Recovery Management Check-ups: An Early Re-Intervention Model

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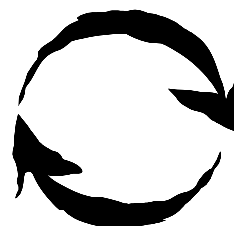

Tracking
Assessment
Linkage
Engagement
Retention

Recovery Management Check-ups: An Early Re-Intervention Approach

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Acknowledgment, Disclaimer and Contact Information

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The opinions are those of the authors and do not reflect official positions of the government. This is a *draft procedural manual* for use in the Early Re-Intervention Experiment-2 (ERI-2) and not intended for use by others. Assuming it is shown to be effective in the experiment, we will update this manual for public dissemination.

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1. Introduction and Background

1.1 The Cyclical Nature of Addiction

Most people who use addictive substances are able to manage their use or choose later to abstain without the aid of either professionally-directed treatment or self-help groups (Burman, 1997; Cunningham, 1999, 2000; Granfield and Cloud, 1996; Hughes, 1996; Humphreys et al., 1995; Kandel & Raveis, 1989; Sobell et al., 2000; Toneatto et al., 1999). However, results from studies conducted over the past 50 years have demonstrated that a subset of substance users suffers from a chronic condition characterized by a range of related problems (Drummond, 1990, 1992; Edwards & Gross, 1976; Jellinek, 1960; Leshner, 1997; Leukefeld & Leukefeld, 1999; McLellan et al., 2000; Muthen, Grant, & Hasin, 1993; Tims, Leukefeld & Platt, 2001).

Both the American Psychiatric Association (APA, 1994, 2000) and the World Health Organization (WHO, 1999) label this condition "substance dependence" and define it as manifesting at least three of the following seven symptoms: increased tolerance, withdrawal, loss of control, inability to cut down or stop, pre-occupation in terms of time spent using a substance or giving up other activities, and continued use despite persistent medical or psychological problems that are probably caused by substance abuse. Approximately 7.1 million people in the U.S. (3.2% of the population over age 12) met this definition of dependence in the year 2000, with only 1 in 5 receiving any type of treatment and about 1 in 10 ending up in publicly-funded substance abuse treatment (Epstein, 2002; OAS, 2000).

Longitudinal studies have repeatedly demonstrated that substance abuse treatment (particularly for 90 or more days) is associated with major reductions in substance use, health/mental health problems, and costs to society (e.g., French, et al., 2000, 2002, in press; Hser, et al, 2001; Hubbard et al., 1989; Salomé, et al., this issue; Sells, 1974; Simpson, et al, 1997; 1999). However, relapse after discharge from treatment and eventual re-admission are also common (Godley, Godley, Dennis, Funk, & Passetti, 2002; Lash, Petersen, O'Connor, & Lehmann, 2001; McKay, Alterman, Cacciola, Rutherford, O'Brien, & Koppenhaver, 1997; McKay, McLellan, Alterman, Cacciola, Rutherford, O'Brien, 1998). For a subgroup of addicts, the risk of relapse does not appear to abate until 4 to 5 years after the initiation of abstinence (Vaillant, 1996; Nathan and Skinstad, 1987; De Soto, et al., 1989; Dawson, 1996; and Jin, et al., 1998).

In looking at the cross section of people admitted to the U.S. public treatment system in 1999, 60% have previously been in treatment (including 23% 1 time, 13% 2 times, 7% 3 times, 4% 4 times, and 13% 5 or more times) (OAS, 2000). Ideally (according to ASAM, 2002), residential and intensive outpatient care should be followed by a step-down to a less intensive level of care, with participants continuing in aftercare following discharge from formal treatment. However, only about 1 in 5 individuals actually participate in aftercare or continuing care following discharge (see Godley et al., 2002 and McKay, 2001 for reviews).

1.1.1 Addiction as a Chronic Condition

Within 12 months after a given treatment episode, 25-35% of the participants return to treatment on their own – with the rates growing closer to 50% after 2 to 5 years

(Hubbard et al., 1989; Peterson et al., 1994; Simpson & Savage, 1980; Simpson et al., 2002). Retrospective and prospective treatment studies report that most participants undergo 3 to 4 episodes of care before reaching a stable state of abstinence (Anglin, Hser, & Grella, 1997; Grella & Joshi, 1999; Hser, Anglin, Grella, Longshore, & Prendergast, 1997; Hser, Grella, Chou, & Anglin, 1998). In a recent survival analysis for an intake cohort (n=1326) from Chicago, the results indicated that the median time was 27 years from first use to at least one year of abstinence in the community. The median time from first treatment entry to a year of abstinence in the community was 8 years, with 3 to 4 intervening episodes of treatment (Dennis, Scott, & Hristova, 2002).

1.1.2 Linkage to Treatment and Relapse

Observational studies that have examined treatment effects across episodes of care have found that participants who relapse can increase the likelihood of positive long-term outcomes through an earlier return to treatment and a greater number of subsequent treatment episodes, particularly episodes over 90 days total (Dennis, 2001; Scott, Foss, & Dennis, this issue; Simpson et al., 1979, 1980,1982a&b, 1990, 1996, 2002). Despite the evidence regarding chronicity and multiple episodes of care, most substance abuse treatment continues to be characterized as relatively self-encapsulated, with serial episodes of acute treatment. The episodes of treatment are followed by a post discharge aftercare that is typically limited to passive referrals to self-help groups (Dennis, Perl, Huebner, & McLellan, 2000; Godley, Godley, et al. 2002; McLellan, et al., 2000; White, 1998; Etheridge et al., 1997). This finding regarding treatment aftercare may be attributable to aspects of service reimbursement.

At least in the State of Illinois, contracts to publicly funded provider organizations generally support services delivered during the course of formal treatment. Although "front-end" services such as assessment and some outreach are reimbursable, continuing care services following discharge are not. For this reason, treatment providers may recognize the importance of maintaining contact with participants following discharge, but they may not be able to allocate resources to a service for which they cannot be reimbursed. The limited public resources which are available to support a high demand for substance abuse services provide a likely rationale for treatment providers to focus the majority of available funding support on what occurs during formal treatment. However, given the commonly accepted belief that substance abuse addiction is a chronic disease characterized by relapse and multiple treatment admissions, it seems contradictory that such limited focus is placed on participant supports following treatment discharge. Participant supports that are designed to prevent relapse and facilitate reentry to treatment when relapse occurs would seem to warrant more significant attention.

1.2 Goals of a Recovery Management Model

Concern about these issues has led to several calls for new treatment approaches modeled after the management of other chronic disorders--such as cancer, type 2 diabetes mellitus, hypertension, and asthma--which have similar kinds of relapse rates, readmission rates, and co-occurring problems that complicate treatment (e.g., Anglin, et al., 1997; Davidson and Straus, 1995; Dennis, Perl, et al., 2000; Else, 1999; Godley, Godley, Dennis, & Funk, 2002; Leukefeld & Leukefeld, 1999; Lamb et al., 1998; Leshner, 1997; Leukefeld, Tims & Platt, 2001; O'Brien and McLellan, 1996**;** McLellan,

Lewis, O'Brien, & Kleber, 2000; White, Boyle & Loveland, in press). Over the past several years, the field of substance abuse treatment has increasingly used step-down or continuing care approaches. Nonetheless, few if any models focus on post-discharge monitoring, re-intervention, and recovery management similar to what is used in managing chronic health disorders.

While relatively new in behavioral health, models of on-going monitoring and early re-intervention occupy a central role in the long-term management of other chronic medical conditions (Dunbar-Jacob et al, 1995; Engel, 1977; 1980; Nicassio, P. M. and Smith, 1995; Roter, et al., 1998). Some of the common goals of these models include: a) proactively tracking patients and providing regular "checkups", b) screening patients for early evidence of problems, c) motivating people to maintain or make changes – including the return to more aggressive treatment when necessary, d) negotiating access to additional formal care and potential barriers to it, and e) emphasizing early formal re-intervention when problems do arise. The core assumption of these approaches is that earlier detection and re-intervention will improve long-term outcomes.

1.2.1 Components of Recovery Management Checkups

The model described in this manual involves a process of recovery management checkups following discharge from substance abuse treatment that proceed according to the following sequential components: **T**racking, **A**ssessment, **L**inkage, **E**ngagement, and **R**etention. Borrowing medical terminology, "checkups" are used to describe the intervention contacts with discharged participants to be consistent with the types of recovery supports provided to individuals with other types of chronic diseases. The

components of the **TALER** Recovery Management Model described in this manual are summarized below.

T*racking*. The protocol described in this manual includes a proactive set of procedures that have proven effective in initiating and maintaining contact with highly mobile participants following their discharge from treatment. These procedures combine telephone contacts, mailings and fieldwork.

A*ssessment.* The post-treatment functioning of participating participants is assessed through quarterly checkups provided over the course of four years following discharge. These checkups focus on determining whether or not participants have re-engaged in substance use. The goal of this component is to "identify" who needs treatment.

L*inkage*. In the case of participants who have relapsed, the model includes procedures that are designed to link individuals back to treatment. The goal of this model component is to link participants back to treatment as quickly as possible in order to minimize the impacts of relapse.

E*ngagement*. The model includes strategies designed to accelerate the intake process, increase motivation, and overcome some of the negative aspects of the admission process and increase the likelihood that participants actually show to treatment after their assessment. The goal of this component is to get people who have completed the admission process to actually "show" to treatment.

R*etention*. Once participants show to treatment, we maintain contact with them and follow-up to make sure that they maintain their motivation to participate and provide

assistance to overcome organizational or environmental barriers to retention. The goal of this component is to get people to stay in treatment for at least 14 sessions of outpatient or 14 days of residential treatment.

1.2.2 Barriers to Recovery Management Checkups

The development of the recovery management model for chronic substance users described in this manual needed to include strategies designed to address several behavioral patterns frequently observed in this population. For example, substance use is often associated with a clandestine, chaotic and transient lifestyle that proves difficult for tracking (Brown et al, 1989; Bale et al, 1984; Goldstein et al, 1977, MacKenzie et al, 1987; Scott, 2003). Following discharge from treatment, many participants return to environments that are not supportive of continued recovery and that contain certain cultural aspects, which negatively influence their motivation to reenter treatment. Additionally, previous influences that led individuals to seek treatment may no longer inspire the same "urgency" at the time when checkups are conducted, thereby resulting in a possible negative motivation to reenter treatment. Components of the **TALER** recovery management model described in this manual are designed, in part, to address these and other potential barriers.

1.3 Some Key Definitions

Below are some key definitions of terms used throughout this manual.

- **TALER Recovery Management Model**: The name of the model described in this manual. The model involves 1) monitoring the status of participating participants following discharge from treatment through quarterly checkups, 2) reviewing the

information obtained during these checkups to assess need for treatment re-entry, 3) obtaining a commitment from the participant (when indicated) to reenter treatment, 4) providing participants who have relapsed with linkage assistance for reentry into treatment, and 5) facilitating retention in treatment.

- **Global Appraisal of Individual Needs (GAIN)** (Dennis et al., 1996): The name of the assessment battery used at intake and at each of the quarterly recovery management checkups, where a shorter version is used.
- **Interviewer:** A paraprofessional who has been trained to assess the participant's status using standardized procedures and the GAIN.
- **Linkage Manager:** A paraprofessional who has been trained and certified to use motivational interviewing the GAIN and trained to implement the linkage component of the TALER model.
- **Outcome Monitoring:** The process of contacting participants on a regularly scheduled basis to determine how they are doing.
- **Relapse:** When someone is showing one or more signs of having returned to substance use that can be categorized as recent (e.g., past week), frequent (e.g., up to weekly or more use), severe (e.g., point of intoxication) or acute (e.g., symptoms such as convulsions, seizures, or multiple symptoms of withdrawal).

1.4 Content of Manual Sections

The following section of this manual provides the procedures that will be followed in the recruitment of participants for participation in the proposed study and their randomized assignment to the treatment and control cohorts. The next five sections

describe procedures specific to the **T**racking, **A**ssessment, **L**inkage, **E**ngagement, and **R**etention components of the proposed recovery management model. The remaining manual sections provide a model fidelity quality assessment protocol and a discussion of motivational interviewing and communication techniques that are basic to the context of the model's recovery management checkups. Report forms and other support materials including "adherence" protocols are provided in the appendices to this manual.

2.0 Recruitment and Enrollment

2.1 Recruitment and Determination of Study Eligibility

Participants will be recruited for participation in this study directly from sequential admissions at the treatment provider agency. Participation will be voluntary. To be included, the individual must: a) be18 years of age or older, b) present with one or more substance use diagnoses of lifetime dependence documented through application of DSM-IV criteria, and c) provide written informed consent to participate. Due to resource constraints, participants will be excluded if they plan to move out of state following discharge from treatment, or if they are assessed as too cognitively impaired to appropriately participate in the study.

When a potential participant arrives at the treatment program for an initial assessment, program staff will complete an ERI Eligibility Form (see Appendix A). A Research Assistant (RA) will score the completed form and determine whether or not the person is eligible to participate in the study. Once the determination has been made, the RA will notify the treatment staff of the person's eligibility status. Treatment program staff, however, will not be responsible for introducing the study to participants. Rather, it will be the research staff who introduce participants to the study.

