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Representative Boone: How much does the mORe campaign cost?
The budget allocated to the mORe campaign is $300,000 per biennium. The campaign includes educational and survey components as well as public awareness focused on reducing underage drinking.
See also http://www.oregonmore.org/

Senator Winters: How many Oregon Department of Corrections inmates have mental health issues and how many have substance use issues?
AMH inquired with the Department of Corrections (DOC) on these questions based on the current incarcerated population. In summary, 58 percent of the inmates now incarcerated in DOC have serious substance use disorders. Among the same population of 14, 602 inmates, 18 percent have severe and serious mental health needs.

This compares to about 5.4 percent of adult Oregonians (164,000) have serious mental illness and about 18.6 percent of adults (566,000) have a substance use disorder diagnosis of abuse or dependence.

Senator Bates: Of those inmates being released from prison, what is the time frame between release date and the first treatment appointment for those with substance abuse problems?
Since 2000, roughly 27 percent of the people released from correction facilities were seen in substance abuse disorder services after release. Slightly more than 50 percent of those people in the prison system have received substance abuse disorder services before, during, or after release.

For people released from prison and seen for substance abuse disorder services, about 10 percent are seen in the year before they are released. For those seen for

substance abuse services after release, 47 percent are seen within a month and 58 percent are seen within two months of release.

Senator Bates: How is Supported Employment funded?
Individual Placement and Support (IPS) Supported Employment is a Medicaid reimbursable service. In addition, the 2013 legislative mental health investments also fund staffing infrastructure for 75 Supported Employment Specialists in Oregon. The Oregon Supported Employment Center of Excellence is funded by Addictions and Mental Health. Appendix A (Pages 11-12)

Senator Bates: Please provide information about Parent Child Interaction Therapy and national data on PCIT and evidence of success. Provide a list of PCIT programs in Oregon, how are children referred, how many were enrolled, what is the waitlist, how are these programs tracked and what is the outcome data?
Most recent studies on the effectiveness of PCIT are listed below:
Nationally, research shows PCIT improves attachment, communication, the effects of chronic trauma and neglect, anxiety, moderate to mild autism, hyperactivity, aggression, tantrums, sassing, defiance and other problems. The research base for PCIT comes from more than 250 studies, 30 of which were randomized clinical studies.
A detailed list of PCIT studies is attached as Appendix B. (Pages 13-33)

Where PCIT programs are located: There are 30 sites in 16 counties providing PCIT: Yamhill, Jackson, Josephine, Coos, Lincoln, Linn, Columbia, Multnomah, Clackamas, Washington, Malheur, Marion, Wasco, Sherman, Hood River and Lane. See attached for more detailed description of sites. Appendix C (Pages 34-36)

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How children are referred to PCIT: PCIT is a mental health therapy which requires a mental health assessment to determine appropriate services. If the clinician and family determine PCIT is the best intervention for the current problem(s), the family then moves into PCIT. Parents are often self-refer due to challenges managing their child's behavior. Other referral sources include: primary care physicians, Head Start (and other preschools), Early Intervention Development Programs, the child's elementary school, Child Welfare, adult substance abuse programs and other community partners.

PCIT enrollment, waitlist and outcomes: In 2014, 600 families received PCIT services in agencies receiving AMH funding. Wait times between a caregiver requesting counseling services and starting PCIT varies by site. Some sites have "open access" mental health assessments which then can lead directly into PCIT services. Some sites have wait lists, especially sites which are fairly new to PCIT. Once their community learns that this effective therapy is available, demand can be high. The estimated range reported by AMH funded PCIT sites is from 1 week to 6 weeks. Sites with a wait list have reported that they provide the mental health assessment and supportive services to the family until a PCIT trained therapist is available. Programs that have been operating PCIT for multiple years have anticipated the need and trained the right number of clinicians to meet the demand of the community so wait lists are less likely. Outcomes for January through September of 2014 in Oregon are similar to outcomes in national studies.

- 76.7 percent of children ended PCIT services with behavior in the normal range, according to behavior measures and clinician observations.
- 62 percent of parent/child pairs showed improvement in their relationships.

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Senator Winters: What parenting programs are available in Oregon? Also, please provide the list of evidence-based prevention practices and programs referenced during the presentation.

Response: The following evidence-based parenting programs are implemented in Oregon. These programs represent a sample of what we know are being implemented. In addition, a list of known evidence-based and culturally validated prevention programs that was referenced during the committee hearing is attached as requested. Appendix D (Page 37)

Program	Focus Areas
Active Parenting Now	Mental health
Guiding Good Choices	Mental health and substance abuse
Parents as Teachers	Mental health
Strengthening Families Program Strengthening Families Program 10 – 14 Strengthening Families Program Multi-Ethnic Families	Mental health and substance Abuse
The Incredible Years	Mental health

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Representative Nathanson: Please provide a map showing where residential treatment programs are located throughout Oregon.
See attached maps Appendix E (Page38) and Appendix F (Page 39)

Senator Bates: What is the housing availability for people with low-incomes?
To help people find affordable housing more easily, the Oregon Health Authority Addictions and Mental Health Division (AMH) has created *Affordable Housing Inventory*. Its goal is to increase access to affordable housing for people in recovery. Behavioral health providers, advocates, people in recovery, and their families and friends can search the inventory for affordable rentals that support independent living.

The *Affordable Housing Inventory* provides a statewide list of affordable properties in an easy-to-use format. The online database lets users search properties in Oregon and get their contact information. Users can sort by city, county or property type. The results of the inventory are attached to this response – Appendix L (Pages 144-173). Soon an interactive web page will be up on the AMH web site (http://www.oregon.gov/oha/amh/Pages/index.aspx) so that people can sort the inventory date by county and other variables.

Senator Winters: Please provide a copy of the NPC Research study data on substance abuse treatment outcomes.
See attachments Appendix G (Pages 40-41) and Appendix H (Pages 42-140)

Representative Nathanson: Do you have any documentation of evidence that health issues improved when people received addiction treatment?
See attached integration info-graphic with citations and fact sheet.
Appendix I (Page 141)

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The following summaries from studies conducted by the state of Washington are provided.

2006: A review of medical expenses of Washington Medicaid clients who received addiction treatment noted health care savings every month:

- $170 for people accessing inpatient treatment;
- $215 for people accessing outpatient treatment;
- $230 for people accessing methadone treatment:

2008: Analyzed impact of $21 million treatment expansions in FY 2005-07. Realized savings in Medicaid: $17.8 million (Mancuso & Norlund).

Committee: How many people access residential substance use and mental health services?

The numbers below represent fiscal year 2014 data for unique individuals who accessed these services:

- Adult mental health residential – 1,971
- Child/youth mental health residential – 727
- Adult substance use disorder residential – 3,974
- Dependent child with parent residential – 524
- Youth substance use disorder residential – 480

Senator Bates: How are school-based health centers fitting into the mental health system? What happens to youth during the summer when they have accessed mental health services during the school year?

Youth who access mental health services during the school year at school-based health centers receive summer-time care at community mental health programs. It is routine practice for youth to be linked to summer-time mental health care when school is no longer in session.

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As of October 2014:

- Sixteen School-based Health Centers (SBHC) are open in the evening (past 5 p.m.) on at least one day each week
- Eleven SBHCs were open during the summer
- Thirty-one SBHCs also serve non-school aged clients (faculty/staff, parents, other adult community members)

Representative Stark: Why are we assuming we will have an increase in civil commitment population (referring to slide #50 of the AMH Ways and Means presentation)?

Linda Ames provided background information about the caseload forecasting methodology to Representative Stark. Her response is re-stated here for the Committee:

> The forecast has the average number of civil commitments during the 2013-15 Biennium at 1,303 and the average number during the 2015-17 biennium is 1,364. The forecast is developed by the Office of Forecasting, Research and Analysis at OHA, with input from the Forecast Advisory Committee. This particular forecast is based on historic trends during the last several years. While the agency's policy direction is to reduce the number of civilly committed people, many of the new investments have only been in effect for the last year. We are not yet seeing a change in the trend line. In addition, the agency only has data through June 2014, making it even less likely that we would see a change in the trend line yet. At this point, the Committee believed it was prudent to stay with the trend line that we are seeing. This forecast will be updated in fall, 2015, at which time we expect to see the new data out of the MOTS system, and we may begin to see the trend line change with that new data.

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Senator Winters: Which counties have the highest utilization at Oregon State Hospital for Aid and Assist and what are the trends?
The attached table has data regarding aid and assist admissions by county and criminal charges. AMH is reviewing trends by county and will return with more detail once complete. Appendix J (Page 142)

Based on the attached table, the following 4 counties are the top counties for referring patients to the state hospital for aid and assist restoration:

- Multnomah
- Marion
- Lane
- Washington

Based on an average length of stay for a patient at OSH for aid and assist restoration, 105.8 days, and the daily cost of care of $806.46 the cost for each patient's stay is $85,323.47.

Senator Bates: Which counties are disproportionately sending people to Oregon State Hospital compared to their population?
The attached table shows the county percentage of state population compared to the county percentage of aid and assist admissions. Appendix K (Page 143)

Representative Stark: Where does OLCC funding fall into the AMH budget?
The OLCC funding shows up in Other Fund revenue in the Addictions and Mental Health (AMH) budget. AMH receives funding that has been dedicated to the Mental Health Alcoholism Services Account appropriated monthly by OLCC. AMH manages 60 percent of the account and counties receive the other 40 percent directly. The portion AMH manages is separated, by statute, into 20 percent, which must be directed to prevention and treatment of correctional populations

and 40 percent, which must be directed to prevention and treatment of the general population. AMH allocates these funds to units of local government and non-profit organizations that serve a county or geographic area representing multiple counties. AMH enters into a matching fund relationship with contractors who also receive Beer and Wine taxes from OLCC to provide alcohol and drug prevention and treatment services. The counties are required to use the 40% directly allocated to them as part of the match toward service plans for alcohol and drug services.

Senator Steiner-Hayward: What has AMH done to build incentives for people to enter the behavioral health workforce?

Addictions and Mental Health (AMH) has several workforce programs underway right now to build capacity.

- AMH contracts with Portland State University to provide scholarships to 10 clinicians to participate in the five- term Infant-Toddler Mental Health Graduate Certificate Program to build early childhood mental health workforce expertise. Scholarship recipients agree to work for and equivalent number of months in agencies serving Medicaid eligible children under five years old, after completing the program.
- AMH contracts with Oregon Health & Science University, Office of Rural Health to administer a Behavioral Health Loan Repayment Program (BHLRP), which is intended to expand the behavioral health workforce in Oregon serving underserved populations. The program works primarily in rural areas and cultural or ethnic communities that are underrepresented in behavioral health services.
- AMH contracts with Portland Community College to provide 10 scholarships yearly to African Americans who want to pursue addiction counseling careers. AMH contracts with the Addiction Counselor Certification Board of

Oregon for cohort training for tribal counselors who need to become certified.

- AMH works with the Center for Substance Abuse Prevention and the Addiction Counselor Certification Board of Oregon to provide cohort training for prevention specialists needing certification.

Jackson County received $137,438 from the 2013 Mental Health Investments for its Supported Employment program in the 2013-2015 Biennium. Supported Employment is a Medicaid-covered service. The investment funded, in part, five Supported Employment FTE positions. In the fourth quarter of 2014, the Jackson County program reported to the Oregon Supported Employment Center for Excellence (OSECE) that it served 125 individuals.

Additionally, Jackson County received $116,417 from the Mental Health Block Grant in the 2103-2015 Biennium to provide Supported Education services. These funds were used to hire one Supported Education FTE. Supported Education is not, in and of itself, a Medicaid-billable service. Mental Health Block Grant funds were also used, in part, to provide direct Supported Education services.

Please see the table below:

Jackson County Supported Employment and Supported Education Funding			
Program	**Funding Source**	**2013-2015 Amount**	**Roll-up?**
Supported Employment	General Funds (100% 2013 Mental Health Investment)	$137,438	Yes
Supported Education	Mental Health Block Grant Discretionary (100% Federal)	$116,417	No
	Total:	**$253,855**	

The table below represents the distribution of funds for the Supported Employment program for the 2013-2015 Biennium:

Supported Employment	
CMHP	**2013-2015 Distribution**
Baker County	$37,500
Benton County	$59,281
Clackamas County	$267,550
Clatsop County	$37,500
Columbia County	$37,500
Coos County	$68,947
Crook County	$53,580
Curry County	$37,500
Deschutes County	$154,038
Douglas County	$72,581
Gilliam County (CCS)	$14,063
Grant County (CCS)	$14,063
Harney County	$37,500
Jackson County	$137,438
Jefferson County	$37,500
Josephine County	$78,121
Klamath County	$46,375
Lake County	$37,500
Lane County	$311,699
Lincoln County	$37,500
Linn County	$78,390
Malheur County	$38,400
Marion County	$225,732
Mid-Columbia Center for Living (Hood River, Sherman, and Wasco counties)	$108,096
Morrow County (CCS)	$14,063
Multnomah County	$615,824
Polk County	$51,437
Tillamook County	$37,500
Umatilla County	$50,238
Union County	$37,500
Washington County	$384,783
Wallowa County	$37,500
Wheeler County (CCS)	$14,063
Yamhill County	$91,208
Total:	**$3,362,468**
*Funded prior to 2013 Mental Health Investments	
*Funds comprised of 2013 Mental Health Investments and other General Funds	

Year	Category 1	Category 2	Title	Authors	Journal	APA Format Reference	Link
2014	Effectiveness Study		Preventing maltreatment with a community-based implementation of Parent-Child interaction therapy.	Lanier, P., Kohl, P. L., Benz, J., Swinger, D., & Drake, B.	Journal of Child and Family Studies	Lanier, P., Kohl, P. L., Benz, J., Swinger, D., & Drake, B. (2014). Preventing maltreatment with a community-based implementation of Parent-Child interaction	http://link.springer.com/article/10.1007/s10826-012-9708-8
2014	Efficacy Study		Parent training for children born premature: A pilot study examining the moderating role of emotion regulation.	Rodríguez, G. M., Bagner, D. M., & Graziano, P. A.	Child Psychiatry and Human Development	Rodríguez, G. M., Bagner, D. M., & Graziano, P. A. (2014). Parent training for children born premature: A pilot study examining the moderating role of emotion	http://link.springer.com/article/10.1007/s10578-013-0385-7
2014	Adaptations		Home-Based Parent-Child Therapy in Low-Income African American, Caucasian, and Latino Families: A Comparative Examination of Treatment Outcomes	Gresl, B. L., Fox, R. A., & Fleischmann, A.	Child & Family Behavior Therapy	Gresl, B. L., Fox, R. A., & Fleischmann, A. (2014). Home-Based Parent-Child Therapy in Low-Income African American,	http://www.tandfonline.com/doi/pdf/10.1080/07317107.2014.878193
2014	Effectiveness Study		Exploring the role of natural helpers in efforts to address disparities for children with conduct problems	Acevedo-Polakovich, I. D., Niec, L. N., Barnett, M. L., Bell, K. M., Aguilar, G., Vilca, J., ... & Peer, S. O.	Children and Youth Services Review	Caucasian, and Latino Families: A Acevedo-Polakovich, I. D., Niec, L. N., Barnett, M. L., Bell, K. M., Aguilar, G., Vilca, J., ... & Peer, S. O. (2014). Exploring the role of natural helpers in efforts to address	http://www.sciencedirect.com/science/article/pii/S0190740914000474
2014	Efficacy Study		The Efficacy of Parent-Child Interaction Therapy With Chinese Families: Randomized Controlled Trial	Leung, C., Tsang, S., Sin, T. C., & Choi, S. Y.	Research on Social Work Practice	Leung, C., Tsang, S., Sin, T. C., & Choi, S. Y. (2014). The Efficacy of Parent-Child Interaction Therapy With Chinese Families: Randomized Controlled Trial. Research on	http://rsw.sagepub.com/content/early/2014/01/16/1049731513519827.abstract
2014	Effectiveness Study		Preventing Maltreatment with a Community-Based Implementation of Parent-child Interaction therapy	Lanier, P., Kohl, P., Benz, J., Swinger, D., & Drake, B.	Journal Of Child & Family Studies	Lanier, P., Kohl, P., Benz, J., Swinger, D., & Drake, B. (2014). Preventing Maltreatment with a Community-Based Implementation of Parent-Child Interaction Therapy.	http://link.springer.com/article/10.1007/s10826-012-9708-8/fulltext.html
2014	Effectiveness Study		Study protocol for a comparative effectiveness trial of two parent training programs in a fee-for-service mental health clinic: can we improve mental health services to low-income families?	Gross, D. A., Belcher, H. M., Ofonedu, M. E., Breitenstein, S., Frick, K. D., & Chakra, B.	Trials	Gross, D. A., Belcher, H. M., Ofonedu, M. E., Breitenstein, S., Frick, K. D., & Chakra, B. (2014). Study protocol for a comparative effectiveness trial of two parent training	http://www.biomedcentral.com/content/pdf/1745-6215-15-70.pdf
2014	Adaptations		Parent-Child Interaction Therapy and autism spectrum disorder: Adaptations with a child with severe developmental delays.	Lesack, R., Bearss, K., Celano, M., & Sharp, W. G.	Clinical Practice In Pediatric Psychology	Lesack, R., Bearss, K., Celano, M., & Sharp, W. G. (2014). Parent-Child Interaction Therapy and autism spectrum disorder: Adaptations with a child with severe	http://psycnet.apa.org/journals/cpp/2/1/68/
2014	Effectiveness		Comparing Client Outcomes for Two Evidence-Based Treatment Consultation Strategies	Funderburk, B., Chaffin, M., Bard, E., Shanley, J., Bard, D., & Berliner, L.	Journal of Clinical Child & Adolescent Psychology	Funderburk, B., Chaffin, M., Bard, E., Shanley, J., Bard, D., & Berliner, L. (2014). Comparing Client Outcomes for Two Evidence-Based Treatment Consultation	http://www.tandfonline.com/doi/pdf/10.1080/15374416.2014.910790
2014	Effectiveness Study		Parent-Child Interaction Therapy for Toddlers: A Pilot Study	Kohlhoff, J., & Morgan, S.	Child & Family Behavior Therapy	Kohlhoff, J., & Morgan, S. (2014). Parent-Child Interaction Therapy for Toddlers: A Pilot Study. *Child & Family Behavior Therapy, 36*(2), 121-139.	http://www.tandfonline.com/doi/pdf/10.1080/07317107.2014.910733
2014	Efficacy Study		Feasibility of Intensive Parent-Child Interaction Therapy (I-PCIT): Results from an Open Trial	Graziano, P. A., Bagner, D. M., Slavec, J., Hungerford, G., Kent, K., Babinski, D., ... & Pasalich, D.	Journal of Psychopathology and Behavioral Assessment	Graziano, P. A., Bagner, D. M., Slavec, J., Hungerford, G., Kent, K., Babinski, D., ... & Pasalich, D. (2014). Feasibility of Intensive Parent-Child Interaction Therapy (I-PCIT):	http://link.springer.com/article/10.1007/s10862-014-9435-0
2014	Adaptations		Parent-Child Interaction Therapy With Deaf Parents and Their Hearing Child A Case Study	Armstrong, K., David, A., & Goldberg, K.	Clinical Case Studies	Armstrong, K., David, A., & Goldberg, K. (2014). Parent-Child Interaction Therapy With Deaf Parents and Their Hearing Child A Case Study. Clinical Case Studies, 13(2),	http://ccs.sagepub.com/content/13/2/115
2014	Reviews		Parent-Child Interaction Therapy: A Meta-Analysis of Child Behavior Outcomes and Parent Stress	Cooley, M. E., Veldorale-Griffin, A., Petren, R. E., & Mullis, A. K.	Journal of Family Social Work	Cooley, M. E., Veldorale-Griffin, A., Petren, R. E., & Mullis, A. K. (2014). Parent-Child Interaction Therapy: A Meta-Analysis of Child Behavior Outcomes and Parent	http://www.tandfonline.com/doi/pdf/10.1080/10522158.2014.888696

2014	Adaptations		Combining Parent-Child Interaction Therapy and Visual Supports for the Treatment of Challenging Behavior in a Child With Autism and Intellectual Disabilities and Comorbid Epilepsy	Armstrong, K., DeLoatche, K. J., Preece, K. K., & Agazzi, H.	Clinical Case Studies	Armstrong, K., DeLoatche, K. J., Preece, K. K., & Agazzi, H. (2014). Combining Parent-Child Interaction Therapy and Visual Supports for the Treatment of Challenging	http://ccs.sagepub.com/content/early/2014/04/22/1534650114531451
2014	Process	Efficacy Study	Language Production in Children With and At Risk for Delay: Mediating Role of Parenting Skills	Garcia, D., Bagner, D. M., Pruden, S. M., & Nichols-Lopez, K.	Journal of Clinical Child and Adolescent Psychology	Garcia, D., Bagner, D. M., Pruden, S. M., & Nichols-Lopez, K. (2014). Language Production in Children With and At Risk for Delay: Mediating Role of Parenting Skills.	http://www.tandfonline.com/doi/pdf/10.1080/15374416.2014.900718
2014	Efficacy Study		Parent training outcomes among young children with callous-unemotional conduct problems with or at risk for developmental delay	Kimonis, E. R., Bagner. D. M., Linares, D., & Blake, C. A., & Rodríguez, G. M.	Journal of Child & Family Studies	Kimonis, E. R., Bagner. D. M., Linares, D., & Blake, C. A., & Rodríguez, G. M. (2014). Parent training outcomes among young children with callous-unemotional conduct	http://link.springer.com/article/10.1007/s10826-013-9756-8/fulltext.html
2014	Efficacy Study		Parent training for children born premature: A pilot study examining the moderating role of emotion regulation	Rodríguez, G. M., Bagner, D. M., & Graziano, P. A.	Child Psychiatry and Human Development	Rodríguez, G. M., Bagner, D. M., & Graziano, P. A. (2014). Parent training for children born premature: A pilot study examining the moderating role of emotion	http://link.springer.com/article/10.1007%2Fs10578-013-0385-7
2013	Process		A pilot study examining trainee treatment session fidelity when Parent-Child Interaction Therapy (PCIT) is implemented in community settings.	Travis, J. K., & Brestan-Knight, E.	The Journal of Behavioral Health Services & Research	Travis, J. K., & Brestan-Knight, E. (2013). A pilot study examining trainee treatment session fidelity when Parent-Child Interaction Therapy (PCIT) is implemented	http://web.ebscohost.com/ehost/detail?sid=ad07fad1-dba9-44cf-a720-bfd2d4155313%40sessi
2013	Adaptations		Kids at the VA? A call for evidence-based parenting interventions for returning veterans.	Pemberton, J. R., Kramer, T. L., Borrego, J. r., & Owen, R. R.	Psychological Services	Pemberton, J. R., Kramer, T. L., Borrego, J. r., & Owen, R. R. (2013). Kids at the VA? A call for evidence-based parenting interventions for returning veterans.	http://psycnet.apa.org/journals/ser/10/2/194/
2013	Adaptations		Coaching approach behavior and leading by modeling: Rationale, principles, and a session-by-session description of the CALM program for early childhood anxiety.	Puliafico, A. C., Comer, J. S., & Albano, A.	Cognitive and Behavioral Practice	Puliafico, A. C., Comer, J. S., & Albano, A. (2013). Coaching approach behavior and leading by modeling: Rationale, principles, and a session-by-session description of the	http://www.sciencedirect.com/science/article/pii/S1077722912000739
2013	Processs	Qualitative and Case Studies	Differential attention as a mechanism of change in Parent-Child Interaction Therapy: Support from time-series analysis.	Pemberton, J. R., Borrego Jr, J., & Sherman, S.	Journal of Psychopathology and Behavioral Assessment	Pemberton, J. R., Borrego Jr, J., & Sherman, S. (2013). Differential attention as a mechanism of change in Parent-Child interaction therapy: Support from time-	http://link.springer.com/article/10.1007/s10862-012-9312-7
2013	Process		Behavioral parent training skills and child behavior: The utility of behavioral descriptions and reflections.	Tempel, A. B., Wagner, S. M., & McNeil, C. B.	Child & Family Behavior Therapy	Tempel, A. B., Wagner, S. M., & McNeil, C. B. (2013). Behavioral parent training skills and child behavior: The utility of behavioral descriptions and reflections. *Child & Family*	http://www.tandfonline.com/doi/pdf/10.1080/07317107.2013.761009
2013	Qualitative and Case Studies	Adaptations	Home-based preventive parenting intervention for at-risk infants and their families: An open trial.	Bagner, D. M., Rodríguez, G. M., Blake, C. A., & Rosa-Olivares, J.	Cognitive and Behavioral Practice	Bagner, D. M., Rodríguez, G. M., Blake, C. A., & Rosa-Olivares, J. (2013). Home-based preventive parenting intervention for at-risk infants and their families: An open	http://www.sciencedirect.com/science/article/pii/S1077722912001010
2013	Adaptations		Parent-Child Interaction Therapy With a Deaf and Hard of Hearing Family	Shinn, M. M.	Clinical Cases Studies	Shinn, M. M. (2013). Parent-Child Interaction Therapy With a Deaf and Hard of Hearing Family. Clinical Case Studies, 12(6). 411-427.	http://ccs.sagepub.com/content/12/6/411
2013	Adaptations		Father's role in parent training for children with developmental delay	Bagner, D. M.	Journal of Family Psychology	Bagner, D. M. (2013). Father's role in parent training for children with developmental delay. *Journal of Family Psychology, 27*(4). 650-657.	http://psycnet.apa.org/journals/fam/27/4/650.html
2013	Efficacy Study		Barriers to success in parent training: The role of cumulative risk.	Bagner, D. M., & Graziano, P. A.	Behavior Modification	Bagner, D. M., & Graziano, P. A. (2013). Barriers to success in parent training: The role of cumulative risk. *Behavior Modification, 37*(3). 356-377. doi:	http://bmo.sagepub.com/content/37/3/356
2012	Adaptations	Effectiveness Study	Parent-child interaction therapy for Mexican Americans: Results of a pilot randomized clinical trial at follow-up.	McCabe, K., Yeh, M., Lau, A., & Argote, C.	Behavior Therapy	McCabe, K., Yeh, M., Lau, A., & Argote, C. (2012). Parent-child interaction therapy for Mexican Americans: Results of a pilot randomized clinical trial at follow-up.	http://www.sciencedirect.com/science/article/pii/S0005789411001390

2012	Effectiveness Study	Adaptations	Parent-Child interaction therapy for preschool children with disruptive behaviour problems in the Netherlands.	Abrahamse, M. E., Junger, M., Chavannes, E., Coelman, F. G., Boer, F., & Lindauer, R. L.	Child and Adolescent Psychiatry and Mental Health	Abrahamse, M. E., Junger, M., Chavannes, E., Coelman, F. G., Boer, F., & Lindauer, R. L. (2012). Parent-Child interaction therapy for preschool children with disruptive	http://www.biomedcentral.com/content/pdf/1753-2000-6-24.pdf
2012	Effectiveness Study	Adaptations	Rationale and modifications for implementing parent-child interaction therapy with rural Appalachian parents.	Taubenheim, A., & Tiano, J. D.	Journal of Rural Mental Health	Taubenheim, A., & Tiano, J. D. (2012). Rationale and modifications for implementing parent-child interaction therapy with rural Appalachian parents.	http://psycnet.apa.org/journals/rmh/36/2/16/
2012	Efficacy Study	Adaptations	A novel early intervention for preschool depression: Findings from a pilot randomized controlled trial.	Luby, J., Lenze, S., & Tillman, R.	Journal of Child Psychology and Psychiatry	Luby, J., Lenze, S., & Tillman, R. (2012). A novel early intervention for preschool depression: Findings from a pilot randomized controlled trial. *Journal Of*	http://onlinelibrary.wiley.com/doi/10.1111/j.1469-7610.2011.02483.x/full
2012	Efficacy Study		Parent-Child Interaction Therapy: An evidence-based treatment for child maltreatment..	Thomas, R., & Zimmer-Gembeck, M. J.	Child Maltreatment	Thomas, R., & Zimmer-Gembeck, M. J. (2012). Parent-Child Interaction Therapy: An evidence-based treatment for child maltreatment. Child Maltreatment, 17(3),	http://cmx.sagepub.com/content/17/3/253
2012	Effectiveness Study		Utilizing benchmarking to study the effectiveness of parent-child interaction therapy implemented in a community setting.	Self-Brown, S., Valente, J. R., Wild, R. C., Whitaker, D. J., Galanter, R., Dorsey, S., & Stanley, J.	Journal of Child and Family Studies	Self-Brown, S., Valente, J. R., Wild, R. C., Whitaker, D. J., Galanter, R., Dorsey, S., & Stanley, J. (2012). Utilizing benchmarking to study the effectiveness of parent-child	http://link.springer.com/article/10.1007/s10826-012-9566-4/fulltext.html
2012	Adaptations	Qualitative and Case Studies	Parent-child interaction therapy as a family-oriented approach to behavioral management following psychiatric traumatic brain injury: A case report.	Cohen, M. L., Heaton, S. C., Ginn, N., & Eyberg, S. M.	Journal of Pediatric Psychology	Cohen, M. L., Heaton, S. C., Ginn, N., & Eyberg, S. M. (2012). Parent-child interaction therapy as a family-oriented approach to behavioral management	http://jpepsy.oxfordjournals.org/content/37/3/251.short
2012	Qualitative and Case Studie		Teaching to improve parent-child interaction: An educational case study.	Hall, S., & Warren, M.	Academic Psychiatry	Hall, S., & Warren, M. (2012). Teaching to improve parent-child interaction: An educational case study. *Academic Psychiatry, 36* (6), 465-467.	Teaching to improve parent-child interaction: An educational case
2012	Adaptations		Adapting parent-child interaction therapy to treat anxiety disorders in young children.	Puliafico, A. C., Comer, J. S., & Pincus, D. B.	Child and Adolescent Psychiatric Clinics of North America	Puliafico, A. C., Comer, J. S., & Pincus, D. B. (2012). Adapting parent-child interaction therapy to treat anxiety disorders in young children. *Child And Adolescent Psychiatric*	http://pcit.phhp.ufl.edu/literature/pincuseyberg2005.pdf
2012	Effectiveness Study	Adaptations	Effectiveness of Parent-Child interaction therapy delivered to at-risk families in the home setting.	Galanter, R., Self-Brown, S., Valente, J. R., Dorsey, S., Whitaker, D. J., Bertuglia-Haley, M., & Prieto, M.	Child & Family Behavior Therapy	Galanter, R., Self-Brown, S., Valente, J. R., Dorsey, S., Whitaker, D. J., Bertuglia-Haley, M., & Prieto, M. (2012). Effectiveness of Parent-Child interaction therapy delivered	http://www.tandfonline.com/doi/pdf/10.1080/07317107.2012.707079
2012	Effectiveness study		Effectiveness of community dissemination of Parent-Child interaction therapy.	Pearl, E., Thieken, L., Olafson, E., Boat, B., Connelly, L., Barnes, J., & Putnam, F.	Psychological Trauma: Theory, Research, Practice, and Policy	Pearl, E., Thieken, L., Olafson, E., Boat, B., Connelly, L., Barnes, J., & Putnam, F. (2012). Effectiveness of community dissemination of Parent-Child interaction	http://psycnet.apa.org/journals/tra/4/2/204/
2012	Effectiveness study	Adaptations	The Holding Hands Project: Effectiveness in promoting positive Parent-Child interactions.	Rait, S.	Educational Psychology in Practice	Rait, S. (2012). The Holding Hands Project: Effectiveness in promoting positive Parent-Child interactions. Educational Psychology In Practice, 28(4), 353-371.	http://www.tandfonline.com/doi/pdf/10.1080/02667363.2012.712916
2012	Efficacy study	Adaptations	An initial investigation of baseline respiratory sinus arrhythmia as a moderator of treatment outcome for young children born premature with externalizing behavior problems.	Bagner, D. M., Graziano, P. A., Jaccard, J., Sheinkopf, S. J., Vohr, B. R., & Lester, B. M.	Behavior Therapy	Bagner, D. M., Graziano, P. A., Jaccard, J., Sheinkopf, S. J., Vohr, B. R., & Lester, B. M. (2012). An initial investigation of baseline respiratory sinus arrhythmia as a	http://www.sciencedirect.com/science/article/pii/S0005789411001456
2012	Adaptations		Using an online viewing system for Parent-Child interaction therapy consulting with professionals.	Wilsie, C. C., & Brestan-Knight, E.	Psychological Services	Wilsie, C. C., & Brestan-Knight, E. (2012). Using an online viewing system for Parent-Child interaction therapy consulting with professionals. Psychological Services, 9(2),	http://psycnet.apa.org/journals/ser/9/2/224/
2012	Adaptations		A pilot feasibility evaluation of the CALM program for anxiety disorders in early childhood..	Comer, J. S., Puliafico, A. C., Aschenbrand, S. G., McKnight, K., Robin, J. A., Goldfine, M. E., & Albano, A.	Journal of Anxiety Disorders	Comer, J. S., Puliafico, A. C., Aschenbrand, S. G., McKnight, K., Robin, J. A., Goldfine, M. E., & Albano, A. (2012). A pilot feasibility evaluation of the CALM program for	http://www.sciencedirect.com/science/article/pii/S0887618511001460

2012	Efficacy Study		Evidence-based intervention for young children born premature: Preliminary evidence for associated changes in physiological regulation.	Graziano, P. A., Bagner, D. M., Sheinkopf, S. J., Vohr, B. R., & Lester, B. M.	Infant Behavior & Development	Graziano, P. A., Bagner, D. M., Sheinkopf, S. J., Vohr, B. R., & Lester, B. M. (2012). Evidence-based intervention for young children born premature: Preliminary	http://www.sciencedirect.com/science/article/pii/S0163638312000458
2012	Review		Disseminating child maltreatment interventions: Research on implementing evidence-based programs.	Self-Brown, S., Whitaker, D., Berliner, L., & Kolko, D.	Child Maltreatment	Self-Brown, S., Whitaker, D., Berliner, L., & Kolko, D. (2012). Disseminating child maltreatment interventions: Research on implementing evidence-based programs.	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3814165/pdf/nihms515008.pdf
2012	Adaptations	Effectiveness Study	Maternal ADHD: Parent-child interactions and relations with child disruptive behavior.	Zisser, A. R., & Eyberg, S. M.	Child & Family Behavior Therapy	Zisser, A. R., & Eyberg, S. M. (2012). Maternal ADHD: Parent-child interactions and relations with child disruptive behavior. *Child & Family Behavior Therapy*	http://www.tandfonline.com/doi/pdf/10.1080/07317107.2012.654450
2012	Effectiveness Study		Therapists' attitudes toward evidence-based practices and implementation of Parent-Child interaction therapy.	Nelson, M., Shanley, J. R., Funderburk, B. W., & Bard, E.	Child Maltreatment	Nelson, M., Shanley, J. R., Funderburk, B. W., & Bard, E. (2012). Therapists' attitudes toward evidence-based practices and implementation of Parent-Child interaction	http://cmx.sagepub.com/content/17/1/47.short
2011	Adaptations		Parent-Child Interaction Therapy (PCIT) in school-aged children with specific language impairment.	Allen, J., & Marshall, C. R.	International Journal of Language & Communication Disorder	Allen, J., & Marshall, C. R. (2011). Parent-Child Interaction Therapy (PCIT) in school-aged children with specific language impairment. International Journal Of	http://onlinelibrary.wiley.com/doi/10.3109/13682822.2010.517600/abstract;jsessionid=C4F90F
2011	Effectiveness Study	Qualitative and Case Studies	Delivering Parent-Child Interaction Therapy in an urban community clinic.	Budd, K. S., Hella, B., Bae, H., Meyerson, D. A., & Watkin, S. C.	Cognitive and Behavioral Practice	Budd, K. S., Hella, B., Bae, H., Meyerson, D. A., & Watkin, S. C. (2011). Delivering Parent-Child Interaction Therapy in an urban community clinic. *Cognitive And*	http://www.sciencedirect.com/science/article/pii/S1077722911000605
2011	Effectiveness Study	Adjunct treatment	A combined motivation and Parent-Child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial.	Chaffin, M., Funderburk, B., Bard, D., Valle, L., & Gurwitch, R.	Journal of Consulting and Clinical Psychology	Chaffin, M., Funderburk, B., Bard, D., Valle, L., & Gurwitch, R. (2011). A combined motivation and Parent-Child interaction therapy package reduces child welfare	http://psycnet.apa.org/journals/ccp/79/1/84/
2011	Adaptation		Parent-child interaction therapy emotion development: A novel treatment for depression in preschool children.	Lenze, S. N., Pautsch, J., & Luby, J.	Depression and Anxiety	Lenze, S. N., Pautsch, J., & Luby, J. (2011). Parent-child interaction therapy emotion development: A novel treatment for depression in preschool children.	http://onlinelibrary.wiley.com/doi/10.1002/da.20770/full
2011	Effectiveness study		Accumulating evidence for Parent-Child interaction therapy in the prevention of child maltreatment.	Thomas, R., & Zimmer-Gembeck, M. J.	Child Development	Thomas, R., & Zimmer-Gembeck, M. J. (2011). Accumulating evidence for Parent-Child interaction therapy in the prevention of child maltreatment. Child Development.	http://onlinelibrary.wiley.com/doi/10.1111/j.1467-8624.2010.01548.x/full
2011	Effectiveness Study		Parent-Child interaction therapy in a community setting: Examining outcomes, attrition, and treatment setting.	Lanier, P., Kohl, P. L., Benz, J., Swinger, D., Moussette, P., & Drake, B.	Research On Social Work Practice	Lanier, P., Kohl, P. L., Benz, J., Swinger, D., Moussette, P., & Drake, B. (2011). Parent-Child interaction therapy in a community setting: Examining outcomes, attrition, and	http://rsw.sagepub.com/content/21/6/689.short
2011	Adaptation		Honoring children, making relatives: The cultural translation of Parent-Child Interaction Therapy for American Indian and Alaska Native families.	BigFoot, D., & Funderburk, B. W.	Journal of Psychoactive Drugs	BigFoot, D., & Funderburk, B. W. (2011). Honoring children, making relatives: The cultural translation of Parent-Child Interaction Therapy for American Indian	http://www.tandfonline.com/doi/pdf/10.1080/02791072.2011.628924
2011	Process		Using Parent-Child Interaction Therapy to develop a pre-parent education module.	Lee, E. L., Wilsie, C. C., & Brestan-Knight, E.	Children and Youth Services Review	Lee, E. L., Wilsie, C. C., & Brestan-Knight, E. (2011). Using Parent-Child Interaction Therapy to develop a pre-parent education module. Children And Youth Services	http://www.sciencedirect.com/science/article/pii/S0190740911000703
2011	Qualitative and Case Studies		Treatment outcome for low socioeconomic status African American families in parent-child interaction therapy: A pilot study.	Fernandez, M. A., Butler, A. M., & Eyberg, S. M.	Child & Family Behavior Therapy	Fernandez, M. A., Butler, A. M., & Eyberg, S. M. (2011). Treatment outcome for low socioeconomic status African American families in parent-child interaction therapy:	http://www.tandfonline.com/doi/pdf/10.1080/07317107.2011.545011
2011	Qualitative and Case Studies		Klinefelter's syndrome in a 5-year-old boy with behavioral disturbances and seizures.	Jensen, E., Palacios, E., & Drury, S.	Psychosomatics: Journal of Consultation and Liaison Psychiatry	Jensen, E., Palacios, E., & Drury, S. (2011). Klinefelter's syndrome in a 5-year-old boy with behavioral disturbances and seizures. *Psychosomatics: Journal Of Consultation*	http://www.sciencedirect.com/science/article/pii/S0033318211002362

