

PINE BELT MENTAL HEALTHCARE RESOURCES
FASD PREVENTION INITIATIVE – PROJECT CHOICES

ANNUAL REPORT – OY 3

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&

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1. PROJECT SUMMARY

Pine Belt Mental Healthcare Resources (PBMHR) is a community mental health service provider in south Mississippi. PBMHR offers a comprehensive system of care which utilizes multiple evidence-based practices and case management services to improve the quality of life of persons suffering from mental illness. Over the past several years, PBMHR has incorporated prevention interventions into this system of care, including initiatives designed to prevent HIV/AIDS and alcohol/substance abuse. Given the scientific evidence which indicates a nexus between mental illness and alcohol abuse, incorporating a prevention intervention aimed at curbing alcohol-involved pregnancies indeed fits within PBMHR's mission. Project CHOICES was selected as the mechanism to combat fetal alcohol spectrum disorders. The primary objectives of PBMHR's FASD Prevention Project are to reduce and/or eliminate alcohol consumption and increase effective contraception use of sexually active women who are able to become pregnant.

PBMHR has integrated Project CHOICES as a component of treatment for women who are ages 18-44, able to become pregnant, and failing to use effective contraception. Potential participants are generally drawn from four points of interception: (1) current clients, (2) new clients, (3) the Forrest County jail, and (4) women receiving ancillary services (e.g., other prevention interventions) in the community. Potential participants are pre-screened to identify obvious exclusionary criteria (e.g., inability to conceive). Women meeting general eligibility criteria who are interested in the program then complete the comprehensive screening process. Those meeting eligibility criteria are then placed in the CHOICES program.

Project CHOICES utilizes motivational interviewing to facilitate changes in behavior. Clinicians delivering the motivational interviewing sessions focus on providing prevention messages in various formats (e.g., brochures, presentations, etc.) in order to increase participants' commitment to change their behaviors regarding alcohol consumption and effective contraception use. The CHOICES intervention consists of four motivational interviewing sessions and a contraceptive counseling session. Participants are assessed at baseline (screening), completion (end of program), six months post-completion, and twelve months post-completion.

PBMHR has accomplished several important project milestones. First, key staff members have received training regarding the delivery of the CHOICES intervention. Utilizing multiple clinicians to deliver the intervention allows PBMHR to provide CHOICES as a treatment option in multiple locations. Second, a CHOICES Task Force has been established to provide guidance to and oversight of project staff. The Task Force is multidisciplinary and includes people with backgrounds in mental health, prevention, and research. Third, PBMHR has developed agency policies which govern identification, referral, and service delivery procedures of the CHOICES initiative. Additionally, PBMHR staff members who are not directly associated with the project are well informed about the purpose and availability of CHOICES as a treatment component for female clients. PBMHR has fully integrated CHOICES into its system of care, which will facilitate the continuation of FASD preventions efforts subsequent to the end of the project's funding period. During OY3, began offering the CHOICES intervention to women in the community who were participating in PBMHR's HIP-HOP (HIV/substance abuse prevention) intervention.

Of the 67 women who passed the pre-screening process in OY3, 57 (85.1%) were screened as eligible for participation in the CHOICES intervention. All eligible women agreed to participate.

Participants included women in residential treatment and women in community-based settings. In total, 25 women (44%) completed the CHOICES intervention, 28 women (49%) left treatment AMA (and therefore discontinued the program), and 4 women (7%) are still active participants. Of the 9 women who were eligible for six month follow-up, 4 (44%) completed questionnaires. No OY3 participants were eligible for 12 month follow-up. As such, results regarding alcohol consumption and effective contraceptive use only reflect behavior changes from screening to six-month follow-up.

The CHOICES intervention yielded mixed results in OY3. Of the 8 women completing the CHOICES intervention in residential treatment settings, 100% maintained abstinence from alcohol from screening to end of program (EOP) assessment. Only 1 woman (12.5%) in residential treatment reported using contraception effectively at EOP. No women in residential treatment settings completed a six-month follow-up questionnaire. Of the 17 women completing the CHOICES intervention in a community setting, EOP results were as follows: 16 (94.1%) decreased past 30 day alcohol use; 14 (82.4%) decreased number of drinks consumed on a typical day; 17 (100%) decreased number of days drinking 4 or more drinks; and 11(64.7%) had not drank any alcohol since the first session on drinking. Five women (29.4%) reported using effective contraception at EOP. Of the 4 women completing six month follow-up questionnaires, results were as follows: 4 women (100%) decreased past 30 day alcohol use; 3 women (75%) decreased number of drinks consumed on a typical day; 4 women (100%) decreased number of days drinking 4 or more drinks; and 1 woman (25%) had not had any alcohol since the first session on drinking. Two women (50%) reported using effective contraception at six month follow-up.

