

## Option Year 3 Annual Report for CHOICES Subcontractors

### 1. Project Summary

The Texas Office for Prevention of Developmental Disabilities (TOPDD) serves as a subcontractor to the Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence (CFE), a subsidiary of Northrop Grumman Corporation, to develop and implement CHOICES alcohol abuse intervention and treatment services for women enrolled in outpatient and residential treatment programs in the state of Texas. The purpose of this intervention is to reduce the risk for prenatal alcohol exposure in the women's subsequent pregnancies.

#### Approach

All women enrolled in one of six outpatient substance abuse treatment programs were eligible for initial screening into Texas CHOICES:

- Alpha Home
- Santa Maria Outpatient Program
- Santa Maria Jacquelyn House
- Volunteers of America Outpatient Program
- Prevention & Addiction Council
- STAR Council Outpatient Program

Each woman underwent a screening to determine eligibility. If the woman was determined to be sexually active, physically able to conceive a child, had evidence of inadequate use of birth control methods, and was determined to be a risky drinker, she was invited to join the Texas CHOICES program. If she agreed, she was provided four intervention sessions as well as a contraception counseling visit.

#### Results

In the most recent reporting year (August 1, 2010 – July 31, 2011), 708 women entered the six outpatient drug treatment programs participating in this project. Of these women, 618 underwent an initial prescreening for eligibility, and 294 women qualified for intake screening. All 294 eligible women were offered the services, and 229 women (77.9%) agreed to enroll in the program.

Both the process and outcome evaluation yielded positive results overall. Enrollment goals were exceeded as 294 eligible women were offered the services and 229 women agreed to enroll. While there were some challenges related to women following through with appointments for MI sessions and contraceptive visits, overall about 40% of enrolled women completed both components of the program. Follow-up data was scheduled to be collected at 6 and 12 months following completion of the program, however there were barriers in reaching the women at these extended intervals due to relocation, changed contact information, and disengagement from the program, thus this data was collected on less than 1% of program completers.

While there were challenges to data collection, the data that was successfully collected demonstrated encouraging results. The preponderance of women (76%) used contraceptives effectively upon completion of the program and all women reduced their alcohol use upon completion of the program. Thus, the program was successful in reaching the overall goal of reducing alcohol-exposed pregnancies for 92% of the women.

### **Discussion**

The Texas CHOICES Program was implemented based on the gaps in services that were identified in the needs assessment. While the expansion of providing services at six sites was certainly welcomed in relation to broadening the reach of women who could be served, it may have had an impact on fidelity as all six sites have varying clinical protocols. However, through staff trainings and guidance from the Texas CHOICES Program Coordinator, all sites were able to successfully enroll women in their program and contribute to effective program results.

One of the most successful components of the Texas CHOICES program has been the integration of FASD education and alcohol-use interventions into substance abuse treatment. Through the Project CHOICES initiative, TOPDD has established a relationship with the Texas Department of State Health Services, the single state agency responsible for substance abuse treatment services and funding. Through this relationship and the success of Project CHOICES, we have been able to make FASD education a required component of treatment programs funded by the state.

Project CHOICES participants are overwhelmingly positive in their comments about the program. For example, they are extremely appreciative of the contraceptive visits and repeatedly discuss the warmth and positive interactions they had with their counselors. These positive comments are underlined by the positive results that were reported by the program this year: the majority of women who completed the program used contraceptives effectively and all reduced their alcohol use.

## **2. Process Objectives:**

Goal 1: Between August 2010 and July 2011, a minimum of 250 females of childbearing age in outpatient or residential treatment will be offered the CHOICES intervention.

Outcome:

- **618** women were screened
- **294** were found eligible, and were offered the intervention
- **229** (77.9%) agreed to participate.

Goal 2: By July 31, deliver four individual counseling sessions using a motivational interviewing approach to 60% of women initially enrolled in the intervention.

Outcome:

- **89** of the 229 women who enrolled in the program (**38.9%**) completed the four sessions.

Goal 3: By July 31, 60% of women enrolled in the intervention will attend a family planning visit.

Outcome:

- **93** of the 229 women (**40.6%**) who initiated CHOICES also participated in a contraceptive visit.

Goal 4: By July 31, administer a brief assessment to 100% of women who complete the intervention.

Outcome:

- **78** out of 86 women (**90.7%**) who completed the intervention services also completed the end of program assessment.

Goal 5: By July 31, administer an assessment at regular intervals (at 6 months and 12 months) to 10% of the women who complete the intervention.

Outcome:

- **25** women were eligible for a 6 month follow-up assessment in OY3 and **1** woman (**4.0%**) completed it. None of the women from OY3 were eligible for a 12 month assessment during this grant year.

### **Outcome Objectives:**

Goal 1: 75% of women who have completed the intervention will reduce their alcohol use.

Outcome:

- **59** of the 62<sup>1</sup> (**95%**) women who completed the CHOICES intervention significantly reduced their number of days drinking, number of drinks in a typical day, and frequency of binge drinking in the last 30 days.

Goal 2: 65% of women who have completed the intervention will use effective contraception.

Outcome:

- **59** of the 78 women (**75.6%**) were using contraception effectively at the end of program assessment.

