

# **2012 NATIONAL SURVEY ON DRUG USE AND HEALTH**

## **METHODOLOGICAL RESOURCE BOOK SECTION 16a: MENTAL HEALTH SURVEILLANCE STUDY OPERATIONS REPORT (2008-2012)**

Substance Abuse and Mental Health Services Administration  
Center for Behavioral Health Statistics and Quality  
Rockville, Maryland 20857

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# 2012 NATIONAL SURVEY ON DRUG USE AND HEALTH: MENTAL HEALTH SURVEILLANCE STUDY OPERATIONS REPORT (2008-2012)

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# 1. Introduction

The overarching goal of the Mental Health Surveillance Study (MHSS) of the National Survey on Drug Use and Health (NSDUH) is to provide accurate estimates of the prevalence of serious mental illness (SMI) among adults aged 18 or older at the national and State levels. Public Law No. 102-321, the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act of 1992, established a block grant for States to fund community mental health services for adults with SMI. The law required States to include prevalence estimates in their annual applications for block grant funds. This legislation also required the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop an operational definition of SMI and to produce national and State estimates. The MHSS clinical follow-up study was conducted as part of NSDUH to develop a model to generate estimates of SMI.

On May 20, 1993, SAMHSA's Center for Mental Health Services (CMHS) published its definition of SMI in the *Federal Register*:

Pursuant to Section 1912(c) of the Public Health Services Act, as amended by Public Law 102-321, "adults with serious mental illness" are defined as the following:

- Persons aged 18 and over, who currently or at any time during the past year, have had diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R [sic] that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities.
- These disorders include any mental disorders (including those of biological etiology) listed in DSM-III-R or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-III-R "V" codes, substance use disorders, and developmental disorders, which are excluded unless they co-occur with other diagnosable serious mental illness.
- All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity or disabling effects. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities, including basic daily living skills (e.g., eating, bathing, dressing); instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts.
- Adults who would have met functional impairment criteria during the referenced year without benefit of treatment or other support services are considered to have serious mental illnesses.

In December 2006, a technical advisory group meeting of expert consultants was convened by the Office of Applied Studies (now the Center for Behavioral Health Statistics and Quality [CBHSQ]) and CMHS to solicit recommendations for mental health surveillance data collection strategies among the U.S. population. The panel recommended that NSDUH be used to produce estimates of SMI among adults by including short scales in NSDUH's main interview

that are strong predictors of SMI and that a "gold standard" clinical psychiatric interview be administered to a subset of respondents to provide the data for estimating a statistical model that predicts SMI. In response, SAMHSA's CBHSQ initiated the MHSS as part of NSDUH to develop and implement a method to estimate SMI. At the time, NSDUH contained a six-item scale (Kessler-6, or K6) with five response options in each item that captured information on psychological distress in the past 12 months (Kessler et al., 2003). However, the K6 scale is not a diagnostic instrument and does not capture information on functional impairment, which is needed to determine whether a respondent can be categorized as having SMI under SAMHSA's definition. In consultation with the technical advisory group, two candidate impairment scales were selected by SAMHSA to be added to the 2008 NSDUH. They were an abridged version of the World Health Organization Disability Assessment Schedule (WHODAS; Rehm et al., 1999) and the Sheehan Disability Scale (SDS; Leon, Olfson, Portera, Farber, & Sheehan, 1997). An initial step was to modify these scales for use in a general population survey, including changes to question wording and length, which resulted in an abbreviated eight-item version of the WHODAS (Novak, Colpe, Barker, & Gfroerer, 2010).

A feasibility study was conducted in June 2007 to test the procedures and instruments proposed for the MHSS, as well as to assess the training needs for both the field interviewers and the clinical interviewers.<sup>1</sup> The MHSS was conducted first in 2008. A split-sample design was used in the 2008 NSDUH, for which all adult respondents to the main NSDUH interview received the K6, but a random half of the sample received the WHODAS and the other half received the SDS. In addition, a subsample of approximately 1,500 adult NSDUH participants completed a follow-up clinical interview to provide data for developing models to estimate mental illness using the NSDUH full-sample interview data. The randomization of the impairment scales was maintained within this clinical interview subsample, so that about half of the MHSS sample participants were administered the WHODAS and half were administered the SDS (i.e., there were approximately 750 completed interviews from each half sample). Each participant in the 2008 MHSS clinical study was administered the Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Non-patient Edition (SCID-I/NP or SCID; First, Spitzer, Gibbon, & Williams, 2002), which was adapted for this study. Trained clinical interviewers administered the paper-and-pencil SCID to respondents over the telephone approximately 2 to 4 weeks after the NSDUH interview. Functional impairment ratings were assigned by clinical interviewers using the Global Assessment of Functioning (GAF) scale.<sup>2</sup> The model estimation analyses used "gold standard" measures (i.e., the SCID/GAF combination as the indicator of SMI) in evaluating which combination of the K6 and impairment scale worked best in the statistical model used to predict SMI status. Based on an analysis of the 2008 MHSS data, it was determined that the WHODAS would be administered as the sole impairment scale in subsequent NSDUHs (starting in 2009) and that it would be used in combination with the K6

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<sup>1</sup> More details on the MHSS feasibility study can be found in Section 3.3 of the 2012 MHSS design and estimation report (Liao et al., in press).

<sup>2</sup> The GAF score is based on a numeric scale (0 through 100) that is used to subjectively rate the social, occupational, and psychological functioning of adults and is presented and described in the DSM-IV-TR (American Psychiatric Publishing, 2000, p. 32; Endicott, Spitzer, Fleiss, & Cohen, 1976). Lower scores represent higher levels of functional impairment. Descriptions of impairment are provided at 10-point intervals such as 1 to 10, 11 to 20, and so on up to 91 to 100. For example, a GAF score between 51 and 60 is described as having moderate symptoms of impairment, while a score higher than 60 represents several categories of impairment ranging from none to slight, and a score lower than 51 represents several categories ranging from serious to extreme.

scale to predict SMI. For more details, refer to the 2008 MHSS analysis report by Aldworth et al. (2009).

From 2009 through 2012, the MHSS was conducted similarly to the 2008 MHSS, with two major differences: (1) only the WHODAS impairment scale was administered in the NSDUH, and (2) the sample size was approximately 500 in 2009 and 2010 and approximately 1,500 in 2011 and 2012. Based on the 2008 MHSS clinical data, a model was developed and implemented in the 2008-2011 NSDUHs to produce a predicted probability of having SMI for each clinical interview respondent. Although this model was optimized to predict SMI, the SMI predicted probabilities were also used to predict mild (or low) mental illness, moderate mental illness, and any mental illness (AMI) using different cut points (for more details about this model, see Liao et al., 2012). After data collection ended for the 2012 MHSS, a revised and improved model was used to predict mental illness for the 2012 NSDUH using the combined clinical data from 2008 to 2012 (subsequently referred to as the "2012 model"). The 2008 model substantially overestimated SMI and AMI among young adults relative to the clinical interview data because of the small number of respondents in the 2008 clinical subsample. In addition, improvements were needed in the weighting procedures for the MHSS clinical data to better account for nonresponse and undercoverage (i.e., because persons with mental illness appeared to be more likely to participate in the clinical follow-up and because only NSDUH respondents who answered their surveys in English were eligible for the follow-up). To reduce bias and improve prediction, additional mental health–related variables and an age variable were added in the 2012 model. To reduce coverage and nonresponse error, alternatives for the weights were applied to the clinical sample data for the model development. To provide consistent data for trend assessment, the mental illness estimates were recomputed for 2008-2011 using the new 2012 model. The 2012 MHSS design and estimation report contains the details on the estimation of mental illness (Liao et al., in press).

This report describes data collection operations for the 2008-2012 MHSS. Specifically, the following topics are described: Management Structure and Staffing, Data Collection Staffing, Data Collection Materials, Staff Training, Data Collection, Data Collection Results, and Data Collection Quality Control. Unless changes are specified in this report, the operations, protocols, and materials remained generally the same for the MHSS each year.

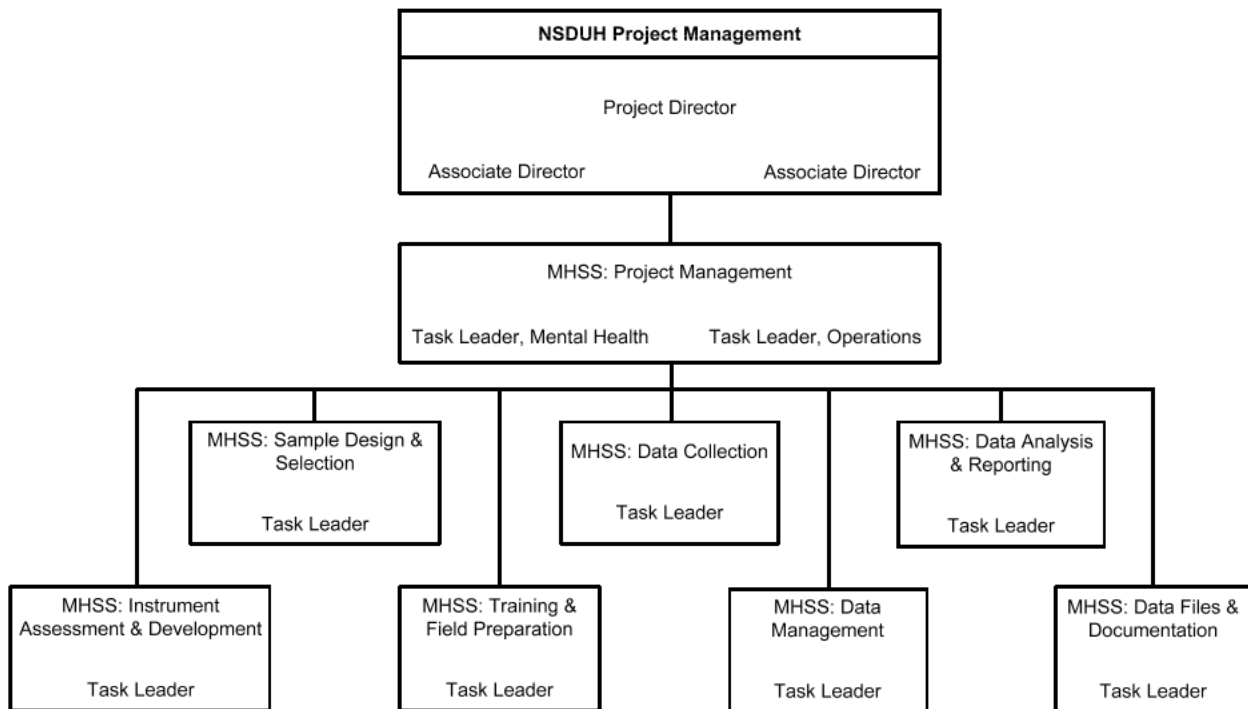


## 2. Management Structure and Staffing

This chapter describes the management organizational structure and staffing for the Mental Health Surveillance Study (MHSS) task on the National Survey on Drug Use and Health (NSDUH) contract. NSDUH is sponsored by the Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies) within the Substance Abuse and Mental Health Services Administration (SAMHSA) and is conducted by RTI International in Research Triangle Park, North Carolina.<sup>3</sup> Exhibit 2.1 shows the organizational structure for the 2012 MHSS, including each operational area and task leader at RTI International.

This chapter provides a general description of the activities performed under each MHSS operational area. Overall project management for the MHSS is described in Section 2.1. For each MHSS operational area, when possible, the task leader for the NSDUH main study led the corresponding MHSS task. This management structure provided efficiency gains for the MHSS by taking advantage of the infrastructure, best practices, and staff experience from the main study. However, for some MHSS operational areas, such as data collection, it was beneficial to have a separate task leader focused on managing the completion of MHSS activities because the work for these tasks differed greatly from the main study activities. Unless specified below, the MHSS management structure and general activities completed under each operational area remained the same from 2008 to 2012.

**Exhibit 2.1 MHSS Organizational Structure**



MHSS = Mental Health Surveillance Study.

<sup>3</sup> RTI International is a trade name of Research Triangle Institute.

## **2.1 Project Management**

The NSDUH Project Director and Associate Project Directors oversaw the schedule, planning, and implementation of major MHSS activities and worked in collaboration with SAMHSA and MHSS task leaders to develop solutions to any anticipated challenges or problems encountered. The mental health task leader oversaw and provided expertise and guidance on clinical activities for the MHSS data collection. For example, this task leader directly supervised the clinical supervisors (CSs) and provided supervision to clinical interviewers (CIs) on challenging cases, distressed respondent cases, and quality control (see Sections 3.2 and 3.3 for more information on CS and CI roles). The mental health task leader was also responsible for consulting as needed with Dr. Michael First, the lead author of the Structured Clinical Interview for DSM-IV Axis I Disorders Non-patient Edition (SCID-I/NP or SCID; First, Spitzer, Gibbon, & Williams, 2002), and making recommendations to SAMHSA for SCID revisions each year. The operations task leader oversaw the day-to-day MHSS project operations, including the schedule, budget, staffing, and implementation of each MHSS operational area described below (and shown in Exhibit 2.1). The operations task leader also directly supervised the data collection managers (DCMs) for the MHSS. (See Section 3.1 for more information on the DCM role.)

## **2.2 Instrument Assessment and Development**

The instrumentation activities for the MHSS included developing the computer-assisted interviewing (CAI) recruitment scripts used at the end of the NSDUH interview and the instrument used for the follow-up clinical interview.

For the CAI recruitment scripts, each NSDUH interview respondent who was eligible and selected for recruitment for the MHSS was asked at the end of the interview to participate in the follow-up clinical interview. As shown in Appendix A, the NSDUH interview included a series of carefully scripted recruitment screens to guide the NSDUH field interviewer (FI) through the recruitment steps for the MHSS. Because these recruitment scripts were part of the NSDUH interview, this part of the instrument assessment and development task for the MHSS was led by the same instrument assessment and development task leader who led this task on the NSDUH main study. This task leader, with assistance from other NSDUH survey methodologists, developed the specifications for these recruitment scripts and then tested them once approved by SAMHSA and programmed in the CAI instrument.

Respondents who agreed to the follow-up interview were administered the paper-and-pencil SCID by trained CIs over the telephone approximately 2 to 4 weeks after the NSDUH interview. As discussed in Section 4.2.2, RTI modified the SCID in 2007 for the MHSS to assess past 12-month mental health disorders (versus past 30-day mental health disorders) and functioning via telephone interview by a trained CI. The mental health task leader consulted with and obtained approval from Dr. Michael First and SAMHSA on these initial SCID modifications and any revisions to the SCID each year of the MHSS. Dr. First provided training and guidance on the SCID as needed throughout the course of the study.

The instrument assessment and development task leader was also responsible for incorporating the MHSS instruments, informed consent protocol, materials, and procedures into the Office of Management and Budget (OMB) and Institutional Review Board (IRB) packages for the NSDUH. The MHSS task leaders from each operational area provided input and materials

for the OMB and IRB packages as needed. Chapter 4 includes additional information on the MHSS data collection instruments, informed consent procedures, and OMB and IRB packages.

### **2.3 Sample Design and Selection**

MHSS sample design and selection included designing the MHSS sample, monitoring the sample yield, creating design-based weights, and calculating response rates for each annual sample. During each data collection quarter, the sample design and selection task leader worked with the DCMs to monitor the sample yield and make projections for the anticipated number of completes. At the end of each quarter, the task leader adjusted the sampling rates as needed to yield the desired number of interviews for the year. At the conclusion of data collection, design-based weights and final response rates were calculated by the RTI statisticians who also completed these activities for the NSDUH main study. Chapter 3 of the 2012 MHSS design and estimation report (Liao et al., in press) includes more information on the MHSS sample design and selection, and Chapter 7 of this report provides more detail on MHSS response rates.

### **2.4 Training and Field Preparation**

The activities for MHSS training and field preparation included recruiting, training, and certifying the CSs and CIs; developing training materials for CI training sessions and NSDUH new-to-project (NTP) and veteran FI training sessions; and developing and duplicating survey materials.

Under the direction of the mental health task leader, the DCMs and CSs conducted extensive efforts to recruit, hire, and maintain a team of CIs. The DCMs assisted the mental health task leader with the logistics and administrative aspects of recruiting and hiring the CIs, while the CSs assisted with the candidate interviews. The number of CIs recruited, trained, certified, and staffed was approximately 7 for the 2009 and 2010 MHSS with a target sample of 500 interviews, and approximately 21 for the 2008, 2011, and 2012 MHSS with a target sample of 1,500 interviews.

To maintain NSDUH best practices for training and materials development, the task leader for MHSS training and field preparation was the same task leader who oversaw training and materials development on the NSDUH main study. As described in Chapter 5, all CIs were required to complete a 4-day, in-person training session with a nonclinical agenda detailing administrative tasks and a clinical agenda focusing on SCID administration and distressed respondent protocols. Under the planning and leadership of the training and field preparation task leader, the mental health task leader and CSs developed and trained CIs on the clinical material, and the DCMs and survey specialists developed and trained CIs on administrative activities associated with MHSS data collection. Once training ended, each CI was required to complete and pass a certification with volunteer respondents on the phone before contacting MHSS sample participants to conduct follow-up interviews. The DCMs assisted with the logistics of these certification interviews, including recruitment, screening, and scheduling. Each certification interview was carefully evaluated by the mental health task leader and/or a CS to determine whether the CI trainee properly administered the instrument. Each CI had three opportunities to complete and pass certification or face termination.



In addition to the CI training and certification materials, the MHSS training development activities included developing training materials for main study NTP and veteran FIs, including self-study materials and in-person training. The training and field preparation task leader and staff prepared the training materials on FI-specific protocols and procedures for recruiting respondents for the follow-up clinical interviews. These procedures included following the scripts provided at the end of the NSDUH interview to recruit respondents, providing the follow-up study description for informed consent, giving the \$30 incentive to respondents who agreed to complete the follow-up interview, and collecting adequate respondent contact information for CI follow-up.

The training and field preparation task leader and staff also developed and duplicated the materials needed for MHSS recruitment and data collection, including the follow-up study description, reminder card, interview payment receipt, and the MHSS SCID booklet. More information is provided on the recruitment and staffing for MHSS data collection in Chapter 3, the MHSS data collection materials in Chapter 4, and the MHSS training in Chapter 5.

## **2.5 Data Collection**

The main activity for the data collection task was to complete 1,500 follow-up clinical interviews for the 2008, 2011, and 2012 MHSS and 500 follow-up clinical interviews for the 2009 and 2010 MHSS. As described in Chapter 3, one to two DCMs managed production through regular e-mail and weekly conference calls with the CIs and reports provided on the Web-based NSDUH Case Management System (CMS). The DCMs assigned MHSS cases, monitored the record of calls, managed production and costs, sent unable-to-contact letters to unresponsive sample participants, and managed administrative tasks for the CIs (e.g., approving time sheets and expense reports). The DCM assigned individual cases to a specific CI, taking time zone considerations and availability into account. The CI then completed the follow-up clinical interview as soon as feasible after the NSDUH interview was completed, with contact attempts beginning within 24 hours of receiving a case. Each follow-up interview was required to be completed within 4 weeks of the date of the NSDUH interview. During each MHSS interview, the CI completed the SCID on paper and audio-recorded the interview (with respondent permission).

Documenting the CIs' performance and providing feedback to the CIs were integral to the MHSS data collection task and the clinical supervision process. As discussed in Chapter 8, the mental health task leader and CSs conducted these quality control activities for data collection. Within 48 hours of completing the interview, the CI uploaded the audio file to the CMS and edited and shipped the paper SCID to RTI for proper handling, keying, and analysis. The CSs reviewed all SCID booklets item by item, compared the notes provided by the CI with the diagnostic rating, and listened to the accompanying audio files, as needed, to ensure confidence in the data. The mental health task leader and CSs reviewed the full audio recordings for a randomly selected 10 percent of the clinical interviews. The SCID data were also checked electronically for internal coding consistency. The CSs provided feedback to the CIs for each full review conducted. The mental health task leader and CSs also reviewed and provided guidance on all distressed respondent cases.

To further ensure the quality of the data being collected in the clinical interviews, interrater reliability exercises were conducted at the end of each calendar quarter. For these

exercises, the mental health task leader, CSs, and CIs listened to the audio file from a selected interview (available through the Web-based CMS) and independently rated the assessed symptoms (e.g., present, absent, subthreshold, or not enough information) and disorders (e.g., present, absent, or not enough information). The mental health task leader and CSs used these exercises to estimate interrater reliability, to evaluate the diagnostic skills of the CIs, and to provide retraining for the CIs to reduce error in data collected in future quarters. More information on MHSS data collection activities is provided in Chapter 6 of this report.

## **2.6 Data Management**

MHSS data management provided for software and system development and support for CIs, CSs, and DCMs. Because the MHSS used similar software, hardware, and CMS functions and reports as the NSDUH main study, this MHSS task was led by the same data management task leader who led this task in the NSDUH main study. MHSS data management included initial and ongoing development and support for the computer systems used to automate and manage MHSS data collection and workflow. The specific systems developed and supported by NSDUH programmers for the MHSS were

- laptop-based MHSS CMS for CIs, preconfigured with encryption software and custom software to automate the secure upload of audio files using the encryption facilities of the HTTPS protocol;
- Web-based MHSS CMS for assignment and transfer of MHSS cases, management of MHSS workflow, and review of MHSS audio files;
- MHSS data transmission system, including server-side Web services, to allow bidirectional transmission of MHSS data and audio files between RTI and MHSS CI laptops;
- MHSS daily and weekly automatic report generation software;
- interactive MHSS job scheduling and background data processing; and
- MHSS laptop software to integrate Skype voice over Internet protocol telephone services into the MHSS laptop configuration using the Skype application programming interface for .NET.

In addition to those activities, the data management task included daily phone and e-mail support for CIs, CSs, and DCMs. A second-tier technical support team provided this support.

## **2.7 Data Analysis and Reporting**

The primary objective of the MHSS analysis is to produce annual national estimates of serious mental illness prevalence that have sound psychometric properties, that are accurate, and that use similar methodologies, so it is possible to examine trends over time. Secondary objectives include predicting other categories of mental illness, such as any mental illness, mild (or low) mental illness, and moderate mental illness. Under this operational area, estimation methodology was developed by RTI statisticians and SAMHSA to produce annual estimates of mental illness.

In addition to creating a method for estimating mental illness, methodological studies and analytic reports were completed as part of the 2011 and 2012 MHSS. Each methodological or analytic study was led by and staffed with substantive, methodological, statistical, and survey data collection experts based on the mental health study topic. To closely monitor the status and progress of these studies, a research epidemiologist was responsible for the overall management (i.e., staffing, quality, schedule, and budget) for all MHSS analytic studies, and a research methodologist was responsible for the overall management for all MHSS methodological studies. This management structure enabled these task leaders to focus on the completion of these special methods and analytic studies while the overall task leader for MHSS analysis focused on modeling analyses.

Finally, under the leadership of the same operational directors responsible for the national reports and data tables on the NSDUH main study, RTI provided data tables, technical appendices, graphs, and other pictorial displays as requested by SAMHSA for the NSDUH mental health findings report.

## **2.8 Data Files and Documentation**

The main activity for the MHSS data files and documentation task was to produce a MHSS analytic data file and codebook each MHSS year. Because the MHSS data file and codebook activities were similar to the NSDUH main study, this MHSS task was led by the same task leader as the NSDUH main study. The master database was initiated with the raw, transmitted CAI data from the NSDUH interview. The SCID data were keyed and edited by data clerks and merged into the master database. As data processing proceeded and data items became available after editing, coding, imputation, and weighting procedures, they were merged onto the master database. As files were needed either for internal use or for delivery to SAMHSA, the requested data were extracted to working data files, and corresponding codebook information was generated under program control.

For each MHSS year, a preliminary weighted data file was prepared from the master database. This file was delivered to SAMHSA on a CD in PC SAS<sup>®</sup> format along with a codebook containing frequencies of data items. These data included all edited, imputed, and recoded analysis variables; weights; estimation variables; and variables used to create the population estimates and associated tables and all special tables.

Once all variable creation was completed, a comprehensive data file was extracted from the master database and a codebook was generated. In addition to the edited variables, imputation-revised variables, recodes, weighting and estimation variables, and selected raw data items were included as requested by SAMHSA. The 2008-2012 Adult Clinical Interview Data File was delivered in PC SAS format to SAMHSA on a CD that also included the electronic version of the file's codebook. Introductory text, selected tables, appendices of codes, and further details were added to the system-generated codebook to document this file.

## 3. Data Collection Staffing

This chapter describes the staffing for Mental Health Surveillance Study (MHSS) data collection, including a description of the data collection manager (DCM), clinical supervisor (CS), and clinical interviewer (CI) positions and responsibilities, as well as any problems encountered with staffing these positions for the MHSS. More information is provided on MHSS training, data collection, and quality control activities in Chapters 5, 6, and 8, respectively.

### 3.1 Data Collection Managers

Depending on DCM workload and availability, one or two DCMs monitored MHSS field operations and data collection staffing, production, and costs. Over the course of the study, six different DCMs worked on the MHSS. The DCMs reported to the National Survey on Drug Use and Health (NSDUH) Associate Project Director overseeing MHSS operational activities. All DCMs were bachelor's- or master's-level survey managers who also worked on the NSDUH main study. DCMs were responsible for

- assigning follow-up clinical interview cases to the CIs based on respondent and CI availability;
- monitoring the completion of clinical interviews, including reviewing the record of calls, providing guidance to CIs on contact attempts, and directing CIs to assign final disposition codes to clinical interview cases (e.g., codes assigned that indicated interview complete, unable to contact, refusal);
- sending unable-to-contact letters to remind unresponsive MHSS sample participants to contact the DCM and schedule an interview appointment;
- confirming interview audio files were uploaded to the Web-based Case Management System;
- confirming the receipt, editing, and keying of completed Structured Clinical Interviews for DSM-IV Axis I Disorders Non-patient Edition (SCID-I/NPs or SCIDs; First, Spitzer, Gibbon, & Williams, 2002) booklets at RTI International;
- producing and reviewing weekly and daily data collection status reports;
- conducting weekly conference calls with CIs to review and discuss case assignment status, schedules, record of calls, challenging cases, and technical problems;
- approving CS and CI weekly timesheets and expense reports;
- assisting with the logistics and administrative aspects of recruiting, hiring, and training CIs;
- assisting with recruitment, screening, and scheduling of certification interviews; and
- monitoring completion of the quarterly interrater reliability (IR) exercises.

### 3.2 Clinical Supervisors

Depending on the MHSS sample size each year, two to four CSs, all of whom had doctoral-level training in psychology, closely monitored the MHSS data for quality and accuracy. As described in Section 5.5, the CSs were licensed psychologists who had been trained and certified in SCID administration by the SCID's developer, Dr. Michael First. The CSs also received refresher training by the developer each year from 2008 to 2011. The CSs reported to the mental health task leader, who oversaw and provided expertise and guidance on clinical activities for the MHSS data collection. The CSs' responsibilities included

- screening, interviewing, and selecting highly qualified CIs;
- developing and revising clinical materials for and conducting new-to-project and veteran CI training sessions and certification interviews;
- developing and revising certification and production versions of the SCID booklet, including the Distressed Respondent Protocol (DRP);
- developing and revising manuals for editing, keying, and coding/recoding SCID data;
- reviewing and editing completed SCID booklets and audio files for quality and accuracy;
- providing individual supervision and feedback to CIs on the SCID, clinical interviewing issues, challenging cases, and distressed respondents;
- monitoring the CIs' quality of work when administering the SCID and alerting the DCMs of any concerns (see Section 8.1 for more information); and
- conducting quarterly interrater reliability (IR) exercises, which included selecting an interview for review; collecting, scoring, and analyzing the CIs' and CSs' IR data; reviewing the results of the exercise during conference calls with the CIs, CSs, and staff from the Substance Abuse and Mental Health Services Administration (SAMHSA); and submitting a quarterly report to SAMHSA summarizing the IR results.

### 3.3 Clinical Interviewers

As shown in Table 3.1, 6 to 23 CIs collected SCID data for each year of the MHSS. The number of CIs needed for the MHSS varied by the target number of completed interviews per year, which was 1,500 in 2008, 2011, and 2012, and 500 in 2009 and 2010. On average, 7 CIs per 500 interviews were staffed for the MHSS.

**Table 3.1 Number of Clinical Interviewers Staffed for the 2008-2012 MHSS**

MHSS	Target Interviews (#)	CIs at Beginning of Year (#)	Replacement CIs Certified (#)	Total CIs (#)	CI Attrition (#)	CIs at End of Year (#)	CI Attrition (%)
2008	1,500	22	3	25	3	22	12
2009	500	8	0	8	2	6	25
2010	500	6	2	8	1	7	13
2011	1,500	21	9	30	7	23	27
2012	1,500	23	0	23	2	21	9

CI = clinical interviewer; MHSS = Mental Health Surveillance Study.

When hiring for the 2008 MHSS, the necessary CI credentials included having a master's or doctoral degree in clinical or counseling psychology, a medical degree with a specialty in psychiatry, or an advanced degree in a related field such as clinical social work. After the first year of the MHSS data collection, it was determined that CIs with a terminal master's degree were not adequately prepared by their graduate training to meet the data quality standards required for this study. Therefore, starting with recruitment for the CI training session held in December 2009 for the 2010 MHSS, all applicants were required, at a minimum, to be enrolled in their third year of a doctoral-level psychology program at the time of applying for the position. CIs were responsible for

- successfully passing CI training and certification before MHSS data collection;
- contacting respondents and scheduling clinical interviews;
- obtaining informed consent and administering the SCID interviews according to MHSS study protocols, including uploading electronic recordings of the interviews and shipping SCID booklets to RTI for editing and keying;
- attending scheduled individual meetings with CSs for supervision and seeking CS supervision as needed;
- participating in quarterly IR exercises, group conference calls, and re-training exercises;
- attending weekly meetings with the DCM and seeking supervision as needed; and
- following the DRP (see Section 4.2.5) when encountering respondents who reported suicidal ideation, reported homicidal ideation, or appeared upset or agitated during the interview.

Potential MHSS CI applicants were drawn from two main sources: (1) American Psychological Association (APA)–accredited graduate programs in clinical and counseling psychology, professional psychology internships, and postdoctoral training (APA Web directory; American Psychology Postdoctoral and Internship Centers directory), and (2) key professional organizations in psychology, psychiatry, social work, and counseling that emphasized research and stated psychological associations (e.g., APA Web directory, Association for Behavioral and Cognitive Therapies Web directory). Additionally, when CI positions became available, former CIs who had proven to be strong interviewers were contacted and encouraged to apply and share the announcement with others.

For the initial training in 2007, a total of 268 Web-based applications were received between September 1 and October 1. The DCMs screened these applications to ensure that the applicants met the necessary criteria. Of the 268 applicants, 84 percent ( $n = 225$ ) met the necessary criteria and were considered as possible hires. These 225 applications were reviewed by the mental health task leader, who selected the applicants for an interview with a CS. With a goal of hiring 30 CIs, the MHSS CSs conducted interviews with the top 90 CI applicants, of whom 45 (50 percent) were considered for hiring based on their credentials and skills. The CSs rank-ordered these candidates to create a list of 30 newly hired CIs and a pool of 15 applicants who would serve as backup CIs.

For the final training in 2011, changes were made to the application process to streamline CI recruiting. First, as described previously, the CI criteria had been revised beginning with the recruitment for the 2009 CI training session to include, at a minimum, being enrolled in their third year of doctoral coursework. By eliminating applicants who were trained in a terminal master's degree program, applicants were pre-selected with the highest potential for hiring. Second, applicants who met the minimal criteria on the Web-based application were automatically sent an e-mail inviting them to schedule a screening interview with an outside hiring agency (under subcontract to RTI). Applicants who passed the screening interviews were then reviewed by the mental health task leader, who selected the top applicants for an interview with a CS. Using this process, a total of 552 Web-based applications were received between March 1 and April 24, 2011. Of these, 285 applicants (52 percent) met the necessary criteria and were considered as possible hires. These 285 applicants were invited for a screening interview with the hiring agency. The first 84 applicants who passed the screening interview were reviewed by the mental health task leader, who selected the applicants for an interview with a CS. The CSs conducted interviews with 53 CI applicants, of whom 35 (66 percent) were considered for hiring based on their credentials and skills. The CSs then rank-ordered the candidates to create a list of 12 newly hired CIs and a pool of backup CIs.

Applicants who met the necessary criteria were categorized as "High," "Medium-High," "Medium," "Medium-Low," and "Low" for priority of interviewing, based on their past or present experience with a structured diagnostic interview (e.g., the SCID or equivalent), comparatively recent research experience (e.g., adhering to a research study protocol in the past 10 years), diagnostic assessment experience with Axis I disorders, and geographic location (with lower priority for applicants applying in time zones for which there was a sufficient number of "High" priority applicants). Applicants were categorized as "No Priority" if they admitted to no recent research experience (e.g., during the last 10 years) and if they reported limited experience conducting Axis I assessments. Individuals in this category most often were private practitioners whose primary activity was conducting psychotherapy. The top applicants for each of the three time zones (Eastern, Central, and Mountain/Pacific Standard Time) were invited for telephone interviews with the MHSS CSs; these interviews included administering parts of the SCID during a mock interview. Approximately three times the number of applicants needed for hire were invited for interviews (i.e., 90 interviews to fill 30 slots in 2007). A pool of backup applicants who completed the telephone interviews but did not make the first round of hiring was also created. The applicants on this alternate list agreed to be contacted if additional opportunities for hiring arose on the MHSS.

To ensure adequate coverage during peak times of interview requests, the CIs hired for the study were distributed across the Eastern, Central, and Mountain/Pacific Standard Time zones. Based on experience hiring CIs of this caliber for the National Vietnam Veterans Longitudinal Study and the NSDUH Clinical Validation Study, it was anticipated that between 20 and 30 percent of the CIs hired would not pass the certification standards. Therefore, 30 percent more CIs were generally hired than needed for data collection (e.g., in 2007, 30 CIs were hired and trained when 20 were needed for data collection).

### **3.4 Problems Encountered**

Some challenges were encountered with staffing CIs on the MHSS. First, it was determined that CIs with a terminal master's degree were not as prepared for data collection as

those who were enrolled in doctoral programs. For this reason, beginning with recruitment for the 2009 CI training session for the 2010 MHSS, the minimum requirements of applicants for the CI position was raised from a terminal master's degree to requiring that, at a minimum, applicants be enrolled in their third year of a doctoral program at the time of applying for the position.

Second, CI availability was inconsistent depending on personal or professional demands. The "ideal" CI was often at the point of his/her education and professional development where availability changed from year to year; internships, dissertations, and launching one's career often took priority. Many strong CIs cut back their available hours as other personal or professional demands took precedence. Additionally, the employment needs for the MHSS in subsequent years was uncertain at the beginning of the study. CIs, as a result, were unable to rely on continued employment beyond the single-year contract and made commitments to other endeavors.

### 3.4.1 CI Turnover

As previously noted, 30 percent more CIs were generally hired than needed for data collection. As shown in [Table 3.2](#), in 2007, 2010, and 2011, approximately 75 percent of the CIs passed certification and, in 2009, 67 percent passed certification. However, at the replacement training in 2008, only 38 percent (3 out of 8) passed certification. As previously discussed, this lower rate of CIs passing certification was the result of having a pool of applicants in 2008 with a lower minimum education requirement. In 2011, the decision was made to overhire and increase the size of the training classes to mitigate the potential risk of staff turnover and costs associated with conducting an additional training at a later time. This larger training session in June 2011 resulted in maintaining the minimum number of CIs needed throughout the 2012 MHSS data collection period.

As reported in [Table 3.1](#), annual attrition rates ranged between about 9 and 27 percent. The average annual attrition rate following certification was 17 percent. Of the 50 CIs who passed certification over the 5 years of the MHSS (including 6 who were re-certified), 11 resigned due to changes in personal commitments, and 4 were terminated due to skill deficiency. Before termination, individual feedback and coaching were provided to improve CIs' performance. A core group of 11 CIs from the initial study year (2008) remained with the project for its duration or returned to the study: 5 CIs remained with the study for the entire 5 years, and 6 CIs who were with the study in 2008 returned in 2010 or 2011 for the remainder of the study. The greatest risk of turnover for any CI was in the initial year following certification.

**Table 3.2 MHSS Clinical Interviewer Training and Certification Results**

<b>Training Date</b>	<b>Attended Training (#)</b>	<b>Passed Certification (#)</b>	<b>Failed Training or Certification (#)</b>	<b>Pass Rate (%)</b>
November 2007	30	22	8	73
March 2008	8	3	5	38
December 2009	3	2	1	67
October 2010	19	14	5	74
June 2011	12	9	3	75
Total	72	50	22	70

MHSS = Mental Health Surveillance Study.





## **4. Data Collection Materials**

RTI International and the Substance Abuse and Mental Health Services Administration (SAMHSA) staff prepared the necessary interview questionnaire, handbooks, and other survey materials for the Mental Health Surveillance Study (MHSS) each year of data collection. This chapter describes the recruitment materials, interview materials, equipment, handbooks, and Office of Management and Budget (OMB) and Institutional Review Board (IRB) packages used on the MHSS.

### **4.1 MHSS Recruitment Materials**

This section provides a description of the computer-assisted interviewing (CAI) recruitment scripts and materials used by the National Survey on Drug Use and Health (NSDUH) field interviewer (FI) to recruit respondents at the end of the NSDUH interview for the MHSS follow-up clinical interview.

#### **4.1.1 CAI Recruitment Scripts**

NSDUH interview respondents who were eligible and selected for recruitment for the MHSS first learned of the MHSS at the conclusion of the NSDUH interview. As shown in Appendix A, the CAI instrument included a series of carefully scripted recruitment screens to guide the FI through the recruitment steps. The scripts first introduced the study, asking the respondent to complete the follow-up interview within the next 2 weeks. For persons unavailable during those 2 weeks, the time period was extended to 4 weeks. Respondents agreeing to participate were asked to provide contact information including first name, phone number, an alternate phone number if available, and best days and times to call. The FI then provided a \$30 cash incentive for the MHSS interview and concluded the NSDUH interview.

#### **4.1.2 Respondent Materials**

Each NSDUH FI had separate Mental Health Study packets containing the materials needed during the MHSS recruitment process. These materials are provided in Appendix B. When introducing the study, the FI gave the NSDUH respondent a Follow-Up Study Description that contained important information about participation. Those respondents agreeing to the additional interview received a reminder card on which the FI recorded the dates and times the respondent provided for potential contact by phone. When providing the \$30 cash incentive for the MHSS interview, the FI signed and gave the respondent a Follow-Up Interview Payment Receipt. All MHSS recruitment materials were printed on blue paper to distinguish them from similar NSDUH materials.

### **4.2 MHSS Interview Materials**

This section describes the materials used by the clinical interviewer (CI) during the follow-up clinical interview.

#### 4.2.1 Introduction and Informed Consent

During a telephone contact, the CI first confirmed the identity of the MHSS respondent using the respondent's first name only and asked several questions about the safety and privacy level of the respondent's current location. As needed, an alternate time was established for an interview. To reference these introduction steps, see Appendix C, Introduction pages 1-2.

For respondents indicating a willingness to continue, the CI covered the necessary elements of informed consent by reading a script (see Appendix C, Introduction page 2) verbatim that detailed the purpose and nature of the study. The CI mentioned the Follow-Up Study Description provided earlier by the FI, asked if there were any questions, and then asked the person if it was okay to continue with the interview.

Next, for willing respondents, the CI read a script to obtain permission to make an electronic audio recording of the interview (see Appendix C, Introduction page 3). The respondent's participation was not contingent upon providing permission to record. See Section 4.3.2 for more information about MHSS audio recordings.

#### 4.2.2 SCID Content

Respondents who agreed to the follow-up interview and who were later contacted by phone were administered the Structured Clinical Interview for DSM-IV Axis I Disorders Non-patient Edition (SCID-I/NP or SCID, 1/2007 revision; First, Spitzer, Gibbon, & Williams, 2002). Based on the criteria for psychiatric illnesses published in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV; American Psychiatric Association, 1994), the SCID-I/NP is a semistructured interview that has been widely used in clinical calibration studies such as the National Comorbidity Survey-Replication (Kessler et al., 2004), the National Survey of American Life (Jackson et al., 2004), and the NSDUH substance use disorders reappraisal study (Jordan et al., 2008). The SCID has demonstrated good reliability (Zanarini et al., 2000) and validity (Basco et al., 2000). Studies that compared telephone versus face-to-face administration of the SCID have found good agreement (Crippa et al., 2008; Hajebi et al., 2012; Lee et al., 2008). In 2007, RTI modified the SCID for the MHSS to assess past 12-month mental health disorders (versus past 30-day mental health disorders) and functioning via telephone interview by a trained CI.

Diagnostic modules contained in the MHSS version of the SCID are listed in [Table 4.1](#). The modules for lifetime major depressive episode and lifetime manic episode were included to provide context for understanding whether a past year major depressive episode was experienced as part of a unipolar mood disorder or as a component of a bipolar disorder. The module to assess intermittent explosive disorder was obtained from the (optional) Impulse Control Disorders section of the SCID. This module was not one of the core SCID modules, but the developer made it available as an optional SCID module if investigators were interested in measuring intermittent explosive disorder. Appendix C contains the MHSS SCID content.

**Table 4.1 Diagnostic Modules Contained in the MHSS SCID**

<p><b>Mood Disorders</b></p> <ul style="list-style-type: none"> <li>Past Year Major Depressive Episode</li> <li>Lifetime Major Depressive Episode</li> <li>Past Year Manic Episode</li> <li>Lifetime Manic Episode</li> <li>Dysthymic Disorder</li> </ul>	<p><b>Past Year Eating Disorders</b></p> <ul style="list-style-type: none"> <li>Anorexia Nervosa</li> <li>Bulimia Nervosa</li> </ul>
<p><b>Past Year Psychotic Disorders</b></p> <ul style="list-style-type: none"> <li>Psychotic Screen</li> </ul>	<p><b>Past Year Impulse Control Disorders</b></p> <ul style="list-style-type: none"> <li>Intermittent Explosive Disorder</li> </ul>
<p><b>Past Year Anxiety Disorders</b></p> <ul style="list-style-type: none"> <li>Posttraumatic Stress Disorder</li> <li>Panic Disorder with and without Agoraphobia</li> <li>Agoraphobia without History of Panic Disorder</li> <li>Social Phobia</li> <li>Specific Phobia</li> <li>Obsessive Compulsive Disorder</li> <li>Generalized Anxiety Disorder</li> </ul>	<p><b>Past Year Substance Use Disorders</b></p> <ul style="list-style-type: none"> <li>Alcohol Abuse</li> <li>Alcohol Dependence</li> <li>Non-Alcohol Substance Abuse</li> <li>Non-Alcohol Substance Dependence</li> </ul>
	<p><b>Past Year Adjustment Disorders</b></p> <ul style="list-style-type: none"> <li>Adjustment Disorder</li> </ul>

MHSS = Mental Health Surveillance Study; SCID = Structured Clinical Interview for DSM-IV.

In addition to the diagnostic modules, the MHSS SCID included the following:

- An open-ended overview module, designed to elicit information about the respondent's diagnostic and treatment history and current status in a way that establishes some level of rapport between the interviewer and the respondent.
- A screener module containing questions for several of the anxiety disorders and eating disorders. Asking these screener questions together in an early part of the interview minimizes the risk of negative response bias (respondents giving "no" answers to speed the interview along when they figure out that "yes" responses typically lead to additional questions).
- A module containing the DSM-IV Axis V Global Assessment of Functioning (GAF) scale. The interviewer was instructed to rate the respondent's period of worst psychological, social, and occupational functioning during the past year.
- A module for documentation of the CI's impressions of the interview situation, including ratings of the respondent's level of privacy, cooperation, and comprehension, as well as the overall validity of the interview data.

Per the standard SCID administration protocol, respondents were read the scripted SCID questions verbatim, in combination with unscripted follow-up questions that the CI tailored to the respondent in order to gather sufficient clinical information to assign a code to the necessary criteria for each symptom. CIs rated each symptom as being absent ("1"), present at a subclinical level ("2"), or present at a clinically significant level ("3"). CIs could also temporarily rate a symptom as having not enough information ("?") before returning to rate the symptom as absent, present at a subclinical level, or present at a clinically significant level. Based on the codes for each symptom and the criteria needed for diagnosis, the CIs then followed the instructions in the SCID, which were to proceed to the next question or skip ahead to the next module.

Following completion of the interview, respondents were read an End of Interview script (see Appendix C, End of Interview page K.4). CIs ensured that respondents had the toll-free number to the National Lifeline Network should they want additional information about mental health services in their area. If the CI felt the respondent was at all in distress or potentially was a danger to himself or herself or others, a Distressed Respondent Protocol (DRP) was followed (see Section 4.2.5).

#### **4.2.2.1 MHSS SCID Changes**

The SCID's publishers at Columbia University, Biometrics, provided changes to the SCID that were then incorporated into the MHSS version of the SCID for the start of 2010 MHSS data collection.<sup>4</sup> Many of the changes were related to inconsistent use of "?" and "2" ratings for individual SCID items, which Biometrics found upon close examination of the ratings. These errors were corrected so that the use of "?" and "2" were consistent throughout the SCID. The MHSS SCID also incorporated a correction made by Biometrics to ensure that all criteria were met for the diagnosis of panic disorder. None of these changes impacted the data collected in prior years.

Beginning with the 2010 MHSS, codes were added to capture more information about respondents' mental health, which was already being collected by the CIs during the interview as part of the SCID. Therefore, the SCID questions remained the same while variables were added to code the existing data. These new variables included the following:

- type of mental health treatment (counseling, medication, or both) in the past year;
- presence of psychiatric hospitalizations in the past year and the reason(s);
- names of psychotropic medications taken in the past year and/or currently taken;
- score on the Short Blessed Scale (SBS), if administered; and
- potential disorders not assessed for which at least some symptoms were reported or demonstrated by the respondent during the MHSS interview (e.g., bipolar II disorder, attention-deficit/hyperactivity disorder, Asperger syndrome, antisocial personality disorder).

Data for potential disorders not assessed were coded and specified by both the CI and clinical supervisor (CS) in the MHSS SCID booklet (see Appendix C, Interviewer Debriefing pages X.4-X.5). The presence of any disorders not assessed was determined by the respondent's self-reports and the CI's and CS's behavioral observations. The presence of any disorder not assessed was coded by the CI and CS as "1" ("No") or "3" ("Yes"). If any potential disorders not assessed were coded as present ("3"), then the CI and CS specified the name(s) of the disorder(s) implicated for rule-out, described as follows. These data were keyed into open text fields in the dataset. Any potential disorder not assessed was coded according to the following four categories:

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<sup>4</sup> SCID changes were posted to the SCID Web site at <http://www.scid4.org/revisions/jan10.html>.

- Rule-out Other Axis I Disorder (not assessed in study; coded as "1")
- Rule-out Axis II Disorder – Personality Disorder (not assessed in study; coded as "2")
- Rule-out Axis II Disorder – Other (e.g., mild mental retardation; coded as "3"), or
- Rule-out Axis I Disorder assessed but missed (due to CI or respondent error; coded as "4").

#### **4.2.3 GAF Score**

At the end of the interview, the CI assigned a GAF score (see Appendix C, End of Interview pages K.2-K.3) to the respondent. Representing the DSM-IV Axis V assessment, the GAF score ranges from 1 to 100, based on a two-dimensional continuum of (1) psychiatric symptoms—from severe mental illness to superior mental health, and (2) psychosocial functioning—from severe impairment to superior functioning. For example, a GAF score of 5 would indicate very serious psychiatric symptoms and/or grossly impaired functioning, a GAF score of 95 would indicate no symptoms and superior functioning across a wide range of psychosocial and occupational activities, and a GAF score of 50 would indicate serious symptoms or serious impairment in social, occupational, or school functioning. Impairment in functioning due to physical or environmental limitations is not included when assigning a GAF score.

For the MHSS, the CI recorded the GAF score that represented both the respondent's worst symptoms and functioning in the past year. A GAF score is determined by rating both symptoms and functioning according to the GAF scale. If the rating based on either symptoms or functioning is lower than the other, then the lower of the two ratings is used for the GAF score. For example, if a respondent's functioning implicated a GAF score of 50, but the symptoms implicated a GAF score of 30, then the GAF score of 30 would be assigned because it is lower. A respondent would be classified as having serious mental illness if (1) the GAF score was 50 or lower and (2) one or more non-substance use disorders were present in the past year.

#### **4.2.4 Short Blessed Scale**

A protocol was developed for encounters with respondents suspected of having problems with basic cognitive functions (such as attention, language production, orientation, language comprehension, and memory), which could lead to invalid data. As part of this Cognitive Impairment Protocol, the CIs were instructed to immediately break off the contact if the respondent showed signs of cognitive impairment during the introduction and informed consent process; however, if they had started the SCID, the CIs were to stop the interview and administer the SBS to respondents. The SBS (see Appendix C, Cognitive Impairment Protocol page CIP.1) is a six-item scale designed to assess cognitive ability according to orientation, memory, and concentration. These questions are provided to CIs in the Cognitive Impairment Protocol section at the back of the SCID booklet. SBS scores indicate the number of errors, ranging from 0 to 28. Errors on the SBS can be indicative of temporary cognitive impairment (e.g., alcohol intoxication, medication side effects) or more long-term cognitive dysfunction (e.g., dementia, head injury).

For 10 or fewer errors on the SBS, CIs were instructed to resume the interview and to note the situation in the interviewer debriefing questions at the end of the SCID. For more than

10 errors, CIs were instructed to break off the interview and to document the situation when they entered the interview status code of "56: Breakoff (Partial Interview)" in the Web-based Case Management System (CMS). CIs were instructed to attempt to complete the interview at another time if the respondent's cognitive impairment was deemed temporary (e.g., under the influence of alcohol or some other mind-altering substance). If completing the SCID at another time, CIs were instructed to review the portions of the SCID completed earlier, to verify accuracy, and to include the reason for the breakoff in the debriefing questions. The results of administering the SBS in the MHSS are provided in Section 7.4.

#### 4.2.5 Distressed Respondent Protocol

CIs were trained to fully assess signs and symptoms of emotional distress by the respondent during the administration of the SCID over the telephone. Respondents' distress can include reports of recent suicidal or homicidal thoughts, plans, or actions, or showing strong feelings of sadness, irritability, or agitation during the SCID administration. If the level of imminent danger was immediate or if the level of distress was such that completing the interview would increase the distress of the respondent, CIs were instructed to terminate the interview immediately and follow the appropriate DRP.

As shown in Appendix C, DRP pages DRP.1-DRP.7, the detailed MHSS DRP covered five different situations according to risk of harm to self or others. As summarized in [Table 4.2](#), DRP Scenario #1 was for respondents reporting recent passive suicidal ideation, which included vague thoughts of suicide in the absence of a plan (risk of self-harm, no imminent danger). DRP Scenario #2 was for respondents reporting recent active suicidal ideation, which included specific plans for suicide and acting on those thoughts (risk of self-harm, possible/definite imminent danger). DRP Scenario #3 was for respondents reporting recent passive homicidal ideation, which included vague thoughts of homicide in the absence of a plan (risk of harm to others, no imminent danger). DRP Scenario #4 was for respondents who reported recent active homicidal ideation, which included specific plans for homicide and acting on those thoughts (risk of harm to others, possible/definite imminent danger). DRP Scenario #5 was for respondents who showed signs of emotional distress during the SCID, such as sadness, irritability, or agitation, in the absence of suicidal or homicidal thoughts (no risk of harm, respondent is agitated or upset).

**Table 4.2 Distressed Respondent Protocol Scenarios**

<b>Distressed Respondent Protocol Scenario</b>	<b>Risk of Harm</b>	<b>Imminent Danger</b>
Scenario #1: Passive suicidal ideation	Self	No
Scenario #2: Active suicidal ideation	Self	Yes/Maybe
Scenario #3: Passive homicidal ideation	Other(s)	No
Scenario #4: Active homicidal ideation	Other(s)	Yes/Maybe
Scenario #5: Respondent agitated or upset	None	No

To ensure respondents' safety, the DRP was changed in 2011 to incorporate the following:

- If a respondent reported recent active suicidal ideation (Scenario #2), the CI would connect the respondent with emergency mental health services in his or her area using

SAMHSA's online database of inpatient mental health providers before contacting local emergency rescue services (that may be less prepared for handling suicidal respondents).

- If a respondent reported recent active suicidal thoughts (Scenario #2) or recent active homicidal ideation (Scenario #4), the CI would connect the respondent with local emergency rescue services (using a searchable national database of numbers that could be used to directly contact emergency rescue services nearest to the respondent) rather than calling 9-1-1 (which automatically routed calls to the emergency rescue services nearest to the CI, not necessarily the respondent, thereby interfering with a respondent being connected with local emergency rescue services).
- If a respondent reported passive suicidal ideation (Scenario #1), reported passive homicidal ideation (Scenario #3), or became upset or agitated during the interview (Scenario #5), respondents were encouraged to call Lifeline's number directly rather than the CI offering to connect them using three-way calling (which sometimes got disconnected or automatically routed calls to the Lifeline nearest to the CI, thereby interfering with a respondent being referred for local mental health services).

To reduce the likelihood of contacting emergency rescue services prematurely, the DRP was changed for Quarter 2 of 2012 to incorporate the following: If a respondent reported recent active suicidal thoughts (Scenario #2) but denied intentions to harm themselves, the CI would strongly suggest mental health counseling rather than connecting him or her with local emergency rescue services (which may not provide access to mental health services). The updated DRP Booklet provided to CIs in 2012 is included in Appendix D (Addendum 2, page DRP-1). Section 7.3 provides the number of respondents classified as distressed during the 2008-2012 MHSS.

#### **4.2.6 Interviewer Debriefing**

Following the conclusion of the interview, the CI completed the Interviewer Debriefing module (see Appendix C, Interviewer Debriefing pages X.1-X.5), which documented the CI's impressions of the interview situation, including ratings of the respondent's level of privacy, cooperation, and comprehension, as well as the overall validity of the interview data. This module also allowed the CI to note "rule-out" disorders that were not assessed but may have impacted the GAF score in the past year. Upon independent review, the clinical supervisor also rated each interview for global validity and noted any potential "rule-out" disorders that were not assessed. Data from interviews with questionable validity were not included in the final dataset.

### **4.3 CI Equipment**

This section describes the equipment and systems used by the CI during the follow-up clinical interview.

#### **4.3.1 Laptop**

Although the MHSS interview was conducted using paper questionnaire booklets, CIs used NSDUH-issued Gateway laptops for several tasks, including making an audio recording of the interview and uploading the resulting audio file to RTI, management tasks such as case



assignment and reporting, and staff communication via e-mail. For security purposes, NSDUH laptops require two separate user name and password entries to reach the desktop, with additional user name and password entries necessary to access the specific Web-based CMS used for the study.

### **4.3.2 Audio Recording**

With respondent permission, CIs made an audio recording of the MHSS interview. Between January 2008 and June 2011, CIs connected the laptop to a telephone using a specialized recording control device. CIs had two devices available: one for analog telephone systems and one for digital systems. Due to ongoing issues with the quality of the resulting audio recordings, CIs began using the Internet-based phone provider Skype in June 2011 for the interview contact with respondents. Skype is a voice over Internet protocol that enables peer-to-peer voice connections (i.e., telephone calls) over the public Internet. Skype connections are secured using 256-bit Advanced Encryption Standard encryption to ensure the privacy of the communication channel. CIs used a Skype headset with a microphone that attached easily to the laptop. Calling via Skype allowed a more direct connection, which provided quality recordings and was straightforward to use. In the event that no Internet connection was available at the time of an interview, CIs still had the option to record the interview using one of the recording control devices.

A specialized computer system on the laptop developed specifically for MHSS allowed the CI to select the appropriate case, conduct a test audio recording (to test functionality and quality), and then, with respondent permission, record the interview. Upon conclusion of the respondent contact, the system allowed CIs to securely upload the audio file directly to RTI servers.

### **4.3.3 Case Management System**

CIs accessed the MHSS Web-based CMS to check case assignments, provide updates on each respondent contact via case status reports, and, as needed, prepare and submit reports for any distressed respondent situations encountered. Data collection managers assigned MHSS cases based on CI availability during the best days and times to call indicated by respondents. Cases could be transferred among the interviewing staff.

The CMS displayed case assignment information collected by the NSDUH FI, including first name, phone number, alternate phone number if provided, and best days and times to call, along with any helpful notes the FI may have entered. The sample participant's home State and time zone are also displayed to assist CIs in properly timing their contacts. The status code and any comments for each attempt to contact a case were available so the CI could see the history of the case.

Also through the CMS, RTI staff carefully tracked each case from initial assignment through interview completion including questionnaire receipt and processing.

## **4.4 MHSS Handbooks**

Interviewing staff used detailed handbooks both as a learning tool and a reference to the required procedures and protocols of the study.

#### 4.4.1 MHSS CI Handbook

The MHSS CI Handbook detailed all aspects of an interviewer's work requirements on the MHSS. The MHSS CI Handbook covered the following topics:

- Introduction to the Study,
- Your Role on the Mental Health Study,
- Equipment Use and Care,
- Contacting Respondents,
- Conducting the Interview,
- Documenting Results,
- Administrative Procedures, and
- Quality Control.

The MHSS CI Handbook files, including the final CI Skype User Guide (Addendum 1, page S-1) and the DRP Booklet (Addendum 2, page DRP-1), are provided in Appendix D and are discussed as follows.

This handbook was sent to all newly hired CIs for review prior to attending CI training. It was used throughout the training session and served as a ready reference when questions arose during work.

Overall, MHSS procedures remained consistent between survey years, allowing veteran staff to continue to reference their CI Handbook. MHSS CI Handbooks were distributed to CIs at the following points: during their initial training for the 2008 study, prior to the start of the 2010 survey year, and in October 2010 when preparing for the 2011 study. For 2009 and 2012, any administrative updates to the handbook for the upcoming year were provided via memo to the CIs.

In June 2011, all new and veteran staff received two separate addenda to the existing handbook:

- The CI Skype User Guide provided instructions for establishing and using a Skype account to contact a respondent and record the interview and for uploading the resulting audio file to RTI (as discussed in Section 4.3.2).
- The DRP Booklet provided additional instructions on properly implementing the updated protocol for MHSS. This booklet contained the instructions and scripts to use when speaking with a distressed respondent and, if needed, an emergency care provider; the detailed instructions on how to locate the proper 9-1-1 emergency number for the respondent's location; and details about submitting an incident report.

Following further updates to the DRP in the spring of 2012 (as discussed in Section 4.2.5), all staff received an updated DRP Booklet for reference beginning in Quarter 2 of 2012.

#### **4.4.2 MHSS FI Handbook**

The MHSS FI Handbook provided detailed instructions for the FIs' tasks on the MHSS. The MHSS FI Handbook covered the following topics:

- Introduction to the Study,
- Equipment and Materials,
- Initial Interview,
- Obtaining Participation,
- Administrative Procedures, and
- Quality Control.

The MHSS FI Handbook files are provided in Appendix E.

Newly hired new-to-project (NTP) field staff received an MHSS FI Handbook for review prior to attending NTP training. All veteran NSDUH FIs received an MHSS FI Handbook to review and reference prior to the start of each survey year with one exception. For the 2010 MHSS, veteran NSDUH FIs received a brief updates memo along with instructions to continue to use and refer to the 2009 MHSS FI Handbook during 2010.

#### **4.5 OMB and IRB Packages**

In order to obtain the necessary approvals and clearances to conduct the MHSS, the MHSS procedures were described in annual OMB and IRB packages submitted for the NSDUH main study.

##### **4.5.1 OMB Package**

Text describing the purpose of and justification for the MHSS were added to the NSDUH OMB Supporting Statement. This document described procedures for collecting MHSS data, justification for imposing the additional burden on NSDUH respondents, confidentiality measures for NSDUH data, and procedures for protecting MHSS respondents' data. Details on the process for certifying CIs were included in the OMB Supporting Statement. MHSS respondent materials planned for use in the study were included in the OMB package. The package included the Follow-Up Study Description, Follow-Up SCID Interview Content, Introduction to the Clinical Follow-Up Interview, Follow-Up Interview Payment Receipt, and Confidentiality Pledge signed by CIs staffed on the study.

OMB clearance to conduct the MHSS as a follow-up study to the NSDUH was granted annually. The 2009 OMB package described the plans for both the 2009 and 2010 MHSS, and clearance was received for these 2 survey years.

##### **4.5.2 IRB Package**

RTI's IRB Committee met annually to review and approve the NSDUH project. From 2008 to 2012, this process included a review of the MHSS materials and procedures. Additions to the IRB's Request for Approval of Research Protocol described the procedures of the MHSS

and how these procedures would protect human subjects. The IRB granted approval to conduct the MHSS annually.

Per IRB procedures, project staff reported adverse events that occurred throughout the duration of the study to RTI's IRB. An adverse event could occur if a study respondent were to become upset or distressed during the administration of the instrument. When such an event occurred, the CI followed the steps prescribed in the IRB-approved DRP. The administration of this protocol was then reported to the IRB during the end-of-year closeout reports. Cases that involved DRP violations and/or emergency services (DRP Scenario #2 or Scenario #4) were immediately reported to the IRB.



# 5. Staff Training

This chapter describes the training programs conducted for field interviewers (FIs), clinical interviewers (CIs), and clinical supervisors (CSs) for Mental Health Surveillance Study (MHSS) recruitment, data collection, quality control, and supervision. Training for these staff occurred prior to the start of data collection each year as well as during the year.

## 5.1 MHSS Recruitment FI Training

This section describes the programs conducted to train veteran FIs and new-to-project (NTP) FIs on the MHSS recruitment process.

### 5.1.1 Veteran FI Training

Prior to the start of each survey year, the National Survey on Drug Use and Health (NSDUH) veteran FIs continuing on the study completed a multipart training program to review changes for the upcoming year and to refresh their knowledge of important study protocols.

Self-study tasks for the MHSS completed by FIs in November/December included reviewing the FI Handbook for the upcoming year and completing an MHSS iLearning course. For the 2010 survey year, the MHSS topics were included as part of the NSDUH main study Practicing Perfection iLearning course instead of as a separate MHSS course.

iLearning, an electronic multimedia interactive training application, allowed FIs to complete the training course at their own pace on their NSDUH laptop and review portions of the course again as needed. The MHSS course consisted of visual slides with text and graphics, an audio component providing important information and instructions, and an assessment portion to ensure the FI's comprehension of the material presented. Beginning in 2010, the content also included training videos and interactive practice exercises. Once a course was completed and the results were successfully transmitted to RTI International from the FI's laptop, the course assessment results were posted to the Web-based NSDUH Case Management System (CMS) for field supervisor and project management review.

Each year in early January, veteran FIs attended an in-person Team Meeting to review key project protocols and procedures, which included a review of MHSS topics. Any FIs unable to attend the meeting in person received training during a conference call. The MHSS portion of the training included instruction on MHSS recruitment steps, results, and lessons learned from prior study years. The training in 2011 and 2012 also incorporated exercises to practice the recruitment steps and answering respondent questions, respectively.

### 5.1.2 NTP FI Training

Newly hired NSDUH FIs received an MHSS FI Handbook (see Appendix E) for review prior to attending the NSDUH NTP FI training session. FI trainees were instructed to review the handbook as part of their preparations for training. After learning and practicing the NSDUH main study interviewing protocols, the trainees were introduced to the MHSS during NTP FI training. Trainers reviewed terminology and detailed recruitment steps along with how to use the

MHSS materials. Training topics also covered ways to answer respondent questions about participation in the MHSS. The trainees watched a video demonstrating the recruitment process and completed a paired exercise to practice all relevant recruitment steps.

### **5.1.3 FI Refresher Training**

Each survey year, MHSS training for FIs continued during the year to provide ongoing refresher training. Prior to each quarter of data collection, all active NSDUH FIs completed their MHSS iLearning training before beginning work. The MHSS iLearning course content and assessment questions varied somewhat for the different quarters to provide helpful training to the FIs. As mentioned in Section 5.2.1, the MHSS content for 2010 was included as part of another veteran iLearning course for the main NSDUH study, also completed quarterly.

## **5.2 NTP CI Training Sessions**

Over the course of the MHSS, four NTP CI trainings were held in November 2007, March 2008, October 2010, and June 2011. Two sessions—in November 2007 for the initial 2008 MHSS and in October 2010 for the expanded 2011 MHSS sample—had two classrooms each of CI trainees, whereas the other two attrition training sessions were smaller, with just one classroom. The first session in 2007 took place in Cincinnati, Ohio, while the other sessions were held in the Raleigh, North Carolina, area.

The NTP CI training program consisted of an initial self-study assignment, 4 days of classroom training, and a certification process. Prior to attending training, CI trainees carefully reviewed the CI Handbook (Appendix D) and the Structured Clinical Interview for DSM-IV Axis I Disorders Non-patient Edition (SCID-I/NP or SCID; First, Spitzer, Gibbon, & Williams, 2002) questionnaire booklet (Appendix C). They also completed an online Institutional Review Board (IRB) training course, which covered ethics and regulations involving research on human subjects, the role of the IRB, and the role of the interviewer in protecting respondents' rights. Trainees also completed an online course on the Confidential Information Protection and Statistical Efficiency Act (CIPSEA) requirements that are used to protect information collected on the NSDUH. The course also described the role of the Office of Management and Budget in providing oversight and designating statistical agencies under CIPSEA.

As part of their pre-training work for the October 2010 and June 2011 sessions, CI trainees also listened to an audio recording of an MHSS clinical interview and completed an Interrater Reliability (IR) Exercise form, which they provided to trainers upon arrival at training.

### **5.2.1 Training Staff**

Classroom training staff included a site leader, a technical support staff member, and training team members.