Although preliminary results indicate that the CHOICES intervention is successful regarding drinking behaviors, several key issues remain to be addressed. First, women in residential treatment settings have less access to alcohol and contraceptive devices than their community counterparts. As such, alcohol use among this population may be reflective of access rather than behavior change and measures of alcohol use may be overestimated. Additionally, measures of effective contraception use may be underestimated due to access to effective contraception and opportunities to engage in sexual activities. Second, there was little follow-up information for this reporting period. Although the available data indicate that CHOICES has had a positive impact, the long-term magnitude of that impact can only be measured at time points subsequent to the EOP assessment. This issue is certainly applicable to the residential treatment population and women in jail, in that participation in residential treatment requires abstinence from alcohol and the availability of alcohol in jails is somewhat sparse. Finally, PBMHR must continue to work to increase completion rates for CHOICES participants. Specifically, half the women who dropped out of the intervention were in the Forrest County jail. Many women had no desire to continue the program subsequent to their release. As such, specific attention will be given to finding a remedy to combat attrition rates among this group.

In conclusion, Project CHOICES has had a positive impact on many PBMHR clients, women in jail, and women in the community. Current service identification, referral, and delivery procedures continue to be successful, and agency staff members have come to accept CHOICES as an excellent treatment component. Although some barriers have been identified (e.g., low follow-up rates, low completion rates of women in jail, etc.), CHOICES staff continue to collaborate on methods to improve program operations.

2. KEY CLIENT RESULTS ACHIEVED

This section provides information regarding screening and client characteristics. *Appendix A* contains data relevant to this section (provided in table form).

A. Target Population

Pine Belt Mental Healthcare Resources utilizes a pre-screener to identify women who would immediately fail to meet criteria for program participation. As such, the number of women entering service is calculated by determining the number of women who pre-screened eligible. During this reporting period, 67 women satisfied the pre-screening criteria and 67 (100%) completed the Project CHOICES screening instrument.

B. Demographic Data

Of the 67 women screened, 59 reported demographic data. White women (51%, n = 30) slightly outnumbered black/African-American women (47%, n = 28). Only one woman (2%) reported Hispanic ethnicity. The average age of women at screening was 27. With regards to highest level of education completed, most women (70%, n = 41) had a high school/GED education or higher. Eighteen women (30%) had less than a high school/GED education. Most women were never married (63%, n = 37). More women reported being divorced (17%, n = 10) than married (10%, n = 6), unmarried/living with partner (7%, n = 4), or widowed (3%, n = 2).

C. Screening

Of the 67 women who pre-screened eligible and completed the comprehensive screening, 57 (85%) were eligible for participation. All eligible women (100%) agreed to participate.

D. Intervention Services (Residential vs. Community-Based Populations)

With regards to intervention services, 8 women (53%) in residential settings completed four motivational interviewing sessions and one contraceptive counseling visit. Seventeen women (41%) in community settings completed four motivational interviewing sessions and one contraceptive counseling visit. In total, during OY3, 25 women (44%) completed the CHOICES intervention, 28 women (49%) left treatment AMA (and therefore discontinued the program), and 4 women (7%) are still active participants.

E. Baseline Characteristics (Residential vs. Community-Based Populations)

Of the 57 women participating in the CHOICES intervention in OY3, 15 (26%) were in a residential treatment setting and 42 (74%) were in a community setting (which includes jail). Baseline alcohol behaviors for women in a residential setting were: (1) a median of 0 drinking days in the last 30 days; (2) a median of 0 drinks on a typical drinking day in the last 30 days; and (3) one woman (6.7%) reporting having four or more drinks in one day during the past 30 days. Women in the community exhibited markedly different baseline alcohol behaviors: (1) a median of 7 drinking days in the last 30 days; (2) a median of 3 drinks on a typical drinking day in the last 30 days; and (3) 42 women (100%) reporting drinking four or more drinks in one day in the last 30 days.

