HEALTH COACH TRAINING MANUAL

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Chapter 1: MOSBIRT Training Introduction and Overview

The Problem

Alcohol and substance abuse is a serious health problem affecting about 16.5% of the population. Alcohol problems are as common among patients in primary healthcare as hypertension and type 2 diabetes but far less likely to be detected. It is the third leading cause of death and costs an estimated $185 billion annually. Despite the obvious magnitude of the problem, nationally only 14.6% of those who need care get it. In Missouri, the percentage of those in need who receive treatment drops to 5%. In estimated 405,000 Missourians have an unmet need for treatment of alcohol use and 134,000 have an unmet need for drug treatment (2004 National Survey on Drug Use and Health). The reasons for this are complex:

Alcohol abuse is viewed by many as moral or characterological weakness and a failure of will power. The genetic, physical, social and psychological factors that contribute to alcohol abuse are not well understood by society in general and, in particular, by providers and the people who generate health care policy and fund health care.

Public and private resources for treating substance abuse are fragmented, isolated from the health care mainstream and seriously underfunded and undersized to meet the need. The substance abuse treatment community generally comprises highly specialized, freestanding and independent agencies that employ traditional techniques with little or no coordination and integration with other health care service providers.

As with many other health problems, substance abuse is seldom recognized or treated until serious physical and psychosocial impairments are manifest.

Screening, Brief Intervention and Referral to Treatment (SBIRT):

A Paradigm Shift

In response to these issues, SAMHSA has implemented an evidence based prevention and early intervention oriented initiative that includes population based screening and brief intervention in general health care settings. This approach expands the substance abuse treatment system dramatically beyond the severe limitations of the specialized provider community, engages the general health care community in screening, brief treatment and referral and builds a critical component in a more comprehensive system of care for substance abuse.

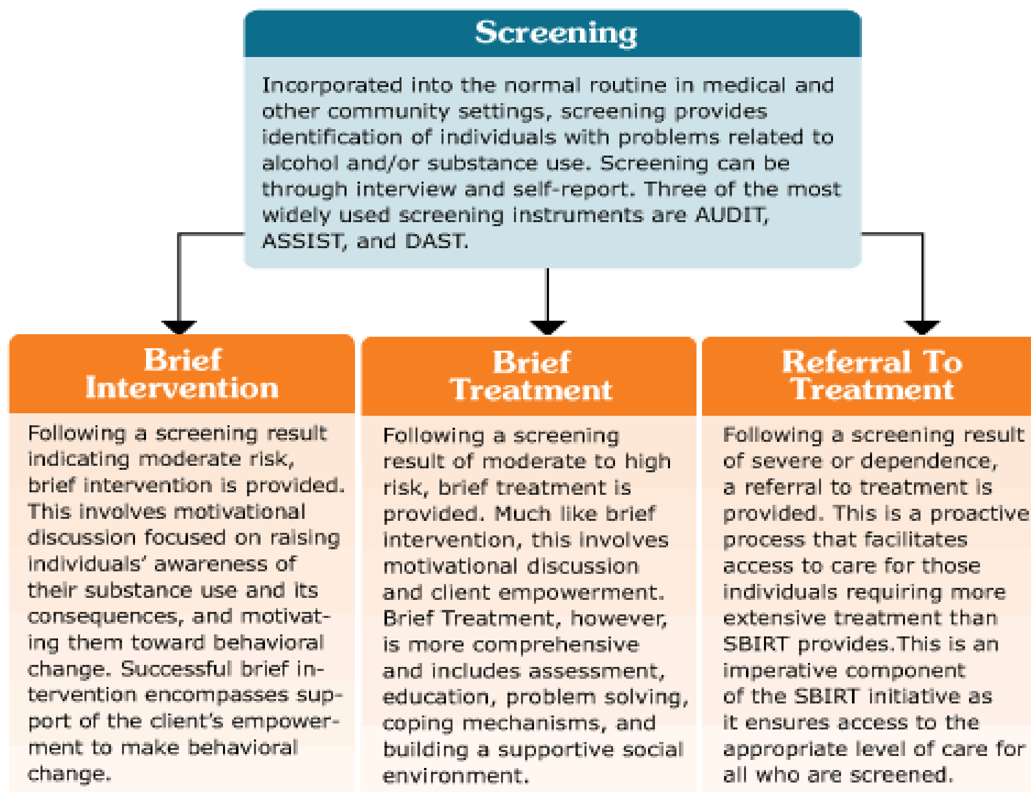
The SBIRT Initiative represents a paradigm shift in the provision of treatment for substance use and abuse. The services are different from but designed to work in concert with specialized or traditional treatment. The primary focus of specialized treatment has been persons with more severe substance use or those who have met the criteria for a Substance Use Disorder. The SBIRT Initiative targets those with **nondependent** substance use and provides effective strategies for intervention prior to the need for more extensive or specialized treatment.

The Initiative involves implementation of a system within community and/or medical settings—including physician offices, hospitals, educational institutions, and mental health centers—that screens for and identifies individuals with or at-risk for substance use-related problems. Screening determines the severity of substance use and identifies the appropriate level of intervention. The system provides for brief intervention or brief treatment within the community setting or motivates and refers those identified as needing more extensive services than provided in the community setting to a specialist setting for assessment, diagnosis, and appropriate treatment.

As of August 2007, SBIRT grantees funded by SAMHSA have screened over 536,000 individuals. Through grantees efforts, researchers are learning how to integrate SBIRT into primary care. Preliminary data suggest the approach is successful in modifying the consumption/use patterns of those who consume five or more alcoholic beverages in one sitting and those who use illegal substances. Grantees have implemented SBIRT in trauma centers/emergency rooms, community clinics, federally qualified health centers, and school clinics.

SBIRT Core Components

The theoretical framework and programmatic structure of different SBIRT programs may vary, but the core components of SBIRT remain the same and can be defined as follows:



The Missouri SBIRT Project (MOSBIRT)

The State of Missouri is home to an estimated 5.84 million people (U.S. Census Bureau, 2006). The Missouri Division of Alcohol and Drug Abuse (ADA) estimates that, of this number, 485,000 (or about 12% of Missouri residents) need treatment for alcohol or drug dependence or abuse. In FY 2007, ADA programs provided treatment services to 13.1% of individuals needing public sector treatment. Of the consumers served, 9,568 are Medicaid funded, 46, 487 are non-Medicaid.

Alcohol is the drug of choice for most Missouri citizens and, as a consequence, the state currently ranks in the upper third for alcohol-related traffic crashes and fatalities (U.S. DOT 2006). In FY 2007, the top five drugs of abuse among people treated by ADA were alcohol (37%), marijuana (27%), cocaine (15%), methamphetamines (11%), and heroin (5%). Missouri leads the nation in methamphetamine abuse. The Treatment Episode Data System (TEDS) recorded an increase of 317% in methamphetamine-related admissions statewide from 1995 to 2003 (Lane, 2005). St. Louis area emergency rooms

reported a 97% increase in treatment episodes involving methamphetamine from 1995 to 2002. In fact, Missouri recorded the highest number of methamphetamine lab incidents of all states in 2003, more than double the number of incidents from the two states with the next highest numbers, and the DEA reports that Missouri "led the nation in methamphetamine related busts in 2004 and in 2006" (DMH, 2006).

Many Missourians with potential alcohol and drug problems first present to medical settings. "The number of alcohol and drug related hospitalizations and emergency department encounters in Missouri has steadily increased, with over 90,000 in 2005" (DMH, 2006). Additionally, in 2005, hospitalization and emergency department charges exceeded $120 million for those individuals (DMH, 2006).

The Missouri Department of Mental Health, Division of Alcohol and Drug Abuse (ADA) received an SBIRT grant from SAMHSA for $12,500,000 over five years. ADA has contracted with the Missouri Institute of Mental Health (MIMH) at the University of Missouri School of Medicine to manage and implement the Missouri SBIRT (MOSBIRT) project. Initial project sites will be at CoxHealth Medical Center in Springfield with Burrell Behavioral Health as a collaborating partner. Subsequent phases will be implemented at other sites.

The ultimate purpose of MOSBIRT is to expand and enhance substance abuse services in the State of Missouri. To achieve that goal, MOSBIRT will:

1. Expand the existing continuum of care to include screening, brief intervention, brief treatment, and referral for individuals with unhealthy levels of alcohol use, over use of prescription medications, or the use of illegal substances in general medical settings.
2. Support clinically appropriate evidence based services for such individuals.
3. Identify systems and policy changes to increase access to early identification and intervention in generalist settings.

The objective is to provide appropriate services to the target population with cultural sensitivity and appropriateness. Our specific goals are to:

- Develop tools and processes to successfully employ SBIRT in generalist settings;
- Provide successful demonstrations of working SBIRT systems in at least three different types of generalist settings;
- Screen for over use of prescription drugs or alcohol, illicit drugs, and tobacco.
- Intervene with patients before they have significant problems so that they can make desirable changes in behavior including substance use, employment, criminal activity, stable housing and all the other GPRA performance indicators;
- Refer individuals to specialized treatment providers when needed;
- Collect and present compelling data demonstrating SBIRT's positive impact; and
- Facilitate policy changes that support SBIRT conceptually and financially.

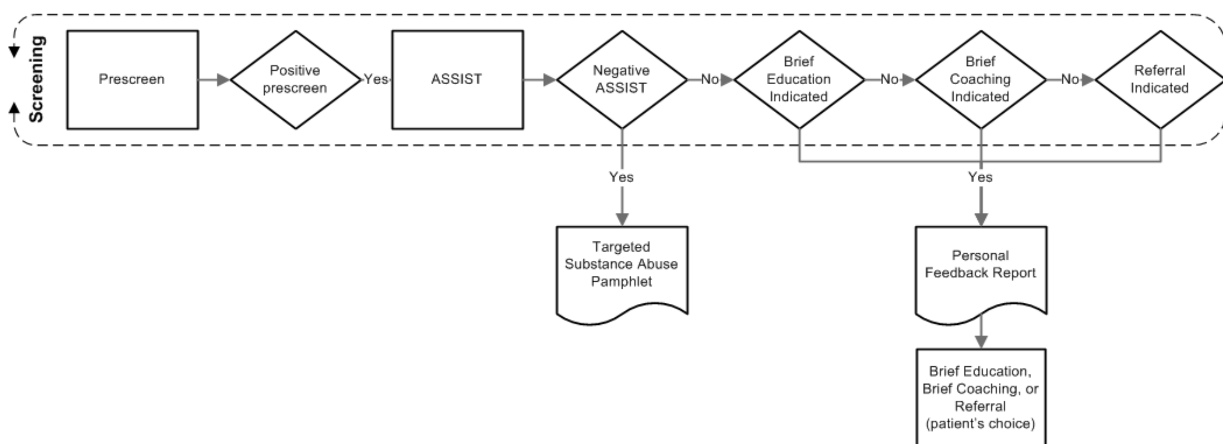
If met, these goals will increase access to professional services by providing indicative prevention, targeting individuals at risk before they develop significant problems. They will make available a new level in our continuum of care, SBIRT, increasing the service options available to Missouri's citizens. Meeting these goals provides primary prevention by expanding patients' awareness of safe alcohol use as well as the adverse medical impact of the use of tobacco, the over use of prescription drugs, and the use of illicit drugs and secondary prevention by providing brief treatments to those who engage in problematic behaviors. Additionally, it will provide outreach into the medical community to identify and refer individuals in need of specialized treatments who were not yet seeking such services.

Overview and Flowchart of the Process

All patients presenting to project site clinics will receive a brief screening for substance abuse that will be administered and reviewed by clinic staff. Individuals scoring positive on the screening will be referred to a **health coach** for more in depth screening (ASSIST, described below) and data collection (GPRA, described below). The health coach will meet with the patient, discuss the project, secure consent to participate, administer and score the ASSIST and GPRA and provide personalized feedback based on his/her unique scores and information.

The health coach will provide brief intervention (one session) and brief treatment either face to face or by phone, depending on the needs and preferences of the patient. Referrals to specialized treatment will be arranged by a case manager/liaison who will make a “warm handoff” to the service provider to maximize patient follow through.

In addition to the ASSIST and GPRA, several other assessment instruments will be administered during the screening process, treatment and after the completion of treatment. Health coaches will work closely with program evaluation staff to maximize patient participation in the evaluation process.



MOSBIRT will make extensive use of tablet computers in all phases of the screening, intervention and evaluation process collectively referred to as “MOSBIRT in a Box” (MOSBox). MOSBox will include online screening instruments, manualized and computer assisted interventions and evaluations tools. The user interface will be tailored to this unique clinical application to facilitate data entry and analysis and to insure treatment interventions that are consistent and which maintain fidelity with the evidenced based practices on which they are based.

The Treatment Model

MOSBIRT will use two evidence based, synergistic treatment strategies – Motivational Enhancement Therapy and Cognitive Behavioral Therapy adapted for substance abuse problems.

Motivational Enhancement Therapy (MET)

In the addictions field, the search for critical conditions that are necessary and sufficient to induce change has led to the identification of six critical elements:

- Feedback regarding personal risk or impairment
- Emphasis on personal responsibility for change
- Clear advice to change
- A menu of alternative change options

- Therapist empathy
- Facilitation of patient self-efficacy or optimism.

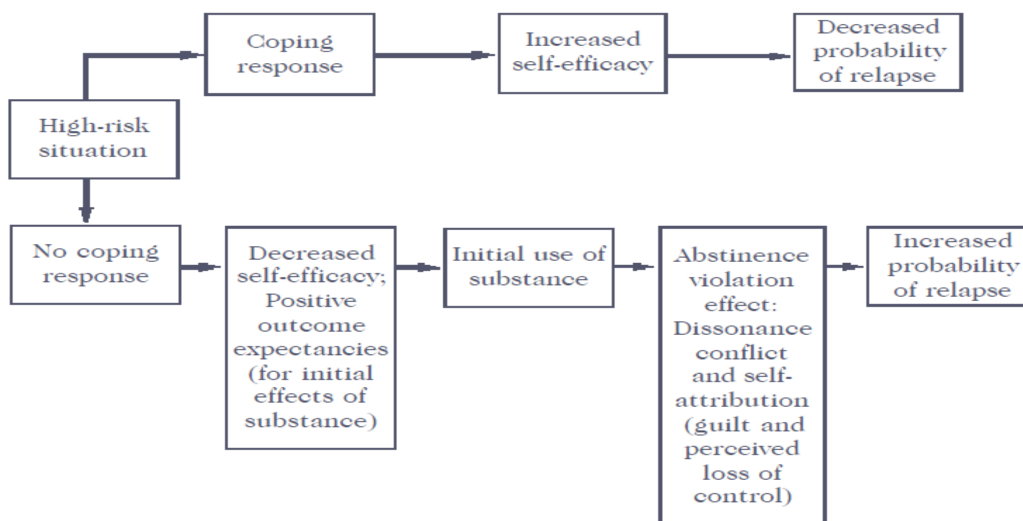
The MET approach is further grounded in research on processes of change. Prochaska and DiClemente describe five stages of change that people progress through in modifying problem behaviors (the stages of pre-contemplation, contemplation, determination, action, and maintenance). The MET approach assists patients in moving through the stages toward action and maintenance.

From a stages-of-change perspective, the MET approach addresses where the patient is currently in the cycle of change, and assists the person to move through the stages toward successful sustained change. For the ME therapist, the contemplation and determination stages are most critical. The objective is to help patients consider seriously two basic issues. The first is how much of a problem their drug use poses for them, and how it is affecting them (both positively and negatively). Tipping the balance of these pros and cons of drug use toward change is essential for movement from contemplation to determination. Secondly, the patient in contemplation assesses the possibility and the costs/benefits of changing the drug use. Patients consider whether they will be able to make a change, and how that change will impact their lives.

Cognitive Behavioral Therapy (CBT)

CBT posits that individuals who misuse drugs and/or alcohol must learn new ways of responding to feelings, states of mind, or situations that have led to use in the past and the internal dissonance that may arise as a consequence of using, despite earlier commitments to abstain. Exhibit 1 suggests that individuals' confidence in their ability to abstain (i.e., their self-efficacy) derives from periodic exposure to high-risk situations that triggered or mediated use in the past. Using coping skills learned through CBT in these situations increases the likelihood that the patient will achieve a positive outcome such as a reward, reduced anxiety, abstinence, or discontinuance of use and, in turn, strengthen his or her *perception that a positive outcome is achievable*. The bottom trajectory of exhibit 1 illustrates the sequence that occurs if the patient lacks coping skills or fails to use coping skills at the appropriate time. In this case, an ineffective response to the risky event yields disappointment (i.e., low self-efficacy) and emergent desire to remedy the situation with drugs or alcohol. Desire leads to use, and use further erodes the perceived ability to abstain.

Exhibit 1. Cognitive Behavioral Model of the Relapse Process



Source: Marlatt & Gordon, 1985. Copyright © 1985 by The Guilford Press.

Overview of interventions

Information, Brief Education, Brief Coaching or Referral for specialized treatment will be offered and provided based on the ASSIST score as follows:

ASSIST Score	Intervention	Number of Sessions
Alcohol = 0-10, Drugs = 0-3	Information and Reinforcement	1 session (5 minutes)
Alcohol = 11-19, Drugs=4-19	Brief Education	1 session (30 minutes)
Alcohol or drugs = 20-26	Brief Coaching	6 sessions (50 minutes each)
Alcohol or Drugs > 26	Referral	

Information and Reinforcement

- ASSIST score range: Alcohol 0-10; Drug 0-3
- Completed in one session (about 5 minutes)
- Starts immediately following a negative ASSIST

Personal Feedback Report (PFR)

Information from the individual’s self report is compared to relevant normative information and to the possible health outcomes based on their substance use behavior. A printed report with this information is generated and given to the patient to take home. The patient is congratulated on having no substance abuse risk factors, provided with any other information about substance use and misuse that they wish and released.

Brief Education

- ASSIST score range: Alcohol 11-19; Drug 4-19
- Completed in one session (about 30 minutes)
- Starts immediately following a positive ASSIST

For alcohol use disorders, interventions lasting one or two sessions were found to be the most methodologically sound and effective of clinical treatments in an analysis of 361 clinical trials. Because of the effectiveness and minimal time requirements, MOSBIRT Brief Education (BE) will be conducted during single face-to-face sessions (about one hour) and generally immediately following the initial screening. Two evidence based components will be employed in the BE:

- Provision of Personal Feedback Report
- Motivational enhancement using the FRAMES model

Personal Feedback Report: Linda Sobell and her coworkers have found that providing individuals with tailored information and tying their behaviors to health outcomes will reduce drinking behaviors for individuals who are not seeking assistance. This approach has been successfully employed in face-to-face encounters, via mail, and on the Internet. The feedback, available on the computer screen and in print will highlight the health difficulties associated with the various substances identified and, as appropriate, present normative information comparing the patient’s behavior with their peers.

Motivational enhancement: Motivational enhancement as a brief opportunistic intervention began in the smoking intervention field and moved into alcohol misuse. However, it can be easily adapted to

other substance misuse. For example, motivational enhancement has been shown to increase retention and participation in substance abuse services.

In presenting and discussing the tailored feedback, staff will use the motivational enhancement techniques described in the FRAMES model. **Feedback** is given to the patient regarding personal risk or impairment. **Responsibility** for change remains with the patient. **Advice** to make a change is given by the provider. A **Menu** of alternative changes options are provided. **Empathetic** conversational style is used, mostly through reflective listening. **Self-efficacy** is supported and enhanced in the patient.

Note: If the ASSIST score is 20-26, this session ends with planning for five additional sessions described below and the assignment of real life practice.

Brief Coaching

- ASSIST score range: Alcohol or Drug 20-26
- Completed in six sessions (50 minutes each)
- First session starts immediately following a positive ASSIST
- Remaining sessions held either face-to-face (at facility) or by phone

The provision of Brief Coaching for mild to moderate substance abuse problems during the course of medical treatment has been shown to be more effective than referral to specialty services. In this model, on-site health coaches work with patients' behavioral issues.

Brief Coaching follows the manualized motivational enhancement therapy/cognitive behavioral therapy (MET/CBT5) initially developed to treat adolescent cannabis use. MET/CBT5 treatment was tested against five others in both community clinics and medical centers, where it was both effective and the most cost effective of the treatments. Research has shown that MET/CBT5 is more effective than less prescriptive "best practice" models.

The implementation of MET/CBT5 is organized across six sessions with *MOSBox* providing the written session outline, assessments, and interactive materials that are used by the staff and patient during each session. MOSBox will also generate printed tailored feedback and information following all sessions. While the MOSBIRT Brief coaching is intended to be a face-to-face intervention, if the patient is unable or unwilling to attend additional sessions, any remaining sessions should be conducted on the phone.

The primary goals of this treatment are to enhance participants' motivation to change their substance use and to develop basic skills needed to achieve abstinence or gain control over it. The first and second sessions are spent enhancing motivation and identifying high-risk situations that may increase the likelihood of relapse. The health coach explores the participant's use patterns, reasons for using, reasons for seeking treatment, prior treatment attempts, goals, self-efficacy, readiness for treatment, and problems associated with substance use. A Personalized Feedback Report is used to compare the participant's substance use and related problems with national norms. In the three subsequent CBT sessions, participants learn basic skills for refusing invitations to use, establishing a social network supporting recovery, developing a plan for engaging in pleasant activities that fill free time formerly occupied with substance use-related activities, coping with unanticipated high-risk situations, problem solving, and recovering from a relapse, should one occur. The following is an overview of the Brief Coaching sessions:

Note: The first session of Brief Coaching is nearly identical to the Brief Education described above. If the ASSIST score is 20-26, it would conclude with a planning for the next five sessions and a real life practice assignment. Session 2 picks up where the Brief Education session leaves off.

Session 2: Goal setting:

- Review
- Concept of functional analysis
- Decisional Balance
- Collaborate on setting a treatment goal or goals for the remaining treatment sessions

Functional analysis is the process of examining the function the behavior in question plays in the individual's life. For example, the patient may become nervous in social situations and drink to relieve their anxiety. Understanding the behavior's function allows the individual to decide if that function is reasonable or if there are alternative behaviors (e.g., learning techniques of talking to strangers in a social situation) which may be preferable.

Decisional balance refers to comparing the costs and benefits of changing and of not changing a specific behavior. It is a process that appears to be a critical factor in either naturally occurring recovery for even severe and chronic drug abuse or as part of a formal treatment. It is also found across cultures.

Specific concrete goal setting is critical in the change process. Meta-analyses show that even if all else is optimized, only a small percentage of individuals will be able to make a change with intention alone. Goals can be hard to translate into action and the link between intention and behavior is weak. Research on self-regulation indicates that concrete plans (in the form of if-then statements) yield a substantial improvement in behavior change outcomes.

Session 3: Triggers and refusal skills:

- Review
- Communications styles awareness
- Develop refusal skills to handle pressure effectively
- Behavioral practice of new skills

Triggers are situations or events that frequently lead to the behavior one is trying to change. These are often identified during functional analysis. Because they "cause" the behavior, the individual must either avoid them altogether, which may be impractical, or develop the skills necessary to refuse to engage.

Adequate refusal skills have been shown to lower the risk for alcohol abuse and dependence. Without a plan, dealing with these situations makes it more difficult to follow through with the intention to change. For example, "IF I'm at a party and someone offers me a drink, THEN I'll tell them I have to get up early tomorrow." Having plans in place beforehand makes a person less susceptible to threats to the behavior change. IF-THENS also heighten the accessibility of long-term goals and healthy actions, even when the person is not actively thinking about them, and yield enhanced implementation and long-term maintenance.

Session 4: Enhancing support network.

- Review
- Replacement: Pleasure and mastery activities
- Discuss social support and how to increase it.
- Behavioral practice of new skills

Replacement activities that lead to immediate reward and feelings of accomplishment are an essential element of long-term "wellbriety." Behavioral change is not something that occurs in isolation but rather in the individual's social environment. Social support can be fostered by developing new relationships with those who share one's desire for change. They can also be reforged links with existing family and friends who support and encourage the new behaviors. Social support has been

shown to be critically useful after the initial behavioral change in helping individuals to remain drug free, to reduce the frequency of relapse, and to maintain sobriety.

Session 5: Planning for emergencies and setbacks:

- Review
- Brainstorm events that could precipitate a relapse
- Teach problem-solving approach to help cope with unforeseen events
- A relapse is likely to be accompanied by guilt and shame, which exacerbates the problem
- Use emergencies and lapses as learning opportunities

Behavior change is a process, not an event. Occasional failures and frustration are to be expected when trying to achieve an ambitious goal. Some of those situations can be anticipated and planned for as discussed in triggers and refusal skills session. If occasional failures do occur, advanced planning on how to cope with the resulting frustrations helps reduce distress and allows the individual to learn from the situation, revised their plans, and try again.

Session 6: Review and close:

- Review
- Adjust plans and goals as appropriate
- Complete discharge assessment
- Leave taking

At the end of BC, the patient can decide, with staff assistance, if additional services are needed and be referred to specialty providers as appropriate. As with the BE, fidelity will be assessed on an ongoing basis through independent and supervisory reviews of taped interviews and a modified version of the MET/CBT5 Therapist Session Report.

Referral

- ASSIST score range: Alcohol or Drug 27 and above
- Starts immediately following a positive ASSIST

Referral, passing an individual from one system to another, is that point in time where many individuals get “lost.” There have been a number of studies examining this phenomenon. The most consistent finding is that when the time between assessment and intake is reduced, fewer dropouts occur. Learning from these efforts, our Referral (RT) intervention will use a **warm hand-off** method. During referral, the patient will be introduced by the health coach to the referral liaison in a face-to-face meeting. The liaison will work with the patient linking them to the appropriate services, providing support and assistance throughout the process.

To support this process, the liaison will use the *MOSBox* treatment matching system. Using previously entered information, this system matches the patient’s needs and cultural characteristics to find appropriate services providers. The patient and liaison then use that listing to help select a specialist provider. This system, previously developed by Missouri Institute of Mental Health, has been used over the last seven years in the St. Louis area (http://samhi.mimh.edu). For SBIRT, it will be extended with information from specialty providers geographically associated with our performance sites. The system does not dictate a specific referral; rather the patient and liaison can review the list of available options and make the best choice to match the patient’s needs and desires.

Liaisons will do whatever it takes to get the individual into services. Funding has been allocated in this grant to provide for such services as transportation. Importantly, the liaison does not simply drop the individual off at the door. They will check up with the patient after admission to make sure that they

are getting services and becoming engaged. Their job will be completed only after the patient is connected to specialized services.

MOSBIRT Treatment Philosophy

The structure and model of treatment outlined above is a core aspect of evidence based practice. The interventions that will be used in the MOSBIRT project were selected because research has demonstrated their efficacy so fidelity to their key features is important. If the same positive outcomes as these interventions have achieved in research are expected, they must be emulated in this project. At the same time, individual patients do not always fit neatly into models of care. For example patients may not move through the stages of change at the pace prescribed in this project. A patient who requires Brief Coaching may not be ready for the CBT component at the end of the second session.

While we expect most patients to respond well to the MOSBIRT treatment model and structure, some will not and it is important to emphasize that patient needs are always the highest priority. Some adaptations in the treatment process may be appropriate such as an additional MET session or referral for specialized treatment in the middle of treatment. Coaches should discuss such patients with supervisors and project management to determine the best course of action to meet their needs.

Common Elements in MOSBIRT Interventions

Therapeutic Alliance

Developing rapport through nonjudgmental, empathetic motivational discussion is a key element of all MOSBIRT interventions. Rapport is built on the idea that eliciting discussions of patient strengths and interests is critical in helping with patient problems. Session time is allotted to “meet and greet” the patient as a human being, in a way that suggests sincere curiosity about their life and not just their “problems.”

Elicit–Provide–Elicit

Many of the intervention steps included in this training will use a standard format used in Motivational Interviewing – Elicit, Provide, Elicit – as a framework for establishing and maintaining rapport and engaging the patient in an interactive therapeutic process.

Elicit: ***The patient is asked open ended questions about a range of issues.***

Provide: ***The provider reciprocates with an appropriate response – reflection, information, a request for clarification.***

Elicit: ***The patient is allowed or asked to respond to the comments of the provider.***

Writing

Filling out and reviewing handouts are a part of all sessions and need to be organized prior to the session.

Real Life Practice Commitment

In reality, treatment time is minimal compared to the other hours of the week. Hence, outcomes are often dependent on patient’s practicing and thinking about session material throughout the week between sessions. MOSBIRT Brief Coaching makes sure patients understand and commit specifically to “real life practice” at the end of each session.

OARS

Open questions, affirmation, reflections and summary reflections (OARS) are the basic interaction techniques and skills that are used “early and often” in the motivational interviewing approach.

Open Questions

Open questions invite others to “tell their story” in their own words without leading them in a specific direction. Open questions should be used often in conversation but not exclusively. Of course, when asking open questions, the health coach must be willing to listen to the person’s response.

Open questions are the opposite of closed questions. Closed questions typically elicit a limited response such as “yes” or “no.” The following example contrasts open vs. closed questions. Note how the topic is the same, but the responses will be very different:

Did you have a good relationship with your parents?
What can you tell me about your relationship with your parents?

Affirmations

Affirmations are statements and gestures that recognize patient strengths and acknowledge behaviors that lead in the direction of positive change, no matter how big or small. Affirmations build confidence in one’s ability to change. To be effective, affirmations must be genuine and congruent. Examples of affirming responses:

I appreciate that you are willing to meet with me today.
You are clearly a very resourceful person.
You handled yourself really well in that situation.

Reflections

Reflections are statements that let the speaker know that you heard what they said by stating your hypothesis, or best guess, about what was said. The statement may be a simple reflection and express what was heard. The statement could also be a complex reflection by reflecting what the speaker experienced and/or felt about the experience. Note that the reflection is a best guess and may not be accurate. The speaker’s response to the reflection will either confirm the accuracy of the reflection or provide further clarification. Developing the ability to listen reflectively will increase the accuracy of reflections.

Reflective listening is a primary skill in outreach. It is the pathway for engaging others in relationships, building trust, and fostering motivation to change. Reflective listening appears easy, but it takes hard work and skill to do well. Sometimes the “skills” we use in working with patients do not exemplify reflective listening but instead serve as roadblocks to effective communication. Examples are misinterpreting what is said or assuming what a person needs. It is vital to learn to *think* reflectively. This is a way of thinking that accompanies good reflective listening. It includes interest in what the person has to say and respect for the person’s inner wisdom.

Summaries

Summaries are special applications of reflections. They can be used to keep the conversation focused and to direct the conversation. Summaries are particularly helpful at transition points, for example, after the person has spoken about a particular topic, has recounted a personal experience, or when the encounter is nearing an end. Summarizing helps to ensure that there is clear communication between the speaker and listener. Also, it can provide a stepping stone towards change.

Change Talk

Understanding how to listen for and generate "change talk" is an essential component of motivational interviewing. Health coaches listen for DARN-C and then utilize two forms of strategies to help motivate change: passive –reflective listening strategies and more active self motivation strategies. Commitment talk is thought to be necessary and lead to the most immediate change. There are five types of change talk (**DARN-C**):

- Desire – "I want to…"
- Ability – "I could…"
- Reasons – "I should because.."
- Need – "I need to…"
- Commitment – "I will…"

Some ways to elicit self-motivational statements:

- Ask evocative question: What help will you need? What is next for you? Any new insights?
- Explore pros and cons…
- Decisional balancing, double sided reflection
- Seek elaboration….
- open ended/reflective
- Imagine extreme outcomes…
- What will happen if this gets worse? When you lose your housing do you know how to be homeless?
- Look Forward, Look Backward
- Use of scaling ("On a scale of one to ten…")
- How important is it for you to change right now?
- If you did decide to change, how confident are you that you could do it on a scale of zero to ten?
- Why are you an x and not a y? What would need to happen for you to go from x to y
- Identify "motivation hooks"…what would have to happen to make quitting smoking more important to you?

Program Evaluation – Instruments and Process

Evaluation is one of the significant areas in MOSBIRT. This program starts and ends with implementing instruments and collecting data from patients. It is conducted three times: at intake, at discharge, and 6 month after intake for a follow-up. The first two data collections will be performed by health coaches, and the follow-up will be conducted by the evaluation staff. Several instruments will be used in MOSBIRT. Each time, different combinations of questionnaires will be implemented (see the MOSBIRT flowchart). The table below summarizes the instruments and the times when each one is presented.

Instruments	Data Collection
Prescreening Questionnaire	Before intake
ASSIST	At intake
GPRA	At intake, discharge, and 6 month after intake
ATOD Attitudes and Beliefs	At intake, discharge, and 6 month after intake
Readiness to Change – Treatment Version	At intake, discharge, and 6-month after intake
Patient Satisfaction Survey	At discharge

Prescreening Questionnaire

The MOSBIRT Prescreening Questionnaire contains 4 questions about the use of tobacco, alcohol, prescription and illicit drugs. The purpose of prescreening is to identify people who may have risky substance use and need a thorough and comprehensive screening. Staff will administer the prescreening as soon as possible after the patient presents and promptly give positive screens to the health coach for follow up.

ASSIST

ASSIST is the World Health Organization's Alcohol, Smoking, and Substance Involvement Screening Test. The current version was revised in 2007 (version 3). The purpose of the ASSIST is to screen patients in primary health care settings where harmful substance use may go undetected. This test consists of eight questions covering 10 main substance groups (tobacco, alcohol, cannabis, cocaine, amphetamine type stimulants, inhalants, sedatives, hallucinogens, opiates, and other drugs). The scores for each substance group are summed; based on the total scores, the type of treatments in MOSBIRT program is determined and recommended to patients (see table 2).

Table 2. ASSIST Total Scores and the Types of Treatments

ASSIST Total Scores	The Level of Risk	Treatment
0-10 for Alcohol; 0-3 for Drugs	Low Risk	No Treatment
11-19 for Alcohol; 4-19 for Drugs	Low Moderate Risk	Brief Education
20-26 for Any Substance	High Moderate Risk	Brief Coaching
27 + for Any Substance	High Risk	Referral

GPRA

The Government Performance and Results Act (GPRA) of 1993 requires all Federal agencies, including CSAT, to develop strategic plans, set annual performance targets, and annually report the degree to which the targets are met. In order to do so, CSAT developed an instrument specifically for SBIRT programs in order to track the success in modifying the consumption/use patterns of those who consume five or more alcoholic beverages in one sitting and those who use illegal substances. This instrument contains items taken from widely used screening, assessment, and diagnostic tools, including the Addiction Severity Index (ASI) and the McKinney Homeless Program reporting system. The GPRA will be collected for all who screen positively on the prescreen. Those referred for Brief coaching (BC) and Referral (RT) services are required to complete all of the GPRA Sections while those referred to Brief Education (BE) services are required to complete modified versions. Only patients who are screened and who require any level of intervention (BE, BC, RT) are eligible for follow-up sampling.

ATOD Attitudes and Beliefs

The official name of ATOD Attitudes and Beliefs is CSAP GPRA Attitudes and Beliefs Regarding Substance Use – adult (2005). ATOD stands for alcohol, tobacco, and other drugs. This questionnaire was developed by the Center for Substance Abuse Prevention (CSAP) to examine the outcomes of substance abuse prevention programs; yet it has been used widely either in substance use prevention or treatment programs. This questionnaire contains 8 items addressing the attitudes and beliefs of adult respondents regarding the use and risks associated with the use of ATOD.

Readiness to Change – Treatment Version

There are several versions of the questionnaires to measure the level of the readiness to change, based on the Transtheoretical Theory. In MOSBIRT project, a treatment version developed by Heather & Hönekopp (2008) will be used. This version is shorter than the other readiness to change scales, but still it shows acceptable reliabilities and validity. There are two scales including the same contents measuring either alcohol or drug use. The number of item is 12; a total score based on responses indicates how much a patient is ready to make changes in his/her use of substance. The levels of readiness are as follows: pre-contemplation, contemplation, or action.

Patient Satisfaction Survey

At discharge, a patient satisfaction survey will be presented to patients. This is a self-administered survey, asking their level of satisfaction regarding the services and health coaches. Health coaches will need to help patients fill out this form privately. Patients will enclose this survey in an envelope and seal it to insure confidentiality.

A Work in Progress – Interactive Development

MOSBIRT will use a Continuous Quality Improvement (CQI) approach to implementation. That is, we will continuously monitor the efficiency and effectiveness of our interventions and processes and patient/provider acceptance of SBIRT to identify and pursue opportunities for improving our approach. This is a five year project and we anticipate considerable evolution of our intervention methods and processes over time based on outcome measures and feedback from patients, project staff and particularly on site staff.

In that context, all MOSBIRT staff are collaborators who must take ownership in the project and provide project managers with the feedback they need to perfect our program. We will solicit that input on a periodic and formal basis but we also invite staff to contribute their thoughts and ideas as you see fit. We are not only open to that but we welcome and expect it.

Chapter 2: Motivational Interviewing Overview

Motivational Interviewing Overview

What Is Motivational Interviewing?

Motivational Interviewing (MI) is an evidence-based practice useful in helping people to resolve their ambivalence (i.e., conflict) about changing behavior, while not evoking resistance (e.g., confrontational, blame, label) and reducing resistance when encountered.

MI is a counseling style used to elicit behavior change that is both patient-centered and directive. With MI, patients are assisted to explore and resolve their ambivalence about changing a targeted behavior. Resolving ambivalence is accomplished by increasing the awareness of the discrepancy between the patient's current behaviors and their desired goals while keeping resistance to a minimum. When using MI, reflective listening is an essential skill needed to minimize resistance.

The Process of Change

Change is a part of life and occurs all the time as a natural and self-directed event among all people. Change occurs in relation to many behaviors and without professional intervention. There is well documented evidence of natural recovery from substance use disorders (SUD)s and smoking in the natural environment. Some examples of common natural changes are going back to college, getting married/divorced, changing jobs, and taking a vacation. Examples of natural changes in substance use are stopping drinking after an accident, eliminating marijuana use prior to applying for a job, increasing alcohol use during a divorce, and decreasing alcohol use after leaving college or military service.

Three elements of any change that occur are readiness, motivation, and ambivalence.

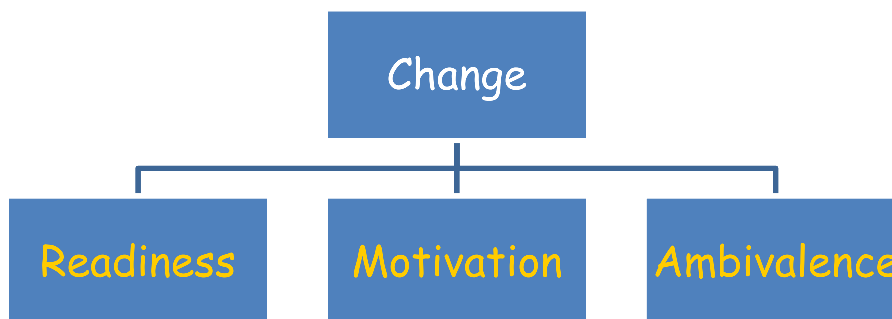


Figure 1: Elements of Change

Miller and Rollnick (2002) break down readiness to change into an awareness of a problem, a commitment to do something, and the action of making a change. This model is based on the theory of change developed by Prochaska and DiClemente (1998). The theory proposes a Stages of Change Model consisting of pre-contemplation, contemplation, preparation, action, and maintenance. The model is viewed as cyclical rather than linear with relapse occurring so that the individual may recycle back through the stages several times during their life.

Traditional views of motivation held that it was static and therefore, practitioners had little or no influence over a patient's motivation. Patients were viewed as either motivated or not motivated. If a patient was not motivated, it was considered their problem, not the practitioners, and sometime the individual was blamed for not being motivated. Individuals who were motivated agreed to follow all instructions and accepted the labels (e.g., alcoholic) given to them. Individuals who were not motivated resisted the idea of having a problem and refused to follow treatment protocol.

It is known that motivation is influenced by practitioner style (Miller, Benefield, & Tonigan, 1993), practitioner expectancies (Leake & King, 1977), and patient expectancies (self help literature). Motivation is positively influenced by practitioners that listen empathetically while negatively influenced by practitioners that are confrontational. When practitioners have biases about their patients this influences the motivation of the individual as well. Assumptions that motivation lies within the individual leads to viewing those who are stuck as resistant, unmotivated, lazy, manipulative, and difficult.

This labeled behavior can often be seen as strategies against fear of failure, annoyance with being dependent in some way on others, or frustration in feeling like someone else has taken charge of your life. MI suggests that if we change the way we interact with patients, or at least act differently with them than others do in their lives, then they will interact differently with us.

Motivation is interactional and although it involves the individual, it is influenced by a larger system. Motivation can be elicited and/or reinforced by others. Understanding motivation as interactional leads to practitioners viewing lack of motivation as a strategy used to protect against fear of failure, loss, unwanted dependence on others, or having others in control. This in turn increases practitioners' acceptance of the individual and decreases the need to control and confront the individual.

Ambivalence is the third element of change and is the result of simultaneous motivations that lead in different directions. Examples include:

- Desire to gain medication benefits and avoid side-effects
- Desire to be strong and healthy and to relax and eat enjoyable foods
- Hope for change / fear of failure

MI is based on the idea that people generally are not *Unmotivated* but instead tend to have multiple motivations that go in different directions, or go directly against one another. This is where people get stuck. People might know that they should make a change, or that things could be better, but they also are attached to something that holds them back: Drugs, Friends**,** A relationship, Convenience, Familiarity, or Security.

Ambivalence is a normal component when dealing with psychological problems although the specifics are unique to each person and sometimes each situation. The experience of ambivalence protects the side that does not want to change.

As practitioners, we DO NOT want to join with side that wants to change prematurely or we will invoke REACTANCE. This goes against our natural tendency to support or protect the opposite viewpoint that exists within the person. MI assumes that people have the capacity to solve their own problems and come up with resourceful solutions…if we help remove the barriers.

The Two Phases of MI

There are two phases to MI. In Phase 1, practitioners resolve ambivalence & build motivation and in Phase 2, practitioners strengthen commitment and create a plan for change. Phase 1 is generally considered to demonstrate the patient-centered aspect of MI with more directive interactions taking place in Phase 2. An added note, sometimes in Phase 1, it is first necessary to raise the awareness of ambivalence or conflicting motivations before resolving the ambivalence.

Phase 1: (Develop) Resolve Ambivalence & Build Motivation

The work of Phase 1 is based upon the MI Spirit with specific principles using identified strategies called OARS.

SPIRIT: The MI Spirit is the underlying assumption that individuals can develop in the direction of health and adaptive behavior given the tools and opportunity to do so. MI Spirit is essential for the full and effective use of MI and anyone can learn it if they are curious and willing to entertain the possibility of:

- Collaboration – work in partnership with patient
- Evocation- listen and elicit from the patient
- Autonomy- accept the patient's ability to choose

PRINCIPLES: There are generally four principles considered as essential to MI. These are:

1. Develop Discrepancy
2. Reduce Resistance
3. Express Empathy
4. Support Self-Efficacy

The purpose of <u>developing discrepancy</u> is to create a mismatch between where the person has been or currently is and where they want to be. The goal is to resolve the discrepancy by changing behavior. Resistance is a behavior and as such, it is a state not a "trait" of an individual.

The principle of <u>reducing resistance</u> implies that it takes two to resist. It is interpersonal. Fortunately, resistance is highly responsive to the practitioner's style. Resistance can be reduced with MI strategies. Specific suggestions for reducing resistance will be discussed below.

<u>Expressing Empathy</u> is one of the most important elements of motivational interviewing. High levels of empathy during treatment have been shown to be associated with positive treatment outcomes across different types of psychotherapy.

The key to expressing empathy is *reflective listening*, **a specific and learnable skill. By l**istening in a supportive, reflective manner, practitioners demonstrate they understand the concerns and feelings of the patient. **An Empathetic Style will:**

- Communicate respect for and acceptance of patients and their feelings
- Encourage a nonjudgmental, collaborative relationship
- Establish a safe and open environment for the patient that is conducive to examining issues and eliciting personal reasons and methods for change
- **Allow clinicians to be supportive and a knowledgeable consultant**
- Compliment rather than denigrate
- Gently persuade with the understanding that change is up to the patient

When practitioners <u>Support Self-Efficacy</u> the patient's ability to make decisions and choices is recognized and respected. This implies that the responsibility for a patient's behavior resides with them. In addition, the practitioner also supports the patient as the only one that can make choices about changing behavior as well.

STRATEGIES (OARS): The OARS consist of:

1. Open-ended questions
2. Affirmations
3. Reflections
4. Summaries

<u>Open-ended questions</u> cannot be answered with a yes or no response or with brief specific information (I'm from Jefferson City). Questions that are rhetorical are not open-ended and avoid socially desirable responses. Open-ended questions allow the practitioner to probe widely for information and assist to uncover the individual's priorities and values. Additionally, they draw people out.

Examples:

"Where did you grow up?" "Tell me a bit about your work." "What brings you here today?"

Affirmations affirm a person's struggles, achievements, values, and feelings. They emphasize strength of the individual or notice and appreciate a positive action. Affirmations should always be genuine and express positive regard and caring.

Examples:

"It takes courage to face such difficult problems" "This is hard work you're doing" "You really care a lot about your family" "Your anger is understandable" "

Reflections are statements made after the patient's utterances. They are a way for the listener to check to see if they understood what was said and/or meant. A reflection can be a guess or hypothesis about what was really meant. Make reflections as statements where the inflexion goes down at the end of your statement. Reflections are the primary way to respond to patients. As a guess, the statement may not be accurate and the patient will let you know and clarify what they meant.

There are two types of reflections, simple and complex reflections. Simple reflections express exactly what was heard. They rephrase (repeat with new words) the patients' comments.

Example:

Patient: "I didn't want to come in." Practitioner: "You don't want to be here today."

Complex reflections paraphrase (makes a guess about unspoken meaning) and/or reflect the feeling. Generally, simple reflections are more common at the beginning of the relationship and complex (deeper) reflections occur more frequently as understanding increases. There are several types of complex reflections.

Double-Sided Reflection**:** reflection presents both sides of what the patient is saying; extremely useful with pointing out ambivalence

Amplified Reflection: amplifies or heightens the resistance that is heard

Reframing or getting a new pair of glasses…. Suggests a new way of looking at something that is more consistent with behavior change or change talk of the patient

Examples:

Patient: "There is no question that my children come first. However, after I put them to bed I do not really see any problem in continuing to smoke weed every night. I am very careful where I buy it so I don't get caught in a sting."

Practitioner: "So on the one hand you seem to be very clear that your children are very important to you and they come first. However, you also appear to be saying that you really don't see anything wrong with your regular use of weed and even appear to discount any risk you might be taking." (double-sided)

Patient: "I could not quit. What would my friends think?" Practitioner: "It sounds like there would be a lot of pressure from your friends if you tried to stop." (amplified)

Summaries are statements that pull together the comments made and/or transition to the next topic. They are good for moving the conversation along. Summaries should only be used after a minimum of three reflections.

Example:

"You mentioned a number of things about your current lifestyle, such as cutbacks at work and the stress you feel. You spoke of having little energy for doing some of the things you use to like to do and did to relax. What do you think might help you get back doing some of the things you once enjoyed?"

Rolling with Resistance & Giving Advice

People frequently ask when, in MI, can they give advice or provide information. Giving advice or information at the wrong time or with the wrong approach is one way to encourage resistance from our patients. There are three situations when giving advice is appropriate. Advice can be given:

1. When the patient asks for advice and/or information;
2. When you ask permission to give advice;
    a. "Can I make a suggestion?"
    b. "Would you be interested in some resources?"
    c. "Would you like to know what has worked for some other people?"
3. If you qualify the advice to emphasize autonomy.
    a. "A lot of people find that _____works well, but I don't know if that's something that interests you."

When the person asks for the advice, it's important not to jump in if you feel that they are not ready or if you think they are not sincere. In these situations it is better to ask permission to get more information BEFORE giving advice.

Example:

"You know, that's certainly something I can do, but I'm wondering if I really have enough information about the problem to really give you good advice right now. Would you mind telling me a little bit more about the situation?"

When resistance is present, it is predictive of (non) change. Resistance is also a signal of cognitive dissonance. In simple terms, cognitive dissonance is an uncomfortable feeling caused by contradictory ideas such as when beliefs and values contradict one's behavior. People are motivated to reduce the dissonance by changing attitudes, beliefs, and behaviors or justifying or rationalizing attitudes, beliefs, and behaviors. When encountering resistance, it is important to avoid arguments with the individual. Do not push back as this places the individual in the position of defending the opposite side. Rolling with resistance implies that the practitioner go with the direction of the conversation rather than confronting, preaching, or trying to control the conversation. The use of reflections, particularly complex reflections, is one of the ways a practitioner can roll with resistance. It is also helpful to remind the person (and yourself) about autonomy and let them know that what they do is ultimately their choice.

Phase 2: Transition from OARS to Change Talk

Change talk can flow naturally by simply using OARS. The application of OARS is primarily a patient-centered mode and serves the purpose of *exploring* the patient's ambivalence about behavior change. Often through empathic, reflective listening, the patient's ambivalence shifts toward the "change" side and away from the "status-quo" side of the ambivalence. In addition, during this phase trust and rapport have been established to an extent that the patient is ready to collaborate with resolving the ambivalence.

Recognizing Change Talk VS Sustain Talk

Change talk and sustain talk are opposites of the same coin. Sustain talk is an expression that supports keeping things the same. Change talk expresses movement in the direction of change.

Examples:

Sustain talk "Marijuana has never affected me." Change talk "It ain't worth it to be landing up in jail."

There are four types of change talk, represented by another acronym, **DARN**:

D - Desire to change ("want, like, wish…")

A - Ability to change ("can, could…")

R - Reasons to change ("If…then…")

N - Need for change ("Got to, have to, need to…")

Our goal with MI in Phase 2 is to increase the change talk and decrease the sustain talk.

Eliciting Change Talk (ECT)

Sometimes, change talk does not occur naturally, and there are tools we can use to elicit the change talk. Trust is now such that questions that would earlier have been classified as roadblocks that engendered resistance are now classified as techniques for eliciting change talk. Thus, it is important to not introduce ECT too early—i.e., not before the patient has sufficiently explored the ambivalence about the behavior and is now ready to explore and resolve ambivalence about change. It is only at this point that the more semi-directive techniques can be employed. The following list provides some of the strategies for eliciting change talk.

- Ask evocative questions
- Explore the decisional balance (weighing costs and benefits)
- Ask for elaboration or examples
- Looking back question (to a time when things were ok)
- Looking forward question (how to you want life to be different)
- Query the extremes (worst that could happen if you quit and best that could happen if you quit)
- Use the change rulers
- Explore goals and values

Commitment Talk

Commitment is the "C" of change talk. It is the language that confirms something different will happen. The difference between change talk and commitment talk lies in the strength of the statement. During change talk, the idea of change is explored; with commitment talk, the intention is expressed to make the change. A good question to use for eliciting commitment talk is "Will you do it?"

Examples:

Change talk “I know my kids want me to.”

Commitment talk “I’ll definitely will give it a go.”

A Change Plan

Once commitment is solidified, it is important to move on and help the individual create a plan for making the changes they have committed to make. The change plan should be expressed verbally at minimum but can also be in writing. Ideally, the patient should actually write the plan or complete the form. Responses to the following questions will create a simple but powerful plan for change.

1. The changes I want to make are: (specifics)
2. The most important reasons I want to make these changes are:
3. The steps I plan to make in changing are:
4. The ways people can help me are:
   Person   Possible ways to help
5. I will know that my plan is working if:
6. The things that could interfere with my plan are:

Chapter 3: Brief Education/Brief Coaching Session 1

Introduction

The purpose of the first session is to develop rapport and an understanding of the patient's severity, problems associated with their use, reasons for quitting, level of motivation and confidence to reduce use. The session structure is based on FRAMES: feedback, responsibility, advice, menu of options, empathize, and supporting self-efficacy. The session should primarily be a nonjudgmental, but thorough discussion based on the Personal Feedback Form from the screening tools. If a Brief Education is indicated, this will be the only contact with the patient. If Brief Coaching is indicated, subsequent sessions will be scheduled.

The Brief Education and Session One of Brief Coaching, using the FRAMES model, consists of:

F Providing ***feedback*** on the patient's screening results;

R Emphasizing that the individual is ***responsible*** for their own behavior;

A Giving clear ***advice*** that the best way to reduce the risk is to cut down or stop drinking;

M Providing a ***menu*** of alternative change options;

E Using ***empathetic*** conversational style (based upon reflective listening); and

S *Supporting self-efficacy* of the individual.

The structure of the Brief Education and Session 1 of the Brief Coaching session is as follows:

Step 1: Brief Education and Brief Coaching Session 1

- Deliver orientation: welcome and rational Administer screening tools
- Print Summary Personal Feedback Form (PFR)

Step 2: Brief Education and Brief Coaching Session 1

- Rapport building – focus on strengths (use *empathy*, *support self-efficacy*)
- Review Personal Feedback Form
- Provide *feedback* on the screening results – focus on concerns
- For Brief Education
- Give clear *advise* (with permission) that the best way to reduce the risk is to cut down or stop drinking
- Provide a *menu* of alternatives for change

Step 3: Brief Education

- Summarize session

Emphasize that the individual is *responsible* for theirown behavior

- Introduce and fill out Session Feedback Form

Step 3: Brief Coaching Session 1

- Summarize Session;
- Assign real life practice (use menu to choose reading on specific use or other appropriate activity)
- Schedule Sessions
- Elicit Feedback
- Introduce and fill out Session Feedback Form

Handouts: (See Appendix)

- Personal Feedback Form
- Welcome Form Brief Coaching
- Session Feedback Form

Step 1: Orientation, Screening, and Printing

Initial contact with All patients:

In many settings, the Health Coach will meet with the patient after the Brief Assessment (Pre-Screening) has been completed. If your setting requires that you administer the Brief Assessment (Pre-Screening) questionnaire, use the following script. If you are not required to administer the Brief Assessment (Pre-Screening) start with the section "Review the Brief Assessment (Pre-Screening).

Hi, may I come in?

My name is [Your Name], and I'm a Health Coach and a member of your treatment team. I see all new patients admitted to [Name of facility]. As a way of improving the quality of care, several hospitals and clinics across the country have taken on some screening procedures to promote healthy lifestyle behaviors for all patients. Your doctor and other doctors here participate in this health project because they think your health habits are important to your overall health. Would it be okay for me to ask you a few questions?

- If the patient says yes, administer the Brief Assessment (Pre-Screening).

Review the Brief Assessment (Pre-Screening).

- If patient screens **negatively**, give them a brochure on healthy behaviors. There is no follow-up required.
- If patient screens **positively**, explain the health initiative using the following script:

Positive prescreen assessment

If the Health Coach did not administer the Brief Assessment (Pre-Screening) use the following script beginning here.

Hi, may I come in?

My name is ______________, and I'm a Health Coach and a member of your treatment team. I see all new patients admitted to [Name of facility]. As a way of improving the quality of care, several hospitals and clinics across the country have taken on some screening procedures to promote healthy lifestyle behaviors for all patients. Your doctor and other doctors here participate in this health project because they think your health habits are important to your overall health. Would it be okay for me to ask you a few questions?

Thank you for your willingness to talk with me about your health habits. I am meeting with you because some of your answers to our brief screening questions suggest that some of your health habits might put you at risk for future health problems.

If the Health Coach administered the Brief Screening (Pre-Screening) the introduction and brief overview have already been provided. If that is the case, **start here after a positive pre-screening assessment**.

Thank you again for your willingness to talk with me about your health habits. Because some of your answers to our brief screening questions suggest that some of your health habits might put you at risk for future health problems I have some additional questions.

HIPPA Consent Form

All Health Coaches must obtain a signed HIPPA consent form before proceeding any further.

Before I can go any further, I need to have you sign the HIPAA form, which is for your protection. This form reviews the purpose of the Missouri Initiative for Healthy Lifestyles, why we are asking you to answer these questions, what we are going to do with the information, and to let you know that you are free to withdraw your consent and participation at any time. It is much like the form you signed at your Doctor's office, the pharmacy, and at the hospital. Here is a copy of the form. Let's review it together. Please stop me at any time if you have any questions.

If the patient agrees, thank them and have them sign the HIPAA form.

The patient gets a copy of the document. Health Coach keeps the signed HIPPA form.

After HIPAA is signed

Now I would like to ask you some more in-depth questions about some of your responses. The questions I'm going to ask will focus on a variety of issues that could affect your overall health. I'd like to start by looking at your drinking, drug use, and the possible relationship with present and future health problems and other health issues, including tobacco use, exercise, nutrition, weight, depression, relationships and stresses in your life. I'm going to ask you some questions about your experience of using substances across your lifetime and in the past 3 months. These substances can be smoked, swallowed, snorted, inhaled, injected, or taking in for form of pills. Remember, our work is funded by a grant so all of my services are free of charge to you and your insurance company.

Some of the substances may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

Feel free to skip any questions at anytime. This first section is for information gathering and takes about 15 to 20 minutes.

ASSIST & GPRA Interviews

- If patient screens **negatively**, give them a brochure on healthy behaviors. There is no follow-up required.
- If patient screens **positively**, AND has the SSN between 50 and 59 then transition to the 6-month Patient Satisfaction and Health Update. Use the following script:

I appreciate you taking the time to talk to me today, and wondered if you'd consider helping the hospital by giving feedback on our new services. We'd like to contact you in 6 months by phone. The survey takes 15-25 minutes, and you'll be given a $20 gift card for your time. As I mentioned earlier, these screening procedures are new, and feedback from patients like you will help us continue to improve our patient care. Please remember that all of your answers will be confidential. We will be looking at the information we receive on all patients grouped together, and not individually. So, the information reported in the results is about the group of answers, not about an individual. As I said, to make the surveys as convenient as possible, we will conduct the survey by phone. Our work is funded by a grant so all of my services are free of charge to you and your insurance company.

Would this be something you could help us complete?

If yes, introduce the Follow-Up Survey Contact form

In order for us to do this, we will need to complete a form to help us contact you for the follow-up interview:

- The Follow-Up Locator Form, which is used to gather information about folks who know where you will be once you leave [name of facility]. We will ask you to sign the form, giving us permission to contact anyone you list on the form, in case you change phone numbers or addresses.

In our experience, we've found that people often move or sometimes change phone numbers —whether or not they expect to. Then when we try to follow up with them, we find we've got their old phone number and/or address, which doesn't work any more. Because your opinions are very important to us, if it's OK with you, I'd like to ask you for information on how to find you if the phone number or address we have doesn't work any more.

We'd like to have the data collector [you met if s/he is on site] to have the names of friends, relatives, or organizations that might be able to help them contact you in case you move. We will also need the correct address to send you the $20 for doing the survey. If they can't reach you, they'll contact these folks to see if they have a new address or telephone number for you.

Thanks for your help. We would like to go ahead and schedule a time now for the 6 month follow-up appointment. We have the following times available, which is most convenient for you?

- After appointment is schedule, patient transitions to appropriate Level Of Care.

Print Personal Feedback Forms

Now that you have completed our forms I am printing the personal feedback for you.

Retrieve printouts

Review the Results for Positive Screening

Anyone whose ASSIST scores indicate a moderate risk will be offered a Brief Education. As a reminder, scores in the moderate level from the ASSIST are between 11 and 19 for Alcohol and/or 4 and 19 for Drugs.

Anyone whose ASSIST scores indicate a high moderate risk should be offered Brief Coaching. As a reminder, scores in the high moderate level from the ASSIST are between 20 and 26 for any substances. Both the Brief Education and the Brief Coaching need to be flexible and take into account the individual's level of risk, any specific problems, their readiness to change and their time available.

Anyone whose ASSIST scores indicate a high risk should be offered a referral to an appropriate substance abuse provider for further assessment for treatment. As a reminder, an indication of a high risk are scores of 27 or above for any substances.

Step 2: Build Rapport, Personal Feedback Form, Feedback on Screening Results (For Brief Education), Give Advice, and Provide Menu of Alternatives

Brief Education and Brief Coaching Session 1

Build Rapport: Once the assessments are completed, spend a couple of minutes using MI to build rapport. If it takes a couple of minutes for the forms to print, this is a good time to do this. A good place to start might be to ask about their reason for visiting the facility today and the experience of the screening process. Of course there are other ways to build rapport. These are just a few suggestions.

Example: "I can imagine that you didn't come here to participate in this screening. What was it that brought you here?" or "Tell me why you came to the clinic/hospital today." Or "It must have been a surprise to have the screening and be referred to talk to someone as a result. What has this experience been like for you?" or, follow up on conversation prior to or during assessments, consents, etc.

Provide Feedback: Providing feedback regarding the individual's score uses motivational interviewing skills and strategies such as the OARS and the Elicit – Provide – Elicit (EPE) strategy. Remember to remain neutral and use a non-judgmental manner.

Examples:

Elicit: "Would you like to see the results of the questionnaire you just completed? Of course what you do with this information is entirely up to you (personal *responsibility)."*

Provide: ""This printout shows the results of the questionnaires you completed a few minutes ago. If you remember, the questions asked about your substance use and whether you have experienced any problems in connection with your substance use. (*Show the Personal Feedback Form*)

Elicit: "What are your concerns about these problems?" or "Tell me more about (an identified problem)." or "Does this information surprise you?"

Review: After providing the personal feedback, review any brochures or other materials related to consequences common for those who drink/use at the same levels reported by the patient.

Examples:

Elicit: "May I share some information for you to think about?"

Provide: "As you can see, your scores fall into the moderate risk range for drinking. (S*how the patient the lists of substance related problems.*) This section shows some of the problems that are caused by risky use of alcohol/drugs at the same level you report using alcohol/drugs."

Elicit: "What are your thoughts about this information?"

Brief Education

<u>Give Advice:</u> Remember to be *empathetic* and *support self-efficacy*. Select components from the menu of options available for the Brief Education appropriate for the individual. Some individuals may be able to go directly to the *menu of options for change* depending on their stage of change. Others may need to further discuss and/or work through an exercise before a discussion of change options.

If the individual is not concerned or indicates that, they are not ready to consider change (pre-contemplator) then consider one or more of the following:

- Further feedback
- Further discussion (using MI)
- Respond to Change Talk
- Elicit Change Talk

If the individual is concerned or indicates readiness to consider change (contemplator) then consider moving on to elicit and support change talk:

- Further discussion (using MI)

If the individual indicates readiness to change (action stage) then go on to the menu of options for change listed below. Offer at least two possible options from the list.

