

2010-2011



CARE OF  
SOUTHEASTERN  
MICHIGAN

## PROJECT FASD ACHIEVE ANNUAL REPORT

improved functioning and life-long achievement for individuals living with FASD

CARE of Southeastern Michigan  
FASD Diagnosis and Intervention in Southeastern Michigan  
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### Background

CARE of Southeastern Michigan (CARE) is a local, non-profit, community agency whose mission is to educate, link and support individuals, families, businesses and communities affected by family concerns, workplace challenges, mental health conditions and the misuse of alcohol, tobacco, and other drugs in Southeastern Michigan.

Reflecting CARE's overriding mission and passion to improve lives of Southeastern Michigan youth, the initiative is named Project FASD ACHIEVE identifying the overall project goal - improved functioning and life-long achievement for individuals living with FASD.

Project FASD ACHIEVE integrates screening for FASD, referral for an FASD diagnostic evaluation and the provision of interventions based on the FASD diagnostic evaluation into CARE's service delivery system for children ages 0-7. Project FASD ACHIEVE includes a case management approach unique to CARE.

CARE provides case management to children and their families beginning at the point of a positive screen.

CARE offers a multitude of programs for families and children within Project FASD ACHIEVE's target population. Working in a collaborative way with Macomb County and other Southeastern Michigan partners and agencies, we are meeting the needs of the community. By formalizing its working relationships with service providers and providing intensive case management, CARE ensures that families receive the supports that they need through the entire process.

### Objectives

Children receiving services will:

- 1) Remain in current home placement at the time they enroll in FASD Achieve
- 2) Improve school performance
- 3) Remain in their daycare or preschool setting
- 4) Meet treatment goals of individual service plan developed from diagnostic evaluation recommendations
- 5) Improve functioning

### Methods

CARE developed policies and procedures and trained staff in order to integrate FASD ACHIEVE into the CARE's service delivery system. Throughout the initiative, CARE has revised policies and procedures as needed including the addition of an FASD orientation to any new CARE staff on a quarterly basis. This activity assists in developing commitment from new staff as key stakeholders in the success of the initiative.

Key to the success of the initiative is trained staff, and an engaged task force and at-large community.

CARE trains any newly hired FASD staff in screening and case management within one month of hire.

CARE integrated FASD intervention into its *Supportive Opportunities with Families (SOF)* program – a contract with the Michigan Department of Human Services, and began screening clients enrolled in SOF in January 2011. Prior to the screening start date, CARE invested in SOF staff by provided FASD screening training to its Case Manager Supervisor and SOF Case Managers.

CARE requested and received technical assistance from the SAMHSA FASD Center for Excellence. In January 2011, Macomb County and the greater southeastern Michigan community received a full-day training, entitled *FASD Training: Getting to Know the Infant, Child, and Adult with Prenatal Alcohol Exposure, and, Difficult Dialogues - Learn how to sensitively and successfully engage families in discussing alcohol use.*

CARE meets with its task force members quarterly and keeps members and community partners informed via monthly “hot sheets” and articles in the quarterly agency newsletter, “Stepping Stones.”

Families stay engaged in the process through a case management model that provides assistance to the child and family beginning at the time of a positive screen for FASD. Beginning in August 1, 2009, CARE enacted a multi-leveled case management approach. By the end of Option Year 3, July 31, 2011, CARE formulated a fourth and final case management level. Level four CARE recognizes that children and families “graduate” from FASD services at the end of intervention activity and are provided 6 month and 12 month follow-up via phone. This case management model is unique to CARE and may serve as a successful approach for serving children in long-term care.

CARE utilizes technology to assist in data collection, evaluation, and case management. Both the Northrop Grumman database and CARE's internal agency database, TIER, are used daily in managing the initiative.

Primary activities include:

- 1) CARE FASD staff enroll eligible children and screen them for FASD;
- 2) Refer children who screen negative to community resources;
- 3) Refer children who screen positive for FASD diagnostic evaluation;
- 4) Level 1 case management - Intake assistance in completing the diagnostic intake packet (medical records, documented prenatal alcohol exposure, other family history and medical history);
- 5) Level 2 case management - Support through home visits and community referrals while awaiting a diagnostic outcome; and
- 6) Level 3 case management - Development of intervention/service plan and case managed interventions based on diagnostic recommendations
- 7) Level 4 case management – A **new** and final level added that defines the end of services; acknowledges that the client/family has “graduated”; and where there is 6 month and 12 month follow-up.

