



**Arizona
Methamphetamine
Treatment Centers
of Excellence**

Program Manual



**Applied Behavioral
Health Policy**

**Arizona State University
College of Human Services**

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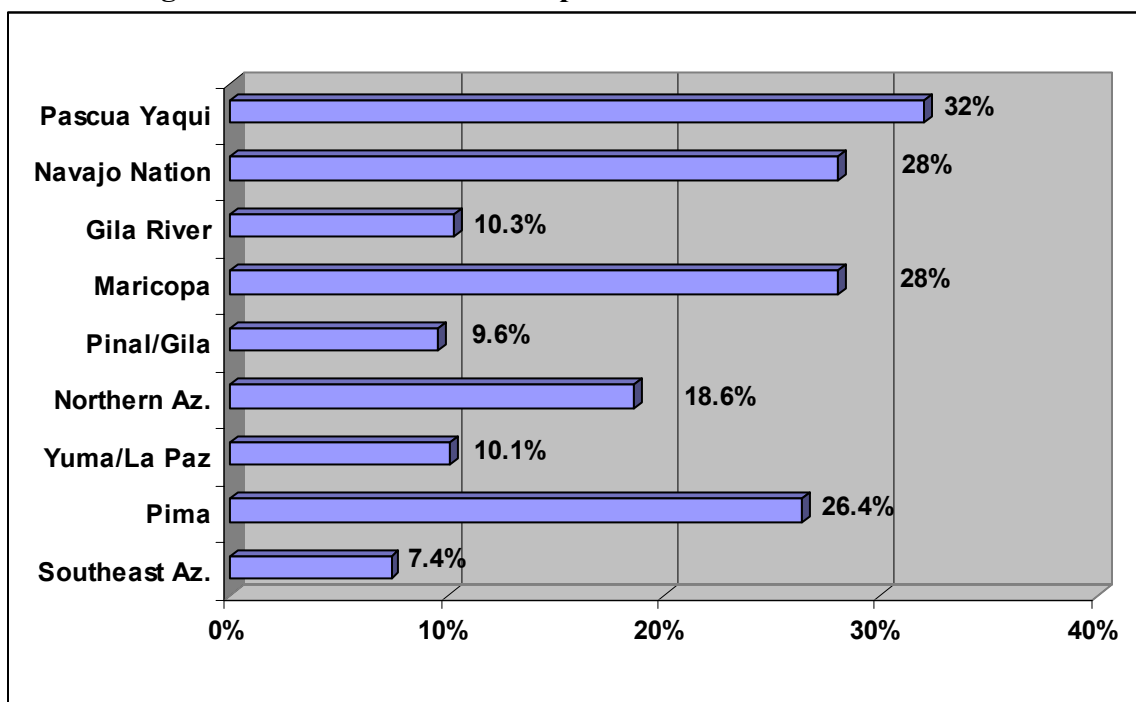
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1. Introduction

RISE IN METHAMPHETAMINE AND JUSTIFICATION FOR THE CENTERS OF EXCELLENCE

Methamphetamine abuse has emerged as the second leading cause of admissions to substance abuse treatment in Arizona, rising from 11% to 24% of all admissions between 2002 and 2003. In 2004, one in four persons receiving substance abuse treatment reported methamphetamine as the primary substance used. Methamphetamine is a primary drug threat to Arizona. High purity, low cost methamphetamine is readily available, and the drug is abused throughout the state. Crystal methamphetamine is becoming increasingly available throughout Arizona; some areas report higher levels of abuse of crystal methamphetamine than powdered methamphetamine. Smoking and snorting the drug are most common routes of administration within the state.

Regional Prevalence of Methamphetamine Use Disorder – FY 2005



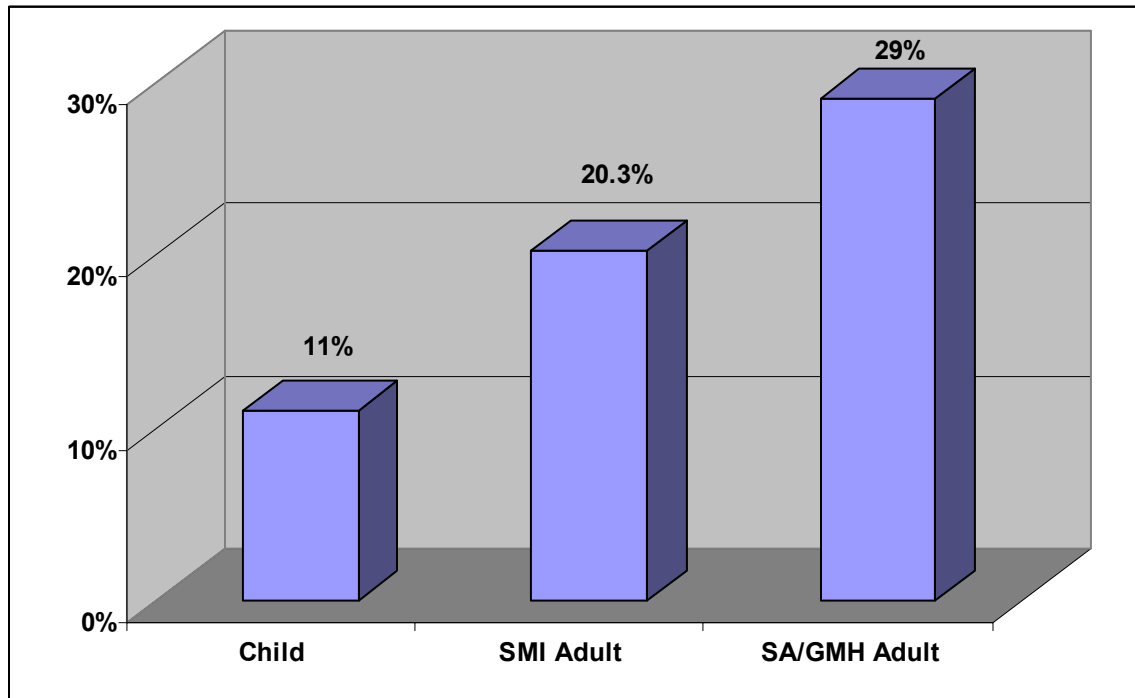
Source: ADHS 2005

In response to the National Drug Intelligence Center (NDIC) National Drug Threat Survey (NDTS) 2002, 29 of the 36 law enforcement respondents in Arizona who rated the levels of methamphetamine abuse in their jurisdictions reported high levels of abuse and six reported medium abuse levels. Arizona Department of Health Services reports that stimulant use disorders accounted for a leading cause of admissions to substance abuse treatment between 2002 and 2005. Methamphetamine rose from one in 10 (11%), to one in four (26%) of all admissions for alcohol and drug treatment¹. Of the 24 Arizona treatment providers interviewed

¹ Arizona Department of Health Services. Division of Behavioral Health. Annual Report on Substance Abuse Treatment Programs - 2005. Phoenix, AZ. December 2005.

in a study by the Office of National Drug Control Policy, 71 percent felt that methamphetamine use was up in their area, overwhelmingly (72%) because it is cheap and/or available. While alcohol (46%) and cocaine (17%) are the primary drugs of abuse at entry in most programs, methamphetamine (13%) ranks third in Arizona. In addition, these programs report an average of 40 percent of their clientele using methamphetamine at entry.

Prevalence of Methamphetamine Use Disorder by RBHA Population – FY 2005



Source: ADHS 2005

Major trends and key characteristics of methamphetamine use include:

- Methamphetamine is a major problem throughout the RBHA-funded treatment system. With the exception of CPSA, most areas of the state report methamphetamine use between 20-30%.
- Families referred by Child Protective Services represent a leading methamphetamine risk group. Methamphetamine is the single most common substance reported at admission among parents referred through the Arizona Families FIRST program. In 2003-2004, 40% of parents enrolled in AFF reported methamphetamine as their primary substance problem, followed by alcohol (32%) and marijuana (26%).
- Proportionately, use of methamphetamine among CPS parents is higher in more rural areas of the state. The range for Maricopa and Pima counties in 2003 was 28-40%, compared with 47-76% in all other areas.
- Women and adolescent girls in the treatment system use methamphetamine at the same levels as men and adolescent males. This differs from patterns seen for alcohol and marijuana where use by males is significantly higher than for females.
- Youth and young adults age 12-24 comprised 53% of total statewide admissions for methamphetamine in 2002.

- Methamphetamine accounts for a growing number of deaths among persons with Serious Mental Illness according to mortality reports submitted to DBHS.
- Arizona's reservations are particularly hard hit and lack a service system infrastructure to effectively prevention and treat methamphetamine abuse in tribal communities.

EVIDENCE BASED TREATMENT MODELS

The National Institute on Drug Abuse and the U.S. Center for Substance Abuse Treatment have identified several evidence-based practices with efficacy for treating methamphetamine abuse/dependence, including statistically significant reductions in drug use. The models are cognitive-behavioral, involve medications for co-occurring mental health symptoms and routine urine monitoring, and are designed for both residential and outpatient settings:

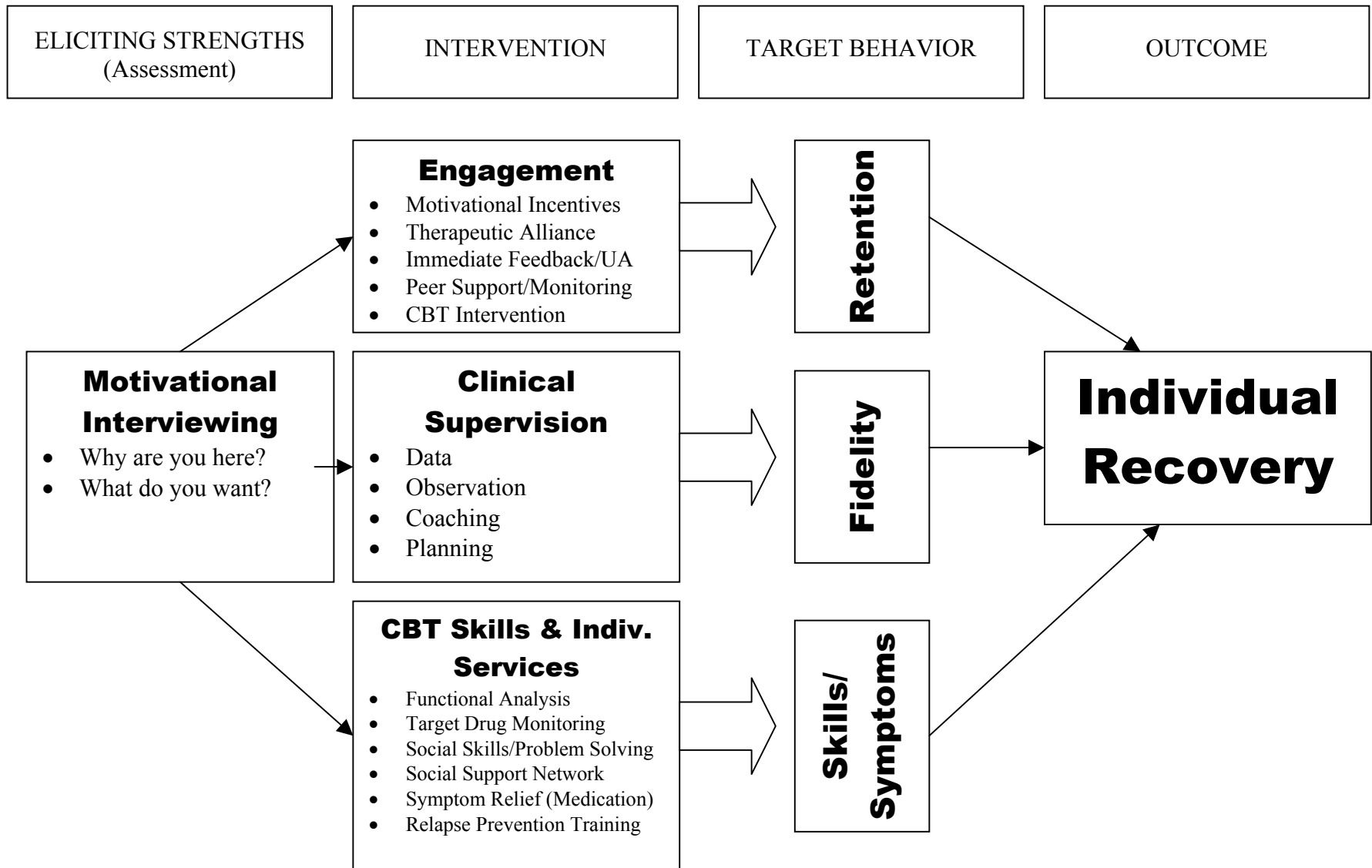
- Matrix Model
- Community Reinforcement Approach
- Day Treatment with Abstinence Contingency Management

In addition, companion studies indicate that methamphetamine abuse treatment delivered involuntarily (e.g., through a drug court) is as effective as voluntary treatment and instills a level of reinforcement needed for long-term treatment participation that could be enabled by the Centers of Excellence.

GOALS, EXPECTATIONS, AND ASSUMPTIONS OF THE CENTERS OF EXCELLENCE

Arizona's Methamphetamine Treatment Centers for Excellence Initiative is a focused approach for implementing evidence-based practices in the treatment of clients with methamphetamine use disorders. The Centers are a set of interwoven best practices and technologies with demonstrated efficacy in improving client retention in treatment, instilling necessary skill competence and social support to overcome cravings to use methamphetamine and providing the foundations for long-term substance abstinence and recovery. The Centers are grounded in Arizona's individualized, strengths-based assessment and service planning approach and use specific, targeted strategies to capitalize on these elements in the delivery of treatment services. The program model on the following page outlines interventions advocated by the Methamphetamine Treatment Centers for Excellence Initiative to assist in an individualized recovery plan for each client.

Program Model



The Center’s model draws upon a base of scientific knowledge gathered across dozens of studies conducted over a period of 30 years:

- **Retention is Critical.** Substance abuse treatment is only effective in reducing long-term drug use when clients remain in services long enough to receive a threshold “dose.” Most studies identify the threshold dose at 90 days (three months). The longer clients remain in contact with supportive, recovery-oriented services (which can include treatment), the stronger the measured outcome.
- **The Power of Hope.** Clients will not remain in services if treatment is not meaningful to them. The challenge of substance abuse treatment is to provide a vision of an alternative future that is powerful enough to overcome physical craving, entrenched lifestyles and psychological desires, along with the specific skills and individual competencies needed to make progress toward that vision. For most clients at one time or another, the ability to clearly see the possibility of an alternative future and to believe they are capable (competent) to achieve it hangs by the thinnest of threads.

Program components that build on hope – including use of peer coaches, providing evidence of progress through skill testing, role playing or therapeutic UA and emphasizing the therapeutic alliance between patient and practitioner as the key foundation of treatment – are essential to successful outcomes.

- **Fostering Resilience.** “Resilience” is defined as the quality of buoyancy or flexibility. Resilience describes the ability of humans to bounce back following setbacks or to overcome a significant period of negative or traumatic life conditions. In the therapeutic context, resilience is fostered through providing a safe setting for resolution of painful and shaming personal actions committed under the influence of drugs and strategic use of “teachable moments,” such as substance relapse, to further hone individual skills and competencies.

Substance use disorder treatment that effectively instills and capitalizes on hope and individual resiliency will engage and retain clients in treatment. These qualities are fostered only in a treatment environment that itself embodies the qualities of hope and resiliency and that operates in a non-punitive, non-judgmental manner.

STATUTORY AND FUNDING AUTHORITY FOR THE CENTERS OF EXCELLENCE INITIATIVE

The Arizona Department of Health Services is the Single State Authority for substance abuse and mental health services in Arizona. The ADHS Division of Behavioral Health administers a comprehensive community system of prevention, treatment and recovery services through contracts with Regional and Tribal Behavioral Health Authorities.

The Centers for Excellence Initiative is managed by the Division of Clinical and Recovery Support Services within ADHS/DBHS under the direction of the Division Chief and the ADHS Deputy Director. Operational oversight is vested with the DBHS Best Practice Oversight Committee.

2005-2006 Implementation Activities

- Select RBHA and tribal sites and identify financing by November 2005.
- Implement a selected evidence based model for methamphetamine treatment for one or more target populations (e.g., adult, youth) by January 2006.
- Develop/construct necessary facilities and settings to provide services in alignment with the evidence based model (scope, duration, intensity) by July 2006.
- Measure outcomes of the intervention beginning March 2006.
- Create routine feedback sessions for Clinical Supervisors to assist with local adaptation of the model for cultural relevance to the target communities and overall refinement of the approach and specific practices by March 2006.
- Build expertise around the identified evidence based model and train other providers on this model within the RBHA region by December 2006.

Role of Best Practice Oversight Committee

- Identify, promote and institute science-based effective treatment services.
- Make recommendations regarding Arizona's implementation of treatment models and help define the scope and model of the Centers for Excellence.
- Developing a technical assistance document on treating Methamphetamine Abuse/Dependence.
- Develop training for first responders using the successful CIT model.
- Establish seed funding to support evidence based treatment in the community.

Best Practice Guidelines for Treating Clients with Stimulant Use Disorders	
Source: Treatment Improvement Protocol 33: Treatment for Stimulant Use Disorders	
<i>Make treatment accessible</i>	<i>Keep initial assessments brief</i>
To maximize treatment engagement, programs must make treatment accessible. Having treatment programs in areas convenient to clients is associated with lower attrition rates. Treatment should be provided during the hours and on the days that are convenient for clients. Programs should be located near public transportation and in a part of town viewed as safe for evening visits.	Initial assessments should be brief, focused, and nonrepetitive.
<i>Provide support for treatment participation</i>	<i>Provide clear orientations</i>
Address clients' concrete needs, including transportation, housing, and finances. Some logistical barriers can be overcome by onsite services, through agreements with subcontractors, or by referrals. These can include onsite childcare services, referrals to temporary shelters, vouchers for lunches, targeted financial assistance, assistance with paperwork regarding insurance, or filing for disability benefits.	Individuals need a thorough, clear, and realistic orientation about stimulant use disorder treatment. Clients should acquire a good understanding about the treatment process, the rules of the treatment program, expectations about their participation, and what they can expect the program to do for them and in what time frame. (2)
<i>Respond quickly and positively to initial telephone inquiries</i>	<i>Offer clients options</i>
Because ambivalence about treatment is common among treatment-seeking stimulant users, methods to "screen out" those who are "in denial" are counterproductive and impede treatment entry. (2) The initial interview should be scheduled within 24 hours after the client initially contacts the program.	Addiction treatment is more effective when a client chooses it from among alternatives than when it is assigned as the only option. Thus, it is important to provide clients with options and negotiate with them regarding the treatment approaches and strategies that are the most acceptable and promising.
<i>Convey empathetic concern</i>	<i>Involve significant others</i>
Counselors should be warm, friendly, engaging, empathetic, straightforward, and non-judgmental. Authoritarian and confrontational behavior by the staff can substantially increase the potential for violence.	Whenever possible, family and significant others who support the treatment goals should be involved in the treatment process.

2. Key Components of an Effective Treatment Program for Methamphetamine Users

While research on the effective treatment of persons with active methamphetamine use disorders is limited, there is ample evidence of the effectiveness of treatment approaches for persons with cocaine use disorders. In fact, the MATRIX treatment model for persons with methamphetamine use disorders (Obert, McCann, & Rawson) was originally developed in the 1980's primarily to treat individuals with cocaine use disorders; as these clinical researchers developed their program, they found wide applicability to individuals with methamphetamine use disorders. As summarized in the preceding section and in SAMHSA's TIP 33, there are a number of treatment approaches that have been demonstrated, under the rigors of clinical trial research studies to be effective in the treatment of stimulant use disorders in general, other treatment approaches that have been documented either in the treatment of stimulant use disorders in general or methamphetamine use disorders in particular, with still other treatment approaches that show promise in the treatment of stimulant use disorders. It is important to recognize that while there are a host psychosocial interventions that have either been documented and/or tested in the treatment of methamphetamine use disorders, there are no known pharmacological interventions with demonstrated agonist or antagonist effects for the treatment of methamphetamine use disorders. Nonetheless, best practice would suggest a comprehensive and coordinated approach of both psychosocial and pharmacological interventions in the treatment of methamphetamine use disorders, with pharmacological interventions primarily targeting the likely depressive symptomology evidenced during early withdrawal and abstinence.

Based upon the existent clinical research information on the treatment of methamphetamine use disorders, the Arizona Methamphetamine Treatment Centers of Excellence Initiative was developed to ensure the development, implementation, and sustained provision of a comprehensive and coordinated approach to meeting the needs of individuals experiencing methamphetamine use disorders that is reflective of current, evidence-based practice in addiction treatment. Rather than mandating a specific treatment model (e.g., Matrix), this initiative was designed to provide for local variation and creativity with unique treatment settings while ensuring the provision of treatment elements demonstrated to be effective in a wide variety of settings and across a diverse range of client groups. The Arizona Methamphetamine Treatment Centers of Excellence Initiative requires that all participating program deliver their treatment services in a manner that includes formal, structured provision of the following treatment components:

- Cognitive Behavioral Treatment
- Therapeutic Urinalysis
- Motivational Incentives/Contingency Management
- Motivational Interviewing/Non-Confrontational Approaches for Promoting Client Engagement

Each component is described briefly below.

