

White Earth

OY 3 Annual Report

Diagnosis and Intervention Subcontract

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Option Year 3 Annual Report for Diagnosis and Intervention Subcontractors-White Earth

1. Executive Summary

a. Brief Overview of Objectives

The White Earth FASD Project screens, diagnoses, and provides interventions to dependent children, ages 0-7, who are in protective custody of the White Earth Tribal Court, primarily in the foster care system.

b. Methods

The primary objective in OY3 was to screen all children coming through the court; however, this was not always possible as the project began seeing more cases closed out in court prior to the completion of screening. In addition, children were lost during the period of time when interventions were being provided. Sixteen children were lost in the process from screening to intervention. Many actions were taken to increase the number of children making it all the way through the process. Despite these attempts, it is now apparent that this challenge with these court-ordered cases will continue in option year 4.

During option year 3, the courts also began ordering early developmental screenings, which contributed to the completion of more timely and efficient FASD screenings. It is suspected that higher numbers of completed developmental screenings accounted for the placement of fewer children in positive monitor status and many more children screening positive and thus being identified earlier.

Along with the screening of children came an alarming increase in the number of children screening positive for drugs only with developmental delays. Minnesota diagnostic clinics require confirmed prenatal alcohol use for a referral for an FASD diagnostic evaluation. Children who screen positive for drugs but not alcohol are referred to other agencies for services. Accordingly, the project does not refer children without confirmed prenatal alcohol exposure for diagnostic evaluation, instead basing referrals on early developmental screening recommendations.

c. Accomplishments and Discussion

One of the great assets of the White Earth FASD project has been its diagnostic clinic located within the boundaries of the White Earth Reservation. The White Earth Diagnostic Clinic originated with funds provided by the Minnesota Organization on Fetal Alcohol Spectrums (MOFAS) but for the majority of option year 3 was funded through state Medicare reimbursement dollars. The clinic is fully functional with pediatrician and psychology services provided in-kind by Indian Health Services and two school psychology students that complete the testing. The project has been fortunate in having its own clinic in the community. There are limited to no wait times, and families do not have to travel great distances to complete the evaluation process. The White Earth Diagnostic Clinic is open every other month and evaluates four to five children annually that are referred by the White Earth FASD project.

Providing interventions to the target population is critical to ensuring that children have

successful outcomes. Although the number of children diagnosed with an FASD has been low, children diagnosed with an FASD did receive interventions. In addition, some children were receiving interventions through other systems prior to the FASD diagnoses. When this occurred, the FASD program and the existing service provider collaborated to ensure that the FASD recommendations were met.

The FASD Task Force is responsible for oversight of the FASD subcontract and the FASD OJJDP grant. In option year 3, the challenge was to look at ways to strengthen task force involvement. With representation from the health department, Indian Child Welfare and the court, an executive committee was established to increase leadership and direction from key stakeholders while optimizing the use of their time. For example, in the process of sustainability planning, it was important to obtain input from leadership regarding how to proceed and ensure their consensus regarding post-subcontract goals and outcomes. This was accomplished through individual meetings between the project director and each executive committee member. The intent for option year 4 is to bring executive committee members together and to facilitate their collaboration for the future of the FASD initiative. Task force subcommittees established during option year 2 continued to meet in option year 3: Early Intervention, Intervention and Diagnostic. In option year 4, a Sustainability Subcommittee will be established to ensure successful and timely implementation of the sustainability plan.

In option year 3, the project increased its focus on sustainability of the FASD initiative. Discussions took place with executive committee members, particularly the Director of the Health Department in which the FASD subcontract is housed. These discussions were critical to begin the development of a working sustainability plan. As a result of these discussions, a decision was made to ask for assistance from the SAMHSA Native American Center for Excellence (NACE) to work on bringing key project partners together to openly discuss the future of the FASD initiative. NACE, the SAMHSA FASD Center for Excellence and the White Earth FASD Project Director began collaborating to address sustainability. This initial work led to a plan to gather the tribal agencies currently involved in the FASD initiative or with potential for future involvement in the process of screening, diagnosing and/or providing interventions to children for the purpose of collaboration on sustainability. A sustainability planning meeting was scheduled for option year 4 (October 4, 2011) with NACE and SAMHSA FASD Center for Excellence staff co-facilitating the training and discussion. The goal of the October 4 meeting will be to bring all of the tribal leaders together to focus on FASD and to formulate and agree on an action plan to guide planning toward full sustainability after the end of the FASD subcontract.