Goal 3: 50% of women who have completed the intervention will have reduced the risk of an alcohol-exposed pregnancy.

Outcome:

- **59** of 62<sup>1</sup> women (**92%**) who qualified for and participated in the entire CHOICES intervention reduced their risk of alcohol-exposed pregnancy

<sup>1</sup> Due to missing data, only 62 of the 78 women who completed the program have responded to the questions related to alcohol use.

## 2. Key Client Results Achieved

### Target Population

Potential participants for the Texas CHOICES intervention included all women admitted to six substance abuse treatment centers, in different regions of Texas, between August 1, 2010 and July 31, 2011. Women who met the criteria for the Texas CHOICES intervention (women between the ages of 18-44 years old and at risk for an alcohol-related pregnancy) at admission to the facility were invited to voluntarily participate in the Texas CHOICES program.

A total of 708 women entered the six treatment programs during the designated time period. Among this population, only 294 women were qualified for the program. The great majority of women who were screened did not qualify for a variety of reasons, including relatively light current alcohol intake, inability to conceive, effective contraceptive use, or not being sexually active. All 294 eligible women were offered the services, and 229 women (77.9%) agreed to enroll in the program.

### Demographic Data

A total of 618 women were screened for the Texas CHOICES project during the reporting period. The average age of the women was 30 years (SD= 9.4),

Of the 341 women for whom racial and ethnic data are recorded:

- 142 (41.6%) were Hispanic
- 213 (34.4%) were White
- 80 (12.9%) were Black/African American
- 7 (1.1%) were American Indian
- 5 (0.8%) were Asian
- 2 (0.3%) were Alaska Native

The large majority (71%; n=242) of the 341 women reporting educational status had a high school diploma/equivalent or higher. Only 99 women (29%) reported having completed less than 12<sup>th</sup> grade.

Of the 341 women for whom data on marital status was recorded:

- 214 women (62.8%) have never been married
- 66 women (19.4%) have been divorced or separated
- 37 women (10.9%,) are currently married
- 22 women (6.5%) are unmarried but living with a partner
- 2 women (0.6%) are widowed

### Screening

Of the 618 women who were screened for intake into the Texas CHOICES program, 294 were found to be eligible, and 324 were ineligible. The most common reasons for

ineligibility, in order of prevalence, were the women had undergone tubal ligation surgery, were pregnant, had undergone a hysterectomy, were currently trying to get pregnant, were menopausal, or were infertile. Of the women who screened eligible, 77.9% (n=229) agreed to participate in the program.

### **Intervention Services**

Of the 229 eligible women who agreed to participate in the Texas CHOICES program, 78 (34.1%) completed four motivational interviewing sessions and one contraceptive visit:

<b>Site</b>	<b>Number</b>
Alpha Home (Outpatient)	10
COADA/Prevention and Addiction Council (Outpatient)	6
Santa Maria Jacquelyn House (residential)	33
Santa Maria (Outpatient)	16
Star Council (Outpatient)	0
Volunteers Of America (Outpatient)	13

### **Baseline Characteristics**

Baseline data are available for 64 of the 229 women in residential treatment populations and 228 women in community based populations.

The following is a summary of the data on the residential participants:

- Median number of days the women drank alcohol over the previous 30 days = **12**.
- Median number of drinks consumed on a typical day when drinking alcohol = **6**.
- 50 (**78.1%**) of the women with a positive screen had four or more drinks in a single day in the past 30 days at screening.

The following is a summary of the data on the community based participants:

- Median number of days the women drank alcohol over the previous 30 days = **4**.
- Median number of drinks consumed on a typical day when drinking alcohol = **4**.
- 168 (**74.3%**) of the women with a positive screen had four or more drinks in a single day in the past 30 days at screening.

Based on these data, the population enrolled in Texas CHOICES is a very high-risk population with a high frequency and amount of alcohol consumption.

### **Alcohol Use Outcomes**

#### ***Residential Treatment Population***

A total of 33 eligible women who participated in Texas CHOICES completed the end of program questionnaire. None completed a 6 month follow-up or a 12 month follow-up.

33 women completed the program and the end of program assessment.

- All 33 (**100%**) of the women decreased their alcohol use in the past 30 days.

- Six month follow up data was obtained on one woman who reported continued decreased alcohol use.
- None of the women were eligible for the 12 month follow-up.
- Of the 33 women who reported drinking 1 or more drinks on a typical day during the screening 33 (100%) had decreased the number of drinks consumed on a typical day in the 30 days prior to exit. One out of one (100%) did this prior to 6 month follow-up and none were eligible at 12 month follow-up.

Binge drinking rates also exhibited significant improvement.

- Among the 27 women enrolled in Texas CHOICES who at screening reported having four or more drinks in one day at least once in the previous 30 days, at exit, 100% reported having decreased the number of days they had drunk four or more drinks in the previous 30 days.
- Six month follow up data was obtained on one woman who reported decreased binge drinking.
- None of the women were eligible at 12 month follow-up.
- The overall decrease in risky drinking patterns is exhibited by data regarding abstinence from alcohol. Of the 33 eligible women who agreed to participate and completed the questionnaire, 32 (97.0%) had not had any alcohol since the first session when the need to abstain from alcohol was discussed.

