Hennepin County FASD Program

Annual Report for Diagnosis and Intervention

August 1, 2010 – July 31, 2011

Better Lives, Stronger Communities

HSPHD

Human Services and Public Health Department

Hennepin

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1. Executive Summary

A. Project Overview and Objectives

The Hennepin County Fetal Alcohol Spectrum Disorders (FASD) Program integrated FASD screening, diagnosis and intervention within Hennepin County's juvenile probation and children's mental health system. The target audience is adjudicated delinquent youth ages 12 through 18. The goals and outcome objectives of the program are to reduce recidivism, maintain stability in out-of-home placements, and improve home and school functioning. These goals are consistent with Minnesota statutes requiring that juvenile justice systems not only provide for public safety and reduce juvenile delinquency but also account for the needs of individual youth and their capacity for growth and change.

B. Methods

During the first two years, the Program screened adjudicated youth between the ages of 12 through 17 who screened positive on the Massachusetts Youth Screening Instrument Version - 2 (MAYSI-2) for a further mental health assessment. In subsequent years, the target population includes those who screen positive on the MAYSI-2 in addition to those direct referrals from Court and Probation where prenatal alcohol exposure is suspected. A Task Force, made up of key decision-makers, has been established to work with, advise and oversee the FASD Program for all subcontract years. The FASD Program has done the following:

Integrated the required FASD screening tool and processes into the existing mental health (MASYI-2) screening process in Juvenile Probation. *Services and Activities:* In the first implementation year, the FASD Program built on the current mental health screening in Juvenile Probation, the MAYSI-2. In the first year, the Program screened 40% of those who screened positive on the MAYSI-2 for prenatal alcohol exposure. In the second year, the Program screened 49% of those who screened positive on the MAYSI-2 for prenatal alcohol exposure. In the third year, the Program screened 33% of those who screened positive on the MAYSI-2 for prenatal alcohol exposure.

Referred youth to the University of Minnesota for an FASD Diagnostic Evaluation**.** *Services and Activities:* Youth who screened positive on the FASD screening tool, were referred for an FASD Diagnostic Evaluation. The University of Minnesota's FASD Diagnostic Clinic in most incidences requires confirmation of prenatal alcohol exposure, though is not required for Fetal Alcohol Syndrome. In the first year, the Program referred 91% of youth who screened positive on the FASD screening tool, to complete an FASD evaluation. In the second year, the Program referred 90% of youth who screened positive on the FASD screening tool, to complete an FASD evaluation. In the third year, the Program referred 100% of youth who screened positive on the FASD screening tool, to complete an FASD evaluation. Overall, the referral process for FASD diagnostic evaluations is working.

Developed individual intervention case plans that address specific recommendations from the FASD evaluation. *Services and Activities:* The Social Worker invites key players (e.g., Family, School, Probation, Diagnostic Evaluator and Therapist) to an intervention case plan meeting. The case plan will be based on recommendations of the FASD Diagnostic Evaluation and goals developed by key players based on the needs of the youth and family, such as school support, individual or family therapy, mentoring, job or life skills coaching, chemical health services, or other appropriate services which are needed for the child to succeed. In the first year, 83% of youth who received an FASD diagnosis received an intervention case plan. In the second year, 64% of youth who received an FASD diagnosis received an intervention case plan. In the third

year, 100% of those who received an FASD diagnosis received in an intervention case plan. Overall, youth are getting diagnoses of FASDs are also getting interventions based on their FASD Diagnostic evaluation.

Used the intervention subcommittee to address the development of new and monitor current interventions to ensure effective interventions are available and utilized. *Services and Activities:* The intervention subcommittee is assessing and identifying current interventions and their effectiveness. The intervention subcommittee is making recommendations for the development of new interventions based on evidence-based practices. The intervention subcommittee holds quarterly training events for community providers, probation officers and parents. These "Provider Network" meetings consist of topics that include: FASD and school success, FASD and chemical dependency, FASD and guardianship and after school/summer leisure and recreational activities for those with FASDs.

C. Project Outcomes

The FASD Program will improve outcomes and increase success for adjudicated delinquent youth with an FASD. Hennepin County recognizes that it is critical to address the mental health needs of youth in the juvenile justice system. Providing FASD screening to youth who have or are at risk of mental health issues is a way of enhancing the opportunity for youth to receive services targeted to their particular needs. The treatment plans for all youth who are diagnosed with an FASD will be modified to provide the most appropriate services. This will ensure that there are successful outcomes of reduced recidivism, increased school success, maintained stability in placements and improve the overall functioning for each youth. As Hennepin County is able to demonstrate improved outcomes for youth with FASD, it will also enhance and improve the public's safety. With these successful outcomes, it will be easier to work with pertinent agencies and organizations in developing sustainable FASD services.

2. Key Client Results

A. Target Population

The target population for this project is delinquent youth ages 10-17, residing in Hennepin County, who meet one of two criteria: either they have received a positive screen on the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) indicating a need for further mental health assessment, or they have been directly referred to the program by the Juvenile Court or Probation based on confirmation of prenatal alcohol exposure. We find that both methods of entry into the program are important. The MAYSI-2 screening provides a mechanism to conduct FASD screening with a large population of youth who otherwise might not be screened. The Direct referrals where prenatal alcohol was suspected, provide a targeted way to reach youth who have already been identified by the court system as being at risk.

In OY3, the total number of youth in the program's target population was 34. This is much smaller than in previous years, in part because the number of youth entering the juvenile justice system declined sharply, and in part because the county performed fewer MAYSI-2 screens among youth entering the system. In OY 3, administration of the mental health screen, MAYSI-2 changed within DOCCR- Juvenile Probation. Following the change, fewer youth were referred for pre-natal alcohol screening. Most of those in the target population (needing an FASD screen) were identified through the MAYSI-2 (N=21). However, only 7 of the youth with positive MAYSI-2 results were referred to the FASD program. All 7 (100%) that were referred to the program completed an FASD screen. A smaller part of the target population were directly referred from

the Court or Probation after documenting prenatal alcohol exposure or being court ordered to complete an FASD screen (N=13). 12 of the 13 direct referrals completed an FASD screen.

B. Screening

The program seeks to conduct an FASD screen with all eligible youth. In OY3, FASD screens were completed with 19 of 20 youth, which represents 95% of those eligible. The program successfully screened 100% of the youth identified by the MAYSI-2, and all but one of the direct referrals from court and/or probation.