<u>Menu of options for change</u>*:* Discuss specific options that would assist with change such as:

- Identifying **high risk situations and strategies to avoid** them or to reduce drinking in those situations
- Identify **other activities** instead of drinking
- Encourage the individual to identify **people who could provide support** and help for the changes they want to make.
- Provide **self-help resources and written information** to reinforce what has been discussed in the consultation.
- Help the individual **decide on their goals**

Step 3: Brief Education: Summarize, Emphasize Responsibility and Complete Session Feedback Form

Brief Education

Summarize

Elicit: *Ask permission to summarize.*

"Was this helpful for you?" and/or "Can we summarize what we've covered today?"

Provide: Summarize the key points discussed while emphasizing that the individual is the only one *responsible* for their behavior; and therefore, making the choice to do anything different is up to them. Thank the individual for spending time on this important issue and affirm them for the work they just completed. Include the following:

- Reason referred for BE
- Summarize feedback form
- Review reasons for change
- Identify 1 or 2 options from the menu that appealed to the patient
- Review goals
- Review resources and handouts
- Reiterate personal responsibility for changing behavior

Example:

"If you remember, you were referred to me because of your pre-screen results with ______. At that point, you completed more questions and your personalized feedback suggested some things (substitute specific reasons) for you to consider as a reason(s) for changing your (drinking or use of ____). We spoke about some specific steps you might want to take in order to be successful at changing and you indicated that __________ (appropriate options from Menu) would be doable for you. You have the following goals: ____________. Here are the resources (handouts and lists of community resources) that some people have found helpful in reaching their goals. (Explain as needed.) What you decide to do after today is up to you because only you can decide what is best for you. Whatever happens, you are the only one responsible for what you do, and I'm confident that you will do what is best for you.

Elicit: *Invite the individual* ***to call*** *to discuss their substance use if they need further help or Information (at that time, the intervention would become Brief Coaching or Referral)*

Example:

"I want to thank you, again, for your time and for honestly facing these issues today. Please know that you can call me if you have any questions or need further information.

Introduce and fill out Session Feedback Form

Step 3: Brief Coaching Session 1: Summarize, Assign Real Life Practice, Schedule BC Sessions, Elicit Feedback and Complete Session Feedback Form

Brief Coaching Session 1

Summarize this Session

Elicit: *Ask permission to summarize.*

"Was this helpful for you?" and/or "Can we summarize what we've covered today?"

Summarize*:* Offer a brief four to five sentence encapsulation of the patient's substance issues and perspective. Your summary should highlight 5 key areas: severity of use, what they enjoy about using, problems related to use, reasons for reducing or quitting, and readiness/motivation to change.

Elicit: ***"****Does this summary seem accurate to you?"*

If time allows ask: "Is there anything else that you feel is important for me to know about your substance use, what you enjoy and the effects it has had on you?"

Advise eligibility for Brief Coaching

Provide: An appropriate recommendation: Continue working together in order to help make progress toward living a healthier lifestyle which can eliminates some of the problems the substance caused.

For example: "Given where you are at right now, I would recommend we continue to work together for a few more sessions. We can provide 5 additional health coaching sessions free of charge to you. During our sessions we would look at setting some goals around the areas of concern we discussed as well as look at strategies for helping you to achieve those goals."

Elicit: *"How does that sound to you?"*

Schedule sessions

Provide: If patient is open to meeting again, schedule all sessions and give patient a reminder card with the dates.

Elicit: *"What dates and times in the next month work for you? "*

Provide and explain Welcome Form for Brief Coaching

Provide: Welcome Form and an explanation of why it is used.

For example: "Before we go any further, I have the Welcome Form that will give you an overvue of what you can expect from me as your health coach and also what our expectations are for you.

Elicit: *Do you have any questions about the Welcome Form?*

Assign real life practice (use menu to choose reading on specific use or other appropriate activity)

Guidelines

Before the patient leaves, you want to give them a "real life practice" assignment. Assignments are designed to get patients familiar with "real life practice." "Real life practice" is a necessity between counseling sessions and thus, to shape and elicit a favorable response, we design assignments to match where the patient is in terms of stage of change. We do not ask for behavior change unless the patient expressed motivation/confidence through their "change talk" (DARN-C - desire, ability, reasons, needs or commitment), Thus, it is generally better in this initial session to offer specific easily accomplished tasks, in line with where the patient is in their ambivalence, or decision to cut down or quit.

For example: assignments (real life practice) could be simple or more recovery oriented:

Menu

- engaging in a web search on substance related health risks or discussions with a non-using peer
- monitoring use patterns
- substituting use with another comfort activity - taking a deep breath or eating a healthy food equivalent
- avoiding "triggers by changing a path to work or changing shopping district

Assignments need to be specific in terms of what is negotiated or required. Commitment to do the assignment also needs to be specific: when, where and how it will get done.

This first assignment needs to be selected based on two principles:

1. 1. Ease of success
2. 2. Individual importance for the patient

Assign: "*I'd like you to commit to reading this information about (primary drug of abuse). The goal of this assignment is to get you to continue thinking about your use and what you might want to do about it. When we meet next, I'd really like to hear your thoughts on this information. How it matches or does not match with what you know about (primary drug of abuse), and whether you learned anything new. When do you think you might have time during the next week to take a few minutes and read through this pamphlet?"*

Elicit: *"I wonder if you would be willing to try something before our next meeting? I have a list of possible activities or strategies that could help reduce some of the problems and concerns you mentioned in our discussion. Would you be willing to pick one of these strategies and commit to trying it out?"*

Provide: Affirmation and post assignment commitment summary

For example: *enthusiastically*, tell the patient that you are interested in them sharing with you how it went and you will check in at the next session.

Guidelines

It is nice to offer to the patient a "mid-week" check in to help remind them of their assignment if they desire. Finally, end the session by doing a "check in" with the patient to see how today's session went for them and providing the feedback form.

Elicit Feedback

Elicit: *How did today's session go for you? Did we cover what you wanted to discuss?*

Introduce and fill out Session Feedback Form

Provide: Feedback Form and an explanation of why and how it is used.

For example: "Finally, I want to turn out attention to the Feedback Form that we will use to track our progress. Together we will track the following items after each session, attendance, participation, real life practice, change in behaviors, motivation and stage of change. Stage of Change is a way of understanding where you are in deciding to take action on particular health choices. This form will help guide us as we discuss and monitor your accomplishments in terms of your wellness plan.

Elicit: *Do you have any questions about the Feedback Form? How do you think we should fill it out for today?*

Chapter 4: Brief Coaching

Session 2: Goal Setting

Introduction

The purpose of this session is to increase motivation for change through the use of decisional balance and goal setting. A majority of the session is spent on developing the patient's goals regarding their alcohol and/or other drug (AOD) use. Setting collaborative achievable goals in treatment is known to help patient progress in many ways including: increasing motivation, accountability, personal choice, monitoring, and feelings of accomplishment. Goals can be either short or long-term. Both usually are discussed in treatment; but the main focus here needs to remain on SMART goals to help reduce use; which are **short, measurable, attainable, realistic and timely**.

The structure of the session is as follows:

Step 1:

- Rapport building
- Review of progress since last session
- Review any real life practice assigned during last session

Step 2:

- Introduce Decisional Balance Activity
- Collaborate with patient to fill in the sections
- Elicit the effect of the activity by asking questions

Step 3:

- Introduce Goal Setting (provide rationale)
- Collaborate with patient to identify their goals
- Identify patient's reasons for goals
- Identify steps patient can take to achieve goals

Step 4:

- Summarize session
- Assign real life practice
- Complete Session Feedback Form
- Schedule next session

Handouts:

- Decisional Balance (Thinking about my use)
- Personal Goal Worksheet

Step 1: Build Rapport and Review

Guidelines

To continue building rapport with the patient, begin the session by eliciting information from them about their life during the past week. Initially, try to focus on non-problem areas. This is an opportunity for you to learn about their interests and strengths. Such information can be used later to develop

strategies for addressing the patient's alcohol and/or drug use. You will continue to use MI skills to do this and, as always, it is helpful if you express genuine curiosity regarding this and other parts of their life.

Elicit: *"How have things been since we last met?"* ***OR*** *"Tell me about something enjoyable you did during the past week?"*

If patient cannot think of anything enjoyable during the past week, ask about interests and activities in which they like to engage in, even if they have not done them in the past week.

Elicit: *"Tell me about some of your interests or hobbies?"* ***OR*** *"What kinds of things do you like to do in your free time?"*

Continue by asking the patient how s/he has been doing over the past week regarding their substance use.

Elicit: *"Tell me about your (patient's drug(s) of choice) use during the past week?"* ***OR*** *"What has your use been like since we last met?"* ***OR*** *"What thoughts have you had about your use since we last spoke?"*

Guidelines

Listen for possible changes in the patient's behaviors, thoughts, and feelings regarding their use. Try to refrain from asking a lot of questions. Let the patient tell you how s/he has been doing regarding his or her use or abstinence. Respond with reflective comments, and attempt to elicit the patient's own motivation-enhancing statements. Affirm any efforts made to reduce use and look for opportunities to support the patient's sense of self efficacy. If there has been little or no change in patient's use, look for opportunities to develop discrepancy through the use of double-sided reflections, exploring pros and cons, and seeking elaboration.

Remember your goal is to use OARS+E to follow the underlying DEARS strategies. OARS + E: (Open-ended questions, Affirmations, Reflections, and Summaries & Elicit motivational statements) and DEARS (Develop discrepancy, Express empathy, Avoid argumentation, Roll with resistance & Support self efficacy).

If patient was assigned a real life practice exercise as part of the initial session, review their experience doing the exercise. Real life practice exercises are critical. In reality, patients spend very little time in their weekly routine with you. Real life practice exercises increase the likelihood the information and skills you are relaying in session transfer into the patient's daily life. Approach assigning and reviewing real life practice exercises as an essential component of treatment. Be prepared to give the patient the rationale for assigning the exercises. Establish a tone that communicates to the patient you will review their progress on such exercises each week and work with them to develop strategies to ensure exercises are completed outside of sessions. This will help shape the patient's behavior.

Elicit: *"Last week, we had decided you would (state assignment). Tell me how it went."*

If you gave the patient information to review regarding their drug of choice, you could also ask the following:

Elicit: *"What thoughts did you have about the information I gave you last week?"* ***OR*** *"How is the information I gave you last week similar or different to what you already know about (drug of choice).*

If the patient did the exercise, affirm their efforts. If the patient did not do the exercise, in an MI style, explore why they did not do it. Begin to identify potential barriers that could be addressed when assigning the next exercise at the end of today's session.

Elicit: *"What were your reasons for not completing the exercise?"* **AND** *"What kinds of things would help you to complete an exercise like this in the future?"*

Step 2: Introduce Decision Balance, Complete Decision Balance, and Elicit Response to Decisional Balance Activity

Provide: After reviewing their real life exercise, introduce the decisional balance activity by providing an explanation of the usefulness of weighing the pros and cons of any decision before taking a course of action.

For example: "It is clear from our discussions, your questions and your life experiences that your alcohol and /or drug use plays a significant part in your life. At this point in our time together, it makes sense for us to look at all the pros and cons that affect your decision about reducing your alcohol and/or drug use. This will help you to consider what goals you want to set for yourself in regard to your alcohol and/or drug use. Let's take a few minutes to fill in the *Decisional Balance Handout*. Try to come up with at least three statements for each of the four possibilities."

Provide: Time to fill in the "Decisional Balance Handout".

Elicit: *"What comes to mind when you look at your completed Decisional Balance Handout?"* **AND** *"Are there any statements that surprise you?* **AND** *"Which section of the balance sheet weighs the most heavily on your thinking now?"*

Step 3: Goal Setting

Provide: After reviewing their decisional balance exercise, introduce goal setting by providing a rationale for setting goals.

For example: "Let's draw from the *Decisional Balance Handout* to focus on goal setting regarding your substance use. Setting goals helps you to get clear about your expectations and priorities. Goals help guide you where you want to focus, especially during the time we will be working together. You could think of goal setting as both a starting point for change and also the map that points the way for future work. Goals are important as they help us improve our lives and increase the chance of success."

Provide: *Personal Goals Worksheet* and a pen/pencil. (If conducting session over the phone, ask patient to take out the handout.)

Guidelines

Get patient to verbalize their responses to each section of worksheet before writing it down. This allows you to offer feedback/suggestions before it is put to paper in a way that the patient is less likely to feel criticized.

Generate a discussion with the patient regarding their goals for their substance use. This is an extremely important step. One of the primary reasons people do not achieve their goals is because their goals were poorly defined from the outset. Help to shape the patient's goals so that they are S.M.A.R.T. – Specific, Measurable, Attainable, Realistic, and Timely. As an example, if the patient drinks five alcoholic drinks daily and indicates their goal is to become abstinent tomorrow, you probably want to use the MI skills to gently direct them towards breaking this goal into a more realistic short term goal. Perhaps an initial goal is to cut back on the number of drinks or the number of days within a certain timeframe. Once that is achieved, their drinking can be reduced further.

Elicit: *"Tell me about your goals regarding your (drug of choice) use."*

Use MI skills to affirm the patient and support their self efficacy if they are identifying goals related to reducing or abstaining from use. Use OARS+E if patient continues to express ambivalence about changing their use.

Write*:* Patient writes down their goal(s) once you both feel it is well defined and follows the S.M.A.R.T. principles.

Elicit: *"What are some reasons why this goal is important to you?"*

Try to have the patient verbalize 2 to 3 reasons why changing their substance use is important. This is another opportunity to affirm the patient and support their sense of self efficacy.

For example: "Being able to start your work day on time and with a clear head is very important to you. You really seem to care about your work and take pride in your job performance. Those are invaluable traits to have."

If the patient has trouble identifying reasons, draw in information you have already learned from session one.

For example: "Last time we met, you indicated one of the negative aspects of your drinking is that it adds stress to your relationship with your wife, which often results in more arguments between the two of you. I'm wondering if you see that as a possible reason for your goal to stop drinking."

Write: Patient writes down their reasons for their goal once you both feel they have been identified sufficiently.

Elicit: *"Now that we have identified your goal(s) and why it is important to you, how do you plan to achieve it?"* ***OR*** *"What steps can you take to reach your goal(s)?*

If the patient experiences difficulty identifying steps they can take, you could ask any one of the following to generate conversation of possible steps:

For example: "Think about a time in the past when you were successful at cutting back or stopping your use. What kinds of things did you do differently? What seemed to work well?" **OR** "What kinds of activities or interests do you have that are incompatible with drinking/using? If someone is an active runner, they are less likely to smoke as it would make it harder to run." **OR** "What do you think you would need to do differently in your daily life to reduce or stop using?"

If the patient continues to have difficulty identifying realistic steps towards achieving their goal, you could also explore with them other behaviors they successfully changed in the past. What did they do to make those changes?

For example you could also suggest: "Sometimes, when people are trying to reduce or quit using, they find it helpful to avoid certain places that make it more likely for them to use. Would avoiding certain places be a possible step for you and if so, what would that look like?"

You can offer other suggestions in a similar manner. Try to refrain from suggesting a lot of steps. Ideally, the patient should be the one to identify which steps will work for him/her.

For example, if needed, you can offer a Menu of choices:

Self monitoring – or keeping track of your use patterns

Substituting use - with another comfort activity - taking a deep breath or eating a healthy food equivalent, doing a crossword puzzle, taking a run.

Avoiding "triggers" - by changing the path to work or changing shopping district.

Write: Patient writes down the steps s/he will use to achieve their goal once you both feel they have been identified sufficiently.

Guidelines

Dependent on the patient's background and experience with drinking/using, decide if it is appropriate to suggest going to self-help. Many patients find self help to be incredibly motivating and even nurturing; regardless of their level of use or their current stage of change.

Elicit: "*Many patients find participating in self help to be an extremely important part of their path toward wellness. I wonder how you feel about adding this to your goal steps?"*

"What has your past experience with self-help been like?"

Provide: Dependent on patient's goals & knowledge, past experience and attitude concerning self help, provide a *Self Help Resource Guide* (provided by site coaches) and have them select /sample different meetings and/or revisit previous helpful meetings as part of their goal steps.

Elicit: *"I wonder if you would be interested in learning more about current self help resources in the area and sampling one or a few of these resources before we meet again?"*

If the patient is optimistic, collaborate to create a specific self help commitment for the week. If patient is not optimistic about self help, ask if they would explore new self help options on the "web" or through other community resources.

Make a copy at end of session to keep in chart. Give original to patient.

Step 4: Summarize Session Assign Real Life Practice and Schedule Next Session

Provide: Summarize the goal setting session and prepare patient for next session. The summary is an opportunity to reinforce the patient's goal(s) and increase their sense of self efficacy.

For example, after your summary, the preparation statement could sound like:

"As you begin to carry out the steps we identified today to help you reduce your use, our future sessions together will focus on increasing your understanding of your own substance use and providing you will skills that can serve as more tools to help you achieve your goal. Next week, we will concentrate on exploring triggers for your use, as well as refusal skills."

Get a commitment from patient to try at least one of the steps s/he identified on their *Personal Goals Worksheet*.

Assign**:** "During the next week, I would like you to practice using one of the steps we just identified to help you reduce your use. The more you practice them outside of our meeting time, the greater likelihood you will use them more regularly and the greater chance you will achieve your goal. Which one do you think you could try?"

Have your patient think about their upcoming week and the most likely time they will be able to use the identified step. Work with the patient to identify and address any barriers to them being able to use the step.

Write: Have the patient write in which step s/he will try in the bottom of the Personal Goals worksheet before they leave today's session.

Get your patient to make a commitment to filling out the bottom of the *Personal Goals Worksheet*, identifying which step they used, when they used it, and how it went. Help them identify a specific day, time and place when they will complete worksheet. Ask them what will help ensure they complete it.

Complete Session Feedback Form

Schedule next session.

Session 3: Triggers and Refusal Skills

Introduction

The purpose of this session is to develop the patient's awareness and knowledge of the thoughts, feelings and situations leading to their substance use. A second purpose is to emphasize, teach, and practice the skill of assertive refusal communication with oneself and others necessary to promote reduction in use and/or recovery.

The structure of the session is as follows:

Step 1:

- Rapport building
- Review of progress since last session
- Review real life practice for Goal Setting

Step 2:

- Introduce "triggers" lesson & Knowledge is Power Sample **(provide rationale)**
- Collaborate with patient to identify their personal triggers for substance use
- List personal triggers leading to most recent opportunity to use
- List behavioral choice – use or no use
- List positive and negative consequences resulting from behavioral choice

Step 3:

- Introduce communication styles & Communication handouts (**Provide rationale for assertive style**)
- Practice assertive communication style (**role play**)

Step 4:

- Summarize session
- Assign real life practice
- Complete Session Feedback Form
- Schedule next session

Handouts:

- Knowledge is Power Sample
- Knowledge is Power - Real life practice

- Assertive Communication
- Assertive Communication Skill Reminders
- Real Life Practice
- Knowledge is Power – What happens before and after I use alcohol or drugs?

Step 1: Rapport Building and Review

Guidelines

To continue building rapport with the patient, begin the session by eliciting information from them about their life during the past week. Initially, try to focus on non-problem areas. This is an opportunity for you to learn about their interests and strengths. Such information can be used later to develop strategies for addressing the patient's AOD use. You will continue to use MI skills to do this and, as always, it is helpful if you express genuine curiosity regarding this and other parts of their life.

Elicit: *"How have things been since we last met?"* ***OR*** *"Tell me about something enjoyable you did during the past week?"*

If patient cannot think of anything enjoyable during the past week, ask about interests and activities in which they like to engage in, even if they have not done them in the past week.

Elicit: *"Tell me about some of your interests or hobbies?"* ***OR*** *"What kinds of things do you like to do in your free time?"*

Continue by asking the patient how s/he has been doing over the past week regarding their alcohol and or drug use.

Elicit: *"Tell me about your (patient's drug(s) of choice) use during the past week?"* ***OR*** *"What has your use been like since we last met?"* ***OR*** *"What thoughts have you had about your use since we last spoke?"*

Guidelines

Listen for possible changes in the patient's behaviors, thoughts, and feelings regarding their use. Try to refrain from asking a lot of questions. Let the patient tell you how s/he has been doing regarding his or her use or abstinence. Respond with reflective comments, and attempt to elicit the patient's own motivation-enhancing statements. Affirm any efforts made to reduce use and look for opportunities to support the patient's sense of self efficacy. If there has been little or no change in patient's use, look for opportunities to develop discrepancy through the use of double-sided reflections, exploring pros and cons, and seeking elaboration.

Remember your goal is to use OARS+E to follow the underlying DEARS strategies:

OARS + E - Open-ended questions, Affirmations, Reflections, and Summaries & Elicit motivational statements

DEARS - Develop discrepancy, Express empathy, Avoid argumentation, Roll with resistance & Support self efficacy

Review patient's experience doing the Goal Setting real life practice: to practice one of the steps toward achieving their goal around their alcohol and/or other drug use. Remember real life practice exercises are critical. Patients spend very little time 1 or 2 hours per week talking to you out of 168 hours in the week. Establish a tone that communicates to the patient you will review their progress on such exercises each week and work with them to develop strategies to ensure exercises are completed outside of sessions. This will help shape the patient's behavior.

Elicit: *"Last week, we decided you would practice one of the steps to help you achieve your goal to change your (patient's drug(s) of choice) use. Tell me how it went."*

If the patient did the exercise, affirm their efforts.

Elicit: *"What additional thoughts have you had about the goals you developed last week?"*

If the patient did not do the exercise, in an MI style, explore why they did not do it. Begin to identify potential barriers that could be addressed when assigning the next exercise at the end of today's session.

Elicit: *"What were your reasons for not completing the exercise?"* ***AND*** *"What kinds of things would help you to complete an exercise like this in the future?"*

For example: "It seems you were not able to begin your action steps toward your goal. How does that feel and should we make adjustments in your goals?"

If the patient needs to change their goals, use a new *Personal Goals Worksheet* and summarize the changes once the goal is developed.

Step 2: Introduce "triggers" Lesson & Identify Personal triggers, Behavioral Choice and Consequences of Choice

Provide*:* An introduction and the rationale for the concept of raising one's self awareness by doing situational analysis of alcohol and/or drug use to the patient.

For example: "We tend to think of substance use as a negative habit, similar to other negative habits. Over time, habits can feel automatic. We become less aware of what keeps the habit going. What we are going to do next is an exercise to help you figure out part of what keeps your alcohol and/or drug use going. This way, if you know what keeps it going, you can use this information to stop the habit."

Elicit: *"In what ways is your use like a habit?"*

Provide: An explanation of "triggers" and how it will be helpful to understand what thoughts, feeling, and situations set off their using substances.

For example: "Oftentimes habits have triggers. Triggers are anything that increases the likelihood of use. Triggers can be situations, feelings, or thoughts. As you described to me, it is clear that your use doesn't just happen – most people state that their use occurs because of positive or negative things that are going on around them, or in the way they are thinking or feeling."

Elicit: *"What are some of your triggers to use?*

<u>Guidelines</u>

Knowing what affects someone's own use gives them more personal awareness (**power)** to decide whether to use or not to use. Looking at the pros and cons of what happens after use also increases understanding and helps you make the decision about use in the future.

Hence, the name of the worksheet for understanding more about triggers is Knowledge is Power."

Provide: Patient with the *Knowledge is Power worksheet*. Walk them through filling it out as it relates to their own use from the previous week or a recent use episode.

Elicit: "*Can you describe in detail the last time you used or had an opportunity to use. As you recall the incident, see if you can identify the triggers, thoughts & feelings, decision to use, pros and cons of your use.*

Provide: Ask the patient to read the columns in the "Knowledge is Power" worksheet and follow-up with a series of questions to help them generate statements for each required column. Get the patient to verbalize their responses to each section of worksheet before writing it down. This allows you to offer feedback/suggestions before it's put to paper in such a way that the patient is less likely to feel criticized as they fill their example into the table.

For example: "Many people report that a common trigger are negative situations such as fights with others and the bad feelings that arise as a result." Has this happened to you recently?

Generate a discussion with the patient regarding their triggers. Then, have the patient fill in their Knowledge is Power worksheet.

Elicit: *"Now that we've filled in your knowledge is power worksheet, I'd like you to read it aloud. To emphasize nonuse decisions, It is also good to ask, "Can you give me an example of a time when the same trigger did not result in your using? "*

Guidelines

If so, affirm the patient…

If not, ask how they can imagine this nonuse occurring?

Provide: A statement that this situational analysis – Knowledge is Power worksheet is something you hope they will continue using and do between each session to help support their decision and steps toward reducing use and future wellness.

For example: "We think that self awareness and self knowledge are essential to breaking the cycle of negative habits like automatically drinking that some people get into. Instead, by using the knowledge is power worksheet, it makes us take a moment to think about all the elements prior and after our actions. This will help us understand how to avoid, replace and cope with the thoughts, feelings and situations in new ways."

Step 3: Communication Styles, and Practice Assertive Communication 3

Assertive Refusal Communication

Provide: Rationale for assertive communication to oneself and others.

For example: "The repetitive nature of negative habits increases the likelihood that the associated thoughts feeling and situations will lead to continued use. In addition, being offered alcohol or other drugs is a very common high-risk situation.

"As one's use increases, there is a "funneling" effect or narrowing of your own thoughts and coping strategies, as well as social relationships. Your nonuse coping thoughts like your circle of nonusing friends gets smaller while your circle of using friends gets bigger. This increases relapse risk."

Elicit: *When was the last time you celebrated without using? And when was the last time you handled a negative situation, feeling or thought without using?*

Affirm: Any instances of nonuse and support that the refusal communication skills will be helpful increasing successful experiences without use.

For example: "Given the increased risk of using thoughts, behaviors, and social pressure, the best initial step is to avoid situations involving alcohol and/or other drug use.

This is not always possible and so it's important that you feel comfortable refusing alcohol and other drugs when offered in social situations. In addition, you also need to be able to tell yourself that it is okay not to use and to cope or celebrate in other ways.

Knowing good strategies and practicing those strategies will help your ability to refuse alcohol and other drugs."

Elicit: *Do these reasons to learn self refusal and social refusal communication skills, make sense to you?*

Provide: Teach styles of refusal & communication– Give patients *Refusal Skills handout & communication styles handout.* Walk them through communication styles, nonverbal and verbal skills.

Guidelines

For role plays:

Describe each of the four types of responses: Passive, aggressive, passive-aggressive, and assertive using the communication styles handout.

Role Play by demonstrating an example of each style and asking the patient to offer you alcohol or marijuana and/or have a self conversation to provide the example of self pressures.

Demonstrate for the patient by refusing with and without use of assertive communication skills; so that patients can identify advantages to using skills.

For the skill related to suggesting an alternative or distraction, ask patients for suggestions for alternative activities.

For the skill related to changing the subject, ask patients for suggestions for possible changes of subject.

Highlight differences between these styles and the desirable assertive style.

Note: Patients often indicate their friends don't "pressure" them. Discuss how simply being offered drugs or being presented with opportunities to use can be tempting. In this type of situation, the goal of these skills is to decrease future opportunities to use.

Have patient practice the assertive style of drug refusal in role plays with self talk and you. Encourage patient by offering support and constructive feedback as he/she practices these skills.

Step 4: Summarize Session and Schedule Next Session

Summarize, Assign Practice, Prepare for Next Session

Guidelines

Summarize trigger and assertive communication session and prepare patient for next session. The summary is an opportunity to reinforce the patient's personal awareness and assertiveness refusal skill learning to increase their sense of self efficacy. After your summary, the preparation statement could sound like:

Summarize: "Today we covered a lot of information about your use, what sets you up to use, and communication skills helpful in working toward your recovery goals. You most frequently reported your triggers are likely to be: ___________________________

(Summarize the types of triggers: the time of day, the situation, the feelings & thoughts are they positive and/or negative).

For example: “Today you learned and practiced two important skills to help you reduce your use”

Elicit: *“I wonder if you can tell me how you would use the trigger awareness and refusal skills to help you meet your goals?*

Provide: In our next session together, we will focus on understanding your social supports and how you can increase your involvement in pleasurable activities and/or hobbies.

Provide: real life practice exercise: Ask the patient to utilize the assertive communication for self talk and with others when confronted by a trigger to use (negative thought, feeling, celebration or social pressure situation). In addition, have the patient fill out the Knowledge is Power worksheet for two situations in which they refused use or if they used.

Assign: “During the next week, I would like you to practice using the Knowledge is Power worksheet and use your assertive refusal skills, similar to how we did today.

Elicit: *How does that sound to you?*

Instructions: If patient says it will be hard, try to help remove any obstacles……

If patient agrees:

Provide: “I am asking for you to commit to filling out the sheet and using your refusal skills in two situations between sessions.

Elicit: *“Please identify a specific day, time and place when you will complete worksheet. “*
“Is there anything I can do to help you complete the real life practice at the times you committed?”

Complete Session Feedback Form

Schedule next session.

Session 4: Enhancing Replacement Activities & Social Support Networks

Introduction

The purpose of this session is for the patient to begin to identify and develop replacement activities and a network of positive individuals who would support the patient adopting a healthier lifestyle. The session also includes practicing the skill of asking for and giving help to others in order to increase one’s connection to a supportive social network.

Replacement activities are essential to developing a sense of “wellbriety” and coping with the stressful and habitual nature of life. Behavioral change is not something that occurs in isolation but rather in the individual’s social environment. Social support can be fostered by developing new relationships with those who share one’s desire for change. They can also be reforged links with existing family and friends who support and encourage the new behaviors. Social support has been shown to be critically useful after the initial behavioral change in helping individuals to remain drug free (Walters, 2000), to reduce the frequency of relapse (Pagano, Friend, Tonigan, & Stout , 2004), and to maintain sobriety (Edwards & Steinglass, 1995).

The structure of the session is as follows:

Step 1:

- Rapport building
- Review of progress since last session
- Review Knowledge is Power real life practice assigned during last session

Step 2:

- Introduce Replacement Activities: Pleasure & MASTERY
- Enhancing Social Support Networks **(provide rationale)**
- Define 5 different types of support
- Discuss different ways to obtain support
- Collaborate with patient to have them begin to identify their own social support network

Step 3:

- Summarize session
- Assign Seeking and Giving Social Support real life practice
- Complete Session Feedback Form
- Schedule next session

Handouts:

- Engaging Replacement Activities
- Enhancing Social Supports Reminder Sheet
- Social Circle Diagram
- Real Life Practice: Seeking and Giving Support worksheet
- Knowledge is Power worksheet
- Enhancing One's Social Support Network

Step 1: Rapport Building and Review

Guidelines

To continue building rapport with the patient, begin the session by eliciting information from them about their life during the past week. Initially, try to focus on non-problem areas. Continue to try to learn about their interests and strengths. Such information can be used when developing strategies for addressing the patient's AOD use. You will continue to use MI skills to do this and, as always, it is helpful if you express genuine curiosity regarding this and other parts of their life.

Elicit: *"How have things been since we last met?"* ***OR*** *"Tell me about something enjoyable you did during the past week?"*

Guidelines

If patient cannot think of anything enjoyable during the past week, ask about interests and activities in which they like to engage in, even if they have not done them in the past week.

Elicit: *"Tell me about some of your interests or hobbies?"* ***OR*** *"What kinds of things do you like to do in your free time?"*

Guidelines

Continue by asking the patient how s/he has been doing over the past week regarding their AOD use.

Elicit: *"Tell me about your (patient's drug(s) of choice) during the past week?"* ***OR*** *"What has your use been like since we last met?"* ***OR*** *" "What thoughts have you had about your use since we last spoke?"* ***OR*** *"As you've been working on the marijuana issue over the past week, has anyone had any problems or successes that you'd like to share with the group?"*

Guidelines

Listen for possible changes in the patient's behaviors, thoughts, and feelings regarding their use. Try to refrain from asking a lot of questions. Let the patient tell you how s/he has been doing regarding his or her use or abstinence. Respond with reflective comments, and attempt to elicit the patient's own motivation-enhancing statements. Affirm any efforts made to reduce use and look for opportunities to support the patient's sense of self efficacy. If little or no change in patient's use, look for opportunities to develop discrepancy through the use of double-sided reflections, exploring pros and cons, and seeking elaboration.

Remember your goal is to use OARS+E to follow the underlying DEARS strategies.

Review patient's experience of doing the Knowledge is Power exercise and using Refusal Skills. Again real life practice exercises are critical. Establish a tone that communicates to the patient you will review their progress on such exercises each week and work with them to develop strategies to ensure exercises are completed outside of sessions. This will help shape the patient's behavior.

Elicit: *"Last week, I asked you to do the Knowledge is Power exercise and use Refusal skills for two situations where you had opportunities to use. Lets start with the Knowledge is Power. Tell me how it went."*

Guidelines

If the patient did the exercise, affirm their efforts. Explore at least one example from the Knowledge is Power worksheet. If the patient's example resulted in abstinence, look for opportunities to affirm and support their self efficacy. If the patient completed the exercise and their thoughts and feelings resulted in use:

Elicit: *What they were thinking/feeling when the use occurred. "It sounds like you were having thoughts that made it more likely for you to use. When you started to have those thoughts/feelings, what kind of counter-thoughts could you have said to yourself to help keep yourself from using?"*

Provide: *A* review of their use of the assertive communication skills. See if they are more informed about their communication in their description of their self talk and talk with others.

Elicit: *"How did it go using the Assertive Communication/Refusal Skills we talked about last week?"* ***OR*** *"Tell me about a situation where you had the opportunity to use and how you handled it?"*

Guidelines

As they are describing the situation, look for opportunities to match up what they did with the specific refusal skills and assertive communication styles you discussed last week. Affirm what aspects went well for the patient. Encourage the patient to continue using these skills.

If the patient did not do the exercise, quickly set up a role play for them to practice the refusal skills (no more than 2 to 3 minutes to do the entire role play, including set up). If the patient has already talked about an incident where they used and wished they had not done so, use that example. If patient is in precontemplation, acknowledge where they are at but at the same time, encourage them to practice the skills.

For example: "I know you have indicated that you are not sure that you want to change your alcohol use right now. So in some ways, it might not make sense for you to learn and practice the refusal skills. Still, there might be times when you do not want to use in the future or there might be other things in your life that you want to refuse or stay away from, so for now, let us quickly practice the refusal skills by doing a role play."

Guidelines

If the patient did not do the exercise at all, in an MI style, explore why they did not do it. Begin to identify potential barriers that could be addressed when assigning the next exercise at the end of today's session.

Elicit: *"What were your reasons for not completing the exercise?"* ***AND*** *"What kinds of things would help you to complete an exercise like this in the future?"*

Step 2: Introduce Replacement Activities: Pleasure & MASTERY, Enhancing Social Support Network and Patient Identifies Support

Provide: Introduce the concept of participating in healthy replacement activities and how vital it is to creating a stimulating and fulfilling lifestyle.

Guidelines

It is understandable that there is a tremendous sense of absence or loss when giving up substance use. Substance use produced a sense of immediate pleasure and/or reward both biologically and psychologically. To replace this sense of loss, most people find they need replacement activities that include two important aspects of their life: Pleasure and Mastery. Pleasure activities bring us the immediate rewards that we all need to feel good: like watching a movie, reading a book, listening to music and eating a nice meal.

Mastery activities, due to the challenge they present, remain novel over time, lead to a long-term sense of accomplishment and ultimately can produce feelings of passion for life (similar to passions for substance use). Mastery activities are challenging and demand creativity and effort in either or both the use of physical and mental skill. Mastery activities can take more initial efforts to pursue, but then often become habit and full of enjoyment: examples include playing a musical instrument, writing, singing, playing a sport – golf, running distance, skiing etc.

Elicit: *"Given the need for both pleasure and mastery activities, what can you do everyday or week to engage in one type or the other so you feel passion in your life?"*

Summarize: Review and affirm any of the stated pleasure and mastery replacement activities. Explain to the patient that you believe this will be a crucial aspect of their recovery and will be getting them to commit to participation in both types later in the session.

Provide: Introduce enhancing social supports by stating what it means to build social supports and providing a rationale for doing so.

For example: “Today we are going to focus on enhancing social supports regarding your substance use. Having support in one’s life leads to an improved confidence in one’s ability to cope. Most individuals do not often have as much support as they would like. There are several potential sources of social support including one’s family, friends, and acquaintances. There are also different types of support people seek. Having a healthy, reliable social support network increases the likelihood you will be able to get the kind of support you need when you need it, which will result in you being more successful.”

Provide: The *Enhancing Social Support Reminders handout*. Begin by reviewing potential sources of support.

Elicit: *“Who in your life supports you now?”* **AND** *“What are some of the ways they support you?” (If patient focuses on support around abstinence or reducing use, broaden focus to other areas of their life where they are supported – e.g. in their job, as a parent, etc.)* **AND** *“Who has been supportive of you in the past?”* **AND** *“What kind of things did they do to show you their support?”* **AND** *“Who is supportive of your efforts to stop using alcohol?”* **AND** *“What kinds of things do they do to show you their support?”*

Guidelines

If the patient has difficulty identifying supportive people, consider information they have already shared with you. If they mentioned examples of family, friends, coworkers, or other community members who were supportive, revisit that example as one possible show of support.

For example: Last week you mentioned your husband is pleased that you are trying to reduce your alcohol use. Sounds like he might be someone who can help you stay positive and offer encouragement.”

Guidelines

After talking about who is or could be supportive of the patient, discuss with the patient the different types of support:

- Help with problem solving—someone good at thinking of options
- Moral support—offers encouragement and understanding
- Sharing the load—help with getting things done
- Information—about activities, transportation, getting a job, etc.
- Emergency help—-for small loans, needed items, a ride, etc.

Summarize: Summarize what the patient has already told you to highlight key sources of support and the types of support those individuals give.

Guidelines

If patient identifies negative sources of support, use MI skills to explore these sources. Your goal in this process is to help the patient draw their own conclusion that the negative sources of support might not be healthy supports.

For example (using a double-sided reflection): “On the one hand Sue is a lot of fun to be with and you feel that she doesn’t judge you, and yet, there have been times when you needed her and she wasn’t there.”

Guidelines

The last task for completing the *Enhancing Social Supports handout,* is to review how patients can get the support they need. These ways include asking for support in a direct and specific manner, add supporters, lend your support to others, and give feedback about the support you get. Discuss three

different ways of seeking support including indirect, direct but not specific, and direct and specific. Asking for support and giving feedback on the support you get overlap with the previous session's emphasis on assertive communication. You can model these three ways using the following example:

Patient wants a friend to show support by doing things together other than drinking alcohol. Or

You may want to substitute a situation described by a patient instead.

Provide: The Social Circle Diagram handout to help the patient visualize their social support network.

For example: "Next we are going to complete the *Social Circle Diagram handout."* The purpose of this is to map out your social support network on paper so you have it handy when you need support. As we complete the handout, try to determine what kind of support you may be able to obtain from your social circle."

Write: Have the patient write down their name in the middle circle. Next, have them write the name of each person who supports them in a different circle. Give your patient a few minutes to do this.

Elicit: *"As you were completing this diagram, what did you learn or notice about your own support system?"* ***OR*** *"Who in your life supports your goals towards abstinence (or reduction)? How?"* ***OR*** *"What types of support do you tend to have more of?"* ***OR*** *"What kinds of support could you build more of?"* ***OR*** *"Did you notice possibilities for asking for and getting more support?"*

Step 3: Summarize Session and Schedule Next Session

Guidelines

Summarize replacement activities and enhancing social support session and prepare patient for next session. The summary is an opportunity to reinforce the patient's goal(s) and increase their sense of self efficacy. The summary statement could sound like:

Summarize: "Today we focused on the importance of replacement activities and having people in our lives who support us in different ways. Consistently participating in the pleasure and mastery activities you chose______________________________(fill in from patient's choices) will help keep you satisfied and fill the void for any loss you currently feel. In addition, having social support increases your confidence to cope with challenging situations. You indicated that *(people's names)* support you in your goals towards abstinence by *(state what support identified people give patient)*. You also seemed to feel that *(people's names)* would be supportive of you if you asked them. The types of support that are most helpful to you in achieving abstinence are *(state types of support patient identified)*. Is there anything I missed?"

Provide: Assign real life practice exercise of seeking and giving support. Explore with the patient a situation in which they would like to seek support around. Give patient the "Real Life Practice: Seeking and Giving Support worksheet".

Assign: "During the next week, I would like you to practice participating in replacement activities and asking someone for support, as well as lending your support to someone else. Let's start by identifying a situation where you would like to get support from someone. Tell me about an activity, problem or situation that it would be nice to have someone's support?"

Elicit: *"What kind of support do you feel would be helpful to you?"* **AND** *"Who could you get this support from?"* **AND** *"How might you ask them for support?"* **AND** *"When could you approach this person to ask for support?"*

*Asking and lending support build on the assertive communication skills from the previous week. When assigning this practice, if time allows, you could quickly role play the patient asking their identified support person for help. Fitting in this type of practice increases the likelihood that the patient will follow through with the real life practice.

Assign: *"The second part of the worksheet focuses on lending your support to someone else. I would like you to think of someone you know that could use your help in some way. Write down the name of that person." (*patient writes down answer*)*

*"What is the situation in which they need help?" (*patient writes down answer*)*

*"What type of help could you offer?" (*patient writes down answer*)*

*"When will you offer your support during the next week?" (*patient writes down answer*)***

***Again, this is an opportunity to engage the patient in a role play on offering support to someone else.

Guidelines

Get patient to make a commitment of acting on the plan to ask for and give support before the next session and record how it went. Work with the patient to identify and address any barriers to them being able to practice receiving and giving support. Ask them what will help ensure they complete it.

Summarize the patient's real life practice. Below is one example:

> "Let's make sure we are clear about your real life practice. To cut down on your drinking, one of your goals is to become more active but it is hard to do this in the middle of winter by yourself. On Tuesday, you are going to ask Joe if you can join him to play basketball after work instead of going to the bar. You are also going to offer to do the dishes on Thursday and Saturday as you know that this gives your wife some time to relax after dinner. You feel that your wife is trying to be supportive of you and this is one way you can show her your appreciation."

Complete Session Feedback Form.

Schedule next session.

Session 5: Planning for emergencies and setbacks

Introduction

The goal of the session is to prepare the patient with helpful tools to cope with the ever present risk and results of relapse. Research demonstrates that planning for high risk is helpful in improving favorable response. If occasional failures do occur, advanced planning on how to cope with the resulting frustrations helps reduce distress and allows the individual to learn from the situation, revise their plans, and try again.

The session begins with review and a discussion of triggers and problems, relapse in general, and moves toward brainstorming known patient events that could precipitate a relapse. Specific strategies and skills rehearsed include: practicing a five step problem-solving approach to help cope with unforeseen events, and filling out a Safety Plan. A relapse is likely to be accompanied by guilt and shame, which exacerbates the problem. The overall guiding philosophy of the session is to be prepared (by utilizing skills from previous sessions: the trigger awareness approach, assertive communication skills, social supports and replacement activities already discussed) and understand that lapses need to be addressed as learning opportunities.

The structure of the session is as follows:

Step 1:

- Rapport building
- Review of progress since last session
- Review any real life practice assigned during last session
- (asking and giving support, and knowledge is power form)

Step 2:

- Introduce “problems” discussion & S.O.L.V.E. model **(provide rationale)**
- Collaborate with patient to identify their current high risk problems
- Utilize the S.O.L.V.E model for a specific patient problem

Step 3:

- Introduce the concept of lapses and relapse
- Describe the current understanding of relapse
- Introduce the High Risk Safety Planning Sheet
- Work with patient to develop a safety plan

Step 4:

- Summarize session
- Assign real life practice
- Utilize S.O.L.V.E. problem solving model & knowledge is power handout
- Complete Session Feedback Form
- Schedule next session

Handouts:

- Planning for High Risk and Setbacks
- S.O.L.V.E. (Problem Solving Steps)
- High Risk Safety Plan
- Knowledge is Power – What happens before and after I use alcohol or drugs?

Step 1: Rapport Building and Review

Rapport & Review of Progress

Guidelines

Conduct a similar review and rapport building as you do in each session. Add new review elements from the previous session. For session four you would ask about engaging in replacement activities and seeking help from and giving help to social supports from the last session.

To continue building rapport with the patient, begin the session by eliciting information from them about their life during the past week. Initially, try to focus on non-problem areas. This is an opportunity for you to learn about their interests and strengths. Such information can be used later to develop strategies for addressing the patient’s AOD use. You will continue to use MI skills to do this and, as always, it is helpful if you express genuine curiosity regarding this and other parts of their life.

Elicit: *“How have things been since we last met?”* ***OR*** *“Tell me about something enjoyable you did during the past week?”*

(If patient cannot think of anything enjoyable during the past week, ask about interests and activities in which they like to engage in, even if they have not done them in the past week.)

Elicit: *"I am interested in hearing about any new pleasant or MASTERY activities you may have engaged in alone or with others"*

Continue by asking the patient how s/he has been doing over the past week regarding their AOD use.

Elicit: *"Tell me about your (patient's drug(s) of choice) during the past week?"* ***OR*** *"What has your use been like since we last met?"* ***OR*** *"What thoughts have you had about your use since we last spoke?"*

Guidelines

Listen for possible changes in the patient's behaviors, thoughts, and feelings regarding their use. Try to refrain from asking a lot of questions. Let the patient tell you how s/he has been doing regarding his or her use or abstinence. Respond with reflective comments, and attempt to elicit the patient's own motivation-enhancing statements. Affirm any efforts made to reduce use and look for opportunities to support the patient's sense of self efficacy. If little or no change in patient's use, look for opportunities to develop discrepancy through the use of double-sided reflections, exploring pros and cons, and seeking elaboration.

Remember your goal is to use OARS+E to follow the underlying DEARS strategies.

If patient was assigned a real life practice exercise, review their experience doing the exercise.

Elicit: *"Last week, we decided you would ____ (commit to engaging and building your social support network by asking for and giving help). Tell me how it went."*

Guidelines

If the patient did the exercise, affirm their efforts. If the patient did not do the exercise, in an MI style, explore why they did not do it. Begin to identify potential barriers that could be addressed when assigning the next exercise at the end of today's session.

Elicit: *"What were your reasons for not completing the exercise?"* ***AND*** *"What kinds of things would help you to complete an exercise like this in the future?"* ***AND*** *"How do you think a sober social network could help you in times of need?"* ***AND*** *"What do you think about doing new sober replacement activities?"* ***AND*** *"Have you had any additional thoughts about the goals you developed?"*

Examples: "From our review discussion already today, it seems you were able to begin to develop a better social support system – how does that feel to you?"

If no progress on goals – ask instead:

"It seems you were not able to begin your action steps toward your own goal – how does that feel and should we make adjustments in your goals?"

If patient needs to change goals – use a new personal goal worksheet and summarize the changes once the goal is developed.

Step 2:Discuss "problems" & S.O.L.V.E. Model, Identify Current High Risk Problems and Utilize S.O.L.V.E. Model for Specific Problem

Provide: Introduction & Rationale for problem solving skills – "Today we are going to learn skills to more successfully handle and prepare for problems and high risk situations, situations that can trigger a lapse and/or relapse."

"As you know, life throws all of us problems; they are part of the fabric of life for everyone. We like to say, problems are not the problem, it is what you do with them that matters"

Guidelines

If there are obvious situations in the patient's life; discuss these situations by asking some open ended questions to get more understanding of the actual facts. "Tell me how you knew it was a problem for you and how you felt about it?"

If there are not obvious problem situations:

Elicit: *Can you tell me about a couple of situations that you would define as problems and how you felt and coped?*

Provide: Once you have elicited a few problems, collaborate with the patient to pick a problem they want to address.

For example: It sounds like you want to focus on the following problem: ___________________

Write: Ask the patient to write down their problem in the S part of the S.O.L.V.E worksheet.

Remember to only address problems where the solution to the problem is in the control of the patient. The model will not work if the answer to the problem relies on someone else's control.

(Example of someone else's problems: I need to make it so my family stops complaining, I need them to learn to speak in a different tone…versus: I need to figure out a way of expressing myself so my family quits complaining about my tone of voice.)

Guidelines

If the patient chooses a problem where the solution is not in their own control, work with them to understand the difference between self and other's ability to influence change (use examples). Then collaborate to re-select or redefine the problem to one that they can have primary influence over the outcome, thus emphasizing self efficacy.

Provide: *S.O.L.V.E. – Steps for Problem Solving Handout*. Using these skills can increase the likelihood of success in coping with these types of situations.

Review 5 problem solving steps:

S = State the problem

Make sure to define the problem specifically.

Example: "My problem is my tone of voice when I talk to my family about my desire to drink."

O = Options – develop a minimum of three to four.

Guidelines: Make sure the brainstorm of options feels "fun" or the spirit is creative, At this point in the SOLVE discussion it does not matter if the solutions are realistic. However make sure the patient understands when they are in someone else's control or not. A common therapist mistake is to not allow the brainstorm to be open ended and elicit enough solutions to really be able to assess which one might be best.

Example: "I could not talk, remain silent; I could try to whisper; I could try to remain positive about the craving and rather than just complain, let them know how much it helps if they listen to me to describe what it feels like to desire so much, and how hard it is to resist; I could ask if they want to know how I feel; I could see if they could listen to me fully before responding (will not work for this model)"

L = Look at Consequences

Guidelines: Examine the long-term and short-term consequences of the possible solutions.

Example: "If I am silent it just makes me want to drink more; if I try to whisper, it seems rude but could work."

V = Vote on one option/solution to try.

Example: "I will take a deep breath and remain calm and soft spoken when I ask for my family to listen to my urge to use and help me cope."

E = Evaluate the result.

Example: "When I remained calm so did my family and they quit complaining about me even thought I was speaking about wanting to drink."

Use the problem the patient identified to practice the 5 step problem solving model.

Step 3: Introduce Lapses & Relapse, Introduce High Risk Safety Planning Sheet and Develop Safety Plan

Provide: Information on lapse and relapse: focus on the fact that it is not uncommon and similar to any other problems and solving them. The most important thing is how one deals with a lapse or relapse after use occurs during the reduction in use. Explain that many people have minor lapses on the road to health and reduction of use, but there are also many people that even relapse. They may have extended periods of use at the same or even increased use levels after periods of abstinence. If the patient wants to know more facts about relapse you can further explain that more than half those ending treatment will have multiple relapses, some begin within 90 days of ending treatment. In addition, research has demonstrated that it takes a year of abstinence before less than 50% of patients relapse and even after 3-7 years of abstinence about 14% of patients relapse.

Elicit: *What has your experience of managing your own previous recovery attempts been to date? What have your previous lapses and/or relapses taught you?*

If patient has no past attempts at reducing use, ask what they have noticed during this attempt?

Provide: Explain to the patient that stories like theirs and others demonstrates that making any change in behavior is a process….as is any lapse or relapse. On the road to reducing use when we make changes in the wellness plan, like deciding not to go to self help , or do healthy consistent MASTERY and pleasure replacement activities this affects the wellness plan strength…and if the patient hits a high risk trigger later on (like a disagreement with a close friend or family member) the response is often less healthy and increases the likelihood of use.

Patients may think that after one slip back to old use patterns (or even a fuller relapse), the whole wellness/reduction plan is ruined, and they might as well give up. Let them know that this does not have to be the case.

Patients may learn something from a slip/relapse. Tell them that by looking at the circumstances of the relapse, they may learn situations to avoid, or changes to make in their coping skills.

Patients can choose to resume their efforts to live without substances after a lapse or full blown relapse.

The take home message is this: recovery strength is based on consistent management of “wellbriety”, a lifestyle that incorporates refusal skills, sober social supports and replacement activities.

Elicit: *What are you doing differently in this recovery, to create and manage a stronger recovery lifestyle?*

Provide: Planning for emergencies and coping with slips/relapse – rationale & have patient examine the *High Risk Sobriety Safety planning sheet*.

For example: “Even if someone avoids situations involving alcohol and drug use, knows how to refuse such offers, increases his or her support system, and plans positive alternative activities, he or she still may encounter unanticipated high-risk (emergency) situations and may lapse and/or relapse. Having a plan in place and written down, like this one, titled : *High Risk Safety Planning worksheet*, increases the likelihood you’ll be able to abstain from using.

Provide: Have the patient to fill out the entire form by eliciting the necessary items, begin by stating:

“Lets brainstorm potential high-risk/emergency situations - unanticipated circumstances that place you at increased risk for substance use. Lets include both negative events and positive events (e.g., a new job or a move to a better home) you are likely to encounter.”

Collaborate with the patient to discuss (fill out) the *High Risk Safety Plan* Sections: (see plan)

Coping strategies

Helpful People

Steps to Reduce the Likelihood of Full Blown Relapse Should Use (lapses) Occur

Elicit: *Have the patient read through the plan and discuss any missing aspects. Affirm the potential benefit of having the plan in place.*

Step 4: Summarize Session, Utilize S.O.L.V.E Model and Schedule Next Session

Summarize and Assign

Summarize: “We covered a lot of ground today. We discussed your progress to date and added to the many ways you have been learning and practicing to increase the strength of your reduction/wellness plan. Specifically, we practiced the S.O.L.V.E. model for handling any problems that arise, and also planned for unavoidable high risk situations with your filling out and keeping a copy of the safety plan.”

Elicit: *How do you feel about the wellness strategies we reviewed today ?*

Provide: A brief reminder of the concept of the path toward wellness being as a process.

For example: “Remember, to try to see your recovery as a learning process; so when any old or new problems arise (leading to lapse/relapse) the whole process can be viewed as a learning opportunity. By continuing to use the situational analysis (*Knowledge is Power*) approach you will be able to learn from the lapse/relapse situations, and how the triggers, response and consequences can change to better manage your reductions in use.

Assign: During this next week, I’d like you to practice using the S.O.L.V.E. by filling it out for any two problems you encounter in the next week. In addition, fill in the Knowledge is Power sheet for the same two situations that arise. Also, if necessary, utilize the Safety plan you created.

Elicit: *Is this real life practice clear to you?*

If not, re-explain.

Elicit Specific Commitment: "*Can you commit to completing the real life practice by our next session? While it is hard to say when you will encounter problems, what time of day will be best for you to fill out the worksheets?"*

Provide: In the next session we will go over the scores from your re-screening. Discuss recommendations and what you choose to be next steps in your treatment and self help program.

Complete Session Feedback Form.

Schedule Next Session.

Session 6: Review and close

Introduction

The main focus of this session is to review progress to date, recommend next steps and refer the patient to specific services, terminate – but leave the door open!

Discuss the patient's use of new wellness skills, other treatment strategies, and their follow through on real life practice activities. During the discussion assess the patient's wellness/reduction plan (recovery strength), motivation, and commitment to continuous health management. Discuss the treatment findings from the feedback form and re-screen (RTC, ATOD &-GPRA summary data table II) and what types of additional treatment/self help & "wellbriety" services are needed. If needed, recommend and link (hand-off) patient to community specialty providers, self help and "wellbriety" resources.

Step 1:

- Rapport building
- Review progress since last session – Replacement Activities, Assertive Communication, Social Support Network
- Review real life practice assigned -S.O.L.V.E./Knowledge is Power worksheets
- Assess recovery strength: attitudes and ability to engage: factors supportive of long-term recovery

Step 2:

- Review Comparison Summary Data Tables I & II
- Review Feedback Form – Attendance, Motivation, Real Life Practice, Behavior Change, Engagement During Treatment, Reported and/or Measured Use
- Discuss: Treatment Motivation, Confidence & Gains
- Describe the need for continued recovery management

Step 3:

- Review Continued Recovery Management Plan including:
    - -Initial BC referral reasons
    - -Discharge recommendations
    - -Community Resources
- Assertive Link for Patient to Treatment/Self Help/Wellbriety resources
- Complete Session Feedback Form

Handouts:

- Continuous Health Management Plan

Step 1: Rapport Building, Review and Assess Recovery Strength, Attitudes and Ability to Engage, Factors Supportive of Long-term Recovery

Guidelines

Continue building rapport with the patient: begin the session by "explaining and affirming that this is the last Brief Coaching session with you. Express to them that you admire the consistent effort demonstrated throughout their treatment (attendance, motivation, follow through, mood, etc.). Elicit information from them about their life during the past week. Initially, try to focus on non-problem areas. By this time you will know many of their interests and strengths.

Ask questions that **assess**:

a) How well they are adapting to reductions in substance use (recovery),

b) Did they develop and use new strategies (covered in the treatment)?

c) Is the patient energized, rather than depressed, in their path to managing substance use (recovery)?

Build Rapport & Review Progress

Elicit: *"How have things been since we last met?"* **OR** *"Tell me about something enjoyable you did during the past week?"*

(If patient cannot think of anything enjoyable during the past week, take note and remember to refer to resources that may help engage them in replacement activities. Ask which of their preferred interests and activities they are most likely to engage in, even if they have not done them in the past weeks.)

Elicit: *"Of all of the interests or hobbies you have mentioned to in our discussions, what is the one you are most likely to want to do – not just should do, but actually feel excited to do?"* ***OR*** *"Who might help you follow through?"*

Continue by asking the patient how she/he has been doing over the past week regarding their alcohol and/or drug use.

Elicit: *"Tell me about your (patient's drug(s) of choice) during the past week?"* ***OR*** *"What has your use been like since we last met?"* ***OR*** *"What thoughts have you had about your use since we last spoke?"* ***OR*** *"As you've been working on the marijuana issue over the past week, have you had any problems or successes that you'd like to share with me?"*

Guidelines

Listen for possible changes in the patient's behaviors, thoughts, and feelings regarding their use. Try to refrain from asking a lot of questions. Let the patient tell you how s/he has been doing regarding his or her use or abstinence. Respond with reflective comments, and attempt to elicit the patient's own motivation-enhancing statements. Affirm any efforts made to reduce use and look for opportunities to support the patient's sense of self efficacy. If little or no change in patient's use, look for opportunities to develop discrepancy through the use of double-sided reflections, exploring pros and cons, and seeking elaboration.

Remember your goal is to use OARS+E to follow the underlying DEARS strategies.

Review Real Life Practice

Elicit: *"Last week, I asked you to use the S.O.L.V.E. model and the Knowledge is Power exercise for two problem situations where you had opportunities or triggers for substance use. Tell me about the situation (s) where you had the opportunity to use and how you handled it?"*

Provide: If the patient did the exercise, affirm their efforts. Explore at least one example from the S.O.L.V.E. & Knowledge is Power worksheets.

If the patient's example resulted in *abstinence*, look for opportunities to support their self efficacy.

Guidelines

If the patient's example resulted in *use*, find out if they tried to use their Safety Plan and ask about the specific thoughts/feelings resulting in the lapse/relapse – use the "Knowledge is Power" worksheet to conduct a functional analysis of the triggers, behavior and consequences for the substance use event.

Elicit: *"After being triggered to use, how did it go using the problem solving or safety planning tools we talked about last week?"*

For example: "It sounds like you were having feelings & thoughts, that made it more likely for you to use. When you started to have those thoughts/feelings, what kind of counter-thoughts could you have said to yourself to help keep yourself from using?"

Guidelines

As they are describing the situation, look for opportunities to match up what they did with the problem solving skills and reduction tools you discussed last week. Affirm what aspects went well for the patient. Encourage the patient to continue using these skills.

Remember, their commitment to the real life practice exercises over the course of treatment and their practice/use of the wellness/reduction skills is critical to managing continuous health. The patient must not only practice but also embrace the learning process to break old habits, and engage in "wellbriety" i.e. new ways of living, experience new pleasures & MASTERY hobbies, use new communication and problem solving skills.

Assess: Does the patient demonstrate this " health oriented learning set" and new admiration for achieved "wellbriety".

Guidelines

If the patient did not use any of the tools covered last week,

Elicit: "*What tools did we learn in treatment last week that might be helpful the next time you encounter these types of feelings/thoughts/ & situations?"*

Utilize MI –OARS/DARN-C strategies to discuss and assess their non-engagement in trying learned strategies and doing the real life practice.

Assess: If the patient understands the S.O.L.V.E. model covered last week, as well as the Safety plan.

Guidelines

Ask yourself, how much the patient's lapse/relapse involved lack of motivation and/or lack of abilities. This information about motivation versus ability will be critical to making appropriate referral recommendations.

Elicit: "*I understand when these types of feelings/thoughts/situations occur it seems hard to break old negative habits and develop new healthier coping strategies, what do you feel is hardest for you?"*

Guidelines

If the patient has attempted or quit using substances, the anticipated and actual rewarding (pleasure, stimulation) aspects of their life maybe completely diminished. The need for healthy replacement activities and supportive social connection becomes a necessity. In addition, most patients when reducing use need to become less secretive about their problems and efforts to quit. One marker of treatment progress is an ability to openly confide in others about their needs and efforts to manage substance reductions. Research demonstrates significant others can be tremendously influential in supporting recovery especially in the context of structured treatment approaches.

Assess: Patient's readiness, and ability to engage in factors supportive of long-term recoveries: compulsory supervision (MD, healthcare worker, sponsor, probation officer), replacement activities, intimate and supportive relationships, spiritual connections.

Does the patient express satisfaction with their recovery? Or rather, is their description of the recovery "Like walking through sand?" This tone in the discussion will be critical to your making appropriate discharge recommendations later on in the session.

Guidelines

You will continue to use MI skills to do this and, as always, it is helpful if you express genuine curiosity regarding this and other parts of their life.

Assess: Patient's experience using strategies learned thus far:

- Knowledge is Power Approach
- Assertive Communication/Refusal Skills
- Seeking and Giving Support
- Problem Solving
- Safety Plan

Guidelines

At this point in the patient's treatment – there should be an expressed sense of "wellness strength" built on the newly acquired use of the recovery skills. The discussions and information gathered in **Step 1** of this final session and the re-screen information from fifth session will directly impact discharge recommendations.

Step 2: Review Comparison Summary Data Tables & Feedback Form, Discuss Motivation, Confidence & Gains, and Describe Need for Continued Recovery Management

Provide: Initial reasons for referral (MD?) – including any health reasons (labwork) and comparison of the screening data tables I & II. Introduce the comparison screening report (data summary tables I & II compared), treatment feedback for and medical reasons for the referral to BC.