### ***Community Based Population***

Of 45 eligible women who completed the program (agreed to participate, participated in 4 motivational interviewing sessions, and one contraceptive visit, and were due for an end of program assessment,) 39 (86.7%) completed the end of program questionnaire.

- Of 39 who completed the end of program questionnaire, 35 (90.0%) of the women abstained completely or decreased their alcohol use in the past 30 days.
- None were eligible for the 6 month follow-up or the 12 month follow-up.
- Of the 39 eligible women, 38 (97%) had decreased the number of drinks consumed on a typical day in the 30 days prior to exit.

Binge drinking rates also exhibited significant improvement.

- Among the 29 women enrolled in Texas CHOICES who, at screening, reported having four or more drinks in one day at least once in the previous 30 days, at exit, 28 (96.6%) reported having decreased the number of days they had drunk four or more drinks in the previous 30 days.
- None were eligible at 6 month follow-up or at 12 month follow-up.
- Of the 39 eligible women who agreed to participate and completed the questionnaire, 30 (76.9%) had not had any alcohol since the first session when the need to abstain from alcohol was discussed.

### **Contraception Use Outcomes**

#### ***Residential Treatment Population***

Among the 34 women who completed program and the end of program questionnaire, 26 (76.5%) reported using contraception effectively. Six month follow up is available on one

individual and she reported using contraception effectively, and at 12 month follow-up, none were eligible.

### ***Community Based Population***

Among the 38\* eligible women who completed the program and the end of program questionnaire, 29 (76.3%) reported using contraception effectively. At six month follow-up and at 12 month follow-up, none were eligible.<sup>1</sup>

### **3. Description of Program and Experiences**

The adaptation of Project CHOICES for implementation in Texas was based on recognized gaps in services and challenges to delivering those services, as delineated through the initial needs assessment:

- 1. The regular screenings done in Texas have emphasized illicit drug use and not alcohol use since the inception of the project. This is a major gap in service which impacts the CHOICES population as well as all women entering treatment. It is unclear if all counselors are knowledgeable about the impact of alcohol on a pregnancy or if its implications for use during pregnancy are consistently addressed during treatment.**

Through Texas CHOICES' work, it has become clear that some women, who should have been identified as needing alcohol treatment during the state's regional screening process for treatment, were not. Since most women entering the programs are mandated clients, it is not surprising that they may not fully disclose the breadth of their substance use. Due to the prevalence of alcohol use, it makes sense to assume alcohol dependence and treat for it unless it is really clear that alcohol is not an issue. The state has revised its contracts to clearly require FASD education for all adult clients. In addition, TOPDD is working with Department of State Health Services (DSHS) to provide additional training to counselors on FASD. These are indications that the state is moving in this direction. Education about alcohol is now going to be a standard part of treatment.

There is still a need to expand this training to mental health service providers, and there is interest in including FASD trainings in all programs that address co-occurring disorders. Through Texas CHOICES' work, we have brought the need for an emphasis on alcohol into sharper focus.

- 2. The needs assessment revealed that women were rationalizing drinking during pregnancy because the drugs they were using would do such harm that they would not have a healthy pregnancy anyway.**

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<sup>1</sup> These numbers differ from the initial report because additional data have been submitted and entered into the database for Option Year 3 since submission of the original report. These data reflect the most up-to-date information that we have on file.

This issue is being addressed successfully in the intervention sessions, as evidenced by the number of women who abstained from alcohol following the initial CHOICES session.

**3. Contraception and pregnancy planning have never been a standard part of substance abuse treatment programs in Texas.**

Because of what providers have learned through Texas CHOICES, about the needs and interest of their clients around contraception, efforts are being made to make contraceptive visits more accessible to clients, with the goal of making them a routine part of treatment. However, making an appointment for contraception consultation is difficult because of multiple funding issues. Unfortunately, some women are ineligible for free contraceptive services because they are undocumented and the funding for women's health programs, including contraceptive visits is very poor and insecure. This is an issue that the Texas CHOICES team is continuing to problem solve around.

**4. A need identified by our substance abuse provider agencies and other stakeholders has been the likelihood that monolingual Spanish speaking women are accessing treatment programs in the state without access to CHOICES materials in their native language.** At this time, the CHOICES curriculum is available only in English, which limits its applicability to all members of the CHOICES target population. In a state like Texas, where demographics are rapidly changing and monolingual Spanish speakers are increasingly part of the population who may need or want to access substance treatment and recover centers, addressing this issue is very important and is an ongoing consideration of TOPDD. Currently, counselors do informal "on the fly," translation, and when this is the case, fidelity can not be assured.

**Service delivery process** (referrals for screening, screening, referrals for intervention, and implementation of intervention)

Six Texas treatment programs are implementing Project CHOICES:

- Alpha Home
- Santa Maria Outpatient Program
- Santa Maria Jacquelyn House
- Volunteers of America Outpatient Program
- Prevention & Addiction Council
- STAR Council Outpatient Program

Potential participants for the Texas CHOICES intervention included all women admitted to these substance abuse treatment centers between August 1, 2010, and July 31, 2011.

