RECOVERY SERVICES FOR ADOLESCENTS AND FAMILIES
SUPPORTING STATEMENT

A. JUSTIFICATION

A.1 Circumstances of Information Collection

The Substance Abuse and Mental Health Administration (SAMHSA)'s Center for Substance Abuse Treatment (CSAT) requests approval from the Office of Management and Budget (OMB) for the new data collection activities of the "Recovery Services for Adolescents and Families (RSAF)" project. This project was created through SAMHSA's ongoing effort to help adolescents maintain therapeutic gains once they are discharged from substance abuse treatment. Data show that many adolescents experience periods of relapse after treatment and that those who participate in continuing care have better substance use outcomes than those who do not (Dennis et al., 2004; Godley et al., 2004; Waldron et al., 2001; Godley, S. H. Godley, Dennis, Funk, & Passetti, 2002, 2007). RSAF is intended to develop and pilot test ways to keep youth connected to recovery support services in ways that are appealing to them and that can be implemented without substantial costs in the community.

The following 28 data collection forms will be used for gathering baseline and clinical data, monitoring preliminary outcomes, and monitoring implementation of the project's recovery support services. Adolescent participants will be asked to complete 3 forms, and collateral participants (parent/guardians) will be asked to complete 6 forms. Staff (consisting of Project Coordinators, Telephone Support Volunteers, Social Networking Site Moderators, Family Support Clinicians, and Support Services Supervisors) will be asked to complete 19 unique forms, with no individual completing more than 7 forms. Please note that the Volunteer/Staff Survey is completed across staff members. Forms are listed below grouped by respondent:

Adolescent Participant

- Global Appraisal of Individual Needs – Initial (GAIN-I 5.6.0 Full) (Attachment B)
  (The GAIN was previously approved under the Persistent Effects of Treatment Study of Adolescents OMB No. 0930-0202.)
- Global Appraisal of Individual Needs – Monitoring 90 Days (GAIN-M90 5.6.0 Full) (Attachment C)
- Supplemental Assessment Form (SAF 0309) (Attachment D)

Collateral Participant (parent/guardian)

- Global Appraisal of Individual Needs – Collateral Monitoring - Initial (GCI) (Attachment F)
- Global Appraisal of Individual Needs – Collateral Monitoring - Monitoring (GCM 5.3.3) (Attachment G)
- Supplemental Assessment Form – Collateral (SAF - Collateral) (Attachment H)
- Self-Evaluation Questionnaire (SEQ) (Attachment I)
- Family Environment Scale (FES) (Attachment J)
- Relationship Happiness Scale (Caregiver Version) (Attachment K)

Project Coordinator

- Eligibility Checklist (Attachment L1)
- Telephone Support Volunteer Notification Form (Attachment L2)
- Family Program Notification Form (Attachment (Attachment L3)
- Follow-Up Locator Form – Participant (FLF-P) (Attachment A)
- Follow-Up Locator Form – Collateral (FLF-C) (Attachment E)
- Follow-Up Contact Log (Attachment M)
- Volunteer/Staff Survey (Attachment N)

Telephone Support Volunteer
- Telephone Support Case Review Form (Attachment O)
- Telephone Support Call Log (Attachment P)
- Adolescent Telephone Support Documentation Form (Attachment Q)
- Telephone Support Discharge Form (Attachment R)
- Volunteer/Staff Survey (Attachment N)

Social Network Site Moderator
- Social Networking Moderator Log (Attachment S)
- Volunteer/Staff Survey (Attachment N)

Family Program Clinician
- Family Program Progress Notes (Attachment T)
- Family Program Attendance Log (Attachment U)
- Family Program Case Review Report (Attachment V)
- Family Program Discharge Form (Attachment W)
- Volunteer/Staff Survey (Attachment N)

Support Services Supervisor
- Adolescent Telephone Support Quality Assurance Checklist (Attachment X)
- Social Networking Quality Assurance Checklist (Attachment Y)
- Family Program QA Checklist (Attachment Z)
- Volunteer/Staff Survey (Attachment N)

The RSAF project is authorized under Section 501(d)(4) of the Public Health Service Act (42 USC 290aa(d)(4)).

This data collection gathers information from adolescents, collaterals (parents/guardians/concerned others), and staff participating in the Recovery Services for Adolescents and Families (RSAF) project. This information will be used for gathering baseline and clinical data, monitoring preliminary outcomes, and monitoring implementation of the project's recovery support services. CSAT's mission is to 'bring effective alcohol and drug treatment to every community' and recognizes that current data reveal that the relapse rate of youth who leave treatment is high and also that a period of continuing care can help to reduce the rate of relapse. Thus, this information will support the planning, development, and implementation of recovery supports that are developmentally appropriate for and specific to youth and can be community based.

Specifically, SAMHSA is pilot testing the following recovery support services across four sites in the US: 1) telephone/text message support; 2) a recovery-oriented social networking site; and 3) a family program. Approximately 200 adolescent respondents will be asked to complete 4 data collection forms (some repeated) during 5 interviews (baseline and 4 follow-ups) over a 12 month period after enrollment or discharge from treatment. Approximately 200 collateral respondents (i.e., a parent/guardian/concerned other) will be asked to complete 7 data collection forms (some repeated) during 5 interviews (baseline and 4 follow-ups) over a 12 month period after their adolescent's enrollment or discharge from treatment. Approximately 15 to 20 project staff respondents, including Project Coordinators, Telephone Support Volunteers, a Social Network Site Moderator, Family Program Clinicians, and a Support Services Supervisor, will be asked to complete between 2 and 5 data collection forms at varying intervals during the delivery of recovery support services. Across all respondents, a total of 32 data collection forms will be used. Data collected will be in the areas of background, substance use, physical health, risk behaviors, mental health, environment, involvement with the legal system, school/employment, service utilization and implementation, and protocol adherence. Depending on the time interval and task, information collections will take anywhere from about 5 minutes to 2 hours to complete. Records must be kept for 7 years past the end of the project.

A.2. Purpose and Use of Information

The information gathered for the RSAF project will be used for baseline and clinical data, monitoring preliminary outcomes, and monitoring implementation of the project's recovery support services. Without this information, CSAT and other federal funding agencies will not have enough data to determine whether or not further study of these support services is warranted to assist adolescents and families in recovery from substance use problems. Evaluation questions for this project include:

- How well were the project's recovery support services implemented?

- How does adolescent participation in the project's recovery support services correlate with changes in time for the following outcomes: substance use frequency; substance-related problems; recovery environment risk; social risk; and utilization of recovery support services?

