

**OPTION YEAR 3 ANNUAL REPORT:**  
August 1, 2010 – July 31, 2011

**Child Guidance Center, Inc.**  
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Intervention Type: FASD Diagnosis and Intervention  
Local Subcontractor

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### 1. Executive Summary

The Child Guidance Center, Inc. (CGC) is a 501(c)(3) private not-for-profit organization located in Jacksonville, Florida. With a staff of over 125 mental health professionals, CGC serves over 5,800 children. These services include outpatient, in-home and school based counseling, mental health case management, psychiatric services and medication management, day care consultation, child abuse prevention, suicide prevention and supervised visitation. The Fetal Alcohol Spectrum Disorders (FASD) project supports the agency mission to provide quality mental health and social services to children and their families. Through this initiative, CGC integrated FASD screening, diagnosis and intervention into its current system of care in Duval County, Florida. The goal is to improve the social, emotional and developmental level of functioning in children with an FASD who receive services from CGC. The audience of interest is all children ages 0-7 receiving clinical services from CGC.

A Needs Assessment was completed on July 18, 2008. The Needs Assessment found that many of the children ages 0-7 receiving clinical services from CGC are referred for disruptive behaviors (e.g. hyperactivity, impulsivity, aggression, and non-compliant behaviors) that may be due to prenatal alcohol exposure. Due to the prevalence of these behaviors in this population, as a part of this initiative, all children ages 0-7 with parental consent are screened for an FASD. The Needs Assessment also determined that CGC had not to date adequately addressed maternal alcohol use. While CGC can provide behavioral health services to those children identified with an FASD, there are still gaps in services. The FASD Team and the FASD Task Force has been addressing gaps in services throughout the duration of the subcontract. Referrals are made to other agencies for non-behavioral health interventions (occupational therapy, speech-language therapy and physical therapy). The process for obtaining referrals from the child's primary care physician has been streamlined throughout the duration of this initiative.

The FASD Initiative has three outcome objectives: Intervention Success, Improvement on Assessment Scores, and Stability of School/Preschool/Daycare placement. Children will show improvement in at least one area of intervention designed specifically for the each child. Only those interventions that the child begins and participates in as recommended for at least 90 days will be measured. Progress will be measured in 6 month intervals. The Children's Global Assessment Scale (CFARS) is used to measure each child's progress before the diagnostic evaluation, before interventions began and again at 6 month intervals. The CFARS is completed by Child Guidance Center therapists and case managers on all children receiving services from the agency. Utilization of the CFARS has already been integrated into the agency. Those children who are actively participating in recommended interventions will demonstrate stability of school (grade school and pre-school/daycare) placement as evidenced by a reduced number of suspensions or expulsions.

In OY2, the target population was changed from 0-5 to 0-7, since most children do not begin exhibiting symptoms until after entering grade school. Our focus remains on early intervention, and we wanted to include school aged children as well. The increase in age range allowed more children to be eligible for screening and is one of the reasons why screening numbers increased in OY3. Policies and procedures to include FASD screening into CGC's client application were

successfully integrated into the agency during OY2. Integrating the permission to screen into the application streamlined the process of obtaining caregiver consent for screening. The successful integration of screening into CGC's policies and procedures was determined to be essential for promoting sustainability, which was a focus in OY3 and will be the major focus of OY4.

In OY3, the strategies and methods implemented were as follows: Provided FASD training to CGC staff; screened all CGC clients ages 0-7 for an FASD with parental consent (282 children); assigned a case manager to children who screened positive (19 children); conducted FASD diagnostic evaluations on children whose parents consent to services (12 children); developed intervention plans for those children diagnosed with an FASD (11 children); provided/monitored referrals for intervention services identified in the intervention plan (11 children); collected data as required by Northrop Grumman; developed annual implementation plan for OY4; maintained an active FASD task force; collaborated with other agencies and organizations serving young children on developing a comprehensive system of treatment; identified gaps in services and continued to work with agencies and organizations in the community to address those gaps in services; maintained on-going communication with the diagnostic evaluation and intervention service providers. CGC formalized a plan of sustainability to ensure that these services continue once subcontract funding ends. For families facing difficult financial situations who do not qualify for Medicaid, the Local Part B and Part C providers (of Florida's Individuals with Education Act) will be utilized. CGC also offers a sliding fee scale to those who pay out of pocket.