2011	Effectiveness Study		The effectiveness of Parent-Child interaction therapy with depressive mothers: The changing relationship as the agent of individual change.	Timmer, S. G., Ho, L. L., Urquiza, A. J., Zebell, N. M., y Garcia, E., & Boys, D.	Child Psychiatry and Human Development	Timmer, S. G., Ho, L. L., Urquiza, A. J., Zebell, N. M., y Garcia, E., & Boys, D. (2011). The effectiveness of Parent-Child interaction therapy with depressive	http://eds.b.ebscohost.com/ehost/detail/detail?sid=32cd1dec-3a76-418b-b3ff-
2011	Assesment		The contribution of the Dyadic Parent-Child Interaction Coding System (DPICS) warm-up segments in assessing parent-child interactions.	Shanley, J. R., & Niec, L. N.	Child & Family Behavior Therapy	Shanley, J. R., & Niec, L. N. (2011). The contribution of the Dyadic Parent-Child Interaction Coding System (DPICS) warm-up segments in assessing parent-child	http://www.tandfonline.com/doi/pdf/10.1080/07317107.2011.596009
2011	Assesment		Analyzing the utility of Dyadic Parent-Child Interaction Coding System (DPICS) warm-up segments.	Thornberry, T. r., & Brestan-Knight, E.	Journal of Psychopathology and Behavioral Assessment	Thornberry, T. r., & Brestan-Knight, E. (2011). Analyzing the utility of Dyadic Parent-Child Interaction Coding System (DPICS) warm-up segments. *Journal Of*	http://link.springer.com/article/10.1007/s10862-011-9229-6
2011	Assesment		Measuring change during behavioral parent training using the Parent-Instruction Game with Youngsters (PIGGY): A clinical replication.	Hupp, S. A., Reitman, D., Everett, G. E., Allen, K. D., & Kelley, M.	Child & Family Behavior Therapy	Hupp, S. A., Reitman, D., Everett, G. E., Allen, K. D., & Kelley, M. (2011). Measuring change during behavioral parent training using the Parent-Instruction Game with	http://www.tandfonline.com/doi/pdf/10.1080/07317107.2011.623091
2011	Effectiveness	Adjunct Treatment	A combined motivation and parent-child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial.	Chaffin, M., Funderbunk, B., Bard, D., Valle, L.A., & Gurwitch, R.	Journal of Consulting and Clinical Psychology	Chaffin, M., Funderbunk, B., Bard, D., Valle, L.A., & Gurwitch, R. (2011). A combined motivation and parent-child interaction therapy package reduces child welfare	http://psycnet.apa.org/psycinfo/2010-26130-001/
2011	Effectiveness		Parent-child interaction therapy in a community setting: Examining outcomes, attrition, and treatment setting.	Lanier, P., Kohl, P.L., Benz, J., Swinger, D., Moussette, P., & Drake, B.	Research on Social Work Practice	Lanier, P., Kohl, P. L., Benz, J., Swinger, D., Moussette, P., Drake, B. (2011). Parent-child interaction therapy in a community setting: Examining outcomes, attrition, and	http://rsw.sagepub.com/content/early/2011/04/28/1049731511406551.abstract
2011	Adaptations	Qualitative and Case Studies	Parent-child interaction therapy emotion development: a novel treatment for depression in preschool children.	Lenze, S.N., Pautsch, J., & Luby, J.	Depression & Anxiety	Lenze, S. N., Pautsch, J., & Luby, J. (2011) Parent-child interaction therapy emotion development: a novel treatment for depression in	http://www.ncbi.nlm.nih.gov/pubmed/21284068
2011	Adaptations		Accumulating evidence for parent-child interaction therapy in the prevention of child maltreatment.	Thomas, R., & Zimmer-Gembeck, M. J.	Child Development	Thomas, R., & Zimmer-Gembeck, M. J. (2011) Accumulating evidence for parent-child interaction therapy in the prevention of child maltreatment. Child Development.	http://www.ncbi.nlm.nih.gov/pubmed/21291436
2011	Effectiveness		The Effectiveness of Parent-Child Interaction Therapy with Depressive Mothers: The Changing Relationship as the Agent of Individual Change.	Timmer, S.G., Ho, L.K., Urquiza, A.J., Zebell, N.M., Fernandez, Y., Garcia, E., & Boys, D.	Child Psychiatry and Human Development	Timmer SG, Ho LK, Urquiza AJ, Zebell NM, Fernandez Y Garcia E, Boys D. (2011) The Effectiveness of Parent-Child Interaction Therapy with Depressive Mothers: The	http://www.ncbi.nlm.nih.gov/pubmed/21479510
2011	Adaptations	Process	Acceptability of behavioral family therapy among caregivers in China	Yu, J., Roberts, M., Wong, M., & Shen, Y.	Journal of Child and Family Studies	Yu, J., Roberts, M., Wong, M., & Shen, Y. (2011). Acceptability of behavioral family therapy among caregivers in China. Journal of Child and Family Studies, 20(3), 272-278.	http://www.springerlink.com/content/vh77717l75044085/
2010	Assessment		Evidence-based school behavior assessment of externalizing behavior in young children.	Bagner, D.M., Boggs, S.R., & Eyberg, S.M.	Education and Treatment of Children	Bagner, D.M., Boggs, S.R., & Eyberg, S.M. (2010) Evidence-based school behavior assessment of externalizing behavior in young children. Education and Treatment	http://www.ncbi.nlm.nih.gov/pubmed/21687781
2010	Adaptations	Efficacy	Parenting intervention for externalizing behavior problems in children born premature: An initial examination.	Bagner, D.M., Sheinkopf, S. J., Vohr, B. R., & Lester, B. M.	Journal of Developmental and Behavioral Pediatrics	Bagner, D. M., Sheinkopf, S. J., Vohr, B. R., & Lester, B. M. (2010) Parenting intervention for externalizing behavior problems in children born premature: An	http://www.tandfonline.com/doi/abs/10.1207/S15374424JCCP3204_13
2010	Effectiveness		Early identification and intervention for behavior problems in primary care: a comparison of two abbreviated versions of parent-child interaction therapy.	Berkovits, M.D., O'Brien, K.A., Carter, C.G., & Eyberg, S.M.	Behavior Therapy	Berkovits, Michelle D. O'Brien, Kelly A. Carter, Carolyn G. Eyberg, Sheila M. (2010). Early identification and intervention for behavior problems in primary care: a	http://www.ncbi.nlm.nih.gov/pubmed/20569786
2010	Adaptations	Effectiveness	Promoting positive interactions in the classroom: Adapting parent-child interaction therapy as a universal prevention program.	Gershenson, R.A., Lyon, A.R., & Budd, K.S.	Treatment of Children	Gershenson, Rachel A; Lyon, Aaron R; Budd, Karen S. (2010) Promoting positive interactions in the classroom: Adapting parent-child	http://muse.jhu.edu/login?uri=/journals/education_and_treatment_of_children/v033/33.2.ger

2010	Effectiveness		A community mental health implementation of Parent-Child Interaction Therapy (PCIT).	Lyon, A.R. & Budd, K.S.	Journal of Child and Family Studies	Lyon, Aaron R; Budd, Karen S. (2010). A community mental health implementation of Parent-Child Interaction Therapy (PCIT). Journal of Child and Family Studies.	http://www.ncbi.nlm.nih.gov/pubmed/20877583
2010	Efficacy		Coaching parents to change: the impact of in vivo feedback on parents' acquisition of skills.	Shanley, J.R. & Niec, L.N.	Journal of Clinical Child Adolescent Psychology	Shanley JR. Niec LN. (2010). Coaching parents to change: the impact of in vivo feedback on parents' acquisition of skills. Journal of Clinical Child Adolescent	http://www.ncbi.nlm.nih.gov/pubmed/20390820
2010	Efficacy		Efficacy of adjunct in-home coaching to improve outcomes in parent child interaction therapy.	Timmer, S. G., Zebell, N. M., Culver, M. A. & Urquiza, A. J.	Research on Social Work Practice	Timmer, S. G., Zebell, N. M., Culver, M. A. & Urquiza, A. J. (2010). Efficacy of adjunct in-home coaching to improve outcomes in parent child interaction therapy. Research	http://rsw.sagepub.com/content/20/1/36.short
2010	Effectiveness		The effectiveness of parent-child interaction therapy for victims of interparental violence	Timmer, S.G., Ware, L.M., Urquiza, A.J., & Zebell, N.M.	Violence and Victims	Timmer SG. Ware LM. Urquiza AJ. Zebell NM. (2010). The effectiveness of parent-child interaction therapy for victims of interparental violence. Victims, volume	http://www.ncbi.nlm.nih.gov/pubmed/20712147
2009	Qualitative and Case Studies		Parent-child interaction therapy for children born premature: A case study and illustration of vagal tone as a physiological measure of treatment outcome.	Bagner, D.M., Sheinkopf, S.J., Miller-Loncar, C.L., Vohr, B.R., Hinckley, M., Eyberg, S.M., & Lester, B.M.	Cognitive and Behavioral Practice.	Bagner, Daniel M; Sheinkopf, Stephen J; Miller-Loncar, Cynthia L; Vohr, Betty R; Hinckley, Matthew; Eyberg, Sheila M; Lester, Barry M. (2009) Parent-child	http://www.ncbi.nlm.nih.gov/pubmed/20428470
2009	Adjunct tx		A motivational intervention can improve retention in PCIT for low-motivation child welfare clients.	Chaffin, M., Valle, L.A., Funderburk, B., Gurwitch, R., Silovsky, J., Bard, D., McCoy, C., & Kees, M.	Child Maltreatment	Chaffin M. Valle LA. Funderburk B. Gurwitch R. Silovsky J. Bard D. McCoy C. Kees M. (2009) A motivational intervention can improve retention in PCIT for low-	http://cmx.sagepub.com/content/14/4/356.short
2009	Process		Predicting treatment and follow-up attrition in parent-child interaction therapy.	Fernandez, M. A., & Eyberg, S. M.	Journal of Abnormal Child Psychology	Fernandez, M. A., & Eyberg, S. M. (2009) Predicting treatment and follow-up attrition in parent-child interaction therapy. Journal of Abnormal Child	http://www.ncbi.nlm.nih.gov/pubmed/19096926
2009	Effectiveness		Change trajectories for parent-child interaction sequences during parent-child interaction therapy for child physical abuse.	Hakman, M., Chaffin, M., Funderburk, B., & Silovsky J.F.	Child Abuse and Neglect	Hakman M. Chaffin M. Funderburk B. Silovsky JF (2009). Change trajectories for parent-child interaction sequences during parent-child interaction therapy for child	http://www.ncbi.nlm.nih.gov/pubmed/19581001
2009	Adaptations	Effectiveness	Effectiveness of Parent-Child Interaction Therapy (PCIT) among Chinese families.	Leung, C., Tsang, S., Heung, K., & Yiu, I.	Research on Social Work Practice	Leung, Cynthia; Tsang, Sandra; Heung, Kitty; Yiu, Ivan. (2009) Effectiveness of Parent-Child Interaction Therapy (PCIT) among Chinese families.	http://rsw.sagepub.com/content/19/3/304.short
2009	Adjunct tx		Early childhood depression	Luby, J.L.	American Journal of Psychiatry.	Luby, Joan L. (2009) Early childhood depression. American Journal of Psychiatry, 166(9), 974-979	http://ajp.psychiatryonline.org/cgi/content/abstract/166/9/974
2009	Adaptations	Effectiveness	Effectiveness of Teacher-Child Interaction Training (TCIT) in a preschool setting.	Lyon, A.R., Gershenson, R.A., Farahmand, F.K., Thaxter, P.J., Behling, S., & Budd, K.S.	Behavior Modification	Lyon AR. Gershenson RA. Farahmand FK. Thaxter PJ. Behling S. Budd KS. (2009) Effectiveness of Teacher-Child Interaction Training (TCIT) in a preschool setting.	http://www.ncbi.nlm.nih.gov/pubmed/19776425
2009	Efficacy		Parent-child interaction therapy for Puerto Rican preschool children with ADHD and behavior problems: a pilot efficacy study.	Matos, M., Bauermeister, J.J., & Bernal, G.	Family Process	Matos M. Bauermeister JJ. Bernal G. (2009) Parent-child interaction therapy for Puerto Rican preschool children with ADHD and behavior	http://www.ncbi.nlm.nih.gov/pubmed/19579907
2009	Adaptations	Effectiveness	Parent-child interaction therapy for Mexican Americans: a randomized clinical trial.	McCabe, K. & Yeh, M.	Journal of Clinical Child Adolescent Psychology	McCabe K. Yeh M. (2009) Parent-child interaction therapy for Mexican Americans: a randomized clinical trial. Journal of Clinical Child Adolescent	http://www.ncbi.nlm.nih.gov/pubmed/20183659
2009	Reviews		Parent management training for reducing oppositional and aggressive behavior in preschoolers.	Pearl, E.S.	Aggression and Violent Behavior	Pearl, Erica S. (2009) Parent management training for reducing oppositional and aggressive behavior in preschoolers. Aggression and Violent Behavior, 14(5),	http://www.sciencedirect.com/science/article/pii/S1359178909000366

2008	Reviews		Positive attention.	Boggs, S.R., & Eyberg, S.M. In W. O'Donohue,& J.D. Fisher (Eds.)	Cognitive behavior therapy: Applying empirically supported techniques in your	Boggs, S.R., & Eyberg, S.M. (2008). Positive attention. In W. O'Donohue,& J.D. Fisher (Eds.). Cognitive behavior therapy: Applying empirically supported techniques	
2008	Adaptations	Reviews	Parent-child interaction therapy with domestic violence populations.	Borrego, J.J., Gutow, M.R., Reicher, S., & Barker, C.H.	Journal of Family Violence	Borrego, Joaquin Jr.; Gutow, Mindy R; Reicher, Shira; Barker, Chikira H. (2008) Parent-child interaction therapy with domestic violence	http://www.springerlink.com/content/u17127g557111138/
2008	Assessment		Parent and teacher SNAP-IV ratings of Attention Deficit/Hyperactivity Disorder symptoms: Psychometric properties and normative ratings from a school district sample.	Bussing, R., Fernandez, M., Harwood, M., Hou, W., Garvan, C., Swanson, J., & Eyberg, S.M.	Assessment	Bussing, R., Fernandez, M., Harwood, M., Hou, W., Garvan, C., Swanson, J., & Eyberg, S.M. (2008). Parent and teacher SNAP-IV ratings of Attention Deficit/Hyperactivity	http://www.ncbi.nlm.nih.gov/pubmed/18310593?dopt=Abstract
2008	Assessment		Examination of the Eyberg Child Behavior Inventory discrepancy hypothesis.	Butler, A.M., Brestan, E.V., & Eyberg, S.M.	Child and Family Behavior Therapy	Butler, A.M., Brestan, E.V.,& Eyberg, S.M. Examination of the Eyberg Child Behavior Inventory discrepancy hypothesis. Child and Family Behavior Therapy, 30, 252-257.	http://www.informaworld.com/smpp/content~db=all~content=a903694558
2008	Efficacy	Effectiveness	Clinical presentation and treatment outcome for children with comorbid externalizing and internalizing symptoms.	Chase, R.M. & Eyberg, S.M.	Journal of Anxiety Disorders	Chase RM. Eyberg SM. (2008) Clinical presentation and treatment outcome for children with comorbid externalizing and internalizing symptoms.	http://www.ncbi.nlm.nih.gov/pubmed/17467229
2008	Adaptations		Parent-child attunement therapy for toddlers: A behaviorally oriented, play-based parent training model.	Dombrowski, S.C., Timmer, S.G., & Zebell, N.	Play therapy for very young children	Dombrowski, Stefan C; Timmer, Susan G; Zebell, Nancy. (2008) Parent-child attunement therapy for toddlers: A behaviorally oriented, play-based parent	http://books.google.com/books?id=Fz1tlBWOhwQC&lpg=PA125&ots=OxSae4rZLY&dq=Parent
2008	Reviews		Evidence-based treatments for child and adolescent disruptive behavior disorders.	Eyberg, S.M., Nelson, M. M., & Boggs, S.R.	Journal of Clinical Child and Adolescent Psychology	Eyberg, S.M., Nelson, M. M., & Boggs, S.R. (2008). Evidence-based treatments for child and adolescent disruptive behavior disorders. Journal of Clinical Child and	http://tandfprod.literatumonline.com/doi/abs/10.1080/15374410701820117
2008	Process		Use and feasibility of telemedicine technology in the dissemination of parent-child interaction therapy.	Funderburk, B.W., Ware, L.M., Altshuler, E., & Chaffin, M.	Child Maltreatment	Funderburk, Beverly W; Ware, Lisa M; Altshuler, Elizabeth; Chaffin, Mark. (2008) Use and feasibility of telemedicine technology in the dissemination of parent-	http://cmx.sagepub.com/content/13/4/377.short
2008	Effectiveness	Process	Parent-child interaction therapy: An examination of cost-effectiveness.	Goldfine, M.E., Wagner, S.M., Branstetter, S.A., & McNeil, C.B.	Journal of Early and Intensive Behavior Intervention	Goldfine, M. E., Wagner, S. M., Branstetter, S. A., & McNeil, C. B. (2008). Parent-child interaction therapy: An examination of cost-effectiveness. Journal of Early and	http://eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_&ERICExtSearch_Search
2008	Reviews		Treatment of preschool bipolar disorder: A novel parent-child interaction therapy and review of data on psychopharmacology.	Luby, J.L., Stalets, M.M., Blankenship, S., Pautsch, J., & McGrath, M.	Treatment of bipolar disorder in children and adolescents.	Luby, Joan L; Stalets, Melissa Meade; Blankenship, Samantha; Pautsch, Jennifer; McGrath, Molly. (2008) Treatment of preschool bipolar disorder: A novel parent-	
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2008	Adaptations		Parent-child interaction therapy and high functioning autism: A conceptual overview.	Masse, J.J., McNeil, C.B., Wagner, S.M., & Chorney, D.B.	Journal of Early and Intensive Behavior Intervention	Masse, J.J., McNeil, C.B., Wagner, S.M., & Chorney, D.B. (2008). Parent-child interaction therapy and high functioning autism: A conceptual overview. Journal of	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ805605
2008	Adaptations	Qualitative and Case Studies	Parent-child interaction therapy with an immigrant family exposed to domestic violence	Pearl, E.S.	Clinical Case Studies	Pearl, Erica S. (2008) Parent-child interaction therapy with an immigrant family exposed to domestic	http://ccs.sagepub.com/content/7/1/25.short
2008	Effectiveness		Pilot evaluation of parent-child interaction therapy delivered in an Australian community early childhood clinic setting.	Phillips, J., Morgan, S., Cawthorne, K., & Barnett, B.	Australian and New Zealand Journal of Psychiatry	Violence. Clinical Case Studies, 7(1), 25- Phillips, Jane; Morgan, Susan; Cawthorne, Karen; Barnett, Bryanne. (2008) Pilot evaluation of parent-child interaction therapy delivered in an	http://www.ncbi.nlm.nih.gov/pubmed/18622779

2008	Adaptations	Effectiveness	The implementation of modified parent-child interaction therapy for youth with Separation Anxiety Disorder.	Pincus, D.B., Santucci, L.C., Ehrenreich, J.T., & Eyberg, S.M.	Cognitive and Behavioral Practice	Pincus, Donna B; Santucci, Lauren C; Ehrenreich, Jill T; Eyberg, Sheila M. (2008) The implementation of	http://www.sciencedirect.com/science/article/pii/S1077722908000291
2008	Assessment		Eyberg child behavior inventory (ECBI): Norwegian norms to identify conduct problems in children.	Reedtz, C., Bertelsen, B., Lurie, J., Handegard, B., Clifford, G., & Morch, W.	Scandinavian Journal of Psychology	Reedtz, C., Bertelsen, B., Lurie, J., Handegard, B., Clifford, G., & Morch, W. Eyberg child behavior inventory (ECBI): Norwegian norms to identify conduct	http://www.ncbi.nlm.nih.gov/pubmed/18190400
2008	Reviews		Empirically supported parent training programs	Shriver, M.D. & Allen, K.D.	Working with parents of noncompliant children: A guide to evidence-based parent	Masse, Joshua J; McNeil, Cheryl B. (2008) In-home parent-child interaction therapy: Clinical considerations. Family Behavior Therapy, 30(2), 127-135	
2008	Adaptations	Effectiveness	The effectiveness of Parent-Child interaction therapy for families of children on the autism spectrum.	Solomon, M., Ono, M., Timmer, S., & Goodlin-Jones, B.	Journal of Autism and Developmental Disorders	Solomon, Marjorie; Ono, Michele; Timmer, Susan; Goodlin-Jones, Beth. (2008) The effectiveness of	http://www.ncbi.nlm.nih.gov/pubmed/18401693
2008	Adaptations	Reviews	Parent-child interaction therapy for ADHD: A conceptual overview and critical literature review.	Wagner, S.M. & McNeil, C.B.	Child and Family Behavior Therapy	Wagner, Stephanie M; McNeil, Cheryl B. (2008) Parent-child interaction therapy for ADHD: A conceptual overview and critical literature review. Family Behavior Therapy,	http://www.informaworld.com/smpp/content~db=all~content=a903694557
2008	Adaptations	Effectiveness	Efficacy of in-home parent-child interaction therapy.	Ware, L.M., McNeil, C.B., Masse, J., & Stevens, S.	Child and Family Behavior Therapy	Ware, Lisa M; McNeil, Cheryl B; Masse, Joshua; Stevens, Sarah. (2008) Efficacy of in-home parent-child interaction therapy. Family Behavior	http://www.informaworld.com/smpp/content~db=all~content=a902297522
2007	Efficacy	Adaptations	Parent-child interaction therapy for disruptive behavior in children with mental retardation: a randomized controlled trial.	Bagner, D.M. & Eyberg, S.M.	Journal of Clinical Child Adolescent Psychology	Bagner DM. Eyberg SM. (2007) Parent-child interaction therapy for disruptive behavior in children with mental retardation: a randomized	http://www.ncbi.nlm.nih.gov/pubmed/17658985
2007	Efficacy		Parent-child interaction therapy with physically abusive families.	Herschell, A.D. & McNeil, C.B.	Handbook of parent training: Helping parents prevent and solve problem	Herschell, Amy D; McNeil, Cheryl B. (2007) Parent-child interaction therapy with physically abusive families. Handbook of parent training:	http://books.google.com/books?id=0X4QoFfnXBkC&lpg=PA234&ots=-AiCGPkGwc&dq=Parent
2007	Reviews		Behavioral outcomes of Parent-Child Interaction Therapy and Triple P-Positive Parenting Program: a review and meta-analysis.	Thomas, R. & Zimmer-Gembeck, M.J.	Journal of Abnormal Child Psychology.	Thomas R. Zimmer-Gembeck MJ. (2007) Behavioral outcomes of Parent-Child Interaction Therapy and Triple P-Positive Parenting Program: a review and meta-	http://www.springerlink.com/content/372357054031hk08/
2006	Assessment		Psychometric considerations in child behavioral assessment.	Bagner, D.M., Harwood, M., & Eyberg, S.M. In M. Hersen (Ed.) Comprehensive handbook of behavioral assessment, Vol. 2: Child	Comprehensive handbook of behavioral assessment, Vol. 2: Child	Bagner, D.M., Harwood, M., & Eyberg, S.M. In M. Hersen (Ed.) Comprehensive handbook of behavioral assessment, Vol. 2: Child assessment. San Diego: Elsevier.	
2006	Effectiveness		Parent-Child Interaction Therapy With a Spanish-Speaking Family	Borrego, J.J., Anhalt, K., Terao, S.Y., Vargas, E.C., & Urquiza, A.J.	Cognitive and Behavioral Practice	Borrego, Joaquin Jr.; Anhalt, Karla; Terao, Sherri Y; Vargas, Eric C; Urquiza, Anthony J. (2006) Parent-Child Interaction Therapy	http://www.sciencedirect.com/science/article/pii/S107772290600023X
2006	Adaptations	Reviews	Parent-child interaction therapy and ethnic minority children.	Butler, A.M. & Eyberg, S.M.	Vulnerable Children and Youth Studies	Butler, Ashley M; Eyberg, Sheila M. (2006) Parent-child interaction therapy and ethnic minority children	http://www.informaworld.com/smpp/content~db=all~content=a759262799
2006	Reviews	Adaptations	Evidence-based psychosocial treatments for children and adolescents with attention-deficit/hyperactivity disorder.	Chronis, A.M., Jones, H.A., & Raggi, V.L.	Clinical Psychology Review	Vulnerable Children and Youth Studies. Chronis, A.M., Jones, H.A., & Raggi, V.L. (2006). Evidence-based psychosocial treatments for children and adolescents with attention-deficit/hyperactivity	http://www.ncbi.nlm.nih.gov/pubmed/16483703
2006	Process		Child-Directed Interaction: Prediction of change in impaired mother-child functioning.	Harwood, M.D., & Eyberg, S.M	Journal of Abnormal Child Psychology	Harwood, M.D., & Eyberg, S.M. (2006). Child-Directed Interaction: Prediction of change in impaired mother-child functioning. Journal of Abnormal Child	http://psycnet.apa.org/psycinfo/2006-08816-005

2006	Adaptations	Effectiveness	Adaptation of Parent-Child Interaction Therapy for Puerto Rican Families: A Preliminary Study	Matos, M., Torres, R., Santiago, R., Jurado, M., & Rodriguez, I.	Family Process	Matos, Maribel; Torres, Rosalie; Santiago, Rocheli; Jurado, Michelle; Rodriguez, Ixa. (2006) Adaptation of Parent-Child Interaction Therapy for	http://www.ncbi.nlm.nih.gov/pubmed/16768019
2006	Adaptations		An Immediate and Long-Term Study of a Temperament and Parent-Child Interaction Therapy Based Community Program for Preschoolers with Behavior Problems.	Pade, H., Taube, D.O., Aalborg, A.E., & Reiser, P.J.	Family Behavior Therapy	Pade, Hadas; Taube, Daniel O; Aalborg, Annette E; Reiser, Paul J. (2006) An Immediate and Long-Term Study of a Temperament and Parent-Child Interaction	http://www.informaworld.com/smpp/content~db=all~content=a902221270
2006	Effectiveness		Challenging foster caregiver-maltreated child relationships: The effectiveness of parent-child interaction therapy.	Timmer, S.G., Urquiza, A.J., & Zebell, N.	Children and Youth Services Review	Timmer, Susan G; Urquiza, Anthony J; Zebell, Nancy (2006). Challenging foster caregiver-maltreated child relationships: The effectiveness of parent-child	http://www.sciencedirect.com/science/article/pii/S0190740905000228
2006	Effectiveness		Parent-child interaction therapy: application of an empirically supported treatment to maltreated children in foster care.	Timmer, S.G., Urquiza, A.J., Herschell, A.D., McGrath, J.M., Zebell, N.M., Porter, A.L., & Vargas, E.C.	Child Welfare	Timmer SG. Urquiza AJ. Herschell AD. McGrath JM. Zebell NM. Porter AL. Vargas EC. Parent-child interaction therapy: application of an empirically supported	http://www.ncbi.nlm.nih.gov/pubmed/17305042
2006	Efficacy	Process	Predicting Outcome in Parent-Child Interaction Therapy Success and Attrition.	Werba, B., Eyberg, S.M., Boggs, S.R., & Algina, J.	Behavior Modification	Werba, B., Eyberg, S.M., Boggs, S.R., & Algina, J. (2006). Predicting Outcome in Parent-Child Interaction Therapy: Success and Attrition. Behavior Modification, 30.	http://bmo.sagepub.com/content/30/5/618.abstract
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2005	Adaptations		Med terapeuten på øret [Parent child interaction therapy].	Bjørseth, Å., & Wormdal, A. K.	Tidsskrift for Norsk Psykologforening	Bjørseth, Å., & Wormdal, A. K. (2005). Med terapeuten på øret [Parent child interaction therapy]. Tidsskrift for Norsk Psykologforening, Vol. 42, 693-699.	http://www.questia.com/library/journal/1G1-131753676/training-foster-parents-in-
2005	Reviews		Principles of psychotherapy with behavior problem children.	Calzada, E., Amiry, A., & Eyberg, S.M. In G.P. Koocher, J.C. Norcross, & S.S. Hill (Eds.)	Psychologist's desk reference (2nd ed).	Calzada, E., Amiry, A., & Eyberg, S.M. (2005). Principles of psychotherapy with behavior problem children. In G.P. Koocher, J.C. Norcross, & S.S. Hill (Eds.).	
2005	Adaptations		Parent-Child Interaction Therapy for Treatment of Separation Anxiety Disorder in Young Children: A Pilot Study.	Choate, M.L., Pincus, D.B, Eyberg, S.M., Barlow, D.H.	Cognitive and Behavioral Practice	Choate, Molly L; Pincus, Donna B; Eyberg, Sheila M; Barlow, David H. (2005) Parent-Child Interaction Therapy for Treatment of Separation Anxiety Disorder in Young	http://www.sciencedirect.com/science/article/pii/S1077722905800471
2005	Adaptations		A Positive Behavioural Intervention for Toddlers: Parent-Child Attunement Therapy	Dombrowski, S.C., Timmer, S.G., Blacker, D.M., & Urquiza, A.J.	Child Abuse Review	Dombrowski, Stefan C; Timmer, Susan G; Blacker, Dawn M; Urquiza, Anthony J. (2005) A Positive	http://onlinelibrary.wiley.com/doi/10.1002/car.888/abstract
2005	Adaptations	Reviews	Tailoring and adapting parent-child interaction therapy to new populations.	Eyberg, S.M.	Treatment of Children	Eyberg, Sheila M. (2005) Tailoring and adapting parent-child interaction therapy to new populations. Treatment of Children,28(2), 197-201. retrieved from.	http://www.questia.com/googleScholar.qst?docId=5009317588
2005	Reviews	Adjunct Treatment	Mindfulness and Behavioral Parent Training: Commentary.	Eyberg, S.M., & Graham-Pole, J.R.	Journal of Clinical Child and Adolescent Psychology	Eyberg, S.M., & Graham-Pole, J.R. (2005). Mindfulness and Behavioral Parent Training: Commentary. Journal of Clinical Child and Adolescent Psychology, 34, 792-	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ722580
2005	Reviews		Parent-child interaction therapy.	Eyberg, S.M., & McDiarmid, M.D. In A.M. Gross & R.S. Drabman (Eds.).	Encyclopedia of behavior modification and cognitive-behavior therapy, Vol. 2	Eyberg, S.M., & McDiarmid, M.D. (2005). Parent-child interaction therapy. In A.M. Gross & R.S. Drabman (Eds.). Encyclopedia of behavior modification and cognitive-	
2005	Process		Keeping families in once they've come through the door: Attrition in parent-child interaction therapy.	Fernandez, M.A., & Eyberg, S.M.	Journal of Early and Intensive Behavior Intervention	Fernandez, M.A., & Eyberg, S.M. (2005). Keeping families in once they've come through the door: Attrition in parent-child interaction therapy. Journal of Early and	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ846774

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2005	Effectiveness		Introducing and Evaluating Parent-Child Interaction Therapy in a System of Care.	Franco, E., Soler, R.E., & McBride, M.	Child and Adolescent Psychiatric Clinics of North America	Franco, Eileen; Soler, Robin E; McBride, Mary. (2005) Introducing and Evaluating Parent-Child Interaction Therapy in a	http://www.ncbi.nlm.nih.gov/pubmed/15694790
2005	Qualitative and Case Studies		Parent-Child Interaction Therapy With Two Maltreated Siblings in Foster Care.	Fricker-Elhai, A.E., Ruggiero, K.J., & Smith, D.W.	Clinical Case Studies	Fricker-Elhai, Adrienne E; Ruggiero, Kenneth J; Smith, Daniel W. (2005) Parent-Child Interaction Therapy With Two Maltreated Siblings in Foster Care. Clinical	http://ccs.sagepub.com/content/4/1/13.full.pdf+html
2005	Adaptations	Reviews	Theoretical and empirical underpinnings of parent-child interaction therapy with child physical abuse populations.	Herschell, A.D. & McNeil, C.B.	Treatment of Children	Herschell, Amy D; McNeil, Cheryl B. (2005) Theoretical and empirical underpinnings of parent-child interaction therapy with child physical	http://www.questia.com/googleScholar.qst?docid=5009317571
2005	Reviews		Parent-Child Interaction Therapy for Children Experiencing Externalizing Behavior Problems.	Herschell, A.D. & McNeil, C.B.	Empirically based play interventions for children. Reddy, Linda A [Ed]; Files-Hall, Tara	Herschell, Amy D; McNeil, Cheryl B. (2005) Parent-Child Interaction Therapy for Children Experiencing Externalizing Behavior Problems.	http://psycnet.apa.org/index.cfm?fa=main.doiLanding&uid=2005-02330-010
2005	Adaptations		The GANA program: A tailoring approach to adapting parent child interaction therapy for Mexican Americans.	McCabe, K.M., Yeh, M., Garland, A.F., Lau, A.S., & Chavez, G.	Treatment of Children	McCabe, Kristen M; Yeh, May; Garland, Ann F; Lau, Anna S; Chavez, Gloria. (2005) The GANA program: A tailoring approach to adapting	http://www.questia.com/googleScholar.qst?docid=5009317561
2005	Adaptations		Parent child interaction therapy for children with disruptive behavior and developmental disabilities.	McDiarmid, M.D. & Bagner, D.M.	Treatment of Children	McDiarmid, Melanie D; Bagner, Daniel M. (2005) Parent child interaction therapy for children with disruptive behavior and developmental	http://www.questia.com/googleScholar.qst?docid=5009317566
2005	Adaptations		Training foster parents in parent-child interaction therapy.	McNeil, C.B., Herschell, A.D., Gurwitch, R.H., & Clemens-Mowrer, L.	Treatment of Children	McNeil, Cheryl B; Herschell, Amy D; Gurwitch, Robin H; Clemens-Mowrer, Laurie. (2005) Training foster parents in parent-child interaction	http://www.questia.com/googleScholar.qst?docid=5009317584
2005	Adaptations	Qualitative and Case Studies	Parent-Child Interaction Therapy: The Rewards and Challenges of a Group Format.	Niec, L.N., Hemme, J.M., Yopp, J.M., & Brestan, E.V.	Cognitive and Behavioral Practice	Niec, Larissa N; Hemme, Jannel M; Yopp, Justin M; Brestan, Elizabeth V. (2005) Parent-Child Interaction Therapy: The Rewards and	http://www.sciencedirect.com/science/article/pii/S107772290580046X
2005	Reviews		Oppositional defiant disorder.	O'Brien, K., Chase, R., & Eyberg, S.M. In J.E. Fisher & W. O'Donohue (Eds.).	Practice guidelines for evidence based psychotherapy.	O'Brien, K., Chase, R., & Eyberg, S.M. (2005). Oppositional defiant disorder. In J.E. Fisher & W. O'Donohue (Eds.). Practice guidelines for evidence based	
2005	Adaptations		Adapting parent-child interaction therapy for young children with separation anxiety disorder.	Pincus, D.B., Eyberg, S.M., & Choate, M.L.	Education and Treatment of Children	Pincus, D.B., Eyberg, S.M., & Choate, M.L. (2005). Adapting parent-child interaction therapy for young children with separation anxiety disorder. Education and Treatment	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ704882
2005	Adaptations	Reviews	Adapting parent-child interaction therapy for young children with separation anxiety disorder.	Pincus, D.B., Eyberg, S.M., & Choate, M.L.	Treatment of Children	Pincus, Donna B; Eyberg, Sheila M; Choate, Molly L. (2005) Adapting parent-child interaction therapy for young children with separation anxiety disorder.	http://pcit.phhp.ufl.edu/Literature/PincusEyberg2005.pdf
2005	Reviews		Parent-Child Interaction Therapy: Maintaining Treatment Gains of Preschoolers With Disruptive Behavior Disorders.	Querido, J.G. & Eyberg, S.M.	Hibbs, Euthymia D [Ed]; Jensen, Peter S [Ed].Psychosocial treatments for child	Washington, DC, US: American Psychological Association. (2005) Parent-Child Interaction Therapy: Maintaining Treatment Gains of	http://psycnet.apa.org/psycinfo/2005-00278-022
2005	Reviews		Announcing Empirically-Based Interventions for Children	Reddy, L.A., Files-Hall, T.M., & Schaefer, C.E. (Eds.)	Empirically based play interventions for children.	Reddy, Linda A [Ed]; Files-Hall, Tara M [Ed]; Schaefer, Charles E [Ed]. (2005) Empirically based play Interventions for children. Washington, DC,	http://apa.org/pubs/books/4317066s.pdf

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2005	Adaptations	Reviews	Introduction: Innovative approaches to parent-child interaction therapy.	Storch, E.A. & Floyd, E.M.	Treatment of Children	Storch, Eric A; Floyd, Erin M. (2005) Introduction: Innovative approaches to parent-child interaction therapy. Treatment of Children, 28(2), 106-	http://www.freepatentsonline.com/article/Education-Treatment-Children/131753671.ht
2005	Adaptations		Training Head Start teachers in behavior management using Parent-Child Interaction Therapy: A preliminary investigation.	Tiano, J.D., & McNeil, C.B.	Journal of Early and Intensive Behavior Intervention	Tiano, J.D., & McNeil, C.B. (2005). Training Head Start teachers in behavior management using Parent-Child Interaction Therapy: A preliminary	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ843640
2005	Adaptations	Process	Managing classroom behavior of Head Start children using response cost and token economy procedures.	Tiano, J.D., Fortson, B.L., McNeil, C.B., & Humphreys, L.A.	Journal of Early and Intensive Behavior Intervention	Tiano, J.D., Fortson, B.L., McNeil, C.B., & Humphreys, L.A. (2005). Managing classroom behavior of Head Start children using response cost and token economy	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ846476
2005	Effectiveness		Parent-child interaction therapy: application to maltreating parent-child dyads.	Timmer, S.G., Urquiza, A.J., Zebell, N.M., & McGrath, J.M.	Child Abuse and Neglect	Timmer SG. Urquiza AJ. Zebell NM. McGrath JM. (2005) Parent-child interaction therapy: application to maltreating parent-child dyads. Child	http://www.ncbi.nlm.nih.gov/pubmed/16051355
2005	Assessment		Factor structure and discriminative validity of the Eyberg Child Behavior Inventory with young children.	Weis, R., Lovejoy, M.C., & Lundahl, B.W.	Journal of Psychopathology and Behavioral Assessment	Weis, R., Lovejoy, M.C., & Lundahl, B.W. (2005). Factor structure and discriminative validity of the Eyberg Child Behavior Inventory with young children. Journal of	http://www.springerlink.com/content/nv5w40338r738714/
2004	Qualitative and Case Studies	Adaptations	Parent-child interaction therapy and chronic illness: A case study.	Bagner, D.M., Fernandez, M.A., & Eyberg, S.M.	Journal of Clinical Psychology in Medical Settings	Bagner, D.M., Fernandez, M.A., & Eyberg, S.M. (2004). Parent-child interaction therapy and chronic illness: A case study. Journal of Clinical Psychology in Medical	http://psycnet.apa.org/psycinfo/2004-11365-001
2004	Efficacy	Effectiveness	Outcomes of parent-child interaction therapy: A comparison of dropouts and treatment completers one to three years after treatment.	Boggs, S.R., Eyberg, S.M., Edwards, D., Rayfield, A., Jacobs, J., Bagner, D., & Hood, K.	Child & Family Behavior Therapy	Boggs, S.R., Eyberg, S.M., Edwards, D., Rayfield, A., Jacobs, J., Bagner, D., & Hood, K. (2004). Outcomes of parent-child interaction therapy: A comparison of	http://www.tandfonline.com/doi/abs/10.1300/J019v26n04_01
2004	Process		Physically abusive mothers' responses following episodes of child noncompliance and compliance.	Borrego, Jr., J., Timmer, S. G., Urquiza, A. J., & Follette, W.C.	Journal of Consulting and Clinical Psychology	Borrego, Jr., J., Timmer, S. G., Urquiza, A. J., & Follette, W.C. (2004). Physically abusive mothers' responses following episodes of child noncompliance and compliance.	http://www.ncbi.nlm.nih.gov/pubmed/15482048
2004	Assessment		Parenting disruptive preschoolers: Experience of mothers and fathers.	Calzada, E., Eyberg, S.M., Rich, B., & Querido, J.G.	Journal of Abnormal Child Psychology	Calzada, E., Eyberg, S.M., Rich, B., & Querido, J.G. (2004). Parenting disruptive preschoolers: Experience of mothers and fathers. Journal of Abnormal Child	http://psycnet.apa.org/psycinfo/2004-12167-007
2004	Efficacy		Parent-child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports	Chaffin, M., Silovsky, J.F., Funderburk, B., Valle, L.A., Brestan, E.V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B.L.	Journal of Consulting Clinical Psychology.	Chaffin M. Silovsky JF. Funderburk B. Valle LA. Brestan EV. Balachova T. Jackson S. Lensgraf J. Bonner BL. (2004) Parent-child interaction therapy with physically	http://www.ncbi.nlm.nih.gov/pubmed/15279533
2004	Reviews		The PCIT story part 1: Conceptual foundation.	Eyberg, S.M.	PCIT Pages: The Parent-Child Interaction Therapy Newsletter,	Eyberg, S.M. (2004). The PCIT story part 1: Conceptual foundation. PCIT Pages: The Parent-Child Interaction Therapy Newsletter, 1, 1-2.	
2004	Process		The use of token economies in preschool classrooms: Practical and philosophical concerns.	Filcheck, H. A., & McNeil, C. B.	Journal of Early and Intensive Behavioral Intervention	Filcheck, H. A., & McNeil, C. B. (2004). The use of token economies in preschool classrooms: Practical and philosophical concerns. Journal of Early and Intensive	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ848682
2004	Process		Using a whole-class token economy and coaching of teacher skills in a preschool classroom to manage disruptive behavior.	Filcheck, H.A., McNeil, C.B., Greco, L.A., & Bernard, R.S.	Psychology in the Schools	Filcheck, H.A., McNeil, C.B., Greco, L.A., & Bernard, R.S. (2004). Using a whole-class token economy and coaching of teacher skills in a preschool classroom to manage	http://onlinelibrary.wiley.com/doi/10.1002/pits.10168/abstract