2.2 Transfer of Eligible Participants to Research Staff

Following completion of the initial assessment, individuals who are referred to treatment and who are determined eligible for the study will be physically escorted by a treatment program staff member to meet with a research assistant. When such a transfer takes place, both program and research staff shall complete a Transfer Log (see Appendix

B). On this log, program staff record the date and time of the transfer, the participant's name, and the location where the RA should physically return the participant upon completion of the research pre-treatment interview. These procedures ensure accountability regarding the participant's whereabouts at all times and minimize the likelihood of failed transfers.

2.3 Completion of Pre-Treatment Assessment Package

When the transfer process has been negotiated, the RA shall introduce himself/herself to the participant, verify the person's eligibility status, provide an overview of the study, and provide a comprehensive review of the Informed Consent. Individuals who refuse to participate will be thanked for their time and escorted to the drop location specified on the Transfer Log. Treatment staff will sign the Transfer Log indicating that the participant was returned to the appropriate place, thus completing the transfer cycle.

In the case of eligible participants who sign the Informed Consent, the RA shall complete the Pre-Treatment Assessment which includes: the Global Assessment of Individual Needs-Initial ERI Version (GAIN-I-ERI), Consent for Disclosure, Request to Locate, Contact Labels, Locator Form, and the Mental Health Release. For quality assurance purposes, all interviews will be audiotaped and reviewed randomly.

Upon completion of the pre-treatment interview, the RA will schedule the date and time for the first quarterly check-up, inform the participant about the location of the appointment, and provide a schedule card. At this point, the RA will check the Transfer

Log to determine the location where the participant should be returned and complete the transfer cycle.

The RA will be responsible for scheduling the pre-treatment interviews of any eligible participants who for any reason are unable to be interviewed on the same day that they complete the program's initial treatment assessment. However, the assessment *must* be completed within 7 days of being referred to treatment or the participant is no longer eligible and therefore lost to recruitment.

Procedures Summary

- Program staff completes ERI Eligibility Form
- RA determines eligibility and notifies program staff
- Program staff transfers eligible participants to RA
- RA completes informed consent procedures
- RA transfers participation refusals to program staff
- RA completes baseline assessment components with eligible participants

3.0 Randomization

When recruitment is completed and 2 weeks before the 3-month assessments begin, the Senior Research Analyst will use a list of participant IDs and random numbers generated by Microsoft Excel ™ to randomly assign each participant to either the control group or the RMC group. In order to improve the likelihood of randomization producing two equivalent groups on a wide range of clinical characteristics, the list of participants will be sorted by a total symptom count across scales related to substance use, internal and external disorders, divided into blocks of 6, and then random assignment will be done within block at a rate of 50% to each condition. After assignment, we will check for significant differences between the two groups on demographic, family, social, environmental, substance, health, mental health, and HIV risk variables. If there are differences, we will test whether controlling for the variable in question impacts findings. We will also check for intervention crossover or demand characteristics by audio taping all interviews and sessions. The PI will conduct quality assurance on these procedures.

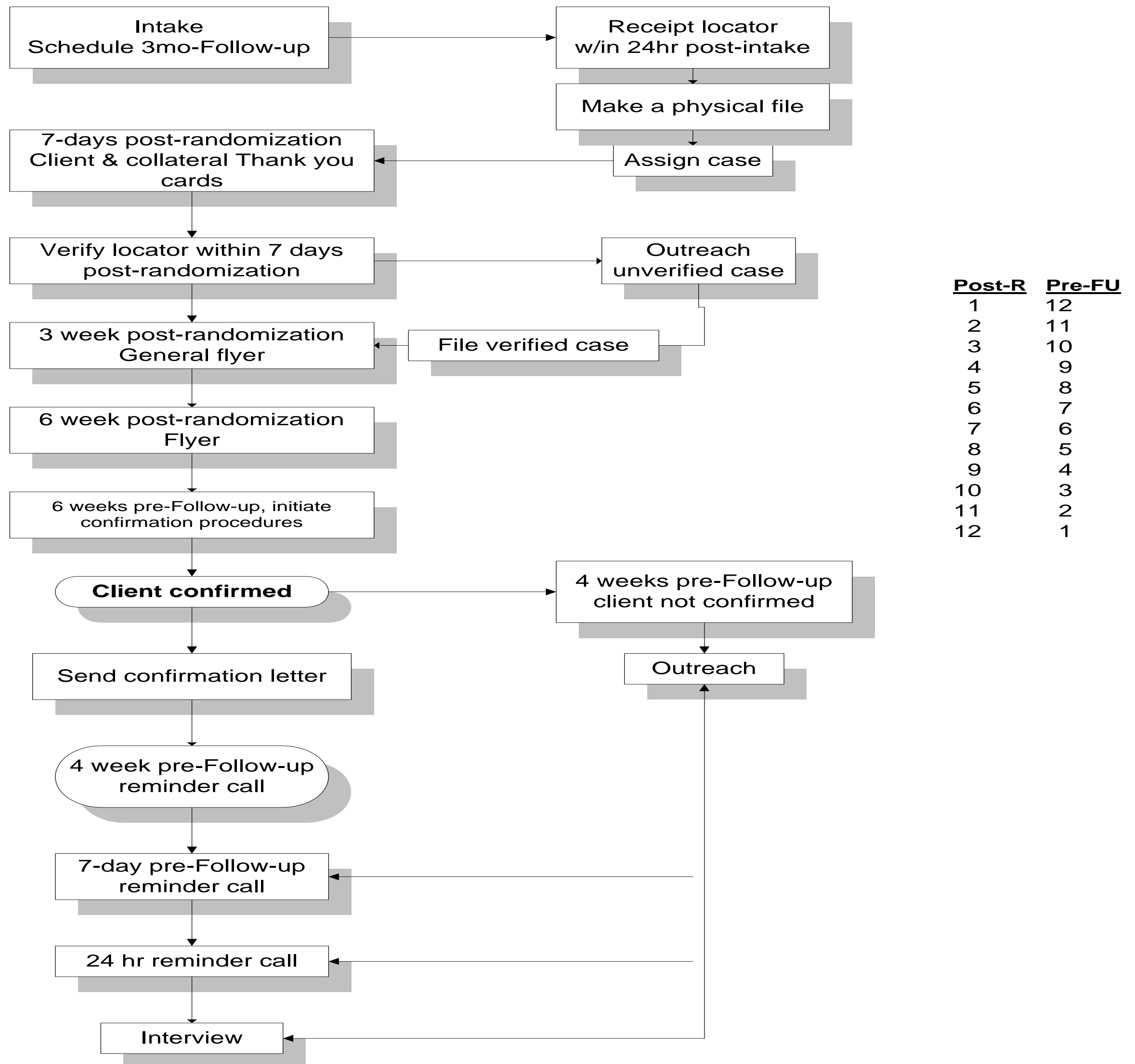
4.0 Tracking

Implementation of Recovery Management Tracking Protocol

The tracking protocol described in this manual is an adaptation of Scott's EVMC Protocol (Scott, under review) and consists of a standardized pro-active set of procedures used to manage the quarterly recovery management checkups in the proposed experiment. Tracking procedures are designed to: (a) maintain contact with participants regardless of high rates of mobility, (b) quickly detect when locating information is no longer accurate, and (c) allow adequate time to relocate participants prior to the quarterly checkups. The protocol outlines a specific set of rules and timelines that combine telephone contacts, mailings, and fieldwork. Implementation of the protocol begins with the baseline assessment and ends with the last quarterly checkup. The time frames for task completion were tested in the original experiment as well as other studies and all implementations produced high follow-up rates. The protocol will be implemented in four phases: (1) **E**ngagement, (2) **V**erification, (3) **M**aintenance, and (4) **C**onfirmation.

4.1 Engagement Phase

The tracking protocol for quarterly recovery management checkups is illustrated in Figure 1. The goals for this phase involve educating and engaging the participant in the quarterly checkup component of the experiment and collecting appropriate consents and comprehensive locator data. Participants need to clearly understand the extent of their involvement and/or rewards for participating. Otherwise, the participants are often difficult to locate, unresponsive to calls, and uncooperative, refusing to participate as planned.



Post-R	Pre-FU
1	12
2	11
3	10
4	9
5	8
6	7
7	6
8	5
9	4
10	3
11	2
12	1

Figure 1

Upon completion of each checkup, the participant will receive a laminated schedule card from the interviewing Research Assistant. The schedule card includes the

date, time, and location of the next interview, a toll free number the participant can use to update locator information or check-in, and the amount of money the person will receive upon completion of the next interview. This is a good time to give the participant a key chain or pen with the study's name on it so that the participant can begin making a space in his/her life for the study. These tangible items serve as reminders or "space savers."

Next, the RA separates the assessment related information from the documents needed for follow-up and makes a separate file for each. Whenever possible, "the case" is then assigned to a specific staff person who becomes responsible for tracking this participant through the end of the study. This method provides continuity for the participant as well as the research team.

The last step in this phase requires that the assigned staff person send a thank you card to each participant within 7 days following completion of the checkup. The thank you card is printed in house to control costs and mailed to participants. This task serves two purposes-- first, it expresses the team's gratitude to the participant for agreeing to participate, and second, it becomes the first indicator that the mailing address on the locator form may be incorrect and that appropriate action should be taken.

Procedures Summary

- Educate participants regarding the project
- Provide participants with schedule cards
- Make staff tracking assignments
- Update locator information
- Send participants thank you cards

4.2 Verification Phase

Within the 7-day time frame of each recovery management checkup, research staff will verify current information on the locator. This protocol requires that information (name, address and phone) for no less than 3 collaterals or contacts will be verified. Techniques used to verify locators include telephone directories, phone discs, directory assistance (phone), Internet links, and telephone contacts with collaterals. Other variables to be considered when verifying locator information include: (a) stability of the collateral (length of time at current address), (b) frequency and recency of communication between participant and collateral, and (c) the collateral's status as a member of the participant's using or recovery network. In the event staff is unable to verify the locator information, it is critical to immediately contact the participant either by phone or in a face-to-face visit to review the information and ask for additional information. It is helpful in these situations for staff to take responsibility for the problem by simply explaining that they may have recorded the information incorrectly. *The longer the time period between collecting the locator information and its use, the greater the difficulty and costs in locating participants.* Even when the case has been transferred to the field for outreach, assigned staff will continue to work the case via phone and mail.

Procedures Summary

- Verify locator information within 7 days of checkup interview
- Conduct contacts with participants and collaterals as needed
- Transfer cases to outreach when indicated

4.3 Maintenance Phase

The recovery management checkup interval in this study is quarterly. This interval drives the timing for a series of mailings and phone contacts. These contacts provide periodic reminders about the next checkup, keep the participant engaged, and identify locating information that has become obsolete. Locating information that is determined to be obsolete triggers additional locating steps within a time frame that allows the team time to relocate the participant as scheduled. The time interval between the baseline assessment and the first checkup is 3 months. For this reason, the protocol requires that a flyer be sent at intervals of 4 weeks and 8 weeks of the baseline assessment. These flyers are typically of a general nature and may or may not contain material of specific interest to an individual participant. The mailings are sent as bulk mail, require little labor, and, if returned, signal the research team that an address is inaccurate with enough time available to relocate the participant.

Procedures Summary

- Make contacts between checkups to determine validity of locator information
- Initiate relocation strategies when indicated

4.4 Confirmation Phase

The Confirmation Phase of the tracking protocol begins six weeks prior to each quarterly checkup. Before a case can be transferred to “confirmed” status, a research staff person must speak directly with the participant to confirm the date, time, and location of the recovery management checkup. A case is NOT confirmed if a message is left on an answering machine, left with a significant other, or with a collateral. It is essential that a staff member speak directly to the participant.

During the Confirmation Phase, staff are required to complete some type of contact activity (phone call, mailing, internet search, outreach) every 48 hours on each unconfirmed case. Beginning this process 6 weeks before the participant is due for a checkup, allows staff adequate time to leave messages for the participant to contact the office to confirm the appointment. Although the majority of participants in previous studies have had no phones, messages left with collaterals during the confirmation phase generally produced confirmation rates ranging from 70% to 95%.

This 6-week advance timeline also provides adequate opportunity to conduct field searches when necessary. In cases where the locating information fails to produce a successful confirmation 3 weeks prior to the quarterly checkup date, the case is reviewed by the Field Supervisor and then transferred to the field for street outreach. Research staff continue to work the case using phones and mailings even after the case is transferred to the field. During the field search, the outreach worker will door knock and leave flyers at the addresses listed on the locator. When the participant is finally located, staff mail a confirmation letter giving the date, time, and location of the checkup interview and indicating that the research team is looking forward to seeing him/her.

During the last portion of this tracking phase, staff place a series of reminder calls – 28 days, 7 days and 24 hours before the interview date. These calls serve two purposes: first, to remind the participant about the appointment and second, to once again alert staff to situations where participants may have moved. At this point, if a telephone has been disconnected or a collateral informs the RA that the participant is no longer residing at the address, then the case is transferred immediately to the field.

Procedures Summary

- Conduct confirmation contacts within 6 weeks of scheduled checkups
- Conduct field outreach contact strategies when needed
- Place regularly scheduled reminder calls before checkup interview date

4.5 Tracking Protocol Compliance Monitoring

A comprehensive MIS will be used to monitor compliance with the previously described protocol. This process provides staff and supervisors with the information needed to manage the Tracking component of the model and helps staff work cases effectively and efficiently. The information contained in the tracking system mirrors the requirements of the protocol and has been used on previous studies. The tracking system is designed to track the dates when required protocol activities are completed. Compliance monitoring information is also useful in helping determine the costs of the intervention. Staff electronically document all tracking related events that they attempt or complete. This tracking includes a variety of activities ranging from faxing a release of information to an agency (so that staff can disclose whether or not the participant is housed there), to making a telephone call but the line is busy, to conducting field searches.

