

Form Approved  
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Expiration Date: ##/##/####

**TARGETED CAPACITY EXPANSION PROGRAM FOR SUBSTANCE ABUSE  
TREATMENT AND HIV/AIDS SERVICES (TCE-HIV)**

**MULTI-SITE EVALUATION PROJECT**

**CLIENT FOCUS GROUP DISCUSSION GUIDE**

**CONDUCTED BY:**

JBS International, Inc., Alliance for Quality Education, Battelle Memorial Institute, and the  
Oregon Health & Science University

Grantee Name:	_____
Grantee ID Number:	_____
Date Completed:	____ / ____ / ____ Month Day Year

**Notice to Respondents**

Public reporting time for this collection is estimated to average 60 minutes, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA OMB Officer, 1 Choke Cherry Road Room 7-1044, Rockville, MD 20850. 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 OMB control number for this project is XXXX-XXXX.

**TCE-HIV Multi-Site Evaluation  
Client Focus Group Guide**

The purpose of this guide is to provide an overview of the information that will be gathered through focus groups with clients involved in the Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services (TCE-HIV) Project. A “client” refers to an individual from the Grantee organization/program who has engaged in TCE-HIV sponsored treatment and/or program activities.

Members of the Multi-Site Evaluation Team will conduct the client focus group in a setting convenient to the focus group participants. Up to nine clients will participate in the focus group. Those clients who have been in the TCE-HIV program for at least 14 days will be considered for participation. The focus group participants will reflect diversity in age and gender. The focus group discussion will last approximately 1 hour.

The goals of the client focus groups conducted during TCE-HIV Multi-Site Evaluation site visits include discussion of:

- (1) clients’ satisfaction with the treatment program.
- (2) barriers and facilitators of treatment services.
- (3) client-level outcomes (i.e., substance use/abuse, risk behavior, quality of life).

Final discussion guides for each Grantee will be customized based on the nature of individual Grantee’s treatment modality (i.e., outpatient vs. residential). The information gathered from this focus group will be used to better understand clients’ perceptions of the TCE-HIV funded program and will be synthesized with information gathered from other TCE-HIV Grantees to inform the Multi-Site Evaluation of the TCE-HIV program.

Following completion of the client focus group, the facilitator(s) should complete the post focus group summary form to validate that each discussion section topic was covered during the focus group discussion. Space is also provided on the form to record other germane topics discussed during the focus group and additional notes/comments relating to the discussion.

For ease of future qualitative analysis coding and thematic content analysis, any key findings/themes that emerged during the focus group discussion should also be recorded in the table. The associated page number note references and a listing of respondents whose statements support reported findings should also be noted, where applicable.

**TCE-HIV Multi-Site Evaluation  
Client Focus Group Discussion Guide**

*NOTE: Co-facilitator will hand out consent forms after participants have entered the room and are seated.*

**Opening: Moderator’s Introduction (5 minutes):**

Hello and welcome. Thank you for taking time to participate in this focus group. My name is \_\_\_\_\_ and I am conducting this discussion on behalf of the Center for Substance Abuse Treatment (CSAT). CSAT has funded four organizations, JBS International, the Alliance for Quality Education, Battelle Memorial Institute, and the Oregon Health & Science University, to conduct a Multi-Site Evaluation of its national Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services (TCE-HIV). (Introduce team members, give brief description of qualifications, and describe functions during the focus group). As part of the evaluation, we are conducting several focus groups around the country with clients of TCE-HIV programs. Although the Multi-Site Evaluation Team is funded by CSAT, we are not part of that federal agency, any other federal agency, or this local program. We are independent evaluators of the TCE-HIV program. I will review the consent form with you. It describes exactly what is expected of you and you will need to sign it stating that you agreed to participate in this discussion.

We are here today to learn about your experiences in the [INSERT PROGRAM NAME]. We are interested in hearing about your successes, challenges, and any feedback about your involvement in the program. The information that you provide will be extremely helpful to CSAT as it seeks to learn how clients may be benefiting from the TCE-HIV program.

Before we begin, I would like to establish some guidelines for our discussion. During our discussion, it would be most helpful if one person talks at a time. Please know that there are no right or wrong answers, just different points of view, and we want to hear all of them. Everyone’s experience is important to us, so please feel free to share your point of view even if it is different from what others have said. Also, keep in mind that we are interested in both positive and negative comments. I mentioned earlier that my colleagues and I are conducting this focus group on behalf of CSAT, but it’s important to let you know that we are not CSAT employees.

The discussion will last about 1 hour.

I also want to mention to you that we are providing some refreshments for you to enjoy. Please help yourself to these snacks during our discussion.

Initial Instructions (2 minutes):

- A. Before we begin, so I—and you—can know who is here, I'd like to let each of you introduce yourself (first name only) and tell us a little something about yourself.
- B. May I have everyone's permission to tape this session? (*Only if everyone gives permission will taping be allowed*). Even though we are recording this session, we will not associate your comments and experiences with your name; and the program staff will not have access to the discussion that we share here today.

Are there any questions before we get started?

**I. Community Context** (*\*Understand how the program is viewed in the community*) (15 minutes)

*Even though you are all clients in the same program, it is likely that your experiences prior to entering the \_\_\_\_\_ (insert name of program) as well as your experiences while in the program are not identical.*

*We are here today to hear your thoughts about the program, including how satisfied or dissatisfied you've been with the program services. I'd like to begin our discussion today by talking about your overall thoughts about the program, and how it is viewed by people who live in the community.*

- A. In your opinion, what do people in the community/neighborhood think about <insert name of program> \_\_\_\_\_? (*Note to facilitator: Be prepared to tailor context questions based on specific setting; e.g., some clients will refer to the physical neighborhood setting, and others may refer to a community of individuals*)

PROBE 1: What, if any, positive impressions do people in the community/neighborhood have about <name of Grantee agency or TCE-HIV project title>

PROBE 2: What, if any, negative impressions do people in the community/neighborhood have about <name of Grantee agency or TCE-HIV project title >

PROBE 3: Do people think that there is a need for this program in the community/neighborhood? Why? Why not?

PROBE 4: Do people think this program has changed the community/neighborhood? If so, how has the program changed the community/neighborhood?

- B. How would you describe drug use in this community/neighborhood?

- C. How would you describe the HIV problem in this community/neighborhood?

*Thank you for sharing your opinions about the program's image in the community/neighborhood and thanks for providing your thoughts on the drug use and HIV in the community/neighborhood.*

**II. Client Satisfaction** (*\*Understand how the clients feel about the services and treatment they received as part of the program*) (10 minutes)

*Now, let's talk a little about how the program is viewed by you—the clients.*

A. What things about this program do you like?

PROBE 1: What is it about this program that would make you want to continue receiving service?

B. What things can/could have been improved?

PROBE 1: What things do/did you dislike about the program?

C. What did you like about the outreach pretreatment (i.e., how people approached you and talked about recovery)?

D. What did you like about the treatment program?

*Thank you for talking about how satisfied or not you have been with the program services.*

### **III. Barriers/Facilitators to Receiving Services (15 minutes)**

*Let's move on to a discussion of barriers and facilitators to your treatment in this program.*

A. What are some things or people that may have prevented you from receiving treatment or program services?

B. What type of things or people may have prevented you from being successful in this program?

PROBE 1: Was the location of this program accessible?

PROBE 2: Was the staff here helpful to you as you were going through treatment? How so? How not?

PROBE 3: Was the staff available when you needed them? Please describe instances where you think they were available to you.

PROBE 4: How, if at all, has the staff been sensitive to your cultural background? Have you been assigned to counselors of the same race? Is that important to you?

C. What could be done to make the program and services more appealing?

D. What suggestions do you have for the program staff that might help make the program better?

*Thanks for sharing how you feel about the program and for providing suggestions for improvement in certain program areas.*

### **IV. Client Outcomes (15 minutes)**

*Now I'd like to move into a discussion of how things in your life may have changed because of this program.*

A. Has anything in your life changed as a result of your participation in this program?

PROBE 1: How, if at all, has your alcohol use changed?

PROBE 2: Has your injection drug use changed?

PROBE 3: Has your sense or level of anxiety or nervousness changed?

PROBE 4: Have you engaged in unprotected sex less frequently?

Attachment 1a: Document 1 - Client Focus Group Discussion Guide

PROBE 5: What, if any at all, specific program services have helped you make the changes we've just discussed?

B. Have you seen changes in other aspects of your life as a result of participation in the program?

PROBE 1: How, if at all, has your living situation changed?

PROBE 2: Have your relationships with those close to you changed since you've been in treatment? How so?

PROBE 3: Have you had less involvement with the criminal justice system since you've been in treatment?

PROBE 4: Have you worked at a job (full or part-time)? (ask if the job is part of an outpatient employment program)

**V. Closing Comments** (\*Concluding remarks) (5 minutes)

*Thank you very much for taking the time to discuss your experiences in this program. In closing, I wanted to give you the opportunity to ask questions or make additional comments.*

A. Do you have any questions, comments, or feedback regarding our discussion?

B. Are there any topic areas, issues, or concerns relating to the TCE-HIV Multi-Site Evaluation that you would suggest?

# **CLIENT FOCUS GROUP FACILITATOR FORM**

*The following form should be completed by the facilitator(s) and it is not part of the focus group guide.*

**Post-Focus Group Summary [Completed by Facilitator]**

**Table: Discussion Topics Covered in Interview and Key Findings/Themes**

✓	Section	Key Interview Findings/Themes by Topic Area	Respondents Supporting Finding*	Supporting Page(s) in Notes
	Community/ Contextual Conditions			
	Client Satisfaction			
	Barriers/ Facilitators			
	Client Outcomes			

\* Code respondents based on Data Sheet numbering: Respondent 1 as R1, Respondent 2 as R2, etc. (e.g., Statements by R1 supported Key Theme 1)

**Other Topic Areas Discussed**

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**List of Documents Obtained**

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**Observations Regarding Interview Setting** (e.g., description of location, disruptions, etc.)

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**Observations Regarding Interview Respondents** (e.g., engagement level, reluctance etc.)

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## TCE-HIV Multi-Site Evaluation INTAKE/BASELINE Client-Level Survey

Funding for data collection supported by the  
Center for Substance Abuse Treatment (CSAT)  
Substance Abuse and Mental Health Services Administration (SAMHSA)  
U.S. Department of Health and Human Services (HHS)

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**Instructions:** These instructions are for program staff administering the TCE-HIV Multi-Site Evaluation Client-Level Survey. The Client-Level Survey should be administered by program staff at baseline (based on the program's definition of baseline), discharge, and 6 months post baseline to all clients receiving TCE-HIV services. ***Please note that this version of the Client-Level Survey is to be used at INTAKE/BASELINE only.***

The Client-Level Survey includes six sections: Background Information, Risky Behaviors, HIV Testing/HIV Status, Social Support, Mental Health and Medical Health, and Motivation for Treatment. All questions in Sections A – F should be asked of the client.

Please read the introduction to each section (in *italics*) and then read each question to the client as it is written. For some questions, you will read the response options to clients. Other questions are open-ended and you will not read the response options to clients. Please see the note in *italics* next to each question to determine whether you should read the response options. Some questions require the use of response options cards. Please provide the response options card to clients when noted.