In OY1, OY2 and OY3, CGC integrated the FASD initiative into its comprehensive system of care. A major accomplishment of this Diagnosis and Intervention initiative is the successful incorporation of FASD screenings, diagnostic evaluations and interventions into CGC's policies and procedures. By incorporating FASD screening as part of the initial evaluation, CGC ensures that FASD services are available to children and families. In addition to internal activities, CGC has reached out to the community to increase collaboration with other healthcare providers to develop a more inclusive approach to treatment. Key partners in this effort were speech and occupational therapists as well as primary care physicians and caregivers. Receiving an FASD diagnosis has enabled caregivers, therapists, and teachers to reframe the behavior problems that the child was exhibiting and to develop more appropriate interventions based on the FASD diagnosis. Thus, the agency has been able to more effectively serve children with an FASD. In OY3, CGC focused on the coherent integration of the FASD services, increased coordination of its diagnostic services, coordinated provision of the intervention services based on the FASD diagnosis, strengthening of the Task Force involvement and data collection. The field of FASD intervention will benefit greatly through the documentation of successful screening programs and interventions, and through the documentation of program limitations and areas that need more research.

## 2. Key Client Results

See the populated report table in Appendix 5(a) and the attached report table generated by the Northrop Grumman Database.

- a. Target Population: In OY2, the target population age range was changed from 0-5 years to 0-7 years. In OY3, CGC provided clinical services to 818 children between the ages of 0-7. Of these 818 children, 31.2% (255 children) were female and 68.8% (563 children) were male). 5.3% (43 children) were between the ages of 0-3; 32.2% (263 children) were between the ages of 4-5; and 62.5% (512 children) were between the ages of 6-7. 39.7% (325 children) were African American; 0.6% (5 children) were American Indian/Alaskan Native; 0.2% (2 children) were Asian; 42.1% (344 children) were Caucasian; 11.7% (96 children) were Hispanic; 5.1% (41 children) were Biracial; and 0.6% (5 children) were Native Hawaiian/Other Pacific Islander.
  
- b. Screening: The protocol developed in OY2 to increase the number of children referred for screening was continued in OY3. This protocol involved individualized communication with each therapist/case manager on a monthly basis regarding new children that may be eligible for screening. Therapists have reported that these reminders are helpful; however, only 34.5% of children were referred during OY3, which is only slightly higher than OY2 (30.0%). Many biological parents are reluctant to sign consents, which is an additional reason why not all eligible children are referred to be screened. Finally, some therapists/case managers do not refer even after reminders are given, due to being overwhelmed with paperwork and insurance requirements. As the number of children screened has increased, the number of positive screenings has decreased; thus reflecting a more accurate percentage of children prenatally exposed to alcohol in the mental health population. There have been no children placed in positive monitor category in OY3 due to the small percentage of screening in children ages 0-3. Most children are referred for counseling after entering preschool or school, therefore CGC serves more school age children.
  - Number of children screened to determine eligibility for referral for a diagnostic evaluation: **282** children (34.5% of total Target Population)
  - Number of children screened positive: 6.7% of total Target Population (**19** children)
  - Number of children placed in positive monitor: 0% (**0** children)
  - Number of children moved from positive monitor to positive screen: 0% (**0** children)
  
- c. Diagnosis: Children receiving services from CGC except those in the High Risk Newborn Program or those siblings of children diagnosed with an FASD will have a mental health diagnosis. Therefore, most children who are diagnosed with an FASD will also have a mental health diagnosis. At the end of OY3, there were 3 children in the process of completing the full diagnostic evaluation. Another child who screened positive in OY3 did not agree to receive the full diagnostic evaluation until OY4, and was therefore not counted as being referred for the full evaluation in OY3.
  - Number of children referred for an FASD diagnostic evaluation: 89.5% (**17** children) of children screened positive
  - Number of children with completed FASD diagnostic evaluations: 70.6% (**12** children) of children referred for diagnostic evaluation
  - Number of children diagnosed with an FASD: 91.7% (**11** children) of children with completed diagnostic evaluation

- Number of children diagnosed with both an FASD and other diagnoses: 90.9% (**10** children) of children diagnosed with an FASD
- Number of children diagnosed with a diagnosis other than FASD: 0% (**0** children)
- Number of children evaluated who did not get any diagnosis: 8.3% (**1** child) of children with completed diagnostic evaluation

d. Intervention Services: All children who are diagnosed with an FASD are offered intervention services. CGC provided most of the behavioral health services (i.e. behavioral health counseling, medication management, targeted case management, family support, educational support and supervised visitation). Referrals are made to outside providers for occupational, physical and speech-language therapies. Families who complete the full diagnostic evaluation generally agree to participate in services.