Of the 19 FASD screenings completed, 10 (53%) were positive. Among those youth identified by MAYSI-2, 29% returned a positive FASD screen. Among direct referrals from court and/or probation, 8 of 13 returned a positive FASD screen. Not all direct referrals screened positive for prenatal alcohol exposure due to 4 of those were Court orders where prenatal alcohol exposure was suspected but once screened, could not be confirmed. The other negative screen was due to the parent refusing to participate in the Program.

C. Diagnosis

The program attempts to refer all youth with a positive screen to complete an evaluation at an FASD diagnostic clinic. In OY3, one youth with a positive screen had previously received a diagnosis within the FASD spectrum. All of the remaining youth were referred for a diagnostic evaluation. The total number referred for evaluation is 9.

Of the 9 referrals, 7 diagnostic evaluations (78%) were completed by the end of OY3. The remaining two referrals occurred within the final month of OY3; it is likely that the diagnostic appointments will occur early in OY4. The program's screening and diagnostic services are accurately identifying youth affected by prenatal alcohol exposure. All youth who completed an evaluation, 4 of 7 (57%), received a diagnosis within the FASD spectrum. As noted above, one youth entered the program with an existing diagnosis, bringing the total of new program participants to 5.

D. Intervention Services

A total of 35 youth were actively receiving intervention services during OY3. Although a small number of youth (2) were lost to follow-up before diagnosis and/or intervention, the program is retaining youth in interventions longer than we had anticipated. During OY3, several youth diagnosed in OY1 and OY2 are still involved in the program and participating in the interventions as indicated in their case plan.

3. Program Description

A. Population Needs Identified and Addressed

The Project conducted an extensive needs assessment in the preliminary stages of the Project. The needs assessment highlighted the needs of the youth with FASD, the providers and professionals who work with those youth and the gaps in the systems were also indentified. The outcome of the needs assessment is highlighted here:

- The adjudicated youth with an FASD might be treated differently given greater understanding of their unique needs, if an evaluation was made available and if the evaluation recommended specific interventions.

- There is a need for FASD specific services across stakeholder groups. The design of new services and the expansion of existing community based interventions are vital to meeting the individual needs of the adjudicated youth with an FASD.
- Knowledge of resources regarding interventions is a prominent need. Access to services and follow through with recommended interventions is a barrier. Funding is one of the greatest challenges especially in this time of budget cut-backs.
- Inadequate communication among systems was evident throughout stakeholder responses

After the first three options years of this initiative, the needs of adjudicated youth have not changed; it is still important that youth with an FASD are identified and given appropriate services and interventions. There has been some growth and expansion in the network of services and community based interventions available to Hennepin County youth. This initiative has brought together a core group of providers who contribute to the Intervention Subcommittee. The group works to identify FASD-appropriate resources, and improve the knowledge base and skill of providers who serve youth with FASD. The case management provided through this initiative has greatly improved follow-through with recommended interventions. Participating youth are connected to services and successfully follow-though with their intervention case plans. However, once the initiative funding ends, it will be a challenge to transfer those case management services to other agencies so that support for youth continues.

B. Service Delivery Process

The FASD Diagnosis and Intervention initiative is integrated into the Juvenile Court systems. Once youth have been adjudicated delinquent by the Juvenile Court, the youth is then immediately referred to the Department of Community Corrections and Rehabilitation – Juvenile Probation. Part of the intake at Juvenile Probation, the adjudicated youth must complete a mental health screen, as mandated by the Minnesota State Legislature. The tool used for the mental health screening is the Massachusetts Youth Screening Instrument Version – 2 (MAYSI-2). Youth who are adjudicated delinquent who receive a positive screen on the MAYSI-2, to warrant further mental health screening, will be screened for prenatal alcohol exposure. This was a challenge in OY 3 due to the change in the administration of the mental health screen. This caused a reduction in referrals for prenatal alcohol screening. However, the Program does have another entry point to the FASD diagnosis and intervention initiative is by the Court, Attorneys and Probation Officers can directly refer youth to the FASD Program with the knowledge that the adjudicated youth was prenatally exposed to alcohol.

Once the youth screens positive on the MAYSI-2, the FASD Social Worker will interview the youth and their guardian/parent. If the youth was a direct referral from the Court, Attorneys or Probation, the FASD Social Worker will set up an appointment to interview the youth and their guardian/parent. As part of the interview, the FASD Social Worker will ask the guardian/parent if any alcohol was used during pregnancy. Once confirmation of pre-natal alcohol exposure, the FASD Social Worker will make the recommendation that the youth receive a FASD Diagnostic Evaluation at the University of Minnesota and Native American Community Clinic.

At that time, if the guardian/parent agrees to the FASD Diagnostic Evaluation, unless Court ordered where no consent is needed, the FASD Social Worker will start with the referral process. The FASD Social Worker will go over forms and consents that need to be completed as part of the FASD Diagnostic process with the guardian/parent. The FASD Social Worker will obtain releases of information to ensure that appropriate parties will receive a copy of the FASD Diagnostic Evaluation. The FASD Social Worker will also assist with transportation needs to and from all FASD Diagnostic Evaluation appointments. There is usually a month wait

for FASD Diagnostic Evaluation appointments. During that time, the FASD Social Worker will collect information regarding previous psychological evaluations, school records, birth records (if available) and child protection records (if available). The FASD Social Worker will deliver a copy of the records a week prior to the FASD Diagnostic Evaluation appointment. To ensure that the Clinician has all appropriate paperwork on the day of the evaluation, the FASD Social Worker will bring the original paperwork to the appointment. Once the FASD Diagnostic Evaluation report is completed, the FASD Diagnostic Clinic will offer the family and multi-disciplinary team members such as: Probation Officer, school personal and interested parties to partake in a "Feedback Session", where the doctors who completed the evaluation will go over the results and make recommendations to the family and providers involved with the youth. If the youth is part of the Minneapolis Public School system, the Clinician will go to the School and complete a private Feedback Session with the schools Social Workers, teachers and any other school personal that works with that specific youth.