The compliance monitoring MIS will include places to record the precise dates when the baseline interview was completed, the thank you card was mailed, the locator was verified, the interim flyers were mailed, the case was confirmed, the case was transferred to outreach, the confirmation letter was mailed, and the reminder calls were completed. Information included in this database serves a number of purposes. First, a number of daily or weekly reports are produced that inform staff about what protocol

tasks need to be completed for which cases. At the beginning of each week, the Data Manager runs data reports that provide staff with the names of participants in each phase of the protocol. For example, a "confirmation" report includes the names of all participants currently in the confirmation window and their status (confirmed, not confirmed), a verification report lists the names of participants whose locating information has not yet been verified, an engagement report lists the names of participants for whom a 7-day thank you card should be mailed and so forth. In addition to generating "to do" lists for the research assistants, the database can be used by supervisors to provide reports with lists of cases that have not been worked or should be transferred to a different step of the protocol.

4.5.1 Standardized Case Tracking Procedures

The purpose of this protocol is to provide a standardized pro-active set of procedures for managing the Tracking component. Research staff will rely on a standardized set of case tracking procedures and work individual cases when participants have become lost. The procedures are modeled after a detailed list of tasks for managing at the case level provided in the manual *Staying in Touch: A Fieldwork Manual for Tracking Procedures for Locating Substance Abusers for Follow-up Studies* (UCLA). The Case Tracking Checklist includes suggestions like checking with social services for public aid recipients, and checking information available from correctional systems, local jails, parole and probation, and the Social Security Administration. This list can easily serve as a reminder of the types of strategies that should be implemented when working a case and can be helpful to supervisors when reviewing cases for thoroughness. It is

important to note however, that when a task has been completed it should not be removed from the checklist but should continue to be included until the participant is located.

4.5.2 Case Review Meetings

Case review meetings will be conducted during the Tracking component of the model. These meetings are similar to clinical review meetings. During a Tracking case review meeting, research staff and supervisors review each case that is in the Verification Phase but is not verified, in the Confirmation Phase but not confirmed, and in a checkup interview but the participant did not show up. The activities completed in each case during the prior week and the outcomes of these activities will be reviewed. Members of the team will also identify activities they plan to complete during the next week. The Field Supervisor will document all next steps identified on a log and review them the following week. Supervisors will also use this log to check with staff on a weekly basis regarding their progress. The case review meeting process is a valuable mechanism for holding individual staff members accountable, but the meetings also provide an opportunity for staff to work cases from a team perspective. The team approach is generally more creative and productive for case management than oversight provided by a single person, and it prevents difficult- to- find cases from being neglected. Information discussed during the case review meetings, when combined with other information obtained through the tracking process, helps achieve the shared perception that multiple staff can work the same case without duplication.

5.0 Assessment and Screening

Overview of Assessment Component

A total of 16 quarterly checkups will be conducted with participants in each of the two conditions during the first four years of the project. Checkups will be conducted on-site at the research office unless circumstances prohibit the participant from making the trip (e.g., incarcerated, in residential treatment, hospitalized). In these cases, interviews will either be conducted off-site in an approved location or over the telephone. Before an interview can be scheduled off-site, the Field Supervisor must give approval for this arrangement. During the 12, 24, 36, and 48-month interviews, the Research Assistants will also collect urine and saliva samples from participants. The Linkage Managers will not conduct interviews with participants in either condition. Before the participant arrives for the checkup, the RA will determine the condition to which the participant was assigned. If the participant is assigned to the ERI condition, the RA will flag the pages of the assessment that will be used to complete the required documentation described below.

5.1 Determination of Eligibility and Assessment of Need for Services

For individuals in each of the two conditions, the checkup will begin with a brief screener (Early Re-Intervention-Linkage Assistance Worksheet; ERI-LAW) (see Appendix C) to determine whether participants meet participation eligibility criteria (reside in the City, not currently in treatment, and not housed in a confined environment) and whether they are assessed to *need* early re-intervention services. The Research Assistant will begin by asking the participant the questions included in Sections A through C on the ERI-LAW. To complete Section A, the RA will record the participant

study identification number and initials, the RA staff identification number and initials, and the date of the current checkup.

Section A. Identifying Information

Participant's ID [XPID]: __________	Participant's Initial: __________________
RA Staff ID [XSIDR]: ____________	LM Staff ID [XSIDL]: _______________
RA Staff Initials: _________________	LM Staff Initials: ____________________
Interview Date: ____ / ____ / ____	LM Meeting Date: _____ / ____ / ____

Section A; ERI-LAW

Questions in Section B on the ERI-LAW pertain to participants' current involvement in substance abuse treatment and the nature of their current living arrangements (controlled environment vs. other). Certain circumstances create an environment in which linkage assistance is either impractical or unnecessary. For example, participants who reside in controlled environments such as prisons, house arrest, and psychiatric hospitals do not qualify for linkage assistance since their restricted movements prohibit them from accessing treatment. Second, participants who are enrolled in substance abuse treatment including residential or outpatient substance abuse services at the time of the quarterly checkup obviously will not be in need of further linkage assistance. Third, participants who do not currently reside in the study geographic area (e.g., Chicago area) prevent staff from providing linkage assistance and are therefore ineligible. For these participants, the RA will complete the checkup, schedule the next check-up appointment, reimburse them, thank them for their time, and end the session.

Section B. Current Linkage Assistance Eligibility
(As the questions in regular type below prior to the or fill them in based on the GM90 information referenced in the first two columns. Put a "Check" in either the Yes or No box.)

P.	Item	B1. Currently Eligibility	Yes	No
14	S7f,1m	Are you currently going to outpatient, intensive outpatient, inpatient or residential substance abuse treatment? *(do not count self help groups, sanctuary, recovery homes, half way houses or detoxification facility use here)*		
42	E1d1-2m	Are you currently living outside of the City of Chicago		
54	L6e,1m	Are you currently in jail, prison, hospital, or any other place where you can **not** use alcohol or drugs		

Section B; ERI-LAW

For persons who are eligible to participate in the study, the next task is to determine whether or not they need early re-intervention services. In order to make this determination, the Research Assistant will complete Section C of the ERI-LAW. The assessment of need for Linkage will be based on level of substance use, withdrawal symptoms, prevalence and severity of problems related to use, and the individual's opinion about his/her need for more treatment.

Section C. Current Need for Linkage Assistance to Substance Abuse Treatment

(As the questions in regular type below prior to the interview or fill them in based on the GM90 information referenced in the first two columns. Put a "Check" in either the Yes or No box.)

Pg	Item	C1. Current Need for Linkage Assistance	Yes	No
10	S2s1 (13+)	During the past 90 days, have you used alcohol, marijuana, cocaine, or other drugs on 13 or more days?		
10	S2s2 (1+)	During the past 90 days, have you gotten drunk or been high for most of 1 or more days?		
10	S2s3 (1+)	During the past 90 days, have has your alcohol or drug use caused you not to meet your responsibilities at work, school or home on one or more days?		
12	S3c1-99 (1+)	During the past week, have you had any withdrawal symptoms when you tried to stop, cut down, or control your alcohol or drug use?		
23	S8g3 (4+)	Do you feel that you need to go back to treatment? *(check no if satisfied in self help, recovery home, sanctuary or recovery home)*		
24	S9c-u (3)	During the past month, has your substance use caused you any problems?		

Positive biomarker for cocaine, opioids, or marijuana.

(If any "yes", transfer the rest of the information from the GM90 to this worksheet and then transfer the participant to the LM to ***Continue.*** If all "no", **STOP**, the person is currently stable and does not need ERI assistance.)

Section C; ERI-LAW

For individuals who deny *any* substance use during the past 30 days, the RA will conduct an on-site urine test. When discrepancies occur between self-report and the urine test, the RA will inform the participant of the results and assure the participant that there are no consequences for reporting use. They should review the anchor point (last 30 days), time frame, and the occurrence of any critical events. If the participant recalls use, the RA should make the appropriate corrections on the screener and continue with the interview. Before proceeding with the checkup, the RA should also notify the Linkage Manager about the eligible participant and estimate the approximate time the assessment will be completed.

5.2 Completion of the Assessment Package

During each quarterly checkup, the RAs will administer the same assessment battery with participants. The package begins with the Global Assessment of Individual Needs (GAIN-M90), which focuses on alcohol and/or drug use during the prior 90 days. The RA and participant will also update the Locator. The interview requires approximately 30-40 minutes to complete.

Upon completion of the assessment, the RA will transfer additional information about substance use and related problems from the M-90 to the ERI-LAW (Sections D.1 and D.2) and give it to the Linkage Manager. The Linkage Manager will use the information on the ERI-LAW to provide feedback to the participant regarding substance use and problems resulting from the use, and to document existing barriers to treatment related to internal and external motivation. The RA should NOT reimburse the participant for the quarterly checkup as the LM will do that at the end of the linkage meeting.

For participants who do NOT need ERI, the RA will schedule the next checkup, reimburse the participants, and escort them out of the building. Ineligible ERI participants do NOT meet with the Linkage Manager unless they meet the previously described criteria. In the case of control group participants, the RA completes the assessment packet and then schedules the next checkup, reimburses the participant, and escorts him/her out of the building. Procedures for dealing with participants in the ERI condition are discussed in the next section.

5.3 Transfer to Linkage Manager for Early Re-Intervention

In the case of participants who meet the criteria for Early Re-Intervention, the Research Assistant transfers them to the Linkage Manager along with the assessment materials. The RA uses something similar to the following script in making this transfer.

> *As part of this project, we are able to provide limited services to help folks re-enter treatment. Based on the information you provided during the interview, it looks like you might qualify for these services, so I would like to introduce you to Mr. Snead, the Linkage Manager, who will explain more about these services.*

Once introductions have been completed, the RA and LM shall complete a Transfer Log documenting the date and time of the transfer.

If the participant declines the opportunity to meet with the Linkage Manager, the RA shall initiate the Pyramid Conversion Protocol by first explaining that s/he needs to inform the Field Supervisor of the participant's wishes. The Field Supervisor should ask the participant if s/he would take 2 to 3 minutes to briefly meet. If the participant agrees, the Field Supervisor will meet briefly with the participant to highlight the advantages of meeting with the Linkage Manager, reiterate the goals of the meeting, remind the participant s/he is under no pressure to return to treatment, and offer the opportunity for the participant to meet with a different Linkage Manager than previously. If the participant declines, the Field Supervisor and RA will thank the participant and express appreciation to the participant for his/her willingness to be in the study.

Procedures Summary

- RA checks on participant’s condition (ERI vs. OM)
- RA flags M-90
- RA administers the M-90 to participant
- RA updates Future Contact Form
- RA schedules next quarterly check-up
- RA reimburses OM participants
- RA escorts OM participants from the building
- RA transfers ERI-eligible participants to LM

6.0 Linkage

6.1 Linkage Meeting Format

The linkage meeting begins with the Linkage Manager engaging in brief casual conversation with the participant as a way to get (re)acquainted. Conversation topics could include parking, the weather, traffic, sports, recent holidays, etc. This conversation should be kept brief, however, in the interest of conserving time for other more important topics that need to be covered during the meeting.

The Linkage Manager next explains that the overriding goal of ERI services is to link participants back to substance abuse treatment before they experience a major relapse and suffer the accompanying negative consequences. The Linkage Manager may want to develop a script such as the following:

> *You may or may not recall from our first interview at Haymarket that under certain circumstances, we are able to provide some help in linking individuals who may be experiencing some difficulties and need or want to return to treatment.*
>
> *The help that I am able to provide is specific to linking folks back to treatment. I am not able, however, to provide help gaining access to any other type of services such as housing, medical, legal, and so forth.*
>
> *Is that clear? Do you have any questions?*
>
> *I would like to share with you a couple of things I'd like to do during the next 20-25 minutes. I'd like to first review with you some of the information that you provided during the interview you completed a few minutes ago. This will give us a picture of how you're doing right now.*
>
> *After we complete this review, I'd like to get a sense of how you feel about returning to treatment and discuss some of the obstacles that may be either making you not WANT to return to treatment or make it very difficult for you to return.*

Last, if you decide you want to give treatment another try, then we will discuss ways that we can work together to make that happen.

Is that clear? Do you have any questions?

Procedures Summary

- Introduce Linkage Manager to participant
- Transfer participant to Linkage Manager
- Complete Transfer Log
- Provide overview of linkage meeting
- LM discusses the goal of ERI model
- LM addresses participant's questions or concerns
- LM explains that the goal of linkage assistance is a successful linkage to substance abuse treatment
- LM compares and contrasts the scope of linkage assistance with case management services

6.2 Providing Feedback to the Participant

After sufficient rapport exists between the Linkage Manager and the participant, the Linkage Manager provides the participant with personalized feedback report (see Appendix D) based on the information obtained during the assessment and extracted from the M-90 to the ERI-LAW. This information is formatted and organized in a manner that promotes discussion between the participant and the Linkage Manager, with a copy being available for each. The Linkage Manager keeps one and gives the other copy to the participant, so that s/he can follow along during the meeting.