## Lessons Learned

CARE integrated FASD early intervention into its Supportive Opportunities for Families (SOF) program, a secondary prevention initiative made possible through a contract with the Michigan Department of Human Services (DHS). **The inclusion of FASD screening with this additional program proved a successful model of integration and was promising for sustainability efforts.**<sup>1</sup>

## Accomplishments

Of the clients that received interventions in this reporting cycle, CARE is excited to share these key findings and outcomes:

- 100% of the foster children CARE serves experience placement stability.
- Of the children diagnosed with an FASD and in daycare, 100% are remaining in their setting.
- 91 % of children diagnosed with an FASD are reporting that their service plan goals are being met.
- 60% of children who have been diagnosed with an FASD have improved school performance based on attendance.

Throughout the initiative, CARE has monitored diagnostic capacity. For the past year, CARE has been working with the Henry Ford Health System, Center for Autism and Developmental Disabilities (CADD) and its directors to increase FASD diagnostic capacity. As such, CADD is committed to evaluating for an FASD, children referred from CARE, at a rate of one evaluation per month, beginning October 2011.

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<sup>1</sup> The SOF contract was for August 2010 through September 30, 2014. However, the DHS budget within the State of Michigan was drastically cut and will eliminate secondary prevention funding, including this contract with CARE. SOF will end on September 30, 2011.

### Target Population

CARE screens children age 0-7 in its service delivery, including clients ages 0-3 enrolled in a new program, *Supportive Opportunities for Families (SOF)*. CARE serves a hi-risk population encompassing children in homes where substance abuse or other trauma may be present; children in foster, kinship care, and adoptive home settings; and children experiencing behavioral concerns.

### Screening

Previous strategies to address barriers and increase the number of children screened were implemented.

CARE hosted a SAMHSA FASD Center for Excellence FASD training in January 2011 that fully engaged the greater community and referrals to CARE increased.

With the addition of screening children enrolled in *SOF*, a secondary prevention activity contracted with the Michigan Department of Human Services (DHS), CARE exceeded projections for the number of children to be screened. CARE provided services and assessments to 170 children age 0-7. 120 children were voluntarily enrolled in FASD ACHIEVE and were screened for an FASD. 40 children screened positive for an FASD.

The number/percentage of children screening positive in OY3 is lower than in previous option years. A smaller number of children participating in *Supportive Opportunities for Families (SOF)* screened positive than originally projected. With the inclusion of *SOF* clients and their negative screens, the rate of a positive screen is 33%. The biological caretakers/parents of *SOF* clients may see CARE as an extension of DHS, as such; time is needed to build a trusting relationship in which to disclose information about alcohol use during pregnancy. Children receiving a negative screen can be screened a second time.

Children screening negative are referred to community resources. Families are encouraged to remain in contact with CARE particularly if new information, .i.e. confirmation of prenatal alcohol exposure, is obtained.

For children who are age 0-3 and were prenatally exposed to alcohol but do not exhibit growth deficiencies, present with physical anomalies, or exhibit central nervous system (CNS) delays are placed in a positive monitor category until they reach the age of 4, or when a CNS delay presents itself. Currently, 7 children are in positive monitor. Children in positive monitor receive bi-monthly communication by CARE and evaluation for development every three months.

CARE is currently at diagnostic capacity and case management capacity. CARE has implemented a short-term waitlist in screening children for an FASD.

## Diagnosis<sup>2</sup>

CARE refers all clients receiving a positive FASD screen for diagnostic referral. This process is also voluntary. 25 children were referred for a diagnostic evaluation. The process is lengthy and although an ideal time-frame would be an evaluation scheduled a month after screening positive, this has not been CARE's experience. Factors for the delay include:

- The diagnostic centers all have an existing 2-3 month wait list;
- Some parents/families are less motivated, may have feelings of being overwhelmed, and are not ready to move on in the process;
- More assessments/testing are needed prior to completing a diagnostic intake packet.

12 children who screened positive in option year 3 (OY3) completed a diagnostic evaluation, with 6 of the 12 receiving a written report with recommendations in the reporting year, OY3. 6 of the 6 children evaluated, or 100%, were diagnosed with an FASD.

Children still active in the process but whose reporting falls outside the parameters of OY3 include:

- 3 children who screened positive and completed their diagnostic evaluation in OY3 received their written report in option year 4 (OY4).
- 4 children who screened positive in OY3 have a scheduled diagnostic evaluation date in OY4.
- 5 children, who screened positive in OY3, were referred in OY4, and are awaiting a diagnostic evaluation appointment.
- 3 children who screened positive in OY3 were lost to follow up before a diagnosis, in OY4.

Prior to indicating a child is "lost to follow up", CARE makes multiple communication attempts with the primary care givers and/or referral source. Per policy, clients may contact CARE at any future point in time and continue in the process

4 children diagnosed with an FASD in a prior option year, are lost to follow-up.