- How does family participation in the project's recovery support services correlate with changes in time for the following collateral (family) outcomes: family environment cohesion and conflict scales; the relationship happiness scale; the self-evaluation questionnaire; and the telephone support satisfaction scale?

The following is a list of project forms, their description, when they are administered, and who administers them:

Adolescent Participant

- *Global Appraisal of Individual Needs – Initial (GAIN-I 5.6.0 Full).* The GAIN is an evidence-based assessment used with both adolescents and adults and in outpatient, intensive outpatient, partial hospitalization, methadone, short-term residential, long-term residential, therapeutic community, and correctional programs. There are over 1000 questions in this initial version that are in multiple formats, including multiple choice, yes/no, and open-ended. Eight content areas are covered: Background, Substance Use, Physical Health, Risk Behaviors and Disease Prevention, Mental and Emotional Health, Environment and Living Situation, Legal, and Vocational. Each section contains questions on the recency of problems, breadth of symptoms, and recent prevalence as well as lifetime service utilization, recency of utilization, and frequency of recent utilization. GPRA data are gathered as part of this instrument in support of performance measurement for SAMHSA programs. It is administered at intake into treatment by clinical staff and used as baseline data for the project.
- *Global Appraisal of Individual Needs – Monitoring 90 Days (GAIN-M90 5.6.0 Full).* The GAIN is an evidence-based assessment used with both adolescents and adults and in outpatient, intensive outpatient, partial hospitalization, methadone, short-term residential, long-term residential, therapeutic community, and correctional programs. There are over 500 questions in this follow-up version that are in multiple formats, including multiple choice, yes/no, and open-ended. Eight content areas are covered: Background, Substance Use, Physical Health, Risk Behaviors and Disease Prevention, Mental and Emotional Health, Environment and Living Situation, Legal, and Vocational. Each section contains questions on the recency of problems, breadth of symptoms, and recent prevalence as well as lifetime service utilization, recency of utilization, and frequency of recent utilization. GPRA data are gathered as part of this instrument in support of performance measurement for SAMHSA programs. It is administered by project staff at each of the follow-up timepoints.
- *Supplemental Assessment Form (SAF 0309).* The SAF contains 72 questions that are a combination of multiple choice, yes/no, and open-ended formats. Content areas include: race, happiness with parent or caregiver in several life areas, participation in prosocial activities, receipt of and satisfaction with telephone support services, and usage of and satisfaction with the project's social networking site. It is administered by project staff at each of the follow-up timepoints.

Collateral Participant (parent/guardian)

- *Global Appraisal of Individual Needs – Collateral Monitoring - Initial (GCI)*. The GCI contains over 200 items in this initial version that are in multiple formats, including multiple choice, yes/no, and open-ended. The following content areas are covered: relationship to the adolescent respondent, background, and the adolescent's background and substance use, environment and living situation, and vocational information. There are questions on the recency of problems, breadth of symptoms, and recent prevalence as well as lifetime service utilization, recency of utilization, and frequency of recent utilization. It is administered at baseline by project staff.
- *Global Appraisal of Individual Needs – Collateral Monitoring – Monitoring (GCM 5.3.3)*. The GCM contains over 200 items in this follow-up version that are in multiple formats, including multiple choice, yes/no, and open-ended. The following content areas are covered: relationship to the adolescent respondent, background, and the adolescent's background and substance use, environment and living situation, and vocational information. There are questions on the recency of problems, breadth of symptoms, and recent prevalence as well as lifetime service utilization, recency of utilization, and frequency of recent utilization. It is administered at each of the follow-up timepoints by project staff
- *Supplemental Assessment Form – Collateral (SAF - Collateral)*. The SAF contains 72 questions that are a combination of multiple choice, yes/no, and open-ended formats. Content areas include: knowledge about the adolescent's participation in prosocial activities, receipt of and satisfaction with telephone support services, and usage of and satisfaction with the project's social networking site. It is administered at each of the follow-up timepoints by project staff.
- *Self-Evaluation Questionnaire (SEQ)*. The SEQ contains 40 multiple choice items that ask the collateral about feelings and symptoms of anxiety. It is administered at each of the follow-up timepoints by project staff.
- *Family Environment Scale (FES)*. The FES contains 18 yes/no items that measure family cohesion and conflict. It is administered at each of the follow-up timepoints by project staff.
- *Relationship Happiness Scale (Caregiver Version)*. The Relationship Happiness Scale contains 8 items that ask the collateral about happiness with his/her relationship with the adolescent respondent in various life areas. It is administered at each of the follow-up timepoints by project staff.

Project Coordinator

- *Eligibility Checklist.* The Eligibility Checklist contains 12 yes/no items that are used to determine whether or not an adolescent meets inclusion/exclusion criteria for the project and is eligible to be approached for informed consent. It is completed prior to informed consent by project staff.
- *Telephone Support Volunteer Notification Form*. This form contains a participant's name and contact information. It is completed by project staff and given to volunteers to notify them when someone is assigned to receive telephone support.
- *Family Program Notification Form*. This form contains a participant's name. It is completed by project staff and given to clinicians to notify them when someone is assigned to the family support group.
- *Follow-Up Locator Form – Participant (FLF-P)*. The FLF-P contains over 50 items that are a combination of yes/no, multiple choice, and open-ended formats. At the time of informed consent, data are gathered by project staff about an adolescent's contact information, personal contacts, criminal justice contacts, school/job contacts, hang-out information, internet contacts, and identifying information in order to locate and interview that adolescent over multiple follow-up intervals.
- *Follow-Up Locator Form – Collateral (FLF-C)*. The FLF-C contains over 50 items that are a combination of yes/no, multiple choice, and open-ended formats. Data are gathered about a collateral's contact information, personal contacts, and job contacts in order to locate and interview that collateral over multiple follow-up intervals. It is administered at the time of informed consent by project staff.

- *Follow-Up Contact Log*. The Follow-Up Contact Log is open-ended and provides space for all data collected during attempted and completed follow-up contacts, over the phone and in-person, to be recorded. It is completed throughout the follow-up timeperiod.
- *Volunteer/Staff Survey*. The Volunteer/Staff Survey contains 10 items in fill-in-the-blank, yes/no, and multiple choice formats. Items ask about background, demographic information, and role in the project. It is completed once by all volunteers and staff at the start of the project.