The purpose of the ERI-LAW is to provide the participants with both written and verbal feedback regarding their substance use and related problems. The goals of the meeting are to increase motivation, impact the participant's opinions about his/her substance use and a decision to return to treatment; to discuss existing barriers to treatment and ways to eliminate them; and lastly, to discuss the participant's level of

motivation for treatment. The Linkage Manager will attempt to engage the participant in a verbal review and discussion of the ERI-LAW utilizing Motivational Interviewing Techniques (see Chapter 9 for more detail). The objective is to elicit the person's thoughts, understanding, and feelings about his/her substance use and its consequences. During this process, the LM provides empathic reflection and feedback to the participant.

Unless the participant has difficulty reading, the Linkage Manager asks the participant to read parts of the ERI-LAW out loud while discussing them. They should begin the review with Section D that focuses on the participant's reported substance use and related problem during the prior 90 days. When the LM feels that this section has been discussed adequately, they then move to the next section and discuss the barriers to treatment that the participant may have identified during the assessment. The emphasis needs to be on problem-solving and identifying ways of removing or addressing any identified barriers. The Linkage Manager uses open-ended questions and comments, inviting elaboration by the participant. Here are some examples:

- *"Tell me some more about that."*
- *"What are some of the health problems that you're concerned about?"*
- *"What makes you say that going to treatment could help save your relationship with your girlfriend?"*

Throughout the feedback discussion, the Linkage Manager should continually use motivational interviewing. Here are some examples of comments the Linkage Manager might make, illustrating each of the Motivational Interviewing strategies (see Chapter 9):

Express Empathy *"Seeing on paper how much drugs and alcohol you've been using seems to be sort of shocking to you."*

Develop Discrepancy *"In what way do you think that going back to drug treatment could help you be a better parent?"*

Avoid Argumentation *"You're saying that drugs should be legalized anyway. I'm not going to debate you on that. In the meantime though, while they're still illegal, it sounds like you're really sick of the legal hassles related to your drug use."*

Roll with Resistance *"I really hear that you don't want to go to treatment at this time in your life. My going over your 'Reasons to Consider Returning to Treatment' with you does not mean that I'm thinking- 'You have to go to treatment now'."*

Support Self-Efficacy *"I admire your openness in talking about these issues."* Or- *"You got clean in treatment before. To me, that's a hopeful sign that you could do it again."*

6.3 Determination of Level of Motivation to Return to Treatment

This portion of the meeting begins with a review of Section F of the ERI-LAW. The Linkage Manager asks the participant to read aloud the items that have been checked. Using motivational interviewing techniques, the LM tries to elicit thoughts and feelings from the participants regarding the reasons they listed for returning to treatment. Near the end of this dialogue, the Linkage Manager asks the participant to complete the final item of the ERI-LAW where the participant is asked to choose a number which best indicates his/her level of motivation to go to substance abuse treatment right now. It is anticipated that most participants will be willing to simply choose and circle a number. In those instances where the participant may ask the Linkage Manager to guide his/her response, the LM shall politely decline to do so. The participant must learn to understand that only he/she can determine a personal level of motivation. The Linkage Manager should record the number chosen by the participant on the ERI-LAW and then determine which of the following three MI procedures to use in discussing the participant's choice.

6.3.1 Discussion with the Participant Who Expresses Little Motivation (0 – 2)

In the case of participants who express little motivation (score 0-2) for going to treatment, the Linkage Manager should avoid trying to pressure them into changing their minds. The primary task here is to engage the participant in discussion that allows the Linkage Manager to get a good understanding of how the participant sees his/her substance use and explains his/her decision about returning to treatment. With low-motivation participants, the Linkage Manager needs to rely primarily on the motivational interviewing strategies listed below (examples of each strategy are given in the section above).

- Express Empathy
- Avoid Argumentation
- Roll with Resistance

This approach has proven effective in helping participants work through some of their negative feelings about returning to treatment. When participants hear themselves describe their thoughts and feelings about their drug/alcohol use to a non-judgmental listener, they are more likely to understand their mixed feelings and thereby increase their level of motivation for treatment. The Linkage Manager helps facilitate this process by asking open-ended questions, by making empathic reflections, and by using summary statements. The following is an example that illustrates the intended approach; it contains all three motivational interviewing strategies listed above.

> *So you're saying that you know that doing dope is bringing you down and messing up your relationships with your family, but you are just so tired, and you feel like "what the hell is another round of treatment gonna do for me?" You think it's possible that it's partly the dope itself that's got you feeling this way, but you just don't feel ready to commit to treatment yet. Is that what you're saying?*

As illustrated in this example, the Linkage Manager is careful to frame the

summary in a nonjudgmental way that reflects the participant's own stated thoughts and feelings. The Linkage Manager does not want to come across as lecturing the participant, and he/she conveys this by speaking the following type of phrases:

> *Is that what you're saying?*
> *Do I understand you correctly that . . .?*
> *So you're saying . . ."*
> *What I'm hearing you say is . . ."*

The Linkage Manager can further connect with the participant by quoting the participant's own language. In the example above, such quotes were "so tired" and "what the hell is another round of treatment gonna do for me?" If a Linkage Manager is not comfortable using certain language (e.g., some forms of profanity), he/she should **not** repeat this language; the Linkage Managers must show the same respect for themselves as they show for the participants. After the Linkage Manager has made reflective statements that express an understanding of why the participant does not want to go to treatment at this time, then the Linkage Manager can move on to the next steps. The Linkage Manager proceeds to use the following approach:

- First, ask the participant what would need to happen to raise the participant's level of

  motivation. Phrase the question in the following way:

  > *You chose a __ (# from 0 to 2) for how motivated you are right now to go to treatment. What sort of thing might happen in your life that would make that number higher?*

- Second, wait quietly for the participant's answer. If the participant says something like "if I got arrested", then ask for more elaboration by saying something similar to:

What is it about getting arrested that would make you feel more motivated to go to treatment?

- Third, listen to the participant's answer and provide empathic reflection. Ask the participant if there are other things that might make the number higher, and repeat the sequence of responses above. If the participant's initial response was something vague or noncommittal like "I don't know", try saying something like:

It's probably hard to know what could happen that could make you feel more motivated for treatment, until you got to that point in your life again.

- Note that that statement is a form of "rolling with resistance." Then add:

"What was it that got you to the point of going to treatment in the past?"

or

"Sometimes people get more motivated to go to treatment because some things in their life get worse, like health problems or money problems (pick examples that that participant has mentioned). Sometimes people get more motivated to go to treatment because something good happens that makes it easier for them, like they find out that they can get transportation there, or something like that. Do you relate to any of these?"

In pursuing these areas of discussion, the Linkage Manager may find that there is something further to work with regarding this participant's motivation for treatment.

- Reflect that back to the participant using the following suggestions. For example:

You are saying that it seems like your wife is thinking about leaving you, and if she does, you'd probably go to treatment to try to get her back. I'm wondering if it might work out better for you to do something before she gets to the point of packing her bags. It sounds like you don't want to lose her. What do you think?

or

You said that you'd be more likely to go to treatment if they could help you get a job. Maybe we should call and see if they have that as part of their program. What do you think?

- Avoid arguing or pressuring if the participant rejects this type of suggestion. Instead, respond with empathy and reflection. If the participant becomes more willing to consider treatment at this present time, respond with empathy and in a way that supports self-efficacy. For example:

> *"You felt hesitant to go back to treatment, but you're thinking that maybe it would be better to go before you lose your home and end up on the street. You're trying to do something good for yourself by going back to treatment, and it takes guts to do that."*

If the participant is willing to pursue treatment options, the Linkage Manager should move on to the parts of the session that deal with barriers to treatment and with linkage to treatment. If the participant is not willing, the LM closes the meeting with a summary statement that reflects that the option is open to return to treatment in the future. Keeping the treatment option open goes like this:

> *You're saying you know that treatment can help people, and has even been helpful to you, but you just don't want to go back at this time in your life, because you don't feel ready to give up the dope yet. You feel like you'll know when you're ready, and you'll go back to treatment then. Is that it?*

Procedures Summary

- Discuss participant's view of returning to treatment, using MI strategies:
- Express empathy
- Avoid argumentation
- Roll with resistance
- Ask what would need to happen to raise the number (level of motivation) and discuss
- If the participant remains unwilling, keep the option open for future treatment

6.3.2 Discussion with the Participant Who Expresses Moderate Motivation (3-7)

A participant who chooses a number indicating a moderate level of motivation is more likely to be aware of his or her ambivalence about returning to treatment. A

participant may identify a moderate level of motivation because he/she partly wants to go back to treatment and partly does not want to. The Linkage Manager's task is to express understanding of this ambivalence, and to elicit self-motivational statements that will help tip the balance in favor of the participant agreeing to treatment. The Linkage Manager can facilitate this discussion by adopting the following approach:

- Explore ambivalence, expressing empathy and using double-sided reflections.

  Ask the participant about both sides of the ambivalence, like this:

  > *Tell me about some of the reasons why you would be motivated to go to treatment.*
  >
  > *Tell me about some of the reasons why you* ***would not*** *be motivated for treatment.*

- Use reflections to express empathy toward the participant's responses. Here are some examples:

  > *So you're saying that you want to go to treatment because you're sick of running. You really* ***sound*** *tired of that life.*
  >
  > *I hear that you don't want to go because you don't like to get up early in the morning and take the bus. That part* ***is*** *hard to do.*
  >
  > *I see the way you light up when you talk about how you'd like to be a better Mom to your kids.*

- Also, use double-sided reflections which include **both** sides of the participant's ambivalence. This really allows the participant to feel understood. Here's an example:

  > *So what I'm hearing is that you don't really feel like going to treatment now because of how much work it is, even though you think it would make things better for you and your family.*

- Elicit self-motivational statements. This includes asking various sorts of questions that invite the participant to describe potential benefits of returning to treatment:

  How do you think it would affect your life if you went to treatment?

  Was it helpful to you in any way when you went to treatment in the past?
  If yes- In what way?
  If no- Any idea why not?

  It sounds like you feel that going to treatment could help your health. Tell me some more about what makes you say that.

- Finally, always remember to roll with resistance.

The key to effectively eliciting self-motivational statements from the participant rests with the Linkage Manager's willingness to accept the possibility that the participant may not respond in a positive manner. If the Linkage Manager operates according to this approach and does not become frustrated by the lack of a positive response, the participant should feel comfortable and unpressured. When or if the participant feels pressured, he/she will likely express some resistance to returning to treatment. The Linkage Manager will experience more success by accepting the fact that ambivalence is common and sometimes the participant may not feel like acknowledging potential benefits of treatment. The trick is to remain patient and express empathy.

6.3.3 Discussion with the Participant Who Expresses High Motivation (8-10)

The key in responding to the participant who expresses a high level of motivation to go back to treatment is for the Linkage Manager to express his/her support. The Linkage Manager should avoid trying to convince the participant that he/she is making a good choice or stating the reasons for this choice because such a response could run the risk of eliciting resistance in someone who is already motivated for treatment. Rather,

the Linkage Manager must allow the participant to explain **his/her** reasons for that motivation. The Linkage Manager can use the following approaches with the participant in a way that is likely to help firm up the participant's motivation:

- Have the participant describe the main reasons for his/her motivation. For example:

  You indicated quite a bit of motivation to go back to treatment right now. Tell me some of the main reasons for that.

  After the participant provides one or two reasons, ask again for additional reasons, possibly bringing up another area of the participant's life that was discussed in the ERI-LAW such as:

  You also mentioned some health concerns. Is that also related to why you want to go back to treatment? How so?

- Explore possible ambivalence. This is helpful because it lets the participant know that it is OK to talk about his/her reservations about going back to treatment. The idea is that such discussions decrease the likelihood that these reservations will result in the participant not following through on the referral. Here is a way to ask about potential ambivalence:

  You're describing a lot of reasons why it would be a good idea for you to go back to treatment now. Sometimes even when someone is really motivated to get back to treatment, they might have some negative feelings or concerns about doing that. How about you?

- Respond with empathic reflection. Note that the statement above both supports the participant's motivation and normalizes the possibility of ambivalence.
- Support self-efficacy, especially as related to his/her motivation to return to treatment. Express recognition and appreciation that the participant is committing

to do something that: a) is not necessarily easy; b) is a positive step to improve his/her life; c) is taking this step willingly and openly. Here's an example:

I appreciate that you've been so open in looking at the ways drugs have been messing things up for you. And now you're planning to take back control of your life by going to treatment. That's a really positive step you're taking, and I know it's not easy.

Procedures Summary

- Have participant describe the main reasons for his/her motivation.
- Explore possible ambivalence.
- Respond with empathic reflection.
- Support self-efficacy.

