New York State

Project CHOICES

FASD Prevention Initiative

Annual Report – OY3

August 1, 2010 through July 31, 2011

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Table of Contents

	Page
Project Summary (brief overview objectives, methods, current accomplishments or results and discussion of the initiative)[1]	3
Key Client Results Achieved (Describe the client data from August 1, 2010 through July 31, 2011.) a. Target Population (calculated outside database) b. Demographic Data c. Screening d. Intervention Services among Residential Treatment and Community-Based Populations e. Baseline Characteristics among Residential Treatment and Community-Based Populations f. Outcomes - Alcohol Use g. Outcomes Contraception Use	5
Program Description and Experiences a. Population Needs Identified and Addressed b. Service Delivery Process c. Staff Training d. Task force and Stakeholders e. Description of barriers and ways to facilitate implementing the evidence-based intervention into the local service delivery system f. Descriptions of woman with alcohol problems and the factors that contribute to their stopping or continuing drinking g. Description of the model approaches to integrating CHOICES into State or local alcohol abuse programs.	9
Project Changes This section should focus on changes that have occurred due to this initiative. Narratives should describe the nature of the changes, how they were achieved, and why the change was deemed necessary or important.	17
Appendices	22

[1] **This will be used to fulfill the deliverable for the 2-page article**

Executive Summary – OY3 (August 1, 2010 to July 31, 2011)

The New York State Office of Alcoholism and Substance Abuse Services (OASAS) is the designated lead State agency for the FASD prevention initiative. *Project CHOICES* is a state-level project that is composed of the OASAS Project Team, selected treatment sites, and the FASD Task Force. The Project used a phase-in model to enroll treatment sites. Starting in OY1 we enrolled three residential sites in the greater New York City area. Each following year, new sites were added to the Project to meet the OY4 proposed total of eight sites. In OY3 the participating sites included: one residential site from OY1, one residential and one outpatient site from OY2, and the five outpatient sites from OY3. The goal of New York's FASD initiative *Project CHOICES* is to reduce the number of alcohol-exposed pregnancies for women enrolled in substance abuse treatment, by eliminating alcohol use and providing effective contraceptive choices. The target is non-pregnant women ages 18-44 with high-risk alcohol use and ineffective contraception.

There are nine Process Objectives and six Outcome Objectives. Process objectives focused on data collected at intake to site through participation in *Project CHOICES*. For examples of Process Objectives, in OY3 Annual data, 412 women were screened, and 40 women completed 4 MI sessions and 1 contraceptive visit. The Outcome Objectives are measures for alcohol use and use of an effective contraception at three distinct points: the End-of-Program, 6-month post intervention and 12-month post-intervention. The objectives are corroborated through other sources of information: the sites' monthly narrative and data reports, monthly calls, site visits, and Technical Assistance (TA).

The principal strategies continue to be integrating *Project CHOICES* into the clinical protocols of the treatment sites, facilitating access to women's reproductive health and family planning, and providing training and educational sessions to staff. The original Needs Assessment is updated every year with data and information from sites through monthly reports, monitoring and TA that are collected and analyzed to inform the implementation strategies. However, the original needs assessment did not include outpatient sites that were added later. During the first three years, we learned the importance of a site's organization and management stability on project implementation which led us to address specific issues. To improve implementation fidelity we addressed Motivational Interviewing (MI) coaching using Northrop Grumman's contractor; the OASAS Project Team continued to educate staff on FASD and provided Train-the-Trainer sessions for staff to deliver these sessions to clients and other staff. To supplement the annual *Project CHOICES* training, the OASAS Project Team developed a training booster for MI. In OY3 a *Project CHOICES* Protocol training was added and a Train-The-Trainers format to train the sites' staff. To enhance implementation fidelity, sites develop written administrative policies & procedures to operationalize the protocol and update them as they work through challenges.

The phase-in approach started with NYC residential sites and each year new treatment sites from different geographic locations were added. In OY3, the Project added the five new outpatient sites, a strategy that established *Project CHOICES* within the NYS OASAS statewide delivery systems for residential and outpatient programs. As research and studies have shown, the integration of an

evidence-based practice (EBP) into established treatment systems will need between two to four years to become established and considered part of the systems' natural treatment procedure. Factors that greatly influenced implementation and have been a consistent theme at all sites have been staff turnover, organizational overhaul, and management changes. All of the sites have experienced staff turnover and organizational changes. At the end of OY3, the agency with three outpatient sites in Western New York withdrew from *Project CHOICES* as a result of such changes. While the OY3 Implementation Plan addressed these types of issues through scheduled site monitoring, monthly conference calls, and customized TA, the sites that discontinued participation faced issues that were not within the purview of the OASAS Project Team to modify or adjust.

Just as organizations need stability to begin a new process, the sites found that the potential participants needed to be stabilized in their treatment environment in order to fully participate. Sites learned how to introduce the Project and refer the client for an assessment within a modified intake process. The sites are still struggling with screening all women who enter treatment, and encouraging them to participate when they are eligible. This challenge is illustrated in the OY3 site data: 915 women were admitted to the sites (37% of total admissions) of which 707 (77%) were ages 18 to 44 years. Of the 915 admissions, 412 (45%) were screened; 145 (35%) women met criteria to participate, and 126 (87%) of these women agreed to participate. However, over 65% of the women screened did not meet the *Project CHOICES* eligibility criteria set by Northrop Grumman. The three main reasons for ineligibility are: 37% - age; 19% - using effective contraception; and 17%- - not able to conceive. The sites' *Project CHOICES* staff used incentives to encourage participation. The sites report that the incentives encouraged patients throughout the Project: individual incentives and incentives for group recognition; i.e., graduation celebrations. A number of sites used patient incentives to acknowledge patients' Project milestones.

As stated above we recognized the need to provide *Project CHOICES* protocol training; for the first time in OY3, the OASAS Project Team developed and delivered the *Project CHOICES* Protocol training to PC staff who could not attend the annual training and for new staff. The OASAS Project Team participated in the Northrop Grumman Learning Community and in the TA conference calls. These combined methods supported the sites and staff implementing *Project CHOICES*. Also in Year 03, the OASAS Project Team initiated performance contracting with sites for data collection through a tiered incentive payment plan.

The FASD Task Force, with representatives from all *Project CHOICES* sites, OASAS staff, maternal/child health representatives, community stakeholders, FASD experts, and the OASAS Project Team, met quarterly to inform members of current FASD information and Project activities. In OY3 the OASAS Project Team addressed turnover of members and a reduction in attendance by modifying the quarterly schedules to accommodate members with phone meetings due to travel and fiscal restraints The OASAS Project Team began addressing sustainability with the sites during the monthly calls. In October 2010, a Task Force subcommittee of the sites began meeting to plan for sustainability with the assistance of the OASAS Project Team, and other OASAS Task Force staff. During OY4, the Task Force subcommittee of stakeholders and OASAS staff will assist the OASAS Project Team concerning *Project CHOICES* sustainability and implementation across the OASAS service delivery system.

Key Client Results Achieved
August 1, 2010 through July 31, 2011

Key Client results Achieved.

The OY3 Annual Report uses two main data sources: OASAS treatment data and OY3 Annual Project data. In New York, all certified OASAS programs are required to collect admission, discharge and other process data for all clients entering providers' service systems. This data is collected and aggregated in the OASAS Client Data System (CDS). OASAS uses the data for management purposes and is analyzed for other agency needs. For *Project CHOICES*, the staff collect data with the required forms and enter the data into the site's Access database. The sites generate monthly reports and the Project Evaluator aggregates the sites' data into a monthly spreadsheet and submits reports to Northrop Grumman. The OY3 Annual data are in tables included in the Appendix.

Target Population. In order to complete the OY3 tables, the total number of women entering treatment services was derived from the OASAS CDS. In OY3, there were 2444 admissions of men and women to all sites. To obtain the number of women in the target population, the total number of women admitted was separated into two categories: all women admitted - 915 (37% of total admissions) and women between18 to 44 years - 707 (77% of all women admitted). The numbers from the two residential sites were separated from the six community/outpatient sites. For the two residential sites, there were 321 women (38% of total admissions); of those, 261 (81%) women were 18 to 44 years. At the six outpatient sites, there were 1065 admissions of men and women of which there were 594 women (47%). Of these women, there were 446 (75%) women ages 18 to 44 years. The proportion of women in target group is slightly higher in the two residential and the one outpatient sites that serve predominately women. These numbers are displayed in the Appendix (Table 6). It should be noted that three OY3 outpatient sites participated for eleven out of twelve months, were not fully staffed for several months; and one of these sites never enrolled a single client. This provider withdrew in June 2011.

