

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH

FASD Diagnosis and Intervention Subcontractor

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

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## **1. Executive Summary**

### **A. Intervention Type:** State FASD Diagnosis and Intervention

### **B. Project Contact Information**

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### **C. Project Summary Statement**

The major goal of this initiative is *to improve the functioning and quality of life of children and youth and their families by diagnosing those with an FASD and providing interventions based on the diagnosis.* The target population to be screened for FASD is children up to seven years of age who are admitted for services by one of the 15 Community Mental Health Centers (CMHC) in Mississippi. The service delivery system for this initiative is being incorporated into the statewide System of Care for children and youth in Mississippi that includes the MAP Team structure. There are currently 43 MAP Teams operating in the state serving all 82 counties as a functional component of each of the 15 CMHCs. MAP Teams exist to serve children and youth with serious emotional/behavioral disorders (SED) who require services from multiple agencies and multiple program systems and who can be successfully diverted from inappropriate institutional placement. Through this statewide system of care, we have integrated identification, diagnosis and treatment of children ages birth to 7 with FASD.

### **D. Objectives**

At least 95% of the children age birth to 7 diagnosed with an FASD will receive FASD specific intervention services as specified in their individualized treatment plans. At least 80% of children age 0-7 diagnosed with an FASD and receiving intervention services will remain in their home / community placement. At least 10% of families/caregivers of children birth to 7 who are diagnosed with FASD will experience less strain and stress in social/family relationships as measured on the Caregiver Strain Questionnaire (CGSQ). At least 75% of children ages 6-7 diagnosed with an FASD and receiving treatment will demonstrate improvement in school performance by improving 10 points on the standard achievement test at intake and end of school year. At least 60% of Children ages 3-7 diagnosed with an FASD and receiving treatment will improve functioning by 5 points or more on the Global Assessment Functioning Scale for Children (C-GAF).

### **E. Methods**

Services and activities implemented during OY3 included (1) Implementing process and protocol for referral to UMC for evaluation and for reporting diagnostic results and recommendations; (2) Implementing specific diagnostic protocol; (3) Coordinate interventions and treatment recommendations; (4) Initiate outcome measures/ outcomes evaluation plan; (5) Provide oversight and, as needed, modifications to project

implementation; (6) Implement the integration of project activities into the state's existing coordinated system of care for children.

Policies that were developed and enacted by the FASD project included: requiring community mental health providers to develop and implement an FASD screening, diagnosis, and intervention process and plan for children served through Day Treatment and other community mental health services; requiring all CMHCs to screen every child enrolled for services for FASD in conjunction with the intake process; requiring all MAP Teams to help coordinate intervention services for youth identified with FASD; requiring monthly and other CMHC and MAP Team reports to include FASD-specific data and additional demographic data as needed; requiring the inclusion of FASD screening, diagnosis and treatment for all community mental health service providers that are certified by DMH; and improving/enhancing FASD-specific data collection surveillance system.

#### **F. Current Accomplishments**

All 15 of the Community Mental Health Centers across the state are fully engaged in the FASD screening, diagnosis, and treatment initiative. During OY3, 1,661 children were screened, 43 were diagnosed with an FASD, and 60 received intervention services (this includes children diagnosed in a previous operational year). Through systematic statewide training, we've equipped case managers and other service staff at the CMHC's to be able to participate in the diagnostic evaluation process, modify the existing treatment and/or service plan to include treatment recommendations resulting from the diagnostic evaluation, and initiate services and treatment recommendations. The FASD database provided by NGC serves as a single statewide database in order to fully support the statewide nature of our project and to help ensure sustainability. Flexible funding is made available to the local CMHCs and MAP Teams in order to cover any FASD-related costs that are not otherwise covered by another funding source. This helps ensure that all recommended services can be provided without the related cost being seen as a barrier. During OY3, the FASD database was fully engaged to capture and report all of the data through a single statewide database. Significant progress was made throughout OY3 to increase the quantity and the timeliness of the FASD information being submitted by the local CMHCs in order to increase the overall quality of data in the database. This high level of commitment to the statewide database will continue throughout OY4.