6.4 Determination of Willingness to Return to Treatment

In the next part of the ERI meeting, the Linkage Manager determines whether or not the participant is willing to re-enter treatment. By now, the Linkage Manager should have a clear sense of whether or not the participant is interested in proceeding with the process of linkage to treatment. Nevertheless, the Linkage Manager should directly ask the participant whether he/she is willing to proceed with linkage. This should dovetail effectively with the summary statements that the Linkage Manager has made in the motivational discussion that recently concluded. These two stages of the meeting need to be linked together. Here are examples for participants at each level of motivation:

Little Motivation: *So I hear that you see more problems with going to treatment than possible help. Even though I mentioned that the program staff and I might be able to help you iron out some of those problems, it doesn't necessarily make you feel more hopeful about going. Right now you mostly just want to keep doing what you have been doing. The next part of this meeting is when I help people see if some of their problems can get ironed out, and I help them set things up to go to treatment. Do you want to do that now together, or would you rather not?*

Moderate Motivation: *You've really described some of your mixed feelings about going to treatment- you partly don't want to go, and you partly think it would help*

you to go. The next part of the meeting is when I help people get things set up to go to treatment and try to iron out problems that could get in the way of that. Would you like us to work on that together now?

High Motivation: *You sound like you really think it would be a good idea for you to get back to treatment. Would you like us to work together now on getting that set up?*

If the participant indicates a willingness to proceed with linkage, the Linkage Manager should proceed to the next step. Although the procedures in the ERI meeting are intended to help participants consider their situation and increase their motivation for treatment, some participants simply will not be interested in returning to treatment at a given point in time. Rather than push them and jeopardize future ERI opportunities, it is important for the Linkage Manager to accept and respect their decision in a non-judgmental manner, so that they may be more willing to accept the notion of returning to treatment during the next checkup. The Linkage Manager should stress, however, that the participant may call if he/she has a change of mind and that the Linkage Manager will see the participant again in three months. The Linkage Manager will document participants' reasons for not returning to treatment in their ERI file. Such information should be reviewed in case conferences and in preparation for subsequent contacts with the participants.

When the participant is unwilling for linkage to treatment, the Linkage Manager will conclude the meeting according to the following plan:

- Briefly summarize the discussion that occurred in this meeting including:
    1. how the participant met the relapse criteria
    2. any ways that the participant expressed showing motivation for treatment

3. reasons that the participant is not interested in treatment at present

- Provide a statement supporting self-efficacy (for attending this meeting, being open and honest, saying that they may choose to return to treatment at some time in the future, etc.) Briefly summarize the plan:

  1. the participant will come back in for another check-up in three months;
  2. the participant can contact you before that time if he/she would like linkage assistance before three months time.

Procedure Summary

- Ask participants whether they are willing for linkage.
- If unwilling, summarize the discussion that took place in this meeting, and the plan for future meetings.

6.5 Scheduling of Treatment Appointment

For cases in which readmission is deemed appropriate, the Linkage Manager will attempt to link the individual to the original treatment program. The linkage will be initiated via a three-way conference call involving the Linkage Manager, the participant, and the designated treatment program staff to try to schedule a treatment appointment. During this conversation, the Linkage Manager and the participant will provide the treatment staff with: (a) a summary of the participant's status in terms of days of alcohol use, drug use, health problems, and mental health problems, (b) current address and telephone number, and (c) a synopsis of current barriers to successful participation in treatment.

The desired outcomes for this communication are to: (1) inform treatment staff of a participant's substance use during the past 90 days, (2) discuss treatment barriers, (3) agree on whether a different treatment program would be optimal given the treatment

barriers, (4) gain support from the treatment program to solve or remove some of the treatment barriers (i.e., providing transportation or child care), and (5) schedule an appointment.

After the appointment has been scheduled, the Linkage Manager will give participants an appointment card and review linkage assistance activities that will follow.

Procedures Summary

- LM and participant telephone the treatment program *via* a three-way conference call to inform treatment staff of participant's substance use during the prior 90 days; and review treatment barriers.
- LM, participant, and treatment staff agree on whether a different treatment program would be optimal in light of the treatment barriers
- LM, participant, and treatment staff resolve or remove some of the treatment barriers (i.e., transportation, child care),
- LM, participant, and treatment staff schedule appointment
- LM provides participant with appointment card

6.6 Post-Linkage Meeting Protocol

The results of the first experiment clearly demonstrated that linkage assistance cannot successfully end with the scheduling of an appointment. Of the participants who agreed to return to treatment, only 55% actually showed up. During the pilot, attendance rates to the assessment were similar in that only 44% showed up for their first assessment appointment. The Linkage Manager contacted those individuals who failed to show and rescheduled 80% (20% were never relocated). Of those who were rescheduled for a second appointment 50% showed up and 50% did not. The rates were the same for the third appointment. Only one participant failed to show up for the fourth appointment at which time linkage assistance was terminated. The time lag between the linkage meeting and the appointment significantly increases attrition rates for participation, and this pattern of results clearly demonstrates the need for assertive support and encouragement for participants while they wait for their appointments. In many cases, the waiting period was as brief as four to five days, and yet the link was unsuccessful.

In the original experiment, a number of linkage activities were included in this protocol and were intended to increase the likelihood that participants showed up for their appointments. Linkage Managers mailed letters or cards to participants immediately following the check-up to remind participants of the date, time, and place of the appointment and to extend wishes for future success. Linkage Managers also attempted reminder calls 24-hours prior to the appointment to review the appointment date, time, and location. They were prepared to discuss transportation, departure time, and any difficulties that might prevent the person from making the appointment; they were also

charged to brainstorm possible solutions to help the participant get to the agency. For different reasons these methods were inadequate in significantly improving linkage rates.

Therefore, it is recommended that Linkage Managers assume responsibility for calling the treatment agency on the day of the appointment to confirm whether the participant arrived according to plan. If not, then the Linkage Manager needs to proceed with actions based on information gleaned during these calls. For example, if the participant rescheduled the appointment, the manager initiates another 24-hour reminder call. If the appointment was missed altogether, the manager will try to locate the participant and reschedule the appointment.

All linkage activities should be documented on event logs and placed in the individual's ERI file. Each time Linkage Managers initiate a contact or activity such as mailing a card or letter or making a telephone call, they will record the date, time, intent of the contact, type of contact (telephone, mail), outcome of the contact, and the next steps to be completed. This information will be used to manage cases and staff. Reports will be produced daily to remind managers of upcoming activities.

7.0 Engagement / Retention

One of the most vexing, prevalent, and long-term problems the health care industry faces is high premature patient dropout rates. The dropout problem plagues surgeons, internist, psychiatrists, and addiction counselors and is most often observed in the context of treating chronic conditions that require prolonged treatment. Baekland and Lundwall's (1975) extensive review of the literature clearly revealed the magnitude of the problem. In general psychiatric clinics, 20-57% of the patients failed to return after the

first visit (Blenkner, 1954; Dodd, 1971; Gallaher & Kanter, 1961; Katz & Solomon, 1958; Overall & Aronson, 1963; Rosenthal & Frank, citations) and 31-56% attended 4 or fewer sessions (Frank et al., 1957; Gallaher & Kanter, 1961; Garfeield & Kurz, 1952; Lindsay, 1965). The situation worsens with outpatient treatment of alcoholism, in which 52-75% of the patients drop out before the 4th session (Baekland, Lundwall & Shanahan, 1973; Blane & Meyers, 1964; Chafetz et al., 1962; Ditman & Cohen 1959; Gerard & Saenger, 1966; Storm & Cutler, 1968; Wilby & Jones, 1962). In a more recent review of substance abuse treatment (Stark, 1992), investigators reported over a 50% drop out rate within the first month of treatment. Stark quickly noted, however, that these rates were not much higher than the 30-60% rate found outpatient mental health clinics (Pekarik, 1983) or the 50-80% dropout range reported in the medical field (Meichenbaum & Turk, 1987). In ERI-1, of the participants who showed to treatment, only 60% (65/110) remained in treatment 14 or more days on average. However, during the best performing quarter 83% stayed over 14 days, which provides some evidence that retention, rates can be increased. Combined these findings across different types of treatments clearly demonstrate that the success of treatment for many chronic conditions is hampered by so many patients failing to persevere in treatment.

The obvious consequence of early termination of treatment is its potential negative impact on participant outcomes. Clients who prematurely terminated treatment for alcoholism reported worse outcomes than program completers (Baekeland & Lundwall, 1975). Several studies yielded similar results for individuals who completed detoxification, therapeutic community, or methadone maintenance treatment. When

compared to individuals who prematurely terminated treatment, clients who completed were more likely to report no drug or alcohol use, lower unemployment and arrest rates, relapse rates, and decreased intravenous drug use (Aron & Daily, 1976; Ball, Lange, Nyers, & Friedman, 1988; Berger & Smith, 1978; Perkins & Bloch, 1971; Raynes, Patch & Fisch, 1972). Moreover, Simpson and colleagues reported that drug-free treatment and therapeutic communities clients who completed treatment also reported more favorable outcomes than those who were expelled or quit (Drug Abuse Reporting Project; DARP).

The prevalence of the problem across different clinical samples provides an opportunity to draw upon other disciplines for approaches that minimize premature treatment termination. While premature termination cannot be eliminated, a proactive approach coupled with a skillful application of attrition prevention techniques can significantly increase retention rates. While many of the techniques seem obvious or intuitive, in the context of a busy clinic, it is often these types of procedures that are squeezed out by the need for efficiency.

The first drop out prevention strategy targets a system related issue, decreasing the amount of time between the linkage meeting and access to treatment. Baekeland and Lundwall found that decreasing the time between a client seeking treatment and the initial appointment reduced premature termination with medical patients (Meichenbaum & Turk, 1987; Miyake, Chemtob, & Torigoe, 1985) outpatient psychotherapy clients (Pekarik, 1985), alcoholics (Miller, 1985), drug-free outpatient (Woody, O'Hare, Mintz, & Obrien, 1975), and methadone clients (Dennis, Ingram, et al, 1994). Facilitating initial treatment entry yielded higher long-term retention and, by extension, improved outcomes

(Ball et al., 1988; Simpson, 1979; Simpson, 1981, Simpson et al., 1979). In an effort to expedite treatment entry, Haymarket's Clinical Director pledged same day admission to treatment for participants in the ERI-2 study. The Linkage Manager will schedule the treatment appointment and transfer the participant to the Engagement Specialist.

Upon arrival at the treatment agency, the Engagement Specialist will meet with the participant. Relying on a range of evidence-based prevention techniques, the Engagement Specialist will educate the participant about the procedures and aims of treatment (Baekland & Lundawall 1975; Meithce & Turk, 1987; Miller, 1985). The Engagement Specialist and participant will also develop a memorandum of understanding (MOU) divided into 3 sections, each pertaining to one of the three goals of the protocol: a) ensuring that the participant understands and agrees to agency rules and expectations, b) identifying reasons why participants miss appointments and developing plans of action in the event that attendance problems arise, c) developing a communication plan between the Engagement Specialist and participant specifying the frequency, mode, and designated initiator of communications between treatment sessions. Such pre-therapy sessions have been effective in reducing attrition and improving outcomes with psychotherapy clients, especially those from lower socioeconomic groups (Lambbert & Lambert, 1984; Orlinsky & Howard, 1986; Pekarik, 1985; Wilson, 1985). After the MOU has been completed and signed by both the Engagement Specialist and participant, the Engagement Specialist will escort the participants to the admission office and support them through this process. The latter might involve helping them complete paper work, gathering information for medical staff and/or making arrangements for a residential stay.

When the admission process ends, the Engagement Specialist and participant will put all treatment appointments on a calendar (with a copy for the Engagement Specialist) and agree on a communication plan for keeping in touch over the upcoming two weeks. The plan will include in person visits, phone calls and personal letters (not form letters) from the Engagement Specialist or a mix of phone calls from the participant to the Engagement Specialist. These procedures have improved retention rates and return after missed appointments (Miller, 1985; Meichenbaum & Turk, 1987; Nirenberg et al 1980). The plan may also include brief meetings prior to the treatment sessions or in the case of inpatient treatment, a brief meeting once or twice a week. The plan will also include procedures for dealing with missed appointments including telephone calls, personal letters, contact with pre-approved relatives or significant others, personal visits, or contact with the referral source.

8.0 Key Techniques in Increasing Motivation to (Re)enter Treatment

Linkage Managers will use motivational interviewing in discussing the participants' recent substance use and in attempting to develop their motivation to return to treatment. Motivational interviewing (MI) is an approach developed by William R. Miller and Stephen Rollnick (1991) to "prepare people to change addictive behavior." It is based on the premise that people are most likely to address addictive problems when the motivation comes from within themselves, rather than being imposed from outside (e.g. by the Linkage Manager). Within the addictions field, the search for critical conditions that are necessary and sufficient to induce change has led to the identification of six critical elements (Miller & Rollnick, 1991):

- Feedback regarding personal risk or impairment
- Emphasis on personal responsibility for change
- Clear advice to change
- A menu of alternative change options
- Therapist empathy
- Facilitation of participant self-efficacy or optimism

Therapeutic interventions containing some or all of these elements have been effective in treating addictive disorders (Bien, Miller & Tonigan, 1993).

The Motivational Interviewing approach is further grounded in research on the processes of change. Prochaska and DiClemente (1984) describe five stages of change that people progress through in modifying problem behaviors; the stages are pre-contemplation, contemplation, determination, action, and maintenance. The MI approach assists the participant to progress through the first three stages toward the last two stages of action and maintenance.