Upon completion of the feedback session, the FASD Social Worker will complete an Intervention Case Plan (ICP) with the family and multi-disciplinary team members associated with the youth. Mostly, this takes place immediately following the feedback session at the University of Minnesota. However, in some cases the intervention case plan meeting will take place at another time and/or location. This is mostly due to not all team members able to be present at the feedback session. We would prefer that all ICPs are completed following the feedback session due to the fresh knowledge of the results, however the alternative also works. The Intervention Case Plan will focus on the recommendations made by the FASD Diagnostic Evaluation report. The Social Worker will indentify providers who will be able to provide services as stated in the ICP and FASD Diagnostic Evaluation. The multi-disciplinary team members will provide assistance and encouragement to the youth in completing those activities.

Once the youth has started to receive interventions, the FASD Social Workers track each youth's progress on a monthly basis. The FASD Social Workers complete the monthly tracking within the first 5 business days on the following month (ie: to track August 2011, the tracking will be completed by September 7, 2011). The FASD Social Worker will contact the youth, parent/guardian, probation, school and any service provider that is currently providing interventions. This ensures that not only are the youth being tracked and accounted for, it also ensures that the youth is receiving their services as planned. If the youth is not receiving at least 50% of their ICP goals, the FASD Social Worker will need to do further follow-up with the youth, guardian and service provider to address any barriers. If goals are being reached, the multi-disciplinary team may decide to complete an updated Intervention Case Plan to address current needs or needs not yet addressed from the FASD Diagnostic Evaluation report.

As part of the data collection, the FASD Social Workers complete baseline measures at the time of intervention case plan services begin and the 6 months prior. Interim measures are completed by the FASD Social Worker every 3 months. The 3 months was decided by our Program instead of the recommended 6 months due to the shorten time a youth could be under the Courts Jurisdiction. Every 3 months, the FASD Social Worker will collect data on our outcome measures and report them in the database. This is done by phone calls and/or email to the multi-disciplinary team members. The FASD Social Worker will also meet with the family and youth to address any areas of concern or areas of success and achievement. The FASD Social Worker will also address any barriers or concerns with the Multi-disciplinary team at that time.
Following up with the youth and their family and service providers after the youth has been closed has continued to be a barrier for the FASD Initiative. The FASD Social Workers are sometimes unable to track down the family, as they may have moved, had a phone number change or just not responsive. In the past years, the FASD Social Workers encountered the barrier of expired release of information with service providers and schools, therefore they were unable to collect follow-up data. In the Option Year 3 plan, this

area of concern was addressed. The FASD Social Workers were able to better collect follow-up data on closed clients.

C. Staff Training

i. Staff training in implementing the Diagnosis and Intervention Project

In the first six months of the planning phase, the Project Director developed a training schedule for staff once hired for the Social Worker positions. Before the implementation of the Project, the first training staff attended was Northrop Grumman sponsored training in Seattle, Washington for FASD Screening training. At that training, the staff was trained on the FASD Center of Excellence Expert Panel criteria for prenatal alcohol exposure. Staff also engaged in motivational interviewing with experts regarding how to interview families and children for pre-natal alcohol exposure. The staff was also trained on the FAS Facial Photographic Analysis software. Once returned from Seattle, the staff continued their practice and learning within the team. The FASD Program developed a screening form to include the FASD Expert Panel screening criteria. The FASD Program staff continued their learning by emerging themselves in FASD literature, handouts and research, to broaden their knowledge regarding FASD.

As part of implementation, the FASD Program Staff reviewed and practiced their job duties and responsibilities. Those duties and responsibilities were outlined in the Option Year 1 report and all addition Option Years. The Process Objectives and flow charts clearly outlined the Program Staff's daily activities, expectations as well as anticipated barriers with strategies on how to overcome those barriers. As expected, many ongoing training needs would occur, such as the Northrop Grumman sponsored case management and intervention training. With any new initiative, processes, unexpected barriers and policies could change at any moment. It is important to have flexible and patient staff who are able to change the way they do their job at a moments notice and who are able to problem solve as they go. The Project Director makes herself available to staff daily. The Project Director has monthly, individual staff meetings which address staff development; support and additional training needs to assist the Project Staff obtain increased knowledge; growth and achievement in their current role.

In Option Year 3, the initiative did not have any staff turn-over. This was a success, as in past option years, there had been staff turnover within the Project. As the Project looks to sustain beyond the Option years, training will be part of the process. To fully integrate and sustain FASD screening, diagnosis and intervention services, the Task Force requested that the County's Probation Officers and Social Workers be trained in those areas. The Program Director added this activity to the Option Year 4 plan.

ii. Database entry and reporting

Data collection and entry is the most common request for additional internal training. Northrop Grumman sponsored data collection training in the first Option Year, which assisted the staff at that time. Since then, there were staff turn-over and the Project Director stepped in to train staff on data collection and entry. The Hennepin County Project added additional elements to the Northrop Grumman issued database. Those elements include process and outcome objectives listed in the Option Year Implementation plans. This will assist the project to collect data specific to the Hennepin County initiative. The Project's independent evaluator, Professional Data Analysis (PDA), provided data entry training to staff regarding those specific elements added into the Northrop Grumman issued database. Database entry was outlined in all the OY implementation plans under the process objectives. This was to ensure that data collection occurred and data was entered in a timely manner. The Project Director

encourages staff to schedule time with them to go over any additional training needs, especially regarding data collection and entry.

D. Task force and Stakeholders

The purpose of the Task Force is to help guide, shape and support the FASD Program. The Task Force's mission is to benefit both children and families in our community who are struggling with FASD and the programs and agencies who work with them. The Task Force is composed of a blend of Children's Mental Health, Juvenile Court, Juvenile Probation and community stake holders. The Task Force assisted in the development and oversight of the Program. The Task Force has provided assistance and direction to Program subcontract staff, contributed their knowledge and expertise to the Program's needs assessment process, and participated in the development of the strategic, implementation and evaluation plans for the Program.

Members were asked to chair/co-chair subcommittees that are charged with assisting staff with the development of assignments. Subcommittees have a dual role – they are task specific subcommittees and a means of gathering information needed for the development and sustainability of the program. The subcommittees met monthly during the planning phase and Option year 1. After the implementation of the Project, the subcommittees met as needed.