> For example: "Today we are going to review your treatment progress to date, re-assess your goals concerning your future use, and review discharge recommendations. In addition, we will discuss helpful community resources for the ongoing management of your recovery.

Guidelines

Discuss the re-screen and treatment progress information using MI skills, ask open-ended questions, affirm and address the patient's data for items on the two forms. This discussion will feel similar to the initial feedback discussion from session one, however the focus is now on the current and changed indicators:

- levels of use
- problems associated with use
- change in motivation,
- confidence/ability to embrace recovery

Elicit: *The patient's understanding of their treatment/recovery progress.*

"How do you feel about the information presented on your treatment/recovery progress?"

Assess: The patient's attitude regarding their treatment/recovery progress. Look for DARN-C talk – desire, ability, reason, need, and commitment for recovery. Emphasize any change in attitudes or behaviors demonstrating efforts to achieve "wellbriety".

Which patient type are they?

Patient A. – engaged, motivated, able - no use.

Patient B. – engaged, motivated, lacks necessary ability - use.

Patient C. – not engaged, not motivated, use.

For Patient Type A**:** Affirm their successful effort to engage in initial strong management of their recovery. Ask questions to elicit and strengthen the recognition of the benefits across many areas of their life (health, relationships, finances, moods, sleeping pattern etc.).

Examples: "What have you noticed regarding your health and moods now that you have had some success in managing your substance use? What have others said about the changes you have made in the last few months during treatment? How do you feel about yourself now?

For Patient Type B: Ask questions to increase their sense of efficacy and motivation for success. Use the MI strategies known to promote change talk such as scaling, seeking elaboration, looking forward or backward.

Examples: "On a scale from 1 to 10 how important is it for you to continue not using right now? If patient states 7 out of 10 , ask them what they would need to turn the 7 into a 9? Or you might ask them if they look ahead to the next three months what will their life be like if they continue with occasional use? And then, if they remain substance free for 12 months what will their life be like and how does that compare to before they started treatment?"

For Patient Type C: Use MI strategies (such as nonjudgmental empathic feedback, pros/cons, sampling sobriety, hopefulness, psychoeducation concerning relapse) to create a positive outlook on future chances of success and diminish guilt/shame concerning current use. Discuss goals in relation to continued use, reasons for quitting, and any concerns of current use the patient mentions. Affirm changes patient made during treatment toward achieving increased "wellbriety".

Examples: "I really appreciate the fact that you continued in treatment regardless of your struggles to manage a recovery. What worked and what did not work for you in this treatment? If you look at your use as a learning opportunity for helping you manage recovery in the future – what would you change? Given your commitment to treatment I wonder what it would be like for you to sample sobriety - being abstinent for the next _____ number of days? What would it take? Do you still have alcohol (substances) readily available to you (at home, work etc.)?

Elicit: *"What do you think you need now to help you remain healthy (abstinent)?"*

Patient is type A or B and he/she state they do not need any more help and can do it on their own.

For example: " Great, it sounds like you are satisfied with your progress to date and even though it was and still is challenging to remain abstinent, you now feel as if you can manage your recovery without a lot of outside help. Would you be open to considering a set of specific recommendations, we developed from your treatment progress and current recovery strength? Again, it is always up to you to determine what to choose as the best resources to manage your recovery."

Patient is type C: and he/she state that they do not know what they need.

For example: "I am sure we can help you figure out a good plan going forward and what will be most helpful now. But, I also understand your feeling uncertain given your effort and struggle to remain in substance free (healthy).

Step 3: Review Continued Recovery Management Plan, Assertive Link for Patient to Treatment/Self Help/Wellbriety Resources, Provide Handouts and Continuous Health Management Plan

Provide: Patient with their individualized continuous health (substance free) management plan

Turn patient's attention to the

- New referral recommendations
- Community resource directory

Guidelines

Link the patient's current treatment progress, their expressed needs and the new recommendations. The goal is to use MI strategies to match the patient's perception of needs/self-determination with the recommendations & specific referral sources.

Remember to emphasize that the recommendations incorporate the current scientific knowledge with an understanding and what has been most helpful to others in trying to manage long term recovery"

Elicit: *What do you think of our recommendations?*

Guidelines

Discuss, using MI strategies, any negative/positive reactions to understand the patient's readiness, willingness and ability toward following through with the proposed recommendations. Explain to the patient that long-term recovery success depends on being able to engage in continuing recovery management.

Elicit: "*Lets work together to schedule and write down which recommended professional and self help meetings you agree are a good match and the one's you will choose to attend in the near future ?"*

Provide: Point the toward the recommendations and possible resources which match the patient's geographic location, schedule, funding and other influential parameters.

Elicit: "*Which of the resources do you now want to commit to participating in?"*

Guidelines

Let the patient pick which resources are best suited to their needs and offer suggestions to ensure the level of intensity and frequency of professional and self help is appropriate and fits the proposed recommendations.

Provide: I will now schedule the professional treatment appointment at __________ as well as your follow up with the MD.

In terms of self help,

Guidelines

If patient has already engaged in self help, ask them which meetings and how many a week they will attend and/or if they have a sponsor how often they will commit to contacting that person.

Provide: If patient has not engaged in any self help offer the following link to self help if available in the health center,

For example: "Our bridging AA/NA fellow has agreed to help you with any questions about the self – help process. I would like to give you their phone number so you can call before leaving our office and make plans for attending the right meetings with them to ease any discomfort of starting a new program. (use the same type of discussion for other community or web based options e.g. rational recovery)"

In terms of social support,

Elicit: "*Who will you contact if you find that you are in a high risk situation/tempted to use or have already lapsed and are using again*?" (we can look at your social support diagram and your safety plan worksheets)

Elicit: "*Do they know that you are in trying to reduce use/or quit. Have you asked them already and or have they offered to help you with this issue in the past?"* (the person may already be part of their social support circle of trusted helpers mentioned in session 4).

Complete Session Feedback Form.

Summarize & Terminate: To summarize, you now have committed to the continuing health management plan of going to _______________for a treatment appointment and going to the following self help meetings ______________. You also stated you would call the following supports if needed _____________________.

I have enjoyed working with you in treatment and hope to hear from you again if you ever need my help or if you have any questions or concerns.

Appendix

Personal Feedback Report example

MOSBIRT - Personal Health Risk Assessment

Participant: Test, Matthew (3948567)

Assessed: Friday, October 02, 2009

	Score	Risk Level
Tobacco	0	low
Alcohol	21	**high**
Cannabis	0	low
Cocaine	19	**moderate**
Ampheatmine	0	low
Inhalants	0	low
Sedatives	0	low
Hallucinogens	0	low
Opioids	0	low
Other	-1	no responses

Key

Low: You are at low risk of health and other problems from your current pattern of use.

Moderate: You are at risk of health and other problems from your current pattern of substance use.

High: You are at high risk of experiencing significant problems (health, social, financial, legal, relationship) as a result of your current pattern of use and may become dependent

Very High: You are probably experiencing significant problems (health, social, financial, legal, relationship) as a result of your current pattern of use and may be dependent or addicted.

Alcohol

Based on what you have told us, your risk of developing a problem with alcohol is high.

Regular excessive alcohol use is associated with:

- Hangovers, aggressive and violent behavior, accidents and injury
- Reduced sexual performance, premature aging
- Digestive problems, ulcers, inflammation of the pancreas, high blood pressure
- Anxiety and depression, relationship difficulties, financial and work problems
- Difficulty remembering things and solving problem
- Stroke, permanent brain injury, muscle and nerve damage
- Liver disease, pancreas disease
- Cancers, suicide

Your problems from alcohol use include:
Having health, social, legal, or financial problems once or twice in the past three months.Having failed to do what is normally expected of you once or twice in the past three months.

How much is too much?

Some say any alcohol is too much. Others think you should only stop if you can't "control it." The truth is, as a man, if you drink more than 2 drinks a day regularly or drink more than 5 drinks at any one time you are at risk for serious problems due to alcohol.

Take a look at the chart to see how the amount of drinking you reported compares to other people in Missouri and across America.

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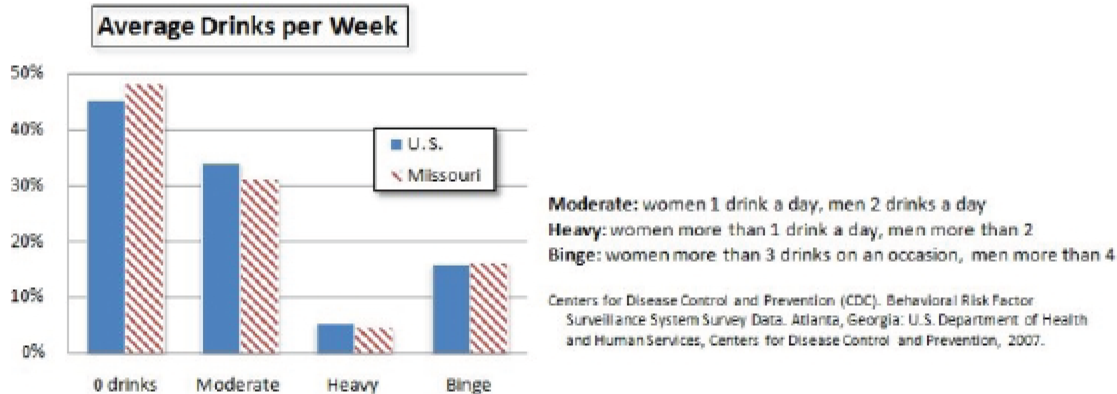
MOSBIRT - Personal Health Risk Assessment



Based on what you have told us, you:

- Have 36 drinks per month, or 468 each year, more than 84% of Missourians.
- Spent anywhere from $1,404 to $2,340 on alcohol during the past year.
- Over five years, you have spent between $7,020 and $11,700.
- Added 5,400 calories per month which is more than 20 pounds per year.
- To burn off these calories each week a 155 lb individual would need to: walk at a very brisk pace (4 mph) for 4.8 hours or ride a bicycle between 14-16 mph for 1.9 hours or garden for 3.8 hours.

Cocaine

Based on what you have told us, you have a moderate risk of developing problems because of your use of cocaine.

Effects of cocaine use:

- Constricts blood vessels, dilates pupils, and increases body temperature, heart rate, and blood pressure
- Heart attacks and strokes
- Decreased appetite and malnourishment
- Snorting cocaine can lead to loss of the sense of smell, nosebleeds, problems with swallowing, hoarseness, and a chronically runny nose
- Ingesting cocaine can cause severe bowel gangrene as a result of reduced blood flow
- Injecting cocaine can bring about severe allergic reactions and increased risk for contracting HIV and other blood-borne diseases

Your problems from cocaine use include:
Having health, social, legal, or financial problems monthly.Having failed to do what is normally expected of you once or twice in the past three months.

By using cocaine, you are in the minority. More than 97 out of 100 Missourians have not used cocaine in the last year.

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MOSBIRT - Personal Health Risk Assessment

Your Motivation To Change

It is possible to change your behaviors. Based on what you have told us, you are to be congratulated because you are currently working to reduce your risky drinking behaviors. In terms of your drug use, you are to be congratulated because you are currently working to reduce your risky drug use.

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Missouri Initiative for Healthy Lifestyles

Promoting healthy lifestyles in Missouri ~ one person at a time

Brief Coaching,
Session 1,
Handout 1
(Welcome to MO Initiative for Healthy Lifestyles

Welcome to Missouri Initiative for Healthy Lifestyles!

What You Can Expect From Us

***Effective Coaching*.** Delivered by a competent coach. Your coach is

---

***Confidential Meetings*.** What you tell us during our meetings is confidential, meaning that we cannot tell anyone what you said other than your doctor or treatment team without your permission, with the exception of those people described on the consent form. However, if you tell us that you are going to harm yourself or another person, or tell us about child abuse or neglect, we are required by law to inform those who can obtain help for you or for others.

What We Ask From You

- ***Attendance*.** We ask that you be ***on time*** to all of your scheduled appointments. If you must cancel, we ask that you call this number (_____-_______) so that your Health Coach can be notified ahead of time and can call you to reschedule.
- ***A clear head*.** We ask that you not use any drugs or alcohol on days when you have an appointment with your Health Coach. We believe that you will be able to benefit most from this program if you are not under the influence during your sessions.
- ***Completion of Coaching Sessions.*** We hope that you will follow through with all of your scheduled sessions. If, however, you ever consider ending early, we ask that you discuss this with your Health Coach as soon as possible.

Brief Coaching,
Session 2,
Handout 1
(Decisional Balance: Thinking about my Substance Use)

THINKING ABOUT MY SUBSTANCE ABUSE

Example

This will help you think about the ***Good Things*** and the ***Not So Good Things*** about your drinking or drug use. Weighing the ***Good Things*** and the ***Not So Good Things*** is what people do when they make decisions. For example, while drinking or drug use may sometimes help you relax, it could also cause you problems with your family or at work. Ask yourself, "what are the good things and not so good things about my current drinking or drug use?" and "what are the good things and not so good things about changing my drinking or drug use?"

Here's an example done by another individual. Remember, every person has different reasons they might want to change their drinking or drug use.

Good things about my drinking or drug use:

- More relaxed
- Will not have to think about my problems for a while
- More comfortable with drinking friends
- Don't think as much about grades

Good things about changing my drinking or drug use:

- More control over my life
- Support from family and friends
- Less legal trouble
- Better health

Not so good things about my drinking or drug use:

- Disapproval from family and friends
- Can't get as much work done
- Costs too much money
- I'm late for class
- I argue with my roommate

Not so good things about changing my drinking or drug use:

- More stress or anxiety
- Feel more depressed
- Feel inhibited with people I don't know
- Harder to socialize at parties

Thinking About My Substance Abuse

Use this page to complete your own thinking exercise about substance abuse. Remember, everyone is different and your exercise will be uniquely yours.

Good things about my drinking or drug use	**Good things about changing my drinking or drug use**
Not so good things about my drinking or drug use	**Not so good things about changing my drinking or drug use**

Brief Coaching,
Session 2,
Handout 2
(Personal Goal Worksheet)

PERSONAL GOAL WORKSHEET

The Desired Change(s)

____

____

People available to support the change plan

____

____

Reasons for wanting to make those changes

1. ______________________________
2. ______________________________
3. ______________________________

Impediments or obstacles to change and how to address them

____________.........____________

____________.........____________

____________.........____________

Steps to make the changes

1. ______________________________
2. ______________________________

Methods of determining whether the plan has worked. (How will I know when I've met my goal?)

____

____

Brief Coaching
Session 3
Handout 1
(Knowledge Is Power Form – Example)

Knowledge Is Power Form

Why? – Helps us become aware of negative habits & the automatic patterns of thinking feeling and doing. Look at the example of how the self-monitoring record may look after the coach has helped the patient complete it while reviewing a recent episode of use:

What Happens Before and After I Use Alcohol and/or Drugs?

TRIGGER	THOUGHTS AND FEELINGS	BEHAVIOR	POSITIVE Results	NEGATIVE Results
(What sets me up to be more likely to use alcohol or drugs?)	(What was I thinking? What was I feeling? What did I tell myself?)	(What did I do then?)	(What good things happened?)	(What bad things happened?)
A close friend called and invited me to drink with him. Was tired of being alone.	"I want to be with my friend we always have a good time" "I'm bored."	Went out with friend and drank.	Had fun. Felt good to drink, and be social.	Didn't get as much done. Didn't feel as healthy.

Brief Coaching,
Session 3,
Handout 2
(Knowledge Is Power Form - Blank)

Knowledge Is Power Form

Why? – Helps us become aware of negative habits & the automatic patterns of thinking feeling and doing. Look at the example of how the self-monitoring record may look after the coach has helped the patient complete it while reviewing a recent episode of use:

What Happens Before and After I Use Alcohol and/or Drugs?

TRIGGER	THOUGHTS AND FEELINGS	BEHAVIOR	POSITIVE Results	NEGATIVE Results
(What sets me up to be more likely to use alcohol or drugs?)	(What was I thinking? What was I feeling? What did I tell myself?)	(What did I do then?)	(What good things happened?)	(What bad things happened?)

Brief Coaching,
Session 3,
Handout 3
(Assertive Communication)

Assertive Communication

Why?

- Immediate, effective response is needed when triggered by negative thoughts, feelings or situations to use. Assertive communication with self and others is often beneficial.
- It is common for one's coping strategies to become limited and one's social circle narrows with increased substance use. Thus, the pressure to use from self and others can be experienced as the only choice.
- It's best, but not always possible, to avoid high-risk people and situations.

Communication Styles

Response Type	This Kind of Person	Response Example
Passive	Tends to give up his or her own desire in favor of another person's desire. Doesn't let others know what he or she is thinking or feeling.	*"I didn't want to drink tonight, but if you really hate drinking by yourself, I might as well"*
Aggressive	Acts to protect his or her own rights but runs over others' rights in the process, which can cause others not to like him or her.	*"I'm not smoking weed and I don't want anyone smoking around me! It's rude and I need you to get out of my face or there will be trouble!"*
Passive-Aggressive	Is indirect, hints at what he or she wants, possibly causing confusion and/or resentment in others.	*"Are you all going to get high now? You know I'm trying not to use and getting treatment but it might be okay this one time, what do you think ? . . ."*
Assertive	States his or her position and makes a direct request.	*"No, I am not drinking and I'd like it if you would not ask me to drink with you anymore. I still want to get together with you to do other things, maybe we could get a bite to eat, okay?"*

Brief Coaching,
Session 3,
Handout 4
(Assertive Communication Skill Reminders)

Assertive Communication Skill Reminders

Nonverbal Behaviors:

- Make eye contact.
- Take a deep breath to calm yourself & slow down your reactions
- Don’t feel guilty about refusing alcohol or drugs.

Verbal Behaviors:

- Speak in a clear, firm voice.
- Even your inner voice needs to be direct.
- “No” should be your first word.
- Suggest an alternative something fun and safe to do instead.
- Change the subject and/or distract yourself.
- Avoid excuses or vague answers.
- If self pressure (urge) continues after deep breathing and self talk, seek help from someone you trust.
- If pressure from someone else continues, ask him or her to stop asking you to use.

Brief Coaching,
Session 3,
Handout 5
(Real Life Practice)

Real Life Practice

Reminders

- Say “No” first.
- Make sure your voice is clear, firm, and unhesitating.
- Take a or many deep breaths,
- Slow down your reaction
- Suggest an alternative:
- Change the subject.
- Avoid vague answers.
- Don’t feel guilty about refusing to use alcohol or drugs.
- If necessary, ask the person to stop offering you substances and not to do so again.
- If urges become to powerful, seek help from trusted support.

Listed below are some examples of people who might offer you alcohol or drugs in the future. Give some thought to how you will respond to them, and write your responses below each item.

Yourself (when cravings/urges to use are intense):

Someone close to you who knows about your alcohol or drug problem:

A coworker (if you have a job):

A new acquaintance:

A person at a party with others present:

Brief Coaching,
Session 3,
Handout 6
(Knowledge Is Power Form - Blank)

Knowledge Is Power Form

Why? – Helps us become aware of negative habits & the automatic patterns of thinking feeling and doing. Look at the example of how the self-monitoring record may look after the coach has helped the patient complete it while reviewing a recent episode of use:

What Happens Before and After I Use Alcohol and/or Drugs?

TRIGGER	THOUGHTS AND FEELINGS	BEHAVIOR	POSITIVE Results	NEGATIVE Results
(What sets me up to be more likely to use alcohol or drugs?)	(What was I thinking? What was I feeling? What did I tell myself?)	(What did I do then?)	(What good things happened?)	(What bad things happened?)

Brief Coaching,
Session 4,
Handout 1
(Engaging Replacement Activities)

Engaging Replacement Activities

Why?

- When we reduce immediate pleasure/reward it is important to replace it
- Both immediate PLEASURE type activities and more skill based MASTERY activities are needed
- Produces the same brain chemicals
- Taps into life passions and keeps us feeling better

WHAT types of immediate pleasure activities do you like to do?

Which are you willing to commit to doing this week?

WHAT types of skill based MASTERY activities would you like to do?

Which are you willing to commit to doing this week?

Brief Coaching,
Session 4,
Handout 2
(Enhancing Social Supports Reminder Sheet)

Enhanciing Social Supports Reminder Sheet

WHO might be able to support you? Consider people in the past who have been:

- Usually supportive, such as friends, family, acquaintances, or others in your community
- Usually neutral (aren't coming in with a bias against you)
- Not supportive, but might become supportive when they see your effort

WHAT types of support will be most helpful?

- Help with problem solving—someone good at thinking of options
- Moral support—offers encouragement and understanding
- Sharing the load—help with getting things done
- Information—about activities, transportation, getting a job, etc.
- Emergency help—-for small loans, needed items, a ride, etc.

HOW can you get the support or help you need?

- Ask for what you need. Be direct and specific.
- Add new supporters. As you work on something new, like trying to quit marijuana, you may need new or additional supporters.
- Lend your support to others. It allows you to get better at receiving support.
- Give your supporters feedback. Let them know when something is or isn't helping.

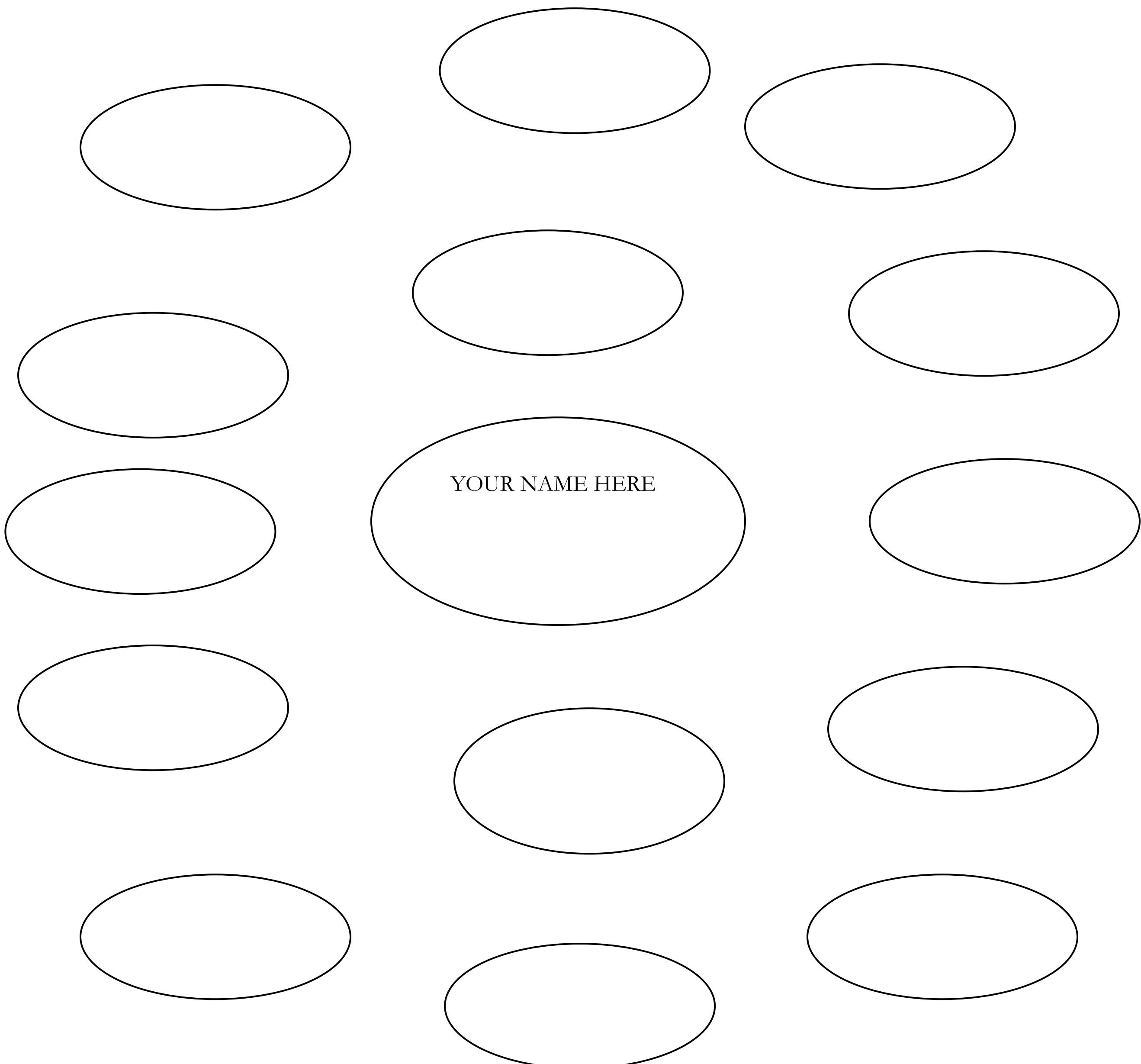
Adapted from Monti et al., 1989

Brief Coaching,
Session 4,
Handout 2
(Social Circle Diagram)

Social Circle Diagram

Use the grid below to diagram your own social support circle, focusing on those who could support you in addressing your alcohol or drug use issue.

Put your name in the center space, then fill in the names of those who do and/or could support you in your goal. Put the people who could be of greatest support to you closest to your space. Fill in as many of the spaces as you can.



Brief Coaching,
Session 4,
Handout 4
(Real Life Practice: Seeking and Giving Support)

Real Life Practice: Seeking and Giving Support

Think of a current problem/goal that you would like help with.

Describe the problem/goal:

Who might help you with this problem/goal?

What might he or she do to give you the support you'd like?

How can you get this support from him or her? Remember, be direct and specific:

Now, choose the right time and situation, and try to get this person to support you. Describe what happened:

Offer support to someone else.

Name a friend or family member who is currently having a problem and who could use more support from you:

Describe what you could do to lend him or her some support:

Now, choose an appropriate time and setting, and give support to this person.

Describe what happened:

Brief Coaching,
Session 4,
Handout 5
(Knowledge Is Power Form - Blank)

Knowledge Is Power Form

Why? – Helps us become aware of negative habits & the automatic patterns of thinking feeling and doing. Look at the example of how the self-monitoring record may look after the coach has helped the patient complete it while reviewing a recent episode of use:

What Happens Before and After I Use Alcohol and/or Drugs?

TRIGGER	THOUGHTS AND FEELINGS	BEHAVIOR	POSITIVE Results	NEGATIVE Results
(What sets me up to be more likely to use alcohol or drugs?)	(What was I thinking? What was I feeling? What did I tell myself?)	(What did I do then?)	(What good things happened?)	(What bad things happened?)

Brief Coaching,
Session 4,
Poster
(Enhancing One's Social Support Network)

Enhancing One's Social Support Network

Why?

- When people try to quit alcohol or drugs, support helps them succeed.
- People often don't have as much support as they would like.

Skill Guidelines

WHO might provide good support?

- Consider family, friends, acquaintances, others in your community.
- Someone who is usually supportive.
- Someone who is usually neutral.
- Someone who might become supportive.

WHAT kinds of support can you ask for?

- Help with problem solving.
- Information.
- Moral support.
- Sharing the load.
- Emergency help.

HOW can you get the support you need?

- Ask for what you need.
- Add new supporters.
- Lend your support to others.
- Give your supporters feedback.

Brief Coaching,
Session 5,
Handout 1
(Planning For High Risk and Setbacks)

Planning For High Risk and Setbacks

Why?

- Preparation for high risk increases good coping skills.
- Problem solving is a way to cope.
- Emergencies and setbacks are learning opportunities.

Types of Possible High Risk or Emergency Situation:

- An unanticipated substance trigger.
- Separation from an important person in your life.
- Work problems.
- Relationship problems.
- Adjustment to a new life situation or new responsibilities.

Skill Guidelines:

- Don’t let problems upset you
- Instead use the S.O.L.V.E. model
- Think things through.
- Cool down by:
    - Physical activity.
    - Doing something relaxing.
    - Media (music, book, magazine, TV, movies).
    - Something creative (writing, art, dance).
    - Ask or call someone for help

Brief Coaching,
Session 5,
Handout 2
(S.O.L.V.E.)

S.O.L.V.E.

Recognize we all have problems to solve. It is how we respond that matters most.

1. **S** = state and Identify the problem.
   Think: What is the problem?
2. **O** = Consider various options.
   Brainstorm approaches: What can I do?
3. **L** = Look ahead to the good and bad that may come out of each possible approach.
4. **V** = Vote: Choose one, and do it.
5. **E** = Evaluate the outcome: Did this work for me?

Brief Coaching,
Session 5,
Handout 3
(High Risk Safety Plan)

High Risk Safety Plan

Plan for:__________________________

Here are some possible high risk situations that I want to be prepared for:

If one of these situations happens, this is how I will help myself cope:

DO the following:

- Think things through.
- Cool down by: ____
- Distract myself with:
  - Physical activity. What kind? _____________________
  - Doing something relaxing. What? _________________
  - Media (music, book, magazine, TV, movies). Which?____
- Something creative (writing, art, dance). Which one(s)? ____
- Ask or call someone for help. Who?__________________

Helpful People

Who	Phone Number

DON'T DO the following:

- Drink alcohol, use drugs.
- Act without thinking.
- Get overemotional.
- Isolate myself and/or stay away from people who care about me.
- Stay in a high-risk situation.

If the high risk situation involves alcohol and/or drug use, the following steps will help me reduce/quit my use:

Brief Coaching,
Session5,
Handout 4
(Knowledge Is Power Form - Blank)

Knowledge Is Power Form

Why? – Helps us become aware of negative habits & the automatic patterns of thinking feeling and doing. Look at the example of how the self-monitoring record may look after the coach has helped the patient complete it while reviewing a recent episode of use:

What Happens Before and After I Use Alcohol and/or Drugs?

TRIGGER	THOUGHTS AND FEELINGS	BEHAVIOR	POSITIVE Results	NEGATIVE Results
(What sets me up to be more likely to use alcohol or drugs?)	(What was I thinking? What was I feeling? What did I tell myself?)	(What did I do then?)	(What good things happened?)	(What bad things happened?)

Brief Coaching,
Session 6,
Handout 1
(Continuous Health Management Plan)

Continuous Health Management Plan

Based on your Treatment Session Feedback Form and Re-Screening Report

We recommend the following:

Schedule appointments with:

MD –

Treatment Agency -

Follow-up with us -

We also recommend trying the following self-help:

AA NA Rational Recovery None

Level of Care Recommendations:

Self help Outpatient Intensive Outpatient Residential

Frequency: ____

Drug Fact Sheets

Alcohol

http://www.drugfree.org/Portal/drug_guide/Alcohol

http://www.collegedrinkingprevention.gov/

http://camy.org/factsheets/index.php?FactsheetID=29

http://pubs.niaaa.nih.gov/publications/FamilyHistory/famhist.htm

http://pubs.niaaa.nih.gov/publications/DrinkingPregnancy_HTML/pregnancy.htm

http://www.cdc.gov/ncbddd/factsheets/FAS.pdf

Understanding Drug Abuse

http://www.drugabuse.gov/infofacts/understand.html

http://www.drugabuse.gov/infofacts/treatmeth.html

http://www.drugabuse.gov/infofacts/DrugAbuse.html

http://www.drugabuse.gov/infofacts/driving.html

http://www.drugabuse.gov/DrugPages/DrugsofAbuse.html

Tobacco

http://www.drugabuse.gov/infofacts/tobacco.html

http://www.drugabuse.gov/DrugPages/Nicotine.html

Cocaine

http://www.drugabuse.gov/infofacts/cocaine.html

Marijuana

http://www.drugabuse.gov/infofacts/marijuana.html

http://www.drugabuse.gov/MarijBroch/Marijteens.html

http://www.drugabuse.gov/MarijBroch/MarijparentsN.html

Methamphetamine

http://www.drugabuse.gov/infofacts/methamphetamine.html

http://www.drugfree.org/Portal/drug_guide/Crystal_Meth

Club Drugs(GHB, Ketamine, and Rohypnol)

http://www.drugabuse.gov/infofacts/clubdrugs.html

Inhalants

http://www.drugabuse.gov/infofacts/inhalants.html

Prescription and Over-the-Counter Abuse

http://www.drugabuse.gov/infofacts/PainMed.html

http://www.drugfree.org/Files/rx_guide

http://www.drugabuse.gov/infofacts/ADHD.html

http://www.drugabuse.gov/drugpages/prescription.html

Hallucinogens – LSD, Peyote, Psilocybin, and PCP

http://www.drugabuse.gov/infofacts/hallucinogens.html

Heroin

http://www.drugabuse.gov/infofacts/heroin.html

Ecstasy

http://www.drugabuse.gov/infofacts/ecstasy.html

Steroids

http://www.drugabuse.gov/infofacts/steroids.html

2012

MOSBIRT **INTERVIEWER TRAINING MANUAL**

Rita E. Adkins, M.P.A.
MIMH

January 6, 2012

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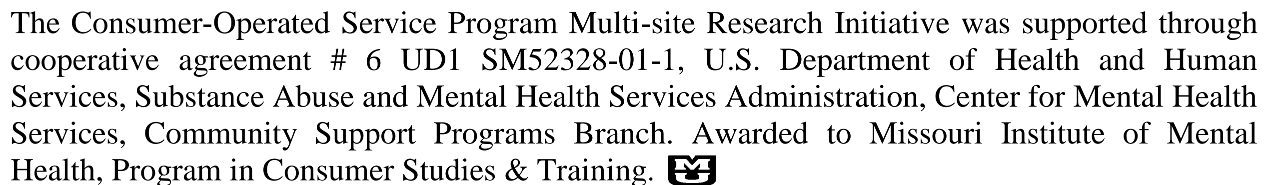
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Rita E. Adkins, M.P.A

Interviewer Training Manual

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STANDARD ABBREVIATIONS

AO…. "Are there any other reasons why you say so?"

DEF…Definition

DIG…Digression

DK…Don't Know

Iw…. Interview

Iwer…Interviewer

MTY… "Whatever ______ means to you" or "Whatever you think of as ______"

P. . . Probe

Q…. Question

R…. Respondent

RQ…. Repeat the question or part of the question

TM…. "Tell me more about that"

WC…. "Which would be closer to the way you feel?"

WM…. "Could you tell me what you mean by that?"

NANS…Don't Know

NASK…Not Asked/Skipped

1. Description of the Project

About the National SBIRT Program

I. An Early Intervention Approach

The SBIRT Initiative represents a paradigm shift in the provision of treatment for substance use and abuse. The services are different from, but designed to work in concert with, specialized or traditional treatment.

II. New Target Population

The primary focus of specialized treatment has been persons with more severe substance use or those who have met the criteria for a Substance Use Disorder. The SBIRT Initiative targets those with nondependent substance use and provides effective strategies for intervention prior to the need for more extensive or specialized treatment.

III. System for Assessment, Intervention, and Treatment

The Initiative involves implementation of a system within community and/or medical settings—including physician offices, hospitals, educational institutions, and mental health centers—that screens for and identifies individuals with or at-risk for substance use-related problems. Screening determines the severity of substance use and identifies the appropriate level of intervention. The system provides for brief intervention or brief treatment within the community setting or motivates and refers those identified as needing more extensive services than provided in the community setting to a specialist setting for assessment, diagnosis, and appropriate treatment.

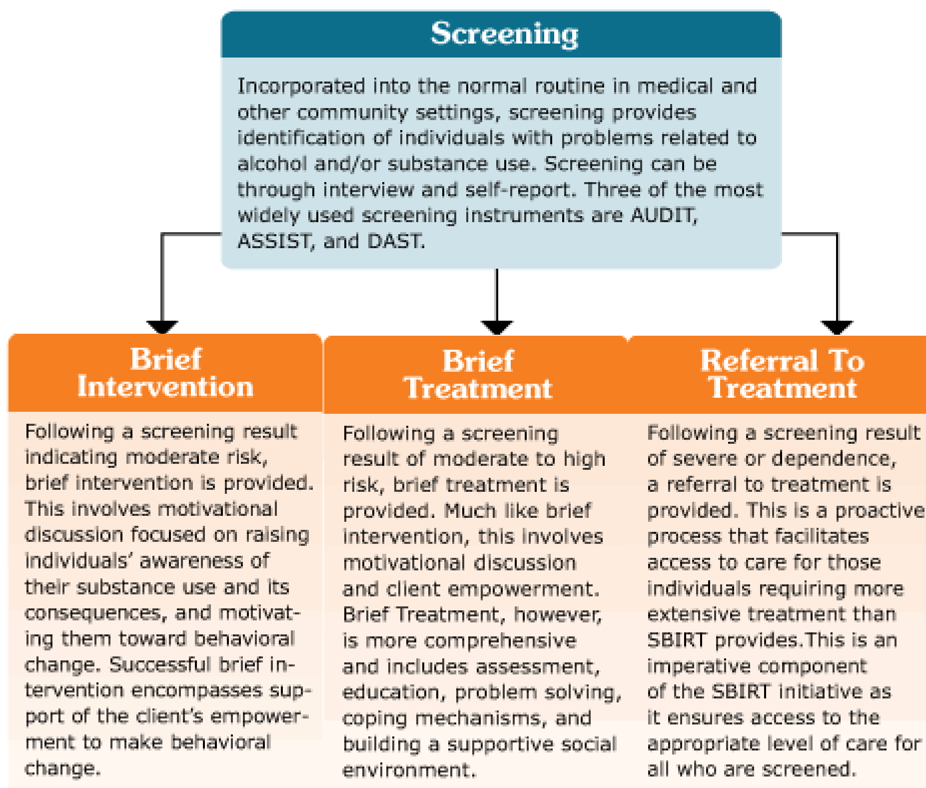
IV. Approach is Successful

As of August 2007, SBIRT grantees funded by SAMHSA have screened over 536,000 individuals. Through grantees efforts, researchers are learning how to integrate SBIRT into

primary care. Preliminary data suggest the approach is successful in modifying the consumption/use patterns of those who consume five or more alcoholic beverages in one sitting and those who use illegal substances. These grantees have implemented SBIRT in trauma centers/emergency rooms, community clinics, federally qualified health centers, and school clinics.

SBIRT Core Components

The theoretical framework and programmatic structure of SBIRT programs may vary, but the core components of SBIRT remain and can be defined as follows:



Source: http://sbirt.samhsa.gov/about.htm

About the MOSBIRT Program

The State of Missouri is home to an estimated 5.84 million people (U.S. Census Bureau, 2006). Of this number, the Missouri Division of Alcohol and Drug Abuse (ADA) estimates that

485,000 (or about 12% of Missouri residents) need treatment for alcohol or drug dependence or abuse. In FY 2007, ADA programs provided treatment services to 13.1% of individuals needing public sector treatment. Of the consumers served, 9,568 are Medicaid funded and 46,487 are non-Medicaid.

Many Missourians with potential alcohol and drug problems first present to medical settings. The number of alcohol and drug related hospitalizations and emergency department encounters in Missouri has steadily increased, with over 90,000 in 2005 (DMH, 2006). Additionally, in 2005, hospitalization and emergency department charges exceeded $120 million for those individuals (DMH, 2006). Yet even for these identified individuals, treatment may have consisted of little more than detoxification or care of alcohol-related injuries or other complications.

However, most of Missouri's ADA dollars are directed toward treatment. And by our treatment shortfall, it is clear the resources do not exist to provide extensive treatment to everyone who needs it. One attractive alternative is to invest more in community-based service delivery that addresses screening and early intervention, at key access points, such as the health care system. It is at these points of access where modest investments of resources could divert substantial numbers of potential clients from a pattern of worsening alcohol or drug abuse (Whitlock et al., 2004). We cannot afford to wait for individuals to develop full blown addiction problems before intervening.

Because of this, it would be strategic to fill this gap with an MOSBIRT screening system in facilities that see clients for their general health needs. Individuals in the general population, who have low or moderate drug or alcohol problems, can be identified early and, with a modest level of effort may be diverted from a path of increasing use or dependence.

Therefore, it is significant to understand the effectiveness of the MOSBIRT program, by examining 6-month follow-up outcome indicators. This outcome evaluation will be able to facilitate the consolidation and expansion of the Missouri SBIRT program.

Section 1 MOSBIRT Description

In September, 2008, the Substance Abuse and Mental Health Services Administration awarded funding to Missouri to provide the expanded capacity to identify individuals with substance abuse problems and intervene appropriately through a MOSBIRT program. Missouri's SBIRT project will build upon the work of previous grantees incorporating manualized evidence based practices into a tablet computer. Using this system, trained substance abuse professionals will conduct face-to-face screening of all individuals entering selected medical care facilities for signs of the misuse of prescription and illicit drugs, alcohol, and tobacco. Most screened patients will have no problems. Of those who do show troubling behaviors, our staff will provide evidence based direct services at the medical facility, either a one session brief intervention or 6 session brief treatment. For those who already show abuse or dependence, we will employ an evidence-based warm hand-off process to get them into a specialized substance abuse treatment program.

Over the five years of the project, the moneys provided will develop and demonstrate effective MOSBIRT processes in general and emergency medical settings. The project will screen over 80,000 Missourians, serving approximately 25,000 individuals with significant risk behaviors before they become addicted (indicated prevention) and make treatment referrals for more than 1,500.

Our MOSBIRT implementation will begin at an ER in Springfield, Missouri and other medical facilities in Columbia, Missouri and St. Louis, Missouri. These practices provide general medical care or emergency treatment to over 70,000 individuals each year.

Missouri's ADA Division will seek collaborative partners at the State and local levels to add this new service to the continuum of care. To sustain and expand these successful demonstrations, Missouri's Department of Mental Health will work with the Department of Social Services to define screening service codes in Medicaid to enable reimbursement. The Department will also work with the State legislature and other sources to fund additional MOSBIRT initiatives. Additionally, they will work with insurance companies to fund these services in emergency rooms.

Section 1 MOSBIRT Description

With this project, Missouri will fill a gap in our continuum of care, develop and showcase an effective MOSBIRT implementation, validate the impact of that demonstration on the health of individuals and the costs to society, and create an environment in which a sustainable MOSBIRT can spread across the state.

MOSBIRT Screening

Screening is a quick, simple way to identify patients who need further assessment or treatment for substance use disorders. It does not establish definitive information about diagnosis and possible treatment needs. The goal of MOSBIRT is to make screening for substance abuse a routine part of medical care.

Screening in a medical setting involves at least two components: biomarkers and patient reports. Biomarkers are objective evidence that an individual may abuse drugs. These can be a simple positive drug screen or physical indications of potential abuse (e.g., liver disease). Patient reports are based on questionnaires designed to get a "big picture" of the individual's substance use and to identify potential red flags. In the MOSBIRT project, we will be using patient reports through a short prescreen to determine individuals who do not meet DSM-IV criteria for addiction/dependence, but who are showing early danger signs, such as disturbances in life tasks or excessive consumption of alcohol and other drugs. This screening is performed using a brief questionnaire about the context, frequency and amount of alcohol, illicit drugs, tobacco and prescription drugs used by the patient. Based on the scores of the prescreen, the patient will either receive a pamphlet that describes early warning signs for excessive consumption of alcohol and other drugs and the life style changes to prevent addiction/dependence, a brief intervention, brief treatment or referral to treatment.

Brief Education

Brief education, or the brief intervention, is a single session of motivational discussion focused on increasing insight and awareness regarding substance use and motivation toward behavioral change. When the prescreen indicates a moderate problem, brief education, also

known as brief intervention, is a one session intervention designed to motivate the individual to do something about their substance use behaviors. This is accomplished using the FRAMES model:

- **F**eedback is given to the patient regarding personal risk or impairment.
- **R**esponsibility for change remains with the patient.
- **A**dvice to make a change is given by the provider.
- **M**enu of alternative changes options are provided.
- **E**mpathic conversational style is used, mostly through reflective listening.
- **S**elf-efficacy is supported and enhanced in the patient

Brief Coaching

When the prescreen indicates a moderate to high problem, brief coaching, or brief treatment is indicated to motivate the individual to do something about their use behavior. This is a six session intervention, either over the phone or face-to-face, using Motivational Enhancement Therapy (MET) or Cognitive Behavioral Therapy (CBT).

These six sessions are designed for:

- **Motivation Building**
- **Goal setting**
- **Triggers and refusal skills**
- **Enhancing support network**
- **Planning for emergencies and setbacks**
- **Review and close**

Referral and Treatment

When screening indicates a moderate to high problem – indicative of a substance use disorder – the patient is referred to a traditional treatment program. Referral to specialized treatment with a warm handoff is provided to those identified as needing more extensive

treatment than offered by the MOSBIRT program. The effectiveness of the referral process to specialty treatment is a strong measure of MOSBIRT success and involves a proactive and collaborative effort between MOSBIRT providers and those providing specialty treatment to ensure access to the appropriate level of care.

2. The Survey Process

In a typical survey procedure, there are a number of important steps that must be completed. These steps include the construction of the survey instrument or questionnaire, the testing and re-testing of the instrument, the collection of the data, the coding of the collected data, the analysis of the data, and preparation of the final report. In the MOSBIRT study we are focusing on the last 4 of these steps. As a health coach, you will be involved in collecting data from individuals who have been identified by a brief screening as having, or are at-risk for developing, a substance use-related problem.

The data are the answers given by the patients to the questions on the survey instrument, and we must interview each patient to obtain the answers. ***Interviewing skills are therefore a very important part of the process.*** The health coach must understand the purpose of the survey, know how to create a comfortable interview environment, how to ask the questions, how to record the answers, how to communicate with the evaluation coordinator, and how to keep track of the process from beginning to end.

The answers obtained from all of the patients will be grouped together for analysis so that the information reported in the results is about the group of answers, not about an individual. Because it is the group of answers that will be analyzed, it is important that the questions be asked of each person in the same way. This allows for the standardization of the instrument, and thus assures that each patient is asked the same question. For example, if you were to ask a sample of people how long they had been attending a specific treatment program, you would have to ask each person the same question. If you suddenly begin asking people how long they had been attending treatment programs in general, you would no longer be able to compare the answers.

We are concerned with maintaining the validity and reliability of the instrument. Validity is whether the questions being asked are really measures of what the researchers want to

know. Reliability refers to the consistency of the responses received, or whether the answers would be the same if the question were asked at a future time. If you change the meaning or the wording of the questions, the validity and reliability of the responses would also be affected thus making it very difficult to compare the responses. It is also important that the survey is completed as much as possible. Finally, you must maintain a neutral position while being able to clarify questions for a patient and probe for a response when information is unclear or incomplete. As an interviewer, your role is one of the most critical in the survey process. The quality of the data depends on you. You are a source of error when:

- **You do not read questions as worded:**
- **You probe directively**
- **You bias answers by the way you relate to patients**
- **You record answers inaccurately**
- **You assume an answer rather than asking the patient directly**

The following sets of instructions have been written to help you learn the skills you will need for the job.

3. Preparing for the Interview

A. Understand the Purpose of the Survey

It is important that you understand the purpose of the project and the survey process so that you can explain them to the patient as needed. Use the standardized explanations.

B. Practice

You will participate in practice interviews during the training period. Continue to practice reading the questions on your own, paying close attention to order. This will help you to ask questions smoothly and without hesitation during the interview. Practice also assures that questions are asked the same way for each patient. It will also be helpful to practice recording answers and making interviewer comment notes during the practice sessions.

C. Reserve Interview Location

The initial interviews will be held in the hospital exam rooms. Most of the follow-up interviews and additional brief coaching sessions will be held over the phone. However, if the individual does not have a phone, or wants to meet you to complete a survey, make sure ahead of time that a room or private space is available on the day and time of the interview. It is important to be sure of a quiet, private, comfortable place.

When scheduling face-to-face interviews with follow- up patients, attempt to ensure that the setting is in a safe place. Also, interviews in homes or apartments should be held in kitchens, living or dining rooms. If the patient lives in a single room, interviewers may want to

suggest that the interview take place in a restaurant or some other place, so long as the environment is quiet and comfortable for the patient.

D. Take Required Forms

Before each interview, prepare the questionnaire with the person's identification code number. Also have available all required documents, including the informed consent form, the lists of resources, and the evaluation director's business card.

E. Take Supplies

Prepare and take with you sharpened pencils, an eraser, a laptop computer, a watch, a box of tissues, and an envelope for the completed satisfaction survey.

F. Prepare Yourself

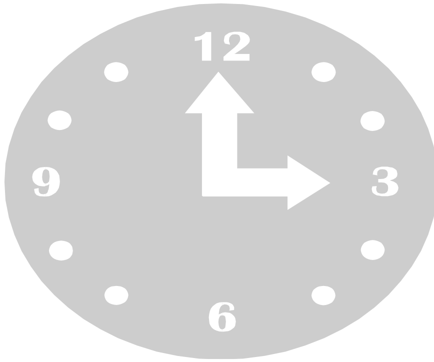
While it may not be possible to know every person you interview well, it is possible to know yourself well. It is important to understand that the beliefs and values of your own culture affect how you perceive and relate to people who appear to be or are in fact different than you. Self-awareness is crucial in order to ensure that you are doing all you can do to be open minded and productive for your interview. The first step to being open-minded is to recognize your own values, biases, and stereotypes in terms of gender, disability, social class, religion, race, ethnicity and cultural background. Be aware that the patient may have many things in common with you or very little in common with you. In either case, every effort must be taken not to presume anything about him or her that you do not know to be a fact.

It is important to accommodate any special needs the patient may have. Therefore, it may be important to know the patient's mode of transportation, basic demographics, language skills, physical disabilities (including mobility, auditory or visual).

G. Create a Favorable Environment

When the patient answers the phone, arrives, or as you enter the exam room, introduce yourself and ask them if this is still a good time for the interview. Although developing a cordial and welcoming atmosphere is important, be careful not to make assumptions about the patient's comfort level. It is possible that patients may fear that information they reveal in the interview may threaten their access to services. Because of this, the patient may try to second-guess what information the health coach is looking for. Breaking down the barriers between patient and health coach in the first interview may help to facilitate a more collaborative relationship in the future.

Always begin by addressing the patient by his/her formal name (such as Mr. Jones, or Ms. Fowler) and then ask him/her what he/she would like you to call them. If you are meeting them face-to-face, you should be seated facing one another, as this position allows each of you to see the other's facial expression and maximizes the ability to hear both questions and answers. You will need to arrange beforehand for a table or hard surface upon which you will place the questionnaire, forms, laptop, supplies, and code cards that you will use with the questionnaire. The patient does not need to see the questionnaire, but he/she needs to be close enough to see the code cards when you display them. After the patient has been seated,



give him/her a few minutes to get comfortable. Thank him/her for coming and spend a few minutes in small talk until you both feel comfortable with starting the interview.

Health coaches should maintain a professional and courteous manner at all times. Health coaches should not smoke during the interview, even if the patient smokes. Also, health coaches should not drink alcoholic beverages before or during the interview.

If the patient does not arrive/answer the phone at the scheduled time, then follow the 15-minute rule. This means you should wait for the patient until 15 minutes after the scheduled interview time. After 15 minutes have passed, you can try to contact the person. After contacting the patient, explain to him/her that the scheduled interview time was missed and that you would like to reschedule. If the patient shows up as you are leaving, you should explain to the patient that he/she was 15 minutes late. It is important to avoid rescheduling. Make an effort to conduct the interview even if the patient is late. Reschedule only if necessary.

It is possible that the patient may bring a friend or guest to a face-to-face interview. In some cultures, it is customary for any professional visit to be conducted in the presence of family or friends. However, the confidentiality procedures strictly prohibit the interview being conducted with more than one patient at a time. The patient may not be completely honest when answering questions if a person other than the health coach is present during the interview. It is also important to make it clear to the patient that in order for the interviews to be considered standardized, they must be conducted in as similar manner as possible. For this reason, if the patient were to have a guest present, it would compromise the comparability of the interview.

Therefore, it may be necessary to make special accommodations outside of the interview area for the patient’s guest. If the patient has questions about this guideline, refer his/her questions to the Evaluation Coordinator.

H. Review the Information for Informed Consent and Confidentiality

Before asking the interview questions, take time to explain once again the purpose of the survey and how the information will be used. Go over the standardized responses, including:

- **Who is sponsoring the health initiative and conducting the study?**
- **How you got the patients name**
- **How you will use the patient’s answers**
- **How the patient will be compensated for their time for a follow-up**
- **Why the patient’s participation is important**

Go over the issue of confidentiality. Review the procedures that will be used to ensure the confidentiality of the patient’s identity and of the information recorded on the questionnaire. It may be reassuring to the patient to know what information the health coach does or does not have regarding personal information. Remind the patients that they may stop participating in the survey at any time.

I. Present the Instructions about the Interview Format:

You will need to explain the format of the interview, covering the following items:

- **Length of the interview**
- **How questions will be read and a selection of possible answers on a card will be presented**

- **How answers will be recorded on a paper questionnaire or a laptop computer**

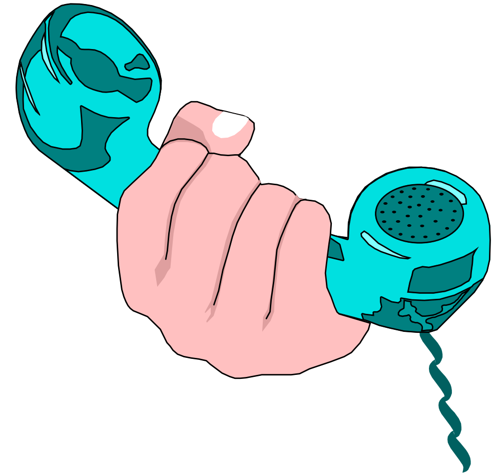
You are now ready to begin asking the survey questions!

4. First Contact

Your introduction is crucial when trying to obtain participants in a project. It is therefore important that you prepare the introduction in advance, and to practice several times before contacting people. It is important to remember that successful introductions take planning, and practice, and that although the introductions may seem difficult at first, they will become easier with time. The following points should be observed with each introduction:

- Immediately give your name and the title of the project/organization with which you are affiliated.
- Provide a brief summary of the project that is non-specific, and does not contain statements that may introduce bias into the study at a later time. (For example: Do not specify that some of your questions are about work and employment.)
- Do not ask questions that may elicit an undesired response. (For example: Are you too busy to answer some questions?)
- Assume that the patient is willing to do the interview and you are trying to find a convenient time.
- Be sure to ask the patient if she or he has any needs for accessibility accommodations, such as Braille or large print materials, wheelchair access, or a sign language interpreter.
- Remind the patients about confidentiality and informed consent procedure.
- Respect the patient’s right to say “No.”

A. Keeping Track of Contacts



You will use the computer database to keep track of your contact attempts for each person. On a periodic basis, you will notify the evaluation coordinator of all of your contact attempts. When you are able to contact the person, please use the following script:

Contact Script

Interviewer: Hello, my name is _________. I am an interviewer with the Missouri Initiative to Promote Healthy Lifestyles, a study that is sponsored by the Missouri Institute of Mental Health. You recently spoke with our staff about the project and indicated that you wanted to participate. I am calling to set up a date and time for an interview with you. Is this a good time to talk? **(If patient says: "Yes," continue with next section)**

Thank you. Your participation is very important for the success of this project. Let me remind you that you will be paid for your time. Now, we need to set a date and a time. I have the following dates and times open (read your list of dates and times). Which of these times work for you? (Decide on a date and time) We appreciate your cooperation and I look forward to talking with you on (date and time).

(If patient says no): What would be a more convenient time to call in the next day or two? Let me remind you that you will be paid for the time you spend being interviewed. (Decide on

date and time for call back) Or, if the patient would feel more comfortable, offer him/her the opportunity to call the health coach when he/she felt ready to schedule the interview.

It is important for patients to understand what is expected of them. It is your responsibility to double-check the date and time of the interview and to explain to the patient how the interview will be conducted. In addition, remind the patient that the interview is confidential, and for that reason it is important not to bring family or friends.

Once the appointment date and time have been decided, record this information on your contact sheet.

B. Handling Refusals

If the person does not seem willing to meet with you to do the interview, never pressure the person. In some cases, however, the person may hesitate or decline when more information or reassurance from you is needed. You may then use one of the following possible responses in asking for his/her participation:

Possible Responses to Refusal Attempts

Too busy We appreciate your time and will pay you for it. Sorry to have caught you at a bad time. I would be happy to call back. When would be a good time to call in the next day or two?

Feel inadequate The questions are not at all difficult. There are no right or wrong answers. We are concerned about how you feel rather than how

	much you know about certain things. These are questions about your health, your daily living situation, and your substance use history.
Not interested	It's very important that we get the opinions of everyone. Otherwise, the results won't be very useful. So, I'd really like to talk with you. Your input is valuable to us and we need your help.
No one's business	I can certainly understand. That's why all of our interviews are confidential. Protecting people's privacy is one of our major concerns, so we do not put people's names on the interview forms. All the results are reported in such a way that no individual can be linked with any answer.

C. Following Confidentiality Procedures

Confidentiality means that the patient's name and identifying information (such as phone number or address), as well as the information supplied by the patient during the interview, are to be kept private. Therefore, you must never share names or information with anyone else, discuss individual responses, or show the questionnaire results to another person. During debriefing meetings, you need to discuss the interview process and any problems you may have experienced; however, you may not refer to a patient by name or use other identifying information.

Although you will use the person's name and telephone number to make the contact and set up the appointment, these will not appear on the questionnaire. Instead, an identification

number will be used. It will be your responsibility to reassure the patient that their identity and answers to the questions will be kept confidential, and grouped with other responses for analysis.

The completed questionnaires will be kept in a locked file cabinet in the health coach's office. OR the questionnaire information entered in the laptop will be encrypted for confidentiality and transmitted by email. Once the data collection has been completed, the finished materials will be stored in locked file cabinets at MIMH for data analysis.

D. Informed Consent

A standard request for informed consent will be conducted prior to each interview. At the beginning of each interview, you will also review the purpose of the MOSBIRT, tell them why you are asking them to answer questions, and remind them that they are free to withdraw their consent and participation at any time. Then you will ask the patient to read the brief informed consent statement included in the introduction and sign it.

You cannot begin an interview until this form has been signed. Instruct the patient that this form will be kept confidential and in a locked file. You will turn in the forms to the evaluation coordinator after completion of the interview. Some patients may decline to sign the consent form. If this should occur, use the responses to refusals (see IIIB). If the patient refuses to sign the consent form, do not conduct the interview and notify the site coordinator.

E. Using Standardized Responses

To prevent bias, there are some explanations that must be stated in the same way for each patient and there will be questions from patients that must be answered in the same way. The following list of standardized responses has been prepared for your use in such situations:

(1) What is the purpose of this health initiative?

Your doctor and other doctors here participate in the Missouri Initiative to Promote Healthy Lifestyles health project because they think your health habits are important to your overall health. The questions I'm going to ask will focus on a variety of issues that could affect your lifestyle and how it may impact your health.

2) What agencies are doing the health initiative?

This health initiative is sponsored by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the Missouri Department of Mental Health and is coordinated by the Missouri Institute of Mental Health. Our work is funded by a grant, so all of the services are free of charge to you and your insurance company.

(3) Why is this health initiative important/needed?

This health initiative is needed to learn about your level of success with healthy behaviors. It is very important that we get the opinions of everyone in order to get useful results. Your input is valuable to us and we need your help to learn what helps folks have long-term success with their healthy behaviors.

(4) How will the results be used?

The results of this health initiative will be used to help policy makers decide how to improve services to help people maintain a healthy lifestyle.

5. Being Culturally Competent

The MOSBIRT project is committed to conducting interviews in a manner that is culturally sensitive to the patient. By this we mean that at all times throughout the interview process, the health coach must maintain a high level of self-awareness to minimize inserting his/her own views, beliefs, values and biases. The health coach must take into account and demonstrate respect for the patient's race, ethnicity, gender, age, sexual preference, literacy level, physical and mental abilities, social class, and cultural background during any interaction.

A. Disability Etiquette

Basic Guidelines

- Make reference to the person first then the disability. Say "a person with a disability" rather than a "disabled person". However, the latter is acceptable in the interest of conserving print space or saving announcing time.
- The term "handicapped" comes from the image of a person standing on the corner with a cap in hand, begging for money. People with disabilities do not want to be the recipients of charity or pity. A disability is a functional limitation that interferes with a person's ability to walk, hear, talk, learn, etc. Use "handicap" to describe a situation or barrier imposed by society, the environment or oneself.
- If the disability isn't germane to the story or conversation, don't mention it.
- Remember, a person who has a disability isn't necessarily chronically sick or unhealthy. He or she is often just disabled.
- A person is not a condition, so avoid describing a person as such. Don't present someone as "an epileptic" or "a post polio". Instead, say "a person with epilepsy" or "a person who has had polio".

Common Courtesies

- Don't feel obliged to act as a caregiver to people with disabilities. Offer assistance, but **wait** until your offer is accepted **before** you help. Listen to any instructions the person may give.

- Leaning on a person's wheelchair is similar to hanging on a person. It is considered annoying and rude. The chair is a part of one's personal body space. Don't hang on it!

- Share the same social courtesies with people with disabilities that you would share with someone else. If you shake hands with people you meet, offer your hand to everyone you meet, regardless of disability. If the person is unable to shake your hand, he or she will tell you.

- When offering assistance to a person with a visual impairment, allow that person to take your arm. This will enable you to guide, rather than propel or lead the person. Use specific directions, such as "left one-hundred feet" or "right two yards", when directing a person with a visual impairment.

- When planning events that involve persons with disabilities, consider their needs before choosing a location. Even if people with disabilities will not attend, select an accessible spot. You wouldn't think of holding an event where other minorities could not attend, so don't exclude people with disabilities.

Conversation

- When speaking about people with disabilities, emphasize achievements, abilities and individual qualities. Portray them as they are in real life: as parents, employees, business owners, etc.

- When talking to a person who has a physical disability, speak directly to that person, not through a companion. For people who communicate through sign language, speak to them, not the interpreter.

- Relax. Don't be embarrassed if you use common expressions such as "See ya later" or "Gotta run".

- To get the attention of a person who has a hearing loss, tap him/her on the shoulder or wave. Look directly at the person and speak clearly, slowly and expressively to establish if he/she reads lips. Not all people with hearing loss can read lips. Those who do rely on facial expressions and body language for understanding. Stay in the light and keep food, hands and other objects away from your mouth. Shouting won't help. Written notes will. Use an interpreter if possible.

- When talking to a person in a wheelchair for more than a few minutes, place yourself at eye level with that person. This will spare both of you a sore neck.

- When greeting a person with a severe loss of vision, always identify yourself and others. For example, say "On my right is John Smith." Remember to identify persons to whom you are speaking. Speak in a normal tone of voice and indicate when the conversation is over. Let him/her know when you move from on place to another.