The site leader at each training site managed all registration and fingerprinting activities, hotel relations, and logistics. The site leader coordinated the evaluation of CI trainee performance, working with trainers to resolve any problems, and also reported the status of training to management and supervisory staff each evening. The site leader role was filled by an experienced NSDUH manager with a leadership role on MHSS.

The technical support staff member provided assistance on all technical issues, including the proper functioning of all equipment and programs. Other duties included supervising training equipment setup and the initialization and distribution of CI computer equipment.

Each classroom was taught by a training team consisting of various MHSS staff working closely together to train on tasks in their primary areas of focus. Data collection managers (DCMs) and members of the NSDUH training and materials development team led the training sections on contacting the respondent, using the equipment for audio recording, e-mail, reporting, and administrative tasks. CSs with in-depth knowledge of the SCID instructed CI trainees in the proper administration of the SCID. The mental health task leader (or lead CS) also provided detailed training on handling unusual situations, such as cognitive impairment and proper implementation of the Distressed Respondent Protocol (DRP).

Training teams used a near-verbatim training guide for the non-SCID training topics, along with detailed discussion slides and exercises to review the content of the various SCID modules. During training, each CI trainee received a training workbook with exercises, instructions, and copies of the SCID presentation slides. Other training materials used for each session included mock interview scripts, SCID booklets, and various administrative forms such as training expense reports and a formal calling card agreement for project use.

### **5.2.2 Content of NTP CI Training Sessions**

Over the course of the 5 years of the MHSS, the content of the 4-day NTP CI training session remained consistent with some minor shifting of topics between the training days to improve coverage and timing. The training program content is described below by day. Appendix F provides the training agenda for the June 2011 NTP CI training session.

#### **5.2.2.1 Day 1**

Training classes began with an introduction to both the NSDUH and the MHSS. Next, trainees reviewed the responsibilities of the CI position and were instructed on the proper use of the laptop computer hardware and the systems used for case assignment and reporting, recording interviews, and e-mail. CI trainees learned about the procedures for contacting MHSS cases, including the contact information provided for each case in the Web-based CMS, the window of time for making contacts and completing the clinical interview, and the introduction and informed consent process once contact was made. CI trainees then practiced answering respondent questions about the study, referring as needed to sample questions and responses found in the CI Handbook. Management reporting tasks were also covered on Day 1, including entering result codes and the proper handling and distribution of the interview materials. Day 1 ended with training on administrative procedures, including the proper completion of production, time, and expense reports.

CI trainees were assigned homework to practice recording and uploading audio files. Trainers were available for 2 hours in the evening via phone for a "virtual" clinical interviewer lab (CI Lab) session to provide support and answer any equipment-related questions. CI trainees were expected to complete the homework assignment and to review the SCID and interviewing topics in the CI Handbook as preparation for Day 2.



#### **5.2.2.2 Day 2**

Day 2 began with an overview of the SCID, followed by reviews of various SCID modules. For each module, trainers explained key concepts of the module, highlighting any issues or differences specifically applicable to the MHSS. Following the detailed review, trainers used a prepared script to lead the CI trainees through an exercise on the content of that module. Day 2 concluded with instructions on the proper use of the Global Assessment of Functioning (GAF) scale. CI trainees completed several GAF exercises during class and were assigned additional GAF exercises for homework. All CI trainees were invited to attend an evening CI Lab to have any questions answered and work one-on-one with a trainer as needed.

#### **5.2.2.3 Day 3**

On Day 3, three of the four NTP CI training sessions began with a review of the GAF homework. For the June 2011 session, CI trainees learned about handling unusual situations on the morning of Day 3 and reviewed the GAF homework on the morning of Day 4.

Day 3 training focused on gaining experience and confidence by conducting several exercises on the clinical interviewing process. After learning about the IR exercises conducted quarterly on the MHSS (in which CIs listen to an interview while independently rating the responses and then discuss their ratings as a group), CI trainees completed an IR exercise in class. After a review of instructions in the SCID booklet for the end of the interview and debriefing tasks, CI trainees worked in pairs to practice properly administering the SCID. All CI trainees were again invited to attend an evening CI Lab with trainers available to answer questions or for additional practice.

#### **5.2.2.4 Day 4**

The key training objective of Day 4 was to practice every step of the clinical interview process, from case assignment to properly conducting the interview, through reporting and shipment of the completed SCID booklet. Following this paired exercise, CI trainees learned how to handle unusual situations. As previously mentioned, CI trainees completed this training topic on Day 3 at the June 2011 session and began Day 4 with a review of GAF homework, and then completed the paired practice exercise.

To wrap up the training session, CI trainees received instructions and appointment information for their initial certification interview and completed a training evaluation to provide feedback on the completed training session.

### **5.2.3 Certifications**

To ensure CI trainees could complete MHSS interviews following protocol, they were required to successfully complete a certification protocol following completion of the NTP CI training.

For a certification, CI trainees completed the entire clinical interview process, including administering and recording the SCID interview, uploading the audio file to NSDUH's Web-based CMS, and shipping the completed hard copy of the SCID to RTI. Upon receipt, each SCID interview was carefully evaluated by CSs to determine whether the CI trainee properly

administered the instrument. Feedback was provided to the CI trainee, and, as needed, another certification interview was scheduled. CI trainees had up to three attempts to pass certification.

The respondents for these certification interviews were recruited from community mental health and substance abuse treatment centers and were pre-screened to ensure they met the necessary requirements (i.e., 18 years or older, received mental health treatment in the past 12 months, and able to demonstrate comprehension of informed consent). Due to the amount of psychopathy in a clinical sample recruited from a community-based setting, certification interviews lasted about 2 hours, which is longer than the average MHSS interview (lasting about 72 minutes, as described in Section 6.2.1). Volunteer respondents were given \$40 for participating in the telephone interview.

Table 3.2 in Chapter 3 provides the MHSS CI training and certification results.

### **5.3 Veteran CI Training Sessions**

Prior to the start of a new survey year and during the survey year as needed, the experienced, or veteran, MHSS CIs participated in training conference calls to review changes and to further refresh and enhance their interviewing skills and knowledge of the MHSS. In addition to veteran training conference calls, one veteran CI training occurred in person in conjunction with the NTP CI Training session held in October 2010.

#### **5.3.1 Staffing**

Veteran CI training conference calls were led by various MHSS project staff. A DCM reviewed topics relevant to his or her project tasks, such as production results, administrative details, and goals and expectations for the coming year. When necessary, DCMs also trained on equipment and computer system-related topics. Based on common problems noted during SCID reviews and discussions with CIs, CSs presented information regarding the proper administration of the SCID for the MHSS, handling unusual situations (e.g., uncooperative, upset, or cognitively impaired respondents), and properly implementing the DRP. The trainers used a detailed training agenda as a training guide and schedule for each conference call.

For the veteran CI in-person training held in October 2010, the DCMs and CSs who were NTP CI trainers also served as training staff for the veteran CIs.

#### **5.3.2 Content of Veteran CI Training Sessions**

The content of the veteran CI training sessions is described below for the annual sessions conducted prior to each survey year as well as the trainings conducted during the year.

##### **5.3.2.1 Annual Veteran CI Training**

In December each year prior to beginning a new survey year, veteran CIs (continuing on the MHSS) completed both independent and group training to review changes for the upcoming year and to refresh their knowledge of important study protocols. Before the group training conference call, CIs were required to complete a few self-study tasks, including completing the annual CIPSEA training course online and reviewing the CI Handbook and any changes for the

upcoming year. With the exception of December 2011, CIs also completed exercises on GAF scale scoring each year as part of their self-study efforts.

The annual veteran CI group conference calls covered the following topics:

- Welcome and Introductions;
- Management, Production, and Data Collection Results and Tips;
- Goals and Expectations;
- DRP Review and Practice Exercises;
- SCID Review and Issue Resolution;
- Review of GAF Exercises (when included);
- Handling Challenging or Unusual Interview Situations;
- Question-and-Answer Session; and
- Wrap-Up.

#### **5.3.2.2 As-Needed Veteran Training Sessions**

Twice during the MHSS, changes to protocols required a special veteran CI training during the year. Each time, the CIs received updated materials, performed self-study tasks, and participated in a group conference call. For more information on the protocol changes necessitating these trainings, refer to Sections 4.2.5 and 4.3.2. The following two special CI trainings were held:

- June 2011: CIs reviewed a Skype User Guide, updated their laptops, and established a Skype account. CIs also read an updated DRP Booklet. Changes were reviewed, and all questions were answered during the group call.
- March 2012: CIs received an updated DRP Booklet and completed a related exercise. The changes were reviewed during the regularly scheduled IR call prior to implementation for Quarter 2 of 2012.

#### **5.3.2.3 Rehired Veteran CI Training**

At the end of 2009, three CIs who worked on the MHSS in 2008 but not in 2009 were rehired to work again in 2010. Due to prior experience, their refresher training was conducted through detailed self-study and participation in two separate conference calls. The first call, led by the DCMs, reviewed the equipment and administrative tasks as well as MHSS protocols for contacting respondents, reporting results, and submitting the audio file and completed SCID to RTI. The second call, led by CSs, reviewed important details for properly conducting an MHSS interview and handling any unusual respondent situations that may occur. Following these calls, the CI trainees completed the certification process. The CIs also participated in the annual veteran training call held later in December 2009. Two of the three CIs passed certification and worked on the MHSS in 2010.

#### 5.3.2.4 2010 In-Person Veteran CI Training

To coincide with the in-person NTP CI training session held in October 2010, veteran CIs attended the SCID-related content training (Days 2 and 3) of this session as a refresher on clinical interview protocols. These veteran CIs listened as CSs presented information about proper SCID interviewing techniques and assisted the CS trainers by serving as respondents for scripted exercises. Additionally, the veteran CIs met one evening to be trained by the DCMs on detailed administrative topics being implemented in 2011.

### 5.4 IR Exercises

To ensure the quality of the data being collected in the clinical interviews, IR exercises were conducted at the end of each calendar quarter. The IR exercises, which included group conference calls to calibrate CIs' ratings with the CSs' consensus ratings, were designed to estimate IR to evaluate the diagnostic skills of the CIs and to provide retraining for the CIs to reduce error in data collected in future quarters.

Clinical interviews used for the IR exercises were selected from the pool of recorded interviews conducted during the calendar year. For Quarters 1 and 2 of 2008, the focus of these end-of-quarter exercises was evaluation and retraining using more complex cases, while the focus shifted to obtaining an estimate of typical IR for the remainder of the MHSS using typical cases. Each IR exercise provided opportunities to evaluate the CIs' diagnostic skills and retrain CIs as needed in rating symptoms, diagnoses, and GAF scores.

At the end of each quarter, CSs and CIs listened to the audio file from the selected interview (available through the CMS) and independently rated the assessed symptoms (e.g., present, absent, subthreshold, or not enough information) and disorders (e.g., present, absent, or not enough information). Having reviewed and rated the interview independently, the CSs met as a group and developed consensus ratings of the symptoms and disorders that became the key for comparison with the CI ratings. CIs had 5-7 days to complete the SCID ratings. CIs used a SCID to record their notes and ratings, then they transferred their ratings to the IR Exercise Rating Form.

Agreement between the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV; American Psychiatric Association, 1994) diagnoses rated by the CSs and the CIs was quantified using Cohen's kappa (Cohen, 1960), a reliability statistic that corrects for chance agreement. A kappa of 0.61 or higher is considered substantial reliability (Landis & Koch, 1977). For each symptom, a reliability coefficient was computed across the SCID rating categories: not enough information (?), absent (1), subclinical (2), and clinically present (3). For each CI, the total percentage of agreement between his or her ratings and the CS consensus ratings across all symptoms and disorders were calculated. The agreement was examined between the CS consensus and CIs' ratings of GAF, the presence of any mental disorder (unrelated to substance use), and the presence of a serious mental illness (SMI)—defined as any mental disorder (unrelated to substance use) and a GAF of 50 or below.

IR exercises were conducted at the end of every quarter except one (Quarter 2, 2009 MHSS, when all CIs were trained/retrained), for a total of 19 exercises. As shown in [Table 5.1](#), participation rates were high, with 86 percent to 100 percent of CIs who collected data during the

quarter participating. CIs who were terminated, who left for personal reasons, or who took a temporary leave of absence did not participate in the end-of-quarter exercise. In the final quarter of the study (Quarter 4, 2012 MHSS), two CIs who were actively employed did not participate due to personal reasons.

The interviews selected for the exercises varied: 11 of the 19 cases (58 percent) were categorized as SMI; that is, the respondents were diagnosed with at least one mental disorder not related to substance use and had a GAF score at or lower than 50. The average GAF score across all IR exercises was 50.7, with a range of 20 to 85.

In many cases, the IR interview was chosen because the GAF score was close to the cut point for classifying the case as having SMI and was therefore more challenging for the CIs to score. The GAF scale, which represented the CI's clinical judgment of the respondent's overall level of "functioning on a hypothetical continuum of mental health-illness," was based on both functioning and symptom severity. To rate the GAF according to the respondent's worst functioning in the past year, the lower of the two scores was used for anchoring the GAF score. As discussed below, problems with reliability in GAF scale ratings (and classification of SMI) in the MHSS appeared to occur mostly from CIs overestimating the seriousness of symptoms, including suicidal ideation. The GAF scale has since been dropped from the DSM-5 due to its conceptual lack of clarity (i.e., including symptoms, suicide risk, and disabilities in the descriptors) and questionable psychometric properties (American Psychiatric Association, 2013, p. 16). As ongoing problems occurred with the reliability of GAF scale ratings, several steps were taken to improve consistency within the MHSS team of CIs and CSs. First, quarterly IR data collection was conducted with group conference calls to discuss and "calibrate" the team's IR ratings. Second, all CI and CS training sessions incorporated GAF lectures and exercises. Third, the CIs and CSs were provided with training and/or supervision by Dr. Michael First (the SCID developer). Despite these efforts, the agreement on the GAF scale ratings remained unreliable.

Over the course of the MHSS, there was high IR agreement between the CIs' and CSs' consensus ratings. Symptom-level agreement was calculated using the total number of variables in the clinical interview as the denominator, and without penalty for omissions and commissions from earlier errors within the same disorder. As shown in [Table 5.1](#), symptom-level agreement improved and was consistently high after the first year, averaging 96 percent. There was also consistently high agreement for having 1 or more mental disorders, with an average of 99 percent. CIs' kappa scores steadily improved each year, with 100 percent of CIs having high kappa scores for the last seven quarters of the study. Less consistent agreement was found for GAF (0 to 95 percent) and SMI (0 to 100 percent). The majority of error for GAF and SMI ratings was due to CIs' GAF ratings that were lower than the CSs' consensus GAF ratings. Discussions during the IR calibration conference calls indicated that CIs' biases toward lower GAF scores were due to overestimations of the severity of the respondent's symptoms (e.g., the seriousness of suicidal thoughts, the danger of driving while impaired by alcohol).

Following each IR exercise, the CSs and CIs participated in group conference calls to calibrate the CIs' ratings to the CSs' consensus ratings. All CIs were encouraged to attend the group calibration conference calls, and over the course of the study, there was 82 percent participation in these calls. Individual make-up calls were held with each CI who could not attend the group conference calls. CIs whose scores were in the lower 33 percent of the

distribution were retrained by the CSs. In all cases, the CIs were able to demonstrate understanding of the content of retraining and, therefore, were not considered for being placed on probation. Using the pre-established cutoff score of 70 percent or lower, no CI was ever considered for termination during the course of the MHSS because of his or her performance on the IR exercises.

Prior to the IR conference calls, CIs were sent an electronic copy of their scored IR rating sheet that listed their ratings compared with the CS consensus ratings and their overall percentages of agreement. The calibration conference calls lasted approximately 1 hour and included a review of all symptoms that were assessed, with particular attention devoted to symptoms for which there was disagreement. Review of each problematic symptom started with a brief rationale for the CS consensus ratings, followed by comments and questions from the CIs and retraining for common sources of error (e.g., inadequate probing, differences between clinical and subclinical symptom ratings). The mental health task leader and CSs also used examples from the stimulus interview to underscore key information that was needed to confidently code a symptom.

**Table 5.1 Interrater Reliability Exercise Performance**

Year	Q	CIs Participating/ Employed (%)	CI Performance					Case Description	
			Agreement: Symptoms (%)	Agreement: ≥ 1 Diagnosis (%)	Agreement: GAF Decile (%)	Agreement: SMI (%)	CIs with Kappa ≥ 0.61 (%)	CS GAF	SMI
2008	1	22/22 (100)	90	100	67	95	100	43	SMI
	2	22/25 (88)	80	100	18	100	23	20	SMI
	3	21/23 (91)	91	100	81	100	100	85	Non-SMI
	4	21/21 (100)	93	100	95	100	100	52	Non-SMI
2009	1	8/8 (100)	97	100	88	88	100	58	Non-SMI
	2	--	--	--	--	--	--	--	--
	3	7/7 (100)	97	86	43	100	71	65	Non-SMI
	4	6/7 (86)	99	100	83	100	100	45	SMI
2010	1	8/8 (100)	99	100	25	25	100	49	SMI
	2	8/8 (100)	96	100	0	0	100	49	SMI
	3	8/8 (100)	97	100	75	100	100	45	SMI
	4	8/8 (100)	99	100	38	100	100	32	SMI
2011	1	20/21 (95)	96	100	60	60	95	50	SMI
	2	18/20 (90)	98	100	89	89	100	53	Non-SMI
	3	23/26 (88)	98	100	91	96	100	45	SMI
	4	23/24 (96)	96	96	57	66	100	53	Non-SMI
2012	1	22/23 (96)	98	100	68	68	100	53	Non-SMI
	2	22/22 (100)	98	100	55	55	100	50	SMI
	3	21/21 (100)	98	95	90	100	100	66	Non-SMI
	4	19/21 (90)	99	100	63	63	100	50	SMI
<b>Average</b>		96	96	99	62	78	94	51	--

-- Not available.

CI = clinical interviewer; CS = clinical supervisor; GAF = Global Assessment of Functioning; Q = Quarter; SMI = serious mental illness.

## 5.5 CS Training

In June 2007, four CSs were trained by the SCID's developer, Dr. Michael First, who was hired as an expert consultant for the MHSS. The CS training included an overview of

interviewing with the SCID, followed by reviews of various SCID modules, including key concepts of the module and highlighting any differences for the MHSS version of the SCID. Dr. First also trained the CSs in using the GAF scale. NSDUH trainers taught the CSs how to perform the technical and administrative procedures using the MHSS laptops. During the training, the CSs completed several practice exercises with the SCID, GAF scale, laptops, technical procedures, and administrative tasks.

To ensure that CSs could provide proper supervision of MHSS interviews, each CS completed the same rigorous certification process described in Section 5.2.3 for the CIs. Each CS certification interview was carefully evaluated by Dr. First, who determined whether the CS properly administered the instrument. Feedback was provided to the CS, and, as needed, another certification interview was scheduled. CSs were given up to three attempts to pass certification; however, all four CSs passed certification after their second interview.

Over the course of the MHSS, the veteran CSs also participated in refresher training to further enhance their skills and knowledge about the study. CS refresher trainings with Dr. First occurred in October 2008, September 2009, August 2010, and October 2011. The CS refresher trainings were 90- to 120-minute group conference calls that focused on clinical interviewing, the DSM-IV diagnostic criteria, and the GAF scale. In addition, the CSs all attended the MHSS CI training sessions provided by Dr. First.

## 6. Data Collection

This chapter describes the data collection procedures used on the Mental Health Surveillance Study (MHSS), including the administration, editing, and keying of the Structured Clinical Interview for DSM-IV Axis I Disorders Non-patient Edition (SCID-I/NP or SCID; First, Spitzer, Gibbon, & Williams, 2002).

### 6.1 Schedule

The 2008, 2011, and 2012 MHSS samples were designed to yield 1,500 clinical interviews distributed across four calendar quarters with approximately 375 interviews occurring per quarter. The 2009 and 2010 MHSS samples were designed to yield 500 clinical interviews distributed across four calendar quarters with approximately 125 interviews occurring per quarter.

National Survey on Drug Use and Health (NSDUH) respondents were selected and recruited for the follow-up clinical interview at the end of the initial NSDUH interview. The clinical interviews were completed within 2 to 4 weeks following the completion of the NSDUH interview. For the first three quarters of each year, the probability of MHSS selection was maintained until the end of NSDUH data collection each quarter. Thus, MHSS data collection was scheduled to end 4 weeks beyond the NSDUH data collection end date each quarter. As shown in [Table 6.1](#), for the fourth quarter of every year except 2012, the probability of selection for the clinical interview was set to zero in late November so that MHSS cases would not be sampled without adequate time for completion (by the main study data collection end date). In 2012, MHSS recruitment ended on the same day as NSDUH main study data collection, which was December 20, 2012. MHSS data collection was scheduled to end within 4 weeks of MHSS recruitment, which was by January 17, 2013.

**Table 6.1 NSDUH and MHSS Data Collection End Date, by Year**

Year	MHSS Recruitment End Date	NSDUH Data Collection End Date	MHSS Data Collection End Date
2008	November 21	December 22	December 19
2009	November 16	December 21	December 14
2010	November 29	December 20	December 20
2011	November 29	December 20	December 20
2012	December 20	December 20	January 17, 2013

MHSS = Mental Health Surveillance Study.

### 6.2 SCID Administration

As discussed in Section 4.1, NSDUH respondents were selected and recruited for the follow-up clinical interview at the end of the NSDUH main study. Respondents agreeing to participate in the follow-up interview were asked to provide contact information, including first name, telephone number, an alternate telephone number if available, and best days and times to call. The field interviewer (FI) entered the NSDUH respondent's contact information into the NSDUH laptop and transmitted the data to RTI International. The next step was for a data



collection manager (DCM) to review the MHSS case and assign it to a clinical interviewer (CI). The DCMs took into consideration the sample participant's time zone and best days and times for contact and the CI's availability and time zone when assigning cases. The CIs made the first attempt to contact MHSS cases within 24 hours of receiving the assigned case to schedule an appointment for the interview. If the case was not reached on the first call attempt, subsequent calls were made during the sample participant's preferred time frame. After CIs made several attempts without success during the time period specified during the NSDUH interview, calls were made at times outside of the preferred time frame in an attempt to reach the case.

At the scheduled interview time, the CI would attempt to contact the respondent by telephone to conduct the interview. As described in Section 4.2.1, CIs were instructed to verify that they were speaking to the respondent who had agreed to participate in the follow-up interview, obtain informed consent, and obtain permission to record the interview using the script provided (see Appendix C, Introduction pages 1-3). Permission to record the interview was not a requirement to participate in the study. CIs were instructed to include notes in the SCID about the respondent's reason for not giving permission to record, if known. To ensure confidentiality and privacy, no identifying information was written in the SCID or solicited during the recorded interview.

As discussed in Section 4.2.2, the follow-up interview was a modified version of the SCID (First, Spitzer, Gibbon, & Williams, 2002). The SCID is a semistructured diagnostic interview used to assess psychiatric disorders according to the criteria in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV; American Psychiatric Association, 1994). As a semistructured clinical interview, the SCID contains structured, standardized questions that are read verbatim and sequentially, combined with unstructured follow-up questions that the CI tailors to the respondent based on clinical judgment and respondent answers. The SCID was administered over the telephone by CIs who had undergone extensive training with clinical supervisors (CSs) and the SCID's developer from Columbia University (see Chapter 5, Staff Training).

CIs were trained to use their clinical judgment to code each item based on the respondent's answers. Using the SCID booklet, each criterion symptom was coded as "1" (Absent or false), "2" (Subthreshold), "3" (Threshold or true), or "?" (Inadequate information). Each diagnosis assessed was coded as "1" (Absent) or "3" (Present). As discussed in Section 4.2.3, the CI would also score the Global Assessment of Functioning (GAF) on a scale of 1 (Persistent Danger to Self or Others) to 100 (Superior Functioning, No Symptoms). The GAF is based on the respondent's psychological, social, and occupational functioning. CIs scored the GAF based on the respondent's worst functioning in the past 12 months. At the conclusion of the SCID, the CI read the End of Interview Script (see Appendix C, End of Interview page K.4), which thanked the respondent for his or her time and mentioned the possibility of needing to speak with a counselor (i.e., "Sometimes the personal issues we've discussed cause people to become upset and in need of speaking with a counselor. If you are feeling upset or disturbed by the personal issues we have discussed in this interview and would like to speak with someone about your feelings, we suggest you call your doctor, counselor, or other treatment provider if you are currently under someone's care. If not, there is also a national lifeline number you can call. This number is on the receipt for the \$30 you received for this interview from the interviewer who met with you earlier.") CIs ensured that the respondent had the toll-free number to the National Lifeline Network should he or she want to speak with a counselor and/or want

additional information about mental health services in his or her area. If the CI felt the respondent was at all in distress or potentially was a danger to himself or herself or others, a Distressed Respondent Protocol (DRP) was followed (Section 4.2.5).

Each clinical interview was completed over the telephone within 4 weeks of the date of the NSDUH interview. After the call ended, the CI completed the interviewer debriefing questions (see Appendix C, page X.1) within the SCID and reviewed the booklet to ensure that documentation was complete. As part of the interviewer debriefing section, CIs recorded information about problems encountered during the interview (i.e., distressed respondent, cognitive impairment, problems with privacy, comprehension, cooperation), stressors the respondents had experienced in the past 12 months, diagnosis that needed further assessment, and the overall validity of the SCID data. If CIs were uncertain of how to code a particular item or were feeling unsure about whether they had gathered enough information, CIs were instructed to consult with one of the CSs for his or her opinion within an hour of completing the interview. Within 48 hours after completion of the interview, the CI uploaded the recorded audio file to the Web-based Case Management System (CMS) and edited and shipped the paper SCID to RTI for final editing and keying in-house. Once shipped, the CI assigned the case a code of "80: Materials Shipment (SCID)" and entered the FedEx tracking number in the notes. The DCM then tracked the shipment to ensure the SCID arrived at RTI.

### **6.2.1 SCID Length**

After obtaining informed consent, the CIs recorded the interview start time and AM/PM designation at the beginning of the Overview section on the SCID (see Appendix C, Overview page i). After reading the End of Interview script at the conclusion of the SCID, the CIs recorded the interview end time and AM/PM designation in the End of Interview section on the SCID (see Appendix C, page K.4). The interview start and end times recorded by the CIs on the SCID were keyed and included in the data file.

As shown in [Table 6.2](#), the average time to complete the SCID during the 2008-2012 MHSS was approximately 72 minutes. The median was 60 minutes. Completed interviews in which a breakoff occurred ( $n = 275$ ) and/or completed interviews with incomplete timing data ( $n = 55$ ), such as the missing start or end time or the AM/PM designation, were excluded from the timing analysis and summary statistics in [Table 6.2](#).

Breakoff interviews occurred when the CI started the interview, but the respondent was unable to complete the interview at that time (e.g., because of interview length, personal nature of the questions, feeling distressed, cognitive impairment) or the phone call was disconnected. If the respondent requested to end the interview, the CI was instructed to inquire about the respondent's concerns, address problems if possible, and try to schedule a convenient time for the respondent to complete the interview as soon as possible but still within 4 weeks of completing the NSDUH interview. If the respondent's concerns could not be satisfactorily addressed, the interview was terminated, and no further contact was made. More information is provided on the breakoff protocol for cognitive impairment and distressed respondent situations in Sections 4.2.4 and 4.2.5. In the cases in which the phone connection was lost, the CI made multiple attempts to reconnect with the respondent the same day and future days within 4 weeks after completing the NSDUH interview. Of the 507 breakoff interviews on the 2008-2012 MHSS, 232 breakoff interviews were not completed and assigned a final status code of "73: Breakoff, Partial

Interview,” and 275 breakoff interviews were resumed and completed later. In these situations, the breakoff interview time and resumed interview time were not captured in the SCID; thus, breakoff interviews were excluded from the timing data in [Table 6.2](#).

**Table 6.2 2008-2012 NSDUH MHSS SCID Length**

	2008	2009	2010	2011	2012	Total (2008- 2012)
<b>Sample Used in Analysis</b>	1,406	482	490	1,399	1,546	5,323
<b>Excluded Records*</b>	94	38	26	96	76	330
<b>Summary Statistics (Minutes)</b>						
Mean	68.95	72.01	73.82	75.26	71.84	72.18
Variance	3,384.24	5,496.82	5,237.02	7,040.61	4,099.42	4,916.49
Standard Deviation	58.17	74.14	72.37	83.91	64.03	70.12
<b>Quartiles</b>						
Maximum	835.00	877.00	844.00	816.00	834.00	877.00
Quartile 3	83.00	82.00	87.00	85.00	85.00	84.00
Median	60.00	59.00	61.00	60.00	62.00	60.00
Quartile 1	43.00	44.00	45.00	43.00	44.00	44.00
Minimum	1.00	22.00	16.00	8.00	19.00	1.00
Mode	60.00	45.00	55.00	60.00	40.00	60.00
Range	834.00	855.00	828.00	808.00	815.00	876.00
<b>Percentiles</b>						
99%	169.00	210.00	190.00	750.00	174.00	195.00
95%	124.00	130.00	128.00	135.00	124.00	128.00
90%	107.00	110.00	112.00	110.00	109.00	109.00
10%	33.00	35.00	33.00	33.00	34.00	33.00
5%	29.00	30.00	29.00	29.00	30.00	29.00
1%	22.00	25.00	23.00	22.00	24.00	23.00
<b>Extremes</b>						
5 Highest (Highest)	835.00	877.00	844.00	816.00	834.00	877.00
	798.00	830.00	800.00	808.00	803.00	844.00
	788.00	770.00	788.00	800.00	787.00	835.00
	770.00	756.00	751.00	794.00	770.00	834.00
	760.00	210.00	190.00	793.00	767.00	830.00
5 Lowest	19.00	25.00	23.00	18.00	21.00	16.00
	19.00	24.00	22.00	17.00	21.00	12.00
	19.00	24.00	21.00	12.00	20.00	9.00
	17.00	23.00	21.00	9.00	20.00	8.00
(Lowest)	1.00	22.00	16.00	8.00	19.00	1.00

MHSS = Mental Health Surveillance Study; SCID = Structured Clinical Interview for DSM-IV.

\* Completed interviews in which a breakoff occurred and/or completed interviews with incomplete timing data were excluded from the timing analysis and summary statistics. Completed interviews with complete, but extreme, timing data were included in the analysis.

### 6.3 SCID Data Processing

When the SCID was received at RTI, it was assigned a status code of "81: SCID Received at Regent." The SCID was then reviewed by CSs, technical editors, and keying clerks, following the editing and keying process described below.

### **6.3.1 Clinical Editing**

When the SCID was delivered to the MHSS CSs, it was assigned a status code of "82: SCID Received at Editing." The CSs reviewed all of the data collected in every SCID booklet, item by item, comparing the notes provided by the CI with the diagnostic rating and listening to parts or all of the accompanying audio files as needed to ensure confidence in the data. The audio file (if recorded) was matched with the corresponding paper-and-pencil SCID booklet. For full reviews, both the audio recordings and the SCID booklet were reviewed in their entirety. A newly hired CI received full reviews of their first two interviews or until he or she demonstrated proficiency in administering all SCID modules. Once a CI was deemed proficient, 10 percent of the remaining interviews for each CI were randomly selected for a full review of the audio recordings and SCID booklet in their entirety.

If the interview was selected for full review, the audio file(s) were listened to in their entirety and compared against the CI's notes. If the interview was not selected for a full review, then the CSs completed a partial review of the audio file(s) to include the SCID's overview section and any other portions of the audio file(s) that needed review to clarify the responses, to supplement the notes, or to support the CI's ratings in the SCID booklet. Cases that presented a more complex clinical picture generally warranted full reviews as well.

As part of the review, CSs ensured that CIs followed project protocol for administering the interview and provided accurate and sufficient notes in the SCID booklet. The CSs also evaluated the CIs' clinical interviewing techniques, diagnostic skills, and the extent to which they captured the overall clinical picture relative to the symptoms, diagnoses, and GAF score. In the back of the SCID booklet, the CS rated the overall validity of the data and noted if there were any other disorders that needed further assessment, such as a disorder that was not assessed in the study or a disorder for which more information was needed for diagnosis. For each interview, the CSs completed a clinical editing form, noting strengths and areas for improvement for the CI (Appendix G). Completed SCID editing forms were filed in separate folders for each CI in a locked filing cabinet.

Completed interviews that one CS considered to be of questionable validity were subject to an independent second review by at least one other CS. To address the potential bias to exclude more complex or unusual cases and those with a difficult respondent, the level of difficulty and overall confidence in the case were considered before making a final disposition. If all CSs agreed, then the case was removed from the study. In these situations, a code of "90: SCID Not Keyed - Reason Unspecified" (before 2010) or "90.X" (after 2010; "X" depending on the reason) was entered into the CMS. Any relevant feedback was given directly to the CI.

Once clinical editing was completed, the corresponding code of "88: SCID Delivered to Technical Editing" was entered into the CMS, and the SCID booklet was given to the technical editors. Refer to Chapter 8 for more information on data collection quality control.

### **6.3.2 Technical Editing**

Once clinical editing was completed, the technical editors reviewed each SCID to check for missing or inconsistent responses (i.e., compare variables that should match because their values are dependent on the value of another variable) and to verify that conditions stated in the

"Skip Logic" criteria were true (i.e., to check that the CI followed the correct skip patterns when the response to one question directed the CI to the next question, a follow-up question, or a question in another module) (see Appendix H, SCID Technical Editing Guide).

As part of this technical review, technical editors checked that (1) SCID responses were recorded correctly on the front cover of the SCID booklet (e.g., FI ID, Quest ID, date of interview), (2) all required variables were recorded and within the range for the response, (3) fields were consistent with screening variables, (4) skip patterns were followed correctly, and (5) conditions were met for a code "3" (present) for symptom criteria and diagnostic variables. For example, the SCID screening questions, which were asked at the end of the SCID overview, are coded on the last two pages of the overview module and at the beginning of the respective diagnostic modules. If the screening question for a specific disorder is coded as "1" (absent) in the overview, then it must also be coded as "1" in the section that assesses that particular disorder. Another example would be Module A and Module D, both of which are used for coding mood disorders at the level of symptoms (Module A) and diagnoses (Module D). The values for the variables in Module D (Mood Differential) are contingent upon the values in Module A (Mood Episodes). If the criteria for a specific mood episode in Module A are met and therefore coded as "3" (present), then the variable for coding that same mood episode in Module D would also be coded as "3" (present).

Any inconsistencies or cases in which the conditions were not true were noted on a technical editing form (see Appendix H, SCID Failed Edit Worksheet). The technical editing form and its respective SCID were returned to the CSs for final review and correction. Once the technical editors had finished, a code of "89: Technical Editing Complete" was recorded in the CMS.

### **6.3.3 Keying**

Once technical editing was completed and inconsistencies were resolved, the data clerks keyed the SCID data into a computer database and stored the keyed data in an electronic file. All codes that did not meet the keying specification criteria (for consistency and skip logic conditions) were flagged by a machine editing program. A report of flagged cases was sent to the CSs indicating the line(s) where the errors were suspected. SCID booklets flagged with potential problems were retrieved from storage and compared to the computer-generated report. Those line(s) were reviewed again to ensure accuracy in both clinical and technical editing. Any errors were communicated to the dataset manager to be corrected in the electronic file if needed.

### **6.3.4 Storage and Destruction**

All hard copy SCIDs, audio files, and supporting documentation were securely stored following data collection. With the exception of the 2008 SCIDs, which were retained for 6 months following the end of data collection, the SCIDs were retained for 18 months after the end of the data collection period. The audio files for the 2008-2010 Quarter 2 SCID interviews were retained for 6 months after the end of the data collection period. Beginning in Quarter 3 of 2010, Institutional Review Board (IRB) approval was received to retain the audio files for 18 months after the end of the data collection period. The Introduction to Clinical Follow-Up Interview script was modified beginning with interviews conducted in Quarter 3 of 2010 to reflect deleting the audio files within 18 months after the end of the data collection period. This

extension allowed for more time in the data processing schedule for coding and keying additional SCID variables. The SCIDs were kept in a secured storage facility until destroyed. All materials set for destruction were directly sent to a secured shredding facility.

## **6.4 Data Collection Management and Reporting**

Management of MHSS data collection placed a strong emphasis on production, cost-effectiveness, data quality, and communication. To stay informed of data collection status, project management maintained a series of routine meetings:

- DCMs conducted a weekly conference call with every CI with active case work to gain feedback and discuss production, methods to maximize efficiency (e.g., while administering the SCID, listen closely, conduct proper probing, provide adequate documentation, avoid asking vague and/or inappropriate questions), and administrative issues.
- CSs conducted conference calls continuously throughout the quarter with every CI with active case work to review and provide specific feedback on data quality, distressed respondent issues, and proper interviewing techniques.
- The mental health task leader conducted weekly conference calls with the CSs to review data quality, distressed respondent issues, editing and keying completion rates, and interview quality.
- The operations task leader conducted monthly meetings with the CSs, DCMs, sampling staff, training and materials development staff, and other key MHSS project staff to discuss the schedule and upcoming operational activities and deadlines.
- MHSS task leaders met with Substance Abuse and Mental Health Services Administration staff every 2 weeks to provide a status update on operational activities.

In addition to these formal meetings, staff communicated frequently through e-mail and by telephone. Project management, DCMs, and CSs monitored the status of data collection through daily reports provided on the NSDUH CMS. The MHSS CMS included the following functions and reports:

- case status—to view cases by status code and date;
- record of calls (ROC)—to view contact attempts and outcomes for each case;
- case transfer/assignment—to assign and transfer cases to CIs;
- clinical interview file repository—for CSs to listen to recorded interviews;
- incident reports—for project management and CSs to view incident reports completed for distressed respondent cases;
- electronic timesheet—to review and approve timesheets completed by CSs and CIs; and
- monitoring reports, including the Executive Summary Report (with production and cost data), Recruitment Report (a list of hired CIs), Pending Clinical Interview Report (with the status code and date, the number of ROCs, and a time window to complete

each interview), MHSS Sample Monitoring Report (Section 6.4.1), and Clinical Interview Current Status Report (Section 6.4.2).

### 6.4.1 MHSS Sample Monitoring Report

The daily MHSS Sample Monitoring Report documented the MHSS eligibility, selection, agreement, and completion rates by the Kessler-6 score. This report was posted daily to the CMS and was accessible to supervisory and management staff. The MHSS Sample Monitoring Report enabled RTI statisticians to monitor all key variables associated with the MHSS sampling yields and take action as needed to ensure the project reached data collection goals every quarter. The report also enabled management staff to anticipate production and CI staffing needs. [Table 6.3](#) provides an example of the MHSS Sample Monitoring Report from the 2012 MHSS, Quarter 4.

**Table 6.3 MHSS Sample Data: 2012 Quarter 4**

Kessler-6 Score	Interview Respondents (Aged 18+)	Eligible for MHSS	Selected for Clinical Follow-up		Agree to Clinical Follow-up		Completed Clinical Follow-up	
			Count	%	Count	%	Count	%
0-3	5,035	4,786	216	4.5	158	73.1	129	81.6
4-5	1,488	1,451	59	4.1	50	84.7	46	92.0
6-7	1,068	1,045	35	3.3	28	80.0	23	82.1
8-9	714	696	42	6.0	37	88.1	34	91.9
10-11	585	580	47	8.1	37	78.7	28	75.7
12-15	918	907	114	12.6	107	93.9	86	80.4
16+	1,010	995	137	13.8	126	92.0	86	68.3
Total	10,818	10,460	650	6.2	543	83.5	432	79.6

MHSS = Mental Health Surveillance Study.

### 6.4.2 Clinical Interview Current Status Report

The Clinical Interview Current Status Report provided the current status of each MHSS case and a summary of MHSS interview completion counts by quarter. By utilizing the ROC system within the CMS, this status report tracked the progress of every case, from when it was first activated and transmitted to RTI to the final receipt, editing, and keying of completed SCIDs. This report enabled management staff to clearly monitor daily contacts made by CIs and to monitor the multistep editing and keying process of incoming SCIDs for completeness and accuracy. At the conclusion of each quarter, this report served as a final progress check to ensure every case was processed and assigned a final code. Appendix I provides an example of the Clinical Interview Current Status Report from the 2012 MHSS.

## 6.5 Problems Encountered

For data collection, the CIs encountered problems with the audio recording of SCID interviews over the telephone. The audio recording system implemented in 2008 required the CIs to use a recording control adaptor between a wall jack and telephone if an analog line or between the telephone handset and telephone if a digital line. Using this method, the CI's voice was clearly recorded, but the respondent's voice was difficult to hear at times. As discussed in Section 4.3.2, after testing, the CIs began using the Internet-based phone provider Skype in June 2011 for the interview contact with respondents. The quality of the recordings was significantly improved.

The CIs also encountered problems with the DRP. As described in Chapter 7, there were times when the CIs did not fully adhere to the IRB-approved protocol for handling distressed respondents. Violations of the DRP occurred when the CI did not recognize the respondent's signs of emotional distress (e.g., sadness, irritability, agitation) or if the CI did not fully assess the respondent's suicidal ideation. As discussed in Chapter 4, DRP violations also occurred due to unforeseen logistical problems with the emergency contact protocol. The DRP was updated to address these issues. The DRP was reviewed and practiced during all veteran and refresher CI training sessions, with special attention on how to listen for and adequately assess suicidal or homicidal thoughts and how to recognize and address emotional distress at any point of the interview (see Chapter 5, Staff Training). Whenever protocol violations occurred, the CI was immediately contacted and either retrained or terminated.





# 7. Data Collection Results

This chapter describes the results from the Mental Health Surveillance Study (MHSS) data collection from 2008 to 2012.

## 7.1 Response Rates

The 2008, 2011, and 2012 MHSS samples were designed to yield 1,500 clinical follow-up interviews distributed across four calendar quarters with approximately 375<sup>5</sup> interviews occurring per quarter. The 2009 and 2010 MHSS samples were designed to yield 500 clinical follow-up interviews distributed across four calendar quarters with approximately 125 interviews occurring per quarter. As discussed in Section 6.1, for every year except 2012, the probability of selection of the National Survey on Drug Use and Health (NSDUH) interview respondents for the clinical follow-up survey in Quarter 4 was set to zero in late November. Respondents who received a zero probability of selection but would have been selected based on their Kessler-6 score, World Health Organization Disability Assessment Schedule score, and age group were referred to as the zero probability cases.

Table 7.1 provides a summary of the MHSS response rates by year. A total of 220,219 NSDUH interview respondents were eligible for the MHSS follow-up interview from 2008 to 2012. Eligible NSDUH respondents were aged 18 years or older and completed the main study interview in English. Over the 5 years of the MHSS, 8,629 respondents were selected for the clinical follow-up interview. Of those selected, 7,222 agreed to participate, for an agreement rate of 83.69 percent.<sup>6</sup> Of the respondents who agreed to participate, a total of 5,653 (78.27 percent) MHSS valid interviews were completed during the entire MHSS data collection period.

In 2008, a total of 2,331 NSDUH respondents were sampled, 47 of whom were zero probability cases and treated as nonrespondents. A total of 1,973 selected respondents agreed to participate, for an agreement rate of 84.6 percent. Excluding the zero probability cases, 2,284 respondents were selected, and 1,973 (86.3 percent) agreed to participate. A total of 1,500 (76.0 percent) of those respondents who agreed to participate completed a valid clinical interview. The overall completion rate was 64.4 percent and does not incorporate the NSDUH main study nonresponse rates. A summary of the 2008 MHSS respondents by quarter is included in Table 7.2.

In 2009, a total of 789 NSDUH respondents were sampled, 21 of whom were zero probability cases and treated as nonrespondents. A total of 665 selected respondents agreed to participate, for an agreement rate of 84.3 percent. Excluding the zero probability cases, 768 respondents were selected, and 665 (86.6 percent) agreed to participate. A total of 520 (78.2 percent) of the respondents who agreed to participate completed a valid clinical interview. The overall completion rate was 65.9 percent and does not incorporate the NSDUH main study nonresponse rates. A summary of the 2009 MHSS respondents by quarter is included in Table 7.3.

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<sup>5</sup> The goals for Quarters 3 and 4 of 2012 were increased from 375 to 385 each quarter.

<sup>6</sup> NSDUH respondents who agreed to clinical follow-up at the time of their main study interview are classified as agreeing to participate.

**Table 7.1 2008-2012 MHSS Response Rate Summary**

<b>Design Parameter</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Interview Respondents Aged 18 or Older	45,678	45,609	45,844	46,599	45,836
Eligible for MHSS <sup>1</sup>	43,593	43,708	43,958	44,740	44,220
<i>Eligibility Rate</i>	<i>0.9544</i>	<i>0.9583</i>	<i>0.9589</i>	<i>0.9601</i>	<i>0.9647</i>
Selected for Telephone Clinical Follow-up <sup>2</sup>	2,331	789	768	2,277	2,464
Zero Probability Cases	47	21	4	41	0
Agreed to Clinical Follow-up	1,973	665	640	1,881	2,063
<i>Percentage Agreeing to Clinical Follow-up (including zero probability cases)</i>	<i>0.8464</i>	<i>0.8428</i>	<i>0.8333</i>	<i>0.8261</i>	<i>0.8373</i>
<i>Percentage Agreeing to Clinical Follow-up (excluding zero probability cases)</i>	<i>0.8638</i>	<i>0.8659</i>	<i>0.8377</i>	<i>0.8412</i>	<i>0.8373</i>
Completed Clinical Interviews	1,500	520	516	1,495	1,622
<i>Clinical Interview Completion Rate</i>	<i>0.7603</i>	<i>0.7820</i>	<i>0.8063</i>	<i>0.7948</i>	<i>0.7862</i>
<i>Overall Clinical Follow-up Response Rate</i> <sup>3</sup>	<i>0.6435</i>	<i>0.6591</i>	<i>0.6719</i>	<i>0.6566</i>	<i>0.6583</i>

MHSS = Mental Health Surveillance Study.

<sup>1</sup> Respondents aged 18 or older who completed their main study interview in English are eligible to be selected for the MHSS.

<sup>2</sup> Includes cases assigned a zero probability of selection that would have been selected based on their Kessler-6 and World Health Organization Disability Assessment Schedule scores and age groups.

<sup>3</sup> Includes zero probability cases and treats them as nonrespondents.

**Table 7.2 2008 MHSS, Quarters 1 through 4 Summary**

<b>Design Parameter</b>	<b>Quarter 1</b>	<b>Quarter 2</b>	<b>Quarter 3</b>	<b>Quarter 4</b>	<b>Total</b>
Interview Respondents Aged 18 or Older	10,692	12,816	11,355	10,815	45,678
Eligible for MHSS <sup>1</sup>	10,215	12,148	10,849	10,381	43,593
<i>Eligibility Rate</i>	<i>0.9554</i>	<i>0.9479</i>	<i>0.9554</i>	<i>0.9599</i>	<i>0.9544</i>
Selected for Telephone Clinical Follow-up <sup>2</sup>	696	529	485	621	2,331
Zero Probability Cases	0	0	0	47	47
Agreed to Clinical Follow-up	586	462	416	509	1,973
<i>Percentage Agreeing to Clinical Follow-up (including zero probability cases)</i>	<i>0.8420</i>	<i>0.8733</i>	<i>0.8577</i>	<i>0.8196</i>	<i>0.8464</i>
<i>Percentage Agreeing to Clinical Follow-up (excluding zero probability cases)</i>	<i>0.8420</i>	<i>0.8733</i>	<i>0.8577</i>	<i>0.8868</i>	<i>0.8638</i>
Completed Clinical Interviews	467	361	317	355	1,500
<i>Clinical Interview Completion Rate</i>	<i>0.7969</i>	<i>0.7814</i>	<i>0.7620</i>	<i>0.6974</i>	<i>0.7603</i>
<i>Overall Clinical Follow-up Response Rate</i> <sup>3</sup>	<i>0.6710</i>	<i>0.6824</i>	<i>0.6536</i>	<i>0.5717</i>	<i>0.6435</i>

MHSS = Mental Health Surveillance Study.

<sup>1</sup> Respondents aged 18 or older who completed their main study interview in English are eligible to be selected for the MHSS.

<sup>2</sup> Includes cases assigned a zero probability of selection that would have been selected based on their Kessler-6 and World Health Organization Disability Assessment Schedule scores and age groups.

<sup>3</sup> Includes zero probability cases and treats them as nonrespondents.

In 2010, a total of 768 NSDUH respondents were sampled, 4 of whom were zero probability cases and treated as nonrespondents. A total of 640 selected respondents agreed to participate, for an agreement rate of 83.3 percent. Excluding the zero probability cases, 764 respondents were selected, and 640 (83.8 percent) agreed to participate. A total of 516 (80.6 percent) of the respondents who agreed to participate completed a valid clinical interview. The overall completion rate was 67.2 percent and does not incorporate the NSDUH main study nonresponse rates. A summary of the 2010 MHSS respondents by quarter is included in [Table 7.4](#).

**Table 7.3 2009 MHSS, Quarters 1 through 4 Summary**

<b>Design Parameter</b>	<b>Quarter 1</b>	<b>Quarter 2</b>	<b>Quarter 3</b>	<b>Quarter 4</b>	<b>Total</b>
Interview Respondents Aged 18 or Older	11,403	11,963	11,264	10,979	45,609
Eligible for MHSS <sup>1</sup>	10,930	11,452	10,786	10,540	43,708
<i>Eligibility Rate</i>	<i>0.9585</i>	<i>0.9573</i>	<i>0.9576</i>	<i>0.9600</i>	<i>0.9583</i>
Selected for Telephone Clinical Follow-up <sup>2</sup>	182	192	211	204	789
Zero Probability Cases	0	0	0	21	21
Agreed to Clinical Follow-up	156	167	183	159	665
<i>Percentage Agreeing to Clinical Follow-up (including zero probability cases)</i>	<i>0.8571</i>	<i>0.8698</i>	<i>0.8673</i>	<i>0.7794</i>	<i>0.8428</i>
<i>Percentage Agreeing to Clinical Follow-up (excluding zero probability cases)</i>	<i>0.8571</i>	<i>0.8698</i>	<i>0.8673</i>	<i>0.8689</i>	<i>0.8659</i>
Completed Clinical Interviews	123	125	142	130	520
<i>Clinical Interview Completion Rate</i>	<i>0.7885</i>	<i>0.7485</i>	<i>0.7760</i>	<i>0.8176</i>	<i>0.7820</i>
<i>Overall Clinical Follow-up Response Rate</i> <sup>3</sup>	<i>0.6758</i>	<i>0.6510</i>	<i>0.6730</i>	<i>0.6373</i>	<i>0.6591</i>

MHSS = Mental Health Surveillance Study.

<sup>1</sup> Respondents aged 18 or older who completed their main study interview in English are eligible to be selected for the MHSS.

<sup>2</sup> Includes cases assigned a zero probability of selection that would have been selected based on their Kessler-6 and World Health Organization Disability Assessment Schedule scores and age groups.

<sup>3</sup> Includes zero probability cases and treats them as nonrespondents.

**Table 7.4 2010 MHSS, Quarters 1 through 4 Summary**

<b>Design Parameter</b>	<b>Quarter 1</b>	<b>Quarter 2</b>	<b>Quarter 3</b>	<b>Quarter 4</b>	<b>Total</b>
Interview Respondents Aged 18 or Older	10,877	12,102	11,844	11,021	45,844
Eligible for MHSS <sup>1</sup>	10,446	11,608	11,341	10,563	43,958
<i>Eligibility Rate</i>	<i>0.9604</i>	<i>0.9592</i>	<i>0.9575</i>	<i>0.9584</i>	<i>0.9589</i>
Selected for Telephone Clinical Follow-up <sup>2</sup>	190	246	175	157	768
Zero Probability Cases	0	0	0	4	4
Agreed to Clinical Follow-up	163	198	146	133	640
<i>Percentage Agreeing to Clinical Follow-up (including zero probability cases)</i>	<i>0.8579</i>	<i>0.8049</i>	<i>0.8343</i>	<i>0.8471</i>	<i>0.8333</i>
<i>Percentage Agreeing to Clinical Follow-up (excluding zero probability cases)</i>	<i>0.8579</i>	<i>0.8049</i>	<i>0.8343</i>	<i>0.8693</i>	<i>0.8377</i>
Completed Clinical Interviews	132	157	115	112	516
<i>Clinical Interview Completion Rate</i>	<i>0.8098</i>	<i>0.7929</i>	<i>0.7877</i>	<i>0.8421</i>	<i>0.8063</i>
<i>Overall Clinical Follow-up Response Rate</i> <sup>3</sup>	<i>0.6947</i>	<i>0.6382</i>	<i>0.6571</i>	<i>0.7134</i>	<i>0.6719</i>

MHSS = Mental Health Surveillance Study.

<sup>1</sup> Respondents aged 18 or older who completed their main study interview in English are eligible to be selected for the MHSS.

<sup>2</sup> Includes cases assigned a zero probability of selection that would have been selected based on their Kessler-6 and World Health Organization Disability Assessment Schedule scores and age groups.

<sup>3</sup> Includes zero probability cases and treats them as nonrespondents.

In 2011, a total of 2,277 NSDUH respondents were sampled, 41 of whom were zero probability cases and treated as nonrespondents. A total of 1,881 selected respondents agreed to participate, for an agreement rate of 82.6 percent. Excluding the zero probability cases, 2,236 respondents were selected, and 1,881 (84.1 percent) agreed to participate. A total of 1,495 (79.5 percent) of the respondents who agreed to participate completed a valid clinical interview. The overall completion rate was 65.7 percent and does not incorporate the NSDUH main study nonresponse rates. A summary of the 2011 MHSS respondents by quarter is included in [Table 7.5](#).

**Table 7.5 2011 MHSS, Quarters 1 through 4 Summary**

<b>Design Parameter</b>	<b>Quarter 1</b>	<b>Quarter 2</b>	<b>Quarter 3</b>	<b>Quarter 4</b>	<b>Total</b>
Interview Respondents Aged 18 or Older	10,840	12,481	12,170	11,108	46,599
Eligible for MHSS <sup>1</sup>	10,392	11,974	11,665	10,709	44,740
<i>Eligibility Rate</i>	<i>0.9587</i>	<i>0.9594</i>	<i>0.9585</i>	<i>0.9641</i>	<i>0.9601</i>
Selected for Telephone Clinical Follow-up <sup>2</sup>	543	672	531	531	2,277
Zero Probability Cases <sup>3</sup>	15	0	0	26	41
Agreed to Clinical Follow-up	450	561	449	421	1,881
<i>Percentage Agreeing to Clinical Follow-up (including zero probability cases)</i>	<i>0.8287</i>	<i>0.8348</i>	<i>0.8456</i>	<i>0.7928</i>	<i>0.8261</i>
<i>Percentage Agreeing to Clinical Follow-up (excluding zero probability cases)</i>	<i>0.8523</i>	<i>0.8348</i>	<i>0.8456</i>	<i>0.8337</i>	<i>0.8412</i>
Completed Clinical Interviews	363	436	359	337	1,495
<i>Clinical Interview Completion Rate</i>	<i>0.8067</i>	<i>0.7772</i>	<i>0.7996</i>	<i>0.8005</i>	<i>0.7948</i>
<i>Overall Clinical Follow-up Response Rate<sup>4</sup></i>	<i>0.6685</i>	<i>0.6488</i>	<i>0.6761</i>	<i>0.6347</i>	<i>0.6566</i>

MHSS = Mental Health Surveillance Study.

<sup>1</sup> Respondents aged 18 or older who completed their main study interview in English are eligible to be selected for the MHSS.

<sup>2</sup> Includes cases assigned a zero probability of selection that would have been selected based on their Kessler-6 and World Health Organization Disability Assessment Schedule scores and age groups.

<sup>3</sup> At the beginning of Quarter 1, 15 interview respondents who should have been selected for the MHSS were inadvertently assigned a zero probability of selection.

<sup>4</sup> Includes zero probability cases and treats them as nonrespondents.

In 2012, a total of 2,464 NSDUH respondents were sampled. No cases were marked as zero probability cases in 2012. A total of 2,063 selected respondents agreed to participate, for an agreement rate of 83.7 percent. A total of 1,622 (78.6 percent) of the respondents who agreed to participate completed a valid clinical interview. The overall completion rate was 65.8 percent and does not incorporate the NSDUH main study nonresponse rates. A summary of the 2012 MHSS respondents by quarter is included in [Table 7.6](#).

**Table 7.6 2012 MHSS, Quarters 1 through 4 Summary**

<b>Design Parameter</b>	<b>Quarter 1</b>	<b>Quarter 2</b>	<b>Quarter 3</b>	<b>Quarter 4</b>	<b>Total</b>
Interview Respondents Aged 18 or Older	10,894	12,144	11,997	10,801	45,836
Eligible for MHSS <sup>1</sup>	10,488	11,699	11,591	10,442	44,220
<i>Eligibility Rate</i>	<i>0.9627</i>	<i>0.9634</i>	<i>0.9662</i>	<i>0.9668</i>	<i>0.9647</i>
Selected for Telephone Clinical Follow-up <sup>2</sup>	585	596	634	649	2,464
Zero Probability Cases <sup>3</sup>	0	0	0	0	0
Agreed to Clinical Follow-up	491	497	532	543	2,063
<i>Percentage Agreeing to Clinical Follow-up (including zero probability cases)</i>	<i>0.8393</i>	<i>0.8339</i>	<i>0.8391</i>	<i>0.8367</i>	<i>0.8373</i>
<i>Percentage Agreeing to Clinical Follow-up (excluding zero probability cases)</i>	<i>0.8393</i>	<i>0.8339</i>	<i>0.8391</i>	<i>0.8367</i>	<i>0.8373</i>
Completed Clinical Interviews	384	379	434	425	1,622
<i>Clinical Interview Completion Rate</i>	<i>0.7821</i>	<i>0.7626</i>	<i>0.8158</i>	<i>0.7827</i>	<i>0.7862</i>
<i>Overall Clinical Follow-up Response Rate</i>	<i>0.6564</i>	<i>0.6359</i>	<i>0.6845</i>	<i>0.6549</i>	<i>0.6583</i>

MHSS = Mental Health Surveillance Study.

<sup>1</sup> Respondents aged 18 or older who completed their main study interview in English are eligible to be selected for the MHSS.

<sup>2</sup> Includes cases assigned a zero probability of selection that would have been selected based on their Kessler-6 and World Health Organization Disability Assessment Schedule scores and age groups.

<sup>3</sup> There were no zero probability cases in 2012.

## 7.2 Number of Contacts

After a respondent was selected at the end of the NSDUH interview to complete a clinical interview, the case was transmitted back to RTI International and assigned to a clinical interviewer (CI). The CIs made the first attempt to contact a case within 24 hours of receiving the assigned case to schedule an appointment for the interview. If the case was not reached on the first call attempt, subsequent calls were made during the case's preferred time frame provided during the NSDUH interview. If a CI made several attempts without success during the time period specified for the case, calls were made at times outside of the case's preferred time frame in an attempt to reach the case. The data collection managers (DCMs) completed reviews of the record of calls to ensure that call attempts were being made at appropriate times and provided guidance on the best days and times to recontact cases. An MHSS case was considered final once a respondent completed the clinical interview or the case was finalized as a nonrespondent (i.e., cases who refused or could not be contacted and therefore did not complete the interview).

[Table 7.7](#) provides the number of call attempts made to contact the MHSS cases across all survey years. In all survey years, about 25 percent of interviews were completed in one or two call attempts, more than 56 percent were completed within four call attempts, and 75 percent within six to seven call attempts. Each year, the CIs made 10 or more call attempts to complete 11 to 14 percent of the clinical interviews, with more than 95 percent of interviews completed within 15 call attempts. The number of call attempts made to contact the MHSS case remained about the same for each year of the MHSS.

[Table 7.8](#) provides the number of call attempts made to contact the MHSS cases finalized as nonrespondents across all survey years. In 2008, the CIs determined 65 percent of these cases to be nonrespondents within 15 contact attempts. The percentage of nonrespondents finalized within 15 contact attempts declined each year of the MHSS. This means that CIs made more call attempts to cases each year before determining the case to be a nonrespondent. In 2012, only 32 percent of nonrespondent cases were finalized within 15 call attempts, and 59 percent of cases were classified as nonrespondents within 20 call attempts.

**Table 7.7 Number of Call Attempts Made To Contact MHSS Respondents: 2008-2012**

Call Attempts (#)	2008			2009			2010			2011			2012		
	Total Respondents (#)	%	Cumulative %	Total Respondents (#)	%	Cumulative %	Total Respondents (#)	%	Cumulative %	Total Respondents (#)	%	Cumulative %	Total Respondents (#)	%	Cumulative %
1	65	4.27	4.27	6	1.14	1.14	13	2.50	2.50	66	4.36	4.36	64	3.89	3.89
2	308	20.22	24.49	114	21.59	22.73	111	21.39	23.89	335	22.13	26.49	351	21.32	25.21
3	297	19.50	43.99	110	20.83	43.56	101	19.46	43.35	288	19.02	45.51	333	20.23	45.44
4	197	12.93	56.93	75	14.20	57.77	73	14.07	57.42	220	14.53	60.04	217	13.18	58.63
5	151	9.91	66.84	62	11.74	69.51	43	8.29	65.70	136	8.98	69.02	151	9.17	67.80
6	101	6.63	73.47	32	6.06	75.57	43	8.29	73.99	85	5.61	74.64	108	6.56	74.36
7	78	5.12	78.59	24	4.55	80.11	29	5.59	79.58	84	5.55	80.13	89	5.41	79.77
8	71	4.66	83.26	26	4.92	85.04	17	3.28	82.85	49	3.24	83.42	62	3.77	83.54
9	60	3.94	87.20	20	3.79	88.83	17	3.28	86.13	51	3.37	86.79	55	3.34	86.88
10-15	145	9.52	96.72	48	9.09	97.92	49	9.44	95.57	134	8.85	95.64	154	9.36	96.23
16-20	33	2.17	98.88	10	1.89	99.81	18	3.47	99.04	48	3.17	98.81	39	2.37	98.60
21-25	10	0.66	99.54	1	0.19	100.00	3	0.58	99.61	11	0.73	99.54	8	0.49	99.09
26-30	5	0.33	99.87	0	0.00	100.00	2	0.39	100.00	7	0.46	100.00	12	0.73	99.82
31+	2	0.13	100.00	0	0.00	100.00	0	0.00	100.00	0	0.00	100.00	3	0.18	100.00
Total	1,523	100.00		528	100.00		519	100.00		1,514	100.00		1,646	100.00	

MHSS = Mental Health Surveillance Study.

54 **Table 7.8 Number of Call Attempts Made To Contact MHSS Nonrespondents: 2008-2012**

Call Attempts (#)	2008			2009			2010			2011			2012		
	Total Non-respondents (#)	%	Cumulative %	Total Non-respondents (#)	%	Cumulative %	Total Non-respondents (#)	%	Cumulative %	Total Non-respondents (#)	%	Cumulative %	Total Non-respondents (#)	%	Cumulative %
1-5	42	9.15	9.15	17	12.41	12.41	11	8.94	8.94	27	7.09	7.09	38	9.00	9.00
6-10	115	25.05	34.20	19	13.87	26.28	8	6.5	15.45	41	10.76	17.85	33	7.82	16.82
11-15	145	31.59	65.80	40	29.20	55.47	33	26.83	42.28	82	21.52	39.37	64	15.17	31.99
16-20	61	13.29	79.08	40	29.20	84.67	25	20.33	62.60	102	26.77	66.14	117	27.73	59.72
21-25	47	10.24	89.32	18	13.14	97.81	32	26.02	88.62	82	21.52	87.66	101	23.93	83.65
26-30	23	5.01	94.34	2	1.46	99.27	13	10.57	99.19	37	9.71	97.38	50	11.85	95.50
31+	26	5.66	100.00	1	0.73	100.00	1	0.81	100.00	10	2.62	100.00	19	4.50	100.00
Total	459	100.00		137	100.00		123	100.00		381	100.00		422	100.00	

MHSS = Mental Health Surveillance Study.

Table 7.9 shows the number of call attempts made to contact the MHSS respondents in 2008. Almost 25 percent of the clinical interviews were completed in one or two call attempts. The CIs made 10 or more call attempts to complete 13 percent of the clinical interviews, and more than 96 percent of interviews were completed within 15 call attempts.

Table 7.10 shows the number of call attempts made to contact the MHSS cases finalized as nonrespondents in 2008. For the vast majority of these cases, the CIs were unable to make contact with the case. The CIs determined 79 percent of these cases to be nonrespondents within 20 contact attempts, and 89 percent of interviews were classified as nonrespondents within 25 contacts.

**Table 7.9 Number of Call Attempts Made To Contact MHSS Respondents: 2008**

Call Attempts (#)	Total Respondents (#)	Total Respondents (%)	Cumulative Total Respondents (%)	Code 70 (Interview Complete, Audio Recorded)	Code 71 (Interview Complete, No Audio—Refusal)	Code 72 (Interview Complete, No Audio—Technical Problem)
1	65	4.27	4.27	63	1	1
2	308	20.22	24.49	283	16	9
3	297	19.50	43.99	277	7	13
4	197	12.93	56.93	175	13	9
5	151	9.91	66.84	137	6	8
6	101	6.63	73.47	93	4	4
7	78	5.12	78.59	70	5	3
8	71	4.66	83.26	63	5	3
9	60	3.94	87.20	53	7	0
10-15	145	9.52	96.72	132	6	7
16-20	33	2.17	98.88	29	2	2
21-25	10	0.66	99.54	9	1	0
26-30	5	0.33	99.87	4	0	1
31+	2	0.13	100.00	2	0	0
Total	1,523	100.00		1,390	73	60

MHSS = Mental Health Surveillance Study.