## Intervention Services

CARE provides case managed interventions to children receiving an FASD diagnosis. CARE's FASD Case Manager works closely with the family to develop a service plan and to obtain planned interventions.

CARE works with the family every step of the way, providing support and education.

6 children screening positive in OY3 and diagnosed with an FASD in OY3 are currently receiving interventions.

23 children received interventions in OY3. 17 of the 23 children receiving interventions were diagnosed in a previous option year.

For the complete data table, please see Appendix.

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<sup>2</sup> Data reflects clients who were screened in OY3. A total of 23 children received interventions in OY3, with 17 of the 23 children screened positive and/or diagnosed with an FASD in a prior option year.

## Program Description

CARE provides community-based FASD identification, diagnosis and intervention.

FASD ACHIEVE identifies and refers for diagnostic evaluation children age 0-7 in CARE services.

The initiative provides case management, training, support, and advocacy for the families of the individual receiving a diagnosis and individual service plan. Furthermore, FASD ACHIEVE will insure children receive the appropriate intervention services that lead to improved functioning and increased life-long achievement.

### Population Needs

#### *FASD Education*

At the beginning of the initiative, CARE staff, its evaluator, and task force identified key population needs to be addressed. FASD education was needed for the client, the community, and service providers. CARE was able to provide IN-KIND training through its locally funded FASD trainer activities to the community and service providers.

In its second option year, CARE recognized that the gap in knowledge continued to be a barrier for potential referral sources. Additionally, the perceived stigma of a disability (FASD) due to maternal alcohol use during pregnancy is a barrier to engaging families to voluntarily participate in needed services. CARE requested and received technical assistance provided by SAMHSA FASD Center for Excellence. In January 2011, SAMHSA FASD trainer, Barbara Wybrecht, delivered a community-wide training on FASD and engaging families in the difficult dialogue of asking about alcohol use and alcohol use during pregnancy. By February, 2011, referrals to CARE increased and remain consistent.

#### *Multi-level Case Management*

The FASD Case Manager provides FASD education and resources to the family. Case management was originally planned to begin after a client is diagnosed with an FASD. CARE evaluated its staff activity and client needs and determined that case management can occur at the time of a positive screen. In this way, families are engaged in the process by receiving education, intake packet assistance and ongoing support/advocacy. CARE now utilizes a multi-tier case management model.

- 1) Level 1 case management - Intake assistance in completing the diagnostic intake packet (medical records, documented prenatal alcohol exposure, other family history and medical history);
- 2) Level 2 case management - Support through home visits and community referrals while awaiting a diagnostic outcome; and
- 3) Level 3 case management - Development of intervention/service plan and case managed interventions based on diagnostic recommendations.

A new and final level was added in the last month of OY3 that defines the end of services and acknowledges that the client/family has “graduated.”

- 4) Level 4 case management – Transition out of service; complete an evaluation and satisfaction survey; and provide 6 month and 12 month follow-up.

### *Service Delivery Funds*

The initial needs assessment identified potential financial barriers in clients obtaining services and many interventions are not covered through medical insurance. CARE utilizes contract dollars in the FASD ACHIEVE budget to assist families in obtaining recommended services. CARE has a policy and process in place for fund request, approval, and uses technology to track allocations.

### *Diagnostic Capacity*

Throughout the initiative, CARE has monitored diagnostic capacity. It is an identified need across the country and in Michigan, affecting the number of children that can receive a timely diagnostic evaluation after screening positive for an FASD. CARE has been working with the Henry Ford Health System, Center for Autism and Developmental Disabilities (CADD) and its directors to increase FASD diagnostic capacity.

In March 2011, CADD’s multi-disciplinary team of professionals attended a Michigan Department of Community Health and Great Lakes Regional FASD Training Center one-day training targeted to diagnosticians and clinic directors, entitled, “FASD Research, Diagnostic Assessment and Clinical Treatment/Management.” Additionally, as part of its preparations to evaluate children for an FASD, members of the Henry Ford Health System Center for Autism and Developmental Disabilities (CADD) observed an FASD clinic day at Children’s Trauma Assessment Center CTAC 2011.

CADD is committed to evaluating for an FASD, children referred from CARE, at a rate of one evaluation per month, beginning October 2011 at its Cottage Hospital Clinic which is in close to moderate proximity for CARE clients and their families.

## Interventions

Children diagnosed with an FASD need strategies that address brain differences. Individualized service plans need to incorporate the unique strengths, interests, and challenges of the child, and success needs to be measurable.