B. Terminology

Acceptable Terms	Unacceptable Terms
Able-bodied; able to walk, see, hear, and so forth; people who are not disabled.	Healthy, when used to contrast with "disabled." Healthy implies that the person with a disability is unhealthy. Many people with disabilities have excellent health.
People who do not have a disability.	Normal. When used as the opposite of disabled, this implies that the person is abnormal. No one wants to be labeled as abnormal.
Person who has/ person with (e.g. person who has cerebral palsy)	Victim/afflicted with/Suffers from (e.g. victim of cerebral palsy) Most people with disabilities do not regard themselves as afflicted or suffering continually. Afflicted: a disability is not an affliction.
Person with a disability/ disabled	Cripple, cripples—the image conveyed is of a twisted, deformed, useless body.
Disability, a general term used for functional limitation that interferes with a person's ability, for example, to walk, hear or lift. It may refer to a physical, mental, or sensory condition.	Handicap, handicapped person or handicapped.
Uses a wheelchair	Restricted, confined to a wheelchair/ wheelchair bound (The chair enables mobility. Without the chair, the person is confined to bed.)
People with cerebral palsy, people with spinal cord injuries.	People with cerebral palsy, people with spinal cord injuries.
Person who had a spinal cord injury, polio, a stroke, and so forth or a person who has multiple sclerosis, muscular dystrophy, arthritis, and so forth.	Victim. People with disabilities do not like to be perceived as victims for the rest of their lives, long after any victimization has occurred.
Has a disability; has a condition of *(name of disability)*, or born without legs, and so forth.	Defective, defect, deformed, vegetable. These words are offensive, dehumanizing, degrading, and stigmatizing.
Deafness/hearing impairment. Deafness refers to a person who has a total loss of hearing. Hearing impairment refers to a person who has a partial loss of hearing within a range from slight to severe. Hard of hearing describes a hearing-impaired person who communicates through speaking and speech-reading, and who usually has listening and hearing abilities adequate for ordinary telephone communication. Many hard of hearing individuals use a hearing aid.	Deaf mute/ deaf and dumb. Deaf and Dumb is as bad as it sounds. The inability to hear or speak does not indicate intelligence.
Person who has a mental or developmental disability/Psychiatric history/ psychiatric disability/ emotional disorder/ mental illness	Crazy, insane, lunatic, mental patient, wacko, the mentally ill, SMI, retarded, moron, imbecile, idiot. These are offensive to people who bear the label.
Epilepsy/seizures	Fits

Source: http://www.stcsig.org/sn/acceptable_terms.shtml

Other preferred terminology:

- Blind (no visual capability)
- Legally blind/ low vision (some visual capability)
- Hearing loss/ hard of hearing (some hearing capability)
- Hemiplegia (paralysis of one side of the body)
- Paraplegia (loss of function in lower body only)
- Quadriplegia (paralysis of both arms and legs)
- Residual limb (post amputation of a limb)

If you are interviewing a person with a hearing loss, remember the following:

- Make sure the patient always has a clear and direct view of your face while you are talking.
- When communicating through an interpreter, always look at the patient, not at the interpreter.
- Speak with a normal voice, neither shouting nor whispering is appropriate.

If you are interviewing a person with a visual impairment, remember the following:

- Speak in a normal manner. Unless you have learned that the person also has a hearing loss, you can take for granted that she or he hears everything quite well.
- Read absolutely everything, that is, do not rely on visual information.
- If other people enter into the room, always verbally describe what is going on, and who is entering.

If you are interviewing a person with a physical disability, such a person who uses a wheelchair, remember the following:

- Do not use insensitive language, such as “confined to a wheel chair” or a “victim of polio.”
- Do not hesitate to shake the person’s hand, even though it might be a “hook” or the hand may be paralyzed.
- Do not express “too much sympathy” for the person, it will be perceived as pity.

6. Asking the Questions

As a health coach, you must be aware of everything that is going on during the question and answer process. While interviewing, it is important to keep in mind the three goals of standardization:

1. ***Each patient is exposed to the same question experience.***
2. ***All answers are recorded in the same manner.***
3. ***Any differences in answers should be directly attributable to differences between patients, NOT to differences in the process that produced that answer.***

The following information should be used as a guideline to help you to recognize potential problems during the interview.

A. Interviewer Effects:

The health coach can influence the patient's answers consciously or unconsciously through the use of verbal and non-verbal cues. You must avoid interjecting your own expectations, values and experiences that could lead the patient to provide biased answers. Respect the patient's personality, customs, and cultural background and do not impose your own beliefs, values, and interpretations on the patient. It is important to note that the

To avoid creating interviewer effects, *do not*:

- **Offer your own opinion during the interview**
- **Display approval or disapproval through your tone of voice, facial expression, or side comments**
- **Discuss your own experiences with the patient**
- **Read the questions using your own words instead of those written on the questionnaire**

questionnaire is filled with personal questions that may draw the patient closer to you if he/she feels comfortable and gains a level of trust. Be careful to respect that confidence without becoming over-familiar.

Always maintain a neutral approach and do not distort the wording of questions or instruction guidelines. If a patient tells you about a painful experience to which you relate, do not share your own experience with them. Instead, you may say, "I am sorry that happened to you," or "That must have been a difficult time for you," or you may offer a contact name and telephone number from the resources list provided to you. Be careful not to over-estimate how comfortable the patient is with you and/or the material.

Examples

The following examples show situations in which you could influence the patient:

A questions reads: What is your profession?"

The Health coach asks, "What is your current job?" A teacher by profession might be currently working in a grocery store because of a teacher's strike and would answer the first question "teacher" and the second "grocery store clerk." The correct response is lost, and what's worse, those who interpret the data will never know it unless a supervisor has observed the interview.

A question reads "How did you find out about our program?" with Interviewer instructions, "Do not read response options."

The health coach does not read the whole list of options out loud but begins offering some of them when the patient hesitates. The patient was about to say she was told about the program by a friend, but when the Health coach suggests a TV commercial, she says, “Oh, maybe I did see one.” She does not go on to say that her friend’s recommendation is what most motivated her to look into the program. The correct response has again been lost.

A question reads, “What is your opinion of how well the President is doing his job?”

Although the health coach’s probing instructions are to remain neutral, to say “un-huh” and “please continue” to get a complete response, when the patient says he is happy with the President’s performance, the Health coach chuckles and asks, “Well, what about that illegal arms deal incident?” The chuckle tells the patient that the Health coach disagrees with him or her, and the question about the arms deal takes the patient in a direction he would not have chosen if left to respond on his/her own.

(From Frey and Oishi, *How to Conduct Interviews by Telephone and In Person,* Sage, 1995, p. 34)

B. Listening Skills

In this context, listening involves two important aspects. First, by listening attentively to the patient you will be able to probe for more information when necessary and be sensitive to the patient’s level of comfort or discomfort with the question. Second, you must be able to hear and understand the patient’s answer to record it correctly on the questionnaire. The best conditions for active listening include a state of “relaxed concentration” during which the

health coach is listening to the patient, watching the patient's face and body language, and trying to understand the patient's ideas.

Although it is important to focus your attention on the patient, it is also important not to overdo it. In listening intently, there is no need to stare unblinkingly at the patient to establish interest in what the person is saying. In fact that is more likely to increase nervousness, especially in areas of the questionnaire that may be sensitive for the patient. Instead, tilting of the head towards the patient indicates extra interest without being an intense, prolonged stare that adds tension.

C. Body Language/Non-verbal Cues:

As a health coach asking the questions, you must be aware of your own and the patient's physical expressions. Non-verbal cues can be conveyed through facial expressions, posture, and hand and foot movements. Slouching in the chair, resting your head on a hand, tapping your fingers, shaking your foot, playing with a pencil, or other object, yawning, fidgeting, or staring may all signal lack of interest in, anxiety about, or frustration with the interview process. Other body signals may indicate different emotional reactions, including sadness, anger, or confusion.

Observe the patient's body language when he or she first enters the room and during the course of the interview. If the body language changes and there are obvious prolonged signs of distress during the interview, you may need to offer the patient a short break to get a drink, go to the restroom, or walk about. Also be tuned-in to your own body language. You may be unintentionally telling the patient you are bored, uninterested, or impatient, and this could affect his or her attitude and answers.

D. Reading the Questions:

When beginning an interview, you should reassure the patient that there are no wrong or right answers.

As an interviewer you must:

- Read questions exactly as they are worded in the questionnaire.
- Read questions in the order in which they are presented on the questionnaire.
- Ask every question on the questionnaire (unless there are skip instructions). After reading the question, listen quietly and patiently for the response. Do not interrupt or make a comment before the patient has completed an answer.
- Read questions with no additions, deletions, or substitutions.
- Read each question slowly at about two words per second.
- Use a tone of voice that conveys assurance, interest, and a professional manner that is neutral and non-judgmental.
- Emphasize underlined words to enhance meaning.
- Remember that bolded words are interviewer instructions that are not to be read aloud.

Do not attempt to re-word or explain a question. If the patient does not understand, repeat the question slowly. Be careful not to over-enunciate to patients who are

racially/ethnically diverse or have a physical/sensory disability. It is important to be sensitive to the needs of patients who speak English as a second language, elderly patients and those with visual or auditory disabilities. You can also use the standardized definitions presented with the questionnaire (see Section IV). If they continue to ask what it means, reply, “Whatever it means to you (MTY).”

In addition, it is important to be aware of socially and personally sensitive questions such as those pertaining to sexual orientation, sexually transmitted disease, homelessness and trauma. Patients may feel comfortable giving only certain facts, making it necessary for you to ask a neutral probe or pause to encourage the patient to comment further.

Sometimes a patient will want to answer a question before you have finished reading it. It is crucial that the patient hear the entire question before answering. If the patient interrupts, you must continue reading the question. This allows the patient to hear the entire question and it also discourages future interruptions.

Good timing is critical to the interview, as it facilitates communication between you and the patient. If the health coach gives directions and asks questions too quickly, this will indicate to the patient that they should give answers quickly, rather than taking time to give thoughtful answers. During the interview, ask yourself the following questions:

- *Did I just hear what he/she said? Can she/he tell that I heard?*

- *Is this question making him/her uncomfortable? Does she/he need a moment/tissue/break before I ask, "Shall I move on to the next question? Or would you like another minute before I continue?"*
- *Am I reading into the question, and putting my own views in my tone of voice? Am I reading into his/her answer?*

Don't skip a question because the answer was given earlier or because you "know" the answer. In those situations in which the patient has already provided information that probably answers the next question, you may preface the question with some combination of the following phrases:

- "I know we've talked about this,"--or—" I know you just mentioned this, but I need to ask each question as it appears in the questionnaire."
- "You have already touched on this, but let me ask you…"
- "You've told me something about this, and this next question asks…"

Do not direct the patient toward an answer or assume that an "answer" you got in passing is the correct answer to a specific question at a particular point in the interview. Do not direct the patient by mentioning an earlier answer. When asked to repeat one response option, repeat all options given. If an answer is different from the one you expect, do not remind the patient of an earlier remark or try to force consistency.

When the patient does not understand the question, there are three types of clarifications:

- Repeat the entire question (or part of the question **only** if you are sure which part of the question is misunderstood).
- Use clarifications or definitions specified in the Question by Question guide.
- Use of phrase like "whatever ______ means to you" when the information requested is not covered in the Question by Question Guide.

Do not react to responses—either in a positive or negative fashion. This will minimize the patients' sense that the health coach is judging them. In turn, this will increase the likelihood that the patient will provide accurate responses, as opposed to socially desirable responses.

Finally, remember that although you may have read these questions many times, the patient is hearing them for the first time and needs time to understand the questions in order to decide on the answers.

E. Using Interview Probes:

There may be situations in which the response to the question is unclear, incomplete, or not related to the question. Some patients may frequently reply that they "don't know" the answer. In these situations, you can use an interviewing technique known as the "probe". Here are examples of probes that are permitted in an interview:

- **Show Interest**. An expression of interest and understanding, such as "uh-huh, "I see," or "yes," conveys the message that the response has been heard and more is expected.
- **Pause**. Silence can tell a patient that you are waiting to hear more.
- **Repeat the question**. This can help a patient who has not understood, who has misinterpreted, or who has strayed from the question.

- ✪ **Repeat the Reply**. This can stimulate the patient to say more, or to recognize an inaccuracy.
- ✪ **Ask a Neutral question.** "Can you tell me more about that?"
- ✪ **For Clarification**: "What do you mean exactly?" "Could you please explain that?"
- ✪ **For Specificity**: "Could you be more specific about that?"
  "Tell me about that. What, who, how, why?"
- ✪ **For Relevance**: "I see. Well, let me ask you again." (repeat question as written)

(From Frey and Oishi, *How to Conduct Interviews by Telephone and in Person*, Sage, 1995, pp. 123-124)

The probe is used to obtain more information, but please remember that probing must not bias the patient's answer. Avoid directive probes, that is any probe that requires a yes or no answer. For instance, if the patient answers "sometimes", or gives any other response which is other than yes or no, ask them whether their response would be closer to "yes" or closer to "no". Do not say "Do you mean yes?". Be careful not to answer for the patient by probing them to elicit a specific answer.

PROBE ABBREVIATIONS

Repeat question
Repeat Frame of Reference (RQ)
Repeat Choices

Whatever ______ means to you (MTY)
Whatever you think of as _________________

What do you mean? (WM)
How do you mean?

Would you tell me more about your thinking on that? (TM)
Would you tell me what you have in mind?

What do you think? (WT)
What do you expect?

Which would be closer to the way you feel? (WC)

Are there any other reasons why you feel that way? (AO)

NEUTRAL PREFACES TO PROBES THAT SHOULD NOT BE RECORDED:

- **Overall… Yes,**
- **Of course no one knows for sure…**
- **Of course there are no right or wrong answers…**
- **Generally speaking…**
- **Well, in general…**
- **In the country as a whole…**
- **We all hope, but…**
- **We're just interested in what you think…**
- **Let me repeat the question…**

Use of Probes

It is important to read the questions slowly, pausing when necessary to allow the patient time to provide complete and accurate responses. At first it may be difficult to know when to repeat questions or how long to pause, but this will become easier with practice. Repeat the entire question if the patient indicates that s/he did not understand it. In contrast to those who are not providing enough information, there may be a patient who talks excessively or rambles in their replies. You will have to remind them that it is important to complete the interview in the given time. You may also have to refocus some patients by saying "Let me make sure I have this down right" and repeating the answer to bring them back to the survey process.

What about the patient who gives an "I don't know" answer?

Consider what s/he might really mean.

- Patient doesn't understand the question but doesn't want to admit it.
- Patient is thinking about his/her answer and is filling the silence.
- Patient doesn't want to answer the question.
- Patient really doesn't know or doesn't have an opinion on the subject.

Remember: You should probe a "don't know" response at least once.

The most effective probe for a "don't know" is to repeat the question (RQ) or pause.

F. Displaying the Scale Cards

There are a number of questions on the survey form that have more than four or five responses. It would be too difficult for the patient to remember all of the choices. For this type of question, a scale card is supplied with the reply choices listed on it. Each of these questions will tell you which scale card to use. Before you read the question, hand the card to the patient. Read the question, ask the patient to look at the code card as you read the responses, and ask the patient to choose one answer from the list. You will use a code packet, so that you can flip to the appropriate card to display to the patient.

G. Answering Questions from the Patient

During the interview, the patient may have questions about the purpose of the survey, the meaning of the questions, or about you as the health coach. Remember that you must try to keep the answers to the questions as standardized and unbiased as possible. For that reason, you must not engage in a general conversation or lengthy explanations. For questions regarding the survey process, use the standardized replies provided on page 26. Do not answer personal questions. You can say something like, “I’m sorry, I can’t answer personal questions, but I’d be happy to answer any questions you have about the interview.” It is important not to give

personal information to the patient, because you will be conducting other interviews in this setting and may also be doing a re-test interview.

Other key phrases that may be used when the patient asks for more information include:

- ***"This is all the information available to us."***
- ***"We would like you to answer the question in terms of the way it is stated."***
- ***"Could I read it again for you?"***
- ***"I'm sorry, I don't have that information."***
- ***"I will write on the questionnaire the qualifications to your answer that you have just mentioned."***

If the patient still requires more information, instruct them to contact the project director. (From Frey and Oishi, *How to Conduct Interviews by Telephone and in Person*, Sage, 1995, p. 134)

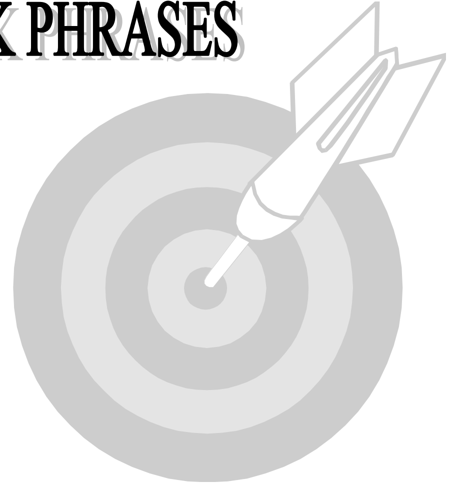
H.Feedback:

Feedback consists of statements or actions that indicate to the patient that s/he is successfully answering your questions, and encourages appropriate behavior and responses for future questions. Feedback should not be confused with interviewer effects. Giving the patient feedback does not lead anyone to answer in a specific way, but rather it indicates to the patient that the answers they are providing are appropriate for the questionnaire. You must decide when and how to give feedback to the patient. Patients who exhibit appropriate behavior will listen to the entire question before beginning to respond, give serious and clear answers, and stay on task when answering a question and avoid digression to unrelated stories or topics. If a patient interrupts your questions, offers partial or unclear answers, or answers each question with a story, this is inappropriate and you should use probes or neutral non-verbal techniques to encourage more appropriate responses.

Since you are interviewing in person, you will have the opportunity to use non-verbal feedback. “Small talk” before beginning an interview may help to establish trust between you and the patient. Once the interview has begun, a smile, or eye contact will acknowledge the patient’s answer and encourage similar responses. However, non-verbal feedback must be used carefully in order to encourage appropriate behavior or discourage inappropriate behavior. For example, if a patient refuses to answer a question or strays from the topic, you must not smile or nod your head. If this should occur, use probing techniques or ask the patient a neutral question. However, please remember that while it is important for the health coach to be

objective when asking the questions, it is essential that they don't come across as cold. Interviewers should be both professional and friendly, but this balance can only be achieved through practice.

FEEDBACK PHRASES



Long

- That's useful/helpful information.
- It's useful to get your ideas on this.
- Thanks, it's important to get your opinion on that.
- I see, that's helpful to know.
- It's important to find out what people think about this.
- That's useful for our research.

Short

- I see…
- Uh-huh/Um-hmm.
- Uh-huh, I see.
- Um-hmm, I see.
- Thank you.
- Thanks.

Interviewer Task-Related Comments

- Let me get that down.
- I need to write it all down.
- I want to make sure I have that right (repeat answer)
- We have touched on this before, but I need to ask every question in the order that it appears in the questionnaire.

For further clarification on feedback, read the following examples and then examine the page of Feedback responses:

Example #1:

Interviewer: Do you do any volunteer work or any other kind of work for which you are not paid?

Patient: Yes, I really like to volunteer at my church, by offering to organize events.

Interviewer: Thank you. That was a very thorough answer.

Example #2:

Interviewer: What is your current marital status? Married, widowed, divorced, separated, or never married?

Patient: I am married but living separately from my husband and children this year.

Interviewer: I see. Now, what is the highest level of school that you have completed?

In the examples above, “I see” and “Thank you” are feedback phrases used to indicate that the patient is providing appropriate answers. In contrast, the next example demonstrates feedback to an inappropriate answer:

Example #3:

Interviewer: Have you had any problems associated with alcohol use in your lifetime?

Patient: Well, growing up, my Aunt Judy used to tell me that I was always going to be a good drinker, then when I went to college, I would hang out with my friends, and drink every now and then, but to this day I still don't like the taste of alcohol, so I guess Aunt Judy was wrong.

Interviewer: I see, (pause) but, 'Have you had any problems associated with alcohol use in your lifetime?'

R: I guess not, no.

Remember that effective Interviewers give feedback for good performance, not "good" content. Health coaches should not use the phrases, "O.K." or "all right" when providing feedback to a patient because they indicate agreement with the response. Instead, you should always use neutral phrases that do not indicate agreement. As a general rule, you should give short feedback phrases for short answers and long feedback phrases for longer answers. You can also use a brief pause followed by a feedback phrase to make it more powerful. The pause signals to the patient that you have considered his/her answer carefully. When asking the questions, the health coach should determine how often to give feedback by considering the performance of the patient. Some patients may need more feedback to encourage appropriate responses while other patients may need less feedback.

I. Recording the Responses:

The patient's answers must be completely and properly coded on the questionnaire or in the laptop, or the interview results cannot be used for analysis. Record every answer in the appropriate category. If a response has been "Don't Know," enter a code of "9" for that question. If the patient refuses to answer the question, also enter a code of "9". If you must probe for a response, write P next to the question. If the patient has difficulty in understanding the question, make a note next to the question. Every question must have some recorded answer, or an explanatory mark, in the available space. If an item was part of a skip pattern, or if you forgot to ask it, enter NASK for that question. Common errors made by the interviewer include:

- ✕ Omitting an answer.
- ✕ Recording the wrong answer code.
- ✕ Circling more than one answer or entering more than one number.
- ✕ Writing illegibly, or in abbreviations that are not readily understandable to the people who are coding.

If you accidentally mark the wrong answer, cross out your mark, write 'error' next to it and circle the correct answer. If you are using a laptop, delete the previous answer and enter the correct answer. Some patients may change their mind while giving an answer, so it is useful to wait a couple seconds between questions to be sure the patient has finished before marking their final answer. Do not record digressions. If something unusual happens that researchers should know, include this information in the Notes section on MOSBox. If you have finished the

interview, but have some concern about whether the patient answered accurately or truthfully, make a note of this or of any other concern in the section for Interviewer's comments.

J. Taking Breaks

Be aware of fidgeting or other non-verbal behaviors that indicate that the patient is tired, restless, or experiencing extreme emotion as some patients may need a break. It is also important to notice any side effects of medication that would necessitate the need for a drink, break or light snack. Be careful during the break not to talk about anything that would bias answers to any of the rest of the questions in the interview. Small talk such as sports or the weather are good topics of conversation during the break.

K. Troubleshooting

It is rare but possible that a person who has agreed to be interviewed may become uncooperative during the interview causing you to feel uncomfortable about the patient's behavior. If you feel that the person cannot actively participate in the interview because he/she is uncooperative, rude, threatening or hostile towards you, or responding in a sexually charged manner, you should end the interview immediately. Conducting interviews at a public place of their choice can reduce these types of behaviors. If an alternate interview setting is needed for a patient, notify the Evaluation Coordinator to receive approval. This policy is intended to ensure your safety and should be followed at all times.

Even if the interview is conducted at a place of their choice, it is possible that people may act inappropriately. Since every person has a different comfort level, it is impossible to foresee

all situations that may cause health coaches discomfort. As a general rule, health coaches and patients should refrain from the following:

- Touching other than to shake hands
- Using profanity
- Acting out (yelling, slamming furniture).

You should also be aware of other behaviors signifying that the patient is not able to complete the interview. Be sensitive to signs indicating that the patient is experiencing emotional distress or is, for any other reason, unable to understand and answer the questions. At times a health coach may encounter a situation in which the patient is unable or unlikely to participate in the interview. Reasons may include disorientation, paranoia, anger or irritability, hearing voices that are distracting, or the use of drugs or alcohol before the interview.

Within the introduction to the study, each site should make available a list of agencies or services with contact information where a person can seek help. This list should be given to a patient at the beginning of the interview process with the following statement: "Answering questions in this survey may bring up emotional issues for you. If you feel uncomfortable and need help, here is a list of agencies in our area that you may contact." At any point in an interview if a person shows distress, and at the conclusion of an interview, the health coach should remind the patient of the list of people from whom s/he can seek help if s/he so desires.

In conclusion, if someone is reluctant to do the interview, remind them of the following: the interview is confidential; they can stop if they choose at any time; they can refuse to answer certain questions if they are uncomfortable; they can take a break. Remind

them of the purpose of the interview and the way in which they will be helping. If they are starting a baseline interview, you can ask if they'd like to start the first few pages (with assurance that you will ask, after a few pages if they would like to continue) just to see what the interview is like. Often patients will agree with this, and then, when asked if they'd like to continue, most say they will.

Also, if at any time you experience discomfort due to the behavior of the patient, you should end the interview immediately. Tell the patient that you have finished your questions, that you appreciate his/her time, and that if the patient has any questions they should be referred to the Project Director. Then promptly leave the interview site. Make written notes in the post-interview Observation Section, and then report your experience to the Evaluation Director immediately, before you conduct another interview.

Finally, if this kind of problem should occur, please stay calm, and know that their behavior is not related to you or this project. Always remember that your safety and comfort comes first and that if you have to end an interview, this will not be held against you.

L. Ending the Interview:

Once the interview is completed, thank the patient for his/her time and effort. Let the patients know that their participation was very important for the success of the project. At this time, they may express some concern about the content of the survey questions and you may need to spend a short time reviewing the purpose of the survey and use of the information. If necessary, give the patient the evaluation coordinator or project director's number and reassure the patient that he/she may contact them at any time regarding the survey content or

process. Remind patients of the payment schedule and have them sign the [Payment Reimbursement] Form. Instruct patients that if there are any problems in receiving the payment, they should contact the field coordinator.

M. Post Interview Observations

Once you have finished the interview and left the interviewing site, take a couple minutes to make some written notes about the interview and the patient. Record any problems you may have had during questioning, whether the patient seemed attentive and responsive, and whether the patient understood the questions. It may be useful to record specific behaviors, statements and impressions that occurred during the interview. In addition, you should record any errors or mistakes that were made during the interview. These notes will help you with future interviews and will also help the Evaluation team ensure the validity of the project by noting patients who may have been giving false or biased answers. This process can also help other health coaches because you can later draw upon these notes to share your experiences with each other.

7. Training the Interviewers

As a trainer, your role is to train the interviewers so that they understand the questionnaire, know how an interview should be conducted, and understand the importance of collecting standardized and valid information. However, before you can train others to administer an interview, it is important for you to understand and be familiar with the information, and to have experienced the role of an interviewer.

A. Training Goals

Effective trainers demonstrate the following attributes:

- Understands the subject matter to be presented during workshop
- Presents material clearly
- Motivates workshop participants to want to learn
- Emphasizes the relevance of the workshop material
- Conveys enthusiasm
- Knows how to create a comfortable learning environment
- Uses a variety of techniques to help workshop participants learn
- Adapts to meet the diverse needs of workshop participants
- Manages group dynamics without being overly authoritative

B. Planning the Workshop

In order to ensure that participants get the most out of the workshop, it is important to plan extensively. Advanced planning for the workshop contributes to the success of the workshop and the overall success of the interviewers and the project. Use the following steps to plan a training workshop:

1. Identify a title for the workshop and the key objectives of the training.
2. Identify presenters *(consult with prospective presenters ahead of time to let them know the purpose of the workshop, the topics you want them to cover, the amount of time they will have for their segment of the training, and some background about the workshop participants. Ask them to submit an outline of their presentation to you ahead of time so you won't be caught off guard or surprised by some of their comments. They should also provide any handouts to you ahead of time so that copies can be made.)*
3. Develop an agenda that includes the start time and end time in addition to breaks.
4. Identify ways to use a variety of techniques to present the workshop material (lecturing, paired discussion, exercises, videotape excerpts, role-play, etc.).
5. Identify an appropriate and comfortable location *(do not select a place where there will be distractions).*
6. Identify a set up for the workshop room, and determine any audiovisual needs.

7. Determine which written materials will be presented and distributed – be sure to have enough copies of the materials for every participant.

8. Develop and distribute a flier or brochure to promote the workshop that includes a statement about why the workshop is valuable to the prospective participants and directions to the site of the workshop if people are not familiar with the location.

9. Decide if you want to use a pretest and posttest in order to evaluate interviewer training effectiveness. Information from a pretest may be helpful for adjusting the focus of the workshop in accordance with the participants' level of prior experience. By comparing the pretest to the posttest, you will be able to gauge what material has been learned in training. This type of testing may also be used to reinforce key points in the training material. Decide if lunch and/or refreshments will be provided for participants, or if they will be responsible for their own food. If they are on their own for lunch, allow ample time in the agenda for participants to find a restaurant and be served. In this instance, it is advisable to schedule lunch at 11:15 or 11:30 to avoid the lunch crowd at restaurants.

10. Decide if "icebreakers" and "energizers" will be used to "warm up" participants, get them interested, or "wake them up" as things begin to slow. Before making this decision, consider the needs and expectations of the participants—some people are offended when time is used for icebreakers and energizers when that time could instead be used to further the content of the workshop. If icebreakers or energizers are used, make sure they are brief and congruent with the theme or purpose of the workshop.

11. Identify ways to incorporate practice time into the learning experience. Decide if guided practice will take place during the actual workshop, if independent practice (homework) will be used, or a combination of both. Although time consuming, having interviewers practice during the workshop will allow you to observe and correct mistakes and to praise good interviewing skills. In addition, it allows the interviewers to become familiar with the questionnaire and interviewing process by practicing and watching others. Although interviewers may be uncomfortable practicing in front of other interviewers, this experience will allow peers to learn from one another, provide an opportunity for constructive criticism and praise, and will ultimately make the actual interviewing experience more comfortable for the interviewer. In addition, it is important for the interviewers to complete an entire "practice" interview with several people before conducting one in the field so that they become familiar with the questions and skip patterns, learn how to correctly use the cue cards, and become accustomed to the length of the questionnaire. Therefore, assigning interviewers to conduct several interviews outside of the workshop as "homework" will give them the opportunity to complete a questionnaire and to bring questions back to the trainer the next day.

12. Consider designing and distributing a certificate of completion for participants. These certificates should be attractive and printed on special paper.

13. Develop an evaluation form to be used to collect feedback on the workshop from participants. Collect evaluation forms before they leave.

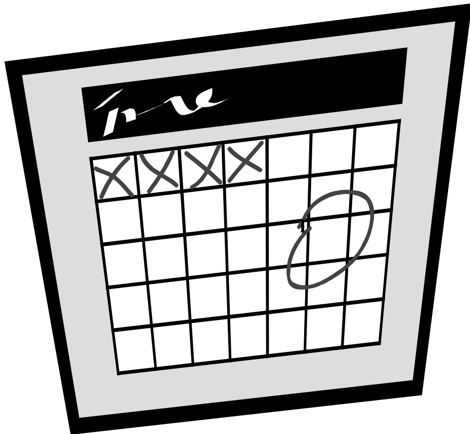
14. Find out ahead of time if any participants have experience with the subject matter so that during the workshop you can draw upon their experience. For example, you may want to administer a pretest. This keeps them from being bored, and it exposes the participants to others who are knowledgeable about the subject matter. This is also a critical point for the trainer to consider when they are developing the outline for the workshop because it indicates the extent to which basic interviewing information needs to be covered.

C. The Day of the Workshop

1. Arrive at the workshop location early enough to allow time to organize materials, check audiovisual equipment, cue any cassette or videotapes to be used, adjust microphones, check for an extra bulb for the overhead projector, and be sure that the VCR is properly connected. Finally, make sure the room is arranged correctly, the temperature of the room is comfortable, and the lighting is adequate.

2. Be there to greet the participants as they arrive – have everything ready when the first person walks through the door so that you are available to chat with people who arrive early.
3. Bring a few extra pens or pencils and some paper in case participants come unprepared.
4. Check the arrangements for the refreshments. If coffee is to be offered first thing in the morning, make sure the coffee is ready by the time the first participant arrives.
5. Make sure the workshop starts on time, ends on time, and that breaks are taken.

D. Follow-up after the Workshop



It is crucial to offer support and guidance for interviewers after their first couple of interviews. Therefore, it is important to designate a contact person for the interviewers as a resource if they have questions, need support or advice. Have this person be available daily for the first couple of weeks.

In addition, interviewers can also learn from listening to the experiences of one another. After the first week of interviews, re-convene the trained interviewers for a structured debriefing session in order to:

- answer their questions
- review key points
- clear up any confusion on the part of interviewers
- obtain feedback on their experience
- allow them to vent and share their experiences
- find out if any unusual incidents occurred and how the interviewers handled them

Prior to the debriefing session, it is a good idea for the trainer to review completed interviews and identify problem areas to discuss during the debriefing session. It is a good idea to have weekly or bi-weekly meetings with the interviewers so that they can share their experiences, including stories of both success and failure. As a trainer, it is important to organize these meetings and facilitate the discussion, but it is also crucial for the interviewers

to discuss amongst themselves and to feel comfortable providing suggestions and support to one another.

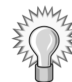
Your role as the trainer should be to facilitate these discussions, and ensure that the interviewers are practicing correct interviewing techniques. You can accomplish this by drawing examples from interviewers that review the important material learned in the training workshop. In these meetings, it is also important to remember the guidelines for confidentiality. Remind the interviewers that they must not share information that will reveal the identity of patients, even to the other interviewers. They should refrain from using the patients' names when sharing examples or asking questions, and they should not reveal specific answers that would also indicate the identity of the patient.

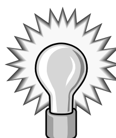
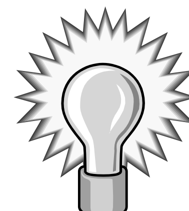
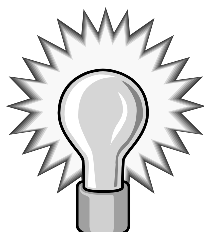
As the trainer, you should also record the most frequently asked questions by interviewers and forward that information to the Evaluation Coordinator. A "Most Frequently Asked Questions" document will be kept for reference.

E. General Workshop Facilitation Tips

- ☆ Establish ground rules or work with the participants to develop ground rules for the workshop. These should include guidelines about confidentiality and respecting the opinions of other participants.
- ☆ Be aware of group dynamics. Take note of the way the interviewers are sharing, listening, and responding to one another.
- ☆ Do not allow one person to monopolize the discussions. Encourage everyone to speak, and deter one person from dominating the conversations by asking individuals to offer their opinions.

- ✫ Draw upon the experience of participants who are knowledgeable about the subject matter.
- ✫ Make sure everyone who wants to speak has the opportunity to do so.
- ✫ Provide positive feedback when participants do something good.
- ✫ Provide constructive criticism when participants do something incorrectly. Do not allow the group to gang up on a person when the group is critiquing the person's interviewing techniques.
- ✫ Be "on the look out" for puzzled or confused facial expressions so that you can check to be sure participants understand what is being presented.
- ✫ Know what to do if a lengthy debate ensues that takes training off track.
- ✫ Provide participants with information about the workshop facilitators and presenters so that they know why they are qualified to conduct the workshop.
- ✫ Realize that after lunch, some participants get sleepy. Try to plan something that involves movement immediately after lunch.
- ✫ If you don't know the answer to a question, indicate that you don't know and offer to find out the answer. Follow through and find out the answer and then report back to the group.
- ✫ Have someone on-site at the workshop who can take care of logistics and handle last-minute needs for copies, etc.



8. Editing the Interview

After you have completed each interview, you will edit the questionnaire. Editing consists of re-reading the questions and answers making sure that every question has been answered, to correct errors you may have made in coding, and to make sure that notations such as NANS for "don't know," or if the patient refused to answer, P for "used probing", or any other note or explanation is clearly written in the proper place on the form. The site coordinator will also review the interview form a second time. If errors or incomplete sections are found, the site coordinator will ask you to make the corrections and if necessary, contact the patient for the missing information.

To each completed questionnaire, attach a control sheet with the following information

[Site specific information]

Control Sheet

Project ID______________

Status	Date	Signature
Interview Completed	_________	_____________________
Edit Completed	_________	_____________________
Corrections Completed	__________	_____________________
Data Entry Completed	__________	_____________________

(From Frey and Oishi, p. 132)

9. Tracking Study Participants

You are responsible for collecting contact information for all participants, and for scheduling all of the 6 month interviews. You will forward the Contact Locator sheet to the Tracker for your site, and this individual will keep track of all contacts in an electronic database, https://tracker.mimh.edu.

A. Follow-up Protocol for the MOSBIRT Project

Overview:
To measure the effectiveness of the MOSBIRT project, we are required to follow up on 10% of the folks that receive an intervention. To ensure that the sample is randomly selected, we have been assigned the following criterion for the follow-up sample:

- Those qualifying for and receiving any intervention (BE, BC or RT), and with
- The last 2 digits of their SSN between the numbers 50-59.

These individuals will be asked to consent to be contacted for a follow-up survey 6 months after their intake interview. The follow-up interview will consist of a phone interview completed by a trained evaluation staff member. The patient will be asked to complete:

- Sections of the GPRA,
- The ATOD Attitudes and Beliefs instrument, and
- The Readiness to Change scale.

The follow-up interview should take between 20 and 30 minutes to complete, and patients completing the interview will be compensated with a $20 gift card for their time. We are required by our funders to maintain an 80% follow up rate, so the follow-up is a very important aspect of the MOSBIRT project.

B. Follow-up Procedures: The Intake Interview

1. The health coach will explain the importance of a follow-up interview for this health care service. One strategy that has been successful in engaging clients for the Follow Up piece has been to present the Follow Up interview appointment in a matter-of-fact manner as simply another part of our normal practice.

- Start with introducing the idea of the 6 month follow-up as the next logical step in this health care service to get their feedback on our services.
- Then acknowledge our appreciation and our plan to compensate patients with a $20 gift card for taking the time to talk with us.

2. If the patient is willing to do the follow-up interview, the health coach will collect contact information.
    1. The health coach will assist the patient in completing the locator form stressing the importance of including collaterals that know how to contact them.
    2. Have the patient sign both copies of the consent form on the locator form, as it gives us permission to contact the folks they have listed if we are unable to find the patient for the 6-month interview. There are 2 copies of this consent form, one for our files, and one for them to take with them.
    3. An appointment for the 6-month follow-up interview will be made at this time, if possible. Consult the Google calendar for an available time to schedule the appointment. Since the window opens 30 days before and closes 30 days after the 6 month date, please try to schedule the appointment 5 months past the intake date. This will allow us more time to find the individual if they move or change phone numbers.
    4. Fill in the appointment time on the appointment sticker, place it on the signed consent form, and give the patient a copy of the signed consent form.
    5. Forward the completed locator sheets to the Cox tracker.
    6. If you are unable to schedule an appointment, please have as much of the locator sheet completed as possible, and have the patient sign the consent. The tracker will make the appointment after consulting the Google calendar for an available time.

C. After Intake

7. A welcome letter will be sent to the patient with forwarding requests to verify the address is correct within 7 days of intake.
8. Six weeks before the appointment, the patient will receive a postcard reminding them of the scheduled follow-up interview date and time.

- Three days before the appointment, the patient will receive a reminder call from MIMH evaluation staff.

D. Interview

- Six months following the completion of the intervention, the patient will receive a phone call from an evaluation staff member at MIMH to complete the interview. Upon

completion of the interview, a $20 gift card will be mailed to the address provided by the patient as compensation for completing the follow-up interview.

E. Addressing the Reluctant Patient:

If the patient is reluctant to agree to do the interview, try asking again, and appeal to the patient's sense of wanting to help, or civic duty:

9. We realize that you live quite a ways away – we conduct our interview by telephone and it should only take a few minutes of your time and we will mail you the $20 gift card.

10. It would really help us out if you would speak with us, as your feedback would be very helpful to us in improving our services.

11. It would help a lot of other people if we could continue to offer our services in the health care system, and in order to do so we need to be able to just touch base with you for a few minutes. Would you help us out?

If the patient says they'll be moving or don't know where they will be in 5 months, still make the interview appointment! Emphasize that it will be by telephone and that we will pay for the call. Then obtain:

12. Their best guess as to what their phone number will be.

13. Their best guess as to where they will have been, just prior to the 5 month date – i.e. Do they expect to be in a treatment program, shelter, away at college, in another state?

14. Name of person or agency who would most likely know where they are – perhaps a parole or probation officer, or primary care provider? (Obtain patient's Consent to Release Information for that person.)

15. Stress that they will still be eligible for the services component of our program, which include free, individual Brief Education sessions, and referral to treatment as needed.

For all patients who decline the Follow Up interview, please:

16. Engage the patient in a conversation about their reasons for declining the follow up service and address the patient's concerns - i.e. If worried about confidentiality – explain in plain language about the protection of HIPAA for health care information.

    Document the patient's concerns, reasons for declining, and any other contributing factors in the "Comments" section of the Locator sheet. Provide as much information as possible: i.e. patient was in a lot of pain, or distracted by visitors, or preoccupied with new diagnoses. Note patient's response to your interaction.

10. Six Month Follow-Up Interview

Patients with the last two SSN digits of 50-59 are eligible for the follow-up interview. They will be given a $20.00 gift card for the 6 month follow-up interview. The MIMH trackers are responsible for making the telephone call to collect the follow-up information, and will forward the gift card to the participant. The gift card will be mailed to the patients' home within 5 working days of completion of the interview.

If the patient is too tired to complete the interview, but is willing to schedule for another time, the tracker should not send the gift card until the second sitting when the interview is complete. If the patient is too tired to complete the interview and is not interested in rescheduling for another time, the tracker should notify the evaluation coordinator that the patient is due a gift card at the conclusion of that session.

Please use the following script as a guide when contacting and interviewing follow-up participants.

Three Day Reminder Call:

If you reach an answering machine:

Hello, my name is ___________, and I'm a member of the Missouri Initiative for Healthy Lifestyles team. I am calling today to remind (Participant's Name) that they have scheduled a time to give us feedback on our new services that promote healthy lifestyle behaviors on _______________ at _______________. Please call us toll free at 1-866-971-8534 if this time is no longer convenient.

If you reach the participant:

Hello, my name is ______________, and I'm a member of the Missouri Initiative for Healthy Lifestyles team. A few months ago, you answered some questions about your lifestyle when you were seen at the Urgent Care in Springfield, as part of a new effort to improve the quality of care. When you answered these questions, you agreed to let us call you to get your feedback on our services. I am calling today to remind you that you have scheduled a time to give us your feedback on our new services that promote healthy lifestyle behaviors on _______________ at _______________.

If participant seems confused, or does not remember the appointment:

Several hospitals and clinics across the country are part of an effort to improve the quality of care offered to their patients. They have taken on some screening procedures to promote healthy lifestyle behaviors for all patients. Your doctor and other doctors at the Urgent Care in Springfield participate in this health project, called the Missouri Initiative for Healthy Lifestyles, because they think your lifestyle habits are important to your overall health. When you answered these lifestyle questions when you were seen at the Urgent Care a few months ago, you agreed to let us call you to get your feedback on our services. Because these screening procedures are new, feedback from patients like you will help us continue to improve our patient care.

All:

Is the appointment time still convenient for you? [NO: When would be a convenient time?] Good, so when we call you, we will ask you some questions similar to the ones we asked you when you were seen at the Urgent Care center a few months ago. We will take about 15-25 minutes of your time, and we'll send you a $20 gift card for

giving your feedback. We will send the gift card to your home address, which you listed as:____. Is that address still correct?

We would like to offer you a choice of gift cards for either Wal-Mart or Quik Trip. Which gift card would you prefer? ___________________Thank you, that will help us make sure we have enough on hand so we can mail it to you the day you give us your feedback on our services.

I appreciate your taking the time to talk to me, and look forward to talking to you again on _______________________________. If you should need to change the time, please call me toll free at (866) 971-8534.

Day of the appointment:

Hello, my name is___________-, a member of the Missouri Initiative for Healthy Lifestyles team, and I talked to you a few days ago to remind you that I would be calling today to get your feedback on the new services offered at the Urgent Care center. I am going to ask you some questions similar to the ones we asked you when you were seen at the Urgent Care center a few months ago, and it should take 15-25 minutes.

Please remember these screening procedures are new, and feedback from patients like you will help us continue to improve our patient care, so we appreciate your help. All of your answers will be confidential, and we will be looking at the information we receive on all patients grouped together, and not individually. So, the information reported in the results is about the group of answers, not about an individual. Do you have any questions before we begin?

Administer appropriate questionnaires.

Thank you so much for your feedback. We will send the _____________ gift card in the mail today, so please look for it within the next 3-5 days. Thank you again for your time, and know that your feedback will be used to help us improve the services for your fellow citizens in Missouri. Have a good day/evening.

Instruments Collected for 6 month Follow-Up (All are asked the number of Standard Drinks/Week)		
Level of Care	**GPRA**	**Other Instruments**
BE	Section B,C, (I)	RTC
BC	Section B-G, (I-K)	RTC, Attitudes & Beliefs

RT	Section B-G, (I-K)	RTC, Attitudes & Beliefs

GPRA Sections I-K are not asked, but rather record management to be completed by the interviewer.

11. Attending Debriefing Meetings

After the training has been completed, the evaluation coordinator will maintain regular contact with you. In addition, there will be regular meetings of the evaluation coordinator and all interviewers. At this meeting, you will be encouraged to discuss any questions that may come up or any difficulties you may be encountering during the interview process. Of course, you may also contact the evaluation coordinator or lead interviewer for your site at any other time.

12. Providing Feedback to the Trainers and the Site Coordinator

Because we are in the developmental stages of this project, it is important that we understand any difficulties that may be occurring for you or the patient in the interview process, including setting up and keeping appointments and asking and answering the questions. As previously indicated, you should make a note next to any question that seems to be confusing or difficult to answer, and provide further explanation if necessary in the interviewer's comments section.

In addition to your feedback on the survey process and instruments, we would like your evaluation of the training process. Please feel free to give us feedback on the various steps in the training itself. You do not have to write your name on your comments, but please, when you have constructive comments or suggestions and leave them in the questionnaire box in the project office. You are also encouraged to speak to the trainers about these issues whenever you feel comfortable in doing so. Some of the topics identified by the interviewers may be brought up for discussion during the debriefing meetings or staff meetings. In addition, it is important to provide regular feedback to the Evaluation Coordinator. We need your input to make sure that we are providing the best possible training to meet the needs of both interviewers and the project.

Training Manual Appendix

Instruments:

Prescreen…………………………………………………………………………………..A

ASSIST…………………………………………………………………………………….B

ASSIST Instructions and Scoring..……………………………………………….….C

GPRA……………………………..………………………………………………………..D

GPRA QXQ……………………..………………………………………………………..E

GPRA FAQ……………………..……………………………………………………….F

Alcohol Use Assessment……………………………………………………………….G

Mental Health Screen…………………………………………………………………..H

Readiness to Change Ruler………………………………………………………....I

ATOD Attitudes and Beliefs………………………………………………………..…J

Patient Satisfaction Survey…………………………………………………………...K

Patient Locator Form……..…………………………………………………………. L

MOSBIRT Follow-Up Protocol...……………………..………………………………M

MOSBIRT Follow-Up Protocol for FQHC………….…………………………………N

Scheduling Follow-up Appointments…………………………………………..….O

A

MOSBIRT Prescreen

Name: ___________________ ID: _____________ Birth date: ___/_____ Date: ___/___/___
mm/yy

SSN:________________________ **Are you a veteran? Yes No**

Gender: Male Female Transgender Refused

What is your race? Check all that apply.

Black or African American	Yes	No
Asian	Yes	No
American Indian	Yes	No
Native Hawaiian or other Pacific Islander	Yes	No
Alaska Native	Yes	No
White	Yes	No

Refused

Hispanic or Latino? Yes No Refused

If yes, What ethnic group do you consider yourself?

Central American	Yes	No
Cuban	Yes	No
Dominican	Yes	No
Mexican	Yes	No
Puerto Rican	Yes	No
South American	Yes	No
Other	Yes	No

Other___________________ Refused

The Size of a STANDARD drink:

1. Have you used any tobacco products in the past three months? Yes No
2. **Females (and Males over 65)**: When was the last time you had 4 standard drinks in a day or night? Was that within the last 3 months? Yes No
   Males: When was the last time you had 5 standard drinks in a day or night? Was that within the last 3 months? Yes No
3. In the last twelve months, did you ever find yourself drinking more than you meant to? Yes No
4. In the last twelve months, did you ever think that maybe you should cut down on your drinking? Yes No
5. In the last twelve months, did you smoke pot, use another street drug, or use a prescription painkiller, stimulant, or sedative for a non-medical reason? Yes No

B

A. WHO - ASSIST V3.0

INTERVIEWER ID		COUNTRY		CLINIC	
PATIENT ID				DATE	

INTRODUCTION *(Please read to patient)*

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

NOTE: BEFORE ASKING QUESTIONS, GIVE ASSIST RESPONSE CARD TO PATIENT

Question 1
(if completing follow-up please cross check the patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried)

In your life, which of the following substances have you ever used? *(NON-MEDICAL USE ONLY)*	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:
"Not even when you were in school?"

If "No" to all items, stop interview.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

Question 2

In the past three months, how often have you used the substances you mentioned *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 3

During the past three months, how often have you had a strong desire or urge to use *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

Question 4

During the <u>past three months</u>, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC)* led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the <u>past three months</u>, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else <u>ever</u> expressed concern about your use of *(FIRST DRUG, SECOND DRUG, ETC.)?*	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 7

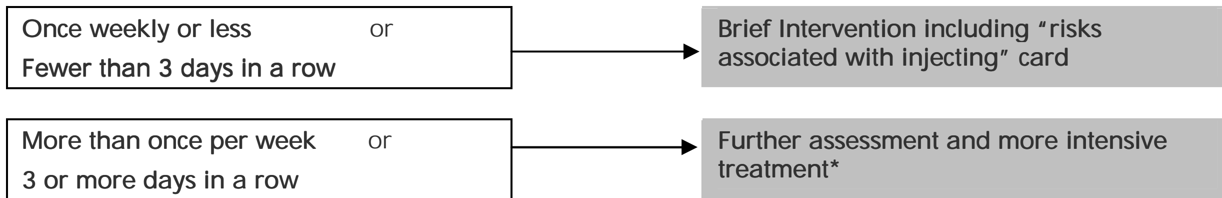
Have you <u>ever</u> tried and failed to control, cut down or stop using *(FIRST DRUG, SECOND DRUG, ETC.)?*	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 8

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you <u>ever</u> used any drug by injection? *(NON-MEDICAL USE ONLY)*	0	2	1

IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.



HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: **Q2c + Q3c + Q4c + Q5c + Q6c + Q7c**

Note that Q5 for tobacco is not coded, and is calculated as: **Q2a + Q3a + Q4a + Q6a + Q7a**

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT'S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Record specific substance score	no intervention	receive brief intervention	more intensive treatment *
a. tobacco		0 - 3	4 - 26	27+
b. alcohol		0 - 10	11 - 26	27+
c. cannabis		0 - 3	4 - 26	27+
d. cocaine		0 - 3	4 - 26	27+
e. amphetamine		0 - 3	4 - 26	27+
f. inhalants		0 - 3	4 - 26	27+
g. sedatives		0 - 3	4 - 26	27+
h. hallucinogens		0 - 3	4 - 26	27+
i. opioids		0 - 3	4 - 26	27+
j. other drugs		0 - 3	4 - 26	27+

NOTE: *FURTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available.

B. WHO ASSIST V3.0 RESPONSE CARD FOR PATIENTS

Response Card - substances

a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
b. Alcoholic beverages (beer, wine, spirits, etc.)
c. Cannabis (marijuana, pot, grass, hash, etc.)
d. Cocaine (coke, crack, etc.)
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
i. Opioids (heroin, morphine, methadone, codeine, etc.)
j. Other - specify:

Response Card (ASSIST Questions 2 – 5)

Never: not used in the last 3 months

Once or twice: 1 to 2 times in the last 3 months.

Monthly: 1 to 3 times in one month.

Weekly: 1 to 4 times per week.

Daily or almost daily: 5 to 7 days per week.

Response Card (ASSIST Questions 6 to 8)

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

C. ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST (WHO ASSIST V3.0) FEEDBACK REPORT CARD FOR PATIENTS

Name______________________________ Test Date ___________________

Specific Substance Involvement Scores

Substance	Score	Risk Level
a. Tobacco products		0-3 Low 4-26 Moderate 27+ High
b. Alcoholic Beverages		0-10 Low 11-26 Moderate 27+ High
c. Cannabis		0-3 Low 4-26 Moderate 27+ High
d. Cocaine		0-3 Low 4-26 Moderate 27+ High
e. Amphetamine type stimulants		0-3 Low 4-26 Moderate 27+ High
f. Inhalants		0-3 Low 4-26 Moderate 27+ High
g. Sedatives or Sleeping Pills		0-3 Low 4-26 Moderate 27+ High
h. Hallucinogens		0-3 Low 4-26 Moderate 27+ High
i. Opioids		0-3 Low 4-26 Moderate 27+ High
j. Other - specify		0-3 Low 4-26 Moderate 27+ High

What do your scores mean?

Low: You are at low risk of health and other problems from your current pattern of use.

Moderate: You are at risk of health and other problems from your current pattern of substance use.

High: You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent

Are you concerned about your substance use?

a. tobacco	Your risk of experiencing these harms is:......... **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular tobacco smoking is associated with:**
	Premature aging, wrinkling of the skin
	Respiratory infections and asthma
	High blood pressure, diabetes
	Respiratory infections, allergies and asthma in children of smokers
	Miscarriage, premature labour and low birth weight babies for pregnant women
	Kidney disease
	Chronic obstructive airways disease
	Heart disease, stroke, vascular disease
	Cancers

b. alcohol	Your risk of experiencing these harms is:......... **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular excessive alcohol use is associated with:**
	Hangovers, aggressive and violent behaviour, accidents and injury
	Reduced sexual performance, premature ageing
	Digestive problems, ulcers, inflammation of the pancreas, high blood pressure
	Anxiety and depression, relationship difficulties, financial and work problems
	Difficulty remembering things and solving problems
	Deformities and brain damage in babies of pregnant women
	Stroke, permanent brain injury, muscle and nerve damage
	Liver disease, pancreas disease
	Cancers, suicide

c. cannabis	Your risk of experiencing these harms is:...... **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of cannabis is associated with:**
	Problems with attention and motivation
	Anxiety, paranoia, panic, depression
	Decreased memory and problem solving ability
	High blood pressure
	Asthma, bronchitis
	Psychosis in those with a personal or family history of schizophrenia
	Heart disease and chronic obstructive airways disease
	Cancers

d. cocaine	Your risk of experiencing these harms is:.... Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of cocaine is associated with:**
	Difficulty sleeping, heart racing, headaches, weight loss
	Numbness, tingling, clammy skin, skin scratching or picking
	Accidents and injury, financial problems
	Irrational thoughts
	Mood swings - anxiety, depression, mania
	Aggression and paranoia
	Intense craving, stress from the lifestyle
	Psychosis after repeated use of high doses
	Sudden death from heart problems

e. amphetamine type stimulants	Your risk of experiencing these harms is:....... Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of amphetamine type stimulants is associated with:**
	Difficulty sleeping, loss of appetite and weight loss, dehydration
	jaw clenching, headaches, muscle pain
	Mood swings –anxiety, depression, agitation, mania, panic, paranoia
	Tremors, irregular heartbeat, shortness of breath
	Aggressive and violent behaviour
	Psychosis after repeated use of high doses
	Permanent damage to brain cells
	Liver damage, brain haemorrhage, sudden death (ecstasy) in rare situations

f. inhalants	Your risk of experiencing these harms is:........... Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of inhalants is associated with:**
	Dizziness and hallucinations, drowsiness, disorientation, blurred vision
	Flu like symptoms, sinusitis, nosebleeds
	Indigestion, stomach ulcers
	Accidents and injury
	Memory loss, confusion, depression, aggression
	Coordination difficulties, slowed reactions, hypoxia
	Delirium, seizures, coma, organ damage (heart, lungs, liver, kidneys)
	Death from heart failure

g. sedatives	Your risk of experiencing these harms is: Low ☐ Moderate ☐ High ☐ (tick one)
	Regular use of sedatives is associated with:
	Drowsiness, dizziness and confusion
	Difficulty concentrating and remembering things
	Nausea, headaches, unsteady gait
	Sleeping problems
	Anxiety and depression
	Tolerance and dependence after a short period of use.
	Severe withdrawal symptoms
	Overdose and death if used with alcohol, opioids or other depressant drugs.

h. hallucinogens	Your risk of experiencing these harms is:……….. Low ☐ Moderate ☐ High ☐ (tick one)
	Regular use of hallucinogens is associated with:
	Hallucinations (pleasant or unpleasant) – visual, auditory, tactile, olfactory
	Difficulty sleeping
	Nausea and vomiting
	Increased heart rate and blood pressure
	Mood swings
	Anxiety, panic, paranoia
	Flash-backs
	Increase the effects of mental illnesses such as schizophrenia

i. opioids	Your risk of experiencing these harms is: Low ☐ Moderate ☐ High ☐ (tick one)
	Regular use of opioids is associated with:
	Itching, nausea and vomiting
	Drowsiness
	Constipation, tooth decay
	Difficulty concentrating and remembering things
	Reduced sexual desire and sexual performance
	Relationship difficulties
	Financial and work problems, violations of law
	Tolerance and dependence, withdrawal symptoms
	Overdose and death from respiratory failure

D. RISKS OF INJECTING CARD – INFORMATION FOR PATIENTS

Using substances by injection increases the risk of harm from substance use.

This harm can come from:

- **The substance**
  - ➢ If you inject any drug you are more likely to become dependent.
  - ➢ If you inject amphetamines or cocaine you are more likely to experience psychosis.
  - ➢ If you inject heroin or other sedatives you are more likely to overdose.
- **The injecting behaviour**
  - ➢ If you inject you may damage your skin and veins and get infections.
  - ➢ You may cause scars, bruises, swelling, abscesses and ulcers.
  - ➢ Your veins might collapse.
  - ➢ If you inject into the neck you can cause a stroke.
- **Sharing of injecting equipment**
  - ➢ If you share injecting equipment (needles & syringes, spoons, filters, etc.) you are more likely to spread blood borne virus infections like Hepatitis B, Hepatitis C and HIV.

❖ **It is safer not to inject**

❖ **If you do inject:**

- ✓ always use clean equipment (e.g., needles & syringes, spoons, filters, etc.)
- ✓ always use a new needle and syringe
- ✓ don't share equipment with other people
- ✓ clean the preparation area
- ✓ clean your hands
- ✓ clean the injecting site
- ✓ use a different injecting site each time
- ✓ inject slowly
- ✓ put your used needle and syringe in a hard container and dispose of it safely

❖ **If you use stimulant drugs like amphetamines or cocaine the following tips will help you reduce your risk of psychosis.**

- ✓ avoid injecting and smoking
- ✓ avoid using on a daily basis

❖ **If you use depressant drugs like heroin the following tips will help you reduce your risk of overdose.**

- ✓ avoid using other drugs, especially sedatives or alcohol, on the same day
- ✓ use a small amount and always have a trial "taste" of a new batch
- ✓ have someone with you when you are using
- ✓ avoid injecting in places where no-one can get to you if you do overdose
- ✓ know the telephone numbers of the ambulance service

E. TRANSLATION AND ADAPTATION TO LOCAL LANGUAGES AND CULTURE: A RESOURCE FOR CLINICIANS AND RESEARCHERS

The ASSIST instrument, instructions, drug cards, response scales and resource manuals may need to be translated into local languages for use in particular countries or regions. Translation from English should be as direct as possible to maintain the integrity of the tools and documents. However, in some cultural settings and linguistic groups, aspects of the ASSIST and it's companion documents may not be able to be translated literally and there may be socio-cultural factors that will need to be taken into account in addition to semantic meaning. In particular, substance names may require adaptation to conform to local conditions, and it is also worth noting that the definition of a standard drink may vary from country to country.

Translation should be undertaken by a bi-lingual translator, preferably a health professional with experience in interviewing. For the ASSIST instrument itself, translations should be reviewed by a bi-lingual expert panel to ensure that the instrument is not ambiguous. Back translation into English should then be carried out by another independent translator whose main language is English to ensure that no meaning has been lost in the translation. This strict translation procedure is critical for the ASSIST instrument to ensure that comparable information is obtained wherever the ASSIST is used across the world.

Translation of this manual and companion documents may also be undertaken if required. These do not need to undergo the full procedure described above, but should include an expert bi-lingual panel.

Before attempting to translate the ASSIST and related documents into other languages, interested individuals should consult with the WHO about the procedures to be followed and the availability of other translations. Write to the Department of Mental Health and Substance Dependence, World Health Organisation, 1211 Geneva 27, Switzerland.

C

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

For each substance (labeled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: Q2c + Q3c + Q4c + Q5c + Q6c + Q7c

Note that Q5 for tobacco is not coded, and is calculated as: Q2a + Q3a + Q4a + Q6a + Q7a

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT'S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Record specific substance score	No intervention	Receive brief intervention	Receive Brief Coaching	Refer to Treatment
a. tobacco		**0-3**	**4-19**	**20-26**	**27+**
b. alcohol		**0-10**	**11-19**	**20-26**	**27+**
c. cannabis		**0-3**	**4-19**	**20-26**	**27+**
d. cocaine		**0-3**	**4-19**	**20-26**	**27+**
e. amphetamine		**0-3**	**4-19**	**20-26**	**27+**
f. inhalants		**0-3**	**4-19**	**20-26**	**27+**
g. sedatives		**0-3**	**4-19**	**20-26**	**27+**
h. hallucinogens		**0-3**	**4-19**	**20-26**	**27+**
i. opioids		**0-3**	**4-19**	**20-26**	**27+**
j. other drugs		**0-3**	**4-19**	**20-26**	**27+**

NOTE: *FURTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available.

C. ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST (WHO ASSIST V3.0) FEEDBACK REPORT CARD FOR PATIENTS

Name________________________________ Test Date _____________________

Specific Substance Involvement Scores

Substance	Score	Risk Level	
a. Tobacco products		0-3 4-19 20-26 27+	Low Moderate High Very High
b. Alcoholic Beverages		0-10 11-19 20-26 27+	Low Moderate High Very High
c. Cannabis		0-3 4-19 20-26 27+	Low Moderate High Very High
d. Cocaine		0-3 4-19 20-26 27+	Low Moderate High Very High
e. Amphetamine type stimulants		0-3 4-19 20-26 27+	Low Moderate High Very High
f. Inhalants		0-3 4-19 20-26 27+	Low Moderate High Very High
g. Sedatives or Sleeping Pills		0-3 4-19 20-26 27+	Low Moderate High Very High
h. Hallucinogens		0-3 4-19 20-26 27+	Low Moderate High Very High
i. Opioids		0-3 4-19 20-26 27+	Low Moderate High Very High
j. Other - specify		0-3 4-19 20-26 27+	Low Moderate High Very High

What do your scores mean?