COGNITIVE BEHAVIORAL TREATMENT

Programs are expected to develop and implement a structured, skills based, group counseling treatment model that is consistent with the tenets of social learning theory and cognitive behavioral therapy. The cognitive behavioral paradigm assumes that thinking, feeling, and doing are separate realms of the human process that became associated through learning.

Methamphetamine use, like any other behavior, can be linked with thoughts, feelings, and other behaviors through direct experience or through observation. When they are strong enough, these associations can then serve as “triggers” (or antecedents) that serve to cue the individual or stimulate their desire (positively reward or consequence) to use, even while the person is planning to, or has already stopped using

methamphetamine. By assuming a cognitive behavioral orientation to treatment, we must then first begin by helping clients to identify, catalogue and understand the flood of thoughts, feelings, and actions that are associated with their use of methamphetamine. In this orientation, CBT helps clients to develop the skills to better understand

Using a structured functional analysis worksheet can help clients identify the feelings, thoughts, and behaviors occurring before, during, and after their use of methamphetamine. Counselors must be comfortable in eliciting this information in a non-judgmental, understanding, and supportive manner.

their methamphetamine use through a process known as **functional analysis** – assisting clients to identify the antecedent and consequent thoughts, feelings and behaviors associated with their use of methamphetamine.

A second theoretical assumption of a CBT orientation is that once identified, clients can be taught alternative strategies for managing and controlling the feelings, thoughts and behaviors associated with their methamphetamine use into more healthy and socially appropriate means. The major thrust of CBT then is to teach clients both alternative coping skills and alternative strategies for accessing the consequences that methamphetamine use previously provided. The therapist that ascribes to this orientation often takes on more of a role of coach or teacher wherein the facilitation of the counselor is directed toward assisting clients comprehend coping skills. Through the use of experiential teachings methods, such as modeling and role playing within the context of individual or group counseling sessions and the assignment of behavioral skill rehearsal homework, therapists help clients to practice, refine and internalize skills that are social appropriate and functional in dealing with specific antecedent situations and accessing consequences for which methamphetamine was previously used. In this approach, the therapist is not viewed as an expert, but rather a consultant and ally who appreciates the difficulty of balancing personal emotions and ambiguous social demands and is prepared to share ideas about how to teach both.

Therapeutic Urinalysis

The use of urinalysis is not new to the substance abuse treatment community. Indeed, within the state of Arizona, like most states in the country, urine testing, or some other form of psychological assessment for substance use is fairly common among clients attending substance abuse treatment programs. Unfortunately, the use of urinalysis is typically restricted to court mandated clients with the results of the tests being required by order of the court and often used

as a basis for increasing sanctions against the client. Ironically, much of the most recent literature regarding best practice in addiction treatment calls for the use of urinalysis as a central element to the treatment program with the subsequent test results being used not to sanction or punish the client, but rather to reward and celebrate with the client continuing periods of abstinence. We use the term *therapeutic urinalysis* to describe this important element in the Arizona Methamphetamine Treatment Centers of Excellence Initiative. It is expected that all participating programs will implement a therapeutic approach to urinalysis as a central element of their program. To be considered a therapeutic approach to drug testing, a number of characteristics need to be in place. First, the testing and analysis of the test must be done on site at the clinic setting. Sending samples off to a laboratory for analysis is not appropriate. Clients need to have immediate feedback and the clinician needs to be able to alter her approach with the client in response to the test results. Second, test results that indicate continuing use cannot be used as a basis to sanction or punish the client. The use of such test results to provide increased justice systems sanction, or to suspend or terminate a client from program participation is not appropriate. In contrast, the use of test results to review continuing use patterns or to revisit functional analyses or relapse prevention plans is appropriate. In short, the use of test results should be used as a point of therapeutic intervention, providing an opportunity for counseling and teaching, regardless of the result. Third, test results should be used to celebrate with the client clinical achievements. For the client with negative test results (reflecting non use), opportunities to congratulate, reward, or celebrate with the client continuing steps on the road to recovery abound. Fourth, test results must be random scheduled and frequent. Best practice literature suggests that more frequent testing (at least twice weekly) is essential early in the treatment sequence and that such testing should be present throughout the duration of a treatment program.

MOTIVATIONAL INCENTIVES/CONTINGENCY MANAGEMENT

Contingency management or motivational incentives is a behavior reinforcement intervention that can effectively motivate clients and facilitate positive changes in their behavior. When considered as a group, contingency management interventions have by far the greatest amount of empirical support for their efficacy in promoting therapeutic behavioral change among stimulant users.

The success of motivational incentives depends greatly on several principles. First, clinicians must arrange for regular and consistent drug use screening to ensure that the patient's use of the targeted substance is readily detected. Ideally, observed urine screening should occur most frequently during initial treatment. Consistent and immediate reinforcement results in the greatest motivation for behavior change. A clinician's initial instinct may be to reward patients only when they demonstrate complete abstinence. The greatest benefit in motivational incentives is achieved in rewarding the small steps that lead to the desired behavior. Targeting a single drug at a time helps the client achieve initial success that may promote further motivation to abstain from secondary drugs as well.

The second principle of motivational incentives is that reinforcers (prizes, vouchers, clinic privileges) should be agreed upon by both the clinician and the client as something that will

motivate the client. There is little motivation in receiving something that you don't want or will not be of any benefit to you. Choose prizes or incentives that are meaningful to your client population, and communicate ahead of time that this will be the result of achieving the desired behavior (e.g., abstinence, treatment attendance, steps toward employment goals). Behaviors must be identified that can be quantified objectively. These can include behaviors such as acting appropriately in a group session, taking steps toward improving interpersonal difficulties, meeting regularly with the parole officer as mandated, or actively pursuing employment.

Optimally, clinicians should conduct a needs assessment with their client to determine appropriate goal-reinforcing activities. One goal may be to acquire gainful employment. Activities that reinforce this final goal might include circling jobs in the newspaper, making three phone calls to employers, attending two job interviews. Rather than simply rewarding a final goal outcome (e.g., gaining employment), clients should be encouraged at various steps along the way, such as compiling a resume or making a list of employment options from the newspaper classified advertising. In other words, you can give a client a token, a clinic privilege, or a gift certificate whenever she or he tests negative for drugs or displays a behavior that you want to reinforce.

Finally, the clinician should assist the patient in establishing alternate and healthier activities to compete with the reinforcement derived from the alcohol or other drug. It is important to help your patients experience the inherent rewards of an alcohol- or drug-free lifestyle to overcome the previous chemical rewards provided by the substance. Without an acceptable or better substitute, patients will likely revert to the behavior that provided the greatest reward for them.

Research has shown that motivational incentives reinforce not only abstinence, but other treatment goals as well. Patients stay in treatment longer when they are motivated to attend sessions, giving the treatment protocol a better opportunity to engage the patient. In one program, only 40% of patients receiving standard treatment completed the 24-week treatment, whereas, seventy-five percent of those patients receiving vouchers for attending sessions remained in treatment for 24 weeks. It is in light of such overwhelming evidence that contingency management was included as a core treatment element of the Arizona Methamphetamine Treatment Centers of Excellence Initiative. It is an expectation that all participating programs will have in place a formalized program of contingency management that adheres to the best practice guidelines for such use (Petry & Stitzer, 2002).

MOTIVATIONAL INTERVIEWING

There are several approaches to treating alcohol and drug problems that researchers have demonstrated to be effective but are yet to be widely used in practice (Miller, et al., 1995). One such approach is motivational interviewing, a style that counselors can use to facilitate clients addressing their ambivalence and reluctance to change their use of alcohol or drugs. The approach uses a model of change that describes how a client might progress through several stages and uses a variety of ways to produce that progress at different stages (Prochaska, DiClemente, & Norcross, 1992). The counselor can conceptualize motivation as a key behavior that is malleable and susceptible to influence. In contrast to a more traditional perspective about

substance abuse, the counselor using motivational interviewing thinks about motivation as a state of readiness or eagerness to change, which can fluctuate over time and from one situation to another. Miller and Rollnick (1991) articulate five principles with which the counselor guides his or her conversation with a client: expressing empathy, developing discrepancy, avoiding arguing, rolling with resistance, and supporting self-efficacy. Miller and Rollnick (2002) describe practical approaches for increasing motivation for clients who are at various stages of change. The overall goal is to have the client identify the reasons to change and take steps toward adjusting his or her substance use.

There is good evidence that this approach, which is one of several brief treatments, is effective. In Miller, et al.'s review (1995), motivational interviewing receives the third highest score for effectiveness out of some 30 different approaches. In a large multi-site comparison study of treatments for alcohol problems (Project MATCH Research Group, 1997), motivational interviewing was found to be as effective as the other two treatment approaches even though they required three times as many client contact hours. A review found nine of eleven clinical trials of motivational interviewing more effective than no treatment, standard care, extended treatment, or being on a waiting list before receiving an intervention (Noonan and Moyers, 1997). Motivational interviewing has been found to enhance the improvement substance abusers experience in outpatient settings (Bien, Miller & Boroughs, 1993) and inpatient settings (Brown & Miller, 1993).

Motivational interviewing has been characterized as easy for counselors to watch but difficult for counselors to replicate. Counselors who are learning motivational interviewing in workshops will report increases in knowledge and skill and yet not demonstrate MI with actual clients.

There are several published evaluations of the effectiveness of training on motivational interviewing. Rubel, Sobell, and Miller (2000) found that counselors increased their knowledge and application of motivational interviewing skills after participating in a continuing education program. Doctors and nurses reported using and finding useful the skills they learned, in formal training sessions, to enhance diabetic patients' motivation for self-care (Stott, Rees, Rollnick, Pill & Hackett, 1996). Nursing students were able to demonstrate improved communication and beginning motivational interviewing skills after studying a problem-based learning package and practicing with a simulated patient (Arthur, 1999). Miller and Mount (2001) found improved motivational interviewing skills immediately after a two-day training but four months later the counselors were more similar to how they were prior to the training than to the desired goals of motivational interviewing.