2004	Assessment		Psychometric properties of the Sutter-Eyberg Student Behavior Inventory with rural middle school and high school children.	Floyd, E.M., Rayfield, A., Eyberg, S.M., & Riley, J.L	Assessment	Floyd, E.M., Rayfield, A., Eyberg, S.M., & Riley, J.L. (2004). Psychometric properties of the Sutter-Eyberg Student Behavior Inventory with rural middle school and	http://www.ncbi.nlm.nih.gov/pubmed/14994955
2004	Process		Therapist Verbal Behavior Early in Treatment: Relation to Successful Completion of Parent-Child Interaction Therapy.	Harwood, M., & Eyberg, S.M.	Journal of Clinical Child and Adolescent Psychology	Harwood, M., & Eyberg, S.M. (2004). Therapist Verbal Behavior Early in Treatment: Relation to Successful Completion of Parent-Child Interaction	http://psycnet.apa.org/psycinfo/2004-16801-017
2004	Process		Effect of therapist process variables on treatment outcome for parent-child interaction therapy.	Harwood, M., & Eyberg, S.M.	Journal of Clinical Child and Adolescent Psychology	Harwood, M., & Eyberg, S.M. (2004). Effect of therapist process variables on treatment outcome for parent-child interaction therapy. Journal of Clinical Child and	http://www.ncbi.nlm.nih.gov/pubmed/15271617
2004	Assessment		Problem-solving interactions between mothers and children.	Hughes, J. C., Brestan, E. V., Klinger, L. J., & Christens, B. D.	Child & Family Behavior Therapy	Hughes, J. C., Brestan, E. V., Klinger, L. J., & Christens, B. D. (2004). Problem-solving interactions between mothers and children. Child & Family Behavior Therapy,	http://psycnet.apa.org/psycinfo/2004-11869-001
2004	Efficacy		Parent-child interaction therapy: one- and two-year follow-up of standard and abbreviated treatments for oppositional preschoolers	Nixon, R.D., Sweeney, L., & Erickson, D.B.	Journal of Abnormal Child Psychology	Nixon RD. Sweeney L. Erickson DB. (2004) Parent-child interaction therapy: one- and two-year follow-	http://www.ncbi.nlm.nih.gov/pubmed/15228175
2004	Adaptations	Efficacy	Parent-Child Interaction Therapy: One- and Two-Year Follow-Up of Standard and Abbreviated Treatments for Oppositional Preschoolers.	Nixon, R.D.V., Sweeney, L., Erickson, D.B., & Touyz, S.W.	Journal of Abnormal Child Psychology: An official publication of the International	up of standard and abbreviated treatments Nixon, Reginald D. V; Sweeney, Lynne; Erickson, Deborah B; Touyz, Stephen W. (2004) Parent-Child	http://www.ncbi.nlm.nih.gov/pubmed/15228175
2004	Assessment		Challenging children in kin versus nonkin foster care: Perceived costs and benefits to caregivers.	Timmer, S. G., Sedlar, G., & Urquiza, A. J.	Child Maltreatment	Interaction Therapy: One- and Two-Year Timmer, S. G., Sedlar, G., & Urquiza, A. J. (2004). Challenging children in kin versus nonkin foster care: Perceived costs and benefits to caregivers. Child Maltreatment,	http://cmx.sagepub.com/content/9/3/251.short
2003	Process		Father involvement in parent training: When does it matter?	Bagner, D.M. & Eyberg, S.M.	Journal of Clinical Child and Adolescent Psychology	Bagner, D., & Eyberg, S.M. (2003). Father involvement in parent training: When does it matter? Journal of Clinical Child and Adolescent Psychology, 32, 599-605.	http://www.ncbi.nlm.nih.gov/pubmed/14710469
2003	Process		Father involvement in treatment.	Bagner, D.M. & Eyberg, S.M. In T.H. Ollendick & C.S. Schroeder (Eds.)	Encyclopedia of clinical child and pediatric psychology	Bagner, D., & Eyberg, S.M. (2003). Father involvement in treatment. In T.H. Ollendick & C.S. Schroeder (Eds.) Encyclopedia of clinical child and pediatric psychology. New	
2003	Reviews		Positive attention.	Bell, S., Boggs, S.R., & Eyberg, S.M. In W. O'Donohue, J.D. Fisher, & S.C.Hayes (Eds.)	Empirically supported techniques of cognitive behavior therapy: A step-by-step guide for	Bell, S., Boggs, S.R., & Eyberg, S.M. (2003). Positive attention. In W. O'Donohue, J.D. Fisher, & S.C.Hayes (Eds.). Empirically supported techniques of cognitive behavior	
2003	Assessment		How annoying is it? Defining parental tolerance for child misbehavior.	Brestan, E.V., Eyberg, S.M., Algina, J., Johnson, S.B., & Boggs, S.R.	Child and Family Behavior Therapy	Brestan, E.V., Eyberg, S.M., Algina, J., Johnson, S.B., & Boggs, S.R. (2003). How annoying is it? Defining parental tolerance for child misbehavior. Child and Family	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ672654
2003	Reviews		Parent-child interaction therapy for oppositional children.	Brinkmeyer, M., & Eyberg, S.M. In A.E. Kazdin & J.R. Weisz (Eds.)	Evidence-based psychotherapies for children and adolescents	Brinkmeyer, M., & Eyberg, S.M. (2003). Parent-child interaction therapy for oppositional children. In A.E. Kazdin & J.R. Weisz (Eds.). Evidence-based	
2003	Reviews		Parent-child interaction therapy.	Eyberg, S.M. In T.H. Ollendick & C.S. Schroeder (Eds.)	Encyclopedia of Clinical child and Pediatric Psychology.	Eyberg, S.M. (2003). Parent-child interaction therapy. In T.H. Ollendick & C.S. Schroeder (Eds.) Encyclopedia of Clinical child and Pediatric Psychology. New York:	
2003	Process		Kids and stress: Understanding your child's emotions.	Eyberg, S.M., Calzada, E., Brinkmeyer, M., Querido, J., & Funderburk, B.W. In L. VandeCreek & T.L. Jackson (Eds.).	Innovations in Clinical Practice: Focus on Children and Adolescents	Eyberg, S.M., Calzada, E., Brinkmeyer, M., Querido, J., & Funderburk, B.W. (2003). Kids and stress: Understanding your child's emotions. In L. VandeCreek & T.L. Jackson	

2003	Assessment	Further psychometric evaluation of the Eyberg and Behar rating scales for parents and teachers of preschoolers.	Funderburk, B.W., Eyberg, S.M., Rich, B., & Behar, L.	Early Education & Development	Funderburk, B.W., Eyberg, S.M., Rich, B., & Behar, L. (2003). Further psychometric evaluation of the Eyberg and Behar rating scales for parents and teachers of	http://tandfprod.literatumonline.com/doi/abs/10.1207/s15566935eed1401_5
2003	Reviews	Effects of parent-child interaction therapy on young children with disruptive behavior disorders.	Gallagher, N.	Bridges Practice-Based Research Syntheses	Gallagher, N. (2003). Effects of parent-child interaction therapy on young children with disruptive behavior disorders. Bridges Practice-Based Research Syntheses, 1, 1-17.	http://www.mendeley.com/research/effects-parentchild-interaction-therapy-young-children-
2003	Effectiveness	Outcomes of parent-child interaction therapy: mothers' reports of maintenance three to six years after treatment.	Hood, K.K. & Eyberg, S.M.	Journal of Clinical Child Adolescent Psychology.	Hood K K Eyeberg SM. (2003) Outcomes of parent-child interaction therapy: mothers' reports of maintenance three to six years after	http://www.ncbi.nlm.nih.gov/pubmed/12881030
2003	Efficacy	Parent-child interaction therapy: a comparison of standard and abbreviated treatments for oppositional defiant preschoolers	Nixon, R.D., Sweeney, L., Erickson, D.B., & Touyz, S.W.	Journal of Consulting & Clinical Psychology	Nixon RD. Sweeney L. Erickson DB. Touyz SW. (2003) Parent-child interaction therapy: a comparison of standard and abbreviated treatments for	http://www.ncbi.nlm.nih.gov/pubmed/12699020
2003	Assessment	Psychometric properties of the Sutter-Eyberg Student Behavior Inventory-Revised with pre-school children.	Querido, J.G. & Eyberg, S.M.	Behavior Therapy	Querido, J. G. & Eyberg, S. M. (2003) Psychometric properties of the Sutter-Eyberg Student Behavior Inventory-Revised with pre-school children. Behavior	http://www.sciencedirect.com/science/article/pii/S0005789403800187
2003	Reviews	Parent-child interaction assessment.	Querido, J.G., & Eyberg, S.M. In T.H. Ollendick & C.S. Schroeder (Eds.)	Encyclopedia of clinical child and pediatric psychology	Querido, J.G., & Eyberg, S.M. (2003). Parent-child interaction assessment. In T.H. Ollendick & C.S. Schroeder (Eds.)	
2002	Reviews	Parent-child interaction therapy.	Bell, S., & Eyberg, S.M. In L. VandeCreek, S. Knapp, & T.L. Jackson (Eds.)	Innovations in Clinical Practice: A Source Book, Vol. 20	Encyclopedia of clinical child and pediatric Bell, S., & Eyberg, S.M. (2002). Parent-child interaction therapy. In L. VandeCreek, S. Knapp, & T.L. Jackson (Eds.). Innovations in Clinical Practice: A Source Book (Vol. 20;	
2002	Process	All parents of preschoolers need support!	Eyberg, S.M., Calzada, E.J., Brinkmeyer, M., Querido, J.G., Funderburk, B.W In L. VandeCreek, S. Knapp, & T.L. Jackson (Eds.)	Innovations in clnical practice: A source book (Vol. 20)	Eyberg, S.M., Calzada, E.J., Brinkmeyer, M., Querido, J.G., Funderburk, B.W. (2002). All parents of preschoolers need support! In L. VandeCreek, S. Knapp, & T.L. Jackson (Eds.)	
2002	Process	Discipline with preschoolers.	Eyberg, S.M., Calzada, E.J., Brinkmeyer, M., Querido, J.G., Funderburk, B.W. In L. VandeCreek, S. Knapp, & T.L. Jackson (Eds.)	Innovations in clnical practice: A source book (Vol. 20).	Eyberg, S.M., Calzada, E.J., Brinkmeyer, M., Querido, J.G., Funderburk, B.W. (2002). Discipline with preschoolers. In L. VandeCreek, S. Knapp, & T.L. Jackson (Eds.)	
2002	Reviews	Parent-child interaction therapy: New directions in research.	Herschell, A., Calzada, E., Eyberg, S.M., & McNeil, C.B.	Cognitive and Behavioral Practice	Herschell, A., Calzada, E., Eyberg, S.M., & McNeil, C.B. (2002). Parent-child interaction therapy: New directions in research. Cognitive and Behavioral	http://psycnet.apa.org/index.cfm?fa=search.displayRecord&uid=2002-01916-002
2002	Reviews	Clinical issues in parent-child interaction therapy.	Herschell, A., Calzada, E., Eyberg, S.M., & McNeil, C.B.	Cognitive and Behavioral Practice	Herschell, A., Calzada, E., Eyberg, S.M., & McNeil, C.B. (2002). Clinical issues in parent-child interaction therapy. Cognitive and Behavioral Practice, 9, 16-27.	http://www.sciencedirect.com/science/article/pii/S1077722902800359
2002	Reviews	Management of disruptive behavior in young children.	Neary, E.M., & Eyberg, S.M.	Infants and Young Children	Neary, E.M., & Eyberg, S.M. (2002). Management of disruptive behavior in young children. Infants and Young Children, 14, 53-67.	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ645019
2002	Reviews	Theory, research, and practice of parent-child interaction therapy.	Querido, J.G., Bearss, K., & Eyberg, S.M. In F.W, Kaslow & T. Patterson (Eds.).	Comprehensive Handbook of Psychotherapy, Volume Two:	Querido, J.G., Bearss, K., & Eyberg, S.M. (2002). Theory, research, and practice of parent-child interaction therapy. In F.W, Kaslow & T. Patterson (Eds.).	
2002	Assessment	Parenting styles and child behavior in African American families of preschool children.	Querido, J.G., Warner, T.D., & Eyberg, S.M.	Journal of Clinical Child and Adolescent Psychology	Querido, J.G., Warner, T.D., & Eyberg, S.M. (2002). Parenting styles and child behavior in African American families of preschool children. Journal of Clinical Child and	http://psycnet.apa.org/psycinfo/2002-12999-011

2002	Reviews		Parent-child interaction therapy.	Rich, B.A., Querido, J.G., & Eyberg, S.M. In M. Hensen & W. Sledge (Eds.)	Encyclopedia of Psychotherapy (Vol. 2: I-Z).	Rich, B.A., Querido, J.G., & Eyberg, S.M. (2002). Parent-child interaction therapy. In M. Hensen & W. Sledge (Eds.) Encyclopedia of Psychotherapy (Vol. 2: I-Z). New York:	
2002	Assessment		Antecedents of coercive interactions in physically abusive mother-child dyads.	Timmer, S.G., Borrego, J., & Urquiza, A.J.	Journal of Interpersonal Violence	Timmer, S.G., Borrego, J., & Urquiza, A.J. (2002). Antecedents of coercive interactions in physically abusive mother-child dyads. Journal of Interpersonal	http://jiv.sagepub.com/content/17/8/836.abstract
2001	Assessment		A comparison between African American and Caucasian children referred for treatment of disruptive behavior disorders.	Capage, L.C., Bennett, G.M., McNeil, C.B.	Child & Family Behavior Therapy	Capage, L.C., Bennett, G.M., McNeil, C.B. (2001). A comparison between African American and Caucasian children referred for treatment of disruptive behavior	http://psycnet.apa.org/psycinfo/2001-17137-001
2001	Reviews		Individual child and family-based treatments for Attention Deficit Hyperactivity Disorder.	Eyberg, S.M., Dabbs, M., & Neary, E.M. In B. L. Maria (Ed.).	Advanced therapy in child neurology (2nd ed.).	Eyberg, S.M., Dabbs, M., & Neary, E.M. (2001). Individual child and family-based treatments for Attention Deficit Hyperactivity Disorder. In B. L. Maria (Ed.).	
2001	Effficacy		Parent-child interaction therapy with behavior problem children: One and two year maintenance of treatment effects in the family.	Eyberg, S.M., Funderburk, B.W., Hembree-Kigin, T.L., McNeil, C.B., Querido, J.G., & Hood, K.	Child & Family Behavior Therapy	Eyberg, S.M., Funderburk, B.W., Hembree-Kigin, T.L., McNeil, C.B., Querido, J.G., & Hood, K. (2001). Parent-child interaction therapy with behavior problem children:	http://pubget.com/paper/pgtmp_a264cdbd2a4ed35e2622645f6ac70e9a
2001	Assessment		Types of verbal feedback that affect compliance and general behavior in disruptive and typical children.	Filcheck, H.A., McNeil, C.B., & Herschell, A.D.	Child Study Journal	Filcheck, H.A., McNeil, C.B., & Herschell, A.D. (2001). Types of verbal feedback that affect compliance and general behavior in disruptive and typical children. Child Study	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ647752
2001	Reviews		Understanding manual-based behavior therapy: Some theoretical foundations of parent-child interaction therapy.	Greco, L.A., Sorrell, J.T., & McNeil, C.B.	Child & Family Behavior Therapy	Greco, L.A., Sorrell, J.T., & McNeil, C.B. (2001). Understanding manual-based behavior therapy: Some theoretical foundations of parent-child interaction	http://www.tandfonline.com/doi/abs/10.1300/J019v23n04_02#preview
2001	Reviews		Parent-Child Interaction Therapy: Can a manualized treatment be functional?	McNeil, C.B., Filcheck, H.A., Greco, L.A., Ware, L.M., & Bernard, R.S.	The Behavior Analyst Today	McNeil, C.B., Filcheck, H.A., Greco, L.A., Ware, L.M., & Bernard, R.S. (2001). Parent-Child Interaction Therapy: Can a manualized treatment be functional? The	http://findarticles.com/p/articles/mi_6884/is_2_2/ai_n28128024/
2001	Efficacy		Changes in hyperactivity and temperament in behaviourally disturbed preschoolers after parent-child interaction therapy (PCIT).	Nixon, R.D.V.	Behaviour Change	Nixon, R.D.V. (2001). Changes in hyperactivity and temperament in behaviourally disturbed preschoolers after parent-child interaction therapy (PCIT).	http://www.atypon-link.com/AAP/doi/abs/10.1375/bech.18.3.168
2001	Assessment		Revisiting the Accuracy Hypothesis in Families of Young Children With Conduct Problems	Querido, J.G., Eyberg, S.M., & Boggs, S.	Journal of Clinical Child Psychology	Querido, J.G., Eyberg, S.M., & Boggs, S. (2001). Revisiting the Accuracy Hypothesis in Families of Young Children With Conduct Problems. Journal of Clinical Child	http://www.tandfonline.com/doi/abs/10.1207/S15374424JCCP3002_12
2001	Assessment		Accuracy of assessment: The discriminative and predictive power of the Eyberg Child Behavior Inventory.	Rich, B.A., & Eyberg, S.M.	Ambulatory Child Health	Rich, B.A., & Eyberg, S.M. (2001). Accuracy of assessment: The discriminative and predictive power of the Eyberg Child Behavior Inventory. Ambulatory Child	http://onlinelibrary.wiley.com/doi/10.1046/j.1467-0658.2001.00141.x/abst
2000	Reviews		Parent-child interaction therapy.	Herschell, A.D., Lumley, V.A., & McNeil, C.B. In L Vandecreek (Ed.).	Innovations in clinical practice: A source book, Vol. 18	Herschell, A.D., Lumley, V.A., & McNeil, C.B. (2000). Parent-child interaction therapy. In L Vandecreek (Ed.). Innovations in clinical practice: A source book (Vol. 18,	
2000	Assessment		Psychometric properties and reference point data for the revised edition of the school observation coding system.	Jacobs, J. R., Boggs, S. R., Eyberg, S. M., Edwards, D., Durning, P., Querido, J. G., et al.	Behavior Therapy	Jacobs, J. R., Boggs, S. R., Eyberg, S. M., Edwards, D., Durning, P., Querido, J. G., et al. (2000) Psychometric properties and refer¬ence point data for the revised	http://www.sciencedirect.com/science/article/pii/S0005789400800398
2000	Qualitative and Case Studies	Adaptations	Parent training through play: Parent-child interaction therapy with a hyperactive child.	Johnson, B.D., Franklin, L.C., Hall, K., & Prieto, L.R.	Family Journal-Counseling & Therapy for Couples & Families	Johnson, B.D., Franklin, L.C., Hall, K., & Prieto, L.R. (2000). Parent training through play: Parent-child interaction therapy with a hyperactive child. Family Journal-	http://psycnet.apa.org/psycinfo/2000-08205-011

1999	Qualitative and Case Studies		Treatment of noncompliance using parent child interaction therapy: A data-driven approach.	Bahl, A.B., Spaulding, S.A., & McNeil, C.B.	Education & Treatment of Children	Bahl, A.B., Spaulding, S.A., McNeil, C.B. (1999). Treatment of noncompliance using parent child interaction therapy: A data-driven approach. Education & Treatment of Children/79867866.htm	http://www.freepatentsonline.com/article/Education-Treatment-
1999	Qualitative and Case Studies	Adaptations	Parent-child interaction therapy with a family at high risk for physical abuse.	Borrego, J., Jr., Urquiza, A.J., Rasmussen, R.A., Zebell, N.	Child Maltreatment	Borrego, J., Jr., Urquiza, A.J., Rasmussen, R.A., Zebell, N. (1999). Parent-child interaction therapy with a family at high risk for physical abuse. Child Maltreatment.	http://cmx.sagepub.com/content/4/4/331.abstract
1999	Assessment		A Consumer Satisfaction Measure for Parent-Child Treatments and Its Relation to Measures of Child Behavior Change.	Brestan, E., Jacobs, J., Rayfield, A., & Eyberg, S.M.	Behavior Therapy	Brestan, E., Jacobs, J., Rayfield, A., & Eyberg, S.M. (1999). A Consumer Satisfaction Measure for Parent-Child Treatments and Its Relation to Measures of	http://www.sciencedirect.com/science/article/pii/S0005789499800434
1999	Assessment		Eyberg Child Behavior Inventory and Sutter-Eyberg Student Behavior Inventory: Professional Manual.	Eyberg, S.M. & Pincus, D.	Odessa, FL: Psychological Assessment Resources.	Eyberg, S.M., & Pincus, D. (1999) Eyberg Child Behavior Inventory and Sutter-Eyberg Student Behavior Inventory: Professional Manual. Odessa, FL: Psychological	
1999	Assessment			Eyberg, S.M., & Pincus, D.	Eyberg Child Behavior Inventory and Sutter-Eyberg Student Behavior Inventory:	Eyberg, S.M., & Pincus, D. (1999). Eyberg Child Behavior Inventory and Sutter-Eyberg Student Behavior Inventory: Professional Manual. Odessa, FL: Psychological	
1999	Efficacy		Importance of early intervention for disruptive behavior problems: Comparison of treatment and waitlist-control groups.	McNeil, C.B., Capage, L.C., Bahl, A., & Blanc, H.	Early Education & Development	McNeil, C.B., Capage, L.C., Bahl, A., & Blanc, H. (1999). Importance of early intervention for disruptive behavior problems: Comparison of treatment and waitlist-	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ593719
1999	Reviews		Parent-child interaction therapy: Review and clinical strategies.	Rayfield, A.R., Monaco, L., & Eyberg, S.M. In S. Russ and T. Ollendick (Eds.).	Handbook of Psychotherapies for Children and Adolescents	Rayfield, A.R., Monaco, L., & Eyberg, S.M. (1999). Parent-child interaction therapy: Review and clinical strategies. In S. Russ and T. Ollendick (Eds.). Handbook of	
1998	Process		A test of the parenting alliance theory.	Bearss, K., & Eyberg, S.M.	Early Education and Development	Bearss, K., & Eyberg, S.M. (1998). A test of the parenting alliance theory. Early Education and Development, 9, 179-185.	http://tandfprod.literatumonline.com/doi/abs/10.1207/s15566935eed0902_5#
1998	Reviews		Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids.	Brestan, E.V., & Eyberg, S.M.	Journal of Clinical Child Psychology	Brestan, E.V., & Eyberg, S.M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and	http://www.ncbi.nlm.nih.gov/pubmed/9648035
1998	Reviews		Parent-child interaction therapy: An effective treatment for young children with conduct problems.	Capage, L.C., McNeil, C.B., Foote, R., & Eyberg, S.M.	The Behavior Therapist	Capage, L.C., McNeil, C.B., Foote, R., & Eyberg, S.M. (1998). Parent-child interaction therapy: An effective treatment for young children with conduct problems.	http://www.abct.org/Members/?m=mMembers&fa=JournalsPeriodicals#sec3
1998	Reviews		Parent-child interaction therapy for oppositional preschoolers.	Eyberg, S.M., & Boggs, S.R. In C.E. Schaefer & J.M. Briesmeister (Eds.)	Handbook of parent training: Parents as co-therapists for children's behavior problems	Eyberg, S.M., & Boggs, S.R. (1998). Parent-child interaction therapy for oppositional preschoolers. In C.E. Schaefer & J.M. Briesmeister (Eds.) Handbook of parent	
1998	Efficacy	Adjunct Treatment	Maintaining the treatment effects of parent training: The role of booster sessions and other maintenance strategies.	Eyberg, S.M., Edwards, D., Boggs, S., & Foote, R.	Clinical Psychology: Science and Practice	Eyberg, S.M., Edwards, D., Boggs, S., & Foote, R. (1998). Maintaining the treatment effects of parent training: The role of booster sessions and other	http://onlinelibrary.wiley.com/doi/10.1111/j.1468-2850.1998.tb00173.x/a
1998	Reviews		Behavior modification in the treatment of Attention Deficit/Hyperactivity Disorder.	Eyberg, S.M., Schuhmann, E., & Foote, R. In B. L. Maria (Ed.).	Advanced therapy in child neurology.	Eyberg, S.M., Schuhmann, E., & Foote, R. (1998). Behavior modification in the treatment of Attention Deficit/Hyperactivity Disorder. In B. L.	
1998	Process		Child and Adolescent Psychotherapy Research: Developmental Issues	Eyberg, S.M., Schuhmann, E., & Rey, J.	Journal of Abnormal Child Psychology	Eyberg, S.M., Schuhmann, E., & Rey, J. (1998). Child and Adolescent Psychotherapy Research: Developmental Issues. Journal of Abnormal Child	http://www.springerlink.com/content/j362936p15548214/

1998	Reviews		Parent-child interaction approaches to the treatment of child conduct problems.	Foote, R., Eyberg, S.M., & Schuhmann, E. In T. Ollendick and R. Prinz (Eds.).	Advances in Clinical Child Psychology	Foote, R., Eyberg, S.M., & Schuhmann, E. (1998). Parent-child interaction approaches to the treatment of child conduct problems. In T. Ollendick and R. Prinz	
1998	Reviews		Parent-child interaction therapy: A guide for clinicians.	Foote, R., Schuhmann, E., Jones, M., & Eyberg, S.M.	Clinical Child Psychology and Psychiatry	Foote, R., Schuhmann, E., Jones, M., & Eyberg, S.M. (1998). Parent-child interaction therapy: A guide for clinicians. Clinical Child Psychology and Psychiatry,3,	http://ccp.sagepub.com/content/3/3/361.abstract
1998	Efficacy		Parent-child interaction therapy with behavior problem children: Maintenance of treatment effects in the school setting.	Funderburk, B.W., Eyberg, S.M., Newcomb, K., McNeil, C., Hembree-Kigin, T. & Capage, L.	Child & Family Behavior Therapy	Funderburk, B.W., Eyberg, S.M., Newcomb, K., McNeil, C., Hembree-Kigin, T. & Capage, L. (1998). Parent-child interaction therapy with behavior problem children:	http://psycnet.apa.org/psycinfo/1998-01485-002
1998	Assessment		Inventario Eyberg del Comportamiento en Ninos: Normalizacion de la version espanola y su utilidad para el pediatra extrahospitalario.	Garcia-Tornel, S., Calzada, E. J., Eyberg, S. M., Alguacil, J. M., Serra, C. V., Mendoza, C. B., Collado, H. V., Garcia, M. G., Hernandez, M. C., &	Anales Espanoles de Pediatria	Garcia-Tornel, S., Calzada, E. J., Eyberg, S. M., Alguacil, J. M., Serra, C. V., Mendoza, C. B., Collado, H. V., Garcia, M. G., Hernandez, M. C., & Domenech, A. T. (1998). Inventario	http://www.aeped.es/sites/default/files/anales/48-5-5.pdf
1998	Assessment		Trastornos del comportamiento en el nino: Utilidad del Inventario Eyberg en la practica diaria del pediatra.	Garcia-Tornel, S., Eyberg, S. M., Calzada, E. J., & Sainz, E.	Pediatria Integral	Garcia-Tornel, S., Eyberg, S. M., Calzada, E. J., & Sainz, E. (1998). Trastornos del comportamiento en el nino: Utilidad del Inventario Eyberg en la practica diaria del	http://bddoc.csic.es:8080/detalles.html?tabla=docu&bd=ICYT&id=120108
1998	Process		Treatment acceptability of behavioral interventions for children: An assessment by mothers of children with disruptive behavior disorders.	Jones, M.L., Eyberg, S.M., Adams, C.D., & Boggs, S.R.	Children & Family Behavior Therapy	Jones, M.L., Eyberg, S.M., Adams, C.D., & Boggs, S.R. (1998). Treatment acceptability of behavioral interventions for children: An assessment by mothers of children with	http://psycnet.apa.org/index.cfm?fa=search.displayRecord&uid=1998-03062-002
1998	Process		Treating multi-problem, high stress families: Suggested strategies for practitioners.	McNeil, C.B., & Herschell, A.D.	Family Relations: Interdisciplinary Journal of Applied Family Studies	McNeil, C.B., & Herschell, A.D. (1998). Treating multi-problem, high stress families: Suggested strategies for practitioners. Family Relations:	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ583374
1998	Assessment		Revision of the Sutter-Eyberg Student Behavior Inventory: Teacher Ratings of Conduct Problem Behavior	Rayfield, A. R., Eyberg, S.M., & Foote, R.	Educational and Psychological Measurement	Rayfield, A. R., Eyberg, S.M., & Foote, R. (1998) Teacher rating of conduct problem behavior: The Sutter-Eyberg Student Behavior Inventory Revised. Educational	http://epm.sagepub.com/content/58/1/88.short
1998	Assessment		Parenting stress in mothers of young children with oppositional defiant disorder and other severe behavior problems.	Ross, C.N., Blanc, H.M., McNeil, C.B., Eyberg, S.M., & Hembree-Kigin, T.L.	Child Study Journal	Ross, C.N., Blanc, H.M., McNeil, C.B., Eyberg, S.M., & Hembree-Kigin, T.L. (1998). Parenting stress in mothers of young children with oppositional defiant disorder	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ572381
1998	Efficacy		Efficacy of parent-child interaction therapy: interim report of a randomized trial with short-term maintenance.	Schuhmann, E.M., Foote, R.C., Eyberg, S.M., Boggs, S.R., & Algina, J.	Journal of Clinical Child Psychology	Schuhmann EM. Foote RC. Eyberg SM. Boggs SR. Algina J. (1998) Efficacy of parent-child interaction therapy: interim report of a randomized	http://www.ncbi.nlm.nih.gov/pubmed/9561935
1997	Process	Assessment	Parent-child interaction therapy: Parent perceptions of untreated siblings.	Brestan, E.V., Eyberg, S.M., Boggs, S.R., & Algina, J.	Child & Family Behavior Therapy	Brestan, E.V., Eyberg, S.M., Boggs, S.R., & Algina, J. (1997). Parent-child interaction therapy: Parent perceptions of untreated siblings. Child & Family Behavior Therapy,	http://psycnet.apa.org/psycinfo/1997-04942-002
1996	Assessment		Screening for conduct problem behavior in pediatric settings using the Eyberg Child Behavior Inventory.	Schuhmann, E.M., Durning, P.E., Eyberg, S.M., & Boggs, S.R.	Ambulatory Child Health	Schuhmann, E.M., Durning, P.E., Eyberg, S.M., & Boggs, S.R. (1996). Screening for conduct problem behavior in pediatric settings using the Eyberg Child Behavior	http://onlinelibrary.wiley.com/doi/10.1046/j.1467-0658.2001.00141.x/abst
1996	Adaptations	Reviews	Parent-child interaction therapy: An intensive dyadic intervention for physically abusive families.	Urquiza, A.J. & McNeil, C.B.	Child Maltreatment	Urquiza, A.J. & McNeil, C.B. (1996). Parent-child interaction therapy: An intensive dyadic intervention for physically abusive families. Child Maltreatment, 1, 134-144.	http://cmx.sagepub.com/content/1/2/134.abstract
1995	Efficacy		Parent-child interaction therapy: A psychosocial model for the treatment of young children with conduct problem behavior and their families.	Eyberg, S.M., Boggs, S., & Algina, J.	Psychopharmacology Bulletin	Eyberg, S.M., Boggs, S., & Algina, J. (1995). Parent-child interaction therapy: A psychosocial model for the treatment of young children with conduct problem	http://www.ncbi.nlm.nih.gov/pubmed/7675994

1995	Reviews			Hembree-Kigin, T., & McNeil, C.	Parent-Child Interaction Therapy.	Hembree-Kigin, T., & McNeil, C. (1995). Parent-Child Interaction Therapy. New York: Plenum.	
1994	Assessment		Interparent agreement on the Eyberg Child Behavior Inventory.	Eisenstadt, T.H., McElreath, L.S., Eyberg, S.M., & McNeil, C.B.	Child and Family Behavior Therapy	Eisenstadt, T.H., McElreath, L.S., Eyberg, S.M., & McNeil, C.B. (1994) Interparent agreement on the Eyberg Child Behavior Inventory. Child and Family Behavior	http://www.informaworld.com/smpp/content~db=all~content=a904372239
1994	Process	Assessment	Assessment of a new procedure to prevent timeout escape in preschoolers.	McNeil, C.B., Clemens-Mowrer, L., Gurwitch, R.H., & Funderburk, B.W.	Child & Family Behavior Therapy	McNeil, C.B., Clemens-Mowrer, L., Gurwitch, R.H., & Funderburk, B.W. (1994). Assessment of a new procedure to prevent timeout escape in preschoolers. Child &	http://www.eric.ed.gov/ERICWebPortal/detail?accno=EJ498757
1993	Efficacy		Parent-child interaction therapy with behavior problem children: Relative effectiveness of two stages and overall treatment outcome.	Eisenstadt, T.H., Eyberg, S., McNeil, C.B., Newcomb, K., & Funderburk, B.	Journal of Clinical Child Psychology	Eisenstadt, T.H., Eyberg, S., McNeil, C.B., Newcomb, K., & Funderburk, B. (1993). Parent-child interaction therapy with behavior problem children: Relative	http://www.tandfonline.com/doi/abs/10.1207/s15374424jccp2201_4#preview
1993	Assessment		Consumer satisfaction measures for assessing parent training programs.	Eyberg, S.M.	Innovations in clinical practice: A source book, Vol. 12.	Eyberg, S.M. (1993). Consumer satisfaction measures for assessing parent training programs. In L. VandeCreek, S. Knapp, & T.L. Jackson (Eds.). Innovations in Clinical	
1992	Assessment		Assessing therapy outcome with preschool children: Progress and problems.	Eyberg, S.M.	Journal of Clinical Child Psychology	Eyberg, S.M. (1992). Assessing therapy outcome with preschool children: Progress and problems. Journal of Clinical Child Psychology, 21, 306-311.	http://www.tandfonline.com/doi/abs/10.1207/s15374424jccp2103_10
1992	Assessment		Parent and teacher behavior inventories for the assessment of conduct problem behaviors in children.	Eyberg, S.M. In L. VandeCreek, S. Knapp, & T.L. Jackson (Eds.)	Innovations in clinical practice: A source book, Vol. 11.	Eyberg, S.M. (1992). Parent and teacher behavior inventories for the assessment of conduct problem behaviors in children. In L. VandeCreek, S. Knapp, & T.L. Jackson	
1992	Assessment		Relationships between maternal parenting stress and child disruptive behavior.	Eyberg, S.M., Boggs, S.R., & Rodriguez, C.M.	Child and Family Behavior Therapy	Eyberg, S.M., Boggs, S.R., & Rodriguez, C.M. (1992). Relationships between maternal parenting stress and child disruptive behavior. Child and Family Behavior	http://psycnet.apa.org/psycinfo/1993-32950-001
1991	Efficacy	Assessment	Parent-child interaction therapy with behavior problem children: Generalization of treatment effects to the school setting.	McNeil, C., Eyberg, S., Eisenstadt, T., Newcomb, K., & Funderburk, B.	Journal of Clinical Child Psychology	McNeil, C., Eyberg, S., Eisenstadt, T., Newcomb, K., & Funderburk, B. (1991). Parent-child interaction therapy with behavior problem children: Generalization	http://www.tandfonline.com/doi/abs/10.1207/s15374424jccp2002_5#preview
1991	Adaptations		Parent-child interaction therapy with a diabetic child.	Miller, E.M., & Eyberg, S.M. In S.R. Boggs & C. M. Rodriguez (Eds.).	Advances in Child Health Psychology: Abstracts.	Miller, E.M., & Eyberg, S.M. (1991). Parent-child interaction therapy with a diabetic child. In S.R. Boggs & C. M. Rodriguez (Eds.). Advances in Child Health	
1991	Assessment		Empirical derivation of child compliance time.	Wruble, M.K., Sheeber, L.B., Sorensen, E.K., Boggs, S.R., & Eyberg, S.M.	Child & Family Behavior Therapy	Wruble, M.K., Sheeber, L.B., Sorensen, E.K., Boggs, S.R., & Eyberg, S.M. (1991). Empirical derivation of child compliance time. Child & Family Behavior Therapy, 13,	http://www.tandfonline.com/doi/abs/10.1300/J019v13n01_04
1990	Assessment		Concurrent validity of the Eyberg Child Behavior Inventory.	Boggs, S.R., Eyberg, S.M., & Reynolds, L.	Journal of Clinical Child Psychology	Boggs, S.R., Eyberg, S.M., & Reynolds, L. (1990) Concurrent validity of the Eyberg Child Behavior Inventory. Journal of Clinical Child Psychology, 19, 75-78. retrieved from:	http://www.informaworld.com/smpp/content~db=all~content=a783763643
1990	Assessment		Assessing the verbal behavior of conduct problem children during mother-child interactions: A preliminary investigation.	Forster, A.A., Eyberg, S.M., & Burns, G.L.	Child & Family Behavior Therapy	Forster, A.A., Eyberg, S.M., & Burns, G.L. (1990). Assessing the verbal behavior of conduct problem children during mother-child interactions: A preliminary	http://psycnet.apa.org/psycinfo/1990-28526-001
1989	Assessment		Psychometric characteristics of the Sutter-Eyberg Student Behavior Inventory: A school behavior rating scale for use with preschool children.	Funderburk, B. & Eyberg, S.M.	Behavioral Assessment	Funderburk, B., & Eyberg, S.M. (1989). Psychometric characteristics of the Sutter-Eyberg Student Behavior Inventory: A school behavior rating scale for use with	http://scholar.google.com/scholar?cluster=7014056679901708789&hl=en&as_sdt=40005&scio

Year	Author	Title	Journal	APA Reference	Link
2010	Masse, Joshua J.	Examining the efficacy of parent-child interaction therapy with high-functioning autism.	Dissertation Abstracts International: Section B: The Sciences and Engineering	Masse, Joshua J. (2010) Examining the efficacy of parent-child interaction therapy with high-functioning autism. Dissertation Abstracts International: Section B: The Sciences and Engineering, 71(10-B), 6558. retrieved from: http://gradworks.umi.com/33/81/3381201.html	http://gradworks.umi.com/33/81/3381201.html
2008	Floress, Margaret T	The effectiveness of teacher-child interaction training on behaviorally at-risk preschool children.	Dissertation Abstracts International: Section B: The Sciences and Engineering	Floress, Margaret T. (2008) The effectiveness of teacher-child interaction training on behaviorally at-risk preschool children. Dissertation Abstracts International: Section B: The Sciences and Engineering, 68(10-B), 6960. retrieved from: http://www.unmc.edu/media/mmi/pdf/theeffectivenessofteacherchild.pdf	http://www.unmc.edu/media/mmi/pdf/theeffectivenessofteacherchild.pdf
2008	Jamison, T. Rene	The effects of parent-child interaction therapy on problem behaviors in three children with autistic disorder.	Dissertation Abstracts International: Section B: The Sciences and Engineering	Jamison, T. Rene. (2008) The effects of parent-child interaction therapy on problem behaviors in three children with autistic disorder. Dissertation Abstracts International: Section B: The Sciences and Engineering,68(7-B), 4828. retrieved from: http://gradworks.umi.com/32/74/3274489.html	http://gradworks.umi.com/32/74/3274489.html
2008	Ridgeway, Lorraine Elizabeth	The effectiveness of group Parent-Child Interaction Therapy (PCIT) with community families.	Dissertation Abstracts International: Section B: The Sciences and Engineering	Ridgeway, Lorraine Elizabeth. (2008) The effectiveness of group Parent-Child Interaction Therapy (PCIT) with community families. Dissertation Abstracts International: Section B: The Sciences and Engineering, 69(2-B),1340. retrieved from: http://etd.auburn.edu/etd/handle/10415/124	http://etd.auburn.edu/etd/handle/10415/124
2008	Ware, Lisa M	Efficacy of in-home parent-child interaction therapy.	Dissertation Abstracts International: Section B: The Sciences and Engineering.	Ware, Lisa M. (2008) Efficacy of in-home parent-child interaction therapy. Dissertation Abstracts International: Section B: The Sciences and Engineering68 (8-B), 5598.	
2007	Baier, Kelly M.	Regulation of affect in children participating in Parent-Child Interaction Therapy.	Dissertation Abstracts International: Section B: The Sciences and Engineering	Baier, Kelly M. (2007) Regulation of affect in children participating in Parent-Child Interaction Therapy Dissertation Abstracts International: Section B: The Sciences and Engineering, 68(1-B), 616. retrieved from:http://gradworks.umi.com/32/47/3247239.html	http://gradworks.umi.com/32/47/3247239.html
2007	Brinkmeyer, Mary Yarbrough	Conduct disorder in young children: A comparison of clinical presentation and treatment outcome in preschoolers with conduct disorder versus oppositional defiant disorder.	Dissertation Abstracts International: Section B: The Sciences and Engineering	Brinkmeyer, Mary Yarbrough. (2007) Conduct disorder in young children: A comparison of clinical presentation and treatment outcome in preschoolers with conduct disorder versus oppositional defiant disorder. Dissertation Abstracts International: Section B: The Sciences and Engineering,67(9-B),5390. retrieved from: http://gradworks.umi.com/32/34/3234523.html	http://gradworks.umi.com/32/34/3234523.html
2007	Farrell, Shannon Scott	Parent-toddler relationship enrichment program: A parenting program based on the theories and techniques of parent-child interaction therapy.	Dissertation Abstracts International: Section B: The Sciences and Engineering	Farrell, Shannon Scott. (2007) Parent-toddler relationship enrichment program: A parenting program based on the theories and techniques of parent-child interaction therapy. Dissertation Abstracts International: Section B: The Sciences and Engineering, 68(5-B), 3381. retrieved from: http://gradworks.umi.com/32/68/3268617.html	http://gradworks.umi.com/32/68/3268617.html
2007	Mason, Christie M.	Parent and therapist perceptions of therapy with a late-placed foster or adopted child.	Dissertation Abstracts International Section A: Humanities and Social Sciences	Mason, Christie M. (2007) Parent and therapist perceptions of therapy with a late-placed foster or adopted child. Dissertation Abstracts International Section A: Humanities and Social Sciences,68 (4-A), 1660. retrieved from: http://gradworks.umi.com/32/61/3261320.html	http://gradworks.umi.com/32/61/3261320.html
2006	Crane, Susan Carol Marie	Child-centered play therapy and Parent-Child Interaction Therapy: A practice-based case study exploration of two play therapies as trauma treatment.	Dissertation Abstracts International: Section B: The Sciences and Engineering.	Crane, Susan Carol Marie. (2006) Child-centered play therapy and Parent-Child Interaction Therapy: A practice-based case study exploration of two play therapies as trauma treatment. Dissertation Abstracts International: Section B: The Sciences and Engineering, 66(7-B), retrieved from: http://gradworks.umi.com/31/83/3183577.html	http://gradworks.umi.com/31/83/3183577.html

2005	Ho, Lareina K. L.	The treatment effectiveness of Parent-Child Interaction Therapy with depressed mother-child dyads.	Dissertation Abstracts International: Section B: The Sciences and Engineering.	Ho, Lareina K. L. (2005) The treatment effectiveness of Parent-Child Interaction Therapy with depressed mother-child dyads. Dissertation Abstracts International: Section B: The Sciences and Engineering,65(7-B),3709	
2004	Herschell, Amy D.	Evaluation of techniques for disseminating parent-child interaction therapy.	Dissertation Abstracts International: Section B: The Sciences and Engineering.	Herschell, Amy D. (2004) Evaluation of techniques for disseminating parent-child interaction therapy. Dissertation Abstracts International: Section B: The Sciences and Engineering,65 (5-B), 2629. retrieved from: http://wvuscholar.wvu.edu:8881//exlibris/dtl/d3_1/apache_media/L2V4bGlicmlzL2R0bC9kM18xL2FwYWNoZV9tZWRpYS82Njl1.pdf	http://wvuscholar.wvu.edu:8881//exlibris/dtl/d3_1/apache_media/L2V4bGlicmlzL2R0bC9kM18xL2FwYWNoZV9tZWRpYS82Njl1
2004	Querido, Jane Gumiran	Early intervention for child conduct problems in head start families.	Dissertation Abstracts International: Section B: The Sciences and Engineering	Querido, Jane Gumiran. (2004) Early intervention for child conduct problems in head start families. Dissertation Abstracts International: Section B: The Sciences and Engineering 64(9-b), 4630.	
2004	Rodgers, Stacey Mccorry	Parent-Child Interaction Therapy: Modified for use as a prevention program for infants, toddlers and their parents.	Dissertation Abstracts International: Section B: The Sciences and Engineering	Rodgers, Stacey Mccorry. (2004) Parent-Child Interaction Therapy: Modified for use as a prevention program for infants, toddlers and their parents. Dissertation Abstracts International: Section B: The Sciences and Engineering, 64(7-B),3540.	