- Number of children with an FASD diagnosis who agreed to participate in intervention: 100% (**11** children) of children diagnosed with an FASD
- Number of children who agreed to participate in at least one intervention: 100% (**11** children) of children diagnosed with an FASD
- Number of children who completed intervention services: 0% (**0** children)<sup>1</sup> of children diagnosed with an FASD

### 3. Program Description

#### a. Population Needs Identified and Addressed

- Population needs identified at the start of this initiative: Child Guidance Center serves a diverse population of children (race, ethnicity and socioeconomic status) and their families in several different settings: outpatient offices, schools, and home. Many of these children are challenged by poverty, chaotic environments, grief and loss, exposure to trauma, physical and sexual abuse, and exposure to substance abuse by parents/caregivers. All of these factors contribute to the behavioral manifestations that cause a child to be referred to the agency.
- How population needs were addressed: These needs are addressed by individual and family therapy, medication management (if indicated), referral and linkage to other resources, advocacy for the child and family, education and support for parents/caregivers, supervised visitations, parenting skills classes, and concrete assistance on a very limited basis (i.e. assistance with housing, transportation, other household needs and food).
- Have these needs changed? CGC's population needs have remained consistent over the years, but have been exacerbated due to the economic recession. Increases in job loss and unemployment have created increases in poverty, chaotic environments, parental stress, exposure to domestic violence, and exposure to substance use. Rises in unemployment and financial stress means that more and more families are qualifying

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<sup>1</sup>As of July 31, 2011, 10 out of the 11 children diagnosed with an FASD in OY3 were still receiving interventions. 1 child out of 11 children diagnosed in OY3, was lost to intervention services due to no contact with the family. This child received some intervention services before being lost to service tracking.

for federal assistance programs such as Medicaid, food stamps, TANF and WIC. The number of children and families served by CGC has increased since Medicaid is the primary insurance company accepted by CGC. A large number of the population is being cared for by relatives or adoptive parents, and a large number of the population is in single parent households. The FASD Diagnosis and Intervention initiative has been helpful in addressing some of these needs by providing information on the origin of some of the behavioral difficulties, providing comprehensive evaluations and assisting families in negotiating the sometimes complicated systems of care.

b. Service Delivery Process

- i. Children are referred for screening by the therapist or case manager who is providing services. The initiative is limited to those children receiving services from Child Guidance Center. When a parent/caregiver comes in for parent orientation, they are given a client application form to complete. At the back of the client orientation form, there is a signature page which includes: Permission to Treat; Permission to Screen; Permission to Inform Referral Source; and an Orientation Certification/Privacy Notification. Once the permission to screen is signed and a psychosocial evaluation is completed, the child can be referred for screening. The therapist or case manager emails the FASD Coordinator or FASD Case Manager with the child's name and next appointment date and time. The FASD Coordinator or Case Manager then attends the next appointment to take the photograph and complete the file review. Since clients are served in outpatient offices, schools, and homes, the screenings and meetings with caregivers can occur in all of these settings.
- ii. The FASD Coordinator and FASD Case Manager complete all of the screenings. The screening consists of taking the child's photograph and analyzing it using the FAS Facial Photographic Analysis Software developed by the University of Washington, and completing a thorough file review. The file typically has information on prenatal substance exposure, birth weight, and other relevant medical history, if available.
- iii. Once a child screens positive, the FASD Case Manager is assigned to the family. The FASD Case Manager and FASD Coordinator then meet with the family to explain the results of the screening and the diagnostic process. At that time, releases are signed so that information can be obtained and exchanged from the primary care physician, child's school and diagnostic evaluation providers. If a child has Medicaid, the FASD Case Manager contacts the Primary Care Physician and requests referrals for an Occupational Therapy Evaluation, Speech-Language Evaluation, and Genetic Evaluation. This assures that the services will be covered by Medicaid insurance. If the child does not have Medicaid, or his/her Medicaid does not cover the evaluations; the subcontract has funding allocated for these services so the family does not assume the cost. The FASD Case Manager then schedules the evaluation appointments for the family and ensures that all diagnostic evaluation providers receive background information on each child so that the evaluation can be completed. All background

information is delivered to the providers within 1 week of the evaluation appointments. All completed evaluations are sent to the FASD Case Manager and FASD Coordinator via email or fax.