3. The Role of Clinical Supervision to Ensure Program Fidelity

CLINICAL SUPERVISION, CLINICAL LEADERSHIP AND PROGRAM FIDELITY

Ensuring that clients are provided with a comprehensive and coordinated program of treatment services that are consistent with best practices in the treatment of substance use disorders in general and methamphetamine use disorders in particular, will require at least four critical elements. First, programs must have in place solid clinical leadership and clinical supervision to provide mentoring, monitoring, supervision, and ongoing instruction and support to their clinicians and therapists. Clinical leaders and clinical supervisors need to be provided the space (i.e., time and release from other duties and responsibilities) to provide individualized supervision and support to their clinicians and other therapeutic and support staff. Second, clinical leadership must be attentive to, and supportive of, ensuring the fluid and dynamic process of ongoing assessment leading to a recovery focused and strengths based approach to treatment planning and services coordination. Clinicians and clinical teams must be supported to individualize and modify the type, intensity, and nature of treatment and services provided to clients based upon changing needs. Third, clinicians need to be provided with competency-based training related to the provision of specific approaches to client engagement and implementation of evidenced based practice along with formal agency guidelines and expectations within the form of a written treatment manual and program guide. Fourth, clinical supervisors and clinical leaders need access to easy to utilize tools and process that allow them to develop an evidence base of their clinicians' performance of key, critical elements of identified evidenced based practices and information on the quality and strength of their therapeutic alliance with their clients. Likewise, clinicians need access to feedback that provides objective, consistent, and timely information regarding their adherence to formal treatment approaches values by the program, along information regarding the quality and strength of their therapeutic alliance with their clients.

Central to the Arizona Methamphetamine Treatment Centers of Excellence Initiative is an expectation that participating agencies will have in place each of the elements just described. As such, programs should have in place written treatment manuals that provide specific and detailed information regarding the structure and key elements of their treatment program. Such a treatment program manual should be written from the orientation of the clinician and designed to provide clinicians and all other staff affiliated with the program the practical information needed to ensure consistent delivery of treatment services in a manner consistent with the goals of this initiative. Similarly, programs should have in place a structured approach to clinical supervision that provides clinicians with objective, consistent, and timely information regarding their performance of key clinical processes and facilitates the delivery of treatment services in a recovery oriented, strengths-based manner. Toward that end, a variety of clinical supervision/program fidelity/clinician feedback tools are summarized on the following pages. Participating programs are encouraged to modify, adapt and utilize these tools, or others, to develop and implement structured processes for providing clinical feedback and clinical

supervision as an element of their participation in the Arizona Methamphetamine Treatment Centers of Excellence initiative.

TOOLS TO CLINICAL SUPERVISION

A variety of fidelity tools are available to aide the clinical supervisor in providing relevant, direct, and objective feedback to clinicians regarding their performance. Many of these tools were developed to monitor adherence to a particular evidence based practice, while other tools were developed to provide clinicians with feedback on the strength of their therapeutic alliance with their clients. Most of the instruments and feedback tools that are available were developed for research purposes and as such, modifications and adaptations may be necessary to make them practical to your situation. Similarly, many of the tools available were designed for providing feedback in individual counseling sessions; few feedback tools are available for providing feedback regarding clinician performance in-group counseling/treatment sessions. For the purposes of the Arizona Methamphetamine Treatment Centers of Excellence Initiative, four clinician feedback systems are summarized on the following pages:

- The Session & Outcome Rating Scales
- The Cognitive Behavioral Training Group Session Form
- The Contingency Management Adherence/Competence Rating Form
- The Motivational Interviewing Treatment Integrity Code

SESSION AND OUTCOME RATING SCALES²

Using the Rating Scales to Improve Practice

The instrument created by Miller and Duncan utilizes two separate scales. The Outcome Rating Scale (ORS) is a brief, four-item, self-report instrument that takes less than a minute to score and is completed by the client prior to any intervention. The Session Rating Scale (SRS) is a four-item measure completed by the client near the end of any session. The ORS and SRS are developed to track client progress and perception of the therapeutic alliance over the course of treatment. On these measures, content and complexity is kept to a minimum. Clients simply place a hash mark on a line nearest to the pole that best describes or fits their experience.

A benefit of the session and outcome rating scales are that they allow clients to directly comment on problems they face and their goals, which becomes the focus of treatment and prohibits the therapist from reformulating treatment along theoretical or diagnostic lines. This client-centered process leaves the door open for frank discussion of these items and can shape the flow of sessions in a therapeutic manner relevant to the client. Therapists in the wake of constant feedback on the client's progress and the status of the therapeutic relationship can then tailor treatment to fit client goals, coping behaviors, situational contexts, resistances and basic beliefs. Either at intake or when scheduling the first session, the therapist can simply explain that the focus of these scales is making sure that "you" get what you want out of treatment. The therapist also should explain to the client that they would be involved in monitoring their own progress and usefulness of sessions after each session. The therapist should lastly explain the nature of

² Bibliography at the end of the section. © 2000, Scott D. Miller and Barry L. Duncan

the scale – the SRS will be administered at the beginning and the ORS will be administered at the end, and the purpose of each item on the scales. The client should know that the scales are just simple questions, which are easy and as quick as making several marks on a piece of paper. Specific ideas for scripts and also case examples can be found at www.thetalkingcure.com.

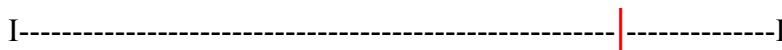
Instructions

- ❑ Visual inspection of these scales shows that each measure contains four items. Clients complete the scales by making a mark on the line of each item nearest to the pole that best fits their experience.
- ❑ Both scales are completed in the presence of the therapist.
- ❑ On the ORS, clients are asked to look back over the last week (or since the last session) and rate their functioning in three different areas. On the SRS, clients are asked to rate the various elements of the alliance for the session just completed.
- ❑ Scoring of the ORS and SRS is simple and straightforward. The lines on each measure are ten centimeters in length. Although adding numbers to or superimposing a metric ruler is prohibited, users may alter the length of any line to appropriate length.
- ❑ To score, determine the distance in centimeters to the nearest millimeter between the left pole and the client’s hash mark on each individual item. Add all four numbers to obtain the total score for the particular measure.

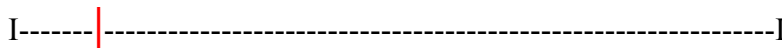
Sample Outcome Rating Scale

The marks represent feasible hash marks that a client could make indicating their state of mind at the beginning of the session.

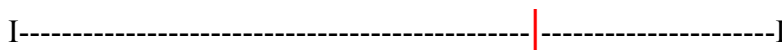
Individually:
(Personal well being)



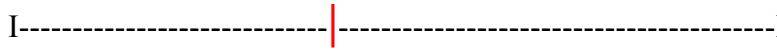
Interpersonally:
(Family, close relationships)



Socially:
(Work, School, Friendships)

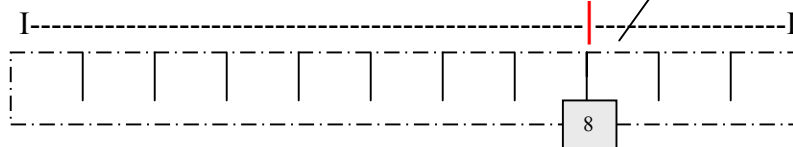


Overall:
(General sense of well-being)



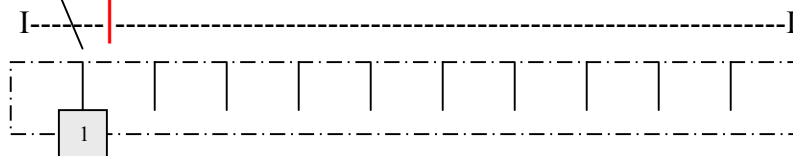
Sample ORS Scoring

Individually³:
(Personal well-being)



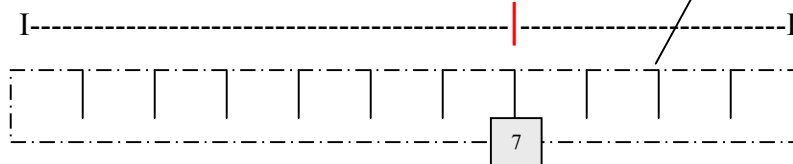
Using a ruler the score on individually is 8 – being the 8th cm out of 10 cm scale.

Interpersonally:
(Family, close relationships)



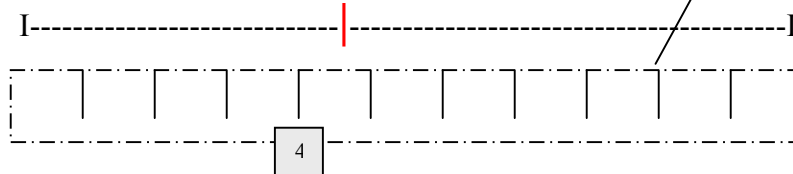
Using a ruler the score on interpersonally is 1.2 – being the 1st cm out of 10 cm scale and 2 mm in.

Socially:
(Work, school, friendships)



The score on socially is 7.

Overall:
(General sense of well-being)



Using a ruler the score on overall is 4.6.