These needs were identified early in the initiative; however, it wasn't until CARE staff received training in the *Functional Assessment Checklist for Individuals with FASD*<sup>3</sup>(FACKL®), that we were able to fully address this need. The family and the FASD case manager complete a FACKL® within 2 weeks of receiving the client's written diagnostic evaluation report. The summary map leads to the development of a service plan with measurable goals.

Children diagnosed with an FASD frequently receive diagnostic recommendations addressing behavior concerns. CARE developed a professional relationship with a local behavioral consultant, Matt Peters, MA, LPC, CRC, who provides behavior techniques, supports, and coaching in either an in-home setting or school setting, or both. Each client diagnosed with an FASD and receiving level 3 case management services are eligible to receive four (4) sessions with Mr. Peters consisting of an initial session to meet child/family to learn more; and, three (3) follow-up sessions.

## Service Delivery Process

CARE provides FASD screening, diagnosis, and early interventions for children age 0-7 in its service delivery and within a community setting. CARE has many programs that serve children age 0-7. CARE staff is able to refer a child to be voluntarily screened for FASD. Community programs can also refer a child to CARE and may include FASD services in their referral.

Referrals for a voluntary FASD screen have been challenging. Earlier in the initiative, CARE clinical staff, as front-line interviewers, was experiencing a communication barrier in engaging families in discussing prenatal alcohol exposure. Potential providers experience a similar communication barrier. The perceived stigma of a disability (FASD) due to maternal alcohol use during pregnancy has been a barrier to engaging families to voluntarily participate in needed services.

CARE addressed these barriers in a variety of ways and increased the number of children screened. CARE re-organized the direct supervision of the FASD initiative into the clinical department; provided training to staff and community; expanded its service area; and expanded CARE programs that include FASD services. (Please refer to page 4, *Key Client Results, Screening*.)

A referral form for an FASD screen may be used, although if FASD staff is available at the time of a clinical assessment, a warm introduction to the client/family can take place. Upon receipt of a request, referral, and when needed, a signed release of information form, the FASD Case Manager schedules and conducts the screen and works with the family to complete a diagnostic intake packet upon receiving a positive FASD screen. Both

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<sup>3</sup> Kalberg & Taylor

client/family and FASD staff enter a service agreement outlining roles and responsibilities. At this time release of information forms are signed to allow for diagnostic and intervention referrals.

CARE is able to refer to 3 diagnostic centers that evaluate children from across the state of Michigan for an FASD: The University of Michigan FASD Diagnostic and Intervention Clinic, The Children's Trauma Assessment Center (CTAC), and the Children's Hospital of Michigan. Beginning October 2011, CARE will be able to refer to a 4<sup>th</sup> diagnostic clinic, Henry Ford Health System, Center for Autism and Developmental Disabilities (CADD). With input from the client/care-givers, CARE staff determines which of the four diagnostic centers to refer a client based on client/care-giver needs. For a child who was prenatally exposed to alcohol and experienced trauma, the family is referred to CTAC whose team evaluates for both factors.

If any assessments are needed prior to scheduling an FASD diagnostic evaluation date, CARE FASD staff assists the family in meeting this requirement. The FASD Case Manager reviews the diagnostic intake packet prior to submission, includes a cover letter indicating the client is enrolled in FASD ACHIEVE, and may flag areas of importance for the diagnostic team. A copy of the completed packet is retained in the client's record.

CARE is notified by the diagnostic center or by the family of the scheduled diagnostic evaluation date.

This date is recorded and the FASD Case Manager follows up with the family and/or the clinic to obtain the written evaluation report.

The FASD Case Manager meets with the family to review the diagnostic report findings and its recommendations. A FACKL<sup>®</sup> is conducted, leading to a service plan. The service plan includes goals to address any barriers in receiving interventions, such as obtaining Medicaid for the client. CARE utilizes service delivery funds when requested, and when necessary, to assist in the client receiving recommended services.

FASD staff maintains communication with the client/family and service providers in order to track planned and actual intervention activity and to address any client needs. FASD staff provides intensive case management, and advocacy for the client/family diagnosed with an FASD and receiving interventions.

At all times, throughout the process and its activity, CARE utilizes the Northrop Grumman Access database and CARE's internal TIER database to assist in case management, data collection, and evaluation.

### **Staff Training**

CARE identified early in the initiative that its staff and management play a key role in the success of the initiative. New staff and interns receive an overview of the initiative. Success stories and updates are shared at monthly all-staff meetings.

CARE hired two new FASD case managers in this reporting period. A full-time case manager was hired to replace the previous FASD case manager who accepted an internal position within a new CARE program.

As staff activity increased, a second, part-time case manager was hired. Both new FASD case managers received training in the foundations of FASD, and in all aspects of the FASD initiative including training on the policies and procedures, screening tools, data collection, and case management tools. A bachelor level social work intern was assigned to the initiative and received training so that she could assist in intake packet preparation and in tracking client's intervention services.