#### **G. Comments**

With the implementation of the FASD initiative in Mississippi, we have taken several bold steps. First, we have included FASD screening, diagnosis and treatment activities into the Department of Mental Health's Operational Standards making these services mandatory for all community mental health providers. Second, we are using our existing MDMH Community Mental Health System of Care (through our MAP Teams) as a primary resource for the treatment of children with an FASD. Finally, we have capitalized on the existing FASD diagnostic capacity at the University of Mississippi Medical Center Child Development Clinic for the diagnostic component of the project. We believe these specific steps, along with the continued efforts of the MDMH, will help build a future for children in Mississippi with an FASD.

## 2. Key Client Results

*For this section, please refer to Appendix A, Table 1 Summary Report: Mississippi and to various sections of the Implementation Plan OY3 as indicated.*

### **a. Target Population.**

The target population for this initiative is children birth to 7 who are served through a Community Mental Health Center (CMHC) in Mississippi and diagnosed with an FASD. The original projection for OY3 was revised from 2800 to 1278 in the August 1, 2010-July 31, 2011 Implementation Plan. The initial projection was based on an erroneous assumption that the number of children birth to 7 served by CMHCs would increase significantly from year to year when in fact this number remains relatively stable over time. However, the actual number of children entering services who were referred for screening for OY3 was 1661—almost a 30 percent increase over that projected and exceeding Process Objective 3A-1 for OY3 of 75 percent admitted to a CMHC. It should be noted that all children birth to 7 who are served by CMHCs in Mississippi are screened for FASD during intake; therefore, the number of children referred for screening and actually screened are the same (100%).

### **b. Screening.**

During OY3, 1661 children were screened for an FASD with 156 screening positive. The actual number of children screening positive is an increase of 22 percent over the projection (156 actual: 128 projected). That is, for OY3 the projection was revised to 1278 screened with 10 percent of those projected as being positive (128). This increase (22%) reflects, in part, a more efficient screening process due to an enhanced training effort during OY3 specifically targeting children case managers and other children's mental health service staff.

In the OY3 Implementation Plan, Objective 3A-2 was to use the FAS photographic software with 75 percent of the children being screened. This was not achieved. The problem was addressed repeatedly at the CMHC Children's Coordinator/MAP Team Coordinator's meetings and follow-up meetings at each CMHC during the year. From these meetings, it was found that adjustments needed to be made to help facilitate use of the photographic software to fit better into the existing CMHC local systems. Currently, a number of the CMHCs are taking photos but require more help using the software and interpreting results. Revised training on use of the photographic software has been piloted at one CMHC, which will begin photographing children who screen positive and reporting results. In addition, it has been determined that the identification of the facial characteristics of FAS are fully incorporated into the diagnostic evaluation process in Mississippi and plans are being made to move use of the photographic software from the screening component to the diagnostic component of the statewide FASD system.

During OY3 an evaluation was conducted of 60 charts (from 6 MHC Regions) of children screening positive for a FASD. The findings showed that 88 percent of the appointments were scheduled with the UMC Diagnostic Center within one month of screening date (Objective 3A-2). In examining those charts in which screening occurred

in the latter part of OY3, the time was less than one month with many made in less than one week of the screening date.

**c. Diagnosis.**

For OY3, the number of children who tested positive and were referred to the UMC Child Development Clinic for diagnostic evaluation was 122, while the number of children with a completed diagnosis is 22. Thus, according to the table in Appendix A (Option Year 3), the number of children referred is smaller than the number who received a diagnosis by a substantial amount. This reflects a data reporting problem occurring when information is not always received from the CMHCs in a timely manner, thereby, resulting in it not being captured in the total OY3 diagnosis evaluations. Given this problem, it may be more useful to make comparisons using Totals To Date. For instance, when comparing OY3 to Totals To Date, 50 percent of *all* children referred (122) were during OY3, while 20 percent of the total received a completed diagnosis in that time period. During OY3, the number of children receiving a diagnosis other than FASD was approximately 10 percent, the lowest over the three-year project. Although other explanations exist, this may reflect a more effective screening process, which is supported as well by the extremely low number of clients during OY3 who were evaluated yet received no diagnosis—only 1 of 6. An important figure to note is the number of children with completed diagnostic evaluations and with written reports completed—100 percent—a noteworthy achievement.