Screening. The sites have been using the Northrop Grumman Access Database since April 2009 to collect assessments and other participation data. Data collection begins with the initial screening/assessment tool when the site staff interview women who enter their treatment services. Of the 915 female admissions, 707 (77%) of women were between 18 and 44 years. Only 412 (45%) women were screened and 145 (35%) women were eligible. Of these women, 126 (87%) women agreed to participate. This data supports sites reporting that they were not fully staffed throughout the year and could not complete the screening on all women in treatment. In residential sites, 159 women were screened with 77 (48%) eligible and 68 (88%) agreed to participate. By comparison, the outpatient sites screened 253 women; only 68 (27%) were eligible and 58 (85%) agreed to participate. The five OY3 outpatient sites had the lowest number of screened women. It also appears that if women are screened and eligible they are very likely to agree to participate.

Demographic description. The section summarizes the data from the OY3 Annual data report with accompanying explanations and interpretations (Tables 1, 2, 3). For all sites, a total of 412 women were screened: 196 (48%) are white, 166 (40%) are African-American and 47 (12%) prefer to report Hispanic/Latina ethnicity. In residential facilities, the breakout is of 159 women screened: 86 (54%) are African-American; 65 (41%) are white and 21 (13%) are of Hispanic/Latina ethnicity. Outpatient population breakouts are different, of the 253 women screened, 131 (52%) are white; 80 (32%) are African-American, and 26 (11%) are Hispanic/Latina. Due to computational factors, "Average age" was estimated for all sites. The "average age" for the population at all sites is 33 years; 34 for years for the residential women, and 32 years for the women in outpatient treatment (see Table 5). For the population at all sites, 258 (65%) of the women have never been married, 60 (15%) report being "separated or divorced;" and 47 (12%) identified as being married. Only 27 (7%) identified as being "unmarried, living with a partner." In residential sites, women report similarly for "marital status:" 109 (69%) of the women have never been married, 21 (13%) report being "separated or divorced;" and 16 (10%) identified as being married. Only 9 (6%) identified as being "unmarried, living with a partner. In community-based sites, women report for "marital status:" 149 (62%) of the women have never been married, 39 (16%) report being "separated or divorced;" and 31 (13%) identified as being married. Only 18 (8%) identified as being "unmarried, living with a partner. The educational level for total population is 66% completing 12th grade or GED, and 34% who completed less that 12th grade/GED level. For women in residential sites, 58% completed 12th grade or GED, and 42% completed less that 12th grade/GED level; in the outpatient population, 72% completed 12th grade or GED, and 29% completed less that 12th grade/GED level. The higher level of the outpatient population's educational level may be attributed to women, who completed educational requirements while previously in residential setting, or women have easier access to educational services in the community, or that having a higher educational level is needed to meet other community requirements, such as having employment.

Baseline Characteristics for All women

Medians, like "average age", cannot be statistically derived from the sites' data that is aggregated in the current Annual Report format. Medians are only meaningful at the sites level. Therefore, Questions 20 and 21 are N/A for the total population in each category: "all sites", "all residential", and "all community-based" data. Questions 20 and 21 will be reported for each site in each category to address the statistical limitations. See below.

Residential Sites:

Table A. Q.20. Of the women who screened positive, median number of days women drank alcohol in the past 30 days *at screening.*

Sites	Number/NA%	Total Responses
30	0	39
40	6	37

Table B. Q.21. Of the women who screened positive, median number of drinks (from "0" to "10 or more") consumed on a typical day when drinking alcohol in the past 30 days *at screening.*

Sites	Number/NA%	Total Responses
30	0	39
40	4	37

Community-Based Sites:

Table C. Q.20. Of the women who screened positive, median number of days women drank alcohol in the past 30 days *at screening.*

Sites	Number/%	Total Responses
50	2	44
60	0	8
70	1	6
80-99	0	5

Table D. Q.21. Of the women who screened positive, median number of drinks (from "0" to "10 or more") consumed on a typical day when drinking alcohol in the past 30 days *at screening.*

Sites	Number/%	Total Responses
50	2	44
60	0	8
70	1	6
80-99	0	5

The numbers are small and it would seem that there is little difference between women in the outpatient setting and women in the residential settings.

Questions 22 and 23 use N/% and can be reported for the above categories:

Alcohol use

Q.22. Of all the women in all the sites who screened positive, N/% of the women had 4 or more drinks in the past 30 days at their screening.

- For the women (77) in residential sites who screened positive, 43 (55.8%) of the women had 4 or more drinks in the past 30 days at their screening.
- For the women (63) in community-based sites who screened positive, 23 (36.5%) of the women had 4 or more drinks in the past 30 days at their screening

Intervention services

Q.23. Of all the eligible women in all the sites who screened positive and agreed to participate, N/% of the women participated in 4 motivational interviewing sessions and 1 contraceptive visit.

- For the 68 women in residential sites, of all the eligible women who agreed to participate, 35 (52%) of the women participated in 4 motivational interviewing sessions and 1 contraceptive visit
- For the 55 women in community-based sites, of all the eligible women who agreed to participate, 15 (27%) of the women participated in 4 motivational interviewing sessions and 1 contraceptive visit

As the data indicates, residential sites have almost twice the number of women completing 4 MI sessions and 1 contraceptive visit.

Outcomes

Residential Treatment: Two active residential sites (159 screened), and 68 (88%) of all eligible women agreed to participate

End of Program (EOP): 35 (100%) of those who participated in 4 MI sessions and 1 contraceptive visit, completed questionnaire

Alcohol Use Outcomes:

- 5 out of 7 decreased alcohol use in past 30 days – 71%
- 27 out of 28 maintained non-use of alcohol in past 30 days – 96%
- 6 out of 8 decreased the number of drinks consumed on a typical day in past 30 days – 75%
- 7 out of 8 decreased the number of days they drank 4 or more drinks in past 30 days – 88%
- 33 out of 35 did not drink any alcohol since the first session – 94%

Contraception Outcomes: 29 (83%) out of 35 women reported using contraception effectively.

Sites improved on collecting this data, since OY2.

Six-month Follow up: Only 1 woman of all eligible women who agreed to participate completed the questionnaire

Alcohol Use Outcomes:

- NA decrease alcohol use in past 30 days
- 1 maintained non-use of alcohol in past 30 days – 96%
- NA decreased the number of drinks consumed on a typical day in past 30 days
- NA decreased the number of days they drank 4 or more drinks in past 30 days
- 1 did not drink any alcohol since the first session – 94%

Contraception Outcomes: 1 woman reported using contraception effectively.

There were no 12-month follow-up interviews, and the number of 6 month interviews was also below the projected numbers.

Community-based: the six community-based sites (253 screened); 68 (27%) women screen eligible and 58 (85%) agreed to participate.
End of Program (EOP): 10 (67%) participated in 4 MI sessions and 1 contraceptive visit (15 responses)
Alcohol Use Outcomes:

- 9 out of 10 decrease alcohol use in past 30 days – 90%
- 1 out of 1 maintained non-use of alcohol in past 30 days – 100%
- 10 out of 10 decreased the number of drinks consumed on a typical day in past 30 days – 100%
- 6 out of 6 decreased the number of days they drank 4 or more drinks in past 30 days – 100%
- 7 out of 11 did not drink any alcohol since the first session – 64%

Contraception Outcomes: 9 (82%) out of 11 women reported using contraception effectively.

Six-month Follow up: 4 (57%) women of 7 women who agreed to participate completed the questionnaire
Alcohol Use Outcomes:

- 4 decrease alcohol use in past 30 days – 100%
- 0 maintained non-use of alcohol in past 30 days – N/A
- 4 decreased the number of drinks consumed on a typical day in past 30 days – 100%
- 4 decreased the number of days they drank 4 or more drinks in past 30 days – 100%
- 4 did not drink any alcohol since the first session – 100%

Contraception Outcomes: there were 3 (75%) woman reporting using contraception effectively.

There were no 12-month interviews conducted; and this was not projected for OY3.

Program Descriptions and Experiences

Population needs identified and addressed. The main strategy of the FASD prevention initiative is the integration of *Project CHOICES* into the treatment protocols of treatment programs. There were eight sites operational in OY3: one intensive residential program from OY1 that admits both men and women and one site from OY2 that admits women and women with children. The sites are enhanced Therapeutic Communities (TC) with a highly structured, peer-driven clinical model. The OY2 site from Queens, the first outpatient program, is located in a family housing shelter. In OY3, five new outpatient sites were added; one site was in the Albany area and four were in Western New York.