Telephone Support Volunteer

- *Telephone Support Case Review Form*. The Telephone Support Case Review Form contains multiple rows that allow a volunteer to record 5 pieces of data about adolescent's that they make phone calls to: initials, treatment discharge status/date, weeks since treatment discharge, date of last telephone session, and number of completed telephone sessions since discharge. This allows the volunteer and supervisor to monitor the progress of active cases. The form is completed by the volunteers every week.
- *Telephone Support Call Log*. The Telephone Support Call Log is open-ended and provides space for all data collected during attempted and completed support contacts to be recorded. The form is completed by the volunteer throughout the period of telephone support.
- *Adolescent Telephone Support Documentation Form*. The Adolescent Telephone Support Documentation Form contains 22 items that are asked of an adolescent during a telephone support contact by a volunteer. The form is used to record yes/no and open-ended responses to questions asking about substance use and recovery-related activities. The volunteers complete the form every time there is a telephone support session with an adolescent.
- *Telephone Support Discharge Form*. The Telephone Support Discharge Form contains 10 fields to record the following information at the end of an adolescent's participation in telephone support: adolescent name, today's date, volunteer name, notification date, telephone support intake date, telephone support discharge date, reason for discharge, number of completed sessions, referral for more intervention, and successful contact for more intervention. This form is completed by volunteers when telephone support ends for each adolescent.
- *Volunteer/Staff Survey (Telephone Support Volunteer)* – See *Volunteer/Staff Survey (Project Coordinator)* above.

Social Network Site Moderator

- *Social Networking Moderator Log*. The Social Networking Moderator Log contains 11 fields for the moderator to record usage data for the project's social networking site. The moderator tracks number of visits to the site, number of unique visitors, messages posted, chat room attendance, and problems with users. This form is completed weekly by project staff.
- *Volunteer/Staff Survey* – See *Volunteer/Staff Survey (Project Coordinator)* above.

Family Program Clinician

- *Family Program Progress Notes*. The Family Program Progress Notes form is open-ended and provides space for all data collected during attempted and completed family program contacts to be recorded. This form is completed by the clinician throughout the time family members are active in the family support program.
- *Family Program Attendance Log*. The Family Program Attendance Log is used to record 6 pieces of information about each attempted session: session number, scheduled date, was the session rescheduled (yes/no), was the family member a no-show (yes/no), did the family member attend the session (yes/no), and comments. This form is completed the clinician throughout the time family members are active in the family support program.
- *Family Program Case Review Report*. The Family Program Case Review Report contains multiple rows that allow a clinician to record information that allows the clinician and supervisor to monitor the progress of active cases. Areas asked about include: family program procedures delivered, date of last session, and

weeks in family program. This form is completed by the clinician weekly throughout the time family members are active in the family support program.

- *Family Program Discharge Form*. The Family Program Discharge Form contains 9 fields to record the following information at the end of participation in the family program: caregiver name, today's date, adolescent name, notification date, clinician name, family program intake date, family program discharge date, reason for discharge, and number of completed sessions. This form is completed by the clinician each time family members of a given participant end involvement in the family support program.
- *Volunteer/Staff Survey* – See *Volunteer/Staff Survey (Project Coordinator)* above.

Support Services Supervisor

- *Adolescent Telephone Support Quality Assurance Checklist*. This checklist contains 43 items that ask the supervisor to rate how well a telephone support volunteer delivered required service components to adolescents. Volunteers are rated on a scale of 1 through 5 in the following areas: substance use since last call (no use), substance use since last call (use), substance use since last call (still using), substance use since last call (stopped using), attendance at 12-step meetings, recovery-related activities, activities related to global health, follow-up since last call, closing the call, overall, general clinical skills, and overall difficulty of session. This form is completed for each reviewed recording of a telephone session by a supervisor.
- *Social Networking Quality Assurance Checklist.* This checklist contains 17 items that ask the supervisor to rate how well a social networking site moderator delivered required service components to adolescents. The moderator is rated on a scale of 1 through 5 in the following areas: group discussions, administrative tasks, overall, and general skills. This form is completed for each review of the social networking site by a supervisor.
- *Family Program QA Checklist.* This checklist contains 72 items that ask the supervisor to rate how well a family program clinician delivered required service components to family members. The clinician is rated on a scale of 1 through 5 in the following areas: initial meeting motivational strategies, domestic violence precautions, functional analysis of substance use, positive communication skills, use of positive reinforcement, time out from positive reinforcement, allowing the identified patient to experience the natural consequences of substance use, helping concerned significant others' enrich their own lives, maintaining the identified patient in recovery-oriented systems of care, and general. This form is completed for each reviewed recording of a family session by a supervisor.
- *Volunteer/Staff Survey* – See *Volunteer/Staff Survey (Project Coordinator)* above.

A.3 <u>Use of Information Technology</u>

In order to reduce the burden of data collection and to improve data quality, agency efficiency, and public responsiveness, two sets of computer software will be used to record and track information. To track delivery of telephone support and family support program services and ensure that they are executed as planned, session information will be entered into a program call EBTx. EBTx is a web-based program that allows both the uploading of digital recordings that can be streamed by a reviewer in another location and the entry of process data related to the services which can then be summarized by individual, site, or overall. The EBTx application will be maintained by the GAIN Coordinating Center Software Support Team at Chestnut Health Systems.

The Global Appraisal of Individual Needs (GAIN) will be administered interactively whenever possible using a computerized version called GAIN ABS. GAIN ABS is maintained by the GAIN Coordinating Center Software Support team at Chestnut Health Systems. Data will be stored from GAIN interviews in a designated database for the study. In order to collect all GAIN assessments from sites, Chestnut will coordinate all communication between the GAIN Coordinating Center and each site. In compliance with HIPAA regulations, all identifying information will be removed before the Data Management team retrieves the data from sites' ABS servers. GAIN ABS is HIPAA compliant software that has role/ID/password limited access and state of the art security. At the conclusion of each interactive

GAIN, a validity report is generated which cues the interviewer to check possible inconsistencies between responses entered for different items. Once cued, the interviewer is responsible for reconciling those differences with the participant or entering notes that explain why certain responses appear inconsistent. When the data is keyed into the GAIN software, the program matches records to known cases, completes range and table look-up checks to ensure valid data, inserts consistency codes for legitimate skips, not applicable, missing, or refused. It also has utilities for editing data, re-keying data, reconciling differences, generating status reports, and exporting the data to SPSS or an ASCII file. Unique ID codes specific to this study will be assigned to data records.