Low: You are at low risk of health and other problems from your current pattern of use.

Moderate: You are at risk of health and other problems from your current pattern of substance use.

High: You are at high risk of experiencing significant problems (health, social, financial, legal, relationship) as a result of your current pattern of use and may become dependent.

Very High: You are probably experiencing significant problems (health, social, financial, legal, relationship) as a result of your current pattern of use and may be dependent or addicted.

Are you concerned about your substance use?

a. tobacco	Your risk of experiencing these harms is:…… Low □ Moderate □ High □ Very High □ (check one) **Regular tobacco smoking is associated with:**
	Premature aging, wrinkling of the skin
	Respiratory infections and asthma
	High blood pressure, diabetes
	Respiratory infections, allergies and asthma in children of smokers
	Miscarriage, premature labor and low birth weight babies for pregnant women
	Kidney disease
	Chronic obstructive airways disease
	Heart disease, stroke, vascular disease
	Cancers

b. alcohol	Your risk of experiencing these harms is:…… Low □ Moderate □ High □ Very High □ (check one) **Regular excessive use of alcohol is associated with:**
	Hangovers, aggressive and violent behavior, accidents and injury
	Reduced sexual performance, premature aging
	Digestive problems, ulcers, inflammation of the pancreas, high blood pressure
	Anxiety and depression, relationship difficulties, financial and work problems
	Difficulty remembering things and solving problems
	Deformities and brain damage in babies of pregnant women
	Stroke, permanent brain injury, muscle and nerve damage
	Liver disease, pancreas disease
	Cancers, suicide

c. cannabis	Your risk of experiencing these harms is:…… Low □ Moderate □ High □ Very High □ (check one) **Regular use of cannabis is associated with:**
	Problems with attention and motivation
	Anxiety, paranoia, panic, depression
	Decreased memory and problem solving ability
	High blood pressure
	Asthma, bronchitis
	Psychosis in those with a personal or family history of schizophrenia
	Heart disease and chronic obstructive airways disease
	Cancers

d. cocaine	Your risk of experiencing these harms is:…… Low □ Moderate □ High □ Very High □ (check one) **Regular use of cocaine is associated with:**
	Difficulty sleeping, heart racing, headaches, weight loss
	Numbness, tingling, clammy skin, skin scratching or picking
	Accidents and injury, financial problems
	Irrational thoughts
	Mood swings - anxiety, depression, mania
	Aggression and paranoia
	Intense craving, stress from the lifestyle
	Psychosis after repeated use of high doses
	Sudden death from heart problems

e. amphetamine type stimulants	Your risk of experiencing these harms is:…… Low □ Moderate □ High □ Very High □ (check one) **Regular use of amphetamine type stimulants is associated with:**
	Difficulty sleeping, loss of appetite and weight loss, dehydration
	jaw clenching, headaches, muscle pain
	Mood swings –anxiety, depression, agitation, mania, panic, paranoia
	Tremors, irregular heartbeat, shortness of breath
	Aggressive and violent behavior
	Psychosis after repeated use of high doses
	Permanent damage to brain cells
	Liver damage, brain hemorrhage, sudden death (ecstasy) in rare situations

f. inhalants	Your risk of experiencing these harms is:…… Low □ Moderate □ High □ Very High □ (check one) **Regular use of inhalants is associated with:**
	Dizziness and hallucinations, drowsiness, disorientation, blurred vision
	Flu like symptoms, sinusitis, nosebleeds
	Indigestion, stomach ulcers
	Accidents and injury
	Memory loss, confusion, depression, aggression
	Coordination difficulties, slowed reactions, hypoxia
	Delirium, seizures, coma, organ damage (heart, lungs, liver, kidneys)
	Death from heart failure

g. sedatives	Your risk of experiencing these harms is:…… Low □ Moderate □ High □ Very High □ (check one) **Regular use of sedatives is associated with:**
	Drowsiness, dizziness and confusion
	Difficulty concentrating and remembering things
	Nausea, headaches, unsteady gait
	Sleeping problems
	Anxiety and depression
	Tolerance and dependence after a short period of use
	Severe withdrawal symptoms
	Overdose and death if used with alcohol, opioids or other depressant drugs

h. hallucinogens	Your risk of experiencing these harms is:…… Low □ Moderate □ High □ Very High □ (check one) **Regular use of hallucinogens is associated with:**
	Hallucinations (pleasant or unpleasant) – visual, auditory, tactile, olfactory
	Difficulty sleeping
	Nausea and vomiting
	Increased heart rate and blood pressure
	Mood swings
	Anxiety, panic, paranoia
	Flash-backs
	Increase the effects of mental illnesses such as schizophrenia

i. opioids	Your risk of experiencing these harms is:…… Low □ Moderate □ High □ Very High □ (check one) **Regular use of opioids is associated with:**
	Itching, nausea and vomiting
	Drowsiness
	Constipation, tooth decay
	Difficulty concentrating and remembering things
	Reduced sexual desire and sexual performance
	Relationship difficulties
	Financial and work problems, violations of law
	Tolerance and dependence, withdrawal symptoms
	Overdose and death from respiratory failure

Form Approved
OMB No. 0930-0208
Expiration Date 02/28/2013

CSAT GPRA Client Outcome Measures for Discretionary Programs (Revised 02/17/2012)

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information, if all items are asked of a client/participant; to the extent that providers already obtain much of this information as part of their ongoing client/participant intake or followup, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 7-1044, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0208.

A. RECORD MANAGEMENT

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|____|____|____|

Client Type:

- ○ Treatment client
- ○ Client in recovery

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|

Interview Type ***[CIRCLE ONLY ONE TYPE.]***

Intake [GO TO INTERVIEW DATE]

6-month follow-up → → → Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

3-month follow-up ***[ADOLESCENT PORTFOLIO ONLY] →***
Did you conduct a follow-up interview? ○ Yes ○ No ***[IF NO, GO DIRECTLY TO SECTION I.]***

Discharge → → → Did you conduct a discharge interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION J.]

Interview Date |____|____| / |____|____| / |____|____|____|____|
Month Day Year

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

---

1. Was the client screened by your program for co-occurring mental health and substance use disorders?

- ○ YES
- ○ NO [SKIP 1a.]

1a. [IF YES] **Did the client screen positive for co-occurring mental health and substance use disorders?**

- ○ YES
- ○ NO

SBIRT CONTINUE. ALL OTHERS GO TO SECTION A "PLANNED SERVICES."

THIS SECTION FOR THE FOLLOWING GRANTS ONLY [REPORTED ONLY AT INTAKE/BASELINE]: SBIRT (Items 2, 2a, & 3)

2. How did the client screen for your SBIRT?

- O Negative
- O Positive

2a. What was his/her screening score?

AUDIT = |____|____|

CAGE = |____|____|

DAST = |____|____|

DAST-10 = |____|____|

NIAAA Guide = |____|____|

ASSIST/Alcohol Subscore = |____|____|

Other (Specify) ______________ = |____|____|

____

____

____

3. Was he/she willing to continue his/her participation in the SBIRT program?

- O YES
- O NO

A. RECORD MANAGEMENT - PLANNED SERVICES *[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT INTAKE/BASELINE.]*

Identify the services you plan to provide to the client during the client's course of treatment/recovery. ***[CIRCLE "Y" FOR YES OR "N" FOR NO FOR EACH ONE.]***

Modality	**Yes**	**No**
[SELECT AT LEAST ONE MODALITY.]		
1. Case Management	Y	N
2. Day Treatment	Y	N
3. Inpatient/Hospital (Other Than Detox)	Y	N
4. Outpatient	Y	N
5. Outreach	Y	N
6. Intensive Outpatient	Y	N
7. Methadone	Y	N
8. Residential/Rehabilitation	Y	N
9. Detoxification (Select Only One)		
A. Hospital Inpatient	Y	N
B. Free Standing Residential	Y	N
C. Ambulatory Detoxification	Y	N
10. After Care	Y	N
11. Recovery Support	Y	N
12. Other (Specify)________________	Y	N

[SELECT AT LEAST ONE SERVICE.]

Treatment Services	**Yes**	**No**
[SBIRT GRANTS: YOU MUST CIRCLE "Y" FOR AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]		
1. Screening	Y	N
2. Brief Intervention	Y	N
3. Brief Treatment	Y	N
4. Referral to Treatment	Y	N
5. Assessment	Y	N
6. Treatment/Recovery Planning	Y	N
7. Individual Counseling	Y	N
8. Group Counseling	Y	N
9. Family/Marriage Counseling	Y	N
10. Co-Occurring Treatment/ Recovery Services	Y	N
11. Pharmacological Interventions	Y	N
12. HIV/AIDS Counseling	Y	N
13. Other Clinical Services (Specify)____________________	Y	N

Case Management Services	**Yes**	**No**
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	Y	N
2. Child Care	Y	N
3. Employment Service		
A. Pre-Employment	Y	N
B. Employment Coaching	Y	N
4. Individual Services Coordination	Y	N
5. Transportation	Y	N
6. HIV/AIDS Service	Y	N
7. Supportive Transitional Drug-Free Housing Services	Y	N
8. Other Case Management Services (Specify)____________________	Y	N

Medical Services	**Yes**	**No**
1. Medical Care	Y	N
2. Alcohol/Drug Testing	Y	N
3. HIV/AIDS Medical Support & Testing	Y	N
4. Other Medical Services (Specify)____________________	Y	N

After Care Services	**Yes**	**No**
1. Continuing Care	Y	N
2. Relapse Prevention	Y	N
3. Recovery Coaching	Y	N
4. Self-Help and Support Groups	Y	N
5. Spiritual Support	Y	N
6. Other After Care Services (Specify)____________________	Y	N

Education Services	**Yes**	**No**
1. Substance Abuse Education	Y	N
2. HIV/AIDS Education	Y	N
3. Other Education Services (Specify)____________________	Y	N

Peer-to-Peer Recovery Support Services	**Yes**	**No**
1. Peer Coaching or Mentoring	Y	N
2. Housing Support	Y	N
3. Alcohol- and Drug-Free Social Activities	Y	N
4. Information and Referral	Y	N
5. Other Peer-to-Peer Recovery Support Services (Specify)____________________	Y	N

A. RECORD MANAGEMENT - DEMOGRAPHICS *[ASKED ONLY AT INTAKE/BASELINE.]*

1. What is your gender?

- ○ MALE
- ○ FEMALE
- ○ TRANSGENDER
- ○ OTHER (SPECIFY) ____
- ○ REFUSED

2. Are you Hispanic or Latino?

- ○ YES
- ○ NO
- ○ REFUSED

[IF YES] **What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.**

	Yes	No	Refused
Central American	Y	N	REFUSED
Cuban	Y	N	REFUSED
Dominican	Y	N	REFUSED
Mexican	Y	N	REFUSED
Puerto Rican	Y	N	REFUSED
South American	Y	N	REFUSED
Other	Y	N	REFUSED *[IF YES, SPECIFY BELOW]*

(Specify) ________________________________

3. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused
Black or African American	Y	N	REFUSED
Asian	Y	N	REFUSED
Native Hawaiian or other Pacific Islander	Y	N	REFUSED
Alaska Native	Y	N	REFUSED
White	Y	N	REFUSED
American Indian	Y	N	REFUSED

4. What is your date of birth?*

|____|____| / |____|____| / ***[*THE SYSTEM WILL ONLY SAVE MONTH AND YEAR. TO MAINTAIN CONFIDENTIALITY, DAY IS NOT SAVED.]***

MONTH DAY

|____|____|____|____|

YEAR

○ REFUSED

MILITARY FAMILY AND DEPLOYMENT

5. Have you ever served in the Armed Forces, in the Reserves, or in the National Guard? *[IF SERVED]* What area, the Armed Forces, Reserves, or National Guard did you serve?

- ○ NO
- ○ YES, IN THE ARMED FORCES
- ○ YES, IN THE RESERVES
- ○ YES, IN THE NATIONAL GUARD
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO QUESTION A6.]

5a. Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard? *[IF ACTIVE]* What area, the Armed Forces, Reserves, or National Guard?

- ○ NO, SEPARATED OR RETIRED FROM THE ARMED FORCES, RESERVES OR NATIONAL GUARD
- ○ YES, IN THE ARMED FORCES
- ○ YES, IN THE RESERVES
- ○ YES, IN THE NATIONAL GUARD
- ○ REFUSED
- ○ DON'T KNOW

5b. Have you ever been deployed to a combat zone? *[CHECK ALL THAT APPLY]*

- ○ NEVER DEPLOYED
- ○ IRAQ OR AFGHANISTAN (E.G., OEF/OIF/OND)
- ○ PERSIAN GULF (OPERATION DESERT SHIELD/DESERT STORM)
- ○ VIETNAM/SOUTHEAST ASIA
- ○ KOREA
- ○ WWII
- ○ DEPLOYED TO A COMBAT ZONE NOT LISTED ABOVE (E.G., BOSNIA/SOMALIA)
- ○ REFUSED
- ○ DON'T KNOW

6. Is anyone in your family or someone close to you on active duty in the Armed Forces, in the Reserves, or in the National Guard or separated or retired from the Armed Forces, Reserves, or National Guard?

- ○ NO
- ○ YES, ONLY ONE
- ○ YES, MORE THAN ONE
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION B.]

[IF YES, ANSWER FOR UP TO 6 PEOPLE] **What is the relationship of that person (Service Member) to you?** *[WRITE RELATIONSHIP IN COLUMN HEADING]*

1 = Mother 5 = Spouse
2 = Father 6 = Partner
3 = Brother 7 = Child
4 = Sister 8 =Other (Specify)____________________

Has the Service Member experienced any of the following? [*CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY]*	__________ **(Relationship) 1.**	__________ **(Relationship) 2.**	__________ **(Relationship) 3.**	__________ **(Relationship) 4.**	__________ **(Relationship) 5.**	__________ **(Relationship) 6.**
6a. Deployed in support of combat operations (e.g., Iraq or Afghanistan)?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW
6b. Was physically injured during combat operations?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW
6c. Developed combat stress symptoms/ difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW
6d. Died or was killed?	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW	○ YES ○ NO ○ REFUSED ○ DON'T KNOW

B. DRUG AND ALCOHOL USE

IN SECTION B, ORP AND EADCSCT GRANTEES SHOULD USE THE 90 DAYS PRIOR TO INCARCERTAION FOR ALL INTAKE INTERVIEW AND 90 DAYS PRIOR FOR FOLLOW-UP AND DISCHARGE INTERVIEWS.

1. During the past 30 days, how many days have you used the following:

		Number of Days	REFUSED	DON'T KNOW
a.	Any alcohol ***[IF ZERO, SKIP TO ITEM B1c.]***	|____|____|	○	○
b1.	Alcohol to intoxication (5+ drinks in one sitting)	|____|____|	○	○
b2.	Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	|____|____|	○	○
c.	Illegal drugs ***[IF B1a OR B1c = 0, RF, DK, THEN SKIP TO ITEM B2.]***	|____|____|	○	○
d.	Both alcohol and drugs (on the same day)	|____|____|	○	○

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following: *[IF THE VALUE IN ANY ITEM B2a THROUGH B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]*

		Number of Days	RF	DK	Route*	RF	DK
a.	Cocaine/Crack	|____|____|	○	○	|____|	○	○
b.	Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)	|____|____|	○	○	|____|	○	○
c.	Opiates:						
	1. Heroin (Smack, H, Junk, Skag)	|____|____|	○	○	|____|	○	○
	2. Morphine	|____|____|	○	○	|____|	○	○
	3. Dilaudid	|____|____|	○	○	|____|	○	○
	4. Demerol	|____|____|	○	○	|____|	○	○
	5. Percocet	|____|____|	○	○	|____|	○	○
	6. Darvon	|____|____|	○	○	|____|	○	○
	7. Codeine	|____|____|	○	○	|____|	○	○
	8. Tylenol 2, 3, 4	|____|____|	○	○	|____|	○	○
	9. OxyContin/Oxycodone	|____|____|	○	○	|____|	○	○
d.	Non-prescription methadone	|____|____|	○	○	|____|	○	○
e.	Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel), MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms, or Mescaline	|____|____|	○	○	|____|	○	○
f.	Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank)	|____|____|	○	○	|____|	○	○

B. DRUG AND ALCOHOL USE (Continued)

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. **During the past 30 days, how many days have you used any of the following:** ***[IF THE VALUE IN ANY ITEM B2a THROUGH B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]***	**Number of Days**	**RF**	**DK**	**Route***	**RF**	**DK**
g. 1. Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estasolam (Prosom and Rohypnol—also known as roofies, roche, and cope)	|____|____|	O	O	|____|	O	O
2. Barbiturates: Mephobarbital (Mebacut) and pentobarbital sodium (Nembutal)	|____|____|	O	O	|____|	O	O
3. Non-prescription GHB (known as Grievous Bodily Harm, Liquid Ecstasy, and Georgia Home Boy)	|____|____|	O	O	|____|	O	O
4. Ketamine (known as Special K or Vitamin K)	|____|____|	O	O	|____|	O	O
5. Other tranquilizers, downers, sedatives, or hypnotics	|____|____|	O	O	|____|	O	O
h. Inhalants (poppers, snappers, rush, whippets)	|____|____|	O	O	|____|	O	O
i. Other illegal drugs (Specify) ____________________	|____|____|	O	O	|____|	O	O

3. **In the past 30 days, have you injected drugs?** ***[IF ANY ROUTE OF ADMINISTRATION IN B2a THROUGH B2i = 4 or 5, THEN B3 MUST = YES.]***

- O YES
- O NO
- O REFUSED
- O DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION C.]

4. **In the past 30 days, how often did you use a syringe/needle, cooker, cotton, or water that someone else used?**

- O Always
- O More than half the time
- O Half the time
- O Less than half the time
- O Never
- O REFUSED
- O DON'T KNOW

C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time? ***[DO NOT READ RESPONSE OPTIONS TO CLIENT.]***

- ○ SHELTER (SAFE HAVENS, TRANSITIONAL LIVING CENTER [TLC], LOW-DEMAND FACILITIES, RECEPTION CENTERS, OTHER TEMPORARY DAY OR EVENING FACILITY)
- ○ STREET/OUTDOORS (SIDEWALK, DOORWAY, PARK, PUBLIC OR ABANDONED BUILDING)
- ○ INSTITUTION (HOSPITAL, NURSING HOME, JAIL/PRISON)
- ○ HOUSED: ***[IF HOUSED, CHECK APPROPRIATE SUBCATEGORY:]***
  - ○ OWN/RENT APARTMENT, ROOM, OR HOUSE
  - ○ SOMEONE ELSE'S APARTMENT, ROOM, OR HOUSE
  - ○ DORMITORY/COLLEGE RESIDENCE
  - ○ HALFWAY HOUSE
  - ○ RESIDENTIAL TREATMENT
  - ○ OTHER HOUSED (SPECIFY) ________________________
- ○ REFUSED
- ○ DON'T KNOW

2. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs? ***[IF B1a OR B1c > 0, THEN C2 CANNOT = "NOT APPLICABLE."]***

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE ***[USE ONLY IF B1a AND B1c = 0.]***
- ○ REFUSED
- ○ DON'T KNOW

3. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities? ***[IF B1a OR B1c > 0, THEN C3 CANNOT = "NOT APPLICABLE."]***

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE ***[USE ONLY IF B1a AND B1c = 0.]***
- ○ REFUSED
- ○ DON'T KNOW

C. FAMILY AND LIVING CONDITIONS (Continued)

4. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems? ***[IF B1a <u>OR</u> B1c > 0, THEN C4 CANNOT = "NOT APPLICABLE."]***

○ Not at all
○ Somewhat
○ Considerably
○ Extremely
○ NOT APPLICABLE ***[USE ONLY IF B1a <u>AND</u> B1c = 0.]***
○ REFUSED
○ DON'T KNOW

5. ***[IF NOT MALE]*** **Are you currently pregnant?**

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

6. Do you have children?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION D.]

a. How many children do you have? ***[IF C6 = YES, THEN THE VALUE IN C6a MUST BE > 0.]***

|____|____| ○ REFUSED ○ DON'T KNOW

b. Are any of your children living with someone else due to a child protection court order?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, SKIP TO ITEM C6d.]

c. ***[IF YES]*** **How many of your children are living with someone else due to a child protection court order?** ***[THE VALUE IN C6c CANNOT EXCEED THE VALUE IN C6a.]***

|____|____| ○ REFUSED ○ DON'T KNOW

C. FAMILY AND LIVING CONDITIONS (Continued)

d. For how many of your children have you lost parental rights? ***[THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.] [THE VALUE IN ITEM C6d CANNOT EXCEED THE VALUE IN C6a.]***

|____|____| ○ REFUSED ○ DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? ***[IF ENROLLED]*** **Is that full time or part time?** ***[IF CLIENT IS INCARCERATED, CODE D1 AS "NOT ENROLLED."]***

○ NOT ENROLLED
○ ENROLLED, FULL TIME
○ ENROLLED, PART TIME
○ OTHER (SPECIFY) ____________________________________
○ REFUSED
○ DON'T KNOW

2. What is the highest level of education you have finished, whether or not you received a degree?

○ NEVER ATTENDED
○ 1ST GRADE
○ 2ND GRADE
○ 3RD GRADE
○ 4TH GRADE
○ 5TH GRADE
○ 6TH GRADE
○ 7TH GRADE
○ 8TH GRADE
○ 9TH GRADE
○ 10TH GRADE
○ 11TH GRADE
○ 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
○ COLLEGE OR UNIVERSITY/1st YEAR COMPLETED
○ COLLEGE OR UNIVERSITY/2nd YEAR COMPLETED/ASSOCIATES DEGREE (AA, AS)
○ COLLEGE OR UNIVERSITY/3rd YEAR COMPLETED
○ BACHELOR'S DEGREE (BA, BS) OR HIGHER
○ VOC/TECH PROGRAM AFTER HIGH SCHOOL BUT NO VOC/TECH DIPLOMA
○ VOC/TECH DIPLOMA AFTER HIGH SCHOOL
○ REFUSED
○ DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME (Continued)

3. Are you currently employed? ***[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.] [IF CLIENT IS "ENROLLED, FULL TIME" IN D1 AND INDICATES "EMPLOYED, FULL TIME" IN D3, ASK FOR CLARIFICATION. IF CLIENT IS INCARCERATED AND HAS NO WORK OUTSIDE OF JAIL, CODE D3 AS "UNEMPLOYED, NOT LOOKING FOR WORK."]***

○ EMPLOYED, FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
○ EMPLOYED, PART TIME
○ UNEMPLOYED, LOOKING FOR WORK
○ UNEMPLOYED, DISABLED
○ UNEMPLOYED, VOLUNTEER WORK
○ UNEMPLOYED, RETIRED
○ UNEMPLOYED, NOT LOOKING FOR WORK
○ OTHER (SPECIFY) ______________________________________
○ REFUSED
○ DON'T KNOW

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from… ***[IF D3 DOES NOT = "EMPLOYED" AND THE VALUE IN D4a IS GREATER THAN ZERO, PROBE. IF D3 = "UNEMPLOYED, LOOKING FOR WORK" AND THE VALUE IN D4b = 0, PROBE. IF D3 = "UNEMPLOYED, RETIRED" AND THE VALUE IN D4c = 0, PROBE. IF D3 = "UNEMPLOYED, DISABLED" AND THE VALUE IN D4d = 0, PROBE.]***

			RF	**DK**
a.	Wages	$ |__|__|__| , |__|__|__|	○	○
b.	Public assistance	$ |__|__|__| , |__|__|__|	○	○
c.	Retirement	$ |__|__|__| , |__|__|__|	○	○
d.	Disability	$ |__|__|__| , |__|__|__|	○	○
e.	Non-legal income	$ |__|__|__| , |__|__|__|	○	○
f.	Family and/or friends	$ |__|__|__| , |__|__|__|	○	○
g.	Other (Specify) ____________________	$ |__|__|__| , |__|__|__|	○	○

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested?

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

[IF NO ARRESTS, SKIP TO ITEM E3.]

2. In the past 30 days, how many times have you been arrested for drug-related offenses? ***[THE VALUE IN E2 CANNOT BE GREATER THAN THE VALUE IN E1.]***

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

E. CRIME AND CRIMINAL JUSTICE STATUS (Continued)

3. In the past 30 days, how many nights have you spent in jail/prison? ***[IF THE VALUE IN E3 IS GREATER THAN 15, THEN C1 MUST = INSTITUTION (JAIL/PRISON). IF C1 = INSTITUTION (JAIL/PRISON), THEN THE VALUE IN E3 MUST BE GREATER THAN OR EQUAL TO 15.]***

|____|____| NIGHTS ○ REFUSED ○ DON'T KNOW

4. In the past 30 days, how many times have you committed a crime? ***[CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c ON PAGE 7. ANSWER HERE IN E4 SHOULD BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]***

|____|____|____| TIMES ○ REFUSED ○ DON'T KNOW

5. Are you currently awaiting charges, trial, or sentencing?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

6. Are you currently on parole or probation?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. How would you rate your overall health right now?

○ Excellent
○ Very good
○ Good
○ Fair
○ Poor
○ REFUSED
○ DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (Continued)

2. During the past 30 days, did you receive:

a. Inpatient Treatment for:

	YES	*[IF YES]* Altogether for how many nights	NO	RF	DK
i. Physical complaint	○	_______ nights	○	○	○
ii. Mental or emotional difficulties	○	_______ nights	○	○	○
iii. Alcohol or substance abuse	○	_______ nights	○	○	○

b. Outpatient Treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint	○	_______ times	○	○	○
ii. Mental or emotional difficulties	○	_______ times	○	○	○
iii. Alcohol or substance abuse	○	_______ times	○	○	○

c. Emergency Room Treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint	○	_______ times	○	○	○
ii. Mental or emotional difficulties	○	_______ times	○	○	○
iii. Alcohol or substance abuse	○	_______ times	○	○	○

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (Continued)

3. During the past 30 days, did you engage in sexual activity?

- ○ Yes
- ○ No → ***[SKIP TO F4.]***
- ○ NOT PERMITTED TO ASK → ***[SKIP TO F4.]***
- ○ REFUSED → ***[SKIP TO F4.]***
- ○ DON'T KNOW → ***[SKIP TO F4.]***

[IF YES] **Altogether, how many:**

		Contacts	RF	DK
a.	Sexual contacts (vaginal, oral, or anal) did you have?	|____|____|____|	○	○
b.	Unprotected sexual contacts did you have? ***[THE VALUE IN F3b SHOULD NOT BE GREATER THAN THE VALUE IN F3a.] [IF ZERO, SKIP TO F4.]***	|____|____|____|	○	○
c.	Unprotected sexual contacts were with an individual who is or was: ***[NONE OF THE VALUES IN F3c1 THROUGH F3c3 CAN BE GREATER THAN THE VALUE IN F3b.]***			
	1. HIV positive or has AIDS	|____|____|____|	○	○
	2. An injection drug user	|____|____|____|	○	○
	3. High on some substance	|____|____|____|	○	○

4. Have you ever been tested for HIV?

- ○ Yes............................... [GO TO F4a.]
- ○ No .... [SKIP TO F5.]
- ○ REFUSED .... [SKIP TO F5]
- ○ DON'T KNOW .... [SKIP TO F5.]

4a. Do you know the results of your HIV testing?

- ○ Yes
- ○ No

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (Continued)

5. In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

		Days	RF	DK
a.	Experienced serious depression	|____|____|	○	○
b.	Experienced serious anxiety or tension	|____|____|	○	○
c.	Experienced hallucinations	|____|____|	○	○
d.	Experienced trouble understanding, concentrating, or remembering	|____|____|	○	○
e.	Experienced trouble controlling violent behavior	|____|____|	○	○
f.	Attempted suicide	|____|____|	○	○
g.	Been prescribed medication for psychological/emotional problem	|____|____|	○	○

[IF CLIENT REPORTS ZERO DAYS, RF, OR DK TO ALL ITEMS IN QUESTION 5, SKIP TO ITEM F7.]

6. How much have you been bothered by these psychological or emotional problems in the past 30 days?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Considerably
- ○ Extremely
- ○ REFUSED
- ○ DON’T KNOW

VIOLENCE AND TRAUMA

7. Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief?)

- ○ YES
- ○ NO ***[SKIP TO ITEM F8.]***
- ○ REFUSED
- ○ DON’T KNOW

[IF NO, REFUSED, OR DON’T KNOW, SKIP TO ITEM F8.]

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (Continued)

Did any of these experiences feel so frightening, horrible, or upsetting that, in the past and/or the present, you:

7a. Have had nightmares about it or thought about it when you did not want to?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

7b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

7c. Were constantly on guard, watchful, or easily startled?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

7d. Felt numb and detached from others, activities, or your surroundings?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

8. In the past 30 days, how often have you been hit, kicked, slapped, or otherwise physically hurt?

- ○ Never
- ○ A few times
- ○ More than a few times
- ○ REFUSED
- ○ DON'T KNOW

G. SOCIAL CONNECTEDNESS

1. In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a non-professional, peer-operated organization that is devoted to helping individuals who have addiction-related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.?

- ○ YES *[IF YES]* SPECIFY HOW MANY TIMES ______ ○ REFUSED ○ DON'T KNOW
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

2. In the past 30 days, did you attend any religious/faith-affiliated recovery self-help groups?

- ○ YES *[IF YES]* SPECIFY HOW MANY TIMES ______ ○ REFUSED ○ DON'T KNOW
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

3. In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?

- ○ YES *[IF YES]* SPECIFY HOW MANY TIMES ______ ○ REFUSED ○ DON'T KNOW
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

4. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

5. To whom do you turn when you are having trouble? *[SELECT ONLY ONE.]*

- ○ NO ONE
- ○ CLERGY MEMBER
- ○ FAMILY MEMBER
- ○ FRIENDS
- ○ REFUSED
- ○ DON'T KNOW
- ○ OTHER (SPECIFY) ______________________________

I. FOLLOW-UP STATUS

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP.]

1. What is the follow-up status of the client? ***[THIS IS A REQUIRED FIELD: NA, REFUSED, DON'T KNOW, AND MISSING WILL NOT BE ACCEPTED.]***

- ○ 01 = Deceased at time of due date
- ○ 11 = Completed interview within specified window
- ○ 12 = Completed interview outside specified window
- ○ 21 = Located, but refused, unspecified
- ○ 22 = Located, but unable to gain institutional access
- ○ 23 = Located, but otherwise unable to gain access
- ○ 24 = Located, but withdrawn from project
- ○ 31 = Unable to locate, moved
- ○ 32 = Unable to locate, other (Specify) ________________________

2. Is the client still receiving services from your program?

- ○ Yes
- ○ No

[IF THIS IS A FOLLOW-UP INTERVIEW, STOP NOW; THE INTERVIEW IS COMPLETE.]

J. DISCHARGE STATUS

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]

1. On what date was the client discharged?

|____|____| / |____|____| / |____|____|____|____|
MONTH DAY YEAR

2. What is the client's discharge status?

- ○ 01 = Completion/Graduate
- ○ 02 = Termination

  If the client was terminated, what was the reason for termination? *[SELECT ONE RESPONSE.]*
  - ○ 01 = Left on own against staff advice with satisfactory progress
  - ○ 02 = Left on own against staff advice without satisfactory progress
  - ○ 03 = Involuntarily discharged due to nonparticipation
  - ○ 04 = Involuntarily discharged due to violation of rules
  - ○ 05 = Referred to another program or other services with satisfactory progress
  - ○ 06 = Referred to another program or other services with unsatisfactory progress
  - ○ 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
  - ○ 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
  - ○ 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
  - ○ 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
  - ○ 11 = Transferred to another facility for health reasons
  - ○ 12 = Death
  - ○ 13 = Other (Specify)________________________________

3. Did the program test this client for HIV?

- ○ Yes................... [SKIP TO SECTION K.]
- ○ No.................... [GO TO J4.]

4. *[IF NO]* Did the program refer this client for testing?

- ○ Yes
- ○ No

K. SERVICES RECEIVED

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]

Identify the number of DAYS of services provided to the client during the client's course of treatment/recovery. *[ENTER ZERO IF NO SERVICES PROVIDED. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY.]*

Modality	**Days**
1. Case Management	|___|___|___|
2. Day Treatment	|___|___|___|
3. Inpatient/Hospital (Other Than Detox)	|___|___|___|
4. Outpatient	|___|___|___|
5. Outreach	|___|___|___|
6. Intensive Outpatient	|___|___|___|
7. Methadone	|___|___|___|
8. Residential/Rehabilitation	|___|___|___|
9. Detoxification (Select Only One)	
A. Hospital Inpatient	|___|___|___|
B. Free Standing Residential	|___|___|___|
C. Ambulatory Detoxification	|___|___|___|
10. After Care	|___|___|___|
11. Recovery Support	|___|___|___|
12. Other (Specify) _______________	|___|___|___|

Identify the number of SESSIONS provided to the client during the client's course of treatment/ recovery. *[ENTER ZERO IF NO SERVICES PROVIDED.]*

Treatment Services	**Sessions**
[SBIRT GRANTS: YOU MUST HAVE AT LEAST ONE SESSION FOR ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]	
1. Screening	|___|___|___|
2 Brief Intervention	|___|___|___|
3. Brief Treatment	|___|___|___|
4. Referral to Treatment	|___|___|___|
5. Assessment	|___|___|___|
6. Treatment/Recovery Planning	|___|___|___|
7. Individual Counseling	|___|___|___|
8. Group Counseling	|___|___|___|
9. Family/Marriage Counseling	|___|___|___|
10. Co-Occurring Treatment/ Recovery Services	|___|___|___|
11. Pharmacological Interventions	|___|___|___|
12. HIV/AIDS Counseling	|___|___|___|
13. Other Clinical Services (Specify) _____________________	|___|___|___|

Case Management Services	**Sessions**
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	|___|___|___|
2. Child Care	|___|___|___|
3. Employment Service	
A. Pre-Employment	|___|___|___|
B. Employment Coaching	|___|___|___|
4. Individual Services Coordination	|___|___|___|
5. Transportation	|___|___|___|
6. HIV/AIDS Service	|___|___|___|
7. Supportive Transitional Drug-Free Housing Services	|___|___|___|
8. Other Case Management Services (Specify) _____________	|___|___|___|

Medical Services	**Sessions**
1. Medical Care	|___|___|___|
2. Alcohol/Drug Testing	|___|___|___|
3. HIV/ AIDS Medical Support & Testing	|___|___|___|
4. Other Medical Services (Specify) _____________________	|___|___|___|

After Care Services	**Sessions**
1. Continuing Care	|___|___|___|
2. Relapse Prevention	|___|___|___|
3. Recovery Coaching	|___|___|___|
4. Self-Help and Support Groups	|___|___|___|
5. Spiritual Support	|___|___|___|
6. Other After Care Services (Specify) _____________________	|___|___|___|

Education Services	**Sessions**
1. Substance Abuse Education	|___|___|___|
2. HIV/AIDS Education	|___|___|___|
3. Other Education Services (Specify) _____________________	|___|___|___|

Peer-to-Peer Recovery Support Services	**Sessions**
1. Peer Coaching or Mentoring	|___|___|___|
2. Housing Support	|___|___|___|
3. Alcohol- and Drug-Free Social Activities	|___|___|___|
4. Information and Referral	|___|___|___|
5. Other Peer-to-Peer Recovery Support Services (Specify) _____________________	|___|___|___|

GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA)
CLIENT OUTCOME MEASURES FOR DISCRETIONARY PROGRAMS

QUESTION-BY-QUESTION INSTRUCTION GUIDE

March 2012
Version 9.1

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GENERAL OVERVIEW

These instructions are for collecting the Center for Substance Abuse Treatment (CSAT) Government Performance and Results Act (GPRA) Core Client Outcome Measures for Discretionary Services Programs. With the exception of the Planned Services and Demographics portions of Section A—Record Management (which are completed only at GPRA intake/baseline) the same set of questions in Sections A, B, C, D, E, F, and G is asked at GPRA intake/baseline, 3-months post-GPRA intake (required only for adolescent programs and some CSAT-designated programs), 6-months post-GPRA intake, and discharge. Section I is completed by program staff about the client only at follow-up. Sections J and K are completed by program staff about the client only at discharge.

For Screening, Brief Intervention, Referral, and Treatment (SBIRT) Grants Only: Brief Treatment (BT) and Referral to Treatment (RT) services are required to complete the GPRA sections as described above. Brief Intervention (BI) services are required to complete only Sections A and B at GPRA baseline/intake; Sections A, B, and I at follow-up; and Sections A, B, J, and K at discharge.

For Access to Recovery (ATR) Grants Only: A positive screen (a client who screens positive and is eligible for the ATR program) requires that the GPRA sections, as described in the first paragraph above, be administered at the screening/assessment. Follow-up and discharge interviews are required for all positive screens. Data on clients who screen negative should not be submitted to CSAT and will not count toward meeting client targets.

Have the client answer all of the questions. At the beginning of each section, you should introduce the next section of questions, (e.g., “Now I’m going to ask you some questions about…”) Read each question as it is written. In certain cases, the item in parentheses may or may not be read to the client. If a client is having trouble understanding a question, you may explain it to the client to help in its understanding; however, do not change the wording of the question.

Read response categories that appear in lower-case lettering. If all response categories are in capital letters, ask the question open-ended (in other words, do not read the responses, but instead let the client answer and then mark which response the client says). If the client refuses to answer a question, mark “RF” on the tool. If the client does not know the answer to a question, mark “DK” on the tool. For items where response options are read to the client, do not offer “don’t know” and “refused” to answer as response options—these options should be client-generated only. There are “don’t know” and “refused” response options for all items that are asked of the client. These response options are not available for items that are supplied by program staff.

Before starting the interview, consider using a calendar to mark off the last 30 days. Many questions in the tool refer to the last 30 days and having a calendar present may assist with client recall of events.

Interviews must be conducted in person, unless a waiver has been given by the grant’s government project officer (GPO).

Windows for GPRA Interview Completion

Intake/Baseline

For residential facilities, GPRA intake/baseline interviews must be completed within 3 days after the client enters the program. For nonresidential programs, GPRA intake/baseline interviews must be completed within 4 days after the client enters the program. For grants under the guidance for applicants (GFA) Recovery Community Services Program (RCSP), GPRA intake/baseline interviews must be completed within two to five contacts after the client enters the program. Program entry date should be the date which the client began receiving CSAT funded services.

Discharge

Discharge interviews must be completed at the time of discharge. The CSAT GPRA definition of discharge should follow the grantee’s definition. If the grantee does not have a definition of discharge, the discharge interview should be completed when the client has had no contact with the program for 30 days.

When to conduct the GPRA discharge interview?

For programs with a discharge policy or definition

- If the client is present on the day of discharge, the GPRA discharge interview should be conducted on the day of discharge.

- If a client has not finished treatment, drops out, or is not present the day of discharge, the project will have to find the client to conduct the in-person interview. The grant will have 10 days after discharge to contact the client and conduct the in-person discharge interview. If the interview has not been conducted by day 15, conduct an administrative discharge. For an administrative discharge when the interview is not conducted, interviewers must complete the first four items in Section A (Client ID, Client Type, Contract/Grant ID, Interview Type), Section J (Discharge), and Section K (Services Received) and mark that the interview was not completed. Follow the skip pattern instructions on the tool.

For programs without a discharge policy or definition

- If you are using the CSAT policy of discharging a client for whom 30 days has elapsed from the time of last service, the grant will have 14 days after discharge to contact the client and conduct the in-person GPRA discharge interview. If the GPRA interview has not been conducted by day 15, conduct an administrative discharge.

For Access to Recovery (ATR) Grants Only: ATR clients are not discharged until the grantee’s program has ceased or completed providing ATR funding for treatment and/or recovery services to the

client and the client's ATR voucher is deactivated. A face-to-face or administrative discharge should be conducted when the voucher is deactivated.

Grantees must attempt to contact clients who have lost contact with the program in order to conduct the interview. It is up to the grantees to track when GPRA discharge interviews are due.

Follow-Up

Follow- up interviews should be completed the number of months specified (3 or 6) from the GPRA intake/baseline interview date (a 12-month follow-up interview is no longer required). CSAT provides a window period of time for these GPRA follow-up interviews to be conducted. The window period allowed for these GPRA follow-up interviews is one month before the (3 or 6 month) anniversary date and up to two months after the (3 or 6 month) anniversary date. Those programs designated by CSAT as homeless programs are allowed a window period of two months before and two months after the 6-month follow-up anniversary date. The target follow-up rate is 100%, meaning programs must attempt to follow-up all clients. The minimum follow-up completion rate is 80%. For example:

> ***For programs completing a 6-month GPRA follow-up interview***- If a client receives the GPRA intake/baseline interview on January 1st, the 6-month follow-up anniversary date would be July 1st. The window period for conducting the 6-month follow-up interview would open one month before the anniversary date on June 1st, and close two months after the anniversary date on September 1st.
>
> ***For homeless programs completing a 6-month GPRA follow-up interview***- If a client receives the GPRA intake/baseline interview on January 1st, the 6-month follow-up anniversary date would be July 1st. The window period for conducting the 6-month follow-up interview would open two months before the anniversary date on May 1st, and close two months after the anniversary date on September 1st.
>
> ***For adolescent and other select programs completing 3-month and 6-month GPRA follow-up interviews***- If a client receives the GPRA intake/baseline interview on January 1st, the 3-month follow-up anniversary date would be April 1st. The window period for conducting the 3-month follow-up interview would open one month before the anniversary date on March 1st, and close two months after the anniversary date on June 1st.

If a client receives the GPRA intake/baseline interview on January 1st, the 6-month GPRA follow-up anniversary date would be July 1st. The window period for conducting the 6-month follow-up interview would open one month before the anniversary date on June 1st, and close two months after the anniversary date on September 1st.

SBIRT Grants: Only clients who are screened and who require any level of intervention (BI, BT, RT) are eligible for follow-up sampling. SBIRT Grants are required to attempt a follow-up with every person in their sampling pool. There must be a minimum sampling pool of 10% per modality and a follow-up rate of at least 80% for each modality.

For Access to Recovery (ATR) Grants Only: Only clients who screen positive are eligible for follow-up. Grantees are not required to conduct follow-up on negative screen clients.

This Question-by-Question Instruction Guide is organized by the sections of the GPRA tool. For each section there is an overview as well as definitions that apply to the items in that section. The following information about each item on the GPRA tool is provided:

Intent/Key Points Describes the intent of the question.

Additional Probes Offers suggestions for probes that may help prompt the client's memory during the interview.

Coding Topics Clarifies how to count or record certain responses. Please pay close attention to coding topics because they address questions that may produce vague answers.

Cross-Check Items Alerts the interviewer to items that should be related, and answers that should be verified, if a contradiction occurs during the course of the interview.

Skip Pattern Indicates which items should be skipped and under what circumstances. There are certain questions that are irrelevant based on answers to previous questions.

SECTION A: RECORD MANAGEMENT

OVERVIEW

This section pertains to the grantee and client identification, planned services, and demographic information. The Record Management information must be filled out for each GPRA interview.

The first two subsections of questions, Record Management and Record Management—Planned Services, are not asked of the client, but are filled in by project staff. The third subsection, Record Management—Demographics, is to be asked of the client at GPRA intake/baseline only.

Coding Topics/Definitions

Client ID

A unique client identifier that is determined by the project. It can be between 1 and 15 characters and can include both numerals and letters. This ID is designed to track a specific client through his/her interviews (GPRA intake, discharge, and 6-month, (if required, 3-month), while maintaining the anonymity of the client. Each client must have their own unique ID which is used at GPRA intake, discharge, 3-month follow-up (if applicable), and 6-month follow-up. The same unique ID is used each time, even if the client has more than one episode of care. For confidentiality reasons, do not use any part of the client's date of birth or Social Security Number in the Client ID.

Client ID for Screening, Brief Intervention, Referral, and Treatment (SBIRT) Grants Only: The GPRA Client ID for SBIRT Grants is made up of three consecutive sets of numbers: Sample Participation, Client ID, and Sample Criteria. These numbers are entered as follows:

- *Column 1: Sample Participation*—Enter a "1" if the client is not sampled for follow-up or a "3 if the client is sampled for follow-up and agrees to participate.
- *Columns 2-13: Client ID as Assigned by Grant*—Enter the client's unique ID, as assigned by the grant.
- *Columns 14-15: Random Sample Criteria*—Enter the last two digits of the client's Social Security Number (SSN).

Client Type

There are two main types of clients to be included in this categorization:

Treatment client—A client who is receiving substance abuse treatment by your agency and these treatment services are being funded by a CSAT grant award.

Client in recovery—A client who is receiving recovery support services funded by a CSAT grant award should record “client in recovery.”

Contract/Grant ID The CSAT-assigned grant identification number for the project. The number usually begins with H79 TI #####. This number is used to identify your grant. For example, a grant ID may be H79 TI12345. The identifying portion of the number is TI 12345.

Interview Type The type of GPRA interview that is being completed. For each interview, indicate (1) the interview type, (2) whether the interview was conducted, and (3), if conducted, the interview date.

GPRA Intake—Initial client interview *and* each time a client leaves treatment and his/her file is closed, but he/she reenters treatment at a later date, an additional round of GPRA interviews must be initiated using the initial identifier assigned to the client. The dates for follow-up interviews will be determined by the date of the most recent GPRA intake interview. For example:

- A client enters in January and completes the first GPRA intake interview. He/she leaves treatment in March and his/her file is closed. He/she re-enters treatment in April and completes the second GPRA intake interview. The client’s first 6-month follow-up interview will be due in October (6 months after April).
- An adolescent client enters an adolescent program in January and completes the first GPRA intake interview. He/she completes the first 3-month interview in April and the first 6-month interview in July, but leaves treatment in August and the file is closed. He/she re-enters treatment in October and completes the second GPRA intake interview. The second 3-month follow-up interview will be due in January (3 months after October); the second 6-month follow-up interview will be due in April (6 months after October) of the following year.

3-month follow-up—3-month follow-up interviews are only required for adolescent, adolescent drug court projects, and other select programs.

6-month follow-up—6-month follow-up interviews are completed by all programs.

Discharge—A GPRA discharge interview is to be conducted at the time the client is discharged from the program. The CSAT GPRA definition of discharge should follow the grantee’s definition. If the grantee does not have a discharge policy, the client should be

discharges after 30 days of inactivity. A GPRA discharge interview is required even if a client has lost contact with the program, so grantees must attempt to contact the client for the interview. If the client is discharged and a GPRA interview cannot be obtained, the program must complete and submit sections A, J, and K for the purpose of the discharge. All other sections will be considered missing data. It is up to the grantee to track when discharge interviews are due and, when due, to contact and conduct the discharge interviews.

Skip Pattern If the GPRA interview type is 6- or 3- month follow-up and the interview will *not* be conducted, skip to Section I.

If the GPRA interview type is discharge and the interview will *not* be conducted, skip to Section J.

Interview Date The date the GPRA interview was completed. (**If an interview was not conducted, do not enter a date.**) The GPRA intake/baseline interview date will determine when subsequent follow-up interviews are due. It is also used to calculate the project's follow-up rate, based on how many of the follow-up interviews that were due have actually been completed. The GPRA intake/baseline interview date combined with the discharge date is used to calculate the client's length of stay.

Skip Pattern If the GPRA interview type is 3- or 6-month follow-up and the interview is being conducted, skip the Planned Services and Demographics subsections of Section A—Record Management. Continue with Section B.

If the interview type is discharge and the interview is being conducted, skip the Planned Services and Demographics subsections of Section A—Record Management. Continue with Section B.

1. Was the client screened by your program for co-occurring mental health and substance use disorders?

Co-occurring disorders screening: Because the presence of a co-occurring mental disorder may affect the likelihood of long-term recovery from a substance use disorder, CSAT has focused attention on co-occurring disorders and has established programs designed specifically for persons with both mental health and substance abuse problems.

While screening clients for co-occurring mental health and substance use disorders by your program is not required, CSAT would like to learn how many programs are currently screening their clients for co-occurring mental health and substance use disorders using CSAT funds.

If you screen your client for a co-occurring mental health disorder after the GPRA baseline interview has been completed answer this question "no."

Yes—The client was screened by your program for co-occurring mental health and substance use disorders.

No—The client was not screened by your program for co-occurring mental health and substance use disorders.

Skip Pattern

If “no,” skip 1a.

1a. [IF YES] Did the client screen positive for co-occurring mental health and substance use disorders?

Yes—The client was screened positive by your program for co-occurring mental health and substance use disorders.

No—The client did not screen positive by your program for co-occurring mental health and substance use disorders.

Skip Pattern

SBIRT grantees should continue with the following screening questions. All others should go to Section A “Planned Services.”

For Screening, Brief Intervention, Referral, and Treatment (SBIRT) Grants Only: Reported Only at GPRA Intake/Baseline (If you are not *an SBIRT grantee, you should skip this section for all clients.)*

2. How did the client screen?

Did the client screen negative or positive for SBIRT services?

Negative—Client scored below the predetermined screening threshold for SBIRT services.

Positive—Client screening score indicated that he or she required some level of SBIRT services.

2a. What was his/her screening score?

Record at least one but no more than three screening scores for screening instruments that were administered to the client. Be sure to record one alcohol and one drug screening score. Grantees are required to use the AUDIT-C, AUDIT, and DAST to screen adults. The screening and collection of the GPRA information must be face-to-face. Additional screening instruments/tools may be used with the agreement of the SAMHSA Project Officer.

If you use the National Institute on Alcohol Abuse and Alcoholism (NIAAA) guide, please provide the raw score from the weekly use questions (weekly = how often/days x how much/# drinks; for men: if the score is more than 14, the patient may be at risk and for women: if the score is more than 7, the patient may be at risk).

Skip Pattern

SBIRT should complete Question 3.

3. Was he/she willing to continue his/her participation in the SBIRT program?

Did the client agree to receive SBIRT services?

Yes—Client agreed to receive SBIRT services, whether or not he/she was at the level indicated by the screen.

No—Client did not agree to receive any SBIRT services.

RECORD MANAGEMENT—PLANNED SERVICES

Identify the services you plan to provide to the client during the client's course of treatment/recovery. **Record only planned services that are funded by this CSAT grant**. Respond by circling Y (yes) or N (no) for each service listed.

MODALITY ***[SELECT AT LEAST ONE MODALITY / PROGRAM TYPE.]***

1. *Case Management*—Defining, initiating, and monitoring the medical, drug treatment, psychosocial, and social services provided for the client and the client's family.

2. *Day Treatment*— a modality used for group education, activity therapy, etc., lasting more than 4 continuous hours in a supportive environment.

3. *Inpatient/Hospital (other than detoxification)*—a patient who is admitted to a hospital or clinic for treatment that requires at least one overnight stay.

4. *Outpatient*— a patient who is admitted to a hospital or clinic for Treatment that does not require an overnight stay.

5. *Outreach*—Educational interventions conducted by a peer or paraprofessional educator face-to-face with high-risk individuals in the client's neighborhood or other areas where clients typically congregate.

6. *Intensive Outpatient*—Intense multimodal treatment for emotional or behavioral symptoms that interfere with normal functioning. These clients require frequent treatment in order to improve, while still maintaining family, student, or work responsibilities in the community. Intensive outpatient services differ from outpatient

by the intensity and number of hours per week. Intensive outpatient services are provided 2 or more hours per day for 3 or more days per week.

7. *Methadone*—Provision of methadone maintenance for opioid-addicted clients.

8. *Residential/Rehabilitation*—A residential facility or halfway house that provides on-site structured therapeutic and supportive services specifically for alcohol and other drugs.

9. *Detoxification (select only one)*—A medically supervised treatment program for alcohol or drug addiction designed to purge the body of intoxicating or addictive substances.

    a. *Hospital Inpatient*—Client resides at a medical facility or hospital during his/her treatment.

    b. *Free-Standing Residential*—Patient resides at a facility other than a hospital while treatment is provided.

    c. *Ambulatory Detox*—Treatment that is performed in a specialized therapeutic environment and is designed to provide both psychological and physiological stabilization to ensure safe withdrawal from alcohol and/or drugs.

10. *After Care*—Treatment given for a limited time after the client has completed his/her primary treatment program, but is still connected to the treatment provider.

11. *Recovery Support*—Support from peers, family, friends, and health professionals during recovery. Includes any of the following: assistance in housing, educational, and employment opportunities; building constructive family and other personal relationships; stress management assistance; alcohol- and drug-free social and recreational activities; recovery coaching or mentoring to help manage the process of obtaining services from multiple systems, including primary and mental health care, child welfare, and criminal justice systems.

12. *Other (Specify)*—Specify any other service modalities to be received by the client.

[SELECT AT LEAST ONE SERVICE.]

TREATMENT SERVICES

Note: SBIRT Grantees must circle 'Y' for at least one of the treatment services numbered one through four.

1. *Screening*—A gathering and sorting of information used to determine if an individual has a problem with alcohol or other drug abuse, and if so, whether a detailed clinical assessment is appropriate. Screening is a process that identifies people at risk for the "disease" or disorder (National Institute on Alcohol Abuse and Alcoholism, 1990). As such, screening refers to a brief procedure used to determine the probability of the presence of a problem, substantiate that there is a reason for concern, or identify the

need for further evaluation. In a general population, screening for substance abuse and dependency would focus on determining the presence or absence of the disorder, whereas for a population already identified at risk, the screening process would be concerned with measuring the severity of the problem and determining the need for a comprehensive assessment.

2. *Brief Intervention*—Those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his/her substance abuse, either by natural, client-directed means or by seeking additional substance abuse treatment.

3. *Brief Treatment*—A systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. Brief therapies usually consist of more (as well as longer) sessions than brief interventions. The duration of brief therapies is reported to be anywhere from 1 session (Bloom, 1997) to 40 sessions (Sifneos, 1987), with the typical therapy lasting between 6 and 20 sessions. Twenty sessions usually is the maximum because of limitations placed by many managed care organizations. Any therapy may be brief by accident or circumstance, but the focus is on *planned* brief therapy. The therapies described here may involve a set number of sessions or a set range (e.g., from 6 to 10 sessions), but they always work within a time limitation that is clear to both therapist and client.

   Note: Brief Treatment is not applicable to ATR Grants.

4. *Referral to Treatment*—A process for facilitating client/consumer access to specialized treatments and services through linkage with, or directing clients/consumers to, agencies that can meet their needs.

   Note: Referral to Treatment is not applicable to ATR Grants.

5. *Assessment*—To examine systematically, in order to determine suitability for treatment.

6. *Treatment/Recovery Planning*—A program or method worked out beforehand to administer or apply remedies to a patient for illness, disease, or injury.

7. *Individual Counseling*—Professional guidance of an individual by utilizing psychological methods.

8. *Group Counseling*—Professional guidance of a group of people gathered together utilizing psychological methods.

9. *Family/Marriage Counseling*—A type of psychotherapy for a married couple or family for the purpose of resolving problems in the relationship.

10. *Co-occurring Treatment/Recovery Services*—Assistance and resources provided to clients who suffer from both mental illness disorder(s) and substance use disorder(s).

11. *Pharmacological Interventions*—The use of any pharmacological agent to affect the treatment outcomes of substance-abusing clients. For example, the use of phenytoin in alcohol withdrawal and the use of buprenorphine in opioid treatment.

12. *HIV/AIDS Counseling*—A type of psychotherapy for individuals infected with and living with HIV/AIDS.

13. *Other Clinical Services (Specify)*—Other client services the client received that are not listed above.

CASE MANAGEMENT SERVICES

1. *Family Services (including marriage education, parenting, and child development services)*—Resources provided by the state to assist in the well-being and safety of children, families, and the community.

2. *Child Care*—Care provided to children for a period of time.

3. *Employment Services*—Resources provided to clients to assist in finding employment.

    a. *Pre-employment Services*—Services provided to clients prior to employment, which can include background checks, drug tests, and assessments. These services allow employers to "check out" prospective employees before hiring them.

    b. *Employment Coaching*—Provides tools and strategies to clients to assist in gaining employment. These strategies include implementing new skills, changes, and actions to ensure that clients achieve their targeted results.

4. *Individual Services Coordination*—Services that families may choose to use when they need help obtaining support for their mentally disabled sons or daughters to live as independently as possible in the community.

5. *Transportation*—Providing a means of transport for clients to travel from one location to another.

6. *HIV/AIDS Service*—Resources provided to clients to improve the quality and availability of care for people with HIV/AIDS and their families.

7. *Supportive Transitional Drug-free Housing Services*—Provides rental assistance for families and individuals who are seeking to be drug-free who can be housed for up to 2 years while receiving intensive support services from the agency staff.

8. *Other Care Management Services (Specify)*—Other care management services the client received that are not listed above.

MEDICAL SERVICES

1. *Medical Care*—Professional treatment for illness or injury.

2. *Alcohol/Drug Testing*—Any process used to identify the degree to which a person has used or is using alcohol or other drugs.

3. *HIV/AIDS Medical Support and Testing*—Medical services provided to clients who have HIV/AIDS and their families.

4. *Other Medical Services (Specify)*—Other medical services the client received that are not listed above.

AFTER CARE SERVICES

1. *Continuing Care*—Providing health care for extended periods of time.

2. *Relapse Prevention*—Identifying each client's current stage of recovery and establishing a recovery plan to identify and manage the relapse warning signs.

3. *Recovery Coaching*—Guidance involving a combination of counseling, support, and various forms of mediation treatments to find solutions to deal with breaking the habit of substance abuse.

4. *Self-Help and Support Groups*—Helping or improving oneself without assistance from others; and/or an assemblage of persons who have similar experiences and assist in encouraging and keeping individuals from failing.

5. *Spiritual Support*—Spiritual/religion-based support for the clients' recovery process.

6. *Other After Care Services (Specify)*—Other after care services the client received that are not listed above.

EDUCATION SERVICES

1. *Substance Abuse Education*—A program of instruction designed to assist individuals in drug prevention, relapse, and/or treatment.

2. *HIV/AIDS Education*—A program of instruction designed to assist individuals with HIV/AIDS and their families with HIV/AIDS prevention and/or treatment.

3. *Other Education Services (Specify)*—Other education services the client received that are not listed above.

PEER-TO-PEER RECOVERY SUPPORT SERVICES

1. *Peer Coaching or Mentoring*—Services involving a trusted counselor or teacher to another person of equal standing or others in support of a client's recovery.

2. *Housing Support*—Providing assistance for living arrangements to clients.

3. *Alcohol- and Drug-Free Social Activities*—An action, event, or gathering attended by a group of people that promotes abstinence from alcohol and other drugs.

4. *Information and Referral*—Services involving the provision of resources to a client that promote health behavior and/or directing a client to other sources for help or information.

5. *Other Peer-to-Peer Recovery Support Services (Specify)*—Other peer-to-peer recovery services the client received that are not listed above.

RECORD MANAGEMENT—DEMOGRAPHICS

OVERVIEW

This section collects demographic information on the client. These questions are only asked at baseline. While some of the information may seem apparent, *ask all questions* for clarification. Do not complete a response based on the client's appearance. *You must ask the question and mark the response given by the client.*

A1	**WHAT IS YOUR GENDER?**

Intent/Key Points

The intent of the question is to ascertain the client's gender. Enter the client's response, even if the client's response does not match his/her obvious appearance.

Additional Probes

If the client does not understand or asks what is meant by gender you may clarify the question by asking if they prefer to be seen/see themselves/be viewed as a man or male, woman or female, as a transgender, or other. If "other," have the client specify and write down the response.

Coding Topics/ Definitions None

Cross-Check Items None

Skip Pattern None

A2 ARE YOU HISPANIC OR LATINO?

Intent/Key Points

The intent of the question is to ascertain whether the client is Hispanic or Latino, and, if yes, of which ethnic group the client considers him/herself.

Note that this is a two-part question. If the client responds that he/she is not Hispanic or Latino, check “no” and continue with question A3. If the client refuses to answer if he/she is Hispanic or Latino, check “Refused” and continue with question A3. If the client responds that he/she is Hispanic or Latino, check “yes” *and* inquire about which ethnic group the client considers him/herself.

Read the available response options. If the client identifies a group that is not represented on the list, select “other” and write in the group.

Additional Probes None

Coding Topics/Definitions

Response options for the first part of the question: Are you Hispanic or Latino are “yes,” “no,” and “refused.”

The follow-up question is: [If yes] What ethnic group do you consider yourself? Please answer “yes” or “no” for each of the following. You may say “yes” to more than one. Read the available response options, and allow the respondent to answer “yes” or “no” to each. If the client identifies an ethnicity that is not on the list, select “other,” and write in the ethnicity.

Cross-Check Items None

Skip Pattern

Skip the second half of the question (If yes, what ethnic group do you consider yourself) if the answer to the first part of the question (Are you Hispanic or Latino) is “no” or “refused.”

A3 WHAT IS YOUR RACE? PLEASE ANSWER YES OR NO FOR EACH OF THE FOLLOWING. YOU MAY SAY YES TO MORE THAN ONE.

Intent/Key Points

The intent of the question is to determine what race the client considers himself or herself. Record the response given by the client, not the interviewer’s opinion.

Read the available response options, and allow the respondent to answer “yes” or “no” to each.

Additional Probes None

Coding Topics/Definitions

Ask this question of all clients, even those who identified themselves as Hispanic or Latino.

The client can choose "yes" to as many as apply.

The client may respond "no" to all races.

Cross-Check Items None

Skip Pattern None

A4	**WHAT IS YOUR DATE OF BIRTH?**

Intent/Key Points

The intent is to record the client's month and year of birth. You may record month, day, and year of birth for the program's records, but only the month and year will be entered and saved in the computer system.

Additional Probes None

Coding Topics/Definitions

Enter date as mm/dd/yyyy. The system will only save the month and year. Day is not saved to maintain confidentiality.