F. Alcohol Use Outcomes (Residential vs. Community-Based Populations)

Of the 8 women completing the CHOICES intervention in residential treatment settings, 100% maintained abstinence from alcohol from screening to end of program (EOP) assessment. No six month follow-up data were available for women in residential settings. Of the 17 women completing the CHOICES intervention in a community setting, EOP data indicated that the CHOICES intervention did have a positive impact on alcohol consumption behaviors. The impacts included decreased past 30 day alcohol use (94%, n = 16); decreased number of drinks consumed on a typical day (82%, n = 14); decreased number of days drinking 4 or more drinks (100%, n = 17); and not drinking any alcohol since the first session on drinking (65%, n = 11). Of the 4 women in community settings completing six month follow-up questionnaires, results were also positive: 4 women (100%) decreased past 30 day alcohol use; 3 women (75%) decreased number of drinks consumed on a typical day; 4 women (100%) decreased number of days drinking 4 or more drinks; and 1 woman (25%) had not had any alcohol since the first session on drinking.

It should be noted that results regarding alcohol consumption of women in residential treatment should be interpreted with caution. Women successfully navigating the process of residential treatment would be expected to abstain from alcohol in order to remain in the program. As such, women successfully completing the CHOICES intervention who remained in residential treatment naturally would have abstained from alcohol, or, at the minimum, reported minimal alcohol use.

In general, the CHOICES intervention seemed to have generally positive impact on the alcohol consumption habits of women in the community at the time of EOP assessment. Although information gleaned from the 12 month follow-up would provide further evidence of CHOICES efficacy, it seems that the intervention is indeed promising with regards to reducing alcohol consumption.

G. Contraception Use Outcomes (Residential vs. Community-Based Populations)

Contraceptive use outcomes were not as positive as alcohol use outcomes. One (12.5%) woman in the residential setting population reported using effective contraception at EOP. For women in the community setting, results were slightly more positive. Five women (29.4%) in community settings reported using effective contraception at EOP. Of the four women in this population who completed a six month follow-up, 2 (50%) reported using effective contraception.

Results regarding contraception use also should be interpreted with caution. Generally, women in residential treatment do not have access to proper contraception. Moreover, engaging in sexual intercourse (or other inappropriate behavior that is sexual in nature) is forbidden in PBMHR's residential treatment program. As such, measures of effective contraception use among women in residential treatment may be underestimated. Additionally, women completing the CHOICES intervention in the Forrest County jail also do not have access to contraception.

3. PROGRAM DESCRIPTION

A. Population Needs Identified & Addressed

PBMHR is transitioning its organizational treatment orientation from a medical model to a recovery model. As such, PBMHR's model of service delivery also is changing from the utilization of specific practices to a system of care which treats the individual rather than the disease. PBMHR is moving toward a holistic approach to treatment which addresses the personal causes and consequences of the disorder rather than the disorder itself. Although PBMHR previously provided services addressing alcohol and substance abuse, HIV/AIDS prevention interventions, and treatment for mental illness, services have not specifically focused on the prevention of FASD.

A coordinated effort across disciplines and treatment modalities to identify women at-risk of having an alcohol-involved pregnancy adds another dimension to the system of care. Integrating FASD prevention interventions into existing behavioral health treatment plans of high-risk women should facilitate a reduction of high-risk pregnancies – thus lowering the number of babies born with FASD in the PBMHR catchment area. Given the known connections between mental illness and alcohol use/abuse, PBMHR is in an excellent strategic position to offer targeted preventive interventions designed to prevent FASD.

A large number of adults with SMI lack the family support and/or financial resources to gain access to treatment and a good quality of life, thus making it difficult for many to access regular treatment. As these persons' conditions deteriorate, concerned stakeholders, such as family members, social workers or law enforcement, utilize the civil commitment process in order to mandate treatment. Many consumers live in fear of this process, and as a result, cling to social relationships (even harmful ones) and children for security.

Inadequate access to transportation, the stigma associated with obtaining treatment and a lack of insurance coverage and/or financial resources to pay for treatment are all barriers to the consumers seeking mental health treatment. Anecdotally, there is a relatively high “no show” rate for clinical and medical appointments within this population.