- iv. After the child's completed diagnostic evaluation, a multidisciplinary report is compiled which includes the results from all of the child's evaluations. Also included are recommendations from each of the providers, including the child's therapist. After the report is compiled, a meeting is scheduled with the child's caregivers to go over the full evaluation. With assistance from the family, needed interventions are determined on an individual basis. Referrals can be made to outside providers for services such as occupational therapy, speech-language therapy and physical therapy. The child's therapy treatment plan is updated to include the FASD diagnosis, which affects medication management as well. If the caregivers would like to pursue services through the school system, then the FASD Coordinator and FASD Case Manager coordinate school meeting with teachers and guidance counselors to determine the appropriate action to take. The public school system has different eligibility criteria for services so children often do not qualify for school-based services based solely on an FASD diagnosis.
- v. Internal services are tracked using the CGC client database. This database tracks all services individually (i.e. outpatient therapy, home-based therapy, school therapy, medication management and case management). These service types/dates are documented in the Northrop Grumman database on a monthly basis. For services not provided by CGC (i.e. occupational therapy, speech-language therapy and physical therapy), communication is made with each provider individually on a monthly basis to obtain the number of units the child received the previous month. At the start of these types of services, contact is made with the provider and the initiative is explained. There has been no resistance to data collection from outside providers. These services are also documented in the Northrop Grumman database on a monthly basis.
- vi. Outcome assessments are administered before interventions begin (baseline), interim every 6 months, 6 months after case closure and 12 months after case closure. Outcome information is obtained from the child's school, family service counselors, caregiver(s), service providers and therapists/case managers. The Northrop Grumman Database is the system used to track clients needed for baseline or follow up. The tools supplied by the database are useful and user friendly. Follow ups are normally administered by phone or email, but can administered in person if applicable. There are multiple procedures used by the FASD Initiative staff to obtain outcome data. Caregivers are valuable sources of outcome information for the child. Open communication is essential with the child's providers, especially case managers, because they have information regarding placement moves. Open communication is also essential with the child's school, especially the child's teacher and guidance counselor, for the information regarding school attendance, suspensions and

expulsions. Each provider, caregiver and school is informed of the child's participation in the initiative after the child is diagnosed, and that the FASD Initiative is tracking this type of outcome information for the child.

As each client begins therapy/case management, the Children's Global Assessment Scale (CFARS) is administered by the therapist. The CFARS is collected by the FASD Team prior to an FASD diagnosis, every 6 months during treatment when possible, and at case closure. The CFARS is updated every 90 days by therapists/case managers, so an updated assessment is easy to obtain.

An excel spreadsheet is used to track the dates for follow ups. The follow ups are administered in person by the FASD Case Manager and FASD Coordinator. Outcome data such as school attendance and moves are obtained by communicating directly with the parent/caregiver, caseworker and the school guidance counselor. Schools are often contacted directly to obtain attendance data.

c. Staff Training

i. Different issues may prompt the need for staff training in implementing this FASD Initiative, and those trainings may be provided in several ways.

1. Staff trainings are a critical component in implementation of the FASD Initiative. In OY1 OY2, and OY3, multiple staff trainings occurred. In order to ensure that all clients in the target population are referred by their therapists, training was provided on the referral process and the Diagnosis and Intervention Project. The FASD Coordinator attended a weekly clinical management meeting to speak to the site supervisors and explain the program. The FASD Coordinator and FASD Case Manager also attended several team meetings to explain the Project directly to the therapists. As new therapists were hired, the FASD Coordinator and/or FASD Case Manager communicated on an individual basis with these new employees either in person or by email regarding the project and the referral process. Since there were five different outpatient locations, home based services and school based services, the FASD Coordinator and FASD Case Manager made an effort to reach out to each of these therapists and case managers with the information. Refresher trainings are scheduled throughout the year.
2. The Northrop Grumman sponsored trainings were essential in implementation of this FASD Initiative as well. The FAS Facial Photographic Analysis Software training that occurred in OY1 was necessary for the facial analysis part of the screening process. As part of sustainability, the FASD Team will train a staff member at each site in using the facial software. The FASD Coordinator and FASD Case Manager attended the Northrop Grumman sponsored training on the initiative in May 2011, and were able to bring that information back to the agency. The training was helpful in identifying ways to improve the referral process, make agency staff aware of the importance of the initiative, planning for sustainability, and planning for the upcoming option year.