Each subcommittee's task is directly related to each area of a member's expertise regarding administrative, intervention and diagnostic. The subcommittees will be divided into the following: The Policy and Procedure Subcommittee is made up of judicial officers, county attorneys, public defenders, children's mental health administration and juvenile probation administration; The Intervention Subcommittee will consist of agencies providing intervention to youth with an FASD, probation officers and children's mental health social workers, community mental health agencies, school districts, group and foster home agencies and out-of-home placements utilized by the courts; The Diagnostic Subcommittee includes the University of Minnesota FASD Diagnostic Clinic Physicians, Hennepin County Psychiatrists, Forensic Psychologist, and organizations that work with diagnostic capacity in Minnesota.

The Policy and Procedure Subcommittee's key role was establishing the daily activities for Program Staff; to make sure that the Program was in compliance with Hennepin County Policies and Procedures; and to ensure integration into current systems.

The Diagnostic Subcommittees key roles were to ensure that diagnostic capacity was available for Hennepin County FASD Program clients and to develop a "reader friendly" summary to be placed at the beginning of each FASD Diagnostic Evaluation report. Diagnostic Capacity was established at the beginning of implementation. Therefore the subcommittee focused on the "reader friendly" summary page that was requested as part of the outcomes of the needs assessment. The "reader friendly" summary page, located at the beginning of the FASD Diagnostic Evaluation report, gives a snap shot of the child's history, results of current testing, diagnosis and recommendations based on the evaluation. We found, as part of the needs assessment, that professionals, families and schools benefited most to see these areas at the beginning of each report. It is organized, easy to read and provides as an easy tool for professionals to plan interventions.

The Intervention Subcommittee key role was to indentify community providers who work with adjudicated youth and review the interventions currently being used for youth with an FASD. As part of that process, the Intervention Subcommittee developed a "Provider Network", made up of community providers who provide services to youth with an FASD. The Provider Network meets quarterly and discusses a new topic that one

might come across with an FASD. The Providers then discuss what interventions that they are currently utilizing, based on each topic.

As a result of the effectiveness of the subcommittees, the larger Task Force meets quarterly. At that time, a member from each subcommittee updates the Task Force on past and current work. These Task Force meetings also provide time for guidance and feedback on the current Program activities and future planning. The independent evaluator, PDA, of the FASD Project presents data collected by the Project and provides suggestions or changes to the Project, if needed.

Due to the FASD initiative, data not normally collected and analyzed, has become a wealth of knowledge to the Departments within Hennepin County. The data has also been able to provide insight to the prevalence of FASD within the juvenile justice system and the service gaps associated. The data has been utilized to capture the population that has crossed over into both juvenile justice and human services. The data collected has been utilized for strategic and future planning for services related to those with FASDs. Overall, the data has driven some areas in Hennepin County to ensure that those with FASDs are getting indentified, diagnosed and the services they need to succeed.

E. Lessons Learned

i. Throughout the Option Years of this initiative, many lessons were learned. Some of those lessons are highlighted below:

- To be able to serve adjudicated youth with FASDs appropriate, we need to have community providers who are also trained in FASD to be able to provide appropriate interventions based on the FASD diagnosis. The Provider Network was formed to meet this need, and has successfully expanded the network of agencies and professionals who are able to provide appropriate services for youth identified with FASDs. However, this is not a one-time fix; there will be an ongoing need to maintain and expand the provider network, and to identify and train new providers to replace agencies that close.
- Another lesson learned was to assume that the youth would be involved with the FASD Program "short term". In reality, those youth with an FASD are participating in interventions and in the FASD Program longer than anticipated. The plan to have the FASD Social Workers provide short-term case management, was actually turned into longer term case management due to multiple factors: Youth are receiving interventions for longer periods; Youth change or move placements and therefore the interventions they receive, while in placement are different than those that they would receive in the community; Youth are successfully completing goals and interventions set in the intervention case plan based on recommendations in the FASD Evaluation and therefore need updated goals and interventions based on FASD Evaluation report. Most interventions can be ongoing and the Social Workers encourage youth to continue their involvement with those providers.
- In the first option year, the Program used one method of identifying youth for FASD screening and diagnostic evaluation: screening of youth via the MAYSI-2 mental health screening tool. As the first year past, Probation Officers, Judges, Attorney's and other justice personal became more knowledgeable about the FASD Program and therefore started to make direct referrals for youth they suspected had been exposed to alcohol prenatally. Therefore in option year 2 and beyond, the Program has relied on two methods of identifying youth for FASD screening and diagnostic evaluation: broad screening of youth via the MAYSI-2 mental health screen and targeted screening through direct referrals from the Court and Probation.
- A lesson learned also included that of predicting the external environment. It is very hard to know what direction the economy, juvenile crime, community providers and State legislatures are

implementing, planning or closing. In option year 3, the Program experienced a State government shutdown, multiple community providers trained in FASD interventions close, a decline in juvenile justice. The FASD program has worked to be flexible and adapt to these changes as much as possible, but in the end we found that the growth of the program was slowed by external issues outside of the program's control.

In conclusion to lessons learned, if we had the opportunity to start a similar initiative, we would include screening, referring for diagnosis and interventions for the child welfare system. With juvenile adjudications declining, there is enough capacity (staff and diagnostic) to include those younger children who were exposed to alcohol prenatally. With indentifying those youth at a younger age, you are able to intervene at an earlier age and hopefully prevent the juvenile justice involvement. What we know and what research shows, is that the earlier you can indentify FASDs, the earlier interventions can occur and the less susceptibility of secondary disabilities including that of the justice system.

ii. Accomplishments

The accomplishments of the FASD initiative have been great. It is great to see the Program and those clients within the Program succeed. We have highlighted some specific accomplishments below:

- Through the ongoing contact between FASD Program staff and the Court and Probation staff, strong relationships and communication pathways have been developed. Over the years FASD training has been provided, awareness of the FASD Program has increased, and many Court and Probation staff members have become knowledgeable about FASD. As a result, the Court and Probation continue to refer youth to the FASD Program on an ongoing basis, and the referrals are being made appropriately. Nearly all direct referrals from probation and the court, return a positive FASD screen, and the majority result in a diagnosis within the FASD spectrum. It is a major accomplishment of the Program that youth are being identified and referred for services because of the connections between the Court, Probation and the Program.

- The program has been able to retain youth and families for much longer periods than expected. When the program was initially designed, the proposal team was concerned that youth may be released from the court's jurisdiction or be lost to follow-up before the first outcome measurements could be captured at 6 months. However, youth have continued to receive services indicated in their intervention case plan, and the FASD Program Social Workers have provided long-term case management and support.