In addition, from the evaluation data (on-site chart reviews), the time from screening to appointment varied from 6 months to 15 days with a mean 82 days—less than the three months indicated in Objective 3A-4. One of the highlights from the evaluation data is the average time from appointment to the written diagnostic evaluation—approximately 5 days.

**d. Intervention Services.**

The Table in Appendix A shows 60 children diagnosed with an FASD receiving interventions during OY3. This number was projected to be 95 percent (Process Objective 3A-5), but success cannot be determined from the data in Appendix A due to the aforementioned data issues. Since all children referred to the CMHC are screened for an FASD as part of intake, and by MDMH Operational Standards, the CMHC is required to have a treatment plan in place two weeks after intake. It is safe to say that all children have a treatment plan in place before and after the diagnostic evaluation and are already receiving services. It must be reiterated that interventions are taking place at a higher rate than we are currently able to capture in the FASD database. In addition, Appendix A reflects 28 children lost to services along the process of screening, diagnostic evaluation, and intervention (Objective 3A-7). While conducting chart reviews, the evaluation included a small sample of cases (n=7) lost to the system and reasons provided included: (1) moved from the area; (2) refused services; (3) no-shows for diagnostic evaluation with no further contact; and, 4) cancellation somewhere in the process. Although the sample was small, it was interesting that most of those refusing services or cancelling

were biological mothers who had admitted during screening to drinking during pregnancy.

Related to intervention services is Outcome Objective 3C-1 that 80 percent of the children receiving interventions will remain in their home/community setting. The evaluation date from the chart reviews showed 100 percent receiving services were in non-restrictive settings in the home or community. As part of outcomes, the CGSQ was used during OY3 to measure family/caregiver strain (Outcome Objective 3C-3). Since it is administrated annually, we are in the process of capturing baseline and annual data. However, the results provided information about where to focus resources. For instance, the mean for the question about how worried the caregiver was about the child's future was 3.77 indicating between "Somewhat and Quite a bit". Others indicated that they were "tired and strained (3.55) and suffered interruptions of personal time (3.64). On a more positive note, few indicated resentment towards the child (1.7) or negative effects on other family members from the child's behavior (1,7). On Outcome Objectives C-3 and C-4, the chart reviews provided no information of school performance based on the Standard Achievement Test or improvement in functioning level and behaviors using the (C-GAF). First, the target population is birth to 7 for this study (mean age = 5); therefore, only a small number in the chart review were school age. Many (22%) were in Head Start, however, and advanced to kindergarten. Those in elementary school advanced through the grades successfully (25%). Only about four were held back. As to the GAF, the data was captured in most charts, but demonstrated limited improvement. For example, many children over a six-month period ranged from 55 to 60, or 51 to 60, or 55 to 58, among others. With such little variation, we might question the appropriateness of the GAF for the FASD population and especially with such young children. On-going analysis will focus on this issue.

### **3. Program Description**

#### **a. Population Needs Identified and Addressed.**

One population need that was identified during OY2 and continued in OY3 was parental resistance to diagnostic referrals, based on anecdotal reports from most of the CMHCs. This was verified in OY3 (Appendix A and on-site chart reviews). From the small sample during chart reviews, it was found that many reasons contribute to this problem. Moving from the area without follow-up information was one while simply refusing service was another. The problem has been addressed by the inclusion (Objective 3A-7) on the FASD screening form of a question asking for the parent/caregiver reason for refusing. This should allow identification of any problems in the system that can be changed to better accommodate the parent/caregiver and child.

Since Mississippi is a poor state with about 20 percent of the population living below poverty compared to the national average of 12.7 percent, many of our families need financial support when seeking services for a child diagnosed with an FASD. One means of addressing this need is the use of case management to ensure Medicaid coverage or eligibility. Additionally, case managers can seek maximum involvement of local MAP Teams in order to obtain flex funds for traditional and non traditional supports for children diagnosed with an FASD (Objective 3B-2). One particular area identified

through the OY3 on-site evaluations was the need for follow-up on medical issues identified in the diagnostic evaluation. These include such medical issues as referrals to an ENT for a tonsillectomy and adenoidectomy, pediatric surgeon for umbilical hernia repair, tests for thyroid and lead levels, and pediatrician for lymph node enlargement, among others. During OY4, case management and MAP Teams will be involved in follow-up on this important issue. Furthermore, service dollars have been and will continue to help pay for day treatment services for pre-school children with an FASD when Medicaid denies coverage.