Women who met the criteria for the Texas CHOICES intervention (women between the ages of 18-44 years old and at risk for an alcohol related pregnancy) at admission to the facilities were invited to voluntarily participate in the Texas CHOICES program.

To determine eligibility for Texas CHOICES, women who volunteered to participate underwent a full screening assessment. This screen was done on 619 women during option year 3. The screening measure included criteria regarding sexual activity (current sexual activity and contraceptive use) as well as behaviors that placed the woman at risk for having an alcohol related pregnancy (frequency and quantity of drinking behaviors). Specifically, the woman had to be 18-44 years old, drinking at risky levels, not using contraception effectively, not pregnant or planning to become pregnant, engaged in sex with a male at least once in the last 90 days, and not diagnosed with any medical condition that would preclude her from becoming pregnant. Among the 619 women screened, 294 (47.5%) were deemed eligible for the program.

If the woman met the eligibility criteria for admission into the Texas CHOICES intervention, she was invited to voluntarily participate in the intervention. The counselor in each program explained Project CHOICES to the woman and obtained consent for participation. 77.9% of the eligible women offered services consented to participation. As in previous years of program implementation, the strongest selling point for recruitment was the inclusion of a contraception consultation. Project CHOICES was then integrated into the woman's treatment plan and delivered by her counselor in the context of the overall treatment services. Referral to contraception services was made through the state's Medicaid Women's Health Program, which has offices and services available in all the communities in which Project CHOICES is being implemented.

The Texas Choices intervention is based on the original Project CHOICES intervention that was found to be efficacious in reducing the risk of alcohol-exposed pregnancy (AEP) among at-risk women of childbearing age.<sup>21</sup> Like the original CHOICES intervention, Texas CHOICES consists of 4 sessions plus a contraceptive visit. This intervention is based on a Motivational Interviewing (MI) approach. MI was developed by Dr. William Miller and Stephen Rollnick<sup>22</sup>, and focuses on preparing "people for change and maintaining their motivation once established" (CHOICES Manual, p. 7). This intervention also relies upon the Transtheoretical Model (TM), which was developed by Dr. James Prochaska and Dr. Carlo DiClemente (1984).<sup>23</sup>

In the CHOICES intervention, motivational interviewing strategies (e.g., open-ended questions, reflective listening, and change statements) and the Stages of Change are used to meet individuals where they are based on their current level of motivation for change. Individuals are encouraged to move from one stage to the next to attain healthy behavioral choices with regard to alcohol and contraception use. While each motivational interviewing session is unique, the intervention was developed to be followed in a sequential manner beginning with Session 1 and continuing through Session 4.

Each woman's counselor followed the guidance provided in the CHOICES Counselor Manual.<sup>24</sup>

Because Texas CHOICES was implemented in 6 different treatment programs, the actual pattern of delivery of services varied. Some women underwent prescreening and screening at the intake visit, while others did not undergo the screen until up to 4 weeks after intake

into the treatment program. There is limited information regarding the fidelity of the delivery of CHOICES in the 6 sites, and the time period between sessions has varied. In an effort to increase opportunity for fidelity to the model, the Project CHOICES team developed a protocol and timeline for implementation, and all sites were instructed to follow this established protocol. According to the protocol, screening took place 1 week after entry into the substance abuse treatment program unless the professional opinion of the CHOICES counselor doing the assessment indicated otherwise. At that time, all women found on the screen to be eligible for the program received an appointment for the contraception visit, since it often takes 3 to 4 weeks to get an appointment. One week after the CHOICES intake (approximately 2 weeks after treatment program intake) eligible women participated in the initial CHOICES intervention, with each of the 3 subsequent interventions being conducted on a weekly basis. The end of program evaluation and a newly formulated satisfaction survey were administered immediately at the conclusion of session IV. The follow-up assessments will be attempted 6 and 12 months after program completion.

At the time the end of program assessment is administered, the follow-up assessments are scheduled. In order to schedule the follow up, the counselor is required to call the phone numbers on record for the client at least 3 times to make an appointment. The follow-up assessments are then conducted by each woman's counselor via telephone. Of the 229 women who were eligible to enter Texas CHOICES and agreed to participate, end of program assessments were conducted on 72 of the 78 women (92.3%) who had completed the program.

### **Staff Training**

Two of the Principal Investigators of the CHOICES model, Dr. Mary Velasquez, and Dr. Linda Sobell conducted all Project CHOICES staff training. All agencies invited to participate in the Texas CHOICES project were required to send at least two CHOICES counselors and 1 clinical supervisor to a two-and-a-half day training on the implementation of the intervention. Principal investigators from the original Project CHOICES studies conducted this training, which was attended by fifteen counselors and two representatives from TOPDD. Counselors were provided with the CHOICES manual and training on both motivational interviewing techniques and how to implement each of the 4 sessions for Texas CHOICES. In addition, they learned how to make assessments and referrals as needed.