Cross-Check Items None

Skip Pattern None

A5	**HAVE YOU EVER SERVED IN THE ARMED FORCES, IN THE RESERVES, OR IN THE NATIONAL GUARD? [IF SERVED] WHAT AREA, THE ARMED FORCES, RESERVES, OR NATIONAL GUARD DID YOU SERVE?**

Intent/Key Points

The intent of this question is to collect information on the client's military service status. (Note: military service status identifies whether or not the client has served in the U.S. Armed Forces [Army, Navy, Air Force, Marine Corps, Coast Guard], Reserves, or National Guard). This item will allow CSAT to identify the number of clients who have ever served in the military. Identifying a client's military service status allows CSAT and its discretionary grantees the ability to monitor the outcomes for these clients.

Note that this is a two-part question. If the client indicates "yes," the area of service must be recorded.

Additional Probes

Probe to determine if client is currently serving or has served in the U.S. military. This question refers to the most recent area of service. Only one response should be coded.

Coding Topics/Definitions

The client has actively served in the U.S. Armed Forces, in the Reserves, or in the National Guard.

No—Client responds that he or she is not or never was in the Armed Forces, in the Reserves, or in the National Guard

Yes—Client responds that he or she is in or has been in the Armed Forces.

Yes—Client responds that he or she is in or has been in the Reserves.

Yes—Client responds that he or she is in or has been in National Guard.

Refused—Client refuses to respond.

Don't know—Client responds that he or she doesn't know.

Cross-Check Items **None**

Skip Pattern If the answer to A5 is "no," "refused," or "don't know," skip to question A6.

A5A ARE YOU CURRENTLY ON ACTIVE DUTY IN THE ARMED FORCES, IN THE RESERVES, OR IN THE NATIONAL GUARD? [IF ACTIVE] WHAT AREA, THE ARMED FORCES, RESERVES, OR NATIONAL GUARD?

Intent/Key Points

The intent of this question is to collect information on the client's current active duty status. (Note: military service status identifies whether or not the client is serving in the U.S. Armed Forces (Army, Navy, Air Force, Marine Corps, Coast Guard, Reserves, or National Guard). This item will allow CSAT to identify the number of clients who are currently on active duty in the military. Identifying a client's active duty status allows CSAT and its discretionary grantees the ability to monitor the outcomes for these clients.

Note that this is a two-part question. If the client indicates “yes,” you must inquire what area of the military he or she is currently serving. Only one response should be coded.

Additional Probes

Active duty refers to a client that is currently serving in the U.S. Armed Forces, in the Reserves, or in the National Guard.

Separated refers to a client that has left active duty service in the U.S. Armed Forces, in the Reserves, or in the National Guard, but might still have an obligation to serve.

Retired refers to a client that left active service in the U.S. Armed Forces, in the Reserves, or in the National Guard. They were under orders in the past and no longer have an obligation to serve.

Coding Topics/Definitions

The client is currently on active duty in the U.S. Armed Forces, in the Reserves, or in the National Guard.

Yes – The client responds that he or she is in the Armed Forces.

Yes – The client responds that he or she is in the Reserves.

Yes – The client responds that he or she is in the National Guard.

No -- The client responds that he or she is discharged, separated, or retired from the Armed Forces, Reserves, or National Guard.

Refused— Client refuses to respond.

Don’t know—Client responds that he or she doesn’t know.

Cross-Check Items **None**

Skip Pattern

A5a should be skipped if the client’s response to A5 is “no,” “refused,” or “don’t know.”

A5B HAVE YOU EVER BEEN DEPLOYED TO A COMBAT ZONE? [CHECK ALL THAT APPLY]

Intent/Key Points

The intent of this question is to determine whether a client has ever been deployed to a combat zone.

Note that this is a two-part question. If the client indicates "yes," the combat zone(s) must be ascertained from the client.

Additional Probes

Deployment is the relocation of forces and material to desired operational areas. Deployment encompasses all activities from origin or home station through destination.

Combat zone refers that area required by combat forces for conduct of operations. A combat zone is any area the President of the United States designates by Executive Order as an area in which the U.S. Armed Forces are engaging or have engaged in combat. An area usually becomes a combat zone and ceases to be a combat zone on the dates the President designates by Executive Order.

"OEF" refers to Operation Enduring Freedom.

"OIF" refers to Operation Iraqi Freedom.

"OND" refers to Operation New Dawn.

Coding Topics/Definitions

The client has been deployed to a combat zone.

Never Deployed – The client was never deployed to a combat zone.

Yes – The client was deployed to Iraq or Afghanistan (i.e., OEF, OIF, OND).

Yes – The client was deployed in the Persian Gulf War (i.e., Operation Desert Shield, or Desert Storm).

Yes – The client was deployed to Vietnam/Southeast Asia.

Yes – The client was deployed to Korea.

Yes – The client was deployed in World War II (WWII).

Yes – The client was deployed in a combat zone other than the ones listed above (e.g., Bosnia, Somalia).

Refused— Client refuses to respond.

Don't know— Client responds that he or she doesn't know.

Cross-Check Items **None**

Skip Pattern

A5b should be skipped if the client's response to A5 is "no," "refused," or "don't know."

A6	**IS ANYONE IN YOUR FAMILY OR SOMEONE CLOSE TO YOU ON ACTIVE DUTY IN THE ARMED FORCES, IN THE RESERVES, OR IN THE NATIONAL GUARD , OR SEPARATED OR RETIRED FROM THE ARMED FORCES, RESERVES, OR NATIONAL GUARD? [IF YES, ANSWER FOR UP TO 6 PEOPLE] WHAT IS THE RELATIONSHIP OF THAT PERSON (SERVICE MEMBER) TO YOU? [WRITE RELATIONSHIP IN COLUMN HEADING]**

Intent/Key Points

The intent of this question is to determine if someone in the client's immediate family or someone close to the client is or was ever on active duty, separated, or retired from the Armed Forces, Reserves, or National Guard. "Someone close to the client" is considered to be a close friend or colleague, but the phrase is ultimately left to the client's interpretation.

Note that this is a two-part question. If the client indicates "yes," then ask the second part of the question to ascertain the relationship to the client. Read the eight noncapitalized response options to your client and place the appropriate number in the column header. The client can list up to six different relationships.

Additional Probes

Active duty refers to a client that is currently serving in the U.S. Armed Forces, in the Reserves, or in the National Guard.

Separated refers to a client that has left active duty service in the U.S. Armed Forces, in the Reserves, or in the National Guard but might still have an obligation to serve.

Retired refers to a client that left active service in the U.S. Armed Forces, in the Reserves, or in the National Guard. They were under orders in the past and no longer have an obligation to serve.

Coding Topics/Definitions

Someone in the client's immediate family or someone close to the client either is or was on active duty, separated, or retired from the Armed Forces, Reserves, or National Guard.

No –	The client responds that no family member and no one close to the client is or was ever on active duty, separated, or retired from the Armed Forces, Reserves, or National Guard.
Yes –	Only one family member or someone close to the client or was ever on active duty, separated, or retired from the Armed Forces, Reserves, or National Guard.
Yes –	More than one family member or person close to the client is or was ever on active duty, separated, or retired from the Armed Forces, Reserves, or National Guard.
Refused –	The client refuses to respond to the question.
Don't know –	The client responds that he or she does not know the answer to this question.

Cross-Check Items **None**

Skip Pattern

If the answer to A6 is "no," "refused," or "don't know," skip to Section B.

A6A HAS THE SERVICE MEMBER EXPERIENCED ANY OF THE FOLLOWING? [CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY]: DEPLOYED IN SUPPORT OF COMBAT OPERATIONS (E.G. IRAQ OR AFGHANISTAN)?

Intent/Key Points

The intent of this question is to determine if someone in the client's immediate family or someone close to the client who either is or was on active duty, separated, or retired from the Armed Forces, Reserves, or National Guard was ever deployed in support of combat operations. "Service Member" is considered to be a close friend or colleague, *but the phrase is ultimately left to the client's interpretation.*

Note that this is a two-part question. If the client responds "yes," ask the second part of the question to ascertain the relationship to the client. The client can list up to six different relationships.

Additional Probes

Deployment is the relocation of forces and material to desired operational areas. Deployment encompasses all activities from origin or home station through destination.

Coding Topics/Definitions

The client responds that a "Service Member" has been deployed in support of combat operations.

Yes –	A "Service Member" has been deployed in support of combat operations. Code under the appropriate relationship.
No –	The client responds that no "Service Member" has been deployed in support of combat operations.
Refused –	The client refuses to respond to the question.
Don't know –	The client responds that he or she does not know the answer to this question.

Cross-Check Items **None**

Skip Pattern

A6a should be skipped if the client's response to A6 is "no," "refused," or "don't know."

A6B HAS THE SERVICE MEMBER EXPERIENCED ANY OF THE FOLLOWING? [CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY]: WAS PHYSICALLY INJURED DURING COMBAT OPERATIONS (E.G. IRAQ OR AFGHANISTAN)?

Intent/Key Points

The intent of this question is to determine if someone in the client's immediate family or someone close to the client who either is or was on active duty, separated, or retired from the Armed Forces, Reserves, or National Guard was injured during combat operations. "Service Member" is considered to be a close friend or colleague, but the phrase is ultimately left to the client's interpretation.

Note that this is a two-part question. If the client responds "yes," ask the second part of the question to ascertain the relationship to the client. The client can list up to six different relationships.

Additional Probes

None

Coding Topics/Definitions
The client responds that a "Service Member" was injured during combat operations.

Yes –	A "Service Member" was injured during combat operations. Code under the appropriate relationship.
No –	The client responds that no "Service Member" was injured during combat operations.
Refused –	The client refuses to respond to the question.
Don't know –	The client responds that he or she does not know the answer to this question.

Cross-Check Items **None**

Skip Pattern

A6b should be skipped if the client's response to A6 is "no," "refused," or "don't know."

A6c HAS THE SERVICE MEMBER EXPERIENCED ANY OF THE FOLLOWING? [CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY]: DEVELOPED COMBAT STRESS SYMPTOMS/DIFFICULTIES ADJUSTING FOLLOWING DEPLOYMENT, INCLUDING PTSD, DEPRESSION, OR SUICIDAL THOUGHTS?

Intent/Key Points

The intent of this question is to determine if someone in the client's immediate family or someone close to the client who either is or was on active duty, separated, or retired from the Armed Forces, Reserves, or National Guard has ever developed combat stress symptoms or difficulties adjusting following deployment, including post-traumatic stress disorder (PTSD), depression, or suicidal thoughts. "Service Member" is considered to be a close friend or colleague, but the phrase is ultimately left to the client's interpretation.

Note that this is a two-part question. If the client responds "yes," then ask the second part of the question to ascertain the relationship to the client. The client can list up to six different relationships.

Additional Probes

Combat stress symptoms include physiological and/or psychological reactions that are manifested by a variety of symptoms during or following combat. The individual is typically rendered temporarily dysfunctional. It is not considered to be a psychiatric disorder.

PTSD is defined as a type of severe anxiety disorder. It typically occurs after someone has seen or experienced a traumatic event. PTSD is a psychiatric disorder whereas combat stress symptoms are not.

This question refers to the client's perceptions of combat stress symptoms, PTSD, depression, and suicidal thoughts, not a clinical diagnosis by a counselor.

Coding Topics/Definitions
The client responds that a "Service Member" has developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts.

Yes – A "Service Member" has developed combat stress symptoms or difficulties adjusting following deployment including PTSD, depression, or suicidal thoughts. Code under the appropriate relationship.

No – The client responds that no "Service Member" has developed combat stress symptoms or difficulties adjusting following deployment including PTSD, depression, or suicidal thoughts.

Refused – The client refuses to respond to the question.

Don't know – The client responds that he or she does not know the answer to this question

Cross-Check Items **None**

Skip Pattern

A6c should be skipped if the client's response to A6 is "no," "refused," or "don't know."

A6D HAS THE SERVICE MEMBER EXPERIENCED ANY OF THE FOLLOWING? [CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY]: DIED OR WAS KILLED?

Intent/Key Points

The intent of this question is to determine if someone in the client's immediate family or someone close to the client who was ever on active duty, separated, or retired from the Armed Forces, Reserves, or National Guard died or was killed in combat operations. "Service Member" is considered to be a close friend or colleague, but the phrase is ultimately left to the client's interpretation.

Note that this is a two-part question. If the client responds "yes," ask the second part of the question to ascertain the relationship to the client. The client can list up to six different relationships.

Additional Probes

None

Coding Topics/Definitions

The client responds that a "Service Member" has died or was killed during combat operations.

Yes –	A "Service Member" has died or was killed in combat operations. Code under the appropriate relationship.
No –	The client responds that no "Service Member" has died or was killed in combat operations.
Refused –	The client refuses to respond to the question.
Don't know –	The client responds that he or she does not know the answer to this question.

Cross-Check Items **None**

Skip Pattern

A6d should be skipped if the client's response to A6 is "no," "refused," or "don't know."

SECTION B: DRUG AND ALCOHOL USE

OVERVIEW

This section contains items to measure alcohol and other drug use in the past 30 days. To ensure that the client understands the terms you are using, you may need to use slang or local terminology for the different technical drug terms. (Slang terms provided in parentheses are only a guide.) Be attentive to the client and what words he or she uses.

Ask specifically about behavior in "the past 30 days." Do not use "in the past month" as a substitute—this may lead to confusion and inaccurate responses. For example, if the interview occurs on May 15th, the past 30 days covers April 15 to May 15.

All programs, with the exception of Offender Re-entry (ORP) and Enhancing Adult Drug Court Services, Coordination, and Treatment (EADCSCT), for questions B1 thru B2, will use "the past 30 days" for questions that captures the number days.

ORP and EADCSCT grants should ask about drug use in "the past 90 days" prior to incarceration for questions B1 thru B2 at intake/baseline and "the past 90 days" at follow-up and discharge.

B1A–B1D DURING THE PAST 30 DAYS, HOW MANY DAYS HAVE YOU USED THE FOLLOWING?

Intent/Key Points

The intent is to record information about the client's recent alcohol and illegal substance use. Record the number of *days* in the last 30 that the client reported any use at all of a particular substance. *The response cannot be more than 30 days for any one category except for ORP and EADCSCT grants where response categories cannot be more than 90 days.*

It is important to ask all alcohol use questions in item B1b1-B1b2 regardless of the presenting problem. *If the client answers zero days to question B1a, skip to question B1c.*

Additional Probes None

Coding Topics/Definitions

B1a *Any alcohol*—Beer, wine, liquor, grain alcohol.

B1b1 *Alcohol to intoxication (5+ drinks in one sitting)*—Refers to the client drinking five or more drinks in one sitting or within a brief period of approximately 1 to 2 hours. If a client reports drinking five or more drinks in one sitting or within a brief period and denies feeling the effects of the alcohol you should still count as alcohol to intoxication.

B1b2 *Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)*—If the client drinks four or fewer drinks in one sitting and feels the effects of alcohol (i.e., getting a "buzz," "high," or drunk), it counts as alcohol to intoxication. If the client reports drinking four or fewer drinks in one sitting and not feeling the effects of alcohol, do not count it here.

A drink is equal to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of liquor. (Retrieved April 10, 2006, from http://pathwayscourses.samhsa.gov/aaac/aaac_2_pg2.htm).

B1c *Illegal drugs*—Unprescribed use of prescription medication or misuse of prescribed medication (e.g., taking more than prescribed) should be counted as the use of illegal drugs in item B1c, and coded under the appropriate generic category in item B2. Additionally, misuse of over-the-counter medications to get high should be counted as use of illegal drugs in question B1c and marked as "other" and specified under B2i. Misuse of over-the-counter products (rubber cement, aerosols, gasoline, etc.) which are sniffed, huffed, or otherwise inhaled to get high should be counted as use of illegal drugs in item B1c and coded under inhalants in B2h.

Use of marijuana, whether prescribed or not, should be counted as the use of illegal drugs in item B1c and counted in item B2b. (Federal law does not recognize use of prescribed marijuana.) Marinol, which also contains THC, is a legal drug and should only be counted if the client is using it in an unprescribed manner. Use of nicotine (i.e., cigarettes, cigars, chewing tobacco, snuff) by clients under the age of 18 years should be counted as the use of illegal drugs in item B1c, and counted as other illegal drugs in item B2i.

B1d *Both alcohol and drugs (on the same day)*—Refers to the client using any alcohol and any illegal drugs on the same day.

Cross-Check Items

Cross-check items B1b1 and B1b2 with item B1a. The number of days reported in items B1b1 and B1b2, either individually or the combined total, cannot be more than the number of days reported in item B1a. The number of days reported in B1d cannot exceed the number of days reported in either B1a or B1c. *The response cannot be more than 30 days for any one category except for ORP and EADCSCT grants where response categories cannot be more*

than 90 days.

Skip Pattern

If the response to B1a is zero, skip to question B1c.

If the response to B1a and/or B1c is "zero," "refused," or "don't know," skip B1d.

B2A–B2I	**DURING THE PAST 30 DAYS, HOW MANY DAYS HAVE YOU USED ANY OF THE FOLLOWING?**

Intent/Key Points

The intent is to record information about the client's recent illegal substance use. Record the number of *days* in the last 30 that the client reported any use at all of a particular substance.

The response cannot be more than 30 days for any one category except for ORP and EADCSCT grants where response categories cannot be more than 90 days.

It is important to ask all substance abuse history questions in item B2a-B2i regardless of the presenting problem even if the client answered zero days to item B1c.

Unprescribed use of prescription medication or misuse of prescribed medication (e.g., taking more than prescribed), or misuse of over-the-counter products (e.g., huffing, sniffing, inhaling) and use of tobacco by someone under the age of 18 should be counted as the use of illegal drugs in item B1c, and coded under the appropriate generic category in item B2.

Additional Probes

If the client indicates that he/she is taking a drug that is usually prescribed, probe for unprescribed use (e.g., taking six pills a day as opposed to the prescribed two pills a day) or unprescribed procurement (e.g., I got the pills from my friend).

Additionally, probe to determine if the individual obtained the prescription under fraudulent means (faking an illness) and then takes the medication as prescribed. If so, it should be counted as illegal use.

Coding Topics/Definitions

Prompt the client with examples (using slang and brand names) of drugs for each specific category. You may use local slang terms for any particular drug that is used in your area.

B2a *Cocaine/crack*—Cocaine crystal, free-base cocaine, crack, or rock cocaine.

Count all forms of cocaine in the same category (even though cocaine is used in many forms and often with different names).

B2b *Marijuana/Hashish*—Use of marijuana, whether prescribed or not, should be counted as the use of illegal drugs in item B1c and counted in item B2b. Marinol, which also contains THC, is a legal drug and should only be counted if the client is using it in an unprescribed manner. (Federal law does not recognize use of prescribed marijuana.)

B2c *Opiates*—Ask about use of each opiate separately: heroin; morphine; Diluadid; Demerol; Percocet; Darvon; codeine; Tylenol 2,3,4; Oxycontin/Oxycodone.

If the client indicates that he/she is taking an opiate that is usually prescribed, probe for unprescribed use (e.g., taking six pills a day as opposed to the prescribed two pills a day) or unprescribed procurement (e.g., I got the pills from my friend). Record under the appropriate opiate category.

Tylenol 2, Tylenol 3, and Tylenol 4 are acetaminophen (Tylenol) with varying levels of codeine added. Record unprescribed use of these under Tylenol 2, 3, 4.

B2d *Nonprescription methadone*—Dolophine, LAAM.

Unprescribed use of LAAM should be counted as nonprescription methadone.

B2e *Hallucinogens/psychedelics, PCP, MDMA, LSD, mushrooms, or mescaline*—Psilocybin, peyote (except if used in a Native American setting for religious purposes), green.

B2f *Methamphetamine or other amphetamines*—Monster, amp, benzedrine, dexedrine, ritalin, preludin.

B2g1 *Benzodiazepines*—Ativan, Librium.

B2g2 *Barbiturates*—Amytal, seconal, phenobarbital.

B2g3 *Nonprescription GHB*—Liquid Ecstasy, Grievous Bodily Harm, Georgia Home Boy.

B2g4 *Ketamine*—Ketalar, cat valium.

B2g5 *Other tranquilizers, downers, sedatives, or hypnotics*—Dalmane, haldol, quaaludes.

B2h *Inhalants*—Nitrous oxide, amyl nitrate, glue, solvents, gasoline, toluene, aerosols (hair spray, Lysol, air freshener).

B2i *Other illegal drugs (specify)*—List any drugs not included above, misuse of over-the-counter medication used by the client to get high, and use of nicotine (i.e., cigarettes, cigars, chewing tobacco, snuff) by clients under the age of 18 years should be counted as the use of illegal drugs in item B1c, and counted as other illegal drugs here.

Cross-Check Items

Cross-check items B2a-B2i with item B1c. The number of days reported in item B1c must be greater than or equal to the number of days reported for any drug in item B2. If the client reports no use of illegal drugs in item B1c, then items B2a through B2i should be zero.

The response cannot be more than 30 days for any one category except for ORP and EADCSCT grants where response categories cannot be more than 90 days.

Skip Pattern None

B2A–B2I ROUTE OF ADMINISTRATION

Intent/Key Points

The intent is to record information about the typical way in which the client administers the illegal drugs he/she uses. Ask this question for each item (B2a-B2i) in which at least 1 day of use is indicated.

Additional Probes

If more than one route of administration is used for the same illegal drug over the past 30 days, choose the one that is used most often. (ORP and EADCSCT grants ask about use during "the past 90 days" prior to incarceration at intake/baseline and "the past 90 days" at follow-up and discharge). If there is more than one route of administration used most often, and they are used equally, choose the most severe. (The routes of administration are numbered in order of their severity with one being the least severe and five being the most severe.)

Example: The interviewer asks the client, "During the past 30 days, how many days have you used the following…Cocaine/crack?" If the client reports at least 1 day of use, the interviewer then asks, "What was the route of administration?" and reads the options. If the client has difficulty understanding what is meant by "route of administration," the interviewer may say "How did you most commonly take the drug?" and record the response.

Example: A client smokes an illegal drug 6 days in the past 30 days and injects the same illegal drug for 4 days, record "3—smoking" because it was the most common route of administration.

Example: A client smokes and intravenously (IV) injects the same illegal drug for 6 days (equally), record "5-IV," because it is the most severe route of administration used equally.

Coding Topics/Definitions

You can indicate only one response. Record the number that corresponds to the most common or usual route of administration. If more than one route of administration is used for the same illegal drug over the past 30 days, choose the one that is used most often. If there is more than one route of administration used most often, and they are used equally, choose the most severe. (ORP and EADCSCT grants ask about use during "the past 90 days" prior to incarceration at intake/baseline and "the past 90 days" at follow-up and discharge). The routes are listed in order of severity, with one being the least severe and five the most severe. If client indicates that he/she injected a substance, non-IV or IV injection needs to be specified.

1. *Oral*—Includes ingesting, swallowing, drinking, or dissolving drugs in the mouth or sublingually.

2. *Nasal*—Includes snorting, sniffing, or otherwise inhaling substances to get high. Includes huffing or sniffing a product or fumes from a product in order to get high. Includes use of anal suppositories, since the drug is also absorbed through the "membrane," (per ASI 11-8-05). Also includes absorption through the skin (e.g., a patch).

3. *Smoking*—Includes lighting or heating the drug and inhaling the resulting smoke. This includes smoking the drug on its own (in a pipe, bong, etc.) and putting the drug in a tobacco cigarette to be smoked.

4. *Non-IV Injection*—Includes injecting drugs subcutaneously (skin popping) or into muscles.

5. *IV*—Includes injecting drugs into veins.

Cross-Check Items None

Skip Pattern

Ask only for items that have been used during the past 30 days (ORP and EADCSCT grants ask about use during "the past 90 days" prior to incarceration at intake/baseline and "the past 90 days" at follow-up and discharge).

Do not ask if the number of days of use was "zero," "refused," or "don't know."

B3	**IN THE PAST 30 DAYS, HAVE YOU INJECTED DRUGS?**

Intent/Key Points

The intent is to record information about the client's recent illegal injection behavior. Record the client's response, even if there is evidence to the contrary.

Additional Probes None

Coding Topics/Definitions

Injection can pertain to either intravenous injection (into a vein) or nonintravenous (under the skin or into a muscle). Do not count injection of legal and prescribed medications (i.e., insulin, hormones).

Cross-Check Items

If client indicates that the route of administration of any substance in Item B2a thru B2i is non-IV injection or IV, the response to Item B3 should be "yes."

Skip Pattern

If the answer to B3 is "no," "refused," or "don't know," skip to question C1.

B4	**IN THE PAST 30 DAYS, HOW OFTEN DID YOU USE A SYRINGE/NEEDLE, COOKER, COTTON, OR WATER THAT SOMEONE ELSE USED?**

Intent/Key Points

The intent is to record information about HIV/AIDS and other infectious disease risks associated with injection behavior in the past 30 days. Read all response options for frequency of needle or paraphernalia sharing.

Additional Probes None

Coding Topics/Definitions

If the client does not recognize the items listed, you may ask if they have used "works," or other local slang terminology, that someone else has used in the last 30 days.

Cross-Check Items None

Skip Pattern

Ask this question only if the client said "yes" in item B3.

SECTION C: FAMILY AND LIVING CONDITIONS

OVERVIEW

This section pertains to the client's living situation during the past 30 days as well as the impact that his/her drug or alcohol abuse has had on his/her stress levels, emotional well-being, and involvement in important activities.

C1	**IN THE PAST 30 DAYS, WHERE HAVE YOU BEEN LIVING MOST OF THE TIME?**

Intent/Key Points

The intent is to record information about the client's living situation in the past 30 days. Read the item as an open-ended question and then code the client's response in the appropriate category.

Additional Probes

If the client asks what is meant by where has he/she been living most of the time, explain that it means where has he/she been staying or spending his/her nights. If the client is having trouble remembering, start with the past evening and work backward in small increments (i.e., "Where did you sleep last night? Where did you sleep most of last week?").

Coding Topics/Definitions

You can check only one response. If the client has been living in more than one place for the past 30 days, count where he/she has been living the longest.
If a client reports "living the longest" in more than one location for an equal amount of time, record the most recent.

For example, if a client reports living the first 14 days in their home, the next 14 days in a shelter, and the last 2 days in jail, you would record "Shelter."

Shelter—Count safe havens, transitional living centers [TLC], low demand facilities, reception centers, and other temporary day or evening facilities.

Street/outdoors—Count living in cars, vans, or trucks as "street."

Institution—Count hospitalization, incarceration, and correctional boot camp (especially for adolescents) as "institution."

Housed—Count living in group homes, trailers, hotels, dorms, or barracks as "housed" and check appropriate subcategory. Probe clients if they indicate "group homes" to determine if it should be counted as a halfway house or residential treatment. Probe clients if they are living in dormitory/college residence.

Own/rent apartment, room, or house—Count living in a room, boarding house, public or subsidized housing, hotel/motel, room at the YMCA/YWCA, and living in an RV or trailer.

Someone else's apartment, room, or house—Count living in the home of a parent, relative, friend, or guardian, "couch surfing," and foster home. Adolescents living at home should be coded here if they are not paying a standard rental rate to the homeowner.

Dormitory/college residence—Count living in a college or dormitory.

Halfway house—Count living in a three-quarter house.

Residential treatment—Count living in a residential facility that provides on-site structured therapeutic and supportive services.

Cross-Check Items

Note response here and compare to response for jail/prison. Section E: Crime and Criminal Justice Status Instructions. Item E3: In the past 30 days, how many nights have you spent in jail/prison? If E3 is greater than 15, then C1 should be coded as institution.

Skip Pattern None

C2 DURING THE PAST 30 DAYS, HOW STRESSFUL HAVE THINGS BEEN FOR YOU BECAUSE OF YOUR USE OF ALCOHOL OR OTHER DRUGS?

Intent/Key Points

The intent is to record the client's feelings about how stressful things have been for them in the past 30 days, due to drug or alcohol problems. The question addresses stress in the past 30 days due to use of alcohol or other drugs, *even if there has been no alcohol or drug use in the past 30 days*. Even if the client has not used in the past 30 days, he/she may still feel stress due to his/her prior use.

Read the first four noncapitalized response options and have the client choose one.

Additional Probes

Examples of stress can include, but are not limited to, feeling overwhelmed or nervous, a craving for alcohol or drugs, withdrawal symptoms, disturbing effects of drug or alcohol intoxication or withdrawal, or wanting to stop and not being able to do so.

Coding Topics/Definitions

Not at all—This option should be checked when the client *has* used alcohol or other drugs in the past 30 days (see Section B), but indicates that things have not been at all stressful for him/her.

Not applicable—This option should be checked when the client *has not* used alcohol or other drugs in the past 30 days (see Section B), *and* indicates that things have not been at all stressful for him/her.

Cross-Check Items

Check responses to questions B1a and B1c to determine whether to check "not at all" or "not applicable" for clients who say that things have been not at all stressful in the past 30 days.

Skip Pattern None

C3 DURING THE PAST 30 DAYS, HAS YOUR USE OF ALCOHOL OR OTHER DRUGS CAUSED YOU TO REDUCE OR GIVE UP IMPORTANT ACTIVITIES?

Intent/Key Points

The intent is to determine if the client's use of alcohol or other drugs has caused him/her to reduce or give up important activities during the past 30 days. The question addresses reducing or giving up important activities during the past 30 days due to use of alcohol or other drugs, *even if there has been no alcohol or drug use in the past 30 days*. Even if the client has not used in the past 30 days, he/she may still feel that alcohol or drug use has caused him/her to reduce or give up important activities.

Read the first four noncapitalized response options and have the client choose one.

Additional Probes

Important activities can include work, school, family responsibilities, treatment involvement, legal responsibilities (e.g., probation appointments), or special events.

Coding Topics/Definitions

Not at all—This option should be checked when the client *has* used alcohol or other drugs in the past 30 days (see Section B), but indicates that he/she has not at all reduced or given up important activities.

Not applicable—This option should be checked when the client has *not* used alcohol or other drugs in the past 30 days (see Section B), *and* indicates that he/she has not at all reduced or given up important activities.

Cross-Check Items

Check responses to questions B1a and B1c to determine whether to check “not at all” or “not applicable” for clients who say that important activities have not at all been reduced or given up in the past 30 days.

Skip Pattern None

C4	**DURING THE PAST 30 DAYS, HAS YOUR USE OF ALCOHOL OR OTHER DRUGS CAUSED YOU TO HAVE EMOTIONAL PROBLEMS?**

Intent/Key Points

The intent is to determine if the client’s use of alcohol or other drugs has caused him/her to have emotional problems during the past 30 days. The question refers to the client’s perception of emotional problems, not a clinical diagnosis by the counselor. The question addresses having emotional problems in the past 30 days due to use of alcohol or other drugs, *even if there has been no alcohol or drug use in the past 30 days*. Even if the client has not used in the past 30 days, he/she may still feel that alcohol or drug use has caused him/her to have emotional problems.

Read the first four noncapitalized response options and have the client choose one.

Additional Probes

If the client does not recognize or understand the term “emotional problems” you may provide examples. Examples of emotional problems include feelings of anxiousness, sadness, insomnia (inability to sleep), stress, or anger.

Coding Topics/Definitions

Not at all—This option should be checked when the client *has* used alcohol or other drugs in the past 30 days (see Section B), but indicates that he/she has not at all experienced emotional problems.

Not applicable—This option should be checked when the client has *not* used alcohol or other drugs in the past 30 days (see Section B), *and* indicates that he/she has not at all experienced emotional problems.

Cross-Check Items

Check responses to questions B1a and B1c to determine whether to check “not at all” or “not applicable” for clients who say that use of alcohol or other drugs have not at all caused emotional problems in the past 30 days.

Skip Pattern None

C5 [IF NOT MALE,] ARE YOU CURRENTLY PREGNANT?

Intent/Key Points

The intent is to determine whether a client is currently pregnant.

Additional Probes None

Coding Topics/Definitions

If the client does not know whether she is pregnant, mark "don't know."

Cross-Check Items None

Skip Pattern

C5 should be skipped if the client answers "male" to A1. If the client answered "female," "transgender," or "other" to A1, ask the question.

C6 DO YOU HAVE CHILDREN?

Intent/Key Points

Ask this question of all clients, regardless of their gender. The intent is to record whether the client has any children, regardless of whether the children live with the client or not. Include all children except children for whom the client has never had legal custody or has never been legally responsible.

Additional Probes

If the client has children, whether or not the children live with the client, the answer to this question should be "yes." This question does *not* include:

- Children for whom the client has never had legal custody or has never been legally responsible (e.g., grandchildren for whom parental rights have not been granted to the grandparent).
- Children who the client is babysitting or taking care of on a temporary basis (e.g., a neighbor's children).
- Foster children.

However, this question *does* include:

- Adult children of any age.
- Adopted children.

- Stepchildren for whom the client is legally responsible.
- Deceased children.

Coding Topics/Definitions

Response options for this question are:

Yes—Client has children, whether living with them or not, of any age, including deceased children, and adopted/step children.

No—Client has no children.

Cross-Check Items None

Skip Pattern

If the response to C6 is “no,” “refused,” or “don’t know,” skip to Section D.

C6A HOW MANY CHILDREN DO YOU HAVE?

Intent/Key Points

The intent is to record the number of children the client has, even if they are not living with the client. Include all children except children for whom the client has never had legal custody or has never been legally responsible.

Additional Probes None

Coding Topics/Definitions

This is the number of children the client has, whether living with the client or not. This question does *not* include:

- Children for whom the client has never had legal custody or has never been legally responsible (e.g., grandchildren for whom parental rights have not been granted to the grandparent).
- Children who the client is babysitting or taking care of on a temporary basis (e.g., a neighbor’s children).
- Foster children.

However, this question *does* include:

- Adult children of any age.
- Adopted children.

- Stepchildren for whom the client is legally responsible.
- Deceased children.

Cross-Check Items

If response to C6 is “yes,” then C6a must be greater than zero. The response to question C6c cannot exceed the response to question C6a. The response to question C6d cannot exceed the response to question C6a.

Skip Pattern

C6a should be skipped if the client’s response to C6 is “no,” “refused,” or “don’t know.”

C6B ARE ANY OF YOUR CHILDREN LIVING WITH SOMEONE ELSE DUE TO A CHILD PROTECTION COURT ORDER?

Intent/Key Points

The intent is to determine whether any of the client’s children are living with someone else due to a *protection court order*. This would not include children who are living elsewhere due to any other reasons (including adoption [if voluntary surrender], family disputes, personal decision, voluntary surrender of parental rights, etc.).

Additional Probes

If the client does not understand the term “child protection court order,” explain that it means a formal order by a court or child protection agency describing where and under whose supervision the child will be living or staying.

Coding Topics/Definitions

Response options for this question are:

Yes—Client has children who are *under the age of 18* living with someone else due to a protection court order.

No—Client has no children who are *under the age of 18* living with someone else due to a protection court order.

Cross-Check Items None

Skip Pattern

If the response to C6b is “no,” “refused,” or “don’t know,” skip to question C6d. C6b should be skipped if the client’s response to C6 is “no,” “refused,” or “don’t know.”

C6C [IF YES] HOW MANY OF YOUR CHILDREN ARE LIVING WITH SOMEONE ELSE DUE TO A CHILD PROTECTION COURT ORDER?

Intent/Key Points

The intent is to determine how many of the client's children are currently living with someone else due to a protection court order. This would not include children that are living elsewhere due to any other reasons (including adoption, family disputes, personal decision, etc.).

Additional Probes

If the client does not understand the term "child protection court order," explain that it means a formal order by a court or child protection agency describing where and under whose supervision the child will be living or staying.

Coding Topics/Definitions

This is the number of children *under the age of 18* that the client has who are currently living with someone else due to a child protection court order.

Cross-Check Items

The response to question C6c cannot exceed the response to question C6a.

Skip Pattern

C6c should be skipped if the client's response to C6 or C6b is "no," "refused," or "don't know."

C6D FOR HOW MANY OF YOUR CHILDREN HAVE YOU LOST PARENTAL RIGHTS? (THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.)

Intent/Key Points

The intent is to determine for how many children the client currently does not have parental rights. This number should include *all* children for whom parental rights have been revoked by a formal court order (not voluntary surrender). If a client voluntarily gives up his/her child for adoption, that is not counted here. *This includes all children, regardless of the child's age*.

Additional Probes

If the client does not understand the term "parental rights," explain that it means that the client no longer has the opportunity to regain legal custody of their child.

Coding Topics/Definitions

This is the number of children for whom the client has lost parental rights.

Cross-Check Items

The response to question C6d cannot exceed the response to question C6a.

Skip Pattern

C6d should be skipped if the client’s response to C6 is “no,” “refused,” or “don’t know.”

SECTION D: EDUCATION, EMPLOYMENT, AND INCOME

OVERVIEW

This section collects information about the respondent's educational and financial resources. To ensure that the client gives an answer that corresponds to one of the response choices, *only read and explain the choices if necessary.*

D1	**ARE YOU CURRENTLY ENROLLED IN A SCHOOL OR A JOB TRAINING PROGRAM? [IF ENROLLED] IS THAT FULL TIME OR PART TIME?**

Intent/Key Points

The intent is to determine whether the client is currently involved in any educational or job training program.

Note that this is a two-part question. If the client responds that he/she is not enrolled, check "not enrolled." If the client responds that he/she is enrolled, you must inquire if that enrollment is full- or part-time or other.

Additional Probes

Job training programs can include apprenticeships, internships, or formal training for a trade.

Coding Topics/Definitions

Full- or part-time definitions will depend on the institution where the client is enrolled.

Enrolled, full time—Usually full-time enrollment is 12 or more credit hours per week for undergraduate enrollment and 9 or more credit hours per week for graduate enrollment. For some job training programs full-time may be 20 hours per week or more.

Enrolled, part time—If the client is enrolled in school or a job training program for anything less than full time, it is considered part-time enrollment.

Other—If the client is enrolled in school or a job training program, but not full- or part-time, specify the terms of enrollment under "other."

If a client is incarcerated, code as "not enrolled." However, if there are credits and/or a degree earned, include these in item D2.

Cross-Check Items None

Skip Pattern None

D2	**WHAT IS THE HIGHEST LEVEL OF EDUCATION YOU HAVE FINISHED, WHETHER OR NOT YOU RECEIVED A DEGREE?**

Intent/Key Points

The intent is to record basic information about the client's formal education. Check the appropriate response to indicate the grade or year of school that the client has *completed*. This can include education received while incarcerated.

Additional Probes None

Coding Topics/Definitions

The question asks the highest grade or year in school that the client has *completed*. Response options for this question are as follows:

Never attended school—The client never attended school or dropped out prior to completing 1st grade.

1st grade completed – 11th grade completed—Choose the response that corresponds with the grade level or year in school that the client has completed.

12th grade completed/high school diploma/equivalent—The client has completed 12th grade, graduated from high school, or completed a general equivalence degree.

College or university/1st year completed—The client has completed 1 full year of college or university coursework. This typically corresponds with completing between 30 and 59 credit hours of college or university coursework, or moving on to but not completing sophomore status at a college or university.

College or university/2nd year completed/associate's degree (e.g., AA, AS) —The client has completed 2 full years of college or university coursework and/or has received his/her associate's degree. Two years of coursework typically corresponds with completing between 60 and 89 credit hours of college or university coursework, or moving on to but not completing junior status at a college or university.

College or university/3rd year completed—The client has completed 3 full years of college or university coursework. This typically corresponds with completing between 90 and 119 credit hours of

college or university coursework, or moving on to but not completing senior status at a college or university.

Bachelor's degree (e.g., BA, BS) or higher—The client has received his/her undergraduate or graduate degree. This includes clients who have received a doctorate-level degree.

Voc/tech program after high school but no voc/tech diploma—The client attended but did not complete vocational or technical training after high school.

Voc/tech diploma after high school—The client completed his/her vocational or technical training after high school.

Determining level for those who dropped out of school—If the client dropped out of high school in the middle of his/her junior year (11th grade), and he/she has not completed any other education programs, you would enter 10 as the highest level of education completed.

Continued education following dropping out—Whether or not the client received a regular high school diploma or general equivalency diploma (GED) if he/she completed additional years in school, select the response associated with the highest year in school completed.

> For example, if the client dropped out of school after completing his/her 10th-grade year and subsequently returned to school as an adult and received a bachelor's degree, you would check the response option "bachelor's degree (BA or BS) or higher."

Distance learning—If the client completed additional years of education via distance learning probe to obtain the grade level or year of distance learning completed.

Cross-Check Items None

Skip Pattern None

D3 ARE YOU CURRENTLY EMPLOYED?

Intent/Key Points

The intent is to determine the client's current employment status. Focus on the status during most of the previous week to determine whether the client worked at all or had a regular job but was off work. Only legal employment (i.e., the job activity is legal) is counted as employment.

Note that this is a two-part question. First determine whether or not the client is employed, then determine his/her status. If the client indicates that he/she is employed you must then determine whether it is full- or part-time. If the client indicates that he/she is unemployed, you must then determine the current status as it relates to unemployment.

Four or more days is considered most of the previous week.

Additional Probes

If the client responds "employed," ask if the job is full- or part-time.

If the client responds "unemployed," ask how long he/she has been unemployed and what prompted the unemployment. You may read the response categories as a probe. Check off the appropriate category.

Gambling, even if it is in a legal casino, is not counted as employment unless the client is an employee of the casino as a dealer or in some other capacity.

If a client is incarcerated and has a job through the jail but no other outside work, record unemployed, not looking for work.

Coding Topics/Definitions

Employment—Employment includes work performed even if the client is paid "under the table" or is working without a permit (in the case of undocumented persons) *as long as the work would be considered legal otherwise*. Employment includes those who are self-employed and those who are receiving services in exchange for their work (e.g., housing, schooling, or care).

Employed full-time—If the client works 35 hours or more a week, regardless of how many jobs make up this time, count as employed full-time. Day work or day labor for 35 or more hours per week should be counted as full-time employment. "Or would have been" means that the client usually works 35 hours or more per week but in the past 30 days, he/she may have taken time off due to illness or a vacation. In this situation, the client should be intending to continue to work 35 hours or more per week.

Employed part-time—If the client works 1 to 34 hours per week, count as employed part-time. Day work or day labor for fewer than 35 hours per week should be counted as part-time employment.

Unemployed—If the client indicates that he/she is unemployed, ask if he/she is currently looking for employment. If necessary, read all unemployed response options. Record the response in the appropriate unemployed category.

Other—If the client is involved in active military service, count as "other" and write in "military service." If the client is working for assistance money, check "other" and put "work fair" or the type of assistance program for which he/she works. If the client's work status covers more than one category, (e.g., is retired, disabled, and does volunteer work) code "other" and write in the categories. If you are interviewing an adolescent who is working and being paid by Job Corps, count it as "other" and write in "Job Corps."

Students who are employed should be coded as full- or part-time. Students who are not working and *not* looking for work should be coded as unemployed, not looking for work. Students who are not working and are looking for work should be coded as unemployed, looking for work.

Cross-Check Items

Cross-check with item D1. Check for consistency between items. For example, if the client indicates that he/she is employed full-time and enrolled full-time in school or a job training program, ask for clarification.

Skip Pattern None

D4	**APPROXIMATELY HOW MUCH MONEY DID YOU RECEIVE (PRE-TAX INDIVIDUAL INCOME) IN THE PAST 30 DAYS FROM…**

Intent/Key Points

The intent is to record the amount of money received by the client in the last 30 days. Do not count money earned by a spouse or other members of the household, only money earned by the *client.*

Additional Probes

In some instances you may need to ask the hourly, daily, weekly, or monthly wage to determine pre-tax income.

For example, if the client tells you that he/she brings home $100 per week, you will need to ask how much he/she gets paid per hour and how many hours he/she works per week to arrive at a pre-tax income.

Coding Topics/Definitions

D4a *Wages*—Money earned through legal full- or part-time employment. Payments made "under the table" to avoid wage garnishments, taxes, etc., if earned legally would be counted here, even if work is performed within a family business.

D4b *Public assistance*—Money received from Temporary Assistance to Needy Families (TANF); welfare; food stamps; housing vouchers; transportation money; or any other source of social, general, or emergency assistance funds**.** Additionally, money made from work fair or other programs within which clients work for assistance money should be recorded here.

D4c *Retirement*—Money received from 401K plans, Social Security, military retirement, or pensions.

D4d *Disability*—Money received from Supplemental Security Income, Social Security Disability, worker's compensation, or veteran disability payments.

D4e *Nonlegal income*—Count as nonlegal income any money received from illegal activities, such as drug dealing, stealing, fencing or selling stolen goods, panhandling (if banned), illicit gambling, or illegal prostitution. If a client has received drugs in exchange for illegal activity, do not convert to a dollar amount.

D4f *Family and/or friends*—Count allowance and monetary gifts.

D4g *Other*—Money received legally from any other sources such as trust fund payments, recycling, gambling if from legal sources (lottery payments, casinos, etc.), alimony, child support, tribal per capita funds, death benefits, and stock options.

Cross-Check Items

Cross-check item D4a with item D3. If the client reports either full- or part-time employment in D3, but reports $0 for wages in D4a, probe to ensure this is correct. If the client reports that he/she is unemployed in D3 and D4a is greater than zero, probe to ensure this is correct.

Cross-check item D4b with item D3. If the client reports that he/she is unemployed and looking for work in D3, but reports $0 for public assistance in D4b, probe to ensure this is correct.

Cross-check item D4c with item D3. If the client reports that he/she is unemployed and retired in D3, but reports $0 for retirement income in D4c, probe to ensure this is correct.

Cross-check item D4d with item D3. If the client reports that he/she is unemployed and disabled in D3, but reports $0 for disability income D4d, probe to ensure this is correct.

Skip Pattern None

SECTION E: CRIME AND CRIMINAL JUSTICE STATUS

OVERVIEW

This section pertains to basic information about the client's involvement with the criminal justice system. It gathers information about arrests and incarceration or detainment. Even if the client is court mandated to treatment, these questions must be asked, and the client's answers recorded. There may be additional information that was not part of the court mandate. Some clients may be reluctant to offer this information. Reassure them of the confidentiality of the information that they are providing to you.

E1	**IN THE PAST 30 DAYS, HOW MANY TIMES HAVE YOU BEEN ARRESTED?**

Intent/Key Points

The intent is to determine how many times the client has been formally arrested and official charges were filed in the last 30 days. These instances should only include formal arrests, not times when the client was just picked up or questioned. For juvenile clients, detention would count as an arrest. When dealing with juvenile clients (those under age 18 years in most states) this information may be sealed. *Check your local laws about juvenile justice arrests.*

Additional Probes None

Coding Topics/Definitions

Arrest—An instance when a person is detained by a law enforcement officer for allegedly breaking the law and is read his/her constitutional rights (Miranda rights—the right to remain silent and the right to an attorney). This does not include times when the client was just picked up, rousted, or questioned.

For juveniles, this would include a formal detainment, since in most states juveniles are not officially arrested.

Drug arrests are counted here.

Count multiple arrests for the same charge as separate arrests.

If there is more than one charge for a single arrest, only count the arrest once.

Cross-Check Items None

Skip Pattern

If none, skip to item E3.

E2 IN THE PAST 30 DAYS, HOW MANY TIMES HAVE YOU BEEN ARRESTED FOR DRUG-RELATED OFFENSES?

Intent/Key Points

The intent is to determine how many of the client's arrests have been related only to drugs. Count the number of *times* the client has been arrested for a drug-related offense. These instances should only include formal arrests, not times when the client was just picked up or questioned. For juvenile clients (those under age 18 years in most states), detention would count as an arrest. When dealing with juvenile clients (those under age 18 years in most states), this information may be sealed. *Check your local laws about juvenile justice arrests.*

Additional Probes None

Coding Topics/Definitions

Drug-related offense—Examples of drug-related offenses are possession; possession with the intent to distribute; distribution, manufacturing, or trafficking of an illegal substance; attempt or conspiracy to do any of the previous things; possession of drug paraphernalia; driving under the influence; driving while intoxicated; and public intoxication**.**

Count multiple arrests for the same charge as separate arrests.

If there is more than one charge for a single arrest, only count the arrest once.

Cross-Check Items

Cross-check item E2 with item E1. Alcohol or illicit drug related arrests in item E2 must be less than or equal to the number of arrests in item E1.

Skip Pattern

E2 should be skipped if the client's response to E1 is zero.

E3 IN THE PAST 30 DAYS, HOW MANY NIGHTS HAVE YOU SPENT IN JAIL OR PRISON?

Intent/Key Points

The intent is to record information about whether the client has spent time in jail/prison in the last 30 days. Count the number of *nights* that the client has spent in jail/prison. *The response cannot be more than 30 nights*. Time in jail or prison can be due to an arrest and incarceration, or just an overnight detainment. Do not distinguish between actual arrest and detainment for this question. A detention center would count as jail/prison for juvenile clients.

This question should be asked of all clients, even those who indicate zero arrests in question E1.

Additional Probes

For clients who have extensive involvement in the justice system or who have memory difficulties, start by estimating how many nights in the past week and then move backward weekly until you reach 30 days.

Coding Topics/Definitions

Do not count instances in which the client was picked up and released in the same day.

Do not count house arrest, only nights in jail/prison.

Cross-Check Items

Cross-check with item C1. If the client indicates that more than 15 nights of the past 30 were spent in jail or prison, the response to item C1 should be “institution.”

If the client indicates that 15 or fewer nights of the past 30 were spent in jail or prison and the response to C1 is “institution,” check to ensure that the response for the *majority* of the past 30 nights is accurate.

Skip Pattern None

E4	**IN THE PAST 30 DAYS, HOW MANY TIMES HAVE YOU COMMITTED A CRIME?**

Intent/Key Points

The intent is to record the number of times the client has committed a crime in the past 30 days, even if he/she was not arrested for any of the crimes committed.

This question should be asked of all clients, even those who indicate zero arrests in question E1.

Additional Probes None

Coding Topics/Definitions

Committed crimes include any unlawful act whether or not it has to do with substance use. Substance use-related crimes include the following: obtaining, using, and/or possessing illegal drugs; fraudulently obtaining prescription drugs; purchasing, possessing, and/or using alcohol if under the age of 21; purchasing, possessing, and/or using tobacco products if under the age of 18.

Clients do not have to admit to committing a crime if they have been arrested. For example, a client may have been arrested for a crime he/she did not commit, so there could be an arrest

in E1, but a zero here.

Cross-Check Items

Check the number of days the client reported using illegal drugs in question B1c. The answer to question E4 should be equal to or greater than the number in B1c because using illegal drugs is a crime.

Skip Pattern None

E5 ARE YOU CURRENTLY AWAITING CHARGES, TRIAL, OR SENTENCING?

Intent/Key Points

The intent is to record whether the client is currently awaiting some resolution for an arrest or crime for which he/she has been charged.

This question should be asked of all clients, even those who indicate zero arrests in question E1.

Additional Probes None

Coding Topics/Definitions

If the client is currently awaiting charges, trial, or sentencing, the response to this question should be “yes.” This is the case even if the client is currently serving time for an unrelated arrest. If the client is not currently awaiting charges, trial, or sentencing, the response to this question should be “no.”

Cross-Check Items None

Skip Pattern None

E6 ARE YOU CURRENTLY ON PAROLE OR PROBATION?

Intent/Key Points

The intent is to record whether the client is currently on parole or probation.

This question should be asked of all clients, even those who indicate zero arrests in question E1.

Additional Probes None

Coding Topics/Definitions

If the client is currently on parole or probation, the response to this question should be "yes." If the client is not currently on parole or probation, the response to this question should be "no."

Cross-Check Items None

Skip Pattern None

SECTION F: MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

OVERVIEW

This section addresses issues of mental and physical health as well as substance abuse treatment experiences in the last 30 days.

F1	**HOW WOULD YOU RATE YOUR OVERALL HEALTH RIGHT NOW?**

Intent/Key Points

The intent of the question is to ascertain how the client would rate his/her overall health. This applies to mental, emotional, and physical health.

Additional Probes

Read all of the response choices that appear in lower-case letters and record the client's answer, *even if you have knowledge that contradicts the client's answer*. Do not read the "refused" or "don't know" response categories.

You may ask the client to clarify the response if the answer is not consistent with the image the client is presenting.

Coding Topics/ Definitions None

Cross-Check Items None

Skip Pattern None

F2Ai–F2Aiii	**DURING THE PAST 30 DAYS, DID YOU RECEIVE INPATIENT TREATMENT FOR:** **i. PHYSICAL COMPLAINT** **ii. MENTAL OR EMOTIONAL DIFFICULTIES** **iii. ALCOHOL OR SUBSTANCE ABUSE**

Intent/Key Points

The intent of the question is to determine if the client received any inpatient treatment and, if so, for how many nights. This question measures use of the medical or treatment community.

Note that this is a two-part question. First, ask the client if he/she received inpatient treatment. If the client responds affirmatively, then ask the second part to ascertain how many nights were spent receiving treatment at the institution.

The number of nights spent in treatment cannot be more than 30 for any one category.

Additional Probes

If the client is having trouble remembering, start with the past week and work backward to cover 30 days.

Coding Topics/Definitions

Treatment in the current agency should be counted under the appropriate category.

If the client received treatment under more than one category during the same stay, count each separate complaint as a separate instance.

> For example, if the client received treatment for injuries sustained during a delusional episode and for mental health issues concurrently, count the nights under physical complaint *and* mental or emotional difficulties.

Cross-Check Items None

Skip Pattern

If the client answers “no,” “refused,” or “don’t know” to receiving inpatient treatment in any category, do not ask how many nights the client stayed for that type of complaint.

F2Bi–F2Biii	**DURING THE PAST 30 DAYS, DID YOU RECEIVE OUTPATIENT TREATMENT FOR:** **i. PHYSICAL COMPLAINT** **ii. MENTAL OR EMOTIONAL DIFFICULTIES** **iii. ALCOHOL OR SUBSTANCE ABUSE**

Intent/Key Points

The intent of the question is to determine if the client received outpatient treatment, and, if so how many *times* (not days) the client received the treatment. This question addresses usage of the medical or treatment community.

Note that this is a two-part question. First, ask the client if he/she received outpatient treatment. If the client responds affirmatively, then ask the second part to ascertain how many times (session, appointments, etc.) he/she attended.

The number of *times* treatment was received in the past 30 days *can* be more than 30.

Additional Probes

If the client is having trouble remembering, start with the past week and work backward to cover 30 days.

Coding Topics/Definitions

Treatment in the current agency should be counted under the appropriate category.

If the client received treatment under more than one category during the same stay, count each separate complaint as a separate instance.

For example, if the client received treatment for injuries sustained during a delusional episode and for mental health issues concurrently, count the times under physical complaint *and* mental or emotional difficulties, as appropriate.

Outpatient treatment does not include emergency department visits.

Cross-Check Items None

Skip Pattern

If the client answers "no," "refused," or "don't know" to receiving outpatient treatment in any category, do not ask how many times the client received outpatient treatment for that type of complaint.

F2ci–F2ciii	**DURING THE PAST 30 DAYS, DID YOU RECEIVE EMERGENCY ROOM TREATMENT FOR:** **i. PHYSICAL COMPLAINT** **ii. MENTAL OR EMOTIONAL DIFFICULTIES** **iii. ALCOHOL OR SUBSTANCE ABUSE**

Intent/Key Points

The intent of the question is to determine if the client received emergency room treatment, and how many *times* (not days). This question addresses usage of the medical or treatment community. Emergency room treatment indicates that the client has visited either a hospital or emergency/urgent care clinic on a drop-in basis.

Note that this is a two-part question. First ask the client if he/she received emergency room treatment. If the client responds affirmatively, then ask the second part to ascertain how many times he/she received treatment.

The number of *times* treatment was received in the past 30 days *can* be more than 30.

Additional Probes

If the client is having trouble remembering, start with the past week and work backward to cover 30 days.

Coding Topics/Definitions

Treatment in the current agency should be counted under the appropriate category.

If the client received treatment under more than one category during the same visit, count each separate complaint as a separate instance.

For example, if the client received treatment for injuries sustained during a delusional episode and received a mental health evaluation or assessment, count the times under physical complaint *and* mental or emotional difficulties.

Cross-Check Items None

Skip Pattern

If the client answers “no,” “refused,” or “don’t know” to receiving emergency room treatment in any category, do not ask how many times the client received emergency room treatment for that type of complaint.

F3 DURING THE PAST 30 DAYS, DID YOU ENGAGE IN SEXUAL ACTIVITY?

Intent/Key Points

The intent is to determine if the client engaged in sexual activity in the past 30 days.

This activity can be with main partners and anyone else with whom the respondent has had sexual activity. This includes male and female partners.

Additional Probes None

Coding Topics/Definitions

Response options for this question are:

Yes—Client has engaged in sexual activity.

No—Client has not engaged in sexual activity.

Not permitted to ask— In cases where the project staff cannot ask this question of a client (i.e., the state or program does not permit sexual activity questions to be asked of an adolescent client), enter “not permitted to ask” as the response option. Projects that serve adolescents are not automatically excused from asking this question. In fact, many programs ask this question of all of their clients. If you are unsure, please speak with your grant’s Project Director. Note: Refusing to ask the questions because it may be embarrassing to the client is not a reason for not asking the question.

Sexual activity includes the following sexual acts:

Vaginal sex—Penetration of the vagina by a penis or other body part; includes vagina-to-vagina contact.

Oral sex—Placement of the mouth or tongue on or in a penis, vagina, or anus during sexual activity.

Anal sex—Penetration of the anus by a penis or other body part. This would include "fisting."

Do not count the use of sex toys.

Count all sexual contacts, whether consensual or not.

Masturbation, if done alone, should not be counted. If someone else is masturbating the client, count it as a sexual act.

Cross-Check Items None

Skip Pattern

If "no," "not permitted to ask," "refused," or "don't know," skip to question F4.

F3A	**[IF YES] ALTOGETHER HOW MANY SEXUAL CONTACTS (VAGINAL, ORAL, OR ANAL) DID YOU HAVE?**

Intent/Key Points

The intent is to determine the number of sexual contacts the client has had in the past 30 days. This includes sexual contact with the main partner and any other sexual partners.

Prompt the respondent to estimate the actual sexual contacts, not the number of days in the last 30 that he/she had sex nor the number of partners with whom he/she had sexual contact.

Additional Probes

For respondents who have a large number of partners, start by estimating daily, then weekly, then monthly sexual contacts.

Explain to the client that he/she should count each *act* as a separate sexual contact (e.g., if the respondent has had oral, vaginal, and anal sex in one encounter, it would count as three contacts).

Coding Topics/Definitions

Record repeated contacts with the same partner as separate sexual contacts. Count each act as a separate sexual contact (e.g., if the respondent has had oral, vaginal, anal sex, and returned to oral in one encounter, it would count as *four contacts*).

Do not count the use of sex toys.

Count all sexual contacts, whether consensual or not.

Masturbation, if done alone, should not be counted. If someone else is masturbating the client, count it as a sexual act.

Cross-Check Items None

Skip Pattern

F3a should be skipped if the client's response to F3 is "no," "refused," "don't know," or if the program is not permitted to ask this question.

F3B	**[IF YES] ALTOGETHER HOW MANY UNPROTECTED SEXUAL CONTACTS DID YOU HAVE?**

Intent/Key Points

The intent is to determine the number of unprotected sexual contacts the client has had in the past 30 days. This includes contact with both main and other partners.

Prompt the client to estimate the number of unprotected sexual contacts, not the number of days in the last 30 that he/she had unprotected sexual contact nor the number of partners with whom he/she had unprotected sexual contact.

Additional Probes

Remind the client that he or she should count each act as a separate sexual contact (e.g., if the respondent has had oral, vaginal, and anal sex in one encounter, that would be three contacts).

Coding Topics/Definitions

Record repeated contacts with the same partner as separate sexual contacts. Count each act as a separate sexual contact (e.g., if the respondent has had oral, vaginal, and anal sex in one encounter, it would be counted as *three contacts*).

Unprotected sex is defined as "vaginal, oral, or anal sex without a condom or other latex barrier (i.e., female condom or dental dam)."

Cross-Check Items

Cross-check with item F3a. The number of unprotected sexual contacts in item F3b should not be more than the number of sexual contacts in item F3a.

Skip Pattern

If none, skip to item F4. F3b should be skipped if the client's response to F3 is "no," "refused," "don't know," or if the program is not permitted to ask this question.

F3c1–F3c3	**[If yes] Altogether, how many unprotected sexual contacts were with an individual who is or was:** 1. **HIV positive or has AIDS** 2. **An injection drug user** 3. **High on some substance**

Intent/Key Points

The intent is to determine the number of unprotected sexual contacts the client has had in the last 30 days with individuals who were likely to be at high risk for HIV infection. This question includes sexual contact with the main partner and other partners.

Prompt the client to estimate the number of unprotected sexual contacts, not the number of days in the last 30 that he/she had unprotected sexual contact nor the number of partners with whom he/she had unprotected sexual contact.

Additional Probes

Remind the client that he or she should count each act as a separate sexual contact (e.g., if the respondent has had oral, vaginal, and anal sex in one encounter, that would be *three contacts*).

The high-risk categories in item F3c are not mutually exclusive. Ask the client about all categories. His/her sexual partner may be counted in more than one category.

Coding Topics/Definitions

Record repeated contacts with the same partner as separate sexual contacts. Count each act as a separate sexual contact (e.g., if the respondent has had oral, vaginal, and anal sex in one encounter, it would be counted as *three contacts*).

> *An injection drug user* can be either an intravenous (i.e., into the vein) or nonintravenous (i.e., into a muscle or under the skin) drug user. If the respondent reports a partner who uses both injected and noninjected drugs, count the respondent as an "injection drug user."

If the respondent is unsure of the status of his or her sexual partner, record the response as "don't know."

Cross-Check Items

Cross-check with item F3b**.** The number of unprotected sexual contacts in each of the items F3c1 to F3c3 should not be more than the number of unprotected sexual contacts in item F3b.

Skip Pattern

F3c1-3 should be skipped if the client's response to F3 is "no," "refused," "don't know," or if the program is not permitted to ask this question; or if F3b is zero.

F4	**HAVE YOU EVER BEEN TESTED FOR HIV?**

Intent/Key Points

The intent is to determine whether the client has ever been tested for HIV.

Coding Topics/Definitions

Response options for this question are:

Yes—Client has been tested for HIV.

No—Client has never been tested for HIV.

Don't Know—Client doesn't know if he/she has been tested.