White Earth Tribal Court, Indian Child Welfare and Health Department leaders have added the FASD initiative to their full rosters of activities. It has been challenging to bring executive committee members face-to-face and fully engage them as a team. Separate meetings between the project director and each committee member have elicited input when needed, but they do not provide opportunities for collective planning. Efforts to increase collaboration among executive team members will increase in option year 4 when it will be even more critical to have a clear direction and plan for sustaining the FASD initiative.

One of the methods that have been critical in every option year is providing the necessary training and support to project staff. Due to high turnover, there is a need to train and re-train staff on FASD screening. In addition, White Earth has an Office of Juvenile Justice and

Delinquency) Prevention grant that provides FASD services to youth between the ages of 8 and 18 in the juvenile justice system. Training provided through this grant is open to FASD subcontract staff as an in-kind service. MOFAS has also provided training in-kind to diagnostic staff, who benefit from keeping abreast of new developments in the field of FASD. An initiative was launched in option year 2 to key partners Indian Child Welfare, Tribal Substance Abuse and Oshki Manidoo, a tribal inpatient treatment facility for youth. Initial screening trainings were provided for these sites in option year 2, but the intent in option year 3 is to make this an annual event with a particular focus on new staff. Project staff conducted a group training for Indian Child Welfare staff, but most training was provided on an individual basis.

Other option year highlights include:

- Screening staff began utilizing the support staff for assistance in completing more timely referrals to clinics once a positive screen was established. Great emphasis was placed on providing ongoing support to the case manager with weekly clinical and administrative supervision.
- Greater attention was paid to how staff proceeded with gathering prenatal confirmation. Prior to OY3, less effort was applied to locating and speaking to the biological mother. Most information was obtained through Indian Child Welfare records or by the verbal confirmation of the worker. In OY3, procedures were changed that made it mandatory for workers to make active efforts to locate and speak to the biological mother when appropriate. The goal in OY4 will be to further support staff in this effort and provide them with motivational interviewing techniques to assist them in having such a sensitive conversation with mothers.

2. Key Client Results

- a. **Target Population:** The total number of children entering the project was 52. The actual number of children ordered to complete the screening is unknown as some cases are closed out in court prior to provision of notification of an order to the project.
 - i. **Race:** All 52 were identified as American Indian. This is the only population serviced by this project as cases are received from tribal court, which only serves individuals who are either enrolled in or descendents of the White Earth Indian reservation. Some identify themselves as two races (e.g., one American Indian and African American; 12 American Indian and White).
 - ii. **Age:** Average age at time of screening was 3 years old. This is typical; in previous years, the project served relatively equal numbers of very young children up to the age of 7.
 - iii. **Residential Status:** In OY3, 65% (34/52) of children were reportedly residing in single parent households at the time of screening. This number was somewhat surprising given that a large percentage of children in this age group are residing not with their biological parents but in out-of-home care. Many of these children are in out-of-home care with relatives where one would not necessarily see the “traditional” two-parent household.

- iv. Placement Moves: The average number of placement moves among children entering the project was one in OY3, much lower than OY2. In OY2, many children entered the project that had already experienced multiple placements. The decrease may be a result of the project's more timely receipt of court orders, which increased the likelihood of completing screenings at the beginning stages of entrance into the child welfare system.

b. **Screening**

A large number of children screen positive for only drug exposure which can be a proxy for alcohol exposure; however, the diagnostic center requires confirmed prenatal alcohol exposure to make a diagnosis on the spectrum.