**Table 7.10 Number of Call Attempts Made To Contact MHSS Nonrespondents: 2008**

Call Attempts (#)	Total Non-respondents (#)	Total Non-respondents (%)	Cumulative Total Non-respondents (%)	Code 73 (Breakoff, Partial Interview)	Code 74 (Unable to Contact)	Code 75 (Phone Number Problem)	Code 76 (Refusal)	Code 77 (Other)
1-5	42	9.15	9.15	12	3	16	4	7
6-10	115	25.05	34.20	20	61	27	4	3
11-15	145	31.59	65.80	9	119	13	1	3
16-20	61	13.29	79.08	11	41	6	0	3
21-25	47	10.24	89.32	2	39	4	1	1
26-30	23	5.01	94.34	3	17	3	0	0
31+	26	5.66	100.00	3	23	0	0	0
Total	459	100.00		60	303	69	10	17

MHSS = Mental Health Surveillance Study.

Table 7.11 shows the number of call attempts made to contact the MHSS respondents in 2009. The CIs completed almost 23 percent of the clinical interviews in one or two call attempts. The CIs made 10 or more call attempts to complete 11 percent of the clinical interviews, and more than 97 percent of cases were completed within 15 call attempts.



**Table 7.11 Number of Call Attempts Made To Contact MHSS Respondents: 2009**

Call Attempts (#)	Total Respondents (#)	Total Respondents (%)	Cumulative Total Respondents (%)	Code 70 (Interview Complete, Audio Recorded)	Code 71 (Interview Complete, No Audio—Refusal)	Code 72 (Interview Complete, No Audio—Technical Problem)
1	6	1.14	1.14	6	0	0
2	114	21.59	22.73	109	5	0
3	110	20.83	43.56	108	2	0
4	75	14.20	57.77	72	3	0
5	62	11.74	69.51	57	5	0
6	32	6.06	75.57	32	0	0
7	24	4.55	80.11	23	1	0
8	26	4.92	85.04	25	1	0
9	20	3.79	88.83	17	3	0
10-15	134	9.09	97.92	39	7	2
16-20	48	1.89	99.81	9	1	0
21-25	10	0.19	100.00	1	0	0
26-30	1	0.00	100.00	0	0	0
31+	0	0.00	100.00	0	0	0
Total	528	100.00		498	28	2

MHSS = Mental Health Surveillance Study.

Table 7.12 shows the number of call attempts made to contact the MHSS cases finalized as nonrespondents in 2009. For the majority of these cases, the CIs were unable to make contact with the case. The CIs determined 84 percent of these cases to be nonrespondents within 20 contact attempts, and almost 98 percent of interviews were classified as nonrespondents within 25 contacts.

**Table 7.12 Number of Call Attempts Made To Contact MHSS Nonrespondents: 2009**

Call Attempts (#)	Total Non-respondents (#)	Total Non-respondents (%)	Cumulative Total Non-respondents (%)	Code 73 (Breakoff, Partial Interview)	Code 74 (Unable to Contact)	Code 75 (Phone Number Problem)	Code 76 (Refusal)	Code 77 (Other)
1-5	17	12.41	12.41	4	1	8	1	3
6-10	19	13.87	26.28	3	7	7	0	2
11-15	40	29.20	55.47	9	25	3	3	0
16-20	40	29.20	84.67	4	33	3	0	0
21-25	18	13.14	97.81	1	17	0	0	0
26-30	2	1.46	99.27	0	2	0	0	0
31+	1	0.73	100.00	0	1	0	0	0
Total	137	100.00		21	86	21	4	5

MHSS = Mental Health Surveillance Study.

Table 7.13 shows the number of call attempts made to contact the MHSS respondents in 2010. Almost 24 percent of the clinical interviews were completed in one or two call attempts. The CIs made 10 or more call attempts to complete 14 percent of the clinical interviews, and more than 95 percent of cases were completed within 15 call attempts.

Table 7.14 shows the number of call attempts made to contact the MHSS cases finalized as nonrespondents in 2010. For the majority of these cases, the CIs were unable to make contact with the case. The CIs determined 62 percent of these cases to be nonrespondents within 20 contact attempts, and 88 percent of interviews were classified as nonrespondents within 25 contacts.

**Table 7.13 Number of Call Attempts Made To Contact MHSS Respondents: 2010**

Call Attempts (#)	Total Respondents (#)	Total Respondents (%)	Cumulative Total Respondents (%)	Code 70 (Interview Complete, Audio Recorded)	Code 71 (Interview Complete, No Audio—Refusal)	Code 72 (Interview Complete, No Audio—Technical Problem)
1	13	2.50	2.50	13	0	0
2	111	21.39	23.89	108	2	1
3	101	19.46	43.35	96	5	0
4	73	14.07	57.42	66	5	2
5	43	8.29	65.70	39	3	1
6	43	8.29	73.99	38	4	1
7	29	5.59	79.58	25	3	1
8	17	3.28	82.85	16	1	0
9	17	3.28	86.13	16	0	1
10-15	49	9.44	95.57	47	0	2
16-20	18	3.47	99.04	17	1	0
21-25	3	0.58	99.61	2	1	0
26-30	2	0.39	100.00	1	0	1
31+	0	0.00	100.00	0	0	0
Total	519	100.00		484	25	10

MHSS = Mental Health Surveillance Study.

**Table 7.14 Number of Call Attempts Made To Contact MHSS Nonrespondents: 2010**

Call Attempts (#)	Total Non-respondents (#)	Total Non-respondents (%)	Cumulative Total Non-respondents (%)	Code 73 (Breakoff, Partial Interview)	Code 74 (Unable to Contact)	Code 75 (Phone Number Problem)	Code 76 (Refusal)	Code 77 (Other)
1-5	11	8.94	8.94	7	2	0	1	1
6-10	8	6.50	15.45	0	5	0	1	2
11-15	33	26.83	42.28	5	23	0	1	4
16-20	25	20.33	62.60	1	22	1	1	0
21-25	32	26.02	88.62	2	28	1	0	1
26-30	13	10.57	99.19	0	11	1	1	0
31+	1	0.81	100.00	0	1	0	0	0
Total	123	100.00		15	92	3	5	8

MHSS = Mental Health Surveillance Study.

Table 7.15 shows the number of call attempts made to contact the MHSS respondents in 2011. The CIs completed more than 26 percent of the clinical interviews in one or two call attempts. Up to six call attempts were made to complete almost 75 percent of the clinical interviews. The CIs made 10 or more call attempts to complete 13 percent of the clinical interviews.

Table 7.16 shows the number of call attempts made to contact MHSS cases finalized as nonrespondents in 2011. For the vast majority of these cases, the CIs were unable to make contact with the case. The CIs determined 66 percent of these cases to be nonrespondents within 20 contacts, and almost 88 percent of interviews were classified as nonrespondents within 25 contacts.

**Table 7.15 Number of Call Attempts Made To Contact MHSS Respondents: 2011**

Call Attempts (#)	Total Respondents (#)	Total Respondents (%)	Cumulative Total Respondents (%)	Code 70 (Interview Complete, Audio Recorded)	Code 71 (Interview Complete, No Audio—Refusal)	Code 72 (Interview Complete, No Audio—Technical Problem)
1	66	4.36	4.36	61	3	2
2	335	22.13	26.49	319	13	3
3	288	19.02	45.51	269	12	7
4	220	14.53	60.04	212	6	2
5	136	8.98	69.02	130	5	1
6	85	5.61	74.64	77	4	4
7	84	5.55	80.13	80	1	3
8	49	3.24	83.42	45	4	0
9	51	3.37	86.79	47	1	3
10-15	134	8.85	95.64	133	1	0
16-20	48	3.17	98.81	47	1	0
21-25	11	0.73	99.54	9	2	0
26-30	7	0.46	100.00	5	2	0
31+	0	0.00	100.00	0	0	0
Total	1,514	100.00		1,434	55	25

MHSS = Mental Health Surveillance Study.

**Table 7.16 Number of Call Attempts Made To Contact MHSS Nonrespondents: 2011**

Call Attempts (#)	Total Non-respondents (#)	Total Non-respondents (%)	Cumulative Total Non-respondents (%)	Code 73 (Breakoff, Partial Interview)	Code 74 (Unable to Contact)	Code 75 (Phone Number Problem)	Code 76 (Refusal)	Code 77 (Other)
1-5	27	7.09	7.09	10	0	7	4	6
6-10	41	10.76	17.85	12	10	12	4	3
11-15	82	21.52	39.37	14	56	10	0	2
16-20	102	26.77	66.14	14	82	5	0	1
21-25	82	21.52	87.66	8	71	1	0	2
26-30	37	9.71	97.38	2	35	0	0	0
31+	10	2.62	100.00	1	8	1	0	0
Total	381	100.00		61	262	36	8	14

MHSS = Mental Health Surveillance Study.

Table 7.17 shows the number of call attempts made to contact the MHSS respondents in 2012. Similar to previous years, about 25 percent of the clinical interviews were completed in one or two call attempts. The CIs made 10 or more call attempts to complete 13 percent of the clinical interviews, and more than 96 percent of cases were completed within 15 call attempts.

Table 7.18 shows the number of call attempts made to contact MHSS cases finalized nonrespondents. For the vast majority of these cases, the CIs were unable to make contact with the case. The CIs determined almost 60 percent of these cases to be nonrespondents within 20 contact attempts, and more than 83 percent of interviews were classified as nonrespondents within 25 contacts.

**Table 7.17 Number of Call Attempts Made To Contact MHSS Respondents: 2012**

Call Attempts (#)	Total Respondents (#)	Total Respondents (%)	Cumulative Total Respondents (%)	Code 70 (Interview Complete, Audio Recorded)	Code 71 (Interview Complete, No Audio—Refusal)	Code 72 (Interview Complete, No Audio—Technical Problem)
1	64	3.89	3.89	63	0	1
2	351	21.32	25.21	329	12	10
3	333	20.23	45.44	315	9	9
4	217	13.18	58.63	200	10	7
5	151	9.17	67.80	132	8	11
6	108	6.56	74.36	102	2	4
7	89	5.41	79.77	82	5	2
8	62	3.77	83.54	54	4	4
9	55	3.34	86.88	51	3	1
10-15	154	9.36	96.23	137	8	9
16-20	39	2.37	98.60	36	2	1
21-25	8	0.49	99.09	8	0	0
26-30	12	0.73	99.82	10	1	1
31+	3	0.18	100.00	3	0	0
Totals	1,646	100.00		1,522	64	60

MHSS = Mental Health Surveillance Study.

**Table 7.18 Number of Call Attempts Made To Contact MHSS Nonrespondents: 2012**

Call Attempts (#)	Total Non-respondents (#)	Total Non-respondents (%)	Cumulative Total Respondents (%)	Code 73 (Breakoff, Partial Interview)	Code 74 (Unable to Contact)	Code 75 (Phone Number Problem)	Code 76 (Refusal)	Code 77 (Other)
1-5	38	9.00	9.00	25	0	5	6	2
6-10	33	7.82	16.82	11	6	12	3	1
11-15	64	15.17	31.99	14	42	8	0	0
16-20	117	27.73	59.72	14	98	3	2	0
21-25	101	23.93	83.65	4	91	4	1	1
26-30	50	11.85	95.50	5	44	1	0	0
31+	19	4.50	100.00	2	17	0	0	0
Total	422	100.00		75	298	33	12	4

MHSS = Mental Health Surveillance Study.

### 7.3 Distressed Respondents

CIs were trained to fully assess signs and symptoms of emotional distress by the respondent during the administration of the Structured Clinical Interview for DSM-IV Axis I Disorders Non-patient Edition (SCID-I/NP or SCID; First, Spitzer, Gibbon, & Williams, 2002) over the telephone. Respondents' distress included reports of recent suicidal or homicidal thoughts, plans, or actions, or showing strong feelings of sadness, irritability, or agitation during SCID administration. As shown in Appendix C, the MHSS had a detailed Distressed Respondent Protocol (DRP) to handle five different scenarios differentiated by risk of harm to self or others.

As summarized in [Table 7.19](#), DRP Scenario #1 was for respondents reporting recent passive suicidal ideation, which included vague thoughts of suicide in the absence of a plan (risk of self-harm, no imminent danger). DRP Scenario #2 was for respondents reporting recent active suicidal ideation, which included specific plans for suicide and acting on those thoughts (risk of self-harm, possible/definite imminent danger). DRP Scenario #3 was for respondents reporting recent passive homicidal ideation, which included vague thoughts of homicide in the absence of a plan (risk of harm to others, no imminent danger). DRP Scenario #4 was for respondents who

reported recent active homicidal ideation, which included specific plans for homicide and acting on those thoughts (risk of harm to others, possible/definite imminent danger). DRP Scenario #5 was for respondents who showed signs of emotional distress during the SCID, such as sadness, irritability, or agitation, in the absence of suicidal or homicidal thoughts (no risk of harm, respondent is agitated or upset).

**Table 7.19 Distressed Respondent Protocol Scenarios: 2008-2012 MHSS**

Distressed Respondent Protocol Scenario	Risk of Harm	Imminent Danger
Scenario #1: Passive suicidal ideation	Self	No
Scenario #2: Active suicidal ideation	Self	Yes/Maybe
Scenario #3: Passive homicidal ideation	Other(s)	No
Scenario #4: Active homicidal ideation	Other(s)	Yes/Maybe
Scenario #5: Respondent agitated or upset	None	No

MHSS = Mental Health Surveillance Study.

As shown in Table 7.20, a total of 201 respondents were classified as distressed during the 2008-2012 MHSS. Among these, 145 were DRP Scenario #1 (passive suicidal ideation), 10 were Scenario #2 (active suicidal ideation), 4 were Scenario #3 (passive homicidal ideation), and 42 were Scenario #5 (respondent upset or agitated). There were no cases that were Scenario #4 (active homicidal ideation).

**Table 7.20 Number of Distressed Respondent Protocol Classifications: 2008-2012 MHSS**

Distressed Respondent Protocol Scenario	2008 ( <i>n</i> =1,581 <sup>1</sup> )	2009 ( <i>n</i> =547 <sup>1</sup> )	2010 ( <i>n</i> =533 <sup>1</sup> )	2011 ( <i>n</i> =1,569 <sup>1</sup> )	2012 ( <i>n</i> =1,721 <sup>1</sup> )	2008-2012 ( <i>n</i> =5,951 <sup>1</sup> )
Scenario #1: Passive suicidal ideation	22	9	13	50	51	145
Scenario #2: Active suicidal ideation	5	2	0	2	1	10
Scenario #3: Passive homicidal ideation	1	0	1	0	2	4
Scenario #4: Active homicidal ideation	0	0	0	0	0	0
Scenario #5: Respondent agitated or upset	4	0	2	10	26	42
Total	32	11	16	62	80	201

MHSS = Mental Health Surveillance Study.

<sup>1</sup>Total number of complete and incomplete Structured Clinical Interviews for DSM-IV.

CIs' adherence to the Institutional Review Board (IRB)-approved protocol for handling distressed respondents was 91.0 percent (*n* = 183) for the 2008-2012 MHSS. As summarized in Table 7.21, among the 18 cases involving protocol violations, 7 cases were Scenario #1 (passive suicidal ideation), 6 cases were Scenario #2 (active suicidal ideation), and 5 cases were Scenario #5 (respondent upset or agitated). Half of the protocol violations were due to unforeseen circumstances, such as trouble connecting the respondent with Lifeline services (*n* = 3), trouble connecting respondent with emergency services (*n* = 3), or lost phone connection before the CI was able to read the DRP script (*n* = 3). The remaining 9 cases resulted from CIs who did not recognize the respondent's distress at the time of the interview (*n* = 6), did not read the DRP script verbatim (*n* = 2), or recontacted the respondent after terminating the interview (*n* = 1). The distribution of IRB violations across DRP scenarios and study years is summarized in Table 7.22.

**Table 7.21 Number of Institutional Review Board Violations, by Distressed Respondent Protocol Scenarios: 2008-2012 MHSS**

<b>Distressed Respondent Protocol Scenario</b>	<b>2008 (n=1,581<sup>1</sup>)</b>	<b>2009 (n=547<sup>1</sup>)</b>	<b>2010 (n=533<sup>1</sup>)</b>	<b>2011 (n=1,569<sup>1</sup>)</b>	<b>2012 (n=1,721<sup>1</sup>)</b>	<b>2008-2012 (n=5,951<sup>1</sup>)</b>
Scenario #1: Passive suicidal ideation	1	1	1	2	2	7
Scenario #2: Active suicidal ideation	3	1	0	2	0	6
Scenario #3: Passive homicidal ideation	0	0	0	0	0	0
Scenario #4: Active homicidal ideation	0	0	0	0	0	0
Scenario #5: Respondent agitated or upset	0	0	1	3	1	5
<b>Total</b>	<b>4</b>	<b>2</b>	<b>2</b>	<b>7</b>	<b>3</b>	<b>18</b>

MHSS = Mental Health Surveillance Study.

<sup>1</sup>Total number of complete and incomplete Structured Clinical Interviews for DSM-IV.

**Table 7.22 Number and Percentage of Cases with Institutional Review Board Violations, by Distressed Respondent Protocol Scenarios: 2008-2012 MHSS**

<b>Distressed Respondent Protocol Scenario</b>	<b>Total Distressed Respondent Protocol Cases (#)</b>	<b>Institutional Review Board Violations (#)</b>	<b>Cases with Institutional Review Board Violations (%)</b>
Scenario #1: Passive suicidal ideation	145	7	4.83
Scenario #2: Active suicidal ideation	10	6	60.00
Scenario #3: Passive homicidal ideation	4	0	0.00
Scenario #4: Active homicidal ideation	0	0	0.00
Scenario #5: Respondent agitated or upset	42	5	11.90
<b>Total</b>	<b>201</b>	<b>18</b>	<b>8.96</b>

MHSS = Mental Health Surveillance Study.

To ensure that mental health services would be available should the respondent require them, modifications were made to the DRP in 2011. First, rather than having the CIs dial 9-1-1 (which routed the call to emergency services in the CI's area only), the CIs began using a national emergency number database to directly call emergency care providers nearest to the respondent. Second, rather than connecting respondents with Lifeline using three-way calling (which routed the call to Lifeline services in the CI's area only), the CIs asked the respondents to call Lifeline's national hotline directly. These modifications to the DRP reduced the likelihood of technical problems due to using three-way calling and increased the likelihood of respondents receiving local emergency and/or mental health services. To ensure that appropriate services were matched to level of risk, modifications to the DRP were made beginning in Quarter 2 of 2012 so that respondents reporting active suicidal ideation (Scenario #2) who denied intentions to harm themselves were referred to mental health counselors rather than being connected with emergency services.

Project management was notified of all 201 encounters with distressed respondents using electronic incident reports. The clinical supervisors (CSs) reviewed all of these incident reports, as well as the SCID booklets and audio files as needed. The IRB and members of the project management team were notified whenever emergency services were contacted as part of Scenario #2 (active suicidal ideation;  $n = 10$ ) or Scenario #4 (active homicidal ideation;  $n = 0$ ) and/or whenever there were DRP violations ( $n = 18$ , including the six cases involving

Scenario #2). In all 18 cases, the IRB was satisfied with the actions taken to protect the safety of the respondents. CIs who violated the DRP received retraining by the CSs.

## 7.4 Short Blessed Scale

As discussed in Section 4.2.4, a protocol was developed for encounters with respondents suspected of having problems with basic cognitive functions (such as attention, language production, orientation, language comprehension, and memory), which could lead to invalid data. As part of this Cognitive Impairment Protocol, the CIs were instructed to immediately break off the contact if the respondent showed signs of cognitive impairment during the introduction and informed consent process; however, if they had started the SCID, the CIs were to stop the interview and administer the Short Blessed Scale (SBS) to respondents. The SBS (Appendix C, page CIP.1) is a six-item scale designed to assess cognitive ability according to orientation, memory, and concentration. These questions are provided to CIs in the Cognitive Impairment Protocol section at the back of the SCID booklet. SBS scores indicate the number of errors, ranging from 0 to 28. Errors on the SBS can be indicative of temporary mental impairment (e.g., alcohol intoxication, medication side effects) or more long-term cognitive dysfunction (e.g., dementia, head injury).

For 10 or fewer errors on the SBS, CIs were instructed to resume the interview and to note the situation in the interviewer debriefing questions at the end of the SCID. For more than 10 errors, CIs were instructed to break off the interview and to document the situation when they entered the status code. CIs were instructed to attempt to complete the interview at another time if the respondent's cognitive impairment was deemed to be short term. If completing the SCID at another time, CIs were instructed to review the portions of the SCID completed earlier, to verify accuracy, and to include the reason for the breakoff in the debriefing questions.

As reported in [Table 7.23](#), a total of 47 respondents exceeded the SBS cutoff score of 10 in the 2008-2012 MHSS. Their average SBS scores ranged from 15.2 to 18.0. More than half of those who exceeded the SBS cutoff score were females (57 percent;  $n = 27$ ). The average age of respondents who exceeded the SBS cutoff score was 45. Long-term cognitive dysfunction was suspected in two thirds of the cases ( $n = 31$ ), including developmental disabilities ( $n = 20$ ) and self-reported cognitive disorders ( $n = 11$ ). Short-term cognitive dysfunction may have been associated with the remaining third of the cases ( $n = 16$ ) in which substance use ( $n = 11$ ) and fatigue ( $n = 5$ ) were suspected; however, none of these interviews were completed at another time. Data from these 47 respondents were considered invalid and not included in the final MHSS datasets or response rates.

**Table 7.23 Demographic Characteristics of Respondents Who Exceeded the SBS Cutoff Score: 2008-2012 MHSS**

Year	Cases	Average SBS Score	Gender	Average Age
2008	13	15.6	5 females, 8 males	46.1
2009	3	16.3	3 females, 0 males	47.5
2010	4	18.0	3 females, 1 males	43.8
2011	9	15.7	7 females, 2 males	35.4
2012	18	15.2	9 females, 9 males	48.9
Total	47	15.7*	27 females, 20 males	45.0*

MHSS = Mental Health Surveillance Study; SBS = Short Blessed Scale.

\*Weighted average.

## 7.5 Problems Encountered

In Quarter 4 of 2011 (October 1-December 31, 2011), RTI data quality staff detected falsified work conducted on a large scale by one Pennsylvania (PA) field interviewer (FI). As a result, a total of 4,864 screenings and 3,412 interviews completed in PA and Maryland (MD) were removed from the 2006-2011 NSDUH data files. Because MHSS clinical interview respondents were recruited at the end of the main study interview beginning in 2008, it was possible for the PA FI to have falsified MHSS clinical interviews as well. Table 7.24 provides a summary by year of the number of respondents who were sampled for MHSS interviews from the main study respondents conducted by this PA FI. The table also includes the number of MHSS sampled cases who then agreed to complete the MHSS interview and the number of cases who completed the MHSS interview. Of the three completed MHSS clinical interviews, one clinical interview was completed in 2008 and two clinical interviews were completed in 2011.

**Table 7.24 MHSS Interviews Associated with Main Study Interviews Completed, by Pennsylvania Field Interviewer: 2008-2011**

Year	Selected for MHSS (#)	Agreed To Participate (#)	MHSS Interviews Completed (#)
2008	4	1	1
2009	3	0	0
2010	1	0	0
2011	9	4	2
Total	17	5	3

MHSS = Mental Health Surveillance Study.

Based on review of the SCID data collected, it was determined that all MHSS cases associated with the PA FI's main study interviews, that is, those that were selected for the MHSS clinical follow-up study, may have also been falsified and therefore removed from the final data files. Falsified cases were also removed for a MD FI during this same time period. Three of the MD FI's 2008 cases were selected for the MHSS, and one completed the MHSS interview.

The final result of the falsified cases from the PA and MD FIs was the removal of two interviews from the 2008 MHSS and two interviews from the 2011 MHSS. Because the PA FI's main study cases were dropped or reworked, her MHSS sampled nonrespondents were not considered as having been sampled for the MHSS clinical follow-up and consequently were not included in the nonresponse adjustments or data files. The MHSS weights from the affected years were recomputed to account for the removal of the PA and MD FIs' falsified interviews.

After processing the 2011 data, a field was added to the RTI internal consistency check Web site to identify MHSS cases linked to invalid main study cases. This new field enabled data quality staff to identify MHSS cases associated with invalid or falsified main study cases throughout the year. Once identified, the MHSS DCM assigned a code of "79: case reworked by FI, respondent not selected" to the MHSS case. This code indicated that the corresponding main study case was invalid for data quality purposes or falsification; thus, the MHSS case had been finalized as a nonrespondent.





# 8. Data Collection Quality Control

In addition to quality control measures implemented during recruiting, training, and certification of the clinical interviewers (CIs) (as discussed in Chapters 3 and 5) and the editing and keying of completed clinical interviews (as discussed in Chapter 6), this chapter further describes the procedures implemented during the Mental Health Surveillance Study (MHSS) data collection to maximize the quality and validity of the clinical interview data collected and delivered in the final analytic data file.

## 8.1 Clinical Supervision

The clinical supervisors (CSs) were responsible for monitoring the quality of the data collected by the CIs and providing timely feedback and retraining to the CIs during data collection. This quality control measure, referred to as "clinical supervision," helped to ensure that CIs were administering the Structured Clinical Interview for DSM-IV Axis I Disorders Non-patient Edition (SCID-I/NP or SCID; First, Spitzer, Gibbon, & Williams, 2002) according to MHSS protocol and using clinical interviewing best practices, while also providing CSs with the opportunity to review and identify invalid cases that should not be included in the final analytic data file.

As discussed in Section 6.3.1, once a completed SCID was received at RTI International, the CSs reviewed all of the data collected in every SCID booklet, item by item, comparing the notes provided by the CI with the diagnostic rating. The quality control protocol required that CIs receive full audio reviews of their first two recorded clinical interviews, along with at least a 10 percent random sample of subsequent recorded interviews. All audio-recorded interviews that were not selected for full review received partial reviews. For full reviews, both the audio recordings and the SCID booklet were reviewed in their entirety. If the interview was not selected for a full review, the CSs completed a partial review of the audio file(s), which included a review of the SCID's overview section and any other portions of the audio file(s) that needed review to clarify responses, to supplement notes, or to support the CI's ratings in the SCID booklet.

The results of the CS review of each clinical interview were documented on the SCID editing form (Appendix G). This form provided a record of clinical editing, a format for individualized feedback, and a system for monitoring and tracking CI performance. The CSs provided a rating of the CI's performance with the administration of each SCID module and documented the strengths and areas of improvement for the CI with clinical interviewing, including the following:

- providing accurate and sufficient notes,
- assigning proper or missed codes,
- amount of probing,
- types of probing,
- obtaining an adequate amount of information,

- obtaining the relevant information,
- resolving inconsistencies,
- maintaining a professional demeanor,
- establishing rapport with the respondent,
- dealing with the respondent's emotions properly,
- asking questions verbatim,
- obtaining a description of the experience in the respondent's own words,
- maintaining the correct time period,
- differentiating between symptoms that are easily confused,
- handling distressed respondents appropriately,
- assessing medical or substance etiologies, and
- completing the entire SCID following correct skip patterns.

An integral part of the data collection quality control process was providing CIs with constructive feedback from the CS reviews of the SCID booklets and audio files. This part of the process enabled the CIs to receive immediate feedback and retraining as needed to improve the quality of clinical interviews. Throughout the MHSS, CIs had individual (i.e., one-on-one) supervision teleconferences with CSs after each full review. These meetings involved in-depth discussion of the case reviewed by the CS and detailed feedback for the CI based on the ratings, strengths, and weaknesses noted on the SCID editing forms. The CSs also provided feedback on any partial reviews of SCID interviews conducted by the CI since the last individual CI supervision meeting, especially if there were any patterns of errors or poor quality across multiple interviews. During individual supervision meetings, CIs had the opportunity to ask questions and to ask for clarification on the feedback provided by the CSs. Also, supervision meetings included role-play exercises for demonstrating and practicing areas for improvement. For example, if the CI was not using adequate probing during the recorded interview, the CS would provide tips and suggestions on proper probes and then incorporate the need for probes into the mock exercise. As the CIs gained experience, these individual supervision meetings focused on honing and fine-tuning the CIs' clinical interviewing skills. The CSs tracked the number of clinical interviews completed by each CI and the dates of individual supervision to ensure that CIs received feedback on their performance in a timely manner (after completing their last interview). CIs met with a CS at least once per quarter to receive individual supervision and feedback on their performance.

To ensure timely supervision, CSs made themselves available by telephone and e-mail during regular business hours as well as evenings and weekends. This enabled CIs to contact CSs directly after conducting an interview to ask questions about a case or to debrief CSs on challenging cases. CIs were also required to seek supervision and notify a CS when the Distressed Respondent Protocol (DRP) was employed for any scenario. The CS also communicated immediately with a CI if a SCID arrived at RTI with a note on its cover indicating that it was a complex case. CSs immediately reviewed the SCID and audio files (as needed) for these cases.

As discussed in Section 5.4, to further ensure the quality of the data being collected in the clinical interviews, the CIs participated in mandatory end-of-quarter interrater reliability exercises. During these exercises, the CIs listened to a selected interview, independently rated the symptoms, and submitted their ratings to the CSs. The CIs' ratings were scored according to their agreement with the CS consensus ratings. After receiving their scored ratings, the CIs participated in a group conference call to discuss and calibrate their ratings. These exercises allowed the CSs to evaluate the CIs' diagnostic skills and to provide retraining as necessary.

## **8.2 Invalid Cases**

Despite the quality control measures taken during MHSS data collection, clinical interviews were deemed invalid each year of the MHSS. Concerns with the quality and validity of these clinical interviews arose when either the respondent did not provide complete and accurate information or the CI did not adequately conceptualize the case or assess the symptoms. Completed interviews that one CS considered to be of questionable validity were subject to an independent second review by at least one other CS. If all CSs agreed that the interview did not meet quality standards, the case was deemed invalid (or unusable) and removed from the final analytic data file. This section describes the types of invalid clinical interviews on the MHSS, as well as how invalid main study cases affected the MHSS.

### **8.2.1 Invalid Clinical Interviews**

As shown in [Table 8.1](#), from 2008 to 2012, data for 298 cases (5.0 percent) were deemed unusable and were discarded from the dataset. Discarded cases included both completed and partial (or breakoff) interviews. The most common reason for a discarded interview was a respondent-induced breakoff, which accounted for 48.3 percent ( $n = 144$ ) of all discarded interviews. Interviews in this category include cases in which respondents requested to terminate the interview (e.g., due to length, the personal nature of the questions) or ended (or appeared to end) the call without giving a reason. If the respondent requested to end the interview, the CI was instructed to inquire about the respondent's concerns and address problems if possible (e.g., reiterate confidentiality safety measures, schedule another time to finish the interview). If the respondent's concerns could not be satisfactorily addressed, the interview was terminated and no further contact was made. In the cases where the phone connection was lost, the CI made multiple attempts to reconnect with the respondent on the day of the initial breakoff and on future days. Interviews that were later completed were not discarded.

The second most common reason for a discarded interview was cognitive impairment. Among all discarded cases, 15.8 percent ( $n = 47$ ) were due to cognitive impairment as captured by the Short Blessed Scale (SBS). CIs were instructed to administer the SBS to respondents who were suspected of cognitive impairment. Respondents who had more than 10 errors on the SBS were classified as having cognitive impairment. Once a respondent was determined to have cognitive impairment based on his or her score on the SBS, the CI terminated the interview and proceeded directly into the End of Interview script. (See Section 7.4 for more information on the SBS.)

Another 6.4 percent ( $n = 19$ ) of all discarded cases were with other respondents who demonstrated signs of cognitive impairment significant enough to affect data quality but who either obtained a passing score on the SBS (less than or equal to 10 errors) or who were not

administered the SBS. The CSs reviewed these cases and determined whether the suspected cognitive impairment significantly reduced the validity of the data and should therefore be discarded.

Language comprehension problems were responsible for 3.0 percent ( $n = 9$ ) of all discarded cases and mainly occurred because English was the respondent's second language. The MHSS interview was conducted in English only. These cases were generally completed interviews (not breakoffs) in which the respondent reported speaking English as a second language, exhibited comprehension problems that persisted even after the CI rephrased or clarified questions, and either answered "no" to nearly all items or provided answers that demonstrated a lack of understanding of the question. Cases in which the CS determined that the respondent appeared to understand the question after the CI rephrased or clarified questions were not discarded.

Interviews terminated due to respondent distress accounted for 7.4 percent ( $n = 22$ ) of all discarded cases. When a respondent became distressed during the interview, the CI used his or her clinical judgment to determine the appropriate course of action: (1) continue the interview after checking in with the respondent, (2) activate the appropriate DRP scenario and terminate the interview with no further contact, or (3) activate the appropriate DRP scenario and schedule a time to continue the interview later (if the respondent was willing and if it did not appear that finishing the interview would be detrimental to the respondent). Interviews that the respondent was willing and able to continue or complete at a later date were not discarded.

Only 4.0 percent of the discarded cases ( $n = 12$ ) were discarded because of CI error. Most cases that were lost because of CI error had complicated clinical presentations and occurred when the CI's incorrect clinical ratings led to missing data, the CI failed to collect sufficient data, or the CI failed to resolve inconsistencies in the respondent's reports.

A final category for discarded cases was used for cases of questionable validity that the other categories did not capture. Among all the discarded cases, 14.4 percent ( $n = 43$ ) fell into this category of questionable data. This category included respondents who (1) were unwilling to disclose personal information or provide detailed responses, (2) provided inconsistent information that could not be resolved, (3) appeared to answer questions haphazardly or not take the interview seriously, (4) grossly over- or under-endorsed symptoms, or (5) had complicated clinical presentations that the MHSS could not fully assess. Also, two cases were coded as "Other" due to quality issues with the corresponding main study interview.

The CS team thoroughly reviewed each case that was considered for discarding and closely reviewed the audio recording. As described in Section 8.1, CIs were provided with individual feedback and retraining if their actions might have contributed to a breakoff or compromised data quality. As described in Section 5.3, CSs also conducted group retraining sessions with all veteran CIs to review common data quality errors and best practices for clinical interviewing. These sessions included example scenarios from actual clinical interviews for discussion during the conference call. The goals of these retraining sessions were to maximize the quality of the data collected in the field and to decrease the likelihood of discarded data in the future.

**Table 8.1 Types of Discarded Cases, by Year: 2008-2012 MHSS**

Code	Description	2008 (n=1,581 <sup>1</sup> ) Cases (#)	2009 (n=547 <sup>1</sup> ) Cases (#)	2010 (n=533 <sup>1</sup> ) Cases (#)	2011 (n=1,569 <sup>1</sup> ) Cases (#)	2012 (n=1,721 <sup>1</sup> ) Cases (#)	2008-2012 (n=5,951 <sup>1</sup> ) Cases (#)	Total (%)
90.1	Respondent-induced	38	14	9	42	41	144	48.3
90.2	Language comprehension	4	1	1	2	1	9	3.0
90.3	Respondent distress	7	1	0	3	11	22	7.4
90.4	Cognitive (fail SBS)	13	3	4	9	18	47	15.8
90.5	Cognitive (non-SBS)	3	1	0	6	9	19	6.4
90.6	Questionable data	14	7	2	6	14	43	14.4
90.7	Clinical interviewer error	1	0	1	6	4	12	4.0
	Other	1	0	0	0	1	2	0.7
	Total	81	27	17	74	99	298	
	Percentage of total number of attempted SCID interviews <sup>1</sup>	5.1%	4.9%	3.2%	4.7%	5.8%	5.0%	

MHSS = Mental Health Surveillance Study; SBS = Short Blessed Scale; SCID = Structured Clinical Interview for DSM-IV.

<sup>1</sup>Total number of complete and incomplete SCID interviews.

## 8.2.2 Invalid Main Study Interviews

As part of the National Survey on Drug Use and Health (NSDUH) main study data quality procedures, project staff perform ongoing mail, telephone, and field verifications of field interviewer work throughout the year. During this process, some interviews are found to have been completed at the wrong dwelling unit, conducted with the incorrect respondent, conducted with a serious protocol violation (e.g., conducted without parental consent), or falsified by an interviewer. These NSDUH main study interviews are considered invalid and are removed from the dataset. If the invalid main study interview had yielded an MHSS interview, the CI was notified immediately not to conduct the MHSS interview. If the MHSS interview was already completed, it was considered invalid and removed from the dataset.

Main study interviews that did not pass the "usable case rule" also were considered invalid. The usable case rule requires that a NSDUH respondent answer "yes" or "no" to the question on lifetime use of cigarettes and "yes" or "no" to at least nine additional lifetime use questions in the core NSDUH modules. If the NSDUH interview did not pass the usable case rule, it and the corresponding MHSS interview were both removed from the final dataset. These invalid NSDUH and MHSS interviews were identified and removed from the final dataset after completion of data collection for the entire survey year. See the 2011 NSDUH mental health findings report (Center for Behavioral Health Statistics and Quality, 2012) for more information on the usable case rule as it is applied to the main NSDUH interview.



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## **Appendix A: CAI Recruitment Scripts**



Forms Answer Navigate Options

You have been randomly selected to participate in one additional study for the U. S. Public Health Service. This interview will ask questions about mental health issues. It will be conducted over the telephone and will take about an hour. Participation in this interview is voluntary and all of your answers will be kept confidential.

**HAND FOLLOW-UP STUDY DESCRIPTION TO RESPONDENT.** Please read this statement. It describes the survey and the legislation that assures the confidentiality of any information you provide.

If you agree to participate, I will pay you an additional \$30 today. Within the next two weeks, a different interviewer will call you to explain more about the interview and to schedule a convenient time to complete it. If you wish, you may complete the full interview when the interviewer calls.

**IF ASKED "WHY WAS I SELECTED?"** (You have been randomly chosen for this special study for the National Survey on Drug Use and Health. This study, sponsored by the U.S. Public Health Service, will ask questions about various mental health issues. Knowledge gained from this study will improve our ability to describe and understand mental health issues in the United States.)

1. RESPONDENT AGREES TO RECONTACT  
 2. RESPONDENT DOES NOT AGREE TO RECONTACT  
 3. RESPONDENT IS NOT AVAILABLE DURING THE SPECIFIED TIME PERIOD

RECRUIT1

Forms Answer Navigate Options

Since another interviewer will be completing the second interview, may I have your first name and phone number so the interviewer can call you?

**ENTER FIRST NAME ONLY AND PHONE NUMBER.**

To check that I entered the number correctly, please repeat the phone number.

**CONFIRM NUMBER. AS NEEDED, READ THE CONTACT INFORMATION ENTERED TO THE RESPONDENT AND CONFIRM IT IS CORRECT.**

Is there another number where the telephone interviewer could contact you about the second interview?

**IF YES: RECORD PHONE NUMBER AND TYPE (CELL, WORK, ETC) IN THE NOTES FIELD. REPEAT ABOVE STEPS TO CONFIRM THE NUMBER. YOU MAY ENTER UP TO 50 CHARACTERS.**

**IF NO: CONTINUE.**

**PRESS [ENTER] TO CONTINUE.**

RECRUIT2 - FIRST NAME

PHONE NUMBER ( ) -

NOTES

Forms Answer Navigate Options

Please also let me know the best days and times when you will be available in the next two weeks. I will give this information to the interviewer, and he or she will try to contact you during one of these times.

**ENTER BEST DAYS/TIMES. AS NEEDED, PROBE FOR ADDITIONAL BEST DAYS/TIMES.  
READ THE INFORMATION ENTERED TO THE RESPONDENT AND CONFIRM IT IS CORRECT.**

**COMPLETE A REMINDER CARD AND HAND TO THE RESPONDENT.**

I have entered these days and times in the computer and recorded them on this card. Please note the interviewer may try to reach you at other times as well.

**INTERVIEWER NOTE: ADDITIONAL INFORMATION REGARDING THE BEST DAYS OR TIMES PROVIDED BY THE RESPONDENT SHOULD BE ENTERED IN THE NOTES FIELD. YOU MAY ENTER UP TO 50 CHARACTERS.**

**TELEPHONE INTERVIEWERS ARE AVAILABLE EVENINGS AND WEEKENDS.**

**PRESS [ENTER] TO CONTINUE.**

<b>RECRUIT3 - BEST DAYS</b>	<input type="text"/>
<b>BEST TIMES</b>	<input type="text"/>
<b>NOTES</b>	<input type="text"/>

Forms Answer Navigate Options

**PAY RESPONDENT \$30 CASH.**

**SIGN FOLLOW-UP INTERVIEW PAYMENT RECEIPT FORM AND GIVE TOP COPY TO RESPONDENT.**

I have signed this form to indicate that I have paid you the \$30 for the telephone interview.

**[IF THE RESPONDENT WILL NOT ACCEPT THE CASH INCENTIVE, MARK THE APPROPRIATE BOX ON THE FOLLOW-UP INTERVIEW PAYMENT RECEIPT FORM.]**

**PRESS [ENTER] TO CONTINUE.**

<b>INCENTMH</b>	<input type="text"/>
-----------------	----------------------

Eforms Answer Navigate Options

**Thank you for your time. I just need to finish a few questions on my own to show that I did the interview. This will only take a few minutes.**

**BE SURE YOU HAVE YOUR SHOWCARD BOOKLET, CALENDAR, QC ENVELOPE W/ FORM, AND PAYMENT RECEIPT COPIES.**

**PRESS [ENTER] TO CONTINUE.**

THANKR2



If unavailable during the next two weeks (response 2 on RECRUIT1):

Forms Answer Navigate Options

**To accommodate your schedule, an interviewer will be available to call you about this study and schedule a convenient time to complete the interview within the next four weeks.**

1. RESPONDENT AGREES TO RECONTACT

2. RESPONDENT DOES NOT AGREE TO RECONTACT

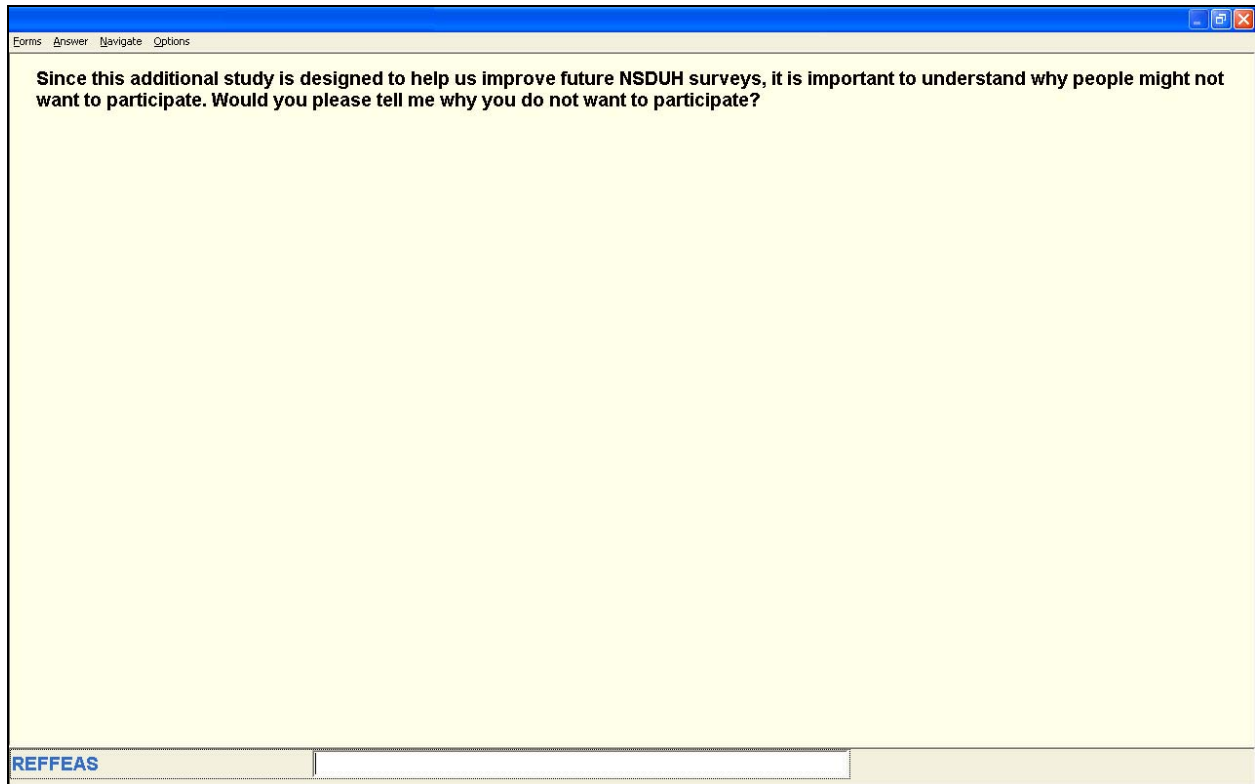
3. RESPONDENT IS NOT AVAILABLE DURING THE SPECIFIED TIME PERIOD

RECRT4WK

If available during the next four weeks:

<p>Forms Answer Navigate Options</p> <p><b>Please also let me know the best days and times when you will be available in the next four weeks. I will give this information to the interviewer, and he or she will try to contact you during one of these times.</b></p> <p><b>ENTER BEST DAYS/TIMES. AS NEEDED, PROBE FOR ADDITIONAL BEST DAYS/TIMES. READ THE INFORMATION ENTERED TO THE RESPONDENT AND CONFIRM IT IS CORRECT.</b></p> <p><b>COMPLETE A REMINDER CARD AND HAND TO THE RESPONDENT.</b></p> <p><b>I have entered these days and times in the computer and recorded them on this card. Please note the interviewer may try to reach you at other times as well.</b></p> <p><b>INTERVIEWER NOTE: ADDITIONAL INFORMATION REGARDING THE BEST DAYS OR TIMES PROVIDED BY THE RESPONDENT SHOULD BE ENTERED IN THE NOTES FIELD. YOU MAY ENTER UP TO 50 CHARACTERS.</b></p> <p><b>TELEPHONE INTERVIEWERS ARE AVAILABLE EVENINGS AND WEEKENDS.</b></p> <p><b>PRESS [ENTER] TO CONTINUE.</b></p>	
<b>RECRUIT3 - BEST DAYS</b>	<input type="text"/>
<b>BEST TIMES</b>	<input type="text"/>
<b>NOTES</b>	<input type="text"/>

If the respondent does not agree to participate (response 2 on RECRUIT1 or RECRT4WK):



The image shows a screenshot of a survey window. The window has a blue title bar with standard OS window controls (minimize, maximize, close) on the right. Below the title bar is a menu bar with the items "Forms", "Answer", "Navigate", and "Options". The main content area is a large yellow rectangle containing the following text: "Since this additional study is designed to help us improve future NSDUH surveys, it is important to understand why people might not want to participate. Would you please tell me why you do not want to participate?". At the bottom of the window, there is a light-colored footer bar. On the left side of this bar is the text "REFFEAS" in blue. To the right of "REFFEAS" is a white rectangular input field.

Eforms Answer Navigate Options

**Thank you for your time. I just need to finish a few questions on my own to show that I did the interview. This will only take a few minutes.**

**BE SURE YOU HAVE YOUR SHOWCARD BOOKLET, CALENDAR, QC ENVELOPE W/ FORM, AND PAYMENT RECEIPT COPIES.**

**PRESS [ENTER] TO CONTINUE.**

THANKR2



## **Appendix B: Recruitment Materials**



## Exhibit B.1 Follow-up Study Description



**U.S. Public Health Service  
Center for Behavioral Health  
Statistics and Quality**

### **Follow-up Study Description**

You have been randomly chosen for this special study for the 2012 National Survey on Drug Use and Health. This study, sponsored by the United States Public Health Service, will ask questions about various mental health issues such as depression, anxiety, post traumatic stress disorder and substance dependence. Although there is no benefit to you personally, knowledge gained from this study will improve our ability to describe and understand mental health issues in the United States.

If you agree to participate in this follow-up interview, your first name and telephone number will be collected but will be used only for re-contact purposes. Your name and telephone number will not be included on the interview forms on which your answers will be written, or on any interview audio files that might be recorded. While the interview has some personal questions, federal law protects the privacy of your answers and requires us to keep all of your answers confidential. Any data that you provide will only be used by authorized personnel for statistical purposes according to the Confidential Information Protection and Statistical Efficiency Act of 2002. The only exception to this promise of confidentiality is if you tell the interviewer that you intend to seriously harm yourself or someone else; in this situation RTI may need to notify a mental health professional or other authorities.

The interview will be conducted over the phone and takes on average an hour to complete. Your participation is voluntary. You may consider some of the questions to be sensitive in nature and some of the questions also may make you feel certain emotions, such as sadness. Remember that you can refuse to answer any questions that you do not want to answer, and you can stop the interview at any time. If you become upset at any time during the interview and wish to speak to a mental health professional about how you are feeling, the interviewer can again provide you with the toll-free hotline numbers that are printed on your payment receipt from the first interview. **If you agree to complete the interview, you will receive \$30 today.**

If you have questions about the study, call the Project Representative at [redacted]. If you have questions about your rights as a study participant, call RTI's Office of Research Protection at [redacted] (a toll-free number). You can also visit our project Website: <http://nsduhweb.rti.org/> for more information.

Thank you for your cooperation and time.

[redacted], Project Officer  
Center for Behavioral Health Statistics and Quality  
Substance Abuse and Mental Health Services Administration (SAMHSA)  
U.S. Public Health Service  
Department of Health and Human Services



**Exhibit B.2 Follow-up Interview Payment Receipt**

## **Follow-up Interview Payment Receipt**

**United States Public Health Service**

and

**Research Triangle Institute**

**thank you for agreeing to participate in a special study for the  
2012 National Survey on Drug Use and Health.**

In appreciation of your participation in this important study, you are eligible to receive a \$30 cash payment. Since maintaining the confidentiality of your information is important to us, your name will not be entered on this form. However, the interviewer must sign and date this form to certify you received (or declined) the cash payment.

_____	_____	_____ - _____
Interviewer	Date	Case ID
<input type="checkbox"/> Accepted Cash Payment		<input type="checkbox"/> Declined Cash Payment

If you ever feel that you need to talk to someone about mental health issues, you can call the National Lifeline Network. Counselors are available to talk at any time of the day or night and they can give you information about services in your area.

1-800-273-TALK or 1-800-273-8255

1-888-628-9454 (Spanish)

<http://suicidepreventionlifeline.org/>

If you ever feel that you need to talk to someone about drug use issues, you can call the Substance Abuse and Mental Health Services Administration's Treatment Referral Helpline. This is a 24-hour service that will help you locate treatment options near you.

1-800-662-HELP or 1-800-662-4357

1-800-487-4889 (TDD)

<http://findtreatment.samhsa.gov>

Disposition: Top copy to Respondent, yellow to Field Supervisor, pink to Field Interviewer.

**Exhibit B.3 Reminder Card**



We appreciate you taking time for this important study and look forward to speaking with you soon.

Your suggested contact days and times are:

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Time							



Research Triangle Institute  
 Research Triangle Park, NC 27709-2194





**Appendix C: Structured Clinical Interview for  
DSM-IV Axis I Disorders (SCID-I)**



# STRUCTURED CLINICAL INTERVIEW FOR DSM-IV AXIS I DISORDERS (SCID-I)

By

Michael B. First, M.D.; Miriam Gibbon, M.S.W.;  
 Robert L. Spitzer, M.D.; and Janet B. W. Williams, D.S.W.

**MODIFIED BY RTI INTERNATIONAL**

**FOR**

## 2012 NATIONAL SURVEY ON DRUG USE AND HEALTH MENTAL HEALTH SURVEILLANCE STUDY

SCID Transmittal Record			
Interviewer ID:		QuestID:	
		Date of Interview:    ___/___/___ MM   DD   YY	
Date Shipped to RTI:	___/___/___ MM   DD   YY	Date Received at RTI:	___/___/___ MM   DD   YY
Clinical QC by:		Date of Clinical QC:	___/___/___ MM   DD   YY
Edited by:		Date Edited:	___/___/___ MM   DD   YY

Public reporting burden for this collection of information is estimated to 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0110); Room 8-1099, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0110.



**Introduction to Clinical Interview**

Before you call, **be prepared:**

- Review the assignment information provided including the respondent name, telephone number, as well as the date of the initial interview.
- Have your schedule available (in case you need to schedule an appointment).
- Have all interviewing materials available.

**VERIFY NUMBER AND LOCATE RESPONDENT**

Hi, my name is \_\_\_\_\_ and I'm calling on behalf of the U.S. Public Health Service. Is this [PHONE NUMBER]?

YES: PROCEED BELOW

NO: I apologize. I need to double check my records. Thank you for your time. END CALL.

I'm trying to reach [FIRST NAME] who agreed to take part in a telephone interview we're conducting. May I speak to [FIRST NAME]?

**IF R NOT HOME OR UNAVAILABLE**

When would be a good time to call again? ENTER CODE 51 AND DETAILS IN CMS.  
Thank you for your time. END CALL.

**IF R AVAILABLE**

(Hi, my name is \_\_\_\_\_.)

You recently completed an interview in your home with an interviewer working on the National Survey on Drug Use and Health. I am the interviewer you were told would contact you for a follow-up telephone interview. Do you recall completing the first interview?

YES: PROCEED BELOW.

NO: VERIFY FIRST NAME OF PERSON YOU ARE SPEAKING TO.  
IF NOT SPEAKING TO CORRECT RESPONDENT, ASK TO SPEAK TO RESPONDENT.

IF NAME IS CORRECT AND RESPONDENT DOESN'T RECALL INITIAL INTERVIEW,  
REMIND OF DATE OF INITIAL INTERVIEW.

IF CORRECT RESPONDENT STILL NOT FOUND: I apologize. I need to double check my records. Thank you for your time. END CALL. ENTER CODE 59 AND INVESTIGATE.

Are you in a place where you can safely talk on the phone and answer my questions?

YES: PROCEED

NO: Are you able to move to a place where you can safely talk?

YES: PAUSE, THEN CONTINUE

NO: When would be a good time to call again? ENTER CODE 50 AND DETAILS IN CMS. Thank you for your time. END CALL.

Is now a good time to complete this interview?

YES: PROCEED. BE SURE TO READ VERBATIM.

NO: When would be a good time to call again? ENTER CODE 50 AND DETAILS IN CMS.  
Thank you for your time. END CALL.



**PRIVACY**

Because you may not want others to hear the responses to some of our questions, I'd like to be sure you're in a private area. Where are you right now? Are you at home, at work, or somewhere else? Are you in an area where you can answer these questions privately?

YES: PROCEED

NO: Please consider moving to a more private area. Do you need more time?

YES: PAUSE, THEN CONTINUE

NO: CONTINUE

**INFORMED CONSENT**

Before we begin, I would like to remind you of the study details. This study, sponsored by the United States Public Health Service, asks questions about various mental health issues such as depression, anxiety, post traumatic stress disorder, and substance dependence. Although there is no benefit to you personally, knowledge gained from this study will improve our ability to describe and understand mental health issues in the United States. While the interview has some personal questions, federal law keeps your answers private. The only exception to this promise of confidentiality is if you tell me that you intend to seriously harm yourself or someone else; in this situation I may need to notify a mental health professional or other authorities.

Your participation is voluntary. You may consider some of the questions to be sensitive in nature and some of the questions may also make you feel certain emotions, such as sadness. Remember that you can refuse to answer any questions that you do not want to answer, and you can stop the interview at any time. If you become upset at any time during the interview and wish to speak to a mental health professional about how you are feeling, I will provide you with the toll-free hotline numbers that are printed on your payment receipt from the first interview. It is important for you to keep in mind that I will not be providing you with a psychological diagnosis or any mental health advice or counseling. The information we are collecting today is only for research purposes.

These study details are also included on the Follow-up Study Description you received from the interviewer who met with you in your home. Do you have any questions before we begin?

ANSWER ANY RESPONDENT QUESTIONS.

Is it OK to continue with the interview?

YES: PROCEED TO NEXT PAGE

NO: BASED ON CONVERSATION:

What sort of concerns do you have about participating?

OR

Are there other questions that I could answer for you?

IF R STILL UNWILLING TO PARTICIPATE: Thank you for your time. END CALL.

**RECORDING PERMISSION**

In order to ensure that I am conducting this interview accurately and properly, I would like to make an electronic audio recording of this interview. This is done strictly for quality control purposes. The recording will only be listened to by staff members on the project who have signed confidentiality pledges. The recording will be stored in a secure manner and will not contain your name—only a random number that will be assigned to this case. To help maintain confidentiality, we ask that you not give your name or any other identifying information, such as an address or place of business, during the interview. All recordings will be permanently destroyed within eighteen months after the end of the data collection period. You can still do the interview if you do not want me to record it.

Do you agree to allow me to record the interview?

YES: I will now begin recording. START RECORDING AND SAY: “This is [YOUR FIRST AND LAST NAME] conducting telephone interview [QUEST ID] on [DATE].”

NO: DON'T RECORD

Ok, let's get started.

**CI NOTES:**

IF ASKED AT ANY TIME BY A RESPONDENT WHETHER THE INTERVIEWER IS A DOCTOR, PSYCHIATRIST, PSYCHOLOGIST, SOCIAL WORKER, OR OTHER MENTAL HEALTH PROFESSIONAL, YOU MAY DISCLOSE THAT YOU HAVE MEDICAL OR PSYCHOLOGICAL TRAINING THAT ALLOWS YOU TO FULLY UNDERSTAND THE SURVEY.

HOWEVER, YOU SHOULD EXPLAIN THAT YOUR INVOLVEMENT IN THIS STUDY IS FOR RESEARCH PURPOSES ONLY AND IN NO WAY CONSTITUTES MEDICAL OR PSYCHOLOGICAL ADVICE, TREATMENT, OR DIAGNOSIS. EXPLAIN THAT THIS IS NOT THE NATURE OF THIS EFFORT.

IF RESPONDENT REQUESTS PSYCHOLOGICAL COUNSELING OR ADVICE OF ANY KIND, REFER HIM/HER TO THE NATIONAL LIFELINE. IF RESPONDENT IS INTERESTED IN CONTACTING THE LIFELINE, OFFER TO STAY ON THE PHONE AND CONNECT THEM VIA A THREE-WAY CALL.

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**OVERVIEW**

I'm going to be asking you about problems or difficulties you may have had, and I'll be making some notes as we go along.

Interview Start Time: \_\_\_\_ \_\_\_\_ : \_\_\_\_ \_\_\_\_ AM/PM

**DEMOGRAPHIC DATA**

SEX: 1 male  
2 female

OV1

What's your date of birth?

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mm dd yyyy

OV2

Are you married?

MARITAL STATUS (most recent): 1 married or living with someone as if married  
2 widowed  
3 divorced or annulled  
4 separated  
5 never married

OV3

IF NO: Have you ever been married?

Do you have any children?

IF YES: How many?  
(What are their ages?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Where do you live?  
(That is, do you live in a house, an apartment, or do you have some other living arrangement?)

Who do you live with?  
(Do you live with family, friends, or roommates?)

**EDUCATION AND WORK HISTORY**

EDUCATION: 1 grade 6 or less  
2 grade 7 to 12 (without graduating high school)  
3 graduated high school or high school equivalent  
4 part college  
5 graduated 2 year college  
6 graduated 4 year college  
7 part graduate/professional school  
8 completed graduate/professional school

OV4

What's the highest grade or year of school you have completed?

IF FAILED TO COMPLETE A PROGRAM IN WHICH THEY WERE ENROLLED: Why did you decide to leave school?

\_\_\_\_\_  
\_\_\_\_\_

What kind of work do you do?  
(Do you work outside of your home?)

\_\_\_\_\_  
\_\_\_\_\_

Are you working now?

→ IF YES: How long have you worked there?

IF LESS THAN 6 MONTHS: Why did you leave your last job?

Have you always done that kind of work?

→ IF NO: Why is that? How long has it been since you worked outside the home? What kind of work have you done?

How are you supporting yourself now?

IF UNKNOWN: Has there ever been a period of time when you were unable to work or go to school?

IF YES: Why was that?

**PAST PERIODS OF PSYCHOPATHOLOGY**

(THE LIFE CHART ON PAGE VIII OF OVERVIEW MAY BE USED TO SUMMARIZE A COMPLICATED HISTORY OF PSYCHOPATHOLOGY AND TREATMENT.)

Have you ever seen anybody for emotional or psychiatric problems?

Treatment for emotional problems with a physician or mental health professional

1 NO  
3 YES

OV5

→ IF YES: What was that for? (What treatment(s) did you get? Any medications?)

→ IF NO: Was there ever a time when you received medication to help your mood, calm your nerves, or to help you sleep?

→ IF NO: Was there ever a time when you, or someone else, thought you should see someone because of the way you were feeling or acting?

If OV5=1, SKIP OV5a

IF NOT ALREADY KNOWN:

Most recent mental health treatment

- 1 Lifetime MH Treatment (not Past Year)
- 2 Past Year – Counseling Alone
- 3 Past Year - Meds alone
- 4 Past Year – Counseling and meds

OV5a

Did you receive any of the treatment you just mentioned in the past 12 months, that is since (this date), 2011?

NOTE: IF OV5a = 3 or 4, medications should be listed at OV7a or OV7b

What about treatment for drugs or alcohol?

Have you ever been a patient in a psychiatric hospital?

IF YES: What was that for? (How many times?)

IF GIVES AN INADEQUATE ANSWER, CHALLENGE GENTLY: e.g., Wasn't there something else? People don't usually go to psychiatric hospitals just because they are tired or nervous.

Number of previous hospitalizations (Do not include transfers)

- 0
- 1
- 2
- 3
- 4
- 5 (or more)

OV6  
IF OV6 = 0, SKIP OV6a and OV6b

Timing of most recent psychiatric hospitalization

- 1 Lifetime Psychiatric Hospitalizations (not Past Year)
- 2 Past Year Psychiatric Hospitalizations

OV6a  
IF OV6a = 1, SKIP OV6b

Reasons for hospitalization in the past year

OV6b

Have you ever been in a hospital for treatment of a medical problem?

IF YES: What was that for?

Thinking back over your whole life, when were you the most upset?

(Why? What was that like? How were you feeling?)

When were you feeling the best you have ever felt?

**PSYCHOPATHOLOGY DURING PAST YEAR**

Now I would like to ask you about the past year, that is since (CURRENT DATE) 2011. How have things been going for you?

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---

Has anything happened that has been especially hard for you?

---

What about difficulties at work or with your family?

---

How has your mood been?

---

How has your physical health been? (Have you had any medical problems?) (USE THIS INFORMATION TO CODE AXIS III)

---

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---

Thinking back over the past year, when were you the most upset?

---

---

---

(IF UNKNOWN:) Are you currently in a relationship?

---

---

IF YES: Tell me a little about that.

---

---

IF NO: How long has it been since you were in a relationship?

---

---

---

Do you take any medications or vitamins?

IF YES: How much and how often do you take (MEDICATION)? (What is that medication for?) (Has there been any change in the amount you have been taking?)

Are there any medications that you have taken in the past year that you are not currently taking?

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---

Psychotropic medications taken in the past year (but not currently)

OV7a

---

---

---

Psychotropic medications taken currently

OV7b

---

---

---



How much have you been drinking (alcohol) (in the past year)?

---

---

Have you been taking any drugs (in the past year)? (What about marijuana, cocaine, other street drugs?)

---

---

Have you (in the past year) gotten "hooked" on a prescribed medicine or taken a lot more of it than you were supposed to?

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---

**CURRENT SOCIAL FUNCTIONING**

How have you been spending your free time?

Who do you spend time with?

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---

**MOST LIKELY CURRENT DIAGNOSES:**

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**DIAGNOSES THAT NEED TO BE RULED OUT:**

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**LIFE CHART**

Age (or date)	Description (symptoms, triggering events)	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____

RETURN TO OVERVIEW PAGE *iv*, **PSYCHOPATHOLOGY DURING PAST YEAR.**

**SCID SCREENING MODULE**

Now I want to ask you some more specific questions about problems you may have had. We'll go into more detail about them later.

RESPOND TO POSITIVE RESPONSES WITH: We'll talk more about that later.

1. In the past year, that is since (CURRENT DATE) 2011, have you had any panic attacks, when you suddenly felt frightened or anxious or suddenly developed a lot of physical symptoms?

1	2	3
CIRCLE "1" ON PAGE E.9	CIRCLE "3" ON PAGE E.9	

S1

2. In the past year, have you been afraid of going out of the house alone, being alone, being in a crowd, standing in a line, or traveling on buses or trains?

1	2	3
CIRCLE "1" ON PAGE E.15	CIRCLE "3" ON PAGE E.15	

S2

3. During the past year, has there been anything that you have been afraid to do or felt uncomfortable doing in front of other people, like speaking, eating, or writing?

1	2	3
CIRCLE "1" ON PAGE E.19	CIRCLE "3" ON PAGE E.19	

S3

4. In the past year have there been any other things that you've been especially afraid of, like flying, seeing blood, getting a shot, heights, closed places, or certain kinds of animals or insects?

1	2	3
CIRCLE "1" ON PAGE E.23	CIRCLE "3" ON PAGE E.23	

S4

5. In the past year have you been bothered by thoughts that didn't make any sense and kept coming back to you even when you tried not to have them?

1	2	3
CIRCLE "1" ON PAGE E.27	CIRCLE "3" ON PAGE E.27	

S5

IF NOT SURE WHAT IS MEANT: Thoughts like hurting someone even though you really didn't want to or being contaminated by germs or dirt.

6. In the past year has there been anything that you had to do over and over again and couldn't resist doing, like washing your hands again and again, counting up to a certain number, or checking something several times to make sure that you'd done it right?