Sample ORS Scoring Cutoff

Once the scales are administered, scored and plotted, attention turns to interpretation. On the SRS, therapists are encouraged to open a dialogue with clients about the alliance whenever the total score on the measure fall below the clinical cut off of 36. Scores of 34 or below always

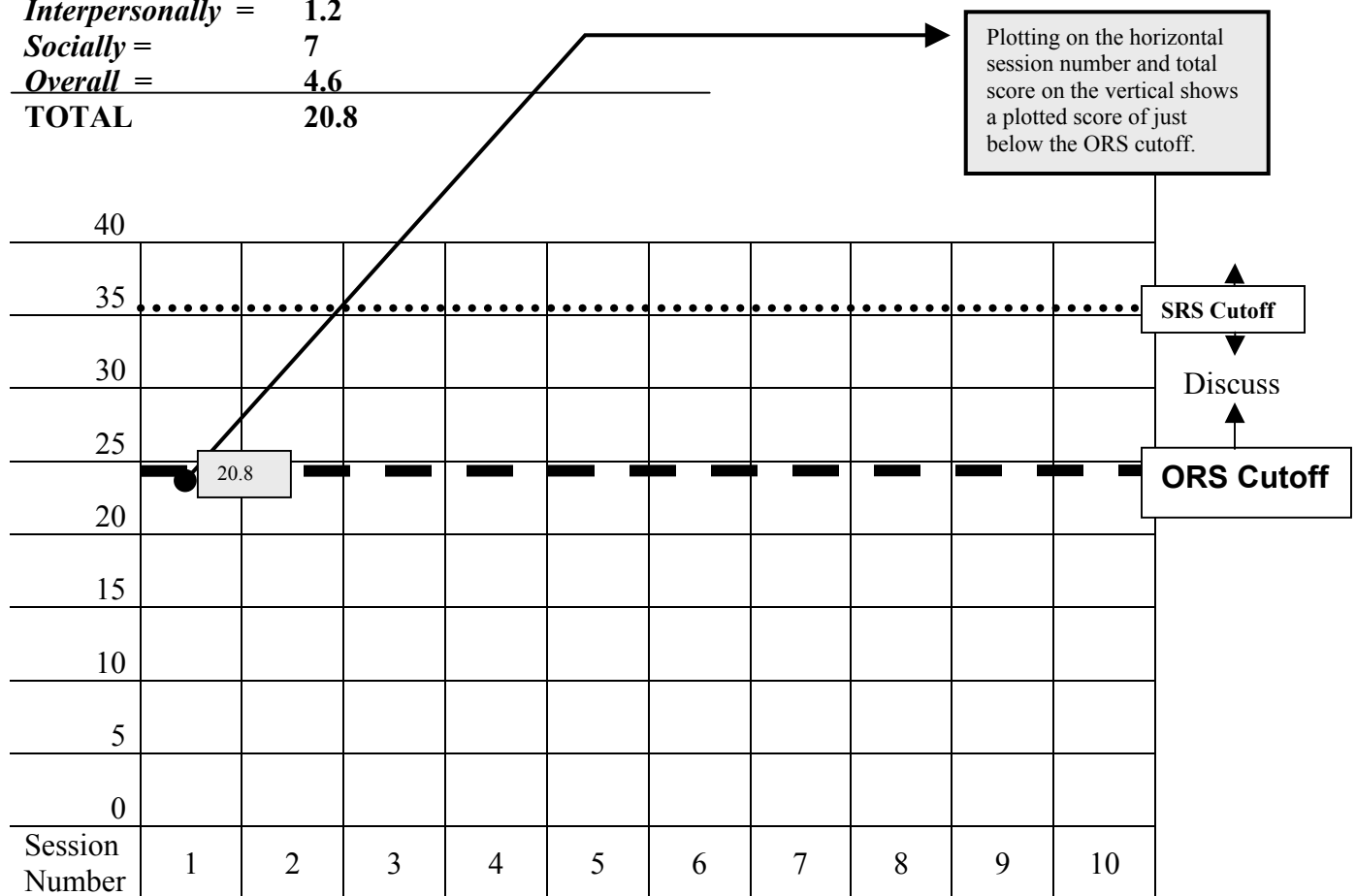
³ Ruler Not to Scale – Simply a Demonstration of How to Score.

merit discussion as such clients are at significant risk for drop out and poor treatment outcome. For cut off scores please examine the second figure.

On the ORS, interpretation varies depending on the particular session, but is particularly useful when beginning a discussion around the clinical cut off. The therapist should indicate to the client when scores are above the cut off – the client has responded like people who are not in therapy, things in their life are on track and little change needs to take place. However, when the client’s score is below the cut off, the therapist should indicate that the client responded to the items more like someone who is in therapy and would like some aspect of their life to change or be different. More specific ideas for scripts and also case examples can be found at www.thetalkingcure.com.

Using the above sample ORS, the scores are as follows:

Individually = 8
Interpersonally = 1.2
Socially = 7
Overall = 4.6
TOTAL 20.8



Outcome Rating Scale (ORS)⁴

Name _____	Age (Yrs): _____
ID# _____	Sex: M / F
Session # _____	Date: _____

Looking back over the last week, including today, help us understand how you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

ATTENTION CLINICIAN: TO INSURE SCORING ACCURACY PRINT OUT THE MEASURE TO INSURE THE ITEM LINES ARE 10 CM IN LENGTH. ALTER THE FORM UNTIL THE LINES PRINT THE CORRECT LENGTH. THEN ERASE THIS MESSAGE.

Individually:
(Personal well-being)

I-----I

Interpersonally:
(Family, close relationships)

I-----I

Socially:
(Work, School, Friendships)

I-----I

Overall:
(General sense of well-being)

I-----I

⁴ © 2000, Scott D. Miller and Barry L. Duncan

Session Rating Scale (SRS V.3.0)⁵

Name _____	Age (Yrs): _____
ID# _____	Sex: M / F
Session # _____	Date: _____

Please rate today's session by placing a hash mark on the line nearest to the description that best fits your experience.

Relationship:

I did not feel heard,
understood, and
respected

I-----I

I felt heard,
understood, and
respected

Goals and Topics:

We did *not* work on or
talk about what I
wanted to work on and
talk about

I-----I

We worked on and
talked about what I
wanted to work on and
talk about

Approach or Method:

The therapist's
approach is not a good
fit for me.

I-----I

The therapist's
approach is a good fit
for me.

Overall:

There was something
missing in the session
today

I-----I

Overall, today's
session was right for
me

⁵ © 2000, Scott D. Miller and Barry L. Duncan

Works Consulted – Session and Outcome Rating Scales Summary

- Lambert, M.J. & Burlingame, G.M. "The Reliability and Validity of the Outcome Questionnaire." *Clinical Psychology and Psychotherapy*, 3, 249-258.
- Miller, S.D. & Duncan, B.L. *Client-Directed, Outcome-Informed Clinical Work: Directing Attention to "What Works" in Treatment*. Chicago, IL: Institute for the Study of Therapeutic Change (2000).
- . "Beyond Integration: the Triumph of Outcome Over Process in Clinical Practice." *Psychotherapy in Australia*, 10, 2-19.
- . *The Outcome and Session Rating Scales: Administration and Scoring Manual*. Chicago, IL: Institute for the Study of Therapeutic Change (2000).
- . "The Outcome Rating Scale: A Preliminary Study of the Reliability, Validity, and Feasibility of a Brief Visual Analog Measure." *Journal of Brief Therapy*, 3, 3-12.
- . "The Session Rating Scale: Preliminary Psychometric Properties of a "Working" Alliance Measure." *Journal of Brief Therapy*, 3, 3-12.

COGNITIVE BEHAVIORAL TRAINING SUPERVISORY GROUP SESSION FORM⁶

The purpose of this instrument is to learn and practice coping skills that will help clinicians identify triggers and beliefs, manage moods and emotions, strengthen self-esteem, improve relationships, and maintain abstinence from methamphetamine abuse and other high-risk behaviors. The form was originally developed for use in the SAMHSA-funded Cannabis Youth treatment project and has been modified for use in the Arizona Methamphetamine Treatment Centers of Excellence Initiative. This form can be used either as a self-assessment or completed by a clinical supervisor or clinical peer and is designed for use during direct observational, in-vivo assessment of treatment groups; it is not well suited for use in individual counseling sessions.

Instructions

- ❑ Provide identifying information at the beginning of the form.
- ❑ For each question, circle the number of the appropriate response and, when asked, write in response on the lines provided.
- ❑ When responding to specific items, refer to the following response set:
 - (1) Not at all: The intervention was not delivered in that session.
 - (2) A little: The intervention was presented but only briefly mentioned and not covered in depth or with great frequency.
 - (3) Somewhat: The intervention was presented with some frequency but not covered in depth.
 - (4) Considerably: The intervention was presented frequently and in depth and was covered in great detail.
 - (5) Extensively: The intervention clearly dominated the session.

In general, most interventions should be rated 2 or 3; ratings of 4 or 5 should be comparatively rare and used only when a particular intervention truly characterized the bulk of a session. Any significant clinical information relevant to the session should be documented in the additional notes section.

⁶ Section adapted from Webb, C., Scudder, M., Kaminer, Y., & Kadden, R. (2004). *The Motivational Enhancement Therapy and Cognitive Behavioral Therapy Supplement: 7 Sessions of Cognitive Behavioral Therapy for Adolescent Cannabis Users – Cannabis Youth Treatment Series, Vol. 2*. Rockville, MD: Center for Substance Abuse Treatment.

Cognitive Behavioral Therapy Group Feedback Form

Name of Therapist: _____ # of Session Participants: _____

Person Providing Feedback: _____ Date: _____

1. To what extent did the therapist assess the participants' use of methamphetamine or other substances since the last session?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

2. In your opinion, should any of the participants be considered for removal from treatment due to clinical deterioration?

1 = Yes If yes, list participants: _____
2 = No If yes, why? _____

3. To what extent did the therapist discuss or address the participants' current commitment to abstinence?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

4. To what extent did the therapist attempt to elicit self-motivational statements from the participants?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

5. To what extent did the therapist attempt to focus on the participants' ambivalence about changing their level of methamphetamine use?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

6. To what extent did the therapist encourage the participants to make a commitment to changing their methamphetamine use?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

7. To what extent did the therapist discuss any high-risk situations the participants encountered since the last session and explore any coping skills used?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

8. To what extent did the therapist teach, model, rehearse, review, or discuss specific skills (e.g. methamphetamine refusing skills, enhancing social support, or planning for emergencies and coping with relapse) during the session?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

9. Did the therapist do a roleplay?

1 = Yes

2 = No

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

10. To what extent did the therapist encourage the participants to anticipate any high-risk situations that might be encountered before the next session and formulate appropriate coping strategies for such situations?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

11. To what extent did the therapist provide one or more specific assignments for the participants to engage in between sessions?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

12. To what extent did the therapist review the participants' reactions to last session's assignment?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

13. To what extent did the therapist emphasize the importance of real life practice of skills between sessions?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

14. To what extent was it difficult for the therapist to engage the group?

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

15. To what extent did the therapist manage disruptions to the group process (e.g. using aggression, telling war stories, using excessive profanity)?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

16. To what extent did the therapist attempt to keep the session focused on prescribed activities (by redirecting dialog when it strayed off task or organizing the session so defined activities were covered)?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

17. To what extent did the therapist communicate understanding of the participants' concerns through reflective listening and comments?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

18. To what extent did the therapist respond to the participants with empathy, warmth, and acceptance?

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

19. To what extent did the therapist discuss the availability and nature of family support for the participants' efforts in treatment?

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

Skill Level

1.....2.....3.....4.....5
not done poor fair adequate well

CONTINGENCY MANAGEMENT ADHERENCE⁷

The purpose of this instrument is to rate how skillfully a contingency management session is delivered. There are appropriate ways to address the questions posed by each scenario, not simply the correct answer. What is important is that there is a consensus between the CM clinician and the trainer as to how to handle a situation. Their responses are then rated on a CM Clinician Adherence/Competence Rating Form on the following page. The checklist rates the clinician's adherence to the CM techniques, which are delivered in a CM session. This checklist is designed for use in individual counseling sessions wherein the results of a urinalysis (or some other form of physiological assessment such as a cheek swab) has been collected and analyzed and the results are being provided to the client with a corresponding motivational incentive/contingency management pay-off being delivered.