- The most important achievement of the program to date is the continuing low rate of recidivism among youth receiving services. In OY2, only 1 of 13 youth had a probation violation and 1 of 13 had a new adjudication after six months of intervention. In OY3, 1 of 12 youth had a new adjudication and 4 of 12 had probation violations. Across both years, there are no new felonies among the group of youth participating in the program. We see this as a major success. However, we acknowledge one important limitation: we have no information about how the program's success compares to that of other interventions, or how these youth might compare to a control or comparison groups of similar youth who have not received an intervention. To address this limitation, we are seeking

additional data to report OY4. We are working with the Hennepin County probation department to obtain comparable recidivism rates for the county-wide juvenile population.

iii. Model Approaches

The FASD initiative in Hennepin County is a model program for other juvenile justice departments to utilized. The Hennepin County FASD initiative has been presented at BFSS conference in the hope that other agencies can model the approach. The Hennepin County FASD initiative model program has also been published in the Journal of Psychiatry and Law in the Spring of 2011. Attaching the mental health screen to a prenatal alcohol screen is an easy approach for families and professionals in indentifying prenatal alcohol exposure. The hope is that other systems are able to take what we have learned, what we know and then can model our program in their system. Below are some specific recommendations to keep when looking at modeling the Hennepin County FASD initiative in the juvenile justice system:

- Referrals from both mental health screening and direct referral from the court and or probation where prenatal alcohol exposure is suspected, is a model approach to indentifying those who were exposed to alcohol prenatally. On average, 30% of those who screen positive on a mental health screen and then screened for FASDs were also exposed to alcohol prenatally. Over the past 3 Option Years, almost 90% of those who were directly referred to from Probation, Court and Attorneys screened positive for prenatal alcohol exposure. After three years of experience, we still recommend using this combination of methods to identify youth who might otherwise be missed, and connect them to services as appropriate.
- Youth with FASDs tend to be the higher needs youth associated with case planning and interventions. Therefore, these youth and families need more in-depth assistance in regards to the FASD referral process, paperwork associated with an FASD diagnostic evaluation. In addition to planning and implementing services after the FASD diagnosis. It is important that a worker assist the youth and family at every step of the process to ensure follow through and successful outcomes.

- After the completion of an FASD diagnostic evaluation, it is important that the results are shared with the family, the worker and any other multidisciplinary team members to ensure accurate interpretation of the diagnostic results and successful planning for interventions based on the FASD diagnostic report. This model is associated with a Feedback session with the Clinician and intervention case planning with the multidisciplinary team members.

- Another model approach we recommend to other programs is our Intervention Subcommittee. The group is composed of professionals (educators, therapists, mental health and social support providers) who serve youth affected by FASD. The group meets monthly to hear guest speakers, share best practices, identify local resources, and learn from each other. The group began as a subcommittee of the Task Force formed under this subcontract, and has continued to meet for three years. Program staff see that this group has helped to build and strengthen the network of skilled FASD providers in Hennepin County.

4. Program Changes

Change Category	Description of Change
State/local policies and procedures	• There are expressed interests from HSPHD administration in continuing the screening, referral for diagnosis and referring children with an FASD to appropriate interventions. • The FASD initiative has assisted with the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS) to address the State legislature in regards to reimbursement for diagnostic evaluations, need for PCA services, adding FASD as a development disability and the need for training in juvenile justice populations.
Organizational policies and procedures(agency policy, Task Force, partner agreements)	• A Task Force was formed to assist with the development of the FASD Program. These members were able to gather information, share knowledge and develop the Strategic Plan of the FASD Initiative. • The FASD Program is housed under the Human Services and Public Health Department. In order to screen youth in the juvenile justice system, the FASD Program partnered with the Juvenile Court and Department of Community Corrections and Rehabilitation – Juvenile Probation. Both these systems were pertinent in planning and developing the FASD Program.
Systems integration (intake, screening, case coordination, agency collaboration, internal and external system referrals, diagnostic team/center, etc.)	• The FASD Program needed to ensure that there was capacity for FASD diagnostic evaluations. The Project Director met with the University of Minnesota's FASD Diagnostic Clinic to ensure that diagnostic capacity was accessible and available to Hennepin County youth. The FASD Diagnostic Clinic was able to set aside 3 appointment slots every other Monday per month. This was necessary to guarantee that FASD diagnostic slots were readily available to receive direct referrals from the Hennepin County FASD Program. • In the development of the FASD Program, Social Worker positions were established to screen for FASDs, to assist youth, families and

	Probation Officers with the referral process, assistance with case planning and implementation of services. Probation Officers maintained as primary workers and FASD Social Workers were secondary workers to assist the Probation Officer.
Service delivery processes (parent engagement, modification of existing case plans or development of new plans, new clinical techniques, case management, etc.)	• The entire FASD Diagnostic process can be long, intensive, confusing and time consuming. To ensure parent engagement and follow through, the FASD Social Worker walks the family through at every step of the process. This has given the FASD Program on average 95% success rate at completions of FASD evaluations. • Youth with FASDs tend to need more intensive services regarding case planning and implementation of services. Due to the FASD Social Worker being knowledgeable about the spectrum, aware of community agencies competent in FASD interventions, the youth and family is able to receive services appropriate to the FASD diagnosis and meet the needs of each youth diagnosed with an FASD. • Some youth who are screened for FASDs are already receiving services through community agencies, probation and school. After the FASD diagnostic evaluation has been completed, a Feedback Sessions is held with those multidisciplinary team members from community agencies, probation officer, school personal, youth, family and FASD Social Worker to receive the overview of the testing and the results and recommendations. Upon completion of the Feedback session, the multidisciplinary members are able to plan appropriately based on the recommendations of the FASD diagnostic evaluation. Therefore, the youth is now receiving appropriate interventions based on their FASDs diagnosis.
Data Systems (integration of program data, centralization, etc.)	• Court records, such as adjudicated offenses, were already existing and easily accessible, but needed to be extracted and recorded in the database to capture baseline and follow-up data. • The Northrop Grumman database is located in a central location so that all FASD Program staff is able to access it at all times, when needed. The database is not connected to other Hennepin County systems due to those systems are managed under the State of Minnesota. • The Hennepin County FASD Program's Process and Outcome Objectives were added to the Northrop Grumman database so that

