam is needed, the FASD case manager will direct the primary caregiver to obtain a referral from the child's primary care physician to the Arkansas Children's Hospital Genetics

clinic. Once the referral is made, the FASD case manager will pull together all background information from the screening for the genetics clinic. The FASD case manager will attend the exam at the genetics clinic to help provide any useful information. The only barrier we have is that the wait to be seen at the genetics clinic can be as long as 6 months. With our population since reunification is the goal for our families it is possible that a child will return home and no longer be in the states custody before the referred diagnostic exam can take place. In this case we can only strongly encourage the family to follow up with the exam and have the child diagnosed.

If the child is diagnosed with an FASD and is still in our custody, we will provide intervention services as outlined above.

v. Once intervention services have started we meet with the service provider to explain the FASD project and the data we are required to obtain for the Northrop Grumman database. We determine what services are being provided, how often they occur, and the best way for us to monitor the service without causing unnecessary burden on the provider. We allow the provider to choose the method of monitoring via phone, e-mail, or mail. At this point all providers prefer transmitting a report bi-weekly via e-mail.

vi. When intervention services begin a baseline assessment is conducted. Using the CHRIS system and the database provided by Northrop Grumman we can see when clients are due for a 6 or 12 month follow-up assessment. Information is gathered about school attendance from the CHRIS system or by contacting the school office directly. The school will provide all information required since the children are in the states custody. The number of placement changes is found in the CHRIS system and transferred into the Northrop Grumman database. Most information is obtained from CHRIS, the primary case manager during a case staffing, the school system either in person or on the phone.

4. Staff Training:

i. & ii. We believe that regular training is vital to our success and to keeping skills at their best.

The project staff who conduct the primary screening and intervention services it is made up of the FASD project manager and FASD case manager. Since the start date of the project we have not had any turnovers in staff. So we have not had the need for re-training of the original screening protocol. Our diagnostic team is lead by the same physician who began the project so she conducts the training of her diagnostic team as needed. Our evaluation team is also comprised of the original staff members and has added one additional staff member since the project start date. This staff member was able to attend the sub-contractor meeting held in Phoenix Arizona in May of 2011. I believe this was very beneficially for her.

III. In Arkansas we are fortunate to have two representatives of the MRFASTC (Midwest Regional Training Fetal Alcohol Syndrome Training Center) located here in the Pulaski County area. This group provides at a minimum at least one annual training on FASD for professionals working in the area of FASD. We have been able to attend sessions hosted by this group.

One of the projects key stakeholders is the Zero to Three Arkansas Court Team and they brought Dr. Larry Burd, a nationally recognized expert in FASD to Arkansas this year. This was an in kind service provided by the Zero to Three project. Dr. Burd spent four days conducting workshops for service providers, teachers, DCFS case managers, families of children diagnosed with an FASD, court staff, and the medical community.

iv. Our project staff would like to be up to date on the latest research and methods for screening children for FASD. We would welcome any training from the Center for Excellence. We still believe the medical community needs further training on diagnosis.

5. Task Force and Stakeholders:

i. The FASD task force was formed in 2008 and continues to meet monthly. The group is made up of leadership from the following agencies: Pulaski County Juvenile Court; UAMS Partners for Inclusive Communities; UAMS PACE –Project for Adolescent and Child Evaluation; UAMS Department of Family Medicine; Division of Alcohol and Drug Abuse Prevention; Division of Child Care and Early Childhood Education; Division of Children and Family Services; Arkansas Department of Health; a DCFS foster parent representative; State Department of Education Special Education Preschool Section 619 Coordinator for Arkansas; Division of Developmental Disabilities (Infant/Toddler (Part C) Coordinator for Arkansas); Administrative Office of the Court (Attorney Ad Litem); Community Coordinator Zero-Three Court Team Project; Program Coordinator – Women’s Treatment Coordinator DBHS-ADAP; Tri-District Early Childhood Program Director (Part B); the ATR (access to recovery) project director; the FASD project case manager, and the FASD project director.

ii. The purpose of the task force is to serve as an advisory group to guide the project planning, implementation, sustainability, and expansion of the Pulaski County Arkansas FASD project. The goal of the FASD initiative is to support and assist state programs and develop and sustain the ability to screen, diagnose, and provide necessary interventions to children diagnosed with FASD. We hope to improve the functioning and quality of life for children and their families by getting an early and accurate diagnosis of FAS/FASD and providing interventions based on the diagnosis.

iii. Through collaborative relationship building, Arkansas has developed systems linking the FASD project staff to several agencies that were either not in place or not being utilized prior to the project, but which now are running smoothly. We have referral systems in place for children to Part C and Part B early child hood education services. There is a higher level of monitoring for intervention and educational services in Pulaski County and a raised level of awareness regarding FASD that can be directly linked to the FASD project.

iv. Beginning in January of 2010, two sub-committees have been constituted: Intervention and Diagnosis. Each of the sub-committees is developing goals that are tied to the ability to sustain and

move forward the services started by the FASD project. The intervention sub-group has met one of the goals starting a family support group for families raising children with FASD in June of 2010. The diagnostic group is working to develop a screening and diagnostic system that can be sustained and taken statewide at the end of the sub-contract. In addition, one of the FASD task force members took the lead in having the Governor of Arkansas to proclaim September 9, 2011 as the First FASD awareness day in Arkansas.