- i. # of children screened to determine eligibility for referral for a diagnostic evaluation: 52 children were screened in OY3 compared to 87 children screened in OY2. The decrease can be correlated with the higher number of children who had entered the system previously and were already screened or may reflect the number of children closed out in court before entering the project. The increased length of time to receive a court order to complete the screening may have been a contributing factor.
- ii. # of children screened positive: 17% of children screened positive (9/52). This was dramatically lower than in OY2, when 41% (36/87) screened positive. Several cases were still in the process of being screened and thus are not reflected in the database. Another reason for this decrease is that this project has seen a much larger number of very young children (under the age of 1) that were drug exposed with no confirmed developmental delays and thus were documented as a negative screen in the database.
- iii. # of children placed in positive monitor: In OY3, six children had confirmed alcohol exposure with no developmental delays. This number was relatively low in part because of the large number of drug exposed-only children. Children in positive monitor status are routinely re-evaluated for developmental delays through the project's collaboration with other existing systems (Home Health, Early Intervention) that assist in the monitoring.
- iv. # of children moved from positive monitor to positive screen: No children moved into positive monitor status in OY3.

c. **Diagnosis**

- i. # of children referred for an FASD diagnostic evaluation: 56% (5/9) of children screened positive were referred for an FASD evaluation. Four children were lost or closed out by the court prior to being referred for the evaluation and no longer are in the target population.
- ii. # of children with completed FASD diagnostic evaluations: Of the 5 children referred, 100% (5/5) had completed diagnostic evaluations.

- iii. # of children diagnosed with an FASD: Out of the 5 children that had completed diagnostic evaluations, 40% (2/5) received an FASD diagnosis.
- iv. # of children diagnosed with both an FASD and other diagnoses: Two of the 5 children who received an FASD diagnosis were diagnosed with another disorder as well.
- v. # of children with a diagnosis other than FASD: No children received a diagnosis other than an FASD.
- vi. # of children evaluated who did not get any diagnosis: Out of the 5 children with completed diagnostic evaluations, 40% (2/5) did not meet the criteria for any diagnosis.

d. **Intervention Services**

- i. # of children with an FASD diagnosis who agreed to participate in intervention: Two children were diagnosed with an FASD; both received intervention services.
- ii. # of children who agreed to participate in at least one intervention: Out of the two children who agreed to participate in intervention services, one actually participated in at least one session.
- iii. # of children who completed intervention services¹: The one child that received intervention services also completed all recommended services, and the case closed.
- iv. # of children who are currently involved in intervention services (all or some services in process): At the present time, four children are receiving intervention services through the project.
- v. Baseline characteristics based on age and population (school attendance, housing placement, day care placements, restrictive placements, number of petition offenses, and number of adjudicated charges in the 6 months prior to completing the baseline questionnaire): Of the two children who agreed to participate in interventions, one child was documented as having one placement change at baseline, and the second child was documented as having 2-3 placement changes in the 6 months prior to providing interventions.

e. **Outcomes²**

¹ Program completers include all participants who have reported completing services as recommended or who received services until program exit (i.e., left the service system and completed an end of service form.)

² This data will be shown as improvements over time, with dosage noted.

- i. Based on age and population (school attendance, housing placement, day care placements, restrictive placements, number of petition offenses, and number of adjudicated charges in the 6 months prior to every six month follow-up during the provision of intervention services, and at end of program, and 6-month and 12-month follow-ups): There were no interim or end-of-service outcomes documented for the one child who participated in intervention services. The child did not participate in intervention services long enough to gather measures past baseline.
- ii. Of the total service provider ratings, #/% of ratings across the improvement rating scale categories at six-month follow-ups during the provision of intervention services, and at end of program, and 6-month and 12-month follow-ups: For the one child documented as completing interventions, there were no end-of-service outcome measures completed as the child did not participate in interventions long enough for the service provider to gain any perception of progress.

3. Program Description

a. Population Needs Identified and Addressed

- i. Population needs identified at the start of the project:

The goal of the initial needs assessment was to learn how to improve outcomes for dependent children ages 0-7 in protection of the tribal court. The assessment examined the delivery system of screening, diagnosis, interventions, and to gain a better understanding of the characteristics, needs, preferences of, and influences on families involved in the White Earth Tribal Court. Dependent children were identified as those children currently involved in the Indian child Welfare department, including those children in need of protection (CHIPS), adoptive placements, and foster children. The goals of the initiative were twofold: increase the child's developmental progress and increase the stability of the child at home, school, and community. Prior to the initiative, the White Earth Tribal Court was ordering some FASD evaluations for children in adoptive placements (screened 25% of the time) with very few other children being screened. If children were diagnosed, there were no intervention services available to the identified.
- ii. How population needs were addressed:

In year 1, tribal court adopted a standard order making it mandatory that all children (adoptive, CHIPS, foster care) be screened for an FASD. A case manager was hired through the initiative to work with the families and children who received a diagnosis to ensure that the child's needs were being met. Procedures about process were established between tribal court, Indian Child Welfare, and the project to ensure that all children in the target population were screened efficiently and effectively. In order for this to be achieved, it was critical in the beginning that a working agreement was put in place between these agencies to make the process as seamless as possible. The project relied heavily on the information obtained from Indian Child Welfare in order to access the child to complete the screening and the biological mother to obtain prenatal alcohol exposure. When biological mom was not available, the project has relied heavily on the court information and other case

file information in order to obtain a positive screen. In year 2, the project continued to improve the delivery of services with an emphasis on setting up a process to effectively monitor those children 0-3 where there has been confirmed prenatal alcohol exposure, but no documented developmental delays. Intervention services were also a focus in OY2 with the goal of setting up standards for the delivery of services to children diagnosed with an FASD. This included working in collaboration with existing tribal service providers to ensure that the identified children received the services necessary to best meet their needs.

- iii. How needs have changed since first identified and how they will be addressed by the initiative: One key element identified in OY3 was the sheer number of children entering the project that had already been identified by the court as having been drug-exposed. Once the project receives these cases, confirmation of any alcohol use is identified and any developmental delays are noted through receipt of the early intervention evaluation that is completed as standard on all children entering the tribal court system. The process of making it mandatory that all children entering tribal court be ordered to complete an early intervention evaluation has been critical to this project in completing more thorough and timely screenings. Prior to the screenings, it was difficult to get children through the project in a timely manner as typically the worker had to make the early intervention referral and then wait for the results which could sometimes take months. This wait time just added to the number of children that were in “limbo” waiting to get through the screening process, and several children were lost partially due to waiting on verification of any developmental delays. Another key issue impacting our population was that 16 of the children that entered the project were documented as being lost to follow-up because of the cases being closed out in court prior to the child’s completion of the entire process. This had been an issue in the previous years as well but did not seem to impact the level of care to the degree it had in OY3. One of the components decreasing this impact has been the timely receipt of court orders, making the process much more efficient and getting the children through the process much more quickly. In addition, more effort was made by project staff to communicate with the courts and Indian Child Welfare regarding the status of the case and the child’s place in the process so there were fewer opportunities for miscommunication. Another strategy implemented was scheduling quarterly meetings with tribal court and Indian Child Welfare to alleviate any other miscommunication and to formulate a plan when there were process issues.

b. **Service delivery process**

- i. Process used to refer children for screening: The referrals for screenings continue to originate from the tribal court, and only those children that are identified as dependent children of the court are referred to the project. The only process delivery component that has been changed is how the initiative is notified on children needing to be screened. Prior to OY3, staff would receive the court schedule and would need to attend court when an initial hearing was scheduled. This took a lot of time for staff and typically didn’t ensure that there would be the opportunity to complete the screening on site. A primary reason for staff attending these was to track children as many times the court orders containing the court-

ordered FASD screenings were not received until sometimes months later. There were several discussions and meetings regarding the importance of receiving the court order in a more timely manner and how not having them was having a negative impact on the number of children getting through the process. The end result of these discussions was that the judge issued a court order for the FASD staff at the end of each hearing so that staff could pursue the screening immediately. In recent months this is no longer the case, but staff are receiving the official court order within a day or so following the court ordering the FASD screening. The impact of this will be that FASD staff will be able to complete screening in a much more timely manner and get children all the way through the process before the case is closed out in court. Obviously, there are still going to be cases that close out prior to completion; however, the new process will lessen this occurrence.

ii. Process used to screen children:

The FASD screener receives the referral from the court and will make contact with Indian Child Welfare to see whether they have documented confirmation of alcohol use (legal documents, case notes, etc.). If not, contact information for the mother will be obtained and the screener will make every effort to speak to mom about prenatal alcohol use. If prenatal alcohol use is obtained from mom or another reliable source, the screener will schedule to take pictures of the child and complete the intake packet. If no confirmation is obtained and all avenues exhausted, the case is closed with the court and ICW being notified.

iii. Process used by project for referrals for diagnostic evaluations:

The screener obtains the confirmation of prenatal alcohol use and completes the intake packet. The intake packet includes a structured interview with the guardian or primary caretaker of the child, birth, medical, mental health, school, and other records that would be relevant for the diagnostic evaluation. Once a file is deemed complete with all required information, the file information is forwarded to the diagnostic team. If the child is referred to an outside diagnostic clinic, the screener would obtain the required packet used by that clinic and assist in obtaining all records. Once all records are obtained, the packet is sent to the designated clinic coordinator. Outside clinics are occasionally utilized when it is demographically makes sense as many of the children in tribal court are living outside of the reservation boundaries.

iv. Process used by project to provide intervention services to children diagnosed with an FASD:

Once a diagnosis of FASD is made, a referral is completed and sent to the FASD case manager. The case manager works with Indian Child Welfare to ensure that the necessary services are obtained, are effective, and are coordinated to decrease duplication. Intervention services are closed when the case is closed in tribal court or the intervention goals are met, whichever occurs first. If the case is closed in tribal court before the intervention goals are met, the case can be referred to tribal

mental health services for continued case management and/or other services that are appropriate for the child and family.

- v. Process used to track services provided to children diagnosed with an FASD:
All services provided to children in the project are tracked in the SAMHSA approved database. The FASD case manager's job responsibilities include making referrals to other service providers, ensuring that the requested services are meeting the needs adequately, and coordinating these services in a way that works for the family and child. Case notes are also completed by the case manager documenting any exchange regarding the case (phone, collateral, face-to-face) and kept in a hard copy that is only accessible to the case manager and project manager.
- vi. Processes program uses for administering outcome assessments, including baseline, interim, end-of-service, six-month and twelve-month follow-up assessments:
All out come assessment data is gathered by the case manager. The baseline is gathered by telephoning the schools to obtain days of school attendance and any expulsion/suspension information. The placement data is obtained by telephoning and/or emailing Indian Child Welfare who is the placing agency. Once this information is initially gathered and entered into the SAMHSA- approved database, a secondary database system (Microsoft Outlook) is utilized that displays a reminder when follow-up data is needed on a child. Since intervention services have been more recent for this project, the post-service follow-up assessments have not yet been completed, but will certainly be a goal in the final year of the project.

c. **Staff Training**

In implementing the project:

- i. Need for staff training in implementing the program: In OY3 the project experienced some consistency in staff that was not found in the previous years. The project was fortunate to have one case manager from the middle of OY2 through OY3 which certainly assisted in formulating and implementing more procedures that had a positive impact on service delivery. With the consistency in staff, the project was not as consumed with trainings but more on developing procedures. Staff also participated in internal trainings throughout OY3 that included cultural traditions in working with Native American families and ongoing formal and informal support from the program manager.
- ii. Northrop Grumman-sponsored trainings received and the extent to which training satisfied project needs: The case manager and program manager participated in all teleconference calls provided by Northrop Grumman.
 - i. Additional internal training provided to staff implementing program: During OY3, project staff did complete the state requirements for case manager training, which was needed in order to bill for services provided by the case manager. These trainings were offered through the Minnesota Department of

Human Services. Another external training that program staff took part in was Motivation Interviewing specific to the Native American culture. This was seen as beneficial for staff in how to effectively and sensitively talk to women about alcohol use.

iii. Remaining unmet training needs in database entry and reporting:

- i. Need for staff training in database entry and reporting: There are currently no additional training needs due to the high degree of staff competency in this area which is in part due to having stability in the position.
- ii. Northrop Grumman-sponsored trainings in data entry and reporting and extent to which these trainings satisfied project needs: Database training was provided to the case manager.
- iii. Additional internal training in data entry and reporting provided to project staff: Training will be provided to project staff that will focus on the development of a process for relocating children and families after they leave the project.
- iv. Remaining unmet training needs in data entry or reporting: None

d. **Task force and stakeholder needs/insights/implications for service delivery**