3. Internal trainings were provided to CGC staff. Training on FASD and its impact on behavior was provided by the FASD Coordinator to CGC therapists in OY1. Also, the occupational therapist utilized for the diagnostic evaluations provided training on sensory integration disorders and FASDs to staff in OY2. Finally, the FASD Coordinator and FASD Case Manager provided an update on the FASD Initiative (including a refresher on the referral process for screenings) at the annual all-staff meeting. Internal training was provided to therapists by their supervisors as needed regarding the process of obtaining permission, referring for screening, and the diagnostic process. Trainings for sustainability are planned for OY4 with staff, clinical management and CGC's Board of Directors.
  4. Training on the Diagnosis and Intervention Project is ongoing as there is always some staff turnover. In addition, Child Guidance Center provides training for many students completing internships in clinical social work and other mental health disciplines. Each semester there is new staff to train. Training for OY3 focused on educating therapist to recognize the value of the screening and diagnostic process in assisting with developing a comprehensive treatment plan. Therapists were trained to ask specifically about prenatal use during the psychosocial evaluation. Most of the therapists had previously received training in OY1 and OY2, so training was provided for new staff that were unfamiliar with the initiative on an individual basis.
- ii. Different issues may prompt the need for staff training in database entry and reporting.
1. The FASD Coordinator and FASD Case Manager were trained in database entry and reporting. As this staff has remained stable, there has been no need for additional training. Since the number of children referred for screening has remained stable in OY3, there is no need to train an additional person as information is entered in a timely manner. However, an FASD Intern participated part-time with the project in OY3 and was trained in data entry in addition to the screening and diagnostic process.
  2. Northrop Grumman has sponsored multiple web-based trainings on the utilization of the database throughout OY2 and OY3. The trainings were very detailed regarding specific data entry and reporting issues. The trainers gave specific instruction on each step of the data entry process. These trainings were very useful, as the database is a valuable way to store necessary information, and a critical tool in tracking FASD clients' services, outcomes and other information. The FASD Coordinator and The FASD Case Manager were both able to effectively utilize the database based on the knowledge obtained through these trainings. Northrop Grumman also assisted the FASD Case Manager with several database issues in OY3 on an individual basis.

3. Since the number of children referred for screening has remained stable in OY2 and OY3, there is no need to train an additional person as information is entered in a timely manner.
  4. Northrop Grumman has been readily available for site specific inquiries regarding data entry and reporting. Questions or issues pertaining to data collection or reporting difficulties have been addressed in a timely manner. The database is periodically updated to suit the needs of our Diagnostic and Intervention Project.
- d. Task Force and Stakeholders
- i. At the beginning of this initiative, the Task Force included more community members. However, as the target population was refined to only include children served directly by CGC, task force membership was also refined to include only those members who had an active investment in the initiative, which included more internal members. The task force was completely restructured by September 2009 to better suit the needs of the project and needs of the Task Force. The Task Force meets quarterly and includes members from the agency and from the community. Agency members include CGC's Clinical Director, CGC's Medical Director, FASD Coordinator and FASD Case Manager. Community members and stakeholders include a 2 adoptive parents, a school principal; a Family Support Services representative (a local foster care lead agency); the Occupational Therapist and Geneticist utilized for the diagnostic evaluations; Early Steps (Part C of IDEA); a Department of Children and Families representative; and a grant writer for a Community Based Care Agency. Child Guidance Center has been a community behavioral health provider for 60 years and maintains relationships with each of the Task Members and stakeholders. All of the Task Force Members have previous experience with Child Guidance Center.
  - ii. Task Force Members provide information on other community resources, suggestions for removing barriers to services, strategies for working with other systems, such as the school system, and ideas for securing additional funding for services. The suggestions have been helpful in developing comprehensive plans for treating children diagnosed with an FASD. Linkages have been established with other services based on recommendations of the Task Force members. The Task Force has been effective in raising awareness in the community regarding the needs of children diagnosed with an FASD.
  - iii. Child Guidance Center has received an increased number of referrals from other agencies as a result of this initiative. The FASD Team has worked with outside agencies to help individual children become enrolled in services with the agency so that the child may be screened. CGC has provided education regarding FASDs and information on diagnosis and treatment to the Task Force and Stakeholders. CGC has provided behavioral health services, case management and medication management for 60 years in the community, including those agencies represented on the Task Force.

iv. The Task Force has played a crucial role in the integration and sustainability of this project. Their efforts at raising awareness of the incidence of FASD and the behavioral health effects have gained the attention of other community partners who play an important role in the sustainability of the project. A more comprehensive system of care has been created and integrated into the service delivery system of CGC due to the influence of the Task Force. During OY4, maintaining the current FASD Task Force or integrating the FASD Task Force into an existing agency task force will be discussed with CGC Board of Directors as part of sustainability.

e. Lessons Learned

Agency support, especially support of the clinical management team, is a critical component in development and sustainability of this project. Lack of support by the clinical staff and clinical management team can be a barrier to implementing FASD screening, diagnosis and intervention into the service setting. Therapists, supervisors and administrators must embrace the screening, diagnostic and intervention process in order to integrate it into the service delivery setting.