The nature of mental illness and substance abuse can contribute to a downward cycle of positive outcomes. When clients are not compliant with their treatment regimens and begin to deteriorate, self monitoring becomes extremely difficult, due to the nature of the disease(s), which causes impaired include hallucinations, delusions, disordered thinking, depressed thoughts, and/or grandiose thoughts, and it becomes very difficult for a client to recognize the need for, and take the initiative to seek treatment for the condition. Additionally, often individuals with SMI have damaged relationships with family members and friends and live alone, thus they lack a support system. The concerns voiced during the needs assessment have been addressed and continue to be a process in the intervention that we will seek to improvement to better our delivery.

B. Service Delivery Process

Clients who are new to the agency follow the normal intake procedures to be enrolled in existing PBMHR services. At the time of intake, the clinician identifies the client as meeting referral criteria using the pre- screener. If the client passes the pre-screener, the clinician describes the

CHOICES program to the client. If the client agrees to participate, the clinician administers the CHOICES Screening Form to determine actual eligibility. If the client is eligible, the clinician identifies the CHOICES intervention as a service on the client's treatment plan. The treatment plan is then reviewed during staffing (CHOICES staff are present). Subsequent to identification of an eligible participant in staffing, a CHOICES staff member signs the treatment plan and is assigned to the client.

In the event that information in the intake is incomplete or inaccurate, primary staff contacts the CHOICES Project Director. If needed, primary staff addresses any issues at the next scheduled clinical staff meeting. It is the responsibility of Project CHOICES staff to follow up on all recommendations made during the staff meeting.

Clients who are currently enrolled in PBMHR services are referred by primary staff via an interagency referral form (sent to the Project Director). Primary staff then presents the client in the next clinical staff meeting. If the client meets criteria for Project CHOICES, a clinician trained in the CHOICES intervention is assigned to the client. There are incidences however, where staff not involved in the intervention will conduct a pre-screen. In these cases, if the client pre-screens as eligible the case will be brought to the staff meeting and referred to a staff member trained to deliver the intervention for screening and delivery of the intervention.

The delivery of the CHOICES intervention normally occurs during scheduled therapy sessions. However, women in residential treatment, transitional housing, the community, or jail receive the intervention when their schedules allow. Women participating in PBMHR's substance abuse and HIV prevention programs who are eligible for the CHOICES intervention usually receive services at the Lumberton Family Life Center. Intervals between sessions are somewhat erratic, given the transient nature of PBMHR clients receiving services and variability in sentence for women receiving services in the Forrest County jail. Barriers such as employment, transportation, and child care often prohibit clients from attending scheduled sessions with their clinicians and case managers. CHOICES staff engage in program activities with clients when they are presented with the opportunity. As such, the time required to complete the intervention can range from one week to several months.

Follow-up assessments are conducted in person or over the telephone by the Project CHOICES Director. The Project Evaluator provides the Project Director with an update list of CHOICES participants on a monthly basis. This provides the Director with three key pieces of information: (1) a list of clients eligible for 6 and 12 month follow-up, (2) a list of clients who are active but have had no activity in several weeks, and (3) a list of clients who need tracking information (i.e., clients who have exceeded the 60 day window for follow-up). The Project Director then acts accordingly to reconcile each issue delineated in the update. Clients due for follow-up receive multiple phone calls and, if unsuccessful, a letter asking them to contact the Director. Subsequent to the expiration of the 60 day window, the Project Evaluator notes the client as "lost" and completes a form noting tracking information.

C. Staff Training

The trainings provided by Northrop Grumman have been helpful to increase the knowledge and understanding of Fetal Alcohol Spectrum Disorder. Due to the arrival of a new Project Director,

Jackie McDougle, and a new CHOICES staff member, Kay Clemts, additional training from Northrop Grumman was required. Both attended a FASD CHOICES training in Maryland in July 2011. Additionally, the Project Director and Project Evaluator delivered booster sessions throughout OY3 to all PBMHR COICES staff.

In cases where formal CHOICES training is not available, new staff are required to observe MI sessions conducted by trained staff. After multiple observations, new staff deliver the intervention under supervision from trained staff until formal training becomes available. This helps to ensure that staff turnover will have minimal impact on PBMHR's capacity to offer the CHOICES intervention.