You may provide clarification to the client to help him or her understand the question, but please do not change the wording of the questions.

**The Client-Level Survey should take approximately 25 minutes to administer.**

Public reporting burden for this collection of information is estimated to average 25 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 follow-up, 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 #####-####.

<b>TCE-HIV Multi-Site Evaluation                  Client-Level Survey                  INTAKE/BASELINE</b>	
Funding for data collection supported by the Center for Substance Abuse Treatment (CSAT) Substance Abuse and Mental Health Services Administration (SAMHSA) U.S. Department of Health and Human Services (HHS)	
<b>Grantee ID</b>	TIO _____
<b>Partner ID (if applicable)</b>	TIO _____ - _____
<b>Client ID</b> _____ <i>(Please use the same Client ID that was assigned to the client for the GPRA)</i>	
<b>Date of Administration (mm/dd/yyyy)</b>	____ / ____ / _____

<b>PROGRAM STAFF: Please complete the following client background questions using information collected from the Intake/Baseline GPRA.</b>	
<b>Client's Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Refused <input type="checkbox"/> Other (specify) _____
<b>Client's Ethnicity: Is the client Hispanic or Latino?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
<b>Client's Race</b>	<input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused
<b>Client's Age</b>	____

Public reporting burden for this collection of information is estimated to average 25 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 follow-up, 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 #####-####.

Client ID: \_\_\_\_\_

(Please use the same Client ID that was assigned to the client for the GPRA)

**Program Staff:** The purpose of these questions is to get more information about how best to provide services. We are asking these questions because it is a requirement for us from the Federal government who gave us funding to provide services to you. All your background information and survey answers will be kept strictly confidential. All survey answers will be provided to the Federal government using only a number for you so there will be no way they can identify who you are. If you have any questions, comments, or concerns, please contact Resa Matthew, Ph.D. at 240-645-4608.

**A. Background Information**

**Program Staff:** First, I am going to ask you some questions about yourself.

A1. What is your marital status? *Do not read response options.*

- |                             |                      |                            |          |                            |                   |
|-----------------------------|----------------------|----------------------------|----------|----------------------------|-------------------|
| <input type="checkbox"/> 1  | Never Married/Single | <input type="checkbox"/> 2 | Married  | <input type="checkbox"/> 3 | Living as Married |
| <input type="checkbox"/> 4  | Separated            | <input type="checkbox"/> 5 | Divorced | <input type="checkbox"/> 6 | Widowed           |
| <input type="checkbox"/> 88 | Refused              |                            |          |                            |                   |

A2. In the past 30 days, have you lived...? You may say yes to more than one. *Please read response options.*

- |                             |                                     |                          |                           |
|-----------------------------|-------------------------------------|--------------------------|---------------------------|
| <input type="checkbox"/>    | Alone                               | <input type="checkbox"/> | With parents              |
| <input type="checkbox"/>    | With children alone                 | <input type="checkbox"/> | With other family members |
| <input type="checkbox"/>    | With significant other alone        | <input type="checkbox"/> | With friends              |
| <input type="checkbox"/>    | With significant other and children | <input type="checkbox"/> | In jail                   |
| <input type="checkbox"/>    | In prison                           | <input type="checkbox"/> | In a hospital             |
| <input type="checkbox"/>    | In residential treatment            | <input type="checkbox"/> | Other (specify) _____     |
| <input type="checkbox"/> 88 | Refused                             |                          |                           |

**B. Risky Behaviors**

**Program Staff:** The next set of questions asks about any behaviors that you may engage in that may put you at risk for substance use disorders or HIV/AIDS. I realize these questions are very personal, but your open and honest answers are very important. There are no right or wrong answers.

B1. Did you use alcohol or drugs in the past 30 days? *Do not read response options.*

- |                             |   |                             |            |
|-----------------------------|---|-----------------------------|------------|
| <input type="checkbox"/> 1  | Yes (specify what substances were used in past 30 days) _____ |                             |            |
| <input type="checkbox"/> 0  | No  | <input type="checkbox"/> 66 | Don't Know |
| <input type="checkbox"/> 88 | Refused   |                             |            |

**Program Staff:** If clients reported alcohol or drug use in Question B1 above please skip to question B3 below. Only ask question B2 below to clients who reported no alcohol or drug use in Question B1 above.

B2. You reported that during the past 30 days you did not use alcohol or drugs. What were your reasons for not using any alcohol or drugs? You may say yes to more than one. *Please read response options.*

- 1 In jail/prison
- 2 On probation/parole
- 3 Lack of money
- 7 Other (specify) \_\_\_\_\_
- 77 Not applicable – used alcohol and/or drugs in the past 30 days.
- 88 Refused
- 4 Medical hospitalization
- 5 Inpatient mental health treatment
- 6 Residential substance use treatment

**Program Staff:** *The next set of questions asks about your sexual behaviors. Again, I realize these questions are very personal, but your open and honest answers are very important.*

B3. In the past 30 days, did you engage in unprotected sexual activity with a male partner?

- 1 Yes
- 0 No
- 66 Don't Know
- 88 Refused

B4. In the past 30 days, did you engage in unprotected sexual activity with a female partner?

- 1 Yes
- 0 No
- 66 Don't Know
- 88 Refused

B5. In the past 30 days, did you engage in unprotected sexual activity with both a male partner and a female partner?

- 1 Yes
- 0 No
- 66 Don't Know
- 88 Refused

**Program Staff:** *Only ask questions B6a – B6j of those clients who reported having unprotected sexual contact during the past 30 days. If the client did not report having unprotected sexual contact during the past 30 days, please skip to Question C1 below.*

**If the client reported having unprotected sexual contact ONLY with a male partner, please ask only questions B6a, B6c, B6e, B6g, and B6i.**

**If the client reported having unprotected sexual contact ONLY with a female partner, please ask questions B6b, B6d, B6f, B6h, and B6j.**

**If the client reported having unprotected sexual contact with BOTH a male partner and a female partner please answer all questions in B6a – B6j.**

B6. In the past 30 days, did you have...

	Oral Sex	Vaginal Sex	Anal Sex	Did you use any of the following before or during... (check all that apply)
a. Unprotected sexual contact with a male partner?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know

Attachment 1a: Document 2 - Intake/Baseline Client-Level Survey

	Oral Sex	Vaginal Sex	Anal Sex	Did you use any of the following before or during... (check all that apply)
				<input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
b. Unprotected sexual contact <b>with a female partner</b> ?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
c. Unprotected sex <b>with a male partner</b> in exchange for money, drugs, or shelter?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
d. Unprotected sex <b>with a female partner</b> in exchange for money, drugs, or shelter?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
e. Unprotected sex <b>with a male partner</b> you know has, or might have a sexually transmitted disease (STD)?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
f. Unprotected sex <b>with a female partner</b> you	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin

Attachment 1a: Document 2 - Intake/Baseline Client-Level Survey

	Oral Sex	Vaginal Sex	Anal Sex	Did you use any of the following before or during... (check all that apply)
know has, or might have sexually transmitted disease (STD)?	<input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
g. Unprotected sex <b>with a male partner</b> you know has, or might have HIV/AIDS?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
h. Unprotected sex <b>with a female partner</b> you know has, or might have, HIV/AIDS?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
i. Unprotected sex <b>with a male partner</b> you know is, or might be an injection drug user?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
j. Unprotected sex <b>with a female partner</b> you know is, or might be an injection drug user?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused

**C. HIV Testing/HIV Status**

**Program Staff:** *These questions about whether you have ever been tested for HIV and your HIV status as well as other sexually transmitted infections (STIs).*

C1. In that past 12 months, have you been diagnosed with a sexually transmitted infection (STI) other than HIV? *Do not read response options.*

- 1 Yes     0 No     66 Don't Know     88 Refused

C2. Have you ever tested positive for HIV? *Do not read response options.*

- 1 Yes     0 No     66 Don't Know     88 Refused

**Program Staff:** *If client answered No, Don't Know, or Refused to Question C2, please skip to Question D1*

C3. How long have you known you were HIV positive? *Do not read response options.*

- 1 30 days or less                       2 Greater than 30 days  
 66 Don't Know                       77 Not applicable – Not HIV positive.  
 88 Refused

**Program Staff:** *Next, I am going to ask you some questions about whether you have changed your behavior since you found out you were HIV positive. I am going to read each answer option and please use Response Card A to tell me how much you have changed your behavior. Please select only one choice for each statement. [Please read response options].*

	<b>Since you found out you were HIV positive, how much have you changed the following behaviors...</b>	Not at all	A little bit	Moderately	Quite a bit	Extremely	N/A	Refused
C4.	Sharing drug injection equipment (needles/syringes) without first cleaning it with anything?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C5.	Sharing drug injection equipment (needles/syringes) with someone you know has, or might have HIV/AIDS?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C6.	Having unprotected sexual contact?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C7.	Having unprotected sex with someone in exchange for money, drugs, or shelter?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C8.	Having unprotected sex with a partner you know has, or might have a sexually transmitted disease (STD)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C9.	Having unprotected sex with a partner you know has or might have HIV/AIDS?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C10.	Having unprotected sex with	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88



Attachment 1a: Document 2 - Intake/Baseline Client-Level Survey

		Not at all	A little bit	Moderately	Quite a bit	Extremely	N/A	Refused
<p><b>Since you found out you were HIV positive, how much have you changed the following behaviors...</b></p> <p>someone you knew is or might be an injection drug user?</p>								
C11.	Having unprotected sex while you were under the influence of drugs or alcohol?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88

**D. Social Support**

**Program Staff:** Next, I am going to ask you some questions about the important people in your life. I am going to read each answer option and please indicate how much you agree or disagree with each statement below using Response Card B. Please select only one choice for each statement. [Please read response options].

		Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly	Refused
D1.	You have people close to you who motivate and encourage your recovery.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
D2.	You have close family members who help you stay away from drugs.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
D3.	You have good friends who do not use drugs.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
D4.	You have people close to you who can always be trusted.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
D5.	You have people close to you who understand your situation and problems.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
D6.	You work in situations where drug use is common.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
D7.	You have people close to you who expect you to make positive changes in your life.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
D8.	You have people close to you who help you develop confidence in yourself.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
D9.	You have people close to you who respect you and your efforts in this program.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88

D10. In the past 30 days, did you attend any self-help groups for recovery (e.g., NA, AA, SMART Recovery)? *Do not read response options.*

- 1 Yes (specify how many times) \_\_\_\_\_
- 0 No
- 88 Refused

**E. Mental Health and Medical Health**

**Program Staff:** *These questions ask about different areas of your life such as your emotional and physical health.*

Mental Health

**Program Staff:** *Next I have a list of problems people sometimes have. As I read each one to you, I want you to tell me how much that problem has distressed or bothered you during the past 30 days including today using Response Card A. [Please read response options].*

	During the past 30 days, how much were you distressed by...	Not at all	A little bit	Moderately	Quite a bit	Extremely	Refused
E1.	Nervousness or shakiness inside	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E2.	Thoughts of ending your life	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E3.	Suddenly scared for no reason	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E4.	Feeling lonely	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E5.	Feeling blue	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E6.	Feeling no interest in things	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E7.	Feeling fearful	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E8.	Feeling hopeless about the future	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E9.	Feeling tense or keyed up	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E10.	Spells of terror or panic	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E11.	Feeling so restless you couldn't sit still	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E12.	Feelings of worthlessness	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88

E13. In the past 30 days, how often have you used drugs (including prescription drugs) or alcohol to help you cope with stressful life events? *I am going to read each answer option and please use Response Card A to provide your answer. [Please read response options].*

- 1 Not at all       2 A little bit       3 Moderately
- 4 Quite a bit       5 Extremely       88 Refused

E14. During the past 3 months, did you receive services for mental or emotional difficulties (i.e., inpatient, outpatient, emergency room)? *Do not read response options.*

- 1 Yes (specify how many times) \_\_\_\_\_       0 No
- 88 Refused

Attachment 1a: Document 2 - Intake/Baseline Client-Level Survey

E15. During the past 3 months, were you prescribed a medication for mental or emotional difficulties (e.g., Prozac, Cymbalta)?