It is essential to utilize medical insurance to cover the components of the diagnostic evaluation (i.e. occupational therapy evaluations, speech-language evaluations, and genetic evaluations), especially for sustainability of this initiative. Since we have a networking diagnostic model rather than a clinic diagnostic model, a separate appointment has to be made for each component of the diagnostic evaluation. The subcontract provides some funding for these components; however, this funding will not be available once the subcontract ends at the end of OY4. Insurance was effectively utilized in OY1, OY2, and OY3 for the speech/language evaluations, the genetic evaluations and some of the occupational therapy evaluations. Wolfson's Children's Rehabilitation Center (a local service provider) has been utilized for the speech/language component of the diagnostic evaluation and for some interventions such as occupational therapy. Insurance will continue to be utilized for these services in OY4.

Engagement of pediatricians is important in sustaining this initiative as well. At the end of OY2, the FASD Coordinator, FASD Case Manager and the geneticist presented at Pediatric Grand Rounds on diagnosis of FASDs and interventions. In OY1 the FASD Coordinator sent a letter to pediatricians who are members of the Northeast Florida Pediatric Society regarding the initiative and let them know that we may be contacting them in the future for referrals. As the project developed in OY1, OY2 and OY3, the FASD team learned that personal contact via phone and fax is necessary to ensure that referrals are received so that insurance will pay for some components of the diagnostic evaluation. This will continue in OY4 for continued engagement of pediatricians.

Therapists have been supportive in providing referrals and intervention services. Therapists who serve children that screen positive and are diagnosed with FASD have expressed that information about an FASD diagnosis has been very helpful in treatment of

their clients. Therapists have also appreciated training on motivational interviewing, provided by the agency, to assess prenatal alcohol exposure. Another lesson learned throughout the duration of this subcontract is that frequent reminders and updates on information relevant to FASD are important in sustaining the enthusiasm of the staff. Engagement of CGC management in sustaining this initiative is needed in OY4. The director of clinical services and the agency psychiatrist/medical director joined the task force in OY2. Their participation is critical for sustainability.

Sustainability has been enhanced by engaging the school system through the Individuals with Disabilities Education Act (IDEA), Part B and Part C. The school system can provide occupational therapy, speech/language therapy, and physical therapy to children that meet their criteria requirements. After the diagnostic evaluation is completed, the FASD Team meets with each child's school regarding the results and possible accommodations in the school setting. In OY2, the FASD Coordinator and FASD Case Manager conducted an informative session for the Pre-Kindergarten Exceptional Education Teachers who frequently encounter children with suspected FASD. Child Find is a program funded by IDEA's Part B to provide evaluations for children aged 3-18 who are at risk of not succeeding in school. Child Find provides a psychological, speech/language, and vision/hearing screenings as part of their evaluation process. Early Steps is a program funded by IDEA's Part C to provide developmental evaluations and interventions for children ages 0-3. Both of these programs have been and will continue to be utilized in OY4 for those children when it is deemed appropriate.

- ii. A major accomplishment of this Diagnosis and Intervention initiative is the successful integration of FASD screenings, diagnostic evaluations and interventions into CGC's policies and procedures. In OY2, these policies and procedures were updated to increase the Target Population age range from 0-5 to 0-7. As a result of this initiative, the consent for screening is a part of the client application. The screening process is reviewed with caregivers during parent orientation, which is part of the intake process for clinical services. The consent for screening is signed during this orientation. This has reduced the apprehension experienced by some therapists when assessing for prenatal alcohol exposure, which was a barrier during the initial part of the project.

The CGC Client Database, and open communication with external providers has enabled data to be collected and reported in a timely manner. The diagnostic approach facilitated greater collaboration with outside providers; and previous relationships were strengthened as a result of this initiative. The Northrop Grumman database has been successfully utilized. Although separate from the CGC general client database, the Northrop Grumman database was a critical component to successful integration of the FASD initiative. With assistance from Northrop Grumman via personal contact or training webinars, the FASD Coordinator and FASD Case Manager have been very successful in the data collection component of this initiative. CGC has purchased new client database software, which is

projected to be utilized in 2012. This new software will include client screening data, which is not a part of the current CGC client database.