	all data was in one central location. Database entry was outlined in all the OY implementation plans under the process objectives. This was to ensure that data collection occurred and data was entered in a timely manner. • In Minnesota, all case management work is documented in one location, Social Services Information System (SSIS). The FASD Program staff received access to this database where case notes and contacts are documented. • HSPHD administration has utilized the data collected to assist with long term strategic planning at the Department level.
Staffing (new training focuses, refresher training, staffing structures, qualifications for new hires, training for service providers, etc.)	• Northrop Grumman provided FASD screening training to FASD Program Staff early in the initiative. However, there was staff turnover in the first two option years. Therefore, retained Project staff were able to assist in training new staff in FASD screening, referral for diagnosis and intervention. • Project Staff attend 2-3 FASD specific trainings per year. This ongoing training is related to FASD interventions and research. • To be able to serve adjudicated youth with FASDs appropriate, we need to have community providers who are also trained in FASD to be able to provide appropriate interventions based on the FASD diagnosis. The Provider Network was formed to meet this need, and has successfully expanded the network of agencies and professionals who are able to provide appropriate services for youth • Data collection and entry is the most common request for additional internal training. Northrop Grumman sponsored data collection training in the first Option Year, which assisted the staff at that time. Since then, there were staff turn-over and the Project Director stepped in to train staff on data collection and entry. The Hennepin County Project added additional elements to the Northrop Grumman issued database. Those elements include process and outcome objectives listed in the Option Year Implementation plans.. The Project's independent evaluator, Professional Data Analysis (PDA), provided data entry training to staff regarding those specific elements added into the Northrop Grumman issued database. The Project Director encourages staff to schedule time with them to go over any additional training needs, especially regarding data collection and entry.

Appendix A

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	20
2. Clients with a positive FASD screen	11
3. Clients placed in positive monitor (+ monitor)	n/a
4. Clients moved from positive monitor to positive FASD screen	n/a
5. Total Number of clients with a positive FASD Screen	11
II. **Diagnosis**	
6. Number of clients referred for diagnosis	9[1]
7. Number of clients with completed diagnostic evaluations	8
8. Number of diagnostic evaluations with written reports completed	7
9. Number of clients diagnosed with an FASD	5[2]
10. Number of clients diagnosed with an FASD and other diagnoses	4[3]
11. Number of clients receiving a diagnosis other than an FASD	1
12. Number of clients not receiving any diagnosis	1
III. **Intervention Services**	

[1] One youth was referred into the program already with an FASD diagnosis
[2] This includes the one youth who was previously diagnosed. In addition two more youth who entered the program in OY 2 but did not receive their FASD diagnosis until OY 3.
[3] This includes two youth who entered in OY 2 but did not receive their FASD diagnosis and other diagnosis until OY 3.

13. Number of clients receiving interventions	35[4]
14. Number reporting as lost to follow up after positive monitor and before positive screen	n/a
15. Number reporting as lost to follow-up after positive screen and before diagnosis	1
16. Number reporting as lost to follow-up after diagnosis and before intervention	1
17. Number of clients diagnosed and received some intervention services but no longer accessible for services	11[5]

Crosswalk between Data Tables and Forms:

1. Screening Form (Form A): Q9 is between report date parameters and client is not a re-screened case (e.g., no ID suffix such as "I2").
2. Screening Form (Form A): "Positive Screen" checkbox in Screening Results section is checked and Q12 is between report date parameters. Positive Monitor Tracking Form (Form B) has not been filled out and client's status did not change to positive screen because the child is now aged 4 or older.
3. Screening Form (Form A): "Positive Screen" checkbox in Screening Results section is checked and Q12 is between report date parameters. Positive Monitor Tracking Form (Form B) has not been filled out and client is not a re-screened case (e.g., no ID suffix such as "I2").
4. Case meets one of these two criteria:
    - Screening Form: Client's screening status changed from positive monitor to positive screen due to a change in the client's age and Q12 on screening form is between report date parameters; *or*
    - Positive Monitor Tracking Form (Form B): Q1 = a and Q2 is between report date parameters.
5. Screening Form (Form A): sum of 2 + 4
6. Screening Form (Form A): Q13 is between report date parameters
7. Screening Form (Form A): Q14 is between report date parameters
8. Screening Form (Form A): Q14 is not null and Q15 is between report date parameters
9. Screening Form (Form A): Q14 is between report date parameters and Q16 = Yes
10. Screening Form (Form A): Q14 is between report date parameters and Q16 = Yes AND Q20 = items completed
11. Screening Form (Form A): Q14 is between report date parameters and Q16 = No AND Q20 = items completed
12. Screening Form (Form A): Q14 is between report date parameters and Q16 = No AND Q20 = No items completed
13. Service Delivery Tracking Form (Form E): At least one Date of Service for client is between report date parameters where Service Units > 0

[4] This includes youth who entered the FASD Program in past Option Years.
[5] This includes youth who entered the FASD Program in past Option Years.

14. Screening Form (Form A): “Positive Monitor” checkbox in Screening Results section is checked and client is not a re-screened case (e.g., no ID suffix such as “I2”). Form B has not been filled out. A Client Participation Tracking Form (Form K) was filled out for the client and date client contact was lost is between report date parameters. On Form K, the most recent date client contact resumed is earlier than the most recent date client contact was lost, or the date client contact resumed is null.
15. Screening Form (Form A): “Positive Screen” checkbox in Screening Results section is checked and Q16 is null. A Client Participation Tracking Form (Form K) was filled out for the client and date client contact was lost is between report date parameters. On Form K, the most recent date client contact resumed is earlier than the most recent date client contact was lost, or the date client contact resumed is null.
16. Screening Form (Form A): Q16 = Yes. Service Delivery Tracking Form (Form E) does not list any service delivery. A Client Participation Tracking Form (Form K) was filled out for the client and date client contact was lost is between report date parameters. On Form K, the most recent date client contact resumed is earlier than the most recent date client contact was lost, or the date client contact resumed is null.
17. Screening Form (Form A): Q16 = Yes. Service Delivery Tracking Form (Form E) lists some services. A Client Participation Tracking Form (Form K) was filled out for the client and date client contact was lost is between report date parameters. On Form K, the most recent date client contact resumed is earlier than the most recent date client contact was lost, or the date client contact resumed is null.