- 1 Yes (specify medications) \_\_\_\_\_  0 No  
 88 Refused

E16. Is this your first time in a substance abuse treatment program? *Do not read response options.*

- 1 Yes  0 No  88 Refused

**Program Staff: If client answered Yes to Question E16, please skip to Question E19**

E17. How many times have you been in substance abuse treatment before coming to this program? *Please read response options.*

- 1 One time  2 2 – 4 times  3 5 – 7 times  
 4 > than 7 times  77 Not Applicable  88 Refused

E18. What type of substance abuse treatment program were you in before coming to this program? *Do not read response options.*

- 1 Outpatient  2 Residential  3 Both  4 Opioid Treatment  
 77 Not Applicable  88 Refused

E19. Why are you enrolling in this treatment program? *Do not read response options.*

- 1 Self-admitted  2 Court Mandated  3 Other (specify) \_\_\_\_\_  
 88 Refused

E20. Which drug(s) do you want to address in this treatment program?

Specify: \_\_\_\_\_

- 66 Don't Know  88 Refused

E21. If you are receiving other substance abuse treatment services, how much of your care is provided by this agency/organization? *Please read response options.*

- 0 I do not receive other substance abuse treatment services  
 1 I receive most of my care from this agency/organization  
 2 I receive about half of my care from this agency/organization and half from another agency/organization  
 3 I receive most of my care from another agency/organization

Medical Health

E22. In the past 30 days, did you have any type of health insurance for yourself? *Please read response options.*

- Yes, private health insurance (e.g., through an employer/union, privately purchased)
- Yes, Medicare  Yes, other Government health insurance
- Yes, Medicaid  0 No  88 Refused

E23. During the past 30 days, did you receive medical treatment (not including substance abuse treatment) for physical illness or injury (i.e., inpatient, outpatient, emergency room)? *Do not read response options.*

- 1 Yes (specify how many times) \_\_\_\_\_  0 No
- 88 Refused

E24. During the past 30 days, for about how many days did poor physical health keep you from doing your usual activities, such as self-care, work, or recreation? *Do not read response options.*

- Number of days \_\_\_\_\_  88 Refused

**F. Motivation for Treatment**

**Program Staff:** *The following questions ask about your attitudes toward substance abuse treatment. Each of the following statements describes a way that you might (or might not) feel about your drug use. For each statement, I am going to read each answer option and please use Response Card C to indicate how much you agree or disagree with each statement right now. [Please read response options].*

**Note:** *If the client's primary substance of choice is alcohol, please replace underlined words with the wording changes suggested in [ ] below.*

		Strongly Disagree	Disagree	Undecided or Unsure	Agree	Strongly Agree	Refused
F1.	I have already started making some changes in my <u>use of drugs</u> [drinking].	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F2.	I was <u>using drugs</u> [drinking] too much at one time, but I've managed to change <u>that</u> [my drinking].	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F3.	I'm not just thinking about changing my <u>drug use</u> [drinking], I'm already doing something about it.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F4.	I have already changed my <u>drug use</u> [drinking], and I am looking for ways to keep from slipping back to my old pattern.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F5.	I am actively doing things now to cut down or stop <u>my use of drugs</u> [drinking].	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88

Attachment 1a: Document 2 - Intake/Baseline Client-Level Survey

		Strongly Disagree	Disagree	Undecided or Unsure	Agree	Strongly Agree	Refused
F6.	I want help to keep from going back to the <u>drug</u> [drinking] problems that I had before.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F7.	I am working hard to change my <u>drug use</u> [drinking].	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F8.	I have made some changes in my <u>drug use</u> [drinking], and I want some help to keep from going back to the way I used [to drink] <u>before</u> .	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88

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**End of INTAKE/BASELINE Client-Level Survey**  
**Thank you for your time!**

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**Program Staff: Please complete the following section on client drug testing after administration of the INTAKE/BASELINE Client-Level Survey. Please consult the client's medical record as necessary to complete this section.**

1. How frequently does your program conduct drug testing? *Mark all that apply.*

- 1 Intake                       2 At each session                       3 Randomly  
 4 Discharge                       5 Post-discharge                       6 Never  
 3 Other (specify) \_\_\_\_\_

2. For what reason(s) does your program conduct drug testing? *Mark all that apply.*

- 1 Scheduled                       2 For Cause                       3 Other (specify) \_\_\_\_\_  
 4 At the request of the legal system (e.g., parole officer, court mandated)

3. Has the client received a drug test in the past 90 days?

- 1 Yes (specify how many times) \_\_\_\_\_                       0 No                       66 Unknown

**Program Staff: Only complete the following questions if the client has received a drug test in the past 90 days**

4. When did the client last receive a drug test?

- Month, Day, Year: \_\_\_\_\_                       66 Unknown

5. What method was used to conduct the client's most recent drug test?

- 1 Saliva                       2 Blood                       3 Urine                       4 Hair                       5 Sweat                       6 Breath

6. Was the sample collection directly observed?

- 1 Yes (specify how many times) \_\_\_\_\_                       0 No

7. The client's most recent drug test checked for the presence of which substances and/or drug groups? *Mark all that apply.*

- Alcohol                       Amphetamines                       Barbiturates  
 Benzodiazepines                       Cocaine/Crack                       Marijuana  
 Methamphetamine                       Opiates                       Phencyclidine (PCP)  
 Other (specify) \_\_\_\_\_                       66 Unknown

8. What were the results of the client's most recent drug test?

- 1 Negative for all drugs tested  
 2 Positive (specify for which substances) \_\_\_\_\_  
 3 Other outcome (i.e., neither negative nor positive), specify \_\_\_\_\_

9. If the test was positive for recent use of alcohol or other drugs, what actions were taken as a result of the positive test?

- Client counseled not to use drugs and/or alcohol  
 More frequent visits required (specify frequency) \_\_\_\_\_  
 More frequent drug testing required (specify frequency) \_\_\_\_\_  
 Other action(s) (specify) \_\_\_\_\_

<b>RESPONSE CARD A</b>	<b>RESPONSE CARD B</b>	<b>RESPONSE CARD C</b>
<b>1 = Not at all</b>	<b>1 = Disagree Strongly</b>	<b>1 = Strongly Disagree</b>
<b>2 = A little bit</b>	<b>2 = Disagree</b>	<b>2 = Disagree</b>
<b>3 = Moderately</b>	<b>3 = Uncertain</b>	<b>3 = Undecided or Unsure</b>
<b>4 = Quite a bit</b>	<b>4 = Agree</b>	<b>4 = Agree</b>
<b>5 = Extremely</b>	<b>5 = Agree Strongly</b>	<b>5 = Strongly Agree</b>

## TCE-HIV Multi-Site Evaluation **DISCHARGE Client-Level Survey**

Funding for data collection supported by the  
Center for Substance Abuse Treatment (CSAT)  
Substance Abuse and Mental Health Services Administration (SAMHSA)  
U.S. Department of Health and Human Services (HHS)

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**Instructions:** These instructions are for program staff administering the TCE-HIV Multi-Site Evaluation Client-Level Survey. The Client-Level Survey should be administered by program staff at baseline (based on the program's definition of baseline), discharge, and 6 months post baseline to all clients receiving TCE-HIV services. ***Please note that this version of the Client-Level Survey is to be used at the DISCHARGE only.***

The Client-Level Survey includes six sections: Background Information, Risky Behaviors, HIV Testing/HIV Status, Social Support, Mental Health and Medical Health, and Motivation for Treatment. All questions in Sections A – F should be asked of the client.

Please read the introduction to each section (in *italics*) and then read each question to the client as it is written. For some questions, you will read the response options to clients. Other questions are open-ended and you will not read the response options to clients. Please see the note in *italics* next to each question to determine whether you should read the response options. Some questions require the use of response options cards. Please provide the response options card to clients when noted.

You may provide clarification to the client to help them understand the question, but please do not change the wording of the questions.

**The Client-Level Survey should take approximately 25 minutes to administer.**

Public reporting burden for this collection of information is estimated to average 25 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 follow-up, 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 #####-####.



<b>TCE-HIV Multi-Site Evaluation                  Client-Level Survey                  DISCHARGE</b>	
Funding for data collection supported by the Center for Substance Abuse Treatment (CSAT) Substance Abuse and Mental Health Services Administration (SAMHSA) U.S. Department of Health and Human Services (HHS)	
<b>Grantee ID</b>	<b>TIO</b> _____
<b>Partner ID (if applicable)</b>	<b>TIO</b> _____ - _____
<b>Client ID</b> _____	
<i>(Please use the same Client ID that was assigned to the client for the GPRA)</i>	
<b>Date of Administration (mm/dd/yyyy)</b>	
_____ / _____ / _____	

<b>PROGRAM STAFF: Please complete the following client background questions                  using information collected from the Discharge GPRA.</b>	
<b>Client's Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Refused <input type="checkbox"/> Other (specify) _____
<b>Client's Ethnicity: Is the client Hispanic or Latino?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
<b>Client's Race</b>	<input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused
<b>Client's Age</b>	_____

Public reporting burden for this collection of information is estimated to average 25 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 follow-up, 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 #####-####.