As stated above, the population demographics at the sites closely match the target intervention population: 77% of all women admitted to the treatment sites are ages 18 to 44 years, with an average age of 33 years. Approximately half of the women report that they had 4

or more drinks in the past 30 days. An observation from the Needs Assessment that held true in OY3, was the need to incorporate information on family planning and reproductive health in staff and patient education. Strengthening effective birth control practices for women who consume alcohol and drugs at risky levels is one of the goals of *Project CHOICES*. We have addressed these needs through a training program that we describe in the "Staff Training" section.

Another goal of the Project is to facilitate access to birth control and family planning clinics. While women in residential facilities have most medical needs met in their treatment program, women in outpatient treatment have these health care issues met in their local communities. Only the OY2 outpatient site has a physician on-site who provides the contraceptive education and some forms of contraception. If women require other birth control technology, they are referred and transported to the medical facility under contract with the agency. The other OASAS outpatient providers established community linkages and/or made arrangements for women to be seen in family planning clinics and other health clinics.

OY3 sites reported that many of the women did not meet the *Project CHOICES* eligibility criteria. That information was validated from the data of women who were ineligible. There were 915 women admitted to treatment and 412 (45%) women were screened. Of these women, 145 (35%) women met eligibility criteria. The other 65% of the women screened did not meet the *Project CHOICES* eligibility for three main reasons: 37% - age; 19% - using effective contraception; and 17%- not able to conceive.

Service Delivery Process. To facilitate the start-up and implementation of the project, the OASAS Project Team provided TA to all sites. Following the Annual *Project CHOICES* training, the Project Evaluator prepares and transmits electronic copies of all PC tools and forms; spreadsheet of all the unique PC_client identifiers, copy of the Access Database and User Guide, copy of the methods of data transmission, and copy of the Process and Outcome Objectives for each site. The Project Associate prepares materials for Project staff: FASD brochures and rack cards, copies of the *Recovering Hope* video, copies of the posters and other media presentations that are sent to each site. This information is supplemented with the TA site visits in which the Project Evaluator provides technical training on the data collection and data entry; as well as training on the administration of the Screening tool and other forms. During the initial visit, the OASAS Project Team discusses the development of Policies and Procedures (P&P) that the sites will write and serve as a guide for the staff as they implement *Project CHOICES*; the P&P are due at the end of the following month. The sites' progress or questions on this information are discussed on the monthly conference calls held around mid-month to overlap with the monthly reports. The sites are also directed to establish PC implementation teams of supervisors, counselors, and other staff to implement project. Bi-weekly team meetings are to be scheduled to help site's staff address challenges and offer support to team.

Every *Project CHOICES* (PC) site has its own process for admission, intake, screening, and project participation that is reflected in its individual operation. However, there is a basic protocol dictated by Northrop Grumman that all sites follow. All woman admitted to treatment at the PC site are screened with the PC assessment form. Intake or PC staff provides basic information about *Project*

CHOICES and refer the women to PC Counselor (PCC) for assessment of eligibility. All women will be screened either by using the PC split-screen (first 10 questions of screen) to determine an initial eligibility, and/or the PCC completes the full PC screener to complete the assessment. Each site determines the time frame when this occurs. The PC assessment will be filed by the PC supervisor or administrative staff in a separate *Project CHOICES* file cabinet and a copy will be kept in the main clinical record/chart.

PC supervisors assign the cases and make referrals to the PCC staff. The PCC staff and woman schedule the four (4) MI sessions during their individual sessions. The sessions will be scheduled no less frequently than one session every two weeks. The schedule will be reviewed by the PC Supervisor at supervision sessions. PCC will send the tracking information to the administrative assistant to track progress, milestones and outreach efforts. PCCs are responsible to make and track referrals for the Contraceptive Visits, conduct all the follow-up interviews, and record discharges or lost to treatment on forms. Each site has designated data entry staff to enter all the information into the Access database. All of this information is written into the sites' Policy and Procedures. Each site determines how they will incentivize their clients who make specific milestones. Client incentives can be individually based or they can be delivered through a group format such as pizza parties to celebrate graduations or a combination of the two methods.

Using the information learned in previous years, the sites begin the projects by determining whether the woman would be directly assigned to the caseload of the PCC or she would remain on the primary counselor's caseload but receive *CHOICES* through the PCC. During the first several months it was important to monitor the time frame to administer the PC screener and determine the best timing for the woman as she begins the treatment process. The residential sites found that the women are often overwhelmed by their new environment, scheduling of community visits, and the orientation period at the facility. Residential PC staff decided to delay the screening process for *CHOICES*, and changes in retention and participation rates are monitored. Outpatient sites chose to use intake staff who are trained to complete the "split-screen" and include that as part of the intake. The outpatient sites reported a number of problems with this: staff ran out of time and omitted the *CHOICES* screening, staff forgot to screen, and the *CHOICES* screen was omitted from the intake package. These issues were complicated if the woman did not come back to the first visit for treatment, intake counselors forgot to notify the PCC that the *CHOICES* screen was not done. If the woman did not return, she was discharged after 30 days; only to re-appear at a later time. The OY3 outpatient sites were serving women from local community women; whereas, the OY2 outpatient site was co-located within a family housing shelter and served those women but was still considered outpatient. The OY3 outpatient sites were still working on resolving the screening scheduling. One major factor that hurt screening was that the three outpatient sites that withdrew from the Project in June 2011 were never fully staffed during this time. Each site either lost their CHOICES staff and/or their other counseling staff over several months or struggled to re-hire staff and get the training completed.

In general, when the women are eligible and agree to participate, about half will complete the four sessions and the contraceptive visit. The challenges to her completing *CHOICES* are related to the woman's progress in treatment and remaining in the treatment setting. The residential sites use their medical care units to provide the contraceptive visits, and the OY2 outpatient site also has a medical

doctor on contract that provides this service. When the birth control technology exceeds the limits of their practice, the women are referred to outside hospitals or clinics that provide those devices. OY3 outpatient sites set up referrals or agreements with health or birth control clinics for contraceptive services; some women preferred to use their own doctors; all visits are documented.

Collecting follow-up data continues to be a challenge for all sites. During the 4th MI session, the PCC conducts the End-of-Program interview (EOP). In OY3, the PCCs were slow to collect the EOP, but improved by the end of the year. The 6- and 12 –month follow-up interviews are the responsibility of the PCCs. They rely on the Access database to generate the names and they make the calls to the women. If a woman is still in treatment the interview is scheduled in person. However, the PCCs report that after a woman leaves the facility, tracking the women is difficult because they are a highly transient population without strong ties to community or family. Often updated contact information is quickly outdated after the women leaves treatment and sets up new living arrangements. All women lost to follow-up are entered into the Access database, and if found, updates are reentered. In previous reports, the Project Evaluator recommended other methods to improve the follow-up rates: offer the woman incentives to complete the interviews, hire a full-time tracking/follow-up staff person, and use other ways to make contact; i.e., Facebook, texting.

Staff Training. The primary training for *Project CHOICES* is delivered by Northrop Grumman's contractors in July prior to the start of the new project year. All new sites are asked to send their site supervisors and PC counselors. Other sites that have experienced staff turnover send their 'new' staff to the training. To meet the challenge of re-organization and staff turnover, the OASAS Project Team developed a training approach to meet these on-going training needs. In OY3, the OASAS Project Team conducted FASD training four times, three FASD Train-the-Trainer events and arranged two MI (2-day) training from the OASAS Training Unit, and two *Project CHOICES* protocol trainings (see details below).

An on-going need was the lack of basic FASD information by staff. To meet this need, the Team created a dual approach. First, the Project Associate conducts 'FASD 101,' the training that covers all the basic information about FASD, for the PC staff and other staff. Next, the site PC supervisor selects staff to be trained to deliver the FASD 101 presentation to other staff and to clients. The Project Associate and Project Evaluator conduct the FASD Train-The-Trainer (TTT) presentation which includes power point slides, handouts and brochures that the FASD trainers can then use for their in-house training. By training the site staff to provide this information, the site now has program capacity to sustain this portion of the project. The clients in treatment who are not in *CHOICES* can benefit from this information as well as other agency staff can understand the importance of addressing FASD in treatment. One residential site has conducted several FASD 101 sessions for staff, and women and men in both separate and mixed gender events. They report great success and positive feedback from clients and staff attending the events. In the spring of 2011, the site hosted a Women's Health event that featured the Project Associate and her daughter speaking about FASD and living with FASD.