A.4. Efforts to Identify Duplication

No studies have been identified through literature searches that investigate recovery support services for adolescents. Additionally, recovery support services specific to this project have been developed, and by definition, have not been tested before in general or with this population. Therefore, the proposed information collection is only for purposes of this program and is not available elsewhere.

A.5 Involvement of Small Entities

Individual subcontractors (performance sites) are agencies in: Seattle, Washington (Science and Management of Addictions); Bloomington, Illinois (Chestnut Health Systems); Tucson, Arizona (University of Arizona); and Fitchburg, Massachusetts (LUK, Inc.). Use of GAIN ABS and EBTx as described above should minimize burden to project staff at these sites and will not have a significant impact on them.

A.6 Consequences If Information Collected Less Frequently

The collection of information is necessary in order to fulfill the terms of CSAT's contract and to gather appropriate and needed data about the implementation and effectiveness of the newly created recovery support services for adolescents and families. The frequency of data collection is timed in order to capture the most accurate information from participants and staff. For example, each adolescent and collateral respondent is asked to voluntarily complete interviews at 90 day follow-up intervals. The length of these intervals was chosen to balance accuracy of memory recall and burden to adolescent and collateral respondents.

A.7 Consistency With the Guidelines in 5 CFR 1320.5(d)(2)

This information collection fully complies with 5 CFR 1320.5(d)(2).

A.8 Consultation Outside the Agency

The notice required in 5 CFR 1320.8(d) was published in the Federal Register on May 15, 2009 (74 FR 22936). No comments were received.

The following individuals have experience with the data collection forms listed for this project in their original or substantially similar form. They were consulted when determining clarity of items and time needed to complete data collection forms:

Name	Title	Organizational Affiliation	Telephone Number
Mike Dennis	Senior Research Psychologist	Chestnut Health Systems, 448 Wylie Drive, Normal, IL 61761	(309) 463-7801
Mark Godley	Director	Chestnut Health Systems, 448	(309) 451-7800

		Wylie Drive, Normal, IL 61761	
Lora Passetti	Research Projects Manager	Chestnut Health Systems, 448 Wylie Drive, Normal, IL 61761	(309) 451-7804

An Advisory Board was also created with voluntary participation from young people in recovery from substance use problems, parents, treatment providers, and researchers to consult about development and testing of the recovery support services. The Advisory Board meets quarterly, and the following is a list of the participants:

Name	Title	Organizational Affiliation	Telephone Number
Angelo Adson	Clinical Administrator	Intercultural Behavioral Health Center, 2317 South 23rd St., Philadelphia, PA 19145	(215) 463-1317
Marsha Baker	Senior Public Health Advisor	SAMHSA/CSAT, 1 Choke Cherry Road, Rockville, MD 20857	(240) 276-1566
Jutta Butler	Team Leader	SAMHSA/CSAT, 1 Choke Cherry Road, Rockville, MD 20857	(240) 276-1567
Luis Flores	Executive Vice President	Serving Children and Adolescents in Need Inc. (SCAN), 2387 E. Saunders, Ste. 2 Laredo, TX 78043	(956) 724-3177, ext. 155
Mark Godley	Director, Lighthouse	Chestnut Health Systems, 448 Wylie Drive, Normal, IL 61761	(309) 451-7800
Susan Godley	Senior Research Scientist and EBT Coordinating Center Director	Chestnut Health Systems, 448 Wylie Drive, Normal, IL 61761	(309) 451-7802
Ashley Hyde	Project Manager	Connecticut Turning to Youth and Families, 135 West Road, Marlborough, CT 06447	(203) 581-1602
Elise Lopez	Program Assistant	University of Arizona, 181 Tucson Blvd., Suite 101, Tucson, AZ 85716	(520) 295-9339
Stephanie Merkle	Research Project Assistant	Chestnut Health Systems, 448 Wylie Drive, Normal, IL 61761	(309) 451-7870
Randy Muck	Chief, Targeted Populations Branch	SAMHSA/CSAT, 1 Choke Cherry Road, Rockville, MD, 20857	(240) 276-1576
Dennis Noonan	Clinical Director	Pima Prevention Partnership, 2525 East Broadway Blvd., Suite 100, Tucson, AZ 85716	(520) 850-0264
Lora Passetti	Research Projects Manager	Chestnut Health Systems, 448 Wylie Drive, Normal, IL 61761	(309) 451-7804
Gina Grappone	Executive Director	SAMA, 1900 N. Northlake Way, Suite 115, Seattle, WA 98103	(206) 328-1719
Sharon Smith	President	MOMSTELL, 4 Plainview Rd., Camp Hill, PA 17011	(717) 730-2020

A.9 Payment to Respondents

Remuneration is offered because this target population is considered hard-to-reach over multiple time points. These individuals tend to be difficult to contact, involved with the legal system, and highly mobile. For example, Meyers, Webb, Frantz, & Randall (2003) found that when attempting to contact adolescents admitted to residential substance use or mental health treatment 6 months later, over 40% required 6 or more contacts to complete the interview. Scott (2004) found that it took 22 contacts or less to capture 70% of an adult population with substance use problems and 33-38 contacts or less to capture 90%. Adolescents will receive a $30 gift card after completing each interview, and collaterals will receive a $20 gift card after completing each of their own shorter interviews. Adolescents and collaterals will also receive an additional $10 gift card for completing each interview on time. The average adolescent respondent and collateral is expected to incur direct expenses related to minutes used on cell phones, travel to a telephone or in-person interview, and possibly childcare.

Published studies in the substance abuse research field suggest that monetary compensation significantly increases response rates in substance-using populations. In one survey that recruited adolescents enrolled in a substance use prevention and intervention program, retention was influenced by incentive size. Payment of $25 after return of a mailed survey was associated with a 4% increase in response rate over a $20 payment (66% vs 62%) (Collins, Ellickson, Hays, & McCaffrey, 2000). In another study, adults in outpatient substance abuse treatment were randomly assigned to receive $10, $40, or $70 compensation after completion of a 6-month follow-up interview. Higher gift certificate amounts were associated with increased follow-up rates ($10 yielded about a 30% response rate; $40 yielded about 35%; and $70 yielded about 42%). The difference in response rates between $10 and $40/$70 gift certificates was significant (Festinger, Marlowe, Croft, Dugosh, Mastro, Lee, DeMatteo, & Patapis, 2005). As part of the 2001 National Household Survey on Drug Abuse incentive experiment, Wright et al. (2002) reported that $20 and $40 incentives each produced about a 10 point gain in overall response rates when compared with a $0 control group. The response rate was higher for the $40 group than the $20 one in many subgroup analyses. Overall, these studies suggest that higher payments may be more cost-effective by reducing the need for more intensive follow-up efforts

Without remuneration, response rates are expected to be below the commonly targeted 70%; however, accepting even a follow-up rate of 70% can introduce significant and unpredictable bias that might compromise the validity of analyses (Scott, 2004). With remuneration and proven follow-up tracking procedures (Scott, 2004), response rates are expected to be 90% and above with 90%+ on-time completion rates for each wave of adolescent information collection.