6. Lessons Learned:

i. While implementing this project we have learned that public awareness about the dangers of drinking during pregnancy is still shockingly low. The fact that diagnosis of an FASD, mostly the ones that are not so clearly obvious, such as ARND (alcohol related neurodevelopment disorders) is still very difficult to obtain. We know the diagnosis is challenging because pediatricians trained in diagnosis are often found in specialty clinics with an extremely long wait list. We would recommend to similar projects in the future that the diagnostic clinic being used by the project receive extensive training on diagnosis of FASD's, and that if it is not a clinic devoted to FASD's, that some time be purchased each week in order to have children seen and diagnosed as soon as possible. The wait time to be seen at a specialty clinic runs from six to nine months on average and can be as long as twelve months. In Arkansas our Garretts' law, which tests for illegal drugs in the newborn or mothers system does not include alcohol because alcohol in women above age 21 is not illegal. Even though it is illegal for those under 21 it is still not tested for. However in the past year the CAPTA (child abuse prevention treatment act) regulations that passed in the 2010 resulted in a new law in Arkansas that requires physicians treating newborns and infants with an FASD to make a call to the child abuse hotline. These calls are not like Garretts' law, which results in an investigation and possible placement of the child in the states' custody. These calls will be directed for supportive services offered to the family, which are entirely optional. Since these calls will come into our child abuse hotline, we now have a method to at least track the number of reports that involve a possible FASD. Up until this, we have not had a method for tracking the number of FASD cases in Arkansas.

One of our more significant lessons learned involves why we are not able to track the number of children diagnosed with an FASD in Arkansas. Without numbers it is difficult to prove the need for FASD services or to show a need to sustain efforts like the Pulaski county FASD project. We discovered that the medical diagnoses codes for FAS, pFAS, ARND, and ARBD are not accepted for financial reimbursement beyond infancy. Most children, who would receive a diagnosis falling on the spectrum, are billed under related functional impairments such as ADHD or behavioral disorders. When we asked if the FASD could be a secondary code we were told by one of our larger hospital that it is not allowed to use a code that is not billable just for tracking purposes.

We hope that Arkansas Children's Hospital through the Genetics clinic, will in fact endorse starting a FASD clinic in Arkansas.

For those who plan to begin an FASD screening and diagnostic project I would highly recommend that raising public awareness be included in your efforts. In general, people do not receive new projects well if they do not understand the need for the project. Also, I would suggest that prevention plays a vital role in these projects. As we learned from Dr. Larry Burds' visit to our state, the best place to begin prevention efforts is with the mother who has given birth to a child diagnosed with an FASD. We know this mother will be a greater risk for having a second child with an FASD if her addiction is not addressed.

ii. & iii. The development of our family team meetings is one of the most helpful interventions we have developed. We include experts on FASD from the UAMS knowledge and skill building team, the family members, attorneys, DCFS case manager, teachers, child care providers, foster parents and anyone else with a vested interest in the child and family and who will be providing the interventions recommended for the child.

The family staffing is something that is usually done by DCFS staff to develop the overall family case plan. In addition to this meeting, we hold a FASD intervention meeting, which we refer to as the family team meeting. In this meeting family and others working with the child can ask questions about the diagnosis the child has received from the FASD experts. In addition, the UAMS knowledge and skill building team will visit the foster family or biological family home to provide guidance on specific concerns the family has and provide intervention strategies. This same service is available to the child care setting or school setting to address issues in the classroom.

Until parental rights have been terminated, the biological family is always encouraged to participate in not only the FASD diagnostic exam, but the family team meeting.

In most cases in a typical foster care situation, visitation between the mother and child is taking place and the mother is notified about medical visits. However, we found that the mothers often needed more encouragement to feel welcome at the visits. In fact many of the mothers may not feel comfortable speaking with medical staff or know what kinds of questions to ask the physician. We found the PACE/FASD evaluation medical visit to be an excellent opportunity to provide parents with skills they will need in future medical visits. Another challenge we faced was the fact that the foster parents were often the people bringing the children to the diagnostic exam. It is expected that some tension between foster and biological families will be shown. However, we found by working with both the foster parents and the biological parent to prepare them, the visits went smoothly. In keeping with the DCFS practice model where reunification is the goal for most families

our extra effort to encourage parents to be involved proved to not only help meet the goals of our initiative, but to build some hands-on parenting experience in mothers.

Our project did start a family support group and it has proven to be a valuable intervention service for families. Once children are diagnosed with FASD you must provide support to the family members or those living with the child. The FASD family support group is a place where families can connect with others and not feel isolated and alone. It is also a place where a great deal of experiential learning takes place. People learn the most from others experiences. While our support group is limited to our project population, we know the need for a statewide support system is great. We hope as we develop our sustainability plan we can work to develop statewide supports for families.