Year	Author	Title	Publication Source	APA Reference	Link
2008	Goldfine, M., Wagner, S., Branstetter, S., McNeil, C.	Parent-Child Interaction Therapy: An Examination of Cost-Effectiveness	Journal of Early and Intensive Behavior Intervention	Goldfine, M., Wagner, S., Branstetter, S., McNeil, C. Parent-Child Interaction Therapy: An Examination of Cost-Effectiveness. Journal of Early and Intensive Behavior Intervention, 5(1), 119-141. retrieved from:http://eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_&ERICExtSearch_SearchValue_0=EJ805952&ERICExtSearch_SearchType_0=no&accno=EJ805952	http://eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_&ERICExtSearch_SearchValue_0=EJ805952&ERICExtSearch_SearchType_0=no&accno=EJ805952
2007	Lundahl, B. W., Tollefson, D., Risser, H., & Lovejoy, C.	A meta-analysis of father involvement in parent training.	Research on Social Work Practice	Lundahl, B. W., Tollefson, D., Risser, H., & Lovejoy, C. A meta-analysis of father involvement in parent training. Research on Social Work Practice. Research on Social Work Practice, 18, 97-106	http://rsw.sagepub.com/content/18/2/97.short
2004	Fikcheck, H. A., & McNeil, C. B.	The use of token economies in preschool classrooms: Practical and philosophical concerns.	Journal of Early and Intensive Behavioral Intervention	Fikcheck, H. A., & McNeil, C. B. The use of token economies in preschool classrooms: Practical and philosophical concerns. Journal of Early and Intensive Behavioral Intervention, 1(1),95-105. retrieved from:http://eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_&ERICExtSearch_SearchValue_0=EJ848682&ERICExtSearch_SearchType_0=no&accno=EJ848682	http://eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_&ERICExtSearch_SearchValue_0=EJ848682&ERICExtSearch_SearchType_0=no&accno=EJ848682
2002	Patterson, G. R.	The early developmental of coercive family process.	Antisocial behavior in children and adolescents: Developmental theories and models for intervention	Patterson, G. R. The early developmental of coercive family process. In J. B. Reid, G. R. Patterson, & J. Snyder (Eds.), Antisocial behavior in children and adolescents: Developmental theories and models for interventionWashington, DC: American Psychological Association. (pp. 25–44).	http://psycnet.apa.org/books/10468/002
1991	Ainsworth, M. S., & Bowlby, J.	An ethological approach to personality development.	American Psychologist	Ainsworth, M. S., & Bowlby, J. An ethological approach to personality development. American Psychologist,46, 333-341	http://psycnet.apa.org/journals/amp/46/4/333/
1991	Baumrind, D.	The influence of parenting style on adolescent competence and substance use.	The Journal of Early Adolescence	Baumrind, D. The influence of parenting style on adolescent competence and substance use. The Journal of Early Adolescence,11, 56-95. retrieved from: http://jea.sagepub.com/content/11/1/56.short.	http://jea.sagepub.com/content/11/1/56.short
1979	Ainsworth, M. S.	Infant-mother attachment.	American Psychologist	Ainsworth, M. S. Infant-mother attachment. American Psychologist,34, 932-937. retrieved from:http://psycnet.apa.org/journals/amp/34/10/932/	http://psycnet.apa.org/journals/amp/34/10/932/
1966	Baumrind, D.	Effects of authoritative control on child behavior.	Child Development	Baumrind, D. Effects of authoritative control on child behavior. Effects of authoritative control on child behavior, 37(4), 887-907. retrieved from: http://psycnet.apa.org/psycinfo/1967-02673-001	http://psycnet.apa.org/psycinfo/1967-02673-001

Category	General Definition
Adaptations	Papers that made changes or modifications to PCIT (e.g., PCIT in the home setting, PCIT with foster kids, etc.) or examined PCIT with a new population or children (e.g., children with traumatic brain injury)
Effectiveness Study	PCIT examined in usual care settings instead of research conditions (e.g., PCIT implemented within a community mental health facility and by mental health providers, not students)
Efficacy Study	Strict research design with high internal validity (e.g., PCIT implemented within a university research clinic) and randomizing families to PCIT and a control group (e.g., standard care, waitlist, alternative treatment)
Process	Papers examining variables within PCIT (e.g., parenting skills, homework completion, therapist coaching)
Qualitative and Case Studies	Papers including focus groups or small numbers of participants to examine the feasibility and promise of PCIT
Reviews	Papers summarizing the current state of the research, like a literature review or meta-analysis
Adjunct treatment	PCIT implemented in addition to another treatment or approach (e.g., PCIT and CBT; PCIT and motivational interviewing)
Assessment	Paper examining assessment procedures in PCIT (e.g., DPICS, ECBI)

AMH-funded PCIT Sites as of February 2015

Contracted Entity	PCIT Provider		Additional PCIT sites with that entity
Jackson County Jennifer Jahnke - child team manager 541-774-8201 for walk-in assessment schedule 541-774-8069 for PCIT questions (Alejandra Moreno)	**JCMH**-Medford		**Family Nurturing Center**/Medford
Yamhill County Family and Youth Programs- Jan Cain - program manager 503-434-7462	**McMinnville**		**Newburg**
Marion County Children's Behavioral Health Gwen Graf - program manager 503-588-5352	**Salem**		**Woodburn**
Washington County Health and Human Services Erin Sewell - program manager 503-704-4276 for PCIT-related questions	**Lifeworks NW** **Tigard** **Cedar Mill** **Hillsboro** Information for new clients: 503-645-9010	**Morrison** **Beaverton** Adrienne Gibson - program manager intake and information 503-256-4381	**Youth Contact** **Hillsboro** **Beaverton** Kristin Sanders – program manager - 503-640-4222

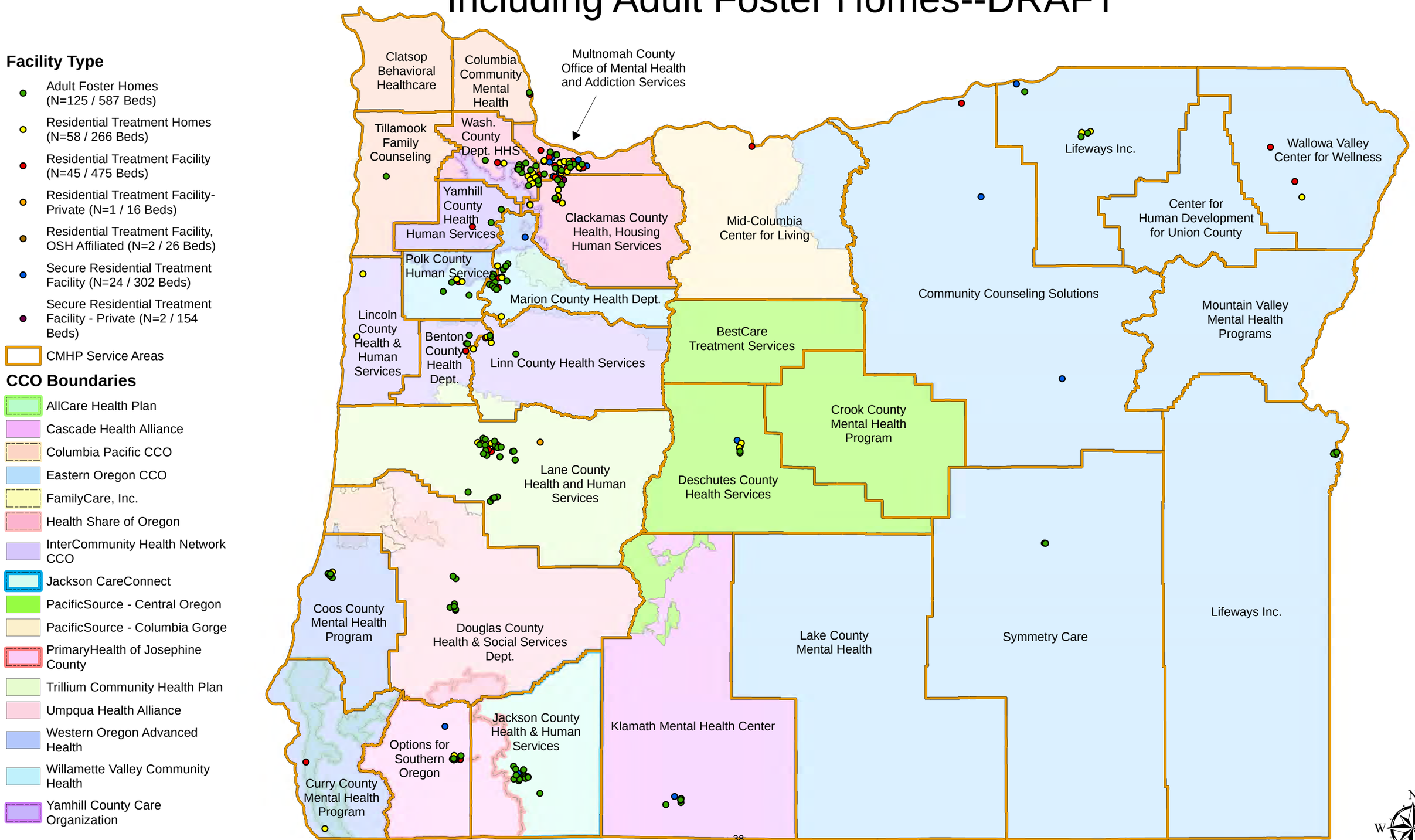
Lifeworks NW Erin Sewell - program manager at 503.704.4276 for PCIT-related questions intake/assessment information for new clients: 503-645-9010	Multnomah County **St. Johns** **PNET**	Clackamas County **Milwaukie**
Mid-Columbia Center for Living Lisa Roth - clinical services manager 541-296-5452 541-296-2731	**Hood River** city and county	Wasco/Sherman **The Dalles**
Options Counseling and Family Services	Marion County - **Salem** Kathryn Nichols - program manager 503-390-5637	
	Lane County **- Eugene** Sally Snyder - supervisor 541-687-6983- Eugene	**Springfield** - 541-762-1971 Florence - 541-997-6261-
Morrison Child and Family Services	Multnomah Co. **Gresham** Colleen Scott - PCIT clinical supervisor - 503-258-4600	**Portland** (Irving Street) Jan Eaton-Bennette - program manager - 503-258-4555
Josephine County Diane Lipparelli - supervisor 541-476-2373	**Options of Southern Oregon** Grants Pass	**Family Nurturing Center**
Malheur County Nancy I. Longoria - project lead	**Lifeways**	

541-889-9167	
Columbia Community Mental Health - Sam Lewis - program manager 503-397-5211	
Coos County Mental Health - Shawna Scharr - project lead 541-751-2500	
Klamath Child and Family Treatment Center - Joseph Ransom - PCIT program coordinator 541-883-1030	
Lincoln County - Linda Gray - program manager 541-265-4179	
Linn County - Jeff Taylor - program manager 541-967-3866	

Oregon Health Authority Addictions and Mental Health Funded Evidence-Based Programs

Activity/Program	Focus Area	EBP/TBP
Active Parenting Now	MH	EBP
Child Development Project	SAP	EBP
Class Action	SAP	EBP
Communities Mobilizing for Change - ALC.	SAP	EBP
Communities That Care	SAP	EBP
Friendly PEERsuasion	SAP	EBP
Guiding Good Choices	MH & SAP	EBP
Life Skills Training	SAP	EBP
Media Ready Program	SAP	EBP
Mental Health First Aid	MH	EBP
Youth Mental Health First Aid	MH	EBP
Parents As Teachers	MH	EBP
Positive Action	MH & SAP	EBP
Project Alert	SAP	EBP
Project Towards No Drug Abuse	SAP	EBP
Protecting You/Protecting Me	SAP	EBP
QPR (Question, Pursuede, Refer)	MH	EBP
Reconnecting Youth Program	MH & SAP	EBP
Safe Dates	MH	EBP
Strengthening Families	MH & SAP	EBP
Strengthening Families Program 10-14	MH & SAP	EBP
Strengthening Multi-Ethnic Families	MH & SAP	EBP
The Incredible Years	MH	EBP
Too Good For Drugs	SAP	EBP
Tribal Program - Basketball Against Alcohol and Drugs	SAP	TBP
Tribal Program - Canoe Journey/Family	SAP	TBP
Tribal Program - Ceremonies and Rituals	MH & SAP	TBP
Tribal Program - Cradleboards	SAP	TBP
Tribal Program - Culture Camp	SAP	TBP
Tribal Program - Domestic Violence Group for men	MH & SAP	TBP
Tribal Program - Family Unity	SAP	TBP
Tribal Program - Healthy Relationships Curriculum	SAP	TBP
Tribal Program - Horse Program	MH & SAP	TBP
Tribal Program - Native American Community Mobilization	SAP	TBP
Tribal Program - Native American Storytelling	SAP	TBP
Tribal Program - Positive Indian Parenting	SAP	TBP
Tribal Program - Powwow	SAP	TBP
Tribal Program - Round Dance	MH & SAP	TBP
Tribal Program - Sweat Lodge	SAP	TBP
Tribal Program - Talking Circle	SAP	TBP
Tribal Program - Tribal Crafts	SAP	TBP
Tribal Program - Tribal Family Activities	SAP	TBP
Tribal Program - Tribal Youth Conference	SAP	TBP

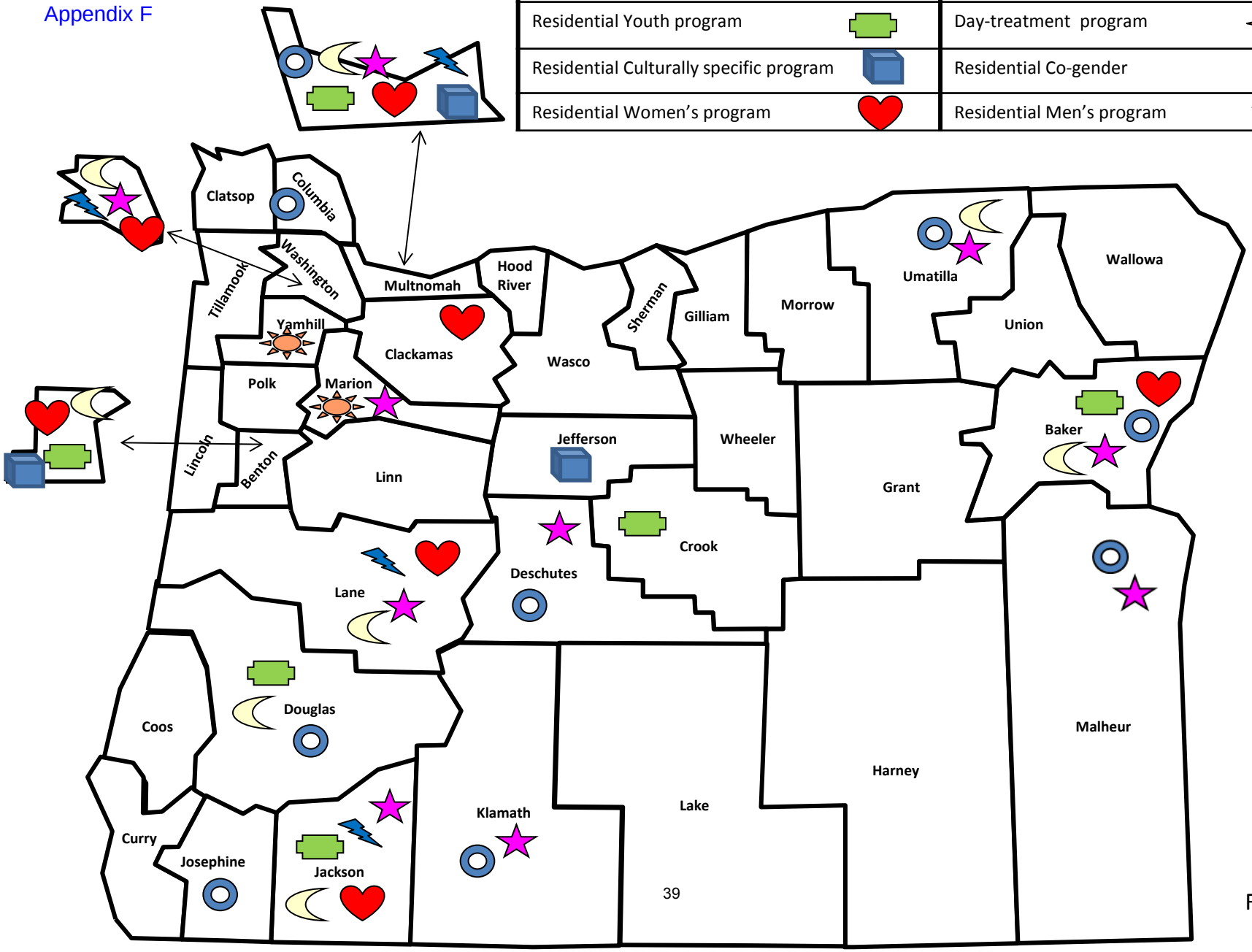
DRAFT--Statewide Residential Treatment Capacity, Including Adult Foster Homes--DRAFT



Source: Office of Health Analytics - Addictions and Mental Health Division Consolidated Database for Certification and Licensure, 5/13/2014

Appendix F

Publicly Funded Substance Use Disorder Treatment Services	
Residential Parent w/dependent child	Detoxification (Clinical & Medical)
Residential Youth program	Day-treatment program
Residential Culturally specific program	Residential Co-gender
Residential Women's program	Residential Men's program



Feb. 2015

Outcomes from Oregon's Substance Abuse Treatment 12-Month Follow-Up Study*

Research Brief
October 19, 2011

"They saved my life. [It's] an awesome place. I would advocate for it in a heartbeat."
~Study participant

Between intake and 12 months follow-up

Substance use in the past 30 days dropped by…

- 93% for amphetamine use
- 83% for heroin use,
- 78% for cannabis use,
- 71% for prescription drug abuse,
- 47% for binge drinking (5 or more drinks within a few hours)

Other positive outcomes

- 87% drop in **arrests** in the past 30 days
- 41% drop in days spent in **jail**
- 29% increase in participants reporting full- or part-time **employment**
- 22% increase in those who said they have clean and sober friends

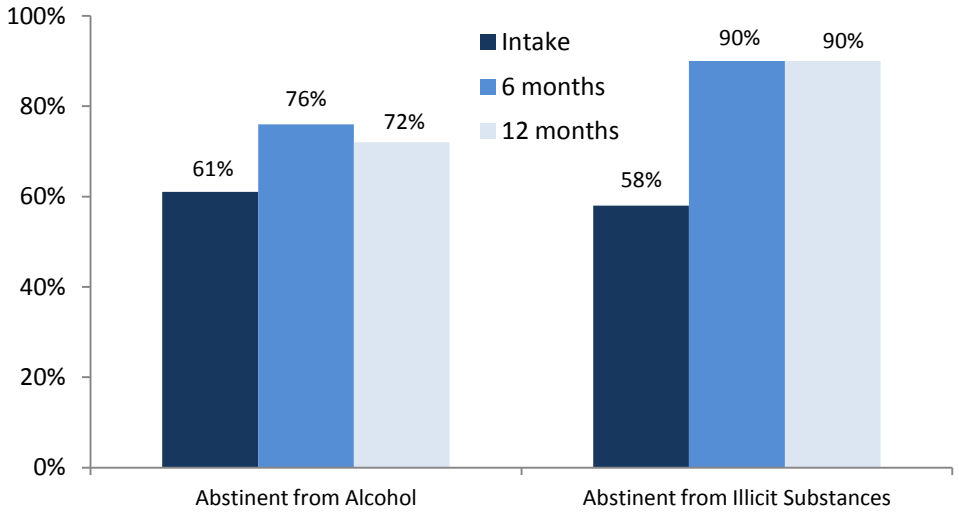
RESULTS: STUDY PARTICIPANTS IMPROVED IN ALMOST EVERY CATEGORY

Last year in Oregon, more than 54,000 adults obtained publicly funded alcohol or drug treatment. To learn more about the ways that treatment benefits Oregonians and their communities, the Oregon Health Authority asked NPC Research to measure treatment outcomes over time and across a range of categories. The results are impressive: at 6 months, reported drug and alcohol use had dropped sharply, while positive indicators in employment and mental health had increased for most participants. **These gains persisted at 12 months, after most had left their treatment program.**

The bottom line

Twelve months after treatment enrollment, 90% of study participants reported abstinence from drug use. 72% reported abstinence from alcohol.

Figure 1. Percentage of Study Participants Using Selected Substances in the Past 30 Days, at Intake, 6 Months and 12 Months

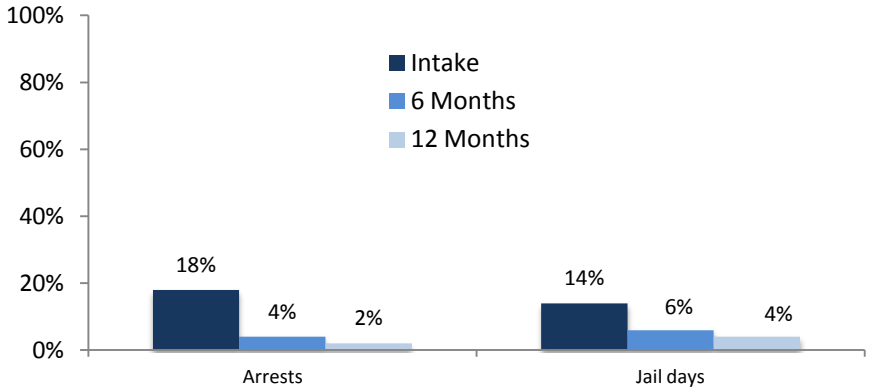


"The counselor taught me about mindfulness, which helped me control my anxiety. I thought it was great that she helped me with that rather than superficially treating my issues with alcohol."
~Study participant

***Note: Details can be found in the full report, which is available upon request.**

NPC Research | 5100 SW Macadam Ave., Ste. 575 | Portland, OR 97239 | (503) 243-2436 | www.npcresearch.com
Addictions & Mental Health Division | 500 Summer St. NE | Salem, OR 97301-1097| (503) 580-1623 | www.oregon.gov/OHA/addiction

Figure 2. Percentage of Study Participants Reporting New Arrests and/or Jail Time in the in the Past 30 Days, at Intake, 6 Months, and 12 Months*



Mental health improvements from baseline to 12 months (past 30 days):

- 67% decrease in reports of s**erious depression**,
- 57% decrease in participant reports of **serious anxiety**,
- 50% decrease in reports of serious thoughts of **suicide**,
- 50% decrease in trouble controlling **violent behavior**, including episodes of rage or violence,
- 38% decrease in trouble **understanding, concentrating or remembering**,
- 6-day (32%) decrease in the number of days that study participants experienced **any mental health issues.**

Opportunities for improvement:

- When talking about their treatment experience, participants were least satisfied with **transportation** options to and from treatment.
- Based on participant feedback, there are opportunities for better **treatment matching** to better serve younger clients and individuals where language barriers exist.
- DUII clients had poorer outcomes than non-DUII clients.

"[Treatment taught me] How to address the situation and my triggers. They helped me control my urges and helped with my family, and be a good role model for my kids."

~Study participant

*Because there were 26 known participants who were incarcerated during some or all of the 12-month follow-up period and could not be interviewed, the 12-month arrest and jail-day information is an underestimate.

"They helped me get into transitional housing after treatment. This was amazing because I was homeless before treatment. Now I am in school and doing well."

~Study participant

Participant Characteristics

- Average age was 36 years
- 59% were male
- 82% identified as White, 12% Latino, 10% AI/AN, 6% Black

Substance Use History

- Alcohol was the substance of choice for over half (54%) the sample at intake, while 19% reported using amphetamines
- 72% reported using tobacco on a daily basis

Criminal Justice Involvement

- 69% of participants reported past incarceration
- 56% of participants had at least one previous DUII
- 28% were currently enrolled in some kind of treatment court at baseline

Medical Health History

- 45% of study participants reported having a chronic medical condition
- One quarter reported lifetime mental health issues serious enough to require hospitalization

Oregon Addictions and Mental Health Division Substance Abuse Treatment Follow-Up Study

Final Report

Submitted to:

Oregon Health Authority
Addictions and Mental Health Division
500 Summer Street NE, E86
Salem, OR 97301-1098

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OREGON HEALTH AUTHORITY
ADDICTIONS AND MENTAL HEALTH DIVISION

Substance Abuse Treatment Follow-Up Study

Final Report

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August 2011

Informing policy, improving programs

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EXECUTIVE SUMMARY

Background & Purpose

The purpose of this study was to collect data on the long-term outcomes of publicly subsidized alcohol and drug treatment services in Oregon and present information gathered to vested stakeholders. Prior to this study, there had been little statewide data and information about what happens to publicly funded clients in Oregon during and after they leave treatment.

The Oregon Health Authority Addictions and Mental Health (AMH) Division designed a 12-month follow-up study to explore long-term outcomes for publicly funded treatment clients. AMH then contracted with NPC Research to conduct the study and partnered with 15 alcohol and drug treatment providers in Oregon to identify eligible clients to participate in the study. Long-term outcomes examined include long-term sobriety, employment, income, selected health, mental health and criminal justice outcomes, as well as client satisfaction measures.

Methods

Study participants were recruited by treatment providers in accordance with study eligibility requirements and protocol with the intention to represent a statewide sample of those receiving outpatient or residential services. Participation in the study was voluntary. Provider staff members were trained by NPC and AMH staff. Using a standardized survey instrument, interviews were conducted by staff at each treatment provider agency at treatment intake (baseline) and lasted about 1 hour. At 6 and 12 months post-intake, follow-up interviews were conducted by trained NPC interview staff and averaged about 20-25 minutes. Individuals were interviewed regardless of whether they were still in treatment or had been discharged from treatment.

Limitations

It would have been preferable to have had a separate control group of people similar to those in the study who were substance abusers – but did not access treatment – to help determine whether the changes from baseline to follow-up were exclusively due to the treatment intervention. However, it is important to note that study designs involving a control group are extremely costly and random assignment to treatment and control group for the duration of a longitudinal study is unlikely to be either an ethical—or workable—option.

As with any study, there is a likelihood of bias in the data, both from participants themselves under-reporting substance use and/or other socially undesirable behaviors, as well from missing data. These are the same limitations associated with most national studies of the subject. Regardless of limitations, however, these data constitute an important and unprecedented look at the impact of publicly funded treatment in Oregon.

Results

Data collectors successfully interviewed 432 out of 592 (73%) eligible clients for the 12-month interview. The 12-month follow-up rate per treatment provider agency ranged

from 60% to 88%. At 6 months, data collectors successfully interviewed 449 out of 606 (74%) eligible clients. The 6-month follow-up rate per treatment provider agency ranged from 50% to 100%.

SAMPLE CHARACTERISTICS

The average age of study participants in the 12-month sample was 36 years old, and 59% were male. Eighty-two percent identified as White, 12% Latino, 10% American Indian or Alaska Native (AI/AN), 6% Black or African American, and slightly less than 3% Asian and Hawaiian.[1] The median education was a high school diploma or GED.

Substance Use History

Alcohol was reported to be the primary substance for 54% of the sample at intake.[2] The next most common primary substances were amphetamine/methamphetamine (19%) and cannabis (14%). Fifty-nine percent reported being multi-substance users in their life-time, while 20% had been multi-substance users in the 30 days prior to intake.[3] Nearly three-quarters of study participants had at least one prior alcohol or drug treatment episode.

Mental and Physical Health

Half the study sample reported having any lifetime treatment for mental health issues, with nearly one quarter of participants reporting mental health issues serious enough to require hospitalization. Nearly half (45%) reported having a chronic medical condition.

Criminal Justice Involvement

Sixty-nine percent of study participants said they had been incarcerated in the past. Fifty-six percent of the entire sample had at least one previous DUII.[4] More than two-thirds of 12-month interview responders were referred to treatment by a court, while 28% percent reported they were enrolled in some kind of treatment court (DUII, drug court, family dependency treatment court) at baseline.

TREATMENT INFORMATION

Of the study participants for whom both 12-month surveys and treatment disposition information is available:

- 64% successfully completed treatment.[5]
- 58% were reported to be abstinent at exit and another 22% had reduced use.
- Average length of stay in treatment was six months.
  - Participants averaged one individual treatment session per month.
  - Participants averaged three group sessions per month.

[1] Participants were allowed to ~~c~~heck all that apply" in the category of race (which does not include Hispanic/Latino which is asked as a separate question); therefore these percentages add to more than 100%.
[2] This percentage refers to people who reported that their main substance of abuse/dependence was alcohol, despite the fact that they may have also reported being abstinent for weeks or months at intake.
[3] Multi-substance use does not include nicotine.
[4] DUII is the acronym for Driving Under the Influence of Intoxicants (liquor, controlled substance(s) or a combination of both).
[5] As determined by the treatment provider, successful completion means that the client has achieved at least two-thirds of his/her signed treatment plan and is no longer abusing and/or is abstinent 30 days prior to termination.

BASELINE TO 12-MONTH FOLLOW-UP OUTCOMES

Descriptive statistics

Study participants improved in almost every outcome category from baseline to the 12-month follow-up interview. The following list highlights some of these gains:

- There was an 18% increase in the number of participants reporting **abstinence from alcohol** use in the past 30 days (61% to 72%).[6,7]
    - Those who reported using alcohol at baseline saw a 63% increase in abstinence in the past 30 days (100% to 37%).
- There was a 76% increase in the proportion of participants reporting **abstinence from cannabis** use in the past 30 days (29% to 7%).
    - Those who reported using cannabis at baseline had an 85% increase in abstinence from cannabis in the past 30 days (100% to 15%).
- **The longest period of abstinence** from illicit substances in the past 30 days increased by six days, or 33% (18 days to 24 days).
- There were improvements in **mental health** status in the 30 days prior to the 12-month interview, especially for those who reported mental health issues in the past 30 days at baseline:
    - 67% decrease in depression for those reporting depression at baseline (100% to 33%);
    - 53% decrease in anxiety for those reporting anxiety at baseline (100% to 47%); and
    - Six-day decrease in days experiencing mental health issues for those reporting any mental health issues at baseline (19 days to 13 days) .[8]
- There was a 23% increase in the proportion of clients who strongly agreed that they have **friends who are clean and sober** (48% to 59%).
- Participants with full- or part-time **employment** increased by 29% (31% to 40%).[9]
- Median monthly **income** increased by 36% or $218.
- 80% to 90% of participants expressed **satisfaction with their treatment** experience over a range of measures at follow-up.

Findings from multivariate analysis of sobriety from alcohol and drug use[10]

- Alcohol use declined from baseline to 6 months and again from 6 months to 12 months, controlling for other factors.[11]

[6] Please note that percentage change is calculated by subtracting the earlier value from the later value and then dividing by the earlier value: (72% - 61%)/61% = 15% (increase). Some of the percentage change results may differ slightly from results calculated from rounded percentages in parentheses.
[7] Statistically speaking, there are too few cases to draw conclusions about drug use.
[8] Among study participants overall there were more modest declines. See report narrative for details.
[9] This is especially notable given the high unemployment rate in Oregon during the study period.
[10] These analyses included all participants for whom relevant data was available and controlled for age and gender (race was not a statistically significant factor and therefore left out of the analysis).
[11] In the multivariate analysis only alcohol use presented enough cases for the analysis. There were too few cases to draw conclusions about drug use.

- Different types of participants were more likely to report sobriety:
  - Those in treatment due to a DUII (driving under the influence) were only one-third as likely to report sobriety at 12 months as those not in treatment due to a DUII;
  - Those whose highest education level was a GED or high school diploma were only one-third as likely to report sobriety as those who had less than a GED/high school diploma;
  - Those who reported having sober friends both at baseline and 12 months were 2½ times more likely to maintain sobriety at 12 months than participants who did not report having sober friends; and
  - Those over 50 were over 3½ times more likely to report sobriety than individuals under 50.

QUALITATIVE INTERVIEW FINDINGS

What study participants liked best about their program:

When asked about what participants liked best about their treatment experience, several main themes emerged, including one-on-one sessions with counselors, relationships with their counselor and fellow treatment clients, the information about addiction and life skills provided, overall support provided by the program, as well as some of the other services provided such as mental health, housing placement, gender-specific treatment programming, and acupuncture.

What study participants would like to see changed in their program:

When asked about what participants would like to change about their treatment experience, participants expressed the desire for more one-on-one sessions, fewer people in group sessions, better educational materials, more respect for clients from the staff, more convenient groups times and locations, separating the DUII clients from clients with other substance abuse issues, better treatment agency management, lowered cost of services, a wider range of services, and more structure to the treatment programs.

> "My counselor had a similar background to mine… She knew what I was going through. She was like my mom. The treatment was very helpful… This was my first time getting clean from my drug of choice, methamphetamine, and I decided to give it a try. I continued doing it [staying clean] as a habit. I guess most of it stuck. Since I've been out, I haven't touched methamphetamine… I think about what I'm doing."
>
> ~Study Participant

OVERVIEW

Goals and Purpose of the Study

The Addictions and Mental Health Division (AMH) of the Oregon Health Authority designed a 12-month follow-up study to explore long-term outcomes for publicly funded treatment clients. AMH then contracted with NPC Research to conduct the study. Currently, there are limited data about what happens to publicly funded clients in Oregon after they leave treatment.

The purpose of this study was to collect data on the long-term outcomes of publicly subsidized alcohol and drug treatment services in Oregon. Ultimately, statewide (aggregate) results from this study will be provided to the Oregon State Legislature during upcoming sessions to aid policy makers in decision-making.

To conduct this study, NPC and AMH partnered with 15 alcohol and/or drug treatment providers in Oregon to identify recipients of publicly funded treatment services and invite them to participate in the study. Long-term outcomes examined include long-term sobriety, employment, income, selected health and mental health outcomes, as well as client satisfaction measures. The study represents the first-ever statewide effort to assess the longer term outcomes for publicly funded treatment clients.

Organization of this Report

This report has three main sections. The first, "Methods," is a detailed description of study methods, including provider and participant recruitment, instrumentation, interviewer training and follow-up protocols.

The second section, "Results," is the lengthiest and includes data tables for 12-month study participant demographics, lifetime alcohol/substance abuse information, mental and physical health issues, and views on treatment. In addition, data tables that compare baseline and 12-month outcomes for alcohol and drug use, mental health, physical health, employment, and social support network indicators. It also includes an overview of the qualitative information gathered from the 12-month interviews.

The next section, "Multivariate Outcomes Analysis," further explores the data through a series of statistical analyses to try to understand the relationship between demographic and individual characteristics and treatment outcomes.

The concluding section, "Conclusion and Recommendations," summarizes key findings and makes recommendations for program improvement.

"This program is the only one I have been successful with. My counselor made recovery something that was attainable and achievable. It is all because of my counselor. He let me be me when I first got there, until it clicked for me and then helped me through the rest of my recovery. I have great respect for my counselor as a mentor."

~Study Participant

METHODS

This section provides a description of the study recruitment procedures, survey instruments, study participant tracking methods, and data management procedures.

Study Recruitment

TREATMENT PROVIDER RECRUITMENT

Substance abuse treatment providers from around Oregon were invited to participate in the study in December 2009. AMH staff conducted an analysis of Oregon treatment providers and, on the basis of this, generated a short list of providers who would 1) be representative of treatment providers and clients statewide, and 2) collectively had enough average admissions per month to provide enough clients to the study. Of the original list of 23 providers,[12] 12 were recruited into the study. An additional three providers were recruited for a total of 15. AMH data showed that these 15 providers average intakes on 1190 clients per month.

NPC convened conference calls for providers to ask any questions treatment provider staff had about the study and their potential role in the study. Treatment agencies which agreed to partner with NPC Research and AMH were asked to complete the following tasks:

1. Recruit eligible clients between February and the end of April 2010. Recruitment involved introducing the study to all eligible clients that enrolled in a treatment program during the intake study window.
2. Review and complete the consent form with each participant.
3. Complete the locator form (part of the consent process) for each participant.
4. Designate staff to conduct data collection, attend a one-day training, and work with NPC throughout the project.
5. Administer the baseline interview to recruited clients no later than 2 weeks after intake.
6. Transmit interviews and consent forms to NPC via pre-paid Federal Express.
7. Work with NPC Research to make sure study intake paperwork was complete and sent each week during the baseline interview period.
8. Complete a discharge summary for each eligible participant.

[12] It should be noted that some of the treatment providers have different sites that are treated by the state addictions data system, the Client Processing and Monitoring System (CPMS), as separate providers. However, for the purposes of this study, the clients of the separate sites are still treated as belonging to a single provider.