A.10 Assurance of Confidentiality

All project forms and procedures have been approved and will continue to be monitored by Chestnut Health Systems' Institutional Review Board (Attachment OO). They will also be reviewed by subcontractors' IRBs when applicable and prior to the beginning of data collection. In accordance with 45 CFR 46, Protection of Human Subjects, procedures for informed consent, data collection, and data maintenance are designed to protect the privacy of respondents and are outlined in the informed consent. When approached about participation, project staff at each performance site will provide adolescents and collaterals with a formal review of informed consent to explain the nature and conditions of the project (Attachments AA and BB). The review will explain: a) that the study is funded by CSAT; b) that participation is voluntary; c) the purpose and procedures of the study; d) the risks and benefits of participation; e) how the information collected will be used; and d) mandated reporting laws. If the adolescent agrees, he/she will be asked to sign the assent form, and a parent or guardian will be asked to sign the consent form. If the adolescent or parent/guardian refuses, he/she will be asked to check a "do not agree" box and sign the form. Consent forms will be stored securely and separately from interview and session data at each site. For analysis, identification codes only and no names will be attached to data records, and these

de-identified data records will be stored in a secured, password protected database at Chestnut Health Systems. All recordings of participant interviews or sessions used for QA purposes will be secured in locked file cabinets and labeled only with a project ID number.

A.11 Questions of a Sensitive Nature

In both the initial and follow-up versions of the GAIN for the adolescent and in the collateral interviews, there are questions of a sensitive nature. In one or all forms, questions ask about the adolescent participant's substance use, sexual behavior, illegal activity, child abuse, and religious involvement. These items are considered necessary because research has consistently shown that all of these variables are correlated with substance use and outcomes from substance abuse treatment. Such variables will be entered into analyses with the intent to evaluate their correlation with participation in the project's recovery support services. In the project's informed consent, as well at the beginning of each interview, respondents are told that they have the right to refuse to answer any question at any time without penalty. They are also told about mandated reporting laws. Parent/guardian consent is required for an adolescent under the age of 18 years old to participate in the project, and the parent/guardian will be asked to sign a consent form for their own participation.

A.12 Estimates of Annualized Hour Burden

The following tables estimate the annualized hour burden for adolescent and collateral respondents as well as for recordkeeping. The first table contains more detail and includes forms to be completed grouped by respondent. Hour burden estimate includes the time for reviewing instructions, searching existing data sources (if applicable), gathering and maintaining data needed, and completing and reviewing collection of information. Hour burden estimates are based on previous use of these or similar forms across hundreds of similar respondents from previous studies. There are no direct costs to adolescent and collateral respondents' time other than time to participate. For adolescents, the hourly wage is based on the Bureau of Labor's estimated average minimum wage ($11.95; 2008) since many adolescents hold minimum wage positions. The hourly wage used in the table for collaterals is based on the Bureau of Labor's estimated average hourly wages for adults ($18.56; July 2009). Cost estimates for staff are based on wages for similar positions and project budget. The second table is an annualized summary table.

Detailed Information on Forms Grouped by Respondent

Instrument/Form	Number of Respondents	Responses Per Respondent	Total Responses	Hours Per Response	Total Annualized Hour Burden*	Hourly Wage	Total Cost**
Adolescent Participant							
GAIN-I 5.6.0 Full	200	1	200	2	400	$11.95	$4,780.00
GAIN-M90 5.6.0 Full	200	4	800	1	800	$11.95	$9,560.00
SAF	200	5	1,000	.25	250	$11.95	$2,987.50
Subtotal	**200**		**2,000**		**1,450**		**$7,327.50**
Collateral (parent/guardian/concerned other) Participant							
Collateral-I	200	1	200	.25	50	$18.56	$928.00
Collateral-M	200	4	800	.25	200	$18.56	$3,712.00
Collateral SAF	200	5	1,000	.25	250	$18.56	$4,640.00
Self-Evaluation	200	5	1,000	.16	250	$18.56	$4,640.00

Questionnaire							
Family Environment Scale (Cohesion and Conflict Scales)	200	5	1,000	.08	80	$18.56	$1,484.80
Relationship Happiness Scale (Caregiver)	200	5	1,000	.08	80	$18.56	$1,484.80
Subtotal	**200**		**5,000**		**910**		**$16,889.60**
Project Coordinator							
Eligibility Checklist	4	50	200	.25	50	$16.35	$817.50
Locator – Participant	4	50	200	.32	64	$16.35	$1,046.40
Locator – Collateral	4	50	200	.25	50	$16.35	$817.50
Follow-Up Contact Log	4	50	200	.16	32	$16.35	$523.20
Telephone Support Volunteer Notification Form	4	50	200	.16	32	$16.35	$523.20
Family Program Notification Form	4	50	200	.16	32	$16.35	$523.20
Volunteer/Staff Survey	4	1	4	.25	1	$16.35	$16.35
Subtotal	**4**		**1,204**		**261**		**$4,267.35**
Telephone Support Volunteer							
Telephone Support Case Review Form	8	450	3,600	.25	900	$0	$0
Telephone Support Call Log	8	25	200	.16	32	$0	$0
Telephone Support Documentation Form	8	450	3,600	.5	1,800	$0	$0
Telephone Support Discharge Form	8	25	200	.16	32	$0	$0
Volunteer/Staff Survey	8	1	8	.25	2	$0	$0
Subtotal	**8**		**7,608**		**2,766**		**$0**
Social Network Site Moderator							
Social Networking	1	52	52	.5	26	$16.35	$425.10