- iv. CGC’s approach to the FASD initiative has been one of a networking diagnostic model rather than an FASD clinic model. The providers utilized for the diagnostic evaluations are providers in the community who have teamed up with CGC to provide the evaluations necessary for diagnosis of FASD. In this aspect, CGC’s model for FASD screening, diagnosis and interventions has been a community approach. CGC has reached out to the community, with assistance from the FASD Task Force, to increase collaboration with other healthcare providers to develop a more inclusive approach to treatment. Key partners in this effort were speech and occupational therapists as well as primary care physicians and caregivers. Receiving an FASD diagnosis has enabled caregivers, therapists, and teachers to reframe the behavior problems that the child was exhibiting and to develop more appropriate interventions based on the FASD diagnosis. Thus, the agency has been able to more effectively serve children with an FASD. The field of FASD intervention will benefit greatly through the documentation of successful screening programs and interventions, and through the documentation of program limitations and areas that need more research. CGC’s collaborative approach to FASD screening, diagnosis and intervention could be used as a model for other agencies with similar structures that necessitate using outside providers in order to ensure a comprehensive approach to assessment and treatment.

#### 4. Program Changes

Change Category	Description of Change
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<p>State/local policies and procedures</p>	<p>The FASD State Task Force partnered with the Developmental Disabilities Council in OY2 to retain a public relations firm to inform the media and the public about the issues involved with FASD. There is now a statewide website specific for Florida that contains information on FASD and the dangers of drinking during pregnancy. In OY2, the state of Florida held their first FASD Summit. The Jacksonville Mayor has issued proclamations for the past three years regarding FASD awareness on September 9<sup>th</sup> to coincide with FASD Awareness Day. The FASD Team has not observed any changes in the state service delivery system as a result of this initiative. However, the local community is much more aware of the complex needs that children diagnosed with an FASD have. This initiative has created a more comprehensive system of care in the community for children diagnosed with an FASD through collaboration with multiple providers including the University of Florida, Wolfsons Children’s Rehabilitation hospital, Hope Haven Children’s Clinic, Early Steps and Child Find and Early Steps (IDEA’s Part and B and C providers) and the Duval County Public School system.</p>
<p>Organizational policies and procedures (agency policy, Task Force, partner agreements)</p>	<p>CGC’s policies and procedures were changed during the implementation process of this initiative. The consent to screening was added to the client application and is reviewed with caregivers during parent orientation, which is a mandatory part of the intake process for clinical services. The consent to screening is given or declined during this orientation.</p>
<p>Systems integration (intake, screening, case coordination, agency collaboration, internal and external system referrals, diagnostic team/center, etc.)</p>	<p><u>Referrals for screenings:</u> A strategy implemented in OY2 attempted to increase the number of children referred for screening. At the beginning of each month, a list of the new clients in the Target Population opened in the previous month is generated by CGC’s IT Specialist. Based on this list, individual contact is made with each therapist/case manager on the children that have not been referred for screenings. This strategy slightly increased the number of children referred for screenings, and was continued in OY3. Since implementation of this strategy, more therapists/case managers are referring before reminders are sent out, which is indicative of a more concrete integration of FASD referrals for screenings.</p> <p><u>Screenings:</u> In OY2, the target population was changed from 0-5 to 0-7 since most children start services after entrance into school. CGC’s policies and procedures were updated to reflect this change in target population at the beginning of OY2. This change has significantly increased the number of children eligible for screenings and the number of completed screenings.</p> <p><u>Diagnostic Evaluations:</u> The diagnostic evaluation process has become more efficient through implementation and integration of this initiative. A strategy implemented in OY2 allowed the diagnostic evaluation process to be completed more quickly. After a child screens positive and the caregivers consent to the diagnostic evaluation, the FASD Coordinator or FASD Case Manager makes personal contact with the child’s primary care physician to obtain records and referrals for the different components of the diagnostic evaluation. After referrals are received, the FASD Coordinator or FASD Case Manager schedules the evaluation appointments for each family. The providers utilized for the diagnostic evaluations make room in their schedules specifically for the children participating in the FASD initiative, so appointments can be scheduled in a timely manner.</p>