CARE added a secondary prevention program to its service delivery, *Supportive Opportunities for Families (SOF)*.

By design, children age 0-3 and enrolled in *SOF* were screened for an FASD. CARE *SOF* case managers received training in the foundations of FASD; engaging parents and families to discuss alcohol use; and FASD screening.

Across the years of the initiative, Northrop Grumman has provided technical assistance and training.

In the 2<sup>nd</sup> option year, CARE requested assistance in addressing the perceived stigma of a disability (FASD)

due to maternal alcohol use during pregnancy as it is a barrier to engaging families to voluntarily participate in needed services. CARE received training for their clinical staff and as well as a community-based training that SAMHSA FASD Center for Excellence provided in January 2011.

CARE's clinical staff and case management staff, including the *SOF* case managers, attended the January 2011 SAMHSA FASD Center for Excellence training, "*FASD Training: Getting to Know the Infant, Child, and Adult with Prenatal Alcohol Exposure, and, Difficult Dialogues - Learn how to sensitively and successfully engage families in discussing alcohol use.*"

In option year 2, Northrop Grumman provided training to CARE's clinical staff. Sr. Mary Sartor of Double ARC, Toledo, trained CARE's master-level clinicians on tips/techniques to interview for FASD. The training included time for staff role-play.

Both trainings addressed the need to increase the number of children referred to CARE and the number of children screened for an FASD. The response was immediate. The number of children being screened did increase. CARE reached case management capacity, to the point where a short-term wait list was enacted.

CARE utilizes technology to assist in managing and evaluating the initiative. Early in the initiative, CARE FASD staff received conference call trainings on the Northrop Grumman database. While the initial roll-out training was difficult in its technical focus, the final database manual is helpful in navigating the database, its required data entry points, and the improvements made in managing the project. The individual training sessions with the Northrop Grumman Evaluator, HSRI, resulted in developing queries that are beneficial in reporting on monthly data collected and in cleaning the data prior to submission.

CARE also received internal training in its (IN KIND) database, TIER, which serves not only as an additional evaluation tool, but as a daily case management tool.

### **Task Force and Stakeholders**

CARE, a community based agency, is a member of 15 collaboratives or networks including the Human Services Coordinating Body and its subcommittees including the Children's Early Intervention Support

Services; Youth Council and Local Inter-agency Coordinating Council, Children's Resource Network, Macomb Homeless Coalition, Juvenile Officers Association, Macomb Interagency Council, Macomb Prevention Coalition and others. As such, CARE has long-standing relationships with professionals in the community.

When CARE initially formed the FASD ACHIEVE Task Force, it looked to its professional relationships and invited those who have worked with CARE in its previous FASD activities.

The purpose of the Task Force is to advise and offer expertise in the planning, development and implementation of Project FASD ACHIEVE.

The Task Force was initially charged with assisting with the needs assessment, deliverables, and project planning. Now in its implementation years, the Task Force is charged with the following:

- Advise and make recommendations for the on-going implementation of Project FASD ACHIEVE activities;
- Increase target population referrals to CARE
- Monitor diagnostic capacity
- Ensure that, where necessary, policy changes are made within their agencies; and
- Keep family and community accountability as a key component of the initiative

Increasing target population referrals to CARE was supported by system change in agencies represented on the Task Force. Specifically, CARE works closely with the Macomb County Intermediate School District (MISD) Early On, where a referral to CARE is automatic for any client in foster care who qualifies for Early On services under the eligibility of toxic exposure.

Members of the Task Force assisted in monitoring diagnostic capacity and in increasing the number of children diagnosed. Henry Ford Health System is a member of the Task Force and in this reporting year worked with CARE so that they can include FASD evaluations into their Center for Autism and Developmental Disabilities (CADD) clinic. Children screening positive for an FASD can be evaluated at CADD beginning October 2011.

Additional members include representatives from local funders, Macomb County Office of Substance Abuse (MCOSA); Macomb County Community Health; Maternal Infant Health providers; Caretakers of individuals diagnosed with an FASD; service providers, including a neuropsychologist and a sensory therapist; FASD diagnostic team members; Early On – Part C provider; and DHS.

Members meet quarterly as a team and continue to work toward meeting the objectives of the initiative.

In this reporting period, task force members were engaged in sustainability discussions and were instrumental in developing and finalizing CARE's FASD Intervention Sustainability Plan.