Moderator Log							
Volunteer/Staff Survey	1	1	1	.25	.25	$16.35	$4.09
Subtotal	**1**		**53**		**26.25**		**$429.19**
Family Program Clinician							
Family Program Progress Notes	4	650	2,600	.16	416	$17.31	$7,200.96
Family Program Attendance Log	4	50	200	.08	16	$17.31	$276.96
Family Program Case Review Form	4	650	2,600	.25	650	$17.31	$11,251.50
Family Program Discharge Form	4	50	200	.16	32	$17.31	$553.92
Volunteer/Staff Survey	4	1	4	.25	1	$17.31	$17.31
Subtotal	**4**		**5,604**		**1,115**		**$19,300.65**
Support Services Supervisor							
Telephone Support QA Checklist	1	12	12	1	12	$16.35	$196.20
Social Networking QA Checklist	1	12	12	.5	6	$16.35	$98.10
Family Program QA Checklist	1	12	12	1	12	$16.35	$196.20
Volunteer/Staff Survey	1	1	1	.25	.25	$16.35	$4.09
Subtotal	**1**		**37**		**30.25**		**$494.59**
TOTAL	**418**		**21,506**		**6,558.50**		**$58,708.88**

Annualized Summary Table

Respondents	**Number of Respondents**	**Total Responses**	**Total Annualized Hour Burden***	**Hourly Wage**	**Total Cost****
Adolescent	200	2,000	1,450	$11.95	$17,327.50
Collateral	200	5,000	910	$18.56	$16,889.60
Project Coordinator	4	1,204	261	$16.35	$4,267.35
Telephone Support Volunteer	8	7,608	2,766	$0	$0
Social Network Site Moderator	1	53	26.25	$16.35	$429.19
Family Program Clinician	4	5,604	1,115	$17.31	$19,300.65
Support Services Supervisor	1	37	30.25	$16.35	$494.59
Total	**418**	**21,506**	**6,558.50**		**$58,708.88**

***Total Annualized Hour Burden = Total Responses x Hours Per Response**
****Total Cost = Hourly Wage x Total Hour Burden**

A.13 Estimates of Annualized Cost Burden to Respondents

There are no respondent costs for capital or start-up or for operation or maintenance.

A.14 Estimates of Annualized Cost to the Government

The field work for which SAMHSA is seeking OMB approval is scheduled to occur over a one year period of time so the cost estimates are based on the known and budgeted costs for this one year period. Known costs include 4 performance sites at $154,000 per site or $616,000. SAMHSA has also estimated $301,800 in project training, monitoring, management, and data management/analysis costs from Chestnut Health Systems staff during the one year implementation phase. Other direct costs to accomplish successful implementation of this project include the costs for the CRAFT (Community Reinforcement And Family Training) model developer to provide ongoing training, coaching, and assist with the certification of clinical staff in this evidence-based treatment ($44, 900), development of a website for project participants (12,000), consultants to assist with website content development and rating CRAFT sessions (15,000), training in and use of the GAIN measurement instrument software ($20,000), travel to sites to review implementation and provide technical assistance (8,000), other miscellaneous direct expenses such as telecommunications, IT maintenance and security costs, office supplies, (10,000).

SAMHSA estimates that approximately 5% of budget is calculated for federal employee time or $59,867.00. All data collected will be made available to the federal government and other treatment agencies and universities to maximize the usefulness of the information for planning and developing services.

Thus the total estimated direct costs are: $1,027,700. The overhead costs (34.5% including only the first 25,000 dollars of subcontracts) adds $169,636, for a grand total estimated cost of $1,197,336.

A.15 Changes in Burden

This is a new project.

A.16 Time Schedule, Publication, and Analysis Plans

The following table outlines key time points for the study and the collection of information. Data collection will last for 12 months.

Activity	Date
Funding begins	Oct 2008
Planning meetings	Oct – Dec 2009
Develop evaluation methodology and measures	Jan – Feb 2009
Form Advisory Group	Jan – Feb 2009
Develop protocol for support services	Jan – Aug 2009
Start Advisory Group meetings	March 2009
Submit IRB materials	March 2009
Begin OMB approval process	March 2009
Choose and contract with performance sites	April – July 2009
Train site staff	Sept – Oct 2009
Begin recruitment and data collection	Oct 2009

Complete data collection	Sept 2010
Closeout report	Sept 2010
Data analysis	Sept 2010
Dissemination of findings	Beginning Sept 2010

The purpose of the project is to pilot test the effectiveness of recovery support services developed as a result of this contract. Results will be preliminary and aid in the decision to pursue funding for further, more rigorous testing. Univariate and multivariate analyses will examine changes over time in the following areas: 1) substance use frequency; 2) substance-related problems; 3) recovery environment risk; 4) social risk; and 5) utilization of recovery support services. We will test for changes in slopes on all dependent variables between the recovery support cohort from this project and a matched cohort from the CSAT Adolescent Treatment Dataset. Analysis of pre-post change scores for parent results of the instruments mentioned above will be used. A final report with results will be submitted to CSAT. Additionally, results may be disseminated via professional presentations at conferences such as the Joint Meeting on Adolescent Treatment Effectiveness and via technical reports. Manuscripts may also be submitted for publication in peer-reviewed journals.

Design. Adolescents from the recovery support cohort will be matched to the CSAT Adolescent Treatment (AT) data set for comparison analysis. They will be matched on gender, age, race, current criminal justice system involvement, days in a controlled environment and baseline versions of the outcome variables. The CSAT AT data set contains GAIN-I and GAIN-Monitoring (follow-up) data from CSAT grant initiatives on over 16,000 adolescents from 132 sites around the United States.

At the three, six, nine, and twelve-month follow-up waves, the participant interviews are supplemented with collateral interviews. The rate of false negatives (collateral vs. self-report) will be calculated. A false negative is defined as the collateral reporting that the adolescent used when the adolescent reports that they did not use. For any scales used in the analysis, internal consistency will be reported using Chronbach's alpha .

Implementation measures. Mean and standard deviation of recovery support services received will be reported in table format (see table shell 1 below).

Analysis of adolescent outcomes. The outcomes will include: 1) days of alcohol and other drug use (AOD) use; 2) substance-related problems; 3) recovery environment risk index; 4) social risk index; and 5) self-help activity scale. We will use repeated measures multivariate analysis of variance to test for differences between the recovery support cohort and the matched cohort from the CSAT AT data set across the follow-up waves (baseline, 3, 6, 9 and 12-months). A significant time by cohort interaction would indicate a difference in the outcome variable over time between the two cohorts. The effect size f-index, based on percent of variance explained, will also be reported. See table shell 2 layout below for reporting outcome results.