Another need was to help PCCs understand how to work with clients who may have children or other family members with an FASD. The Project Associate and Project Evaluator created an enhanced training using the *Recovering Hope* video for PC counselors and other counseling staff. In addition to the video guide, the training incorporates MI language to assist the counselors as they use this interactive video with individual clients or in groups. Staff are trained to conduct the sessions and use other information to supplement the information on the video. The detailed training model is discussed in the Staff Training below.

The OASAS Project Team conducts site visits to monitor the progress of the Project, and provides training and technical assistance as needed via the telephone or in-person. The Project Evaluator, an OASAS MI trainer, addressed the need for on-going MI training to keep the sites staff's newly acquired skills sharp and focused to improve implementation fidelity through MI training and PC consultation which establishes peer-led coaching groups within each site. Another need is for MI supervisory sessions to monitor, evaluate the quality of the sessions, and provide feedback to the counselors. In OY3 Northrop Grumman provided MI coaching through the University of Texas-Austin to many of the PCCs. In OY3, the Project Evaluator designed and delivered a new *CHOICES* protocol training to sites in western New York through a video telecast. The Project Director and Project Evaluator recorded a second webinar on *Project CHOICES* that included the Director of the OY2 outpatient site in Queens. They also presented at the Annual meeting of the New York State Association of Alcoholism & Substance Abuse Providers (ASAP).

Task Force and Stakeholders. The FASD Prevention Task Force members include staff from the *CHOICES* sites, OASAS staff from different bureaus (such as Field Offices, Treatment, and Fiscal/Grants Management), community stakeholders, and the OASAS Project Team. The PC sites select who will represent their agency on the Task Force, and in most instances it is a combination of the agency's administrative contact and/or their PC site coordinator. While they have a regular designated representative to the Task Force, each PC site can invite other staff to the Task Force meetings, and depending on time availability, the PCC counselors do attend. The OASAS representatives include representation from the addiction prevention and treatment field, as well as the local governmental units (such as counties which also operate and fund addiction programs). The community stakeholders represent a cross-section of other New York state agencies, non-profit organizations, and maternal/child health and FASD experts.

Several of these individuals were members of the prior FASD Task Force that OASAS established under the prior Northrop Grumman subcontract, and it was felt that their continued participation and expertise would be beneficial. While some Task Force members regularly receive services (even funding) or are otherwise involved with OASAS, for some of these agencies/individuals this is their only collaboration with OASAS. Quarterly Task Force meetings are scheduled after the majority of the members report dates that they can join the calls. As with any multi-year initiative, Task Force membership experienced staff changes at the individual agencies and organizations, and member turnover. In OY3, the Task Force experienced changes to the OASAS representation as many staff moved on to other job responsibilities and/or retired. In OY3, the Project went from a NYC-based Project to a statewide Project, which more closely mirrors our Task Force. The FASD Task Force did help in the dissemination of information and advocacy within the OASAS

treatment system and in the larger provider community. Task Force members from maternal/child health, reproductive health, and perinatal sectors have learned a tremendous amount about FASD from their involvement in *Project CHOICES*; and Task Force members representing the PC sites used the meetings to learn from other PC sites.

Task Force members have the opportunity to ask critical questions of the PC sites, as some of them are in a position to refer clients from their agencies or service delivery systems. Discussions over the past year highlighted low agency enrollments due to declining referrals from drug courts. In response, Task Force members offered insights and suggestions regarding outreach and marketing. One of the Task Force members, Susan Brandau from the OASAS Performance Improvement Initiatives Unit, has participated in the sites' sustainability meetings. The State Health Department representatives on the Task Force offered their assistance early on when one of the sites experienced difficulties accessing local Planned Parenthood clinic services for the contraceptive visits. On an ongoing basis Task Force members share important information about local FASD activities in their own communities, including conferences and FASD Awareness Day celebrations that our Local Project CHOICES sites can then connect with or send staff to. By having statewide FASD experts, educators and advocates involved in the Task Force, the PC sites can better understand the importance of the work they do with Project CHOICES, and how that fits within the state's overall FASD prevention & treatment goals.

During the October 2010 Task Force meeting, it was decided that there would be two sustainability subcommittees, one for the PC sites and one for state-level stakeholders. The Site sustainability subcommittee has met three times since January 20, 2011 and shared important information on what has and hasn't worked in their sites. The state-level Stakeholders subcommittee will convene in OY4. The overall goal is the sustainability of *Project CHOICES* within the OASAS treatment system, and members will assist in the development of the OASAS sustainability activities.

<u>Descriptions of the barriers and ways to facilitate implementing the evidence-based intervention into the local service delivery organizations</u>.

In New York, *Project CHOICES* is a state-level project that consists of individual Chemical Dependence providers from across the state, an OASAS Project Team and the FASD Task Force. The Project uses a phase-in approach to enroll new sites; the OASAS Project Team recruits a new cohort of sites to join those sites that have been implementing the project in the previous year(s). The initial projections had eight sites operating in OY4. At the start of OY1, three NYC-based residential sites began the Project. As the year progressed, the OASAS Team found that the sites' ability to integrate *PC* was strongly linked to the stability of their organizational structure, project staffing, and leadership of the project at the site level. The two large residential sites experienced major staff turnover and reorganizations, and, eventually withdrew in December 2009. The remaining residential site also underwent reorganization as well as staff turnovers, but became stronger and more focused on implementing *Project CHOICES* and they have continued. The two NYC intensive residential sites that withdrew from the project in December 2009 were not replaced. After sites

declined to participate or withdrew, OASAS Team found it difficult to replace sites during project years, and it is not possible to have 'backup sites'. If new sites were found, the OASAS Project Team would be faced with providing *Project CHOICES* training as well as all startup processes requiring extensive OASAS Project Team time in the form of additional training and TA.

At the site-level, the OASAS Project Team uses a model for sites that includes forming an implementation team that consists of the Project liaison or staff person who is responsible for implementation, PCCs, and the FASD trainers. They meet every other week to discuss the project, clients and challenges and plan strategies to address them. Using the OASAS Project Team training model, after staff complete training, they are required to "practice" the training. For the FASD 101 trainers, they must prepare a training event for the site's PC team within 30 days of their training. At this time they practice their presentation skills and demonstrate their knowledge of FASD to a group of peers. Within 60 days of their training, they must develop and deliver FASD 101 training to the staff and/or to a group of clients. The site PC Team must develop a presentation schedule and obtain administrative approval. Staff trained in the *Project CHOICES* protocol are instructed to setup peer-led training with the other assigned PCCs and the Team. They can use a number of different approaches to peer mentoring or coaching that include: one-to-one in situ, role play in the Team meeting, observation of interviews with feedback in a group setting or in individual sessions with their team or supervisor.

As discussed above, in OY1 there were 3 intensive residential sites; in OY2, the Team expanded the Project from intensive residential sites in the greater New York City area to include another intensive residential women's program on Long Island, and an outpatient site in Queens. In OY3 the Project expanded geographically to the Western and Capital District areas of New York by adding five new outpatient sites. Using this model, the OASAS Project Team was able to implement *Project CHOICES* in two modalities: residential programs for women only and women with children; co-ed residential programs with women's treatment tracks; as well as outpatient programs for men and women, and a unique site that is co-located with a family housing shelter that serves women and children predominately. In OY3, three of the four outpatient sites in Western New York decided that they would not continue into OY4; they withdrew in June 2011. On the positive side, the OY2 outpatient site requested to expand within their programs to include another outpatient site on Staten Island.

In spite of all the pre-implementation preparations, consistent TA and training, the OASAS Project Team learned that sites have found implementing the EBP to be challenging. To implement *Project CHOICES,* the PC site staff must integrate it into the existing structure of the treatment agency. As research and studies have shown, the integration of an EBP into established treatment systems will need at least three full years to become established and considered part of the systems' natural treatment procedure which this model supports. Using the model sites can benefit from their previous year's experiences, and it is also a good method that helps new sites learn from the more experienced sites. Each type of service delivery system used different approaches to integrate *Project CHOICES* that reflect each system or program procedures. While the five OY3 outpatient sites had a difficult time getting started and keeping the momentum going because of high staff turnover, it does not appear that the type of services delivery system is a major

factor in integration. The most consistent factors are the sites' overall stability of staffing and management, sites' leadership championing the intervention and staff committed to implementing *Project CHOICES*.