## Lessons Learned

Of particular interest to other programs may be lessons CARE has learned since the beginning of the initiative:

- Task Force members have needs beyond just their involvement of the initiative. They require acknowledgement of their commitment and seek additional professional development in their FASD competency. CARE now provides professional in-service opportunities for members at quarterly meetings, and members receive a year-end appreciation certificate that may be used for their portfolio and/or for accreditation.
- Primary FASD staff's knowledge of the diagnostic criteria language and matrix of the 4-digit code is helpful in explaining the diagnostic evaluation to clients, other CARE staff, and community partners.
- CARE's case management model has been shared with other subcontractors and highlighted at the national early childhood mental health conference, *Project ABC, Strive to Thrive*. The breakout session entitled, Early Intervention: FASD Screening, Diagnosis & Intervention for Children 0-7 Years. CARE finds that in providing case management, in varying degrees of activity, beginning at the point of a positive screen, families are engaged and supported throughout the screening, diagnostic and intervention process.
- CARE FASD staff does not provide a mental health/ behavior assessment, and as such has limited resources to help identify a client's strengths and areas of challenge. Since being trained in the FACKL<sup>®</sup> tool and utilizing it with clients, CARE has found the FACKL<sup>®</sup> to be of value to staff, family, and service providers.

Parents find that the process of using the FACKL<sup>®</sup> tool helps them organize learned information about their child. It helps put down on paper their every-day experiences, validates the complexity of an FASD diagnosis, and helps parents overcome their feelings of anxiety and feelings of being overwhelmed. It moves them towards developing a summary map that narrows down distinct "areas of improvement" to concentrate on in developing their child's initial service delivery plan.

- Parents and school staff express positive feedback with behaviorist, Matt Peters, who provides behavior techniques, supports, and coaching in either an in-home setting, school setting, or both. Each client diagnosed with an FASD and receiving level 3 case management services is eligible to receive four (4) sessions with Matt Peters, and include an initial assessment session to meet the child/family and learn more. Three (3) follow-up sessions consist of implementing a behavior plan, and

coaching or support depending on the level and intensity of the activity which is decided between the client's care taker, CARE FASD Case Manager, and Matt Peters.

- Training community referral sources in how to engage their client in discussing alcohol use can address barriers in referring to CARE and can increase the number of children screened for an FASD.
 

215 persons representing many disciplines including foster care, community mental health, public health nurses, Early On (Part C) providers, school personnel, and therapists received 6 hours of training from Barbara Wybrecht, SAMHSA FASD Trainer. Referrals to CARE increased immediately following the training.
- Lastly, lessons learned to share with any community seeking a similar initiative include:
  - A high level of coordination, both internally and externally, is necessary for integration into a community-based service delivery system;
  - Acknowledge that system change takes time;
  - Senior management - its leadership, and its relationships with community members is an essential ingredient to obtaining community involvement and commitment
  - Understanding what motivates key staff and acknowledging their role in a child's success is key to maintaining their cooperation

## Program Changes

Prior to the award of the Northrop Grumman subcontract to provide community based FASD screening, diagnosis and early intervention, CARE had a history of FASD service activity. Through local and state funding sources, CARE provided universal FASD prevention activities, and support to families living with FASD through educational offerings, a monthly support group, and a parent liaison that linked families to resources.

Today, in addition to providing FASD education and targeted FASD prevention activities, CARE provides a community-based best practice case managed system of care for children exposed prenatally to alcohol and/or other drug – through screening, referral for diagnostic evaluation and interventions based on diagnostic recommendations. The following chart highlights the change across several categories:

Change Category	Description of Change
State/local policies and procedures	<ul style="list-style-type: none"> <li>• The Michigan Department of Human Services (DHS) has an increased awareness of FASD and an increased understanding of the value in identifying children prenatally exposed to alcohol who may be at risk of an FASD. Within the design of the awarded DHS contract with CARE for secondary prevention, <i>Supportive</i></li> </ul>

*Opportunities for Families*, children were screened for an FASD.

While the SOF program funding will be cut as of October 1, 2011, CARE's relationship with DHS remains strong. DHS foster care workers and child-protective service workers increasingly refer their clients to CARE, resulting in their clients being screened for an FASD, screening positive, being referred for a diagnostic evaluation, and being diagnosed with an FASD.

- The Macomb County Great Start Collaborative (early childhood community) is addressing FASD prevention and early intervention. The Strategic Plan for Early Childhood in Macomb County 2010 – 2013 includes within the pediatric and family health action steps, “increase the awareness of the effects of drug and alcohol use during pregnancy, while breastfeeding and the effects on child development as well as the importance of assessment and early intervention.” This strategic plan provides an additional community agenda for FASD early intervention inclusion.
- FASD intervention has been given a voice state-wide. The Michigan Department of Health, Early On, engaged cross-professionals to participate in an FASD Work group, which included CARE's FASD Project Director, for the purpose of developing a Recommended Service Coordination Practice Guide for Children aged 0 to 3: Fetal Alcohol Spectrum Disorders. The guide, intended for Early On coordinators and service providers awaits final approval and distribution.