The initial sessions were very successful in establishing a foundation upon which staff has been able to deliver the CHOICES intervention. The program motivated staff and provided the background theory and information that guide Project CHOICES. However, there was limited information regarding how to actually conduct the interventions and the intricacies of interacting with women about very personal issues. The staff and administrators from the programs needed ongoing technical assistance on how to make the CHOICES interventions flow within the larger treatment plan and specific training on the screening tool. As in previous years, the trainings did not address specific cultural

differences for Hispanic women that can affect how the intervention is delivered as well as how the information is received.

Across the project option years, TOPDD staff members have followed up with further training as needed, especially in light of a significant amount of staff turnover in the programs and in errors found as programs were audited and observed. It has been especially important for staff to receive further support and technical assistance in how to obtain contraception services for the women enrolled in CHOICES.

In the final option year, TOPDD and its consultants will offer further training and consultation to the subcontractor agencies to meet some of these remaining training needs. TOPDD will specifically target the following issue areas: how to communicate FASD information to women who may have existing guilt and anxiety about their drug and alcohol use and about having exposed previous children, information on contraceptive services provision, and technical assistance around the CHOICES paperwork and processes. The Project Director in concert with TOPDD will diligently monitor counselor interest in and need for these training services and provide them accordingly.

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

The Texas Office for the Prevention of Developmental Disabilities is a legislated agency responsible for the prevention of developmental disabilities in the State of Texas. Members of the TOPPD Executive Committee are appointed by the governor, lieutenant governor, and speaker of the house.

<b>Name</b>	<b>Appointment Source</b>	<b>Agency/Association</b>
State Representative Vicki Truitt, Chair of Executive Committee	Speaker of the House of Representatives	Texas House of Representatives
Marian Sokol, Ph.D, M.P.H., Vice-Chair of Executive Committee	State Governor	First Candle
Richard Garnett, Ph.D.	Speaker of the House of Representatives	ARC of Greater Tarrant County
Angelo P. Giardino, M.D.	State Lieutenant Governor	Texas Children's Hospital
Ashley Givens	State Governor	Texas Scottish Rite Hospital for Children
State Representative Jim Jackson	Speaker of the House of Representatives	Texas House of Representatives
Valerie Kiper, R.N.	State Governor	Universal Health Services
Joan Roberts-Scott	State Lieutenant Governor	Texas Rehabilitation Commission
Mary S. Tijerina, Ph.D,	State Lieutenant Governor	Texas State University,

LMSW-AP		School of Social Work
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The TOPDD Executive Committee formed the FASD Task Force in 1990 to specifically address prevention, early intervention, and treatment for women and children affected by prenatal use of alcohol. The members of the FASD Task Force represent a wide variety of public and private agencies:

<b>Name</b>	<b>Title</b>	<b>Agency/Association</b>
Becca Crowell, M. Ed., Ed.S., LCDC, LPC	Executive Director	Nexus Recovery Center
Carole Hurley, J.D.	Attorney at Law	Chair, Texas State Bar Association Child Abuse and Neglect Committee
Denese Thetford, M.Ed	Ministry Development Coordinator	Buckner Children and Family Services
Emily West, M.S.W.	Administrative Services Officer	University of Texas, Dallas
Esther Colunga-Betts	Prevention Team Lead/ Child and Adolescent Services	Texas Department of State Health Services
Helen Dale Simons	Co-Chair of Texas FASD Leadership & Planning Collaborative	Community advocate
Joan Roberts-Scott	Manager, CE Scheduling Unit	Texas Dept. of Assistive & Rehabilitative Services
Julie Wisdom-Wild, BAAS	Chief Executive Officer	Alpha Home, Inc.
Lisa Ramirez, M.A., LCDC	Project Link Program Manager	Prevention & Addiction Council
Mahmoud S. Ahmed, Ph.D.	Professor	University of Texas Medical Branch
Mary Tijerina, Ph.D. LMSW-AP	Associate Professor Director BSW Program	Texas State University
Melanie Lane, MSW, LCDC, AAC	Unit Coordinator	Center for Health Care Services Restoration Center
Milton R. Ayala LMSW	Substance Abuse Program Specialist	Texas Department of Family and Protective Services
Natalie Furdek, M.Ed., LPC	Women's Substance Abuse Services Coordinator	Texas Department of State Health Services
Nhung T. Tran, MD, FAAP	Asst. Prof. of Pediatrics Section Head, Developmental -Behavioral Pediatrics	UT Health Science Center at San Antonio – Center of Hope

		Clinic
Robert S. Miles, LCDC	Counselor	Private Practice
Shelley Alexander	Quality Development and Training Supervisor	Tarrant County Juvenile Services
Shelley Koslan-Joiner, LMSW	Mom & Baby Special Services Coordinator	JPS Health Network (Tarrant Co. Hospital Dist.)
Sheryl Draker, J.D.	Lead instructor of attorneys	WJF Institute
Stevie Hansen, LCDC, NCAC, BA	Chief of Addiction Services	MHMR of Tarrant County
Linda Kagey, LCDC	Assistant Director of Treatment Services	Volunteers of America Houston Region
Cindy Wier, M.Ed.	Executive Vice President	Serenity Foundation of Texas
Kay Austin, LCDC	CEO	Santa Maria Hostel, Inc.