In addition, to the monitoring and methods describe above, the OASAS Project Team continues to use the technology transfer's "active ingredients" to promote the adoption (and sustainability) of evidence-based practices (Brown, 2000). The Mountain West ATTC's common themes identify nine active ingredients to promote the adoption of a new practice or behavior:

1) focus on bottom-up strategies
2) deal with resistance
3) provide multiple exposures
4) ensure accessibility and suitability
5) influence and involve opinion leaders
6) enhance ownership
7) increase personal contact
8) provide rewards
9) utilize regeneration strategies

(Mountain West ATTC. Poster, June 2008)

Brown, B.S. (2000). From research to practice. The bridge is out and the water is rising. *Advances in Medical Sociology*, 7, 345-365

Adapted from Mountain West, 2008: http://www.attcnetwork.org/explore/priorityareas/techtrans/docs/MWATTC_technology_transfer_poster.pdf

Descriptions of the experiences of women with alcohol problems and the factors that contribute to their stopping or continuing drinking. In order to implement *Project CHOICES* with fidelity, there must be a level of trust and rapport between the woman and her PCC. Honest disclosures by the woman are valued by all treatment programs and their staff, and are integral to the *Project CHOICES* protocol. When sites' program rules conflict with the *Project CHOICES* protocol that asks the women to disclose sexual activity, alcohol use, etc., the organization and staff often felt conflicted. They addressed this challenge by reviewing and adapting policies to help the women make honest disclosures without a threat or punishment. This is a delicate balancing act that sites must adopt to support the woman if she is to fully participate in *Project CHOICES* and meet program requirements. Written policies and procedures must address issues and staff needs to be trained and have organizational support. The Project collects this information from the screening assessment and follow-up data described in the Key Results.

Description of model approaches to integrating *Project CHOICES* into State or local alcohol or substance abuse programs. There were eight sites implementing *Project CHOICES* in OY3. The OASAS Project Team used a phased-in approach that has evolved into a model that can be use to implement *Project CHOICES* into a state system. First, the OASAS Project Team completes several steps in a vetting process of potential sites: analyze the past year's data from the OASAS Client Data System (CDS), conduct telephone interviews with the site's corporate group, make inquiries about the sites' operational, programmatic, fiscal, QA/certification status,

and interview sites' OASAS Field Officers who provide oversight for these agencies. The potential sites complete an interest form with additional information related to their organization, and complete an interview by phone. After the sites are selected, the OASAS Project Team conducts an in-person site visit. The OASAS PC Team follows up with the OASAS staff if there are any unanswered questions, and to provide project information. This process reveals the site's strengths and challenges that they have faced in the past as well as current performance indicators. As described above, the site staff participate in CHOCIES training and prepare for implementations by assembling CHOCIES teams, writing P&P, and scheduling meetings and TA calls.

In OY1 the phased-in began with a "type" or modality of treatment in New York City area that was Intensive Residential treatment sites for women. This allowed the project to include the largest providers of this type of treatment in the state. Using lessons learned to reach other populations of women, the project expanded in two dimensions in OY2: geographically, the project included another Intensive Residential for adult women and women with children on Long Island, and added another modality, an Intensive Outpatient site for women in Queens. In year OY3, the project added three outpatient providers and continued expansion into the Albany and Buffalo areas of New York. This model of phased-in implementation provides the structure and experience that benefits the old and new sites and provides the Project management opportunities to address the barriers and challenges with knowledge and informed actions.

Program Changes

Overview

The goal of the Project is to integrate *Project CHOICES* protocols into treatment agencies, through their policies, procedures and treatment protocols. As reported in the Strategic Plan, the integration of *Project CHOICES* into the sites' current program operations and treatment protocol requires changes to both administrative and clinical systems in the short term, and adaptation of the organization culture to help sustain the intervention in the long term. The Strategic Plan states that the feasibility of implementing *Project CHOICES* within these programs is related to the extent to which 1) *Project CHOICES* can be integrated into the treatment protocol, 2) clinical staff master Motivational Interviewing (MI), 3) MI supervision is consistently available, and 4) the organizational culture supports these changes and adapts to these changes. While the staffs recognize that *Project CHOICES* has many benefits for the women, staff turnover has created gaps in implementation. Corporate support has come in the form of release for MI training, PC staff meetings, and modifications to P&P. However, the culture of the organization has been slow to adopt the new EBP and the requisite MI culture. Studies have shown that full implementation of an EBP can take up to 5 year. In OY4, there will be six sites with varying periods of implementation experience: Site 30 operating for three years, Sites 40 and 50 operating for two years, Sites 60 and 70 operating for one year; and these sites will be joined by the new Site 55.

Change Category	Description of Change
State/local policies and procedures	In OY3, there were no changes to the existing policies and procedures at the state or local levels. While sites have developed their policy and procedures for operationalizing *Project CHOICES*, it is not clear that they have been integrated into the organizational policies and procedures at all sites (see below). To date, the greatest impact on the implementation of *CHOICES* has been at the site level with the internal organizational changes, the staff training, and the services to the women. Any changes to State or local policies may result from sustainability efforts following the close of the project.
Organizational policies and procedures	Every site is different and those differences are reflected in their Policies and Procedures. Organizationally, the site leaders who may consider *CHOICES* an 'add-on' program and may not have shown support for their team's efforts toward integration pose the greatest barrier for the initiative. At sites where the leadership was weak or ambivalent, even when, the PC staff was very supportive, the project could not survive in the organization. Other challenges are associated with the staff turnover and organizational stability. At those sites where the leadership was consistent and visible, *CHOICES* was integrated with the existing program structures. The strength of management is found in its 'idea champion' and a team capable of implementing the protocol. The OASAS Project Team cannot predict how the programs and staff will react or perform when they are implementing a new practice or EBP. There are stressors and problems that occur which may or may not be related to the implementation of an EBP that must be addressed during implementation, such as, a program reorganization, staff turnover, lower numbers of admissions, austere fiscal environments, and other factors both internal and external to the organization. From the monthly reports and TA calls, the OASAS Project Team developed "Lessons Learned" and they were applied when developing the local P&P and the project's annual implementation plans. These lessons are used to make adjustments as quickly as possible with the sites, and make on-going modifications to assist the sites. If the providers' operational structures are flawed or they have dysfunctional organizational behavior that cannot be discerned through vetting, the OASAS Project Team can offer TA at each step of implementation to meet the challenges. The OASAS Project Team will continue to include all levels of management in monthly calls, Task Force meetings and ask for direct input from all levels of the organization. For *Project CHOICES* to be successful, the organizational culture must evolve to embrace MI as the foundation for communications and behaviors. These changes must be supported within the organizations and from the external resources like OASAS. Stakeholders and providers consider the MI training as critical to sustaining *Project CHOICES.* To achieve positive outcomes, patients must be able to comprehend the basic protocol to make behavioral changes, an important element of MI. The challenge to site-specific integration of an EBP is the time required to train and re-train staff, learn the new protocols, and adopt a new form of counseling (MI).

Systems integration (intake, screening, MI sessions, contraceptive visit, case coordination, etc.)	Following *Project CHOICES* protocol is necessary for implementation fidelity and this is consistent with the intent to integrate *Project CHOICES* into treatment. All sites have modified the timing of the PC screening to match/coordinate with their intake processes by: 1) adjusting the timing of the screening during the intake process, 2) modifying the screening form to accommodate a 'split-screening' process with other trained staff, 3) having the PC counselor conduct the entire screening, and 4) combining the first three to accommodate the sites' physical plant and staffing patterns. Trained program staff can administer the first 10 screening questions, known as 'split-screen', to all women and determine initial eligible. For the women who screen out, a copy of the screen is sent to the data entry staff, and then filed. All women who meet the initial eligibility criteria are interviewed by the PCC who determines the final eligibility to *Project CHOICES*. However, the current PC protocol may create an artificial barrier for staff as they try to integrate PC into their patients' treatment plans. At some sites, selected PC staff did not have substance abuse caseloads and PC clients were considered additional workload. While *PC* counselors who have direct case load responsibility for the women can initiate and maintain a relationship with clients, this procedure may not "fit" within the woman's treatment plan. Some of the sites have discussed the 'timing' of CHOICES within the woman's treatment episode. Normally, CHOICES is provided when the woman enters the treatment process and she completes it within an 8 week period. For some residential providers this may be too early because the woman may continue in treatment for another three to six months in which she will have more time to experience the world outside of the facility. The assumption is that the woman has set her behavioral goals and will be able to manage the challenges and stresses. In those sites, the staff are considering *Project CHOICES* as part of the woman's entry into the main society with support from the MI sessions and PC counselor. The *PC* counselor obtains the consent for follow-up, and schedules the MI sessions, Contraceptive Visit, and follow-up interviews. MI sessions are included as part of the client's individual counseling. Likewise, the normal screening and the PC intervention would be delivered in the course of the client's treatment plan and integrated into the treatment protocol; not conducted to fit the *Project CHOICES* protocol timeframe. At residential sites and sites with Medical Directors, the contraceptive visits can be included as part of the normal medical exam. For other sites, referrals and agreements have been made with external health clinics and birth control clinics. In OY3, the more rural sites had a harder time providing this service to women who could not paid for it. Two types of service delivery were selected: Intensive Residential and Outpatient Rehab. Each type of service system used different approaches to integrate PC that reflect each system or program procedures. It does not appear that the type of service systems was a major factor in integration. The most consistent factors are sites' leadership championing the intervention and staff committed to implementing PC, and consistent delivery of the protocols by the PC counselors. Consistent support by the sites leadership, supported by the OASAS Project Team's technical assistance will encourage the staff to remain committed to PC implementation. The challenge is to refresh the original needs assessment with new information, lessons learned and data collected through monitoring and