This activity and its final document will assist service providers in meeting the specific needs of children diagnosed with an FASD. It may also be a potential opportunity to integrate FASD screening, diagnosis, and intervention into Part C coordinated activity.

- CARE's Project FASD ACHIEVE is a standing agenda item at the Michigan FASD State Task Force quarterly meetings. This provides an opportunity for state level leaders in Department of Human Services, Education, Juvenile Justice, Head Start, Community Health, Community Mental Health, Early On, and Maternal Infant Health to learn about the initiative, and be a part of its sustainability.

<p>Organizational policies and procedures (agency policy, Task Force, partner agreements)</p>	<ul style="list-style-type: none"> <li>• CARE formalized the FASD integration into its service delivery at the beginning of the initiative. It developed written policies and procedures for the process of FASD screening, referral for diagnosis, and case-managed interventions for children in CARE's many programs. CARE invested in the success of the initiative through technical assistance and training requests. Most importantly, CARE looks for ways to include FASD intervention into any new program, as evidenced by the inclusion of FASD screening into its DHS <i>Supportive Opportunities for Families</i> contract.</li> </ul>
<p>Systems integration (intake, screening, case coordination, agency collaboration, internal and external system referrals, diagnostic team/center, etc.)</p>	<ul style="list-style-type: none"> <li>• Prior to the subcontract award, CARE screened children, youth, and adults who contacted CARE through its Family Program Division. The screening tool used was the Michigan FASD Pre-screen tool that documents facial features via a FAS facial diagram, any behavior concerns, and any growth/weight deficits.</li> <li>• Since the beginning of the implementation of the initiative, CARE has a written policy and procedure where any child 0-7 in CARE's service delivery system can be screened for FASD using both the Northrop Grumman FASD screening tool developed by a SAMHSA expert panel and the Michigan Pre-screen tool.</li> <li>• With the Northrop Grumman initiative, CARE was able to create a formal, structured and integrated approach to FASD screening, referral to diagnostic centers, and an intensive case management model that begins at the point of a positive screen.</li> <li>• When CARE identified barriers to screening, some due to the perceived stigma of a disability caused by one's drinking while pregnant, CARE overcame these challenges through ongoing training and incorporating visuals to introduce a family to the topic prior to a clinical evaluation. An additional challenge to increasing the number of children screened was the reliance on community referrals to CARE for a clinical evaluation wherein FASD screening can occur. CARE worked with its community partners to determine barriers for referrals to CARE and sought opportunities to address system change where a referral to CARE is incorporated into agency service plans for their clients.</li> <li>• Prior to the initiative, CARE had a loose relationship with</li> </ul>

	<p>the diagnostic centers. Both parties were members of the Michigan FASD State Task Force and CARE referred children, youth, and families to FASD diagnostic centers using the Michigan FASD Pre-Screening tool developed by the Michigan FASD State Task Force. There was not much follow-up or ongoing communication at that time.</p> <ul style="list-style-type: none"> <li>• CARE now experiences a supportive and defined relationship with the diagnostic centers. Significant advances include: <ul style="list-style-type: none"> <li>▪ Diagnostic team staff participate and find value in the Northrop Grumman Diagnostic Learning Community bi-monthly conference calls;</li> <li>▪ CARE observed an FASD diagnostic evaluation at each of the three referral sites.</li> <li>▪ Children's Trauma Assessment Center (CTAC) expedites CARE referrals and has "tweaked" their intake process to include an immediate email correspondence to CARE's FASD Case Manager to communicate receipt of the intake packet and provide the client's scheduled diagnostic evaluation date.</li> <li>▪ CARE built upon its existing relationship with Henry Ford Health System Center for Autism and Developmental Disabilities (CADD) whereas in October 2011, CARE can refer children with a positive FASD screen to CADD for a comprehensive, multi-disciplinary diagnostic evaluation. CARE will use a portion of its service delivery funds to cover the cost of the neuropsychological exam for each child. CADD has agreed to use its grant funds to offset the remaining out-of-pocket costs for the evaluation.</li> </ul> </li> </ul>
<p>Service delivery processes (parent engagement, modification of existing case plans or development of new plans, new clinical techniques, case management, etc.)</p>	<ul style="list-style-type: none"> <li>• Prior to the subcontract, CARE did not previously provide case managed interventions. CARE referred families to diagnostic centers for evaluation, but did not have the resources to follow-up with a family. CARE did not have the resources in staff time and expertise to develop a service plan and assist in obtaining interventions.</li> <li>• CARE now has one full-time and one part-time FASD Case Manager. CARE utilizes technology, its TIER database that did not exist previously, to help manage a caseload of clients diagnosed with FASD. CARE</li> </ul>