- i. Stakeholders involved in the project: The key stakeholders include the tribal health division, Indian Child Welfare, Tribal Court. Other stakeholders include the local schools, tribal home health, tribal mental health, tribal substance abuse, tribal head start programs, tribal child care, Early Intervention services, and Indian Health Services.
- ii. Input stakeholders provide: The task force in OY3 has been much more engaged than in previous years with the addition of task force subcommittees. These subcommittees were formulated at the end of OY2 but really began working in OY3. These subcommittees have been key in setting up a process for the further monitoring of children in positive monitor status, investigating and formulating an FASD-specific resource manual for families and resource providers, and researching and implementing an FASD curriculum in the local schools, and they have provided a great deal of guidance in planning for OY4. One of the areas of focus for this coming year will be to keep the executive committee (tribal court, Indian Child Welfare, Health Division) informed and actively engaged as the project works through the sustainability planning and ongoing integration of the project into existing systems.
- iii. Any services provided to stakeholders as a result of this initiative:
This initiative has provided the stakeholders with a number of training opportunities related to FASD. The internal trainings have been offered to many of the tribal agencies that have focused on what to look for when identifying a child with a

possible FASD to providing the most effective interventions for this population. In the final year of the project, it is anticipated that many more children will be reached as the screenings will expand to include screening all children that enter any of the tribal programs. It is expected that screening children in multiple settings will identify children early. This early identification is expected to minimize unnecessary strains on these systems where services have been expended without positive outcomes.

e. **Lessons Learned**

i. **Main Lessons Learned:**

OY3 was the first full year that intervention services were provided by the project, and with this new endeavor came some unexpected findings. The biggest surprise was that as children were being diagnosed and intervention services were offered, we were finding increased involvement from other systems because of these children's needs. This has been positive in that these multiple-needs children have options for services, and collaboration has increased among service delivery systems.

Another big lesson was our perception that because these screenings are court-ordered we would have limited difficulty in ensuring that all court-ordered children were screened was incorrect. Many cases referred from court with Indian Child Welfare involvement have been non-compliant and closed by the project. This has negatively impacted the screening numbers. Lastly, another key lesson learned has been the extreme difficulty in obtaining prenatal alcohol exposure confirmation. This became more evident in OY3 when the project began seeing an increase in confirmed drug exposure but not in confirmed alcohol exposure. The project then had to make some adjustments in the process to ensure that children with drug exposure only were being evaluated and receiving services from other providers when appropriate.

ii. **Top Accomplishments:**

The project is unique in that screenings are being ordered by the tribal court. This project has been able to provide early detection and intervention services to children and families. Without the early screenings, many of the affected children would have gone undetected until years later, likely when they were already exhibiting difficulties. Another accomplishment is that this project has put the topic of FASD in the forefront and that other service providers are now thinking about this as a possibility to rule out when working with children. Although there is always room for improvement, this project has also effected positive change in the way in which tribal providers are communicating about FASD and taking some positive action. This can be seen in the way that various tribal agencies are coming together to continue the project past May 2012 and by their commitment to enhance the target population by incorporating the screenings into their existing screening protocol. Finally, although the intervention component of the project was slow in taking off, the project is seeing an increasing number of intervention cases. This is positive in two ways: Due to the project's heightened visibility in the community, professionals know they can turn to the project when needing support and guidance for families

and other providers; and secondly, there are increased reimbursement opportunities for the project with the movement toward sustainability.

iii. Model Approaches:

The receipt of referrals from the court and way in which screenings are included as a standard court order are models for other courts. Additionally, the standard by which children are diagnosed on the reservation may be quite different than other programs as White Earth is fortunate to have its own FASD clinic designed to be culturally specific in meeting the unique needs of the people of the White Earth Indian reservation. The White Earth Project directly offers services along a full continuum of care from screenings to interventions that are culturally sensitive.

4. Project Changes

Change Category	Description of Change
State/local policies and procedures	Tribal court make it a standard order that all dependent children of tribal court will be screened for an FASD. This is possible due to the support of tribal court and, more specifically, the chief judge, who worked to get everyone else on board. This change has been integral to combat the traditional messages given to women that occasional drinking is okay and also sends the message that the tribe is there to support and not condemn the mother.
Organizational policies and procedures (agency policy, Task Force, partner agreements)	This initiative has increased the overall communication among tribal agencies and has specifically increased the awareness and knowledge of FASD. The increase in communication has brought agencies together to work toward one common goal and have encouraged agencies to work together that would have not normally done so. There have been verbal agreements put in place with some agencies, such as tribal mental health, Indian Child Welfare, and Tribal Court to process policies necessary to increase the likelihood that the child will make it through the system before case closure and to further ensure that services provided are not being duplicated.
Systems integration (intake, screening, case	One of the areas that were focused on more in OY3 was agency collaboration. Educating other tribal providers has been