	evaluating each site as they implement. This type of on-going evaluation informs the site and the Project Team of changes that are needed, or assets that went unnoticed.
Service delivery processes (individual vs. group formats, new clinical techniques, etc.)	The sites have not changed any of their protocols and all sites will continue to implement all aspects of *Project CHOICES* through the OY4. However, discussion at the Task Force Site sustainability meetings show that some sites are thinking about modifications like offering *PC* sessions to women with no age limitation who are able to have children and are at risk of an alcohol-exposed pregnancy determined through their intake and screening process. Another consideration is the format of *PC* sessions and whether to offer a combination of individual and group formats. Most sites plan on continuing FASD educational sessions in groups for all clients and their staff, and individually for women as needed. They have not determined if they will maintain the incentives as they are currently provided. For sites with in-house training units, staff training for *CHOICES* and Motivational Interviews will be handled through their in-house training program and training through the OASAS Training Unit. As mentioned in the above section, the timing of *Project CHOICES* in the treatment plan may be more appropriate later in the process instead of at the beginning of treatment for some women..
Data Systems (integration of program data, centralization, etc.)	Access is the database used at each site for this project. Access is a standalone application that includes data entry, data management, and analyses features. Sites are responsible for their data entry, data quality and creation of reports. Unless one is proficient in Access' queries and reports, data management and analyses are cumbersome and difficult for the site users. The Access data system is used as a data entry system at project site level, but data management at the state-level was difficult because the databases reside at each site. At the state-level, the Project Evaluator does not have direct access to the sites' databases. Northrop Grumman's contractor, HSRI, made all the modifications to the databases and designed reports. The PC site staff collected all data on paper, send paper to data entry staff, and they produce monthly reports that are sent to the Project Evaluator. While sites' staffs have become proficient with data collection and entry, they only use the database to produce the required reports. At the state-level, the Project Evaluator provides basic Access TA to the staff for data collection and data entry and this will continue in OY4. The sites and Project Evaluator perform limited data management and data quality reporting; HSRI makes database modification and create major reports. A better choice would have been a web-based system to collect and manage the data with built-in report functions that were transparent to all users at all levels. In the future, OASAS will determine if it is feasible to add items from the screening form to the OASAS Client Data System (CDS) that are specific to women's health issues; such as use of contraceptives that are not currently collected.
Staffing (new training focuses, staffing structures, qualifications for new hires, etc.)	The OASAS Project Team requests that the sites select their staff to implement *Project CHOICES*; the sites make the selection and/or replace staff, but selection must include the supervisor and at least two counselors who will implement the project. Northrop Grumman provides the Annual *Project CHOICES* training. Normally, these training events can be attended by only a few program staff due to the caseload and time out of the office that results in loss of billing hours. This creates a need for additional training for more staff as the project gears up. A lesson learned is

	that the required two-day *Project CHOICES* training is necessary, but it is not sufficient for site staff to learn and maintain their Motivation Interviewing (MI) skills. MI counseling skill levels vary greatly among the sites' staffs. MI is not easily learned and practiced by counseling staff; developing MI proficiency requires on-going supervision, monitoring and coaching to be considered effective. In OY3, Northrop Grumman's consultant, University of Texas-Austin, provided MI coaching. Staff who participated in University of Texas MI coaching had positive feedback, but some staff had difficulty with the technology of taping and transmitting tapes to Texas. As stated above staff turnover also creates a need for more training that is currently provided by the OASAS Project Team and/or they assist the sites' staff to obtain MI training from the OASAS Training Unit that provides regional training within their overall schedule. Because Chemical Dependence staff do not have a comprehensive knowledge of FASD, basic education on FASD is also needed. New in OY3, the OASAS Project Team delivered the first training telecast of the CHOICES protocol to sites in Western New York. The training needs will continue due to staff turnover and management changes. From the monthly reports and calls, the sites state that the population has liked the Project and has found the FASD information valuable. The OASAS Project Team-led training is requested by site staff as the needs arise. The OASAS Project Team developed two training programs to meet training needs: Basic FASD 101 is for all site staff and Train-the-Trainer (TTT) model for staff who would train other staff and patients, and basic implementation of data collection and CHOICES procedures. Next, OASAS Project Team conducts the TTT for FASD and *CHOICES.* A pre-requisite for CHOICES Protocol training is having recent MI training and experience. Other training consisted of MI Booster sessions to supplement staff who attend the annual training. Site staff are encouraged and assisted by the OASAS team to enroll in OASAS training for MI. New in OY4 is the MI Coaching Pilot which will address MI supervision with staff from selected sites who will be involved with individual and group coaching to augment the previous MI coaching experiences. The OASAS Project Team developed the FASD 101 and Train-the-Trainer (TTT) models to educate the sites' staff and to help them understand the project's goals and their clients. The OASAS Project Team learned that the training format delivered to selected staff must include platform skills, and practice demonstrations in conjunction with the didactic materials and videos. Due to the complexity of the FASD material and varying skill levels of presenters, the format was structured to include practice demonstrations to model and refine presentations. Following the CHOICES protocol training, the OASAS Project Team works with PC site managers to establish peer-led coaching and mentoring groups for PC staff. This has led to capacity building for each site through FASD training programs, MI training and coaching and PC protocol training of staffing. Each site is an independent entity that determines its own policies for hiring, training and termination of staff. Potential influences to these practices may result from their efforts to sustain *Project CHOICES.*

APPENDICES

Table 1. Data collection activity between 8/1/2010 and 7/31/2011 - All sites*

Table 2. Data collection activity between 8/1/2010 and 7/31/2011 - Residential Only – at Two Sites

Table 3. Data collection activity between 8/1/2010 and 7/31/2011 – Community-Based Only Sites (6)

Table 4. OASAS Admissions to *Project CHOICES'* Sites from August 1, 2010 through July 31, 2011

Table 5. Estimating "Average Age" for sites

Table 6. Screening results from PC Access Databases: August 1, 2010 through July 31, 2011 (OY3)*

Table 7. CHOICES Participation Data from PC Access Databases (raw data): August 1, 2010 to July 31, 2011*

Table 1. Data collection activity between 8/1/2010 and 7/31/2011 - All sites*

	Number	Percent	Total Responses
1. Total women entering the service**	915	N/A	N/A
2. Of the women entering the service, N/% screened	412	45%	N/A
Demographic Data			
3. Of the women who reported race, N/% Alaska Native	0	0	412
4. Of the women who reported race, N/% American Indian	9	2.2	412
5. Of the women who reported race, N/% Asian	3	0.7	412
6. Of the women who reported race, N/% Black or African-American	166	40.3	412
7. Of the women who reported race, N/% Native Hawaiian or other Pacific Islander	2	0.5	412
8. Of the women who reported race, N/% White	196	47.6	412
9. Of the women who reported ethnicity, N/% Hispanic/Latina	47	11.9	396
10. Average age of women at screening	N/A	N/A	N/A
11. Of the women who reported educational status, N/% who completed GED/12th grade or higher	263	66.2	397
12. Of the women who reported educational status, N/% who completed less than GED/12th grade	134	33.8	397
13. Of the women who reported marital status, N/% who identified as "married"	47	11.8	397
14. Of the women who reported marital status, N/% who identified as "unmarried, living with partner"	27	6.8	397
15. Of the women who reported marital status, N/% who identified as "never married"	258	65	397
16. Of the women who reported marital status, N/% who identified as "widowed"	5	1.3	397
17. Of the women who reported marital status, N/% who identified as "divorced or separated"	60	15.1	397
Screening			
18. Of the women screened, N/% screened eligible for program	145	35.2	412
19. Of the women who screened eligible, N/% who agreed to participate in program	126	86.9	145