Client ID: \_\_\_\_\_

*(Please use the same Client ID that was assigned to the client for the GPRA)*

**Program Staff:** *The purpose of these questions is to get more information about how best to provide services. We are asking these questions because it is a requirement for us from the Federal government who gave us funding to provide services to you. All your background information and survey answers will be kept strictly confidential. All survey answers will be provided to the Federal government using only a number for you so there will be no way they can identify who you are. If you have any questions, comments, or concerns please contact Resa Matthew, Ph.D. at 240-645-4608.*

**A. Background Information**

**Program Staff:** *First, I am going to ask you some questions about yourself.*

A1. What is your marital status? *Do not read response options.*

- |                             |                      |                            |          |                            |                   |
|-----------------------------|----------------------|----------------------------|----------|----------------------------|-------------------|
| <input type="checkbox"/> 1  | Never Married/Single | <input type="checkbox"/> 2 | Married  | <input type="checkbox"/> 3 | Living as Married |
| <input type="checkbox"/> 4  | Separated            | <input type="checkbox"/> 5 | Divorced | <input type="checkbox"/> 6 | Widowed           |
| <input type="checkbox"/> 88 | Refused              |                            |          |                            |                   |

A2. In the past 30 days, have you lived...? You may say yes to more than one. *Please read response options.*

- |  |  |
|--|--|
| <input type="checkbox"/> Alone                               | <input type="checkbox"/> With parents              |
| <input type="checkbox"/> With children alone                 | <input type="checkbox"/> With other family members |
| <input type="checkbox"/> With significant other alone        | <input type="checkbox"/> With friends              |
| <input type="checkbox"/> With significant other and children | <input type="checkbox"/> In jail                   |
| <input type="checkbox"/> In prison                           | <input type="checkbox"/> In a hospital             |
| <input type="checkbox"/> In residential treatment            | <input type="checkbox"/> Other (specify) _____     |
| <input type="checkbox"/> 88 Refused                          |  |

**B. Risky Behaviors**

**Program Staff:** *The next set of questions asks about any behaviors that you may engage in that may put you at risk for substance use disorders or HIV/AIDS. I realize these questions are very personal, but your open and honest answers are very important. There are no right or wrong answers.*

B1. Did you use alcohol or drugs since entering treatment? *Do not read response options.*

- |                             |  |                             |            |
|-----------------------------|--|-----------------------------|------------|
| <input type="checkbox"/> 1  | Yes (specify what substances were used since entering treatment) _____ |                             |            |
| <input type="checkbox"/> 0  | No   | <input type="checkbox"/> 66 | Don't Know |
| <input type="checkbox"/> 88 | Refused  |                             |            |

**Program Staff:** *If clients reported alcohol or drug use in Question B1 above please skip to question B3 below. Only ask question B2 below to clients who reported no alcohol or drug use in Question B1 above.*

B2. You reported that since entering treatment you did not use alcohol or drugs. What were your reasons for not using any alcohol or drugs? You may say yes to more than one. *Please read response options.*

- 1 In jail/prison
- 2 On probation/parole
- 3 Lack of money
- 7 Other (specify) \_\_\_\_\_
- 77 Not applicable – used alcohol and/or drugs since entering treatment.
- 88 Refused
- 4 Medical hospitalization
- 5 Inpatient mental health treatment
- 6 Residential substance use treatment

**Program Staff:** *The next set of questions asks about your sexual behaviors. Again, I realize these questions are very personal, but your open and honest answers are very important.*

B3. In the past 30 days, did you engage in unprotected sexual activity with a male partner?

- 1 Yes
- 0 No
- 66 Don't Know
- 88 Refused

B4. In the past 30 days, did you engage in unprotected sexual activity with a female partner?

- 1 Yes
- 0 No
- 66 Don't Know
- 88 Refused

B5. In the past 30 days, did you engage in unprotected sexual activity with both a male partner and a female partner?

- 1 Yes
- 0 No
- 66 Don't Know
- 88 Refused

**\*\*\*Program Staff:** *Only ask questions B6a – B6j of those clients who reported having unprotected sexual contact during the past 30 days. If the client did not report having unprotected sexual contact during the past 30 days, please skip to Question C1 below.*

**If the client reported having unprotected sexual contact ONLY with a male partner, please ask only questions B6a, B6c, B6e, B6g, and B6i.**

**If the client reported having unprotected sexual contact ONLY with a female partner, please ask questions B6b, B6d, B6f, B6h, and B6j.**

**If the client reported having unprotected sexual contact with BOTH a male partner and a female partner please answer all questions in B6a – B6j. \*\*\***

B6. In the past 30 days, did you have...

	Oral Sex	Vaginal Sex	Anal Sex	Did you use any of the following before or during... (check all that apply)
a. Unprotected sexual contact with a male partner?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A

Attachment 1a: Document 3 - Discharge Client-Level Survey

	Oral Sex	Vaginal Sex	Anal Sex	Did you use any of the following before or during... (check all that apply)
				<input type="checkbox"/> 88 Refused
b. Unprotected sexual contact <b>with a female partner</b> ?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
c. Unprotected sex <b>with a male partner</b> in exchange for money, drugs, or shelter?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
d. Unprotected sex <b>with a female partner</b> in exchange for money, drugs, or shelter?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
e. Unprotected sex <b>with a male partner</b> you know had, or suspected of having a sexually transmitted disease (STD)?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
f. Unprotected sex <b>with a female partner</b> you know had, or suspected of	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack

Attachment 1a: Document 3 - Discharge Client-Level Survey

	Oral Sex	Vaginal Sex	Anal Sex	Did you use any of the following before or during... (check all that apply)
having a sexually transmitted disease (STD)?	<input type="checkbox"/> 88 Refused	<input type="checkbox"/> 88 Refused	<input type="checkbox"/> 88 Refused	<input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
g. Unprotected sex <b>with a male partner</b> you know had, or suspected of having HIV/AIDS?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
h. Unprotected sex <b>with a female partner</b> you know had, or suspected of having HIV/AIDS?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
i. Unprotected sex <b>with a male partner</b> you knew was, or suspected of being an injection drug user?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
j. Unprotected sex <b>with a female partner</b> you knew was, or suspected of being an injection drug user?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused

**C. HIV Testing/HIV Status**

**Program Staff:** *These questions about whether you have ever been tested for HIV and your HIV status as well as other sexually transmitted infections (STIs).*

C1. In that past 12 months, have you been diagnosed with a sexually transmitted infection (STI) other than HIV? *Do not read response options.*

- 1 Yes     0 No     66 Don't Know     88 Refused

C2. Have you ever tested positive for HIV? *Do not read response options.*

- 1 Yes     0 No     66 Don't Know     88 Refused

**\*\*\*\*Program Staff: If client answered No, Don't Know, or Refused to Question C2, please skip to Question D1\*\*\*\***

C3. How long have you known you were HIV positive? *Do not read response options.*

- 1 30 days or less                       2 Greater than 30 days  
 66 Don't Know                               77 Not applicable – Not HIV positive.  
 88 Refused

**Program Staff:** *Next, I am going to ask you some questions about whether you have changed your behavior since you found out you were HIV positive. I am going to read each answer option and please use Response Card A to tell me how much you have changed your behavior. Please select only one choice for each statement. [Please read response options].*

	<b>Since you found out you were HIV positive, how much have you changed the following behaviors...</b>	Not at all	A little bit	Moderately	Quite a bit	Extremely	N/A	Refused
C4.	Sharing drug injection equipment (needles/syringes) without first cleaning it with anything?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C5.	Sharing drug injection equipment (needles/syringes) with someone you know had, or suspected of having HIV/AIDS?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C6.	Having unprotected sexual contact?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C7.	Having unprotected sex with someone in exchange for money, drugs, or shelter?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C8.	Having unprotected sex with a partner you know had, or suspected of having a sexually transmitted disease (STD)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C9.	Having unprotected sex with a partner you know had, or suspected of having HIV/AIDS?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C10.	Having unprotected sex with	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88

Since you found out you were HIV positive, how much have you changed the following behaviors...

Not at all    A little bit    Moderately    Quite a bit    Extremely    N/A    Refused

someone you knew was, or suspected of being an injection drug user?

- C11. Having unprotected sex while you were under the influence of drugs or alcohol?     1     2     3     4     5     77     88

**D. Social Support**

**Program Staff:** Next, I am going to ask you some questions about the important people in your life. I am going to read each answer option and please indicate how much you agree or disagree with each statement below using Response Card B. Please select only one choice for each statement. [Please read response options].

- |      |  | Disagree Strongly                  | Disagree                    | Uncertain                  | Agree                      | Agree Strongly             | Refused                     |
|------|--|------------------------------------|-----------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|
| D1.  | You have people close to you who motivate and encourage your recovery.   | <input type="checkbox"/> 1         | <input type="checkbox"/> 2  | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |
| D2.  | You have close family members who help you stay away from drugs.   | <input type="checkbox"/> 1         | <input type="checkbox"/> 2  | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |
| D3.  | You have good friends who do not use drugs.  | <input type="checkbox"/> 1         | <input type="checkbox"/> 2  | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |
| D4.  | You have people close to you who can always be trusted.  | <input type="checkbox"/> 1         | <input type="checkbox"/> 2  | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |
| D5.  | You have people close to you who understand your situation and problems.   | <input type="checkbox"/> 1         | <input type="checkbox"/> 2  | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |
| D6.  | You work in situations where drug use is common.   | <input type="checkbox"/> 1         | <input type="checkbox"/> 2  | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |
| D7.  | You have people close to you who expect you to make positive changes in your life.   | <input type="checkbox"/> 1         | <input type="checkbox"/> 2  | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |
| D8.  | You have people close to you who help you develop confidence in yourself.  | <input type="checkbox"/> 1         | <input type="checkbox"/> 2  | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |
| D9.  | You have people close to you who respect you and your efforts in this program.   | <input type="checkbox"/> 1         | <input type="checkbox"/> 2  | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |
| D10. | In the past 30 days, did you attend any self-help groups for recovery (e.g., NA, AA, SMART Recovery)? <i>Do not read response options.</i> |                                    |                             |                            |                            |                            |                             |
|      | <input type="checkbox"/> 1   | Yes (specify how many times) _____ |                             |                            |                            |                            |                             |
|      | <input type="checkbox"/> 0   | No                                 | <input type="checkbox"/> 88 | Refused                    |                            |                            |                             |

**E. Mental Health and Medical Health**

**Program Staff:** *These questions ask about different areas of your life such as your emotional and physical health.*

Mental Health

**Program Staff:** *Next I have a list of problems people sometimes have. As I read each one to you, I want you to tell me how much that problem has distressed or bothered you during the past 30 days including today using Response Card A. [Please read response options].*

	During the past 30 days, how much were you distressed by...	Not at all	A little bit	Moderately	Quite a bit	Extremely	Refused
E1.	Nervousness or shakiness inside	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E2.	Thoughts of ending your life	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E3.	Suddenly scared for no reason	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E4.	Feeling lonely	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E5.	Feeling blue	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E6.	Feeling no interest in things	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E7.	Feeling fearful	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E8.	Feeling hopeless about the future	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E9.	Feeling tense or keyed up	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E10.	Spells of terror or panic	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E11.	Feeling so restless you couldn't sit still	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E12.	Feelings of worthlessness	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88

E13. In the past 30 days, how often have you used drugs (including prescription drugs) or alcohol to help you cope with stressful life events? *I am going to read each answer option and please use Response Card A to provide your answer. [Please read response options].*

- 1 Not at all     
  2 A little bit     
  3 Moderately  
 4 Quite a bit     
  5 Extremely     
  88 Refused

E14. During the past 3 months, did you receive services for mental or emotional difficulties (i.e., inpatient, outpatient, emergency room)? *Do not read response options.*

- 1 Yes (specify how many times) \_\_\_\_\_     
  0 No     
  88 Refused

E15. During the past 3 months, were you prescribed a medication for mental or emotional difficulties (e.g., Prozac, Cymbalta)?

- 1 Yes (specify medications) \_\_\_\_\_     
  0 No  
 88 Refused



Attachment 1a: Document 3 - Discharge Client-Level Survey

E16. Why did you enroll in this treatment program? *Do not read response options.*

- 1 Self-admitted     2 Court Mandated     3 Other (specify) \_\_\_\_\_  
 88 Refused

E17. Which drug(s) did you want to address in this treatment program?