Motivational Interviewing requires the use of good therapeutic interviewing skills. These include: communicating interest and acceptance, using active listening skills, and formulating open-ended questions. In contrast to closed-ended questions, which can be answered in a brief, one-word answer, open-ended questions invite a response with elaboration. Here are some examples of open-ended and close-ended questions:

Open-Ended Questions	Closed-Ended Questions
What are your main concerns about having gone back to smoking freebase?	How many times have you relapsed in your life?
How is your drug use affecting your relationship with your kids? How do you	How many kids do you have? Did they ever see you drunk?

feel about that?	
If you went to treatment, how might it help your family?	How many more months do you have until your parental rights could be terminated?
You said you'll never go back to treatment again. Tell me more about that.	You said you'll never go to treatment again. Who was your case manager there? Did you go to the 4 week program or the 8 week one? What month was that?
You mentioned that you are worried about shooting up? What are your worries?	Have you been tested for HIV? Do you share needles?

The open-ended questions encourage the participant to elaborate on concerns and feelings related to substance abuse, while the closed-ended questions are most likely to elicit brief answers that convey little useful information. While the Linkage Manager will need some factual information to communicate in making the link to a treatment agency, much of this information will have already been obtained through the GAIN M90. Rather than spending a lot of time repeating this information, the Linkage Manager should solicit important information from the participants and give them an opportunity to talk about their thoughts and feelings concerning their substance use. MI is based on the assumption that participants are likely to have mixed or ambivalent feelings about their substance use and about whether or not they want to stop using. This ambivalence is considered to be normal. By listening carefully as the participants' express this ambivalence about their substance use, the Linkage Manager can help them develop motivation to return to treatment.

The Linkage Manager will use the following MI strategies (Miller and Rollnick, 1991) to develop and enhance motivation during the discussion with the participant. The descriptions of the MI strategies are drawn from the Miller and Rollnick book (1991) and from the treatment manuals of three previous studies using motivational interviewing

strategies with substance abusers: 1) the *Motivational Enhancement Therapy Manual* used with alcohol abusers in Project MATCH (Miller, Zweben, DiClemente, & Rychtarik, 1995); 2) the *Marijuana Treatment Project Therapist Manual* (Steinberg, Carroll, Roffman, and Kadden, 1997); and 3) the *Motivational Enhancement Therapy and Cognitive Behavioral Therapy (MET-CBT-5) for Adolescent Cannabis Users* manual from the Cannabis Youth Treatment project (Sampl & Kadden, 1998). The MI strategies are adapted here for use with the ERI participants.

8.1 Motivational Interviewing Strategy 1: Express Empathy

The Linkage Manager always strives to communicate respect for the participant. Communications that imply a superior/inferior relationship between the LM and participant are to be avoided. This interviewing approach is not based on confrontation, and it is important that the Linkage Manager not give the impression of trying to convince the participants of the "errors of their ways." Rather, the Linkage Manager's role is a blend of supportive listener and knowledgeable consultant. Much of MI is *thoughtful listening rather than telling*. The Linkage Manager demonstrates thoughtful listening by making *reflections* to the participant. This means that the Linkage Manager states his or her understanding of what the participant has just said. Reflections can involve a simple restatement of what the participant said, or they can reflect the meaning or feeling implied by the words. The following example shows how the Linkage Manager can respond to the participant with any of these types of reflection:

> Participant: *"My partner and my kids are always on my case about my drinking. They search our place for bottles, smell my breath, and sometimes even follow me when I go out."*
>
> Linkage Manager using ***Simple Reflection*** (just say what they have said, but in different words): *"They bug you about your drinking, and they spy on you about it."*

or

Linkage Manager using ***Reflection of Meaning*** (state back the meaning that may be implied behind the words): *"They act as though they're always trying to figure out if and when you're drinking."*

or

Linkage Manager using ***Reflection of Feeling*** (state back to the participant what you perceive to be the feeling conveyed in their statement): *"It sounds like it's annoying to you, for them to get on your case like that."*

The Linkage Manager may use any of the above types of reflections to convey understanding. The technique required to reflect the participant's meaning or feeling connected with his/her words, however, usually involves an element of guessing. Therefore, the Linkage Manager should try to keep the guess close to what the participant has said. If the participant disagrees with the guess, the LM should not become defensive or attempt to explain the guess. Instead, the Linkage Manager should simply say something like "Tell me some more, so I'll understand it better."

Empathic listening and accurate reflection are crucial to facilitating change. If the ERI participants feel that they are truly being understood and accepted by the Linkage Manager, they will be increasingly open to considering behavior change. The Linkage Manager is encouraged to accurately reflect the participant's mixed feelings about quitting marijuana. The Linkage Manager should use "***double-sided reflections***" (reflections that acknowledge both sides of the participant's ambivalence) in empathizing with the participant's mixed feelings. For example:

"So you're saying that you really enjoy getting high, but you're worried that it might be hurting your health."

Or

"You're not sure that you want to stop doing dope, but at the same time, you don't want to get into any more trouble with the law."

8.2 Motivational Interviewing Strategy 2: Develop Discrepancy

Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be. This MI strategy, "develop discrepancy," means that the Linkage Manager is involved in helping participants recognize the discrepancy between the effects of substance use on their present life vs. how they would like their life to be. The participants' awareness of this discrepancy is often the engine that drives the desire for change.

Here again, the Linkage Manager needs to convey respect and empathy, as described above. Thus, in developing discrepancy, the Linkage Manager is **not** setting out to convey to the participant the impression that "You are a loser because you have a substance abuse problem," but rather to reflect back the participant's own stated concerns of how his/her substance use is interfering with what he or she wants in life. For example:

"You'd like to get a job, but you figure that you'd fail the drug test."

Linkage Managers may be aware that many chronic substance abusers may not express a lot of goals, especially beyond the most immediate future. Linkage Managers, therefore, need to listen for what is important to the participant in the immediate future.

> *"You're not thrilled about going to treatment, but you would like your wife to stop bugging you."*
>
> *or*
>
> *"You're saying that if you didn't spend so much money on drinking and drugs, you'd probably have it for the rent."*

Even if the participants are unable to state any specific goals, they may have a vague belief that their lives might be better if they stopped using and went back to treatment. In such cases, it is still helpful for the Linkage Manager to reflect this generalized positive expectation back to the participant, as in the following example:

> *"You want something better from your life than you have now. You're wondering if you go back to the treatment program, whether your life might start to go better, is that it?"*

Notice that in the previous example, the Linkage Manager asks the participant whether the Linkage Manager has correctly understood the participant. This gives the participant the chance to correct an inaccurate reflection, and ultimately may allow the participant to feel better understood.

Another type of "discrepancy" that the Linkage Manager should be aware of in working with participants is the discrepancy between how they view themselves currently and how they would like to view themselves. For example, the Linkage Manager may reflect to the participant:

"So you're saying that you feel crappy about yourself since you picked up again. You think you'd feel better about yourself if you could quit using again. Is that it?"

8.3 Motivational Interviewing Strategy 3: Avoid Argumentation

The Motivational Interviewing style explicitly avoids arguments, which tend to evoke resistance. The LM does not seek to prove or convince by force of argument. When MI is conducted properly, *the participant and not the therapist (Linkage Manager) voices the arguments for change* (Miller & Rollnick, 1991).

If a participant becomes increasingly defensive or hostile, the Linkage Manager should consider the possibility that his/her previous comments may have played a role in eliciting this reaction. The Linkage Manager may have drifted from an MI approach towards a confrontational approach. In such a case, the Linkage Manager will need to back off and resume the motivational interviewing style.

Sometimes Linkage Managers may think of resistance as meaning that the participant is not cooperating. Within the MI approach, however, participant resistance is seen as a cue that there may be a problem with the Linkage Manager's behavior. So when the participant becomes increasingly resistant, the Linkage Manager should try shifting strategies. Similarly, if Linkage Managers find themselves in the position of pressuring and debating the participants, something has gone wrong in the session. The LM must stop, listen to the participant, and reflect what he/she is hearing from the participant.

8.4 Motivational Interviewing Strategy 4: Roll with Resistance

This Motivational Interviewing strategy is related to the one just discussed. In using MI, the Linkage Manager should not tackle resistance head-on but rather "roll" with it. When a participant voices opposition to change, the Linkage Manager may feel tempted to respond with a counter-argument. If the Linkage Manager does so, however, the participant is likely to defend and further strengthen the originally- stated position. The Linkage Manager can "roll with resistance" by empathically reflecting the participant's hesitancy to change, and then letting the participant know that it will be up to him/her to decide if and when to change. Here's an example:

> Participant: *"It's not going to make a difference if I go to treatment now, or if I go in a few months. I don't do well under pressure.*
>
> LM: *"I don't think anybody likes to be pressured to do something. It is totally up to you if and when you go for treatment. While you are here meeting with me is a time that I could help you get back into treatment if you'd like to, but I recognize that the choice is yours."*

In the example above, if the Linkage Manager had responded with a mini-lecture along the lines of, "You are taking a big chance if you keep using like this," the participant would likely have become more resistant. When participants are genuinely assured that the decision to change is up to them, they often become more willing to looking at the issue with an open mind. In the above instance, once the participant is assured in this manner, he/she might be more open to questions like, "Do you feel there are any possible risks to you, if you keep using now?" This latter question is a way to address the issue of "taking a big chance" in a way that is less likely to elicit resistance because it uses an open question and does not have a confrontational tone. The Linkage Manager conveys

the message that it is the participant who decides whether to risk the potential consequences of his/her decision about whether or not to return to treatment.

8.5 Motivational Interviewing Strategy 5: Support Self-Efficacy

This MI strategy refers to helping develop and support the participant's belief that he/she **can** change. This is important because people who believe that they have a serious problem may still be unlikely to move toward change if they see little hope for success. So even if ERI participants acknowledge that resumed substance use is a problem, they may be disinclined to return to treatment without the belief that they can be successful in treatment. The Linkage Manager's role is to help the participants develop and/or strengthen their sense of self-efficacy, i.e. their belief that they can be effective and successful, even in the face of prior treatment failure. In order to support self-efficacy, the Linkage Manager may ask participants about previous successful experiences they have had in the following areas:

- times that they used treatment productively in the past
- earlier success in quitting or reducing use of drugs or alcohol
- past accomplishment in gaining control over another problematic habit
- attainment of previous goals that was facilitated once they set their mind to it

Some participants may not make the connection between these previous accomplishments and the likelihood that they will be successful now. They may benefit from the Linkage Manager's help in pointing out this relationship. For example:

> *"So you're telling me that you're no good at treatment, that you ended up getting kicked out of the program because of too many positive drug tests. But you also said that you had been clean for a while there for several weeks. To me that's a sign that treatment was helpful in the beginning, at least, and maybe could work for you."*

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Appendix A

ERI Eligibility Form

1. Are you...
   a. under 18 years of age? . . . .Yes 1 No 0
   b. living <u>outside</u> of the city of Chicago?...Yes 1 No 0
   c. planning to move <u>outside</u> of the city of Chicago in the next 12 months?...........Yes 1 No 0
   d. sentenced to be in Jail or Prison for <u>most</u> of the next 12 months?.......................Yes 1 No 0
   e. going to treatment because of a DUI offense?..Yes 1 No 0
   f. in need of an interpreter for a language <u>other than</u> English or Spanish? ....Yes 1 No 0

2. Have you used alcohol or other drugs in the past 90 days?................................Yes 1 No 0

3. In your <u>lifetime</u> ...
   h. have you kept using alcohol or drugs even though you knew it was keeping you from meeting your responsibilities at work, school, or home?.......Yes 1 No 0
   j. have you used alcohol or drugs where it made the situation unsafe or dangerous for you, such as when you were driving a car, using a machine, or where you might have been forced into sex or hurt?.......................Yes 1 No 0
   k. has your alcohol or drug use caused you to have repeated problems with the law? . . . .Yes 1 No 0
   m. have you kept using alcohol or drugs even after you knew it could get you into fights or other kinds of legal trouble?...Yes 1 No 0
   n. have you needed more alcohol or drugs to get the same high or found that the same amount did not get you as high as it used to?...............................Yes 1 No 0
   p. have you had withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or drugs to stop being sick or avoid withdrawal problems? ....Yes 1 No 0
   q. have you used alcohol or drugs in larger amounts, more often or for a longer time than you meant to?. . ...Yes 1 No 0
   r. have you were unable to cut down or stop using alcohol or drugs?....................Yes 1 No 0
   s. have you spent a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)? . . . .Yes 1 No 0
   t. has your use of alcohol or drugs caused you to give up, reduce or have problems at important activities at work, school, home or social events?...........Yes 1 No 0
   u. have you kept using alcohol or drugs even after you knew it was causing or adding to medical, psychological or emotional problems you were having? . . . .Yes 1 No 0

4. What is your gender? 1 - Male 2- Female

5. Which of the following best describes your race/ethnicity?
   1 - Black/African-American
   2- Hispanic
   3- White, non-Hispanic
   4- Native American/Alaskan Native
   5- Asian or Pacific Islander
   99- Other (Please describe v. _____________________)

6. In what year were you born? |___|___|___|___| a. What is your current age? |___|___|

7. What is your Social Security Number? ___ ___ ___ - ___ ___ - ___ ___ ___ ___

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8. Is a new participant in ERI? Yes $_1$ No $_0$
9. Is the client eligible based on screener? Yes $_1$ No $_0$

(NO to all of question 1, YES to question 2, YES to any part of question 3, YES to question 8)

10. Was the person asked to participate? (if eligible and no, why not?) Yes $_1$ No $_0$

v.____

11. Was this person referred to a Haymarket Treatment Unit (from Transfer Slip) Yes $_1$ No $_0$

(If yes, complete as much as possible of information below)

a. Treatment Unit Name: ____

b. Treatment Unit Code: ___ ___ ___ ___ ___ ___

Appendix B

ERI Linkage Transfer Log
(*Lighthouse*)

Participant's Name: ____________________ Participant's ID: __________

Participant Transfer Section

RA Initials: _____________ RA ID: ____________

Interview completion date: ____/____/____

Interview completion time: ____:____ am/pm

ERI date: ____/____/____

Time ERI started: ____:____ am/pm

Participant had to wait for LM Y N

Participant eligible: Y N

Participant qualifies for linkage: Y N

Document Transfer Section

RA completed:

	Y/N	LM Initials	If not, why?
ERI-LAW Section A			
ERI-LAW Section B			
ERI-LAW Section C			
ERI-LAW Section D			
ERI-LAW Section E			
ERI-LAW Section F			

RA provided:

	Y/N	LM Initials	If not, why?
ERI-LAW			
GM-90			
Participant file			

________________________________ RA Signature

________________________________ LM Signature

Appendix C LINKAGE ASSISTANCE WORKSHEET (ERI-LAW)

(Version [LVER]: LAW080301)

Section A. Identifying Information

Participant's ID [XPID]: __________ Participant's Initial: ___________________

Participant's ID [XPID]: __________ Participant's Initial: ___________________

RA Staff ID [XSIDR]: ____________ LM Staff ID [XSIDL]: _______________

RA Staff Initials: __________________ LM Staff Initials: _____________________

Interview Date: ____ / ____ / ____ LM Meeting Date: _____ / ____ / ____

Section B. Current Linkage Assistance Eligibility

(As the questions in regular type below prior to the or fill them in based on the GM90 information referenced in the first two columns. Put a "Check" in either the Yes or No box.)