	<p>developed a multi-level case management model where the case manager works with the family step-by-step in the process. Case management is more structured, defined and managed; and families remain engaged.</p> <ul style="list-style-type: none"> <li>• The FASD Case Manager meets with the client/family and reviews the diagnostic evaluation report. The FASD Case Manager works with the family to complete a FACKL<sup>®</sup> assessment, and a summary map, leading to the initial service plan. This plan is an active document and as goals are reached, new goals may be added depending on the multitude of diagnostic recommendations. Again, this process did not exist prior to the implementation of the initiative.</li> <li>• For children diagnosed with an FASD where behavior is an area of concern noted in the diagnostic report, CARE provides and funds 4 sessions with a behavioral consultant either in the home setting, school setting, or both. Families express great benefit in this hands-on, skill-building approach.</li> </ul>
<p>Data Systems (integration of program data, centralization, etc.)</p>	<ul style="list-style-type: none"> <li>• Technology to assist in data management was absent prior to this initiative. The Northrop Grumman supplied Access database along with the internal database TIER is used daily by FASD staff to manage and evaluate the initiative.</li> </ul>
<p>Staffing (new training focuses, refresher training, staffing structures, qualifications for new hires, training for service providers, etc.)</p>	<ul style="list-style-type: none"> <li>• All new staff, and interns, receives an overview as part of their New-Hire Orientation, occurring quarterly at CARE. Updates on the FASD initiative are provided bi-weekly to clinical staff and monthly to all staff during CARE's monthly All Staff meeting. Prior to this initiative, an FASD staff in-service was infrequently provided.</li> <li>• Newly hired FASD staff receives training on the foundation of FASD, policies and procedures, as well as the requirements of the FASD intervention initiative within the first month of hiring.</li> <li>• CARE invests in its workforce. Upon recognition of barriers to client referrals for screening, CARE management re-assigned direct supervision of the initiative into its Clinical department resulting in a better fit of activities and staff relationship building among shared clients. CARE sought out and received training for its clinical staff and case managers to learn more about FASD, screening, and how to engage families in discussing alcohol use and prenatal</li> </ul>

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## Final Word

CARE, its staff, and community partners have built a best practice model of community-based FASD screening, diagnosis and interventions. CARE has enhanced this model with the inclusion of a multi-level case management approach in serving children in long-term care.

FASD ACHIEVE is changing how Southeastern Michigan children are served, and more importantly, is laying a foundation for lifelong achievement for a child, age 0-7, diagnosed with an FASD.

## FASD Diagnosis and Intervention Monthly Report Table

	Between 7/1/2011 and 7/31/2011	Option Year 1	Option Year 2	Option Year 3	Option Year 4	Totals to Date
<b>Screening and Referral for Diagnosis</b>						
1. Total clients screened for an FASD	3	27	24	120	0	171
2. Clients with a positive FASD screen	3	24	17	40	0	81
3. Clients placed in positive monitor (+ monitor)	0	2	4	2	0	8
4. Clients moved from positive monitor to positive FASD screen	0	1	0	0	0	1
5. Total number of clients with a positive FASD screen	3	25	17	40	0	82
<b>Diagnostic Evaluation</b>						
6. Number of clients referred for diagnosis	7	21	13	25	0	59
7. Number of clients with completed diagnostic evaluations	3	20	11	12	0	43
8. Number of diagnostic evaluations with written reports completed	0	20	9	6	0	35
9. Number of clients diagnosed with an FASD	0	11	7	6	0	24
10. Number of clients diagnosed with an FASD and other diagnoses	0	8	3	1	0	12
11. Number of clients receiving a diagnosis other than an FASD	0	9	0	0	0	9
12. Number of clients not receiving any diagnosis	0	0	2	0	0	2
<b>Interventions</b>						
13. Number of clients received interventions	19	4	13	23	2	23
14. Number reporting as lost to follow up after positive monitor and before positive screen		0	1	0	2	0 3
15. Number reporting as lost to follow-up after positive screen and before diagnosis		0	5	6	1	0 12
16. Number reporting as lost to follow-up after diagnosis and before intervention		0	2	0	0	0 2
17. Number of clients diagnosed and received some intervention services but no longer accessible for services		0	2	2	4	0 4

	<b>Number Referred for Screening</b>	<b>% Referred for Screening</b>	<b>Total Entering Service</b>
Total N/% of children/adolescents entering service who are referred for screening (between 8/1/2010 and 7/31/2011)	120	71%	170