Specify: \_\_\_\_\_

- 66 Don't Know     88 Refused

E18. If you are receiving other substance abuse treatment services, how much of your care is provided by this agency/organization? *Please read response options.*

- 0 I do not receive other substance abuse treatment services  
 1 I receive most of my care from this agency/organization  
 2 I receive about half of my care from this agency/organization and half from another agency/organization  
 3 I receive most of my care from another agency/organization

Medical Health

E19. In the past 30 days, did you have any type of health insurance for yourself? *Please read response options.*

- Yes, private health insurance (e.g., through an employer/union, privately purchased)  
 Yes, Medicare                       Yes, other Government health insurance  
 Yes, Medicaid                       0 No  
 88 Refused

E20. During the past 30 days, did you receive medical treatment (not including substance abuse treatment) for physical illness or injury (i.e., inpatient, outpatient, emergency room)? *Do not read response options.*

- 1 Yes (specify how many times) \_\_\_\_\_  0 No  
 88 Refused

E21. During the past 30 days, for about how many days did poor physical health keep you from doing your usual activities, such as self-care, work, or recreation? *Do not read response options.*

- Number of days \_\_\_\_\_                       88 Refused

**F. Motivation for Treatment**

**Program Staff:** The following questions ask about your attitudes toward substance abuse treatment. Each of the following statements describes a way that you might (or might not) feel about your drug use. For each statement, I am going to read each answer option and please use Response Card C to indicate how much you agree or disagree with each statement right now. [Please read response options].

**Note:** If the client's primary substance of choice is alcohol, please replace underlined words with the wording changes suggested in [ ] below.

		Strongly Disagree	Disagree	Undecided or Unsure	Agree	Strongly Agree	Refused
F1.	I have already started making some changes in my <u>use of drugs</u> [drinking].	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F2.	I was <u>using drugs</u> [drinking] too much at one time, but I've managed to change <u>that</u> [my drinking].	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F3.	I'm not just thinking about changing my <u>drug use</u> [drinking], I'm already doing something about it.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F4.	I have already changed my <u>drug use</u> [drinking], and I am looking for ways to keep from slipping back to my old pattern.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F5.	I am actively doing things now to cut down or stop <u>my use of drugs</u> [drinking].	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F6.	I want help to keep from going back to the <u>drug</u> [drinking] problems that I had before.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F7.	I am working hard to change my <u>drug use</u> [drinking].	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F8.	I have made some changes in my <u>drug use</u> [drinking], and I want some help to keep from going back to the way I used [to drink] <u>before</u> .	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88

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**End of DISCHARGE Client Level Survey**  
**Thank you for your time!**

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**Program Staff: Please complete the following section on client drug testing after administration of the DISCHARGE Client Level Survey. Please consult the client's medical record as necessary to complete this section.**

1. How frequently does your program conduct drug testing? *Mark all that apply.*

- 1 Intake                       2 At each session                       3 Randomly  
 4 Discharge                       5 Post-discharge                       6 Never  
 3 Other (specify) \_\_\_\_\_

2. For what reason(s) does your program conduct drug testing? *Mark all that apply.*

- 1 Scheduled                       2 For Cause                       3 Other (specify) \_\_\_\_\_  
 4 At the request of the legal system (e.g., parole officer, court mandated)

3. Has the client received a drug test in the past 90 days?

- 1 Yes (specify how many times) \_\_\_\_\_                       0 No                       66 Unknown

**\*\*\*\*Program Staff: Only complete the following questions if the client has received a drug test in the past 90 days \*\*\*\***

4. When did the client last receive a drug test?

- Month, Day, Year: \_\_\_\_\_                       66 Unknown

5. What method was used to conduct the client's most recent drug test?

- 1 Saliva                       2 Blood                       3 Urine                       4 Hair                       5 Sweat                       6 Breath

6. Was the sample collection directly observed?

- 1 Yes (specify how many times) \_\_\_\_\_                       0 No

7. The client's most recent drug test checked for the presence of which substances and/or drug groups? *Mark all that apply.*

- Alcohol                       Amphetamines                       Barbiturates  
 Benzodiazepines                       Cocaine/Crack                       Marijuana  
 Methamphetamine                       Opiates                       Phencyclidine (PCP)  
 Other (specify) \_\_\_\_\_                       66 Unknown

8. What were the results of the client's most recent drug test?

- 1 Negative for all drugs tested  
 2 Positive (specify for which substances) \_\_\_\_\_  
 3 Other outcome (i.e., neither negative nor positive), specify \_\_\_\_\_

9. If the test was positive for recent use of alcohol or other drugs, what actions were taken as a result of the positive test?

- Client counseled not to use drugs and/or alcohol  
 More frequent visits required  
 More frequent drug testing required (specify frequency) \_\_\_\_\_  
 Other action(s) (specify) \_\_\_\_\_

<b>RESPONSE CARD A</b>	<b>RESPONSE CARD B</b>	<b>RESPONSE CARD C</b>
<b>1 = Not at all</b>	<b>1 = Disagree Strongly</b>	<b>1 = Strongly Disagree</b>
<b>2 = A little bit</b>	<b>2 = Disagree</b>	<b>2 = Disagree</b>
<b>3 = Moderately</b>	<b>3 = Uncertain</b>	<b>3 = Undecided or Unsure</b>
<b>4 = Quite a bit</b>	<b>4 = Agree</b>	<b>4 = Agree</b>
<b>5 = Extremely</b>	<b>5 = Agree Strongly</b>	<b>5 = Strongly Agree</b>

## TCE-HIV Multi-Site Evaluation 6-MONTH FOLLOW-UP Client-Level Survey

Funding for data collection supported by the  
Center for Substance Abuse Treatment (CSAT)  
Substance Abuse and Mental Health Services Administration (SAMHSA)  
U.S. Department of Health and Human Services (HHS)

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**Instructions:** These instructions are for program staff administering the TCE-HIV Multi-Site Evaluation Client-Level Survey. The Client-Level Survey should be administered by program staff at baseline (based on the program's definition of baseline), discharge, and 6-months post-baseline to all clients receiving TCE-HIV services. ***Please note that this version of the Client-Level Survey is to be used at the 6-MONTH FOLLOW-UP (i.e., 6-months post-intake/baseline) only.***

The Client-Level Survey includes six sections: Background Information, Risky Behaviors, HIV Testing/HIV Status, Social Support, Mental Health and Medical Health, and Motivation for Treatment. All questions in Sections A – F should be asked of the client.

Please read the introduction to each section (in *italics*) and then read each question to the client as it is written. For some questions, you will read the response options to clients. Other questions are open-ended and you will not read the response options to clients. Please see the note in *italics* next to each question to determine whether you should read the response options. Some questions require the use of response options cards. Please provide the response options card to clients when noted.

You may provide clarification to the client to help them in understanding the question, but please do not change the wording of the questions.

**The Client-Level Survey should take approximately 25 minutes to administer.**

Public reporting burden for this collection of information is estimated to average 25 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 follow-up, 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 #####-####.

<b>TCE-HIV Multi-Site Evaluation                  Client-Level Survey</b>  <b>6-MONTH FOLLOW-UP</b>	
Funding for data collection supported by the Center for Substance Abuse Treatment (CSAT) Substance Abuse and Mental Health Services Administration (SAMHSA) U.S. Department of Health and Human Services (HHS)	
<b>Grantee ID</b>	<b>TIO</b> _____
<b>Partner ID (if applicable)</b>	<b>TIO</b> _____ - _____
<b>Client ID</b> _____ <i>(Please use the same Client ID that was assigned to the client for the GPRA)</i>	
<b>Date of Administration (mm/dd/yyyy)</b> ____ / ____ / ____	

<b>PROGRAM STAFF: Please complete the following client background questions using information collected from the 6-months post-intake/baseline GPRA.</b>	
<b>Client's Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Refused <input type="checkbox"/> Other (specify) _____
<b>Client's Ethnicity: Is the client Hispanic or Latino?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
<b>Client's Race</b>	<input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused
<b>Client's Age</b>	_____

Public reporting burden for this collection of information is estimated to average 25 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 follow-up, 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 #####-####.

Client ID: \_\_\_\_\_

(Please use the same Client ID that was assigned to the client for the GPRA)

**Program Staff:** The purpose of these questions is to get more information about how best to provide services. We are asking these questions because it is a requirement for us from the Federal government who gave us funding to provide services to you. All your background information and survey answers will be kept strictly confidential. All survey answers will be provided to the Federal government using only a number for you so there will be no way they can identify who you are. If you have any questions, comments, or concerns they can be directed to Resa Matthew, Ph.D. at 240-645-4608.

**A. Background Information**

**Program Staff:** First, I am going to ask you some questions about yourself.

A1. What is your marital status? *Do not read response options.*

- |                             |                      |                            |          |                            |                   |
|-----------------------------|----------------------|----------------------------|----------|----------------------------|-------------------|
| <input type="checkbox"/> 1  | Never Married/Single | <input type="checkbox"/> 2 | Married  | <input type="checkbox"/> 3 | Living as Married |
| <input type="checkbox"/> 4  | Separated            | <input type="checkbox"/> 5 | Divorced | <input type="checkbox"/> 6 | Widowed           |
| <input type="checkbox"/> 88 | Refused              |                            |          |                            |                   |

A2. In the past 30 days, have you lived...? You may say yes to more than one. *Please read response options.*

- |                             |                                     |                          |                           |
|-----------------------------|-------------------------------------|--------------------------|---------------------------|
| <input type="checkbox"/>    | Alone                               | <input type="checkbox"/> | With parents              |
| <input type="checkbox"/>    | With children alone                 | <input type="checkbox"/> | With other family members |
| <input type="checkbox"/>    | With significant other alone        | <input type="checkbox"/> | With friends              |
| <input type="checkbox"/>    | With significant other and children | <input type="checkbox"/> | In jail                   |
| <input type="checkbox"/>    | In prison                           | <input type="checkbox"/> | In a hospital             |
| <input type="checkbox"/>    | In residential treatment            | <input type="checkbox"/> | Other (specify) _____     |
| <input type="checkbox"/> 88 | Refused                             |                          |                           |

**B. Risky Behaviors**

**Program Staff:** The next set of questions asks about any behaviors that you may engage in that may put you at risk for substance use disorders or HIV/AIDS. I realize these questions are very personal, but your open and honest answers are very important. There are no right or wrong answers.

B1. Did you use alcohol or drugs since leaving treatment? *Do not read response options.*

- |                             |   |                             |            |
|-----------------------------|---|-----------------------------|------------|
| <input type="checkbox"/> 1  | Yes (specify what substances were used since leaving treatment) _____ |                             |            |
| <input type="checkbox"/> 0  | No  | <input type="checkbox"/> 66 | Don't Know |
| <input type="checkbox"/> 88 | Refused   |                             |            |

**Program Staff:** If clients reported alcohol or drug use in Question B1 above please skip to question B3 below. Only ask question B2 below to clients who reported no alcohol or drug use in Question B1 above.