Analysis of parent outcomes. These outcomes include: 1) Family Environment cohesion and conflict scales; 2) the relationship happiness scale; 3) the self-evaluation questionnaire; and 4) the telephone support satisfaction scale. These will be evaluated with repeated measures across baseline, 3, 6, 9 and 12-months. Since there is no comparison cohort, we will be looking for significant time effects. When there are significant time effects, we will follow-up with post-hoc simple effect tests to see which follow-ups are significantly different from baseline. The effect size d, calculated by subtracting the baseline mean from the follow-up mean and dividing by the standard deviation of the baseline, will be reported. See table shell 3 layout below for reporting results.

Table Shells

Table 1. Implementation Outcomes							
			Baseline	1-3 months	4-6 months	7-9 months	10-12 months
		n	*M(SD)*	*M(SD)*	*M(SD)*	*M(SD)*	*M(SD)*
Telephone Support Calls							
Recovery Support Cohort							
Effect size d							
Visits to Support Services Website							
Recovery Support Cohort							
Effect size d							
Participation in Chatroom Sessions							
Recovery Support Cohort							
Effect size d							
Forum Posts							
Recovery Support Cohort							
Effect size d							
Family Support Group Meetings							
Recovery Support Cohort							
Effect size d							
Note: Effect size calculation: Post-Pre/SD(Pre)							

Table 2. Adolescent Outcomes												
		Baseline	1-3 months	4-6 months	7-9 months	10-12 months	Time Effect		Cohort Effect		Interaction Effect	
	n	*M(SD)*	*M(SD)*	*M(SD)*	*M(SD)*	*M(SD)*	*F*	*p-value*	*F*	*p-value*	*F*	*p-value*
Days of Use												
Recovery Support Cohort												
CSAT AT Cohort												
Effect Size												
Substance Problem Scale (Past Month)												
Recovery Support Cohort												
CSAT AT Cohort												
Effect Size												
Recovery Environment Risk												
Recovery Support Cohort												
CSAT AT Cohort												
Effect Size												
Social Risk												
Recovery Support Cohort												
CSAT AT Cohort												
Effect Size												
Self-help Activity Scale												
Recovery Support Cohort												
CSAT AT Cohort												
Effect Size												

Note. CSAT AT Cohort = CSAT Adolescent Treatment Cohort.
Effect size calculation: (Recovery Support Cohort mean-CSAT AT mean)/pooled standard deviation
F index is the effect size statistic reported for time, cohort, and interaction effects

Table 3. Parent Outcomes

		Baseline	1-3 months	4-6 months	7-9 months	10-12 months	Time Effect	
	n	*M(SD)*	*M(SD)*	*M(SD)*	*M(SD)*	*M(SD)*	*F*	*p-value*
Relationship Happiness Scale								
Effect Size d								
Family Environment Scale								
Cohesion								
Effect Size d								
Conflict								
Effect Size d								
Self Evaluation Questionnaire								
Effect Size d								
Telephone Support Services Questionnaire								
Effect Size d								

Note: Effect size calculation: Post-Pre/SD(Pre)

A.17 Display of Expiration Date

The expiration date will be displayed.

A.18 Exceptions to Certification Statement

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions.

B. COLLECTIONS OF INFORMATION EMPLOYING STATISTICAL METHODS

B.1 Respondent Universe and Sampling Methods

The following 4 performance sites will recruit respondents: University of Arizona (Tucson, AZ), LUK, Inc. (Fitchburg, MA), Chestnut Health Systems (Bloomington, IL), and Science and Management of Addictions Foundation (Seattle, WA). Sites were selected based on their current use of the GAIN instrument as well as Chestnut's familiarity with their performance on prior projects. All sites were asked to complete a recruitment worksheet in order to determine if they could recruit enough participants within the project's timeframe.

Eligible adolescents and their collaterals will be recruited from outpatient and residential substance abuse treatment programs in those areas within a 3 month period. At the beginning of recruitment, all eligible adolescents currently enrolled in participating treatment programs and their collaterals will be approached about participating in the project. If time permits, any other eligible adolescents admitted to treatment during the recruitment period will also be approached. SAMHSA anticipates enrolling at least 50 adolescents/collaterals per site, for a combined sample size of 200. Based on prior adolescent studies conducted by Chestnut Health Systems, a response rate of 80% or better is expected.

B.2 Information Collection Procedures

The goal is to recruit all eligible adolescents/collaterals enrolled in participating treatment programs at each of the 4 performance sites during the 3 month recruitment period. For practical and safety reasons, adolescents to be included in the project must: a) be aged 13-17 at the time of recruitment; b) meet DSM-IV-TR diagnostic criteria for substance abuse or dependence; c) be enrolled in and remain in treatment for at least 4 outpatient sessions within a six week period or at least 21 days of residential treatment; d) reside in the RSAF project catchment area; and e) have telephone and internet access at home or have access at another location. Additionally, adolescents will not be able to participate if they: a) show evidence of a psychotic or organic state of sufficient severity to interfere with understanding of project instruments, project procedures, or the informed consent process; b) are deemed an imminent danger to themselves or others; c) are a ward of child protective services; d) are currently participating in another treatment study; or e) are likely to enter a state juvenile justice or correctional system institution within 3 months of recruitment. Since this is a pilot study, results are intended to inform the possibility of future, more rigorous research rather than generalize to the entire population of adolescents in substance abuse treatment.

Adolescents and collaterals who agree to participate, will be asked to sign assent and consent forms, complete locator forms, and sign releases that allow the follow-up team to ask other individuals or agencies for contact information should respondents not be located for follow-up interviews. Project staff will complete baseline and 3, 6, 9, and 12 month follow-up interviews with adolescents and collaterals. Interviews may take place over the phone, in homes, in parks, in institutions, or wherever there is privacy. Specific follow-up procedures are detailed more fully in Section B.3.

Project staff will be trained on all project forms before the beginning of data collection. They will complete information collection forms according to the timetables described in Section A.2. Form completion will be monitored by the Site Coordinators and the Research Projects Manager.