OY3 (8/1/2010 and 7/31/2011) - All sites

Baseline Characteristics	Residential Treatment Population			Community-Based Population		
	Number	Percent	Total Responses	Number	Percent	Total Responses
20. Of the women who screened positive, median number of days women drank alcohol in the past 30 days *at screening*	N/A	N/A	N/A	N/A	N/A	N/A
21. Of the women who screened positive, median number of drinks (from "0" to "10 or more") consumed on a typical day when drinking alcohol in the past 30 days *at screening*	N/A	N/A	N/A	N/A	N/A	N/A
22. Of the women screened positive, N/% of women who had 4 or more drinks in 1 day in the past 30 days *at screening*	43	55.8	77	23	36.5	63
Intervention Services	**Residential Treatment Population**			**Community-Based Population**		
	Number	Percent	Total Responses	Number	Percent	Total Responses
23. Of the eligible women who agreed to participate, N/% participated in 4 motivational interviewing sessions and 1 contraceptive visit	35	51.5	68	15	27.3	55

***All sites are (2) residential and (6) Community-based sites.**
****NYS OASAS CDS – data extract August 2011.**

Table 2. Data collection activity between 8/1/2010 and 7/31/2011 - Residential Only – at Two Sites

a	Number	Percent	Total Responses
1. Total women entering the service*	321	N/A	N/A
2. Of the women entering the service, N/% screened	159	49.5	N/A
Demographic Dat			
3. Of the women who reported race, N/% Alaska Native	0	0	159
4. Of the women who reported race, N/% American Indian	1	0.6	159
5. Of the women who reported race, N/% Asian	2	1.3	159
6. Of the women who reported race, N/% Black or African-American	86	54.1	159
7. Of the women who reported race, N/% Native Hawaiian or other Pacific Islander	0	0	159
8. Of the women who reported race, N/% White	65	40.9	159
9. Of the women who reported ethnicity, N/% Hispanic/Latina	21	13.5	159
10. Average age of women at screening	N/A	N/A	N/A
11. Of the women who reported educational status, N/% who completed GED/12th grade or higher	92	58.2	158
12. Of the women who reported educational status, N/% who completed less than GED/12th grade	66	41.8	158
13. Of the women who reported marital status, N/% who identified as "married"	16	10.1	158
14. Of the women who reported marital status, N/% who identified as "unmarried, living with partner"	9	5.7	158
15. Of the women who reported marital status, N/% who identified as "never married"	109	69	158
16. Of the women who reported marital status, N/% who identified as "widowed"	3	1.9	158
17. Of the women who reported marital status, N/% who identified as "divorced or separated"	21	13.3	158
Screening			
18. Of the women screened, N/% screened eligible for program	77	48.4	159
19. Of the women who screened eligible, N/% who agreed to participate in program	68	88.3	77

***NYS OASAS CDS – data extract August 2011.**

All Sites - Residential Treatment Population – at Two Sites (cont)

Outcomes – Alcohol Use	Note: These measures will be used to assess outcomes at End of Program.		
	Number	Percent	Total Responses
24a. Of the eligible women who agreed to participate, participated in 4 MI sessions and 1 contraceptive visit, and are due for assessment, N/% completed a questionnaire	35	100	35
25a. Of the eligible women who agreed to participate, reported drinking alcohol on at least 1 day in the past 30 days at screening, and completed the questionnaire, N/% of women who decreased alcohol use in the past 30 days	5	71.4	7
26a. Of the eligible women who agreed to participate, reported non-use of alcohol in the past 30 days at screening, and completed the questionnaire, N/% of women who maintained non-use of alcohol in the past 30 days	27	96.4	28
27a. Of the eligible women who agreed to participate, reported drinking 1 or more drinks on a typical day when drinking alcohol in the past 30 days at screening, and completed the questionnaire, N/% of women who decreased the number of drinks consumed on a typical day in the past 30 days	6	75	8
28a. Of the eligible women who agreed to participate, reported having 4 or more drinks in 1 day at least once in the past 30 days at screening, and completed the questionnaire, N/% who decreased the number of days drank 4 or more drinks in the past 30 days	7	87.5	8
29a. Of the eligible women who agreed to participate and completed the questionnaire, N/% who did not drink any alcohol since the first session when we talked about drinking	33	94.3	35
Outcomes – Contraception Use	**Note: These measures will be used to assess outcomes at End-of-Program**		
30a. Of the eligible women who agreed to participate and completed the end of program follow-up questionnaire, N/% who reported using contraception effectively	29	82.9	35

Outcomes – Alcohol Use	Note: These measures will be used to assess outcomes at 6 Months Follow-Up.		
	Number	Percent	Total Responses
24a. Of the eligible women who agreed to participate, participated in 4 MI sessions and 1 contraceptive visit, and are due for assessment, N/% completed a questionnaire	0	0	0
25a. Of the eligible women who agreed to participate, reported drinking alcohol on at least 1 day in the past 30 days at screening, and completed the questionnaire, N/% of women who decreased alcohol use in the past 30 days	0	N/A	0
26a. Of the eligible women who agreed to participate, reported non-use of alcohol in the past 30 days at screening, and completed the questionnaire, N/% of women who maintained non-use of alcohol in the past 30 days	1	100	1

27a. Of the eligible women who agreed to participate, reported drinking 1 or more drinks on a typical day when drinking alcohol in the past 30 days at screening, and completed the questionnaire, N/% of women who decreased the number of drinks consumed on a typical day in the past 30 days	**0**	**N/A**	**0**
28a. Of the eligible women who agreed to participate, reported having 4 or more drinks in 1 day at least once in the past 30 days at screening, and completed the questionnaire, N/% who decreased the number of days drank 4 or more drinks in the past 30 days	**0**	**N/A**	**0**
29a. Of the eligible women who agreed to participate and completed the questionnaire, N/% who did not drink any alcohol since the first session when we talked about drinking	**1**	**100**	**1**
Outcomes – Contraception Use Note: These measures will be used to assess outcomes at 6 Month Follow-Up			
30a. Of the eligible women who agreed to participate and completed the 6 month follow-up questionnaire, N/% who reported using contraception effectively	**1**	**100**	**1**

There were no (0) data for 12 month Follow-Up assessments for All Residential Populations

Table 3. Data collection activity between 8/1/2010 and 7/31/2011 – Community-Based Only Sites (6)

	Number	Percent	Total Responses
1. Total women entering the service*	594	N/A	N/A
2. Of the women entering the service, N/% screened	253	42.6	N/A
Demographic Data			
3. Of the women who reported race, N/% Alaska Native	0	0	253
4. Of the women who reported race, N/% American Indian	8	3.2	253
5. Of the women who reported race, N/% Asian	1	0.4	253
6. Of the women who reported race, N/% Black or African-American	80	31.6	253
7. Of the women who reported race, N/% Native Hawaiian or other Pacific Islander	2	0.8	253
8. Of the women who reported race, N/% White	131	51.8	253
9. Of the women who reported ethnicity, N/% Hispanic/Latina	26	10.8	241
10. Average age of women at screening	N/A	N/A	N/A
11. Of the women who reported educational status, N/% who completed GED/12th grade or higher	171	71.5	239
12. Of the women who reported educational status, N/% who completed less than GED/12th grade	68	28.5	239
13. Of the women who reported marital status, N/% who identified as "married"	31	13	239
14. Of the women who reported marital status, N/% who identified as "unmarried, living with partner"	18	7.5	239
15. Of the women who reported marital status, N/% who identified as "never married"	149	62.3	239
16. Of the women who reported marital status, N/% who identified as "widowed"	2	0.8	239
17. Of the women who reported marital status, N/% who identified as "divorced or separated"	39	16.3g	253
18. Of the women screened, N/% screened eligible for program	68	26.9	253
19. Of the women who screened eligible, N/% who agreed to participate in program	58	85.3	68

Note: Outpatient Sites 80, 90 and 99 (combined data) were active from August 1, 2010 to June 30, 2011.