1	2	3
CIRCLE "1" ON PAGE E.29	CIRCLE "3" ON PAGE E.29	

S6

7. In the past year, have you had times when you have been particularly nervous or anxious?

1	2	3	S7
CIRCLE "1" ON PAGE E.33	CIRCLE "3" ON PAGE E.33		

8. During the past year, have you had a time when you weighed much less than other people thought you ought to weigh?

1	2	3	S8
CIRCLE "1" ON PAGE F.1	CIRCLE "3" ON PAGE F.1		

9. In the past year, have you often had times when your eating was out of control?

1	2	3	S9
CIRCLE "1" ON PAGE F.3	CIRCLE "3" ON PAGE F.3		

**A. MOOD EPISODES**

**\*PAST YEAR MAJOR DEPRESSIVE EPISODE\***

In the past year, that is since (CURRENT DATE) 2011, has there been a period of time when you were feeling depressed or down most of the day nearly every day? (What was that like?)

IF YES: When was that? How long did it last? (As long as two weeks?)

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

IF DEPRESSED MOOD: During that time did you lose interest or pleasure in things you usually enjoyed?

IF NO DEPRESSED MOOD: What about a time in the last year when you lost interest or pleasure in things you usually enjoyed? (What was that like?)

IF YES: When was that? Was it nearly every day? How long did it last? (As long as two weeks?)

Have you had more than one time in the past year like that? (Which time was the worst?)

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

**MDE CRITERIA**

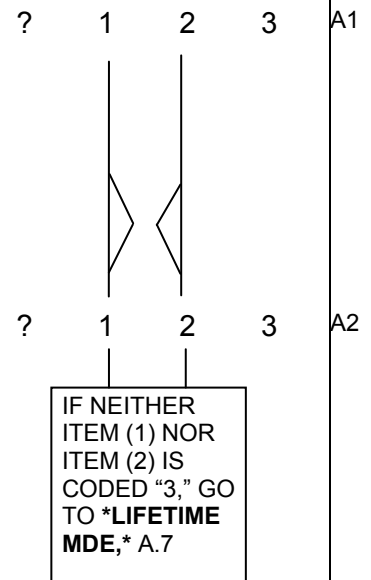
A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure.

(1) depressed mood most of the day, nearly every day, as indicated either by subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: in children or adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation made by others).

NOTE: IF MORE THAN ONE PAST EPISODE IS LIKELY, SELECT THE "WORST" ONE FOR YOUR INQUIRY ABOUT A MAJOR DEPRESSIVE EPISODE.

NOTE: WHEN RATING THE FOLLOWING ITEMS, CODE "1" IF CLEARLY DUE TO A GENERAL MEDICAL CONDITION, OR TO MOOD-INCONGRUENT DELUSIONS OR HALLUCINATIONS



FOR THE FOLLOWING QUESTIONS,  
FOCUS ON THE WORST TWO WEEKS  
OF THE MAJOR DEPRESSIVE  
EPISODE THAT YOU ARE INQUIRING  
ABOUT

During that (TWO WEEK PERIOD) . . .

. . . how was your appetite? (What about compared to your usual appetite?) (Did you have to force yourself to eat?) (Eat [less/more] than usual?) (Was that nearly every day?) (Did you lose or gain any weight) (How much?) (Were you trying to [lose/gain] weight?)

(3) significant weight loss when not dieting, or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day. Note: in children, consider failure to make expected weight gains.

? 1 2 3

A3

. . . how were you sleeping? (Trouble falling asleep, waking frequently, trouble staying asleep, waking too early, OR sleeping too much? How many hours a night compared to usual? Was that nearly every night?)

(4) insomnia or hypersomnia nearly every day

? 1 2 3

A4

. . . were you so fidgety or restless that you were unable to sit still? (Was it so bad that other people noticed it? What did they notice? Was that nearly every day?)

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

? 1 2 3

A5

IF NO: What about the opposite -- talking or moving more slowly than is normal for you? (Was it so bad that other people noticed it? What did they notice? Was that nearly every day?)

. . . what was your energy like? (Tired all the time? Nearly every day?)

(6) fatigue or loss of energy nearly every day

? 1 2 3

A6

During this time . . .

. . .how did you feel about yourself?  
(Worthless?) (Nearly every day?)

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

? 1 2 3

A7

IF NO: What about feeling guilty about things you had done or not done? (Nearly every day?)

NOTE: CODE "1" OR "2" IF ONLY LOW SELF-ESTEEM

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

. . .did you have trouble thinking or concentrating? (What kinds of things did it interfere with?) (Nearly every day?)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

? 1 2 3

A8

IF NO: Was it hard to make decisions about everyday things? (Nearly every day?)

\_\_\_\_\_  
\_\_\_\_\_

. . .were things so bad that you were thinking a lot about death or that you would be better off dead? What about thinking of hurting yourself?

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

? 1 2 3

A9

IF YES: Did you do anything to hurt yourself?

NOTE: CODE "1" FOR SELF-MUTILATION W/O SUICIDAL INTENT

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



AT LEAST FIVE OF THE ABOVE SXS [A(1-9)] ARE CODED "3" AND AT LEAST ONE OF THESE IS ITEM (1) OR (2)

1

3

A10

IF NOT ALREADY ASKED: Has there been any other time in the past year when you were (depressed/OWN WORDS) and had even more of the symptoms that I just asked you about?

CONTINUE WITH NEXT ITEM, CRITERION C, MIDDLE OF PAGE

IF YES: RETURN TO \*PAST YEAR MDE\* A.1, AND CHECK WHETHER THERE HAVE BEEN ANY OTHER MAJOR DEPRESSIVE EPISODES IN THE PAST 12 MONTHS THAT WERE MORE SEVERE AND/OR CAUSED MORE SYMPTOMS. IF SO, ASK ABOUT THAT EPISODE.

NOTE: DSM-IV criterion B (i.e., does not meet criteria for a mixed episode) has been omitted from the SCID.

IF NO: GO TO \*LIFETIME MDE\* A.7.

IF UNCLEAR: Did (depressive episode/OWN WORDS) make it hard for you to do your work, take care of things at home, or get along with other people?

C. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

1

2

3

A11

IF NOT ALREADY ASKED: Has there been any other time in the past year when you were (depressed/OWN WORDS) and it caused even more problems than the time I just asked you about?

CONTINUE ON NEXT PAGE

IF YES: RETURN TO \*PAST YEAR MDE\*, A.1, AND CHECK WHETHER THERE HAVE BEEN ANY OTHER MAJOR DEPRESSIVE EPISODES IN THE PAST 12 MONTHS THAT WERE MORE SEVERE AND/OR CAUSED MORE SYMPTOMS. IF SO, ASK ABOUT THAT EPISODE

IF NO: GO TO \*LIFETIME MDE\*, A.7.

In what month (and what year) did this (PAST YEAR MAJOR DEPRESSIVE EPISODE) start?

PAST YEAR MAJOR DEPRESSIVE EPISODE STARTED:

Month/Yr: \_\_\_\_ / \_\_\_\_

A12  
A13

Just before this began, were you physically ill?

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or to a general medical condition

? 1 3

A14

IF YES: What did the doctor say?

DUE TO SUBSTANCE USE OR GMC

Just before this began, were you using any medications?

IF THERE IS ANY INDICATION THAT THE DEPRESSION MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A GMC OR SUBSTANCE), GO TO \*MOOD EPISODES DUE TO GMC/SUBSTANCE\* IN THE BACK OF THIS BOOKLET, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

IF YES: Was there any change in the amount you were taking at that time?

PRIMARY MOOD EPISODE

Just before this began, were you drinking or using any street drugs?

IF UNKNOWN: Has there been any other time when you were (depressed / OWN WORDS) like this but were not (using SUBSTANCE / ill with GMC)?

Etiological general medical conditions include: degenerative neurological illnesses (e.g., Parkinson's disease), cerebrovascular disease (e.g., stroke), metabolic conditions (e.g., Vitamin B-12 deficiency), endocrine conditions (e.g., hyper- and hypothyroidism, hyper- and hypoadrenocorticism); viral or other infections (e.g., hepatitis, mononucleosis, HIV), and certain cancers (e.g., carcinoma of the pancreas).

CONTINUE ON NEXT PAGE

IF YES: RETURN TO \*PAST YEAR MDE\*, A.1, AND CHECK WHETHER THERE HAVE BEEN ANY OTHER MAJOR DEPRESSIVE EPISODES IN THE PAST 12 MONTHS THAT WERE MORE SEVERE AND/OR CAUSED MORE SYMPTOMS. IF SO, ASK ABOUT THAT EPISODE

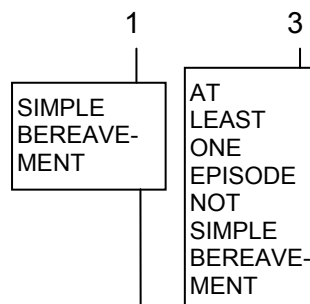
Etiological substances include: alcohol, amphetamines, cocaine, hallucinogens, inhalants, opioids, phencyclidine, sedatives, hypnotics, anxiolytics. Medications include antihypertensives, oral contraceptives, corticosteroids, anabolic steroids, anticancer agents, analgesics, anticholinergics, cardiac medications.

IF NO: GO TO \*LIFETIME MDE\*, A.7.

Did this begin soon after someone close to you died?

E. The symptoms are not better accounted for by [Simple] Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation.

NOTE: CODE "3" IF EITHER NOT FOLLOWING THE LOSS OF LOVED ONE OR IF BEREAVEMENT IS COMPLICATED BY MAJOR DEPRESSIVE EPISODE. CODE "1" IF SIMPLE BEREAVEMENT



A15

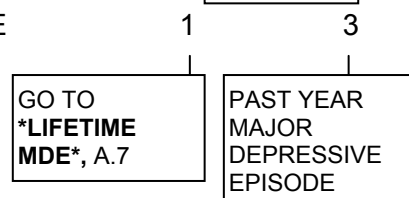
IF UNKNOWN: Has there been any other time in the past year when you were (depressed / OWN WORDS) like this that did not occur after someone close to you died?

IF YES: GO TO \*PAST YEAR MDE \*, A.1 AND CHECK WHETHER THERE HAS BEEN ANY OTHER MAJOR DEPRESSIVE EPISODE IN THE PAST 12 MONTHS THAT WAS NOT BETTER ACCOUNTED FOR BY BEREAVEMENT. IF SO, ASK ABOUT THAT EPISODE.

IF NO: GO TO \*LIFETIME MDE\*, A.7.

CONTINUE BELOW

MAJOR DEPRESSIVE EPISODE CRITERIA A, C, D, AND E ARE CODED "3"



A16

How many separate times in your life have you been (depressed / OWN WORDS) nearly every day for at least two weeks and had several of the symptoms that you described like (SXS OF WORST EPISODE)

Total number of Major Depressive Episodes (CODE 98 IF TOO NUMEROUS OR INDISTINCT TO COUNT)

GO TO \*PAST YEAR MANIC EPISODE\*, A.13

A17

**\*LIFETIME MAJOR DEPRESSIVE EPISODE\***

**MDE CRITERIA**

Looking back before the past year, have you ever had a period when you were feeling depressed or down most of the day nearly every day? (What was that like?)

A. Five or more of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms was either (1) depressed mood or (2) loss of interest or pleasure.

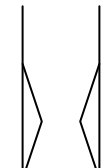
IF YES: When was that? How long did it last? (As long as two weeks?)

---

---

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: in children and adolescents, can be irritable mood.

? 1 2 3 A18



(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation made by others).

? 1 2 3 A19

IF NEITHER ITEM (1) NOR (2) IS CODED "3", GO TO \*PAST YEAR MANIC EPISODE\* A.13

IF PAST DEPRESSED MOOD: During that time, did you lose interest or pleasure in things you usually enjoyed? (What was that like?)

IF NO PAST DEPRESSED MOOD: Looking back before the past year, did you ever have a time when you lost interest or pleasure in things you usually enjoyed? (What was that like?)

IF YES: When was that? Was it nearly every day? How long did it last? (As long as two weeks?)

---

---

---

---

---

NOTE: IF MORE THAN ONE PAST EPISODE IS LIKELY, SELECT THE "WORST" ONE FOR YOUR INQUIRY ABOUT A MAJOR DEPRESSIVE EPISODE.

Have you had more than one time like that? (Which time was the worst?)

FOR THE FOLLOWING QUESTIONS, FOCUS ON THE WORST TWO WEEKS OF THE MAJOR DEPRESSIVE EPISODE THAT YOU ARE INQUIRING ABOUT

NOTE: WHEN RATING THE FOLLOWING ITEMS, CODE "1" IF CLEARLY DIRECTLY DUE TO A GENERAL MEDICAL CONDITION, OR TO MOOD-INCONGRUENT DELUSIONS OR HALLUCINATIONS

During that (TWO WEEK PERIOD) . . .

. . . how was your appetite? (What about compared to your usual appetite?) (Did you have to force yourself to eat?) (Eat [less/more] than usual?) (Was that nearly every day?) (Did you lose or gain any weight?) (How much?) (Were you trying to [lose/gain] weight?)

(3) significant weight loss when not dieting, or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day.

? 1 2 3

A20

. . . how were you sleeping? (Trouble falling asleep, waking frequently, trouble staying asleep, waking too early, OR sleeping too much? How many hours a night compared to usual? Was that nearly every night?)

(4) insomnia or hypersomnia nearly every day

? 1 2 3

A21

. . . were you so fidgety or restless that you were unable to sit still? (Was it so bad that other people noticed it? What did they notice? Was that nearly every day?)

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

? 1 2 3

A22

IF NO: What about the opposite -- talking or moving more slowly than is normal for you? (Was it so bad that other people noticed it? What did they notice? Was it nearly every day?)

. . . what was your energy like? (Tired all the time? Nearly every day?)

(6) fatigue or loss of energy nearly every day

? 1 2 3

A23

During that time . . .

. . . how did you feel about yourself?  
(Worthless?) (Nearly every day?)

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

? 1 2 3

A24

IF NO: What about feeling guilty about things you had done or not done? (Nearly every day?)

NOTE: CODE "1" OR "2" FOR LOW SELF-ESTEEM BUT NOT WORTHLESSNESS

. . . did you have trouble thinking or concentrating? (What kinds of things did it interfere with?) (Nearly every day?)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

? 1 2 3

A25

IF NO: Was it hard to make decisions about everyday things? (Nearly every day?)

. . . were things so bad that you were thinking a lot about death or that you would be better off dead? What about thinking of hurting yourself?

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

? 1 2 3

A26

NOTE: CODE "1" FOR SELF-MUTILATION W/O SUICIDAL INTENT

IF YES: Did you do anything to hurt yourself?

AT LEAST FIVE OF THE ABOVE SXS [A(1-9)] ARE CODED "3" AND AT LEAST ONE OF THESE IS ITEM (1) OR (2)

1

3

A27

IF NOT ALREADY ASKED: Has there been any other time when you were (depressed/OWN WORDS) and had even more of the symptoms that I just asked you about?

CONTINUE WITH NEXT ITEM, CRITERION C, MIDDLE OF PAGE

IF YES: RETURN TO \*LIFETIME MDE\*, A.7, AND CHECK WHETHER THERE HAVE BEEN ANY OTHER MAJOR DEPRESSIVE EPISODES THAT WERE MORE SEVERE AND/OR CAUSED MORE SYMPTOMS. IF SO, ASK ABOUT THAT EPISODE.

IF NO: GO TO \*PAST YEAR MANIC EPISODE\*, A.13.

NOTE: DSM-IV criterion B (i.e., does not meet criteria for a mixed episode) has been omitted from the SCID.

IF UNCLEAR: Did (depressive episode/OWN WORDS) make it hard for you to do your work, take care of things at home, or get along with other people?

C. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

1

2

3

A28

IF NOT ALREADY ASKED: Has there been any other time when you were (depressed/OWN WORDS) and it caused even more problems than the time I just asked you about?

CONTINUE ON NEXT PAGE

IF YES: RETURN TO \*LIFETIME MDE\*, A.7, AND CHECK WHETHER THERE HAVE BEEN ANY OTHER MAJOR DEPRESSIVE EPISODES THAT WERE MORE SEVERE AND/OR CAUSED MORE SYMPTOMS. IF SO, ASK ABOUT THAT EPISODE

IF NO: GO TO \*PAST YEAR MANIC EPISODE\*, A.13.

How old were you when this (LIFETIME MAJOR DEPRESSIVE EPISODE) started?

LIFETIME MAJOR DEPRESSIVE EPISODE STARTED:

AGE: \_\_\_\_

A29

Just before this began, were you physically ill?

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or to a general medical condition (e.g., hypothyroidism)

? 1 3

A30

IF YES: What did the doctor say

DUE TO SUBSTANCE USE OR GMC

Just before this began, were you using any medications?

IF YES: Was there any change in the amount you were taking at that time?

IF THERE IS ANY INDICATION THAT THE DEPRESSION MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A GMC OR SUBSTANCE), GO TO \*MOOD EPISODE DUE TO GMC/SUBSTANCE\* IN THE BACK OF THIS BOOKLET, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

Just before this began, were you drinking or using any street drugs?

REFER TO LIST OF GENERAL MEDICAL CONDITIONS AND SUBSTANCES, A.5.

IF UNKNOWN: Has there been any other time when you were (depressed/ OWN WORDS) like this but were not (using SUBSTANCE / ill with GMC)?

PRIMARY MOOD EPISODE

IF YES: GO TO \*LIFETIME MDE\*, A.7 AND CHECK WHETHER THERE HAS BEEN ANY OTHER MAJOR DEPRESSIVE EPISODE NOT DUE TO A SUBSTANCE OR GENERAL MEDICAL CONDITION. IF SO, ASK ABOUT THAT EPISODE.

IF NO: GO TO \*PAST YEAR MANIC EPISODE\*, A.13

CONTINUE ON NEXT PAGE

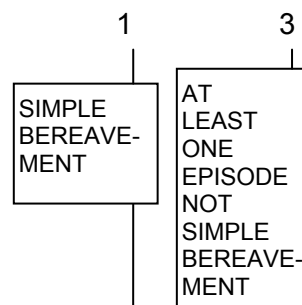


Did this begin soon after someone close to you died?

\_\_\_\_\_  
\_\_\_\_\_

E. The symptoms are not better accounted for by [Simple] Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation.

NOTE: CODE "3" IF EITHER NOT FOLLOWING THE LOSS OF LOVED ONE OR IF BEREAVEMENT IS COMPLICATED BY MAJOR DEPRESSIVE EPISODE. CODE "1" IF SIMPLE BEREAVEMENT



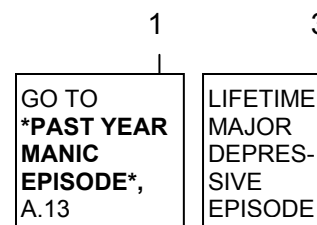
IF UNKNOWN: Has there been any other time when you were (depressed/ OWN WORDS) like this that did not occur after someone close to you died?

→ IF YES: GO TO \*LIFETIME MDE\*, A.7 AND CHECK WHETHER THERE HAS BEEN ANY OTHER MAJOR DEPRESSIVE EPISODE THAT WAS NOT BETTER ACCOUNTED FOR BY BEREAVEMENT. IF SO, ASK ABOUT THAT EPISODE.

→ IF NO: GO TO \*PAST YEAR MANIC EPISODE\*, A.13.

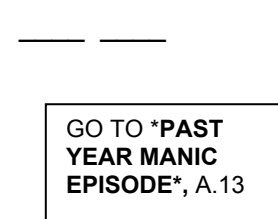
CONTINUE BELOW

MAJOR DEPRESSIVE EPISODE CRITERIA A, C, D, AND E ARE CODED "3"



How many separate times in your life have you been (depressed/OWN WORDS) nearly every day for at least two weeks and had several of the symptoms that you described like (SXS OF WORST EPISODE)

Total number of Major Depressive Episodes (CODE 98 IF TOO NUMEROUS OR INDISTINCT TO COUNT)



A31

A32

A34

**\*PAST YEAR MANIC EPISODE\***

**MANIC EPISODE CRITERIA**

In the past year has there been a period of time when you were feeling so good, "high," excited, or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?

▶IF YES: What was it like? (Did anyone say you were manic?) (Was that more than just feeling good?)

▶IF NO: In the past year, have you had a period of time when you were feeling irritable or angry every day for at least several days?

What was it like? (Did you find yourself often starting fights or arguments?)

---

---

---

---

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood

? 1 2 3

GO TO \*LIFETIME MANIC EPISODE\*, A.19

A35

How long did that last? (As long as one week?) (Did you have to go into a hospital?)

... lasting at least one week (or any duration if hospitalization is necessary)

? 1 2 3

NOTE: IF ELEVATED MOOD LASTS LESS THAN ONE WEEK, CHECK WHETHER IRRITABLE MOOD LASTS AT LEAST ONE WEEK BEFORE SKIPPING TO A.19.

GO TO \*LIFETIME MANIC EPISODE\*, A.19

A36

FOCUS ON THE WORST PERIOD OF THE EPISODE THAT YOU ARE INQUIRING ABOUT.

IF UNCLEAR: During (EPISODE), when were you the most (OWN WORDS FOR MANIA)?

During that time . . .

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

<p>. . .how did you feel about yourself? (More self-confident than usual?) (Any special powers or abilities?)</p> <hr/> <hr/>	<p>(1) inflated self-esteem or grandiosity</p>	<p>?</p>	<p>1</p>	<p>2</p>	<p>3</p>	<p>A37</p>
<p>. . .did you need less sleep than usual? (How much sleep did you get?) IF YES: Did you still feel rested?</p> <hr/> <hr/>	<p>(2) decreased need for sleep (e.g., feels rested after only three hours of sleep)</p>	<p>?</p>	<p>1</p>	<p>2</p>	<p>3</p>	<p>A38</p>
<p>. . .were you much more talkative than usual? (Did people have trouble stopping you or understanding you? Did people have trouble getting a word in edgewise?)</p> <hr/> <hr/>	<p>(3) more talkative than usual or pressure to keep talking</p>	<p>?</p>	<p>1</p>	<p>2</p>	<p>3</p>	<p>A39</p>
<p>. . .were your thoughts racing through your head? (What was that like?)</p> <hr/> <hr/>	<p>(4) flight of ideas or subjective experience that thoughts are racing</p>	<p>?</p>	<p>1</p>	<p>2</p>	<p>3</p>	<p>A40</p>

During that time . . .

. . .were you so easily distracted by things around you that you had trouble concentrating or staying on one track?  
(Give me an example of that.)

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

? 1 2 3

A41

---



---

. . .how did you spend your time? (Work, friends, hobbies?) (Were you especially productive or busy during that time?) (Were you so active that your friends or family were concerned about you?)

(6) increase in goal- directed activity (either socially, at work or school, or sexually) or psychomotor agitation

? 1 2 3

A42

IF NO INCREASED ACTIVITY:  
Were you physically restless?  
(How bad was it?)

---



---

. . .did you do anything that could have caused trouble for you or your family? (Buying things you didn't need?) (Anything sexual that was unusual for you?) (Reckless driving?)

(7) excessive involvement in pleasurable activities which have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

? 1 2 3

A43

---



---

AT LEAST THREE "B" SXS ARE CODED "3" (FOUR IF MOOD ONLY IRRITABLE)

1

3

A44

IF NOT ALREADY ASKED: Has there been any other times in the past year when you were (high/irritable/OWN WORDS) and had even more of the symptoms that I just asked you about?

A44a

- IF YES: RETURN TO **\*PAST YEAR MANIC EPISODE\***, A.13, AND INQUIRE ABOUT WORST EPISODE.
- IF NO: GO TO **\*LIFETIME MANIC EPISODE\***, A.19.

NOTE: DSM-IV criterion C (i.e., does not meet criteria for a Mixed Episode) has been omitted from the SCID.

CONTINUE BELOW

IF NOT KNOWN: At that time, did you have serious problems at home or at work (school) because you were (SYMPTOMS) or did you have to go into a hospital?

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others or there are psychotic features.

1

2

3

A45

IF NOT ALREADY ASKED: Have there been any other times in the past year when you were (high/irritable/OWN WORDS) and had (ACKNOWLEDGED MANIC SYMPTOMS) and you got into trouble with people or were hospitalized?

DESCRIBE:

- IF YES: RETURN TO **\*PAST YEAR MANIC EPISODE\***, A.13 AND INQUIRE ABOUT THAT EPISODE
- IF NO: GO TO **\*LIFETIME MANIC EPISODE\***, A.19.

CONTINUE ON NEXT PAGE

In what month (and what year) did this (PAST YEAR MANIC EPISODE) start?

PAST YEAR MANIC EPISODE STARTED:

Month/Yr: \_\_\_\_ / \_\_\_\_

A46  
A47

Just before this began, were you physically ill?

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or to a general medical condition

? 1 3

A48

IF YES: What did the doctor say?

DUE TO SUBSTANCE USE OR GMC

Just before this began, were you taking any medications?

IF THERE IS ANY INDICATION THAT THE MANIA MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A GMC OR SUBSTANCE), GO TO \*MOOD EPISODE DUE TO GMC/SUBSTANCE\* IN THE BACK OF THIS BOOKLET, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

IF YES: Was there any change in the amount you were taking at that time?

Just before this began, were you drinking or using any street drugs?

NOTE: MANIC-LIKE EPISODES THAT ARE CLEARLY CAUSED BY SOMATIC ANTIDEPRESSANT TREATMENT (E.G., MEDICATION, ECT, LIGHT THERAPY) SHOULD NOT COUNT TOWARD A DIAGNOSIS OF BIPOLAR I DISORDER BUT ARE CONSIDERED SUBSTANCE-INDUCED MOOD DISORDERS.

Etiological general medical conditions include: degenerative neurological illnesses (e.g., Huntington's disease, multiple sclerosis), cerebrovascular disease (e.g., stroke), metabolic conditions (e.g., Vitamin B-12 deficiency, Wilson's disease), endocrine conditions (e.g., hyperthyroidism), viral or other infections, and certain cancers (e.g., cerebral neoplasms).

IF UNKNOWN: Has there been any other times in the past year when you were (high / irritable / OWN WORDS) and were not (using SUBSTANCE / ill with GMC)?

Etiological substances include: alcohol, amphetamines, cocaine, hallucinogens, inhalants, opioids, phencyclidine, sedatives, hypnotics, and anxiolytics. Medications include psychotropic medications (e.g., anti-depressants), corticosteroids, anabolic steroids, isoniazid, antiparkinson medication (e.g., levadopa), and sympathomimetics/decongestants

PRIMARY MOOD EPISODE

IF YES: RETURN TO \*PAST YEAR MANIC EPISODE\*, A.13, AND INQUIRE ABOUT OTHER EPISODE.

IF NO: GO TO \*LIFETIME MANIC EPISODE\*, A.19.

MANIC EPISODE CRITERIA A, B, D AND E ARE CODED "3"

1 3

A49

GO TO \*LIFETIME MANIC EPISODE\*, A.19

MANIC EPISODE PAST YEAR

?=inadequate information

1=absent or false

2=subthreshold

3=threshold or true

SCID-I (for DSM-IV-TR)

Past Year Mania

(March 2012)

Mood Episodes A.18

How many separate times in your life were you (HIGH/OWN WORDS) and had [ACKNOWLEDGED MANIC SYMPTOMS] for at least a week (or were hospitalized)?

Number of Manic Episodes, including past year (CODE 98 IF TOO INDISTINCT OR NUMEROUS TO COUNT)

\_\_\_\_\_

A50

GO TO \***PSYCHOTIC SCREEN\***, B/C.1

?=inadequate information

1=absent or false

2=subthreshold

3=threshold or true

**\*LIFETIME MANIC EPISODE\***

**MANIC EPISODE CRITERIA**

Looking back before the past year, did you ever have a period of time when you were feeling so good, "high," excited, or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?

IF YES: What was it like? (Did anyone say you were manic?) (Was that more than just feeling good?)

IF NO: Looking back before the past year, did you ever have a period of time when you were feeling irritable or angry every day for at least several days?

What was it like? (Did you find yourself often starting fights or arguments?)

---

---

When was that?

---

How long did that last? (as long as one week?) (Did you need to go to the hospital?)

---

---

Have you had more than one time like that? (Which time was the most extreme?)

---

---

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood . . .

? 1 2 3

GO TO \*DYSTHYMIC DISORDER\*, A.25

A51

. . . lasting at least one week (or any duration if hospitalization is necessary)

? 1 2 3

NOTE: IF ELEVATED MOOD LASTS LESS THAN ONE WEEK, CHECK WHETHER IRRITABLE MOOD LASTS AT LEAST ONE WEEK BEFORE SKIPPING TO A.25.

GO TO \*DYSTHYMIC DISORDER\*, A.25

A52

NOTE: IF THERE IS EVIDENCE FOR MORE THAN ONE PAST EPISODE, SELECT THE "WORST" ONE FOR YOUR INQUIRY ABOUT PAST MANIC EPISODE.



FOCUS ON THE WORST PERIOD OF THE EPISODE THAT YOU ARE INQUIRING ABOUT.

IF UNCLEAR: During (EPISODE), when were you the most (OWN WORDS FOR MANIA)?

During that time . . .

. . .how did you feel about yourself? (More self-confident than usual?) (Any special powers or abilities?)

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity ?

1 2 3

A53

. . .did you need less sleep than usual? (How much sleep did you get?)

(2) decreased need for sleep (e.g., feels rested after only three hours of sleep) ?

1 2 3

A54

IF YES: Did you still feel rested?

. . .were you much more talkative than usual? (Did people have trouble stopping you or understanding you? Did people have trouble getting a word in edgewise?)

(3) more talkative than usual or pressure to keep talking ?

1 2 3

A55

. . .were your thoughts racing through your head? (What was that like?)

(4) flight of ideas or subjective experience that thoughts are racing ?

1 2 3

A56

. . .were you so easily distracted by things around you that you had trouble concentrating or staying on one track? (Give me an example of that.)

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) ?

1 2 3

A57

. . .how did you spend your time? (Work, friends, hobbies?) (Were you especially productive or busy during that time?) (Were you so active that your friends or family were concerned about you?)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation ?

1 2 3

A58

IF NO INCREASED ACTIVITY: Were you physically restless? (How bad was it?)

During that time . . .

. . .did you do anything that could have caused trouble for you or your family? (Buying things you didn't need?) (Anything sexual that was unusual for you?) (Reckless driving?)

(7) excessive involvement in pleasurable activities which have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

? 1 2 3

A59

\_\_\_\_\_

\_\_\_\_\_

AT LEAST THREE "B" SXS ARE CODED "3" (FOUR IF MOOD ONLY IRRITABLE)

1

3

A60

IF NOT ALREADY ASKED: Has there been any other time when you were (high/irritable/OWN WORDS) and had even more of the symptoms that I just asked you about?

A60a

IF YES: RETURN TO \*LIFETIME MANIC EPISODE\*, A.19, AND INQUIRE ABOUT WORST EPISODE.

IF NO: GO TO \*DYSTHYMIC DISORDER\*, A.25.

NOTE: DSM-IV criterion C (i.e., does not meet criteria for a Mixed Episode) has been omitted from the SCID.

CONTINUE BELOW

IF NOT KNOWN: At that time, did you have serious problems at home or at work (school) because you were (SYMPTOMS) or did you have to go into a hospital?

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others or there are psychotic features.

1 2 3

A61

\_\_\_\_\_

IF NOT ALREADY ASKED: Has there been any other time when you were (high/irritable/OWN WORDS) and had (ACKNOWLEDGED MANIC SYMPTOMS) and you got into trouble with people or were hospitalized?

DESCRIBE:

IF YES: RETURN TO \*LIFETIME MANIC EPISODE", A.19 AND INQUIRE ABOUT THAT EPISODE

IF NO: GO TO \*DYSTHYMIC DISORDER\*, A.25.

CONTINUE ON NEXT PAGE

How old were you when this (LIFETIME MANIC EPISODE) started?

LIFETIME MANIC EPISODE STARTED:

AGE: \_\_\_\_

A62

Just before this began, were you physically ill?

E The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or to a general medical condition

? 1 3

A63

IF YES: What did the doctor say?

DUE TO SUBSTANCE USE OR GMC

Just before this began, were you taking any medications?

IF THERE IS ANY INDICATION THAT THE MANIA MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A GMC OR SUBSTANCE), GO TO \*MOOD EPISODE DUE TO GMC/SUBSTANCE\* IN THE BACK OF THIS BOOKLET, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

IF YES: Was there any change in the amount you were taking at that time?

Just before this began, were you drinking or using any street drugs?

NOTE: MANIC-LIKE EPISODES THAT ARE CLEARLY CAUSED BY SOMATIC ANTIDEPRESSANT TREATMENT (E.G., MEDICATION, ECT, LIGHT THERAPY) SHOULD NOT COUNT TOWARD A DIAGNOSIS OF BIPOLAR I DISORDER BUT ARE CONSIDERED SUBSTANCE-INDUCED MOOD DISORDERS.

REFER TO LIST OF GENERAL MEDICAL CONDITIONS AND SUBSTANCES, A.17

IF UNKNOWN: Has there been any other time when you were (high / irritable / OWN WORDS) and were not (using SUBSTANCE / ill with GMC)?

PRIMARY MOOD EPISODE

IF YES: RETURN TO \*LIFETIME MANIC EPISODE\*, A.19, AND INQUIRE ABOUT OTHER EPISODE.

IF NO: GO TO \*DYSTHYMIC DISORDER\*, A.25.

CONTINUE ON NEXT PAGE

MANIC EPISODE CRITERIA  
A, B, D AND E ARE CODED "3"

1

3

A64

GO TO  
**\*DYSTHYMIC  
DISORDER\***,  
A.25

LIFETIME  
MANIC  
EPISODE

How many separate times in your life  
were you (HIGH / OWN WORDS) and  
had [ACKNOWLEDGED MANIC  
SYMPTOMS] for a period of time (or  
were hospitalized)?

Number of Manic Episodes (CODE 98  
IF TOO INDISTINCT OR NUMEROUS  
TO COUNT)

\_\_\_\_\_

A65

GO TO  
**\*PSYCHOTIC  
SCREEN\***,  
B/C.1

*This page has been intentionally left blank.*

**\*DYSTHYMIC DISORDER\*  
(PAST YEAR)**

**DYSTHYMIC DISORDER CRITERIA**

For the past couple of years, have you been bothered by depressed mood most of the day, more days than not? (More than half of the time?)

IF YES: What was that like?

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation made by others, for at least two years. Note: in children and adolescents, mood can be irritable and duration must be at least 1 year.

? 1 2 3

GO TO  
\*PSYCHOTIC  
SCREEN\*, B/C.1

A66

During these periods of (OWN WORDS FOR CHRONIC DEPRESSION) do you often . . .

B Presence, while depressed, of two (or more) of the following:

. . . lose your appetite? (What about overeating?)

(1) poor appetite or overeating

? 1 2 3

A67

. . . have trouble sleeping or sleep too much?

(2) insomnia or hypersomnia

? 1 2 3

A68

. . . have little energy to do things or feel tired a lot?

(3) low energy or fatigue

? 1 2 3

A69

. . . feel down on yourself? (Feel worthless, or a failure?)

(4) low self-esteem

? 1 2 3

A70

. . . have trouble concentrating or making decisions?

(5) poor concentration or difficulty making decisions

? 1 2 3

A71

... feel hopeless?  
 \_\_\_\_\_  
 \_\_\_\_\_

(6) feelings of hopelessness

? 1 2 3

A72

AT LEAST TWO "B"  
 SYMPTOMS CODED "3"

? 1 2 3

A73

GO TO  
 \*PSYCHOTIC  
 SCREEN\*, B/C.1

What is the longest period of time,  
 during this period of long-lasting  
 depression, that you felt OK? (NO  
 DYSTHYMIC SYMPTOMS)

C. During the two year period of the  
 disturbance, the person has never  
 been without the symptoms in  
 criteria A and B for more than two  
 months at a time.

1 3

A74

GO TO  
 \*PSYCHOTIC  
 SCREEN\*,  
 B/C.1

NOTE: CODE "1" IF NORMAL MOOD  
 FOR AT LEAST TWO MONTHS AT A  
 TIME

How long have you been feeling this  
 way? (When did this begin?)

D. No Major Depressive Episode has  
 been present during the first 2 years  
 of the disturbance (1 year for  
 children and adolescents): i.e., not  
 better accounted for by chronic  
 Major depressive Disorder or Major  
 Depression in partial remission.

1 3

A75

GO TO  
 \*PSYCHOTIC  
 SCREEN\*,  
 B/C.1

COMPARE ONSET OF DYSTHYMIC  
 SXS WITH DATES OF PAST MAJOR  
 DEPRESSIVE EPISODES TO  
 DETERMINE IF THERE WERE ANY  
 MAJOR DEPRESSIVE EPISODES IN  
 FIRST TWO YEARS OF DYSTHYMIC  
 DISORDER.

Age at onset of current Dysthymic  
 Disorder (CODE 98 IF UNKNOWN)

\_\_\_\_\_

A76

IF A MAJOR DEPRESSIVE EPISODE  
 PRECEDED DYSTHYMIC SXS: Now  
 I want to know whether you got  
 completely back to your usual self  
 after that (MAJOR DEPRESSIVE  
 EPISODE) you had (DATE), before  
 this long period of being mildly  
 depressed? (Were you back to your  
 usual self for at least two months?)

Note: There may have been a previous  
 Major Depressive Episode provided  
 there was a full remission (no significant  
 signs or symptoms for 2 months) before  
 development of the Dysthymic Disorder.  
 In addition, after the initial 2 years (1  
 year for children or adolescents) of  
 Dysthymic Disorder, there may be  
 superimposed episodes of Major  
 Depressive Disorder, in which case both  
 diagnoses may be given when criteria  
 are met for a Major Depressive Episode.

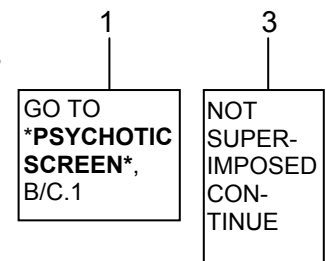
NOTE: CODE "3" IF NO PAST MAJOR DEPRESSIVE EPISODES OR IF MAJOR DEPRESSIVE EPISODES WERE NOT PRESENT DURING THE FIRST TWO YEARS OR IF THERE WAS AT LEAST A TWO-MONTH PERIOD WITHOUT SYMPTOMS PRECEDING THE ONSET.

E. NOTE: RULE OUT FOR MIXED EPISODE AND HYPOMANIC EPISODE AND CYCLOTHYMIC DISORDER ARE NOT ASSESSED HERE.

IF NOT ALREADY CLEAR: RETURN TO THIS ITEM AFTER COMPLETING THE PSYCHOTIC SYMPTOMS SECTION.

F. The disturbance does not occur exclusively during the course of a chronic psychotic disorder, such as Schizophrenia or Delusional Disorder.

NOTE: CODE "3" IF NO CHRONIC PSYCHOTIC DISORDER OR IF NOT SUPERIMPOSED ON A CHRONIC PSYCHOTIC DISORDER



A77



Just before this began, were you physically ill?

IF YES: What did the doctor say?

Just before this began, were you using any medications?

IF YES: Was there any change in the amount you were taking at that time?

\_\_\_\_\_  
\_\_\_\_\_

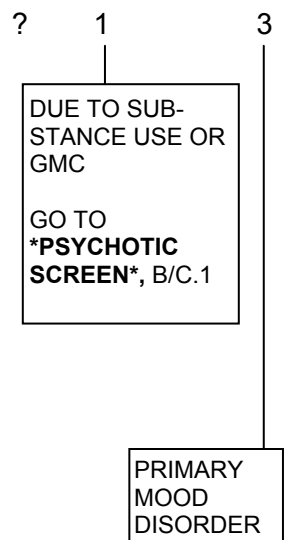
Just before this began, were you drinking or using any street drugs?

G. Not due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or to a general medical condition

IF THERE IS ANY INDICATION THAT THE DYSTHMIA MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A GMC OR SUBSTANCE), GO TO **\*MOOD EPISODE DUE TO GMC/SUBSTANCE\*** IN THE BACK OF THIS BOOKLET AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

Etiological general medical conditions include: degenerative neurological illnesses (e.g., Parkinson's disease, Huntington's disease, cerebrovascular disease, metabolic and endocrine conditions (e.g., B-12 deficiency, hypothyroidism, autoimmune conditions (e.g., systemic lupus erythematosus), viral or other infections (e.g., hepatitis, mononucleosis, HIV), and certain cancers (e.g., carcinoma of the pancreas)

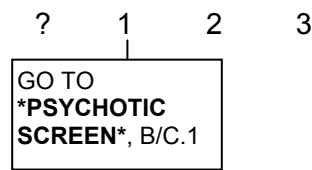
Etiological substances include: alcohol, amphetamines, cocaine, hallucinogens, inhalants, opioids, phencyclidine, sedatives, hypnotics, anxiolytics. Medications include antihypertensives, oral contraceptives, corticosteroids, anabolic steroids, anticancer agents, analgesics, anti-cholinergics, and cardiac medications.



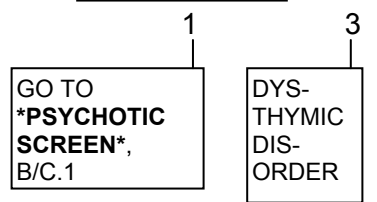
CONTINUE BELOW

IF UNCLEAR: How much do your depressed feelings interfere with your life?

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning



DYSTHYMIC DISORDER CRITERIA A, B, C, D, F, G, AND H ARE CODED "3."



A78

A79

A80

**B/C PSYCHOTIC SCREENING MODULE**

THIS MODULE IS FOR CODING PSYCHOTIC AND ASSOCIATED SXS THAT HAVE BEEN PRESENT AT ANY POINT IN THE PAST YEAR.

FOR EACH PSYCHOTIC SYMPTOM CODED "3," DESCRIBE THE ACTUAL CONTENT AND INDICATE THE PERIOD OF TIME DURING WHICH THE SYMPTOM WAS PRESENT.

FOR ANY DELUSIONS OR HALLUCINATIONS CODED "3", DETERMINE WHETHER THE SYMPTOM IS DEFINITELY "PRIMARY" OR WHETHER THERE IS A POSSIBLE OR DEFINITE ETIOLOGIC SUBSTANCE (INCLUDING MEDICATIONS) OR GENERAL MEDICAL CONDITION. THE FOLLOWING QUESTIONS MAY BE USEFUL IF THE OVERVIEW HAS NOT ALREADY PROVIDED THE INFORMATION:

Just before (PSYCHOTIC SXS) began, were you using drugs? ...on any medications? ...did you drink much more than usual or stop drinking after you had been drinking a lot for a while? ...were you physically ill?

IF YES TO ANY: Has there been a time when you had (PSYCHOTIC SXS) and were not (USING DRUGS/TAKING MEDICATION/CHANGING YOUR DRINKING HABITS/ILL)?

Now I am going to ask you about unusual experiences that people sometimes have.

**DELUSIONS**

False personal beliefs based on incorrect inference about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture. Code overvalued ideas (unreasonable and sustained beliefs that are maintained with less than delusional intensity) as "2."

In the past year, that is since (CURRENT DATE) 2011...

...did it ever seem like people were talking about you or taking special notice of you?

Delusion of reference, i.e., events, objects, or other people in the individual's immediate environment have a particular or unusual significance.

	?	1	2	3
		1		3
		POSS/DEF		PRI-
		SUBST/		MARY
		GMC		

BC1

BC2

IF YES: Were you convinced they were talking about you or did you think it might have been your imagination?

...what about receiving special messages from the TV, radio, or newspaper, or from the way things were arranged around you?

DESCRIBE:

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In the past year...  
 ...have you felt that someone was going out of their way to give you a hard time, or trying to hurt you?

Persecutory delusion, i.e., the individual (or his or her group) is being attacked, harassed, cheated, persecuted, or conspired against.

?	1	2	3
	1		3
	POSS/DEF		PRI-
	SUBST/		MARY
	GMC		

BC3  
BC4

DESCRIBE:

---



---



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...have you felt that you were especially important in some way, or that you had special powers to do things that other people couldn't do?

Grandiose delusion, i.e., content involves exaggerated power, knowledge or importance, or a special relationship to a deity or famous person.

?	1	2	3
	1		3
	POSS/DEF		PRI-
	SUBST/		MARY
	GMC		

BC5  
BC6

DESCRIBE:

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---



---

In the past year have you felt that something was very wrong with you physically even though your doctor said nothing was wrong...like you had cancer or some other terrible disease?

Somatic delusion, i.e., content involves change or disturbance in body appearance or functioning.

?	1	2	3
	1		3
	POSS/DEF		PRI-
	SUBST/		MARY
	GMC		

BC7  
BC8

...have you been convinced that something was very wrong with the way a part or parts of your body looked?

...have you felt that something strange was happening to parts of your body?

DESCRIBE:

---



---



---

In the past year...

Other delusions

? 1 2 3

BC9

...have you had any unusual religious experiences?

1	3
POSS/DEF	PRI-
SUBST/	MARY
GMC	

BC10

...have you felt that you had committed a crime or done something terrible for which you should be punished?

...have you been convinced that your spouse or partner was being unfaithful to you?

IF YES: How did you know they were being unfaithful?

...did you feel you had a special, secret relationship with someone famous, or someone you didn't know very well?

DESCRIBE:

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**HALLUCINATIONS (PSYCHOTIC):**

A sensory perception that has the compelling sense of reality of a true perception but occurs without external stimulation of the relevant sensory organ. (CODE "2" FOR HALLUCINATIONS THAT ARE SO TRANSIENT AS TO BE WITHOUT DIAGNOSTIC SIGNIFICANCE)

In the past year...

...have you heard things that other people couldn't hear, such as noises, or the voices of people whispering or talking? (Were you awake at the time?)

Auditory hallucinations when fully awake, heard either inside or outside of head

? 1 2 3

BC11

1	3
POSS/DEF	PRI-
SUBST/	MARY
GMC	

BC12

IF YES: What did you hear? How often did you hear it?

DESCRIBE:

---



---



---

IF VOICES: Did they comment on what you were doing or thinking?

A voice keeping up a running commentary on the individual's behavior or thoughts as they occur

? 1 2 3

BC13

How many voices did you hear? Were they talking to each other?

Two or more voices conversing with each other

? 1 2 3

BC14

How about having visions or seeing things that other people couldn't see? (Were you awake at the time?)

Visual hallucinations

? 1 2 3

BC15

1	3
POSS/DEF	PRI-
SUBST/	MARY
GMC	

BC16

NOTE: DISTINGUISH FROM AN ILLUSION, I.E., A MISPERCEPTION OF A REAL EXTERNAL STIMULUS.

DESCRIBE:

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---

...what about strange sensations in your body or on your skin?

Tactile hallucinations, e.g., electricity

? 1 2 3

BC17

DESCRIBE:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1	3
POSS/DEF	PRI-
SUBST/	MARY
GMC	

BC18

(What about smelling or tasting things that other people couldn't smell or taste?)

Other hallucinations, e.g., gustatory, olfactory

? 1 2 3

BC19

DESCRIBE:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1	3
POSS/DEF	PRI-
SUBST/	MARY
GMC	

BC20

ANY ITEM CODED "3" IN "PRIMARY" SECTION

? 1 3

BC21

GO TO *MOOD DISORDERS*, D.1
-----------------------------

A PRIMARY PSYCHOTIC SX HAS BEEN PRESENT
---

EXPLORE DETAILS AND DESCRIBE DIAGNOSTIC SIGNIFICANCE:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**D. MOOD DISORDERS**

IF THERE HAVE NEVER BEEN ANY CLINICALLY SIGNIFICANT MOOD SYMPTOMS, CIRCLE 1 AND GO TO **\*PTSD\***, E.1.

1 3 D1

IF THERE HAVE BEEN ANY CLINICALLY SIGNIFICANT MOOD SYMPTOMS, CIRCLE 3 AND CONTINUE.

**BIPOLAR I DISORDER CRITERIA**

CODE BASED ON RATINGS OF MANIC EPISODE PAST YEAR (A49) AND MANIC EPISODE LIFETIME (A64)

History of one or more Manic or Mixed Episodes

1 3 D2

Note: In a Mixed Episode, the criteria are met for both a Manic Episode and a Major Depressive Episode (except for duration nearly every day during at least a 1-week period)

GO TO **\*MAJOR DEPRESSIVE DISORDER\***, D. 2

At least one Manic or Mixed Episode is not due to the direct physiological effects of a general medical condition or substance use

1 3 D3

GO TO **\*MAJOR DEPRESSIVE DISORDER\***, D.2

Note: Manic-like Episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, ECT, light therapy) should not count toward a diagnosis of Bipolar I Disorder

At least one Manic or Mixed Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS

1 3 D4

GO TO **\*MAJOR DEPRESSIVE DISORDER\***, D. 2

BIPOLAR I DISORDER

Indicate time frame of manic episode:  
 1 – Manic episode in past 12 months  
 2 – Manic episode lifetime (i.e., prior to past 12 months)

D5

GO TO **\*PTSD\***, E.1



**\*MAJOR DEPRESSIVE DISORDER\* MAJOR DEPRESSIVE DISORDER CRITERIA**

CODE BASED ON RATINGS OF PAST YEAR MAJOR DEPRESSIVE EPISODE (A16) AND LIFETIME MAJOR DEPRESSIVE DISORDER (A32)

At least one Major Depressive Episode that is not due to the direct physiological effects of a general medical condition or substance use

1

3

D6

GO TO \*PTSD\*, E.1

At least one Major Depressive Episode that is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified

1

3

D7

GO TO \*PTSD\*, E.1

Has never had any Manic, Mixed, or unequivocal Hypomanic Episodes

1

3

D8

GO TO \*PTSD\*, E.1

MAJOR DEPRESSIVE DISORDER

Indicate type:  
 1 - Single Episode  
 2 - Recurrent (i.e., to be considered separate episodes, there must be an interval of at least two months in which criteria are not met for a Major Depressive Episode)

D9

GO TO \*PTSD\*, E.1

**E. ANXIETY DISORDERS**

**\*POSTTRAUMATIC STRESS DISORDER\***

Sometimes things happen to people that are extremely upsetting--things like being in a life threatening situation like a major disaster, very serious accident or fire; being physically assaulted or raped; seeing another person killed or dead, or badly hurt, or hearing about something horrible that has happened to someone you are close to. At any time during your life, have any of these kinds of things happened to you?

IF NO: Have you ever been in any serious car accidents or have you ever been a victim of a crime? (Tell me about that.)

IF NO SUCH EVENTS, CIRCLE 1 AND GO TO **\*PANIC DISORDER\*** ON PAGE E.9.

IF ONE OR MORE SUCH EVENTS, CIRCLE 3 AND CONTINUE:

**TRAUMATIC EVENT(S)**

NO      YES  
1            3

E1

Traumatic Events List

Brief Description	Date (Month/Yr)	Age
_____	___/___	___
_____	___/___	___
_____	___/___	___
_____	___/___	___
_____	___/___	___
_____	___/___	___
_____	___/___	___

IF ANY EVENTS LISTED: Sometimes traumatic experiences like (TRAUMAS LISTED ABOVE) keep coming back in nightmares, flashbacks, or thoughts that you can't get rid of. Has that ever happened to you?

IF NO: What about being very upset when you were in a situation that reminded you of one of these terrible things?

IF NO TO BOTH OF THE ABOVE, CIRCLE 1 AND GO TO **\*PANIC DISORDER\*** ON PAGE E.9.

1            3

E2

IF YES TO EITHER OR BOTH OF THE ABOVE, CIRCLE 3 AND CONTINUE:

**POSTTRAUMATIC STRESS DISORDER CRITERIA**

FOR FOLLOWING QUESTIONS, FOCUS ON TRAUMATIC EVENT(S) MENTIONED IN SCREENING QUESTION ABOVE.

IF MORE THAN ONE TRAUMA IS REPORTED: Which of these do you think affected you the most?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IF UNCLEAR: How did you react when (TRAUMA) happened? (Were you very afraid or did you feel helpless or horrified?)

\_\_\_\_\_  
\_\_\_\_\_

Now I'd like to ask a few questions about specific ways that it may have affected you in the past year.

For example, in the past year . . .

. . . did you think about (TRAUMA) when you didn't want to or did thoughts about (TRAUMA) come to you suddenly when you didn't want them to?

\_\_\_\_\_  
\_\_\_\_\_

. . . what about having dreams about (TRAUMA)?

\_\_\_\_\_  
\_\_\_\_\_

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

? 1 2 3

GO TO \*Panic\*, E.9

E3

(2) the person's response involved intense fear, helplessness or horror.

? 1 2 3

GO TO \*Panic\*, E.9

E4

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions

? 1 2 3

E5

(2) recurrent distressing dreams of the event

? 1 2 3

E6

SCID-I (for DSM-IV-TR)

PTSD Past Year

(March 2012)

Anxiety Disorders

E.3

... what about finding yourself acting or feeling as if you were back in the situation?

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated)

? 1 2 3

E7

... what about getting very upset when something reminded you of (TRAUMA)?

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

? 1 2 3

E8

... what about having physical symptoms--like breaking out in a sweat, breathing heavily or irregularly, or your heart pounding or racing, when something reminded you of (TRAUMA)?

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

? 1 2 3

E9

AT LEAST ONE "B" SX IS CODED "3"

1

3

E10

GO TO  
\*Panic\*, E.9

?=inadequate information

1=absent or false

2=subthreshold

3=threshold or true

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

IF TRAUMA HAS OCCURRED IN THE PAST YEAR: Since (THE TRAUMA)...

IF TRAUMA OCCURRED PRIOR TO PAST YEAR: In the past year, that is since (CURRENT DATE) 2011  
 . . . have you made a special effort to avoid thinking or talking about what happened?

---



---

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

? 1 2 3

E11

. . . have you stayed away from things or people that reminded you of (TRAUMA)?

---



---

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

? 1 2 3

E12

. . . have you been unable to remember some important part of what happened?

---



---

(3) inability to recall an important aspect of the trauma

? 1 2 3

E13

. . . have you been less interested in doing things that used to be important to you, like seeing friends, reading books or watching TV?

---



---



---

(4) markedly diminished interest or participation in significant activities

? 1 2 3

E14

... have you felt distant or cut off from others?

(5) feeling of detachment or estrangement from others

? 1 2 3

E15

... have you felt "numb" or like you no longer had strong feelings about anything or loving feelings for anyone?

(6) restricted range of affect, (e.g., unable to have loving feelings)

? 1 2 3

E16

... did you notice a change in the way you think about or plan for the future?

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

? 1 2 3

E17

AT LEAST 3 "C" SXS ARE CODED "3"

1 3

E18

GO TO \*Panic\*, E.9

IF TRAUMA HAS OCCURRED IN THE PAST YEAR: Since (THE TRAUMA). . .

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:

IF TRAUMA OCCURRED PRIOR TO PAST YEAR: In the past year...

. . . have you had trouble sleeping? (What kind of trouble?)

---



---

(1) difficulty falling or staying asleep

? 1 2 3

E19

. . . have you been unusually irritable? What about outbursts of anger?

---



---

(2) irritability or outbursts of anger

? 1 2 3

E20

. . . have you had trouble concentrating?

---



---

(3) difficulty concentrating

? 1 2 3

E21

. . . have you been watchful or on guard even when there was no reason to be?

---



---

(4) hypervigilance

? 1 2 3

E22

. . . have you been jumpy or easily startled, like by sudden noises?

---



---

(5) exaggerated startle response

? 1 2 3

E23

AT LEAST TWO "D" SXS ARE CODED "3"

1 3

E24

GO TO  
\*Panic\*,  
E.9

About how long did these problems--  
(CITE POSITIVE PTSD SYMPTOMS)--  
last?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E. Duration of the disturbance  
(symptoms in criteria B, C, and D)  
is more than one month

? 1 2 3

GO TO  
**\*Panic\***,  
E. 9

E25

F. The disturbance causes clinically  
significant distress or impairment  
in social, occupational, or other  
important areas of functioning

? 1 2 3

GO TO  
**\*Panic\***,  
E.9

E26

POSTTRAUMATIC STRESS  
DISORDER CRITERIA A, B, C, D, E,  
AND F ARE CODED "3" AND  
PRESENT IN THE PAST YEAR

1 3

GO TO  
**\*PANIC\***,  
E.9

POST-  
TRAUMATIC  
STRESS  
DISORDER  
IN THE  
PAST YEAR

E27



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**PANIC DISORDER**

**PANIC DISORDER CRITERIA**

IF SCREENING QUESTION #1 EQUALS 1, CIRCLE 1 AND GO TO \*AWOPD\*, ON PAGE E.15

E28

IF SCREENING QUESTION #1 EQUALS 2 OR 3, CIRCLE 3 AND CONTINUE:  
You've said that in the past year you have had a panic attack, when you suddenly felt frightened, or anxious or suddenly developed a lot of physical symptoms . . .

SCREEN Q#1	
<u>NO</u>	<u>YES</u>
1	3

Have these attacks ever come on completely out of the blue--in situations where you didn't expect to be nervous or uncomfortable?

A. (1) recurrent unexpected panic attacks.

? 1 2 3

E29

GO TO *AWOPD*, E.15
---------------------

IF UNCLEAR: How many of these kinds of attacks have you had? (At least two?)

After any of these attacks . . .

(2) at least one of the attacks has been followed by a month (or more) of one of the following:

? 1 2 3

E30

GO TO *AWOPD*, E.15
---------------------

Did you worry that there might be something terribly wrong with you, like you were having a heart attack or were going crazy? (How long did you worry?) (At least a month?)

(b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy");

IF NO: Did you worry a lot about having another one? (How long did you worry?) (At least a month?)

(a) persistent concern about having additional attacks;

IF NO: Did you do anything differently because of the attacks (like avoiding certain places or not going out alone?) (What about avoiding certain activities like exercise?) (What about things like always making sure you're near a bathroom or exit?)

(c) a significant change in behavior related to the attacks;

NOW CHECK TO SEE IF CRITERIA ARE MET FOR A PANIC ATTACK.

When was the last bad one?  
 What was the first thing you noticed? Then what?

IF UNKNOWN: Did the symptoms come on all of a sudden?

The panic attack symptoms developed abruptly and reached a peak within ten minutes

? 1 2 3

E31

IF YES: How long did it take from when it began to when it got really bad? (Less than ten minutes?)

GO TO  
 \*AWOPD\*,  
 E.15

During that attack . . .

. . .did your heart race, pound or skip?

(1) palpitations, pounding heart, or accelerated heart rate

? 1 2 3

E32

. . .did you sweat?

(2) sweating

? 1 2 3

E33

. . .did you tremble or shake?

(3) trembling or shaking

? 1 2 3

E34

. . .were you short of breath? (Did you have trouble catching your breath?)

(4) sensations of shortness of breath or smothering

? 1 2 3

E35

. . .did you feel as if you were choking?

(5) feeling of choking

? 1 2 3

E36

. . .did you have chest pain or pressure?

(6) chest pain or discomfort

? 1 2 3

E37

. . .did you have nausea or upset stomach or the feeling that you were going to have diarrhea?

(7) nausea or abdominal distress

? 1 2 3

E38

<i>SCID-I (for DSM-IV-TR)</i>	<i>Panic Past Year (March 2012)</i>	<i>Anxiety Disorders</i>			<i>E.11</i>	
...did you feel dizzy, unsteady, or like you might faint?	(8) feeling dizzy, unsteady, light-headed or faint	?	1	2	3	E39
...did things around you seem unreal or did you feel detached from things around you or detached from part of your body?	(9) derealization (feelings of unreality) or depersonalization (being detached from oneself)	?	1	2	3	E40
...were you afraid you were going crazy or might lose control?	(10) fear of losing control or going crazy	?	1	2	3	E41
...were you afraid that you might die?	(11) fear of dying	?	1	2	3	E42
...did you have tingling or numbness in parts of your body?	(12) paresthesias (numbness or tingling sensations)	?	1	2	3	E43
...did you have flushes (hot flashes) or chills?	(13) chills or hot flushes	?	1	2	3	E44
	AT LEAST FOUR ITEMS CODED "3" AND REACHED A PEAK WITHIN 10 MINUTES (E31 CODED "3")		1		3	E45
		GO TO *AWOPD*, E.15				

?=inadequate information

1=absent or false

2=subthreshold

3=threshold or true

Just before you began having panic attacks, were you taking any drugs, caffeine, diet pills, or other medicines?

(How much coffee, tea, or caffeinated soda do you drink a day?)

Just before the attacks, were you physically ill?

IF YES: What did the doctor say?

C. Not due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or to a general medical condition

? 1 3

DUE TO SUBSTANCE USE OR GMC  
GO TO \*AWOPD\*, E.15

IF THERE IS ANY INDICATION THAT PANIC ATTACKS MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A GMC OR SUBSTANCE), GO TO \*ANXIETY DUE TO GMC/SUBSTANCE\* IN THE BACK OF THIS BOOKLET AND RETURN HERE TO MAKE A RATING OF "1" OR "3"

PRIMARY ANXIETY DISORDER

Etiological general medical conditions include: hyperthyroidism, hyperparathyroidism, pheochromocytoma, vestibular dysfunctions, seizure disorders, and cardiac conditions (e.g., arrhythmias, supraventricular tachycardia).

Etiological substances include: intoxication with central nervous stimulants (e.g., cocaine, amphetamines, caffeine) or cannabis or withdrawal from central nervous system depressants (e.g., alcohol, barbiturates) or from cocaine.

CONTINUE

D. The panic attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia, Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder, or Separation Anxiety Disorder.

? 1 3

A, C, AND D coded "3"

1 3  
GO TO \*AWOPD\*, E.15 PANIC DISORDER

E46

E47

E47a

**PANIC DISORDER WITH AGORAPHOBIA**

IF NOT OBVIOUS FROM OVERVIEW:  
Are there situations that make you nervous because you are afraid that you might have a panic attack?

Tell me about that.

IF CANNOT GIVE SPECIFICS:  
What about . . .

- . . .being uncomfortable if you're more than a certain distance from home?
- . . .being in a crowded place like a busy store, movie theatre, or restaurant?
- . . .standing in a line?
- . . .being on a bridge?
- . . .using public transportation--like a bus, train, or subway--or driving a car?

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---



---

Do you avoid these situations?

IF NO: When you are in one of these situations, do you feel very uncomfortable or like you might have a panic attack?

(Can you go into one of these situations only if you are with someone you know?)

---



---



---



---

B. The presence of Agoraphobia: ? 1 2 3

- (1) Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train or automobile.

PANIC DISORDER WITHOUT AGORAPHOBIA

GO TO \*SOCIAL PHOBIA\*, E.19

E48

- (2) Agoraphobic situations are avoided (e.g., travel is restricted), or else endured with marked distress or with anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.

? 1 2 3

PANIC DISORDER WITHOUT AGORAPHOBIA

GO TO \*SOCIAL PHOBIA\*, E.19

E49

(3) The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as Social Phobia (e.g., avoidance limited to social situations because of fear of embarrassment), Specific Phobia (e.g., avoidance limited to a single situation like elevators), Obsessive-Compulsive Disorder (e.g., avoidance of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., avoidance of leaving home or relatives).

? 1 3

E50

PANIC DISORDER WITHOUT AGORA-PHOBIA  
  
GO TO \*SOCIAL PHOBIA\*, E.19

NOTE: CONSIDER SPECIFIC PHOBIA IF FEAR IS LIMITED TO ONE OR ONLY A FEW SPECIFIC SITUATIONS OR SOCIAL PHOBIA IF FEAR IS LIMITED TO SOCIAL SITUATIONS

B(1), B(2), B(3) ALL CODED "3"

1 3

E51

PANIC DISORDER WITHOUT AGORA-PHOBIA IN PAST YEAR      PANIC DISORDER WITH AGORA-PHOBIA IN PAST YEAR

**\*AGORAPHOBIA WITHOUT HISTORY OF PANIC DISORDER (AWOPD)\* AGORAPHOBIA WITHOUT HISTORY OF PANIC DISORDER (AWOPD) CRITERIA**

IF MET PAST YEAR CRITERIA FOR PANIC DISORDER, CIRCLE 3 AND GO TO **\*SOCIAL PHOBIA\*** ON PAGE E.19.

<b>PANIC DISORDER</b>	
<u>NO</u>	<u>YES</u>
1	3

E52

IF CRITERIA FOR PAST YEAR PANIC DISORDER NOT MET, CIRCLE 1 AND CONTINUE:

IF SCREENING QUESTION #2 EQUALS 1, CIRCLE 1 AND GO TO **\*SOCIAL PHOBIA\*** ON PAGE E.19.

<b>SCREEN Q#2</b>	
<u>NO</u>	<u>YES</u>
1	3

E53

IF SCREENING QUESTION #2 EQUALS 2 or 3, CIRCLE 3 AND CONTINUE:

You've said that in the past year you have been afraid of going out of the house alone, being in crowds, standing in a line, or traveling on buses or trains . . .

A. The presence of Agoraphobia:

- (1) anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having panic-like symptoms (e.g., dizziness or diarrhea). Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or car.

What were you afraid could happen?

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---



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---



---

? 1 2 3

GO TO <b>*SOCIAL PHOBIA*</b> , E.19
---

E54

INDICATE FEARED SYMPTOM:



Do you avoid these situations?

IF NO: When you are in one of these situations, do you feel very uncomfortable or like you might have a panic attack?

(Can you go into one of these situations only if you are with someone you know?)

---



---

(2) Agoraphobic situations are avoided (e.g., travel is restricted), or else endured with marked distress or with anxiety about having panic-like symptoms, or require the presence of a companion.

? 1 2 3

GO TO  
\*SOCIAL  
PHOBIA\*,  
E. 19

E55

(3) The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as Social Phobia (e.g., avoidance limited to social situations because of fear of embarrassment), Specific Phobia (e.g., avoidance limited to single situations like elevators), Obsessive-Compulsive Disorder (e.g., avoidance of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of leaving home or relatives).