If the client refuses to answer, "refused" should be written on the tool under the response categories.

Skip Pattern

If "no," "refused," or "don't know," skip to question F5.

F4A	**[IF YES] DO YOU KNOW THE RESULTS OF YOUR HIV TESTING?**

Intent/Key Points

The intent is to determine whether the client is aware of the results from his/her HIV test.

Yes—Client indicates that he/she knows the results of HIV testing.

No—Client indicates that he/she does not know the results of HIV testing.

If the client refuses to answer, "refused" should be written on the tool under the response categories.

Cross-Check Items None

Skip Pattern None

F5	**IN THE PAST 30 DAYS, (NOT DUE TO YOUR USE OF ALCOHOL OR DRUGS) HOW MANY DAYS HAVE YOU:**
	F5A. EXPERIENCED SERIOUS DEPRESSION
	F5B. EXPERIENCED SERIOUS ANXIETY OR TENSION
	F5C. EXPERIENCED HALLUCINATIONS
	F5D. EXPERIENCED TROUBLE UNDERSTANDING, CONCENTRATING, OR REMEMBERING
	F5E. EXPERIENCED TROUBLE CONTROLLING VIOLENT BEHAVIOR
	F5F. ATTEMPTED SUICIDE
	F5G. BEEN PRESCRIBED MEDICATION FOR PSYCHOLOGICAL/EMOTIONAL PROBLEM

Intent/Key Points

The intent is to determine the number of days in the past 30 that the client has experienced any serious psychiatric symptoms that were not due to alcohol or other drug use.

Ask about each psychiatric symptom separately, and enter the number of days that the client experienced that symptom. *The answer cannot be more than 30 days*.

Note: Reports of recent suicide attempts or thoughts should be brought to the attention of the clinical supervisor from the treatment agency. If the client expresses suicidal ideation (talks about killing him/herself) at the time of the interview he/she should be seen by the clinical supervisor before leaving the office.

Additional Probes

Explain that the symptoms refer to times when he/she was not under the direct effects of alcohol, drugs, or withdrawal. This means that the behavior or mood was not due to a state of drug or alcohol intoxication, or to withdrawal effects.

Coding Topics/Definitions

F5a	*Serious depression*—This is the client's subjective feeling of "serious" depression. It does not refer to a diagnosis of depression.
F5b	*Serious anxiety or tension*—This is the client's subjective feeling of "serious" anxiety or tension. It does not refer to a diagnosis of anxiety disorder.
F5c	*Hallucinations*—Refers to seeing or hearing things that were not present, or that other people could not see or hear. The hallucinations can be auditory or visual.
F5d	*Trouble understanding, concentrating, remembering*—Can be long- or short-term lapses.

F5e *Trouble controlling violent behavior*—Can refer to violence against another person, oneself, an animal, an object, or against no directed target.

F5f *Attempted suicide*—This does not include thoughts of suicide. Count only actual attempts. If interviewing an adolescent, reports of self-harm and/or cutting should not be considered suicide unless the client explicitly states that the intention was to commit suicide.

F5g *Prescribed medication for psychological/emotional problem*—Medication must have been prescribed by a nurse practitioner, physician's assistant, physician, or psychiatrist for a psychiatric or emotional problem. Record the number of days for which the medication was prescribed, even if the client did not take the medication.

> Example: If a doctor prescribes the client to take two pills per day for 10 days, you would enter the number 10.

Any prescribed medication for a psychological or emotional problem should be recorded here, whether newly prescribed or refill.

If the prescription is on a "take as needed" basis, ask how many times the client took the drug in the past 30 days.

If the client has been prescribed more than one drug, count the highest number of days prescribed. Count each day for drugs that are prescribed to be taken in sequence (i.e., if Drug A is to be taken for 10 days followed by Drug B for 10 days, the response would be 20 days). However, if Drug A is prescribed for 10 days and Drug B is to be taken for 15 days (10 of which are concurrent with Drug A), the response would be 15 days.

Cross-Check Items

Cross-check with item B2 from the Drug and Alcohol Use section. Make sure that any medication that the client was prescribed for a psychological or emotional problem and for which he/she is *taking it correctly* is not counted in item B2.

Skip Pattern

If responses to F5a–F5g all equal "zero," "refused," or "don't know," skip to question F7.

F6 HOW MUCH HAVE YOU BEEN BOTHERED BY THESE PSYCHOLOGICAL OR EMOTIONAL PROBLEMS IN THE PAST 30 DAYS?

Intent/Key Points

The intent is to record the client's feelings about how bothersome the previously mentioned psychological or emotional problems have been in the past 30 days.

Do not read the options for "refused" or "don't know," but read all of the other response options and allow the client to choose one.

Additional Probes

Remind the client to respond to whatever problem he/she identified in question F5. Probe clients if they report a serious condition but say they were not bothered at all by it.

Coding Topics/Definitions

You may want to reread the item(s) from F5 that the client indicated he/she had experienced.

> Example: The client reported that he/she had experienced serious depression on 12 of the last 30 days and serious anxiety or tension on 6 of the last 30 days. Ask the client about when he/she experienced the serious depression and anxiety or tension, was he/she: not at all bothered by it; slightly bothered by it; moderately bothered by it; considerably bothered by it; or extremely bothered by it.

Cross-Check Items None

Skip Pattern None

F7 HAVE YOU EVER EXPERIENCED VIOLENCE OR TRAUMA IN ANY SETTING (INCLUDING COMMUNITY OR SCHOOL VIOLENCE; DOMESTIC VIOLENCE; PHYSICAL, PSYCHOLOGICAL, OR SEXUAL MALTREATMENT/ASSAULT WITHIN OR OUTSIDE OF THE FAMILY; NATURAL DISASTER; TERRORISM; NEGLECT; OR TRAUMATIC GRIEF)?

Intent/Key Points

The intent of this question is to determine whether the client has ever experienced or witnessed violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment or assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief).

Additional Probes

Some examples of violence might include experiencing hitting, slapping, or punching. Some examples of trauma might include witnessing or experiencing a disturbing or upsetting event. The terms “violence” and “trauma” are left to the client’s interpretation.

Coding Topics/Definitions

The client responds whether he or she has ever experienced or witnessed violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment or assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief).

Yes –	The client responds that he or she has experienced the abovementioned conditions.
No–	The client responds that he or she has not experienced the abovementioned conditions.
Refused –	The client refuses to respond to the question.
Don’t know –	The client responds that he or she does not know the answer to this question.

Cross-Check Items **None**

Skip Pattern If the response to F7 is “no,” “refused,” or “don’t know,” skip to item F8.

F7A DID ANY OF THESE EXPERIENCES FEEL SO FRIGHTENING, HORRIBLE, OR UPSETTING THAT, IN THE PAST AND/OR THE PRESENT, YOU: HAVE HAD NIGHTMARES ABOUT IT OR THOUGHT ABOUT IT WHEN YOU DID NOT WANT TO?

Intent/Key Points

The intent of this question is to ascertain whether the violence or trauma mentioned in question F7 has resulted in frightening, horrible, or upsetting feelings in the past or the present and, if so, whether these feelings led the client to have nightmares or thoughts about them that were unwanted.

Additional Probes

None

Coding Topics/Definitions

Response options for this question are:

Yes –	The client responds that he or she has experienced the abovementioned conditions.
No –	The client responds that he or she has not experienced the abovementioned conditions.
Refused –	The client refuses to respond to the question.
Don't know –	The client responds that he or she does not know the answer to this question.

Cross-Check Items **None**

Skip Pattern

F7a should be skipped if the client's response to F7 is "no," "refused," or "don't know."

F7B DID ANY OF THESE EXPERIENCES FEEL SO FRIGHTENING, HORRIBLE, OR UPSETTING THAT, IN THE PAST AND/OR THE PRESENT, YOU: TRIED HARD NOT TO THINK ABOUT IT OR WENT OUT OF YOUR WAY TO AVOID SITUATIONS THAT REMIND YOU OF IT?

Intent/Key Points

The intent of this question is to ascertain whether the violence or trauma mentioned in question F7 has resulted in frightening, horrible, or upsetting feelings in the past or the present and, if so, have these feelings caused the client to try hard not to think about them or to go out of his or her way to avoid situations that remind the client of the experiences.

Additional Probes

None

Coding Topics/Definitions

Response options for this question are:

Yes –	The client responds that he or she has experienced the abovementioned conditions.

No – The client responds that he or she has not experienced the abovementioned conditions.

Refused – The client refuses to respond to the question.

Don't know – The client responds that he or she does not know the answer to this question.

Cross-Check Items **None**

Skip Pattern

F7b should be skipped if the client's response to F7 is "no," "refused," or "don't know."

F7C DID ANY OF THESE EXPERIENCES FEEL SO FRIGHTENING, HORRIBLE, OR UPSETTING THAT, IN THE PAST AND/OR THE PRESENT, YOU: WERE CONSTANTLY ON GUARD, WATCHFUL, OR EASILY STARTLED?

Intent/Key Points

The intent of this question is to ascertain whether the violence or trauma related in question F7 has resulted in frightening, horrible, or upsetting feelings in the past or the present and, if so, have these feelings caused the client to be constantly on guard, watchful, or easily startled.

Additional Probes **None**

Coding Topics/Definitions

Response options for this question are:

Yes – The client responds that he or she has experienced the abovementioned conditions.

No – The client responds that he or she has not experienced the abovementioned conditions.

Refused – The client refuses to respond to the question.

Don't know – The client responds that he or she does not know the answer to this question.

Cross-Check Items **None**

Skip Pattern

F7c should be skipped if the client's response to F7 is "no," "refused," or "don't know."

F7D	DID ANY OF THESE EXPERIENCES FEEL SO FRIGHTENING, HORRIBLE, OR UPSETTING THAT IN THE PAST AND/OR THE PRESENT, YOU: FELT NUMB AND DETACHED FROM OTHERS, ACTIVITIES, OR YOUR SURROUNDINGS?

Intent/Key Points

The intent of this question is to ascertain whether the violence or trauma mentioned in question F7 has resulted in frightening, horrible, or upsetting feelings in the past or the present and, if so, have these feelings have caused the client to feel numb or detached from others, activities, or his or her surroundings.

Additional Probes **None**

Code Topics/Definitions

Response options for this question are:

Yes – The client responds that he or she has experienced the abovementioned conditions.

No – The client responds that he or she has not experienced the abovementioned conditions.

Refused – The client refuses to respond to the question.

Don't know – The client responds that he or she does not know the answer to this question.

Cross-Check Items **None**

Skip Pattern

F7d should be skipped if the client's response to F7 is "no," "refused," or "don't know."

F8 IN THE PAST 30 DAYS, HOW OFTEN HAVE YOU BEEN HIT, KICKED, SLAPPED, OR OTHERWISE PHYSICALLY HURT?

Intent/Key Points

The intent of this question is to determine if the client has ever been hit, kicked, slapped, or otherwise physically hurt in the past 30 days, and if so, how often.

Additional Probes **None**

Coding Topics/Definitions

The client responds that he or she has been hit, kicked, slapped, or otherwise physically hurt. Read the first three response options and record the response in the appropriate category.

Never–	The client responds that he or she has not experienced the abovementioned conditions.
A few times –	The client responds that he or she has experienced the abovementioned conditions “a few times.” “A few times” can be considered up to five times, but it is ultimately left to the client’s interpretation.
More than a few times –	The client responds that he or she has experienced the abovementioned conditions “more than a few times.” “More than a few times” can be considered more than five times but it is ultimately left to the client’s interpretation.
Refused –	The client refuses to respond to the question.
Don’t know –	The client responds that he or she does not know the answer to this question.

Cross-Check Items **None**

Skip Pattern **None**

SECTION G: SOCIAL CONNECTEDNESS

OVERVIEW

This section addresses the client's use of social support and recovery services during the 30 days prior to the interview.

G1 IN THE PAST 30 DAYS, DID YOU ATTEND ANY VOLUNTARY SELF-HELP GROUPS FOR RECOVERY THAT WERE NOT AFFILIATED WITH A RELIGIOUS OR FAITH-BASED ORGANIZATION? IN OTHER WORDS, DID YOU PARTICIPATE IN A NONPROFESSIONAL, PEER-OPERATED ORGANIZATION DEVOTED TO HELPING INDIVIDUALS WHO HAVE ADDICTION-RELATED PROBLEMS SUCH AS: ALCOHOLICS ANONYMOUS, NARCOTICS ANONYMOUS, OXFORD HOUSE, SECULAR ORGANIZATION FOR SOBRIETY, WOMEN FOR SOBRIETY, ETC.?

Intent/Key Points

The intent of this item is to measure whether clients have attended nonprofessional, peer-oriented self-help groups to assist in their recovery during the past 30 days. *Note that this is a two-part question*. If the client indicates that he/she has attended these groups in the past 30 days, the number of times attended must be probed. The client does not have to be in "recovery" in order to attend these types of groups. Therefore, ask this question of all clients.

Additional Probes

If the client asks what is meant by "voluntary self-help groups," explain that it means a self-help or support group in which *participation* is voluntary, whether or not attendance to that group is voluntary. For example, even if the client's parole officer has required him/her to attend 30 self-help groups in 30 days, the participation in these groups would still be considered voluntary. This is because once the client is in the group setting; he/she is not required to be an active participant in the group in order to get credit for attending the group.

Coding Topics/Definitions

This does not include meetings or groups that are sponsored or run by religious organizations. However, these types of group meetings may be held in churches, temples, or other religious buildings or locations without being affiliated with any particular religious group.

A peer-operated organization is one in which the person or people who facilitate the group are not there as paid professionals (whether or not they are, in fact, professionals). Rather, the person or people who run the group are peers and/or members of the group.

There is typically no fee (other than voluntary donation or dues) to attend the group. Volunteers, who are not paid for their services, run the group.

Response options for this question are:

Yes—Client has attended voluntary self-help groups for recovery in the past 30 days. If yes, specify the number of times these groups have been attended.

No—Client has not attended voluntary self-help groups for recovery in the past 30 days.

Cross-Check Items None

Skip Pattern None

G2 IN THE PAST 30 DAYS, DID YOU ATTEND ANY RELIGIOUS/FAITH-AFFILIATED RECOVERY SELF-HELP GROUPS?

Intent/Key Points

The intent is to record whether, in the past 30 days, the client has attended any self-help groups or recovery groups that are religious/faith-based and are focused on recovery.

Note that this is a two-part question. If the client indicates that he/she has attended these groups in the past 30 days, the number of times attended must be probed.

The client does not have to be in "recovery" in order to attend these types of groups. Therefore, ask this question of all clients.

Additional Probes

If the client asks what is meant by "religious or faith-based," explain that it means a group that is run by a religious organization and/or has a religious or faith-based message for recovery. Clarify that this does not include secular groups that meet in religious buildings.

Coding Topics/Definitions

This does not include secular meetings or groups that are held in religious buildings, such as churches or temples. The organization running or sponsoring the group must be a religious/faith-based organization and/or the group must have a religious message for recovery.

These may be peer-operated groups, or they may be run or facilitated by a member of the clergy or religious organization. Additionally, this may include services provided through other CSAT-funded religious/faith-affiliated recovery service providers.

There is no fee (other than voluntary donation or dues) to attend the group. Volunteers, who are not paid for their services, typically run these groups. However, paid members of the religious organization sponsoring the groups may run them.

Participation in sweat lodges for Native Americans can be counted here if the purpose was for recovery/self-help.

Response options for this question are:

Yes—Client has attended religious/faith-affiliated self-help or recovery group in the past 30 days. If yes, specify the number of times these groups have been attended.

No—Client has not attended religious/faith-affiliated self-help or recovery group in the past 30 days.

Cross-Check Items None

Skip Pattern None

G3 IN THE PAST 30 DAYS, DID YOU ATTEND MEETINGS OF ORGANIZATIONS THAT SUPPORT RECOVERY OTHER THAN THE ORGANIZATIONS DESCRIBED ABOVE?

Intent/Key Points

The intent is to record whether the client has attended any meetings, activities, or events that support recovery, or self-help/recovery groups that were run or sponsored by an organization that is not focused on recovery in the past 30 days.

Note that this is a two-part question. If the client indicates that he/she has attended these groups in the past 30 days, the number of times attended must be probed.

The client does not have to be in “recovery” in order to attend these types of groups. Therefore, ask this question of all clients.

Additional Probes None

Coding Topics/Definitions

Example: The client may have attended a presentation on diabetes awareness. The presenting organization deals primarily with the issue of diabetes, and supports recovery through the promotion of a healthy lifestyle.

Response options for this question are:

Yes—Client has attended meetings of organizations that support recovery other than those listed in G1 and G2 in the past 30 days. If “yes,” specify the number of times these groups have been attended.

No—Client has not attended meetings of organizations that support recovery other than those listed in G1 and G2 in the past 30 days.

Cross-Check Items None

Skip Pattern None

G4	**IN THE PAST 30 DAYS, DID YOU HAVE INTERACTION WITH FAMILY AND/OR FRIENDS THAT ARE SUPPORTIVE OF YOUR RECOVERY?**

Intent/Key Points

The intent of this item is to measure whether clients have a social support network outside of a treatment or recovery support network.

The client does not have to be in "recovery" in order to attend these types of groups. Therefore, ask this question of all clients.

Additional Probes/Issue

The terms "interaction" and "supportive" are open to wide interpretation. An interaction may be viewed as supportive and nonsupportive at the same time, depending on one's perspective; therefore, we recommend that you clarify the question by saying to the client that what he/she is being asked is if "*In the past 30 days have you spent time with people who are supportive of your recovery, including family and friends?"*

Coding Topics/Definitions

Response options for this question are:

Yes—Client has had interaction with family and/or friends who are supportive of his/her recovery in the past 30 days.

No—Client has not had interaction with family and/or friends who are supportive of his/her recovery in the past 30 days.

Cross-Check Items None

Skip Pattern None

G5	**TO WHOM DO YOU TURN WHEN YOU ARE HAVING TROUBLE?**

Intent/Key Points

The intent of this question is to determine to whom the client most commonly turns when he or she is having trouble.

Additional Probes

Read as an open-ended question and mark down the client's response.

Coding Topics/Definitions

The client should specify only one response indicating the person to whom he or she turns to most commonly for support. Response options for this question are:

No One—Client does not have anyone to turn to or relies on himself or herself only.

Clergy Member—Client turns to a member of the clergy, including minister, preacher, priest, rabbi, nun, elder, imam, swami, lama, etc.

Family Member—Client looks to family members for support when in trouble. This includes members of immediate and extended family, and spouses or children.

Friends—Client turns to anyone he or she considers to be friends.

Other (Specify)—Specify. Record boyfriend/girlfriend/significant other here. Also record "sponsor" here.

Cross-Check Items None

Skip Pattern

If this is a GPRA intake/baseline interview, stop now: the interview is complete.

SECTION I: FOLLOW-UP STATUS

(REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP)

OVERVIEW

This section pertains to the client's status at the 3- or 6-month follow-up interview. This information is only completed at follow-up, and is reported by the program staff without asking the client.

GPRA follow- up interviews should be completed the number of months specified (3 or 6) from the GPRA intake/baseline interview date (a 12-month follow-up interview is no longer required). CSAT provides a window period of time for these GPRA follow-up interviews to be conducted. The window period allowed for these GPRA follow-up interviews is one month before the (3 or 6 month) anniversary date and up to two months after the (3 or 6 month) anniversary date. Those programs designated by CSAT as homeless programs are allowed a window period of two months before and two months after the 6-month follow-up anniversary date. The target follow-up rate is 100%, meaning programs must attempt to follow-up all clients. The minimum follow-up completion rate is 80%. For example:

> ***For programs completing a 6-month follow-up interview***- If a client receives the GPRA intake/baseline interview on January 1st, the 6-month follow-up anniversary date would be July 1st. The window period for conducting the 6-month follow-up interview would open one month before the anniversary date on June 1st, and close two months after the anniversary date on September 1st.
>
> ***For homeless programs completing a 6-month follow-up interview***- If a client receives the GPRA intake/baseline interview on January 1st, the 6-month follow-up anniversary date would be July 1st. The window period for conducting the 6-month follow-up interview would open two months before the anniversary date on May 1st, and close two months after the anniversary date on September 1st.
>
> ***For adolescent and other select programs completing 3-month and 6-month follow-up interviews***- If a client receives the GPRA intake/baseline interview on January 1st, the 3-month follow-up anniversary date would be April 1st. The window period for conducting the 3-month follow-up interview would open one month before the anniversary date on March 1st, and close two months after the anniversary date on June 1st.
>
> If a client receives the GPRA intake/baseline interview on January 1st,

the 6-month follow-up anniversary date would be July 1st. The window period for conducting the 6-month follow-up interview would open one month before the anniversary date on June 1st, and close two months after the anniversary date on September 1st.

I1 WHAT IS THE FOLLOW-UP STATUS OF THE CLIENT?

Intent/Key Points

The intent is to document the client's status at the 6-month (and if required, 3-month) follow-up time point and the project's effort to complete the interview. Select the response that best fits.

Additional Probes None—response is not made by client.

Coding Topics/Definitions

Response 01 *Deceased at time of due date*—If the client is deceased at the time of follow-up and this information has been verified.

Response 11 *Completed interview within the specified window*—Check this category if the interview was completed within the CSAT-specified window for data collection. (See previous page for definitions of the specified windows.)

Response 12 *Completed interview outside specified window*—Check this category if the interview was completed outside of the CSAT-specified window for data collection. (See previous page for definitions of the specified windows.)

Response 21 *Located, but refused, unspecified*—The client is still enrolled in the program but refused to complete the GPRA follow-up interview.

Response 22 *Located, but unable to gain institutional access*—You located the client in an institution but were unable to secure permission to have a face-to-face interview. The institution can be any setting in which the client is currently located (jail/prison, hospital, mental institution, residential or other drug treatment setting which does not allow the client to have outside contact).

Response 23 *Located, but otherwise unable to gain access*—You know where the client is located, but are unable to gain access due to distance or other factors. For example, you learned that the client has moved to another country and this information has been verified.

Response 24 *Located, but withdrawn from the project*—The client is no longer enrolled in the program and refused to complete the GPRA follow-up interview.

Response 31 *Unable to locate, moved*—The client has moved out of the area, this information has been verified, and you are still unable to locate.

Response 32 *Unable to locate, other*—The client may or may not have left the area and you are unable to determine their location or current status (living/deceased, etc.) and are unable to verify if any of the above noted conditions exist. Record a description of the situation in the space provided.

Cross-Check Items None

Skip Pattern None

I2 IS THE CLIENT STILL RECEIVING SERVICES FROM YOUR PROGRAM?

Intent/Key Points

The intent is to record whether CSAT-funded services are ongoing for the client at your agency at the time of the follow-up interview.

Additional Probes None

Coding Topics/Definitions

This is a “yes” or “no” question.

Cross-Check Items None

Skip Pattern

If this is a follow-up interview, this is the last section completed.

SECTION J: DISCHARGE STATUS

(REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE)

OVERVIEW

The information in this section pertains to the client's discharge status. This information is only completed at discharge. It is not asked of the client, but should be filled in by the project staff.

J1	**ON WHAT DATE WAS THE CLIENT DISCHARGED?**

Intent/Key Points

The intent of the question is to determine when the client was discharged from the treatment program, whether the discharge was voluntary or involuntary. Enter the date the client was discharged, not the date of the discharge interview.

Additional Probes None—response is not made by client.

Coding Topics/Definitions

Enter date as mm/dd/yyyy.

> The CSAT GPRA definition of discharge should follow the grantee's definition. If the grantee does not have a definition of discharge, the grantee must use 30 days without contact as the GPRA discharge date and attempt to complete a discharge interview at that time. (See pages 5 and 6 for more information about discharge.)

Cross-Check Items None

Skip Pattern None

J2	**WHAT IS THE CLIENT'S DISCHARGE STATUS?**

Intent/Key Points

The intent of this question is to determine the client's discharge status.

Note that this is a two-part question. If the client completed or graduated from the program, check "completion/graduate." If the client was terminated from the program, check "termination" *and* indicate the reason for the client's termination from the program using the response options from the list provided. If the reason for termination is not on the list, choose "other" and give the reason.

Additional Probes None—response is not made by client.

Coding Topics/Definitions

Response 01 *Left on own against staff advice with satisfactory progress*—client was compliant with the program/treatment plan but left before completion.

Response 02 *Left on own against staff advice without satisfactory progress*—client was *not* compliant with the program/treatment plan and left before completion.

Response 03 *Involuntarily discharged due to nonparticipation*—client was *not* compliant with the program/treatment plan and was terminated by the program.

Response 04 *Involuntarily discharged due to violation of rules*—client violated program rules or committed a dischargeable offense and was terminated by the program.

Response 05 *Referred to another program or other services with satisfactory progress*—client was compliant with the program/treatment plan but was referred to another program or services.

Response 06 *Referred to another program or other services with unsatisfactory progress*—client was *not* compliant with the program/treatment plan and was referred to another program or services.

Response 07 *Incarcerated due to offense committed while in treatment with satisfactory progress*—client was compliant with the program/treatment plan but was incarcerated due to offense committed during treatment.

Response 08 *Incarcerated due to offense committed while in treatment with unsatisfactory progress*—client was *not* compliant with the program/treatment plan and was incarcerated due to offense committed during treatment.

Response 09 *Incarcerated due to old warrant or charge from before entering treatment with satisfactory progress*—client was compliant with the program/treatment plan but was incarcerated due to offense committed prior to treatment.

Response 10 *Incarcerated due to old warrant or charge from before entering treatment with unsatisfactory progress*—client was *not* compliant with the program/treatment plan and was incarcerated due to offense committed prior to treatment.

Response 11 *Transferred to another facility for health reasons*—client's health made transfer to another facility necessary prior to completion of treatment.

Response 12 *Death*—client died prior to completing treatment.

Response 13 *Other*—client was terminated prior to completion of treatment for a reason not listed above. Specify the reason for termination.

Cross-Check Items None

Skip Pattern None

J3	**DID THE PROGRAM TEST THIS CLIENT FOR HIV?**

Intent/Key Points

The intent is to record whether or not the client was tested by this CSAT-funded program for HIV.

Additional Probes None

Coding Topics/Definitions

Response options for this question are:

Yes—The program tested this client for HIV.

No—The program did not test this client for HIV.

Skip Pattern

If "yes," skip to Section K. If "no," go to J4.

Cross-Check Items None

J4	**[IF NO] DID THE PROGRAM REFER THIS CLIENT FOR TESTING?**

Intent/Key Points

The intent is to record whether or not the program referred this client for HIV testing.

Additional Probes None

Coding Topics/Definitions

Response options for this question are:

Yes—The program referred this client for HIV testing.

No—The program did not refer this client for HIV testing.

Cross-Check Items None

Skip Pattern

Skip Section K if any interview type other than discharge.

SECTION K: SERVICES RECEIVED

(REPORTED AT DISCHARGE)

OVERVIEW

Identify the number of days and sessions of service provided to the client during the course of treatment. Services recorded in this section should only include those funded by this CSAT grant. The number of days refers to the number of days that the client is enrolled in the program. This information is not asked of the client, but filled in by program staff. (Count total number of days of intake to the date of discharge.)

Coding Topics/Definitions

MODALITY

Enter the number of DAYS of services provided during the client's course of treatment/recovery. ***[ENTER ZERO IF NO SERVICES PROVIDED. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY/PROGRAM TYPE.]***

1. Case Management – defining, initiating, and monitoring the medical, drug treatment, psychosocial, and social services provided for the client and the client's family.

2. Day Treatment – a modality used for group education, activity therapy, etc., lasting more than four continuous hours in a supportive environment.

3. Inpatient/Hospital (other than detoxification) – a patient who is admitted to a hospital or clinic for treatment that requires at least one overnight stay.

4. Outpatient – a patient who is admitted to a hospital or clinic for treatment that does not require an overnight stay.

5. Outreach – educational interventions conducted by peer or paraprofessional educator face to face with high risk individuals in the clients' neighborhoods or other areas where clients' typically congregate.

6. Intensive Outpatient – intense multi-modal treatment for emotional or behavioral symptoms that interfere with their normal functioning. These clients require frequent treatment in order to improve, while still maintaining family, student, or work responsibilities in the community. Intensive outpatient services differ from outpatient by the intensity and number of hours per week. Intensive outpatient services are provided two or more hours per day for three or more days per week.

7. Methadone – provision of methadone maintenance for opioid addicted clients.

8. Residential/Rehabilitation – a residential facility or halfway house that provides on-site structured therapeutic and supportive services specifically for alcohol and other drugs.

9. Detoxification (select only one) – a medically supervised treatment program for alcohol or drug addiction designed to purge the body of intoxicating or addictive substances.

    a. Hospital Inpatient – client resides at a medical facility or hospital during his/her treatment.

    b. Free-Standing Residential – patient resides at a facility other than a hospital while treatment is provided.

    c. Ambulatory Detox – treatment that is performed in a specialized therapeutic environment and is designed to provide both psychological and physiological stabilization to ensure safe withdrawal from alcohol and/or drugs.

10. After Care – treatment given for a limited time after the client has completed his/her primary treatment program, but is still connected to the treatment provider.

11. Recovery Support – support from peers, family, friends and health professionals during recovery. Includes any of the following: assistance in housing, educational, and employment opportunities; building constructive family and other personal relationships; stress management assistance; alcohol- and drug-free social and recreational activities; recovery coaching or mentoring to help manage the process of obtaining services from multiple systems, including primary and mental health care, child welfare, and criminal justice systems.

12. Other (Specify) – specify any other service modalities to be received by the client.

TREATMENT SERVICES

Enter the number of SESSIONS provided to the client during the course of treatment/recovery. ***[ENTER ZERO IF NO SERVICES PROVIDED.***

Note: SBIRT Grants must have at least one session for one of the treatment services numbered one through four.

1. Screening – a gathering and sorting of information used to determine if an individual has a problem with AOD abuse, and if so, whether a detailed clinical assessment is appropriate. Screening is a process that identifies people at risk for the "disease" or disorder (National Institute on Alcohol Abuse and Alcoholism, 1990). As such, screening refers to a brief procedure used to determine the probability of the presence of a problem, substantiate that there is a reason for concern, or identify the need for further evaluation. In a general population, screening for substance abuse and

dependency would focus on determining the presence or absence of the disorder, whereas for a population already identified at risk, the screening process would be concerned with measuring the severity of the problem and determining need for a comprehensive assessment.

2. Brief Intervention – those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his substance abuse, either by natural, client-directed means or by seeking additional substance abuse treatment.

3. Brief Treatment – a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. Brief therapies usually consist of more (as well as longer) sessions than brief interventions. The duration of brief therapies is reported to be anywhere from 1 session (Bloom, 1997) to 40 sessions (Sifneos, 1987), with the typical therapy lasting between 6 and 20 sessions. Twenty sessions usually is the maximum because of limitations placed by many managed care organizations. Any therapy may be brief by accident or circumstance, but the focus is on *planned* brief therapy. The therapies described here may involve a set number of sessions or a set range (e.g., from 6 to 10 sessions), but they always work within a time limitation that is clear to both therapist and client.

   Note: Brief Treatment is not applicable to ATR Grants.

4. Referral to Treatment – a process for facilitating client/consumer access to specialized treatments and services through linkage with, or directing clients/consumers to, agencies that can meet their needs.

   Note: Referral to Treatment is not applicable to ATR Grants.

5. Assessment – to examine systematically in order to determine suitability for treatment.

6. Treatment/Recovery Planning – a program or method worked out beforehand to administer or apply remedies to a patient for illness, disease or injury.

7. Individual Counseling – professional guidance of an individual by utilizing psychological methods.

8. Group Counseling – professional guidance of a group of people gathered together utilizing psychological methods.

9. Family/Marriage Counseling – a type of psychotherapy for a married couple or family for the purpose of resolving problems in the relationship.

10. Co-occurring Treatment/Recovery Services – assistance and resources provided to clients who suffer from both mental illness disorder(s) and substance use disorder(s).

11. Pharmacological Interventions – the use of any pharmacological agent to affect the treatment outcomes of substance-abusing clients. For example, the use of phenytoin in alcohol withdrawal and the use of buprenorphine in opioid treatment.

12. HIV/AIDS Counseling – a type of psychotherapy for individuals infected with and living with HIV/AIDS.

13. Other Clinical Services (Specify) – other client services the client received that are not listed above.

CASE MANAGEMENT SERVICES

1. Family Services (Including marriage education, parenting, and child development services) – resources provided by the state to assist in the well-being and safety of children, families and the community.

2. Child Care – care provided to children for duration of time.

3. Employment Services – resources provided to clients to assist in finding employment.

    a. Pre-employment Services – services provided to clients prior to employment, which can include background checks, drug tests and assessments. These services allow employers to "check out" prospective employees before hiring them.

    b. Employment Coaching – provides tools and strategies to clients to assist in gaining employment. These strategies include implementing new skills, changes and actions to ensure clients' achieve their targeted results.

4. Individual Services Coordination – services families may choose to use when they need help obtaining support for their mentally disabled sons or daughters to live as independently as possible in the community.

5. Transportation – providing a means of transport for clients to travel from one location to another.

6. HIV/AIDS Service – resources provided to clients to improve the quality and availability of care for people with HIV/AIDS and their families.

7. Supportive Transitional Drug-free Housing Services – provides rental assistance for families and individuals who are seeking to be drug-free who can be housed for up to two years while receiving intensive support services from the agency staff.

8. Other Care Management Services (Specify) – other care management services the client received that are not listed above.

MEDICAL SERVICES

1. Medical Care – professional treatment for illness or injury.

2. Alcohol/Drug Testing – any process used to identify the degree to which a person has used or is using alcohol or other drugs.

3. HIV/AIDS Medical Support & Testing – medical services provided to clients who have HIV/AIDS and their families.

4. Other Medical Services (Specify) – other medical services the client received that are not listed above.

AFTER CARE SERVICES

1. Continuing Care – providing health care for extended periods of time.

2. Relapse Prevention – identifying each client's current stage of recovery and establishing a recovery plan to identify and manage the relapse warning signs.

3. Recovery Coaching – guidance involving a combination of counseling, support and various forms of mediation treatments to find solutions to deal with breaking the habit of substance abuse.

4. Self-Help and Support Groups – helping or improving oneself without assistance from others; and/or an assemblage of persons who have similar experiences and assist in encouraging and keeping individuals from failing.

5. Spiritual Support – spiritual/religion-based support for the clients' recovery process.

6. Other After Care Services (Specify) – other after care services the client received that are not listed above.

EDUCATION SERVICES

1. Substance Abuse Education – a program of instruction designed to assist individuals in drug prevention, relapse, and/or treatment.

2. HIV/AIDS Education – a program of instruction designed to assist individuals with HIV/AIDS and their families with HIV/AIDS prevention and/or treatment.

3. Other Education Services (Specify) – other education services the client received that are not listed above.

PEER-TO-PEER RECOVERY SUPPORT SERVICES

1. Peer Coaching or Mentoring – services involving a trusted counselor or teacher to another person of equal standing or others in support of a client's recovery.

2. Housing Support – providing assistance for living arrangements to clients.

3. Alcohol-and Drug-Free Social Activities – action, event or gathering taken by a group of people that promotes abstinence from alcohol and other drugs.

4. Information and Referral – services involving the provision of resources to a client promoting health behavior and/or direction of a client to other sources for help or information.

5. Other Peer-to-Peer Recovery Support Services (Specify) – other peer-to-peer recovery services the client received that are not listed above.

REFERENCES

Bloom, B.L. (1997). *Planned short-term psychotherapy: a clinical handbook*. Boston: Allyn and Bacon.

National Institute on Alcohol Abuse and Alcoholism (1990). Screening for alcoholism. *Alcohol Alert 8*(PH285):1-4.

Sifneos, P.E. (1987). *Short-term dynamic psychotherapy: evaluation and technique*. New York: Plenum Medical Book Company.

F

GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA) CLIENT OUTCOME MEASURES

FREQUENTLY ASKED QUESTIONS (FAQs) FOR

Discretionary Services Programs

March 2012
v4.0

GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA)
CENTER FOR SUBSTANCE ABUSE TREATMENT (CSAT)
FREQUENTLY ASKED QUESTIONS (FAQs)

GPRA

1. What is the Government Performance and Results Act (GPRA) of 1993?

GPRA is a public law that was passed by Congress in 1993. GPRA was enacted to improve stewardship in the Federal government and to link resources and management decisions with program performance. GPRA requires that all Federal departments do the following:

- Develop a strategic plan specifying what they will accomplish over a 3- to 5-year period.
- Set performance targets related to their strategic plan on an annual basis.
- Report annually the degree to which the targets set in the previous year were met.
- Conduct regular evaluations of their programs, and use the results to explain their successes and failures on the basis of the performance monitoring data.

2. Do we have to comply with GPRA?

All Center for Substance Abuse Treatment (CSAT) discretionary programs—both Best Practices and Discretionary Services—must comply with GPRA. In their grant applications, prospective grantees should state the procedures they will put in place to ensure both compliance with GPRA and the collection of CSAT's GPRA Core Client Outcome Measures data elements at baseline, discharge, and 6-month follow-up interviews. CSAT-designated adolescent programs and other designated programs must also conduct 3-month follow-up interviews. The 12-month follow-up interview is no longer required.

For a more detailed description of grantees' GPRA requirements, see CSAT's GPRA strategy under General Information on the CSAT-GPRA Web site (https://www.samhsa-gpra.samhsa.gov/).

CSAT-GPRA Client Outcome Measures for Discretionary Programs

3. What are the Core Client Outcome Measures in the CSAT-GPRA data collection tool?

The CSAT-GPRA Core Client Outcome Measures in the CSAT-GPRA data collection tool (the GPRA tool) are client-level data items that have been selected from widely used data collection instruments (e.g., the Addiction Severity Index and the McKinney Homeless Program reporting system). Outcome measures include substance use, criminal activity, mental and physical health, family and living conditions, education/ employment status and social connectedness.

4. How will these data be used?

These data will help CSAT do the following:

- Demonstrate tangible CSAT contributions to meeting GPRA objectives.
- Report to Congress via the GPRA Plan/Report, aggregated by program, along with a narrative developed by your Government Project Officer (GPO) on the status of grant activities, services provided, and client outcomes.
- Report to the Substance Abuse and Mental Health Services Administration (SAMHSA) on the National Outcome Measures (NOMs). For more information on SAMHSA's NOMs, go to: http://www.nationaloutcomemeasures.samhsa.gov/.
- Make the case to Congress that the money awarded to grantees is being spent effectively.

5. Do we need IRB approval to collect GPRA data?

This is specific to each program. SAMHSA does not require IRB approval for the collection of GPRA data. However, we encourage you to check with your local IRB should you have questions. For those who require IRB approval, please note that only the GPRA contractor has access to raw, client-level data. Once data are entered into the system, they are only presented in aggregate form.

6. Can projects change the GPRA?

No, the GPRA tool cannot be changed.

CSAT encourages projects to use other data collection instruments to enhance their data collection efforts. However, data from additional questions should not be forwarded to CSAT as part of GPRA reporting.

Grantees can submit supplemental data that are specific to target populations, such as Native Americans and clients who have or are at risk for HIV.

7. Do we have to ask and report the questions as written in the GPRA tool?

Yes, questions must be asked as written. However, grantees may use their existing instruments (in lieu of the GPRA tool) to collect data for GPRA reporting as long as their questions have the **exact same wording** as those in the CSAT-GPRA tool and the response categories are exactly the same or can be rolled up to the exact categories in the tool.

8. Are grantees responsible for submitting data for the first few months of their grant?

Yes. When grantees do not expect to have clients for a particular time period, they must discuss this situation with their CSAT GPO.

9. Do we have to collect information on every person our program serves?

The designation of an individual as a client is left up to the program, not the individual grantee. Program staff must collect data on **all** clients as defined by the CSAT grant.

CSAT-GPRA Core Client Outcome Measures data items must be collected at baseline, discharge, and 6 months post-baseline, and discharge. Some CSAT-designated programs are also required to conduct a 3-month follow-up interview. Twelve-month follow-up interviews are not required. Sites should collect follow-up data on all clients, regardless of whether a client drops out of the program. When a site cannot follow-up on a client, the site must use the GPRA tool to report that information to CSAT (see Question 16 below) and explain why.

10. Should we use the CSAT-GPRA Core Client Outcome Measures elements to collect data on adolescents and juveniles, even though the core elements are designed for use with adults? Will there be a separate set of GPRA core elements for use with adolescents? Should we just not collect data on adolescents?

CSAT recognizes the difficult issues involving collecting data on adolescents and juveniles. At this time, Discretionary Services grantees are to use the GPRA tool to collect GPRA data on all juveniles and adolescents in their programs.

Data Collection Points

11. What are the required data collection points for the GPRA information?

GPRA data are to be collected face-to-face for each individual client at three specific points:

- Intake/baseline
- Six months after the initial collection of CSAT-GPRA Core Client Outcome Measures data

- Three months after the initial collection of CSAT-GPRA Core Client Outcome Measures data (only required of certain CSAT-designated programs)
- Discharge

It is imperative that grantees begin to collect GPRA data on each client as soon as possible after the client's intake assessment.

To comply with the requirement to collect GPRA data at intake/admission, **residential programs** must collect GPRA data on each client as soon as possible after assessment but no later than 3 days after the client officially enters the substance abuse treatment program. All types of outpatient programs other than RCSP must collect GPRA data on each client as soon as possible after assessment or intake but no later than 4 days after the client officially enters the substance abuse treatment program. For grants under the guidance for applicants (GFA) Recovery Community Services Program (RCSP), GPRA intake/baseline interviews must be completed within two to five contacts after the client enters the program. Program entry dates should be the date which the client began receiving CSAT funded services.

GPRA Intake/Baseline

12. Who develops the client identification system?

Each individual grant develops its own client identification (ID). Each client should have his/her own unique client ID that is used at all three data collection points (i.e., GPRA intake/baseline, 6 months GPRA post-intake/baseline, 3 months GPRA post baseline for CSAT-designated programs, GPRA discharge, 12 months post-baseline, if collected. Note that the 12 month post-GPRA baseline is no longer required.) The same unique ID is used each time, even if the client has more than one episode of care. For confidentiality reasons, do not use any portion of the client's date of birth or Social Security Number in the Client ID.

13. How should we handle clients who are readmitted for treatment services?

Grantees have two options for readmitting clients. Grantees are only required to administer the GPRA baseline one time per client. However, grantees may choose to administer a second (or third, fourth, etc.) baseline GPRA. In this case, the subsequent 6-month follow-up will be required from the latest baseline only. Each client will only count once toward reaching the target number of clients to be seen, regardless of the number of GPRA intakes. The same client ID number should be used, regardless of the number of times the client presents for services.

There is an exception to this for SBIRT grantees, given the purpose of their grant. A client may be discharged and counted again only if the client is coded in a different category (screening and positive feedback [SF], brief intervention [BI], brief therapy [BT], or referral to treatment [RT]), but one client will only count once in each category (SF, BI, BT, or RT).

14. If a client is discharged and returns for services, does the client count toward my GPRA targets as another client?

No. Only one GPRA intake for each client counts toward your target numbers.

There is an exception to this for the SBIRT grantees, given the purpose of their grant. A client may be discharged and counted again only if the client is coded in a different category (SF, BI, BT, or RT), but one client will only count once in each category (SF, BI, BT, or RT).

GPRA Follow-up

15. Do we have to follow-up on each client? What is the targeted follow-up rate?

Yes, each site should attempt to conduct a GPRA follow-up on every client, regardless of discharge status (i.e. complete, dropout).

The minimum targeted follow-up rate is 80 percent.

For Access to Recovery (ATR) Grants only: GPRA Follow-up and discharge interviews are not required for negative-screen clients and will not be accepted in CSAT's GPRA system.

For SBIRT Grants: GPRA follow-ups are only required for those clients falling into one of the SBIRT sampling frames.

16. What if the objective of our program is such that 6-month GPRA follow-ups are not anticipated or feasible?

The CSAT-GPRA Core Client Outcome Measures data items must be collected from all programs funded in the Discretionary Services line item in the budget at each required data collection point. Programs will have to modify their protocols accordingly, as was clearly stated in the Guidance for Application (GFA).

17. What if we locate clients before or after their scheduled 6-month GPRA follow-up interview date?

The GPRA follow-up interview window is one month before and two months after the scheduled 6-month GPRA follow-up interview. For example, if you locate a client 5 to 8 months after the initial GPRA intake/baseline data collection, you may conduct a 6-month GPRA follow-up, and the client will be included in CSAT's report to Congress. If you locate a client for the 6-month GPRA follow-up 9 or 10 months after the initial GPRA data collection, you may conduct a GPRA follow-up interview, but the data from the GPRA follow-up interview may not be included in any analyses reported to Congress.

(Note: For those collecting the 3-month GPRA follow-up [CSAT-designated programs], the same window applies to the 3-month GPRA follow-up [one month before and two months after the initial GPRA intake/baseline interview]. Those programs designated by

CSAT as homeless are allowed two months before and up to two months after the GPRA intake /baseline date.)

18. Do we collect follow-up data on dropouts?

Yes.

19. What if the follow-up period for the last client served is past the funding period of the project?

All grantees are expected to conduct 6-month follow-up GPRA data collection for all clients who receive grant-funded services. The sole exception to this rule is for follow-ups due after the grant ends.

Grantees who receive no-cost extensions may be required to continue 6-month data collection past the normal ending date of the grant.

GPRA Discharge

20. Does CSAT require a GPRA discharge on every client?

Yes. Starting July 1, 2005, CSAT requires you to submit a GPRA discharge record for every client. The only exception to this rule is when the client is still in the program after the grant ends. You will not be responsible for submitting GPRA discharge interviews for clients who are still in treatment when the grant ends. At the time of a client's discharge (as defined by the grantee), you should complete a face-to-face GPRA discharge interview (see Questions 20 and 21 below for more information on discharge).

For ATR Grants only: GPRA follow-up and GPRA discharge interviews are not required for negative-screen clients and will not be accepted in CSAT's GPRA system.

21. How does CSAT define discharge?

CSAT defines discharge in the following ways:

If your program has an existing discharge definition or policy, you should follow it and conduct the discharge interview on the day of discharge.

If you do not have a discharge definition or policy, you must complete a discharge interview for all clients for whom 30 days have elapsed from the time of last service. In other words, if the client does not present between May 16 and June 15, a GPRA discharge interview would have to be conducted.

For an administrative discharge when the interview is not conducted, interviewers must complete the first four items in Section A (Client ID, Client Type, Contract/Grant ID, Interview Type), marking that the GPRA discharge interview was not completed; Section J (Discharge); and Section K (Services Received). Follow the skip pattern instructions on the tool.

If a client is discharged from your program within 7 calendar days of his/her GPRA intake interview, a face-to-face interview is not required. You will be required to complete the first four GPRA items in Section A (Client ID, Client Type, Contract/Grant ID, Interview Type), marking that the interview was not completed; Section J (Discharge); and Section K (Services Received). Follow the skip pattern instructions on the tool.

For ATR Grants only: ATR clients are not discharged until the grantee's program has ceased or completed providing ATR funding for treatment and/or services to the client and/or the client ATR voucher is deactivated.

22. Is there a window period for conducting and submitting a GPRA discharge interview record?

For programs with a discharge policy or definition:

If the client is present on the day of discharge, the GPRA discharge interview should be conducted on the day of discharge.

If a client has not finished treatment, drops out, and is not present the day of discharge, the project will have to find the client to conduct the in-person GPRA discharge interview. The grant will have 14 days after discharge to contact the client and conduct the in-person GPRA discharge interview. If the GPRA interview has not been conducted by day 15, conduct an administrative discharge (see Question 20 above).

For programs without a discharge policy or definition:

If you are using the CSAT policy of discharging a client for whom 30 days has elapsed from the time of last service, the grant will have 14 days after discharge to contact the client and conduct the in-person GPRA discharge interview. If the interview has not been conducted by day 15, conduct an administrative discharge (see Question 20 above).

23. The typical episode of care for my clients is very short, so many clients may end up with GPRA intake and discharge interview dates very close to one another. Do we still have to collect both records?

Yes. Grantees should collect all GPRA data for each data collection point, regardless of how close they are to one another. But for those clients who are discharged less than or equal to 7 calendar days from the GPRA intake/baseline interview, a face-to-face GPRA discharge interview is not required. In this case, you will be required to complete an administrative discharge, which means that you must complete the first four items in Section A (Client ID, Client Type, Contract/Grant ID, Interview Type), marking that the interview was not completed; Section J (Discharge); and Section K (Services Received). Follow the skip pattern instructions on the tool. If the client receives services 8 or more days from the GPRA intake interview, then a full face-to-face GPRA discharge interview is required.

24. Is there a target discharge rate?

At this time, CSAT has not specified a discharge target rate.

GPRA Follow-up and Discharge Timing Issues

25. What if the discharge GPRA interview is due during the 6-month GPRA follow-up interview window? Do we still have to collect both records?

Yes. There may be cases when the client's GPRA discharge is due during the window of time that the 6-month GPRA follow-up interview is due. In other words, if a discharge is done anywhere between 5 and 8 months after GPRA intake/baseline (or 4 to 8 months after GPRA intake/baseline for those programs in the Co-Occurring and Homeless Activities Branch at CSAT), this interview could double as a GPRA follow-up interview. In these cases, you must still enter data for both the GPRA discharge **and** the 6-month GPRA follow-up interviews. Conduct the interviews using these guidelines: conduct an interview by completing the appropriate items in Section A, indicating that an interview was conducted; otherwise, you will not be able to enter the responses into the system for each section. You may conduct the face-to-face GPRA interviews simultaneously, completing all sections, including Sections I, J, and K. You will then enter the data into the system as two records: one for discharge with Sections J and K, so that the service provided is documented in the GPRA system; and the other for follow-up with Section I, so that the follow-up status is documented in the GPRA system.

If the client's GPRA discharge interview from the program occurs during the 6-month follow-up window, and you have already conducted the GPRA follow-up interview, you will need to do a separate GPRA discharge interview.

(Note: For CSAT-designated programs, the same rule applies when the GPRA discharge interview is due close to when the 3-month GPRA follow-up interview is due.)

26. Do we collect 6-month follow-up information if the GPRA discharge interview is before or after the 6-month GPRA follow-up interview?

Yes, grantees must locate clients and complete the 6-month GPRA follow-up record, regardless of when the client is discharged.

(Note: For adolescent programs and other CSAT designated programs, the same rule applies for the 3-month GPRA follow-up.)

27. Do we need to conduct an in-person 6-month GPRA follow-up interview if the client could not be contacted to conduct the discharge interview?

If the client cannot be reached for the discharge GPRA interview and receives an administrative discharge, a separate 6-month GPRA follow-up interview must be conducted, completed, and entered into the system for the follow-up to count toward the program's target rate.

(Note: For CSAT-designated programs, the same rule applies for the 3-month GPRA follow-up.)

Data Collection Issues

28. Do all programs use "the past 30 days" as the basis for client reported data?

All programs, with the exception of Offender Re-entry Programs (ORP and EADCSCT,) for questions B1 thru B2, will use "the past 30 days" for questions that capture the number days.

ORP and EADCSCT grants should ask about drug use in "the past 90 days" prior to incarceration for questions B1 thru B2 at intake/baseline and "the past 90 days" at follow-up and discharge.

29. Do we count a client's reported use of illegal drugs in Question B1c as having committed a crime for Question E4 ("In the past 30 days, how many times have you committed a crime?")?

Yes. If a client reports the use of illegal drugs in response to Question B1c but his/her answer to Question E4 is not consistent with Question B1c, the interviewer should probe the client for clarification. The interviewer must be certain that the number in Question E4 is equal to or greater than the number in Question B1c.

30. Does CSAT allow offering incentives for completed interviews?

For certain types of interviews, CSAT funding can be used for incentives, with a maximum cash value of $20 per interview. The incentives can include items such as food vouchers, transportation vouchers, or phone cards. Incentives are permitted for completion of a 6-month GPRA follow-up interview. For GPRA discharge interviews, the incentive cannot be used for routine discharge interviews; they can only be used when program staff must search for a client who has left the program or a client has dropped out of a program. Because 12-month follow-up interviews are no longer required, CSAT funding is not permitted for 12-month follow-up interviews.

Web Site Use/Technical Issues

31. Is it mandatory to use the online GPRA data entry tool?

Yes, staff members at each grantee site will be issued their own username and password for use in accessing the Web site.

For submitting client GPRA data, SBIRT, ATR and select Services grantees have the option of using either the online GPRA data entry tool or submitting data via data upload. ATR Voucher Information and Transaction Data can only be uploaded. Data that are uploaded are automatically submitted to CSAT as well.

32. How do we report the GPRA data to CSAT and our Government Project Officer?

33. The GPRA data you enter via the Web site or data upload are automatically submitted to CSAT. These data will be included in GPRA reports and available for downloading 24-48 hours after it is entered into SAIS. How often should we enter our GPRA data?

Grantees are required to have all of their GPRA data entered in as close to real time as possible. Thus, grantees should aim to enter their data within 1 business day—but no later than 7 business days—after the GPRA interview is conducted.

34. Can I save partial records?

No, the system will not save partial records. You must enter all sections of a record before can be saved in the system.

Caution: The system will automatically timeout after 20 minutes of inactivity and an incomplete record will be lost.

35. What happens to the GPRA data once they are submitted via the Web site?

The data are stored in a central repository known as SAIS. Grantees can edit submitted records. Grantees can also download data in Excel and HTML formats.

Grantees, GPOs, and contractors associated with grantees can access reports that are generated from submitted GPRA data.

36. How do I contact the CSAT-GPRA Help Desk?

You can call the Help Desk at 1-888-507-9351. It is available Monday–Friday, 8 a.m.–7 p.m. (EST). The Help Desk e-mail address is GPRAHelp@SAIS.RTI.org.

37. How can I get a CSAT-GPRA web account?

To get access to the password-protected sections of the site, send an e-mail to the GPRA Help Desk with the following information:

- User's first and last name
- E-mail address (one that is not already in the system, as no duplicates are allowed)
- Phone number (please include your extension number, if applicable)
- Grant ID(s)

All the above items are required to successfully create a new user account. You should also Cc: your project director to let him/her know that a new account has been created for his/her respective grant.

Users who have access to more than one grant will be able to use the same login ID and password to access all their grants.

38. The system shows that my password has been disabled. What do I do now?

As a security feature, accounts become disabled when there were too many unsuccessful password attempts. You can either call or send an e-mail to the Help Desk requesting to have your password reset. Once the Help Desk resets your password, an e-mail will be sent to you with a new, temporary password. When you log in successfully with the temporary password, you will be asked to change your password. Once you change it and confirm it, click on the “Save” button on the top right to save your new password. The temporary password (sent to you via e-mail) will no longer be valid.

Here are some steps you can take to prevent your account from being disabled:

- Passwords are case sensitive. Make sure you type it in exactly, and that you do not have your Caps Lock enabled.

- Try copying the password sent in the e-mail, and then paste it directly into the password field at the login page.

39. Do I have to update my password?

Yes, all users are required to update their password every 6 months.

40. I do not have access to my grant anymore. How do I get it back?

It is possible that your grant has expired in the system. If you believe you have a no-cost extension, please contact your government project officer (GPO) or Deepa Avula (CSAT) to authorize us to extend the grant in the system. Deepa’s e-mail address is Deepa.Avula@samhsa.hhs.gov.

41. Where can I get a copy of the GPRA Tool, QxQ Guide, or codebooks?

These documents, along with some others, are available under the “Data Collection Tools” section in the left-hand-side menu. Make sure you click on your respective submenu (“Services” or “Best Practices”) to get to the correct page. (Discretionary Services grants only.) I entered erroneous data under Section A (i.e., wrong Client ID, Interview Date, etc.) in the “Data Entry” section, but it will not let me edit it. How can I change the data?

Neither you nor the Help Desk can edit any data under Section A “Record Management’. If you need data changed in this section, please contact the Help Desk at 1-888-507-9351 or GPRAHelp@SAIS.RTI.org with the request to remove the erroneous record so that you can reenter the record with the correct data. We will need your Grant ID, Client ID, reason for removal, and which interview you want removed (i.e., all of the client’s record, a particular follow-up record, or just the discharge record). (Note: To remove a GPRA Intake, the SAIS system will need to remove all corresponding follow-ups to that GPRA Intake as well.)

After your e-mail is received, it will be forwarded to CSAT for approval. Once approved, the SAIS system will remove the record and send you a confirmation e-mail. The turnaround for this is generally 1–2 business days, but it may take longer. **Please do not resend the same request**. If you want to verify that we received your request, call the GPRA Help Desk. To avoid having to re-enter a record, the Help Desk strongly recommends that you make sure everything under Section A is correct before you save your record.

42. (Discretionary Services grants only.) I mistakenly entered a client's Follow-up as a GPRA Intake. Now I have two GPRA Intakes in the system, one active and one inactive. How do I rectify this?

Send the Help Desk an e-mail indicating which client record you would like removed. Since the Client IDs will be identical, the best way to specify which record you want removed is to provide the GPRA Intake Date. Please state in your e-mail the Grant ID, Client ID, GPRA Intake Date of the one you want removed, and the reason for deletion, so that we can forward this along to CSAT.

43. In the "Data Download" section, I clicked on "Yes" when it asked me if I wanted to proceed to download the records, but nothing happened. Where did my data go?

You probably have a pop-up blocker that is preventing you from downloading your data. Use the following procedure to momentarily disable your pop-up blocker: go back to the screen where it asks you if you are sure you want to proceed. Hold down the Ctrl key, and then click on the "Yes" button. **It is important that you keep the Ctrl key down until a new window or dialog box appears**. Once the new window appears, you can let go of the Ctrl key.

44. In the Reports section, when I click on the "Print" or "Export" icon, nothing happens.

You probably have a pop-up blocker that is preventing you from printing or exporting your report. Use the following procedure to momentarily disable your pop-up blocker: before you click on the printer/envelope icon, hold down the Ctrl key, and then click on the icon. **It is important that you keep the Ctrl key down until a new window or dialog box appears**. Once the new window appears, you can let go of the Ctrl key.

45. At the start of the Web site, I click on the "CSAT-GPRA" button, and then I click on the "Go" button to get to the CSAT-GPRA home page, but nothing happens.

You probably have a pop-up blocker that is preventing you from going any further. Use the following procedure to momentarily disable your pop-up blocker: before you click on the "Go" button, hold down the Ctrl key, and then click on the button. **It is important that you keep the Ctrl key down until the new window appears**. Once the new window appears, you can let go of the Ctrl key.

46. When I went to enter a discharge interview into the data entry system, I found that there was already a discharge record in the system. What should I do?

You may find that a discharge record exists for a client who has not been discharged yet, but who had a follow-up completed before July 5, 2005. The reason the SAIS system generated a discharge record for these clients was to capture the services data that were collected during the follow-up interview when there was no discharge data collection point.

When you go in to the SAIS-generated discharge interview, note that you cannot edit the discharge date field. You will need to contact the Help Desk; the staff there will delete the existing discharge interview so that you may enter the actual discharge interview. This is the cleanest and safest way to correct the data. If you have any questions on this, please contact the Help Desk at 1-888-507-9351 or at GPRAHelp@SAIS.RTI.org.

Additional Support

47. Where can I find the upcoming schedule for GPRA trainings, and how do I sign up?

The SAIS Online Learning Center offers access to a variety of trainings, including on-demand courses, live webinars, recorded webinars, and face-to-face training.

After logging in to the CSAT-GPRA website, click on the “GPRA Training” link in the left menu bar.

Once on the Online Learning Center home page, click on the course category link to view course titles, descriptions, and registration information for each type of course. Additional details on the Online Learning Center are covered in the “How to Use the SAIS Online Learning Center” located in the “On-Demand Courses” section of the site.

48. We have additional questions that need to be addressed. How do we get them answered?

For all questions related to the CSAT-GPRA Web site, please contact the Help Desk at 1-888-507-9351 or GPRAHelp@SAIS.RTI.org. Alternatively, you may use the “Web Master E-mail” link that appears on the Web site.

For questions related to obtaining additional training or technical assistance related to GPRA, please submit an online request at: https://www.samhsa-gpra.samhsa.gov/. Click on “Technical Assistance” from the menu on the left-hand side.

For questions about how to implement GPRA in your project, please contact your GPO or the contractor working with your program, or you may complete an online Technical Assistance (TA) request at: https://www.samhsa-gpra.samhsa.gov/. Click on “Technical Assistance” from the menu on the left-hand side.

Voucher FAQs: For Access to Recovery Grants Only

Voucher Information

1. Do all clients need to receive a voucher?

Yes. CSAT requires that all positive-screen clients receive a voucher to be part of your program. (Note: Negative-screen clients do not receive a voucher.)

2. Should each voucher have a unique Voucher ID?

Yes.

3. Can voucher information data be entered directly into CSAT-GPRA system?

No. All voucher information data must be uploaded into CSAT's GPRA system.

4. Are we required to upload a voucher information record prior to a voucher transaction record?

Yes. There must be a voucher information record in CSAT's GPRA system before a corresponding voucher transaction record can be uploaded.

5. Do we have to let CSAT know when vouchers are closed?

Yes. When vouchers are closed, grantees are required to upload a voucher cancellation record for each closed voucher. This is done via the Voucher Information Tool.

6. When vouchers are closed, do we need to update the dollar amount of the voucher?

When a voucher has expired or is closed by your site, whether all of the money has been used or not, grantees must update the voucher information record by indicating that the voucher record is closed. In addition, the grantee must update (if necessary) the voucher amount to reflect how much money was actually used on that voucher. For example, if a voucher is issued for $100, it has expired, and only $50 was used, grantees must upload an update record (Voucher Information form) to the GPRA system to change the voucher amount to $50 and include the voucher cancel date.

7. Can we increase the dollar amount of a voucher?

Yes. If grantees decide to add more money to a voucher, the voucher amount must be updated to reflect the additional amount using the Voucher Information form.

8. Are we allowed to indicate that multiple services are associated with a voucher?

Yes. When a voucher is issued, it is possible that multiple services may be associated with each voucher.

9. How often should voucher information data be uploaded?

Voucher information data should be uploaded daily.

10. What is the suggested file size to upload voucher information data?

The suggested file size for uploading voucher information record data is 600K. Files should not exceed this size, and if you are sending multiple files, try to adhere to this file size as much as possible. Multiple small files and files that exceed the aforementioned size limit may impede the upload process.