Appendix B. Additional Report Measure

	Number Referred for Screening	**% Referred for Screening**	**Total Entering Service**
Total N/% of children/adolescents entering service who are referred for screening	21	48%	10

Appendix C: Results: Process and Outcome Objectives

Outcome Objectives

The outcome evaluation explores the extent to which youth served by the Hennepin County FASD Project achieve desired outcomes. The program seeks to prevent recidivism, out-of-home placement changes and inappropriate residential placements. Program services support youth to fulfill their intervention case plan goals and to improve indicators of school success.

Results presented in this section are based on data collected during Option Year 3 (OY3): Aug 1 2010 – July 31, 2011. During OY3, 19 youth were actively participating in intervention services. From this group, 16 youth had reached the 6-month follow-up point at which interim outcome measures are assessed, and data were collected for 12 of these cases (4 additional cases were closed prior to the 6-month data collection point). ***This section presents results for these 12 youth.***

Outcome Objective 1

Who: Youth diagnosed with an FASD.

What: Reduce recidivism - no new adjudications at the same or higher level offense (baseline) and no new probation violations.

How much: 50% of youth diagnosed with an FASD.

When: Compare baseline (six month period prior to ICP) with first interim measure (six month period following development of ICP).

> **Results:** This objective was met. At the time of 6-month follow-up, 58% of youth (7 of 12) had no new offenses *and* no probation violations. Only one youth had a new offense at the same or higher level as compared to the adjudicated offense at the time of entry into the program (a gross misdemeanor), and four had probation violation(s). Additionally, across the entire group there were no new felonies by the first 6-month follow-up period.
>
> In addition, six of these 12 youth have been receiving services long enough to reach the 12-month follow-up point. Among these six cases, there was one new offense (a misdemeanor) between the 6- and 12-month follow-up points. None of the 6 youth had new gross misdemeanors, felonies, or disposition modifications between the 6 and 12 month follow-up points.

Outcome Objective 2

Who: Youth diagnosed with an FASD.

What: No change in placement or moved to any placement that is equally or more appropriate for his/her needs as determined by the FASD Subcontract Social Worker. (This includes out-of-home and in-home placements.)

How much: 50% of youth diagnosed with an FASD.

When: Compare baseline (six month period prior to ICP) with first interim measure (six month period following development of ICP).

Results: This objective was met. 9 of 12 youth (75%) had either no change in placement *or* moved to a placement that was equally or more appropriate for his/her needs as specified in the diagnostic evaluation report.

Additional details: The majority of youth *did* have a change in placement; only two remained in the same placement for the entire six-month period. Seven moved to a placement that was judged to be equally or more appropriate for their needs, and two had a change in placement judged to be less appropriate, and one had a placement change that the social worker was unable to rate.

Outcome Objective 3

Who: Youth diagnosed with an FASD.

What: Increase school success. (Defined as decreased suspensions, decreased expulsions, decreased incident reports, and increased attendance).

How much: 50% of youth diagnosed with an FASD.

When: Compare baseline (six month period prior to ICP) with first interim measure (six month period following development of ICP or until graduation, whichever occurs first).

Results: This objective was not met. The target was that 50% of youth would show improvement on *all school performance indicators combined*. Only 3 youth (25%) improved on all four indicators.

We consider this objective to set a rather high bar, and do not find it a serious concern that so few youth met the objective. In fact, when the school performance indicators are examined separately, three of the four targets were met by 50% or more of youth.

- ✓ 10 youth (83%) show no or reduced numbers of suspensions at follow-up as compared to baseline.
- ✓ All 12 youth (100%) show no expulsions at follow-up.
- ✓ 8 youth (67%) show increased attendance levels.
- ✗ Only 3 youth (25%) show no or reduced numbers of incidence reports at follow-up as compared to baseline. However, in some cases an increase in incident reports may actually be a positive result. It may indicate that appropriate supervision and monitoring of a youth results in an incident report rather than a suspension or expulsion, although we do not have any documentation about this.

Outcome Objective 4

Who: Youth diagnosed with an FASD.

What: Complete 50% or more of current intervention case plan goals.

How much: 50% of youth diagnosed with an FASD.

When: 3 months after the intervention case plan has been written, and every 3 months for the duration of program participation.

Results: This objective describes the extent to which youth are fulfilling the activities, therapies, and other elements of their intervention case plan. It can be considered a measure of compliance. The objective is assessed earlier than other objectives, beginning at 3 month follow-up, and continuing every three months as long as youth remain in the program.

<u>This objective was met.</u>

- Data were available for 13 youth who were receiving services and had reached the 3-month follow-up point. 9 of 13 youth (69%) completed at least half of their case plan goals.
- For youth who had reached the 6-month point, 10 of 11 (91%) completed at least half of case plan goals.
- For youth who had reached the 9 month and 12 month follow-up point, 6 of 6 (100%) met this objective.
- For youth who had reached the 15 month and 18 month follow-up points, 3 of 3 (100%) met this objective.

Outcome Objective 5

Who: Youth diagnosed with an FASD.

What: Achieve moderate to significant improvement in level of functioning, as rated by FASD subcontract social work at close of service.

How much: 50% of youth diagnosed with an FASD.

When: At end of service.

Results: This objective will be assessed at the end of OY4.

Process Objectives

Results presented in this section are based on data collected in OY3 (Aug 1 2010 – July 31, 2011).

Process Objective 1

Who: FASD Subcontract Social Workers

What: Conduct FASD screen for delinquent youth age 10-17 who have received a positive screen on the MAYSI-2 for further mental health assessment.

How much: Conduct FASD Screen of 60% of 100 (60 youth) youth ages 10-17 who screen positive on the MAYSI-2

When: Within 20 minutes following the positive MAYSI-2 screen, August 1, 2010 – July 31, 2011

Results: Only 7 youth were referred to the program based on a positive MAYSI-2 screen. The program conducted an FASD screen for 100% of these 7 youth, and all FASD screens were conducted on the same day as the MAYSI-2 screens.

While the actual number of youth screened was far short of the original projection, the program exceeded the objective that 60% would be screened. There are two reasons for the lower number of youth identified via MAYSI-2. First, the number of youth entering the county juvenile justice system was down very sharply in 2010. Second, while 21 youth received a positive score on the MAYSI-2, indicating eligibility for FASD screening, only 7 youth were referred to the program.

Process Objective 2

Who: FASD Subcontract Social Workers

What: Conduct FASD screen for delinquent youth age 10-17 who are referred by the Court or Probation based on conformation of prenatal alcohol exposure.