Attachment 1b: Document 1 – Six Month Follow-Up Client-Level Survey

B2. You reported that since leaving treatment you did not use alcohol or drugs. What were your reasons for not using any alcohol or drugs? You may say yes to more than one. *Please read response options.*

- 1 In jail/prison
- 2 On probation/parole
- 3 Lack of money
- 7 Other (specify) \_\_\_\_\_
- 77 Not applicable – used alcohol and/or drugs since leaving treatment.
- 88 Refused
- 4 Medical hospitalization
- 5 Inpatient mental health treatment
- 6 Residential substance use treatment

**Program Staff:** *The next set of questions asks about your sexual behaviors. Again, I realize these questions are very personal, but your open and honest answers are very important.*

B3. In the past 30 days, did you engage in unprotected sexual activity with a male partner?

- 1 Yes
- 0 No
- 66 Don't Know
- 88 Refused

B4. In the past 30 days, did you engage in unprotected sexual activity with a female partner?

- 1 Yes
- 0 No
- 66 Don't Know
- 88 Refused

B5. In the past 30 days, did you engage in unprotected sexual activity with both a male partner and a female partner?

- 1 Yes
- 0 No
- 66 Don't Know
- 88 Refused

**\*\*\*Program Staff:** *Only ask questions B6a – B6j of those clients who reported having unprotected sexual contact during the past 30 days. If the client did not report having unprotected sexual contact during the past 30 days, please skip to Question C1 below.*

**If the client reported having unprotected sexual contact ONLY with a male partner, please ask only questions B6a, B6c, B6e, B6g, and B6i.**

**If the client reported having unprotected sexual contact ONLY with a female partner, please ask questions B6b, B6d, B6f, B6h, and B6j.**

**If the client reported having unprotected sexual contact with BOTH a male partner and a female partner please answer all questions in B6a – B6j. \*\*\***

B6. In the past 30 days, did you have...

	Oral Sex	Vaginal Sex	Anal Sex	Did you use any of the following before or during... (check all that apply)
a. Unprotected sexual contact with a male partner?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know



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	Oral Sex	Vaginal Sex	Anal Sex	Did you use any of the following before or during... (check all that apply)
				<input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
b. Unprotected sexual contact <b>with a female partner</b> ?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
c. Unprotected sex <b>with a male partner</b> in exchange for money, drugs, or shelter?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
d. Unprotected sex <b>with a female partner</b> in exchange for money, drugs, or shelter?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
e. Unprotected sex <b>with a male partner</b> you know had, or suspected of having a sexually transmitted disease (STD)?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
f. Unprotected sex <b>with a female partner</b> you know had, or	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin

Attachment 1b: Document 1 – Six Month Follow-Up Client-Level Survey

	Oral Sex	Vaginal Sex	Anal Sex	Did you use any of the following before or during... (check all that apply)
suspected of having a sexually transmitted disease (STD)?	<input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
g. Unprotected sex <b>with a male partner</b> you know had, or suspected of having HIV/AIDS?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
h. Unprotected sex <b>with a female partner</b> you know had, or suspected of having HIV/AIDS?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
i. Unprotected sex <b>with a male partner</b> you knew was, or suspected of being an injection drug user?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused
j. Unprotected sex <b>with a female partner</b> you knew was, or suspected of being an injection drug user?	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 # of times ____ <input type="checkbox"/> 0 No <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused	<input type="checkbox"/> 1 Alcohol <input type="checkbox"/> 2 Marijuana <input type="checkbox"/> 3 Heroin <input type="checkbox"/> 4 Cocaine/ Crack <input type="checkbox"/> 5 Other _____ <input type="checkbox"/> 66 Don't Know <input type="checkbox"/> 77 N/A <input type="checkbox"/> 88 Refused

**C. HIV Testing/HIV Status**

**Program Staff:** *These questions about whether you have ever been tested for HIV and your HIV status as well as other sexually transmitted infections (STIs).*

C1. In that past 12 months, have you been diagnosed with a sexually transmitted infection (STI) other than HIV? *Do not read response options.*

- 1 Yes     0 No     66 Don't Know     88 Refused

C2. Have you ever tested positive for HIV? *Do not read response options.*

- 1 Yes     0 No     66 Don't Know     88 Refused

**\*\*\*\*Program Staff: If client answered No, Don't Know, or Refused to Question C2, please skip to Question D1\*\*\*\***

C3. How long have you known you were HIV positive? *Do not read response options.*

- 1 30 days or less                       2 Greater than 30 days  
 66 Don't Know                               77 Not applicable – Not HIV positive.  
 88 Refused

**Program Staff:** *Next, I am going to ask you some questions about whether you have changed your behavior since you found out you were HIV positive. I am going to read each answer option and please use Response Card A to tell me how much you have changed your behavior. Please select only one choice for each statement. [Please read response options].*

	<b>Since you found out you were HIV positive, how much have you changed the following behaviors...</b>	Not at all	A little bit	Moderately	Quite a bit	Extremely	N/A	Refused
C4.	Sharing drug injection equipment (needles/syringes) without first cleaning it with anything?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C5.	Sharing drug injection equipment (needles/syringes) with someone you know had, or suspected of having HIV/AIDS?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C6.	Having unprotected sexual contact?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C7.	Having unprotected sex with someone in exchange for money, drugs, or shelter?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C8.	Having unprotected sex with a partner you know had, or suspected of having a sexually transmitted disease (STD)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C9.	Having unprotected sex with a partner you know had, or suspected of having HIV/AIDS?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88
C10.	Having unprotected sex with	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 77	<input type="checkbox"/> 88

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- |  |  | Not at all                 | A little bit               | Moderately                 | Quite a bit                | Extremely                  | N/A                         | Refused                     |
|--|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|-----------------------------|
| <p><b>Since you found out you were HIV positive, how much have you changed the following behaviors...</b></p> <p>someone you knew was, or suspected of being an injection drug user?</p> |  |                            |                            |                            |                            |                            |                             |                             |
| C11.   | Having unprotected sex while you were under the influence of drugs or alcohol? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 77 | <input type="checkbox"/> 88 |

**D. Social Support**

**Program Staff:** Next, I am going to ask you some questions about the important people in your life. I am going to read each answer option and please indicate how much you agree or disagree with each statement below using Response Card B. Please select only one choice for each statement. [Please read response options].

- |      |  | Disagree Strongly          | Disagree                   | Uncertain                  | Agree                      | Agree Strongly             | Refused                     |  |
|------|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|--|
| D1.  | You have people close to you who motivate and encourage your recovery.   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |  |
| D2.  | You have close family members who help you stay away from drugs.   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |  |
| D3.  | You have good friends who do not use drugs.  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |  |
| D4.  | You have people close to you who can always be trusted.  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |  |
| D5.  | You have people close to you who understand your situation and problems.   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |  |
| D6.  | You work in situations where drug use is common.   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |  |
| D7.  | You have people close to you who expect you to make positive changes in your life.   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |  |
| D8.  | You have people close to you who help you develop confidence in yourself.  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |  |
| D9.  | You have people close to you who respect you and your efforts in this program.   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 88 |  |
| D10. | In the past 30 days, did you attend any self-help groups for recovery (e.g., NA, AA, SMART Recovery)? <i>Do not read response options.</i> |                            |                            |                            |                            |                            |                             |  |
|      | <input type="checkbox"/> 1 Yes (specify how many times) _____  |                            |                            |                            |                            |                            |                             |  |
|      | <input type="checkbox"/> 0 No <input type="checkbox"/> 88 Refused  |                            |                            |                            |                            |                            |                             |  |

**E. Mental Health and Medical Health**

**Program Staff:** *These questions ask about different areas of your life such as your emotional and physical health.*

Mental Health

**Program Staff:** *Next I have a list of problems people sometimes have. As I read each one to you, I want you to tell me how much that problem has distressed or bothered you during the past 30 days including today using Response Card A. [Please read response options].*

	During the past 30 days, how much were you distressed by...	Not at all	A little bit	Moderately	Quite a bit	Extremely	Refused
E1.	Nervousness or shakiness inside	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E2.	Thoughts of ending your life	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E3.	Suddenly scared for no reason	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E4.	Feeling lonely	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E5.	Feeling blue	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E6.	Feeling no interest in things	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E7.	Feeling fearful	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E8.	Feeling hopeless about the future	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E9.	Feeling tense or keyed up	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E10.	Spells of terror or panic	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E11.	Feeling so restless you couldn't sit still	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
E12.	Feelings of worthlessness	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88

E13. In the past 30 days, how often have you used drugs (including prescription drugs) or alcohol to help you cope with stressful life events? *I am going to read each answer option and please use Response Card A to provide your answer. [Please read response options].*

- 1 Not at all     
  2 A little bit     
  3 Moderately  
 4 Quite a bit     
  5 Extremely     
  88 Refused

E14. During the past 3 months, did you receive services for mental or emotional difficulties (i.e., inpatient, outpatient, emergency room)? *Do not read response options.*

- 1 Yes (specify how many times) \_\_\_\_\_     
  0 No  
 88 Refused

E15. During the past 3 months, were you prescribed a medication for mental or emotional difficulties (e.g., Prozac, Cymbalta)?

- 1 Yes (specify medications) \_\_\_\_\_     
  0 No  
 88 Refused

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E16. Why did you enroll in this treatment program? *Do not read response options.*

- 1 Self-admitted     2 Court Mandated     3 Other (specify) \_\_\_\_\_  
 88 Refused

E17. Which drug(s) did you want to address in this treatment program?

Specify: \_\_\_\_\_

- 66 Don't Know     88 Refused

E18. If you are receiving other substance abuse treatment services, how much of your care is provided by this agency/organization? *Please read response options.*

- 0 I do not receive other substance abuse treatment services  
 1 I receive most of my care from this agency/organization  
 2 I receive about half of my care from this agency/organization and half from another agency/organization  
 3 I receive most of my care from another agency/organization

Medical Health

E19. In the past 30 days, did you have any type of health insurance for yourself? *Please read response options.*

- Yes, private health insurance (e.g., through an employer/union, privately purchased)  
 Yes, Medicare     Yes, other Government health insurance  
 Yes, Medicaid     0 No  
 88 Refused

E20. During the past 30 days, did you receive medical treatment (not including substance abuse treatment) for physical illness or injury (i.e., inpatient, outpatient, emergency room)? *Do not read response options.*

- 1 Yes (specify how many times) \_\_\_\_\_  0 No  
 88 Refused

E21. During the past 30 days, for about how many days did poor physical health keep you from doing your usual activities, such as self-care, work, or recreation? *Do not read response options.*

- Number of days \_\_\_\_\_  88 Refused

**F. Motivation for Treatment**

**Program Staff:** The following questions ask about your attitudes toward substance abuse treatment. Each of the following statements describes a way that you might (or might not) feel about your drug use. For each statement, I am going to read each answer option and please use Response Card C to indicate how much you agree or disagree with each statement right now. [Please read response options].

**Note:** If the client's primary substance of choice is alcohol, please replace underlined words with the wording changes suggested in [ ] below.