Members of the FASD Task Force are clinicians, program administrators, and public officials; Dr. Mary Tijerina, one of the members of the Executive Committee, serves as chair. Many of the clinicians on the Task Force are implementing or have implemented the CHOICES curriculum within substance abuse treatment programs and thus have the ability to provide technical assistance as well as oversight and quality assurance for the Texas CHOICES initiative. In the coming year, the Task Force will continue to address the replication of CHOICES and the sustainability of FASD education and intervention efforts as part of the overall strategy to meet the unique needs of women in treatment and across systems in Texas.

The Task Force, which is a stakeholder group, in combination with other stakeholders regularly discuss their observations, needs, and insights for CHOICES service delivery. The following are key issues, needs, observations of the task force:

- Whether to collect data on women who are not eligible for CHOICES but are still in need of receiving the information, and if so, what and how should data be collected on these women.
- How to make contraceptive services available to all women in treatment (regardless of eligibility for the CHOICES program.)
- How to best retain clients in the program who are in a transient population, as many of the women in the subcontractor treatment sites are. Many clients are not completing all four sessions. Although this is not a problem that is unique to Texas, the Task Force and stakeholder groups are consistently seeking better ways to retain clients.

- How to increase the number of completed follow ups. Many members and counseling teams note that without incentives, the likelihood of attaining follow-ups decreases. In Texas, treatment centers must do follow-ups related to the treatment services at 30 and 90 days after treatment. . The sites report that their successful completion rate of these surveys is fairly small. Because CHOICES follow ups are scheduled so much longer after a woman leaves treatment, it is understandable that completion of follow ups are relatively rare. However, we all understand the benefit of the follow-up data and will continue to brain storm around this issue.
- CHOICES sustainability is an ongoing conversation with the stakeholders, including the Task Force. Although one of the main intentions of CHOICES is to be sustainable and become a part of regular treatment delivery, lack of funding for basic treatment services in the treatment system makes this more challenging. However, there is tremendous support and interest in the program. One issue related to sustainability is ongoing data collection. In order for CHOICES to be truly permanent, we need to continue to collect data and those issues have not been worked out.
- Other topics discussed include: offering a shorter brief intervention, providing ongoing access to women’s health and birth control services, maintaining integrity to the model, identifying the best settings for future CHOICES interventions, identifying the best age group to target (it has been repeatedly suggested that college aged women would be a good target.) Additionally, the stakeholders, including Task Force members recommend considering targeting facilities and women in settings beyond traditional substance abuse treatment programs.

Provision of services for women who may have an FASD themselves is an ongoing issue that agencies must be considerate of and conscientious about every day. Furthermore, figuring out how to provide appropriate prevention services for this group is a consideration that we must continue to tackle collectively. While strategies such as providing mentors, modeling behavior, and “hands on” approaches are very valuable for prenatal alcohol exposed individuals, they can be expensive to implement so agencies are going to need to be creative to meet the needs of this population.

Although the stakeholder groups don’t always have immediate solutions, they are committed, creative and have a wealth of experience. In addition, they are good problem solvers. Thus, they have what it takes to tackle difficult problems.

**Descriptions of the barriers and ways to facilitate implementing the evidence-based intervention into the local service delivery organizations.**

1. Many of the past year's data problems have been mitigated by the database centralization that TOPDD undertook to help manage this issue. The data is much cleaner as it is managed in a monthly way by TOPDD's evaluation contractor, NTI Upstream. However, data collection at the agency level is a challenge. Busy clinical schedules make the necessary prompt completion of necessary paperwork burdensome and of low priority. The Project Director and site liaisons meet regularly to address data concerns or issues. Project Director consults with NTI Upstream to identify problems and develop solutions. If needed, NTI Upstream and Project Director consult as a group with the clinical CHOICES team. This is an ongoing process, varying in depth from month to month. Generally though, the database centralization has been a very effective method of monitoring and maintaining high quality data.

2. To achieve consistency and reliability of data across sites, protocols and specific guidelines have been given to each of the sites. TOPDD staff has trained and will continue to train all sites in the policies and procedures.

3. Cultural issues must continue to be addressed. None of the screening materials and few of the educational materials had been translated into Spanish. Furthermore, many of the educational materials are written at a high literacy level (approximately 10<sup>th</sup> grade). These materials must be revised to a literacy level of fourth to fifth grade, at the highest, in order to be appropriate to more of the population that we serve in our treatment programs. In regards to language, our sites report that 80% of their CHOICES clients speak primarily English at home, 11% speak primarily Spanish at home, and 6.5% speak some combination of English and Spanish at home. This leads TOPDD to believe that there are in fact women in the CHOICES programs in the state who would benefit from Spanish language materials which are formally translated and have been back translated as well.

There is undoubted variety from counselor to counselor in regards to how these situations are handled just as there is variety from client to client in level of understanding and comfort disclosing accurate information around literacy and language preference. Globally, we know that the CHOICES counselors across the state try to make things understandable for their clients. However, translating or re-phrasing on the fly increases the likelihood that a counselor may make a mistake which could impact the intervention's effectiveness and/or the client's comfort. While our screenings results show that women overwhelmingly report being able to read and speak English, we have concerns about whether or not this is completely true. There is certainly some social desirability bias in the way that women may perceive these questions. While we encourage counselors to try and solicit the levels of understanding from their clients, without a formal translation of the materials, there is no way for TOPDD to ensure that each counselor delivers the materials in a fully accurate way when a CHOICES client may need a modification of language and/or readability level of the materials.