**b. Service Delivery Process.**

The MDMH and the FASD Project Staff have been very successful in integrating screening, diagnosis and intervention activities of the FASD service delivery system into the overall system of care in the state. That is, all children aged birth to 7 who are referred to a CMHC are automatically screened for FASD during intake. As part of the process, FAS photographic software was to be used in screening. Yet, implementation of the software has proven to be a challenge at the CMHC level during OY3. Through meetings with CMHC Children's Coordinator, MAP Team Coordinators and local CMHC staff, these barriers were identified and plans are moving forward for implementation in OY4 (see the Screening section for more details).

Also as part of the process, children who screen positive are assigned a case manager (Objective 3A-9) who develops a treatment plan so services can be delivered immediately. The child is referred to the UMC Child Development Center for a diagnostic evaluation. The case manager, family member/caregivers, and child go to the diagnostic evaluation together in order to maximize understanding and ensure a more efficient process. Once the child is diagnosed with an FASD, the case manager is responsible for integrating the diagnostic evaluation plan into the original treatment plan and, hence, coordinating the delivery of FASD specific interventions and services. In addition, the local MAP Teams are included as part of the coordination process.

What has become apparent in the preceding years is that the process requires fine-tuning on a regular basis. For one, training has to be an on-going process due not only to staff turnover, but also to unforeseeable needs that arise from the implementation process. IN addition, new training programs are developed as new needs are identified. An example is the Connecting the FASD Dots program. To illustrate, once the diagnostic evaluation is completed and received by the CMHC, the case manager modifies the original plan including FASD specific interventions and services along with referrals for specialized treatment. From the OY2 chart reviews, it was found that the charts often did not reflect the diagnostic evaluation in a comprehensive manner; therefore, Connecting the FASD Dots was developed in OY3. Another barrier identified in OY2 was the limited availability of specific FASD interventions and treatment options in certain areas of the state. During OY3, the FASD project hosted Mr. Dan Dubovsky in two separate training sessions to provide intervention-specific training for approximately 100 CMHC staff; each of the 15 CMHCs were also given a complete set of Goldstein's Skillstreaming in Early Childhood Training and The Prepare Curriculum. Wraparound training continued during OY3 and is considered an FASD intervention.

The fine-tuning also requires constant communication and collaboration between the FASD Project staff and various components of the system including regular meetings with the UMC Diagnostic Evaluation Center, MAP Team Coordinators, Children Coordinators and staff at local CMHCs. This has been particularly important with the implementation of the new MDMH Operational Standards for all the certified mental health service providers that requires each provider to incorporate the implementation of relevant FASD-specific policies and guidelines into their respective agency Policy and Procedure Manuals as well as in their Annual Operational Plans.

**c. Staff Training.**

By its very nature, an FASD initiative includes training as an on-going activity. In our experience, educational sessions continue to prove invaluable in ensuring consistency across the state with regard to how the FASD process is carried out statewide. They also are essential in responding to unforeseen needs that arise during implementation of innovations such as a FASD service delivery system. Related to this is one problem that has continued during the entire project and is inherent in the nature of the work--CMHC staff turnover. Another relates to implementation issues, the development of the Connect the FASD Dots training, described in the preceding section. Experiences from OY3 also demonstrate a need for continued training and technical support on data reporting by the CMHCs.

To ensure sustainability of FASD and full integration of FASD screening, diagnosis and treatment into the children's mental health service delivery system in Mississippi is that FASD staff members as well as children's staff from all 15 CMHC's have completed training in the nationally recognized Wraparound approach. Examples of other training opportunities during OY3 were: a) participation in 7th Annual FASD Symposium; b) statewide CMHC MAP Team Coordinator's meetings; c) continued work with case managers on understanding the service delivery process and their role as a critical component to the successful implementation and completion of interventions; and, d) use by MAP Teams of "What MAP Teams Need to Know About FASD" packet for better understanding of screening issues. Additionally, FASD Project staff have presented FASD information to groups indirectly involved with the MDMH including school teachers, Youth Court, regional IDD residential facilitates staff, Mississippi Mental Health Planning Council, regional Child Abuse Awareness Conference, Early Intervention Service Coordinators, and local service providers who participate in various local MAP Teams in the state. As for the FASD Project staff, select members participated in the quarterly FASD Diagnostic Learning Center conference calls, the 2011 BFSS conference in Phoenix, and the new FASD Prevention and Treatment: Addressing Race, Ethnicity, and Culture in Service Delivery conference call,