		Strongly Disagree	Disagree	Undecided or Unsure	Agree	Strongly Agree	Refused
F1.	I have already started making some changes in my <u>use of drugs</u> [drinking].	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F2.	I was <u>using drugs</u> [drinking] too much at one time, but I've managed to change <u>that</u> [my drinking].	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F3.	I'm not just thinking about changing my <u>drug use</u> [drinking], I'm already doing something about it.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F4.	I have already changed my <u>drug use</u> [drinking], and I am looking for ways to keep from slipping back to my old pattern.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F5.	I am actively doing things now to cut down or stop <u>my use of drugs</u> [drinking].	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F6.	I want help to keep from going back to the <u>drug</u> [drinking] problems that I had before.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F7.	I am working hard to change my <u>drug use</u> [drinking].	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88
F8.	I have made some changes in my <u>drug use</u> [drinking], and I want some help to keep from going back to the way I used [to drink] <u>before</u> .	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 88

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**End of 6-MONTH FOLLOW-UP Client Level Survey**  
**Thank you for your time!**

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<b>RESPONSE CARD A</b>	<b>RESPONSE CARD B</b>	<b>RESPONSE CARD C</b>
<b>1 = Not at all</b>	<b>1 = Disagree Strongly</b>	<b>1 = Strongly Disagree</b>
<b>2 = A little bit</b>	<b>2 = Disagree</b>	<b>2 = Disagree</b>
<b>3 = Moderately</b>	<b>3 = Uncertain</b>	<b>3 = Undecided or Unsure</b>
<b>4 = Quite a bit</b>	<b>4 = Agree</b>	<b>4 = Agree</b>
<b>5 = Extremely</b>	<b>5 = Agree Strongly</b>	<b>5 = Strongly Agree</b>



# TARGETED CAPACITY EXPANSION PROGRAM FOR SUBSTANCE ABUSE TREATMENT AND HIV/AIDS SERVICES (TCE-HIV)

## MULTI-SITE EVALUATION PROJECT

### CLIENT DOSAGE FORM

Grantee Name:	_____
Grantee ID Number:	_____
Client ID Number: (same as GPRA ID)	_____
Date Completed:	____ / ____ / ____ Month Day Year

#### Notice to Respondents

Public reporting burden for this collection of information is estimated to average 15 minutes per response; including the time for reviewing instructions, searching existing data sources data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. 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 XXXX-XXXX.

## Dosage Instructions and Client Dosage Form

### DOSAGE MEASUREMENT

Individual clients in a program can have very different types and amounts of contact (i.e., dosage) due to absences, participation in different components, or dropping out; thus it is critical to have dosage information to accurately assess program effects. Dosage is a measure of the *type* and *amount* of contact that a client has with the program.

The documentation of client exposure to program services is an important feature of the CSAT TCE-HIV multi-site evaluation. The dosage measurement developed for this evaluation study is designed to meet several criteria. First, the client dosage form must reflect the actual services and treatment activities of the funded programs. Second, the client dosage form must be simple enough to implement across all treatment grantees. Third, the client dosage form should be completed only at client discharge.

### TCE-HIV EVALUATION DOSAGE GENERAL INSTRUCTIONS

Multi-site dosage measurement applies only to those services that **directly involve TCE-HIV clients**. Dosage data will *not* be collected on services for which the client is not individually involved, such as case management review meetings or referral calls made on behalf of the client. Most direct services will involve face-to-face contact between the client and service provider, but there may be direct services provided over the telephone such as crises intervention or case management counseling. Program services and treatment activities included are only those provided directly by the grantee or through contractual arrangements. Services that clients receive outside of the program will *not* be measured for multi-site purposes, even if the services were received through referrals from the program. Because dosage is a measurement of program exposure to services and treatment activities, **dosage data will be collected on TCE-HIV clients only**.

There is no expectation that a program would conduct activities in all of the service/treatment activities categories listed in the client dosage form. However, for the purposes of dosage recording, it is important that each program activity conducted at the local level be attached to one of these intervention types.

Some program encounters will involve only one intervention type, e.g., a family counseling session. However, clients can receive more than one type of service or treatment activity during a daily encounter. For example, as part of a daily program encounter, clients may learn about the harmful effects of alcohol, tobacco, and drugs (Substance Abuse Education) during the first hour and then during the second hour participate in a group substance abuse counseling (Group Substance Abuse Treatment Counseling) session and spend a third hour working on exercises to improve parent-child communication (Parenting Skills Education). Two tables provided below contain definitions to assist in completing the client dosage form. Table 1 has definitions of the treatment modalities for completing the first section of the client dosage form and Table 2 has definitions on various service and treatment activities for the completion of the second section of the client dosage form.

### COMPLETING THE CLIENT DOSAGE FORM

Below are some suggestions that will facilitate your completion of the Client Dosage Form. Please complete one form for each TCE-HIV client in your program.

1. Complete a Client Dosage Form for each TCE-HIV client at discharge. The definition of discharge should follow your program definition. If your program does not have a definition of discharge, the Client Dosage Form should be completed when the client has had no contact with the program for 30 days.
2. It is critical that you are familiar with the form and have the client's chart/records (or other records of the client's services received and activities) available prior to completing the form. Give yourself about 15 minutes to complete the form when you have the client's records.

**INSTRUCTIONS FOR COMPLETION**

**DATE:** Please fill in the date you complete the form.

**CLIENT IDENTIFICATION:** Enter the client’s program identification number. The client’s ID number should be the same number assigned to the client for his/her GPRA administration.

**PERSON COMPLETING FORM:** Fill in your name as the person completing the form.

**GRANT NUMBER:** Enter your grant identification number starting with TIO.

**QUESTION 1 [LENGTH OF STAY]:** To complete this question you will need to refer to the client’s treatment records to assess how many days the client spent in your treatment program and place an “X” in the box next to the corresponding number of days the client spent in treatment.

**QUESTION 2 [TYPE OF TREATMENT]:** For this question you will need to indicate the type of treatment the client engaged in while in your program. Please refer to Table 1 for clarification if you are uncertain of the type of treatment. Please place an “X” in the appropriate box(es) for the type of treatment the client engaged in while in your program.

**Table 1: Dosage Treatment Modalities**

<b>TREATMENT MODALITY</b>
<b>Outpatient:</b> This modality is for clients who require treatment that entails group education, activity therapy, etc., lasting more than 4 continuous hours in a supportive environment.
<b>Intensive Outpatient:</b> This modality consists of intense multimodal treatment for clients who 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.
<b>Methadone:</b> This modality includes the provision of methadone maintenance for opioid-addicted clients.
<b>Residential:</b> This modality is for a residential facility that provides onsite structured therapeutic and supportive services specifically for alcohol and other drugs.

**SERVICE/TREATMENT ACTIVITIES:** These series of statements refer to the services and treatment activities a client received or in which he or she participated. Please refer to Table 2 if you need a definition for the service/treatment activity. Begin with the first service/treatment activity and look across to the column labeled “A Services Received.” Choose the response category (i.e., 1 = yes, 0 = no, -1 = N/A, -8 = Don’t know) for the service or treatment activity and record the number in column A. If you record a N/A (-1) for receiving a service in Column A, then it is anticipated that the client will also receive N/A in Columns B–C. Repeat the same process for Columns B and C. Go through each of the service/treatment activity and repeat the process until you are finished.

**Table 2: Dosage Service/Treatment Activities**

<b>SERVICE/TREATMENT ACTIVITIES</b>
<b>Case Management Services:</b> These services involve <i>direct</i> services between the client and the case manager, including individual assessments, service plan development and evaluation, arranging for and monitoring needed services, making and following up on referrals, and other case management services as defined by the program. Routine telephone calls are <i>not</i> included.

Attachment 1b: Document 2 - Client Dosage Form

<p><b>Parenting Skills Education:</b> Activities included in this category include instruction on developmental expectations parents should have given their child’s age, provision of information about positive parenting practices and forms of discipline, lessons on parent-child communication, and other parenting-related information.</p>
<p><b>Family Counseling:</b> Activities included in this category include relationship-building activities conducted with the client and family members together, family mediation, family counseling (individual family or multi-family), parenting counseling (individual or group), and self-help/support groups for clients.</p>
<p><b>Physical Exam:</b> The category includes any physical examination by a licensed professional such as a medical doctor, nurse practitioner, or physician’s assistant that includes assessment of height, weight, vital signs, body mass index, or body systems such as respiratory, cardiac, gastrointestinal, genitourinary, skin, and neurological.</p>
<p><b>Educational Services:</b> This category includes activities such as tutoring assistance to improve reading, literacy, and math skills or other educational activities leading to a high school diploma, GED, or higher education.</p>
<p><b>Employment Placement/Vocational Support:</b> Vocational support activities are included in this category, such as career counseling, job training, resources provided to clients to assist in finding employment, and job placement.</p>
<p><b>Life Skills Training:</b> Activities in this category focus on training on specific personal or interpersonal skills that have been identified as important to successful individual and social development. This category includes skills development training that targets competencies, such as communication, decision making, problem solving, conflict resolution, refusal skills, as well as more general life skills (e.g., budgeting, cooking). Also included in this category are program sessions that specifically address self-esteem, self-concept, and self-confidence building.</p>
<p><b>Positive Recreation and Enrichment:</b> This category includes a broad range of program activities that share a primary concern about leisure time activities that take place in a drug-free environment, are appealing to clients, and may contribute to enrichment or skills development by providing an opportunity to engage in stimulating and rewarding activities. Activities in this category may be loosely structured, e.g., self-care time and group meals, or more structured activities such as crafts courses or art classes.</p>
<p><b>Substance Abuse Education:</b> This category includes education, training, or discussion sessions that focus directly or indirectly on information concerning Alcohol, Tobacco, or Other Drugs (ATOD) awareness, knowledge, or use. The category also includes training or education on risk situations specifically related to ATOD use, such as HIV/AIDS, and preventing and controlling violent impulses, especially those resulting from substance abuse.</p>
<p><b>Rapid HIV Testing and Counseling:</b> Included in this category are the private pre and post test counseling sessions associated with each rapid HIV testing session.</p>
<p><b>HIV Prevention Education:</b> Activities in this category focus on training on specific personal or interpersonal skills that have been identified as important to prevent or reduce the risk for HIV infection. This category includes skills for condom negotiation, practicing safer sex, and awareness of barrier methods and microbicides.</p>
<p><b>Childcare:</b> This category includes care provided to children for a period of time so clients can participate in individual and group activities or receive services.</p>
<p><b>Relapse Prevention:</b> This category includes the activities and processes for identifying each client’s current stage of recovery and establishing a recovery plan to identify and manage the relapse warning signs.</p>
<p><b>Social Support Groups:</b> Included in this category are the sessions clients engage in to help or improve themselves with assistance from others; and/or an assemblage of persons who have similar experiences and assist in encouraging and keeping individuals from relapsing.</p>
<p><b>Spiritual Activity:</b> Included in this category is spiritual/religion-based support for the clients’ recovery process (meditational activities/use of media, attendance at services).</p>