Voucher Transactions

11. Do all providers need a unique Provider ID?

Yes.

12. How do we identify faith-based providers?

If the provider who is redeeming funds is a faith-based provider, indicate "yes" when asked if the provider is faith-based. This question is not on the voucher transaction tool, but it is part of the voucher transaction upload.

13. Can a voucher transaction record be uploaded prior to the corresponding voucher information record?

No. There must be a voucher information record in CSAT's GPRA system before a voucher transaction can be uploaded for a specific voucher.

14. Can multiple services be selected with a voucher transaction?

No. Only one service can be selected for each voucher transaction. However, multiple units of the service may be recorded on the voucher transaction.

15. Can voucher transaction data be entered directly into the CSAT-GPRA system?

No. All voucher transaction data must be uploaded into CSAT's GPRA system.

16. How often should voucher transaction data be uploaded?

Voucher transaction data should be uploaded daily.

17. What is the suggested file size to upload voucher transaction data?

The suggested file size for uploading voucher record data is 600K. Files should not exceed this size, and if you are sending multiple files, try to adhere to this file size as much as

possible. Multiple “small” files and files that exceed the aforementioned size limit may impede the upload process.

Violence, Trauma and Military FAQs

---

1. Should we collect data on a client’s veteran status?

Effective March 5, 2012, CSAT no longer simply collects data on the number of clients who are veterans of the military. You should now collect data on a client’s military service status, which includes active duty, separation, and retirement from the military.

2. What branches of the military are included in the U.S. Armed Forces?

The U.S. Armed Forces consist of the Army, the Navy, the Marine Corps, the Air Force, and the Coast Guard.

3. How does CSAT differentiate between separation and retirement from the U.S. Armed Forces, Reserves, or the National Guard?

When a client becomes separated from the U.S. Armed Forces, Reserves, or National Guard, he or she has left active duty but might still have an obligation to serve. Separation from the military typically occurs when the client reaches his or her Expiration of Term of Service (ETS) and is released from active duty but still must complete military reserve obligations. When a client completes his or her full military obligation, he or she is then discharged.

When a client retires from the U.S. Armed Forces, Reserves, or National Guard, he or she has left active service and is entitled to a pension, a percentage of his or her base pay, or 100 percent of his or her base pay from the previously mentioned organizations.

4. If a client states that he or she was discharged from the U.S. Armed Forces, the Reserves, or the National Guard, should we ascertain the client’s discharge status?

No. A client’s discharge status is not considered in the GPRA tool and therefore will not be asked by grantees. CSAT is not asking for data regarding a client’s discharge status.

G

Alcohol Use Assessment

1. In the past three months, how often do you have a drink containing alcohol?

   Never
   Monthly or Less
   2-4 times a month
   2 to 3 times a week
   4 or more times a month

2. In the past 3 months, how many drinks containing alcohol do you have on a typical day when you are drinking?

   1 or 2
   3 or 4
   5 or 6
   7 to 9
   10 or more

3. In the past 3 months, how often do you have 4/5 (female/male) standard drinks on one occasion?

   Never
   Less than monthly
   Monthly
   Weekly
   Daily or almost daily

4. How many drinks did you have in the last 7 days?

   ___

MOSBIRT Mental Health Screener[1] (www.MOSBIRT.org)

4. In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

a. Experienced serious depression
_____ days ○ RF ○ DK

b. Experienced serious anxiety or tension
_____ days ○ RF ○ DK

c. Experienced hallucinations
_____ days ○ RF ○ DK

d. Experienced trouble understanding, concentrating, or remembering
_____ days ○ RF ○ DK

e. Experienced trouble controlling violent behavior
_____ days ○ RF ○ DK

f. Attempted suicide
_____ days ○ RF ○ DK

g. Been prescribed medication for psychological/emotional problem
_____ days ○ RF ○ DK

[IF CLIENT REPORTS ZERO DAYS, RF OR DK TO ALL ITEMS IN QUESTION 4, SKIP # 5.]

5. How much have you been bothered by these psychological or emotional problems in the past 30 days?

○ Not at all ○ Slightly ○ Moderately ○ Considerably ○ Extremely ○ RF ○ DK

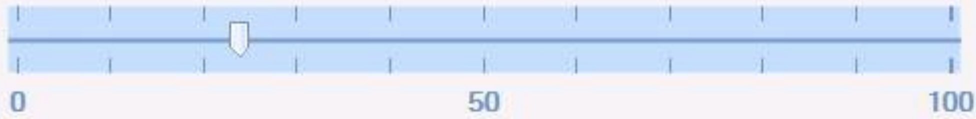
Scoring:

4.a > 0 1 point	5. Not at all	0 points
4.b > 0 1 point	Slightly	1 point
4.c > 0 3 points	Considerably	2 points
4.d > 0 1 point	Moderately	3 points
4.e > 0 1 point	Extremely	4 points
4.f > 0 3 points		
4.g > 0 1 point		

Sum all items a score >= 3 gets a mental health assessment referral recommendation

Readiness to Change - Drug (Matilda Test) [MIMH 1]

Move the marker to the part of the scale that describes how you think about
how ready you are to make changes in your drug use.



No Response

Never think about changing my drug use.

My drug use has changed. I now use drugs less than before.

Back

Next

CSAP GPRA Attitudes and Beliefs Regarding Substance Use - Adult (2005).

1. How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?

Pick one:
_______ No risk
_______ Slight risk
_______ Moderate risk
_______ Great risk

2. How much do people risk harming themselves physically and in other ways when they smoke marijuana once a month?

Pick one:
_______ No risk
_______ Slight risk
_______ Moderate risk
_______ Great risk

3. How much do people risk harming themselves physically and in other ways when they have four or five drinks of an alcoholic beverage nearly every day?

Pick one:
_______ No risk
_______ Slight risk
_______ Moderate risk
_______ Great risk

4. How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?

Pick one:
_______ No risk
_______ Slight risk
_______ Moderate risk
_______ Great risk

5. How do you feel about adults smoking one or more packs of cigarettes per day?

Pick one:
_______ Neither approve nor disapprove
_______ Somewhat disapprove
_______ Strongly disapprove

6. How do you feel about adults trying marijuana or hashish once or twice?

Pick one:
_______ Neither approve nor disapprove
_______ Somewhat disapprove
_______ Strongly disapprove

7. How do you feel about adults having one or two drinks of an alcoholic beverage nearly every day?

Pick one:
_______ Neither approve nor disapprove
_______ Somewhat disapprove
_______ Strongly disapprove

8. How do you feel about adults driving a car after having one or two drinks of an alcoholic beverage?

Pick one:
_______ Neither approve nor disapprove
_______ Somewhat disapprove
_______ Strongly disapprove

K

Patient Satisfaction Survey

Date: Month ________ Year__________ Gender: __M___F____ Age: ______

Please respond to each item by circling a number using the following scale of 1 to 5. After you have answered the questions, please put the form in the envelope provided, seal it, and put in the box for evaluation. Remember, this survey is completely anonymous, and if any specific question makes you uncomfortable, you do not have to answer it. ***Your input is important to us, as we will use your answers to help improve our services.***

First, please think about the 6 questions that a health coach asked about your substance use. **How much do you agree with the following statements?**

HEALTH INFORMATION QUESTIONS					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I was embarrassed when asked about my substance use.	1	2	3	4	5
I think it is important for my health care provider to ask about my substance use.	1	2	3	4	5

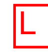
Please think about the health coach who served you. **How much do you agree with the following statements?**

THE HEALTH COACH					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The health coach explained health behaviors in a way I could understand.	1	2	3	4	5
The health coach answered my questions.	1	2	3	4	5
I am overall satisfied with the health coach who served me.	1	2	3	4	5

Thank you for completing the survey!

BE BC RT

MIHL Locator Form



SCREENING DATE ________________ **MIHL ID#** ________________
INTERVIEWER NAME ________________

MIHL LOCATOR FORM

On this form, we collect information that will help us reach you for your feedback on our services. The information you give us will be kept in a separate place from your answers to the questions we ask. It will be used only to locate you, and it will not be given to anyone else. We will only tell anybody you list below that you are participating in a health study, and this form will be shredded after you give us your feedback on our services.

Your Information: Please tell me your full name:

LAST	FIRST	MIDDLE	NICKNAME	MAIDEN NAME

Other names you have used/had in the past:

LAST	FIRST	MIDDLE	NICKNAME

Other information:

DOB / / MO DAY YR	SSN	GENDER	RACE	HISPANIC Y/N

I can be reached at:

Email	IM	Facebook	MySpace	Other web contact

My Phone(s):

NUMBER	HOME/CELL	MAY WE LEAVE MESSAGE?
NUMBER	HOME/CELL	MAY WE LEAVE MESSAGE?

Address(es):

Current Home Address: OWNER: ________________ (INCLUDE IN CONTACTS BELOW)

STREET	APT	CITY	STATE	ZIP

Current Mailing Address: OWNER: ________________ (INCLUDE IN CONTACTS BELOW)

STREET	APT	CITY	STATE	ZIP

Previous Home Address: OWNER: ________________ (INCLUDE IN CONTACTS BELOW)

STREET	APT	CITY	STATE	ZIP

Contact Information

Please tell me about the person who knows best how to contact you:

LAST FIRST AGENCY/SCHOOL RELATIONSHIP

STREET APT CITY STATE ZIP

1st NUMBER HOME/CELL 2nd NUMBER HOME/CELL MAY WE LEAVE MESSAGE?

Please tell me about the 2nd person who knows best how to contact you:

LAST FIRST AGENCY/SCHOOL RELATIONSHIP

STREET APT CITY STATE ZIP

1st NUMBER HOME/CELL 2nd NUMBER HOME/CELL MAY WE LEAVE MESSAGE?

Please tell me about the 3rd person who knows how to contact you:

LAST FIRST AGENCY/SCHOOL RELATIONSHIP

STREET APT CITY STATE ZIP

1st NUMBER HOME/CELL 2nd NUMBER HOME/CELL MAY WE LEAVE MESSAGE?

Please tell me about the 4th person who knows how to contact you:

LAST FIRST AGENCY/SCHOOL RELATIONSHIP

STREET APT CITY STATE ZIP

1st NUMBER HOME/CELL 2nd NUMBER HOME/CELL MAY WE LEAVE MESSAGE?

You are willing to be called:

	Monthly		Every Other Month		Other, please specify:

Please check and/or fill-out 1 option.

Client may be/have:

	Forgetful		Cloudy Judgment		Other, please specify:

Please check and/or fill-out all that apply.

ADDITIONAL NOTES TO ADD BY HEALTH COACH/COMMUNITY LIAISON:

(Include any information that will assist in locating patients in the coming months.)

MIHL Locator Form

University of Missouri—Missouri Initiative for Healthy Lifestyles (MIHL)

MIHL ID ______________________ DATE ________________

I, ____

(Print Participant's Name)

Authorize University staff to contact the people and agencies I have provided on the Locator form to locate me for continued participation in the follow-up evaluation. The purpose of this disclosure is to enable the staff of the University to locate me to complete the follow-up interview which I have agreed to complete and for which I will be paid to complete. I also understand that the permission I grant hereby to disclose my whereabouts to the University of Missouri staff will last only so long as I am a participant in the follow-up evaluation and I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature of Participant

Date Signed

Signature of Witness

Copy of this release for was offered to client:
______Copy was accepted by participant
______Copy was declined by participant

Participant Initials__________

Thanks for agreeing to help us improve our services.

_______________________ will call you:
Date:_______________ Time:____________

You will receive a $20 gift card for your time!

Please contact us if your information changes.

Missouri Initiative for Healthy Lifestyles
5400 Arsenal
St. Louis, MO 63139

Toll Free: (866)971-8534
Main Office: (314)877-3399
Cell Phone: (314) 971-8534
Email: MOinitiative@gmail.com

University of Missouri—Missouri Initiative for Healthy Lifestyles (MIHL)

MIPHL ID ______________________ DATE ________________

I, ____
(Print Participant's Name)

Authorize University staff to contact the people and agencies I have provided on the Locator form to locate me for continued participation in the follow-up evaluation. The purpose of this disclosure is to enable the staff of the University to locate me to complete the follow-up interview which I have agreed to complete and for which I will be paid to complete. I also understand that the permission I grant hereby to disclose my whereabouts to the University of Missouri staff will last only so long as I am a participant in the follow-up evaluation and I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature of Participant

Date Signed

Signature of Witness

Copy of this release for was offered to client:
______Copy was accepted by participant
______Copy was declined by participant

Thanks for agreeing to help us improve our services.

____________________________ will call you:
Date:________________ Time:_____________

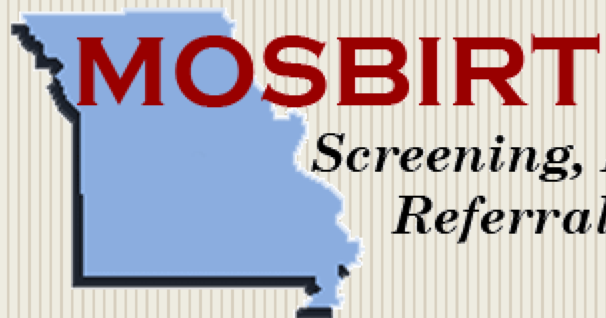
You will receive a $20 gift card for your time!

Please contact us if your information changes.

Missouri Initiative for Healthy Lifestyles
5400 Arsenal
St. Louis, MO 63139

Toll Free: (866)971-8534
Main Office: (314)877-3399
Cell Phone: (314) 971-8534
Email: MOinitiative@gmail.com

M



MOSBIRT Follow-up Protocol

Revised November 30 2011

MISSOURI INSTITUTE OF MENTAL HEALTH

Rita E. Adkins, M.P.A

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Interview 6
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For all patients who decline the Follow-up interview, please: 7
Collecting Follow-Up/Updated Locator Forms 7

MOSBIRT Tracking Protocol

Overview:

To measure the effectiveness of the MOSBIRT project, we are required to follow 10% of the patients that receive an intervention. To ensure that the sample is randomly selected, we have been assigned the following criterion for the follow-up sample:

- Those receiving any intervention (BE, BC or RT), and with
- The last 2 digits of their SSN between the numbers 50-59.

These individuals will be asked to participate in a follow-up survey 5-6 months after their intake interview. The follow-up interview will be conducted by phone by a trained evaluation staff member. At the follow-up interview, the patient will be asked to complete:

- Required sections of the GPRA,
- The ATOD Attitudes and Beliefs instrument (BC and RT patients), and
- The Readiness to Change scale (BC and RT patients).

The follow-up interview should take between 10 and 25 minutes to complete, and patients completing the interview will be compensated with a $20 gift card for their time. We are required by our funders to maintain an 80% follow-up rate, so the follow-up is a very important aspect of the MOSBIRT project.

Follow-up Procedures:

The Intake Interview

1. The health coach will explain the importance of a follow-up interview for our health care service. One strategy that has been successful in engaging clients for the Follow-up piece has been to present the Follow-up interview appointment in a matter-of-fact manner as simply another part of our normal practice.
   - Start with introducing the idea of the 6 month follow-up as the next logical step in this health care service to get their feedback on our services.

- **A script that can be used:** "Another portion of our service involves a representative of our program calling the patients that we talk to in about 5 or 6 months. We like to check in and see how you're doing and ask for your feedback at that time to help us improve our services. Our services are new, and feedback from patients like you will help us continue to improve our patient care. This interview will take place over the telephone and should only take about 10 to 20 minutes of your time.

  We realize that you are busy and have other things to take care of, so we'd like to compensate you for the time you take to do this by providing you with a $20 gift card for completing the follow-up survey in 5 months."

- If the patient is willing to do the follow-up interview, the health coach will collect contact information on the Locator Form. This form requires a signature from the patient. Their signature gives us permission to contact anyone they list on the form. So, from a liability perspective it is very important to get their signed consent.

- The health coach will assist the patient in completing the locator form stressing the importance of including collaterals that know how to contact them. You might try this script: "What is the best way to reach you?" (Phone, address, email). *SLOWLY & CLEARLY REPEAT INFO BACK TO PATIENT AND VERIFY ACCURACY.*
  - "Do you plan on being at this location & phone/email address in 5 months?"
  - (if not) – "Where do you think you can be contacted in about 5 months?"
  - "Do you have any nicknames or aliases that people might know you by?"
  - Please try to collect:
    - Phone numbers and addresses of at least 3 contacts, including the closest female relative/friend. Make sure at least 2 of the contacts have different phone numbers/addresses than the patient.
    - Make sure to include contact information that is different than the number and addresses of the patient.
    - If the patient is giving an address or phone number of someone who accepts messages for them, be sure to get that person's name as well.
    - The previous address is also quite helpful for difficult to locate patients, as is the contact information of a neighbor.
    - Get email address, and note if they are on Facebook, MySpace, or other social networking sites.
    - Any social services they may use, especially if they use Burrell services at the Springfield location, as the tracker can access contact information internally.
    - The tracker will need to include this information in the tracking database, so please write legibly.

The health coach will tell the patient to expect a welcome call from a MIHL team member. At that time, they can supply more contact information if they can't remember the numbers/addresses of family and friends.

Scheduling Appointments

1. An appointment for the follow-up interview will be made at this time, if possible. Consult the calendar on the MOSBIRT website (http://www.mosbirt.org/) for an available time to schedule the appointment. Since the window opens 30 days before and closes 60 days after the 6 month date, please try to schedule the appointment **5 months past the intake date**. This will allow us more time to find the individual if they move or change phone numbers. The earliest the follow-up interview can be conducted is 5 months post intake. The 5 months is based on the day, i.e., if the intake date is **February 1, 2010**, the earliest the interview can be conducted is **July 1, 2010**, or 5 months to the day.
    - Script for scheduling the interview: "So let's see – would you be available to speak with us on ______? I know it's a long way off, so why don't we start with (this date) and as it gets closer, we can reschedule if needed."
        - Open the shared calendar on the MOSBIRT site and select time/date for 5 months after today's date: i.e., if the initial interview is **1/10/10** then the follow-up interview should be scheduled no earlier than **6/10/10**.
        - Try to schedule the appointment on a weekday (M-F) between 9 am to 7 pm. Schedule on a weekend as a last resort.

- Enter patient appointment in available interview slot by putting their initials and the time of the appointment on the calendar. Fill in the appointment time on the appointment reminder located on the bottom right hand corner of both copies of the signed consent form, and give the patient a copy of the signed consent form.
- Forward the completed locator sheets to your assigned tracker.
- If you are unable to schedule an appointment, please have as much of the locator sheet completed as possible, and have the patient sign the consent. The tracker will make the appointment after consulting the shared calendar on the MOSBIRT website for an available time.

After Intake

1. A welcome letter will be sent to the patient within 7 days of intake. A magnet with the appointment reminder will be included in the letter. A forwarding request will be added to verify the address is correct.

2. The MIMH Data Collector will call the patient after 2 weeks to verify the phone number is correct.

3. Two months post intake, an encouragement letter with health information will be sent to patient.

4. Three months post intake, the data collector will make a telephone call to remind the patient of their appointment. A review of contact information will be made at that time.

Six weeks before the appointment, the patient will receive a postcard reminding them of the scheduled follow-up interview date and time. Three days before the appointment, the patient will receive a reminder call from MIMH evaluation staff. Birthday cards and certain holiday cards from MIHL will be distributed as appropriate.

Collecting Locator Information by Phone

At some sites, the interventions are conducted by phone (i.e. Student Health in Columbia). If the patient qualifies for the follow-up group, please use the scripts detailed above in Section I to encourage the patient to participate in the follow-up group. We do need a recording of verbal confirmation for our files. To accomplish this, please explain that consent must be obtained before continuing. Recording devices have been purchased for each site. Use the following procedures to record the verbal consent from the patient:

1. Prior to turning on the phone recorder, explain that consent can be given over the phone and that for verification purposes their actual verbal consent will be recorded. Ask them if they consent to have their voice recorded for the express purpose of creating a record of consent to follow-up.

2. Turn on your recorder. You may need to place the caller on speaker phone.

3. Ask the caller to re-confirm their consent to have their voice recorded by verifying that verbal permission was given prior to starting the recorder.

4. Read the text on the consent form to the patient. Inform them that a copy of the agreement will be mailed to them. Ask them to state their agreement. Turn off recorder.

5. Begin collecting the information on the locator sheet and follow the procedures stated in Section 1.2 above.

6. Notify the evaluation team at MIMH that a verbal consent has been obtained. Upload the file with the verbal consent to the MOSBIRT website where the taped

interventions are uploaded. The files will be downloaded and kept on the MIMH server.

Interview

Five months following the completion of the intervention, the patient will receive a phone call from an evaluation staff member at MIMH to complete the interview. Upon completion of the interview, a $20 gift card will be mailed to the address provided by the patient as compensation for completing the follow-up interview.

Addressing The Reluctant Patient:

If the patient is reluctant to agree to do the interview, try asking again, and appeal to the patient's sense of wanting to help, or civic duty:

1. We realize that you live quite a ways away – we conduct our interview by telephone and it should only take a few minutes of your time and we will mail you the $20 gift card.

2. It would really help us out if you would speak with us, as your feedback would be very helpful to us in improving our services.

3. It would help a lot of other people if we could continue to offer our services in the health care system, and in order to do so we need to be able to just touch base with you for a few minutes. Would you help us out?

If the patient says they'll be moving or don't know where they will be in 5 months, still make the interview appointment! Emphasize that it will be conducted by telephone and that we will pay for the call. Then obtain:

1. Their *best guess* as to what their phone number will be.

2. Their *best guess* as to where they will have been, just prior to the 5 month date – i.e. do they expect to be in a treatment program, shelter, away at college, in another state?

3. Name of person or agency who would most likely know where they are – perhaps a parole or probation officer, or primary care provider? (Obtain patient's Consent to Release Information for that person.)

Stress that they will still be eligible for the services component of our program, which include free, individual Brief Education sessions, and referral to treatment as needed.

For all patients who decline the Follow-up interview, please:

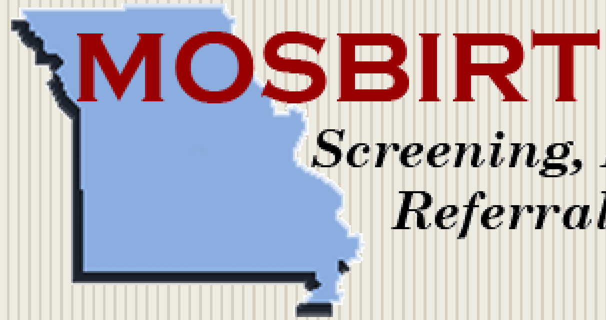
1. Engage the patient in a conversation about their reasons for declining the follow-up service and address the patient's concerns - i.e. if worried about confidentiality – explain in plain language about the protection of HIPAA for health care information.

2. Document the patient's concerns, reasons for declining, and any other contributing factors in the "Comments" section of the Locator sheet. Provide as much information as possible: i.e. – patient was in a lot of pain, or distracted by visitors, or preoccupied with new diagnoses. Note patient's response to your interaction.

Collecting Follow-Up/Updated Locator Forms

1. Since the patients are likely to return to the ER, MOSBox now identifies patients that are within the timeframe for a follow-up, so coaches have the ability to collect the follow-up information on their tablet computer. If the follow-up data are collected by the health coach, please make sure to collect the correct address for the patient. Please notify MIMH that the data have been collected so we can forward the gift card to the patient's address. We are currently giving gift cards to Wal-Mart and Walgreens at all sites, along with QuikTrip cards in St. Louis (There are no longer QuikTrips in Springfield and Columbia). If the patient does not want to complete the follow-up at the time, please update the Locator information to ensure the trackers have the latest information.

N



MOSBIRT Follow-up Protocol FQHC Implementation

Revised February 29, 2012

MISSOURI INSTITUTE OF MENTAL HEALTH

Rita E. Adkins, M.P.A
Mandy Lay, B.S
Jeff Noel, Ph.D.

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…………… **MOSBIRT Tracking Protocol**

Overview:

To measure the effectiveness of the MOSBIRT project, we are required to follow 10% of the patients that receive an intervention. To ensure that the sample is randomly selected, we have been assigned the following criterion for the follow-up sample:

- Those receiving any intervention (BE, BC or RT), and with
- The last 2 digits of their SSN between the numbers 50-59.

To avoid any reference to substance use, we refer to the follow-up portion of the **MOSBIRT Project** the "***Missouri Initiative for Healthy Lifestyles" (MIHL)***. Any correspondence or contact with the patients in the follow-up group is referred by this name.

The qualifying individuals will be asked to participate in a follow-up survey 5-6 months after their intake interview. The follow-up interview will be conducted by phone by a trained evaluation staff member at the Missouri Institute of Mental Health (MIMH). At the follow-up interview, the patient will be asked to complete:

- Required sections of the GPRA,
- AUDIT-C
- The ATOD Attitudes and Beliefs instrument (BC and RT patients), and
- The Readiness to Change ruler (BC and RT patients).

The follow-up interview should take between 10 and 25 minutes to complete, and patients completing the interview will be compensated with a $20 gift card for their time. We are currently giving gift cards to Wal-Mart, Target and Walgreens. Since we are required by our funders to maintain an 80% follow-up rate, the follow-up is a very important aspect of the MOSBIRT project. Therefore it is important to be able to contact the patient to collect the 5-6 month information. We have found this can be accomplished by our Follow-Up Procedures.

Follow-up Procedures:

The Intake Interview

1. The Behavioral Health Consultant will explain the importance of a follow-up interview for our health care service. One strategy that has been successful in engaging patients for the follow-up portion has been to present the follow-up interview in a matter-of-fact manner as simply another part of our normal practice.
   - Start with introducing the idea of the 5-6 month follow-up as the next logical step of their health care to get their feedback on our services.
   - **A script that can be used:** "Another portion of our service involves a representative of our program calling the patients that we talk to in about 5 or 6 months. We like to check in and see how you're doing and ask for your feedback at that time to help us improve our services. Our services are new, and feedback from patients like you will help us continue to improve our patient care. This interview will take place over the telephone and should only take about 10 to 20 minutes of your time.

     We realize that you are busy and have other things to take care of, so we'd like to compensate you for the time you take to do this by providing you with a $20 gift card for completing the follow-up survey in 5 months. Also, we have a bi-monthly drawing for a $20 Target gift card for all those agreeing to participate, so your name will be added to this drawing."

Contest to Improve Follow-Up Participants

- We currently have a contest to increase the numbers in the follow-up group. Any Locator sheet submitted with **AT LEAST 2 VALID CONTACTS** will be entered in the drawing on the 15th and last day of each month. The BHC or Health Coach (HC) that collects the information from the winning entrant will also receive a $20 Target card. For each month, there will be 2-$20 cards distributed to patients agreeing to participate, and 2-$20 gift cards for the BHC or HC that collects the information. **Please note that only Locator forms with at least 2 contacts (different phone and addresses from the patient) will be entered into the drawing.**
- If the patient is willing to do the follow-up interview, the Behavioral Health Consultant will collect contact information on the Locator Form. **This form requires a signature from the patient.** Their signature gives us permission to contact anyone they list on the form. Therefore, it is very important to get their signed consent from a liability perspective.

- The Behavioral Health Consultant will assist the patient in completing the locator form stressing the importance of including collaterals that know how to contact them. You might try this script: "What is the best way to reach you?" (Phone, address, email). *SLOWLY & CLEARLY REPEAT INFO BACK TO PATIENT AND VERIFY ACCURACY.*
  - "Do you plan on being at this location & phone/email address in 5 months?"
  - (if not) – "Where do you think you can be contacted in about 5 months?"
  - "Do you have any nicknames or aliases that people might know you by?"
  - Please try to collect:
    - Phone numbers and addresses of at least 2 contacts, including the closest female relative/friend.
    - Make sure to include contact information that is different than the number and addresses of the patient.
    - If the patient is giving an address or phone number of someone who accepts messages for them, be sure to get that person's name as well.
    - The previous address is also quite helpful for difficult to locate patients, as is the contact information of a neighbor.
    - Get email address, and note if they are on Facebook, MySpace, or other social networking sites.
    - Any social services they may use.
  - The Behavioral Health Consultant will fax the completed, signed Locator form to Mandy Lay, an evaluation staff member at MIMH to (314) 877-6477 or mail in the envelopes enclosed in your packet.
  - The evaluation staff at MIMH will need to include this information in a tracking database, so please write legibly.

Scheduling Appointments

The Behavioral Health Consultant will tell the patient to expect a welcome call from a Missouri Initiative for Healthy Lifestyles team member. On that call, an appointment will be made for the 5-6 month follow-up interview. Please let the patient know if they can't remember the numbers/addresses of family and friends they can supply more contact information at that time.

After Intake

1. The MIHL Data Collector at MIMH will call the patient within a week after intake to make an appointment for the 5-6 month follow-up interview and to verify the phone number is correct.

2. A welcome letter will be sent to the patient within 7-14 days of intake. A magnet with the appointment reminder will be included in the letter. A forwarding request will be added to verify the address is correct.

3. Two months post intake, an encouragement letter with health information will be sent to the patient.

4. Three months post intake, the data collector will make a telephone call to remind the patient of their appointment. A review of contact information will be made at that time.

5. Six weeks before the appointment, the patient will receive a postcard reminding them of the scheduled follow-up interview date and time.

6. Three days before the appointment, the patient will receive a reminder call from MIMH evaluation staff.

Birthday cards and certain holiday cards from MIHL will be distributed as appropriate.

Collecting Locator Information by Phone

Due to time constraints with the patient, it is not always possible to collect the Locator information during the office visit. If the patient qualifies for the follow-up group and is willing to participate but there is not enough time to collect the contact information, please contact Mandy Lay at (314) 877-6498 to let her know of the potential follow-up participant. We have a procedure in place to collect and record consent and collateral information for the patient. Please provide a phone number where the patient can be contacted and let the patient know to expect a call from a member of the MIHL staff.

Follow-Up Interview

Five months following the completion of the intervention, the patient will receive a phone call from an evaluation staff member at MIMH to complete the interview. Upon completion of the interview, a $20 gift card will be mailed to the address provided by the patient as compensation for completing the follow-up interview.

Addressing the Reluctant Patient

If the patient is reluctant to agree to do the interview, try asking again, and appeal to the patient’s sense of wanting to help, or civic duty:

1. We realize that you live quite a ways away – we conduct our interview by telephone and it should only take a few minutes of your time and we will mail you the $20 gift card.

2. It would really help us out if you would speak with us, as your feedback would be very helpful to us in improving our services.

3. It would help a lot of other people if we could continue to offer our services in the health care system, and in order to do so we need to be able to just touch base with you for a few minutes. Would you help us out?

If the patient says they'll be moving or don't know where they will be in 5 months, still encourage them to participate in the follow-up.! Emphasize that it will be conducted by telephone and that we will pay for the call. Then obtain:

1. Their *best guess* as to what their phone number will be.

2. Their *best guess* as to where they will have been, just prior to the 5 month date – i.e. do they expect to be in a treatment program, shelter, away at college, in another state?

3. Name of person or agency who would most likely know where they are – perhaps a parole or probation officer, or primary care provider? (Obtain patient's Consent to Release Information for that person.)

Stress that they will still be eligible for the services component of our program, which include free, individual Brief Education sessions, and referral to treatment as needed.

For all patients who decline the Follow-up interview, please:

1. Engage the patient in a conversation about their reasons for declining the follow-up service and address the patient's concerns - i.e. if worried about confidentiality – explain in plain language about the protection of HIPAA for health care information.

2. Document the patient's concerns, reasons for declining, and any other contributing factors in the "Comments" section of the Locator sheet. Provide as much information as possible: i.e. – patient was in a lot of pain, or distracted by visitors, or preoccupied with new diagnoses. Note patient's response to your interaction.

MIHL LOCATOR FORM

SCREENING DATE ____________________ MIHL ID# ____________________
INTERVIEWER NAME ____________________

On this form, we collect information that will help us reach you for your feedback on our services. The information you give us will be kept in a separate place from your answers to the questions we ask. It will be used only to locate you, and it will not be given to anyone else. We will only tell anybody you list below that you are participating in a health study, and this form will be shredded after you give us your feedback on our services.

Your Information: Please tell me your full name:

LAST FIRST MIDDLE NICKNAME MAIDEN NAME

Other names you have used/had in the past:

LAST FIRST MIDDLE NICKNAME

Other information:

DOB / /

MO DAY YR SSN GENDER RACE HISPANIC Y/N

I can be reached at:

Email IM Facebook MySpace Other web contact

My Phone(s):

NUMBER HOME/CELL MAY WE LEAVE MESSAGE?

NUMBER HOME/CELL MAY WE LEAVE MESSAGE?

Address(es):

Current Home Address: OWNER: (INCLUDE IN CONTACTS BELOW)

STREET APT CITY STATE ZIP

Current Mailing Address: OWNER: (INCLUDE IN CONTACTS BELOW)

STREET APT CITY STATE ZIP

Previous Home Address: OWNER:

STREET APT CITY STATE ZIP

Contact Information

Please tell me about the person who knows best how to contact you:

LAST FIRST AGENCY/SCHOOL RELATIONSHIP

STREET APT CITY STATE ZIP

1st NUMBER HOME/CELL 2nd NUMBER HOME/CELL MAY WE LEAVE MESSAGE?

Please tell me about the 2nd person who knows best how to contact you:

LAST FIRST AGENCY/SCHOOL RELATIONSHIP

STREET APT CITY STATE ZIP

1st NUMBER HOME/CELL 2nd NUMBER HOME/CELL MAY WE LEAVE MESSAGE?

Please tell me about the 3rd person who knows how to contact you:

LAST FIRST AGENCY/SCHOOL RELATIONSHIP

STREET APT CITY STATE ZIP

1st NUMBER HOME/CELL 2nd NUMBER HOME/CELL MAY WE LEAVE MESSAGE?

Please tell me about the 4th person who knows how to contact you:

LAST FIRST AGENCY/SCHOOL RELATIONSHIP

STREET APT CITY STATE ZIP

1st NUMBER HOME/CELL 2nd NUMBER HOME/CELL MAY WE LEAVE MESSAGE?

You are willing to be called:

	Monthly		Every Other Month		Other, please specify:

Please check and/or fill-out 1 option.

Client may be/have:

	Forgetful		Cloudy Judgment		Other, please specify:

Please check and/or fill-out all that apply.

ADDITIONAL NOTES TO ADD BY HEALTH COACH/COMMUNITY LIAISON:
(Include any information that will assist in locating patients in the coming months.)

University of Missouri—Missouri Initiative for Healthy Lifestyles (MIHL)

MIHL ID ______________________ DATE ________________

I, ____
(Print Participant's Name)

Authorize University staff to contact the people and agencies I have provided on the Locator form to locate me for continued participation in the follow-up evaluation. The purpose of this disclosure is to enable the staff of the University to locate me to complete the follow-up interview which I have agreed to complete and for which I will be paid to complete. I also understand that the permission I grant hereby to disclose my whereabouts to the University of Missouri staff will last only so long as I am a participant in the follow-up evaluation and I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

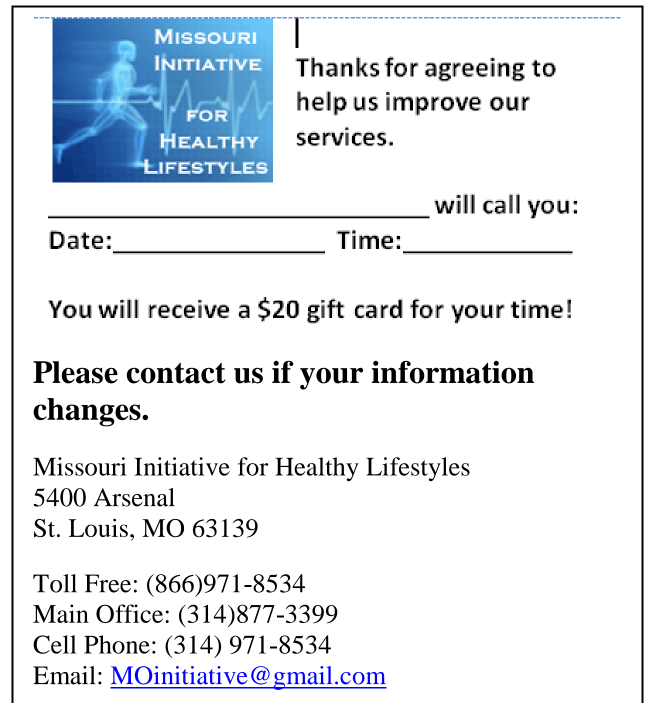
Signature of Participant ____

Date Signed ________________________

Signature of Witness ___________________

Copy of this release for was offered to client:
_____Copy was accepted by participant
_____Copy was declined by participant

Participant Initials__________



University of Missouri—Missouri Initiative for Healthy Lifestyles (MIHL)

MIPHL ID _______________________ DATE ________________

I, ____
(Print Participant's Name)

Authorize University staff to contact the people and agencies I have provided on the Locator form to locate me for continued participation in the follow-up evaluation. The purpose of this disclosure is to enable the staff of the University to locate me to complete the follow-up interview which I have agreed to complete and for which I will be paid to complete. I also understand that the permission I grant hereby to disclose my whereabouts to the University of Missouri staff will last only so long as I am a participant in the follow-up evaluation and I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature of Participant____

Date Signed_________________

Signature of Witness_______________________

Copy of this release for was offered to client:
_____Copy was accepted by participant
_____Copy was declined by participant

Thanks for agreeing to help us improve our services.

_________________________ will call you:
Date:______________ Time:____________

You will receive a $20 gift card for your time!

Please contact us if your information changes.

Missouri Initiative for Healthy Lifestyles
5400 Arsenal
St. Louis, MO 63139

Toll Free: (866)971-8534
Main Office: (314)877-3399
Cell Phone: (314) 971-8534
Email: MOinitiative@gmail.com

F A X

To: Mandy Lay
Fax number: (314) 877-6477
(866) 971-8534 (Toll Free Phone)
(314) 877-6498 (Main phone)

From: ___________________________________

Site:____________________________________

Fax number: ____________________________

Phone Number:___________________________

Date:	# of pages:

Comments:

MIMH

Scheduling Follow-Up Interviews

MOSBIRT Calendar Instructions

Rita Adkins and Mandy Lay
5/7/2010

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Using the MOSBIRT calendar

The funders of the MOSBIRT project require that we collect 6 month follow-up information on 10% of the patients that receive services from our program (BE, BC or RT). We have asked the health coaches to try and schedule the follow-up appointment when they provide the services to the patients, and place the appointment time on the locator sheet used to collect contact information. To prevent duplicate appointments, a calendar system for scheduling follow-up appointments has been developed on the MOSBIRT.org site. While the original plan was to use Google calendar, due to security issues at some of the medical sites, the health coaches have been unable to access the Google site.

This guide is designed to walk you through the steps for scheduling appointments. Please remember to schedule the appointment 5 months after the patient is seen. While it is called the "Six-Month Follow-Up", the funder says the "window" opens 30 days before the 6 month date, and closes 60 days after the 6 month date. For example, a patient seen on May 1, 2010 would have a 6 month date of November 1, 2010. However, this patient can be scheduled as early as October 1, 2010. Their "window" to collect the follow-up data will close on January 1, 2011. Scheduling the appointment at 5 months will give us a longer period to collect the information on patients that are difficult to find.

Step 1: Logging on the MOSBIRT site:

Go to http://www.MOSBIRT.org.

You must first register with the MOSBIRT site, by clicking on the "Register" icon.

User Registration

User Registration

***Note:** Membership to this portal is Private. Once your account information has been submitted, the portal Administrator will be notified and your application will be subjected to a screening procedure. If your application is authorized, you will receive notification of your access to the portal environment. All fields marked with a red arrow are required. -
*(**Note:** - Registration may take several seconds. Once you click the Register button please wait until the system responds.)*

User Name:
First Name:
Last Name:
Display Name:
Email Address:

Enter a password.

Password:
Confirm Password:

Agency
Unit:
Street:
City:
Country:
Region: Missouri
Postal Code:
Telephone:
Cell/Mobile:
Fax:
Website:
IM:

Register Cancel

Figure 1. MOSBIRT Registration form.

Complete the fields with the red arrows on the registration form, and Hit the "Register" button. After you are registered, the website administrator will give permission to access the "Coaches" tab on the website. Please allow a day for permissions to be granted by the administrator.

To log on, go to http://www.MOSBIRT.org and click the Login icon.

Enter the user name and password you created when you registered, and hit the login button.

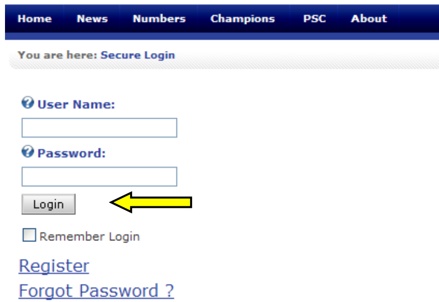

Figure 2. MOSBIRT Login.

Step 2: Accessing the Calendar on the Coach Tab:

MOSBIRT will open to the home page. Click the "Coaches" tab on the menu bar.

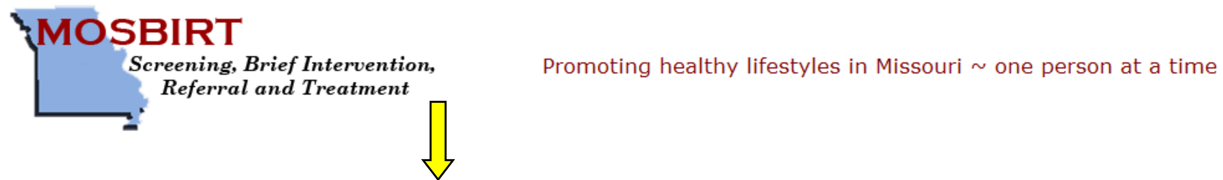

Figure 3 . MOSBIRT Menu.

This takes you to the page for the Health Coaches, which is only seen by individuals with permissions. Click the link that says "Calendar" on the right-hand side of the screen. You will be taken to the calendar page.

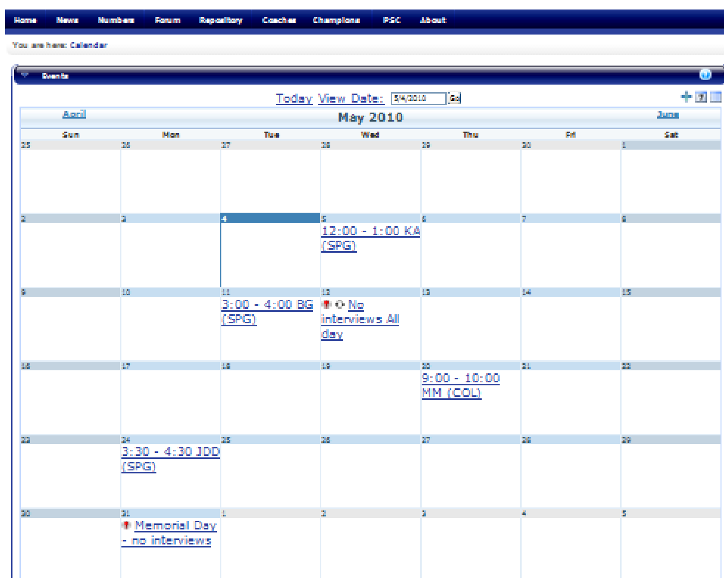

Figure 4. Example of Calendar for May, 2010.

Step 3: Checking Appointment Availability:

To schedule an appointment, first choose a date, and check the calendar for availability. Type the date you wish to view into the "view date" box and click "go."

Figure 5 . MOSBIRT Event Date Selection by typing a date.

OR

Click on "view date".

Figure 6 . MOSBIRT Event Date Selection by accessing a calendar to select a date.

A calendar will appear: select the date you wish to check for available times, and click "go"

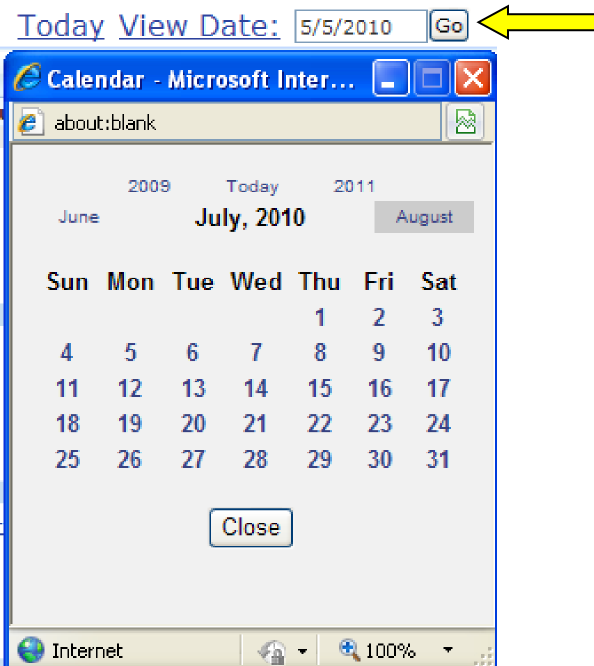

Figure 7 . MOSBIRT Select date to view appointment availability.

OR, you can also just click on the underlined Months to go forward/backward to another month:

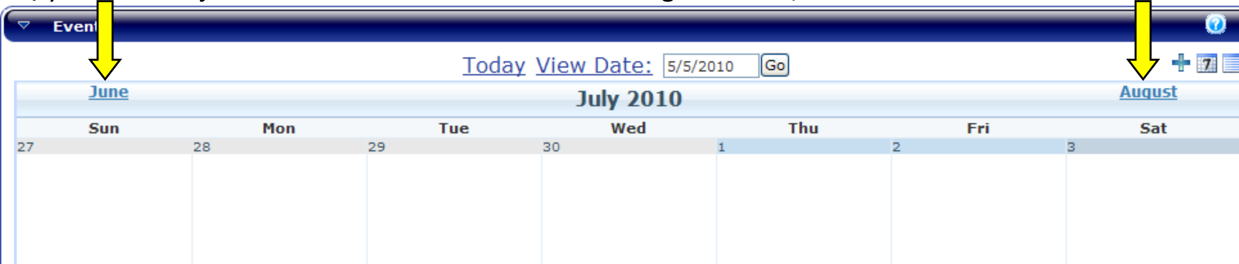

Figure 8 . MOSBIRT Scrolling ability by clicking on the month to proceed to next/previous month.

Step 4: Adding Interview Information:

Once you determine an available time, add the appointment time and patient information to the calendar. Mouse over the up-side-down triangle by "events" and click on "Add Event" **or** click the "+" (plus sign) toward the right of the screen.

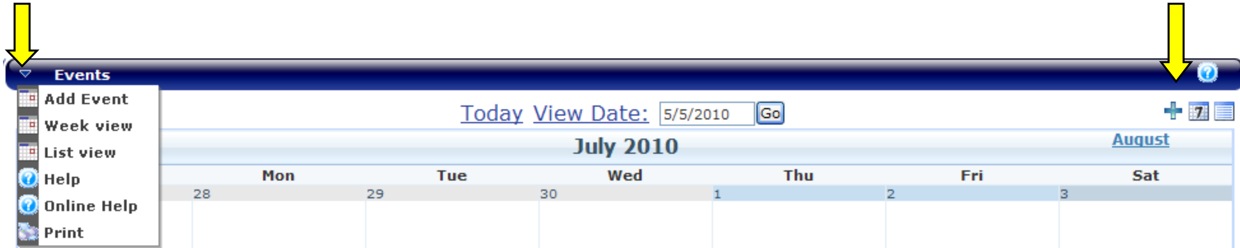

Figure 9. Accessing event settings.

This brings you to the "Event Settings" page.

Edit Event

Event Settings

Title: 3:00 pm, REA, Col

All Day Event:

Start Date/Time: 7/5/2010 3:00 PM Copy to End Date

End Date/Time: 7/5/2010 4:00 PM

Display End Date:

Importance: Normal

Category: None

Location: None

Notes:

Editor: Basic Text Box Rich Text Editor

Source Style Format Normal Font Size

REA had a BE for alcohol

Update Cancel Copy as New Event

Figure 10. Entering interview information on the "Event Settings" page.

Please follow these steps to enter interview information.

1) **Enter title**. Using the current format, enter the time, initials of participant, and site screened. For example: 3:00pm – 4:00pm, REA, COL. Please remember to schedule an hour to allow for administrative time.
2) **Enter start date/ time and end date/time**. **Hint:** Pressing "copy to end date" will automatically copy the start date to the end date.
3) **Add any additional details** to the "event description" box. Please enter the type of services the patient received/substance addressed in the service, i.e. BE, Alc & Drug.
4) Importance level should be "normal" ("High" importance is indicated when no follow-up times are available).
5) "Category, Location, Send Reminder, Display Image, Recurring event" – Ignore, we do not use these features.
6) **Click on "update**" to add event to the calendar. **Note:** The event will not be saved to the calendar until you press "update."

Step 5: Viewing, Editing and Deleting Interview Information:

To view an event, click the underlined date to view the details. **Hint:** Hovering the mouse over the event will display more details.

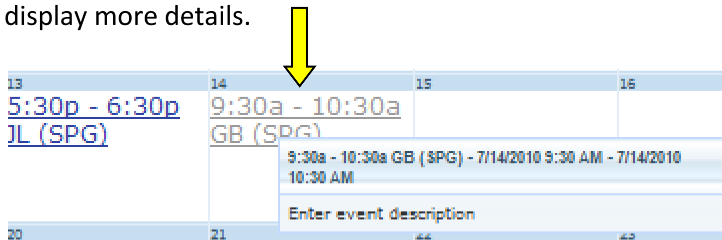

Figure 11 . Viewing the interview information for the July 14, 2010 scheduled event.

Now, you can view the details of the individual event. From this screen you can also edit and delete an event.

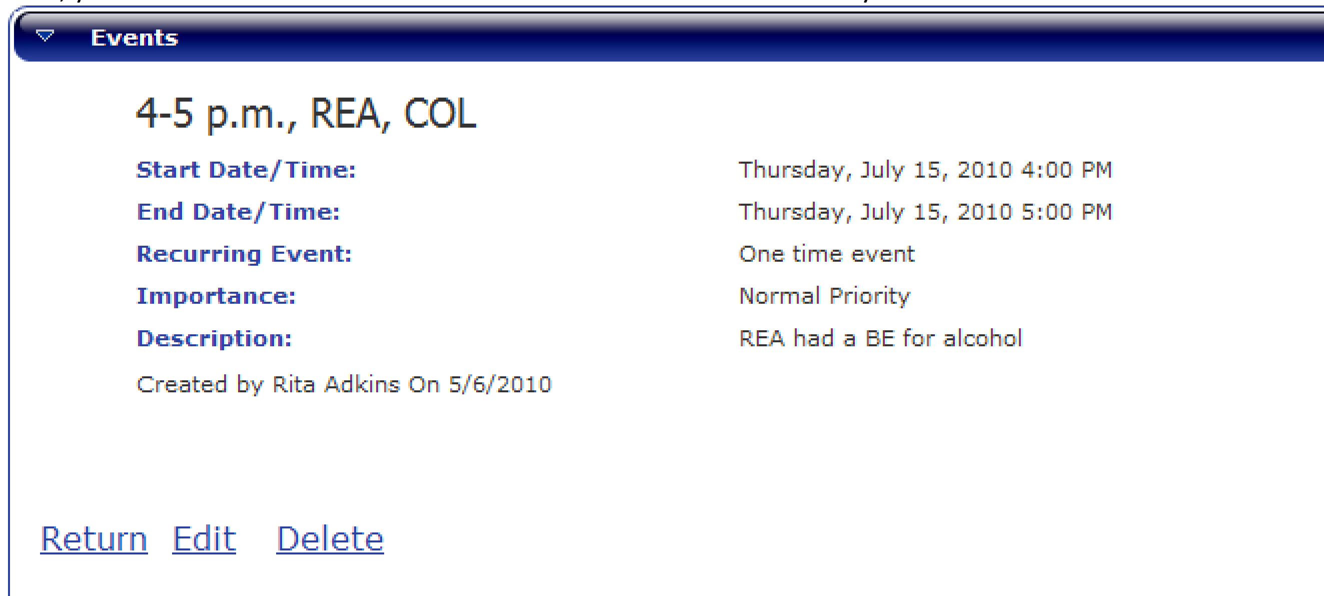

Figure 12. Viewing the interview information for the July 15, 2010 scheduled event.

To edit the event, click the "edit" at the bottom of the page. This will take you to the "Event Settings" page. After you make the necessary changes, click the "Update" at the bottom of the page to save the changes. To

delete the event, click the “Delete” at the bottom of the page. You will get a dialogue box asking if you are sure you want to delete. Once you click “OK”, the interview information is deleted. **NOTE**: Please notify trackers and follow-up personnel if any changes are made to the calendar ***after*** the locator sheet has been forwarded for input into the Tracking database.

Other Options:

The MOSBIRT calendar comes with features that let you change your view (month, week and list) and print.

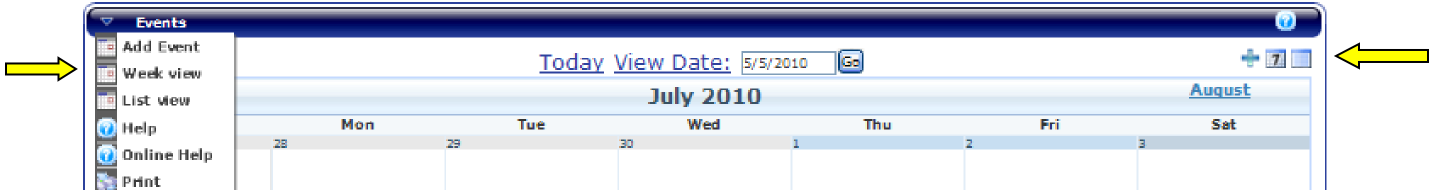

Figure 13. Viewing the event options.

Change your view: You can change your view of the calendar to weekly or monthly by clicking on “Events” and selecting the view listed, or by clicking on the calendar on the upper right hand side.

Print: Click on the up-side-down triangle next to “events” and select print. **Note**: You will need to temporarily allow pop-ups for this option to work.

List view: By choosing this option from the drop down box, you get a list of the next 10 upcoming events:

Event Start	Event End	Title
5/11/2010 3:00 PM	5/11/2010 4:00 PM	3:00 - 4:00 BG (SPG)
5/12/2010	5/12/2010	No interviews All day
5/20/2010 9:00 AM	5/20/2010 10:00 AM	9:00 - 10:00 MM (COL)
5/24/2010 3:30 PM	5/24/2010 4:30 PM	3:30 - 4:30 JDD (SPG)
5/31/2010	5/31/2010	Memorial Day - no interviews
6/1/2010 9:00 AM	6/1/2010 10:00 AM	9:00am - 10:00 am HB (COL)
6/9/2010 6:00 PM	6/9/2010 7:00 PM	6:00 - 7:00pm CB (COL)
6/15/2010 7:30 PM	6/15/2010 8:30 PM	7:30p - 8:30p SS (SPG)
6/21/2010 10:30 AM	6/21/2010 11:30 AM	10:30a - 11:30a DM (SPG)
6/24/2010 9:00 AM	6/24/2010 10:00 AM	9:00a - 10:00a DB (COL)

Figure 14. List view of the next 10 scheduled events.

Current Follow-Up Protocol:

As a reminder, here are the current follow-up procedures for the MOSBIRT project:

Follow-up Protocol for the MOSBIRT Project

Overview:
To measure the effectiveness of the MOSBIRT project, we are required to follow 10% of the patients that receive an intervention. To ensure that the sample is randomly selected, we have been assigned the following criterion for the follow-up sample:

- Those receiving any intervention (BE, BC or RT), and with
- The last 2 digits of their SSN between the numbers 50-59.

These individuals will be asked to participate in a follow-up survey 5-6 months after their intake interview. The follow-up interview will be conducted by phone by a trained evaluation staff member. At the follow-up interview, the patient will be asked to complete:

- Sections of the GPRA,
- The ATOD Attitudes and Beliefs instrument, and
- The Readiness to Change scale.

The follow-up interview should take between 20 and 25 minutes to complete, and patients completing the interview will be compensated with a $20 gift card for their time. We are required by our funders to maintain an 80% follow-up rate, so the follow-up is a very important aspect of the MOSBIRT project.

Follow-up Procedures:

The Intake Interview

1. The health coach will explain the importance of a follow-up interview for our health care service. One strategy that has been successful in engaging clients for the Follow-up piece has been to present the Follow-up interview appointment in a matter-of-fact manner as simply another part of our normal practice.
   - Start with introducing the idea of the 6 month follow-up as the next logical step in this health care service to get their feedback on our services.
   - **A script that can be used:** "Another portion of our service involves a representative of our program calling the patients that we talk to in about 5 or 6 months. We like to check in and see how you're doing and ask for your feedback at that time to help us improve our services. This interview will take place over the telephone and should only take about 20 minutes of your time."
   - "We realize that you are busy and have other things to take care of, so we'd like to compensate you for the time you take to do this by providing you with $20 in a gift card for completing the follow-up survey in 5 months."
   - If the patient is willing to do the follow-up interview, the health coach will collect contact information on the Locator Form. This form requires a signature from the patient. Their signature gives us permission to contact anyone they list on the form, so it is very important to get their consent from a liability perspective.

- The health coach will assist the patient in completing the locator form stressing the importance of including collaterals that know how to contact them. You might try this script: "What is the best way to reach you?" (phone, address, email). *SLOWLY & CLEARLY REPEAT INFO BACK TO PATIENT AND VERIFY ACCURACY.*
  - "Do you plan on being at this location & phone/email address in 5 months?"
  - (if not) – "Where do you think you can be contacted in about 5 months?"
  - "Do you have any nicknames or aliases that people might know you by?"
  - Please try to collect:
    - Phone numbers and addresses of at least 3 contacts, including the closest female relative/friend.
    - Make sure to include contact information that is different than the number and addresses of the patient.
    - The previous address is also quite helpful for difficult to locate patients, as is the contact information of a neighbor.
    - Get email address, and note if they are on Facebook, MySpace, or other social networking sites.
    - Any social services they may use, especially if they use Burrell services at the Springfield location, as the tracker can access contact information internally.
    - The tracker will need to include this information in the tracking database, so please write legibly.
    - Since the patients are likely to return to the ER, a spreadsheet will be kept of individuals that we are unable to contact. This information will be shared with the Liaison, who will note in MOSBox that we have been unable to contact the patient, so please get new contact information on any patients with this notation.

2. An appointment for the follow-up interview will be made at this time, if possible. Consult the calendar on the MOSBIRT website (http://www.mosbirt.org/) for an available time to schedule the appointment. Since the window opens 30 days before and closes 60 days after the 6 month date, please try to schedule the appointment **5 months past the intake date**. This will allow us more time to find the individual if they move or change phone numbers. The earliest the follow-up interview can be conducted is 5 months post intake. The 5 months is based on the day, i.e., if the intake date is **February 1, 2010**, the earliest the interview can be conducted is **July 1, 2010**, or 5 months to the day.

  - Script for scheduling the interview: "So let's see – would you be available to speak with us on ______ ? I know it's a long way off, so why don't we start with (this date) and as it gets closer, we can reschedule if needed."
    - Open MOSBIRT Google Shared Calendar and select time/date for 5 months after today's date: i.e., if the initial interview is **1/10/10** then the follow-up interview should be scheduled no earlier than **6/10/10**.
    - Try to schedule the appointment on a weekday (M-F) between 9 am to 7 pm. Schedule on weekend as last resort.
    - Enter patient appointment in available interview slot and fill out patient appointment card on the Locator Sheet.

- Fill in the appointment time on the appointment reminder located on the bottom right hand corner of both copies of the signed consent form, and give the patient a copy of the signed consent form.
- Forward the completed locator sheets to your assigned tracker.
- If you are unable to schedule an appointment, please have as much of the locator sheet completed as possible, and have the patient sign the consent. The tracker will make the appointment after consulting the Google calendar for an available time.

After Intake

1. A welcome letter will be sent to the patient with forwarding requests to verify the address is correct within 7 days of intake.

2. The MIMH Data Collector will call the patient after 2 weeks to verify the phone number is correct.

3. Two months post intake, an encouragement letter with health information will be sent to patient.

4. Six weeks before the appointment, the patient will receive a postcard reminding them of the scheduled follow-up interview date and time.

5. Three days before the appointment, the patient will receive a reminder call from MIMH evaluation staff.

Interview

Five-six months following the completion of the intervention, the patient will receive a phone call from an evaluation staff member at MIMH to complete the interview. Upon completion of the interview, a $20 gift card will be mailed to the address provided by the patient as compensation for completing the follow-up interview. ADDRESSING THE RELUCTANT PATIENT:

If the patient is reluctant to agree to do the interview, try asking again, and appeal to the patient's sense of wanting to help, or civic duty:

1. We realize that you live quite a ways away – we conduct our interview by telephone and it should only take a few minutes of your time and we will mail you the $20 gift card.

2. It would really help us out if you would speak with us, as your feedback would be very helpful to us in improving our services.

3. It would help a lot of other people if we could continue to offer our services in the health care system, and in order to do so we need to be able to just touch base with you for a few minutes. Would you help us out?

If the patient says they'll be moving or don't know where they will be in 5 months, still make the interview appointment! Emphasize that it will be conducted by telephone and that we will pay for the call. Then obtain:

1. Their *best guess* as to what their phone number will be.

2. Their *best guess* as to where they will have been, just prior to the 5 month date – i.e. Do they expect to be in a treatment program, shelter, away at college, in another state?

3. Name of person or agency who would most likely know where they are – perhaps a parole or probation officer, or primary care provider? (Obtain patient's Consent to Release Information for that person.)

Stress that they will still be eligible for the services component of our program, which include free, individual Brief Education sessions, and referral to treatment as needed.

For all patients who decline the Follow-up interview, please:

1. Engage the patient in a conversation about their reasons for declining the follow-up service and address the patient's concerns - i.e. If worried about confidentiality – explain in plain language about the protection of HIPAA for health care information.

2. Document the patient's concerns, reasons for declining, and any other contributing factors in the "Comments" section of the Locator sheet. Provide as much information as possible: ie – patient was in a lot of pain, or distracted by visitors, or preoccupied with new diagnoses. Note patient's response to your interaction.