4. Ongoing training in how to administer the screening instrument is vital. Some of the questions are open to interpretation, and in the past, some of the women who were screened answered incorrectly because of misunderstanding. Project Director and

evaluation team are in contact with the CHOICES implementation teams on a regular basis about any inconsistencies or areas to problem solve.

5. One of the most successful components of the Texas CHOICES program has been the integration of FASD education and alcohol-use interventions into substance abuse treatment. Through the Project CHOICES initiative, TOPDD has established a relationship with the Texas Department of State Health Services, the single state agency responsible for substance abuse treatment services and funding. Through this relationship and the success of Project CHOICES, we have been able to make FASD education a required component of treatment programs funded by the state.

6. TOPDD and its partners have been successful in collaborating with multiple entities to make contraception services more available to women in treatment and are continuing to work with DSHS to make it a core component of substance abuse treatment programs. However, the unstable funding of contraceptive services is a barrier to the implementation of Project CHOICES in the long term. TOPDD and the Task Force are actively monitoring this situation and seeking creative solutions to this challenge.

7. It has become clear that strong leadership within the clinical programs is a key to success. From the beginning, administrative and clinical directors must be part of the planning and development of the program. With buy-in at both the highest programmatic and clinical levels, all staff will be more likely to participate fully. The programs that were chosen to continue CHOICES in OY4 have a high level of commitment to and appreciation of the CHOICES model, from the counselors to the administrators.

8. The model we have developed for collaborative networking across state agencies is one that is applicable for all aspects of integrated services in the behavioral health care system. Through such an approach, we have generated interest across substance abuse, mental health, public health, and judicial programs and have brought a level of awareness to the importance of prevention within intervention and treatment services. In the coming year, we will continue to use the knowledge and connections of this group of people and agencies in efforts to influence the statewide systems of care.

9. Access to services continues to be a problem for women with substance abuse disorders. Due to federal guidelines, preference for treatment services is accorded to

- a) pregnant injecting drug users;
- b) pregnant substance abusers;
- c) injecting drug users;
- d) parents with children in foster care; and
- e) veterans with honorable discharges.

TOPDD participates in a national consortium of state leaders addressing FASD and will bring to the attention of this organization the fact that in order to change this on a state level, federal law will have to be changed.

## **Descriptions of the experiences of women drinking during pregnancy and women with alcohol problems and the factors that contribute to their stopping or continuing to drink**

In general, drinking during pregnancy occurs for a variety of reasons, including inadequate access to women's health care, ignorance about being pregnant, limited or inaccurate information about the dangers of drinking while pregnant, and the prevalence of alcohol use in all age, socioeconomic status, racial, and ethnic populations. Similarly, there are countless reasons why women choose to stop drinking, and just as many why some do not make that decision. Our target population is unique in that they are chemically dependent and drink at very high levels. Women in these situations cannot "just stop." We regularly hear CHOICES counselors reflect that there is a wide variety of reasons that women come into treatment for alcohol and other drugs. Particularly common, is court mandate or referral from child protective services, although a desire to improve the lives of their children and/or of themselves is also often stated. Drinking at very risky levels is often a primary cause for these court and CPS mandated referrals. Many need medical detoxification services and treatment. The state of Texas has a total of 200 medical detoxification slots throughout the state. Furthermore few addicted people readily accept treatment.

In August of 2011, the American Society of Addiction Medicine released a public policy statement, defining addiction differently than it has ever been defined before, emphasizing the impact on the brain and the effects of the brain in addiction. This statement also goes in to detail about the factors contributing to addiction, including genetics and life experience. It also covers the cognitive, emotional and behavioral changes resulting from addiction, and the neurobiology of reward, which is an important part of addiction to understand. Many of the CHOICES teams report in our monthly calls that they believe that one or several of their active treatment clients may have been prenatally exposed to alcohol themselves. The research shows that those with an FASD may be more likely to use substances than their non-prenatally exposed peers. Female clients talk frequently with their counselors about their life outside of treatment, including their own experiences and histories, which sometimes include domestic violence, homelessness, and major life stressors. Most of the CHOICES subcontractor agencies practice trauma informed care for this reason.

"Addiction affects neurotransmission and interactions within reward structures of the brain, including the nucleus accumbens, anterior cingulate cortex, basal forebrain and amygdala, such that motivational hierarchies are altered and addictive behaviors, which may or may not include alcohol and other drug use, supplant healthy, self-care related behaviors. Addiction also affects neurotransmission and interactions between cortical and hippocampal circuits and brain reward structures, such that the memory of previous exposures to rewards (such as food, sex, alcohol and other drugs) leads to a biological and behavioral response to external cues, in turn triggering craving and/or engagement in addictive behaviors." *American Society of Addiction Medicine, 2011*

We found that some women were rationalizing drinking during pregnancy because their understanding was that the other drugs that they were using would do such harm that they believed that they would not have a healthy pregnancy anyway.