<p>coordination, agency collaboration, internal and external system referrals, diagnostic team/center, etc.)</p>	<p>necessary in order to really coordinate our efforts. For example, Indian Child Welfare is also a case manager to the child, so clear boundaries are needed that outline who provides which services to eliminate confusion for the families. This has also been the case with tribal mental health as they also provide Children’s Mental Health-Case Management services, so it has been critical to communicate with them when a child has an FASD diagnosis to ensure there is no duplication of services, resulting in less confusion for families.</p>
<p>Service delivery processes (parent engagement, modification of existing case plans or development of new plans, new clinical techniques, case management, etc.)</p>	<p>One of the areas that have been a focus for the project this year and will continue to be a focus is engaging families and finding creative ways to keep the families engaged. One of the primary drawbacks of having the FASD screenings court-ordered is that many families that come to the project involuntarily. Program staff have to be well-equipped to handle an array of situations that may include defensiveness and occasionally hostile clients. One technique that staff utilizes to engage a family is really being present with the person and building a trusting, respectful working relationship. In the development of case plans, it is highly encouraged that families have equal input into the plan even if the goal does not directly correlate with the FASD evaluation. This is critical in getting the family to engage and have some level of ownership in the plan.</p>
<p>Data Systems (integration of program data, centralization, etc.)</p>	<p>This is one area that has not been easy for this project, which works within so many other divisions where data is not shared. For instance, Indian Child Welfare utilizes the state child welfare database that does not share data with other systems; there are very strict protocols regarding who accesses it. This initiative is administratively located within the Health Division, which utilizes the same database, but there are still limits to who can access the information. There continues to be a need for a database system that fully integrates the health division; work on this is currently underway. The new system would be shared so programs could see others are doing with the goal of minimizing duplication of services.</p>
<p>Staffing (new training focuses, refresher</p>	<p>There is currently no structured training course that is mandatory for existing staff; however, for new staff, it is mandatory to obtain</p>

<p>training, staffing structures, qualifications for new hires, training for service providers, etc.)</p>	<p>40 hours of state case management training within the first six months of employment. Since the inception of this initiative, one of the more impactful changes made was requiring that the qualified candidate have a four-year degree in social work or a related field. This was a priority given the state guidelines for reimbursement under Medicaid for Mental Health Targeted Case Management and is critical for the future of the initiative. In the new employee orientation, it is important to provide training on FASD 101 and cultural training specific to the population served. There is currently no specific schedule for training other service providers; this is scheduled based on the specified need. Some service providers have requested more training than others, and in other agencies, the training focus is more on educating staff about the initiative and integration of service delivery.</p>
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5. Appendix

a. Additional Report Measure

	Number Referred for Screening	% Referred for Screening	Total Entering Service
Total N/% of children/adolescents entering service who are referred for screening	62	87%	54

b. Report Table

FASD Diagnosis and Intervention Monthly Report with Crosswalk

	Option Year 3 Between 8/1/2010 and 7/31/2011
I. Screening	
1. Clients screened for an FASD	54
2. Clients with a positive FASD screen	17
3. Clients placed in positive monitor (+ monitor)	5
4. Clients moved from positive monitor to positive FASD screen	0
5. Total Number of clients with a positive FASD Screen	17
II. Diagnosis	
6. Number of clients referred for diagnosis	14
7. Number of clients with completed diagnostic evaluations	27
8. Number of diagnostic evaluations with written reports completed	28
9. Number of clients diagnosed with an FASD	13
10. Number of clients diagnosed with an FASD and other diagnoses	11
11. Number of clients receiving a diagnosis other than an FASD	2
12. Number of clients not receiving any diagnosis	12
III. Intervention Services	
13. Number of clients receiving interventions	6
14. Number reporting as lost to follow up after positive monitor and before positive screen	8
15. Number reporting as lost to follow-up after positive screen and before diagnosis	11
16. Number reporting as lost to follow-up after diagnosis and before intervention	5
17. Number of clients diagnosed and received some intervention services but no longer accessible for services	7