Instructions

- ❑ Provide identifying information at the beginning of the form.
- ❑ For each question, circle the number of the appropriate response.
- ❑ When responding to specific items, refer to the following response set:

Quantity

- (1) Not at all: The technique was not delivered in that session.
- (3) Somewhat: The technique was presented with some frequency but not covered in depth.
- (5) Considerably: The technique was presented frequently and in depth and was covered in great detail.
- (7) Extensively: The technique clearly dominated the session.

Quality

- (1) Poor: The technique was of poor quality session.
- (3) Adequate: The technique was presented with some frequency but and of an adequate nature.
- (5) Good: The intervention was presented in good depth and was covered in great detail.
- (7) Excellent: The technique was of a very high quality and could not be improved.

⁷ Section adapted from Petry, N. & Stitzer, M. *Contingency Management: Using Motivational Incentives to Improve Drug Abuse Treatment*. West Haven, CT: Yale University Psychotherapy Development Center.

MOTIVATIONAL INTERVIEWING TREATMENT INTEGRITY (MITI) CODE⁸

The Motivational Interviewing Treatment Integrity Code (MITI) represents the latest variation in program fidelity monitoring for motivational interviewing developed by Dr. Teresa Moyers and her colleagues. As described in the following pages, the MITI is designed for use in the evaluation of individual counseling sessions that have been audiotaped; while somewhat complex, the MITI could be used as an in-vivo or direct observational tool as well.

Designating A Target Behavior

An important component of using motivational interviewing well involves the interviewer's attention to facilitating change of a particular behavior or problem. Coders should know, in advance of the coding task, what is the designated target behavior for the intervention. This will allow coders to judge more accurately whether the therapist is directing interventions toward the target behavior, or is off-target. The MITI is not designed to be used for interventions in which a target behavior cannot be identified.

Global Scores

Global scores are intended to capture the rater's overall impression of how well or poorly the interviewer meets the intent of the scale. While this may be accomplished by simultaneously evaluating a variety of elements, an all-at-once judgment is paramount. The global scores should reflect the holistic evaluation of the interviewer, one that cannot necessarily be separated into individual elements.

1. **Empathy** - This scale is intended to capture the extent to which the therapist understands and/or makes an effort to grasp the client's perspective.
2. **Motivational Interviewing Spirit** - This rating is intended to capture the overall competence of the clinician in using motivational interviewing. It explicitly focuses on the three characteristics of **evocation**, **collaboration** and **autonomy**. The rater should consider all three characteristics when assigning a value for this scale and low scores in any of these dimensions should be reflected in a lower overall spirit score.

Behavior Counts

Parsing Interviewer Speech to Assign Behavior Codes

An utterance is defined as a complete thought. An utterance ends when one thought is completed. A new utterance begins when a new idea is introduced. One utterance can succeed another in the flow of the interviewer's speech, as with a sentence that conveys successive ideas. A client response always terminates an interviewer utterance, and the next interviewer response following client speech is therefore always a new utterance.

Not all interviewer utterances will receive behavior codes. The MITI does not represent an exhaustive list of all possible codes; therefore, some therapist utterances will likely remain uncoded. Although they are not exhaustive, MITI codes are mutually exclusive, such that the same utterance does not receive more than one code.

⁸ Section from Moyers, T.B., Martin, T., Manuel, J.K. & Miller, W.R. *The Motivational Interviewing Treatment Integrity (MITI) Code: Version 2.0*. Albuquerque, NM: University of New Mexico.

Any utterance may be assigned one of seven primary behavior codes. Each utterance receives one and only one code: the same utterance may not receive more than one code.

List of MITI Codes

GI	Giving Information
MiA	MI Adherent
MiNa	MI Non-adherent
OQ	Open Question
CQ	Closed Question)
Rs	Reflection simple
Rc	Reflection complex

Behavior Codes

- 1. Giving Information** - This category is used when the interviewer gives information, educates, provides feedback or discloses personal information. When the interviewer gives an opinion.
- 2. Questions**
 - 2a. Closed Question* - This behavior code is used when the interviewer asks the client a question that can be answered with a “yes” or “no” response.
 - 2b. Open Question* - An open question is coded when the interviewer asks a question that allows a wide range of possible answers. The question may seek information, may invite the client’s perspective or may encourage self-exploration.
 - 2c. Questions-trying-to-be-reflections* - Occasionally the interviewer will offer a statement that otherwise meets the criteria for a reflection, but is given with an inflection at the end (thereby making it “sound like” a question). These statements are coded as Questions (either open or closed), **NOT** as reflections.
- 3. Reflection** - This category is meant to capture reflective listening statements made by the therapist *in response to* client statements. A Reflection may introduce new meaning or material, but it essentially captures and returns to clients something about what they have just said. Reflections must be further categorized into Simple or Complex categories.
- 4. MI Adherent** - This category is used to capture particular interviewer behaviors that are consistent with a motivational interviewing approach. Coders may be tempted to code especially good examples of MI practice in one of these categories, even if they do not genuinely “fit.” Instead, the coder should consider such examples within the overall rating assigned for MI Spirit or Empathy, as appropriate, reserving the MI Consistent behavior counts for the designated behaviors only. The MI Adherent Category is comprised of:
 - 4a. Asking permission before* giving advice or information or asking what the client already knows or has already been told about a topic *before* giving advice or information.
 - 4b. Affirm the client* by saying something positive or complimentary about their progress. Affirming may also take the form of commenting on the client’s strengths, abilities or efforts in any area (not simply related to the target behavior).
 - 4c. Emphasizing the client’s control*, freedom of choice, autonomy, ability to decide.
 - 4d. Supporting the client* with statements of compassion or sympathy.
- 5. MI Non-Adherent** - This category is used to capture those interviewer behaviors that are inconsistent with a motivational interviewing approach. No differentiating sub-codes are assigned to the MI Non-Adherent behaviors. The rater merely identifies them as

belonging to this category and assigns the MI Non-Adherent code.

MITI Coding Sheet Instructions

Coders typically do best beginning with fairly simple tasks, proceeding to more complex ones only when competence on the simpler tasks is solid. We recommend that coders begin by learning Level I tasks to an acceptable reliability standard prior to attempting Level II tasks. Only when acceptable standards for simultaneous I and II tasks have been accomplished should coders begin on Level III tasks. The self-review of MI text and video learning tools can be used at any time (perhaps as a prelude to beginning Level I tasks).

Level I competencies: parsing utterances, giving information and open/closed questions

Level II competencies: add reflections, MiA and MiNa

Level III competencies: add global ratings

Instructions

- ❑ *Global Scores* — Pick a single number from a seven-point scale to characterize the entire interaction. Two global dimensions are rated: empathy and MI spirit.
- ❑ *Behavior Count* — A behavior count requires the coder to tally instances of particular interviewer behaviors. These running tallies occur from the beginning of the segment being reviewed until the end. The coder is not required to judge the quality or overall adequacy of the event, as with global scores, but simply to count up the numbers of specific MITI codes found in the table on page.

Typically both the global scores and behavior counts are assessed within a single review of a session tape, and typically a random 20-minute segment is used. Careful attention should be paid to insuring that the sampling of the tape segments is truly random, especially within clinical trials, so that proper inferences about the overall integrity of the MI intervention can be drawn.

The tape may be stopped as needed, however excessive stopping and restarting in actual coding (as opposed to training or group review) may disrupt the ability of the coder to form a gestalt impression needed for the global codes. Coders may therefore decide to use two passes through the tape until they are proficient in using the coding system. In that case, Pass One should be used for the global scores and Pass Two for the behavior counts.

MITI Coding Sheet

Tape# _____

Coder: _____

Time: _____

Global Ratings

Empathy/ Understanding		1 Low	2	3	4	5	6	7 High
Spirit		1 Low	2	3	4	5	6	7 High

Behavior Counts

Giving Information			
<i>MI</i> Adherent	Asking permission, affirm, emphasize control, support.		
<i>MI</i> Non-adherent	Advise, confront, direct.		
Question (subclassify)	Closed Question		
	Open Question		
Reflect (subclassify)	Simple		
	Complex		
	TOTAL REFLECTIONS:		

First sentence: _____

Last sentence: _____

4. Evaluation & Reporting Requirements

The evaluation of the Arizona Methamphetamine Treatment Centers of Excellence Initiative has been designed to provide both formative information (i.e., information that will aide in program implementation and program strengthening), as well as summative information (i.e., information that will document the effectiveness and impacts of the program). Both elements of information are critical, the former more from a programmatic perspective; the latter from a systems perspective. When combined, both perspectives provide complimentary information that drives programs toward excellence, while providing clear and unambiguous information about the impact, effectiveness, and efficiency of the programs. A graphic representation of the model appears later in this document.

Evaluation Questions for the Arizona Methamphetamine Treatment Centers of Excellence Initiative

1. Do clients served by the Arizona Methamphetamine Treatment Centers of Excellence Initiative demonstrate reductions in their use of methamphetamine and other illicit substances and do they also demonstrate improvements in other indicators of recovery (e.g., employment, residential stability, reduced criminal behavior, etc.)?
2. To what extent are programs implemented as proposed and in a manner consistent with the core program elements of the initiative (CBT programming, use of frequent urinalysis and contingency management)?
3. How has the implementation of the Arizona Methamphetamine Centers of Excellence affected the organizational climate and culture of the implementing agencies and the perceptions, attitudes, and knowledge of staff regarding the treatment of clients with methamphetamine use disorders?

As a condition of your agency's participation in the Arizona Methamphetamine Treatment Centers of Excellence Initiative, you are required to participate in the following activities and data reporting requirements for the purposes of program evaluation.

1. Complete an ADHS Uniform Assessment of all participating clients within ADHS specified timelines (Core within seven days; Complete Assessment within 45 days).
2. Update the ADHS Uniform Assessment for all participating clients every ninety (90) days of their continuing participation in your methamphetamine treatment program.
3. Complete ADHS required disenrollment data of all participating clients following their termination from your methamphetamine treatment program.
4. Provide ongoing, in-treatment updates of all participating clients through the ADHS Methamphetamine Treatment Centers of Excellence web-based client tracking program. This web-based program will be operational no later than March 1, 2006 and will allow you to maintain rosters of clients and staff assigned to your Methamphetamine Treatment program, track results of urinalysis tests, payouts from your contingency management programs, and the results of client completed Session Rating Scales.
5. Provide access to program personnel, program clients, and clinical records/charts to evaluators from Applied Behavioral Health Policy (ABHP). At least once per year, evaluators from ABHP will conduct a site visit of your program, during which they will conduct semi-structured interviews and/or focus groups with your clinical director, clinical staff, and clients to gather information about your program's implementation and

to aide in the identification of programmatic strengths and areas for improvement in your program. Following these site visits, ABHP will provide a summary report that your agency will be able to review and correct any errors in fact before they are submitted to ADHS.