B.3. Methods to Maximize Response Rates

Methods to maximize response rates begin at the time of recruitment. Chestnut Health Systems has a history over multiple projects of recruiting 80% or more of eligible adolescents. Staff try to address any questions or concerns that an adolescent or guardian may raise about the project. For example, if a concern is raised about the inconvenience of a follow-up interview, staff will assure the potential participant that scheduling the interview is flexible. Any refusals are debriefed with the Site Coordinator to determine if

other techniques might be considered in the recruitment process. Adolescents and guardians will be independently asked to sign the consent form and given a copy for their records. Once the informed consent process is completed, locator information is collected and an appointment for the next interview is provided. In terms of maximizing follow-up response rates, Chestnut has developed a state of the art follow-up protocol (Scott, 2004) that reliably allowed the achievement of better than 90% follow-up on all of our adolescent studies. The steps of this protocol include: (a) administer a follow-up package at intake, (b) receipt documents in a management information system, (c) assign case to follow-up case manager, (d) verify locator data, (e) outreach unverified cases and discuss at weekly meetings, (f) mail thank-you card to adolescent/collateral, (g) schedule follow-up appointment at discharge, (h) mail three-week post-discharge/post-interview flyer, (i) mail six-week post-discharge/post-interview flyer, (j) implement returned mail procedures, (k) call participant/collateral six weeks before appointment to confirm date and location, (l) mail confirmation letter, (m) outreach unconfirmed cases and review at weekly meetings, (n) make reminder calls to participant/collateral seven days prior to appointment, (o) make reminder call to participant/collateral 24 hours prior to appointment, (p) complete follow-up interview and schedule next appointment, and (q) implement no-show protocol. Progress is monitored during regular follow-up meetings with staff and monthly management reports to a steering committee. Across waves, approximately 94% of our interviews are conducted within plus or minus two weeks of the target date. See follow-up materials in Attachments CC-NN.

Adolescents will receive a $30 gift card after completing each interview, and collaterals will receive a $20 gift card after completing each of their own shorter interviews. Adolescents and collaterals will also receive an additional $10 gift card for completing each interview on time. The average adolescent respondent and collateral is expected to incur direct expenses related to minutes used on cell phones, travel to a telephone or in-person interview, and possibly childcare. Remuneration is offered because this target population is considered hard-to-reach over multiple time points. These individuals tend to be difficult to contact, involved with the legal system, and highly mobile. Published studies in the substance abuse research field suggest that monetary compensation significantly increases response rates in substance-using populations. This research is described in detail in section A.9. Without remuneration, response rates are expected to be below the commonly targeted 70%; however, accepting even a follow-up rate of 70% can introduce significant and unpredictable bias that might compromise the validity of analyses (Scott, 2004). With remuneration and proven follow-up tracking procedures (Scott, 2004), response rates are expected to be 90% and above with 90%+ on-time completion rates for each follow-up wave of information collection.

B.4 Tests of Procedures

The telephone support service was implemented for a trial run with less than 10 adolescent respondents in order to identify potential problems with the Telephone Support Documentation Form and to gain experience working with volunteers in this role. All other data collection forms (or similar versions) have been tested in prior adolescent studies by Chestnut Health Systems. OMB will be informed of any changes to procedures or data collection instruments as quickly as possible before data collection begins.

B.5 Statistical Consultants

The following is a table of statistical consultants and individuals responsible for the collection and analysis of project data:

Name	Title	Organizational Affiliation	Phone #
Michael Dennis	Senior Research Psychologist	Chestnut Health Systems 448 Wylie Drive Normal, IL 61761	309-451-7801.

Rod Funk	Research Associate	Chestnut Health Systems 448 Wylie Drive Normal, IL 61761	309-451-7808
Stephanie Schade	Site Coordinator	Chestnut Health Systems 448 Wylie Drive Normal, IL 61761	309-451-7871
Interviewers TBD	Interviewers	Chestnut Health Systems 448 Wylie Drive Normal, IL 61761	
Gina Grappone	Executive Director	Science and Management of Addictions Foundation 1900 N. Northlake Way, Suite 115 Seattle, WA 98103	206-328-1719
Site Coordinator & Interviewers TBD	Site Coordinator & Interviewers	Science and Management of Addictions Foundation 1900 N. Northlake Way, Suite 115 Seattle, WA 98103	
Bridget Ruiz	Associate Research Professor	University of Arizona 181 Tucson Blvd., Suite 101 Tucson, AZ 85716	520-295-9339
Stephanie Springer	Site Coordinator	University of Arizona 181 Tucson Blvd., Suite 101 Tucson, AZ 85716	
Interviewers TBD	Interviewers	University of Arizona 181 Tucson Blvd., Suite 101 Tucson, AZ 85716	
Dave Hamolsky	Director	LUK, Inc. 545 Westminster Street Fitchburg, MA 01420	978-829-2236
Site Coordinator & Interviewers TBD	Site Coordinator & Interviewers	LUK, Inc. 545 Westminster Street Fitchburg, MA 01420	

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LIST OF ATTACHMENTS

Instruments

A) Follow-Up Locator Form – Participant (FLF-P)
B) Global Appraisal of Individual Needs – Initial (GAIN-I 5.6.0 Full)
C) Global Appraisal of Individual Needs – Monitoring 90 Days (GAIN-M90 5.6.0 Full)
D) Supplemental Assessment Form (SAF 0309)
E) Follow-Up Locator Form – Collateral (FLF-C)
F) Global Appraisal of Individual Needs – Collateral Monitoring (GCI)
G) Global Appraisal of Individual Needs – Collateral Monitoring (GCM 5.3.3)
H) Supplemental Assessment Form – Collateral (SAF - Collateral)
I) Self-Evaluation Questionnaire (SEQ)
J) Family Environment Scale (FES)
K) Relationship Happiness Scale (Caregiver Version)
L1) Eligibility Checklist
L2) Telephone Support Volunteer Notification Form
L3) Family Program Notification Form
M) Follow-Up Contact Log
N) Volunteer/Staff Survey
O) Telephone Support Case Review Form
P) Telephone Support Call Log
Q) Adolescent Telephone Support Documentation Form
R) Telephone Support Discharge Form
S) Social Networking Moderator Log
T) Family Program Progress Notes
U) Family Program Attendance Log
V) Family Program Case Review Report
W) Family Program Discharge Form
X) Adolescent Telephone Support Quality Assurance Checklist
Y) Social Networking Quality Assurance Checklist
Z) Family Program QA Checklist

Other Attachments

AA) Adolescent Assent Form
BB) Parent/Guardian Consent Form
CC) Request for Locating Information
DD) Followup Appointment Card (Adolescent)
EE) Followup Appointment Card (Collateral)
FF) Followup Door Flier
GG) Fliers – 3wk, 6wk (Adolescent)
HH) Fliers – 3wk, 6wk (Collateral)
II) Followup Appointment Confirmation Letter
JJ) Welcome to the Project Card (Adolescent)
KK) Welcome to the Project Card (Collateral)
LL) Thank You Card – Completed Interview (Adolescent)
MM) Thank You Card – Completed Interview (Collateral)
NN) Thank You Card - Final
OO) Chestnut Health Systems IRB Approval