How much: Conduct a FASD Screen of 90% of referrals or 13 of 15 adjudicated youth who are referred by the Court or Probation.

When: Within 1 week of the referral to the FASD Program by Probation and/or the Court. August 1, 2010 – July 31, 2010

Results. The screening objective was met. Thirteen youth were directly referred to the FASD Program (6 referred by the Court and 7 by Probation). The program screened 92% or 12 of 13 youth who were referred. The timeline of the objective was not met. 10 of 12 were screened within the target of one week's time; the two cases which did not meet the timeline were screened after 21 to 29 days.

Process Objective 3

Who: FASD Subcontract Social Workers

What: Refer youth who have a positive FASD screen to the University of Minnesota for an FASD diagnostic evaluation

How much: We anticipate that 24 youth who receive a positive FASD screen. 23 (or 95% of 24 youth) will be referred. (100% will not be referred as some youth and families may "opt out" of referral for an evaluation.)

When: Within one week of the youth receiving a positive FASD screen. August 1, 2010– July 31, 2011

Results. This objective was met. Due to a smaller number of screenings conducted, a smaller than anticipated number of youth screened positive. There were 10 positive FASD screens. Of this group, one had entered the program with a previous diagnosis. Of the remaining 9, all were referred for a diagnostic evaluation (100%), which exceeds the target. However, 1 referral was not made within the target time frame (within 7 days).

Process Objective 4

Who: University of Minnesota KDWB Pediatric Family Center

What: Complete FASD diagnostic evaluation.

How much: 21 (90% of 23) to complete FASD Diagnostic evaluation at University of Minnesota.

When: Within 5 weeks of positive FASD Screen. August 1, 2010– July 31, 2011

Results. This objective was not met. *Completion:* 9 youth were referred for diagnosis, but only 7 (78%) completed a diagnostic appointment before the end of OY3. However, the two appointments that were not completed were referred near the end of OY3 (the cases had not reached the 5-week point before the year ended). These appointments are likely to occur in OY4. *Timeliness:* 5 of the diagnostic evaluations were completed within the target 35-day timeframe, and two were completed after that point.

Of the 7 completed diagnostic evaluations, 4 returned an FASD diagnosis.

Process Objective 5

Who: FASD Subcontract Social Workers

What: Develop the intervention case plan

How much: Intervention case plans will be created for 80% of 21 youth with an FASD diagnosis, or 14 youth.

When: The intervention case plan will be completed within 1 week of the intervention case plan meeting, August 1, 2010 – July 31, 2011

Results: In OY3, a total of 10 youth required an intervention case plan (ICP) to be developed. There were four youth receiving a new FASD diagnosis, and six youth who were diagnosed in a previous year, but had not yet had an intervention case plan meeting.

This objective was met. Of the ten youth requiring an ICP, eight ICP meetings (80% of youth) were held and resulted in documentation of a completed ICP before the end of OY3. One plan was developed and sent out after 10 days, which is two days longer than the target timeframe.

Process Objective 6

Who: Parents/guardians and multidisciplinary team members

What: Attend Intervention Case Plan meeting and contribute to the development of the intervention case plan. (This may include School Personnel, Guardians/Parents, Probation Officers, FASD Diagnostic Evaluator, Therapists and other advocates for an intervention case plan meeting as appropriate.)

How much: Minimum of two multidisciplinary team members in addition to the FASD Subcontract Social Worker will attend the meeting and contribute to development of the intervention case plan. This will occur for 80% of 21 youth with an FASD diagnosis, or 14 youth.

When: Within 1 month of receiving the FASD Diagnostic Report. August 1, 2010 – July 31, 2011

Results. This objective was met. A total of 8 meetings were held. At 100% of ICP meetings (8 of 8), at least 2 parents and/or multidisciplinary team members were in attendance.

Process Objective 7

Who: FASD Subcontract Social Workers

What: Make contact with agencies to facilitate referrals for interventions as provided in the case plan

How much: One or more e connection made[1] for 90% of 14 youth with a new OY3 intervention case plan, or 13 youth.

When: Within 1 week of the development of the intervention case plan, August 1 2010 - July 31, 2011

Results: 100% (8 of 8) cases resulted in successful connections with one or more services or therapies recommended in the ICP.

Process Objective 8

Who: FASD Subcontract Social Workers

What: Provide monthly follow-up[1] for youth receiving interventions. (Including: provider(s), school, guardian and Probation.)

How much: 75% of 59 youth eligible to receive services in OY3, or 44 youth

* This includes youth with a new ICP in OY3 and youth from prior years who still have an active ICP and are still eligible for services.

When: By the 5th day of the following month, August 1 2010 - July 31, 2011

Results: At the time of this report, 17 youth were receiving intervention services. All 17 had some follow-up tracking activity conducted by the FASD Subcontract Social Workers. We calculated the proportion of successful monthly reviews by dividing the actual number of reviews that occurred by the number of reviews that should have occurred. For cases that closed mid-way through OY3, the closed months were excluded from this calculation. The objective was met, with 90% of expected monthly reviews taking place. Only two youth had fewer than than 80% of the expected monthly reviews completed. Many of the cases were open for a long period of time, 11

[1] Connection means: contact was made by both the FASD Social Worker and the Provider. The youth has either been accepted or registered for the service

months on average, with the longest open case continuing for 24 months. The consistency of monthly case plan review indicates the program is providing frequent, long term case management and support.

Process Objective 9

Who: FASD Subcontract Social Workers

What: Mail end of service and release of information forms to parents/guardians for youth with closed cases.

How much: 100% of 12 cases closed out in OY3, or 12 cases.

When: Within one week of closing services, August 1 2010 - July 31, 2011

Results: During OY3, twelve cases were closed due to the client being lost to follow-up, moving out of the county or state, or aging out of the program. The program sent end of service and release of information forms to the parents/guardians in all twelve closed cases.

Process Objective 10

Who: FASD Subcontract Social Workers

What: Refer youth who have previously screened positive for an FASD and were either lost, opted out prior to an FASD diagnostic evaluation was completed.

How much: 90% of those who re-enter the FASD Program

When: Within 1 week of the re-entrance into the FASD Program. August 1, 2010 – July 31, 2011

Results: No cases met these criteria. During OY3, five cases that had been closed were reopened, although none of these cases had been lost or closed prior to completing the diagnostic appointment.