P.	Item	B1. Currently Eligibility	Yes	No
14	S7f,1m	Are you currently going to outpatient, intensive outpatient, inpatient or residential substance abuse treatment? *(do not count self help groups, sanctuary, recovery homes, half way houses or detoxification facility use here)*		
42	E1d1-2m	Are you currently living outside of the City of Chicago		
54	L6e,1m	Are you currently in jail, prison, hospital, or any other place where you can **not** use alcohol or drugs		

*(If any of the above responses were checked "yes", **STOP**, the person is currently occupied and not currently ERI eligible. If all responses were "no", **CONTINUE** with section C.)*

Section C. Current Need for Linkage Assistance to Substance Abuse Treatment

(As the questions in regular type below prior to the interview or fill them in based on the GM90 information referenced in the first two columns. Put a "Check" in either the Yes or No box.)

Pg	Item	C1. Current Need for Linkage Assistance	Yes	No
10	S2s1 (13+)	During the past 90 days, have you used alcohol, marijuana, cocaine, or other drugs on 13 or more days?		
10	S2s2 (1+)	During the past 90 days, have you gotten drunk or been high for most of 1 or more days?		
10	S2s3 (1+)	During the past 90 days, have has your alcohol or drug use caused you not to meet your responsibilities at work, school or home on one or more days?		
12	S3c1-99 (1+)	During the past week, have you had any withdrawal symptoms when you tried to stop, cut down, or control your alcohol or drug use?		
23	S8g3 (4+)	Do you feel that you need to go back to treatment? *(check no if satisfied in self help, recovery home, sanctuary or recovery home)*		
24	S9c-u (3)	During the past month, has your substance use caused you any problems?		

*(If any "yes", transfer the rest of the information from the GM90 to this worksheet and then transfer the participant to the LM to **Continue.*** If all "no", **STOP**, the person is currently stable and does not need ERI assistance.)

Section D: Substance Use and Problems

D1. During the past 90 days you told us that …

Please turn to S2s on page 10 of the GM90, record the days of use reported there.

❑ 1. you used any substance on __ __ days
❑ 2. you got drunk or high for most of the day on __ __ days
❑ 3. your use kept you from meeting your responsibilities on __ __ days

D2. Some problems that you said this was causing you in the past month include:

Please turn to S9 on page 24 of the GM90 and check each box were the participant reported a past month problem (3).

❑ c You were trying to hide your use
❑ d Your family, friends or coworkers are complaining about your use.
❑ e You are using weekly
❑ f Your use is causing you psychological problems (like feeling depressed, nervous, suspicious, uninterested in things, reduced your sexual desire)
❑ g Your use is causing you to have health problems (like numbness, tingling, shakes, blackouts, hepatitis, TB, or sexually transmitted disease)

❑ h Kept using alcohol or drugs even though you knew it was keeping you from meeting your responsibilities at work, school, or home.
❑ j Using in situations where it was unsafe for me (driving a car, using a machine, or where you might have been forced into sex or hurt)
❑ k Problems with the law
❑ m Kept using alcohol or drugs even after you knew it could get you into fights or other kinds of legal trouble?

❑ n Needed more to get the same high (high or found that the same amount did not get you as high as it used to)
❑ p Had withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping (or that you used any alcohol or drugs to stop being sick or avoid withdrawal problems)
❑ q You used alcohol or drugs in larger amounts, more often or for a longer time than you meant to.
❑ r You were unable to cut down or stop using
❑ s You spent a lot of time either getting alcohol or drugs, using them, or feeling their effects (high, sick).
❑ t Your use caused you to give up, reduce or have problems at important activities at work, school, home or social events.
❑ u Kept using after you knew it was causing or adding to medical, psychological or emotional problems you were having.

D3. Are there any <u>other</u> problems your drug or alcohol use cause you?

v1. ____

v2. ____

v3. ____

Section E: Barriers to Treatment

E1. Here are things that you said might make it difficult for you to go to treatment …

Please turn to S8e on page 22 of the GM90 and check each box were the participant agreed (4) or strongly agreed (5) with the statements below.

- ❑ e1. You have too many outside responsibilities to be in this treatment program now.
- ❑ e2. Treatment seems too demanding for you.
- ❑ e3. Treatment will not be very helpful to you.
- ❑ e4. It will be hard for you to resist drugs where you currently live, work or go to a training program or school?
- ❑ e5. Your old friends may try to get you to drink or use drugs again?

Please turn to S8f on page 22 of the GM90 and check each box were the participant agreed (4) or strongly agreed (5) with the statements below.

- ❑ f1. Getting transportation to the program
- ❑ f2. Getting childcare or some to take care of your family.
- ❑ f3. Getting insurance or money to pay for treatment.
- ❑ f4. How far or how long it takes to get to treatment
- ❑ f5. The treatment or counseling program hours are not convenient
- ❑ f6. There are no openings in the treatment or counseling program you want.
- ❑ f7. The program doesn't offer the type of treatment or counseling you want.
- ❑ f8. There are other reasons that it might difficult for you to (re)enter treatment or counseling?
  v.______________________________

E2. Are there other things that might make it difficult for you to go to treatment?

v1. ____

v2. ____

v3. ____

Section F: Motivation for Treatment

F1. Here are things that you said you currently feel that…

Please turn to S8g on page 23 of the GM90 and check each box were the participant agreed (4) or strongly agreed (5) with the statements below.

- ❑ g1. Someone else wants you go to treatment .
- ❑ g2. You can get the help you need in treatment.
- ❑ g3. You want to be in a drug or alcohol treatment program.
- ❑ g4. Treatment may be your last chance to solve your drug or alcohol problems.
- ❑ g5. You plan to stay in treatment for at least a month
- ❑ g6. You will probably need to come back to treatment again one or more times during your lifetime
- ❑ g7. You need support from friends and relatives to deal with your alcohol or drug use

Please turn to S8h on page 23 of the GM90 and check each box were the participant agreed (4) or strongly agreed (5) with the statements below.

- ❑ h1. Have family members who want you to be in treatment.
- ❑ h2. Need to go to treatment to keep your family together
- ❑ h3. Are concerned about legal problems.
- ❑ h4. Have legal problems that require you to be in treatment.
- ❑ h5. Could be sent to jail or prison if you are not in treatment
- ❑ h6. Are under a lot of pressure to be in treatment.

F2. Are there other reasons why you want to or need to go to treatment?

v1. ____

v2. ____

v3. ____

F3. What is the most important reason you want to return to treatment?
(Use the GM-90 or LAW number above if applicable)

v1. ____

v2. ____

v3. ____

F4. On a scale of 0 to 10, with 0 being not motivated, 5 somewhat motivated, and 10 very motivated: How motivated are you right now to return to treatment?

0 1 2 3 4 5 6 7 8 9 10

Not motivated Somewhat Motivated Very Motivated

Section G. Next Steps

G1. Status

Transported Directly to Haymarket 1

Scheduled for Haymarket Assessment (give date and time) 2

Date: __ __ / __ __ / __ __

Time: __ __ : __ __ AM/PM

Scheduled for Other Admission (give date and time) 3

Program: v. ____

Date: __ __ / __ __ / __ __

Time: __ __ : __ __ AM/PM

Unable/Willing to go to treatment (describe why) 4

v. ____

Other (describe below) 99

v. ____

G2. Additional steps we will take.

v1. ____

v2. ____

v3. ____

If you have any problems or questions about getting back into treatment – contact Haymarket's central intake department directly at

Haymarket Center
120 N. Sangamon Street
Chicago, IL 60607-2202
Telephone: 1-312-226-7984

or call Lighthouse Institute at 1-800-990-5670 and ask for ____________________________ or the Linkage Manager on duty.

Appendix D

Personalized Feedback Report

Annotated Version

Comments in red indicate how these items are obtained from the corresponding GAIN items.

(annotated version)

Personalized Feedback Report (ERI-LAW) for first name, last initial

Date ____________

This personalized feedback report is provided to you to give you some feedback and information, and to help in the discussion between you and your Linkage Manager. You will have a chance to correct anything that is not accurate, and to discuss your reactions.

Recent (past 90 days) Drug or Alcohol Use ***(The items below correspond to the participant's responses on the Eligible for linkage worksheet. The bulleted items below would only appear for those items which apply to a given participant. If none apply under a given category, "none reported" would appear there)***

You identified the following drug or alcohol use, or withdrawal problems during the past 90 days:

Alcohol

- Alcohol use on (*response to 2s1a)*) of the past 90 days 2s1a>12
- At least one day of drinking most of the day or 5 or more drinks in one day 2s.2?>0 or S2 1b>0
- Alcohol interfered with responsibilities at home, work or school 1 or more days in the last 90 S2a = "5" or "6"
- Some drinking during the past week (modified) SFI 2s.3>0

Drugs (including the following drugs: ______________________) *(list here any specific drugs that they have reported using in the past 90 days. If none, "none reported".)*

- Drug use on 13 or more of the past 90 days (modified) 2s1b>12
- At least one day of using drugs most of the day or 5 or more times in one day (modified) 2s2b>0
- Drugs interfered with responsibilities at home, work or school 1 or more days in the last 90 (modified) 2s2b>0
- Some drug use during the past week S2 response of "5" or "6" on any drug (c through r)

Withdrawal

- Symptoms of D.T.'s, convulsions, or seizures in the past week when trying to cut down. S3a = 1
  - The following withdrawal symptoms during the past week: S3c1-99 (list all that=1)

Problems Related to My Alcohol and/or Drug Use ***Only the items that apply would appear below***

Here are some problems that you said were related to your substance use:

- Complaints from my family, friends or coworkers S9c=3 or 2
- Health problems S9g=3 or 2
- Not meeting my responsibilities at work, school, or home 2s3>0
- Needed more to get the same high S9n= 3 or 2
- Using in situations where it was unsafe for me (driving a car, using a machine, or where you might have been forced into sex or hurt) S9j = 3 or 2
- Problems with the law S9k = 3 or 2
- Being unable to cut down or stop using S9r = 3 or 2
- Spending a lot of time getting drugs and alcohol, using, or feeling the effects (high, sick) S9s = 3 or 2
- Trying to hide your alcohol or drug use S9c = 3 or 2
- **Causing you to feel depressed, nervous, suspicious, uninterested in things, reduced sexual desire, or other psychological problems S9f = 3 or 2**
- Causing or adding to medical or emotional problems S9u = 3 or 2

Possible Barriers to Treatment ***Only the items that apply would appear below***

Here are some current concerns that you indicated could possibly get in the way of your going to treatment.

- Difficulties with transportation to the program S8f1
- Difficulties with childcare, or other care of my family S8f2
- Getting insurance or money to pay for treatment S8f3
- How far or long it takes to get to the treatment program S8f4
- Inconvenient hours of the program S8f5
- No openings in the program S8f6
- The program doesn't offer the type of treatment or counseling that I want S8f7
- Too many outside responsibilities to be in a program now S8e1
- Treatment seems too demanding S8e2
- Believing that treatment will not be helpful S8e3
- Knowing how hard it is to resist drugs where I live, work or go to school/training S8e4
- Pressure from old friends who may try to get me to drink or use drugs again S8e5
- Other possible barriers: ________________ (fill in the blank, if they listed one) S8f8

Reasons to Consider Returning to Treatment ***Only the items that apply would appear below***

> *We asked you about some reasons why people sometimes consider going to drug and alcohol treatment, and had you rate whether you agree with them.*

Here are the reasons that you agreed with:

- My drug or alcohol use is more trouble than it's worth S8b2
- My drug or alcohol problems are out of control S8c4
- My drug or alcohol problems are making my life become worse and worse S8b8
- My drug or alcohol problems are going to cause my death if I do not quit soon S8b9
- My drug or alcohol is causing problems in finding or keeping a job S8b6
- I need help in dealing with my drug or alcohol use S8d1
- I can get the help I need in treatment S8g2
- I am tired of the problems caused by my drug or alcohol use S8d3
- I have family members who want me to be in treatment S8h1
- I need to go to treatment to keep my family together S8h2
- I have legal problems that require me to be in treatment S8h4
- I could be sent to jail or prison if I am not in treatment S8h5
- I want to be in a drug or alcohol treatment program S8g3
- My drug and alcohol problems are solvable S8c5
- I want to get my life straightened out S8d7

Motivation to Return to Treatment

Having reviewed all of the previous information and feedback, please indicate below (by circling a number) how motivated you are **right now** to return to treatment.