The 15 treatment providers who agreed to participate in the study received training and on-going support for voluntary recruiting of individuals, obtaining and documenting informed consent, and administering the surveys. The provider collective recruited 592 eligible participants in the 3-month enrollment period. The following is a list of the participating treatment providers and their locations:

- ADAPT (Roseburg)
- Addictions Recovery (Medford)
- Bridgeway Recovery Services (Salem)
- Cascadia Behavioral Health (Portland)
- Central City Concern (Portland)
- Change Point (Portland & Beaverton)
- Choices Counseling Center (Grants Pass)
- CODA, Inc. (Portland)
- Columbia County Mental Health (St. Helens)
- De Paul Treatment Centers (Portland)
- Eastern Oregon Alcohol Foundation (Pendleton)
- Lifeworks, NW (Portland & Beaverton)
- OnTrack, Inc. (Medford)
- Pfeiffer & Associates (Bend)
- Yamhill County Chemical Dependency (McMinnville)

STUDY PARTICIPANT RECRUITMENT

Study participants were recruited by providers in accordance with study eligibility requirements and protocol. As is the case in all research of this type, per federal code on the treatment of human subjects, participation in the study was voluntary; clients did not have to participate if they did not want to. If they did agree, they were invited to participate in three interviews: at baseline, 6 months post-baseline, and 12 months post-baseline. Baseline interviews took about one hour, and participants received a $20 gift card in exchange for their time at the baseline interview.[13] The follow-up interviews averaged about 20-25 minutes each and participants received a $10 Fred Meyer (or Wal-Mart) gift card upon completion of each follow-up interview.

Participant Eligibility

Providers were trained to invite clients into the study based upon the following eligibility requirements:

1. If any part of a client's treatment services were paid for by publicly funded sources (e.g., publicly subsidized treatment clients) OR if they were a DUII[14] client;

[13] Originally there was not a budget to provide participants with incentives: however, it became clear that without incentives, it was unlikely that enough participants would be recruited for this study.
[14] DUII is the acronym for Driving Under the Influence of Intoxicants (liquor, controlled substance(s) or a combination of both).

2. If the client completed intake into services no more than 2 weeks prior to completing the baseline survey;
3. If the client completed the baseline survey during the enrollment period (2/1/2010-4/30/2010);
4. If the client had not received any drug or alcohol treatment (other than detoxification) within the past 30 days;
5. If the client was *not* being enrolled/transitioned into outpatient services directly after completing residential services;
6. If the client did not complete an intake with the *sole* purpose of obtaining an assessment;
7. If the client did not complete an intake for detoxification services only.

A total of 1,095 clients were invited into the study by the 15 treatment providers, which is about one third the number of clients estimated by AMH to enroll in any given 3-month window. Of these 1,095 clients, 612 clients agreed to participate, while 483 declined.[15] Of the 612 who agreed to participate, a total of 592 clients were eligible for the study.[16]

Survey Instruments

BASELINE SURVEY OVERVIEW

The baseline interviews (Appendix A) were conducted by staff from the respective treatment providers after client consent paperwork was complete. The baseline interview included questions from the Addictions Severity Index (Short Form), a common, well validated and highly regarded assessment instrument. It asks about client substance use (current and lifetime), employment, income, housing, mental health, medical, and other issues.[17] Additional questions from the Clinically Informed Outcomes Management (CIOM) survey[18] included measures related to recovery, social connectedness, symptoms, and functioning. Additional questions specific to AMH programs and internal questions on outcomes were also included.

[15] There were some strong differences between those who agreed to participate in the study at baseline and those who refused: more African Americans (58%) declined participation than other racial/ethnic groups, which had refusal rates of 44% (White), 39% (Latino) and 10% (AI/AN). Additionally, males refused to participate at a higher rate than females (47% vs. 41%), and those *not* involved in treatment courts (e.g., drug courts) tended to refuse at a higher rate (48% vs. 30%). Because of this, the sample cannot be seen as a representative sample from the participating providers and limits overall generalizability of the overall findings.

[16] Twenty of the clients who agreed to participate dropped out of treatment after the initial assessment without ever receiving treatment; this rendered them ineligible for the study.

[17] Because one of the providers uses the ASI as part of its intake process, they provided NPC with a copy of their data rather than duplicate many of the questions for the AMH intake interview. NPC provided this provider with a supplementary interview instrument to collect the additional survey items that are not included in the provider's usual intake assessment. Some of the questions were worded slightly differently. A data crosswalk is available from NPC upon request.

[18] For more information, see the CalMend Web page: http://www.calmend.org/CIOM.html

6-MONTH INTERVIEW OVERVIEW[19]

Information collected at 6 months mirrored the baseline survey (minus the lifetime behavioral health, criminal justice, etc. questions). Additional questions were added about client satisfaction with treatment services. The vast majority of the 6-month follow-up interviews (Appendix B) were conducted by trained NPC staff via telephone at a convenient time for each participant. A very small number (6%) of interviews were conducted in person, either at jail (for those incarcerated), at a location in the community (such as a coffee shop or treatment facility) or in participant homes when that was considered to be the only method to gain access to a participant.

12-MONTH INTERVIEW OVERVIEW

The 12-month survey (Appendix C) was very similar to the 6-month survey. Based upon issues that clients had with various 6-month questions, several questions were dropped at 12 months and the client satisfaction questions were rephrased. Twelve-month interviews were conducted by trained NPC staff primarily via telephone at a convenient time for each participant. A very small number (2%) of interviews were conducted in person at a location in the community (such as a coffee shop) or in participant homes when that was considered to be the only method to gain access to a participant.[20]

DISCHARGE SUMMARY SHEET

One final instrument was used to collect participant-level data: the discharge summary sheet (Appendix D). The discharge summary sheets gathered information about treatment dosage, exit date, exit status (i.e., successful completion, left without clinic agreement, moved away, etc.). Providers were asked to submit discharge summary sheets via fax or regular mail for each study participant they enrolled.

TIMELINE FOR THE FOLLOW-UP INTERVIEWS

The follow-up interview timeline mirrored the Substance Abuse and Mental Health Services Administration (SAMHSA) Government Performance and Results Act (GPRA) guidelines for client outcomes follow-up: study participants could be contacted as one month before their 6- or 12-month baseline survey anniversary and up to 2 months after their 6- or 12-month baseline survey anniversary. Due to the tight timeline for report delivery (draft on June 1st; final report on June 30th), 12-month interviews were conducted up through the beginning of May only. Data collectors made a vigorous effort to reach as many eligible study participants as possible by May 4, 2011. Ninety-eight percent of 12-month interviews were conducted on a rolling basis between 11 months and 14 months (334 days and 427 days) after study participant intake. Six participants were interviewed slightly early (between 298 and 331 days) and four participants were interviewed after 428 days (between 430 and 442 days).

Interviewer Training

A one-day training was held for treatment provider staff prior to client recruitment. This training was video-taped for those provider staff members unable to attend the training.

[19] Results from the 6-month survey can obtained from AMH upon request.
[20] No interviews, either by phone or in person, were conducted with incarcerated participants at 12 months. Please see explanation in the Limitations section.

For the 6- and 12-month follow-up interviews, NPC utilized up to eight trained interviewers at any one time, including one Spanish-speaking interviewer. NPC interviewers participated in a day-long training prior to the 3-month contact calls (to introduce NPC and update locator information) and 2-day trainings for both the 6- and 12-month interviews. Trainings provided information and standardized procedures (including scripts and forms) for protecting client confidentiality, tracking participants, engaging with study participants and locators over the phone (including text messages), email, and regular mail, as well as in-person and phone interviewing techniques, and post-interview tasks. Team meetings occurred weekly and were used to discuss any questions or issues that came up, brainstorm ways to contact hard-to-locate clients, and provide a congenial forum for interviewers to share strategies and stories.

CONFIDENTIALITY

Per NPC policy, AMH follow-up study project interviewers are required to keep all participant information confidential, take an online human subjects training, and sign a confidentiality agreement prior to beginning to contact study participants. The training further reinforced the importance of confidentiality and protocols for appropriately handling confidential data. NPC obtained IRB approval from the Portland State University Institutional Review Board (PSUIRB).

Mandatory Reporting

AMH data collectors were trained to keep information confidential in all but three circumstances: when an interviewer observed language or behavior that might be construed as 1) a medical emergency, 2) child or elder abuse, and/or 3) a threat of serious harm to self or others. Because interviewers conducted the vast majority of interviews over the phone, there was little chance to observe either medical emergencies, abuse, or harm to others. One such case was reported to the DHS hotline and Portland State University Institutional Review Board (PSUIRB), which oversees NPC‘s research protocols. In addition, several study participants reported having serious thoughts of suicide in the past 30 days and, of these, data collectors believed that half were currently having suicidal thoughts. NPC staff provided mental health crises resources over the phone to these clients and followed up by sending a list of resources in the client‘s county of residence. These cases were also reported to the PSUIRB and AMH.

ENGAGING WITH STUDY PARTICIPANTS AND LOCATORS

As part of the training, interviewers were instructed about the importance of being professional yet friendly, accessible, and responsive. The prime directive for data collectors is to make the interview experience as pleasant and meaningful as possible, both for its own merit and – in the case of the 6-month interview – to encourage participants to engage in the 12-month interview. NPC staff provided interested 12-month study participants with the web address of the 6-month progress report findings to let these important study partners know the results of their participation.

PARTICIPANT TRACKING

The key to successfully conducting 6- and 12-month follow-up interviews with study participants was to have up-to-date contact information for them. Staff at treatment facilities filled out locator forms that included the address and phone number(s) for study partici-

pants and the people/organizations they designated to be contacts in the event NPC staff was unable to contact the participant at follow-up. While some locator information was very complete, for others almost no useful information was provided. This made it extremely difficult for interviewers to contact some study participants in a timely way.

Tracking Strategies

Some of the more helpful strategies NPC staff employed involved creating a specialized contacts database where they recorded the date, time, and type of contact with each study participant or their designated locators. As updated contact information was obtained, it was recorded immediately in the database. Data collectors made phone calls, texted, sent emails and letters to participants, their locators, treatment agencies, and parole or probation (if a release was obtained). For a few participants, interviewers attempted to contact them or their locators a total of 70 times in order to obtain an interview!

In order to access as many study participants as possible, a toll-free number was set up, as was a cell phone with a 541 number to contact participants in the 541 area (after it was determined that some participants might assume a 503 number was from a bill collector or might be a marketing call).

Other strategies included searching for participants on the Victim's Information and Notification Everyday (VINE) Web site, an online resource for checking on the status of a criminal offender) and/or the Oregon Judicial Information Network (OJIN) Web site where there is information about anyone who has a civil, small claims, tax, domestic, and/or criminal case pending), and/or via social networking Web sites such as MySpace and public information resources such as MyLife.com and PeopleFinder.com.

Because many of the participants were homeless and did not have a phone number at treatment intake, data collectors made visits to several of the transitional housing complexes in Portland where these people were known to have lived to personally deliver letters about the 6- and 12-month interviews. In the final weeks of the study, interviewers also made visits to the homes of Portland Metro area participants. These were people who NPC staff was fairly certain were living in their homes, but simply not responding to efforts to contact them.

NPC also sent out birthday cards and thank you cards to participants in order to keep the study on their minds and associate NPC staff with friendliness. More than one study participant said that they really appreciated this. One participant even said that the birthday card NPC sent was the only birthday card she received this year.

POST-INTERVIEW TASKS

Once the phone interview was completed, NPC interviewers mailed the $10 gift card, a thank you card, and a resource sheet tailored to the specific county each client lived in.

Preparing the data for analysis

Because providers were responsible for data collection at intake, there were three intake databases to clean and merge: 1) scannable survey forms used by providers and sent to NPC; 2) a dataset from one of the treatment providers (which uses the ASI at intake), and; 3) a handful of surveys which were photocopied by providers from the training materials and unable to be scanned. The provider dataset used different field names and val-

ues from the ASI; therefore much work was involved in preparing that dataset in order to merge it with all the other data.

Preparing the final dataset involved one last level of complexity: obtaining discharge summary sheets from the providers for each study participant and then matching these data (identified by provider case number) back to each record at NPC. Providers were asked to submit discharge summary sheets via confidential fax or regular mail for each study participant they enrolled. Of the 606 eligible study participants at 6 months, 14 more were determined to be assessment only (i.e., dropped out of treatment before they had received any treatment sessions) from information contained in their discharge summaries. These 14 clients had to be dropped from the study – even those who had completed all three surveys, leaving 592 eligible participants.

In all, some or all discharge summary information was submitted on 447 of the eligible clients.[21] Of these 447 discharge summaries, 360 were for participants who were interviewed at 12 months, while another 87 discharge summaries were for eligible participants with no 12 month survey.[22,23]

> "They should make breathalyzers on your car mandatory for all DUIIs and for at least a year. Additionally, they should make you go to a victim's panel to get your driver's license back. Going to the victim's panel was really moving."
>
> ~Study Participant

[21] Despite repeated requests to providers for discharge information, NPC did not receive discharge summaries for 145 of the eligible clients.

[22] An additional 18 participants with 12 month interviews were still in treatment from the same treatment episode which began the previous year and led to their eligibility for this study. Therefore, there is treatment disposition data for 86% of the 12 month participants.

[23] Interestingly, 80 of the 12-month clients were not found in a download of CPMS data (Oregon data system that should contain records for all publicly funded A&D treatment clients) that included clients from the 15 participating providers who entered treatment from January 2011 through April 30 (slightly earlier than the study enrollment window). In consultation with AMH staff, a decision was made to include these clients in the study because treatment providers are key study partners that had been trained in the eligibility criteria and, as such, should be trusted to know whether clients were eligible. Two possible reasons that the 80 clients were not in CPMS download are 1) that they were flagged for having out-of-range data (and temporarily pulled from the system) or 2) provider staff had not yet entered the data into the system.

"They need to have more counselors, smaller group sizes, and more one-on-ones. There were only two counselors for 65 women. There were usually 40-55 people per group for the entire nine months I was there. I only saw the counselor about once every 2.5 months for one-on-ones for 15 minutes if that. I think that's why… [I] wasn't successful."

~Study Participant

RESULTS

This section of the report includes a description of study participant characteristics and the results from the 12-month interviews.

Data collectors successfully interviewed 432 out of 592 (73%) eligible clients at the 12-month interview. At 6 months, data collectors successfully interviewed 449 out of 606 (74%) eligible clients. The 6-month follow-up rate per treatment provider agency ranged from 50% to 100%. NPC was notified that 6 study participants died between intake and the 12-month interview, while 24 more (4%) total refused to be interviewed from baseline to 12-months. The most common reason cited for refusal was lack of time and interest. Data collectors were more successful locating the participants who entered treatment at some provider agencies than others. The 12-month follow-up rate per provider ranged from 60% to 88% for eligible clients.

> "They helped me get into transitional housing after treatment. This was amazing because I was homeless before treatment. Now I am in school and doing well."
>
> ~Study Participant

In general, this 12-month sample was similar the overall sample of eligible participants. A refusal analysis comparing all 592 eligible clients and the 432 who completed a 12-month interview showed that there were no significant differences in race/ethnicity, number of prior treatments for substance abuse or mental health issues, or prior number of incarcerations.[24] However, there *were* significant differences in for gender, education, and mean income: participants who were female, who had higher incomes, higher educational levels, and/or were in treatment for a DUII[25] were more likely to have completed a 12-month interview. Participants who reported more substance use at baseline (more years of lifetime alcohol and drug use and more days of substance use in the past 30 days) were less likely to have a 12-month interview. Furthermore, there was a slight trend for those whose primary substance was alcohol or cannabis to be more likely to complete the 12-month survey than those who reported that their primary drug was heroin, cocaine, methadone, and prescription drugs. Amphetamine users were equally likely to have completed a 12-month interview. Please note that there were very few people who reported using heroin, cocaine, methadone, or prescription drugs – either at baseline or 12 months.[26]

Baseline Characteristics of 12-Month Sample

The average age of study participants in the 12-month sample was 36 years old and 59% were male. Eighty-two percent identified as White, 12% Latino, 10% American Indian or Alaska Native (AI/AN), 6% Black or African American, and 3% Asian and Hawaiian. More than half (54%) said that they had never been married, almost a quarter were divorced, and only about 12% reported that they were currently married. One-fifth (21%) of the 12-month sample did not have a high school diploma or GED, while the highest educational level for a third of study participants was high school or a GED. Another

[24] See footnote 15 for details.
[25] DUII is the acronym for Driving Under the Influence of Intoxicants (liquor, a controlled substance(s) or a combination of both).
[26] Because of the small numbers, statistical significance could not be reliably calculated.

third had an associate's degree or some college, while 4% reported completing a four-year college degree.

Table 1 provides detailed information on these basic demographic characteristics of the 12-month sample as reported at baseline. Further demographic information comparing participants at baseline and 12-months follow-up can be found later in this report.

Table 1. Demographic Characteristics of 12-Month Responders at Baseline

Characteristic	Percentage of respondents (unless otherwise noted)
Average age	36 years (N=432)
Male	59% (N=432)
Race/ethnicity[27]	
• Hispanic or Latino	12% (N=429)
• American Indian or Alaskan Native	10% (N=430)
• Black or African American	6% (N=430)
• Asian or Hawaiian	3% (N=430)
• White	82% (N=430)
Marital status[28]	(N=431)
• Never Married	54%
• Divorced	23%
• Married	12%
• Separated	9%
Children	
• Have children of any age……and for those with children: ○ Ever had children removed from care due to A&D	• 66% (N=431) ○ 23% (N=281)
Education[29]	(N=432)
• Less than high school, no GED	21%
• High school diploma or passed GED	33%
• Any vocational or trade school	12%
• Two-year Associate degree	5%
• Some college (no degree)	26%
• Four-year college degree (Bachelor's degree) or higher	4%
Homeless	10% (N=407)

[27] Participants were allowed to "check all that apply" in the category of race (which does not include Hispanic/Latino); therefore these percentages add to more than 100%.
[28] Marital status does not include the category "widow/widower."
[29] Education percentages do not add exactly to 100% due to rounding.

Nearly three-quarters of the respondents had at least one prior alcohol or drug treatment episode. Alcohol was the primary substance for over half (54%) the 12 month respondents, and the next most common primary substance was amphetamine or methamphetamine at 19%.[30] For most respondents (81%), the treatment episode that led to eligibility for this study was outpatient treatment, while the remaining 19% were enrolled in residential treatment. Table 2 shows key behavioral health measures for the 12-month sample of respondents.

> "It helped a lot to talk in group about my problems, and get feedback. We could relate to each other about what we were going through. The counselor was really good too."
>
> ~Study Participant

There were some intravenous injection drug users; 11 (65%) of the 17 heroin users, 33 (54%) of 61 amphetamine/methamphetamine users, seven (29%) of the 24 cocaine/crack users, and four (18%) of the 22 other opiates users reported intravenous use.[31] In addition to the drugs listed in Table 2, a very small percentage of participants reported that their main substance of choice was inhalants, non-prescribed methadone, prescription drugs, and other sedatives or tranquilizers.

This population has been involved with the criminal justice system, as evidenced by the fact that at baseline 69% of participants reported having been incarcerated in the past.[32] Fifty-six percent of the entire sample had at least one previous DUII, while 44% of the entire sample was receiving treatment for a DUII in the current episode. More than two-thirds of 12-month interview responders were referred to treatment by a court, while 28% percent reported they were enrolled in some kind of treatment court at baseline.

Table 2. Behavioral Health Indicators for 12-Month Responders at Baseline

Behavioral health item description	**Percentage of Respondents** (unless otherwise noted)
Average # of years alcohol and illicit drug use for those who reported using	3 years[33] (N=386)
Past alcohol or drug treatment	73% (N=420)
Average # of past alcohol treatment episodes	2 episodes (N=380)
Average # of past drug treatment episodes	2 episodes (N=390)

[30] This percentage refers to people who reported that their main substance of abuse/dependence was alcohol or methamphetamine/amphetamines despite the fact that they may have also reported being abstinent for weeks or months at intake.

[31] The baseline route of administration information was missing for over between 47 and 68 participants, depending on the illicit substance.

[32] There were 40 cases missing past incarceration information; therefore, it is difficult to know whether these clients were not asked the question at baseline or the question was skipped because they had not been incarcerated before.

[33] This is the average of all years that each person used all substances; for example, if someone used cannabis for 20 years, alcohol for 30 years and heroin for five years, their average number of years of use would be 18.3 years. As might be imagined, there was wide variation on this.

Behavioral health item description	Percentage of Respondents (unless otherwise noted)
Lifetime DTs – alcohol withdrawal for those with any DTs[34]	13 DTs (N=72)
Lifetime drug overdoses for those with any drug overdoses	5 (N=69)
Primary substance of dependence/abuse (whether or not used in past 30 days)	(N=404)
• Alcohol	54%
• Amphetamines/Methamphetamine	19%
• Cannabis[35]	14%
• Heroin	6%
• Other opiates/analgesics	4%
• Cocaine or crack	3%
Longest average period of abstinence	485 days (N=401)
Current episode is due to a DUII	44% (N=432)
Prior incarceration	69% (N=388)
Number of days of last incarceration	179 days (N=246)[36]
Current treatment episode is court-referred	70% (N=429)
• If court referred, participating in treatment court[37]	40% (N=302)
Past treatment for psychological/emotional problems	49% (N=405)
Average number of treatments (lifetime) for psychological/emotional problems for those with any such treatment	5 times (N=198)
• In a hospital	23%
• Outpatient treatment	44%
Emotionally abused in lifetime	59% (N=428)
Physically abused in lifetime	40% (N=426)
Sexually abused in lifetime	20% (N=425)
Have a chronic medical condition	45% (N=430)

In addition to the various substance abuse or dependencies, it is clear from Table 2 that study participants have considerable mental/physical health issues: half the study sample reported having prior treatment for mental health issues, with nearly one quarter of partic-

[34] D.T. is short for *delirium tremens*, delirium that is caused by withdrawal from alcohol.
[35] Ten percent of 12 month cannabis users reported having a medical marijuana card at baseline.
[36] Information from the provider dataset (N=25) was unclear about how to understand the values for this variable; therefore, they are not included here.
[37] Total number participating in drug court is 28% (40% of the 70% for whom treatment is court-referred).

ipants reporting mental health issues serious enough to require hospitalization. Nearly half (45%) reported having a chronic medical condition.

Key Measures of Interest from Baseline to 12-Month Follow-Up Interview

Across several measures from employment and income to abstinence, mental health, and social supports, study participants reported better situations than when they first entered treatment. Tables 3 through 11 explore study participant changes from baseline to 12-month follow-up interview. Data for both baseline and 12-month follow-up (primarily percentages of participants with a particular outcome) are reported for those participants who completed a 12-month survey to ensure an appropriate comparison; therefore, unless otherwise noted, N=432. **Statistically significant bivariate relationships (baseline to 12 months) are noted by a "*" next to the item description.** Details about the tests can be found in Appendix E.

Table 3 shows that more participants were employed at 12 months and they had higher incomes. This is especially notable given the high unemployment rate in Oregon during the study period.

Table 3. Comparison of Baseline and 12-Month Follow-Up Outcomes: Living Situation, Income and Employment Measures

Item description	Percentage of participants (unless otherwise noted)	
	Baseline	12 Months
Employment[38]*	(N=431)	(N=432)
• Full-time	16%	23%
• Part-time	15%	17%
• Retired/disability	7%	9%
• Student/volunteer	6%	9%
• Unemployed	51%	42%
Average Income* Median Income*	$1,009 (N=424) $612	$1,110 (N=431) $830
Have dependents relying on them for the majority of their food, shelter, etc.*	57% (N=428)	38% (N=432)
Living with someone with A&D problem?*	19% (N=406)	9% (N=428)
Controlled living status (past 30 days)[39]	(N=415)	(N=432)
• Jail*	13%	4%
• Inpatient A&D treatment*	13%	2%
• Other (sober house, psychiatric tx, etc.)*	6%	12%

[38] The only other employment category not included in this table is ~~"in~~ controlled environment" which accounted for the remaining percentage of participants at baseline and 12 months.

[39] At baseline, respondents could choose only one: on the 6- and 12-month surveys, the response option was changed to ~~"a~~ll that apply" in order to better understand a participant's situation.

Although interviewers were unable to interview incarcerated participants, they were able to determine from online criminal justice databases that 26 more participants were incarcerated for some or all of the follow-up period. This undoubtedly exacerbated the reduced incarceration rate at follow-up.

Study participants who completed the 12-month interview collectively reported a higher rate of abstinence from both drug and alcohol use over the past 30 days, reduced binge drinking, and reduced amounts of money spent on both alcohol and drugs. Those with alcohol as their primary substance reported a 49% increase in abstinence from alcohol (35% to 52%).[40] For those who did drink or use, the average number of days they used declined. Drug use showed more dramatic reductions than alcohol use, although there were too few cases to draw conclusions about statistical significance. There was also decreased alcohol and drug use from 6 to 12 months, a point which will be further explored in the section on multivariate analyses. Table 4 displays information about alcohol and drug use at baseline and 12 months.

Table 4. Comparison of Baseline and 12-Month Follow-Up Outcomes: Alcohol and Drug Use

Item description	Percentage of participants (unless otherwise noted)	
	Baseline	12 Months
Abstinent from alcohol use (past 30 days)*	61% (N=387)	72% (N=432)
Abstinent from illicit substance use (past 30 days)*	58% (N=389)	90% (N=432)
Average # days longest period of abstinence from alcohol and/or illicit substances (past 30 days)*	18 days (N=377)	24 days (N=432)
Average # days of alcohol use (past 30 days) for participants reporting use*	9 days (N=150)	7 days (N=123)
Average # days of all illicit drug use (past 30 days) for participants reporting use[41]*	20 days (N=162)	24 days (N=44)
More than once substance used per day (past 30 days)*	20% (N=366)	6% (N=428)
For participants who said they spent money on alcohol or drugs in the past 30 days, the average amount of money spent:		
• Alcohol*	$87 (N=115)	$53 (N=108)
• Illicit drugs*	$645 (N=73)	$350 (N=19)

[40] Note that this is different than the proportion of study participants who reported drinking any alcohol at baseline, for whom there was a 63% increase in abstinence at 12 months.

[41] "Average days of drug use" is the total number of days in the past 30 days that a participant used each possible type of drug. For example, if the participant used cannabis on 20 days, methamphetamine on 10 days and prescription drugs (without a prescription) for 30 days, the total number of days will be 60. These totals are then averaged across clients. At 12 months 118 fewer clients report using but, on average, these 44 clients were using more frequently.

Table 5 shows information about substance use over the past 30 days for both intake and at 12-month follow-up. Alcohol was the most common substance of abuse/dependency followed by cannabis and amphetamine/methamphetamine. It is likely that the high number of missing substance data on the baseline surveys is due to interviewers not marking ~~–0~~" for substances that clients did not use. This could mean that baseline rates reported are higher than they might actually be (if all those missing data were actually ~~–0~~").

At the 12-month follow-up interview, very few participants reported using substances. As a precaution, when asking questions about substance use during follow-up interviews, interviewers were instructed to mention again that the information shared during the interview would be kept confidential.

Table 5. Comparison of Baseline and 12-Month Follow-Up Outcomes: Illegal/Non-Prescribed Substances Used in the Past 30 Days[42]

Substance Used	Percentage of participants (unless otherwise noted)	
	Baseline	**12 months**
Any alcohol*	39% (N=387) *100% (N=150)*	28% (N=432) *37% (N=150)*
Binge drinking (5+drinks in a few hours)[43]*	23% (N=381)	12% (N=430)
Alcohol to intoxication*	26% (N=358)	16% (N=432)
Cannabis*	29% (N=376) *100% (N=109)*	7% (N=432) *15% (N=109)*
Amphetamine/methamphetamine*	45 people (N=364)	10 people (N=432)
Other opiates/painkillers*	28 people (N=363)	11 people N=430)[44]
Prescription drugs (not prescribed or not for the prescribed purpose)*	22 people (N=336)	6 people (N=430)
Heroin*	16 people (N=360)	2 people (N=431)
Other sedatives or tranquilizers*	15 people (N=359)	1 person (N=431)
Cocaine*	13 people (N=359)	5 people (N=431)
Methadone[45]*	13 people (N=360)	3 people (N=431)
Barbiturates*	8 people (N=357)	0 people (N=430)
Inhalants	5 people (N=356)	2 people (N=431)
Hallucinogens	2 people (N=355)	0 people (N=431)
Uses tobacco on a daily basis*	72% (N=424)	66% (N=431)

[42] Selected outcomes for study participants who reported the various alcohol/substance use in the 30 days prior to their baseline interview is reported in italics – only for reported when the 12 month valid N≤10.
[43] For one provider (N=25), the definition used at baseline was 5 or more drinks in a day.
[44] The valid N for people who had used at baseline was less than 10, meaning that some participants who did not initially report use did so at 12 months.
[45] Please note that participants who use methadone as a prescribed medication-assisted therapy are not included in the figures for illicit methadone use in this table.

Overall, study participants reported improvement across every mental health indicator, as seen in Table 6 below. The percentage of participants reporting serious depression, anxiety, hallucinations, episodes of rage, and/or suicidal thoughts dropped by nearly half, though it is important to note that some of the numbers are very small (i.e., suicidal ideation/behavior). For those who did experience mental health issues at 12 months, the average number of days in the past month respondents experienced these issues declined by four days from baseline to follow-up. There was a very slight increase in the average number of days that respondents with medical issues reported experiencing such issues.

When examining outcomes only for study participants who reported mental health issues in the 30 days prior to their baseline interview (as measured by a composite of the various mental health issues), more dramatic declines occurred. For example, the percentage of those who reported depression in the 30 days prior to the intake interview declined 67% (from 100% to 33%), compared with a 44% decline in the full sample (43% to 24%).

Table 6. Comparison of Baseline and 12-Month Follow-Up Outcomes: Mental Health and Medical Issues in the Past 30 Days[46]

Mental health issue	Percentage of participants (unless otherwise noted)	
	Baseline	**12 months**
Experienced serious depression (past 30 days)*	43% (N=430) *100% (N=185)*	24% (N=432) *33% (N=185)*
Experienced serious anxiety (past 30 days)*	56% (N=430) *100% (N=241)*	35% (N=432) *47% (N=241)*
Experienced hallucinations (past 30 days)*	6% (N=431)	2% (N=432)
Experienced trouble understanding, concentrating, or remembering (past 30 days)*	42% (N=427) *100% (N=179)*	26% (N=430) *45% (N=178)*
Experienced trouble controlling violent behavior, including episodes of rage or violence (past 30 days)*	10% (N=430) *100% (N=430)*	5% (N=432) *6% (N=432)*
Experienced serious thoughts of suicide (past 30 days)	4% (N=431)	2% (N=431)
Attempted suicide (past 30 days)	1% (N=431)	0% (N=428)
Been prescribed medication for any psychological or emotional problems (past 30 days)*	23% (N=430) *100% (N=98)*	12% (N=432) *29% (N=98)*
Average # of days participants report experiencing any of the above psychological/emotional problems (past 30 days)*	19 days (N=213) *19 days (N=213)*	15 days (N=201) *13 days (N=150)*
Average # of days participants report experiencing any medical issues (past 30 days)	15 days (N=166)	15 days (N=152)

[46] Selected outcomes for study participants who reported the various mental health issues in the 30 days prior to their baseline interview reported in italics. Data not reported when the 12 month valid N≤10.

Both the baseline and 12-month interviews also asked questions about whether participants were currently in treatment, if they tried to access treatment services; if so, what types of treatment they tried to access, and how long the wait time was getting into treatment. At 12 months follow-up, more than one-quarter of participants were still in treatment (compared with 46% at 6 months). About one fifth of 12-month participants reported trying to access self-help groups, while another 9% tried to access outpatient treatment. For those responding to the question about accessing services at a community clinic, three-quarters were able to access services and the average wait time was about 2 weeks. Table 7 provides a summary of these data.

Table 7. Comparison of Baseline and 12-Month Follow-Up Outcomes: Treatment Services[47]

Item description	Percentage of participants (unless otherwise noted)	
	Baseline	12 months
Currently receiving substance abuse treatment*	100% (N=432)	28% (N=432)
Tried to access a self-help group (past 30 days)*	36% (N=276)	19% (N=431)
Tried to access outpatient A&D treatment at a community clinic (past 30 days)*	46% (N=297)	9% (N=430)
Tried to access residential A&D treatment at a community clinic (past 30 days)*	20% (N=271)	1% (N=430)
Tried to access detoxification services (past 30 days)*	11% (N=273)	1% (N=430)
Tried to access A&D treatment at a local community hospital (past 30 days)*	4% (N=270)	<1% (N=430)
Tried to access A&D treatment at a public health clinic (past 30 days)	3% (N=271)	1% (N=430)
For those who tried to access treatment at community outpatient or residential clinic, received those services	95% (N=149)	77% (N=43)
For those who were able to access outpatient or residential A&D treatment services at a community clinic, average wait time	10 days (N=66)	13 days (N≤10)**
Using medication-assisted therapy for substance abuse[48]	3% (N=427)	5% (N=432)

** For those items where there are 10 or fewer respondents "N≤10" ensures client confidentiality.

The proportion of participants who reported attending self-help groups at 6 and 12 months was linked to whether they were still in treatment, which often requires self-help group attendance as part of the treatment plan. At 6 months, 82% of participants who were still in treatment reported attending self-help groups, while 78% of those still in treatment at 12 months were attending self-help groups. Conversely, of the participants

[47] Note that when the baseline sample size is quite small, caution in interpretation is needed.
[48] Please note that participants using methadone as a prescribed medication-assisted therapy are not included in these figures.

who were *not* in treatment at 6 months, only 36% reported attending self-help groups, while 34% of those *not* in treatment at 12 months said they attended self-help groups.

Of the 198 participants at 12 months follow-up who reported actually attending self-help groups, 53% said they attended 3 or more times per week, 35% attended 1 to 2 times per week and the remaining 12% said they attended 1 to 2 times per month.

At intake, small number of participants (14 at intake) reported using medication-assisted therapy for their alcohol/substance use and all of them felt that they still needed to take these medicines. At 12 months, 20 participants reported using medication-assisted therapy, and a third (6) of them felt that they no longer needed to take these medicines. Thirteen people (68%) said that they always take these medications just as the doctor prescribed, five others said that they take the medications according to doctor's orders most of the time, but that they forgot sometimes. Eighteen people reported that their medications were working fine, but four said that they could not afford these medications.

Table 8 below shows some of the criminal justice outcomes for study participants. At 12 months, fewer participants reported having been arrested in the past 30 days and were incarcerated for shorter times. Part of the reason is that many participants who came into treatment at baseline had just been released from incarceration and entered treatment; therefore, they would necessarily average fewer days of incarceration. It is important to note that there are 26 known participants who were incarcerated during some or all of the follow-up period and were therefore unable to be interviewed.

Table 8. Comparison of Baseline and 12-Month Follow-Up Outcomes: Criminal Justice Involvement[49]

Item description	Percentage of participants (unless otherwise noted)	
	Baseline	12 months
Arrested in the past 30 days*	15% (N=309)	2% (N=432)
For those who were incarcerated in the past 30 days, the average days of incarceration*	12 days (N=56)	7 days (N=19)

Study participants also were asked for their perspective on how well they were doing in their recovery process (Table 9). Percentages of those who responded "strongly agree" are shown because this response shows the highest degree of commitment. More than half of respondents said that they were not likely to use alcohol or other drugs, progressing in their recovery goals, and that the recovery skills they have are working well for them. At baseline, 12% *disagreed* that they were not likely to use alcohol or drugs (in other words, that they *were* likely to use alcohol or drugs) and this increased slightly to 14% at follow-up. None of the other questions were asked at baseline.

[49] Because there were 26 known participants who were incarcerated during some or all of the follow-up period and were unable to be interviewed, the 12-month information in Table 8 is certainly underestimated.

Table 9. Comparison of Baseline and 12-month Follow-Up Outcomes: Clients' Perceived Outcomes[50]

Item description	Percentage of participants who strongly agree	
	Baseline	12 months
I am not likely to use alcohol and/or other drugs*	42% (N=430)	57% (N=431)
I am making progress in my wellness/recovery goals	na	60% (N=428)
I am doing well in my wellness/recovery goals	na	55% (N=425)
The wellness/recovery tools and skills that I use are effective for me	na	56% (N=426)

Because of the importance of having social support to the recovery process, participants were asked about this at both at baseline and 12-month follow-up (Table 10). Generally speaking, the proportions of respondents increased from baseline to follow-up by a few percentage points across each indicator. Very few participants disagreed at either time point. The strongest increase (11 percentage points or a 23% increase) was for having friends who are clean and sober, which is often a byproduct of treatment.[51] This result is further underscored by the multivariate analysis presented in the next section.

Table 10. Comparison of Baseline and 12-Month Follow-Up Outcomes: Social Connectedness[52]

Item description	Percentage of participants who strongly agree	
	Baseline	12 months
There is someone who cares about whether I am doing better	71% (N=429)	78% (N=432)
I have someone who will help when I have a problem*	68% (N=430)	73% (N=432)
I have people in my life who are a positive influence	69% (N=428)	70% (N=432)
The people I care about are supportive of my recovery	67% (N=429)	72% (N=425)
People count on me to help them when they have a problem	40% (N=428)	39% (N=431)
I have friends who are clean and sober*	48% (N=430)	59% (N=431)
I have someone who will listen to me when I need to talk	63% (N=430)	65% (N=432)

[50] These items are subscales on the CalMend CIOM. Response options are ~~-s~~trongly agree," ~~-a~~gree," somewhat agree," and ~~-d~~isagree." ~~-N~~a" indicates that these questions were not asked at baseline.
[51] Please note that percentage change is calculated by subtracting the later value from the earlier value and then dividing by the earlier value: (48% - 59%)/48% = 23% increase.
[52] These items are subscales on the CalMend CIOM. Response options are ~~-s~~trongly agree," ~~-a~~gree," somewhat agree," and ~~-d~~isagree."

Table 11 provides information about whether participants felt they had a substance abuse problem. At baseline, 43% of respondents strongly agreed they had an alcohol or drug problem and that they needed to work on this problem. At follow-up, this dropped to about 27%. About one fifth of participants strongly agreed that they had alcohol problems at baseline and that dropped to 13% at follow-up. The proportion of participants reporting a drug problem at baseline decreased from 27% to 1% from baseline to 12-months follow-up.

The "disagree" responses are also quite revealing. In particular, the proportion of "disagree" responses increased from baseline to follow-up for the first two items in Table 11: at baseline 26% of participants *disagreed* that "alcohol or drugs is a problem for me" and this increased to 51% at 12 months. Similarly, 18% of respondents at baseline *disagreed* with the statement "I need to work on my problems with alcohol and/or drugs" and this increased to 44% at 12 months. Given the other positive results in the report, it is possible that participants believe they no longer have a drug or alcohol problem.

Table 11. Comparison of Baseline and 12-Month Follow-Up Outcomes: Clients' Recognition That They May Have a Problem[53]

Item description	Percentage of participants who strongly agree	
	Baseline	12 months
Using alcohol and/or drugs is a problem for me*	43% (N=428)	27% (N=430)
I need to work on my problems with alcohol and/or drugs*	47% (N=428)	23% (N=431)
Reported having "alcohol problems" in the past 30 days*	22% (N=367)	13% (N=432)
Reported having "drug problems" in the past 30 days*	27% (N=353)	1% (N=432)

Finally, participants were asked about their satisfaction with treatment services (Table 12). Between 39% and 47% strongly agreed with the various statements about their treatment experience. The one exception to this level of satisfaction was about the convenience of transportation to treatment, where only 32% of participants strongly agreed and 16% disagreed.

[53] The first two items are subscales on the CalMend CIOM. Response options are "strongly agree," "agree," "somewhat agree," and "disagree." The second two items are from the ASI Short Form ("ASLite").

Table 12. Client Satisfaction With A&D Treatment Services at 12 months[54]

Item description	Percentage of participants who strongly agree/agree
When I needed services right away, I was able to see someone as soon as I wanted	79% (N=429)
The people I go to/went to for services spent enough time with me	86% (N=431)
I helped to develop my service and treatment goals	88% (N=431)
The people I went to for services were sensitive to my cultural background	92% (N=426)
I was given information about different services that were available to me	88% (N=429)
I was given enough information to effectively handle my problems	89% (N=430)
Transportation to and from treatment is convenient*	72% (N=424)

TREATMENT DISPOSITION AND RELATED INFORMATION

Participating treatment agencies were asked to complete a discharge summary (Appendix D) for all study participants upon each client's exit from treatment. Of the total of 592 eligible clients, treatment agencies provided 447 discharge summaries, 359 (83%) of which were for study participants who had completed the 12-month survey. An additional 18 clients were still receiving treatment as part of the same treatment episode that made them eligible for this study, bringing the total of 12-month participants with treatment disposition data up to 377 (87%). It should be noted that many treatment providers seemed not to have this information in an easy-to-access digital format. In fact, some treatment agency staff had to pull client files and sift through them by hand in order to provide the needed information. Table 13 displays discharge summary information for participants who completed 12-month interviews.