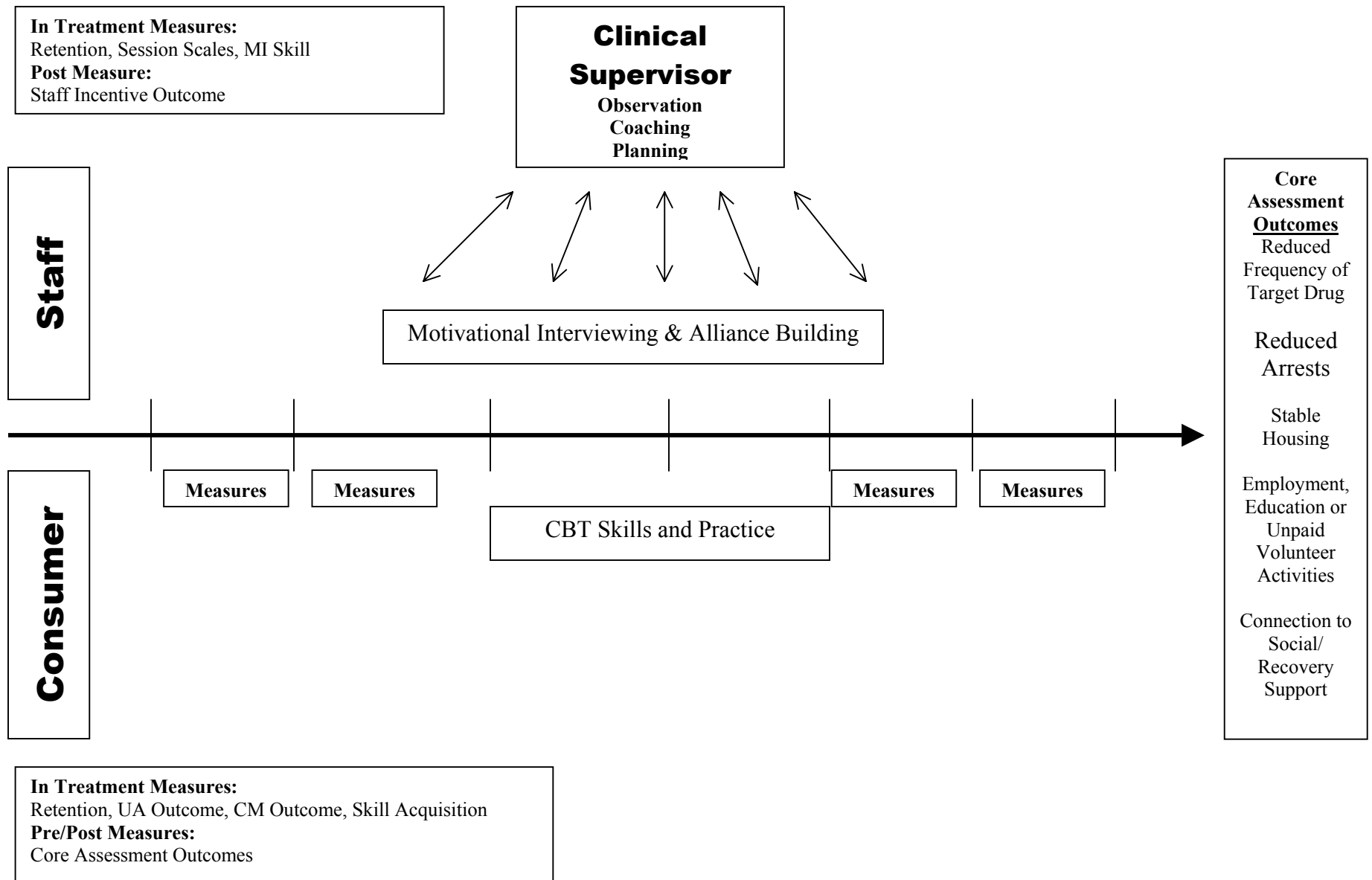
ADHS METHAMPHETAMINE TREATMENT CLIENT TRACKING SYSTEM

As a participating program in the ADHS Methamphetamine Treatment Centers of Excellence Initiative, you will have the opportunity to utilize a web-based data entry and report-generating program developed specifically for use in this initiative. It is anticipated that data entry functions for this program will be fully operational no later than March 1, 2006 with Report functions operational no later than April 15, 2006. This program will consist of a web-based application developed with SQL Server 2000 as a back-end database. The web application will include the following features:

- User Authentication
 - Separate login for each provider and clinician
 - Authenticate the user
- Client Management
 - Add a new client (first Name, Last Name, AHCCCS and CIS Identification Numbers)
 - Modify existing client information
 - Modify client status (Active/Inactive; Referral, Start, Termination Dates)
- Data Entry Forms
 - Indicate Treatment schedule
 - Specify Session Type (individual, group, or family) and session attendance
 - Specify lead therapist by session
 - Indicate urinalysis schedule and results
 - Indicate motivational incentive draws
 - Report session rating scale scores
 - Add treatment/urinalysis/session rating scale score details for each day of treatment
 - Modify treatment/urinalysis/session rating scale details for each day of treatment

Data entry to the ADHS Methamphetamine Treatment Centers of Excellence Initiative is expected to be maintained in near real-time, with data entry never lagging more than five (5) working days beyond the point of occurrence (program entry, program exit, session attendance, etc.). These data will allow programs the opportunity to generate a number of reports for aiding in program monitoring and program management. Additionally, these data will be combined with other data maintained with the ADHS Client Information System (CIS) to provide a comprehensive assessment about the clients served and the outcomes achieved, as a result of your programming efforts. Evaluators at ABHP will be available for providing your program staff with ongoing technical assistance in the operation of the client tracking system.

Measurement Model



5. Resources

PUBLISHED RESOURCES

Brecht, M., O'Brien, A., von Mayrhauser, C., & Anglin, M. D. (2004). Methamphetamine use behaviors and gender differences. *Addictive Behaviors, 29*(1), 89-106.

- Results show while many MA-related characteristics and behaviors are similar for males and females, gender differences in certain factors were shown. Females were more likely to be introduced to MA and continue to gain access to MA through spouses/boyfriends than were males, who were more likely to be introduced through friends and gain later access through coworkers than were females.

Cohen, J. B., Dickow, A., Homer, K., Zweben, J. E., Balabis, J., & Vanderstoot, D. et al. (2003). Abuse and violence history of men and women in treatment for methamphetamine dependence. *American Journal on Addictions, 12*(5), 377-385.

- The Methamphetamine Treatment Project offers the opportunity to examine the history of abuse and violence in a sample of 1016 methamphetamine users participating in a multi-site study between 1999-2001. Reporting of abuse and violence was extensive, with 80% of women reporting abuse or violence from a partner.

Copeland, A. L., & Sorensen, J. L. (2001). Differences between methamphetamine users and cocaine users in treatment. *Drug and Alcohol Dependence, 62*(1), 91-95.

- To better understand the distinguishing characteristics of meth users versus cocaine users, this study conducted a retrospective chart review of 345 patients admitted to an outpatient stimulant treatment program. Analyses revealed an increase in meth patients over the 3-year period and that these patients were more likely than cocaine patients to be male, Caucasian and gay or bisexual.

Cretzmeyer, M., Sarrazin, M. V., Huber, D. L., Block, R. I., & Hall, J. A. (2003). Treatment of methamphetamine abuse: Research findings and clinical directions. *Journal of Substance Abuse Treatment, 24*(3), 267-277.

- This article reviews effective treatments for meth, including, aversion therapy, medication (imipramine), psychosocial treatment (Matrix) and case management.

Newton, T. F., Kalechstein, A. D., Duran, S., Vansluis, N., & Ling, W. (2004). Methamphetamine abstinence syndrome: Preliminary findings. *American Journal on Addictions, 13*(3), 248-255.

- Retrospective reports suggest that chronic use of methamphetamine is associated with a prolonged abstinence syndrome; however, there are no prospective studies confirming this. Moderate levels of depression were reported during the first several days of abstinence, with minimal levels reported thereafter. The most prominent symptoms were anhedonia, irritability, and poor concentration.

Obert, J. L., Brown, A. H., Zweben, J., Christian, D., Delmhorst, J., & Minsky, S. et al. (2005). When treatment meets research: Clinical perspectives from the CSAT methamphetamine treatment project. *Journal of Substance Abuse Treatment, 28*(3), 231-237.

- This article examines the introduction of research, via manualized treatment (i.e. The Matrix Model) into community treatment settings that participated in the CSAT Meth treatment project; a multi-site randomized controlled trial with 1016 individuals. Implementation went smoothly within the context of the project.

Rawson, R. A., Gonzales, R., & Brethen, P. (2002). Treatment of methamphetamine use disorders: An update. *Journal of Substance Abuse Treatment, 23*(2), 145-150.

- Cognitive behavioral therapy and contingency management are among the most promising approaches for treatment of MA abuse and dependence. An ambitious program of pharmacotherapy development research using fluoxetine was sponsored by NIDA and results are preliminary though positive.

Rawson, R., McCann, M., Huber, A., & Shoptaw, S. (1999). Contingency management and relapse prevention as stimulant abuse treatment interventions. In S. T. Higgins, & K. Silverman (Eds.), *Motivating behavior change among illicit-drug abusers: Research on contingency management interventions*. (pp. 57-74) American Psychological Association.

- Currently both the contingency management and relapse prevention strategies have the best empirical support as treatment approaches for stimulant-related problems; the systematic study of contingency management and relapse prevention procedures is likely to provide considerable theoretical and practical knowledge to guide the development of these treatment approaches.

Rawson, R. A., Marinelli-Casey, P., Anglin, M. D., Dickow, A., Frazier, Y., & Gallagher, C. et al. (2004). A multi-site comparison of psychosocial approaches for the treatment of methamphetamine dependence. *Addiction*, 99(6), 708-717.