? 1 3

GO TO  
\*SOCIAL  
PHOBIA\*,  
E. 19

E56

NOTE: CONSIDER SPECIFIC PHOBIA IF FEAR IS LIMITED TO ONE OR ONLY A FEW SPECIFIC SITUATIONS, OR SOCIAL PHOBIA IF FEAR IS LIMITED TO SOCIAL SITUATIONS

A(1), A(2), A(3) ALL CODED "3"

1 3

GO TO  
\*SOCIAL  
PHOBIA\*,  
E. 19

E57

Just before you began having these fears, were you taking any drugs, caffeine, diet pills, or other medicines?

(How much coffee, tea, or caffeinated soda do you drink a day?)

Just before the fears began, were you physically ill?

IF YES: What did the doctor say?

---



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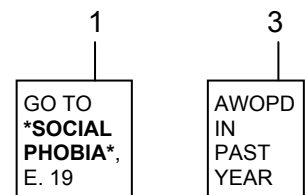
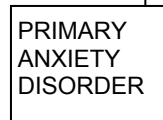
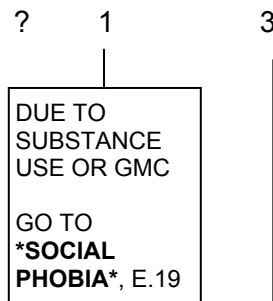
C. Not due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or to a general medical condition

IF THERE IS ANY INDICATION THAT THE ANXIETY MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A GMC OR SUBSTANCE), GO TO **\*ANXIETY DUE TO GMC/SUBSTANCE\*** IN THE BACK OF THIS BOOKLET, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

Etiological general medical conditions include hyper- and hypo-thyroidism, hypoglycemia, hyper-parathyroidism, pheochromocytoma, congestive heart failure, arrhythmias, pulmonary embolism, chronic obstructive pulmonary disease, pneumonia, hyperventilation, B-12 deficiency, porphyria, CNS neoplasms, vestibular dysfunction, encephalitis.

Etiological substances include intoxication with central nervous stimulants (e.g., cocaine, amphetamines, caffeine) or cannabis, hallucinogens, PCP, or alcohol, or withdrawal from central nervous system depressants (e.g., alcohol, sedatives, hypnotics) or from cocaine.

D. If an associated general medical condition is present, the fear described in criterion A is clearly in excess of that usually associated with the condition.



E58

E59

*This page has been intentionally left blank.*

**\*SOCIAL PHOBIA\***

**SOCIAL PHOBIA CRITERIA**

→ IF SCREENING QUESTION #3 EQUALS 1, CIRCLE 1 AND GO TO **\*SPECIFIC PHOBIA\***, ON PAGE E.23.

SCREEN Q#3	
<u>NO</u>	<u>YES</u>
1	3

E60

→ IF SCREENING QUESTION #3 EQUALS 2 OR 3, CIRCLE 3 AND CONTINUE:

You've said that during the past year there have been things that you are afraid to do in front of other people, like speaking, eating, or writing . . .

Tell me about it.

What are you afraid would happen when \_\_\_\_\_?

IF PUBLIC SPEAKING ONLY: (Do you think that you are more uncomfortable than most people are in that situation?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.

? 1 2 3

GO TO <b>*SPECIFIC PHOBIA*</b> , E.23
---------------------------------------

E61

Note: In adolescents, there must be evidence of capacity for age-appropriate relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.

Have you always felt anxious when you (CONFRONTED PHOBIC STIMULUS)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack.

? 1 2 3

GO TO <b>*SPECIFIC PHOBIA*</b> , E.23
---------------------------------------

E62

Did you think that you are more afraid of (PHOBIC ACTIVITY) than you should have been (or than made sense)?

C. The person recognizes that the fear is excessive or unreasonable. Note: in children, this feature may be absent.

? 1 2 3

GO TO \*SPECIFIC PHOBIA\*, E.23

E63

IF NOT OBVIOUS: Do you go out of your way to avoid \_\_\_\_\_?

D. The feared social or performance situations are avoided, or else endured with intense anxiety or distress.

? 1 2 3

GO TO \*SPECIFIC PHOBIA\*, E.23

E64

IF NO: How hard was it for you to \_\_\_\_\_?

IF UNCLEAR WHETHER FEAR WAS CLINICALLY SIGNIFICANT: How much does \_\_\_\_\_ interfere with your life?

E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

? 1 2 3

GO TO \*SPECIFIC PHOBIA\*, E.23

E65

IF DOES NOT INTERFERE WITH LIFE: How much has the fact that you have this fear bothered you?

F. NOTE: CRITERION F HAS BEEN OMITTED FROM THIS VERSION OF THE SCID.

Just before you began having these fears, were you taking any drugs, caffeine, diet pills, or other medicines?

(How much coffee, tea, or caffeinated soda did you drink a day?)

Just before the fears began, were you physically ill?

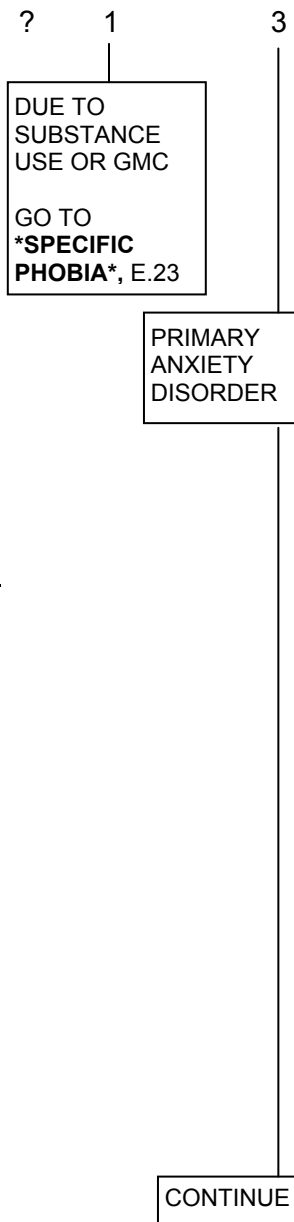
IF YES: What did the doctor say?

G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

IF THERE IS ANY INDICATION THAT THE ANXIETY MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF THE GMC OR SUBSTANCE), GO TO **\*ANXIETY DUE TO GMC/SUBSTANCE\*** IN THE BACK OF THIS BOOKLET, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

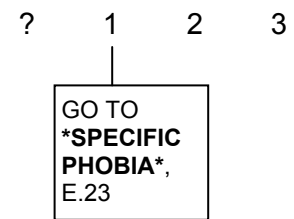
Etiological general medical conditions include: hyper- and hypo-thyroidism, hypoglycemia, hyper-parathyroidism, pheochromocytoma, congestive heart failure, arrhythmias, pulmonary embolism, chronic obstructive pulmonary disease, pneumonia, hyperventilation, B-12 deficiency, porphyria, CNS neoplasms, vestibular dysfunction, encephalitis.

Etiological substances include: intoxication with central nervous stimulants (e.g., cocaine, amphetamines, caffeine) or cannabis, hallucinogens, PCP, or alcohol, or withdrawal from central nervous system depressants (e.g., alcohol, sedatives, hypnotics) or from cocaine.



E66

... and is not better accounted for by another mental disorder (e.g., Panic Disorder Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).



E67

IF NOT ALREADY CLEAR: RETURN TO THIS ITEM AFTER COMPLETING INTERVIEW.

H. If a general medical condition or other mental disorder is present, the fear in A is unrelated to it, e.g., the fear is not of stuttering, trembling (in Parkinson's disease) or exhibiting abnormal eating behavior (in Anorexia Nervosa or Bulimia Nervosa).

? 1 2 3

GO TO \*SPECIFIC PHOBIA\*, E.23

E68

SOCIAL PHOBIA CRITERIA A, B, C, D, E, G, AND H ARE CODED "3"

1

3

GO TO \*SPECIFIC PHOBIA\*, E.23

SOCIAL PHOBIA IN PAST YEAR

E69

**\*SPECIFIC PHOBIA\***

**SPECIFIC PHOBIA CRITERIA**

IF SCREENING QUESTION #4 EQUALS 1, CIRCLE 1 AND GO TO **\*OCD/OBSESSIONS\*** ON PAGE E.27

SCREEN Q#4	
<u>NO</u>	<u>YES</u>
1	3

E70

IF SCREENING QUESTION #4 EQUALS 2 OR 3, CIRCLE 3 AND CONTINUE:

You've said that in the past year there have been other things that you've been especially afraid of, like flying, seeing blood, getting a shot, heights, closed places, or certain kinds of animals or insects . . .

Tell me about that.

What are you afraid would happen when (CONFRONTED WITH PHOBIC STIMULUS)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A. Marked and persistent fear that is excessive or unreasonable, ? 1 2 3  
 cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

GO TO <b>*OCD/OBSESSION*</b> , E.27
-------------------------------------

E71

Have you always felt frightened when you (CONFRONTED PHOBIC STIMULUS)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack. ? 1 2 3

GO TO <b>*OCD/OBSESSION*</b> , E.27
-------------------------------------

E72

Did you think that you are more afraid of (PHOBIC STIMULUS) than you should have been (or than made sense)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. The person recognizes that the fear is excessive or unreasonable. ? 1 2 3

GO TO <b>*OCD/OBSESSION*</b> , E.27
-------------------------------------

E73



Do you go out of your way to avoid (PHOBIC STIMULUS)?

D. The phobic situation(s) is avoided, or else endured with intense anxiety or distress.

? 1 2 3

E74

(Are there things you don't do because of this fear that you would otherwise have done?)

GO TO \*OCD/OBSESSION\*, E.27

IF NO: How hard is it for you to (CONFRONT PHOBIC STIMULUS)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IF UNCLEAR WHETHER FEAR WAS CLINICALLY SIGNIFICANT: How much does (PHOBIA) interfere with your life?

E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

? 1 2 3

E75

(Is there anything you've avoided because of being afraid of [PHOBIC STIMULUS])?

GO TO \*OCD/OBSESSION\*, E.27

IF DOES NOT INTERFERE WITH LIFE: How much has the fact that you were afraid of (PHOBIC STIMULUS) bothered you?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NOTE: CRITERION F HAS BEEN OMITTED FROM THIS VERSION OF THE SCID.

IF NOT ALREADY CLEAR:  
RETURN TO THIS ITEM AFTER  
COMPLETING SECTION ON PTSD  
AND OBSESSIVE-COMPULSIVE  
DISORDER.

G. The anxiety, panic attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g. avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e. g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder.

? 1 3

E76

GO TO \*  
**OCD/  
OBSESSION\***,  
E.27

SPECIFIC PHOBIA CRITERIA A, B,  
C, D, E, AND G ARE CODED "3."

1

3

E77

GO TO \* **OCD/  
OBSESSION\***, E.27

**SPECIFIC  
PHOBIA  
PAST  
YEAR**

*This page has been intentionally left blank.*

**\*OBSESSIVE COMPULSIVE DISORDER\***

**OBSESSIVE COMPULSIVE DISORDER CRITERIA**

SCREEN Q#5	
<u>NO</u>	<u>YES</u>
1	3

E78

IF SCREENING QUESTION #5 EQUALS 1, CIRCLE 1 AND GO TO \*COMPULSIONS\* ON PAGE E.29

IF SCREENING QUESTION #5 EQUALS 2 OR 3, CIRCLE 3 AND CONTINUE: You've said that in the past year that you have had thoughts that didn't make any sense and kept coming back to you even when you tried not to have them . . .

A. Either obsessions or compulsions:

(What were they?)

Obsessions as defined by (1), (2), (3) and (4)

IF SUBJECT NOT SURE WHAT IS MEANT: . . . Thoughts like hurting someone, even though you really didn't want to or being contaminated by germs or dirt?

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate, and that cause marked anxiety or distress

? 1 2 3

E79

(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems.

? 1 2 3

E80

When you had these thoughts, did you try hard to get them out of your head? (What would you try to do?)

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.

? 1 2 3

E81

IF UNCLEAR: Where did you think these thoughts were coming from?

(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

? 1 2 3

E82

OBSESSIONS

NO OBSESSIONS GO TO \*COMPULSIONS\*, E.29

DESCRIBE CONTENT OF OBSESSIONS:

*This page has been intentionally left blank.*

**\*COMPULSIONS\***

IF SCREENING QUESTION #6 EQUALS 1, CIRCLE 1 AND GO TO **\*CHECK FOR OBSESSIONS/COMPULSIONS\*** ON PAGE E.30 (TOP OF NEXT PAGE)

SCREEN Q#6	
<u>NO</u>	<u>YES</u>
1	3

E83

IF SCREENING QUESTION #6 EQUALS 2 OR 3, CIRCLE 3 AND CONTINUE:

You've said that in that past year there were things that you had to do over and over again and couldn't resist doing, like washing your hands again and again, counting up to a certain number or checking something several times to make sure that you had done it right . . .

(What did you have to do?)

Compulsions as defined by (1) and (2)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(1) repetitive behaviors (e. g., handwashing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

? 1 2 3

E84

IF UNCLEAR: Why did you have to do (COMPULSIVE ACT?) What would happen if you didn't do it?

IF UNCLEAR: How many times would you do (COMPULSIVE ACT)? How much time a day would you spend doing it?

\_\_\_\_\_  
\_\_\_\_\_

(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive

? 1 2 3

E85

COMPULSIONS

GO TO **\*CHECK FOR OBSESSIONS / COMPULSIONS\***, E.30 (TOP OF NEXT PAGE)

DESCRIBE CONTENT OF COMPULSION(S)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*CHECK FOR OBSESSIONS/COMPULSIONS\***

IF NEITHER OBSESSIONS NOR COMPULSIONS, CIRCLE 1 AND GO TO **\*GENERALIZED ANXIETY\*** ON PAGE E.33

IF EITHER OBSESSIONS, OR COMPULSIONS, OR BOTH, CIRCLE 3 AND CONTINUE:

OBSESSIONS/ COMPULSIONS	
<u>NO</u>	<u>YES</u>
1	3

E86

Do you (think about [OBSESSIVE THOUGHTS]/do [COMPULSIVE ACTS]) more than you should have (or than makes sense)?

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: this does not apply to children.

? 1 2 3

E87

GO TO **\*GAD\***, E.33

IF NO: How about when you first started having this problem?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E88

Check here \_\_\_ if **With Poor Insight:** i.e., for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

What effect has this (OBSESSION OR COMPULSION) had on your life? (Did [OBSESSION OR COMPULSION] bother you a lot?)

C. The obsessions or compulsions cause marked distress, are time-consuming (take more than an hour a day), or significantly interfere with the person's normal routine, occupational functioning, or usual social activities or relationships.

? 1 2 3

E89

GO TO **\*GAD\***, E.33

(How much time have you spent on [OBSESSION OR COMPULSION])?

\_\_\_\_\_  
\_\_\_\_\_

IF NOT ALREADY CLEAR: RETURN TO THIS ITEM AFTER COMPLETING INTERVIEW

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia, or guilty ruminations in the presence of Major Depressive Disorder).

? 1 3

GO TO \*GAD\*, E.33

E90

Just before you began having (OBSESSIONS OR COMPULSIONS) were you taking any drugs or medicines?

E. Not due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or to a general medical condition

? 1 3

DUE TO SUBSTANCE USE OR A GMC  
GO TO \*GAD\*, E.33

E91

Just before the (OBSESSIONS OR COMPULSIONS) started, were you physically ill? (What did the doctor say?)

IF THERE IS ANY INDICATION THAT THE OBSESSIONS OR COMPULSIONS MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A GMC OR SUBSTANCE), GO TO \*ANXIETY DUE TO GMC/SUBSTANCE,\* IN THE BACK OF THIS BOOKLET, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

PRIMARY ANXIETY DISORDER

Etiological general medical conditions include: certain CNS neoplasms.

Etiological substances include: intoxication with central nervous system stimulants (e.g., cocaine, amphetamines)

CONTINUE

OBSESSIVE COMPULSIVE DISORDER CRITERIA A, B, C, D, AND E ARE CODED "3"

1 3  
GO TO \*GAD\*, E. 33  
OBSESSIVE COMPULSIVE DISORDER IN PAST YEAR

E92



*This page has been intentionally left blank.*

**\*GENERALIZED ANXIETY DISORDER\* GENERALIZED ANXIETY DISORDER CRITERIA**

IF SCREENING QUESTION #7 EQUALS 1, CIRCLE 1 AND GO TO \*ANOREXIA\* ON PAGE F.1.

SCREEN Q#7	
<u>NO</u>	<u>YES</u>
1	3

E93

IF SCREENING QUESTION #7 EQUALS 2 OR 3, CIRCLE 3 AND CONTINUE:  
You've said that in the last year there have been times you've been particularly nervous or anxious . . .

Do you also worry a lot about bad things that might happen?

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least six months, about a number of events or activities (such as work or school performance)

? 1 2 3

E94

IF YES: What do you worry about? (How much do you worry about [EVENTS OR ACTIVITIES]?)

GO TO *ANOREXIA*, F.1
-----------------------

Has there been a six month period of time in the past year when you were worrying for more days than not?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When you're worrying this way, do you find that it's hard to stop yourself?

B. The person finds it difficult to control the worry.

? 1 2 3

E95

GO TO *ANOREXIA*, F.1
-----------------------

When did this anxiety start? COMPARE ANSWER WITH ONSET OF MOOD OR PSYCHOTIC DISORDER.

F(2). Does not occur exclusively during the course of a Mood Disorder, Psychotic Disorder, or a Pervasive Developmental Disorder

? 1 3

E96

GO TO *ANOREXIA*, F.1
-----------------------

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Now I am going to ask you some questions about symptoms that often go along with being nervous.

Thinking about those periods in the past year when you're feeling nervous or anxious . . .

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past six months):

---



---

. . . do you often feel physically restless--can't sit still?

(1) restlessness or feeling keyed up or on edge      ?      1      2      3      E97

---



---

. . . do you often feel keyed up or on edge?

---



---

. . . do you often tire easily?

(2) being easily fatigued      ?      1      2      3      E98

---



---

. . . do you have trouble concentrating or does your mind go blank?

(3) difficulty concentrating or mind going blank      ?      1      2      3      E99

---



---

. . . are you often irritable?

(4) irritability      ?      1      2      3      E100

---



---

. . . are your muscles often tense?

(5) muscle tension      ?      1      2      3      E101

---



---

... do you often have trouble falling or staying asleep?

(6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

? 1 2 3

E102

---



---

? 1 2 3

E103

AT LEAST THREE "C" SXS ARE CODED "3"

GO TO  
\*ANOREXIA\*,  
F.1

CODE BASED ON PREVIOUS INFORMATION

D. The focus of the anxiety and worry is not confined to the features of another Axis I Disorder, e.g., the anxiety or worry is not about having a panic attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety or worry do not occur exclusively during Posttraumatic Stress Disorder.

? 1 3

E104

GO TO  
\*ANOREXIA\*,  
F.1

IF UNCLEAR: What effect has the anxiety, worry, or (PHYSICAL SYMPTOMS) had on your life? (Has it made it hard for you to do your work or be with your friends?)

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

? 1 2 3

E105

GO TO  
\*ANOREXIA\*,  
F.1

---



---



---

Just before you began having this anxiety, were you taking any drugs, caffeine, diet pills, or other medicines?

(How much coffee, tea, or caffeinated soda do you drink a day?)

Just before these problems began, were you physically ill?

IF YES: What did the doctor say?

F. Not due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or to a general medical condition

? 1 3 E106

IF THERE IS ANY INDICATION THAT THE ANXIETY MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF A GMC OR SUBSTANCE), GO TO **\*ANXIETY DUE TO GMC/SUBSTANCE\*** IN THE BACK OF THIS BOOKLET, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

DUE TO SUBSTANCE USE OR A GMC  
GO TO **\*ANOREXIA\***, F.1

PRIMARY ANXIETY DISORDER

Etiological general medical conditions include: hyper- and hypo-thyroidism, hypoglycemia, hyper-parathyroidism, pheochromocytoma, congestive heart failure, arrhythmias, pulmonary embolism, chronic obstructive pulmonary disease, pneumonia, hyperventilation, B-12 deficiency, porphyria, CNS neoplasms, vestibular dysfunction, encephalitis.

Etiological substances include: intoxication with central nervous stimulants (e.g., cocaine, amphetamines, caffeine) or cannabis, hallucinogens, PCP, or alcohol or withdrawal from central nervous system depressants (e.g., alcohol, sedatives, hypnotics) or from cocaine.

CONTINUE

GENERALIZED ANXIETY CRITERIA A, B, C, D, E AND F ARE CODED "3"

1 3 E107  
GO TO **\*ANOREXIA\***, F.1  
GENERALIZED ANXIETY DISORDER

F. EATING DISORDERS

\*ANOREXIA NERVOSA\*

ANOREXIA NERVOSA CRITERIA

IF SCREENING QUESTION #8 EQUALS 1, CIRCLE 1 AND GO TO \*BULIMIA\* ON PAGE F.3

IF SCREENING QUESTION #8 EQUALS 2 OR 3, CIRCLE 3 AND CONTINUE: You've said that there was a time in the past year When you weighed much less than other people thought you ought to weigh . . .

SCREEN Q#8 NO 1 YES 3

F1

Why was that? How much did you weigh? How tall are you?

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected)

? 1 2 3 GO TO \*BULIMIA\*, F.3

F2

At that time, were you very afraid that you could become fat?

B. Intense fear of gaining weight or becoming fat, even though underweight.

? 1 2 3 GO TO \*BULIMIA\*, F.3

F3

At your lowest weight, did you still feel too fat or that part of your body was too fat?

IF NO: Did you need to be very thin in order to feel good about yourself?

IF NO AND LOW WEIGHT IS MEDICALLY SERIOUS: When you were that thin, did anybody tell you it could be dangerous to your health to be that thin? (What did you think?)

C. Disturbance in the way in which one's body weight or shape is experienced; undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight

? 1 2 3 GO TO \*BULIMIA\*, F.3

F4

FOR FEMALES: Before this time, were you having your periods? Did they stop? (For how long?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. In postmenarchal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is still considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration)

? 1 2 3

GO TO \*BULIMIA\*, F.3

F5

ANOREXIA NERVOSA CRITERIA A, B, C, AND D ARE CODED "3"

1 3

GO TO \*BULIMIA\*, F.3

ANOREXIA NERVOSA PAST YEAR

F6

**\*BULIMIA NERVOSA\***

**BULIMIA NERVOSA CRITERIA**

IF CRITERIA MET FOR ANOREXIA NERVOSA, CIRCLE 3 AND GO TO **\*IED\*** ON PAGE G.1.

<b>ANOREXIA NERVOSA</b>	
<u>NO</u>	<u>YES</u>
1	3

F7

IF CRITERIA NOT MET FOR ANOREXIA NERVOSA, CIRCLE 1 AND CONTINUE.

IF SCREENING QUESTION #9 EQUALS 1, CIRCLE 1 AND GO TO **\*IED\*** ON PAGE G.1.

<b>SCREEN Q#9</b>	
<u>NO</u>	<u>YES</u>
1	3

F8

IF QUESTION #9 EQUALS 2 OR 3, CIRCLE 3 AND CONTINUE:  
You've said that in the past year, you've often had times when your eating was out of control. Tell me about those times.

---



---



---

A. Recurrent episodes of binge eating.  
An episode of binge eating is characterized by BOTH of the following:

? 1 2 3

F9

(2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

?	1	2	3
GO TO <b>*IED*</b> , G.1			

IF UNCLEAR: During these times, do you often eat within any two hour period what most people would regard as an unusual amount of food? Tell me about that.

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(1) eating, in a discrete period of time (e.g., within any two hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

? 1 2 3

F10

?	1	2	3
GO TO <b>*IED*</b> , G.1			

Did you do anything to counteract the effects of eating that much? (Like making yourself vomit, taking laxatives, enemas or water pills, strict dieting or fasting, or exercising a lot?)

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---

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as: self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

? 1 2 3

F11

?	1	2	3
GO TO <b>*IED*</b> , G.1			



How often were you eating that much (AND COMPENSATORY BEHAVIOR)? (At least twice a week for at least three months?)

Four horizontal lines for handwritten response.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for three months.

? 1 2 3  
GO TO \*IED\*, G.1

F12

Were your body shape and weight among the most important things that affected how you felt about yourself?

Two horizontal lines for handwritten response.

D. Self-evaluation is unduly influenced by body shape and weight.

? 1 2 3  
GO TO \*IED\*, G.1

F13

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa

? 1 3  
GO TO \*IED\*, G.1

F14

BULIMIA NERVOSA CRITERIA A, B, C, D AND E ARE CODED "3"

1 3  
GO TO \*IED\*, G.1  
BULIMIA NERVOSA PAST YEAR

F15

**G. INTERMITTENT EXPLOSIVE DISORDER**

**INTERMITTENT EXPLOSIVE DISORDER CRITERIA**

In the past year, that is since (CURRENT DATE) 2011, have you had times when you lost control of your anger, resulting in your hitting or seriously threatening someone or damaging things?

IF YES: What did you do?  
When did you do it? How often did it happen?

DESCRIBE ASSAULTIVE ACTS:

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What happened that set you off? (Do you think your reaction was much stronger than it should have been given the circumstances?) (Has anyone told you that your reaction was way off-base given the situation?)

---



---

Did this happen only when you were drinking or using drugs?

Did this happen only when you were sick with a medical illness?

IF HX OF MANIA OR PSYCHOSIS:  
Did this happen only when you were feeling excited or irritable or only when you were (PSYCHOTIC SXS)?

(Did you do [ASSAULTIVE ACTS] because you were hearing voices or because your thinking was confused?)

(Did you do [ASSAULTIVE ACTS] on purpose or was it really beyond your control?)

---

A. Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.

? 1 2 3

GO TO  
\*ALCOHOL  
USE  
DISORDERS\*,  
H.1

G1

B. The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating psychosocial stressors.

? 1 2 3

GO TO  
\*ALCOHOL  
USE  
DISORDERS\*,  
H.1

G2

C. The aggressive episodes are not better accounted for by Antisocial Personality Disorder, Borderline Personality Disorder, a psychotic disorder, a Manic Episode, Conduct Disorder, or Attention-Deficit/ Hyperactivity Disorder and are not due to the physiological effects of a substance or a general medical condition.

? 1 2 3

GO TO  
\*ALCOHOL  
USE  
DISORDERS\*,  
H.1

G3

ITEMS A, B, AND C ARE CODED "3"

1

3

G4

GO TO  
**\*ALCOHOL  
USE  
DISORDERS\***,  
H.1

INTER-  
MITTENT  
EXPLOSIVE  
DISORDER  
PAST YEAR

**H. SUBSTANCE USE DISORDERS**

RECORD TYPICAL WEEKLY PATTERN OF USE:

**\*ALCOHOL USE DISORDERS (PAST YEAR)\***

Next I'd like to ask about your use of alcohol. What have your drinking habits been like in the past year? (How much do you drink?) (Have there been any times in the past year when you had five or more drinks on one occasion?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When in the past year were you drinking the most? (How long did that period last?)

RECORD DATE OF HEAVIEST USE AND DESCRIBE PATTERN

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

During that time . . .

how often were you drinking?

what were you drinking? how much?

\_\_\_\_\_  
\_\_\_\_\_

During that time . . .

did your drinking cause problems for you?

did anyone object to your drinking?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

→ IF R HAS NOT DRUNK AT LEAST 6 DRINKS IN THE PAST YEAR, CIRCLE THE 1 AND SKIP TO **\*NON-ALCOHOL SUBSTANCE USE DISORDERS\***, H. 9

1 3

→ IF R HAS DRUNK AT LEAST 6 DRINKS IN THE PAST YEAR, CIRCLE THE 3 AND CONTINUE TO NEXT PAGE.

H1

**ALCOHOL DEPENDENCE**

**ALCOHOL DEPENDENCE CRITERIA**

I'd now like to ask you some more questions about (TIME IN PAST YEAR WHEN DRINKING THE MOST OR TIME WHEN DRINKING CAUSED MOST PROBLEMS).

A maladaptive pattern of alcohol use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following occurring at any time in the same twelve month period:

During that time...

NOTE: CRITERIA FOR ALCOHOL DEPENDENCE ARE NOT IN DSM-IV-TR ORDER

...did you often find that when you started drinking you ended up drinking much more than you were planning to? (Tell me about that.)

(3) alcohol is often taken in larger amounts OR over a longer period than was intended      ?      1      2      3

H2

IF NO: What about drinking for a much longer period of time than you were planning to?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

...did you try to cut down or stop drinking alcohol?

(4) there is a persistent desire OR unsuccessful efforts to cut down or control alcohol use      ?      1      2      3

H3

IF YES: Did you actually stop drinking altogether?

(How many times did you try to cut down or stop altogether?)

IF NO: Did you want to stop or cut down? (Is this something you kept worrying about?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SCID-I (for DSM-IV-TR)

Alcohol Use Disorders Past Year (March 2012)

SUDs

H.3

...did you spend a lot of time drinking, being high, or hung over? (How much time?)

(5) a great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects

? 1 2 3

H4

...did you have times when you would drink so often that you started to drink instead of working or spending time at hobbies or with your family or friends, or engaging in other important activities, such as sports, gardening, or playing music?

(6) important social, occupational, or recreational activities given up or reduced because of alcohol use

? 1 2 3

H5

IF NOT ALREADY KNOWN: During that time did your drinking cause any psychological problems like making you depressed or anxious, making it difficult to sleep, or causing "blackouts?"

(7) alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

? 1 2 3

H6

IF NOT ALREADY KNOWN: Did your drinking cause significant physical problems or made a physical problem worse?

IF YES TO EITHER OF ABOVE: Did you keep on drinking anyway?

Have you found that you needed to drink a lot more in order to get the feeling you wanted than you did when you first started drinking?

IF YES: How much more?

IF NO: What about finding that when you drank the same amount, it had much less effect than before?

---



---



---

(1) tolerance, as defined by either of the following:

(a) a need for markedly increased amounts of alcohol to achieve intoxication or desired effect

(b) markedly diminished effect with continued use of the same amount of alcohol

? 1 2 3

H7

During the past year have you had any withdrawal symptoms when you cut down or stopped drinking like . . .

. . . sweating or racing heart?

. . . hand shakes?

. . . trouble sleeping?

. . . feeling nauseated or vomiting?

. . . feeling agitated?

. . . or feeling anxious?

(How about having a seizure or seeing, feeling, or hearing things that weren't really there?)

---



---

(2) withdrawal, as manifested by either (a) or (b):

(a) at least TWO of the following:

- autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)
- increased hand tremor
- insomnia
- nausea or vomiting
- psychomotor agitation
- anxiety

- grand mal seizures
- transient visual, tactile, or auditory hallucinations or illusions

? 1 2 3

H8

IF NO: During the past year, have you ever started the day with a drink, or did you often drink or take some other drug or medication to keep yourself from getting the shakes or becoming sick?

(b) alcohol (or a substance from the sedative / hypnotic / anxiolytic class) taken to relieve or avoid withdrawal symptoms

---



---

AT LEAST THREE  
DEPENDENCE ITEMS CODED  
"3" AND ITEMS OCCURRED IN  
THE PAST YEAR

1

3

H9

ALCOHOL  
DEPENDENCE  
  
GO TO  
\*ALCOHOL  
ABUSE\*, H.6

GO TO \*ALCOHOL  
ABUSE\*, H.6



**\*PAST YEAR ALCOHOL ABUSE\***

**ALCOHOL ABUSE CRITERIA**

Let me ask you a few more questions about (TIME IN PAST YEAR WHEN DRINKING THE MOST OR TIME WHEN DRINKING CAUSED MOST PROBLEMS).

A. A maladaptive pattern of alcohol use, leading to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a twelve month period:

During that time...

...did you miss work or school because you were intoxicated, high, or very hung over? (What about doing a bad job at work or failing courses at school because of your drinking?)

(1) Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household).

? 1 2 3

H10

IF NO: What about not keeping your house clean [IF CHILDREN: or not taking proper care of your children] because of your drinking?

IF YES TO EITHER: How often? (Over what period of time?)

---

---

---

---

...did you drink in a situation in which it might have been dangerous to drink at all? (In the past year have you driven while you were really too drunk to drive?)

(2) Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol use)

? 1 2 3

H11

IF YES AND UNKNOWN: How many times? (When?)

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---

During the past year has your drinking gotten you into trouble with the law?

(3) recurrent alcohol-related legal problems (e.g., arrests for alcohol-related disorderly conduct)

? 1 2 3

H12

IF YES AND UNKNOWN: How often? (Over what period of time?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IF NOT ALREADY KNOWN: Did your drinking cause problems with other people, such as with family members, friends, or people at work? Did you get into physical fights when you were drinking? What about having bad arguments about what happens when you drink too much?

(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

? 1 2 3

H13

IF YES: Did you keep on drinking anyway? (Over what period of time?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

AT LEAST ONE "A" ITEM CODED "3"

1 3

H14

GO TO \*NON-ALCOHOL SUBSTANCE USE DISORDERS\*, H.9

ALCOHOL ABUSE  
GO TO \*NON-ALCOHOL SUBSTANCE USE DISORDERS\*, H.9

*This page has been intentionally left blank.*

**\*NON-ALCOHOL SUBSTANCE USE DISORDERS\*  
(PAST YEAR DEPENDENCE AND ABUSE)**

Now I am going to ask you about your use of drugs or medicines in the past 12 months.

CIRCLE THE NAME OF EACH DRUG USED IN THE PAST YEAR (OR WRITE IN NAME IF "OTHER")

RECORD PATTERN OF USUAL USE AND PERIOD/PATTERN OF HEAVIEST USE (INCLUDING DATE AND DURATION)

INDICATE PAST YEAR USE LEVEL\*

In the past 12 months have you taken any pills to calm you down or mellow you out or to help you sleep - drugs like Valium, Xanax, Ativan, Klonopin, Rohypnol or "roofies", Ambien, Sonata, Lunesta, Halcion, or Restoril?

**Sedatives-hypnotics-anxiolytics:**

1 3

H15

How about stimulants or "uppers", like speed, methamphetamine, crystal meth, "crank", Ritalin, dexadrine, Adderall or prescription diet pills?

**Stimulants:**

1 3

H16

How about prescription pain relievers like morphine, codeine, Darvocet, Darvon, Tylenol with Codeine, Percocet, Percodan, Tylox, Vicodin, Lortab, Lorcet, OxyContin, or any other prescription pain reliever?

**Opioids:**

1 3

H17

How about marijuana (pot, grass, weed) or hashish?

**Cannabis:**

1 3

H18

How about heroin?

**Heroin:**

1 3

H19

How about cocaine, "crack", or freebase?

**Cocaine:**

1 3

H20

How about LSD, "acid", PCP, peyote, mescaline, psilocybin, Ecstasy, Ketamine or other hallucinogens?

**Hallucinogens/PCP**

1 3

H21

How about sniffing glue, paint, correction fluid, "poppers," gasoline, laughing gas or other inhalants to get high?

**Inhalants:**

1 3

H22

\*FOR ANY DRUG CLASS USED NONMEDICALLY MORE THAN ONCE (FOR CANNABIS, THRESHOLD IS AT LEAST 6 TIMES) IN THE PAST YEAR, CIRCLE 3 FOR USE LEVEL. FOR ALL OTHERS, CIRCLE 1.

\*FOR PRESCRIBED MEDICATIONS, CIRCLE 3 IF SUBJECT REPORTS BEING DEPENDENT ON A PRESCRIBED DRUG OR USING MORE THAN WAS PRESCRIBED.

IF NO DRUG CLASSES HAVE A 3 CIRCLED FOR PAST YEAR USE LEVEL, CIRCLE 1 AND GO TO **\*ADJUSTMENT DISORDER\***, J.1.

1

3

H23

IF ANY DRUG CLASS HAS A 3 CIRCLED FOR LEVEL OF USE, CIRCLE 3 AND CONTINUE.

**\*SUBSTANCE DEPENDENCE\***

**SUBSTANCE DEPENDENCE CRITERIA**

I'd now like to ask you some more questions about (TIME IN THE PAST YEAR WHEN YOU WERE USING THE MOST DRUG[S] / YOUR USE OF DRUG[S] DURING THE PAST 12 MONTHS).

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following occurring at any time in the same twelve month period:

During that time...

NOTE: CRITERIA FOR SUBSTANCE DEPENDENCE ARE NOT IN DSM-IV-TR ORDER

...did you often find that when you started using (DRUG[S]) you ended up using much more of it than you were planning to? (Tell me about it.)

(3) substance is often taken in larger amounts OR over a longer period than was intended

SED	?	1	2	3	H24
STIM	?	1	2	3	H25
OPI	?	1	2	3	H26
CAN	?	1	2	3	H27
HER	?	1	2	3	H28
COC	?	1	2	3	H29
HAL	?	1	2	3	H30
INH	?	1	2	3	H31

IF NO: What about using it over a much longer period of time than you were planning to?

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...did you try to cut down or stop using (DRUG[S])?

(4) there is a persistent desire OR unsuccessful efforts to cut down or control substance use

SED	?	1	2	3	H32
STIM	?	1	2	3	H33
OPI	?	1	2	3	H34
CAN	?	1	2	3	H35
HER	?	1	2	3	H36
COC	?	1	2	3	H37
HAL	?	1	2	3	H38
INH	?	1	2	3	H39

→ IF YES: In the past year, did you ever actually stop using (DRUG[S]) altogether?

(How many times did you try to cut down or stop altogether?)

→ IF NO: Did you want to stop or cut down? (Is this something you kept worrying about?)

---



---



---

<p>...did you spend a lot of time using (DRUG[S]) or doing whatever you had to do to get it? Did it take you a long time to get back to normal? (How much time?)</p> <hr/> <hr/> <hr/>	(5) a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects	SED	?	1	2	3	H40
		STIM	?	1	2	3	H41
		OPI	?	1	2	3	H42
		CAN	?	1	2	3	H43
		HER	?	1	2	3	H44
		COC	?	1	2	3	H45
		HAL	?	1	2	3	H46
		INH	?	1	2	3	H47
<p>...did you often have times when you would use (DRUG[S]) so often that you used (DRUG[S]) instead of working or spending time with your family or friends or engaging in other important activities, such as sports, gardening, or playing music?</p> <hr/> <hr/> <hr/>	(6) important social, occupational, or recreational activities given up or reduced because of substance use	SED	?	1	2	3	H48
		STIM	?	1	2	3	H49
		OPI	?	1	2	3	H50
		CAN	?	1	2	3	H51
		HER	?	1	2	3	H52
		COC	?	1	2	3	H53
<p>IF NOT ALREADY KNOWN: Did [DRUG(S)] cause any psychological problems like making you depressed, agitated, or paranoid?</p> <p>IF NOT ALREADY KNOWN: Did [DRUG(S)] cause any significant physical problems or make a physical problem worse?</p> <p>IF YES TO EITHER OF ABOVE: Did you keep on using (DRUG[S]) anyway?</p> <hr/> <hr/> <hr/>	(7) substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., recurrent cocaine use despite recognition of depression)	SED	?	1	2	3	H56
		STIM	?	1	2	3	H57
		OPI	?	1	2	3	H58
		CAN	?	1	2	3	H59
		HER	?	1	2	3	H60
<hr/> <hr/> <hr/>		COC	?	1	2	3	H61
		HAL	?	1	2	3	H62
		INH	?	1	2	3	H63

<p>Have you found that you needed to use a lot more (DRUG[S]) in order to get the feeling you wanted than you did when you first started using it?</p> <p>→ IF YES: How much more?</p> <p>→ IF NO: What about finding that when you used the same amount, it had much less effect than before?</p> <hr/> <hr/> <hr/>	<p>(1) tolerance, as defined by either of the following:</p> <p>(a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect</p> <p>(b) markedly diminished effect with continued use of the same amount of the substance</p>	SED	?	1	2	3	H64		
		STIM	?	1	2	3	H65		
		OPI	?	1	2	3	H66		
		CAN	?	1	2	3	H67		
		HER	?	1	2	3	H68		
		COC	?	1	2	3	H69		
		HAL	?	1	2	3	H70		
		INH	?	1	2	3	H71		
		<p>In the past year, have you had any withdrawal symptoms, that is, felt sick when you cut down or stopped using (DRUG[S])?</p> <p>→ IF YES: What symptoms did you have? REFER TO LIST OF WITHDRAWAL SYMPTOMS ON H.18</p> <p>→ IF NO: After not using (DRUG[S]) for a few hours or more, did you sometimes use it to keep yourself from getting sick with (WITHDRAWAL SYMPTOMS)?</p> <hr/> <hr/> <hr/>	<p>(2) withdrawal, as manifested by either of the following:</p> <p>(a) the characteristic withdrawal syndrome for the substance</p> <p>(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms</p>	SED	?	1	2	3	H72
				STIM	?	1	2	3	H73
OPI	?			1	2	3	H74		
CAN	?			1	2	3	H75		
HER	?			1	2	3	H76		
COC	?			1	2	3	H77		
HAL	?			1	2	3	H78		
INH	?			1	2	3	H79		



<i>SCID-I (for DSM-IV-TR)</i>	<i>Non-Alcohol SUDs Past Year (March 2012)</i>		<i>SUDs</i>		<i>H. 14</i>
IF UNKNOWN: When did (SXS CODED "3" ABOVE) occur? (Did they all happen around the same time?)	AT LEAST THREE DEPENDENCE ITEMS CODED "3" AND ITEMS OCCURRED WITHIN THE SAME TWELVE MONTH PERIOD	SED	1	3	H80
		STIM	1	3	H81
		OPI	1	3	H82
		CAN	1	3	H83
		HER	1	3	H84
		COC	1	3	H85
		HAL	1	3	H86
		INH	1	3	H87
				Substance Dependence	

?=inadequate information

1=absent or false

2=subthreshold

3=threshold or true

**\*NON-ALCOHOL SUBSTANCE ABUSE PAST YEAR\***

Now I'd like to ask you some questions about (TIME IN THE PAST YEAR WHEN USED DRUG[S] THE MOST / YOUR USE OF DRUG[S] DURING THE PAST 12 MONTHS).

During that time...

...did you miss work or school because you were very high or very hung over? (What about doing a bad job at work or failing courses at school because you used [DRUG(S)]?)

IF NO: What about not keeping your house clean [IF CHILDREN: or not taking proper care of your children] because of using (DRUG[S])?

IF YES TO EITHER: How often? (Over what period of time?)

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---

...have you used (DRUG[S]) in a situation in which it might have been dangerous to be using (DRUG[S]) at all? During the past year, have you driven while you were really too high to drive?)

IF YES AND UNKNOWN: How many times? (When?)

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**NON-ALCOHOL SUBSTANCE ABUSE CRITERIA**

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a twelve month period:

(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use;	SED	?	1	2	3	H88
substance-related absences, suspensions, or expulsions from school; neglect of children or household)	STIM	?	1	2	3	H89
	OPI	?	1	2	3	H90
	CAN	?	1	2	3	H91
	HER	?	1	2	3	H92
	COC	?	1	2	3	H93
	HAL	?	1	2	3	H94
	INH	?	1	2	3	H95
(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)	SED	?	1	2	3	H96
	STIM	?	1	2	3	H97
	OPI	?	1	2	3	H98
	CAN	?	1	2	3	H99
	HER	?	1	2	3	H100
	COC	?	1	2	3	H101
	HAL	?	1	2	3	H102
	INH	?	1	2	3	H103

SCID-I (for DSM-IV-TR)	Non-Alcohol SUDs Past Year (March 2012)	SUDs	H. 16			
...has your use of (DRUG[S]) gotten you into trouble with the law?  IF YES AND UNKNOWN: How often? (Over what period of time?)  <hr/> <hr/> <hr/>	(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)	SED	? 1 2 3	H104		
		STIM	? 1 2 3	H105		
		OPI	? 1 2 3	H106		
		CAN	? 1 2 3	H107		
		HER	? 1 2 3	H108		
		COC	? 1 2 3	H109		
		HAL	? 1 2 3	H110		
		INH	? 1 2 3	H111		
		IF NOT ALREADY KNOWN: Has your use of (DRUG[S]) caused problems with other people, such as with family members, friends, or people at work? (Did you get into physical fights or bad arguments about your [DRUG(S)] use?)  IF YES: Did you keep on using (DRUG[S]) anyway? (Over what period of time?)  <hr/> <hr/>	(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)	SED	? 1 2 3	H112
				STIM	? 1 2 3	H113
OPI	? 1 2 3			H114		
CAN	? 1 2 3			H115		
HER	? 1 2 3			H116		
COC	? 1 2 3			H117		
HAL	? 1 2 3			H118		
INH	? 1 2 3			H119		

?=inadequate information

1=absent or false

2=subthreshold

3=threshold or true

SCID-I (for DSM-IV-TR)

Non-Alcohol SUDs Past Year (March 2012)

SUDs

H.17

SUBSTANCE ABUSE

AT LEAST ONE "A" ITEM  
CODED "3"

SED	1	3	H120
STIM	1	3	H121
OPI	1	3	H122
CAN	1	3	H123
HER	1	3	H124
COC	1	3	H125
HAL	1	3	H126
INH	1	3	H127

Substance  
Abuse

?=inadequate information

1=absent or false

2=subthreshold

3=threshold or true

**LIST OF WITHDRAWAL SYMPTOMS (FROM DSM-IV CRITERIA)**

Listed below are the characteristic withdrawal symptoms for those classes of psychoactive substances for which a withdrawal syndrome has been identified. (NOTE: A specific withdrawal syndrome has not been identified for CANNABIS AND HALLUCINOGENS/PCP). Withdrawal symptoms may occur following the cessation of prolonged moderate or heavy use of a psychoactive substance or a reduction in the amount used.

**SEDATIVES, HYPNOTICS, AND ANXIOLYTICS:**

Two (or more) of the following, developing within several hours to a few days after cessation (or reduction) of sedative, hypnotic, or anxiolytic use, which has been heavy and prolonged:

- (1) autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)
- (2) increased hand tremor
- (3) insomnia
- (4) nausea or vomiting
- (5) transient visual, tactile, or auditory hallucinations or illusions
- (6) psychomotor agitation
- (7) anxiety
- (8) grand mal seizures

**STIMULANTS/COCAINE**

Dysphoric mood AND two (or more) of the following physiological changes, developing within a few hours to several days after cessation (or reduction of substance use which has been heavy and prolonged):

- (1) fatigue
- (2) vivid, unpleasant dreams
- (3) insomnia or hypersomnia
- (4) increased appetite
- (5) psychomotor retardation or agitation

**OPIOIDS:**

Three (or more) of the following, developing within minutes to several days after cessation (or reduction) of opioid use which has been heavy and prolonged (several weeks or longer) or after administration of an opioid antagonist (after a period of opioid use):

- (1) dysphoric mood
- (2) nausea or vomiting
- (3) muscle aches
- (4) lacrimation or rhinorrhea
- (5) pupillary dilation, piloerection, or sweating
- (6) diarrhea
- (7) yawning
- (8) fever
- (9) insomnia

**J. ADJUSTMENT DISORDER**

IF THERE IS A DISTURBANCE IN THE PAST YEAR AND IT DOES NOT MEET THE CRITERIA FOR ANOTHER AXIS I DSM-IV DISORDER, CIRCLE 3 AND CONTINUE. OTHERWISE, CIRCLE 1 AND GO TO \*END OF INTERVIEW\* ON PAGE K.1.

INFORMATION OBTAINED FROM OVERVIEW OF PRESENT ILLNESS WILL USUALLY BE SUFFICIENT TO RATE THE CRITERIA.

DISTURBANCE IN PAST YEAR THAT DOES NOT MEET CRITERIA FOR DSM DISORDER	
<u>NO</u> 1	<u>YES</u> 3

**ADJUSTMENT DISORDER CRITERIA**

IF UNKNOWN: Did anything happen to you just before (ONSET OF CURRENT DISTURBANCE)?

IF YES: Do you think that [STRESSOR] had anything to do with your getting [SYMPTOMS]?

DESCRIBE:

\_\_\_\_\_  
\_\_\_\_\_

(What effect has [SYMPTOMS] had on you and your ability to do things?) (How upset were you?) (Has it made it hard for you to do your work or be with friends?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Have you had this kind of reaction many times before?)

(Were you having these [SYMPTOMS] even before [STRESSOR] happened?)

\_\_\_\_\_  
\_\_\_\_\_

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within three months of the onset of the stressor(s).

? 1 2 3

GO TO *END OF INTERVIEW*, K.1
-------------------------------

B. These symptoms or behaviors are clinically significant as evidenced by either of the following:

? 1 2 3

GO TO *END OF INTERVIEW*, K.1
-------------------------------

(1) marked distress that is in excess of what would be expected from exposure to the stressor

(2) significant impairment in social or occupational (academic) functioning

C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

? 1 3

GO TO *END OF INTERVIEW*, K.1
-------------------------------

IF UNKNOWN: Did someone close to you die just before (ONSET OF CURRENT DISTURBANCE)?

---



---

D. The symptoms do not represent Bereavement.

? 1 3

GO TO \*END OF INTERVIEW\*, K.1

J5

(How long has it been now since [STRESSOR AND COMPLICATIONS ARISING FROM THE STRESSOR] was over?)

---



---

E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

? 1 2 3

GO TO \*END OF INTERVIEW\*, K.1

J6

ADJUSTMENT DISORDER CRITERIA A, B, C, D, AND E ARE CODED "3"

1 3

GO TO \*END OF INTERVIEW\*, K.1      ADJUSTMENT DISORDER

J7

CODE SUBTYPE BASED ON PREDOMINANT SYMPTOMS

- 1 WITH DEPRESSED MOOD (e.g., depressed mood, tearfulness, feelings of hopelessness)
- 2 WITH ANXIETY (e.g., nervousness, worry, jitteriness, or in children, fears of separation from major attachment figures)
- 3 WITH MIXED ANXIETY AND DEPRESSED MOOD (e.g., a combination of depression and anxiety)
- 4 WITH DISTURBANCE OF CONDUCT (a disturbance in conduct in which there is a violation of the rights of others or of major age-appropriate societal norms or rules, e.g., truancy, vandalism, reckless driving, fighting, defaulting on legal responsibilities)
- 5 WITH MIXED DISTURBANCE OF EMOTIONS AND CONDUCT (e.g., depression and disturbance of conduct)
- 6 UNSPECIFIED (e.g., physical complaints, social withdrawal, or work or academic inhibition)

J8

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BEFORE YOU END THIS ASSESSMENT, REVIEW THE INFORMATION YOU HAVE ABOUT THE RESPONDENT'S PAST YEAR SYMPTOMS AND FUNCTIONING. IN ORDER TO ACCURATELY ASSIGN A GAF SCORE ON THE NEXT PAGE, YOU NEED TO UNDERSTAND THE EXTENT TO WHICH MENTAL HEALTH/ILLNESS HAS:

- IMPAIRED/INHIBITED THE RESPONDENT'S ABILITY TO MAINTAIN A HOME, CARE FOR CHILDREN;
- IMPAIRED/INHIBITED THE RESPONDENT'S ABILITY TO FUNCTION AT WORK AND OR SCHOOL;
- IMPAIRED/IMHIBITED THE RESPONDENT'S ABILITY TO TAKE CARE OF HIM/HERSELF WITH REGARD TO PERSONAL HYGIENE AND SAFETY;
- IMPAIRED/INHIBITED THE RESPONDENT'S ABILITY TO MAINTAIN FRIENDSHIPS AND POSITIVE RELATIONSHIPS WITH FAMILY MEMBERS;
- MADE THE RESPONDENT A DANGER TO HIM/HERSELF OR OTHERS

QUERY ANY UNKNOWN DIMENSIONS OF THE RESPONDENT'S PAST YEAR SYMPTOMATOLOGY AND FUNCTIONING, AND ASSIGN A GAF SCORE ON THE NEXT PAGE.

**DSM-IV Axis V: Global Assessment of Functioning Scale**

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Rate the respondent's period of worst functioning in the past year. Do not include impairment in functioning due to physical (or environmental) limitations.

**CODE** (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72). \_\_\_\_ \_\_\_\_ \_\_\_\_ EOI1

- 100  
|  
91 **Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his many positive qualities. No symptoms.**
- 90  
|  
81 **Absent or minimal symptoms** (e.g., mild anxiety before an exam); **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).
- 80  
|  
71 **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in school work).
- 70  
|  
61 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**
- 60  
|  
51 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or coworkers).
- 50  
|  
41 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).
- 40  
|  
31 **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
- 30  
|  
21 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).
- 20  
|  
11 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).
- 10  
|  
1 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**
- 0 Inadequate information.

That was my last question. Thank you for your time and cooperation in completing this interview.

Sometimes the personal issues we've discussed cause people to become upset and in need of speaking with a counselor. If you are feeling upset or disturbed by the personal issues we have discussed in this interview and would like to talk with someone about your feelings, we suggest you call your doctor, counselor, or other treatment provider if you are currently under someone's care. If not, there is also a national lifeline number you can call. This number is on the receipt for the \$30 you received for this interview from the interviewer who met with you earlier. Do you still have that receipt?

IF NO: We would like to give you the hotline number for the National Lifeline Network where counselors are available to talk at any time of the day or night. They can also give you information about (additional) mental health services in your area. Their toll-free number is 1-800-273-8255.

IF YES: OK. Please know that counselors at the National Lifeline are available to talk at any time of the day or night. They can also give you information about mental health services in your area if you request this information.

Do you have any additional questions you'd like to ask me before we end our call?

Thank you again for your time, and have a good (day/afternoon/evening).

*Interview End Time:* \_\_\_\_ \_\_\_\_ : \_\_\_\_ \_\_\_\_ AM/PM

**INTERVIEWER DEBRIEFING SECTION**

**Distressed Respondent Protocol**

	<u>No</u>	<u>Yes</u>	
Was the Distressed Respondent Protocol used?	1	3	IDS1
<i>Specify problems:</i>			IDS2
_____			
_____			
_____			

**Cognitive Impairment Screener**

	<u>No</u>	<u>Yes</u>	
Was the Short Blessed Scale used?	1	3	IDS3 IF IDS3 = 1, SKIP IDS4 and IDS4a
<i>Specify problems:</i>			IDS4
_____			
_____			
_____			

Indicate score on the Short Blessed (0-28)			IDS4a
---	--	--	-------

**Stressful Life Circumstances**

	<u>No</u>	<u>Yes</u>	
Were there significant problems in these areas?			
Problems with primary support group	1	3	IDS5
Problems related to social environment	1	3	IDS6
Educational problems	1	3	IDS7
Occupational problems	1	3	IDS8
Housing problems	1	3	IDS9
Economic problems	1	3	IDS10
Problems with access to health care services	1	3	IDS11
Problems related to interaction with the legal system/crime	1	3	IDS12
Life-threatening illness – self	1	3	IDS13
Life-threatening illness – partner, spouse, family member	1	3	IDS14
Other psychosocial and environmental problems	1	3	IDS15

### Comprehension Rating

Estimate the respondent's understanding of the interview:

**Circle response**

- No difficulty -- No language or comprehension problem 1
- Just a little difficulty – almost no language or comprehension problems 2
- A fair amount of difficulty - some language or comprehension problems 3
- A lot of difficulty – considerable language or comprehension problems 4
- Extreme problems with language or comprehension problems 5

IDS16

*Specify problems:*

IDS17

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### Cooperation Rating

Rate how cooperative the respondent was during the interview

**Circle response**

- Very Cooperative 1
- Fairly Cooperative 2
- Not Very Cooperative 3
- Uncooperative 4
- Openly Hostile 5

IDS18

*Specify problems:*

IDS19

---



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**Privacy Rating**

Indicate on a scale of 1 through 5 how private the interview was:

**Circle response**

IDS20

Completely Private – No one who could overhear any part of the interview

appeared present

1

Minor Distractions – Other person(s) seemed present or listening for less

than 1/3 of the time

2

Moderate Distractions – Others seemed to present about 1/3 of the time

3

Severe Distractions - Interruptions of Privacy More Than Half the Time

4

Constant Presence of Other Person(s)

5

*Specify problems:*

IDS21

---



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---

**Global Validity Rating**

Rate the overall validity of the interview

**Circle response**

IDS22

Excellent, no reason to suspect invalid responses

1

Good, factors present that may adversely affect validity

2

Fair, factors present that definitely reduce validity

3

Poor, substantially reduced validity

4

Invalid responses, severely impaired mental status or possible deliberate

“faking bad” or “faking good”

5

*Specify problems:*

IDS23

---



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**Potential Disorders Not Assessed**

		<u>No</u>	<u>Yes</u>	
Were there any disorders not assessed that would need to be ruled out?		1	3	IDS24 IF IDS24 = 1, SKIP IDS24a and IDS25
Rule-out disorder present	1 Rule-out Other Axis I Disorder (not assessed in study) 2 Rule-out Axis II Disorder – Personality Disorder (not assessed in study) 3 Rule-out Axis II Disorder – Other (e.g. Developmental Disability) (not assessed in study) 4 Rule-out Axis I Disorder assessed but missed (due to CI or R error)			IDS24a
Specify disorders implicated:				IDS25
<hr/>				
<hr/>				
<hr/>				

## CLINICAL SUPERVISOR'S RATINGS

### CS: Global Validity Rating

Rate the overall validity of the interview

**Circle response**

IDS26

Excellent, no reason to suspect invalid responses

1

Good, factors present that may adversely affect validity

2

Fair, factors present that definitely reduce validity

3

Poor, substantially reduced validity

4

Invalid responses, severely impaired mental status or possible deliberate  
"faking bad" or "faking good"

5

*Specify problems:*

IDS27

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### CS: Potential Disorders Not Assessed

**No   Yes**

Were there any disorders not assessed that would need to be ruled out?

1

3

IDS28

IF IDS28 = 1,  
SKIP IDS28a  
and IDS29

Rule-out disorder present

- 1 Rule-out Other Axis I Disorder (not assessed in study)
- 2 Rule-out Axis II Disorder – Personality Disorder (not assessed in study)
- 3 Rule-out Axis II Disorder – Other (e.g. Developmental Disability) (not assessed in study)
- 4 Rule-out Axis I Disorder assessed but missed (due to CI or R error)

IDS28a

*Specify disorders implicated:*

IDS29

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**\*GMC/SUBSTANCE CAUSING MOOD SYMPTOMS\***

**MOOD DISORDER DUE TO A GENERAL MEDICAL CONDITION**

**MOOD DISORDER DUE TO A GENERAL MEDICAL CONDITION CRITERIA**

IF SYMPTOMS NOT TEMPORALLY ASSOCIATED WITH A GENERAL MEDICAL CONDITION, CHECK HERE \_\_\_ AND GO TO **\*SUBSTANCE-INDUCED MOOD DISORDER,\*** MDGS.3.

CODE BASED ON INFORMATION ALREADY OBTAINED

A. A prominent and persistent disturbance in mood predominates in the clinical picture and is characterized by either (or both) of the following:

- (1) depressed mood or markedly diminished interest or pleasure in all, or almost all, activities      ?      1      2      3
- (2) elevated, expansive, or irritable mood      ?      1      2      3

Do you think your (MOOD SXS) were in any way related to your (COMORBID GENERAL MEDICAL CONDITION)?

B./C. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition and the disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder With Depressed Mood, in response to the stress of having a general medical condition).      ?      1      2      3

GO TO **\*SUBSTANCE INDUCED\***, MDGS.3

IF YES: Tell me how.

(Did the [MOOD SXS] start or get much worse only after [COMORBID GENERAL MEDICAL CONDITION] began?)

IF YES AND GMC HAS RESOLVED: Did the (MOOD SXS) get better once the (COMORBID GENERAL MEDICAL CONDITION) got better?

THE FOLLOWING FACTORS SHOULD BE CONSIDERED AND SUPPORT THE CONCLUSION THAT THE GMC IS ETIOLOGIC TO THE MOOD SYMPTOMS:

- 1) THERE IS EVIDENCE FROM THE LITERATURE OF A WELL-ESTABLISHED ASSOCIATION BETWEEN THE GMC AND MOOD SYMPTOMS.
- 2) THERE IS A CLOSE TEMPORAL RELATIONSHIP BETWEEN THE COURSE OF THE MOOD SYMPTOMS AND THE COURSE OF THE GENERAL MEDICAL CONDITION.
- 3) THE MOOD SYMPTOMS ARE CHARACTERIZED BY UNUSUAL PRESENTING FEATURES (E.G., LATE AGE AT ONSET)

4) THERE ARE NO ALTERNATIVE EXPLANATIONS (E.G., MOOD SYMPTOMS AS A PSYCHOLOGICAL REACTION TO THE GMC).

IF UNCLEAR: How much did (MOOD SYMPTOMS) interfere with your life?

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

? 1 2 3

GO TO \*SUBSTANCE INDUCED\*, MDGS.3

NOTE: THE D CRITERION (DELIRIUM R/O) HAS BEEN OMITTED.

MOOD DISORDER DUE TO GMC CRITERIA A, B/C, AND E CODED "3"

1 3

MOOD DISORDER DUE TO A GMC

CHECK HERE \_\_\_ IF CURRENT IN PAST MONTH

Indicate which type of symptom presentation predominates:  
1 - With Major Depressive-like episode  
2 - With Depressive Features (if predominant mood is depressed but the full criteria are not met for a Major depressive episode)  
3 - With Manic Features  
4 - With Mixed Features

CONTINUE ON NEXT PAGE

**\*SUBSTANCE-INDUCED MOOD DISORDER\***

**SUBSTANCE-INDUCED MOOD DISORDER CRITERIA**

EPISODE BEING EVALUATED:	
Past Year MDE	A.5
Lifetime MDE	A.11
Past Year Manic	A.17
Lifetime Manic	A.22
Dysthymic	A.29

IF SYMPTOMS NOT TEMPORALLY ASSOCIATED WITH SUBSTANCE, CHECK HERE \_\_\_ AND RETURN TO EPISODE BEING EVALUATED.

CODE BASED ON INFORMATION ALREADY OBTAINED.

A. A prominent and persistent disturbance in mood predominates in the clinical picture and is characterized by one (or both) of the following:

- (1) depressed mood or markedly diminished interest or pleasure in all, or almost all, activities      ?      1      2      3
- (2) elevated, expansive or irritable mood      ?      1      2      3

IF NOT KNOWN: When did the (MOOD SYMPTOMS) begin? Were you already using (SUBSTANCE) or had you just stopped or cut down your use?

B. There is evidence from the history, physical examination or laboratory findings that either (1) the symptoms in A developed during or within a month of substance intoxication or withdrawal, or (2) medication use is etiologically related to the disturbance      ?      1      2      3

NOT SUBSTANCE INDUCED RETURN TO EPISODE BEING EVALUATED

Do you think your (MOOD SXS) are in any way related to your (SUBSTANCE USE)?

IF YES: Tell me how.

C. The disturbance is not better accounted for by a Mood Disorder that is not substance-induced. Evidence that the symptoms are better accounted for by a Mood Disorder that is not substance-induced might include:

?      1      2      3  
NOT SUBSTANCE INDUCED RETURN TO EPISODE BEING EVALUATED

ASK ANY OF THE FOLLOWING QUESTIONS AS NEEDED TO RULE OUT A NON-SUBSTANCE-INDUCED ETIOLOGY

IF UNKNOWN: Which came first, the (SUBSTANCE USE) or the (MOOD SYMPTOMS)?

1) the mood symptoms precede the onset of the Substance Abuse or Dependence (or medication use)

IF UNKNOWN: Have you had a period of time when you stopped using (SUBSTANCE)?

2) the mood symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication

IF YES: After you stopped using (SUBSTANCE) did the (MOOD SXS) get better?

IF UNKNOWN: How much of (SUBSTANCE) were you using when you began to have (MOOD SYMPTOMS)?

3) the mood symptoms are substantially in excess of what would be expected given the type, duration or amount of the substance used

IF UNKNOWN: Have you had any other episodes of (MOOD SYMPTOMS)?

4) there is evidence suggesting the existence of an independent non-substance-induced Mood Disorder (e.g. , a history of recurrent Major Depressive Episodes)

IF YES: How many? Were you using (SUBSTANCES) at those times?

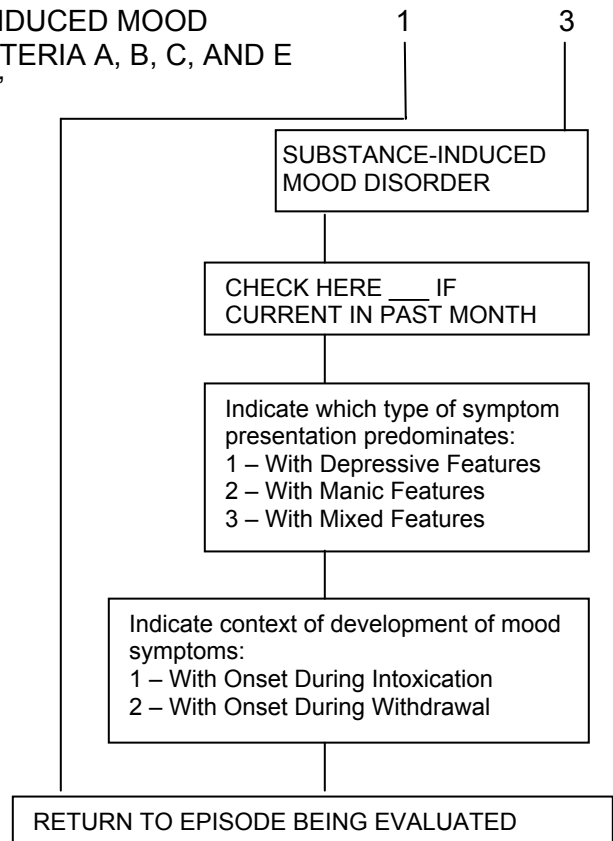
IF UNKNOWN: How much did (MOOD SYMPTOMS) interfere with your life?

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. ? 1 2 3

RETURN TO EPISODE BEING EVALUATED

NOTE: THE D CRITERION (DELIRIUM R/O) HAS BEEN OMITTED.