[54] These items are subscales on the CalMend CIOM. Response options are "strongly agree," "agree," "somewhat agree," and "disagree."

Table 13. Discharge Summary Outcomes for A&D Treatment Services

Item description	Percentage of participants who strongly agree/agree
Average length of stay in treatment this episode	121 days (N=344)
Average number of group sessions	41 sessions (N=359)
Average number of individual sessions	5 sessions (N=359)
Exit status[55]	(N=369)
• Successfully completed treatment[56]	64%
• Termination/dropped out of treatment	30%
• Neither successful nor unsuccessful treatment completion[57]	6%
Provider's assessment of substance use at exit (as compared with baseline)	(N=305)
• No use at exit	58%
• Less substance use	22%
• No change	12%
• More substance use	1%
• Unknown or not assessed	8%

"Just the knowledge I got from drinking and driving. The atmosphere was very positive. The counselor was a great - a great speaker, very knowledgeable, very nice. He let everybody know they were there for a purpose. He didn't humiliate you."

~Study Participant

[55] Other exit status types include _client incarcerated' and _termination due to mental health' (both 0.8%); _client moved' and _initial appointment not kept within 14 days' (both 0.6%).

[56] Successful treatment completion is determined by the treatment provider in accordance with CPMS guidelines: at minimum, the client has achieved at least two-thirds of his/her signed treatment plan and is no longer abusing and/or is abstinent 30 days prior to termination.

[57] This category includes 18 clients still in treatment, as well as two clients who moved out of area, one who did not have transportation to the treatment facility, one who could not make it to treatment during facility hours and one client who was listed as being withdrawn from treatment by parent or guardian.

Open-ended Responses at 12 Months

The final questions on the 12-month survey were about what study participants like best about their treatment experience and what, if anything, they would like to see changed. The comment boxes throughout this report are taken from these two questions. It was clear that, for many participants, the opportunity to answer these two questions was the most meaningful part of their study participation; many provided thoughtful and constructive feedback for the treatment agencies about what about the treatment experience worked and what did not. The vast majority of clients reported having a positive experience overall. Some themes did emerge from this qualitative information; these are listed below with representative participant quotes.

In response to the question, "What was the most helpful service or support that you received from [treatment provider]?"

Overall support

- "Everything. They saved my life several times."
- "They had everything I needed."

Individualized treatment/individual counseling

- "The individualized care they provided. I just wasn't another case. They took a lot of time to get to know my issues and problems. They addressed my specific issues. They did whatever they had to, to help me."
- "The one-on-one counseling. The counselor taught me about mindfulness, which helped me control my anxiety. I thought it was great that she helped me with that rather than superficially treating my issues with alcohol."

Groups/relationships with peers

- The group meetings. The interactions and ability to speak was very comfortable and the environment was great. The method of mixing new and old patients was helpful."
- "It's all about the people. Making a connection with people that was meaningful was helpful. Sharing in the groups was helpful."
- "Women's group. [I'm] comfortable talking with only women."

Education

- "Scientific information regarding addiction and the brain. [It] explained how addiction works and that was helpful. It was great."

Housing

- "They helped me get into transitional housing after treatment. This was amazing because I was homeless before treatment. Now I am in school and doing well."

Other services

- "All women's group. I liked the content about healthy relationships..."
- "Mental health counseling. I saw a mental health professional and she put me on anti-depressants. It was like someone flipped a switch on in my brain. It was amazing."

- "Acupuncture treatment. The meditation aspect made me really think about myself and my issues. They do a really great job at [treatment provider]."
- "Bus voucher was greatly appreciated."

In response to the question, "What would you change about the treatment services you received from [treatment provider]?"

Provide more individual sessions/increase staffing levels

- "They need more one-on-one support. It would be helpful to have regular one-on-ones with the same counselor, so that there is more consistency in follow-ups."
- "I only saw the counselor about once every 2.5 months for one-on-ones for 15 minutes if that. I think that's why my time with [provider wasn't successful.
- "I wish there were more counselors. When I needed a counselor, I couldn't see one. They were always busy and hard to see."

Keep group size down/increase staffing levels

- "The groups were too big. They had 30+ girls in them. I felt like it was wasted time because the counselor couldn't possibly interact with everyone."
- "They do not have enough staff to handle their case load. Staff consistently called me by the wrong name. How can you expect clients to build trust when you can't remember their name?"

Ensure that staff maintains a fair and non-judgmental attitude toward all clients

- "They shouldn't be judgmental just because you are a certain race. They assumed certain races did certain things."
- "More empathy from the staff. They think everyone is lying. No respect."
- "They treat everyone like cattle and have no respect for the individual."

Reduce/be flexible with treatment costs

- "Staff [need] to be more understanding of financial hardships. It felt like blackmail when the staff would threaten to notify the court that I was not fulfilling my requirements when I could not pay."

Tighten the program structure/accountability/consistency

- "UAs were not always observed. Staff was too lenient with rules."
- "It was more about attendance than actually learning about addiction."
- "The counselors and staff…are inconsistent with treatment plans, rules, and guidelines."

Provide more/different services

- "I wish I could go more than once a week."
- "I wish they provided aftercare. I could have used support after exiting."
- "I wish they had mental health resources."
- "More family support."

Change location and/or provide transportation support; provide a wider range of treatment times

- –Make it more accessible. Have different locations than [location]… It's hard to go to treatment, when it's also your drug area."
- –There's no weekend class. Most people work during the week…I'm scheduled to work, but I tell them I have to leave for class."
- –Bus passes and transportation for people so they can get help."

Separate clients according to their specific issues

- –I was at inpatient with mostly drug addicts. As an alcoholic, much of the material was a waste. They should have drug and alcohol patients separate."
- –Put people in appropriate groups. For example, they shouldn't place people who use marijuana with people who are addicted to meth or heroin."

Update program materials

- –Some of their videos were really outdated. They addressed this, and said that some of the information in them was inaccurate."

Improve bookkeeping practices to be more accurate

- The bookkeeping was terrible. Many times I paid, but they didn't recognize that I had.

In summary, study participants provided qualitative feedback on their experiences and insights while attending treatment. The consumer perspective is, for the most part, echoed by the data. This consumer perspective is, for the most part, echoed by the data. Many of the recommendations in this report are, in part or in total, derived from this feedback. Providing a greater role for consumers in program evaluation and the ongoing quality improvement of treatment systems is a low-cost method for doing this.

"Hire more counselors to talk with people who are in distress. I saw them shuffle crying women out just because they were off the clock. They treat everyone like cattle and have no respect for the individual. The receptionists are rude and act like the police. It takes too long to get treatment. I was sober eight months before the court sentenced me to [treatment agency]. Then it took another three months for [treatment agency] to get me in."

~Study Participant

MULTIVARIATE OUTCOMES ANALYSIS

Background & Purpose

Previous evaluation research in the area of alcohol and substance abuse treatment has suggested individual level characteristics such as social support networks, employment, mental health history, and socioeconomic status predict successful program completion and continued sobriety (McCarty, 2007; Kaskutas, Bond, & Humphreys, 2002; Roll et al, 2005; Weisner, Matzger, & Kaskutas, 2003; Walton, Blow, Bingham, & Chermack, 2003). The current dataset offers a unique opportunity to examine predictors of abstinence and other treatment outcomes from a sample of Oregon clients and explore how results from this study match with previous research. For the multivariate analyses, we opted to look at four separate outcomes at the 12 month survey: sobriety from drugs and alcohol, sobriety from alcohol, employment status, and days of alcohol use. The initial analysis plan was to examine sobriety from drugs at 12 months and housing status at 12 months; however, the small number of individuals in these categories (only 47 individuals reported using drugs at 12 months, and only 13 individuals reported no stable housing at 12 months) precluded running these analyses.

Methods

In order to determine which measures to examine as potential predictors of treatment, we explored peer reviewed literature regarding evaluation of alcohol/drug treatment programs, reviewed participant comments from this study regarding portions of the program they found to be meaningful, and conducted exploratory bivariate analyses (e.g., comparing one independent variable at a time to the outcome variable). A complete list of variables examined as well as coding comments can be seen in Appendix F. After indentifying relevant independent variables, we entered these variables in stepwise logistic multiple regressions with biological variables on the first step (e.g., gender and age), sociodemographics on the second step (e.g., education and abuse history), social support on the third step (having sober friends, perceived conflict in social support structure), and treatment variables on the fourth step (e.g., treatment outcome and sessions attended).[58] Individuals with missing data or missing 12 month outcomes were excluded from the regression analyses, resulting in a total sample size of 304 individuals.[59]

In addition to the multiple regressions, we also used Hierarchal Linear Modeling (HLM) to examine days of drinking and days of drinking to intoxication at baseline, 6, and 12 months.[60] HLM is a useful statistical procedure for analyzing nested data (e.g., different levels in the dataset, such as individual/group level variables or different time points). HLM is useful in evaluation research due to its robustness to missing data and the ability

[58] Please note that sessions attended were treated as a continuous variable, and we elected to look only at individual sessions, given that there was anecdotal evidence in participant responses to open ended questions that more individual sessions were useful in maintaining abstinence.

[59] A variable describing number of days of most recent incarceration at baseline was also dropped due to missing data, although bivariate analyses suggested this variable may have a relationship to abstinence at twelve months. Future research in this area should strive to re-examine this effect to determine the robustness of the finding.

[60] HLM is similar to the SAS PROC MIXED procedure.

to easily look at not only differences in means but in rates of change. In our case the nested design is using multiple time points. HLM also allowed us to optimize the number of cases in the analysis by using pairwise rather than listwise exclusion of missing data as well as to examine not only the average number of days drinking, but also the rate of change over time. Analyses done in HLM used the only significant predictors found in the regression equations in order to maximize analysis power.

Results

The first regression focused on predicting sobriety at 12 months from both drugs and alcohol. We found that the variables in this regression explained approximately 16 percent of the variation in outcomes. It should be noted that the effect size is low, even though the correlation is significant. Individuals who were in treatment due to a DUII were only one-third as likely to report sobriety as individuals who were not referred due to a DUII, controlling for all other variables. Similarly, individuals whose highest educational attainment was a high school diploma or GED were only one-third as likely to report sobriety as individuals who did not have a GED/high school diploma, controlling for all other variables. Individuals who were over 50 were over 3½ times more likely to report sobriety than individuals under 50. We also found that individuals who reported having sober friends both at baseline and 12 months were 2½ times more likely to maintain sobriety at 12 months than individuals who did not report having sober friends at both time points, controlling for all other variables.

The second regression focused on predicting sobriety at 12 months from alcohol only. The outcomes were the same as when predicting sobriety from drugs and alcohol, with the exception of a slightly lower effect for having sober friends (individuals with sober friends were a little less than twice as likely to maintain sobriety, rather than 2½ times), and a slightly lower effect for age (individuals over 50 were a little over 3 times more likely to report sobriety, controlling for all other variables). The variables in this regression explained 18 percent of the outcome. Again, although this is a relatively small effect size in social science, the finding is still statistically significant.

When looking at employment at 12 months, we found that only one variable was predictive- employment status at baseline. Not surprisingly, individuals who were employed at baseline tended to be employed at 12 months. These individuals employed at baseline were four times as likely as individuals who were not employed at baseline to be employed at 12 months after controlling for all other variables.

The HLM analyses were useful in examining the number of days an individual used alcohol at baseline, 6, and 12 months, as well as the number of days an individual drank to intoxication at baseline, 6, and 12 months, after controlling for demographic variables such as age and gender. Table 14 presents the average days with any alcohol use at each time point.

Table 14. Average Days With Any Alcohol Use Over Time, Controlling for Age and Gender

	Days drinking at baseline	Days drinking at 6 months	Days drinking at 12 months
Overall mean	**3.6**	**2.8**	**1.9**
Individuals with a DUII	2.5*	2.7*	2.9
Individuals with a GED	4.6	3.7	2.7
Individuals with friends who are sober	2.3*	1.5*	0.5*

*significantly different from the overall mean, $p<.05$

In addition, at all three time points, individuals with a DUII have a flatter slope (e.g., change at a lower rate on days sober) than individuals without a DUII. Table 15 presents the average days drinking alcohol to intoxication at each time point.

Table 15. Average Days Drinking Alcohol to Intoxication Use Over Time, Controlling for Age and Gender

	Days drinking at baseline	Days drinking at 6 months	Days drinking at 12 months
Overall mean	**2.7**	**2.3**	**1.8**
Individuals with a DUII	1.5*	1.7*	1.8
Individuals with a GED	3.3	2.8	2.1
Individuals with friends who are sober	1.4*	.9*	.4*

*significantly different from the overall mean, $p<.05$

In addition, at all times, individuals with a DUII have a flatter slope (e.g., change a lower rate on intoxicated days) than individuals without a DUII.

Discussion

Some results from the regression equation are consistent with previous research in this area when looking at social support variables (e.g. having sober friends). Other findings in the research literature were significant in bivariate analyses (e.g. mental health symptoms) but were not significant in the final regression models. The findings for this Oregon sample of treatment clients are consistent with previous published research suggesting the treatment needs and treatment experience of individuals mandated to treatment after a DUII are different than non-DUII individuals (e.g., Dill & Wells-Parker, 2002). The findings that individuals over 50 are more likely to report being abstinent and that individuals with a GED\high school diploma are less likely to be abstinent do not completely match with previous research. Previous research on alcoholism has suggested that older individuals with alcohol problems leave programs at a higher rate and may have

worse outcomes (e.g., Booth et al, 1992), and that individuals without a GED\high school diploma may show higher rates of substance abuse (e.g., Crum et al, 1992). However, the population in the current study differs from much of the published research due to the non-voluntary nature of treatment for a high proportion of the sample, as well as the inclusion of individuals with a DUII. Previous research on trajectories of alcohol use over time (e.g., Muthen & Muthen, 2006) point out the non-linear progression of alcohol and substance use over time, and the need for longitudinal data to adequately understand this relationship, complicating our interpretation of sobriety over one single year.

When examining the regression models, we find the level of variance explained by the models is somewhat low (e.g., approximately 18 percent) suggesting there are other variables in play which may better predict abstinence from drugs and alcohol. It is possible that individuals in the study may have been reluctant to disclose information to interviewers, which would affect the ability to find statistically significant predictors of abstinence. Nonetheless, the regression equations point out differential treatment effects for individuals entering treatment after a DUII charge, for individuals with a GED/high school diploma, for individuals over 50, and for individuals reporting stable sober friends. These findings suggest additional screening for those individuals entering treatment with a DUII or higher education levels may be useful in improving treatment outcomes, consistent with previous research calling for attention to be paid to the match between client need and treatment structure (e.g., Woody & Munoz, 2000). There is a good amount of previous research highlighting the issue that individuals referred for DUII treatment may be different from individuals presenting from other treatment sources in terms of diagnostic profiles and commitment to treatment and may be an under-researched group (e.g., Dill & Wells-Parker, 2006). In addition, encouraging individuals to integrate sober individuals into their social support structures may encourage longer term sobriety, a finding which is supported by previous research as well.

One of the major findings of the current study is the heterogeneity of the sample. Differential outcomes were present for different ages and DUII/non-DUII groups and individuals with more severe drug use tended not to complete instruments. In addition, the amount of variation we were able to explain was relatively low. This suggests other unifying variables may help to predict outcomes and improve treatment. One possible variable which has been shown to assist in predicting outcomes across groups is the stages-of-change model (e.g., Prochaska et al., 1992). It may be useful to add a *stages of change* questionnaire to initial screening instruments to help program managers better match program participants to the treatment model.[61] This has been shown to be effective in improving substance abuse outcomes when doing motivational interviewing, which often focuses on moving individuals to a state where they wish to engage in behavior change. Tailoring programs in this manner may help to reduce differential outcomes and increase satisfaction with treatment.

Hierarchal Linear Modeling results are consistent with, and add to, the regression results. Overall, there is a significant reduction in days of any drinking as well as the number of days drinking to intoxication during the study. Interestingly, individuals in the program

[61] Please note that we attempted to examine this by including baseline questions in the regression models which asked how important the individual felt treatment for drug or alcohol problems was. These questions were non-significant, possibly due to these questions not being assessing specific behavioral motivators and patterns.

for a DUII charge report fewer days of drinking (and fewer days of drinking to intoxication) at baseline and 6 months, and then conform to the overall mean at 12 months. They also change at a different rate: rather than reduced days of drinking over time, their rate of drinking is flat (i.e., they had about the same number of days drinking at all three time points). Combined with the regression results, this suggests individuals in the program for a DUII charge do drink less than individuals not in the program for a DUII charge, but are less likely to be completely abstinent from drinking and have less change over time in their drinking than other individuals entering treatment not due to a DUII charge. In contrast, individuals who report having sober friends at baseline and 12 months drink less at all time points than individuals who do not report having sober friends at baseline and 12 months, but reduce their days of drinking (and drinking to intoxication) at the same rate as the other individuals.

Limitations

The current study used a quasi-experimental design whereby sample subjects acted as their own controls (e.g., their responses were compared at baseline, 6 months, and 12 months of treatment). This is an accepted and commonly used technique in evaluation research, although not without limitations. It would have been preferable to have had a control group of people similar to those in the study who were substance abusers—but did not access treatment—to help determine whether the changes from baseline to follow-up were due to the treatment intervention or another variable such as passage of time or overall system change. However, it is important to note that study designs involving a control group are extremely costly and random assignment to treatment and control group for the duration of a longitudinal study is unlikely to be either an ethical—or workable—option.

There were some key differences between those who agreed to participate in the study at baseline and those who refused to participate by race and gender. Additionally, those not involved in treatment courts tended to refuse at a higher rate. Because of this, the AMH study sample cannot be seen as randomly selected from all publicly funded treatment clients in Oregon. However, the 592 eligible clients do represent a large segment of the population of alcohol and drug use treatment clients entering treatment in Oregon from February 1 through April 30, 2010.[62]

The follow-up rate of 73% is respectable for such a study, but there are still a sizeable number of participants for whom there is no follow-up data.[63] These people are likely to be different in some way from those who did complete the 12-month interview. Indeed, a refusal analysis of participants who did not complete the 12 month survey with those who did found the 12-month refusers more likely to be male, less educated, and more likely to be using _hard core' substances (such as heroin, cocaine, prescription drugs, etc.) than those who completed a 12-month survey. Although this might be seen to constitute a

[62] Information about how representative the 15 participating treatment providers were from the universe of those that provide publicly-funded A&D treatment services in Oregon was not available. Similarly, the demographics and other key characteristics of publicly-funded treatment clients statewide were not available. Having this information might help determine how representative the 592-client sample is as compared with clients statewide.

[63] In fact, because no discharge summaries were received for 80 study participants, it is possible that some of these people would not be eligible for the study. If so, the response rate could be lower – or higher – than 73% and the refusal analysis might also reveal different trends.

source of study bias (albeit one that is well-known in addictions research), it is important to point out that the majority of participants had a prior record of incarceration and prior drug and/or alcohol treatment, which does indicate that this sample is not widely divergent from similar populations, despite the differences in refusers listed above.

There were also missing data among many of the baseline indicators and discharge summary measures. It is unclear whether the baseline questions were asked and not recorded or whether the blank survey items were meant to indicate ―0.‖ This could mean that the actual baseline substance usage is lower than what is reported here (if all the missing data were ―0‖ instead), and therefore the change over time between baseline and follow-up is less than this report indicates. For one provider's clients (N=25 at 12 months), the baseline instrumentation was slightly different[64] and, there are a few indicators for which no data are available. Regardless of the reason, however, missing data at baseline is another source of bias.

Studies based upon self-reported data, particularly data about socially proscribed behaviors, are likely to experience under-reporting of illegal or socially unacceptable behaviors. At the same time, it is important to note that self-report is a standard method for substance abuse and addictions research: the vast majority of existing research and evaluation studies use self-report – including GAO-approved GPRA data collection.[65] Moreover, rigorous training of follow-up interviewer staff and weekly staffing meetings to discuss issues that come up in the tracking or interviewing process provided standardization to data collection, which helps ensure measurement validity and reliability (Del Boca & Noll, 2000).

As noted, we could not conduct analyses on sobriety from drugs at 12 months or on homelessness at 12 months due to having too few cases. This makes it difficult to assess whether different variables predict sobriety for alcohol vs. drugs (as has been noted in the research literature. It is also possible the 12 month follow-up was not long enough post baseline to see lasting treatment effects, a finding supported by other researchers (Hubbard, Craddock, & Anderson, 2003; Stout et al., 1999). Lastly, the regression results suggest there are additional variables not captured which may help to better predict sobriety. Future evaluation of these programs should take this into account when designing research instruments and determining what data to collect.

The limitations mentioned above are commonly found in addictions treatment research. Despite these limitations, the data collected at baseline, 6 months, and 12 months follow-up constitute an unprecedented source of information for Oregon policymakers and treatment providers to use for program improvement and decision-making.

[64] See footnote 15 above.

[65] Although self-report is sometimes supplemented with drug testing, this was not possible given the budget for this study, not to mention the fact that ―objective‖ alternatives such as drug testing have their own inherent problems (such as lack of standardized procedures at providers - random sampling, full observation, method of drug testing, false positives, false negatives, etc.).

CONCLUSION AND RECOMMENDATIONS

Substance abuse and dependency treatment clients from around the state of Oregon collectively reported increased abstinence from alcohol and illicit drugs. For those who *did* use alcohol or drugs, study participants reported fewer days of use from baseline to 6 months to 12 months post intake. Other positive results were also found, such as increased income, decreased unemployment reduced mental health issues, increased social supports, and a high level of satisfaction with their treatment experience.

Many lessons can be drawn from the data presented throughout the report. Research-related lessons learned and ideas for future research raised by this study can be found in Appendix G. Several programmatic and policy recommendations are suggested below based both on survey results and study participant feedback.

Recommendations

- **Specialized programming for DUII clients.** The findings in this report are consistent with previous research suggesting individuals in treatment for a DUII charge are different from individuals not in treatment for a DUII charge, and are themselves a heterogeneous group (e.g. Dill & Wells-Parker, 2006). This was also reflected in the open-ended comments of individuals in treatment for DUII charges. When designing effective services for this group additional needs assessment may be required to establish a better fit between individual needs and program effectiveness.
    - Greater emphasis should be placed on not driving under the influence rather than not drinking at all (harm reduction model). For example, one of the study participants suggested mandatory participation in victim‘s impact panels and breathalyzers for DUII offenders for one year.
- **Enhanced attention to matching individual needs to program type.** Similar to the recommendation above for DUII clients, it is important to recognize the other client characteristics that may require specialized programming or at least specialized attention:
    - **Treatment matching by addictions/abuse issue.** Numerous study participants gave feedback that clients should be separated into specialized groups by specific substance(s) used and whether they are dependent on alcohol/drugs or are abusers. Clients who were ―lumped together" felt that the treatment providers did not understand or care about clients. This perception alone could create an alienating atmosphere. There is research to support participants‘ beliefs that matching client needs to treatment type is effective (e.g., Witkiewitz, Hartzler, & Donovan, 2010) and, in fact, not doing so can result in poorer outcomes, particularly in the drug treatment court context (Marlowe, et al., 2007).[66] Furthermore, research has shown that treatment matching clients with the highest severity to more intensive treatment modalities is cost-effective (Chen, Barnett, Sempel & Timko, 2006).

[66] Please note that there is still some controversy about the benefits of treatment matching (e.g., Babor, 2008).

- **Culturally and linguistically-appropriate programming**. A handful of Latino study participants (and other cultural/ethnic minorities) expressed the concern that language specific programming was not available. For those mandated to treatment, not being able to understand the counselors or curriculum materials is a serious barrier to positive outcomes. Participants felt that the lack of cultural sensitivity was a barrier. Conversely, Latino participants with a Latino counselor felt that their treatment experience was greatly enhanced, which is reflected in other research (Castro, F.G. & Alarcon, E.H., 2002).[67]
- **Sensitivity to the needs of disabled clients**. At least two participants disclosed that they felt that their treatment providers were unequipped to deal with their disabilities.
- **Engaging younger treatment clients.** The findings of this report that clients over 50 were more likely to maintain sobriety are also consistent with research showing that younger clients do not fare so well in treatment. While this may, in part, be a developmental phenomenon, study participant feedback about how outdated some curricular material could also be a contributory factor. Particularly true of the digital age, treatment providers might consider innovations such as daily text messages, YouTube videos, and other media that are part of today's multimedia culture.

- **Focus more on identifying and creating opportunities for social support networks for recovery.** The finding that support from friends for sobriety is a predictor of sobriety at 12 months suggests that program managers may wish to evaluate social support at baseline as well as encourage contact with sober friends and involvement in sober communities in order to maximize treatment success.
- **Provide resources and oversight to ensure adequate staffing levels at treatment agencies.** Discharge summary data shows that treatment agency clients average slightly more than one individual counseling session per month. Study participants commented repeatedly that the best part of their treatment was their opportunity to meet with their counselor individually and recommendations for program improvement similarly highlighted their desire to meet more frequently with their counselor. Research has shown that the client-counselor relationship is a crucial piece of the puzzle of successful treatment outcomes and this is why most evidence-based substance abuse/dependency treatment practices require at least weekly individual sessions for the early weeks of treatment (e.g., Mercer & Woody, 1999).[68] Without further information, it is assumed that the primary barrier to ensuring individual counseling occurs at least weekly for the first 2 months of treatment is inadequate resources. Further discussion between AMH and treatment agencies might reveal other barriers to ensuring an adequate level of one-on-one counseling.

[67] This overview article in the Journal of Drug Issues shows that using cultural specific language and cultural adaptations of evidence-based programs greatly increase program effectiveness. (PDF is available at http://www.360translations.com/educ533/integrating.pdf)
[68] This NIDA treatment manual on cocaine addiction recommends 1:1 counseling twice-per-week for the first 12 weeks, and then once once-per-week for the next 12 weeks. (http://archives.drugabuse.gov/TXManuals/IDCA/IDCA5.html).

- **Recognize that there are people for whom self-help groups do not work and therefore other aftercare options may be needed.** Many study participants expressed the desire for more/any aftercare services. Data from this study also show that at least one third of participants who had completed treatment were not participating in self-help groups, which is one of the most common aftercare strategies and has been shown to help maintain sobriety (Kaskutas, 2009). Research shows that many people who might benefit from self-help groups do not attend due to the perceived religious aspects of many 12-step meetings, prior negative experiences with 12-step meetings, lack of identification with other group members (Lopez Gaston, Best, Day & White, 2010: 306), and the tendency for 12-step programs not to support use of prescribed psychiatric medicines (Kelly, Kahler & Humphreys, 2010). Other aftercare options should be available for clients for whom traditional 12-step group participation is not perceived to be helpful.
- **Provide resources and oversight to ensure adequate drug testing at treatment agencies.** Several study participants noted that UAs were not given frequently; one person said that UAs were given only once per month. Research in the drug court context (Carey, Mackin, & Finigan, in process) shows that drug testing 2 times per week is significantly related to positive outcomes.
- **Provide resources to strengthen treatment providers' capability to systematically collect and analyze treatment data.** While participating providers were generous enough to contribute their own time and effort to this study, it was evident that, for most providers in the current fiscal environment, their priority was necessarily day-to-day operations rather than long-term evaluation, program planning, and improvement. Each provider had its own data system (hardcopy paper, digital or a combination) to collect information on the number of treatment sessions and other summary information. A more systematic and unified system for all treatment providers would ensure that providers have comparable data. Equipping such a data system with a reporting mechanism and training staff to use it properly would allow treatment agencies the ability to engage in data-driven policy and program improvement.
- **Create opportunities for consumers to play a greater role in program evaluation and improvement.** Study participants provided much valuable feedback about what worked and what about their treatment experience could be improved. Incorporating the consumer voice in an impartial and systematic way is a low cost and valuable method to conduct ongoing quality improvement.

"They go overboard with the amount of classes that some people need. Not everyone needs intensive treatment. They would be better off spending their time and money on the people that need it most."

~Study Participant

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APPENDIX A: INTAKE INTERVIEW INSTRUMENT

AMH Follow-up Study Interview
(Intake/Baseline)

v. 1.0 1/20/10

A1. Client Name: _____

A2. Interviewer Name: _____

A3. Date of Interview: Month ☐☐ Day ☐☐ Year ☐☐

A4. Time Started: ☐☐ : ☐☐ ○ am ○ pm

A5. Time Completed: ☐☐ : ☐☐ ○ am ○ pm

A6. Agency:
- ○ Ontrack
- ○ ChangePoint
- ○ Lifeworks
- ○ ADAPT
- ○ Bestcare
- ○ DePaul
- ○ Yamhill
- ○ CODA
- ○ Cascade Behavioral
- ○ Central City Concern
- ○ Bridgeway Cascadia
- ○ Columbia Mental Health
- ○ Eastern Oregon Alcoholism Foundation
- ○ Addictions Recovery Center Inc.
- ○ Pfeifer and Associates
- ○ Other: _____

A8. Processing Information	Initial	mm/dd/yy
A7a. Checked by interviewer	_____	☐☐/☐☐/☐☐
A7b. Received by coordinator	_____	☐☐/☐☐/☐☐
A7c. Checked by coordinator	_____	☐☐/☐☐/☐☐
A7d. Data entered	_____	☐☐/☐☐/☐☐
A7e. NPC ID: ☐☐☐☐		

NPC ID: ☐☐☐☐

Introduction: Thank you for agreeing to take part in today's interview. The interview will take no more than an hour. The important information you share today will help improve future treatment services. If you need to take a break during the interview, or need a drink of water, please let me know. Are you ready to get started?

It is very important that you answer our questions honestly, so that data will be as valid as possible. There are no right or wrong answers; we just need to know what is true for you, based on your experiences. Remember that this information will be kept confidential and private, as we talked about before.

Also, it is important that I read every question, all the way through, for everyone who participates in our project so that everyone is treated the same way. Sometimes, this will mean I have to read all the way through the answer choices, so please wait until I have read all the possible answers before giving me yours, even if your answer was the first one that I read. Let me know if you have any questions.

First, I have some basic background questions for you.

B1. What is your date of birth? Month ☐☐ Day ☐☐ Year ☐☐
[Code 88/88/88 = Refused]

B2. Are you of Hispanic or Latino background?
- ○ Yes
- ○ No
- ○ **Refused**

B3a. How would you describe your racial background; that is, with which groups do you identify? ***[Read each response and mark all that apply]***
- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African-American
- ○ Native Hawaiian or other Pacific Islander
- ○ White or Caucasian
- ○ Other [Specify] _____
- ○ **Refused**

B3b. What is the language spoken most often in your home?
- ○ English
- ○ Spanish
- ○ Russian
- ○ Other [Specify] _____
- ○ **Refused**

The next set of questions asks about your household status.

B4. Please tell me all of the places where you have lived in the past 30 days. (ASI LITE)
[Read each and mark all that apply]
- ○ With spouse/partner & children
- ○ With just your spouse/partner
- ○ With children alone
- ○ With parents
- ○ With other family
- ○ With friends
- ○ Alone
- ○ Controlled environment (Residential treatment center, other care facility, nursing home, detox, group home, sober living homes, jail, etc.)
- ○ No stable housing (homeless)
- ○ Other: _____
- ○ **Refused**

B5. Are you satisfied with these living arrangements? (ASI LITE)
○ Yes ○ No ○ Indifferent ○ **Refused**

B6. What is your current marital status? (ASI LITE)
{Check only one} {Skip to B8 if response = Never Married)
- ○ Married
- ○ Remarried
- ○ Widowed
- ○ Separated
- ○ Divorced
- ○ Never Married
- ○ **Refused**

B7. How long have you been in this marital status? (ASI LITE) Yrs. ☐☐ Mos. ☐☐

For the following questions, indicate:

'Y' in relative catagory where the answer is clearly yes for **any** relative within the catagory.

'N' where the answer is clearly no for all relatives in the catagory.

'DK' where the answer is uncertain or "I don't know".

'88' for refused.

B11. Would you say you have had close, long-lasting personal relationships with any of the following people in your life:

a. Mother	O Y O N O DK O 88
b. Father	O Y O N O DK O 88
c. Brothers/Sisters	O Y O N O DK O 88
d. Spouse or Partner	O Y O N O DK O 88
e. Children	O Y O N O DK O 88
f. Friends	O Y O N O DK O 88

B12a. Have you had significant periods in which you have experienced serious problems in getting along with the following people in the **past 30 days**? (ASI LITE)

a. Mother	O Y O N O DK O 88
b. Father	O Y O N O DK O 88
c. Brothers/Sisters	O Y O N O DK O 88
d. Spouse or Partner	O Y O N O DK O 88
e. Children	O Y O N O DK O 88
f. Other significant family	O Y O N O DK O 88
g. Close friends	O Y O N O DK O 88
h. Neighbors	O Y O N O DK O 88
i. Co-workers	O Y O N O DK O 88

B12b. Have you had significant periods in which you have experienced serious problems in getting along with the following people in your **life**? (ASI LITE)

a. Mother	O Y O N O DK O 88
b. Father	O Y O N O DK O 88
c. Brothers/Sisters	O Y O N O DK O 88
d. Spouse or Partner	O Y O N O DK O 88
e. Children	O Y O N O DK O 88
f. Other significant family	O Y O N O DK O 88
g. Close friends	O Y O N O DK O 88
h. Neighbors	O Y O N O DK O 88
i. Co-workers	O Y O N O DK O 88

B13a. In the past 30 days, did any of these people listed above abuse you… (ASI LITE)

a) Emotionally (make you feel bad through harsh words)?
O Yes O No O **Refused**

b) Physcially (cause you physical harm)?
O Yes O No O **Refused**

c) Sexually (force sexual advances or sexual acts)?
O Yes O No O **Refused**

B13b. In your lifetime ,did any of these people listed above abuse you… (ASI LITE)

a) Emotionally (make you feel bad through harsh words)?
O Yes O No O **Refused**

b) Physcially (cause you physical harm)?
O Yes O No O **Refused**

c) Sexually (force sexual advances or sexual acts)?
O Yes O No O **Refused**

B14. How many days in the past 30 have you had serious conflicts: *[If 0 skip B15a-d]*

With your family? ☐☐
With other people (excluding family)? ☐☐

Go to next page

(ASI LITE Family/Social)
SEE SHOW CARD A
[Review show card with client]

	Not at all	Slightly	Considerably	Moderately	Extremely	Don't know	Refused	N/A
B15a. How troubled or bothered have you been in the past 30 days by these family conflicts or problems? Would you say, "not at all, slightly, considerably, moderately, or extremely"?	O	O	O	O	O	O	O	O
B15b. How troubled or bothered have you been in the past 30 days by these conflicts with other people? Would you say, "not at all, slightly, considerably, moderately, or extremely"?	O	O	O	O	O	O	O	O
B15c. How important to you now is treatment or counseling for these family problems? Would you say, "not at all, slightly, considerably, moderately, or extremely"?	O	O	O	O	O	O	O	O
B15d. How important to you now is treatment or counseling for these conflicst with other people? Would you say, "not at all, slightly, considerably, moderately, or extremely"?	O	O	O	O	O	O	O	O

B16. Do you live with anyone who: (ASI LITE)

a. Has a current alcohol problem? O Yes O No O **Refused**

b. Uses non-prescribed drugs? O Yes O No O **Refused**

B17. Have you been at risk for having your children removed from your care due to alcohol and/or drug abuse/dependency issues? {*If no, skip to ?*}
O Yes O No O **Refused** O NA

B18. If yes, do you still have current custody of your children?
O Yes O No O **Refused** O NA

Thank you for answering those questions. The next set of questions are about your employment status.

Employment and Education Questions

E1. What is the highest level of education you have completed? {*Read all responses*} (ASI LITE)

- O Less than High School, NO GED
- O High School Diploma or passed GED
- O Vocational or trade school certification/degree
- O Some vocational or trade school
- O Two-year Associate degree
- O Some college (no degree)
- O Four-year college degree (Bachelor's degree) or higher

E2. What was your employment status in the past 30 days?
{*Mark only one; mark any paid employment if several apply*}

- O Full time (40 hours/week)
- O Part time (regular hours but less than 40 hours/week)
- O Part time (irregular hours, day labor; infrequent employment)
- O Student (not working)
- O Service (volunteer/unpaid work)
- O Retired/disability
- O Unemployed
- O In controlled environment

E3. How many days were you paid for working in the past 30 days? (ASI LITE) ☐☐ days

E4. How much money did you receive from the following sources in the past **30 days**? (ASI LITE)

a. Employment ("take home pay" -amount after taxes)	$☐☐☐☐
b. TANF or welfare/DHS	$☐☐☐☐
c. Pension, other benefits or social	$☐☐☐☐
d. Money from your spouse/partner, family or friends (money for personal expenses)	$☐☐☐☐
e. Illegal	$☐☐☐☐
f. Other	$☐☐☐☐
g. Other	$☐☐☐☐
h. Other	$☐☐☐☐

E5. How many people depend on you for the majority of their food, shelter, etc? (ASI LITE) ☐☐
(Do not include self-supporting spouse/partner)

E6. How many days have you experienced employment problems in the past 30 days (such as inability to find work (only if patient has tried to), or problems with present employment (if employment is in jeopardy or unsatisfactory, etc)? (ASI LITE) Estimated number of days: ☐☐

SEE SHOW CARD A	Not at all	Slightly	Considerably	Moderately	Extremely	Don't know	Refused	N/A
E7. How troubled or bothered have you been by these employment problems in the past 30 days? Would you say, "not at all, slightly, considerably, moderately, or extremely"?	O	O	O	O	O	O	O	O
E8. How important to you *now* is counseling for these employment problems? Would you say, "not at all, slightly, considerably, moderately, or extremely"?	O	O	O	O	O	O	O	O

Now, we would like to ask you some questions about your past and current medical status.

MEDICAL STATUS

(Do not include medical problems that would stop if abstinent)

M1. How many times in your life have you been hospitalized overnight for medical problems, not including hospital stays that are just 'detox'? (ASI LITE) *(include o.d.'s, d.t.'s, exclude detox)* Estimated number of times: ☐☐

M2. How long ago was your last hospitalization for a physical problem? (ASI LITE) Years ago: ☐☐

Months ago: ☐☐

M3. Do you have any chronic medical problems that continue to interfere with your life? (ASI LITE)

O Yes O No O **Refused**

If yes, specify: _____

M4. Are you taking any prescribed medication on a regular basis for a physical problem? (ASI LITE)

O Yes O No O **Refused**

M5. Do you receive a pension for a physical disability (not a mental or psychiatric disability)? (ASI LITE)

O Yes O No O **Refused**

If yes, specify: _____

M5b. In the past 30 days, how often have you been treated at an emergency room? ☐☐

M6. In the last 30 days, how many days have you experienced medical problems (include the days on which he/she experienced these problems such as cirrhosis, phlebitis, or pancreatitis, cold or flu)? {*If 0 days, skip M7-M8)* (ASI LITE)

Estimated number of days: ☐☐

(ASI LITE Medical) SEE SHOW CARD A	Not at all	Slightly	Considerably	Moderately	Extremely	Don't know	Refused	N/A
M7. How troubled or bothered have you been by these medical problems in the past 30 days? Would you say, "not at all, slightly, considerably, moderately, or extremely"?	O	O	O	O	O	O	O	O
M8. How important to you *now* is treatment for these medical problems? Would you say, "not at all, slightly, considerably, moderately, or extremely"?	O	O	O	O	O	O	O	O

M9. Are you currently using any type of specific medication-assisted therapy to achieve and/or maintain abstinence (no use) of alcohol and/or illicit drugs? (CalMed CIOM)

- O Yes - if yes, specify: _____
- O No{*if No, skip to M12*}
- O **Refused**

M10. Please tell me which of the statements below describe how you feel about your medication-assisted treatment for your addiction. Please only respond about your medication-assisted treatment and not other types of medication for physical or mental health conditions. (CalMed CIOM)

[Read all responses, ask "Would you say "yes" or "no"? Mark "yes" or "no".]

a. I no longer feel I need my medications:	O Yes	O No
b. I would like to change my medications and/or dose:	O Yes	O No
c. My medications aren't working for me the way I expected they would:	O Yes	O No
d. I use vitamins, herbs, or food supplements:	O Yes	O No
e. My medications make me too tired:	O Yes	O No
f. My medications make me anxious:	O Yes	O No
g. My medications interfere with my sexuality:	O Yes	O No
h. My medications make me gain weight:	O Yes	O No
i. I cannot affort my medications:	O Yes	O No
j. My medications are working fine:	O Yes	O No

M11. Please tell me which *one* statement that best describes the way you take your medications. (CalMed CIOM) (choose only one response)

- O I always remember to take my medications the way my doctor prescribed
- O I take my medications most of the time, but occasionally I forget
- O I take my medications until I start to feel better then I stop
- O I seldom take my medications
- O I never take my medications
- O **Refused**

M12. Do you currently smoke or use any tobacco product on a **daily** basis? O Yes O No O **Refused**

The next set of questions have to do with your alcohol and drug use. Again, remember everything you tell me in this interview is confidential.