**d. Task Force and Stakeholders**

The MS Advisory Council for FASD (MS AC-FASD) is made up of essential stakeholders including members representing Mississippi Department of Health, Mississippi Department of Mental Health (e.g., Bureau of Alcohol and Drug), Children's Coordinators from CMHCs, and Director of the UMC Child Development Clinic, among

others. During OY3, the Council expanded to include a member from ARC and Behavioral Health of the MS Band of Choctaws. The Task Force has an elected Chairperson and Vice-Chairperson with two functioning committees: Diagnosis and Intervention Subcommittee and the Prevention Subcommittee. The MS AC-FASD meets 10 times per year and receives updates on the FASD Initiative and the status of the MDMH Strategic Plan objectives that are specific to FASD in Mississippi.

MS AC-FASD members have input regularly into the service delivery process through the committee structure. For instance, the Task Force during OY3 explored ways to help ensure sustainability by determining if there was interest in expanding FASD diagnostic resources into other geographic areas of the state. CMHC referrals of children screened positive to the UMC Diagnostic Clinic are growing in volume; therefore, the Council will continue to explore during OY4 the future expansion of our statewide diagnostic resources. MS AC-FASD also functions as a collaborative arm to other agencies by focusing on such issues as possible ways to collaborate with the MS Department of Health, ways to effectively provide information and resources regarding FASD interventions in the public schools, and providing information to primary care providers through conferences and meetings. Related to this, Prevention Committee members participate in a number of in-service trainings such as ones at the Recovery House, Hudspeth, Wildwood Development Center, and universities and colleges throughout the state,

**e. Lessons Learned**

During OY3, one key lesson involved the adoption and implementation of the new Mississippi Department of Mental Health (MDMH) Operational Standards that include standards requiring FASD screening, diagnosis and intervention for children ages birth to 18. In so doing, it was necessary to develop a system for providing introductory training on the new standards to all the certified mental health providers in the state. This was especially true for the FASD standards because they were new and never before implemented. A training team was put together at the state level with directors or representative from each of the service or administrative areas included in MDMH (children and youth, adult mental health, developmental disabilities, substance abuse, crisis services, peer support, residential, outpatient, and others) and regional training sessions were conducted for the service providers. The FASD portion of the standards was presented at the sessions by the Director of the Division of Children and Youth Services who is both knowledgeable of and directly involved in the implementation and inclusion of FASD in the overall system of care in Mississippi. Ongoing technical assistance and support will have to be provided by the FASD program staff during OY4. In conjunction with the new Operational Standards, it was necessary to revise or develop forms/tools for documenting or systematically recording various aspects of service delivery. These forms/tools are included in a DMH Record Guide along with instructions and guidance for recording and maintaining case records for individuals receiving services. The FASD screening tool and the FASD data tool are included in the new Record Guide for use by all the MDMH-certified service providers in the state.

A second lesson evolved from the integration of the diagnostic and intervention stages of the FASD Service delivery system. With integration and implementation of innovative processes never easy, a tool was developed—the FASD diagnosis/mental health services matrix—that will be helpful to both the UMC Diagnostic Clinic staff as they provide the mental health-specific treatment recommendations and to the CMHCs as they seek to implement all the FASD treatment and intervention recommendations that are part of each child’s diagnostic evaluation. While the medical (e.g., internal medicine, pediatrics) treatment recommendations were much more concrete and understandable, the mental health treatment recommendations were not always as clear or specific. For that reason, we believed it would be helpful for the UMC diagnostic team to have a more detailed understanding of the specific children’s mental health services that each CMHC provides and what children (depending on age and other factors) could best benefit from each of these services. A draft of the matrix was developed by CMHC clinical staff and is currently being reviewed by FASD project staff and other DMH Children’s Mental Health staff. After recommended modifications, the matrix will be released to the Diagnostic Clinic and all CMHCs as a tool in selecting the most appropriate service(s) or treatment options for each child receiving a diagnosis.