Initially, there were concerns about the accuracy of measurements regarding alcohol and conception use. In order to overcome this barrier staff have been trained to conduct the pre-screen throughout therapy instead of asking questions in a manner that would illicit dishonesty. For example, staff will ask questions in the course of an hour in a way that is not threatening or frightening. Some clients will be pre-screened and by the end of the therapy session will be unaware they have even been evaluated for the FASD intervention. This has proven useful in order to get accurate information without the client feeling paranoid and skeptical (which is often an issue when dealing with persons with severe mental illness).

D. Task Force & Stake Holders

The Task Force is responsible for overseeing CHOICES activities regarding project development, implementation, operations, and sustainability. This working group is tasked with ensuring the completion of deliverables, providing feedback, and assisting with evaluation of the program. All members have equal responsibility in assisting project staff in overcoming barriers or obstacles. Task Force members are trained in the CHOICES intervention; as such, they bear the ultimate responsibility for ensuring consistent delivery of services to consumers.

The Project Director is responsible for developing and setting agendas based on the current needs of the program. The Project Director communicates Task Force recommendations to the NG TA Liaison and PBMHR Director of Adult Services prior to acting on those recommendations. Any such action (or inaction) is reported to the Task Force at the next scheduled meeting. The Task Force is not responsible for making decisions regarding CHOICES policies and procedures; these decisions are made in accordance with existing agency guidelines, which mandate that all such decisions be considered by the PBMHR Management Council.

The task force has been instrumental in developing ways in which the FASD Project CHOICES can be sustained after the grant years have ended. Developing a strategy to incorporate the intervention in the current system of care has been a process that we continue to strive. Currently we have integrated the intervention into the client routine therapy session. This has allowed the client to feel as if the intervention is part of the holistic approach without having to intrude on the clients time any further by increasing the amount of appointment they already have to attend.

The addition of Dr. Rita Porter to our task force has been also been instrumental in the decision making capabilities of the group. As a member of Pine Belt's executive management team, Dr. Porter has the authority to execute and implement the change processes necessary for successful

achievement of the project's goals. She will continue to be involved in strategic planning and evaluative processes. She is also committed to the sustainability of the FASD Project CHOICES intervention within our agency. As the Director of Adult Services, she will coordinate with other factions of the agency's leadership to ensure that project processes and policies become systematic.

Task Force members are listed below:

NAME	AOE	ROLE
Jackie McDougale	Substance Abuse & Contraception	Project Director
Paul Frederickson	Mental Health	Severe Mental Illness Education
Jewel Lee	Clerical	Secretary
Debbie Long	Mental Health	Former Project Director/Advisor
John Hubbell	Alcohol Recovery	Implementation
Sonya Robinson	Case Mgt Services	Resources
Elise Bagley	Clinician	Implementation
Carol Brown	Clinician	Implementation
Dr. Rita Porter	Director of Adult Services	Severe Mental Illness Education
Ragan Downey	Research	Evaluation

E. Barriers & Lessons Learned

In OY2, our primary barriers were effective communication between CHOICES staff and low follow-up rates. After strengthening efforts to boost and improve communication as well as placing greater focus on tracking clients subsequent to EOP, both of those barriers have been ameliorated.

In OY3, the primary barrier was the transition of a new Project Director. In general, program activities continued as usual. However, as with all such transitions, our activities did slow down temporarily. After the Project Director and Project Evaluator identified potential gaps in communication and data collection/paperwork issues, they met with each member of the CHOICES staff individually in order to conduct booster sessions on the intervention's delivery process and data collection requirements. After approximately one month, these issues were resolved and the CHOICES program was operating at a normal pace.

Follow-up rates continue to fall below ideal levels. However, CHOICES staff have been, for lack of a better term, relentless in pursuing women for six and twelve month follow-ups. Unfortunately, many of the women that engage in PBMHR do not live in a stable environment, and as a result, are difficult to locate after protracted periods of absence from the program.