Drug/Alcohol Use

DA1. How many times in your life have you been treated for Alcohol Abuse? ☐☐

DA2. How many times in your life have you been treated for Drug Abuse? ☐☐

DA3. How many of these were detox only? (ASI LITE) ☐☐

DA4. How much money would you say you spent during the past 30 days on: a. alcohol $☐☐☐☐

b. drugs $☐☐☐☐

DA5. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days? ☐☐

DA6. If you used alcohol or any illicit or non-prescribed drug in the past 30 days, which of the following describes how you looked for help or support?

{*Read each response and mark yes or no*}

a. I did not seek any support services.
O Yes O No O **Refused**

b. I tried to access a self-help group or AA/NA
O Yes O No O **Refused**

c. I tried to access treatment at a community oupatient clinic for group and/or individual counseling.
O Yes O No O **Refused**

d. I tried to access treatment at a community residential clinic for group and/or individual counseling.
O Yes O No O **Refused**

e. I tried to access detoxification services.
O Yes O No O **Refused**

f. I tried to access treatment at a local community hospital.
O Yes O No O **Refused**

g. I tried to access treatment at a public health clinic.
O Yes O No O **Refused**

h. If you tried to access treatment, were you able to get into services? O Yes O No O **Refused**
If no, what was the estimated wait time?
Estimated wait time in days: ☐☐

DA7. How often have you attended self help groups (e.g. AA, NA) during the last 30 days? Would you say:

- O None
- O 1-3 times per month
- O 1-2 times per week
- O 3-4 times per week
- O Daily
- O **Refused**

DA8. Which of the following people are currently supportive of your recovery? {*read list, fill in all that apply*}

- O Spouse/domestic partner/significant other
- O Immediate family (parents, guardians, brothers sisters, daughters, sons)
- O Extended family (grandparents, uncles, aunts, cousins)
- O Friends
- O Roommate/housemate
- O Co-worker
- O Other, specify:_____
- O No one is really supportive of my recovery
- O **Refused**

DA9. How many days in the past30 have you experienced Alcohol Problems? (be sure to keep in mind we are interested in the number of days the participant had problems *directly related to using alcohol*) ☐☐ {*If 0, skipDA11*}

DA10. How many days in the past30 have you experienced Drug Problems? (be sure to keep in mind we are interested in the number of days the participant had problems *directly related to drug use*) ☐☐ {*If 0, skipDA12)*}

(ASI LITE) **SEE SHOW CARD A**	Not at all	Slightly	Considerably	Moderately	Extremely	Don't know	Refused	N/A
DA11. How important to you now is treatment for Alcohol Problems?	O	O	O	O	O	O	O	O
DA12. How important to you now is treatment for Drug Problems?	O	O	O	O	O	O	O	O

SUBSTANCE ABUSE QUESTIONS

DA13. In the past 30 days, on how many days have you used? {*read each item a-p, put responses in first column of boxes*}

DA14. In your lifetime, how many years did you use each of the following substances regularly? By "regularly" I mean about 3 times per week for 6 months or more. {*read each item a-p, put responses in second column of boxes*}

DA15. For the following drugs, how do you typically "take-in"or use the drug? {*read each item a-p, put responses in third column of boxes*}; *[INTERVIEWER, code Route of Administration as follows; 1=Oral (by mouth), 2=Nasal (snorting), 3=Smoking, 4=Non IV injection, 5=IV injection. If multiple, code highest number present.]*

	30 days	Lifetime	Admin
a. Alcohol - Any use at all	☐☐ days	☐☐ yrs	
b. Alcohol - to intoxication	☐☐ days	☐☐ yrs	
c. Alcohol - At least one drink	☐☐ days	☐☐ yrs	
d. Alcohol - At least 5 drinks within a few hours	☐☐ days	☐☐ yrs	
e. Heroin*	☐☐ days	☐☐ yrs	☐
f. Methadone	☐☐ days	☐☐ yrs	☐
g. Other opiates/analgesics (morphine)	☐☐ days	☐☐ yrs	☐
h. Barbituates ("downers")	☐☐ days	☐☐ yrs	☐
i. Other sed/hyp/tranq. (roofies)	☐☐ days	☐☐ yrs	☐
j. Cocaine* or Crack	☐☐ days	☐☐ yrs	☐
k. Amphetamines/Methamphetamine	☐☐ days	☐☐ yrs	☐
l. Cannabis (marijuana, pot)	☐☐ days	☐☐ yrs	☐
m. Hallucinogens* (acid, LSD)	☐☐ days	☐☐ yrs	☐
n. Inhalants* (laughing gas, poppers)	☐☐ days	☐☐ yrs	☐
o. Presc. drugs (not for the purpose described)	☐☐ days	☐☐ yrs	☐
p. More than one substance per day (incl. Alcohol)	☐☐ days	☐☐ yrs	☐

DA16. Which substance is the major problem? (choose one)

- O Alcohol
- O Heroin*
- O Methaodne
- O Other opiates/analgesics
- O Barbituates
- O Other sed/hyp/tranq.
- O Cocaine* or Crack
- O Amphetamines/Methamphetamine
- O Cannabis
- O Hallucinogens*
- O Inhalants*
- O Prescription drugs (not for purpose prescribed)
- O **Refused**

DA17. How long was your last (most recent) period of voluntary abstinence (not using at all) from this major substance? (ASI LITE)

☐☐ days ☐☐ months ☐☐ years

DA18. How many months ago did this abstinence end? (ASI LITE) ☐☐ months

DA19. In the past 30 days, what is the longest period of time you did not use any alcohol or illicit/non-prescribed drug?

Estimated number of days (or)	☐☐
Estimated number of weeks (or)	☐☐
Estimated number of months	☐☐

DA20. How many times have you had "d.t's" from not using alcohol? (ASI LITE) ☐☐ times

DA21. How many times have you overdosed on drugs? (ASI LITE) ☐☐ times

DA22. Do you currently have a medical marijuana card?

O Yes O No O **Refused**

DA23. When I read each statement below, think about how things are going in your life. Tell me which answer best describes how you are feeling right now.

USE SHOW CARD B
[Explain Show Card B to client]

	Disagree	Somewhat Agree	Agree	Strongly Agree
a. I am not likely to use alcohol and/or other drugs	O	O	O	O
b. There is someone who cares about whether I am doing better	O	O	O	O
c. I have someone who will help when I have a problem	O	O	O	O
d. I have people in my life who are a positive influence	O	O	O	O
e. The people I care about are supportive of my recovery	O	O	O	O
f. People count on me to help them when they have a problem	O	O	O	O
g. I have friends who are clean and sober	O	O	O	O
h. I have someone who will listen to me when I need to talk	O	O	O	O
i. Using alcohol and/or drugs is a problem for me	O	O	O	O
j. I need to work on my problems with alcohol and/or drugs	O	O	O	O
k. I am satisfied with the amount of physical activity I get	O	O	O	O
l. My physical health is a concern	O	O	O	O
m. I am getting care for any physical health conerns I have	O	O	O	O
n. Transportation to and from treatment is convenient	O	O	O	O

The next set of questions are about your legal status. Once again, remember everything you tell me on this interview is confidential.

CRIMINAL INFORMATION

CJ1. In the past 30 days, were you a victim of any violent crimes such as assualt, rape, mugging, or robbery?

○ Yes ○ No ○ **Refused** ○ N/A

CJ2. In your lifetime, were you ever the victim of any violent crime such as assualt, rape, mugging, or robbery?

○ Yes
○ No
○ **Refused**

CJ3. In the past 30 days, were you a victim of any nonviolent crimes such as burglary, theft of your property or money, or being cheated?

○ Yes ○ No ○ **Refused** ○ N/A

CJ4. In your lifetime, were you ever the victim of any nonviolent crimes such as burglary, theft of your property or money, or being cheated?

○ Yes
○ No
○ **Refused**

CJ5. How many times in the last 30 days have you been arrested and charged with the following? {*If 0 on all, skip to CJ7*} (modified ASI LITE)

a. Disorderly conduct, vagrancy, public intoxication	☐☐
b. Driving under the influence of intoxicants (DUII)	☐☐
c. Major driving violation (e.g. reckless driving)	☐☐
d. Identity theft	☐☐
e. Shoplifting/vandalism	☐☐
f. Parole/probation violations	☐☐
g. Drug charges	☐☐
h. Forgery	☐☐
i. Weapon offense	☐☐
j. Burglary/larceny/breaking and entering	☐☐
k. Robbery	☐☐
l. Assault	☐☐
m. Arson	☐☐
n. Rape	☐☐
o. Homicide/manslaughter	☐☐
p. Prostitution	☐☐
q. Contempt of court	☐☐
r. Other (specify): _____	☐☐

CJ6. How many of these charges resulted in convictions? (ASI LITE) ☐☐

CJ7. Are you presently awaiting charges, trial, or sentence? (ASI LITE) ○ Yes ○ No ○ **Refused**

CJ8. In the past 30 days, how many days were you detained or incarcerated? ☐☐

CJ9. How long was your last incarceration? ☐☐☐ days

a. What was the reason (most severe charge): _____

CJ10. How many times in your life have you been charged with the following: (ASI LITE)

a. Disorderly conduct, vagrancy, public intoxication ☐☐
b. Driving while intoxicated ☐☐
c. Major driving violations (reckless driving, speeding, no license, etc.) ☐☐

(ASI LITE) **USE SHOW CARD A**	Not at all	Slightly	Considerably	Moderately	Extremely	Don't know	Refused	N/A
CJ11a. How serious do you feel your present legal problems are? (NOT including civil court problems such as child welfare, evictions, etc.)	○	○	○	○	○	○	○	○
CJ11b. How important to you *now* is counseling or referral for these legal problems?	○	○	○	○	○	○	○	○

CJ12. Have you been in any controlled living environment (such as jail or residential treatment) in the past 30 days? {*if no, skip to CJ?)* (ASI LITE)

- O No
- O Jail
- O Alcohol or Drug Treatment
- O Psychiatric Treatment
- O Other (specify): _____
- O **Refused**

CJ13. How many days were you in this living situation (out of the past 30 days)? (ASI LITE)

Estimated number of days: ☐☐

CJ14. Are you currently on probation or parole?

O Yes O No O **Refused**

CJ15. How many days in the past 30 have you engaged in illegal activities for profit (to make money)? (ASI LITE) Estimated number of days: ☐☐

CJ16. Thinking about the treatment you are beginning right now, was this treatment ordered or suggested by criminal or family court?

- O Yes, criminal court (DUII, drug court, or other)
- O Yes, family court (child welfare)
- O No
- O **Refused**

If yes, are you participating in a treatment court program (drug court, DUI court, or family drug court)?

O Yes O No O **Refused**

The next set of questions ask about psychological status.

P1. Have you had a significant period of time **within the last 30 days** (that was not a direct result of alcohol/drug use) in which you have *[see table below, read each item, record yes or no; do not code if condition only occurs while client is using substances]:* (ASI LITE)

P2. Have you had a significant period of time **in your lifetime** (that was not a direct result of alcohol/drug use) in which you have *[see table below, read each item, record yes or no; do not code if condition only occurs while client is using substances]:* (ASI LITE)

	Past 30 Days	**Lifetime**
a. Experienced serious depression - sadness, hopelessness, loss of interest, difficulty with daily function?	O Yes O No O **Refused**	O Yes O No O **Refused**
b. Experienced serious anxiety/tension -- feeling unreasonably worried, inability to feel relaxed?	O Yes O No O **Refused**	O Yes O No O **Refused**
c. Experienced hallucinations - saw things or heard voices that were not there?	O Yes O No O **Refused**	O Yes O No O **Refused**
d. Experienced trouble understanding, concentrating, or remembering?	O Yes O No O **Refused**	O Yes O No O **Refused**
e. Experienced trouble controlling violent behavior, including episodes of rage or violence?	O Yes O No O **Refused**	O Yes O No O **Refused**
*f. Experienced serious thoughts of suicide? (seriously considered a plan for taking your life)	O Yes O No O **Refused**	O Yes O No O **Refused**
*g. Attempted suicide? (doing suicidal gestures or attempts)	O Yes O No O **Refused**	O Yes O No O **Refused**
h. Been prescribed medication for any psychological or emtional problems? (prescribed by an MD and/or psychiatric)	O Yes O No O **Refused**	O Yes O No O **Refused**

**NOTE: If serious current suicide risk is present, please contact NPC and your supervisor*

P3. How many days in the past 30 have you experienced these psychological or emotional problems? (ASI LITE) ☐☐

{If 0, skip to P6}

(ASI LITE) **USE SHOW CARD A**	Not at all	Slightly	Considerably	Moderately	Extremely	Don't know	Refused	N/A
P4. How much have you been troubled or bothered by the psychological or emotional problems described above in the past 30 days?	○	○	○	○	○	○	○	○
P5. How important to you now is treatment for these psychological problems?	○	○	○	○	○	○	○	○

P6. How many times in your life have you been treated for any psychological or emotional problems? (ASI LITE)

a. In a hospital	☐☐
b. As an outpatient or in private individual treatment	☐☐

P7. Do you receive a pension for a psychiatric disability? (ASI LITE) ○ Yes ○ No ○ **Refused**

Thank you for answering those questions for us today. Do you have anything else to tell me about yourself or your situation?

Okay, that completes the interview. Remember, like we talked about, someone from NPC will be contacting you to do another interview like this in about 6 months. Thank you for agreeing to be in this important study!

Please use the back of this page for notes or comments.

INTERVIEWER PLEASE COMPLETE: The remaining items on this page are NOT TO BE ASKED OF THE CLIENT, but are to be completed by the interviewer.

I1. At the time of the interview, is client: (ASI LITE)

a. Obviously depressed/withdrawn	○ Yes ○ No
b. Obviously hostile	○ Yes ○ No
c. Obviously anxious/nervous	○ Yes ○ No
d. Having trouble with reality testing, thought disorders, paranoid thinking	○ Yes ○ No
e. Having trouble comprehending, concentrating, remembering	○ Yes ○ No
f.Having suicidal thoughts	○ Yes ○ No

APPENDIX B: 6-MONTH FOLLOW-UP INTERVIEW INSTRUMENT

AMH Follow-up Study Interview
(6-Month Follow Up Interview Form)

A7e. ID ☐☐☐☐

Last date of contact with client: _____

A1. Client Name: _____

A2. Interviewer: _____

A3. Date of Interview: Month ☐☐ / Day ☐☐ / Year ☐☐

A4. Time Started: ☐☐ : ☐☐ ○ am ○ pm

A5. Time Completed: ☐☐ : ☐☐ ○ am ○ pm

A7. Date of baseline Interview: Month ☐☐ / Day ☐☐ / Year ☐☐

A6. Name of Referring Agency *(source of referral to study)*:_____

A8. Was this interview *[the 6-month interview]* conducted in-person or on the phone?

○ In-Person

○ Phone

A8. Processing	Initial	mm/dd/yy
A8a. Recorded in database by interviewer	_____	☐☐/☐☐/☐☐
A8b. Gift card given/sent to participant	_____	☐☐/☐☐/☐☐
A7b. Received by coordinator	_____	☐☐/☐☐/☐☐
A7c. Checked by coordinator	_____	☐☐/☐☐/☐☐
A7d. Scanned by coordinator	_____	☐☐/☐☐/☐☐

[Note to data collector: please remember to review the AMH database to see if 3 month questions have been answered and, if so, to log them here before the interview starts. The question about whether they are currently in treatment needs to be asked again, even if it was answered at 3 months]

NPC ID: ☐☐☐☐

Thanks again for agreeing to participate in this study. It is the first study of its kind in Oregon, and the results will be really important to helping improve treatment services and keep them funded. The study wouldn't be possible without your help. The interview should take about half an hour.

Anything you tell me today will be kept private. The only exceptions to privacy would be if we (1) saw that there was a medical emergency; (2) heard statements indicating that you are planning to harm yourself or others or (3) observed child abuse.

There are no right or wrong answers; we just need to know what is true for you, based on your experiences. Again, this information will be kept private.

Also, it is important that I read every question, all the way through, for everyone who participates in our project so that everyone is treated the same way. Are you ready to get started?

---

1. Are you still receiving substance abuse treatment at *[name of referral agency]?*

O Yes ***[If yes, skip to 2]***
O No

1a. Are you receiving treatment anywhere else right now?

O No - study participant is not receiving treatment anywhere else right now. ***[If no, skip to 2]***
O Yes

1aa. Do you know the name of the agency?

O No - study participant does not know the name of the agency. ***[If no, skip to1b]***
O Yes

1ab. What is the name of the agency? _____

1b. What is the name of the counselor that you are working with there?_____

[Interviewer note: Don't ask the client for agency contact info.]

1c. May we have permission to contact that agency if we need to locate you to schedule an interview?

O Yes *[Record this in the "releases" section of the database AND in the "additional notes" section of the database]*
O No - NPC does not have permission. *[Add a note that we do not have permission to contact new agency in the "additional notes" section of the database]*

[note, skip to B4 if 2 & 3 were asked at 3 months call]

2. When you first agreed to participate in this study (that is, when you started at *[name of referral agency*] can you tell me if you were going there to receive inpatient services or outpatient services?

O Inpatient or Day Treatment *[note: inpatient = residential, spending the night there]*
O Outpatient *[includes OP, Intensive OP, day treatment and DUI education]*

3. Ok, now can you tell me when you were receiving treatment at *[name of referral agency]*, was this part of required treatment because of a DUI *[driving under the influence]* case? O Yes O No

The next set of questions asks about your household status. *[Read each response]*

B4. Please tell me all of the places where you have lived in the past 30 days - since about *[let the participant know what the date was 30 days ago]*. *(modified ASI LITE)*

[Read each response and mark all that apply]

- O With spouse/partner & children
- O With just your spouse/partner
- O With children alone
- O With parents
- O With family
- O With friends
- O Alone
- O Controlled environment (Residential treatment center, other care facility, nursing home, detox, group sober living homes, jail, etc.)
- O No stable housing (homeless)
- O Other: _____
- O Refused

B16. Did you live with anyone who in the past 30 days : *(ASI LITE)*

a. Has a current alcohol problem? O Yes O No O Refused

b. Uses non-prescribed drugs? O Yes O No O Refused

B17. Have you been at risk for having your children removed from your care due to alcohol and/or drug abuse/dependency issues? *[Here's an example you can read to the participant: has your family been investigated because of reports to child welfare in the past 30 days?]*

- O Yes
- O No ***[If no, mark NA for the next 3 questions and then skip to E2]***
- O Refused
- O NA ***[If NA, mark NA for the next 3 questions and then skip to E2]***

B18. If yes, do you still have current custody of your children? O Yes O No O Refused O NA

B19. Did you meet the child welfare service agreement during treatment to progress towards regaining custody of your children?

- O Yes
- O No/Not Yet ***[If no, mark NA for the next question and then skip to E2]***
- O Refused
- O NA

B19a. Have you had your children returned to you since you have met the child welfare service agreement?

O Yes O No O Refused O NA

Thank you for answering those questions. The next set of questions is about your employment status.

E2. What was your employment status in the past 30 days? ***[only mark one - the highest level]***

- O Full time (40 hours/week)
- O Part time (regular hours but less than 40 hours/week)
- O Part time (irregular hours, day work)
- O Student (not working)
- O Service (volunteer/unpaid work)
- O Retired/disability
- O Unemployed
- O In controlled environment

E3. How many days were you paid for working in the past 30 days, including "under-the-table" work? *(ASI LITE)*

☐☐ days

E4. How much money did you receive from the following sources in the past 30 days *[read response options]*? *(ASI LITE)*

a. Employment ("take home pay"- amount after taxes)	$☐☐☐☐
b. Unemployment compensation	$☐☐☐☐
c. TANF or welfare/DHS payments/Food Stamps	$☐☐☐☐
d. Pension, other benefits, social security, disability or child support	$☐☐☐☐
e. Money from your spouse/partner, family or friends (money for personal expenses)	$☐☐☐☐
f. Illegal sources	$☐☐☐☐
g. Other (specify):	$☐☐☐☐
h. Other (specify):	$☐☐☐☐
i. Other (specify):	$☐☐☐☐

E5. How many people depend on you for the majority of their food, shelter, etc? *[does not include self or self-supporting spouse/partner) (ASI LITE)* Estimated number of people:☐☐

E9. During the past 30 days, has someone else contributed the majority of your financial support *[more than 50%]*? *(ASI LITE)* ○ Yes ○ No ○ Refused ○ NA

The next set of questions have to do with your alcohol and drug use. Again, remember everything you tell me in this interview is confidential.

DA4. How much money would you say you spent during the past 30 days on: a. alcohol $☐☐☐☐

b. drugs $☐☐☐☐

DA6. In the past 30 days, which of the following are true for you? (*Read each response and mark yes or no)*

b. I tried to access a self-help group or AA/NA.	○ Yes ○ No ○ Refused
c. I tried to access A & D treatment at a community outpatient clinic for group and/or individual counseling.	○ Yes ○ No ○ Refused
d. I tried to access A & D treatment at a community residential clinic for group and/or individual counseling.	○ Yes ○ No ○ Refused
e. I tried to access detoxification services.	○ Yes ○ No ○ Refused
f. I tried to access A & D treatment at a local community hospital.	○ Yes ○ No ○ Refused
g. I tried to access A & D treatment at a public health clinic.	○ Yes ○ No ○ Refused
h. If you tried to access A & D treatment, were you able to get into services? *[if they tried accessing 2+ places, and got into any of them, it is a "yes"]*	○ Yes ○ No ○ Refused ○ NA

[if yes, skip to DA7]

If no, what was the estimated wait time? *[if they tried accessing 2+ places, waiting time should be the shortest]*

Estimated wait time in days: ☐☐

DA7. How often have you attended self help groups (e.g. AA, NA) during the last 30 days? Would you say:

O None	O 3-4 times per week
O 1-3 times per month	O Daily
O 1-2 times per week	O Refused

DA9. How many days in the past 30 have you experienced Alcohol Problems? *[be sure to keep in mind we are interested in the number of days the participant had problems directly related to their use. Problems may inlcude cravings, withdrawal symptoms, wanting to stop using, but not being able to stop; social or legal consequences, such as DUIIs/court consequences, family members upset with use; and emotion consequences as a result of their use]* ☐☐ days

DA10. How many days in the past 30 have you experienced Drug Problems? *[be sure to keep in mind we are interested in the number of days the participant had problems directly related to drug use]* ☐☐ days

DA13. In the past 30 days, on how many days have you used? *[make sure to read each item (b-p) below, and allow the participant to answer after reading each item]*

	Number of Days
b. Alcohol - to intoxication (feeling "buzzed" or "high")	☐☐
c. Alcohol - At least one drink	☐☐
d. Alcohol - At least 5 drinks within a few hours	☐☐
e. Heroin (Lady, white girl, horse, black tar, brown sugar, smack, goods, H, junk, Harry)*	☐☐
f. Methadone (Dolophine, LAAM)	☐☐
g. Other opiates/pain killers (e.g., Morphine {M, white stuff, cube, morf, mud, nasty}, Dilaudid, Demerol, Percocet, Oxycontin, Ocycodone, Darvon, Talwin, Codeine, Tylenol 2, 3, 4, Syrups, Robitussin, Fentanyl)	☐☐
h. Barbituates (Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol)	☐☐
i. Other sedatives or tranquilizers (Benzodiazepines: Valium, Xanax, Librium, Ativan, Serax, Quaaludes, Tranxene, Dalmane, Halcion, Miltown)	☐☐
j. Cocaine* or Crack (Cocaine Crystal, Free-Base Cocaine or "Crack" and "Rock")	☐☐
k. Amphetamines/Methamphetamine (Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal)	☐☐
l. Cannabis *[The intent is to get at use of substances not for their intended purpose. If the marijuana is being legally prescribed and used for its intended purpose then it would not be counted here.]*	☐☐
m. Hallucinogens* (LSD (acid), Mescaline, Mushrooms (Psilocybin), Peyote, Green, PCP (Phenocyclidine), Angel Dust, Ecstasy)	☐☐
n. Inhalants* (Nitrous Oxide, Amyl Nitrate, Whippits, Poppers, Glue, Solvents, Gasoline, Toluene)	☐☐
o. Prescription drugs (not for the purpose prescribed)	☐☐
p. More than one substance per day (including Alcohol)	☐☐

DA19. In the past 30 days, what is the longest period of time you did not use any alcohol or illicit/non-prescribed drug?

Estimated number of days: ☐☐☐☐

DA23. When I read each statement below, think about how things are going in your life. Tell me which answer best describes how you are feeling **RIGHT NOW.**

USE SHOW CARD B	Disagree	Somewhat Agree	Agree	Strongly Agree
a. I am not likely to use alcohol and/or other drugs	O	O	O	O
b. There is someone who cares about whether I am doing better	O	O	O	O
c. I have someone who will help when I have a problem	O	O	O	O
d. I have people in my life who are a positive influence	O	O	O	O
e. The people I care about are supportive of my recovery	O	O	O	O
f. People count on me to help them when they have a problem	O	O	O	O
g. I have friends who are clean and sober	O	O	O	O
h. I have someone who will listen to me when I need to talk	O	O	O	O
i. Using alcohol and/or drugs is a problem for me	O	O	O	O
j. I need to work on my problems with alcohol and/or drugs	O	O	O	O
o. I am less bothered by my symptoms (of substance abuse)	O	O	O	O
p. I am better able to cope when things go wrong	O	O	O	O
q. I am better able to accomplish the things I want to do	O	O	O	O
r. I am making progress in my wellness/recovery goals	O	O	O	O
s. I am doing well in my wellness/recovery goals	O	O	O	O
t. The wellness/recovery tools and skills that I use are effective for me	O	O	O	O

DA24. When you started participating in this study, you were receiving treatment from *[referral agency name]*. Thinking about the treatment that you received there - or your most recent treatment experience - please tell me whether you disagree, somewhat agree, agree, or strongly agree with each statement I am about to read.

u. When I needed services right away, I was able to see someone as soon as I wanted	O	O	O	O
v. The people I go to (went to) for services spent enough time with me	O	O	O	O
w. I helped to develop my service and treatment goals	O	O	O	O
x. The people I went to for services were sensitive to my cultural background (race, ethnicity, religion, sexual orientation)	O	O	O	O
y. I was given information about different services that were available to me	O	O	O	O
z. I was given enough information to effectively handle my problems	O	O	O	O
n. Transportation to and from treatment is (or was) convenient	O	O	O	O

M9. Are you currently using any type of specific medication-assisted therapy to achieve and/or maintain abstinence (no use) of alcohol and/or illicit drugs? *[examples: Anabuse, Naltrexone (Revia or Vivitrol), Acamprosate, Bupreonorphine (Suboxonel)] (CalMed CIOM)*

- O Yes - If yes, specify:_____
- O No **[if No, skip to M12]**
- O Refused

M10. Please tell me which of the statements below describe how you feel about your medication-assisted treatment for your addiction. Please only respond about your medication-assisted treatment and not other types of medication for physical or mental health conditions. *(CalMed CIOM)*

[Read all responses, ask "Would you say "yes" or "no"? Mark all items that the participant agrees with.]

a. I no longer feel I need my medications	O Yes O No
b. I would like to change my medications and/or dose	O Yes O No
c. My medications aren't working for me the way I expected they would	O Yes O No
d. I use vitamins, herbs, or food supplements	O Yes O No
e. My medications make me too tired	O Yes O No
f. My medications make me anxious	O Yes O No
g. My medications interfere with my sexuality	O Yes O No
h. My medications make me gain weight	O Yes O No
i. I cannot afford my medications	O Yes O No
j. My medications are working fine	O Yes O No

M11. Please tell me which *one* statement that best describes the way you take your medications. *(CalMed CIOM)* *[choose only one response]*

- O I always remember to take my medications the way my doctor prescribed
- O I take my medications most of the time, but occasionally I forget
- O I take my medications until I start to feel better then I stop
- O I seldom take my medications
- O I never take my medications
- O Refused

M12. Do you currently smoke or use any tobacco product on a **daily** basis? O Yes O No O Refused

The next set of questions are about your criminal justice status. Once again, remember everything you tell me on this interview is confidential.

CJ1. In the past 30 days, were you a victim of any violent crimes such as assualt, rape, mugging, or robbery? O Yes O No O Refused O N/A

CJ3. In the past 30 days, were you a victim of any nonviolent crimes such as burglary, theft of your property or money, or being cheated?
O Yes O No O Refused O N/A

CJ5a. Have you been arrested and charged for any offense in the past 30 days? This includes things like major driving violations, contempt of court, disorderly condunt, probation/parole violations, as well as any other type of offense?

- O Yes
- O No **[if No, skip to CJ8]**
- O Refused **[if refused, skip to CJ8]**

CJ5. How many times in the last 30 days have you been arrested and charged with the following? *[If 0 on all, skip to CJ8] (modified ASI LITE)*

a. Disorderly conduct, vagrancy, public intoxication	☐☐
b. Driving under the influence of intoxicants (DUII)	☐☐
c. Major driving violation (e.g. reckless driving)	☐☐
d. Identity theft	☐☐
e. Shoplifting/vandalism	☐☐
f. Parole/probation violations	☐☐
g. Drug charges	☐☐
h. Forgery	☐☐
i. Weapon offense	☐☐
j. Burglary/larceny/breaking and entering	☐☐
k. Robbery	☐☐
l. Assault	☐☐
m. Arson	☐☐
n. Rape	☐☐
o. Homicide/manslaughter	☐☐
p. Prostitution	☐☐
q. Contempt of court	☐☐
r. Other _____	☐☐

CJ6. How many of these charges resulted in convictions? *(ASI LITE)* ☐☐

CJ8. In the past 30 days, how many days were you detained or incarcerated? *(modified ASI LITE)* ☐☐ days

CJ12. Have you been in any controlled living environment (such as jail or residential treatment) in the past 30 days? *[mark all that apply]* *(ASI LITE)*

O No
O Jail
O Alcohol or Drug Treatment
O Psychiatric Treatment
O Other *[this includes sober house]* (specify):_____
O Refused

The next set of questions ask about psychological status.

P1. Have you had a significant period of time within the last 30 days (that was not a direct result of alcohol/drug use) in which you have: *[see table below, read each item, record yes or no]* *(ASI LITE)*

a. Experienced serious depression - sadness, hopelessness, loss of interest, difficulty with daily function?	O Yes O No O Refused
b. Experienced serious anxiety/tension -- feeling unreasonably worried, inability to feel relaxed?	O Yes O No O Refused
c. Experienced hallucinations - saw things or heard voices that were not there?	O Yes O No O Refused
d. Experienced trouble understanding, concentrating, or remembering?	O Yes O No O Refused
e. Experienced trouble controlling violent behavior, including episodes of rage or violence?	O Yes O No O Refused
*f. Experienced serious thoughts of suicide? (seriously considered a plan for taking your life)	O Yes O No O Refused
*g. Attempted suicide? (doing suicidal gestures or attempts)	O Yes O No O Refused
h. Been prescribed medication for any psychological or emotional problems? (prescribed by an MD and/or psychiatrist)	O Yes O No O Refused

P3. How many days in the past 30 have you experienced these psychological or emotional problems? *(ASI LITE)*

☐☐ days ***[If 0, mark P4 as NA and go to S1]***

(ASI LITE) **USE SHOW CARD A**	Not at all	Slightly	Considerably	Moderately	Extremely	Don't know	Refused	N/A
P4. How much have you been troubled or bothered by the psychological or emotional problems described above in the past 30 days?	O	O	O	O	O	O	O	O

Thank you for answering those difficult questions. Now, I just have a few remaining questions to close our interview.

Final Questions

S1. Please tell us anything you think is important for us to know about the services you received from *[name of referral agency].*

S2. Are there any services or supports that you think would have helped you that you did not receive?

S3. What was the most helpful service or support that you received from *[name of referral agency]*?

Can you tell me if any of your contact information has changed? [*This information should be kept on a separate sheet of paper, entered in the database after the interview, and then shredded].*

I2. Is there important clarifying information that should be included?

INTERVIEWER PLEASE COMPLETE: The remaining items on this page are NOT TO BE ASKED OF THE CLIENT, but are to be completed by the interviewer.

I1. At the time of the interview, is client: (ASI LITE)

a. Obviously depressed/withdrawn	O Yes O No
b. Obviously hostile	O Yes O No
c. Obviously anxious/nervous	O Yes O No
d. Having trouble with reality testing, thought disorders, paranoid thinking	O Yes O No
e. Having trouble comprehending, concentrating, remembering	O Yes O No
f. Having suicidal thoughts - [mandated reporting trigger]	O Yes O No

APPENDIX C: 12-MONTH FOLLOW-UP INTERVIEW INSTRUMENT

AMH Follow-up Study Interview
(12-Month Follow Up Interview Form)

Version 3

A7e. ID ☐☐☐☐

A1. Client Name: _____

A2. Interviewer: _____

A3. Date of Interview: Month ☐☐ Day ☐☐ Year ☐☐

A4. Time Started: ☐☐ : ☐☐ ○ am ○ pm

A5. Time Completed: ☐☐ : ☐☐ ○ am ○ pm

A7. Date of baseline Interview: Month ☐☐ Day ☐☐ Year ☐☐

A9. Was 6-month interview completed? ○ Yes ○ No

A6. Name of Referring Agency *(source of referral to study)*:_____

A8. Was this interview *[the 12-month interview]* conducted in-person or on the phone?

○ In-Person

○ Phone

A8. Processing	Initial	mm/dd/yy
A8a. Recorded in database by interviewer	_____	☐☐/☐☐/☐☐
A8b. Gift card given/sent to participant	_____	☐☐/☐☐/☐☐
A7b. Received by coordinator	_____	☐☐/☐☐/☐☐
A7c. Checked by coordinator	_____	☐☐/☐☐/☐☐
A7d. Scanned by coordinator	_____	☐☐/☐☐/☐☐

[Note to data collector: please remember to review the AMH database to see if 3 month questions have been answered IF THIS PERSON DID NOT COMPLETE 6M INTERVIEW and, if so, to log them here before the interview starts. The question about whether they are currently in treatment needs to be asked again, even if it was answered at 3 or 6 months]

Thanks again for agreeing to participate in this study. It is the first study of its kind in Oregon, and the results will be really important to helping improve treatment services and keep them funded. The study wouldn't be possible without your help. The interview should take about half an hour.

Anything you tell me today will be kept private. The only exceptions to privacy would be if we (1) saw that there was a medical emergency; (2) heard statements indicating that you are planning to harm yourself or others or (3) observed child abuse.

There are no right or wrong answers; we just need to know what is true for you, based on your experiences. Again, this information will be kept private.

Also, it is important that I read every question, all the way through, for everyone who participates in our project so that everyone is treated the same way. Are you ready to get started?

---

1. Are you still receiving substance abuse treatment at *[name of referral agency]?*

O Yes ***[If yes, skip to 2]***
O No

1a. Are you receiving treatment anywhere else right now?

O No - study participant is not receiving treatment anywhere else right now. ***[If no, skip to 2]***
O Yes

2. When you first agreed to participate in this study (that is, when you started at *[name of referral agency*] can you tell me if you were going there to receive inpatient services or outpatient services?

O Inpatient or Day Treatment *[note: inpatient = residential, spending the night there]*
O Outpatient *[includes OP, Intensive OP, day treatment and DUI education]*

3. Ok, now can you tell me when you were receiving treatment at *[name of referral agency]*, was this part of required treatment because of a DUI *[driving under the influence]* case? O Yes O No

---

The next set of questions asks about your housing status. *[Read each response]*

B4. Who have you lived with over the past 30 days? - since about *[let the participant know what the date was 30 days ago]*. *(modified ASI LITE)*

[Read each response and mark all that apply] [Cross check with CJ12]

O With spouse/partner & children
O With just your spouse/partner
O With children alone
O With parents
O With family
O With friends
O Alone
O Controlled environment (Residential treatment center, other care facility, nursing home, detox, group sober living homes, jail, etc.)
O No stable housing (homeless)
O Other: _____
O Refused

B4a. In the past 30 days, where have you been living most of the time? *[DO NOT READ RESPONSE OPTIONS TO CLIENT.]*

- O Shelter (Save Havens, transitional living center (TLC), low demand facilities, reception centers, other temporary day or evening facility)
- O Street/Outdoors (Sidewalk, doorway, park, public or abandoned building)
- O Institution (Hospital, nursing home, jail/prison)
- O Housed*: [IF HOUSED, CHECK APPROPRIATE SUBCATEGORY]*
  - O Own/Rent apartment, room, or house
  - O Someone else's apartment, room or house
  - O Halfway house
  - O Residential treatment
  - O Other housed (specify): _____
  - O Refused
  - O Don't Know

B16. Did you live with anyone who in the past 30 days : *(ASI LITE)*

a. Has a current alcohol problem? O Yes O No O Refused

b. Uses non-prescribed drugs? O Yes O No O Refused

Thank you for answering those questions. The next set of questions is about your employment status.

E2. What was your employment status in the past 30 days? ***[only mark one - the highest level]***

- O Full time (40 hours/week)
- O Part time (regular hours but less than 40 hours/week)
- O Part time (irregular hours, day work)
- O Student (not working)
- O Service (volunteer/unpaid work)
- O Retired/disability
- O Unemployed
- O In controlled environment

E3. How many days were you paid for working in the past 30 days, including "under-the-table" work? *(ASI LITE)*

☐☐ days

E4. How much money did you receive from the following sources in the past 30 days *[read response options]*? *(ASI LITE)*

a. Employment ("take home pay"- amount after taxes)	$☐☐☐☐
b. Unemployment compensation	$☐☐☐☐
c. TANF or welfare/DHS payments/Food Stamps	$☐☐☐☐
d. Pension, other benefits, social security, disability or child support	$☐☐☐☐
e. Money from your spouse/partner, family or friends (money for personal expenses)	$☐☐☐☐
f. Illegal sources	$☐☐☐☐
g. Other (specify):	$☐☐☐☐
h. Other (specify):	$☐☐☐☐
i. Other (specify):	$☐☐☐☐

E5. How many people depend on you for the majority of their food, shelter, etc? *[does not include self or self-supporting spouse/partner) (ASI LITE)* Estimated number of people:☐☐

E9. During the past 30 days, has someone else contributed the majority of your financial support *[more than 50%]*? *(ASI LITE)* ○ Yes ○ No ○ Refused ○ NA

The next set of questions have to do with your alcohol and drug use. Again, remember everything you tell me in this interview is confidential.