Community-Based Treatment Population – Six Sites (cont)

Outcomes – Alcohol Use Note: These measures will be used to assess outcomes at End of Program	Community Treatment Population		
	Number	Percent	Total Responses
24b. Of the eligible women who agreed to participate, participated in 4 MI sessions and 1 contraceptive visit, and are due for assessment, N/% completed a questionnaire	10	66.7	15
25b. Of the eligible women who agreed to participate, reported drinking alcohol on at least 1 day in the past 30 days at screening, and completed the questionnaire, N/% of women who decreased alcohol use in the past 30 days	9	90	10
26b. Of the eligible women who agreed to participate, reported non-use of alcohol in the past 30 days at screening, and completed the questionnaire, N/% of women who maintained non-use of alcohol in the past 30 days	1	100	1
27b. Of the eligible women who agreed to participate, reported drinking 1 or more drinks on a typical day when drinking alcohol in the past 30 days at screening, and completed the questionnaire, N/% of women who decreased the number of drinks consumed on a typical day in the past 30 days	10	100	10
28b. Of the eligible women who agreed to participate, reported having 4 or more drinks in 1 day at least once in the past 30 days at screening, and completed the questionnaire, N/% who decreased the number of days drank 4 or more drinks in the past 30 days	6	100	6
29b. Of the eligible women who agreed to participate and completed the questionnaire, N/% who did not drink any alcohol since the first session when we talked about drinking	7	63.6	11
Outcomes – Contraception Use Note: These measures will be used to assess outcomes at End of Program.			
30b. Of the eligible women who agreed to participate and completed the end of program/6 month follow-up/12 month follow-up questionnaire, N/% who reported using contraception effectively	9	81.8	11
Outcomes – Alcohol Use Note: These measures will be used to assess outcomes at 6 month follow-up			
Community-Based (cont)	Number	Percent	Total Responses
24b. Of the eligible women who agreed to participate, participated in 4 MI sessions and 1 contraceptive visit, and are due for assessment, N/% completed a questionnaire	3	42.9	7
25b. Of the eligible women who agreed to participate, reported drinking alcohol on at least 1 day in the past 30 days at screening, and completed the questionnaire, N/% of women who	4	100	4

decreased alcohol use in the past 30 days			
26b. Of the eligible women who agreed to participate, reported non-use of alcohol in the past 30 days at screening, and completed the questionnaire, N/% of women who maintained non-use of alcohol in the past 30 days	**0**	**N/A**	**0**
27b. Of the eligible women who agreed to participate, reported drinking 1 or more drinks on a typical day when drinking alcohol in the past 30 days at screening, and completed the questionnaire, N/% of women who decreased the number of drinks consumed on a typical day in the past 30 days	**4**	**100**	**4**
28b. Of the eligible women who agreed to participate, reported having 4 or more drinks in 1 day at least once in the past 30 days at screening, and completed the questionnaire, N/% who decreased the number of days drank 4 or more drinks in the past 30 days	**4**	**100**	**4**
29b. Of the eligible women who agreed to participate and completed the questionnaire, N/% who did not drink any alcohol since the first session when we talked about drinking	**4**	**100**	**4**
Outcomes – Contraception Use Note: These measures will be used to assess outcomes at 6 month follow-up.			
30b. Of the eligible women who agreed to participate and completed the 6 month follow-up questionnaire, N/% who reported using contraception effectively	**3**	**75**	**4**

No Data for 12 month Follow-Up assessments for Community-Based Populations – 0

OY3 Sites – Data Tables

Table 4. OASAS Admissions to *Project CHOICES'* Sites from August 1, 2010 through July 31, 2011

Sites	Modality	Provider # PRU #	Men and women n	Total women n		Women 18 to 44 yrs n
30	Residential	39050 1656	654	136 (21%)		98 (72%)
40	Residential	50570 4321, 6607	185	185 (100%)		163 (88%)
50	Outpatient	12030 5594	218	123 (56%)		117 (95%)
60	Outpatient	118 93	293	101 (34%)		74 (73%)
70	Outpatient	50230 50357	347	121 (35%)		90 (74%)
80	Outpatient	38020 51852	283	104 (37%)		69 (66%)
90	Outpatient	38020 50083	314	99 (32%)		65 (66%)
99	Outpatient	38020 50952	150	46 (31%)		31 (67%)
	totals		2444	915 (37%)		707 (77%)

Notes: * Total admissions to services are all admitted men and women.
Data Source: OASAS Client Data System, Data Warehouse - extract 8/20/2011.

Table 5. Estimating "Average Age" for sites.

Calculations of the average age = [(average age per site) x (n of women per site)] = (Sum of sites "average age")/ N of all women

Residential sites

Site 30: (37 x 84) = 3108
Site 40: (31 x 75) = 2325

Outpatient sites

Site 50: (27 x 73) = 1971
Site 60: (32 x 39) = 1248
Site 70: (31 x 65) = 2015
Site 80-99: (38 x 76) = 2888

Estimating "Average Ages"

Residential **Average age = (5433/159) = 34 years for residential sites**
Outpatient **Average age = (8122/253) = 32 years for community-based sites**
Total **Average age = (13555/412 = 33 years for Total pop of all sites**

Residential Treatment Sites	Site 30			Site 40	
Demographics	Number	Total Responses		Number	Total Responses
10. Average age of women at screening.	37	84		31	75

Community-based Sites	Site 50		Site 60		Site 70		Site 80-99	
Demographics	N	TR	N	TR	N	TR	N	TR
10. Average age of women at screening.	27	73	32	39	31	65	38	76

N=Number TR=Total Responses. There are no % with an Average.

Table 6. Screening results from PC Access Databases: August 1, 2010 through July 31, 2011 (OY3)*

Results		Women admitted	Screen	Screened eligible		Not eligible reasons						
Sites	modality	n	n	n (%) & agree	n (%) & refuse	Total Not eligible	n age	n Preg /trying	n infertile	n contra effect	n Alcohol no risk	n No sex
30	R	136	86 (63%)	35 (41%)	4	47 (55%)	23(49%)	6 (13%)	12 (26%)	0	6 (13%)	7 (15%)
40	R	185	74 (40%)	33 (45%)	5	36 (49%)	10 (28%)	3 (8%)	4 (11%)	9 (25%)	10 (28%)	1 (3%)
50	O	123	73 (59%)	43 (59%)	1	29 (40%)	4 (14%)	11 (38%)	4 (14%)	6 (21%)	3 (10%)	2 (7%)
60	O	101	39 (39%)	6 (15%)	2	31 (79%)	9 (29%)	4 (13%)	6 (19%)	7 (23%)	0	4 (13%)
70	O	121	65 (54%)	2 (3%)	6	57 (88%)	18 (32%)	6 (11%)	6 (11%)	25 (44%)	0	6 (11%)
80-99	O	249	76 (31%)	7 (9%)	1	67 (88%)	36 (54%)	7 (10%)	13 (19%)	5 (7%)	5 (7%)	2 (3%)
totals		915	413 (45%)	126(31%)	19 (4%)	267 (65%)	100 (37%)	37 (14%)	45 (17%)	52 (19%)	24 (9%)	22 (8%)

Table 7. CHOICES Participation Data from PC Access Databases (raw data): August 1, 2010 to July 31, 2011*

Sites	Women		Participate	MI sessions				CV	EOP
	Admitted n	Screened n	agreed n (%)	MI 1	MI 2	MI 3	MI 4	n	n
30	136	86	35 (41%)	36	36	35	34	35	34
40	185	74	33 (45%)	9	4	3	1	2	1
50	123	73	43 (59%)	32	25	18	14	20	8
60	101	39	6 (15%)	5	4	3	2	0	1
70	121	65	2 (3%)	1	1	0	0	0	0
80-99	249	76	7 (9%)	5	4	4	4	4	2
total	915	413 (45%)	126 (31%)	88 (70%)	74 (59%)	63 (50%)	55 (44%)	61 (48%)	46 (37%)

*** Data Source: OY3 monthly *Project CHOICES'* Access databases – August 1, 2010 to July 31, 2011 (Raw data not cleaned Annual report data); and OASAS Client Data System, Data Warehouse - extract 8/20/2011**

Reasons for Ineligible – individual items sum = 276 that is> 267 (errors in 30, 40, 50)

- **Modality: Residential = R; Outpatient = O**
- **'Preg/trying' = combined numbers for those pregnant and those trying to get pregnant.**
- **Contra effect = Using contraception effectively**
- **No sex = no heterosexual activity, not sexually active**
- **Outpatient Sites 80, 90 and 99 are combined for report**