F. Experiences of Women in PBMHR's CHOICES Program

“**Alice**” is a 36 year old African American woman. A long term alcohol and drug addict, Alice stated that she was happy to participate in this intervention because she has firsthand experience with giving birth to an alcohol exposed child. Of her four children, one was severely affected by her alcohol and drug use during pregnancy. Alice’s son stayed in ICU for three months after birth due to alcohol, crack, marijuana, and heroine in his system. He had to go through physical therapy because of his inability to walk, talk, and eat, and had difficulty responding to certain stimuli. Home Health was deeply involved in her son’s life for the first 3-6 months after his birth. Even though her other children were not affected as severely as this child, she does notice some other symptoms associated with drinking while pregnant with the other children.

“**May**” is presently in our A&D treatment facility. She has one son born with FASD who is now 6 years old. She also has a daughter who was born (three months prematurely) with FASD, died, revived by medical personnel, and spent three months in ICU. Her daughter is now 5 years of age. After her daughter was released from hospital, she had to go home on a heart monitor for a year. Her daughter also requires medication to help her withdrawal symptoms.

May did not think anything about drinking while pregnant. People always told her that one drink “wouldn’t hurt.” Therefore, with her son, she drank the first three to four months of her pregnancy. With her daughter, she drank throughout her entire pregnancy. May’s son has had considerable behavioral problems. However, her daughter had to learn how to eat through a tube and experiences frequent breathing complications. Additionally, she has seizures due to withdrawals from alcohol. May had to take a class in case she needed to revive daughter.

May wants other women to know it is very dangerous and unhealthy to drink while pregnant. May feels guilty, angry, and sad that her children had to go through this. When asked what would she change or do differently, she wishes she could “change the clock.” May is now working on forgiving herself. According to her, “...a mother is supposed to be there to protect and love her kids, not put them in danger.”

G. Model Approaches for Integrating CHOICES into State or Local Programs

PBMHR has incorporated policy directives designed to address the referral and service delivery processes for the CHOICES intervention. Additionally, clinicians who are trained in CHOICES attend staffing sessions in order to address questions, referrals, and service questions. Moreover, a large majority of PBMHR staff are aware of the availability of the CHOICES intervention and are well informed regarding the referral process.

Regarding a model approach for integration, CHOICES staff have generally agreed that this intervention would be an appropriate approach to FASD prevention in various types of organizations (e.g., community health centers, community outreach programs, local clinics, etc.). However, it should be noted that some components of the intervention, such as the order of presentation and delivery format (i.e., one-on-one) would likely be altered depending on the capacity and type organization. Additionally, some organizations may need to augment or reduce the information collected via available CHOICES instruments (again, based on organizational purpose and capacity).

4. PROGRAM CHANGES

A. State/Local Policies & Procedures

No changes have been made to State or local policy regarding prevention of FASD. However, PBMHR's integration of the CHOICES intervention in the Forrest County jail and expanded outreach through the Lumberton Family Life Center sends a powerful and positive message to the community. Hopefully, policy makers at the state and local level will take notice.

B. Organizational Policies & Procedures

As previously mentioned, PBMHR has incorporated the screening process for the CHOICES program into its organizational policy. This pre-screening process eliminates potential participants who cannot conceive, do not drink alcohol, or are not sexually active. The pre-screening process was introduced after OY 1 to ameliorate the paperwork generated by screening every woman entering services at PBMHR. Thus far, this process has been largely successful.

C. Systems Integration

CHOICES functions as one of many therapeutic tools available to clinicians. No substantive changes have been made as a result of integrating CHOICES into PBMHR's system of care. Minimal changes include (1) the addition of a CHOICES pre-screener at Clearview Recovery Center (PBMHR's residential treatment facility for substance and alcohol abuse) and Oak Arbor (PBMHR's transitional housing facility for alcohol and drug treatment) and (2) increased focus on FASD screening for women in traditional alcohol outpatient treatment.

D. Service Delivery

To date, PBMHR's CHOICES staff have not made any changes to the service delivery process of the intervention.

E. Data Systems

No substantive changes have been with regards to PBMHR data systems. Information Systems technicians are still in the process of rolling out a new electronic medical records system (DiagnoSys), and we anticipate that this system will be useful in identifying potential CHOICES participants and tracking active and completed participants.

F. Staffing

Due to the advancement of Debbie Long, it was necessary to recruit a new Project Director. Jackie McDougle was hired as the CHOICES Project Director during the middle of OY3. Her experience in outreach programs addressing substance abuse and HIV/AIDS prevention made her a perfect fit for this position. Additionally, two new clinicians were trained to deliver the CHOICES intervention in OY3.