The last lesson is one that has been on going throughout the project. That is, the need for open communication and constant collaboration and coordination. This effort involves the cultivation and maintenance of positive relationships between the FASD Project staff and all others in the FASD service delivery system. Moreover, this effort involves all stakeholders in the process—often including those not directly involved but who have interest and resources. The accomplishments outlined in this annual Report are testimony to success of this type of culture and working philosophy. Although the words—communication, collaboration, and coordination— are easy to pay lip service to, in reality, they require hard work and continual effort.

#### 4. Program Changes

Change Category	Description of Change
State/local policies and procedures	MDMH Operational Standards were revised and implemented in OY3 to require FASD screening, diagnosis, and treatment of children ages birth to 18 who are enrolled for services through a certified community mental health provider
Organizational policies and procedures (agency policy, Task Force, partner agreements)	<p>MS AC-FASD (task force) membership was expanded to include a representative from The Arc of Mississippi to ensure inclusion of FASD services for children and youth with a developmental disability.</p> <p>MS AC-FASD prepared and adopted an updated FASD State Plan that includes activities in support of the statewide FASD service initiative</p>

	Additional MAP Teams were established to increase access to these critical services in more areas of the state.
Systems integration (intake, screening, case coordination, agency collaboration, internal and external system referrals, diagnostic team/center, etc.)	CMHCs now include FASD screening as part of the intake process for children ages birth to 18
Service delivery processes (parent engagement, modification of existing case plans or development of new plans, new clinical techniques, case management, etc.)	<p>CMHC staff have been trained to implement the FASD treatment recommendations using various community-based providers such as the local MAP Team, Early Intervention providers, and primary health providers</p> <p>DMH Operational Standards require update or modification of Individual Service Plans as a result of the FASD diagnostic evaluation results</p>
Data Systems (integration of program data, centralization, etc.)	Because of other state level data collection requirements, Mississippi has opted to use a centralized state-level data collection system for FASD program data. Currently, FASD data is being maintained separately for children ages birth to 7 and children ages 8 to 18. At some point in the future, these two data files will be merged into one statewide FASD data system for children served through the CMHCs
Staffing (new training focuses, staffing structures, qualifications for new hires, etc.)	<p>Virtually all aspects of the FASD initiative have been designed to fit into the existing staffing structure of the CMHCs. Each CMHC is required by DMH Operational Standards to have a Children’s Coordinator to oversee provision of all children’s services and to help ensure compliance with all standards and policies for services. Based on the FASD-specific training that has been provided to all of the CMHCs up to this point, the Children’s Coordinators have been equipped to provide basic ongoing training for existing and new staff.</p> <p>Where feasible, some CMHCs have opted to designate one case manager to be responsible for all children in their catchment area that are referred for an FASD diagnostic evaluation.</p>

## **APPENDIX A**

ADDITIONAL REPORT MEASURE

	<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	1,661	100%	1,661/100%

### FASD Diagnosis and Intervention Monthly Report with Crosswalk

	<b>Option Year 3</b> Between 8/1/2010 and 7/31/2011
<b>I. Screening</b>	
1. Clients screened for an FASD	1,661
2. Clients with a positive FASD screen	155
3. Clients placed in positive monitor (+ monitor)	0
4. Clients moved from positive monitor to positive FASD screen	0
5. Total Number of clients with a positive FASD Screen	155
<b>II. Diagnosis</b>	
6. Number of clients referred for diagnosis	122
7. Number of clients with completed diagnostic evaluations	22
8. Number of diagnostic evaluations with written reports completed	22
9. Number of clients diagnosed with an FASD	19
10. Number of clients diagnosed with an FASD and other diagnoses	19
11. Number of clients receiving a diagnosis other than an FASD	2
12. Number of clients not receiving any diagnosis	1
<b>III. Intervention Services</b>	
13. Number of clients receiving interventions	60
14. Number reporting as lost to follow up after positive monitor and before positive screen	0
15. Number reporting as lost to follow-up after positive screen and before diagnosis	43
16. Number reporting as lost to follow-up after diagnosis and before intervention	2
17. Number of clients diagnosed and received some intervention services but no longer accessible for services	0