## SERVICE/TREATMENT ACTIVITY

	<b>A</b> <b>Services Received</b>	<b>B</b> <b>Sessions</b>	<b>C</b> <b>Where and by Whom</b>
1. Pretreatment Services.....	<input type="checkbox"/> DF_STA01_A	<input type="checkbox"/> DF_STA01_B	<input type="checkbox"/> DF_STA01_C
2. Rapid HIV Testing and Counseling .....	<input type="checkbox"/> DF_STA02_A	<input type="checkbox"/> DF_STA02_B	<input type="checkbox"/> DF_STA02_C
3. Substance Abuse Education .....	<input type="checkbox"/> DF_STA03_A	<input type="checkbox"/> DF_STA03_B	<input type="checkbox"/> DF_STA03_C
4. HIV Prevention Education, including prevention education for:.....	<input type="checkbox"/> DF_STA04_A	<input type="checkbox"/> DF_STA04_B	<input type="checkbox"/> DF_STA04_C
a. Safe sex practices.....	<input type="checkbox"/> DF_STA04a_ SAFE_A	<input type="checkbox"/> DF_STA04a_ SAFE_B	<input type="checkbox"/> DF_STA04a_ SAFE_C
b. Condom negotiation skills .....	<input type="checkbox"/> DF_STA04b_ CONDOM_A	<input type="checkbox"/> DF_STA04b_ CONDOM_B	<input type="checkbox"/> DF_STA04b_ CONDOM_C
c. Barrier protection methods .....	<input type="checkbox"/> DF_STA04c_ BARRIER_A	<input type="checkbox"/> DF_STA04c_ BARRIER_B	<input type="checkbox"/> DF_STA04c_ BARRIER_C
d. Peer education.....	<input type="checkbox"/> DF_STA04d_ PEER_A	<input type="checkbox"/> DF_STA04d_ PEER_B	<input type="checkbox"/> DF_STA04d_ PEER_C
e. HIV risk in pregnancy & childbirth .....	<input type="checkbox"/> DF_STA04e_ PREGNANT_A	<input type="checkbox"/> DF_STA04e_ PREGNANT_B	<input type="checkbox"/> DF_STA04e_ PREGNANT_C
5. Sexually Transmitted Infections Screening and Treatment.....	<input type="checkbox"/> DF_STA05_A	<input type="checkbox"/> DF_STA05_B	<input type="checkbox"/> DF_STA05_C
6. Medical Diagnosing and Follow-up Treatment.....	<input type="checkbox"/> DF_STA06_A	<input type="checkbox"/> DF_STA06_B	<input type="checkbox"/> DF_STA06_C
7. Physical Exam by Healthcare Providers (including height, weight, vital signs, body mass index, and body systems such as respiratory, cardiac, gastrointestinal, genitourinary, skin, neurological).....	<input type="checkbox"/> DF_STA07_A	<input type="checkbox"/> DF_STA07_B	<input type="checkbox"/> DF_STA07_C
8. Laboratory Testing (urinalysis, complete blood count, electrolytes).....	<input type="checkbox"/> DF_STA08_A	<input type="checkbox"/> DF_STA08_B	<input type="checkbox"/> DF_STA08_C
9. Substance Abuse Treatment Planning.....	<input type="checkbox"/> DF_STA09_A	<input type="checkbox"/> DF_STA09_B	<input type="checkbox"/> DF_STA09_C
10. Mental Health Assessment .....	<input type="checkbox"/> DF_STA10_A	<input type="checkbox"/> DF_STA10_B	<input type="checkbox"/> DF_STA10_C
11. Mental Health Treatment.....	<input type="checkbox"/> DF_STA11_A	<input type="checkbox"/> DF_STA11_B	<input type="checkbox"/> DF_STA11_C
12. Group Psychiatric Therapy (based on psychiatric diagnosis).....	<input type="checkbox"/> DF_STA12_A	<input type="checkbox"/> DF_STA12_B	<input type="checkbox"/> DF_STA12_C

**SERVICE/TREATMENT ACTIVITY (continued)**

	<b>A Services Received</b>	<b>B Sessions</b>	<b>C Where and by Whom</b>
13. Individual Psychiatric Therapy (based on psychiatric diagnosis).....	<input type="checkbox"/> DF_STA13_A	<input type="checkbox"/> DF_STA13_B	<input type="checkbox"/> DF_STA13_C
14. Individual Substance Abuse Treatment Counseling.....	<input type="checkbox"/> DF_STA14_A	<input type="checkbox"/> DF_STA14_B	<input type="checkbox"/> DF_STA14_C
15. Group Substance Abuse Treatment Counseling.....	<input type="checkbox"/> DF_STA15_A	<input type="checkbox"/> DF_STA15_B	<input type="checkbox"/> DF_STA15_C
16. Gender Specific Sessions.....	<input type="checkbox"/> DF_STA16_A	<input type="checkbox"/> DF_STA16_B	<input type="checkbox"/> DF_STA16_C
17. Trauma-informed services, including assessment and interventions for:	<input type="checkbox"/> DF_STA17_A	<input type="checkbox"/> DF_STA17_B	<input type="checkbox"/> DF_STA17_C
a. Emotional abuse.....	<input type="checkbox"/> DF_STA17a_ EMOTIONAL_A	<input type="checkbox"/> DF_STA17a_ EMOTIONAL_B	<input type="checkbox"/> DF_STA17a_ EMOTIONAL_C
b. Sexual abuse.....	<input type="checkbox"/> DF_STA17b_ SEXUAL_A	<input type="checkbox"/> DF_STA17b_ SEXUAL_B	<input type="checkbox"/> DF_STA17b_ SEXUAL_C
c. Physical abuse.....	<input type="checkbox"/> DF_STA17c_ PHYSICAL_A	<input type="checkbox"/> DF_STA17c_ PHYSICAL_B	<input type="checkbox"/> DF_STA17c_ PHYSICAL_C
18. Case Management Services.....	<input type="checkbox"/> DF_STA18_A	<input type="checkbox"/> DF_STA18_B	<input type="checkbox"/> DF_STA18_C
19. Social Support Groups.....	<input type="checkbox"/> DF_STA19_A	<input type="checkbox"/> DF_STA19_B	<input type="checkbox"/> DF_STA19_C
20. Aftercare Planning.....	<input type="checkbox"/> DF_STA20_A	<input type="checkbox"/> DF_STA20_B	<input type="checkbox"/> DF_STA20_C
21. Life Skills Training.....	<input type="checkbox"/> DF_STA21_A	<input type="checkbox"/> DF_STA21_B	<input type="checkbox"/> DF_STA21_C
22. Employment Readiness Training.....	<input type="checkbox"/> DF_STA22_A	<input type="checkbox"/> DF_STA22_B	<input type="checkbox"/> DF_STA22_C
23. Employment Placement.....	<input type="checkbox"/> DF_STA23_A	<input type="checkbox"/> DF_STA23_B	<input type="checkbox"/> DF_STA23_C
24. Recreational Activity (field trips, movies, team sports, cultural experiences, picnics).....	<input type="checkbox"/> DF_STA24_A	<input type="checkbox"/> DF_STA24_B	<input type="checkbox"/> DF_STA24_C
25. Spiritual Activity (meditational activities/use of media, attendance at services).....	<input type="checkbox"/> DF_STA25_A	<input type="checkbox"/> DF_STA25_B	<input type="checkbox"/> DF_STA25_C
26. Transitional Housing.....	<input type="checkbox"/> DF_STA26_A	<input type="checkbox"/> DF_STA26_B	<input type="checkbox"/> DF_STA26_C
27. Permanent Housing Arrangements.....	<input type="checkbox"/> DF_STA27_A	<input type="checkbox"/> DF_STA27_B	<input type="checkbox"/> DF_STA27_C
28. Educational Services (for GED and other educational needs).....	<input type="checkbox"/> DF_STA28_A	<input type="checkbox"/> DF_STA28_B	<input type="checkbox"/> DF_STA28_C

**SERVICE/TREATMENT ACTIVITY (continued)**

	<b>A</b> <b>Services</b> <b>Received</b>	<b>B</b> <b>Sessions</b>	<b>C</b> <b>Where and</b> <b>by Whom</b>
29. Vocational Services.....	_  DF_STA29_A	_  DF_STA29_B	_  DF_STA29_C
30. Childcare.....	_  DF_STA30_A	_  DF_STA30_B	_  DF_STA30_C
31. Transportation.....	_  DF_STA31_A	_  DF_STA31_B	_  DF_STA31_C
32. Parenting Skills Education.....	_  DF_STA32_A	_  DF_STA32_B	_  DF_STA32_C
33. Family Counseling.....	_  DF_STA33_A	_  DF_STA33_B	_  DF_STA33_C
34. Discharge Planning (including community reintegration, socio-economic support at State and Federal level if eligible).....	_  DF_STA34_A	_  DF_STA34_B	_  DF_STA34_C
35. Planned or Arranged Post Treatment Continuing Care.....	_  DF_STA35_A	_  DF_STA35_B	_  DF_STA35_C



TCE-HIV Multi-Site Evaluation  
 Client Focus Group Participant Information

CSAT would like to learn more about you and your involvement with this organization/program. Please take a few minutes to answer these questions before the focus group begins. Your help in answering these questions is greatly appreciated and your answers will be held in confidence.

**Grantee ID Number:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**1. How long have you been a client of the program?** \_\_\_\_\_

**2. Is this your first time in a substance abuse treatment program?**  Yes  No

If no, how many times have you been in treatment? \_\_\_\_\_

**3. What is your gender?**  Male  Female  Transgender

**4. What is your age?** \_\_\_\_\_ years old

**5. Are you Hispanic or Latino?**  Yes  No

**6. 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.**

- |                  |                              |                             |
|------------------|------------------------------|-----------------------------|
| Central American | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cuban            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dominican        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mexican          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Puerto Rican     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| South American   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

(If Yes in "Other", please specify) \_\_\_\_\_

**7. What is your race? Please answer yes or no for each of the following. You may check all that apply.**

- |                           |                              |  |
|---------------------------|------------------------------|--|
| Alaska Native             | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |
| American Indian           | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |
| Asian                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |
| Black or African American | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Native Hawaiian           | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |
| Other Pacific Islander    | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |
| White                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |
| Other                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |

(If Yes in "Other", please specify) \_\_\_\_\_

**8. Education (Highest Completed):**

- |   |  |
|---|--|
| <input type="checkbox"/> Some High School                   | <input checked="" type="checkbox"/> Associate's Degree |
| <input type="checkbox"/> High School Diploma/GED            | <input type="checkbox"/> Bachelor's Degree             |
| <input type="checkbox"/> Some vocational/technical training | <input type="checkbox"/> Other (please specify) _____  |
| <input type="checkbox"/> Vocational technical diploma       |  |

**Satisfaction with TCE-HIV Program Services**

*Please indicate how much you agree or disagree with each statement below. Please select the one that best describes how you feel about each statement.*

	Disagree	Somewhat Agree	Agree	Strongly Agree	Does Not Apply
1. When I needed services right away, I was able to see someone as soon as I wanted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The people I went to for services spent enough time with me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I helped to develop my service/treatment goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The people I went to for services were sensitive to my cultural background (race, religion, language, sexual orientation, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I was given information about different services that were available to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I was given enough information to effectively handle my problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**THANK YOU!**

**Notice to Respondents**

Public reporting time for this collection is estimated to average 60 minutes, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA OMB Officer, 1 Choke Cherry Road Room 7-1044, Rockville, MD 20850. 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 OMB control number for this project is XXXX-XXXX.