<p>Service delivery process (parent engagement, modification of existing case plans or developmental of new plans, new clinical techniques, case management, etc.)</p>	<p><u>Intervention Services:</u> Therapists who serve children who are diagnosed with FASD have expressed that information about an FASD diagnosis has been very helpful in treatment of their clients. Knowledge about an FASD diagnosis helps reframe treatment goals and the way that they interpret behavior. Treatment plans for children diagnosed with an FASD are often revised to include other interventions such as referrals for occupational therapy and speech-language therapy. CGC provides behavioral interventions in the office, school and home settings. Behavioral therapists use a combination of play therapy, art therapy, behavior modification and family therapy to effect change. Therapists working with children with FASD are incorporating more creative therapies in their treatment to build on the strengths of the child. Therapies provided by outside providers (i.e. occupational therapy, speech-language therapy and physical therapy) are also monitored by the FASD Case Manager. A diagnosis of FASD influences therapists' and caregivers' expectations of the child's capacity for change. Targeted Case Managers are now referring children diagnosed with an FASD for outside services that include occupational and speech-language therapies as well.</p> <p><u>Assessment Information:</u> Communication with each child's school occurs more frequently as a result of this initiative for children diagnosed with FASD. Contact is made on a biannual basis (at the very least) to obtain attendance data. The FASD Team is the only team that communicates with families after their exit from the program to determine their child's level of functioning.</p>
<p>Data Systems (integration of program data, centralization, etc.)</p>	<p>Data management is more inclusive as a result of this initiative. Each child's screening results are included in the child's therapy file. For children that screen positive and complete the diagnostic evaluation, the results of the diagnostic evaluation are also included in the child's file.</p>
<p>Staffing (new training focuses, refresher training, staffing structures, qualifications for new hires, training for service providers, etc.)</p>	<p>Staff trainings are a critical component in implementation of the FASD Initiative. In order to ensure that all clients in the target population are referred by their therapists, training was provided to therapists/case managers on the referral process and the Diagnosis and Intervention Project. The FASD Coordinator attended a weekly clinical management meeting to speak to the site supervisors and explain the program. The FASD Coordinator and FASD Case Manager also attended several team meetings to explain the Project directly to the therapists. As new therapists were hired, the FASD Coordinator and/or FASD Case Manager communicated on an individual basis with these new employees either in person or by email regarding the project and the referral process. Since there are five different outpatient locations, home based services and school based services, the FASD Coordinator and FASD Case Manager made an effort to reach out to each of these services with the information. The occupational therapist utilized for the diagnostic evaluations provided training on sensory integration disorders and FASDs to staff in OY2. The FASD Coordinator and FASD Case Manager provided an update on the FASD Initiative (including a refresher on the referral process for screenings) at the annual all-staff meeting. Internal training was provided to therapists by their supervisors as needed regarding the process of obtaining permission, referring for screening, and the diagnostic process. Trainings for sustainability are planned for OY4 with staff, directors, management and CGC's board.</p>

## 5. Appendix

a. Report Table: see attached in addition to the chart below

<b>Option Year 3: Between 8/1/2010 and 7/31/2011</b>	
<b>I. Screening</b>	
1. Client Screened for an FASD	<b>282</b>
2. Clients with a positive FASD screen	<b>19</b>
3. Clients placed in positive monitor (+ monitor)	<b>0</b>
4. Client moved from positive monitor to positive FASD screen	<b>0</b>
5. Total Number of clients with a positive FASD screen	<b>19</b>
<b>II. Diagnosis</b>	
6. Number of clients referred for diagnosis	<b>17</b>
7. Number of clients with completed diagnostic evaluations	<b>12</b>
8. Number of diagnostic evaluations with written reports completed	<b>12</b>
9. Number of clients diagnosed with an FASD	<b>11</b>
10. Number of clients diagnosed with an FASD and other diagnosis	<b>10</b>
11. Number of clients receiving a diagnosis other than an FASD	<b>0</b>
12. Number of clients not receiving any diagnosis	<b>1</b>
<b>III. Intervention Services</b>	
13. Number of clients receiving interventions	<b>32<sup>2</sup></b>
14. Number of reporting as lost to follow-up after positive monitor and before positive screen	<b>0</b>
15. Number reporting as lost to follow-up after positive screen and before diagnosis	<b>4</b>
16. Number reporting as lost to follow-up after diagnosis and before intervention	<b>0</b>
17. Number of clients diagnosed and received some intervention services but no longer accessible for services	<b>1</b>

b. Additional Report Measure

	<b>Number Referred for Screening</b>	<b>% Referred for Screening</b>	<b>Total Entering Service</b>
Total N/% of children entering service who are referred for screening	<b>282</b>	<b>34.5%</b>	<b>818</b>

<sup>2</sup> Includes children diagnosed in previous option years