DA4. How much money would you say you spent during the past 30 days on: a. alcohol $ ☐☐☐☐

b. drugs $ ☐☐☐☐

DA9. How many days in the past 30 have you experienced Alcohol Problems? *[be sure to keep in mind we are interested in the number of days the participant had problems directly related to their use. Problems may inlcude cravings, withdrawal symptoms, wanting to stop using, but not being able to stop; social or legal consequences, such as DUIIs/court consequences, family members upset with use; and emotion consequences as a result of their use]* ☐☐ days

DA10. How many days in the past 30 have you experienced Drug Problems? *[be sure to keep in mind we are interested in the number of days the participant had problems directly related to drug use]* ☐☐ days

DA13. In the past 30 days, on how many days have you used? *[make sure to read each item (b-p) below, and allow the participant to answer after reading each item]*

	Number of Days
b. Alcohol - to intoxication (feeling "buzzed" or "high")	☐☐
c. Alcohol - At least one drink	☐☐
d. Alcohol - At least 5 drinks within a few hours	☐☐
l. Cannabis *[The intent is to get at use of substances not for their intended purpose. If the marijuana is being legally prescribed and used for its intended purpose then it would not be counted here.]*	☐☐
k. Amphetamines/Methamphetamine (Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal)	☐☐
e. Heroin (Lady, white girl, horse, black tar, brown sugar, smack, goods, H, junk, Harry)*	☐☐
f. (Non-Prescribed) Methadone (Dolophine, LAAM)	☐☐
g. Other opiates/pain killers (e.g., Morphine {M, white stuff, cube, morf, mud, nasty}, Dilaudid, Demerol, Percocet, Oxycontin, Ocycodone, Darvon, Talwin, Codeine, Tylenol 2, 3, 4, Syrups, Robitussin, Fentanyl)	☐☐
h. Barbituates (Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol)	☐☐
i. Other sedatives or tranquilizers (Benzodiazepines: Valium, Xanax, Librium, Ativan, Serax, Quaaludes, Tranxene, Dalmane, Halcion, Miltown)	☐☐
j. Cocaine* or Crack (Cocaine Crystal, Free-Base Cocaine or "Crack" and "Rock")	☐☐
m. Hallucinogens* (LSD (acid), Mescaline, Mushrooms (Psilocybin), Peyote, Green, PCP (Phenocyclidine), Angel Dust, Ecstasy)	☐☐
n. Inhalants* (Nitrous Oxide, Amyl Nitrate, Whippits, Poppers, Glue, Solvents, Gasoline, Toluene)	☐☐
o. Prescription drugs (not for the purpose prescribed)	☐☐
p. More than one substance per day (including Alcohol)	☐☐

M12. Do you currently smoke or use any tobacco product on a **daily** basis? O Yes O No O Refused

DA19. In the past 30 days, what is the longest period of time you did not use any alcohol or illicit/non-prescribed drug? Estimated number of days: ☐☐☐☐

DA7. How often have you attended self help groups (e.g. AA, NA) during the last 30 days? Would you say:
O None O 1-3 times per month O 1-2 times per week O 3-4 times per week O Daily O Refused

DA6. In the past 30 days, which of the following are true for you? (*Read each response and mark yes or no)*

b. I tried to access a self-help group or AA/NA.	O Yes O No O Refused
c. I tried to access A & D treatment at a community outpatient clinic for group and/or individual counseling.	O Yes O No O Refused
d. I tried to access A & D treatment at a community residential clinic for group and/or individual counseling.	O Yes O No O Refused
e. I tried to access detoxification services.	O Yes O No O Refused
f. I tried to access A & D treatment at a local community hospital.	O Yes O No O Refused
g. I tried to access A & D treatment at a public health clinic.	O Yes O No O Refused
h. If you tried to access A & D treatment, were you able to get into services? *[if they tried accessing 2+ places, and got into any of them, it is a "yes"]*	O Yes O No O Refused O NA

[if yes, skip to DA7]

If no, what was the estimated wait time? *[if they tried accessing 2+ places, waiting time should be the shortest]*
Estimated wait time in days: ☐☐

DA23. When I read each statement below, think about how things are going in your life. Tell me which answer best describes how you are feeling **RIGHT NOW.**

USE SHOW CARD B

	Disagree	Somewhat Agree	Agree	Strongly Agree
a. I am not likely to use alcohol and/or other drugs	O	O	O	O
b. There is someone who cares about whether I am doing better	O	O	O	O
c. I have someone who will help when I have a problem	O	O	O	O
d. I have people in my life who are a positive influence	O	O	O	O
e. The people I care about are supportive of my recovery	O	O	O	O
f. People count on me to help them when they have a problem	O	O	O	O
g. I have friends who are clean and sober	O	O	O	O
h. I have someone who will listen to me when I need to talk	O	O	O	O
i. Using alcohol and/or drugs is a problem for me	O	O	O	O
j. I need to work on my problems with alcohol and/or drugs	O	O	O	O
r. I am making progress in my wellness/recovery goals	O	O	O	O
s. I am doing well in my wellness/recovery goals	O	O	O	O
t. The wellness/recovery tools and skills that I use are effective for me	O	O	O	O

DA24. When you started participating in this study, you were receiving treatment from *[referral agency name]*. Thinking about the treatment that you received there please tell me whether you disagree, somewhat agree, agree, or strongly agree with each statement I am about to read.

	Disagree	Somewhat Agree	Agree	Strongly Agree
u. When I needed services right away, I was able to see someone as soon as I wanted	O	O	O	O
v. The people I go to (went to) for services spent enough time with me	O	O	O	O
w. I helped to develop my service and treatment goals	O	O	O	O
x. The people I went to for services were sensitive to my cultural background (race, ethnicity, religion, sexual orientation)	O	O	O	O
y. I was given information about different services that were available to me	O	O	O	O
z. I was given enough information to effectively handle my problems	O	O	O	O
n. Transportation to and from treatment is (or was) convenient	O	O	O	O

M6. In the last 30 days, how many days have you experienced medical problems? (include the days on which he/she experienced these problems such as cirrhosis, phlebitis, or pancreatitis, cold or flu) *[If 0 days, skip to M9]*

Estimated number of days: ☐☐☐☐

M7. How troubled or bothered have you been by these medical problems in the past 30 days? Would you say, "not at all, slightly, considerably, moderately, or extremely?"

- O Not at all
- O Slightly
- O Considerably
- O Moderately
- O Extremely
- O Don't know
- O Refused
- O N/A

M9. Are you currently using any type of specific medication-assisted therapy to achieve and/or maintain abstinence (no use) of alcohol and/or illicit drugs? *[examples: Anabuse, Naltrexone (Revia or Vivitrol), Acamprosate, Bupreonorphine (Suboxonel)] (CalMed CIOM)*

- O Yes - If yes, specify:_____
- O No **[if No, skip to B18a]**
- O Refused

M10. Please tell me which of the statements below describe how you feel about your medication-assisted treatment for your addiction. Please only respond about your medication-assisted treatment and not other types of medication for physical or mental health conditions. *(CalMed CIOM)*

[Read all responses, ask "Would you say "yes" or "no"? Mark all items that the participant agrees with.]

a. I no longer feel I need my medications	O Yes O No
b. I would like to change my medications and/or dose	O Yes O No
c. My medications aren't working for me the way I expected they would	O Yes O No
d. I use vitamins, herbs, or food supplements	O Yes O No
e. My medications make me too tired	O Yes O No
f. My medications make me anxious	O Yes O No
g. My medications interfere with my sexuality	O Yes O No
h. My medications make me gain weight	O Yes O No
i. I cannot afford my medications	O Yes O No
j. My medications are working fine	O Yes O No

M11. Please tell me which *one* statement that best describes the way you take your medications. *(CalMed CIOM)* *[choose only one response]*

- O I always remember to take my medications the way my doctor prescribed
- O I take my medications most of the time, but occasionally I forget
- O I take my medications until I start to feel better then I stop
- O I seldom take my medications
- O I never take my medications
- O Refused

The next questions are about children and child custody.

B18a. Do you have children (regardless of age)?
[If no, skip to CJ5a]

O Yes O No O Don't know O Refused O N/A

B18b. How many children do you have?
[If only older kids, skip to B18c1]

Number of children under 18 years: ☐☐

Number of children older than 18 years: ☐☐

O Refused O N/A

B18c. Have you ever had children removed from your care by DHS (or authorities)?
[If no, skip to CJ5a]

O Yes O No O Don't know O Refused O N/A

B18c1. How many children have been removed from your care?

Number of children *(this is actually children - times to account for having one or more children removed 1+ times):* ☐☐

B18c2. How many children were removed from your care due to alcohol and/or drug issues?

Number of children/times: ☐☐
(88=Refused, 99=NA)

Thank you for answering those questions. The next few questions are about your legal status.

CJ5a. Have you been arrested and charged for any offense in the past 30 days? This includes things like major driving violations, contempt of court, disorderly condunt, probation/parole violations, as well as any other type of offense?

- O Yes
- O No **[if No, skip to CJ8]**
- O Refused **[if refused, skip to CJ8]**

CJ5. How many times in the last 30 days have you been arrested and charged with the following? *[If 0 on all, skip to CJ8]* *(modified ASI LITE)*

a. Disorderly conduct, vagrancy, public intoxication	☐☐
b. Driving under the influence of intoxicants (DUII)	☐☐
c. Major driving violation (e.g. reckless driving)	☐☐
d. Identity theft	☐☐
e. Shoplifting/vandalism	☐☐
f. Parole/probation violations	☐☐
g. Drug charges	☐☐
h. Forgery	☐☐
i. Weapon offense	☐☐
j. Burglary/larceny/breaking and entering	☐☐
k. Robbery	☐☐
l. Assault	☐☐
m. Arson	☐☐
n. Rape	☐☐
o. Homicide/manslaughter	☐☐
p. Prostitution	☐☐
q. Contempt of court	☐☐
s. Theft	☐☐
r. Other _____	☐☐

CJ6. How many of these charges resulted in convictions? *(ASI LITE)* ☐☐

CJ8. In the past 30 days, how many days were you detained or incarcerated? *(modified ASI LITE)* ☐☐ days

CJ12. Have you been in any controlled living environment (such as jail or residential treatment) in the past 30 days? *[mark all that apply] (ASI LITE) [cross check with B4]*

- O No
- O Jail
- O Alcohol or Drug Treatment
- O Psychiatric Treatment
- O Other *[this includes sober house]* (specify):_____
- O Refused

The next set of questions ask about psychological status.

P1. Have you had a significant period of time within the last 30 days (that was not a direct result of alcohol/drug use) in which you have: *[see table below, read each item, record yes or no] (ASI LITE)*

a. Experienced serious depression - sadness, hopelessness, loss of interest, difficulty with daily function?	O Yes O No O Refused
b. Experienced serious anxiety/tension -- feeling unreasonably worried, inability to feel relaxed?	O Yes O No O Refused
c. Experienced hallucinations - saw things or heard voices that were not there?	O Yes O No O Refused
d. Experienced trouble understanding, concentrating, or remembering?	O Yes O No O Refused
e. Experienced trouble controlling violent behavior, including episodes of rage or violence?	O Yes O No O Refused
*f. Experienced serious thoughts of suicide? (seriously considered a plan for taking your life)	O Yes O No O Refused
*g. Attempted suicide? (doing suicidal gestures or attempts)	O Yes O No O Refused
h. Been prescribed medication for any psychological or emotional problems? (prescribed by an MD and/or psychiatrist)	O Yes O No O Refused

P3. How many days in the past 30 have you experienced these psychological or emotional problems? *(ASI LITE)*

☐☐ days ***[If P1a through P1g are 0, skip to S1]***

(ASI LITE) **USE SHOW CARD A**	Not at all	Slightly	Considerably	Moderately	Extremely	Don't know	Refused	N/A
P4. How much have you been troubled or bothered by the psychological or emotional problems described above in the past 30 days?	O	O	O	O	O	O	O	O

Thank you for answering those difficult questions. Now, I just have a few remaining questions to close our interview.

Final Questions

S1. What was the most helpful service of support that you received from *[name of referral agency]?*

S2. What would you change about the treatment services you received at *[name of referral agency]*?

I2. Is there important clarifying information that should be included?

INTERVIEWER PLEASE COMPLETE: The remaining items on this page are NOT TO BE ASKED OF THE CLIENT, but are to be completed by the interviewer.

I1. At the time of the interview, is client: (ASI LITE)

a. Obviously depressed/withdrawn	O Yes O No
b. Obviously hostile	O Yes O No
c. Obviously anxious/nervous	O Yes O No
d. Having trouble with reality testing, thought disorders, paranoid thinking	O Yes O No
e. Having trouble comprehending, concentrating, remembering	O Yes O No
f. Having suicidal thoughts - [mandated reporting trigger]	O Yes O No

APPENDIX D: DISCHARGE SUMMARY SHEET

AMH Client Discharge Summary Sheet

Instructions: Please complete for each client at the time s/he exits treatment. This form should be completed when the client exits the treatment modality that they entered at the beginning of the research study. So, if the client is enrolled in the study at intake for residential treatment, then this form should be completed when the client exits residential treatment, **even if the client moves on to another treatment modality.**

Please mail or fax all completed forms to: NPC Research, Attention: AMH Follow-up study
Fax Number: 503-243-2454

Name of person completing this form: _____

1. Client's Case Number/Unique ID (# submitted to CPMS):
_____

2. Client Name (please print neatly):
_____

3. Date of client's first contact with program: _____/_____/_____
mo day year

4. Date of assessment: _____/_____/_____
mo day year

5. Date of admission: _____/_____/_____
mo day year

Please list the dates of the first four treatment sessions provided to the client, and indicate whether each session was a group (G) or individual (I) session. If the client is exiting residential treatment, please list the first 4 days of residential treatment.

6. Date of session #1: _____/_____/_____ ____Group *or* _____Individual
mo day year

7. Date of session #2: _____/_____/_____ ____Group *or* _____Individual
mo day year

8. Date of session #3: _____/_____/_____ ____Group *or* _____Individual
mo day year

9. Date of session #4: _____/_____/_____ ____Group *or* _____Individual
mo day year

10. Date of last service delivered to client: _____/_____/_____ Was this ____Group *or* ____Ind?
mo day year

11. Date of Program Exit: _____/_____/_____
mo day year

12. Total number of individual treatment sessions completed: _____

13. Total number of group treatment sessions completed: _____

14. As compared to intake, **at exit** was the client's overall substance use (please do not include any nicotine products in your assessment) (CIRCLE ONE):

1=reduced at exit
2=stayed the same at exit
3=increased at exit
4=no use at exit
5=unknown or not assessed.

15. What was the client's ASAM level of care at intake? _____

16. What was the client's last ASAM level of care prior to exit? _____

17. Exit Status: Please **circle the answer** that best describes this client's situation at exit:

1 =Initial Appointments Not Kept Within 14 Days of Enrollment

2 =Client Termination Without Clinic Agreement

3 =Treatment is Complete

4 =Further treatment is not appropriate for client at this facility or in this service

5 =Non-compliance with Rules

6 =Client Moved out of Catchment Area

7 =Client Cannot Get to Facility

8 =Client Cannot Come for Service During Facility Hours

9 =Client Incarcerated

10 =Client Deceased

11 =Parents/Legal Guardian Withdrew Client

12 =Termination Due to Program Cut/Reduction

13 =Termination Due to Physical Health

14 =Termination Due to Mental Health

15 = Client transferred to a different treatment modality (e.g. from residential to outpatient) within the same agency.

APPENDIX E: BIVARIATE SIGNIFICANCE TEST TABLES

Table E3. Significance Tests for Comparison of Baseline and 12-Month Follow-Up Outcomes: Living Situation, Income and Employment Measures[69,70]

Item description	N for test	Statistical test and test values
Employment	431	Wilcoxon Z = -4.83, p =.000
Income	370	Wilcoxon Z = -4.04, p =.000
Number of dependents relying on them for the majority of their food, shelter, etc.	428	Wilcoxon Z = -6.61, p =.000
Living with someone with A&D problem?	427	McNemar's Chi-Square with continuity correction =16.41, p =.000
Controlled living status (past 30 days) • Jail • Inpatient A&D treatment • Other (sober house, psychiatric treatment, etc.)	 • 431 • 431 • 431	 • McNemar's Chi-Square with continuity correction =19.34, p =.000 • McNemar's Chi-Square with continuity correction =37.50, p =.000 • McNemar's Chi-Square with continuity correction = 10.08, p =.001

Table E4. Significance Tests for Comparison of Baseline and 12-Month Follow-Up Outcomes: Alcohol and Drug Use in the Past 30 Days

Item description	N for test	Statistical test and test values
Abstinent from alcohol use	387	McNemar's Chi-Square with continuity correction =7.56 p =.006
Abstinent from substance use	389	McNemar's Chi-Square with continuity correction =96.99, p =.000
Number of days longest period of abstinence	377	Wilcoxon Z = -7.66, p =.000
Number of days of alcohol use	387	Wilcoxon Z = -2.63, p =.009
Number of days of all illicit drug use	389	Wilcoxon Z = -8.52, p =.000

[69] Due to the highly non-parametric nature of data distributions, non-parametric paired tests were used for all analyses. All tests were conducted in SPSS Version 19. For paired tests of nominal data, McNemar tests were used; when there were too few responses to run a McNemar test, the binomial test was used (see Glantz. (2002). *Primer of biostatistics* (5th ed.). New York: McGraw Hill Medical Publishing Division, pp. 330-333, 219. For paired tests of ordinal or non-normal scale data, the Wilcoxon test was used (Glantz, pp. 354-355). These tests provide more conservative estimates of statistical significance.

[70] Please note that Appendix D table numbers corresponds with table numbers in the main part of the report. For example, the first table in Appendix D (Table D3) corresponds with report Table 3 in the Results section: this is the first table to report significant results for baseline to 12-month survey data.

Item description	N for test	Statistical test and test values
Number of days more than once substance used per day	362	Wilcoxon Z = -5.22, p =.000
The average amount of money spent on: • Alcohol • Drugs	 • 392 • 383	 • Wilcoxon Z = -2.59, p =.010 • Wilcoxon Z = -5.93, p =.000

Table E5. Significance Tests for Comparison of Baseline and 12-Month Follow-Up Outcomes: # of Days Illegal/Non-Prescribed Substances Used in the Past 30 Days

# Days substance used	N for test	Statistical test and test values
Any alcohol use	387	Wilcoxon Z = -2.63, p =.009
Binge drinking (5+drinks in a few hours) [71]	379	Wilcoxon Z = -4.37, p =.000
Alcohol to intoxication	358	Wilcoxon Z = -4.11, p =.000
Cannabis	376	Wilcoxon Z = -7.16, p =.000
Amphetamines/methamphetamine	364	Wilcoxon Z = -4.94, p =.000
Other opiates/painkillers	361	Wilcoxon Z = -2.78, p =.005
Prescription drugs (not prescribed or not for the prescribed purpose)	334	Wilcoxon Z = -2.88, p =.004
Heroin	359	Wilcoxon Z = -2.86, p =.004
Cocaine	358	Wilcoxon Z = -2.26, p =.024
Methadone	359	Wilcoxon Z = -2.31, p =.021
Other sedatives or tranquilizers	358	Wilcoxon Z = -2.85, p =.004
Barbiturates	355	Wilcoxon Z = -2.53, p =.012
Inhalants	355	Wilcoxon Z = -0.67, p =.500
Hallucinogens	354	Wilcoxon Z = -1.34, p =.180
Uses tobacco on a daily basis*	423	McNemar's Chi-Square with continuity correction = 7.55, p =.006

* The possible responses to this item are —yes" and —no."

[71] For one provider (N=25), the definition used at baseline was 5 or more drinks in a day.

Table E6. Significance Tests for Comparison of Baseline and 12-Month Follow-Up Outcomes: Mental Health

Mental health issue	N for test	Statistical test and test values
Experienced serious depression (past 30 days)	430	McNemar's Chi-Square with continuity correction =39.24, p =.000
Experienced serious anxiety (past 30 days)	430	McNemar's Chi-Square with continuity correction =52.41, p =.000
Experienced hallucinations (past 30 days)	431	McNemar's Chi-Square with continuity correction =8.83, p =.003
Experienced trouble understanding, concentrating, or remembering (past 30 days)	425	McNemar's Chi-Square with continuity correction =35.07, p =.000
Experienced trouble controlling violent behavior, including episodes of rage or violence (past 30 days)	430	McNemar's Chi-Square with continuity correction =8.51, p =.004
Experienced serious thoughts of suicide (past 30 days)	430	Binomial test, p =.052
Attempted suicide (past 30 days)	427	Binomial test, p =.250
Been prescribed medication for any psychological or emotional problems (past 30 days)	430	McNemar's Chi-Square with continuity correction =20.38, p =.000
Average # of days experienced any of the above psychological/emotional problems (past 30 days)	213	Wilcoxon Z = -3.55, p =.000
Average # of days participants report experiencing any medical issues (past 30 days)	401	Wilcoxon Z = -1.85, p =.064

Table E7. Significance Tests for Comparison of Baseline and 12-Month Follow-Up Outcomes: Treatment Services

Item description	N for test	Statistical test and test values
Currently receiving substance abuse treatment	432	McNemar's Chi-Square with continuity correction =311.00, p =.000
Tried to access a self-help group (past 30 days)	275	McNemar's Chi-Square with continuity correction =20.38, p =.000
Tried to access outpatient A&D treatment at a community clinic (past 30 days)	295	McNemar's Chi-Square with continuity correction =74.07, p =.000
Tried to access residential A&D treatment at a community clinic (past 30 days)	269	McNemar's Chi-Square with continuity correction =43.86, p =.000
Tried to access detoxification services (past 30 days)	271	McNemar's Chi-Square with continuity correction =25.29, p =.000
Tried to access A&D treatment at a local community hospital (past 30 days)	268	Binomial test, p =.002
Tried to access A&D treatment at a public health clinic (past 30 days)	269	Binomial test, p =.227
Was able to get into above services	33	Binomial test, p =.727
For those who were able to access services, average wait time	3	Wilcoxon Z = -1.07, p =.285
Using medication-assisted therapy for substance abuse	418	Binomial test, p =.263

Table E8. Significance Tests for Comparison of Baseline and 6-Month Follow-Up Outcomes: Criminal Justice Involvement[72]

Item description	N for test	Statistical test and test values
Arrested in the past 30 days	309	McNemar's Chi-Square with continuity correction =25.41, p =.000
For those who were incarcerated in the past 30 days, # of days of incarceration	355	Wilcoxon Z = -5.09, p =.000

[72] Because there were 26 known participants who were incarcerated during some or all of the follow-up period and were unable to be interviewed, the 12-month information in Table 8 is certainly underestimated.

Table E9. Significance Tests for Comparison of Baseline and 12-month Follow-Up Outcomes: Clients' Perceived Outcomes

Item description	N for test	Statistical test and test values
I am not likely to use alcohol and/or other drugs	429	Wilcoxon Z = -3.16, p =.002

Table E10. Significance Tests for Comparison of Baseline and 12-Month Follow-Up Outcomes: Social Connectedness

Item description	N for test	Statistical test and test values
There is someone who cares about whether I am doing better	429	Wilcoxon Z = -1.83, p =.067
I have someone who will help when I have a problem	430	Wilcoxon Z = -2.08, p =.038
I have people in my life who are a positive influence	428	Wilcoxon Z = -0.86, p =.390
The people I care about are supportive of my recovery	422	Wilcoxon Z = -1.80, p =.071
People count on me to help them when they have a problem	427	Wilcoxon Z = -1.24, p =.212
I have friends who are clean and sober	429	Wilcoxon Z = -6.06, p =.000
I have someone who will listen to me when I need to talk	430	Wilcoxon Z = -1.81, p =.071

Table E11. Significance Tests for Comparison of Baseline and 12-Month Follow-Up Outcomes: Clients' Recognition That They May Have a Problem

Item description	N for test	Statistical test and test values
Using alcohol and/or drugs is a problem for me	426	Wilcoxon Z = -7.94, p =.000
I need to work on my problems with alcohol and/or drugs	427	Wilcoxon Z = -10.02, p =.000
Reported having "alcohol problems" in the past 30 days	367	Wilcoxon Z = -3.50, p =.000
Reported having "drug problems" in the past 30 days	353	Wilcoxon Z = -6.32, p =.000

Table E12. Significance Tests for Comparison of 6-Month and 12-Month Follow-Up Outcomes: Client Satisfaction[73]

Item description	N for test	Statistical test and test values
When I needed services right away, I was able to see someone as soon as I wanted	368	Wilcoxon Z = -0.89, p =.373
The people I go to/went to for services spent enough time with me	375	Wilcoxon Z = -1.09, p =.275
I helped to develop my service and treatment goals	374	Wilcoxon Z = -0.89, p =.372
The people I went to for services were sensitive to my cultural background	367	Wilcoxon Z = -0.22, p =.825
I was given information about different services that were available to me	373	Wilcoxon Z = -0.10, p =.917
I was given enough information to effectively handle my problems	373	Wilcoxon Z = -0.34, p =.738
Transportation to and from treatment is convenient	367	Wilcoxon Z = -2.02, p =.044

[73] The comparison is between 6- and 12-month surveys because client satisfaction questions were not asked at baseline.

APPENDIX F: VARIABLES USED IN THE MULTIVARIATE ANALYSES

Variables Used in the Multivariate Analyses

Type of variable	Variable	Notes
Outcome		
	Abstinent from drugs and alcohol at 12 months	Drug abstinence collecting by looking for individuals who reported zero use across all drugs. 0 = No, 1 = Yes
	Abstinent from alcohol at 12 months	0 = No, 1 = Yes
	Abstinent from drugs at 12 months	Drug and alcohol abstinence collecting by looking for individuals who reported zero use across all drugs and alcohol. 0 = No, 1 = Yes
	Unemployed at 12 months	Individuals who reported being unemployed at 12 months for any reason. 0 = No, 1 = Yes
Baseline demographics		
	Gender	
	Mental health issues in past 30 days	Calculated by looking for individuals who answered yes to any questions about mental health symptoms in past 30 days. Individuals who chose not to answer these questions were coded as missing.
	Age in 2010	Computed from year of birth
	Ethnicity	Coded into the following groups: Multiracial, Caucasian, African-American, Hispanic, Native American/Alaskan, Asian/Other
	Income	Overall income from all sources of income
	Physical/sexual/emotional abuse in past 30 days	Calculated by looking for individuals reporting any forms of abuse in past 30 days. Individuals who chose not to answer these questions were coded as missing. 0 = No, 1 = Yes
	Physical health issues	Recoded into yes/no from the question "how many days in the past month have you experienced physical health problems?" 0 = No, 1 = Yes, individuals who chose not to answer were coded as missing

	DUII status	Asked at 6 and 12 months 0 = No, 1 = Yes
	GED status	Highest education attained at baseline 0 = No GED/high school, 1 = Yes GED/high school
	Unemployed	0 = No, 1 = Yes, individuals who did not give their employment status were coded as missing.
	Conflict with social group	Continuous variable expressing how many people individuals report having conflict with. Higher values indicate greater levels of conflict. Individuals who chose not to answer these questions were coded as missing.
	Friends who are sober at baseline and 12 months	Individuals who rated they agree or strongly agree they have friend who are sober both at baseline and again at 12 months. Individuals who did not answer either the baseline or 12 month question were coded as missing.
Treatment items		
	Treatment graduation status	Coded to reflect successful program completion rather than ending services prematurely. 0 = Non successful, 1 = successful, individuals with missing outcomes were coded as missing.
	Number of individual treatment sessions per week	Collapse to reelect the average number of sessions per week to control for individuals being in the program for different lengths of time
	Number of past treatment events	Sum of past drug or alcohol treatment events previous to the current event. Individuals who chose not to answer these questions were coded as missing.

APPENDIX G: LESSONS LEARNED FROM THIS STUDY TO INFORM FUTURE RESEARCH

Lessons Learned to Inform Future Research

This report constitutes the first step toward a product that might be used to guide AMH policy and practice in the months and years to come. Therefore, it is important to reflect upon what has been learned so far. The following points are organized loosely in chronological order.

Working with providers to obtain buy-in – at baseline and throughout the study period

It became clear early on in attempting to recruit treatment providers to participate in this study that the staff time required for training, recruiting participants into the study, and conducting the baseline interviews and discharge summaries was a significant obstacle for agencies already operating in a difficult fiscal environment.

- When at all possible, **funds should be set aside to compensate providers** for their staff time.
- Using **qualitative research tools** with treatment providers to understand the context of their treatment model, their treatment philosophy, and methods may serve both to encourage participation as well as provide needed information about the treatment environment.

A related issue to obtaining treatment agency buy-in is fostering a sense of accountability on the part of providers. For example, to be able to report each provider's own results back to them, a sufficient number of participants from each provider are required so as not to breach confidentiality. Because of the small numbers of clients obtained from some agencies, giving providers anything more than very basic data would constitute a breach of participant confidentiality (e.g., the referred two cocaine users who both continued using).

- A specialized, **hands-on and user-friendly training for providers** on how research and evaluation can be valuable both for program improvement, advocacy, and for obtaining new funding could prove an important way to increase buy-in, accountability, and increased numbers of participants in future studies.

Tracking clients

Undoubtedly, tracking substance abuse treatment clients—particularly ones involved with the criminal justice system—can be challenging. Providers were asked to fill out locator forms with contact information both for the study participants, but also for friends, family, and others who might know the whereabouts of clients at follow-up. Data collectors relied heavily upon these locator forms for contacting participants to schedule follow-up interviews. Due in part to the demands on provider staff time and/or the fact that many clients simply did not have good contact information, the locator forms often had little or no actionable telephone numbers or addresses for clients; this made following-up with some participants all but impossible.

- Again, **compensating treatment providers** for their time might resolve this issue, as would **providing more generous incentives for individual study participants** who complete the follow-up interviews. The ten dollars allocated for the AMH study follow-up interviews is quite low for such incentives.

- Further **training for providers as to the importance of locator forms** might also be useful.[74]

Related to the issue of provider buy-in, successfully tracking clients, and ensuring client confidentiality, is the question of who should complete enrollment into a study of this type.

- Having an **impartial research organization with trained research staff** conduct the baseline data collection would certainly be more costly; however, it would also result in less missing data, better locator information and the ability for research staff to establish relationships with study participants early on that might lead to more honest responses to questions about socially-proscribed behavior.

Future study of DUII treatment

The dearth of past studies specifically relating to DUII treatment, as well as the results of this study, indicate that DUII clients behave differently than other clients in the study.

- Future research which takes a closer look at **DUII treatment effectiveness** would be very useful to help inform state policies on DUII treatment. Such a study might involve more qualitative data on DUII treatment curricula, including materials review, interviews with treatment staff and clients, observation of treatment groups, etc. It would be very interesting to compare those treatment providers who separate DUII clients from other addictions/dependency clients and those who do not.
- Furthermore, the current sample of DUII clients tended to use alcohol throughout the study period, but we have no information about whether their drinking/using and driving behavior changed. Adding questions to explore **the extent to which DUII clients refrain from drinking/using and driving** (and if not, why not) would be an important area of clarification.

Future study of substance abuse / addictions treatment

- In addition, the amount of variability explained by the multivariate models was medium to low. This suggests other unifying variables which may help to predict outcomes and improve treatment. One possible variable which has been shown to assist in predicting outcomes across groups is the stages-of-change model (e.g., Prochaska et al, 1992). It may be useful to add a **stages of change questionnaire** to initial screening instruments – both to help program managers better match program participants to the treatment model – and to generate more predictive analytical models.
- Individuals involved in substance abuse treatment or DUII treatment may struggle to find ways to describe their experiences as well as what they feel their treatment needs are and may find themselves marginalized due to socioeconomic status, ethnicity, drug use, or other factors. It may be useful for future evaluators to examine research paradigms from the **Participatory Action Research** field (e.g., Whyte, 1991) where client involvement is integrated into the research process, helping to obtain input from voices that are not typically heard and helping to pose research hypotheses which may not be apparent to academic researchers.

[74] Please note that NPC staff did follow up with treatment provider staff to help complete missing intake forms, including the locator form, and were more successful with some providers than others.

- Program completion status (e.g., successful graduation as opposed to early withdrawal) was not found to be significant in final regression questions. Nevertheless, attention should be paid to the fact that **individuals had different number of treatment sessions, different proportions of individual vs. group sessions, different program length of stays, and different program outcomes.** It may be useful in the future to gather additional formative evaluation data on programmatic experience in other to better understand the relationship between baseline measures such as readiness to change and amount of program involvement.
- One of the most common elements of substance abuse treatment **aftercare** is self-help group attendance. In this sample, the proportion of participants who reported attending self-help groups at 6 and 12 months was linked to whether they were still in treatment. At 6 months, 82% of participants still in treatment reported attending self-help groups and 78% of those in treatment at 12 months were attending self-help groups. Conversely, of the participants who were *not* in treatment at both 6 and 12 months, 34% reported attending self-help groups. Further exploring why self-help groups ~~"s~~tick" for some treatment clients and not others after treatment is important. If self-help groups are the only form of aftercare, and one third of study participants were not making use of such groups, then other strategies may be needed.
- The data collected and analyzed as part of this study are just one important piece of the puzzle about treatment effectiveness. To really understand what types of treatment work best for what types of clients, in depth **qualitative research** is needed. For example, a content analysis of the various treatment curricula, interviews with treatment staff and clients, observation of treatment groups, treatment model fidelity measurement, etc., would all help unlock the ~~"b~~lack box" of treatment.
- From a policy standpoint, it would be extremely valuable to conduct a **cost-benefit analysis for alcohol and drug treatment**. What does it cost to provide treatment services and what are the costs (criminal recidivism, foster care, court costs, healthcare, early death, etc.) to society of not providing such services? Such a study design would be challenging: the ideal would be important to find a sample of people who did not receive treatment services, but were otherwise similar to those who did receive services.

Opportunities for future research using these data and existing administrative databases

There are some very exciting ways that the data from this study can be further explored in the coming months and years.

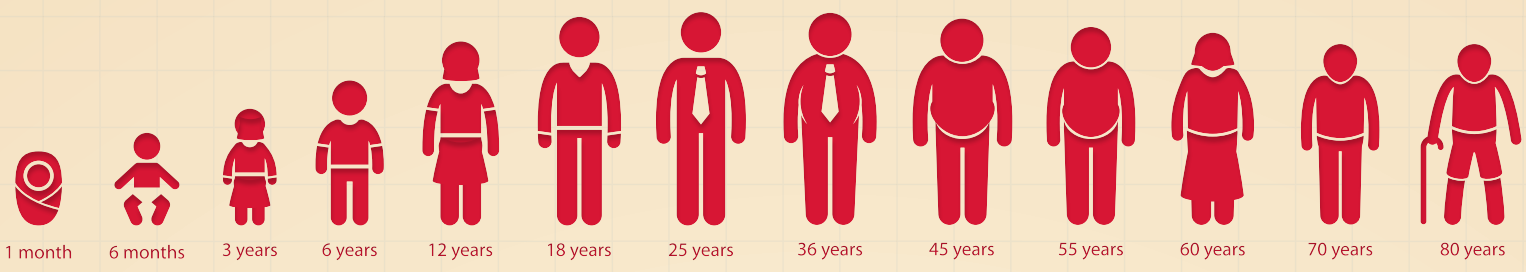
- This study has established a **methodology** for follow-up which future longitudinal projects can use to build from this project by linking these data to other state administrative databases. The aim would be to explore more deeply to understand how to produce better outcomes thereby supporting data-driven decision- and policy-making. There are several databases that could potentially be linked to the AMH study database. **Linking these datasets together** and exploring them with an eye to determining the more far-reaching impact of publicly funded substance abuse treatment will be a major contribution to the ongoing conversations about budget priorities and data driven decision making in Oregon. For example:

- **OHP data for medical utilization** can be linked with AMH follow-up study data to examine whether substance abuse treatment helped to reduce medical system utilization;
- **Criminal justice system data** can be linked to gain objective information about whether treatment resulted in decreased criminal recidivism;
- **Statewide treatment data** contains information about drug testing that can be linked with these data to explore more objective information (than self-report) about substance use; and
- **Child welfare system data** can be linked to find out how many participants lost custody of their children—or, more happily, were reunited with them.

- AMH itself has quite a large, longitudinal database (the Client Processing and Monitoring System and, its successor, the Web Infrastructure for Treatment Services system) that can be used to probe issues important to Oregon policy makers and citizens. **Funding exists for data analysis**, especially from the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute on Drug Abuse (NIDA), etc. Seeking funding for additional research with Oregon's own data to answer Oregon's specific questions would be an important step toward answering some of the questions raised by this study.

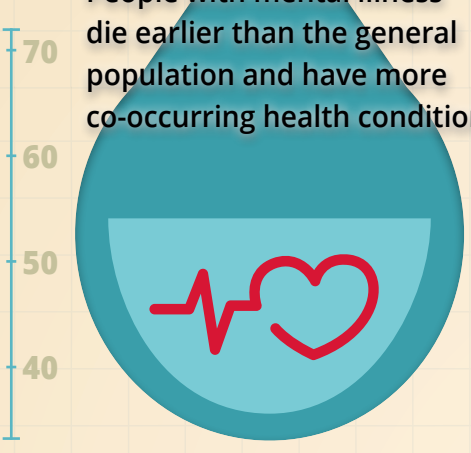
CAN WE LIVE LONGER?

Integrated Healthcare's Promise



The PROBLEM

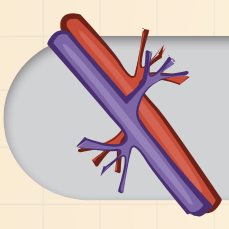
People with mental illness die earlier than the general population and have more co-occurring health conditions.



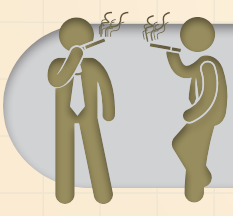
68% of adults with a mental illness have one or more chronic physical conditions

more than **1 in 5** adults with mental illness have a co-occurring substance use disorder

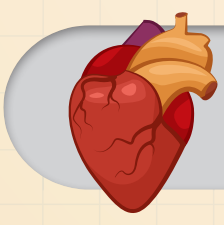
Co-occurrence between mental illness and other chronic health conditions:



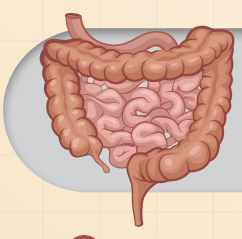
	Mental Illness	No Mental Illness
High Blood Pressure	21.9%	18.8%



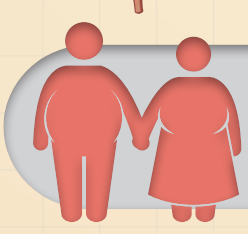
	Mental Illness	No Mental Illness
Smoking	36%	21%



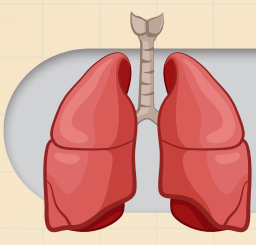
	Mental Illness	No Mental Illness
Heart Disease	5.9%	4.2%



	Mental Illness	No Mental Illness
Diabetes	7.9%	6.6%

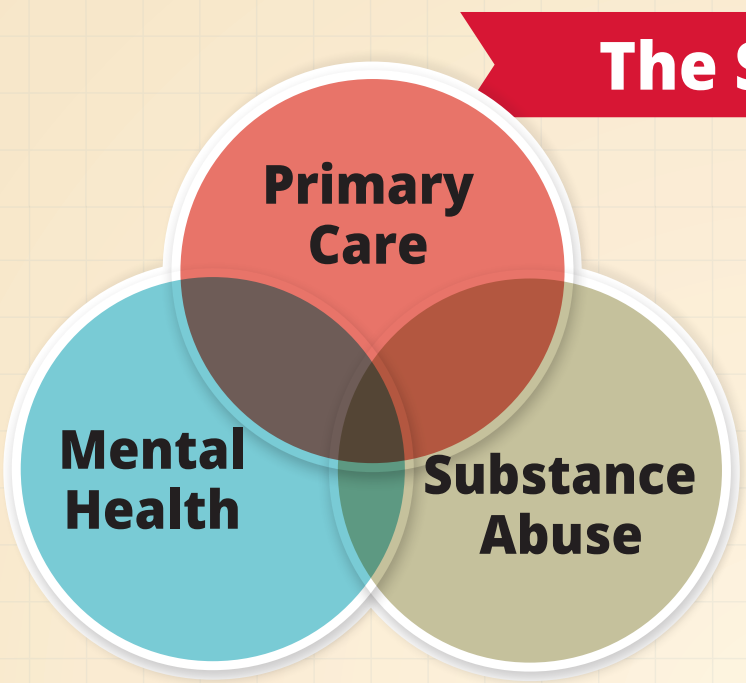


	Mental Illness	No Mental Illness
Obesity	42%	35%



	Mental Illness	No Mental Illness
Asthma	15.7%	10.6%

The SOLUTION



The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services.

Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.

INTEGRATION WORKS

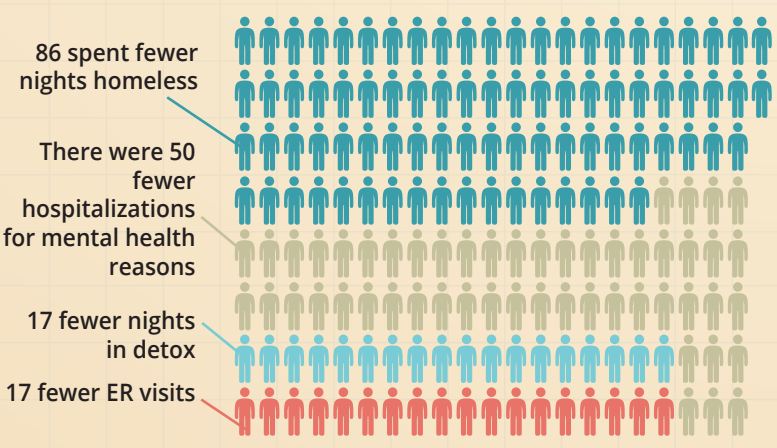
Community-based addiction treatment can lead to...

- **35%** in inpatient costs
- **39%** in ER cost
- **26%** in total medical cost

Reduce Risk ➡ Reduce Heart Disease
(for people with mental illnesses)

Maintenance of ideal body weight (BMI = 18.5 – 25)	=	35%-55% decrease in risk of cardiovascular disease
Maintenance of active lifestyle (~30 min walk daily)	=	35%-55% decrease in risk of cardiovascular disease
Quit Smoking	=	50% decrease in risk of cardiovascular disease

One integration program* enrolled 170 people with mental illness. After one year in the program, in one month:



This is **$213,000** of savings per month.

That's **$2,500,000** in savings over the year.

Integration works.
It improves lives.
It saves lives.
And it reduces healthcare costs.

SAMHSA-HRSA
Center for Integrated Health Solutions

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
Healthy Minds. Strong Communities.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov 1-877-SAMHSA-7 (1-877-726-4727)

www.integration.samhsa.gov

1 in 5 Who Do You Know?

PEOPLE HAVE A MENTAL ILLNESS OR ADDICTION

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Heritage Behavioral Health Center, based on data in...
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* A grantee of the Substance Abuse and Mental Health Services Administration's Primary and Behavioral Health Care Integration program.