APPENDIX A

OY3 ANNUAL REPORT MEASURES

CHOICES ANNUAL REPORT: PINE BELT

Data Collection Activity Between 8/1/2010 and 7/31/2011

	N	%	Total Responses
Demographic Data			
3. Of the women who reported race, N/% Alaska Native	0	0	67
4. Of the women who reported race, N/% American Indian	0	0	67
5. Of the women who reported race, N/% Asian	0	0	67
6. Of the women who reported race, N/% Black or African-American	28	41.8	67
7. Of the women who reported race, N/% Native Hawaiian or Pacific Islander	0	0	67
8. Of the women who reported race, N/% White	30	44.8	67
9. Of the women who reported ethnicity, N/% Hispanic/Latina	1	1.7	59
10. Average age of women at screening	27 years	N/A	67
11. Of the women who reported educational status, N/% who completed GED/12th grade or higher	41	69.5	59
12. Of the women who reported educational status, N/% who completed less than GED/12th grade	18	30.5	59
13. Of the women who reported marital status, N/% who identified as "married"	6	10.2	59
14. Of the women who reported marital status, N/% who identified as "unmarried, living with partner"	4	6.8	59
15. Of the women who reported marital status, N/% who identified as "never married"	37	62.7	59
16. Of the women who reported marital status, N/% who identified as "widowed"	2	3.4	59
17. Of the women who reported marital status, N/% who identified as "divorced or separated"	10	16.9	59
Screening			
18. Of the women screened, #/% screened eligible for program	57	85.1	67
19. Of the women who screened eligible, #/% who agreed to participate in program	57	100	57

CHOICES ANNUAL REPORT: PINE BELT

Data Collection Activity Between 8/1/2010 and 7/31/2011

	Residential Treatment Population			Community-Based Population				
	N	%	Total Responses	N	%	Total Responses		
Baseline Characteristics								
20. Of the women who screened positive, median number of days women drank alcohol in the past 30 days at screening	0	days	N/A	15	7	days	N/A	42
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	0	drinks	N/A	15	3	drinks	N/A	42
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	1		6.7	15	42		100	42
Intervention Services								
23. Of the eligible women who agreed to participate, N/% participated in 4 motivational interviewing sessions and 1 contraceptive visit	8		53.3	15	17		40.5	42

CHOICES ANNUAL REPORT: PINE BELT

Data Collection Activity Between 8/1/2010 and 7/31/2011

Residential Treatment Population

	End of Service			6 Month Follow-up			12 Month Follow-up		
	N	%	Total Responses	N	%	Total Responses	N	%	Total Responses
Outcomes - Alcohol Use									
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	8	100	8	0	N/A	0	0	N/A	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 who completed the questionnaire, N/% of women who decreased alcohol use in the past 30	0	N/A	0	0	N/A	0	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	8	100	8	0	N/A	0	0	N/A	0
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	0	N/A	0	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	0	N/A	0	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	8	100	8	0	N/A	0	0	N/A	0
Outcomes - Contraception Use									
30a. Of the eligible women who agreed to participate and completed the questionnaire, N/% who reported using contraception effectively	1	12.5	8	0	N/A	0	0	N/A	0

CHOICES ANNUAL REPORT: PINE BELT

Data Collection Activity Between 8/1/2010 and 7/31/2011

Community-Based Population

	End of Service			6 Month Follow-up			12 Month Follow-up		
	N	%	Total Responses	N	%	Total Responses	N	%	Total Responses
Outcomes - Alcohol Use									
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	17	100	17	3	33.3	9	0	N/A	0
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 who completed the questionnaire, N/% of women who decreased alcohol use in the past 30	16	94.1	17	4	100	4	0	N/A	0
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	0	N/A	0	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	14	82.4	17	3	75	4	0	N/A	0
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	17	100	17	4	100	4	0	N/A	0
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	11	64.7	17	1	25	4	0	N/A	0
Outcomes - Contraception Use									
30b. Of the eligible women who agreed to participate and completed the questionnaire, N/% who reported using contraception effectively	5	29.4	17	2	50	4	0	N/A	0