SUBSTANCE-INDUCED MOOD DISORDER CRITERIA A, B, C, AND E ARE CODED "3"



**\*GMC/SUBSTANCE AS ETIOLOGY FOR ANXIETY SYMPTOMS\***

**ANXIETY DISORDER DUE TO A GENERAL MEDICAL CONDITION**

**ANXIETY DISORDER DUE TO A GENERAL MEDICAL CONDITION CRITERIA**

IF SYMPTOMS NOT TEMPORALLY ASSOCIATED WITH A GENERAL MEDICAL CONDITION CHECK HERE \_\_\_ AND GO TO **\*SUBSTANCE-INDUCED ANXIETY DISORDER,\*** ADGS.3

CODE BASED ON INFORMATION ALREADY OBTAINED

A. Prominent anxiety, panic attacks, ? 1 3  
obsessions or compulsions  
predominate in the clinical picture.

Did the (ANXIETY SYMPTOMS) start or get much worse only after (GMC) began?

B/C. There is evidence from this history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition and the disturbance is not better accounted for by another mental disorder (e.g., adjustment disorder With Anxiety), in which the stressor is a serious general medical condition). ? 1 2 3

GO TO  
**\*SUBSTANCE INDUCED\***  
ADGS.3

IF GMC HAS RESOLVED: Did the (ANXIETY SYMPTOMS) get better once the (GMC) got better?

\_\_\_\_\_

\_\_\_\_\_

THE FOLLOWING FACTORS SHOULD BE CONSIDERED AND SUPPORT THE CONCLUSION THAT THE GMC IS ETIOLOGIC TO THE ANXIETY SYMPTOMS.

- 1) THERE IS EVIDENCE FROM THE LITERATURE OF A WELL-ESTABLISHED ASSOCIATION BETWEEN THE GMC AND ANXIETY SYMPTOMS.
- 2) THERE IS A CLOSE TEMPORAL RELATIONSHIP BETWEEN THE COURSE OF THE ANXIETY SYMPTOMS AND THE COURSE OF THE GENERAL MEDICAL CONDITION.
- 3) THE ANXIETY SYMPTOMS ARE CHARACTERIZED BY UNUSUAL PRESENTING FEATURES (E.G., LATE AGE AT ONSET)
- 4) THE ABSENCE OF ALTERNATIVE EXPLANATIONS (E.G., ANXIETY SYMPTOMS AS A PSYCHOLOGICAL REACTION TO THE GMC).

IF UNCLEAR: How much did (ANXIETY SYMPTOMS) interfere with your life?

(Has it made it hard for you to do your work or be with your friends?)

\_\_\_\_\_

\_\_\_\_\_

E. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

? 1 2 3

GO TO \*SUBSTANCE INDUCED\* ADGS.3

NOTE: THE D CRITERION (DELIRIUM R/O) HAS BEEN OMITTED.

ANXIETY DISORDER DUE TO GMC CRITERIA A, B/C, AND E CODED "3"

1

3

ANXIETY DISORDER DUE TO A GMC

CHECK HERE \_\_\_ IF CURRENT IN PAST MONTH

Indicate which type of symptom presentation predominates:  
1 - With Generalized Anxiety  
2 - With Panic attacks  
3 - With Obsessive-Compulsive symptoms

CONTINUE ON NEXT PAGE

**SUBSTANCE-INDUCED ANXIETY DISORDER**

**SUBSTANCE-INDUCED ANXIETY DISORDER CRITERIA**

IF SYMPTOMS NOT TEMPORALLY ASSOCIATED WITH SUBSTANCE USE, CHECK HERE \_\_\_ AND RETURN TO DISORDER BEING EVALUATED.

EPISODE BEING EVALUATED:	
Panic	E.12
AWOPD	E.17
Social Phobia	E.21
OCD	E.31
GAD	E.36

CODE BASED ON INFORMATION ALREADY OBTAINED

A. Prominent anxiety, panic attacks, ? 1 2 3 obsessions or compulsions predominate in the clinical picture.

IF NOT KNOWN: When did the (ANXIETY SYMPTOMS) begin? Were you already using (SUBSTANCE) or had you just stopped or cut down your use?

B. There is evidence from the ? 1 2 3 history, physical examination, or laboratory findings that either: (1) the symptoms in A developed during, or within a month of, substance intoxication or withdrawal, or (2) medication use is etiologically related to the disturbance

NOT SUBSTANCE INDUCED  
RETURN TO DISORDER BEING EVALUATED

ASK ANY OF THE FOLLOWING QUESTIONS AS NEEDED TO RULE OUT A NON-SUBSTANCE-INDUCED ETIOLOGY:

C. The disturbance is NOT better ? 1 3 accounted for by an Anxiety Disorder that is not substance-induced.

NOT SUBSTANCE INDUCED  
RETURN TO DISORDER BEING EVALUATED

Guidelines for Primary Anxiety:  
Evidence that the symptoms are better accounted for by a primary (i.e., non-substance-induced) Anxiety Disorder may include any (or all) of the following:

IF UNKNOWN: Which came first, the (SUBSTANCE USE) or the (ANXIETY SYMPTOMS)?

(1) the anxiety symptoms precede the onset of the Substance Abuse or Dependence (or medication use)

IF UNKNOWN: Have you had a period of time when you stopped using (SUBSTANCE)?

IF YES: After you stopped using (SUBSTANCE) did the (ANXIETY SYMPTOMS) get better or did they continue?

(2) the anxiety symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication



IF UNKNOWN: How much (SUBSTANCE) were you using when you began to have (ANXIETY SYMPTOMS)?

\_\_\_\_\_  
\_\_\_\_\_

(3) the anxiety symptoms are substantially in excess of what would be expected given the character, duration, or amount of the substance used

IF UNKNOWN: Have you had any other episodes of (ANXIETY SYMPTOMS)?

IF YES: How many? Were you using (SUBSTANCES) at those times?

\_\_\_\_\_  
\_\_\_\_\_

(4) there is evidence suggesting the existence of an independent, non-substance-induced Anxiety Disorder (e.g., a history of recurrent non-substance-related panic attacks)

IF UNKNOWN: How much did (ANXIETY SYMPTOMS) interfere with your life?

(Has it made it hard for you to do your work or be with your friends?)

\_\_\_\_\_  
\_\_\_\_\_

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

?      1      2      3

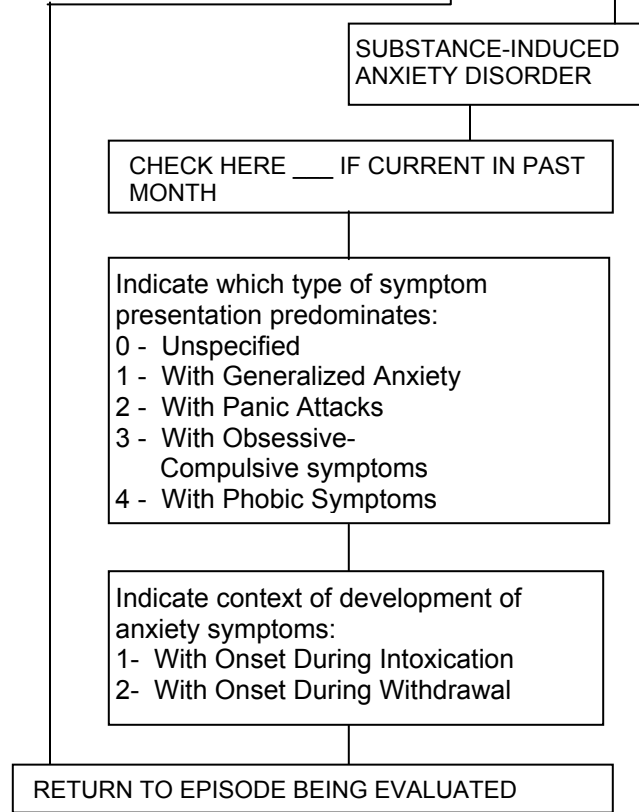
RETURN TO DISORDER BEING EVALUATED

NOTE: THE D CRITERION (DELIRIUM R/O) HAS BEEN OMITTED.

SUBSTANCE-INDUCED ANXIETY DISORDER CRITERIA A, B, C, AND E ARE CODED "3"

1

3



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### Specific Guidelines

If respondents report any of the issues listed below during any interactions with the recruiter or clinical interviewer, including before, during, or after a telephone screening or interview, the staff member will immediately refer to the scenario chart below and follow the instructions provided. Details of all incidents will be documented on the case management system and reported to project management staff immediately.

- Has had **any suicidal thoughts in the past two weeks (p. A.3)**, including
  - passive suicidal thoughts (i.e., thoughts or wishes about his/her death **in the absence of** thoughts about specific ways s/he could die or attempt suicide, plans for how s/he could die or attempt suicide, or intention of dying or attempting suicide) [**SCENARIO 1**] or
  - active suicidal thoughts (i.e., thoughts or wishes about his/her death **combined with** thoughts about specific ways s/he could die or attempt suicide, plans for how s/he could die or attempt suicide, the intention of dying or attempting suicide, the means to carry out that plan, and will not promise you that s/he will not hurt him/herself) [**SCENARIO 2**]
- Has had **any homicidal thoughts in the past two weeks**, including
  - passive homicidal thoughts (i.e., thoughts or wishes about seriously harming someone else **in the absence of** thoughts about specific ways in which s/he could seriously harm another person, plans for how s/he could seriously harm another person, intentions of seriously harming another person) [**SCENARIO 3**] or
  - active homicidal thoughts (i.e., thoughts or wishes about seriously harming someone else **combined with** thoughts about specific ways s/he could seriously harm another person, plans for how s/he could seriously harm another person, the intention of seriously harming another person, and the means to carry out that plan) [**SCENARIO 4**]

<b>Scenario Chart</b>		
<b>Scenario Number</b>	<b>Individual at Risk of Harm</b>	<b>Imminent Danger?</b>
1	Self	No
2	Self	Possible / Yes
3	Other(s)	No
4	Other(s)	Possible / Yes
5	No risk of harm; respondent is agitated or upset	No

Scenario Number	Individual at Risk of Harm	Imminent Danger?
1	Self	No
<b>STEPS</b>		
<p><b>A. COMPLETE SCREENING/INTERVIEW AND THEN READ TO R:</b> When you agreed to participate in this interview, I promised that I would not tell anyone what you have told me unless it was necessary to protect you or other people. You told me earlier that you have recently had thoughts or wishes about your death or dying.</p> <p><b>B.</b> Do you have a doctor, counselor, or someone you can talk to about how you are feeling now?</p> <p><b>IF YES:</b> I strongly suggest that you contact this person immediately so you can talk to him or her about how you have been feeling, especially about the thoughts you've been having about death and dying. Would you be willing to do that?</p> <p><b>IF YES:</b> Okay. There is also a national Lifeline hotline you can call where counselors are available to talk at any time of the day or night. Their toll-free number is 1-800-273-8255. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>IF NO:</b> I strongly suggest that you contact the national Lifeline hotline at 1-800-273-8255. Lifeline has counselors available 24-hours a day to talk to you about how you are feeling. They may also help you locate (additional) mental health services in your area. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away. If you are not able to get to an emergency room immediately, you should call 911 for assistance. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>C. WHEN CALL IS COMPLETED, CALL <span style="float: right;">IF YOU HAVE</span></b>  <b>QUESTIONS OR WOULD LIKE TO DEBRIEF. FILL OUT ONLINE INCIDENT REPORT.</b></p>		

Scenario Number	Individual at Risk of Harm	Imminent Danger?
2	Self	Possible / Yes
<b>STEPS</b>		
<p><b>A. END SCREENING/INTERVIEW AND THEN READ TO R:</b> When you agreed to participate in this interview, I promised that I would not tell anyone what you have told me unless it was necessary to protect you or other people. You told me earlier that you are thinking about harming yourself. Can you promise me that you will not harm yourself today?</p> <p><b>IF NO: GO TO STEP B.</b></p> <p><b>IF YES:</b> Do you have a doctor, counselor, or other professional you can talk to about how you are feeling?</p> <p><b>IF YES:</b> I strongly suggest that you contact this person so you can talk to him or her about how you have been feeling, especially about the thoughts you've been having about death and dying. Would you be willing to do that?</p> <p><b>IF YES:</b> Okay. There is also a national Lifeline hotline you can call where counselors are available to talk at any time of the day or night. Their toll-free number is 1-800-273-8255. Lifeline has counselors available 24-hours a day to talk to you about how you are feeling. They may also help you locate (additional) mental health services in your area. I strongly suggest you contact counselors at Lifeline. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away. If you are not able to get to an emergency room immediately, you should call 911 for assistance. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>IF NO:</b> I strongly suggest that you contact the national Lifeline hotline at 1-800-273-8255. Lifeline has counselors available 24-hours a day to talk to you about how you are feeling. They may also help you locate (additional) mental health services in your area. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away. If you are not able to get to an emergency room immediately, you should call 911 for assistance. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>B.</b> I strongly suggest that we contact emergency care services in your area, such as a crisis center or nearby hospital. I am going to look-up that number. Can you remain on the line while I do that? It may take a few minutes.</p> <p><b>IF NO:</b> Okay, if I don't connect you with the local emergency care provider, then I will need to call the provider myself to see if they can send someone to you who can provide the care you need in order to keep you safe. I'll call you back to let you know what I find out.</p> <p><b>C. FIND THE NEAREST EMERGENCY PSYCHIATRIC SERVICES USING THE SAMHSA WEBSITE (<a href="http://mentalhealth.samhsa.gov/databases/">http://mentalhealth.samhsa.gov/databases/</a>). SEARCH FOR <u>INPATIENT</u> MH TREATMENT USING THE R'S CURRENT ZIP CODE.</b></p>		

**D. CALL THEIR LOCAL INPATIENT PSYCHIATRIC CARE FACILITY OR CRISIS CENTER AND READ THIS STATEMENT:** I work for RTI International, a research company in North Carolina, and we are conducting a research study. During an interview with a respondent, the respondent told me that (he/she) is thinking about killing or harming (himself/herself) and I am concerned about (his/her) safety. I can give you additional information about the research study, if you would like. I can also provide you with the respondent's contact information.

**IF ASKED FOR NSDUH OVERVIEW:** This study, part of the National Survey on Drug Use and Health sponsored by the United States Public Health Service, is designed to test procedures for use in future NSDUH surveys. Questions ask about various mental health issues such as depression, anxiety, post traumatic stress disorder, and substance dependence. Please note that this information was obtained through the respondent's participation in a research study. We went through appropriate informed consent procedures, during which I told the respondent that if (he/she) told me something that caused me to be concerned about (his/her) well-being, I would report that to someone else who could help or intervene. Given the context in which the information was obtained, however, we cannot guarantee that the participant understood the questions nor that (he/she) provided truthful responses. Do you have any questions about the study?

**ANSWER QUESTIONS.**

**E. GIVE R FIRST NAME, TELEPHONE NUMBER, AND ADDRESS (IF KNOWN) TO LOCAL EMERGENCY CARE REPRESENTATIVE. IF THEY ARE UNABLE TO PROVIDE SERVICES THAT ENSURE THE R'S SAFETY, SEARCH FOR THE R'S LOCAL EMERGENCY NUMBER USING THE NATIONAL 911 DATABASE.**

**F. IF R NOT ON THE OTHER LINE, END CALL WITH THE EMERGENCY CARE PROVIDER OR LOCAL 911 DISPATCHER AND ATTEMPT TO CONTACT R AGAIN WITH AN UPDATE.**

**IF R ON THE OTHER LINE, CONNECT R TO EMERGENCY CARE REPRESENTATIVE OR LOCAL 911 DISPATCHER AND STAY ON THE LINE; IF YOU HANG-UP, THEIR CONNECTION WILL ALSO END.**

**G. YOU MAY STAY ON THE LINE TO WAIT FOR THE RESCUE TEAM TO ARRIVE. IF SO, DO NOT CONTINUE THE INTERVIEW. KEEP THE DISCUSSION LIGHT AND AVOID EMOTIONAL TOPICS. DEMONSTRATE EMPATHIC LISTENING BUT REFRAIN FROM COUNSELING OR PRACTICING PSYCHOLOGY.**

**H. WHEN CALL IS COMPLETED, CALL [REDACTED] TO DEBRIEF. IF SHE DOES NOT RETURN CALL WITHIN 15 MINUTES, CALL [REDACTED] TO DEBRIEF. IF NEITHER ONE OF THEM IS AVAILABLE, CONTACT [REDACTED] OR [REDACTED] TO NOTIFY ONE OF THEM ABOUT THE INCIDENT. FILL OUT ONLINE INCIDENT REPORT.**

Scenario Number	Individual at Risk of Harm	Imminent Danger?
3	Other(s)	No

**STEPS**

**A. COMPLETE SCREENING/INTERVIEW AND THEN READ TO R:** When you agreed to participate in this interview, I promised that I would not tell anyone what you have told me unless it was necessary to protect you or other people. You told me earlier that you have recently had thoughts or wishes about seriously harming someone else. Do you have a doctor, counselor, or someone you can talk to about how you are feeling now?

**IF YES:** I strongly suggest that you contact this person immediately so you can talk to him or her about how you have been feeling, especially about the thoughts you've been having about seriously harming someone else. Would you be willing to do that?

**IF YES:** Okay. There is also a national Lifeline hotline you can call where counselors are available to talk at any time of the day or night. Their toll-free number is 1-800-273-8255. **THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.**

**IF NO:** I strongly suggest that you contact the national Lifeline hotline at 1-800-273-8255. Lifeline has counselors available 24-hours a day to talk to you about how you are feeling. They may also help you locate (additional) mental health services in your area. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away. If you are not able to get to an emergency room immediately, you should call 911 for assistance. **THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.**

**B. WHEN CALL IS COMPLETED, CALL \_\_\_\_\_ TO DEBRIEF. IF DIRECTED BY ONE OF THEM, FOLLOW SCENARIO 4 FOR POSSIBLE IMMINENT DANGER TO OTHERS. FILL OUT ONLINE INCIDENT REPORT.**



Scenario Number	Individual at Risk of Harm	Imminent Danger?
4	Other(s)	Possible / Yes
<b>STEPS</b>		
<p><b>A. END SCREENING/INTERVIEW AND END CALL.</b></p> <p><b>B. SEARCH FOR THE R’S LOCAL EMERGENCY NUMBER USING THE NATIONAL 911 DATABASE.</b></p> <p><b>C. CALL THEIR LOCAL 911, AND READ THIS STATEMENT:</b> I work for RTI International, a research company in North Carolina, and we are conducting a research study. During an interview with a respondent, the respondent told me that (he/she) is thinking about killing or harming another individual. I am concerned about this individual’s safety. I can give you additional information about the research study, if you would like. I can also provide you with the respondent’s contact information.</p> <p><b>IF ASKED FOR NSDUH OVERVIEW:</b> This study, part of the National Survey on Drug Use and Health sponsored by the United States Public Health Service, is designed to test procedures for use in future NSDUH surveys. Questions ask about various mental health issues such as depression, anxiety, post traumatic stress disorder, and substance dependence. Please note that this information was obtained through the respondent’s participation in a research study. We went through appropriate informed consent procedures, during which I told the respondent that if (he/she) told me something that caused me to be concerned about (him/her) harming someone else, I would report that to someone else who could help or intervene. Given the context in which the information was obtained, however, we cannot guarantee that the participant understood the questions nor that (he/she) provided truthful responses. Do you have any questions about the study?  <b>ANSWER QUESTIONS.</b></p> <p><b>D. GIVE R FIRST NAME, TELEPHONE NUMBER, ADDRESS (IF KNOWN), AND VICTIM’S IDENTIFYING INFORMATION TO LOCAL 911 DISPATCHER. END CALL.</b></p> <p><b>E. WHEN CALL IS COMPLETED, CALL _____ TO DEBRIEF. IF SHE DOES NOT RETURN CALL WITHIN 15 MINUTES, CALL _____ TO DEBRIEF. IF NEITHER ONE OF THEM IS AVAILABLE, CONTACT _____ OR _____ TO NOTIFY ONE OF THEM ABOUT THE INCIDENT. FILL OUT ONLINE INCIDENT REPORT.</b></p>		

Scenario Number	Individual at Risk of Harm	Imminent Danger?
5	No risk of harm; respondent is agitated or upset	No

**STEPS**

**A. END SCREENING/INTERVIEW AND THEN READ TO R:** I know these questions are very personal, and they seem to be upsetting you. Do you have a doctor or someone you can talk to about how you are feeling?

**IF YES:** I suggest that you call that individual immediately so that she or he can help you talk about and work through how you are feeling. There is also a national Lifeline hotline you can call where counselors are available to talk at any time of the day or night. Their toll-free number is 1-800-273-8255. **THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.**

**IF NO:** I suggest that you contact the national Lifeline hotline at 1-800-273-8255. Lifeline is a 24-hour hotline that you could call to discuss this with a counselor. They may also help you locate (additional) mental health services in your area. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away or call 911 for assistance. **THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.**

**B. WHEN CALL IS COMPLETED, CALL \_\_\_\_\_ IF YOU HAVE ANY QUESTIONS OR NEED TO DEBRIEF. FILL OUT ONLINE INCIDENT REPORT.**

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**SHORT BLESSED SCALE EXAM**

**THE SHORT BLESSED SCALE IS TO BE COMPLETED AT ANY POINT DURING THE INTERVIEW IF THE RESPONDENT APPEARS TO BE COGNITIVELY IMPAIRED.**

**ERROR SCORES**

- SB-1. What year is it now? \_\_\_\_\_  
CIRCLE 4 FOR ANY ERROR ..... 0 4
- SB-2. What month is it now? \_\_\_\_\_  
CIRCLE 3 FOR ANY ERROR ..... 0 3
- Please repeat this phrase after me: John Brown, 42 Market Street, Chicago.  
NO SCORE – FOR ITEM SB-6.
- SB-3. About what time is it? \_\_\_\_\_  
CIRCLE 3 FOR ANY ERROR ..... 0 3
- SB-4. Please count backwards from 20 to 1.  
[20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1]  
2 PER ERROR ..... 0 2 4
- SB-5. Please say the months of the year in reverse order.  
[DEC, NOV, OCT, SEP, AUG, JUL, JUN, MAY, APR, MAR, FEB, JAN]  
2 PER ERROR ..... 0 2 4
- SB-6. Please repeat the phrase I asked you to repeat before.  
[JOHN BROWN / 42 MARKET STREET / CHICAGO]  
2 PER ERROR ..... 0 2 4 6 8 10

**TOTAL NUMBER OF ERRORS IN SB-1 TO SB-6: ..... \_\_\_\_\_**

**IF THE TOTAL NUMBER OF ERRORS IS GREATER THAN 10, TERMINATE THE INTERVIEW.**

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Clinical Interviewer Handbook**

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# 2011 NATIONAL SURVEY ON DRUG USE AND HEALTH

## Mental Health Surveillance Study Clinical Interviewer Handbook

Contract No. HHSS283200800004C

Project No. 0211838

Prepared for:

Substance Abuse and Mental  
Health Services Administration  
Rockville, Maryland 20857

Prepared by:

Research Triangle Institute

June 2011



## Mental Health Study Contacts and Information

**Data Collection Managers:** For assignments, case management, reporting, status updates, CMS and administrative questions.

<b>Data Collection Mgr:</b>		
Work Phone:		
E-mail:		
Cell Phone:		

Note: If your assigned Data Collection Manager is unavailable and your situation requires immediate assistance, please contact the other Data Collection Manager.

**Clinical Supervisor:** For questions on SCID administration and quality reviews.

<b>Clinical Supervisor:</b>			
Work Phone:			
E-mail:			
Cell Phone:			

Note: If your usual Clinical Supervisor is unavailable and your situation requires immediate assistance, please contact another supervisor listed above.

**Distressed Respondent Situations:** Refer to protocol in Chapter 5.

Call:	Phone Number:

**Placing a call using the Calling Card:**

1. Dial \*67 (optional)
2. Dial the toll-free number (back of card): \_\_\_\_\_
3. Enter the card number (front or back of card) : \_\_\_\_\_
4. Enter 0 + Area Code + Telephone number you wish to call

**Technical Support:**

# **2011 NATIONAL SURVEY ON DRUG USE AND HEALTH**

## **Mental Health Surveillance Study Clinical Interviewer Handbook**

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Prepared for:

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Rockville, Maryland 20857

Prepared by:

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June 2011

# Research Triangle Institute

## MISSION

To improve the human condition by turning knowledge into practice.

## VISION

To be the world's leading independent research organization, recognized for solving critical social and scientific problems.

## VALUES

**Integrity** - We perform with the highest ethical standards of individual and group honesty. We communicate openly and realistically with each other and with our clients.

**Excellence** - We strive to deliver results with exceptional quality and value.

**Innovation** - We encourage multidisciplinary collaboration, creativity and independent thinking in everything we do.

**Respect for the Individual** - We treat one another fairly, with dignity and equity. We support each other to develop to our full potential.

**Respect for RTI** - We recognize that the strength of RTI International lies in our commitment, collectively and individually, to RTI's vision, mission, values, strategies and practices. Our commitment to the Institute is the foundation for all other organizational commitments.

**Fiscal Responsibility** - We operate with financial integrity and transparency. We are accountable for cost competitiveness and continuing financial responsibility.

**Objectivity** - Our work is independent of undue influences by political, economic, or other factors. We maintain the highest level of scientific objectivity in our work.

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# 1. INTRODUCTION TO THE STUDY

You have been selected as a clinical interviewer (CI) for the Mental Health Surveillance Study (MHSS) of the National Survey on Drug Use and Health (NSDUH). The project staff welcomes you to the team for this important study and hopes you will find your responsibilities challenging, interesting, and enjoyable. We at Research Triangle Institute (RTI) look forward to working with you and appreciate the commitment and skill you bring to the project.

## 1.1 Research Triangle Institute (RTI)

Research Triangle Institute is an independent, nonprofit organization dedicated to conducting research that improves the human condition. With a worldwide staff of more than 2,800 people, RTI offers innovative research in survey and statistics, health and pharmaceuticals, advanced technology, education and training, and economic and social policy, international development, energy and the environment. Universities in North Carolina founded RTI in 1958 as the first scientific organization in and centerpiece of the Research Triangle Park, a science park located between the cities of Raleigh, Durham, and Chapel Hill, NC. In addition to its headquarters in North Carolina, RTI has eight regional offices within the United States and six offices around the world.

RTI's research is performed both in the United States and abroad under contract with federal, state, and local governments; public service agencies; and private-sector clients. In keeping with RTI's vision of becoming the world's leading independent research organization, the trade name has been changed to RTI International.<sup>1</sup> For survey work here in the United States, we continue to use both Research Triangle Institute and RTI because of positive respondent associations and name recognition.

## 1.2 Brief History of NSDUH

The National Survey on Drug Use and Health is currently an annual nationwide survey funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services. These goals have been established for the NSDUH:

- to provide accurate data on the level and patterns of licit and illicit substance use;
- to track trends in the use of alcohol, tobacco products, and various types of other drugs;
- to assess the consequences of substance use and abuse;
- to identify groups at high risk for substance use and abuse;
- to monitor mental health problems, treatment and unmet need for treatment.

First conducted in 1971, the NSDUH has become the nation's leading source of information on substance use patterns and behaviors. Early on, the study was conducted at various intervals, settling into a pattern of about every two years. The demand for current, accurate information rose sharply by the early

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<sup>1</sup> RTI International is a trade name of Research Triangle Institute.

1990s, prompting SAMHSA to conduct the survey annually starting in 1990. In 1992, the design shifted to a quarterly design where one fourth of the cases for the year are contacted and interviewed in each calendar quarter. Beginning in 1999, the sample size and design was expanded to allow for the reporting of drug use estimates for each of the 50 states and the District of Columbia. Beginning in 2002, the survey name was changed from the National Household Survey on Drug Abuse (NHSDA) to the National Survey on Drug Use and Health (NSDUH). The name was changed to more accurately reflect the survey's interest in the effects of drug use on users' mental health and overall health. Eliminating the term "abuse" from the title also projects a more positive, inclusive tone since researchers are interested in the experiences of drug users and non-users.

Research Triangle Institute has conducted the study since 1988. Over the years, RTI has revised or implemented new procedures designed to simplify and enhance the data collection process while maintaining the highest level of data quality.

The entire NSDUH data collection process is fully computerized. All screenings—which determine whom, if anyone, to interview in the household—are completed using a small handheld computer called a Hewlett-Packard iPAQ. Selected respondents are interviewed using Computer-Assisted Interviewing (CAI) on a Gateway laptop computer. Portions of the interview are conducted via computer-assisted personal interviewing (CAPI) where the field interviewer (FI) asks the questions and records the answers in the computer. The sensitive questions are completed using audio computer-assisted self-interviewing (ACASI), where the respondents read and/or listen to the questions and enter their own responses. With ACASI, even the interviewer does not know the responses to these personal questions. Studies repeatedly show that maximizing privacy helps encourage honest, accurate answers and produces high quality data.

*Appendix A* contains copies of materials and handouts often given to respondents by NSDUH field interviewers. Feel free to review these materials or visit the NSDUH website (<http://nsduhweb.rti.org>) to learn more about NSDUH.

### **1.3 Overview of the Mental Health Surveillance Study**

The Mental Health Surveillance Study (also referred to as the Mental Health Study) was first conducted as part of the 2008 NSDUH. This study continues to be conducted in all states and is designed to assess the questions used within NSDUH's Mental Health module by:

- collecting data from all adult interview respondents through a Mental Health module within the NSDUH interview, and
- recruiting and completing in-depth follow-up telephone interviews with selected adult respondents.

For 2011, additional funding was provided to expand the MHSS from 500 follow-up telephone interviews conducted annually to 1,500 interviews. This expansion, referred to as the Expanded Mental Health Surveillance Study (EMHSS), will enhance researchers' ability to analyze and report on major mental health conditions (e.g., Post-Traumatic Stress Disorder, Manic Episode, Anorexia Nervosa, etc.) based on data collected from a nationally representative sample. While the MHSS and EMHSS have

separate funding sources, both studies follow the same protocols and procedures, and are conducted under the Mental Health Surveillance Study.

NSDUH field interviewers will be responsible for completing the initial NSDUH interview. For selected interview respondents, FIs will use special recruitment scripts displayed in the initial interview to recruit randomly selected respondents for a follow-up telephone interview.

As a clinical interviewer, you will be responsible for completing the follow-up telephone interview. Follow-up telephone interviews will be completed with selected adult respondents using a revised version of the Structured Clinical Interview for DSM-IV Axis I Disorders, also known as the SCID.

#### **1.4 Study Sample**

The Mental Health Study is being conducted in all 50 states and Washington, DC. Eligible persons will be the civilian, non-institutionalized population aged 18 years old and older. Persons aged 12 to 17 years old and respondents who complete the initial NSDUH interview in Spanish will not be eligible for the follow-up interview.

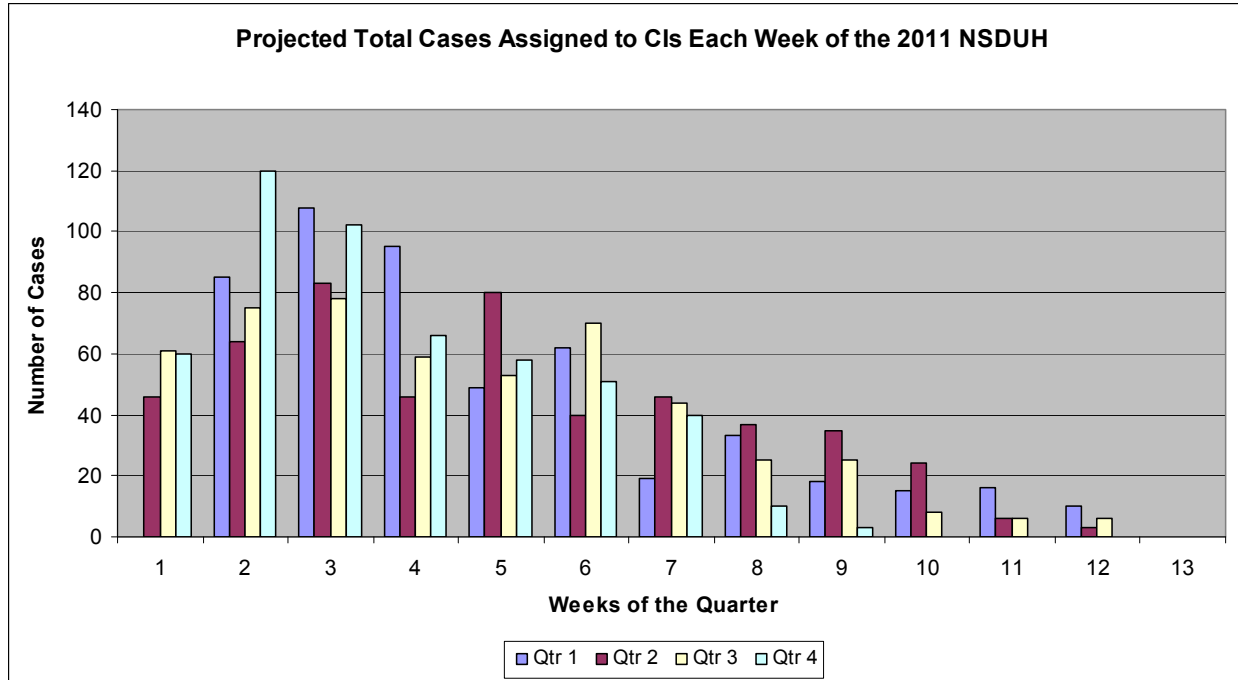
The MHSS sample will be embedded within the NSDUH sample. A sub-sample of English-speaking respondents aged 18 or older that complete the initial NSDUH interview will be selected to complete the follow-up telephone interview. The target number of completed follow-up telephone interviews for this year is approximately 1,500. Thus, each CI can expect to complete approximately 12-20 interviews per quarter.

#### **1.5 Schedule**

The Mental Health Study uses the same quarterly schedule as the NSDUH. Data collection will take place in all four quarters of the calendar year.

Given the cyclical nature of the schedule in that a new group of cases is released to field interviewers at the start of each calendar quarter, your workload will also be somewhat cyclical with more follow-up interviews generated and assigned at the beginning of the quarter than at the end. The graph on the following page illustrates the typical flow of total assigned follow-up interview cases through each quarter of the year.

Of course, it is best to complete the follow-up interview as soon as possible, preferably within the first week following the initial NSDUH interview. The vast majority of your assigned **follow-up interviews should be completed within 2 weeks** from the date of the initial interview. You have at most four weeks to complete the follow-up interview, so as needed, use the remaining 2 weeks for follow-up of difficult to contact respondents or persons who were out of town for a portion of the time period.



## 1.6 Organization

Because of the specialized nature of this study, the Mental Health Study organization structure has two types of supervisors for clinical interviewers. Knowing which type to contact for assistance is important.

You will report to one of two Data Collection Managers at RTI for all aspects of case assignment, management, completion, and reporting including case status and production, time, and expense information. Your Data Collection Manager will assign follow-up interview cases, monitor completion, and support you as needed to successfully complete your work.

For supervision of the follow-up interview task, that is, conducting the interview, asking the questions, documenting the answers and completing the SCID instrument, you will work with several Clinical Supervisors at RTI. These Clinical Supervisors will review your completed SCIDs, provide you with direct feedback, and answer any questions you may have about the proper administration of the SCID.

Please note that the Clinical Supervisors and Data Collection Managers work as a team to support your efforts while ensuring the collection of the highest quality data possible. *Exhibit 1.1* includes supervisory contact information. The chart also lists other contacts such as RTI project management, Headway (an RTI subcontractor) and RTI's Technical Support.

**Exhibit 1.1 Project Staff Information**

<b>DATA COLLECTION MANAGERS</b>			
<b>Name</b>	<b>Work Phone</b>	<b>Cell Phone</b>	<b>E-Mail</b>
<b>CLINICAL SUPERVISORS</b>			
<b>Name</b>	<b>Work Phone</b>	<b>Cell Phone</b>	<b>E-Mail</b>
<i>Study Manager</i>			
<b>RTI MANAGEMENT</b>			
<b>Name</b>	<b>Work Phone</b>	<b>Cell Phone</b>	<b>E-Mail</b>
<i>Assistant Study Manager</i>			
<i>Operations Manager</i>			
<b>HEADWAY</b>			
Headway Representative		FAX	
<b>TECHNICAL SUPPORT GROUP (TSG) -</b>			

## **1.7 Project Abbreviations and Terminology**

Throughout this handbook, and in other project materials, abbreviations are used. As a general aid for you, a list of these abbreviations is provided in *Exhibit 1.2*. Some of the abbreviations and terms used have exact meanings or refer to specific project materials. These terms are briefly explained in *Exhibit 1.3*, in alphabetical order.

## **1.8 Use of the Mental Health Study Handbook**

This procedural handbook provides a detailed description of the tasks you will be required to complete for all aspects of the Mental Health Study, and is an excellent reference source. When searching for information, think about where the topic fits in the flow of work. Consult the detailed Table of Contents and the List of Exhibits. Using the key words shown there will help you narrow down your search.

Adherence to prescribed procedures and duties is extremely important to the success of the study. This handbook should be carefully studied before you attend training, as you prepare for work, and throughout data collection each quarter.

You may, however, have questions or encounter a situation for which you do not find an answer in this handbook. When in doubt about any situation, contact your Data Collection Manager.

## Exhibit 1.2 List of Abbreviations

<b>ACASI</b>	Audio Computer-Assisted Self-Interviewing
<b>CAI</b>	Computer-Assisted Interviewing
<b>CAPI</b>	Computer-Assisted Personal Interviewing
<b>Case ID</b>	Case Identification Number
<b>CBHSQ</b>	Center for Behavioral Health Statistics and Quality (the SAMHSA office in charge of NSDUH and MHSS)
<b>CI</b>	Clinical Interviewer
<b>CMS</b>	Case Management System
<b>CS</b>	Clinical Supervisor
<b>DCM</b>	Data Collection Manager
<b>DHHS</b>	U.S. Department of Health and Human Services
<b>DU</b>	Dwelling Unit
<b>ePTE</b>	Electronic Production, Time, and Expense Report
<b>EMHSS</b>	Expanded Mental Health Surveillance Study
<b>FI</b>	Field Interviewer
<b>FS</b>	Field Supervisor
<b>GQU</b>	Group Quarters Unit
<b>HU</b>	Housing Unit
<b>ID</b>	Identification
<b>INS</b>	Immigration and Naturalization Services
<b>MHSS</b>	Mental Health Surveillance Study (Mental Health Study)
<b>NHSDA</b>	National Household Survey on Drug Abuse (past name)
<b>NSDUH</b>	National Survey on Drug Use and Health (current name)
<b>PAPI</b>	Paper and Pencil Interviewing
<b>PT&amp;E</b>	Production, Time, and Expense Report
<b>Q&amp;A</b>	Question and Answer Brochure
<b>QuestID</b>	Questionnaire ID
<b>R</b>	Respondent
<b>ROC</b>	Record of Calls
<b>RTI</b>	Research Triangle Institute
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SCID</b>	Structured Clinical Interview for DSM-IV Axis I Disorders
<b>SDU</b>	Sample Dwelling Unit
<b>TSG</b>	Technical Support Group
<b>USPHS</b>	United States Public Health Service



### **Exhibit 1.3 Definitions of Project Terminology**

**Audio Computer-Assisted Self-Interviewing (ACASI)** – a type of computer-assisted interviewing used within the initial NSDUH interview to collect information from selected respondents for questions of a sensitive or personal nature. Respondents listen through headphones as the questions are read from computer audio files and enter the answers themselves directly into the computer.

**Case Identification (Case ID)** – a ten-character code that starts with the state abbreviation and uniquely identifies a dwelling unit selected for the NSDUH.

**Case Management** – a broad term used to describe the process of organizing, keeping track of and completing your work in a timely fashion.

**CMS (Case Management System)** – the web-based system that provides case assignment information and allows for the documentation of all work efforts through the Record of Calls (*see definition*). Through the CMS, CIs also perform other study tasks such as documenting a distressed respondent situation.

**Computer-Assisted Interviewing (CAI)** – a generic term used to indicate that a computer is used during the NSDUH interview. It includes CAPI and ACASI (*see definitions*).

**Computer-Assisted Personal Interviewing (CAPI)** – using a computer, the field interviewer reads the questions displayed on the computer screen to the respondent, then enters the response directly into the computer.

**Consent** – agreement to participate in a research study given by an adult or by a parent or guardian for his/her child. Giving consent indicates that he/she understands the meaning of, and has agreed to participate in, the study. The consent process used in any research project must be approved by a Human Subject's Committee or Institutional Review Board.

**Electronic Production, Time, and Expense Report (ePTE)** – CIs maintain an accurate record of daily production, time and expenses while working on this study and enter their information into the ePTE system. Payments for hours worked and reimbursement of expenses are based on the information submitted through the ePTE system. (In case of computer problems, paper PT&E forms are available as a backup).

**Expanded Mental Health Surveillance Study (or EMHSS)** – Additional funding provided to expand the MHSS from 500 follow-up telephone interviews conducted annually to 1,500 interviews for 2011. Both MHSS and EMHSS follow the same study protocols and procedures, and are fielded as the Mental Health Surveillance Study (see below).

**Follow-up Interview** – The follow-up telephone interview conducted with selected respondents who complete the initial interview. A clinical interviewer completes the follow-up interview, which asks questions about various mental health and other related issues.

**Initial Interview** – The NSDUH interview conducted with respondents, including respondents selected for the Mental Health Study follow-up interview.

**Mental Health Surveillance Study (or Mental Health Study)** – Nationwide study being conducted to assess the NSDUH's Mental Health module questions. This study is designed to collect data from all adult interview respondents through a Mental Health module within the NSDUH interview, and complete in-depth follow-up telephone interviews with selected adult respondents.

**MH Case Manager** – the system allowing CIs to easily audio record each interview through the laptop and then upload the audio file to a secure location at RTI.

### **Exhibit 1.3 Definitions of Project Terminology (continued)**

**Nonrespondent** – a person who is eligible and selected for the NSDUH but who chooses not to participate.

**Production Time and Expense (PT&E)** – Backup paper forms used infrequently as needed to allow CIs to maintain and submit an accurate report of daily production, time and expenses while working on this study. Instructions for the proper completion of paper PT&Es are in **Appendix B**.

**Questionnaire ID (QuestID)** – the identification code initially entered by the FI into the laptop in order to begin the initial NSDUH interview. The QuestID also represents that same respondent when assigned to a CI for a follow-up telephone interview.

**Record of Calls (ROC)** – a term referring to the system that allows CIs to record details about each and every attempt to contact a respondent. Details include the date and time, the status code, and any important comments.

**Recruitment Scripts** – After completing the initial NSDUH interview, field interviewers use a script programmed in the back-end CAPI portion of the interview to describe the follow-up interview to the respondent. The series of screens are referred to as "recruitment scripts" and it is the first time the follow-up interview is introduced to the respondent.

**Respondent** – a person who is eligible and selected for the study, and who agrees to participate.

**Status Codes** – two-digit codes used to indicate the current status of each case. These codes are recorded in the Record of Calls in the CMS, and are reviewed with your Data Collection Manager. When compiled into regular reports, these codes provide important information to project managers and the client on the progress of data collection.

**Sample Dwelling Unit (SDU)** – a dwelling unit [either a housing unit (such as a single family home or apartment) or a group quarters unit (such as a dormitory room or a bed in a homeless shelter)] that has been randomly chosen for inclusion in the NSDUH.

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## 2. YOUR ROLE ON THE MENTAL HEALTH STUDY

### 2.1 Introduction

Many factors make an interviewer successful. Some general guidelines are to follow **all** procedures and instructions carefully, know the study, listen and reply to respondents' needs and concerns, and maintain open communication with your supervisors.

This chapter outlines your responsibilities as a clinical interviewer (CI) for the Mental Health Study and shows in general how the above factors come together for a successful experience.

### 2.2 Your Responsibilities

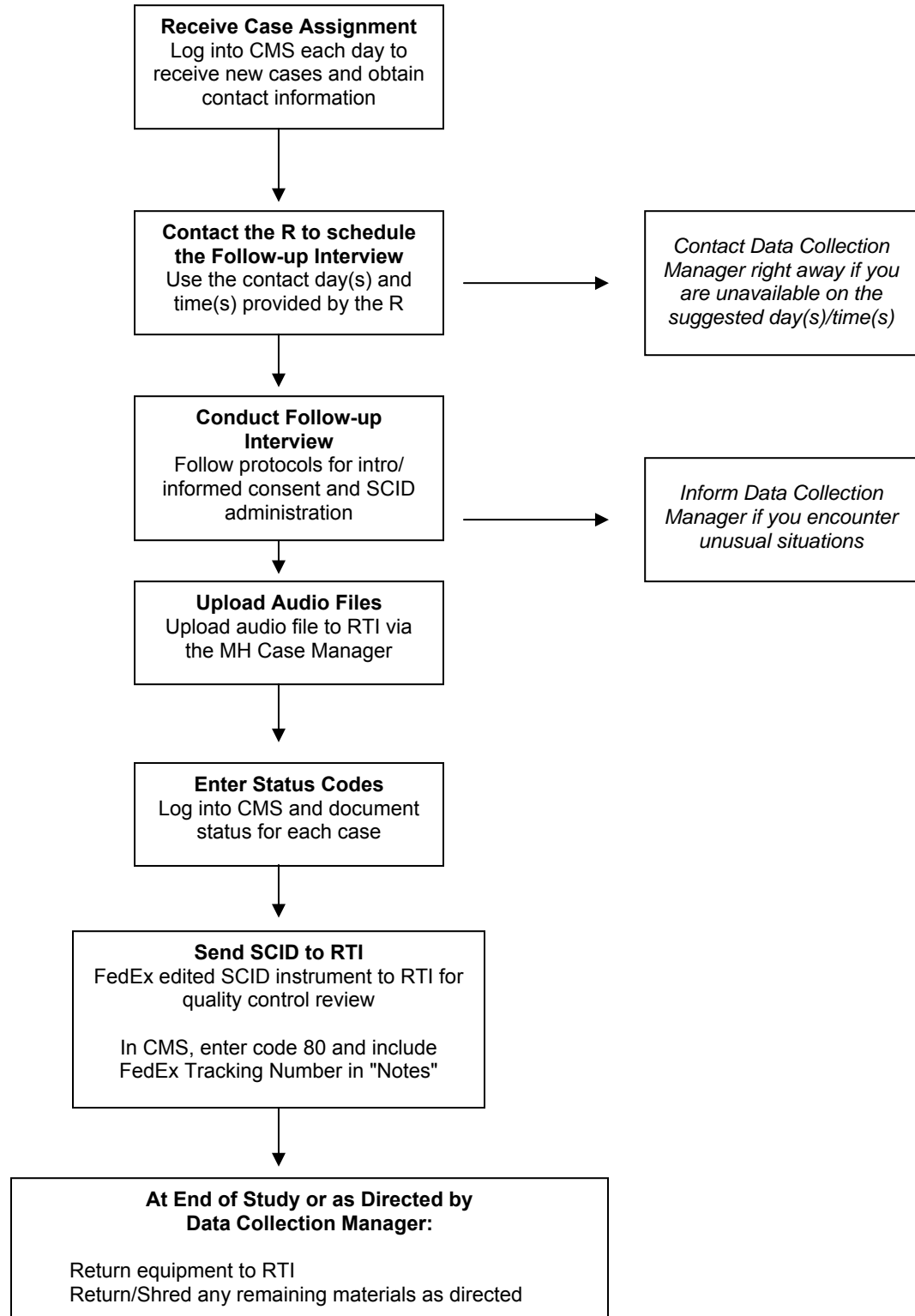
For this study, NSDUH field interviewers (FIs) will complete the initial NSDUH interview with selected respondents. When prompted at the conclusion of the interview, the FI asks the respondent about participating in an additional follow-up telephone interview. For respondents who agree to participate, the FI obtains the respondent's first name, telephone number and suggested contact day(s) and time(s). The FI then pays the respondent \$30 cash in advance, as a token of appreciation for participating in the follow-up interview.

As a CI, you are responsible for the next steps, including:

- receipt of follow-up interview case assignment;
- contacting the respondent; as needed, scheduling follow-up interview appointments;
- obtaining informed consent, including permission to audio record the interview;
- recording the interview (if permission granted);
- conducting the interview following all project procedures;
- evaluating possible respondent distress, handling the situation according to protocols;
- thanking the respondent for participating;
- copying the audio recording file to a secure website;
- shipping the completed and edited SCID to RTI; and
- reporting the status of each case promptly.

*Exhibit 2.1* contains a diagram of the overall process.

## Exhibit 2.1 CI Data Collection Process



Additional CI responsibilities include:

- read this handbook carefully prior to training;
- successfully complete the training program including assigned certification interviews;
- maintain the confidentiality of all survey data and materials at all times;
- maintain daily records of your data collection activities;
- review the status of cases during telephone conferences with your Data Collection Manager, providing detailed information about any problems with pending cases;
- review the technical aspects of SCID administration during calls with a Clinical Supervisor, accepting feedback to improve the quality of your interviews;
- complete and submit weekly electronic production, time and expense reports (ePTE reports) and other administrative forms in a timely manner and according to prescribed schedules;
- complete occasional training modules and/or exercises as assigned;
- meet or exceed project efficiency goals provided by the Data Collection Manager; and
- meet or exceed project quality standards (see *Chapter 8*).

### 2.3 Professional Ethics and Respondents' Rights

Given your education and professional training, you are very familiar with professional ethics and respondents' rights. Therefore, the information in this section is not intended so much to educate you as to share RTI's specific policies related to these topics.

Ethics can be broadly defined as a set of moral values or principles of conduct governing an individual or a group. Organizations must show clients, employees, and the public, a prevailing sense of integrity, honesty, and responsibility in all aspects of work.

All survey research conducted by RTI is based on the highest ethical standards. Interviewers are expected to maintain the same professional ethics as all RTI researchers. RTI's professional reputation depends upon all employees and all interviewing staff making the commitment to ethical standards a high priority.

As part of professional ethics, the rights of survey respondents **must** be protected by all RTI and Headway personnel. These rights include:

- The right of informed consent refers to the legal requirement that respondents be given complete and accurate information so that they can make an informed decision about their participation in the survey.
- To ensure that all RTI studies meet the legal and ethical requirements of informed consent, all projects involving human subjects must be approved by our Office of Research Protection, which serves as RTI's Institutional Review Board (IRB) under federal regulations. This committee looks very closely at the written introduction to the study to be sure that the respondents are being properly informed.
- The right to refuse refers to an individual's right to decline to participate in the study or to refuse to answer individual questions once an interview has begun.

- The right of privacy is guaranteed by the federal **Privacy Act of 1974**. This Act prohibits the release of data gathered by or for a federal agency without the written consent of the respondent. Fines and penalties apply to individuals or organizations that violate this law. You can explain this to a respondent when trying to gain his or her trust.
- The right to accurate representation requires honesty in dealing with respondents and answering their questions about the survey. For example, you cannot tell the respondent that an interview will take only a few minutes if you know it will last about an hour, or say that you work for a government agency such as the Census Bureau or the Public Health Service.

All staff involved in the collection, processing, and analysis of the survey data must be continually aware of the important responsibility to safeguard the rights of the survey participants. As clinical interviewers, you are in direct contact with these respondents and must demonstrate high ethical standards in **all** project contacts.

## 2.4 Importance of Confidentiality

Any and all information you learn about respondents, whether directly from a response you receive or simply through casual communication during a telephone call must be treated as confidential. Because of the sensitive nature of the NSDUH subject matter, project staff members must take special precautions to protect the confidentiality of respondents.

- The confidentiality of all responses to the questions is protected under federal law by the Confidential Information Protection and Statistical Efficiency Act of 2002 (CIPSEA), a government-wide law that provides strong confidentiality protections to many federal agencies conducting statistical surveys. Under CIPSEA, all answers are used for statistical purposes only and cannot be used for any other purpose.
- The NSDUH is one of the few surveys where the full name of the respondent completing the interview is never recorded. While the respondents' addresses are known, this information is kept separate from the respondents' answers.
- Respondents should be reassured that any potentially identifying data, such as their address, are never made available to anyone outside the project staff.
- Individual responses are only analyzed in combination with other responses collected nationwide.

All NSDUH staff including project planners at SAMHSA, RTI managers and technical staff, and all interviewing staff must share the commitment to protect the confidentiality of the respondents. Under CIPSEA, the penalties for knowingly and willfully disclosing confidential information are a Class E Felony which includes imprisonment for up to five years and fines up to \$250,000. Several NSDUH respondent materials outline the consequences of divulging respondent information to make it clear that their confidentiality will be protected.

Each year you must complete CIPSEA training, and then sign a Clinical Interviewer Confidentiality Pledge (shown in **Exhibit 2.2**). By signing, you are entering into a contractual agreement that you will keep confidential all data you collect. If you have any questions regarding this policy, discuss them with your Data Collection Manager prior to signing.

## Exhibit 2.2 Confidentiality Pledge

### National Survey on Drug Use and Health (NSDUH)

#### CLINICAL INTERVIEWER CONFIDENTIALITY PLEDGE

Conducted by:  
Research Triangle Institute (RTI)

Under contract to:  
Substance Abuse and Mental Health Services Administration (SAMHSA)

#### Assurance of Confidentiality

RTI assures each respondent that the confidentiality of their responses to this survey's information request will be maintained by RTI and that no information obtained in the course of this activity will be used for any purpose other than the statistical purpose for which it was supplied. This assurance of confidentiality is required by the Privacy Act and supported by Section 511 of the Confidential Information Protection and Statistical Efficiency Act of 2002 (CIPSEA). The Confidential Information Protection and Statistical Efficiency Act of 2002 ensures the confidentiality of all information provided is protected under Federal Law and protects the privacy of research subjects by stipulating that all information collected shall be used exclusively for statistical purposes.

Under the authority vested in the Secretary of Health and Human Services by Title V of the Confidential Information Protection and Statistical Efficiency Act of 2002 (PL107-347), all persons who --

1. are employed by RTI and its contractors and cooperating agencies; and
2. have, in the course of that employment, access to information which would identify individuals who are the subjects of a research project referred to as "National Survey on Drug Use and Health,"

are required to protect the privacy of the individuals who are the subjects of that research by withholding their names and other identifying characteristics from all persons not connected with the conduct of that research.

#### Agreement and Pledge

I have carefully read and I understand the Assurance of Confidentiality that pertains to the confidential nature of all data to be handled in regard to this project. As someone who will have access to data from the NSDUH, I pledge that I will not disclose any confidential information obtained under the terms of this contract to anyone other than authorized project staff at RTI or SAMHSA. I understand that under the Confidential Information Protection and Statistical Efficiency Act of 2002 [Section 513] I am subject to criminal felony penalties of imprisonment for not more than five years, fines of not more than \$250,000, or both, for violation of the Act. I have also completed and fully understand the CIPSEA training provided to me.

I further understand and agree to comply with the following confidentiality provisions:

1. Any materials that would permit the identification of survey participants are to be treated as confidential. These include both hardcopy and electronic records.
2. When confidential records are in use, access to all such records is limited to persons who have signed the project Confidentiality Pledge.
3. Confidential records must be kept in a secured (locked or password-protected) location when not in use.
4. Information obtained from the data collected or used under this contract may not be released to unauthorized persons.
5. Any involvement in the study is for research purposes only. Interviewers cannot and will not utilize their clinical knowledge or skills to provide medical or psychiatric advice, diagnosis or treatment to respondents.
6. No data, tabulations, or analyses obtained under this contract may be released or used without prior written approval of SAMHSA. At the close of the contract all data must be returned to SAMHSA.
7. Any breach of confidentiality must be reported immediately to the RTI Project Director. This information will be shared with the SAMSHA Project Officer.
8. Obligations under this agreement will survive the termination of any assignment with RTI.

\_\_\_\_\_  
*Name (Print)*

\_\_\_\_\_  
*RTI ID #*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

*Disposition: Original to the NSDUH Project File maintained by the Project Secretary.  
Revised: November 21, 2007*



## 2.5 Protecting Both Confidentiality and Study Integrity

In order to protect the confidentiality of respondents and preserve the scientific integrity of the Mental Health Study, there are several important protocols to follow regarding your interactions with respondents:

- Avoid calling the respondent by name (once you have confirmed you are speaking with the correct person).
- Never write down any potentially identifying information on the paper SCID while you are conducting the interview.
- Remind respondents, if needed, to not say their own name or potentially identifying information such as a place of business or address during the interview.
- Do not identify or introduce yourself as Dr. Jane Smith, but simply as Jane Smith.
- Do not offer information about your training or specialized background. If a respondent asks whether you are a doctor, psychiatrist, psychologist, social worker, or other mental health professional, you may disclose that you have medical or psychological training that allows you to fully understand the questions you are asking. Explain that your involvement in the study is for research purposes only.
- **Do not** provide psychological or medical counseling, advice, or other mental health services, even if you are qualified to do so. If asked for advice/diagnosis/treatment, refer the respondent to the national Lifeline.

Additionally, always consider the security of the confidential data you are collecting.

- Be sure the paper SCID is stored in a securely locked place when not in use, such as in a locked file cabinet.
- Since the laptop contains audio recordings of interviews, press the Ctrl/Alt/Del keys simultaneously to lock the computer or turn off the laptop when you are not working so that others cannot use it (see *Section 3.2.3*).
- Log out of the web-based case management system when finished, to maintain security.

## 2.6 Materials, Supplies, and Equipment

There are a variety of materials, supplies, and equipment you will use to conduct your work. Adequate quantities of materials and supplies will be sent to you prior to your data collection activities. You must use the proper materials for each follow-up interview. Be sure to monitor your level of supplies for upcoming work and if you require additional supplies, contact your Data Collection Manager. Descriptions of the purpose and use of each item can be found throughout this handbook.

### **Materials Needed for Interviewing:**

- NSDUH laptop computer equipment, including power cords and headphones
- One of two recording controls (telephone handset or wall jack) to use when audio recording the interview
- SCID booklet
- Pens to use with the SCID, either blue or black ink

- Mental Health Study CI Handbook
- SAMHSA Calling Card

**Administrative and Other Materials**

- Pre-printed Confidentiality envelopes for SCID
- Prepared FedEx labels to RTI and to RTI Technical Support
- FedEx packages/envelopes
- Working copy ePTEs
- Headway Expense Report Form
- Paper PT&Es (for backup)
- Pens, pencils,

This list of equipment and materials includes everything you need to conduct interviews according to project protocol. If you feel the need for some additional item or handout, please forward your suggestion to your Data Collection Manager who can pass it along to the appropriate staff for consideration. Please do not create your own materials.

At the conclusion of data collection, make arrangements to properly dispose of any remaining study materials as instructed by your Data Collection Manager, by either shipping them back to RTI or by recycling or trashing the documents.

Also, when finished with your Mental Health Study assignment or as directed by your Data Collection Manager, return the laptop and its accessories to RTI Technical Support. Use the packaging provided to safely pack the equipment, and then ship it via FedEx using the supplied, preaddressed label to Technical Support. **Section 7.8** contains detailed FedEx instructions.

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## 3. EQUIPMENT

### 3.1 Introduction

Because all follow-up interviews for the Mental Health Study will be conducted over the telephone, RTI will provide you with a calling card to use for contacting respondents and conducting interviews. RTI also provides a Gateway laptop to use for e-mail and connecting to the Internet for assignment and reporting information. In addition, all telephone interviews will be recorded (with the respondent's permission) using the laptop connected to your telephone via one of two recording controls. These audio recordings will be reviewed along with the SCIDs to assure the data collected are of high quality. **Remember, respondents must give their permission before the interview can be recorded.** Information regarding the procedures for obtaining respondents' permission to record the interview is in *Chapter 4*.

### 3.2 The NSDUH Laptop

You will use a NSDUH laptop computer to perform a number of your duties including accessing the Case Management System (CMS), checking e-mail, and audio recording interviews through the MH Case Manager. The next sections review the initial laptop set up and the login process. As needed for reference, consult *Appendix C* for details regarding the laptop hardware.

#### 3.2.1 Initial Set Up

During training, you will learn and practice each of the following steps in the initial set up of your laptop. Refer to Appendix C for additional details.

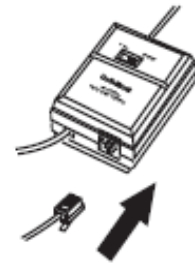
1. Connect the laptop to electrical power (see *Section C.4.1*).
2. As needed, connect the laptop to your high speed internet connection. If using a wireless connection, be sure to use a secure network.
3. Plug the headphones into the green headphone jack on the left side to disable the laptop speakers.
4. Connect the laptop to the telephone.

**For an ANALOG PHONE LINE**, use the Wall Jack Recording Control (pictured below) which goes between the wall and the telephone and follow these steps:

- 4a. Be sure the switch on the recording control is set to "Record" (not "Play").



4b. Disconnect the phone cord from the wall jack and plug into the control.



4c. Connect the recording control to the wall jack using the phone line attached to the controller.



4d. Connect the recording control's audio plug to the Mic jack on the front of the laptop, which is the jack to the left of the headphone jack near the right hand speaker.

**For a DIGITAL PHONE LINE**, use the Handset Recording Control (pictured to the right) which goes between the telephone and the telephone handset. Please note that this control does NOT work with a cordless telephone. Recording takes place through the handset of the telephone; therefore you must always speak through the telephone handset.

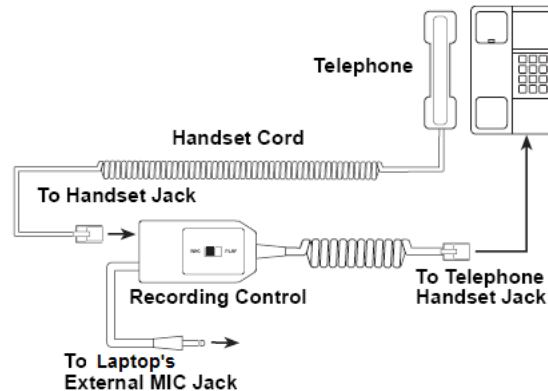


To connect, follow these steps:

4e. Be sure the switch on the recording control is set to "Record" (not "Play").

4f. Disconnect the coiled cord from the handset jack on the telephone and plug it into the jack labeled "Handset" on the recording control.

4g. Plug the short coiled cord from the recording control into the handset jack on the telephone.



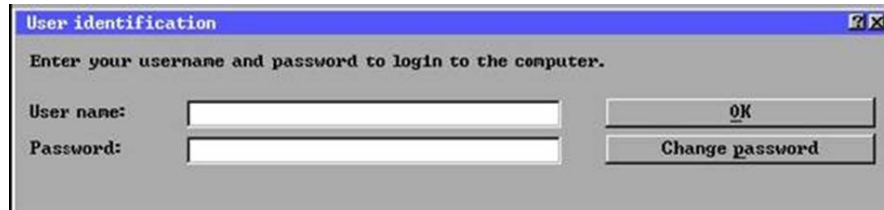
4h. Connect the recording control's audio plug into the Mic jack on the front of the laptop, which is the jack to the left of the headphone jack near the right hand speaker.

**Note:** Due to electrical interference between the Handset Recording Control and the AC Adapter for the laptop, you may notice a buzzing sound. This sound can be minimized if you disconnect the laptop from electrical power and run the laptop solely on battery power. To prevent loss of audio data, BE SURE you have adequate battery power to keep the laptop running for the entire interview. See **Section C.4** for more information on battery power and low battery warnings.

### 3.2.2 Login Procedures

Once your laptop computer is correctly connected, begin the login process to establish the proper connection with RTI.

1. Press the power button to turn on the laptop. Wait patiently as it powers on.
2. The PointSec security password prompt appears:



3. Carefully enter your user name (supplied separately) and the case-sensitive password. Note: The Touchpad does not work on this entry screen, so press TAB to move between the fields. When finished, press Enter.
4. The next pop-up box indicates your log in was successful. Press Enter.
5. At the Windows Login screen, use the same user name and password. The user name is prefilled, so type your password and press Enter.
6. You will next arrive at the Desktop. Icons on the desktop include:

- My Documents
- My Computer
- Recycle Bin
- Internet Explorer
- CMS Shortcut (see *Section 3.3*)
- E-mail Shortcut (see *Section 3.4*)
- Sound Volume
- MH Case Manager (see *Section 3.6*)
- ePTE Shortcut (See *Section 7.5*)

### 3.2.3 Locking the Laptop

Because your laptop contains confidential information, access **MUST** be limited to only project personnel. Each time you step away from the laptop, you must lock it to protect the information it contains.

1. To lock the laptop, simultaneously press the Ctrl/Alt/Delete keys.
2. At the Windows Security screen, click Lock Computer. As needed, click Cancel. Note: Do NOT use the Change Password option from this screen.

When ready to resume work, simply press Ctrl/Alt/Delete again. Enter your Security Login password as prompted.

### 3.2.4 Shutting Down the Laptop

When you have finished working for the day, go ahead and shut down the laptop. Doing so increases security and saves energy as well as wear on the laptop.

1. To shut down the laptop, simultaneously press the Ctrl/Alt/Delete keys, and then choose Shut Down.

OR

2. Click the Start button, select Shut Down, and then click OK.

### 3.3 Accessing the CMS

The CMS is the central point for many of your Mental Health Study tasks including case assignment and reporting.