0 1 2 3 4 5 6 7 8 9 10

Not motivated Somewhat Motivated Very Motivated

Personalized Feedback Report

The following is a "clean", non-annotated copy of the Personalized Feedback Report including every possible ERI-LAW item. For any given participant, non-relevant items would be deleted, leaving only the items that apply to that participant. Thus, for most or all participants, the actual ERI-LAW would be shorter than what is shown on the next few pages.

Personalized Feedback Report (ERI-LAW) for first name, last initial
Date ____________

This personalized feedback report is provided to you to give you some feedback and information, and to help in the discussion between you and your Linkage Manager. You will have a chance to correct anything that is not accurate, and to discuss your reactions.

Recent (past 90 days) Drug or Alcohol Use

You identified the following drug or alcohol use, or withdrawal problems during the past 90 days:

Alcohol

- Alcohol use on ___ of the past 90 days
- At least one day of drinking most of the day or 5 or more drinks in one day
- Alcohol interfered with responsibilities at home, work or school 1 or more days in the last 90
- Some drinking during the past week

Drugs (including the following drugs: ______________________)

- Drug use on 13 or more of the past 90 days
- At least one day of using drugs most of the day or 5 or more times in one day
- Drugs interfered with responsibilities at home, work or school 1 or more days in the last 90
- Some drug use during the past week

Withdrawal

- Symptoms of D.T.'s, convulsions, or seizures in the past week when trying to cut down.
  - The following withdrawal symptoms during the past week: ______________________

Problems Related to My Alcohol and/or Drug Use

Here are some problems that you said were related to your substance use:

- Complaints from my family, friends or coworkers
- Health problems
- Not meeting my responsibilities at work, school, or home
- Needed more to get the same high
- Using in situations where it was unsafe for me (driving a car, using a machine, or where you might have been forced into sex or hurt)
- Problems with the law
- Being unable to cut down or stop using
- Spending a lot of time getting drugs and alcohol, using, or feeling the effects (high, sick)
- Trying to hide your alcohol or drug use
- **Causing you to feel depressed, nervous, suspicious, uninterested in things, reduced sexual desire, or other psychological problems**
- Causing or adding to medical or emotional problems

Possible Barriers to Treatment

Here are some current concerns that you indicated could possibly get in the way of your going to treatment.

- Difficulties with transportation to the program
- Difficulties with childcare, or other care of my family
- Getting insurance or money to pay for treatment
- How far or long it takes to get to the treatment program
- Inconvenient hours of the program
- No openings in the program
- The program doesn't offer the type of treatment or counseling that I want
- Too many outside responsibilities to be in a program now
- Treatment seems too demanding
- Believing that treatment will not be helpful
- Knowing how hard it is to resist drugs where I live, work or go to school/training
- Pressure from old friends who may try to get me to drink or use drugs again
- Other possible barriers: ________________

Reasons to Consider Returning to Treatment

We asked you about some reasons why people sometimes consider going to drug and alcohol treatment, and had you rate whether you agree with them.

Here are the reasons that you agreed with:

- My drug or alcohol use is more trouble than it's worth
- My drug or alcohol problems are out of control

- My drug or alcohol problems are making my life become worse and worse
- My drug or alcohol problems are going to cause my death if I do not quit soon
- My drug or alcohol is causing problems in finding or keeping a job
- I need help in dealing with my drug or alcohol use
- I can get the help I need in treatment
- I am tired of the problems caused by my drug or alcohol use
- I have family members who want me to be in treatment
- I need to go to treatment to keep my family together
- I have legal problems that require me to be in treatment
- I could be sent to jail or prison if I am not in treatment
- I want to be in a drug or alcohol treatment program
- My drug and alcohol problems are solvable
- I want to get my life straightened out

Motivation to Return to Treatment

Having reviewed all of the previous information and feedback, please indicate below (by circling a number) how motivated you are **right now** to return to treatment.

0 1 2 3 4 5 6 7 8 9 10

Not motivated Somewhat Motivated Very Motivated

Appendix E

ERI Linkage Manager Self-Rating Form

For office use only:

Participant ID [XPID]: |___|___|___|___| Version: 052600
(Use Sticker if available) Review Date: |__|__|/|__|__|/|__|__|__|__|

LS1.	As the Linkage Manager, did you	Yes	No
a.	review the participant's substance use and related problems?	1	0
b.	review the problems the participant might have in trying to go to treatment or stay in treatment?	1	0
c.	review the reasons why he/she might want to go to treatment?	1	0
d.	offer to help him/her make an appointment for treatment intake assessment?	1	0
e.	offer to help with transportation or other things so that he/she could go for the intake appointment?	1	0

LS5.	As the Linkage Manager, I...	Strongly Disagree	Disagree	Mixed	Agree	Strongly Agree
a.	did a good job 1	2	3	4	5	
b.	was fair with the participant	1	2	3	4	5
c.	argued with the participant1	2	3	4	5	
d.	explained the rules of the program.	1	2	3	4	5
e.	had the time to see the participant	1	2	3	4	5
f.	respected the participant. 1	2	3	4	5	
g.	explained what the meeting was supposed to accomplish 1	2	3	4	5	
h.	asked for their opinions about the problems.	1	2	3	4	5
i.	had a good understanding of their substance use and problems 1	2	3	4	5	
j.	helped the participant recognize their substance use problem . .	1	2	3	4	5
k.	helped them think about how their life could be better if they stopped using drugs and alcohol	1	2	3	4	5
l.	pressured them to do something about their substance use	1	2	3	4	5
m.	helped them do something about their substance use	1	2	3	4	5
n.	got them to want to go back to treatment more	1	2	3	4	5
o.	helped them feel good about their self	1	2	3	4	5
p.	was sensitive to their cultural background.	1	2	3	4	5
q.	talked down to them	1	2	3	4	5
r.	gave them enough help for now.	1	2	3	4	5
s.	was someone they would gladly work with again	1	2	3	4	5

LS6

a. To what extent did you **discuss the participant's current motivation** to participate in substance abuse treatment?

1……….……..2……..…..….3…….….…….4……………..5
not at all a little somewhat considerably extensively

b. To what extent did you attempt to **focus on ambivalence** (mixed feelings) about going to substance abuse treatment?

1……….……..2……..…..….3…….….…….4……………..5
not at all a little somewhat considerably extensively

c. To what extent did you attempt to **elicit self-motivational statements** from the participant?
1……….……..2……..…..….3……….…….4……………..5
not at all a little somewhat considerably extensively

d. To what extent did you **encourage the participant to consider** returning to substance abuse treatment?
1……….……..2……..…..….3……….…….4……………..5
not at all a little somewhat considerably extensively

e. To what extent did you **communicate understanding** of the participant's concerns, **through reflective comments**?
1……….……..2……..…..….3……….…….4……………..5
not at all a little somewhat considerably extensively

f. To what extent did you respond to the participant with **empathy and acceptance**?
1……….……..2……..…..….3……….…….4……………..5
not at all a little somewhat considerably extensively

g. To what extent did the participant appear **motivated for abstinence**?
1……….……..2……..…..….3……….…….4……………..5
not at all a little somewhat considerably extensively

h. To what extent did the participant appear **motivated to reduce** their substance use?
1……….……..2……..…..….3……….…….4……………..5
not at all a little somewhat considerably extensively

i. To what extent was the **participant resistant** to considering treatment?
1……….……..2……..…..….3……….…….4……………..5
not at all a little somewhat considerably extensively

j. To what extent did you **roll with resistance**?
1……….……..2……..…..….3……….…….4……………..5
not at all a little somewhat considerably extensively

Appendix F

ERI Linkage Manager Supervisor Form

For office use only:

Participant ID [XPID]: |___|___|___|___| Version: 052600
(Use Sticker if available) Review Date: |__|__|/|__|__|/|__|__|__|__|

LS1.	Did the Linkage Manager...	Yes	No
a.	review the participant's substance use and related problems?	1	0
b.	review the problems the participant might have in trying to go to treatment or stay in treatment?	1	0
c.	review the reasons why he/she might want to go to treatment?	1	0
d.	offer to help him/her make an appointment for treatment intake assessment?	1	0
f.	offer to help with transportation or other things so that he/she could go for the intake appointment?	1	0

LS5.	The Linkage Manager...	Strongly Disagree	Disagree	Mixed	Agree	Strongly Agree
a.	did a good job 1	2	3	4	5	
b.	was fair with the participant	1	2	3	4	5
c.	argued with the participant1	2	3	4	5	
d.	explained the rules of the program.	1	2	3	4	5
e.	had the time to see the participant	1	2	3	4	5
f.	respected the participant. 1	2	3	4	5	
g.	explained what the meeting was supposed to accomplish 1	2	3	4	5	
h.	asked for their opinions about the problems.	1	2	3	4	5
i.	had a good understanding of their substance use and problems 1	2	3	4	5	
k.	helped the participant recognize their substance use problem . .	1	2	3	4	5
k.	helped them think about how their life could be better if they stopped using drugs and alcohol	1	2	3	4	5
l.	pressured them to do something about their substance use	1	2	3	4	5
m.	helped them do something about their substance use	1	2	3	4	5
n.	got them to want to go back to treatment more	1	2	3	4	5
o.	helped them feel good about their self	1	2	3	4	5
p.	was sensitive to their cultural background.	1	2	3	4	5
q.	talked down to them	1	2	3	4	5
r.	gave them enough help for now.	1	2	3	4	5
s.	was someone they would gladly work with again	1	2	3	4	5

LS6

f. To what extent did the Linkage Manager **discuss the participant's current motivation** to participate in substance abuse treatment?

1……….……..2……..…..…3…………….…4……………..5
not at all a little somewhat considerably extensively

g. To what extent did the Linkage Manager attempt to **focus on ambivalence** (mixed feelings) about going to substance abuse treatment?

1……….……..2……..…..…3…………….…4……………..5
not at all a little somewhat considerably extensively

---

h. To what extent did the Linkage Manager attempt to **elicit self-motivational statements** from the participant?

1……….……..2……..…..….3…….….……4……………..5

not at all a little somewhat considerably extensively

i. To what extent did the Linkage Manager **encourage the participant to consider** returning to substance abuse treatment?

1……….……..2……..…..….3…….….……4……………..5

not at all a little somewhat considerably extensively

j. To what extent did the Linkage Manager **communicate understanding** of the participant's concerns, **through reflective comments**?

1……….……..2……..…..….3…….….……4……………..5

not at all a little somewhat considerably extensively

f. To what extent did the LM respond to the participant with **empathy and acceptance**?

1……….……..2……..…..….3…….….……4……………..5

not at all a little somewhat considerably extensively

g. To what extent did the participant appear **motivated for abstinence**?

1……….……..2……..…..….3…….….……4……………..5

not at all a little somewhat considerably extensively

k. To what extent did the participant appear **motivated to reduce** their substance use?

1……….……..2……..…..….3…….….……4……………..5

not at all a little somewhat considerably extensively

l. To what extent was the participant resistant to considering treatment?

1……….……..2……..…..….3…….….……4……………..5

not at all a little somewhat considerably extensively

m. To what extent did the Linkage Manager **roll with resistance**?

1……….……..2……..…..….3…….….……4……………..5

not at all a little somewhat considerably extensively

Appendix G

ERI Linkage Mgmt Module - [Linkage-MainForm : Form]

ClientID	Lastname	Firstname	Project
3058			ERI-3mthFllwUp

Find Client

Linkage Management meeting

LM-staff: 1512
Stay-Mtg: Yes
Stay-reason:
LMDate: 10/4/2000
LMBeginTime: 10:45 AM
LMEndTime: 11:10 AM
LM outcome: Will call if interested
Not interested reason:
Transportation: No
Comments: client stated she did need treatment but will call back later today for arrangements for an appointment. Client was extremely ill.

Record: 1 of 1

Linkage Scheduling

Scheduled Assessment: No / Yes / N/A (checked) — Sched Date — Sched Time
Showed to Assessment: N/A — Showed Date
Tx appt date — Tx appt time — Program
Other Tx program — Program requirements
Showed to Tx: N/A — Showed Date

Record: 1 of 1

Linkage events
Linkage3mth
Linkage 6mth
Linkage 9mth
Linkage Date

LM-Staff	Event date	Time began	Time ended	
6477	1/5/2001	12:12 PM	12:12 PM	797

LM-Task	LM-Event	LM-Disp	LM-Outcome1	LM-Outcome2
Follow-up	Call	Received a ca	Left message	

Comments: received call from Meshoun, that clt was not at residence, so Meshoun left flyer.

Record: 1 of 1792

Form View NUM