Also, we offer FASD parenting classes to our biological and foster families. The course is the Triumph through the challenges of Fetal Alcohol Syndrome model. Families are very engaged and pleased to have a course that addresses the needs of this population.

7. Program Changes

Change Category	Description of Change
State/local policies and procedures	<p>During the 2010 legislative session, CAPTA (child abuse prevention treatment act) was amended to include FASD. As a result the following law was passed in Arkansas: A.C.A. § 12-18-310 (2011)</p> <p>Referrals on children born with Fetal Alcohol Spectrum Disorder.</p> <p>(a) All health care providers involved in the delivery or care of infants shall:</p> <p>(1) Contact the Department of Human Services regarding an infant born and affected with a Fetal Alcohol Spectrum Disorder; and</p> <p>(2) Share all pertinent information, including health information, with the department regarding an infant born and affected with a Fetal Alcohol Spectrum Disorder.</p> <p>(b) The department shall accept referrals, calls, and other communications from health care providers involved in the delivery or care of infants born and affected with a Fetal Alcohol Spectrum Disorder.</p> <p>(c) The department shall develop a plan of safe care for infants</p>

	<p>affected with a Fetal Alcohol Spectrum Disorder.</p> <p>Based on our experience and knowledge of FASD the Department of Human Services, Division of Children and Family Services, looked to the FASD project staff to give guidance on the development of policy and procedures to address the new CAPTA laws.</p> <p>Because of the FAS initiative was housed at the Arkansas Department of Human Services in the Division Children and Family Services, and the project staff has been trained and have experience working with children diagnosed with an FASD and their families this is a good fit and ensures that the project efforts will be sustained and move to a statewide level.</p>
<p>Organizational policies and procedures (agency policy, Task Force, partner agreements)</p>	<p>The Division of Children and Family services (DCFS) has developed screens in its' CHRIS system for referrals to the FASD project. Policies and procedures for referrals and screening of children in the custody of the state have been developed.</p> <p>UAMS partners for inclusive communities has joined with FASD project in developing a FASD family support group.</p>
<p>Systems integration (intake, screening, case coordination, agency collaboration, internal and external system referrals, diagnostic team/center, etc.)</p>	<p>The FASD project staff have their own assignment unit set up in the CHRIS system. Cases can be assigned directly in the CHRIS system to the project staff.</p> <p>The Pulaski County Juvenile court has developed a system for referring cases to the project.</p> <p>The UAMS PACE team (who conducts the FASD exams) has developed a system for notifying the FASD project director of schedule PACE exams.</p>
<p>Service delivery processes (parent engagement, modification of existing case plans or development of new plans, new clinical techniques, case</p>	<p>The FASD case manager and DCFS case manager work together to develop referrals and case plans for the child who has been diagnosed with an FASD.</p> <p>The FASD case manager handles referrals for services for the child who is diagnosed and keeps the primary case manager informed of all referrals. The FASD case manager schedules family team meetings and</p>

management, etc.)	will schedule meetings with child care or school staff to discuss the child's diagnosis and services needed.
Data Systems (integration of program data, centralization, etc.)	The FASD diagnosis is recorded in the CHRIS system along with the recommendations for services made by the PACE/FASD diagnostic team. The FASD project director does have a unit established in the CHRIS system.
Staffing (new training focuses, refresher training, staffing structures, qualifications for new hires, training for service providers, etc.)	<p>The UAMS knowledge and skill building team provides trainings for our project staff, as well as service providers who are working with our children diagnosed with an FASD.</p> <p>We currently have two chairs from the Midwest regional FAS training center (MRFASTC) here in Pulaski county who conduct annual trainings on FASD.</p>

Appendix A. Report Table

FASD Diagnosis and Intervention Monthly Report

	Option Year 3 Between 8/1/2010 and 7/31/2011
I. Screening	
1. Clients screened for an FASD	93
2. Clients with a positive FASD screen	22
3. Clients placed in positive monitor (+ monitor)	1
4. Clients moved from positive monitor to positive FASD screen	0
5. Total Number of clients with a positive FASD Screen	23
II. Diagnosis	
6. Number of clients referred for diagnosis	22
7. Number of clients with completed diagnostic evaluations	22
8. Number of diagnostic evaluations with written reports completed	22
9. Number of clients diagnosed with an FASD	6
10. Number of clients diagnosed with an FASD and other diagnoses	3
11. Number of clients receiving a diagnosis other than an FASD	2
12. Number of clients not receiving any diagnosis	14
III. Intervention Services	
13. Number of clients receiving interventions	5
14. Number reporting as lost to follow up after positive monitor and before positive screen	0
15. Number reporting as lost to follow-up after positive screen and before diagnosis	0
16. Number reporting as lost to follow-up after diagnosis and before intervention	1
17. Number of clients diagnosed and received some intervention services but no longer accessible for services	0

Appendix B. Additional Report Measure

	Number Referred for Screening	% Referred for Screening	Total Entering Service
Total N/% of children/adolescents entering service who are referred for screening	93	100%	93