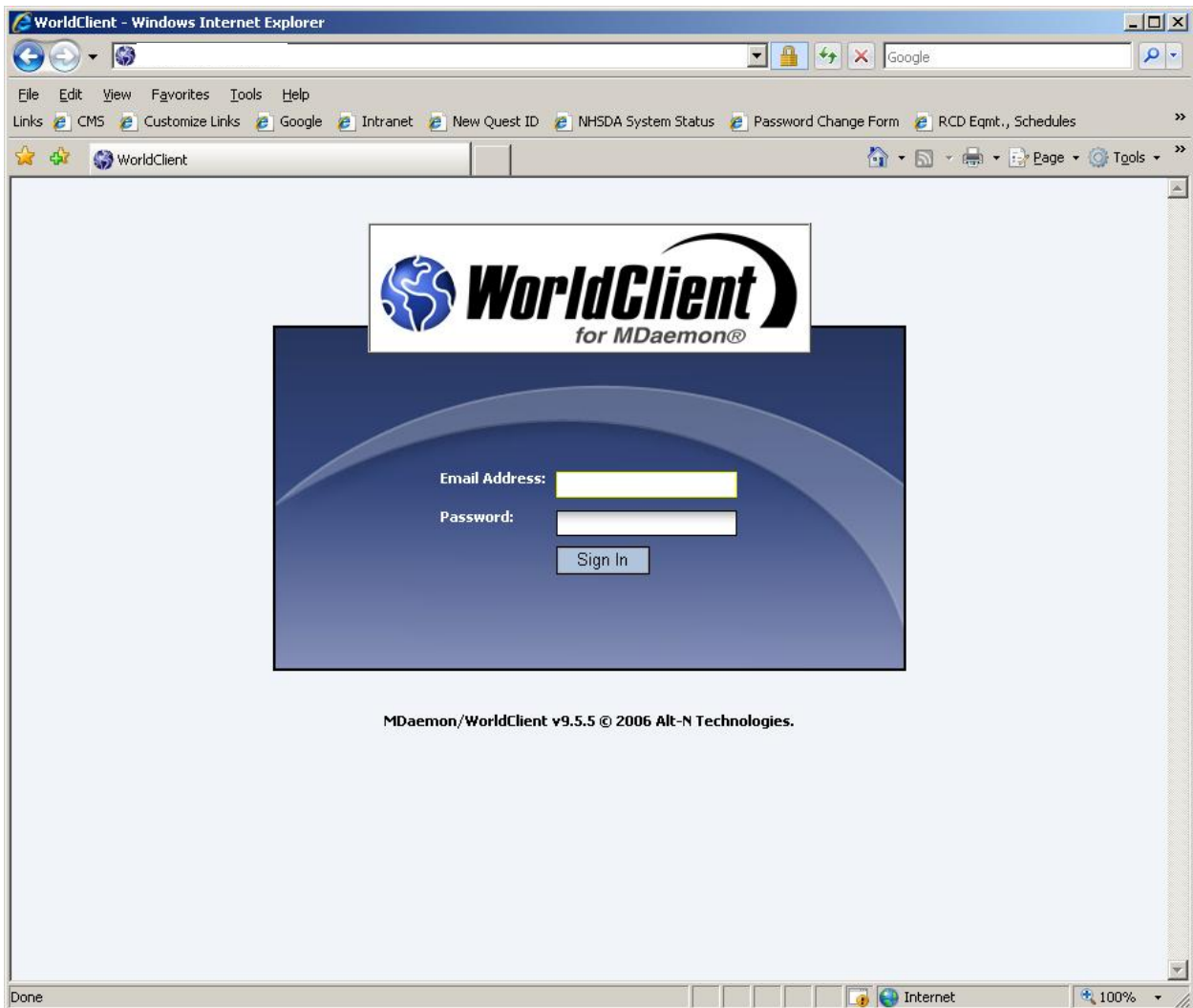
1. Be sure you are connected to the Internet either via an Ethernet cable or a wireless connection. To check, open Internet Explorer and see if you can view a standard web page such as yahoo.com.
2. Double click the CMS icon on the desktop. The website address is:
3. Enter the CMS user name and password (provided separately).
4. Then enter your individual CI user name and password to access the site.
5. The CMS Main Page appears. On the CMS Main Page are several different options allowing you to perform various tasks:

Link	Tasks	Reference
Case Status	Check assignment Update case status	Section 4.2.2 Section 6.2.4
Email	Link to RTI e-mail	Section 3.4
Incident Report Form	Document any distressed respondent situation	Section 5.7.4
Change Password	Update password, as needed	For use as needed Consult Data Collection Manager

### 3.4 RTI E-Mail

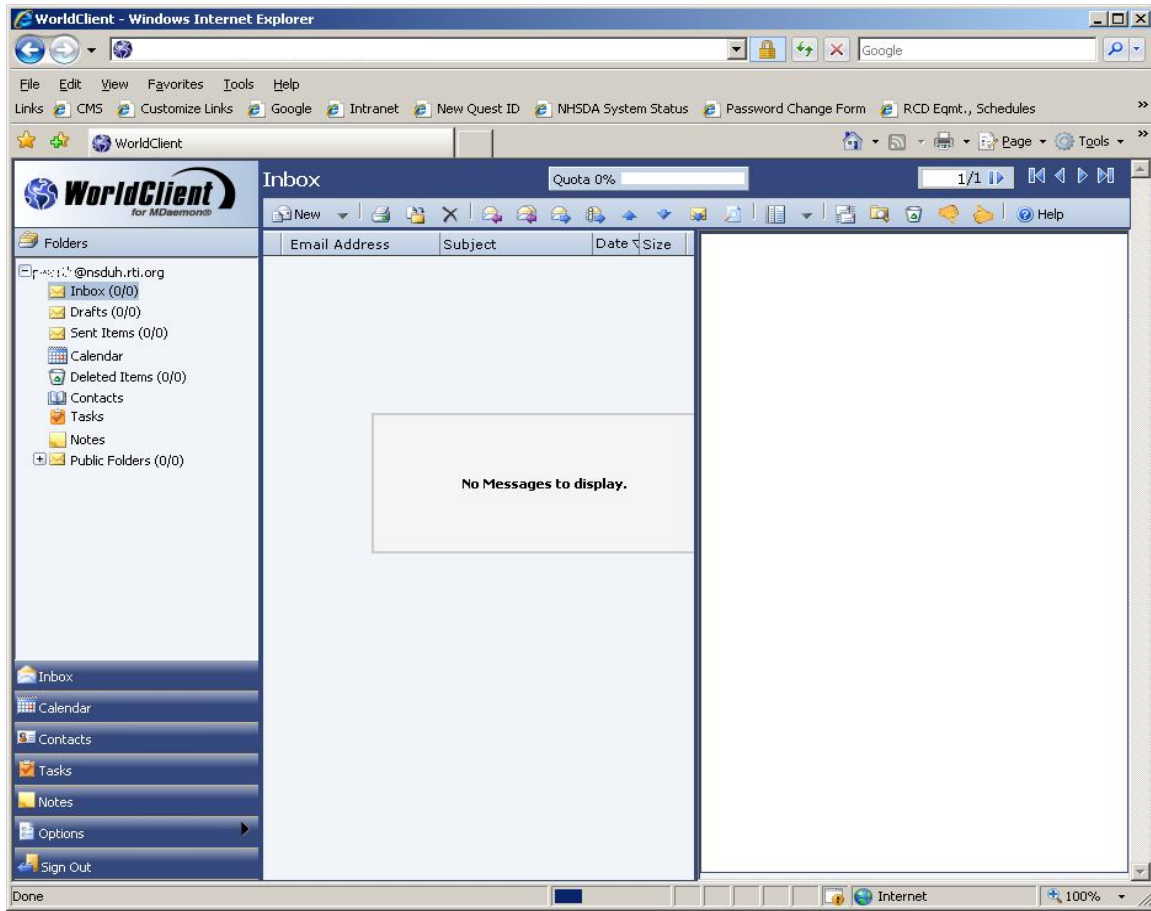
To ensure the secure exchange of information through e-mail, you will receive an RTI e-mail address and password. To access the RTI e-mail system, follow these steps:

1. With the laptop connected to the Internet, use the shortcut on the Desktop, or go to the following link:  
You can also access the system through the link on the Main Page of the CMS.
2. Next, you will see the screen shown below. Enter your full *Email Address* and *Password* in the fields provided, and click **Sign In**.





3. The next screen you see will be your Inbox.



The RTI e-mail system contains many typical e-mail features. Working knowledge of typical e-mail functions is required. Should you have any questions or problems using the RTI e-mail system, feel free to contact your Data Collection Manager.

### 3.5 Calling Card

RTI will provide you with a calling card for your work on the Mental Health Study. This card should be used for all calls you make for the Mental Health Study that are not toll-free calls. Follow these steps to use the calling card:

5. Dial \*67 on your telephone. (*Optional*: This step blocks your phone number from displaying on Caller ID)
6. Dial the toll-free number on the back of the card
7. Enter the card number (printed on the front and back of the card)
8. Enter 0 + Area Code + Telephone number you wish to call

Please remember Step 1 which is not included with the instructions for placing a call printed on the back of the calling card. This optional step blocks the phone number from which you are calling from being displayed on a Caller ID feature that may be on the respondent's telephone. If you are unable to successfully place a call to a respondent because of a privacy blocker function on his/her phone system and you do not feel comfortable unblocking your number, notify your Data Collection Manager.

### 3.6 Audio Files

As an important quality control measure, you will ask permission and if granted, will make an audio recording of each interview. By connecting your telephone through the laptop, special software on the laptop then records the conversation. When finished, you can upload this audio file to a secure RTI website accessible only by qualified RTI personnel.

The MH Case Manager available on the laptop controls all aspects of the audio recording process. The following sections provide details on using the MH Case Manager.

#### 3.6.1 Connecting and Using the MH Case Manager

Follow the steps below to use the laptop to record audio files:

1. Be sure the laptop is properly connected to the telephone. Refer to *Section 3.2.1* as needed.
2. Be sure you are connected to the Internet either via an Ethernet cable or a wireless connection. To check, open Internet Explorer and see if you can view a standard web page such as yahoo.com.

**Note:** If you are unable to connect to the Internet, you can still record an interview. See the end of *Section 3.6.3* for directions.

3. Double click the Case Manager icon on the desktop.
4. Enter the same main CMS user name and password used to access the CMS.
5. The Case Manager screen appears, listing available cases and various task buttons.

Case Manager										
File View Configure Action Help										
Quest ID	Status Code	Quarter	Create Date	Contact Name	Contact Phone	Time Zone	Contact Date	Contact Time		
9999990	52 08/17/2010	4	10/12/2010	Jane	(999)-999-9999	Eastern	any day	mornings		
▶ 9999991	00 10/03/2010	4	10/03/2010	Inez	(999)-999-9990	Eastern	M, W	7-9 pm		
9999992	00 10/04/2010	4	10/04/2010	Keith	(999)-999-9991	Eastern	Tuesday	afternoon		
9999993	00 10/05/2010	4	10/05/2010	Jasmine	(999)-999-9992	Mountain	W or Th	6 or 7 pm		
9999994	00 10/06/2010	4	10/06/2010	Rosa	(999)-999-9993	Pacific	weekends	any time		
9999995	00 10/07/2010	4	10/07/2010	Alberto	(999)-999-9994	Eastern	weekdays	evening		
9999996	00 10/08/2010	4	10/08/2010	Gretchen	(999)-999-9995	Central	Tuesday	afternoon		
9999997	00 10/09/2010	4	10/09/2010	Sarah	(999)-999-9996	Mountain	Saturday	10 am to noon		
9999998	00 10/10/2010	4	10/10/2010	Timothy	(999)-999-9997	Pacific	weekends	any time		
9999999	51 08/17/2010	4	10/11/2010	Joe	(999)-999-9998	Eastern	any day	mornings		

Quest ID	9999991	Contact Date	M, W
Time Zone	Eastern	Contact Time	7-9 pm
Recording Test		Start Recording	
		Upload	
Quest ID	9999991	Contact Phone	(999)-999-9990

File Name	WAV Size (KB)	MP3 Size (KB)	Record Start Date/Time	Record Stop Date/Time	Converted?	Convert Date/Time	Uploaded?	Upload Date/Time

The chart shows the identification number for each case—the QuestID—along with other respondent contact information. For details, see *Section 4.2.2*.

6. As the number of files increases and eventually fills the screen, you may have to scroll through the list to find a specific case. By default, cases are displayed in numerical order by QuestID. To change the order, click the column heading you wish to sort by. For example, if you wish to have the more recent files showing, click Create Date.

### 3.6.2 Initial Test Audio Files

Before contacting a respondent, you must first perform a quality control check to ensure the laptop is properly recording audio files. Each time before calling a respondent, follow the steps below to complete an initial test audio file:

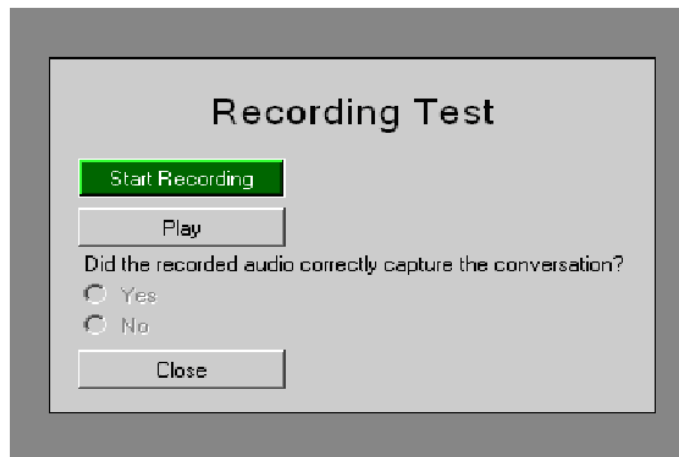
1. Highlight the appropriate QuestID for the case. The information for the selected case displays towards the bottom of the screen.
2. Click "Recording Test" in the lower left corner. The following screen appears:



3. Click the green "Start Recording" button.
4. Make your test call by calling a local number with an automated voice. Listen for that voice, and also say a few words yourself. One suggestion is to call a work or cell phone which will be answered by voice mail.
5. When finished, click the red "Stop Recording" button.



6. On the next screen, click Play to listen to the recording. Be sure you can hear both sides of the conversation. Since the headphones connected to the laptop disable the laptop speakers, use the headphones to listen to the recording.



7. When the audio test file finishes playing, answer the question "Did the recorded audio correctly capture the conversation?" Click Yes or No as appropriate. For a No response, you must complete another test recording before contacting the respondent.

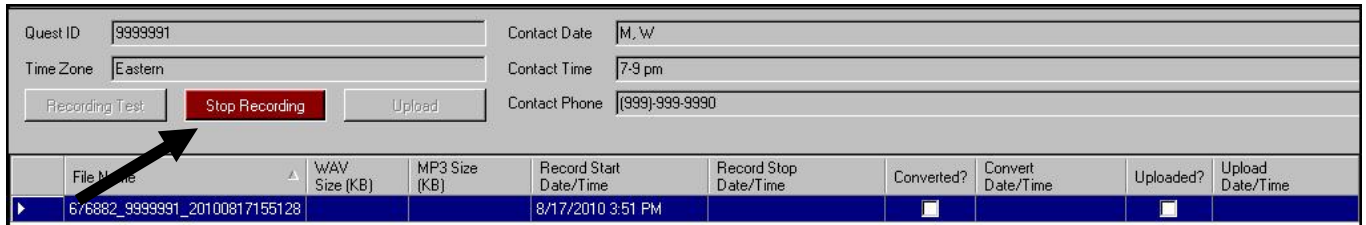


8. When finished, click "Close."

### 3.6.3 Recording the Interview

After properly completing the test recording, you can contact the respondent (see *Chapter 4*) and with permission, record the interview.

1. The "Start Recording" option becomes active following the successful test recording. So once you have permission to record, click the green "Start Recording" button.
2. The button turns red and says "Stop Recording" as shown below. You will see blue flashes along the bottom of the screen, indicating that recording is taking place. All the fields fill automatically.



The screenshot shows a web interface for recording interviews. At the top, there are input fields for Quest ID (9999991), Contact Date (M, W), Time Zone (Eastern), Contact Time (7:9 pm), and Contact Phone ((999)999-9990). Below these fields are three buttons: "Recording Test" (disabled), "Stop Recording" (active, red), and "Upload" (disabled). An arrow points to the "Stop Recording" button. Below the buttons is a table with the following columns: File Name, WAV Size (KB), MP3 Size (KB), Record Start Date/Time, Record Stop Date/Time, Converted?, Convert Date/Time, Uploaded?, and Upload Date/Time. The table contains one row with the following data: File Name: 6/6882\_9999991\_20100817155128, WAV Size (KB): [blank], MP3 Size (KB): [blank], Record Start Date/Time: 8/17/2010 3:51 PM, Record Stop Date/Time: [blank], Converted?: [checkbox], Convert Date/Time: [blank], Uploaded?: [checkbox], Upload Date/Time: [blank].

Also, the audio file name appears in the bottom left corner of the screen under the "File Name" column. The audio file is automatically named, and includes your interviewer ID, the QuestID, as well as the date and time the file was recorded.

3. When finished with the interview, hang up the telephone and click the red "Stop Recording" button.

Note: Should you need to stop the interview and start again, please note that you will have two audio files associated with the case. Be sure to upload both files to RTI.

It is possible to record an interview when you are **unable to connect to the Internet**. While this is not preferred, it is possible. Follow these steps:

1. When accessing the MH Case Manager, click "Cancel" in the user name and password pop-up box.
2. Enter the QuestID for the interview in the "QuestID" box at the bottom of the screen.
3. Enter your interviewer ID when prompted.
4. Complete the initial test recording and then record the actual interview.
5. Please note you must be properly connected to the Internet to upload the audio file to RTI.

### 3.6.4 Uploading Audio Files to RTI

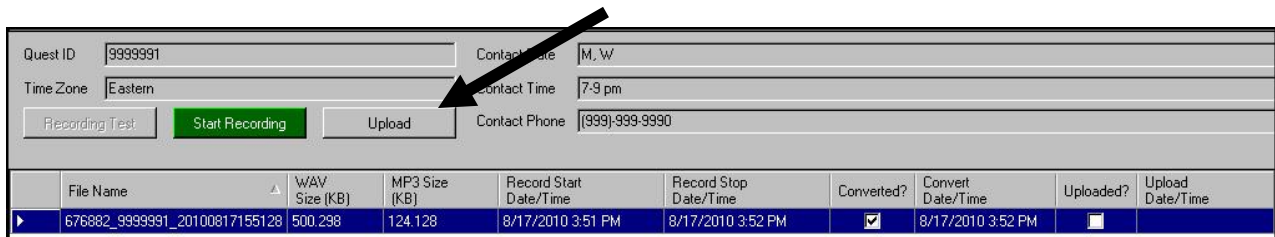
After completing each interview (and before starting another interview), upload the audio recording to RTI through the MH Case Manager, so that the files can be accessed by authorized project staff. After hanging up with the respondent and clicking "Stop Recording," follow these steps to upload the audio files:

1. In the second to last column on the right, notice the response in the "Uploaded?" column is blank, meaning the file has not been sent to RTI but has been saved on the laptop.



Quest ID	9999991	Contact Date	M, W					
Time Zone	Eastern	Contact Time	7-9 pm					
<input type="button" value="Recording Test"/>	<input type="button" value="Start Recording"/>	<input type="button" value="Upload"/>	Contact Phone	(999)999-9990				
File Name	WAV Size (KB)	MP3 Size (KB)	Record Start Date/Time	Record Stop Date/Time	Converted?	Convert Date/Time	Uploaded?	Upload Date/Time
▶ 676882_9999991_20100817155128	500.298	124.128	8/17/2010 3:51 PM	8/17/2010 3:52 PM	<input checked="" type="checkbox"/>	8/17/2010 3:52 PM	<input type="checkbox"/>	

2. Click the "Upload" button located to the right of the green "Start Recording" button. All interviews that have not yet been sent to RTI will be uploaded.



Quest ID	9999991	Contact Date	M, W					
Time Zone	Eastern	Contact Time	7-9 pm					
<input type="button" value="Recording Test"/>	<input type="button" value="Start Recording"/>	<input type="button" value="Upload"/>	Contact Phone	(999)999-9990				
File Name	WAV Size (KB)	MP3 Size (KB)	Record Start Date/Time	Record Stop Date/Time	Converted?	Convert Date/Time	Uploaded?	Upload Date/Time
▶ 676882_9999991_20100817155128	500.298	124.128	8/17/2010 3:51 PM	8/17/2010 3:52 PM	<input checked="" type="checkbox"/>	8/17/2010 3:52 PM	<input checked="" type="checkbox"/>	

3. When finished, the "Uploaded?" column has a check indicating that the file has been uploaded to RTI. The Upload Date/Time column is filled as well.

NOTE: You must be connected to the Internet to upload successfully. If you get an error message, first check your Internet connection (minimize the Case Manager and click on Internet Explorer to see if you can view a web page such as yahoo.com). If you are connected, return to the Case Manager and try to upload again.

The audio files will remain on the laptop's hard drive. You will not have to delete these files.

### **3.7 Technical Support Contact Information**

If you have any problems using the audio recording process or uploading files, first contact your Data Collection Manager. If he/she is unavailable or directs you to do so, contact the NSDUH Technical Support Group (TSG) at . Technical Support is available Monday through Friday from 8:30 am to midnight (Eastern time) and from 10:00 am to midnight (EST) on weekends.

Explain that you are a clinical interviewer working on the **Mental Health Study** and you have a problem requiring their assistance.

## 4. CONTACTING RESPONDENTS

### 4.1 Introduction

With every scientific survey, many components contribute to the overall success of the research. As a clinical interviewer for this study, you are responsible for one of the most important aspects of the study: making sure the follow-up interview is administered properly. The interview process begins with preparation tasks as explained in this chapter including receiving cases, initially contacting respondents, and completing the study introduction process according to protocol. *Chapter 5* discusses the steps required while conducting an interview and offers suggestions for dealing with some respondent situations you may encounter.

### 4.2 Case Assignment

This section describes the process of learning details about a case assigned to you for completion.

#### 4.2.1 Case Identification Information

Each household selected for an initial NSDUH interview is assigned a Case Identification number (Case ID) which is a 10-character code that starts with the state abbreviation and uniquely identifies that household for the study (e.g. NY10010001). When the initial interview is generated and completed, a 7-digit number called the Questionnaire ID (Quest ID) is assigned to that particular interview respondent (e.g. 9994435).

Because you will be conducting follow-up interviews with NSDUH respondents who have already completed an initial interview, the cases you are assigned will be identified by the 7-digit **Quest ID**. All cases will be stored and tracked on a secure RTI web site that will be accessible to you and NSDUH project staff. All clinical interviews must be completed within four weeks from the time of the initial interview with the vast majority of **cases completed within two weeks**, leaving the final two weeks for continued follow-up of difficult-to-contact cases. All clinical interviewing work must be completed by the deadlines provided. The Data Collection Manager will assign cases based on the time the initial interviews are completed and your availability.

#### 4.2.2 Case Assignment Details

On each day you have indicated you are available to work, check for new cases assigned to you. The web-based Case Management System (CMS) provides important details about new cases including contact information for the respondent with whom you will be conducting the follow-up interview.

To check for new cases, first log into the CMS website (refer to *Section 3.3*, Accessing the CMS, for details).

To see assignment information, click the "**Case Status**" link on the CMS Main Page.



At the top of the screen, a table allows you to filter the information displayed.

The screenshot shows a filtering interface with the following elements:

- Case Type:** All Cases
- Status / Review Code:** All (00-40)
- State:** All (AZ)
- After:** Jan 1
- Created Date:** Between
- Status Date:** Aug 17
- Before:** (empty)
- DCM:** All FS
- CI:** ALL CT's
- Buttons:** Filter Data, Set, Main Page
- Input:** QuestID

To easily view your cases, simply click "Filter Data."

A listing of cases assigned to you and additional information associated with each case appears.

10 Records shown below.

Case Data Information for CS (902)

QuestID	Status Code	Qtr	Created Date	Contact Name	Contact Phone	Contact Note	Time Zone	State	Best Days	Best Time	DateTime Note	CI	Case Note	Address
9999991	00	4	10/03/2010	Inez	(999)-999-9990	(999)-999-0001 work	Eastern	NC	M, W	7-9 pm		SMITH JANE (676882)	No	<a href="#">Click here</a>
9999992	00	4	10/04/2010	Keith	(999)-999-9991		Eastern	IN	Tuesday	afternoon	weekends also	SMITH JANE (676882)	No	<a href="#">Click here</a>
9999993	00	4	10/05/2010	Jasmine	(999)-999-9992	(999)-999-0002 cell	Mountain	CO	W or Th	6 or 7 pm	works late nights, sleeps days	SMITH JANE (676882)	No	<a href="#">Click here</a>
9999994	00	4	10/06/2010	Rosa	(999)-999-9993	Cell phone only	Pacific	CA	weekends	any time	weekends when cell minutes free	SMITH JANE (676882)	No	<a href="#">Click here</a>
9999995	00	4	10/07/2010	Albeta	(999)-999-9994		Eastern	NH	weekdays	any time		SMITH JANE (676882)	No	<a href="#">Click here</a>

The information displayed in each column is defined below.

- Quest ID:** A unique identifying number used to identify the case
- Status Code:** A code that indicates the current status of the case (refer to *Section 6.2*) along with the entry date for the code
- Qtr:** Indicates the Quarter in which the case is generated
- Created Date:** Displays the date of the initial interview
- Contact Name:** Interview respondent's first name
- Contact Phone:** Interview respondent's phone number
- Contact Note:** Notes made by the field interviewer about the respondent's name/number including an alternate contact number
- Time Zone:** Time Zone for the respondent's area
- State:** Respondent's home state
- Best Days:** Best day(s) to reach the respondent, as reported by the respondent during the initial interview
- Best Time:** Best times to reach the respondent, as reported by the respondent
- DateTime Note:** Notes made by the field interviewer about the contact day/time information
- CI:** Assigned Clinical Interviewer name and ID number for the case
- Case Note:** "Yes" indicates notes about the case have been entered by the Clinical Interviewer and/or the Data Collection Manager (click "Yes" to display notes)
- Address:** Link to respondent's address. This should only be used in the case of a distressed respondent and according to the Distressed Respondent protocol (see *Section 5.7.4*).

The columns most useful to you when obtaining your assignment information are the **Quest ID** column, and the **Contact Name, Contact Phone, Best Days and Time** columns which display the respondent's first name, phone number and the best day and time to contact. Any notes provided by the field interviewer may also be informative. The **Time Zone** column lets you know the time of day in the respondent's area. Be sure to also note the **Created Date** column as interviews should be completed within 2 weeks, and must be completed within 4 weeks of this date.

Due to these deadlines as well as the importance of contacting the respondent soon after the completion of the initial NSDUH interview, do not wait more than a day or so to contact the respondent. For example, if the best day/time listed for a newly assigned case is 5 days away, go ahead and contact the respondent. Perhaps you can establish a firm appointment to complete the interview at that best day/time, or maybe you can go ahead and complete the interview when you call.

### 4.3 Contacting the Selected Respondent

The interview respondents you will be contacting are familiar with the purpose of your call as they will have already agreed to participate in this special study. However, they may have questions or need additional information. Strategies and tools for contacting selected respondents are outlined here.

#### 4.3.1 Preparation

Before you dial the number, review the list of interviewing materials in *Section 2.6* to make sure you have all necessary paperwork and equipment. Also be sure your laptop is connected to the telephone, ready to record the audio, and that you have completed the initial test recording through the MH Case Manager (see *Section 3.6* for details).

Keep in mind the subtle differences when interviewing over the telephone.

Location: To ensure privacy for your respondent, be sure you are in a private location within your home or office. Even though you are not to call the respondent by name during the interview, other identifying information may be mentioned, such as asking for the respondent or verifying the telephone number when you call.

Speakerphone: Do NOT use a speakerphone while conducting the interview, as that greatly increases the chance the respondent's answers could be overheard. To increase your comfort level while interviewing, you may use a headset with the Wall Jack Recording Control used with analog phones (refer to *Section 3.2.1*).

Style: Think about your telephone style. You should be serious, pleasant, and self-confident. Your voice and words must convey your credibility; it is not just *what you say* but *how you say* it. For example, if you sound uncertain, this feeling will be communicated to the respondent, who will react accordingly.

Voice: Be sure to speak clearly, and at a comfortable, conversational pace. Based on RTI's experience, the first twenty seconds of your telephone call can determine the outcome, so be prepared.

Communicate: Remember to *talk to* the respondents, *not at* them. This requires that you respond interactively and listen to what the respondents say. If they believe you are really interested in them, they will be more likely to participate fully.

Always keep in mind that you are a professional doing a very important job. As a professional, you are expected to possess a great deal of knowledge about the survey you are conducting—its purpose, the type of sample, the interview process, etc. Also, you must always maintain the highest of ethical standards, collecting data with complete objectivity and treating with the utmost confidentiality and respect **all** information gathered or observed during an interview. You must convey to every respondent that you are a professional, that you are completing the interview in a completely confidential manner, and that you are not affected by any personal biases, opinions or prejudices.

#### **4.3.2 Initial Contacts**

Often your first call establishes a connection between you and the respondent as well as an appointment time for the interview. To maximize efficiency and save time for both you and the respondent, be prepared and attempt to complete the interview during your first contact.

An introductory script contained within the first few pages of the SCID booklet (*Exhibit 4.1*) guides you through the introduction process as well as the necessary steps before beginning the interview (refer to *Section 4.4*).

## Exhibit 4.1 Clinical Interviewer Introduction Script

Before you call, **be prepared**:

- Review the assignment information provided including the respondent name, telephone number, as well as the date of the initial interview.
- Have your schedule available (in case you need to schedule an appointment).
- Have all interviewing materials available.

### VERIFY NUMBER AND LOCATE RESPONDENT

Hi, my name is \_\_\_\_\_ and I'm calling on behalf of the U.S. Public Health Service. Is this [PHONE NUMBER]?

YES: PROCEED BELOW.

NO: I apologize. I need to double check my records. Thank you for your time. END CALL.

I'm trying to reach [FIRST NAME] who agreed to take part in a telephone interview we're conducting. May I speak to [FIRST NAME]?

### IF R NOT HOME OR UNAVAILABLE

When would be a good time to call again? ENTER CODE 51 AND DETAILS IN CMS.  
Thank you for your time. END CALL.

### IF R AVAILABLE

(Hi, my name is \_\_\_\_\_.)

You recently completed an interview in your home with an interviewer working on the National Survey on Drug Use and Health. I am the interviewer you were told would contact you for a follow-up telephone interview. Do you recall completing the first interview?

YES: PROCEED BELOW.

NO: VERIFY FIRST NAME OF PERSON YOU ARE SPEAKING TO.

IF NOT SPEAKING TO CORRECT RESPONDENT, ASK TO SPEAK TO RESPONDENT.

IF NAME IS CORRECT AND RESPONDENT DOESN'T RECALL INITIAL INTERVIEW, REMIND OF DATE OF INITIAL INTERVIEW.

IF CORRECT RESPONDENT STILL NOT FOUND: I apologize. I need to double check my records. Thank you for your time. END CALL. ENTER CODE 59 AND INVESTIGATE.

Are you in a place where you can safely talk on the phone and answer my questions?

YES: PROCEED

NO: Are you able to move to a place where you can safely talk?

YES: PAUSE, THEN CONTINUE

NO: When would be a good time to call again? ENTER CODE 50 AND DETAILS IN CMS. Thank you for your time. END CALL.

Is now a good time to complete this interview?

YES: PROCEED. BE SURE TO READ VERBATIM.

NO: When would be a good time to call again? ENTER CODE 50 AND DETAILS IN CMS.

Thank you for your time. END CALL.

## Exhibit 4.1 Clinical Interviewer Introduction Contact Script (Continued)

### PRIVACY

Because you may not want others to hear the responses to some of our questions, I'd like to be sure you're in a private area. Where are you right now? Are you at home, at work, or somewhere else? Are you in an area where you can answer these questions privately?

YES: PROCEED

NO: Please consider moving to a more private area. Do you need more time?

YES: PAUSE, THEN CONTINUE

NO: CONTINUE

### INFORMED CONSENT

Before we begin, I would like to remind you of the study details. This study, sponsored by the United States Public Health Service, asks questions about various mental health issues such as depression, anxiety, post traumatic stress disorder, and substance dependence. Although there is no benefit to you personally, knowledge gained from this study will improve our ability to describe and understand mental health issues in the United States. While the interview has some personal questions, federal law keeps your answers private. The only exception to this promise of confidentiality is if you tell me that you intend to seriously harm yourself or someone else; in this situation I may need to notify a mental health professional or other authorities.

Your participation is voluntary. You may consider some of the questions to be sensitive in nature and some of the questions may also make you feel certain emotions, such as sadness. Remember that you can refuse to answer any questions that you do not want to answer, and you can stop the interview at any time. If you become upset at any time during the interview and wish to speak to a mental health professional about how you are feeling, I will provide you with the toll-free hotline numbers that are printed on your payment receipt from the first interview. It is important for you to keep in mind that I will not be providing you with a psychological diagnosis or any mental health advice or counseling. The information we are collecting today is only for research purposes.

These study details are also included on the Follow-up Study Description you received from the interviewer who met with you in your home. Do you have any questions before we begin? ANSWER ANY RESPONDENT QUESTIONS.

Is it OK to continue with the interview?

YES: PROCEED TO NEXT PAGE

NO: BASED ON CONVERSATION:

What sort of concerns do you have about participating?

OR

Are there other questions that I could answer for you?

IF R STILL UNWILLING TO PARTICIPATE: Thank you for your time. END CALL.

## Exhibit 4.1 Clinical Interviewer Introduction Contact Script (Continued)

### RECORDING PERMISSION

In order to ensure that I am conducting this interview accurately and properly, I would like to make an electronic audio recording of this interview. This is done strictly for quality control purposes. The recording will only be listened to by staff members on the project who have signed confidentiality pledges. The recording will be stored in a secure manner and will not contain your name—only a random number that will be assigned to this case. To help maintain confidentiality, we ask that you not give your name or any other identifying information, such as an address or place of business, during the interview. All recordings will be permanently destroyed within eighteen months after the end of the data collection period. You can still do the interview if you do not want me to record it.

Do you agree to allow me to record the interview?

YES: I will now begin recording. START RECORDING AND SAY: "This is [YOUR FIRST AND LAST NAME] conducting telephone interview [QUEST ID] on [DATE]."

NO: DON'T RECORD

Ok, let's get started.

#### CI NOTES:

IF ASKED AT ANY TIME BY A RESPONDENT WHETHER THE INTERVIEWER IS A DOCTOR, PSYCHIATRIST, PSYCHOLOGIST, SOCIAL WORKER, OR OTHER MENTAL HEALTH PROFESSIONAL, YOU MAY DISCLOSE THAT YOU HAVE MEDICAL OR PSYCHOLOGICAL TRAINING THAT ALLOWS YOU TO FULLY UNDERSTAND THE SURVEY.

HOWEVER, YOU SHOULD EXPLAIN THAT YOUR INVOLVEMENT IN THIS STUDY IS FOR RESEARCH PURPOSES ONLY AND IN NO WAY CONSTITUTES MEDICAL OR PSYCHOLOGICAL ADVICE, TREATMENT, OR DIAGNOSIS. EXPLAIN THAT THIS IS NOT THE NATURE OF THIS EFFORT.

IF RESPONDENT REQUESTS PSYCHOLOGICAL COUNSELING OR ADVICE OF ANY KIND, REFER HIM/HER TO THE NATIONAL LIFELINE. IF RESPONDENT IS INTERESTED IN CONTACTING THE LIFELINE, OFFER TO STAY ON THE PHONE AND CONNECT THEM VIA A THREE-WAY CALL.

### 4.3.3 Follow-Up with Respondents

If the respondent cannot complete the interview during your initial call, try to set a firm appointment with him/her for the interview. At a minimum, ask for a good time of day to call back. Document all details of the contact in the CMS, including appointment information (see *Section 6.2*). Review all contact information prior to calling again.

If you get an answering machine or voice mail, listen carefully to the message as it can help you verify the name and/or telephone number. On your first call, leave a message such as:

"Hi. I'm [YOUR NAME] and I'm calling on behalf of the U.S. Public Health Service, trying to reach [RESPONDENT'S NAME] about an important study. I am sorry I missed you. I will call again. Thank you."

If you continue to call and only get voicemail, leave messages every third call and for any call made during the time specified by the respondent as a good time to call.

In general, it is best to not leave a call back number for security reasons. However, if you are having trouble reaching a respondent, you may consider leaving a call back number. For privacy reasons, we recommend not using your home number. Also, you should not contact a respondent using a cell phone, since you would be unable to conduct/record the interview. If you leave a work number on the voice mail, the respondent might call you at an inconvenient time for you to conduct the interview, although you could perhaps establish an appointment. Consider providing that number only for difficult cases and be sure to discuss the situation with your Data Collection Manager.

## 4.4 Beginning the Clinical Interview

Once you have the respondent on the phone ready to begin the interview, you have a few more steps to complete before you can begin the actual interview. First, as scripted on the introductory script (refer to *Exhibit 4.1*), remind the respondent about the importance of privacy.

### 4.4.1 Informed Consent

Even after a respondent has initially agreed to participate, you must follow all informed consent procedures. The respondents' Right to Informed Consent is a critical part of any legitimate research project, as each person must receive all the information necessary to make a completely informed and knowledgeable decision about participating. Even if the respondent immediately agrees to be interviewed, you are still required to follow the informed consent procedures and read the scripted introduction before you begin the interview. If a respondent interrupts while you are reading the informed consent script, thank him/her for his/her willingness to participate, but explain that you are required to read certain information to make sure he/she is fully informed prior to agreeing to participate. This information **must** be made available to each respondent. By following the scripted introduction (refer to *Exhibit 4.1* as needed), you will properly cover all informed consent requirements.

#### **4.4.2 Explaining the Survey and Answering Questions**

Although the respondent has already agreed to participate and received a Follow-up Study Description (see *Exhibit 4.2*) and the additional cash payment for the telephone interview, you may still encounter respondents with questions or concerns about participating in an additional interview.

Be sure you are familiar with the background information on the study (see *Chapter 1* and *Appendix A*). We encourage you to learn as much as possible about the NSDUH so that you are comfortable answering questions about it. Specific questions relating to the Mental Health Study interview and suggested responses are given in *Exhibit 4.3*.

#### **4.4.3 Recording the Interview**

As a quality control measure, you are to create an audio recording of each interview. (See *Chapter 3* for details on the audio recording process.) During the introduction, you must review the recording process with each respondent and ask for permission to record. If the respondent agrees, start the recording, read the statement found on the introductory script identifying you as the CI and the Quest ID for the case, then begin the interview.

If the respondent does not give permission for recording, do not start recording but proceed with the interview. When later entering the status for the case, include in the Notes the respondent's reason for not giving permission to record, if you know the reason.



## Exhibit 4.2 Follow-Up Study Description



**U.S. Public Health Service  
Center for Behavioral Health  
Statistics and Quality**

### **Follow-up Study Description**

You have been randomly chosen for this special study for the 2011 National Survey on Drug Use and Health. This study, sponsored by the United States Public Health Service, will ask questions about various mental health issues such as depression, anxiety, post traumatic stress disorder and substance dependence. Although there is no benefit to you personally, knowledge gained from this study will improve our ability to describe and understand mental health issues in the United States.

If you agree to participate in this follow-up interview, your first name and telephone number will be collected but will be used only for re-contact purposes. Your name and telephone number will not be included on the interview forms on which your answers will be written, or on any interview audio files that might be recorded. While the interview has some personal questions, federal law protects the privacy of your answers and requires us to keep all of your answers confidential. Any data that you provide will only be used by authorized personnel for statistical purposes according to the Confidential Information Protection and Statistical Efficiency Act of 2002. The only exception to this promise of confidentiality is if you tell the interviewer that you intend to seriously harm yourself or someone else; in this situation RTI may need to notify a mental health professional or other authorities.

The interview will be conducted over the phone and takes on average an hour to complete. Your participation is voluntary. You may consider some of the questions to be sensitive in nature and some of the questions also may make you feel certain emotions, such as sadness. Remember that you can refuse to answer any questions that you do not want to answer, and you can stop the interview at any time. If you become upset at any time during the interview and wish to speak to a mental health professional about how you are feeling, the interviewer can again provide you with the toll-free hotline numbers that are printed on your payment receipt from the first interview. **If you agree to complete the interview, you will receive \$30 today.**

If you have questions about the study, call the Project Representative at [redacted]. If you have questions about your rights as a study participant, call RTI's Office of Research Protection at [redacted] (a toll-free number). You can also visit our project Website: [redacted] for more information.

Thank you for your cooperation and time.

[redacted], Project Officer  
Center for Behavioral Health Statistics and Quality  
Substance Abuse and Mental Health Services Administration (SAMHSA)  
U.S. Public Health Service  
Department of Health and Human Services

### Exhibit 4.3 Answering Questions About the Follow-up Interview

Respondent Question:	Suggested Response:
How long will the interview take?	<p>The time varies, but it generally takes about an hour. Of course each person may take a little more or less time, depending on the individual.</p> <p>If now is not a good time, we can schedule the interview for a more convenient time.</p>
The interview is too long!	<p>The time varies depending on the individual. We can always stop and finish later if necessary.</p> <p>OR</p> <p>If now is not a good time, we can schedule the interview for a more convenient time.</p>
Will my name be associated with the interview?	Absolutely not. I will not record your name on any documents. I needed your name to contact you about the interview, but that information is kept separate from your responses.
Are the questions personal?	Some questions may seem personal to some people. All answers are confidential and you don't have to answer any questions that you don't feel comfortable answering.
What type of questions will you ask? What types of personal information will you be asking?	You will be asked questions about various mental health issues such as mood, anxiety, and substance dependence.
How do I refuse to answer a question?	Simply tell me that you do not want to answer that question.
Why am I being chosen for the interview?	You were randomly chosen for this special study, which asks questions about various mental health issues. Knowledge gained from this study will improve our ability to describe and understand mental health issues in the United States.
What is your background? Why a different interviewer?	I have received special training to conduct the interviewing process for this study.
Who do you work for?	I work with Research Triangle Institute, a private, nonprofit research organization. RTI is conducting this study for the U.S. Public Health Service.
Are you going to call the police?	If you tell me that you intend to seriously harm yourself or someone else, I may need to notify the appropriate authorities.

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## 5. CONDUCTING THE INTERVIEW

### 5.1 Introduction

*Chapter 4* described preparing for an interview, including the informed consent process and permission to audio record the interview. This chapter reviews the actual interview process including information on administering the SCID, scoring the components, and the procedures to follow at the close of the interview. Also covered are suggestions for dealing with some respondent situations you may encounter, including respondents in distress.

### 5.2 Conduct during the Interview

Recall your involvement on this project is for research purposes only, and you **MUST NOT** offer psychiatric or medical counseling, advice, diagnosis, treatment or other mental health services, even if you are qualified to do so. Refer to *Section 2.5* for details on this important protocol.

### 5.3 SCID Overview

The follow-up interview is a slightly modified version of the Structured Clinical Interview for DSM-IV for Axis I Disorders (SCID-I), which is a semi-structured interview to assess various mental disorders according to the criteria set forth by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). A semi-structured interview is one in which a sequence of structured questions and follow-up "probes" are carefully chosen in advance to ensure consistency across respondents. Targeted, consistent questions help turn subjective responses into objective data that can be readily compared. At the same time, a properly administered interview extends well beyond the written probes provided in the protocol. As a clinical interviewer, you will be required to use your research and clinical skills as well as judgment to determine when you have gathered enough information to confidently assess the presence or absence of a symptom. If more information is needed, you should probe further until you can confidently assess whether the symptom is present or absent. As is true with any assessment, establishing rapport and maintaining a non-judgmental, objective stance are also critical behaviors to gathering good, valid information.

#### 5.3.1 SCID Content

The Mental Health Study version of the SCID consists of the following diagnostic modules:

- A. Mood Disorders
  - Major Depressive Episode – Past Year
  - Major Depressive Episode - Lifetime
  - Manic Episode – Past Year
  - Manic Episode – Lifetime
  - Dysthymic Disorder – Recent
- B/C. Psychotic Symptom Screen – Past Year
- D. Mood Differential

- E. Anxiety Disorders
  - Posttraumatic Stress Disorder – Past Year
  - Panic Disorder – Past Year
  - Panic Disorder with Agoraphobia – Past Year
  - Agoraphobia without History of Panic Disorder – Past Year
  - Social Phobia – Past Year
  - Specific Phobia – Past Year
  - Obsessive Compulsive Disorder- Past Year
  - Generalized Anxiety Disorder – Past Year
- F. Eating Disorders
  - Anorexia Nervosa – Past Year
  - Bulimia Nervosa – Past Year
- G. Intermittent Explosive Disorder – Past Year
- H. Substance Use Disorders
  - Alcohol Dependence – Past Year
  - Alcohol Abuse – Past Year
  - Non-alcohol Substance Dependence – Past Year
  - Non-alcohol Substance Abuse – Past Year
- J. Adjustment Disorder – Past Year

Specifications for each of these SCID modules can be found in *Appendix D* of this handbook.

These modules are preceded by the Introduction, Overview, and Screening sections and followed by the End of Interview and Interviewer Debriefing sections. The back of the SCID booklet also contains supplemental questions for discerning whether a mood or anxiety disorder has been induced by a general medical condition or substance use, as well as the Distressed Respondent and Cognitive Impairment Protocols discussed later in this chapter.

### 5.3.2 SCID Format

The diagnostic modules of the SCID have a three column format. The column on the left side of each page contains the interview questions and structured probes that help determine whether or not a criterion is met. The actual DSM-IV diagnostic criterion is printed in the center column and the codes for scoring the symptom are in the right column. *Exhibit 5.1* contains a sample SCID page.

**Exhibit 5.1 Sample SCID Page**

SCID-I (for DSM-IV-TR)

Anorexia Nervosa Past Year (March 2011)

Eating Disorders

F.1

**F. EATING DISORDERS**

**\*ANOREXIA NERVOSA\***

**ANOREXIA NERVOSA CRITERIA**

IF SCREENING QUESTION #8 EQUALS 1, CIRCLE 1 AND GO TO **\*BULIMIA\*** ON PAGE F.3

IF SCREENING QUESTION #8 EQUALS 2 OR 3, CIRCLE 3 AND CONTINUE:  
You've said that there was a time in the past year  
When you weighed much less than other people  
thought you ought to weigh . . .

SCREEN Q#8	
NO	YES
1	3

F1

Why was that? How much did you weigh? How tall are you?

---



---



---

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected)

? 1 2 3

GO TO <b>*BULIMIA*</b> , F.3
------------------------------------

F2

At that time, were you very afraid that you could become fat?

---



---

B. Intense fear of gaining weight or becoming fat, even though underweight.

? 1 2 3

GO TO <b>*BULIMIA*</b> , F.3
------------------------------------

F3

At your lowest weight, did you still feel too fat or that part of your body was too fat?

IF NO: Did you need to be very thin in order to feel good about yourself?

IF NO AND LOW WEIGHT IS MEDICALLY SERIOUS: When you were that thin, did anybody tell you it could be dangerous to your health to be that thin? (What did you think?)

---



---



---

C. Disturbance in the way in which one's body weight or shape is experienced; undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight

? 1 2 3

GO TO <b>*BULIMIA*</b> , F.3
------------------------------------

F4

?=inadequate information

1=absent or false

2=subthreshold

3=threshold or true

## 5.4 Administering the SCID

### 5.4.1 Asking the Questions

The questions printed in the SCID are to be asked ***VERBATIM AND IN THE ORDER PROVIDED***, unless the respondent has already clearly provided **all** of the necessary information earlier in the interview process. In such instances, you should confirm the information already obtained by paraphrasing the original question. Do not just assume that the symptom is present without asking for confirmation, because some aspect of the criterion may not have been adequately explored. However, you **SHOULD NOT** rely solely on the questions provided in the protocol. Further probes are almost always necessary to determine, with confidence, whether a symptom is present, and if so, if it is clinically significant (meets threshold). Follow-up questions should be phrased in ways that are understandable for respondents based on their age and cultural background. ***Ask as many follow-up questions as are necessary to rate each symptom with a high degree of confidence.***

### 5.4.2 Common Pitfalls to Avoid

When interviewing, be sure to avoid the following:

- Asking leading questions (e.g., "So, this hasn't really bothered you, right?")
- Failure to listen closely (e.g., not probing about behaviors/experiences/symptoms previously reported)
- Not providing adequate documentation (e.g., recording "Yes" on the SCID without any supporting remarks, examples, etc.)
- Inadequate probing (e.g., administering the interview as if it had a "True-False" format )
- Asking vague and/or inappropriate questions (e.g., "Have you ever been in trouble due to your drinking?")

### 5.4.3 If You Feel the Respondent Is Not Providing Valid Data

What you should do if you feel that a respondent is not providing good, valid data depends on the nature and source of your concern:

- ***Poor Comprehension*** – Some respondents have difficulties understanding the questions or the underlying constructs or are not inclined to admit the symptom exists. Your first step will be to rephrase or explain the target symptom in words that the respondent might better understand.
- ***Poor Insight and/or Response Biases*** – Poor insight and response biases are also common obstacles to gaining good, valid information. Given the sensitive nature of these questions, the validity of the data is under constant threat by under-reporting, positive impression management, and/or denial.

Typically, this difficulty arises with the respondent reporting a heavy pattern of substance use but denying negative consequences of his/her use. However, an occasional respondent reports a relatively light pattern of use but then over-endorses or pathologizes the substance use.

In all cases, if the respondent is reporting information that is inconsistent with his/her previous reports and/or your clinical judgment, gently point out the discrepancy. Try using phrases like this:

"I don't think I'm following you..."

"Please help me understand this..."

"So let me make sure I've got this right..."

It can be difficult to maintain rapport when you are pointing out discrepancies. But in the name of science, please err on the side of being slightly confrontational to increase confidence in the validity of the data.

## 5.5 Scoring the Symptoms

Each criterion symptom is coded as "?," "1," "2," or "3." Use your clinical judgment to rate each symptom based on the respondent's verbatim answers and follow-up questions.

**1 = Absent or false** – The symptom is absent or false.

**2 = Subthreshold** – The threshold for the criterion is almost, but not quite, met. A "2" rating is usually given when the behavior in question occurred, but at a frequency, duration, or intensity less than that required to meet full threshold. Code a "2" if the behavior specified was present in the past 12 months, but not at a clinically significant level.

**3 = Threshold or true** – The criterion is clearly met. A "3" rating is given if the behavior was present at a clinically significant level during the past 12 months. In order to be coded as a "3," a symptom needs to be clinically significant (i.e., problematic and/or distressing), and in most cases, also has to be persistent or recurrent.

**? = Inadequate information** – A question mark ("?") is a **temporary code** and should be coded when you are unable to determine after probing whether the criterion has actually been met. We strongly discourage the use of this code, but if you truly cannot determine the code at that time, code "?" and continue on with the interview. If, in the course of the rest of the interview, it becomes clear how the criterion should have been coded, please go back and code the correct category and note on the appropriate lines what information helped you determine the code. If at the end of the interview it is still unclear whether the criterion has been met, go back to the question and try one more time to clarify. If it is still unclear after additional probing, code the lower of the possible codes. For example, if you are not sure if it should be a "2" or a "3," code as a "2."

If you are not certain how to code a particular item or are feeling unsure about whether you have gathered enough information, collect as much information as you can and then consult with one of the clinical supervisors for her/his opinion. Call preferably within an hour of completing the interview. The CS will be happy to talk with you about the coding decision and provide guidance/feedback on proper SCID administration procedures.

*Exhibit 5.2* contains a list of "Dos and Don'ts" for the administering the SCID.



## Exhibit 5.2 Dos and Don'ts of SCID Administration

DO	DON'T
Emphasize you are using a standardized interview protocol and are required to ask all questions verbatim.	Apologize for the questions you are asking, clarifying responses, or the length of the interview.
Stick to the initial questions, as they are written, except for minor modifications to consider what the respondent has already said, or to request elaboration or clarification.	Make up your own initial questions because you feel that you have a better way of getting the same information. Your minor "improvement" may have a major unwanted effect on the meaning of the question.
Focus on obtaining the necessary information to judge all of the particulars of the criterion under consideration. Ask additional clarifying questions to elicit details in the respondent's own words, such as "Can you tell me about that?" or "What do you mean by that?"	Focus only on getting a "Yes" or "No" answer to the question. It often takes additional questions and probing to determine whether or not the criterion has been met during the past 12 months.
Use your judgment about a symptom, consider all of the information available, and gently confront the respondent about responses that conflict with other information.	Automatically accept a respondent's response if it contradicts other information or you believe it is not valid.
Make sure the respondent understands what you are asking. It may be necessary to repeat or rephrase questions or to ask if he/she understands. In some cases it may be valuable to describe the entire symptom cluster you are asking about (e.g., withdrawal). Follow the lead of the respondent in the terms you use to refer to a substance. For example, if he/she uses the term "pot," then you do the same.	Use words or jargon that the respondent does not understand (e.g., referring to low-level chronic depression as "dysthymia")
Always be sure that you and the respondent are focusing on the same time period for each question.	Assume that the respondent is remaining cognizant of the timeframe.
Take care to communicate that you are listening to the respondent. For example, "You told me you got a DUI last month. During the past 12 months, has there been another time in which you were in trouble with the law because of your alcohol use?"	Ignore information that you have already obtained.

## 5.6 Concluding the Clinical Interview

At the conclusion of the SCID, closing statements must be read to each respondent to ensure all necessary information is provided. The End of Interview Script (*Exhibit 5.3*) thanks the respondent for his or her time and mentions the possibility of needing to speak with a counselor. Remember that during the initial NSDUH interview the respondent received the \$30 cash payment from the field interviewer in appreciation of the time spent completing this telephone interview. *Exhibit 5.4* contains a copy of the Follow-up Interview Payment Receipt provided by the interviewer to the respondent. Note the contact information for both the Lifeline and treatment hotlines. As the script indicates, provide the Lifeline number for an interested respondent who does not have the receipt.

As you finish the End of Interview script, ask for any further questions and then conclude the call. After ending the call, click the red "Stop Recording" button. Complete the Interviewer Debriefing questions within the SCID (see *Appendix D* for details).

Be sure to document the results of your contact, as explained in the next chapter.

Except while editing the document prior to shipment, be sure to protect the confidentiality of the paper SCID by keeping it in a locked location at all times.

### **Exhibit 5.3 End of Interview Script**

That was my last question. Thank you for your time and cooperation in completing this interview.

Sometimes the personal issues we've discussed cause people to become upset and in need of speaking with a counselor. If you are feeling upset or disturbed by the personal issues we have discussed in this interview and would like to talk with someone about your feelings, we suggest you call your doctor, counselor, or other treatment provider if you are currently under someone's care. If not, there is also a national lifeline number you can call. This number is on the receipt for the \$30 you received for this interview from the interviewer who met with you earlier. Do you still have that receipt?

IF NO: We would like to give you the hotline number for the National Lifeline Network where counselors are available to talk at any time of the day or night. They can also give you information about (additional) mental health services in your area. Their toll-free number is 1-800-273-8255.

IF YES: OK. Please know that counselors at the National Lifeline are available to talk at any time of the day or night. They can also give you information about mental health services in your area if you request this information.

Do you have any additional questions you'd like to ask me before we end our call?

Thank you again for your time, and have a good (day/afternoon/evening).

**Exhibit 5.4 Follow-up Interview Payment Receipt**

**Follow-up Interview Payment Receipt**  
**United States Public Health Service**  
and  
**Research Triangle Institute**  
**thank you for agreeing to participate in a special study for the**  
**2011 National Survey on Drug Use and Health.**

In appreciation of your participation in this important study, you are eligible to receive a \$30 cash payment. Since maintaining the confidentiality of your information is important to us, your name will not be entered on this form. However, the interviewer must sign and date this form to certify you received (or declined) the cash payment.

Interviewer _____	Date _____	Case ID _____
<input type="checkbox"/> Accepted Cash Payment		<input type="checkbox"/> Declined Cash Payment

If you ever feel that you need to talk to someone about mental health issues, you can call the National Lifeline Network. Counselors are available to talk at any time of the day or night and they can give you information about services in your area.

1-800-273-TALK or 1-800-273-8255  
1-888-628-9454 (Spanish)  
<http://suicidepreventionlifeline.org/>

If you ever feel that you need to talk to someone about drug use issues, you can call the Center for Substance Abuse Treatment's national referral service. This is a 24-hour service that will help you locate treatment options near you.

1-800-662-HELP or 1-800-662-4357  
1-800-487-4889 (TDD)  
1-877-767-8432 (Spanish)  
<http://findtreatment.samhsa.gov>

Disposition: Top copy to Respondent, yellow to Field Supervisor, pink to Field Interviewer.

## 5.7 Handling Unusual Situations

In most cases the interview progresses smoothly as planned. For the cases that do not, the following explanations should help you properly handle the case.

### 5.7.1 Breakoff

You may start the interview but the respondent cannot complete the interview at that time. Perhaps a child runs in with an injury, or the respondent forgot another scheduled event and must leave. Or, perhaps the respondent seems distracted by argumentative voices in the background, in which case you should diplomatically end the interview ("It sounds like this is not a good time to talk. I can call back later."). If you suspect the respondent is cognitively impaired, follow the protocol in *Section 5.7.3*.

If possible with a breakoff, try to schedule a convenient time for the respondent to complete the interview. Record the details of the appointment and the situation in the CMS. Try to complete the case in the next day or two to keep the portions of the interview close together.

When you begin the interview again, you must complete the informed consent requirements again by reading the complete introductory script (refer to *Section 4.4*).

### 5.7.2 Refusal

At times a respondent may refuse to begin the interview, or may breakoff the interview in an unfriendly manner. In these refusal cases, tactfully try to persuade the respondent to begin or continue. Be sure to listen carefully to the respondent's concerns so that you can first acknowledge the concern or misunderstanding, and then address it by providing appropriate additional information.

Use either the pending breakoff or the pending refusal code for the case. Be sure to discuss the case with your Data Collection Manager. There are currently no plans to recontact refusals for the Mental Health Study, but it is still important to discuss the case and note the issues before finalizing the case.

### 5.7.3 Cognitive Impairment Issues

Occasionally as you talk with a respondent, you may suspect that the respondent is intoxicated or otherwise impaired and currently unable to complete the interview.

If you have started the SCID, stop and administer the Short Blessed Scale. These questions, shown in *Exhibit 5.5*, are found in the Cognitive Impairment Protocol Section at the back of the SCID Booklet.

- For 10 or less errors, resume the interview. Be sure to note the situation in the interviewer debriefing questions at the end of the SCID.
- For more than 10 errors, breakoff the interview, documenting the situation when you enter the status code. Should you be able to complete the interview at another time, include the reason for the breakoff in the debriefing questions. Be sure to review the portions of the SCID completed earlier, to verify accuracy, before continuing.

If you have not yet started the actual SCID but are still completing the introduction and informed consent process when you suspect the respondent is cognitively impaired, breakoff the contact as explained in *Section 5.7.1*.

**Exhibit 5.5 Short Blessed Scale Exam**

**SHORT BLESSED SCALE EXAM**

**THE SHORT BLESSED SCALE IS TO BE COMPLETED AT ANY POINT DURING THE INTERVIEW IF THE RESPONDENT APPEARS TO BE COGNITIVELY IMPAIRED.**

**ERROR SCORES**

- SB-1. What year is it now? \_\_\_\_\_  
CIRCLE 4 FOR ANY ERROR ..... 0 4
- SB-2. What month is it now? \_\_\_\_\_  
CIRCLE 3 FOR ANY ERROR ..... 0 3
- Please repeat this phrase after me: John Brown, 42 Market Street, Chicago.
- NO SCORE – FOR ITEM SB-6.
- SB-3. About what time is it? \_\_\_\_\_  
CIRCLE 3 FOR ANY ERROR ..... 0 3
- SB-4. Please count backwards from 20 to 1.  
[20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1]  
2 PER ERROR ..... 0 2 4
- SB-5. Please say the months of the year in reverse order.  
[DEC, NOV, OCT, SEP, AUG, JUL, JUN, MAY, APR, MAR, FEB, JAN]  
2 PER ERROR ..... 0 2 4
- SB-6. Please repeat the phrase I asked you to repeat before.  
[JOHN BROWN/ 42 MARKET STREET/ CHICAGO]  
2 PER ERROR ..... 0 2 4 6 8 10

**TOTAL NUMBER OF ERRORS IN SB-1 TO SB-6: ..... \_\_\_\_\_**

**IF THE TOTAL NUMBER OF ERRORS IS GREATER THAN 10, TERMINATE THE INTERVIEW.**

#### 5.7.4 Distressed Respondents

Due to the sensitive nature of portions of the SCID interview, you may encounter a respondent who becomes upset during the interview. In situations where you feel that based on indirect and direct statements made by the respondent that he or she has had suicidal or homicidal thoughts within the past two weeks or is otherwise distressed, use the Distressed Respondent Protocol (see *Exhibit 5.6*) to determine the proper course to follow. So that it is always readily available, this Protocol is printed at the back of each SCID booklet. The first page of the protocol lists issues to be aware of before, during, and following the interview as you interact with the respondent. Although you may be qualified, you are NOT to provide counseling or other services. For your work on this study, you must follow the approved protocol.

The chart at the bottom of the first page lists various scenarios you may encounter and refers to the more detailed instructions on the following pages. Deciding which scenario to use is a judgment call for you to make based on your interactions with the respondent.

In certain scenarios and in ANY case where you are unsure of the proper scenario or correct approach, you are to consult with project staff to determine the best course of action for the situation. The Clinical Supervisors ( ), who are licensed psychologists, will act primarily as a sounding board for you. If there is a question about what action to take in response to your interactions with a respondent, you will discuss the situation with one of the Clinical Supervisors, and the Clinical Supervisor will make the final decision as to what action, if any, should be taken beyond documenting the situation. These steps are for your protection and are required by RTI's IRB.

In accordance with the Distressed Respondent Protocol or after consulting with one of the Clinical Supervisors ( ), you may need to call an emergency psychiatric care provider or 911 in the respondent's area (e.g., crisis center, inpatient hospital) so emergency help can be dispatched to the respondent's location as needed. Obtain referral information for the respondent's area from the SAMHSA website (<http://mentalhealth.samhsa.gov/databases/>) and the national 911 database.

When calling an emergency psychiatric care provider, use 3-way calling to keep the respondent on the line while you call. Be familiar with and practice using 3-way calling on your telephone prior to initiating any interviews so you can perform this operation smoothly, if needed. Note: with 3-way calling, once the respondent is speaking with the other person, you must **remain on the line** in order to maintain their connection.

Once speaking with an emergency psychiatric care representative or 911 in the respondent's area, use the script in the Distressed Respondent Protocol to explain the situation, and provide the respondent's name, telephone number, and, if needed, the address reported by the respondent (if known) as well as the respondent's home address (if the respondent reports a different location). To protect respondent confidentiality, when possible, only share information required to properly assist the respondent. The emergency care representative or 911 dispatcher will need the entire address to send assistance.

To report the respondent's address to the emergency psychiatric care representative or 911 dispatcher:

- ask the respondent for the address of his/her current location; and
- obtain the respondent's home address from the CMS. From the CMS, access the case (through the Case Status link), and click as directed in the Address column to display the address for the QuestID. To protect confidentiality the address is not provided as assignment information, but is readily available should you need it in an urgent situation.

While you are not to participate in the conversation between the respondent and the emergency care representative, do pay attention to be sure the respondent receives instructions for how to receive emergency services. If the emergency care representative is not able to provide services to protect the safety of the respondent, call 911 in the respondent's area. Note the protocol includes these instructions to ensure proper handling of each respondent's situation.

When finished with any distressed respondent situation, be sure to document both the situation and your response by completing an online Incident Form accessible through the Main Page of the CMS. See *Exhibit 5.7* for the types of incident information to enter. **Proper documentation of all distressed respondent situations is critically important** to protect respondents' rights. For non-emergency situations (Scenarios 1, 3, 5), contact \_\_\_\_\_ to consult with them about the course of action that may need to be taken to protect the respondent or other possible victims. If you have questions about what to include in an Incident Report, or if you want to debrief about the case, you may also call \_\_\_\_\_. Additionally, you must contact \_\_\_\_\_ immediately for any cases for which imminent danger is or may possibly be involved (Scenarios 2 and 4) to receive supervision and debrief. If it is an urgent situation and \_\_\_\_\_ is unavailable within 15 minutes, try the next person on the list, and so on. In addition to the study contact summary printed in the inside cover of this handbook, the chart below lists these contacts:

Call:	Cell Phone Numbers:

Please note that \_\_\_\_\_ do not have clinical training. Calling one of them is important to alert project staff that the Distressed Respondent Protocol has been enacted and you are attempting to contact the Clinical Supervisors ( \_\_\_\_\_ ).

The study's IRB approval rests on following these carefully developed procedures exactly.



## Exhibit 5.6 Distressed Respondent Protocol

### Specific Guidelines

If respondents report any of the issues listed below during any interactions with the recruiter or clinical interviewer, including before, during, or after a telephone screening or interview, the staff member will immediately refer to the scenario chart below and follow the instructions provided. Details of all incidents will be documented on the case management system and reported to project management staff immediately.