- The Center for Substance Abuse Treatment (CSAT) Methamphetamine Treatment Project (MTP) is the largest randomized clinical trial of treatments for methamphetamine (MA) dependence to date. Study results demonstrate a significant initial step in documenting the efficacy of the Matrix approach.

Rawson, R. A., & Anglin, M. D. (Eds.). (2000). *Journal of Psychoactive Drugs Theme Issue: The CSAT Methamphetamine Treatment Project: Moving Research into the Real World*. San Francisco, CA: Haight-Ashbury Publications.

- The drug use pattern is highly variable, the drug can be administered by a variety of routes, and triggers for cravings and use vary widely. The difficulties of specialty populations is especially pronounced and can be defined along a variety of continua including geography, culture, sexual orientation and circumstances that lead to treatment.

Reiber, C., Ramirez, A., Parent, D., & Rawson, R. A. (2002). Predicting treatment success at multiple timepoints in diverse patient populations of cocaine-dependent individuals. *Drug and Alcohol Dependence*, 68(1), 35-48.

- These studies found significantly superior in-treatment outcomes for patients assigned to interventions where CM procedures were featured compared to interventions where CBT procedures were featured. However, at 6 and 12 months after intake, patients receiving CBT treatments appeared to be doing as well or better than those patients receiving CM interventions.

Robles, E., Silverman, K., Preston, K. L., Cone, E. J., Katz, E., & Bigelow, G. E. et al. (2000). The brief abstinence test: Voucher-based reinforcement of cocaine abstinence. *Drug and Alcohol Dependence*, 58(1-2), 205-212.

- This study assessed the effectiveness of a brief abstinence reinforcement procedure for initiating cocaine abstinence in methadone maintenance patients. The procedure of incentives for negative urine tests and decreasing amounts of cocaine in the bloodstream over two day periods were highly efficacious and may have clinical application where reliable abstinence initiation is desired either on a temporary bases or at the start of long-term interventions.

Shoptaw, S., Reback, C. J., Peck, J. A., Yang, X., Rotheram-Fuller, E., & Larkins, S. et al. (2005). Behavioral treatment approaches for methamphetamine dependence and HIV-related sexual risk behaviors among urban gay and bisexual men. *Drug and Alcohol Dependence*, 78(2), 125-134.

- Among high-risk meth dependent GBM, drug abuse treatments produced significant reductions in meth use and sexual risk behaviors (interventions used were cognitive behavioral therapy, contingency management, a tailored CBT approach and a combination of the two former treatments).

Simon, S. L., Dacey, J., Glynn, S., Rawson, R., & Ling, W. (2004). The effect of relapse on cognition in abstinent methamphetamine abusers. *Journal of Substance Abuse Treatment, 27*(1), 59-66.

- Treatment for stimulant dependent individuals, such as those who use MA, incorporates behavioral, cognitive, and psychological techniques that are primarily emphasized during the period immediately following cessation of acute withdrawal from MA.

Völlm, B. A., de Araujo, I. E., Cowen, P. J., Rolls, E. T., Kringelbach, M. L., & Smith, K. A. et al. (2004). Methamphetamine activates reward circuitry in drug naïve human subjects. *Neuropsychopharmacology, 29*(9), 1715-1722.

- In this study findings indicate that the first administration of a psychostimulant to human subjects activates classical reward circuitry. Our data also support recent hypotheses suggesting a central role for the orbitofrontal cortex in drug reinforcement and the development of addiction.

Yudko, E., & Gagnet, T. (2003). Treatment of Methamphetamine Abuse – Lack of Evidence for the Efficacy of Any of the Models Currently in Use. In E. Yudko, H. V. Hall, & S. B. McPherson (Eds.), *Methamphetamine Use: Clinical and Forensic Aspects*. (pp. 203-210) CRC Press.

- Traditional treatment program based on Minnesota Model have been shown to be ineffective for the treatment of stimulant addiction. Effective models focus heavily on appropriate assessment of emotional risk, medical emergencies, dual diagnosis and any other social or emotional needs.

Zweben, J. E., Cohen, J. B., Christian, D., Galloway, G. P., Salinardi, M., & Parent, D. et al. (2004). Psychiatric symptoms in methamphetamine users. *American Journal on Addictions, 13*(2), 181-190.

- The Methamphetamine Treatment Project (MTP) offers the opportunity to examine co-occurring psychiatric conditions in a sample of 1016 methamphetamine users participating in a multi-site outpatient treatment study between 1999-2001. Findings continue to support the value of integrated treatment for co-occurring conditions, especially the importance of training counseling staff to handle psychotic symptoms when needed.

WEB RESOURCES

Methamphetamine Resource Websites for Providers

- Office of National Drug Control and Policy, Department of Justice & Dept. of Health and Human Services. <http://www.methresources.gov/>
- Methamphetamine Treatment Project. <http://www.methamphetamine.org/>
 - The Methamphetamine Treatment Project (MTP) is a multi-site initiative to study the treatment of methamphetamine dependence. Jointly implemented by the UCLA Integrated Substance Abuse Programs (ISAP), and the Matrix Institute on Addictions, its goal is to generate knowledge regarding how a new comprehensive treatment protocol developed by Matrix can be effectively transferred to the community drug treatment system. The project is funded by the Substance Abuse & Mental Health Services Administration (SAMHSA) and Center for Substance Abuse Treatment (CSAT).
- Office of National Drug Control and Policy. <http://www.whitehousedrugpolicy.gov/drugfact/methamphetamine/index.html>
 - Concise summaries of available research on drug-related topics.

- Consumer Healthcare Products Association. <http://www.methwatch.com/index.aspx>
 - Meth Watch is a program developed and sponsored by CHPA based on the successful Kansas model, to help curtail suspicious sales and theft of pseudoephedrine products, as well as other precursor products, used in the illegal manufacturing of methamphetamine in the small toxic labs. A key goal of this program is to promote cooperation between retailers and law enforcement to prevent the diversion of legitimate products to illegal use.

Factsheets and Reports on History and Trends in Methamphetamine Abuse

- Office of National Drug Control and Policy.
<http://www.whitehousedrugpolicy.gov/publications/factsht/methamph/index.html>
<http://www.whitehousedrugpolicy.gov/publications/pdf/ncj197534.pdf>
- National Drug Intelligence Center. <http://www.usdoj.gov/ndic/pubs5/5049/5049p.pdf>
- National Institute on Drug Abuse. <http://www.nida.nih.gov/ResearchReports/Methamph/Methamph.html>
<http://www.drugabuse.gov/MethAlert/MethAlert.html>
<http://www.nida.nih.gov/Infofacts/methamphetamine.html>
 - Community Epidemiology Work Group
http://www.drugabuse.gov/PDF/CEWG/AdvReport_Vol1_105.pdf
- U.S. Drug Enforcement Administration. <http://www.usdoj.gov/dea/pubs/intel/02016/index.html>
- Office of Justice Programs, U.S. Dept. of Justice. <http://www.ncjrs.gov/pdffiles1/jr000245c.pdf>
<http://www.ncjrs.gov/pdffiles1/nij/grants/209730.pdf>

Statistics-based SAMHSA Reports

- The DASIS Report
 - Amphetamine Treatment Admissions Increase: 1993-1999
<http://www.oas.samhsa.gov/2k1/Speed/Speed.pdf>
 - Characteristics of Primary Amphetamine Treatment Admissions: 2001
<http://oas.samhsa.gov/2k4/SpeedTX/SpeedTX.pdf>
 - Primary Methamphetamine/Amphetamine Treatment Admissions: 1992/2002
<http://oas.samhsa.gov/2k4/methTX/methTX.pdf>
 - Smoked Methamphetamine/Amphetamines: 1992-2002
<http://oas.samhsa.gov/2k4/methSmoked/methSmoked.pdf>
 - Treatment Admissions for Injection of Multiple Drugs: 2000
<http://www.oas.samhsa.gov/2k3/IVmultipleTX/IVmultipleTX.pdf>
- The DAWN Report
 - Amphetamine and Methamphetamine Emergency Department Visits, 1995-2002
http://dawninfo.samhsa.gov/old_dawn/pubs_94_02/shortreports/files/DAWN_tdr_amphetamine.pdf

Methamphetamine Use in Arizona

- “An Evaluation of the COPS Office Methamphetamine Initiative - Combating Meth in Phoenix: Innovation and Intervention.” *Community Oriented Policing Services: U.S. Dept. of Justice*. <http://www.cops.usdoj.gov/Default.asp?Open=True&Item=848>
- “Meth Matters: Report on Methamphetamine Users in Five Western Cities - Phoenix.” *National Institute of Justice* (April 1999). <http://www.ncjrs.gov/pdffiles1/176331.pdf>
- "Methamphetamine." *National Drug Intelligence Center -Arizona Drug Threat Assessment* (December 2003). <http://www.usdoj.gov/ndic/pubs6/6384/meth.htm>
- "Pulse Check, National Trends in Drug Abuse: Methamphetamine Trends in Five Western States and Hawaii." *Executive Office of the President, Office of National Drug Control Policy* (Summer 1997). <http://www.whitehousedrugpolicy.gov/publications/drugfact/pulsechk/summer97/pcappa.html>

Treatment Modalities

- “Methamphetamine Addiction: Cause for Concern-Hope for the Future.” *Richard Rawson* (2005). www2.apa.org/ppo/rawson62805.ppt
- “Treatments for Methamphetamine-Related Disorders.” *Richard Rawson* (2005). www.psattc.org/events/cates/III/presentations/Rawson_Treatment%20Approaches%20I.ppt
- “Treatment of Methamphetamine Use Disorders: An Update.” *Journal of Substance Abuse Treatment* (2002). http://ncctn.dcri.duke.edu/public/resources/2002/science_p145-150.pdf
- “Treating Methamphetamine Dependence: Healing Injured Brains and Repairing Broken Lives.” *Richard Rawson*. <http://www.ocjc.state.or.us/PSReview/references/RawsonMethTx.pdf>
- “Methamphetamine Treatment Approaches.” *Jeanne Obert*. http://www.psattc.org/events/cates/III/presentations/Obert_TreatmentApproachesII.ppt
- “TIP 33: Treatment of Stimulant Use Disorders.” *Center for Substance Abuse Treatment* (1999). <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.57310>
- “A Multi-Site Comparison of Psychosocial Approaches for the Treatment of Methamphetamine Dependence.” *Addiction* (2004). http://www.ebcprp.org/subpage_folder/MTP_Outcome_Paper.pdf
- “Barriers to Treatment Entry: Case Studies of Applicants Approved for Admission.” *Rand* (2003). <http://www.rand.org/publications/DRU/DRU2949/DRU2949.pdf>