Nevada State Opioid Response Client GPRA Information Sheet

Overview

The treatment in which you are participating was partially funded by the State Opioid Response Grant, a program funded by the Center for Substance Abuse Treatment under the auspices of the Substance Abuse and Mental Health Services Administration (SAMHSA). As part of receiving this funding, we are required to submit data on participants' characteristics and outcomes.

The intent of this evaluation is to assess the impact of funding for substance abuse treatment agencies on patient outcomes. Although it is known that substance abuse treatment aids individuals in the recovery process, your responses will help determine if enhancements made through the funding improve patient outcomes. We believe this evaluation will provide such data.

Evaluation process

You are being asked to complete an interview at three time-points: one at admission to treatment, one six months later, and one at discharge. Each survey will take about 30 minutes to complete. The surveys will ask you about your demographics, alcohol use and illegal drug use, family and living conditions, employment and income, criminal justice involvement, physical and mental health, and social connectedness. You may experience discomfort when you are talking about your story. **You may choose to withdraw from the surveys at any time.**

Your participation in completing these surveys is completely ***voluntary*** and your responses ***confidential*****.** Your receipt of treatment or recovery support services will not be affected by your choice to participate in the evaluation. However, if the project is not able to collect data required by the funding agency, your treatment agency may not provide the same level of services paid for by the project. The risks of participation are minimal because we have taken steps to protect your privacy. All contact information will be stored separately from the interviews.

Your responses will be entered into a secure SAMHSA website for program evaluation purposes, where they will only be reported in aggregate. Aggregate results may also be used by the State, grant, or treatment agency to adjust services funded. The interviewers and the University of Nevada, Reno will treat your identity and the information collected about you with professional standards of confidentiality and protect it to the extent allowed by law. The US Department of Health and Human Services, the University of Nevada, Reno Research Integrity Office, and the Institutional Review Board may look at your study records.

If you choose to participate in the interviews, you will receive a gift card in exchange for your time. A gift card will be given to you after each interview – admission to treatment, discharge from treatment, and follow-up 6-months after admission to treatment. If the interview is completed over the phone, the gift card will be mailed to the address you provide or given to you at your next appointment.

If you have questions about the evaluation, please contact Carina Rivera, 775.682.8501 at any time.

You may ask about your rights as a participant. If you have questions, concerns, or complaints about the form, you may report them (anonymously if you so choose) by calling the University of Nevada, Reno Research Integrity Office at 775.327.2368.

Thank you for your participation!

Client Consent and Contact Form

I have read the information above or it has been read to me. The evaluation has been explained and all questions have been answered. By signing this consent form, I agree to:

- Be part of this evaluation and for my interview information to be used for evaluation purposes.
- Be contacted at discharge and six-month follow-up. I can decide at that time whether to be interviewed.
- I agree to share information regarding my treatment and services I receive as a result of this grant.
- I give permission for this treatment facility or the evaluators at the University of Nevada, Reno to try to find me for an interview through the names and contact information I provide (i.e., family member, friend, probation officer, sponsor, etc.).

Print Name of Client: _____

Signature of Client: _____ Date: _____

Signature of Agency Witness: _____ Date: _____

Treatment Center Code

First letter of first name	First letter of your middle name (if none, use X)	Sex (1=male 2=female)	First letter of city/town you were born in

First letter of mother/female guardian's first name (can be natural or adoptive)	How many older brothers do you have (half, living, or deceased, if none write X)	How many older sisters do you have (half, living, or deceased, if none write X)

Client First and Last Name: _____

Client Phone Number: _____

Client Address: _____

Client Email Address: _____

Okay to call	Yes ☐	No ☐
Okay to text	Yes ☐	No ☐
Okay to leave voicemail	Yes ☐	No ☐

Sometimes people are more likely to have phone service during the beginning or end of the month.

1. Is there a time of the month when you are more likely to have minutes on your phone?

   _____

When we contact you or others who may know of your whereabouts, we will not share any information about your treatment.

1. **Is it okay to say that we are from this treatment organization?**
   - ○ **Yes**, it's okay to say where you are calling from
   - ○ **No**, please do not say where you are calling from.

2. **Is it okay to say that you are participating in "a health survey"?**
   - ○ **Yes**, it's okay to say that I'm participating in a health survey.
   - ○ **No**, please do not say that I'm participating in a health survey.

Do you have any relatives who usually know how to reach you if you should change your phone number or leave the program?

First and Last Name: _____

Relationship to client: _____

Phone Number: _____

Email Address: _____

Okay to call	Yes ☐	No ☐
Okay to text	Yes ☐	No ☐
Okay to leave voicemail	Yes ☐	No ☐

Do you have any friends who usually know how to reach you if you should change your phone number or leave the program?

First and Last Name: _____

Relationship to client: _____

Phone Number: _____

Email Address: _____

Okay to call	Yes ☐	No ☐
Okay to text	Yes ☐	No ☐
Okay to leave voicemail	Yes ☐	No ☐

Do you have a peer recovery specialist or an AA, NA, DRA, or other self-help group sponsor or fellow that would know how to reach you?

First and Last Name: _____

Relationship to client: _____

Phone Number: _____

Email Address: _____

Okay to call	Yes ☐	No ☐
Okay to text	Yes ☐	No ☐
Okay to leave voicemail	Yes ☐	No ☐

Are there any other people who may know of your whereabouts, such as a doctor, caseworker, community clinic, or counselor that you see regularly?

First and Last Name: _____

Relationship to client: _____

Phone Number: _____

Email Address: _____

Okay to call	Yes ☐	No ☐
Okay to text	Yes ☐	No ☐
Okay to leave voicemail	Yes ☐	No ☐

Are you currently on probation/parole?

Yes ☐ No ☐

If yes, which one?

Probation ☐ Parole ☐

When does it end? Month:_____ Year:_____

Name of Officer	
Phone Number	( ) -
Email Address	