Much research exists on this topic. For many women who find success in recovery, part of this success involves replacing addiction with another passion in their lives, ranging from physical exercise to volunteer work to school. Many of the CHOICES programs that we have worked with over the contract period have mentoring or graduate programs, where women who have completed the program have the opportunity to support and role model for other women who are in the process of overcoming addiction.

Alcohol, like other drugs, can be used to mask the pain of family violence and low self esteem. Risk factors for alcohol use include having a family member who is an addict. Much research revolves around the role that a woman's children have in her decision to quit. Some new research also suggests that if a woman quits for her kids alone, but not necessarily for herself too, she is much more likely to relapse.

Reports have shown that female substance abusers experience a number of barriers to receiving treatment, including child care responsibilities, stigmatization, and inability to pay for treatment. Female substance abusers are more vulnerable than male substance abusers to some of the physiological effects of substance use, and substance abuse among females is rooted more often in psychosocial problems and traumatic life events than it is for men. Factors that contribute to success include: treatment at women-only facilities or access to facilities offering child care services, after controlling for client and facility characteristics. *SAMHSA, 2005*

Feedback from CHOICES participants shows reasons for hope, based closely on some of the success factors outlined above. We have heard from women in the program that feeling like their counselor was trustworthy and caring made a real difference in their experience with the intervention and with the recovery process. All of the programs that we have CHOICES in exclusively serve women and almost all have an option for women with children. Counselors shared some positive feedback from clients: *"Project Choices has helped me feel more confident about my behaviors."* *"From CHOICES I learned not to drink, how important it is to use birth control and to practice using my personal right to say no."* *"CHOICES teaches you how to take care of yourself and your unborn child."*

### **Description of model approaches to integrating CHOICES into State or local alcohol or substance abuse programs**

A model approach would include: Wide collaboration at the state level – departments of health and human services, departments of state health services, departments of substance use and mental health, etc. Some awareness of and knowledge about FASD is also an important first step in integrating CHOICES in any clinical setting. Buy-in at multiple levels of any organization that is implementing CHOICES must be present, from the clinicians who deliver the program, to the administration, and the leadership must all understand and value the program for it to be both successful and sustainable. Access to

and familiarity with women's health services would be needed, as would knowledge of applying for (or helping a client to apply for) medical insurance to increase accessibility. Clean, carefully regulated data collection yields high quality data that can lead to demonstrated results. This data collection piece is one of the components of CHOICES that would need ongoing support.

An opportunity to continue some funding of this initiative is needed. Regular high quality trainings and train the trainer opportunities would be very valuable. Continued technical assistance support could also be beneficial.

#### 4. Project Changes

Change Category	Description of Change
State/local policies and procedures	The state of Texas now requires all substance abuse treatment programs (for both males and females) to provide education on FASD as part of their contracting requirements. It was important for numerous reasons, most notably to start to address the widespread ignorance about FASD. This happened through collaboration with other state agencies and key Task Force members. CHOICES paved the way for this change.
Organizational policies and procedures	CHOICES sites have developed individual policies and procedures to ensure that all female clients are screened, and to ensure that the CHOICES protocol is followed. This change was instituted in order to ensure that the CHOICES intervention was made available to as many eligible women as possible and to encourage sustainability. It was achieved through close collaboration with the Project Director and the subcontractor agencies.
Systems integration (intake, screening, MI sessions, contraceptive visit, case coordination, etc.)	Most agencies have integrated CHOICES into client treatment planning, thus creating more accountability around implementation. This was intended as a step towards keeping CHOICES going beyond May 2012. Along with organizational policies and procedures, this has been an ongoing effort achieved through regular discussions and planning with the subcontractor agencies and other stakeholders.
Service delivery processes (individual vs. group formats, new clinical techniques, etc.)	While the sessions are provided separately, clients may also discuss their experiences and reflections in group or individual sessions. After OY2, it was decided by TOPDD that there was value to be gained by attempting to increase the consistency of program implementation across subcontract agencies and counselors. For this reason and in an effort to increase the opportunity to fairly review data across sites, all of the sites are now following specific protocol about implementation which we

	gave them to make sure that implementation is parallel and consistent from site to site.
Data Systems (integration of program data, centralization, etc.)	The change to the data and evaluation system that TOPDD enacted this year was an effort to increase the opportunity for Project Director to work on program level work instead of spending such a large amount of time on data cleaning and interpreting. TOPDD released an RFA for the data collection and evaluation duties, and NTI Upstream was selected. With the incorporation of this new evaluation team this year, we now have our sites mail their hard data (paper copies) to NTI Upstream who has centralized the data into a combined database for the entire project. Data is input and cleaned by the NTI Upstream team. Each month, NTI Upstream sends us a “Data Issues Report,” which lists the questions and problems there are with various sites’ data. These are addressed and resolved as soon as possible with the specific sites.
Staffing (new training focuses, staffing structures, qualifications for new hires, etc.)	With the hope that CHOICES will continue to be an intergrated part of recovery center’s regular practice, participating agencies inform new staff about CHOICES regardless of whether they work on CHOICES directly or not so that processes can be done more smoothly and to make sure all counselors are prepared for CHOICES related issued in counseling sessions, if they arise.