- Has had **any suicidal thoughts in the past two weeks (p. A.3)**, including
  - passive suicidal thoughts (i.e. thoughts or wishes about his/her death **in the absence of** thoughts about specific ways s/he could die or attempt suicide, plans for how s/he could die or attempt suicide, or intention of dying or attempting suicide) [**SCENARIO 1**] or
  - active suicidal thoughts (i.e. thoughts or wishes about his/her death **combined with** thoughts about specific ways s/he could die or attempt suicide, plans for how s/he could die or attempt suicide, the intention of dying or attempting suicide, and the means to carry out that plan) [**SCENARIO 2**]
- Has had **any homicidal thoughts in the past two weeks**, including
  - passive homicidal thoughts (i.e. thoughts or wishes about seriously harming someone else **in the absence of** thoughts about specific ways in which s/he could seriously harm another person, plans for how s/he could seriously harm another person, intentions of seriously harming another person) [**SCENARIO 3**] or
  - active homicidal thoughts (i.e. thoughts or wishes about seriously harming someone else **combined with** thoughts about specific ways s/he could seriously harm another person, plans for how s/he could seriously harm another person, the intention of seriously harming another person, and the means to carry out that plan) [**SCENARIO 4**]

Scenario Chart		
Scenario Number	Individual at Risk of Harm	Imminent Danger?
1	Self	No
2	Self	Possible / Yes
3	Other(s)	No
4	Other(s)	Possible / Yes
5	No risk of harm; respondent is agitated or upset	No

**Exhibit 5.6 Distressed Respondent Protocol (continued)**

Scenario Number	Individual at Risk of Harm	Imminent Danger?
1	Self	No
<b>STEPS</b>		
<p><b>A. COMPLETE SCREENING/INTERVIEW AND THEN READ TO R:</b> When you agreed to participate in this interview, I promised that I would not tell anyone what you have told me unless it was necessary to protect you or other people. You told me earlier that you have recently had thoughts or wishes about your death or dying. Do you have a doctor, counselor, or someone you can talk to about how you are feeling now?</p> <p><b>IF YES:</b> I strongly suggest that you contact this person immediately so you can talk to him or her about how you have been feeling, especially about the thoughts you've been having about death and dying. Would you be willing to do that?</p> <p><b>IF YES:</b> Okay. There is also a national Lifeline hotline you can call where counselors are available to talk at any time of the day or night. Their toll-free number is 1-800-273-8255. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>IF NO:</b> I strongly suggest that you contact the national Lifeline hotline at 1-800-273-8255. Lifeline has counselors available 24-hours a day to talk to you about how you are feeling. They may also help you locate (additional) mental health services in your area. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away. If you are not able to get to an emergency room immediately, you should call 911 for assistance. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>B. WHEN CALL IS COMPLETED, CALL <span style="float: right;">IF YOU HAVE QUESTIONS</span> OR WOULD LIKE TO DEBRIEF. FILL OUT ONLINE INCIDENT REPORT.</b></p>		

**Exhibit 5.6 Distressed Respondent Protocol (continued)**

Scenario Number	Individual at Risk of Harm	Imminent Danger?
2	Self	Possible / Yes
<b>STEPS</b>		
<p><b>A. END SCREENING/INTERVIEW AND THEN READ TO R:</b> When you agreed to participate in this interview, I promised that I would not tell anyone what you have told me unless it was necessary to protect you or other people. You told me earlier that you are thinking about harming yourself. I strongly suggest that we contact emergency care services in your area, such as a crisis center or nearby hospital. I am going to look-up that number. Can you remain on the line while I do that? It may take a few minutes.</p> <p><b>IF NO:</b> Okay, if I don't connect you with the local emergency care provider, then I will need to call the provider myself to see if they can send someone to you who can provide the care you need in order to keep you safe. I'll call you back to let you know what I find out.</p> <p><b>B. FIND THE NEAREST EMERGENCY PSYCHIATRIC SERVICES USING THE SAMHSA WEBSITE</b> (<a href="http://mentalhealth.samhsa.gov/databases/">http://mentalhealth.samhsa.gov/databases/</a>). <b>SEARCH FOR INPATIENT MH TREATMENT USING THE R'S CURRENT ZIP CODE.</b></p> <p><b>C. CALL THEIR LOCAL INPATIENT PSYCHIATRIC CARE FACILITY OR CRISIS CENTER AND READ THIS STATEMENT:</b> I work for RTI International, a research company in North Carolina, and we are conducting a research study. During an interview with a respondent, the respondent told me that (he/she) is thinking about killing or harming (himself/herself) and I am concerned about (his/her) safety. I can give you additional information about the research study, if you would like. I can also provide you with the respondent's contact information.</p> <p><b>IF ASKED FOR NSDUH OVERVIEW:</b> This study, part of the National Survey on Drug Use and Health sponsored by the United States Public Health Service, is designed to test procedures for use in future NSDUH surveys. Questions ask about various mental health issues such as depression, anxiety, post traumatic stress disorder, and substance dependence. Please note that this information was obtained through the respondent's participation in a research study. We went through appropriate informed consent procedures, during which I told the respondent that if (he/she) told me something that caused me to be concerned about (his/her) well-being, I would report that to someone else who could help or intervene. Given the context in which the information was obtained, however, we cannot guarantee that the participant understood the questions nor that (he/she) provided truthful responses. Do you have any questions about the study? <b>ANSWER QUESTIONS.</b></p> <p><b>D. GIVE R FIRST NAME, TELEPHONE NUMBER, AND ADDRESS (IF KNOWN) TO LOCAL EMERGENCY CARE REPRESENTATIVE. IF THEY ARE UNABLE TO PROVIDE SERVICES THAT ENSURE THE R'S SAFETY, SEARCH FOR THE R'S LOCAL EMERGENCY NUMBER USING THE NATIONAL 911 DATABASE.</b></p> <p><b>E. IF R ON THE OTHER LINE, CONNECT R TO EMERGENCY CARE REPRESENTATIVE OR LOCAL 911 DISPATCHER AND STAY ON THE LINE; IF YOU HANG-UP, THEIR CONNECTION WILL ALSO END.</b></p> <p><b>IF R NOT ON THE OTHER LINE, END CALL WITH THE EMERGENCY CARE PROVIDER OR LOCAL 911 DISPATCHER AND ATTEMPT TO CONTACT R AGAIN WITH AN UPDATE.</b></p>		

Exhibit 5.6 Distressed Respondent Protocol (continued)

**SCENARIO 2 (Continued)**

**F. WHEN CALL IS COMPLETED, CALL [REDACTED] TO DEBRIEF. IF SHE DOES NOT RETURN CALL WITHIN 15 MINUTES, CALL [REDACTED] TO DEBRIEF. IF NEITHER ONE OF THEM IS AVAILABLE, CONTACT [REDACTED] TO NOTIFY ONE OF THEM ABOUT THE INCIDENT. FILL OUT ONLINE INCIDENT REPORT.**

**Exhibit 5.6 Distressed Respondent Protocol (continued)**

Scenario Number	Individual at Risk of Harm	Imminent Danger?
3	Other(s)	No
<b>STEPS</b>		
<p><b>A. COMPLETE SCREENING/INTERVIEW AND THEN READ TO R:</b> When you agreed to participate in this interview, I promised that I would not tell anyone what you have told me unless it was necessary to protect you or other people. You told me earlier that you have recently had thoughts or wishes about seriously harming someone else. Do you have a doctor, counselor, or someone you can talk to about how you are feeling now?</p> <p><b>IF YES:</b> I strongly suggest that you contact this person immediately so you can talk to him or her about how you have been feeling, especially about the thoughts you've been having about seriously harming someone else. Would you be willing to do that?</p> <p><b>IF YES:</b> Okay. There is also a national Lifeline hotline you can call where counselors are available to talk at any time of the day or night. Their toll-free number is 1-800-273-8255. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>IF NO:</b> I strongly suggest that you contact the national Lifeline hotline at 1-800-273-8255. Lifeline has counselors available 24-hours a day to talk to you about how you are feeling. They may also help you locate (additional) mental health services in your area. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away. If you are not able to get to an emergency room immediately, you should call 911 for assistance. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>B. WHEN CALL IS COMPLETED, CALL _____ TO DEBRIEF. IF DIRECTED BY ONE OF THEM, FOLLOW SCENARIO 4 FOR POSSIBLE IMMINENT DANGER TO OTHERS. FILL OUT ONLINE INCIDENT REPORT.</b></p>		

1.1.1

**Exhibit 5.6 Distressed Respondent Protocol (continued)**

Scenario Number	Individual at Risk of Harm	Imminent Danger?
4	Other(s)	Possible / Yes
<b>STEPS</b>		
<p><b>A. END SCREENING/INTERVIEW AND END CALL.</b></p> <p><b>B. SEARCH FOR THE R'S LOCAL EMERGENCY NUMBER USING THE NATIONAL 911 DATABASE.</b></p> <p><b>C. CALL THEIR LOCAL 911, AND READ THIS STATEMENT:</b> I work for RTI International, a research company in North Carolina, and we are conducting a research study. During an interview with a respondent, the respondent told me that (he/she) is thinking about killing or harming another individual. I am concerned about this individual's safety. I can give you additional information about the research study, if you would like. I can also provide you with the respondent's contact information.</p> <p><b>IF ASKED FOR NSDUH OVERVIEW:</b> This study, part of the National Survey on Drug Use and Health sponsored by the United States Public Health Service, is designed to test procedures for use in future NSDUH surveys. Questions ask about various mental health issues such as depression, anxiety, post traumatic stress disorder, and substance dependence. Please note that this information was obtained through the respondent's participation in a research study. We went through appropriate informed consent procedures, during which I told the respondent that if (he/she) told me something that caused me to be concerned about (him/her) harming someone else, I would report that to someone else who could help or intervene. Given the context in which the information was obtained, however, we cannot guarantee that the participant understood the questions nor that (he/she) provided truthful responses. Do you have any questions about the study?</p> <p><b>ANSWER QUESTIONS.</b></p> <p><b>D. GIVE R FIRST NAME, TELEPHONE NUMBER, ADDRESS (IF KNOWN), AND VICTIM'S IDENTIFYING INFORMATION TO LOCAL 911 DISPATCHER. END CALL.</b></p> <p><b>E. WHEN CALL IS COMPLETED, CALL [REDACTED] TO DEBRIEF. IF SHE DOES NOT RETURN CALL WITHIN 15 MINUTES, CALL [REDACTED] TO DEBRIEF. IF NEITHER ONE OF THEM IS AVAILABLE, CONTACT [REDACTED] TO NOTIFY ONE OF THEM ABOUT THE INCIDENT. FILL OUT ONLINE INCIDENT REPORT.</b></p>		

**Exhibit 5.6 Distressed Respondent Protocol (continued)**

Scenario Number	Individual at Risk of Harm	Imminent Danger?
5	No risk of harm; respondent is agitated or upset	No
<b>STEPS</b>		
<p><b>A. END SCREENING/INTERVIEW AND THEN READ TO R:</b> I know these questions are very personal, and they seem to be upsetting you. Do you have a doctor or someone you can talk to about how you are feeling?</p> <p><b>IF YES:</b> I suggest that you call that individual immediately so that she or he can help you talk about and work through how you are feeling. There is also a national Lifeline hotline you can call where counselors are available to talk at any time of the day or night. Their toll-free number is 1-800-273-8255. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>IF NO:</b> I suggest that you contact the national Lifeline hotline at 1-800-273-8255. Lifeline is a 24-hour hotline that you could call to discuss this with a counselor. They may also help you locate (additional) mental health services in your area. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away or call 911 for assistance. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>B. WHEN CALL IS COMPLETED, CALL <span style="float: right;">IF YOU HAVE ANY</span> QUESTIONS OR NEED TO DEBRIEF. FILL OUT ONLINE INCIDENT REPORT.</b></p>		

## Exhibit 5.7 Incident Report Form

Incident Report Form	
When completing the Incident Report Form, <b>DO NOT</b> include identifying information such as the respondent's name or address *required fields	
<b>Project Title:</b>	National Survey on Drug Use and Health (NSDUH): Mental Health Surveillance Study
<b>*Date of Incident:</b>	4 / 15 / 2011
<b>*Respondent's Location:</b>	
<b>*Participant's QuestID :</b>	
<b>*Describe in detail the nature and timing of this incident:</b>	6000 characters remaining
<b>If Report or Referral was made to an outside agency:</b>	
<b>Date and time of report/referral:</b>	MM/DD/YYYY [ ] / [ ] / [ ] HH:MM AM/PM [ ] : [ ] N/A
<b>Agency and person who took report/referral:</b>	
<b>Current disposition of situation:</b>	1000 characters remaining
<input type="button" value="Save"/> <input type="button" value="Submit Report"/> <input type="button" value="Reset"/> <input type="button" value="Cancel"/>	



### **5.7.5 Unable to Contact**

If no one answers your call, be sure to document that attempted contact in the CMS. Plan your next call at a different time of day or on another day of the week.

If you do speak with someone but not the actual respondent, try to determine a good time to catch the respondent at home. If that person on the phone offers another telephone number such as a cell phone or a work number as a way to reach the respondent, make note of the number. Do not **ask** for an alternate number, but take the information if provided. While you would not want to complete the interview while the respondent is working, you could use the work number to contact him or her about setting an appointment for the interview.

For cases with ongoing challenges, be sure to discuss the situation with your Data Collection Manager.

### **5.7.6 Other Non-Response**

Rarely, you may encounter a person who should not have been included as a potential study respondent (youth under 18, language barrier, or physical impairment preventing a telephone interview). In such a case, select the appropriate code and describe the situation in the CMS. During your next conference call, be sure to let your Data Collection Manager know about the case.

## 6. DOCUMENTING RESULTS

### 6.1 Introduction

The documentation and reporting of interviewing activities you provide is used to closely monitor the ongoing data collection efforts. There are a number of ways you document and report your activities, through:

- Record of Calls. The actions you take to complete interviews are documented in the Record of Calls on the CMS (see *Section 6.2*).
- Audio Transfer. Upload the audio recording of each interview within 2 hours of its completion (see *Section 3.6*).
- SCID Shipment. FedEx edited SCID booklets within 48 hours of completing the interview (see *Section 6.3*).
- Conference Calls. You and your Data Collection Manager will have scheduled conference calls usually once each week (see *Section 7.3*).
- ePTE. Each week you will submit your electronic Production, Time and Expense report (ePTE). In the event of computer problems, paper PT&E reports serve as a backup and must also be submitted weekly (see *Chapter 7*).

### 6.2 Documenting Results

Accurate and timely documentation of the final results for each case is crucial to the success of the study.

#### 6.2.1 Record of Calls

Each case will have a "Record of Calls" associated with it which describes the details of what happened from the time the follow-up case was generated to the time it is completed. The listing will help you keep track of what happens each time you contact a respondent. It is also used by your supervisors and other RTI project staff to understand how long it takes to complete the interview process and potential problems that may arise in the process of completing those interviews.

You will track all calls in the web-based CMS from which you receive your initial assignment of cases.

#### 6.2.2 Status Codes

The Record of Calls is essentially a listing of various "Status Codes" which you assign each time you contact a respondent regarding the follow-up interview. These status codes identify what happened during each contact or attempted contact. In addition to assigning the status code, you will enter any notes regarding what transpired. The system associates the entry date and time with the record as well. There are two types of codes: Pending and Final.

## **PENDING CODES**

Pending codes are used when the case is not yet complete. For cases to which you assign pending codes for breakoffs, refusals, or other, you should discuss the situation with your Data Collection Manager who will help you to determine the next step. Explanations of when to use a particular code, and what action to take to resolve the situation so that the case can be completed, are provided in *Exhibit 6.1*.

## **FINAL CODES**

Final interview result codes indicate the case is finished, either because the interview was successfully completed or because you were unable to obtain an interview (see *Exhibit 6.2*).

### **6.2.3 Recording Comments**

Since it is important that project staff understand the entire process by which interviews get completed and any problems encountered while completing the interviews, please enter detailed notes. When you have contacted a respondent and scheduled an appointment to complete the interview, record the date and time of the appointment in the Notes. If you have to breakoff an interview, record notes about why the breakoff occurred as well as any information about re-contacting the respondent. If the respondent refuses to complete the interview, or refuses to allow you to record the interview, please document the reasons for refusing.

### Exhibit 6.1 Pending Status Codes

Status Code	Status Code Description	Use This Code When...	Follow Up Actions to Take
50	<b>APPOINTMENT FOR FOLLOW-UP INTERVIEW</b>	The respondent cannot complete the interview now but you have scheduled an appointment	<ul style="list-style-type: none"> <li>Record the time and date of the appointment in the Notes.</li> <li>If you become unavailable to call at the time of the appointment, be sure to inform your Data Collection Manager so the case can be assigned to another interviewer.</li> </ul>
51	<b>R UNAVAILABLE</b>	Spoke with someone but not respondent	<ul style="list-style-type: none"> <li>Ask for a good time to reach the respondent and record in the Notes.</li> </ul>
52	<b>RING NO ANSWER, BUSY</b>	The phone rings continually or is busy	<ul style="list-style-type: none"> <li>Complete the ROC, making a note if busy</li> </ul>
53	<b>MACHINE/VOICE MAIL: NO MSG</b>	An answering machine or other voice mail responds and you did not leave a message	<ul style="list-style-type: none"> <li>Complete the ROC, making notes</li> <li>After the initial call with a message, leave a message every 3<sup>rd</sup> time you encounter an answering machine.</li> </ul>
54	<b>MACHINE/VOICE MAIL: LEFT A MSG</b>	An answering machine or other voice mail responds and you left a message	<ul style="list-style-type: none"> <li>Complete the ROC, making notes.</li> <li>If you continue to have trouble reaching the respondent, consider leaving a message with your number so the R can call you back to arrange an appointment.</li> </ul>
56	<b>BREAKOFF (PARTIAL INTERVIEW)</b>	You have started the interview, but must stop the call	<ul style="list-style-type: none"> <li>Arrange another time to contact the R and complete the interview.</li> <li>If the breakoff is unfriendly (R refuses to continue), tactfully try to persuade the respondent to continue.</li> <li>Record the reason for the breakoff in the "Notes" section.</li> </ul>
57	<b>REFUSAL</b>	The respondent refuses to let you start the interview	<ul style="list-style-type: none"> <li>Tactfully try to persuade the respondent to participate.</li> <li>Record the refusal reason in the Notes.</li> <li>Contact your Data Collection Manager and discuss the case.</li> </ul>
59	<b>OTHER, SPECIFY</b>	Use this code for cases that do not fit any of the other categories	<ul style="list-style-type: none"> <li>Be sure to fully describe the situation in the Notes section</li> <li>Discuss with your Data Collection Manager</li> </ul>

## Exhibit 6.2 Final Status Codes

Status Code	Status Code Description	Use This Code in This Situation
70	<b>INTERVIEW COMPLETED, AUDIO RECORDED</b>	The respondent has completed the follow-up interview AND you were able to record the interview. This is the BEST result code and is the desired result for all selected interviews.
71	<b>INTERVIEW COMPLETED, NO AUDIO (REFUSAL)</b>	The respondent has completed the follow-up interview, but refused to allow the audio recording of the interview. In the Notes, specify why the audio was refused, if known.
72	<b>INTERVIEW COMPLETED, NO AUDIO (TECHNICAL PROBLEM)</b>	The respondent has completed the follow-up interview, but the audio recording of the interview did not take place due to technical problems. In the Notes, specify why the audio could not be recorded, if known. Work with your Data Collection Manager and Technical Support as needed to resolve any technical issues.
73	<b>BREAKOFF – PARTIAL INTERVIEW</b>	You have started the interview and the respondent either refuses to allow you to complete the interviewing process or is unable to complete the interview. Speak with your Data Collection Manager before assigning this code.
74	<b>UNABLE TO CONTACT RESPONDENT AFTER REPEATED CALLS</b>	We hope that with persistence this code will be used rarely. Although you may have spoken with other(s) at the number, you have not reached the respondent, or you may have spoken with the respondent earlier to set an appointment, but since then have been unable to reach him/her to complete the interview. Use this code after repeated attempts to contact the respondent to complete the interview have been unsuccessful. Speak with your Data Collection Manager before assigning this code.
75	<b>FINAL NUMBER PROBLEM</b>	The case cannot be completed due to problems with the telephone number provided. Describe the situation in the Notes. Speak with your Data Collection Manager before assigning this code.
76	<b>FINAL REFUSAL</b>	All attempts to convert the respondent to participate have been unsuccessful. Be sure you indicate the reason for the refusal in the Notes. Speak with your Data Collection Manager before assigning this code.
77	<b>FINAL OTHER, SPECIFY</b>	Use this code for cases that do not fit any of the other categories. Be sure to fully describe the situation in the Notes. Speak with your Data Collection Manager before assigning this code.
<b>Supplemental Status Code</b>		
80	<b>MATERIALS SHIPMENT</b>	Once you have prepared the completed SCID for shipment, make another entry using Status Code 80 to indicate that you are FedExing the confidential SCID booklet. Enter the FedEx tracking number in the Notes.

## 6.2.4 Entering Records in the CMS

Following each call to a respondent, enter a status code and any notes into the web-based CMS so your supervisors and project staff can view the most current information regarding the status of the case.

To enter the status codes in the CMS, follow the same steps outlined in *Section 4.2.2* to get to the "Case Status" page and obtain a listing of all your cases.

Locate the appropriate Quest ID and click on the current status code displayed in the **Status Code** column. A pop-up box entitled **Assign a New Event/Status Code** appears.

The Quest ID displays at the top of the box along with the most recent status code associated with the case.

In the **New Event** box select the appropriate code from the drop down menu.

Record any notes associated with the contact in the "New Event Note" box. (See *Exhibits 6.1* and *6.2* for details on the codes.)

Then click the **Update** button at the bottom of the box to save the entry. The CMS automatically associates the date and time of your entry with that record, which means it is helpful to make your entries soon after the call is completed. NOTE: The CMS always uses Eastern time.

Assign a New Event/Status Code

QuestID:	9999990
Current Status:	00 Initialized -- Not worked
New Event:	No Change
New Event Note:	

Update Reset Cancel

Back at the Case Status page, please note the new entry displays in the row for the case AFTER you click "Filter Data" (refer to *Section 4.2.2*).

To view all the Status codes associated with the case (i.e. the case history, or Record of Calls) simply click on the Quest ID on the Case Status page. A pop-up box appears displaying all status codes, the time and date those entries were made and any notes entered.

File Edit View Favorites Tools Help

2 Records

ROC Events for QuestID: 9999999				
Event Date	Day of Week	Event Code	Event By	Comments
08/17/2010 03:16 PM	Tue	50		Sat 8/21 @ 11:00 am EST
08/17/2010 03:05 PM	Tue	51		Try again in 10 minutes

OK

### 6.3 Disposition of Materials

Once you complete the interview, the last step is to distribute the information and interview materials as shown in the below chart.

Item:	Send to:	Method:	Time Frame:
SCID booklet (with Cover Sheet completed) placed in manila envelope preprinted with Confidential Information Sheet	RTI	FedEx	Within 48 hours
Audio file	Secure website	Computer transfer through MH Case Manager	Within 2 hours of completing the interview

As explained in *Section 3.6*, it is best to upload the audio file as soon after the interview as possible.

Soon after, but within 24 hours, edit the SCID. To prepare the edited SCID for shipment, complete the SCID Cover Sheet (Transmittal Record) (see *Exhibit 6.3*) by entering:

- your ID number,
- the Quest ID for the case,
- the date the interview was completed, and
- the date you are shipping the SCID to RTI.

Once you have completed the Cover Sheet of the SCID booklet, place it in one of the provided manila envelopes with a Confidential Information Sheet (see *Exhibit 6.4*) preprinted on the envelope. Then seal the envelope prior to placing it in the FedEx package. *Section 7.8* contains detailed instructions for FedEx packages.

Once you have successfully shipped the SCID, enter that information in the CMS to document the FedEx tracking number of the SCID package. Add an additional status code of 80 and **include the FedEx tracking number** in the notes. The system uses the 80 code to generate an e-mail message to your Data Collection Manager and the Clinical Supervisors so they know the package has been sent. The e-mail includes the tracking number, should there be any delivery issues with this confidential package.

### 6.4 Summary of the Interview Process

For each case assigned to you, there are a number of steps to complete. As you work, use the CI Case Checklist shown in *Exhibit 6.5* as a guide to be sure you have completed each step. If you have questions about procedures, first refer to the appropriate place in this handbook, then as needed, please check with your Data Collection Manager.

**Exhibit 6.3 SCID Cover Sheet Transmittal Record**

**OMB # 0930-0110**  
**Expiration Date: 01-31-12**  
**V.6, 3/4/11**

**STRUCTURED CLINICAL INTERVIEW FOR  
 DSM-IV AXIS I DISORDERS (SCID-I)**

**By**

Michael B. First, M.D.; Miriam Gibbon, M.S.W.;  
 Robert L. Spitzer, M.D.; and Janet B. W. Williams, D.S.W.

**MODIFIED BY RTI INTERNATIONAL**

**FOR**

**2011 NATIONAL SURVEY ON DRUG USE AND  
 HEALTH**

**MENTAL HEALTH SURVEILLANCE STUDY**

SCID Transmittal Record			
Interviewer ID:		QuestID:	
		Date of Interview:    /    /	
		MM    DD    YY	
Date Shipped to RTI:		Date Received at RTI:	
	MM    /    /		MM    /    /
	MM    DD    YY		MM    DD    YY
Clinical QC by:		Date of Clinical QC:	
			MM    /    /
			MM    DD    YY
Edited by:		Date Edited:	
			MM    /    /
			MM    DD    YY

Public reporting burden for this collection of information is estimated to 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0110); Room 7-1045, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0110.



# **CONFIDENTIAL INFORMATION**

**IF FOUND, PLEASE CONTACT**

**@**

**Ext.**

**FEDEX TRACKING NUMBER: \_\_\_\_\_**

**Property of:  
RTI International  
3040 Cornwallis Road, Research Triangle Park, NC 27709**

**Exhibit 6.5 CI Case Checklist**

<b>Clinical Interviewer Case Checklist</b>	
<b>Task</b>	<b>Established Deadline</b>
<b>Receive Case Assignment</b>	
Check web CMS for new cases (daily)	
<b>Prepare for the Interview</b>	
Gather materials	
Set up recording equipment, complete initial test recording	
<b>Introduce and Complete the Interview</b>	
Use Introduction script	
With permission, begin recording	
Complete SCID	
Handle distressed R situation appropriately, if needed	
When finished, thank R and stop recording	
<b>Document and Distribute Information</b>	
Upload audio file to web through MH Case Manager	Within 2 hours
Update case status results in CMS	Within 2 hours
Document distressed R situation, if needed	Within 2 hours
Edit SCID	Within 24 hours
Complete SCID Cover Sheet, place in manila envelope with preprinted Confidential Information Sheet, and FedEx to RTI	Within 48 hours
On CMS, document FedEx shipment by adding a code 80 and including the FedEx tracking number in the Notes	Within 48 hours

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## 7. ADMINISTRATIVE PROCEDURES

### 7.1 Introduction

Knowing and following all administrative procedures is vital to the success of this study. Be sure to read this chapter carefully, refer back to it when necessary, and do not hesitate to contact your Data Collection Manager whenever you have questions about administrative issues.

### 7.2 Terms of Employment

As a clinical interviewer, you are an employee of Headway Corporate Resources, referred to as Headway. The terms of your employment are spelled out in the Employee Guidelines and Supplemental Guidelines along with other employment forms signed by you. Headway handles the payment for hours worked and expenses, including deductions for Federal, State, and Social Security taxes. You must complete a W-4 form so that appropriate deductions are withheld.

In addition to all payroll functions, Headway is responsible for all necessary personnel documentation and the actual hiring and terminating of all employees. Your Data Collection Manager acts as your direct supervisor with full authority to manage staff.

### 7.3 Working with your Supervisors

During your work on this study, you will report to, and work closely with the Clinical Supervisors for issues related to the SCID and the actual interview administration process, and your Data Collection Manager for issues related to case assignments, production, contacting respondents, and administrative topics such as expenses and supplies. Your supervisors are a team and will work closely together to support you.

You will participate in regularly scheduled conference calls with your Data Collection Manager to discuss your work progress and any other important issues. More than likely you will speak with him/her at least once per week. Due to the nature of the study, it is imperative that you keep him/her informed of any problems. Administratively, your Data Collection Manager will be approving your timesheets each week so you get paid in a timely fashion.

Your contact with the Clinical Supervisors will vary, with more conferences at the beginning of data collection as you receive feedback and perfect your administration of the SCID.

As needed, refer to *Exhibit 1.1* for contact information for the entire MHSS management team.

#### 7.3.1 Conference Calls

As mentioned, your Data Collection Manager will hold a regularly scheduled conference call with you usually once per week. During this call, be prepared to discuss your weekly work, and schedule of availability. In order to assign cases to you, he/she must have detailed knowledge of your schedule. Have your Case Status information from the CMS available in order to discuss any respondent contact issues you may be having.

Once a Clinical Supervisor completes the review of your work, he/she will contact you directly with any feedback. In addition to this ongoing feedback, the supervisors may periodically host group or individual conference calls to discuss important SCID administration topics.

### **7.3.2 E-mail**

You will be issued an RTI e-mail account for use on the Mental Health Study for additional contact with your supervisors, such as documenting a difficult case or situation, and sharing any changes in your work schedule availability. Do not use this e-mail account for personal correspondence; it should only be accessed for work directly related to the Mental Health Study. Be sure to check your e-mail daily on days you have indicated you are available to work.

### **7.3.3 Web Updates**

Timely updates of the web CMS are extremely important due to the rigid data collection schedule. The information you enter is used to generate project reports and thus affects management decisions. Delay of information entry into the CMS may cause problems in the day-to-day management of the study. Your supervisors and others at RTI need to be aware of your work as soon as possible via the web updates. Refer to *Section 6.2* of this handbook for detailed information on your responsibilities in updating the CMS.

## **7.4 Electronic Production Time and Expense (ePTE) Reports**

All clinical interviewers must complete an electronic Production Time, and Expense (ePTE) report weekly and submit it in order to be paid. In addition to serving as your timesheet, the ePTE gives RTI managers a detailed summary of the tasks completed during the period covered by the report and the time and expenses required for completing those tasks. You must submit a complete and accurate ePTE report each week for all work done in order to be paid.

While you are required to submit an ePTE each week, there may be times when you are not able to access the electronic system due to computer or other problems. In such instances, you will need to submit a paper PT&E as instructed in *Appendix B*. Keep a small supply of paper PT&Es as a back up for situations such as these. Additionally, there may be times when an ePTE is submitted and approved, and then errors are discovered, such as a forgotten expense that was not reported. You must submit a revised report using a paper report.

## **7.5 The ePTE System**

### **7.5.1 Overview**

The focus of this section is how to use the ePTE program. It gives detailed instructions on entering information in the various forms as well as detailing where to enter specific hours or expenses.

Similar to paper forms, the ePTE system has several screens for you to complete. Details for the various forms are given in subsequent sections.

- Default Value Setting Form – The first time you access the system, you must identify yourself and set certain values such as your RTI ID number and the project number. You will only need to complete this form the first time you use the ePTE system (see *Section 7.5.2*).

- Entry Form – This is the form you will use as you enter the system to provide important information that defines an individual report such as the proper project number, your Data Collection Manager, and the week for which you are submitting the form (see *Section 7.5.3*).
- Detail Form – This form has the rows and columns in which you record the details of the time spent on various tasks and a daily account of your expenses (see *Section 7.5.4*).

In each of these forms, you can use your mouse to navigate or press the **[Tab]** key to move from one field to the next. Holding down the Shift key while pressing the Tab key (**[Shift] [Tab]**) moves the cursor backwards through the fields. The field which is currently active will have the cursor in that field or will be a highlighted button with a dotted line around it. Within the fields, use the left and right arrow keys to move around, the delete key to remove characters, and letter and number keys as needed.

*Sections 7.5.5* and *7.5.6* provide instructions on using the system's edit checks, how to handle various messages that may appear, and tips for some advanced functions.

To access your ePTE system, double click the ePTE icon on the Desktop. Enter your RTI Employee ID number and your password when prompted.

## 7.5.2 Default Value Settings

The first time you enter the ePTE system, you must provide some personal identifying information. It is *critical* that you enter this information correctly since it is used to identify the reports you submit so your payment can be processed. It is particularly important that you enter your RTI ID number correctly. An example of this form is shown below.

**RTI Electronic PTE System Default Value Setting**

This information will fill your PT&E Entry Form-please enter it accurately. If you have questions, consult your manual. If help is still needed, contact your supervisor. You must enter a valid RTI ID before using other ePTE functions. Note that once you Save, you CANNOT change RTI ID on this computer without authorization from RTI.

RTI ID: 000999

Last Name: Interviewer First Name: A. Professional

St. Address: 1234 Main Street

City: Raleigh State: NC Zip: 27529

Phone #: (111) 222-3333 New Name/Address/Phone:

Supervisor Name: Patience Supervisor Supervisor Area #: 321

Project Number: 0212682 120.005

Allow Past PT&E Edit: 15 Days

Allow PTE Type

Data Collection:  Count & List:  Supervisor:

Save Exit Help

- In the first 8 fields: Carefully enter your personal identifying information (through the phone number field). Be very careful to enter your RTI ID number correctly. Press [Tab] to move to the next field. Pressing [Shift] [Tab] moves backwards. If your name is longer than the displayed field, the program accepts the additional characters (there is a maximum of 50 characters).
- New Name/Address/Phone: When a change is made to a name, address, or phone number field (including the first time you complete the form), this box should be checked. Having the box checked means the information/changes are transmitted to Headway for processing. You must also inform your Data Collection Manager of any address changes. He/she will forward the changes to Headway so that all files are updated.

**Important:** If Headway already has your correct name and address on file, press [**Space bar**] (or click Name/Address/Phone) to uncheck this box. Only leave the box checked if there have been changes to your name and/or address that Headway needs to know about.

- Supervisor Name and Area #: Next, enter the name of your Data Collection Manager, the area ID number [either 901 ( ) or 902 ( )].
- Project Number: The project number belongs in the next two fields. Initially, your default settings should be set to the corresponding training/certification project number as shown in the chart below. During data collection, each week you will divide your hours between two codes at the ratio of approximately 1/3 and 2/3 (see Dividing Charges later in this section for more information).

	Training/Certification	2011 Data Collection	Ratio
New CI	0212682.120.005	0211838.212.006	1/3
		0212682.120.006	2/3
Returning CI	0211838.212.005	0211838.212.006	1/3
		0212682.120.006	2/3

When finished with the certification process, change the default setting to one of the two data collection numbers. The project number can be changed in the Entry Form.

- Allow Past PT&E Edit – This box is pre-filled with 15 days. Do not change this number unless instructed to do so.
- Allow PTE Type – When Data Collection is highlighted (with a box around it) press the [**Space bar**] to place a check mark in that box. At this point, leave the other boxes unchecked. If you don't make a selection here, Data Collection is automatically chosen by default.
- Save – Once you have filled in all fields and double checked all your entries, then triple check your RTI ID. Next, press [**Alt**] [**s**] (for Save) or click Save.

If the New Name/Address/Phone field is checked when you save your information, a message box then appears asking if you want to transmit this address to Headway. Choose Yes if Headway does not have your up-to-date name, address or telephone number on file; otherwise choose No.

If the New Name/Address/Phone field is not checked, you will not get this message box.

After you have saved your information, the RTI ID field is shaded in light blue indicating that this field is "read-only." You can no longer change this value without obtaining a special password from your Data Collection Manager.

NOTE: You must enter a valid RTI ID before moving on to the ePTE Entry Form.

- Help – If you have any questions about any of the fields on this form, simply press [Alt] [h] (for Help). Read the topics displayed in the help window using the **Down Arrow** key to scroll through the text. Close the help window by pressing [Alt] [F4].
- Exit – Once you have filled in all information on this form and have saved it, you can exit by pressing [Alt] [x] (for Exit) or click Exit to automatically continue with the Entry Form.

### 7.5.3 Entry Form

The first time you work in the ePTE system, you complete the Default Value Settings Form as described in *Section 7.5.2*. Upon exiting that form, you see the PT&E Application Entry Form, referred to as the Entry Form. Each subsequent time you enter the ePTE system, you start at the Entry Form. An example of this form is shown below.

The default values from the Default Value Settings Form are pre-filled in their appropriate fields. In particular, note the blue shading around RTI ID and the Counting & Listing and Supervisor buttons indicating that these fields are read only. The Data Collection Manager and project number information from the Default Value Settings Form displays, but can be altered on this form.

The screenshot shows a software window titled "Research Triangle Institute PT&E Application - Entry Form (Version 3.0)". The window has a menu bar with "File", "Edit", "Tools", "Utilities", and "Help". Below the menu bar is a banner that reads "Electronic Production Time and Expense".

The form contains several input fields and buttons:

- RTI ID: 000999 (highlighted in blue)
- Supervisor Name: Patience Supervisor
- Area: 321
- Week Begin Date: 08/22/2010
- RTI Project Number: 0212682
- Value: 120.005
- Travel Status:
- PTE Type: Radio buttons for Data Collection, Counting & Listing (highlighted in blue), and Supervisor (highlighted in blue).
- Did Not Work:
- Employee: A. Professional
- Buttons: Enter PT&E, Exit, and Transmit ePT&E.
- Logos: HEADWAY and RTI INTERNATIONAL.



When completed, the information on this Entry Form defines a specific ePTE record.

- Supervisor Name – Your Data Collection Manager's name is displayed. Tab through this field to prepare an ePTE for this supervisor.
- Area ID – The proper Area ID is displayed from your default values. Tab through this field to prepare an ePTE for this Area ID.
- Week Begin Date – Enter the date of the Sunday which begins the work week you are reporting. Use the format shown in the example.
- RTI Project Number – Your default project number is displayed. Tab through these fields to prepare an ePTE for this number.

To submit an ePTE for a different project number, press delete to remove the current number and then carefully enter the correct project number and task number.

If the new number is similar, it may be easier to edit: use the arrow keys to move to the right of the digit to be altered, press Backspace to delete and then type the new digit. If you need to alter the Default Values Form, see *Section 7.5.6*, item 10. Please complete any changes carefully. Entering incorrect project numbers causes problems and may delay your payment.

- Travel Status – Leave the Travel Status box blank.
- PTE Type – The options available for PTE Type depend on which PTE types you marked on the Default Values Form. You can only choose from the types that are not shaded a light blue.
- Did Not Work – If you did not perform any work during the given reporting period, place a check in this box by pressing the [**Space bar**] or clicking Did Not Work. For accurate reports, it is important for you to submit a Did Not Work ePTE record by marking this box and transmitting that information. See *Section 7.5.6*, items 6 and 7 for additional details.

There are also several buttons on the Entry Form:

- Enter PT&E – Once you have completed all fields, click the "Enter PT&E" button to proceed to the Detail Form for that report.
- Exit – If you don't want to enter ePTE information now, click the Exit button. When you exit in this way, any changes just made to the information displayed are not saved. When you return to the ePTE system, your default values appear.

After indicating you want to exit, a confirmation box appears asking if you are sure you wish to exit. A "Yes" response takes you to the desktop. A "No" response clears the boxes and you remain at the Entry Form.

- Transmit ePT&E – Once you have finalized your entire report and marked it on the Detail Form as ready to transmit, click the "Transmit ePT&E" button to begin the process to submit your report to RTI. This process is explained more later in this chapter.

## 7.5.4 Detail Form

After identifying an ePTE record and choosing the "Enter PT&E" button on the Entry Form, the Detail Form shown below appears. This section explains the process of entering information on the ePTE and gives you detailed explanations for the various columns including where to enter certain hours or expenses.

**Research Triangle Institute PT&E Application - Detail Form**

**Data Collection PT&E**      Project: 0212682-120.005      RTI ID: 000999  
 Week Begin: 08-22-2010      Travel: N      Supervisor: 321-Patience Supervisor

A		B	C									B-1	
Day of Week	Date	Production	Time									Note	
		# of Completed Interviews*	Training	Home Study	Travel	Contact Locate	Inter-viewing	Editing	Confe-rence	Other*	Daily Total*		
Sun	08-22											0.00	
Mon	08-23											0.00	
Tues	08-24											0.00	
Wed	08-25											0.00	
Thurs	08-26											0.00	
Fri	08-27											0.00	
Sat	08-28											0.00	
<b>Totals</b>		0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	

\* Click on labels denoted by "\*" for more details

A		D							
Day of Week	Date	Expense							
		Miles Driven	Lodging	Meals Expense*	Tele- phone*	Auto Rental*	Misc. *	Incentive*	Total Expense
Sun	08-22								0.00
Mon	08-23								0.00
Tues	08-24								0.00
Wed	08-25								0.00
Thurs	08-26								0.00
Fri	08-27								0.00
Sat	08-28								0.00
<b>Totals</b>		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

**Advance Repayment\***

Save      Cancel      Print

### How to Start

First, check that the header information at the top of the form is correct. Also make sure the dates on the left-hand side correspond to the work week for which you are reporting. If you notice any mistakes, do not enter any information. Exit this form by clicking the "Cancel" button at the top. Make the necessary corrections on the Entry Form page before proceeding.

### How to Move

Within the Detail Form, move from field to field using [Tab], [Shift] [Tab], or any of the arrow keys. You can also use the Touchpad to click the next fields. The field that is active—that is, if you enter information it appears in that field—is shaded a light orange. On the Detail Form shown above, the active field is Sunday, Production. Once you enter an amount in a field, the left and right arrow keys allow you to move among the characters in that field. To continue to the next field, you must press [Tab] or [Enter]. Using the Touchpad to click is a simple way to move to fields in different parts of the form.

To move from one section of the form to another, use the Touchpad or press [Tab] from the lower right field in that section. For example, to move from "C -- Time" to "D -- Expense," use [Tab] or the arrow keys to move to the last cell in the Time chart, which is Saturday, Other. Press [Tab] to move to section D, Sunday, Miles Driven. To move back to the "C -- Time" section from the "D -- Expense" section, be in the Sunday, Miles Driven field and then press [Shift] [Tab]. The chart flows in this way:

**Time → Expenses → Advance Repayment → Notes → Save/Cancel/Print.**

**How to Enter**

Time entered should be rounded to quarter hours and recorded in decimal form. Do not record time in minutes. The program rounds your entries as needed, and supplies the standard two decimal place value. So, if you enter 2 hours, the program displays 2.00. If you enter 2.2 hours, the program displays 2.25. For example if you had 1 hour and 45 minutes of interviewing time, you should enter your time as "1.75." If you enter your time in minutes, "1.45," the program would automatically round ".45" to ".50". You would only get paid for one and a half hours instead of an hour and three quarters. The table below shows examples of correct and incorrect time entries:

<b>Time Worked</b>	<b>Incorrect Entry</b>	<b>Correct Entry</b>
1 hour and 15 minutes	1:15	<b>1.25 hrs.</b>
1 hour and 20 minutes	1:20	<b>1.25 hrs.</b>
1 hour and 30 minutes	1:30	<b>1.50 hrs.</b>
1 hour and 40 minutes	1:40	<b>1.75 hrs.</b>
1 and 3/4 hours	1:45	<b>1.75 hrs.</b>

The program automatically calculates totals for each task (column) and day (row).

**What and Where to Enter**

This section details the various charges and their corresponding location on the Detail Form. Please refer to these instructions and the example that follows as you are completing your reports to be sure you are making all required entries correctly.

**SECTION B -- PRODUCTION:**

- Enter the total number of completed **interviews** (code 70s, 71s, and 72s) each day. You must record the QuestIDs for all completed interviews and all breakoff interviews in the Notes section (see below). Make sure to keep up with your entries daily on an ePTE Working Copy (see *Exhibit 7.1*) so you will know what you completed that day.

**SECTION C -- TIME:** In each column, enter the hours worked each day to the nearest .25 hour. Hours must be entered as decimals and are rounded to the nearest quarter hour. Show how your hours were spent on project work by distributing the time worked across the various columns as appropriate. The program totals your entries by row and column. Hours submitted on your ePTE should be entered in the following columns:

- Training – Except for training, this column will not be used. However, if you are authorized to spend time doing additional study, record the time in this column.
- Home Study – This column is only used in rare situations when instructed by your Data Collection Manager or Clinical Supervisor.
- Travel – Use this column for any travel required for your work.
- Contact/Locate – Record time spent contacting respondents, including time spent making appointments.
- Interviewing – Record time spent administering the SCID from start to finish including any initial conversations with the respondent during the call.
- Editing – Enter any time spent editing the SCID in this column. Do not include interviewing time here.
- Conference – Record time spent preparing for and in conference with your supervisors, compiling weekly reports, completing incident reports, and any calls with other RTI or research staff such as Technical Support.
- Other – Record time spent performing other allowable project activities such as entering information into the web as well as time spent transferring audio files and preparing FedEx packages. You must include a short description of any "Other" activity in the "Notes" section on the side of the report.

**SECTION D -- EXPENSES:** You must **check with your Data Collection Manager before incurring any expenses**. Expenses submitted on your ePTE should be entered in the following columns:

- Miles Driven – Record the total **miles** driven (rounded to the nearest mile) each day on project business (check to make sure that the corresponding travel time is shown in the Travel column). Mileage is reimbursed at the established government mileage reimbursement rate of \$0.51 per mile. Note: This rate is set by the federal government and is subject to change.
- Lodging, Meals, Telephone, and Auto Rental – Do not use these columns unless instructed by your Data Collection Manager.
- Miscellaneous Expenses – On the ePTE, record all miscellaneous expenses under \$10.00 such as reimbursement for adding 3-way calling. You must explain the expense in the Notes and receipts are not required. **Expenses over \$10.00 are submitted with receipts on the Headway Expense Report** (see *Section 7.6*) and sent to your Data Collection Manager for approval. They are NOT reported on the ePTE.  
Note that parking tickets, traffic tickets, and other fines are not reimbursable expenses.
- Incentives – For this study, you should not have any incentive expenses since respondents were paid for the telephone interview at the time of the initial interview.
- Total Expenses – The program will total your eligible expenses for each day.

**Exhibit 7.1 ePTE Working Copy**

**Clinical Interviewer WORKING COPY of the ePTE**

Data Collection ePTE    **Week Begin** / / 2011    **Travel**  Yes  No (circle one)    **Project #** See charts below    **Supervisor Area #** 901    902

Each week record hours in this table, then total at the end of the week. Make corresponding notes as well.

Day of Week	Date	Production							Time					Notes
		# Comp. Interviews*	Training	Home Study	Travel	Contact Locate	Inter-viewing	Editing	Confer-ence	Other^	Daily Total			
Sun														
Mon														
Tues														
Wed														
Thur														
Fri														
Sat														
<b>TOTALS</b>														

Divide your total hours into the 1/3, 2/3 split. Record the splits in the first row below, then separate the charges between the two charts/codes so the splits and totals are close. Be sure the QuestIDs in the Notes correspond to the interviewing time recorded.

Day of Week	Date	MHSS 1/3: 0211838-212.006				1/3 total:				EMHSS 2/3: 0212682-120.006				2/3 total:			
		# Int.*	Travel	Contact Locate	Inter-viewing	Confer-ence	Other^	Daily Total	# Int.*	Travel	Contact Locate	Inter-viewing	Edit	Confer-ence	Other^	Daily Total	
Sun																	
Mon																	
Tues																	
Wed																	
Thur																	
Fri																	
Sat																	
<b>TOTALS</b>																	

Notes:

**Exhibit 7.1 ePTE Working Copy (continued)**

<b>Charges on ePTE:</b>	Miscellaneous Expenses less than or equal to \$10 Miles Driven Meal Expenses	<b>Charges on Headway Expense Report:</b>	Miscellaneous Expenses over \$10 Lodging Costs, Auto Rental Telephone Charges
<ul style="list-style-type: none"> <li>Remember you must have approval from your Data Collection Manager before incurring any expenses.</li> <li>All Miscellaneous Expenses must be explained in the Notes. Expenses over \$10 belong on the Headway Expense Report. (If you have multiple miscellaneous charges on one day that are <u>each</u> less than \$10, but together total more than \$10, use the ePTE and explain the charges in the Notes.)</li> <li>Divide total miles and total expenses using the 1/3, 2/3 split, and separate charges between the two charts.</li> </ul>			

Day of Week	Date	Expense							Total Expense
		Miles Driven	Lodging#	Meal Expenses	Tele- phone#	Auto Rental#	Miscellaneous^	Incentive	
Sun									
Mon									
Tues									
Wed									
Thur									
Fri									
Sat									
<b>TOTALS</b>									

Day of Week	Date	MHSS 1/3: 0211838-212.006				EMHSS 2/3: 0212682-120.006			
		Miles Driven	Meals	Misc.^	Total Expense	Miles Driven	Meals	Misc.^	Total Expense
Sun									
Mon									
Tues									
Wed									
Thur									
Fri									
Sat									
<b>TOTALS</b>									
Notes:									

## Advance Repayment

Do not use this box. You will not have an outstanding travel or incentive advance with Headway.

## Notes

Type the following in the Notes section and press **[Enter]** after each item:

- QuestIDs of all completed interviews
- QuestIDs for any breakoff interviews that occurred and were not subsequently completed during the week. Enter BRK before the QuestID to indicate it is a breakoff case. You need not record breakoffs that result in a completed interview within the same week.
- Explanations of all time charges under "Other."
- Explanations of all Miscellaneous expenses \$10.00 and under reported on ePTE.

## When to Enter

You MUST record your ePTE information daily on the provided ePTE working copies. Record the information daily in the chart on the top half of the document as you work. Make notes to help you calculate your hours: record beginning and ending times as well as the stop and start times for any breaks taken. Make other helpful notes such as how long each interview took and any expenses paid. Then, when finished working, make your entries for each column in that day's row. Once you have finished working for the week, divide the data collection charges as explained in the next section, then transfer accurate data from your working copy to the ePTE system and submit it. Once a report is submitted, you cannot update it.

Remember, you must have your ePTE information entered into the ePTE system and submitted to RTI before **10:30 pm Eastern Time on Sunday**.

## Dividing Charges

All CI data collection hours and expenses must be divided between two project numbers at the approximate ratio of 1/3 to MHSS and 2/3 to EMHSS. The ePTE Working Copy design helps in the division of charges. Follow these steps and consult the completed example provided in *Exhibit 7.2*.

1. When finished working for a given week, total your hours in the chart on the top half of the ePTE Working Copy.
2. Divide the total hours into approximately 1/3 and 2/3, entering those values in the split charts at the bottom of the page, to the right of the MHSS/EMHSS project numbers. For example, if you work 12 hours, the split totals are 4 to MHSS and 8 to EMHSS.

Total hours do not always divide cleanly into a 1/3 and 2/3 split, so round your divided totals to the closer quarter hour. The split does not have to be exact, but close. For example, if you work 14 hours, the split totals are 4.75 to MHSS and 9.25 to EMHSS.

3. Transfer the various amounts from your daily entries at the top to the split charts at the bottom so the totals reflect the 1/3 and 2/3 split. Consider these examples:
  - Divide a charge of 0.75 hours into 0.25 and 0.50.
  - If there are three separate charges for 0.25, record one on the first chart (MHSS) and the other two on the second chart (EMHSS).
  - Divide 1 hour into 0.25 and 0.75. However if you have three 1 hour charges, record 1 hour for MHSS and 2 hours for EMHSS.
  - Look at row totals for each day in the chart on the top to see if using daily totals makes it easier to divide, so that charges for one day are on one of the split charts and charges for another day are on the other chart. Use the smaller charges of 0.25 and 0.50 where needed to achieve the appropriate totals for each chart.
4. Balance your hours so the overall division works. If you have one charge that doesn't divide cleanly, look for another charge that also does not divide evenly, and balance these over the entire ePTE to achieve an approximate 1/3 and 2/3 split. Use the divided total hours recorded at the top of the split charts as your goal.

Carefully review the completed example in *Exhibit 7.2*. This CI:

- Completed 3 interviews during the week while working 6.75 hours
- Divided 6.75 into the 1/3 and 2/3 splits, recording 2.25 for MHSS and 4.50 for EMHSS
- Looked along the daily row totals at the top of the chart, noting that for 8/26, the daily total was 1.75 (close to 2.25) while the total for 8/28 was 4.00, (close to 4.50)
- Recorded hours for 8/26 on the MHSS chart on the row for 8/26, and recorded hours for 8/28 on the EMHSS chart
- Used the remaining charges (conference, contact/locate) to balance the totals in each chart to end up with 2.25 hours for MHSS and 4.50 hours for EMHSS
- Added the appropriate QuestIDs and documentation for the 'Other' time in the Notes at the bottom.

Should you have any expenses, divide those entries into the 1/3 and 2/3 split as well using the charts on the reverse side of the ePTE Working Copy.

Remember to record the QuestIDs of any completed interviews in the Notes. Have the QuestIDs correspond (generally) to the interviewing hours charged.

Do your best to divide charges without spending too much time on the task. Your Data Collection Manager will provide any necessary feedback and is available to answer your questions.



**Exhibit 7.2 Properly Completed ePTE**

**Clinical Interviewer WORKING COPY of the ePTE**

Data Collection ePTE **08/22/2011** **Week Begin** **08/22/2011** **Travel**  Yes  No **Project #** **Supervisor** **Area #** **901** **(902)**

Each week record hours in this table, then total at the end of the week. Make corresponding notes as well.

Day of Week	Date	Production							Time					Notes			
		# Comp. Interviews*	Training	Home Study	Travel	Contact Locate	Inter-viewing	Editing	Confer-ence	Other^	Daily Total	* Record QuestID for completed interviews ^ Explain 'Other' hrs					
Sun	8/22																
Mon	8/23																
Tues	8/24							0.25									
Wed	8/25							0.25									
Thur	8/26	1						0.25	0.75	0.25						9994321 Other: 8/26 + 8/28 audio, web entries, FedEx	
Fri	8/27							0.25			0.25						
Sat	8/28	2						0.25	2.75	0.50						9995432	
<b>TOTALS</b>		<b>3</b>						<b>1.25</b>	<b>3.50</b>	<b>0.75</b>	<b>0.25</b>	<b>1.00</b>	<b>0.25</b>	<b>0.50</b>	<b>4.00</b>	<b>6.75</b>	<b>9996543</b>

Divide your total hours into the 1/3, 2/3 split. Record the splits in the first row below, then separate the charges between the two charts/codes so the splits and totals are close. Be sure the QuestIDs in the Notes correspond to the interviewing time recorded.

Day of Week	Date	MHSS 1/3: 0211838-212.006							EMHSS 2/3: 0212682-120.006							Daily Total		
		# Int.*	Travel	Contact Locate	Inter-viewing	Edit	Confer-ence	Other^	Daily Total	# Int.*	Travel	Contact Locate	Inter-viewing	Edit	Confer-ence		Other^	
Sun	8/22																	
Mon	8/23																	
Tues	8/24			0.25					0.25									
Wed	8/25			0.25					0.25									
Thur	8/26	1		0.25	0.75	0.25			1.75									
Fri	8/27										0.25							0.50
Sat	8/28										0.25	2.75	0.50					4.00
<b>TOTALS</b>				<b>0.75</b>	<b>0.75</b>	<b>0.25</b>			<b>2.25</b>		<b>0.50</b>	<b>2.75</b>	<b>0.50</b>	<b>0.25</b>	<b>0.25</b>	<b>0.50</b>	<b>0.50</b>	<b>4.50</b>

Notes: 9994321 Other 8/26 audio, web, FedEx  
9995432 Other 8/28 audio, web, FedEx  
9996543

**Exhibit 7.2 Properly Completed ePTE (continued)**

Research Triangle Institute PT&E Application - Entry Form (Version 3.0)

File Edit Tools Utilities Help

**Electronic Production Time and Expense**

RTI ID: 000999    Supervisor Name: Patience Supervisor    Area: 321

Week Begin Date: 08/22/2010    RTI Project Number: 0211838-212.006    Travel Status:

PTE Type: Data Collection  Counting & Listing  Supervisor     Did Not Work:

Employee: A. Professional

Buttons: Enter PT&E, Exit, Transmit ePT&E

Research Triangle Institute PT&E Application - Detail Form

**Data Collection PT&E**    Project: 0211838-212.006    RTI ID: 000999

Week Begin: 08-22-2010    Travel: N    Supervisor: 321-Patience Supervisor

A		B	C								B-1	
Day of Week	Date	Production # of Completed Interviews*	Time								Note	
			Training	Home Study	Travel	Contact Locate	Inter-viewing	Editing	Confere- rence	Other*	Daily Total*	
Sun	08-22										0.00	9994321 Other: 8/26 Audio, web entries, FedEx
Mon	08-23										0.00	
Tues	08-24					0.25					0.25	
Wed	08-25					0.25					0.25	
Thurs	08-26	1				0.25	0.75	0.25		0.50	1.75	
Fri	08-27										0.00	
Sat	08-28										0.00	
<b>Totals</b>		1	0.00	0.00	0.00	0.75	0.75	0.25	0.00	0.50	2.25	

A		D							
Day of Week	Date	Expense							
		Miles Driven	Lodging	Meals Expense*	Tele- phone*	Auto Rental*	Misc. *	Incentive*	Total Expense
Sun	08-22								0.00
Mon	08-23								0.00
Tues	08-24								0.00
Wed	08-25								0.00
Thurs	08-26								0.00
Fri	08-27								0.00
Sat	08-28								0.00
<b>Totals</b>		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

\* Click on labels denoted by "\*" for more details

\$0.00

**Advance Repayment\***

Buttons: Save, Cancel, Print

**Exhibit 7.2 Properly Completed ePTE (continued)**

Research Triangle Institute PT&E Application - Entry Form (Version 3.0)

File Edit Tools Utilities Help



**Electronic Production Time and Expense**

000999    **Patience Supervisor**    321  
RTI ID                      Supervisor Name &                      Area

08/22/2010    0212682    120.006    Travel   
Week Begin Date                      RTI Project Number                      Status

PTE Type  
 Data Collection     Counting & Listing     Supervisor     Did Not Work

Employee: A. Professional

Research Triangle Institute PT&E Application - Detail Form

**Data Collection PT&E**    Project 0212682-120.006    RTI ID 000999  
 Week Begin 08-22-2010    Travel N    Supervisor 321-Patience Supervisor

A		B	C										B-1	
Day of Week	Date	Production # of Completed Interviews*	Time										Daily Total*	Note
			Training	Home Study	Travel	Contact Locate	Inter-viewing	Editing	Confere- rence	Other*				
Sun	08-22												0.00	9995432 9996543 Other: 8/28 audio, web entries, FedEx
Mon	08-23												0.00	
Tues	08-24												0.00	
Wed	08-25												0.00	
Thurs	08-26												0.00	
Fri	08-27					0.25				0.25			0.50	
Sat	08-28	2				0.25	2.75	0.50	0.25	0.50			4.00	
<b>Totals</b>		2	0.00	0.00	0.00	0.50	2.75	0.50	0.25	0.50			4.50	

A		D							Total Expense
Day of Week	Date	Expense							Total Expense
		Miles Driven	Lodging	Meals Expense*	Tele- phone*	Auto Rental*	Misc. *	Incentive*	
Sun	08-22								0.00
Mon	08-23								0.00
Tues	08-24								0.00
Wed	08-25								0.00
Thurs	08-26								0.00
Fri	08-27								0.00
Sat	08-28								0.00
<b>Totals</b>		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

\* Click on labels denoted by "\*" for more details

\$0.00  
**Advance Repayment\***

## When Finished Entering Data

If you want to exit the form without submitting (transmitting) it at this time, click the "Cancel" button on the Detail Form. A confirmation box appears asking if you want to save the changes you have made to the form. If you want to close without saving, click the "No" button. If you want to save the time sheet, click "Yes."

To save from within the Detail Form, click the "Save" button. The "Ready to Transmit" box appears:



If you have **not** completed the entire week's information for your ePTE, click the "No" button. A box then appears confirming for you that the ePTE has been saved, and can be edited and transmitted later. Press **[Enter]** to close this box.

If you are finished with this report and wish to send it to RTI, click "Yes." The following box appears:



**YES:** Answering "Yes" to this question certifies the charges you are submitting are accurate. This is like signing a paper document. Click "Yes" to sign and finalize your ePTE record.

**NO:** If you have any doubts about the information that you entered before you certify your information is accurate and correct, click "No." The next message box confirms for you that the ePTE has been saved, and can be edited and transmitted later. Click "OK" to close that message box.

Next you are asked if you want to enter another ePTE or transmit the data you have entered. If you are finished with the ePTE system, click "No" to exit. If you have additional tasks, click "Yes" and the system will return you to the Entry Form.

## **Transmitting Data to RTI**

A finalized ePTE record marked as ready to transmit must be sent to RTI before 10:30 pm EST on Sunday. To transmit (send) your final ePTE information to RTI, follow these steps:

1. Be sure your computer is connected to the Internet.
2. Be sure your ePTE report is finished, and confirmed as "Ready to Transmit" through the "Save" process within the Detail Form (see previous page).
3. At the Entry Form, click "Transmit ePT&E."
4. The following text appears in a message box:

The system is going to transmit ePT&E records to RTI. Please press OK and wait until the program finishes before performing any other operations. If you do not intend to transmit at this time, press Cancel.

If you do not wish to transmit, click "Cancel." To continue and transmit to RTI all ePTE records marked as ready to transmit, click "OK."

5. Wait patiently (i.e., don't try to multi-task) while the process takes place. When finished, the next message indicates the results.
6. **If successful:** The following text appears in a message box:

You have successfully transmitted your data. In this transmission you have transmitted x PT&E record(s) and y record(s) on address information.

In the text, x and y represent the number of records sent to RTI. You may safely exit the system.

7. **If not successful:** A message box appears explaining the nature of the error and steps to take to correct the problem. Follow the instructions carefully. As needed, check with your Data Collection Manager.

During the transmission process, the record will be sent to RTI. Then, it will be processed, and forwarded to your Data Collection Manager for approval. Once the record is transmitted you can no longer edit the information. It becomes a read-only record which you can view but you cannot change (see **Section 7.5.6**, item 4). If you need to make changes to a transmitted record, see **Section 7.5.6**, item 5.

### **7.5.5 Edit Checks in the ePTE System**

The program is sophisticated enough to provide some built in checks to prevent errors when filling out your ePTE. The system displays a message or warning box which identifies the problem and includes suggestions for resolving the problem. If you encounter a pop-up box, read it carefully. Press **[Enter]** to close the box and then continue.

The following are possible scenarios that cause an error pop-up message:

1. Begin work week date is in the future or is too far in the past.
2. Begin work week date is not a Sunday.
3. Letters and other characters can't be entered in a numeric field (such as hours worked).
4. You can't charge more than 20 hours in a day.

## 7.5.6 Advanced Features

The previous sections provide all the steps necessary to complete a regular ePTE report. This section includes additional system features and focuses on making changes to your ePTE data and your personal information.

### 1. **Editing Hours and Expenses on an untransmitted ePTE record:**

You can open and edit any ePTE record in the system as long as the record has not been transmitted to RTI.

- On the Entry Form, key in the exact information that you entered previously for that PT&E and click "Enter PT&E."

You can use this method to update Hours or Expenses or other information in any un-transmitted records. Transmitting to RTI only sends those records that you specify as "Ready to Transmit" when answering "OK" to the certification question. If you choose not to transmit the record when you save it, by canceling or not certifying it, you must open it later using this method, and then save it with a transmission confirmation in order for RTI to receive the record before **10:30 pm Eastern Time on Sunday**.

### 2. **Deleting an ePTE Record that hasn't been transmitted:**

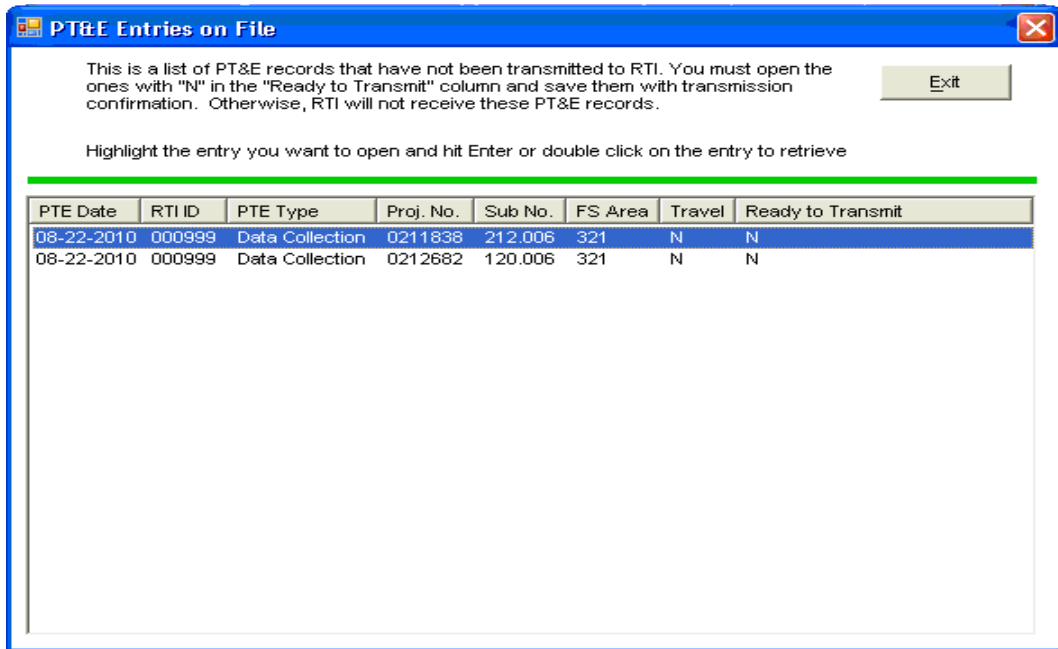
To delete an un-transmitted ePTE record, key in the exact information on the Entry Form that you entered and saved previously. Once you have reached the Detail Form for the un-transmitted ePTE you wish to delete, click the "Delete" button at the top of the page. The system asks if you really want to delete this record. If you answer yes, the record is removed from the system. Please note that you can only delete records that are not yet transmitted to RTI.

### 3. **Locating Un-transmitted ePTE Records:**

As explained above, you can locate and edit an un-transmitted record by providing the exact same information on the Entry Form as the record you want to locate. Sometimes, however, you may not remember the ePTE records that you have previously entered. The Entry Form provides a tool to help you. To find un-transmitted records:

- Press [Alt] [f] (for File) then [u] for Search Un-transmitted ePTE.

The PT&E Entries on File Form (shown on the next page) lists all ePTE entries in the system that have not been transmitted. Use the arrow keys to move up or down in the list until the record you wish to edit is highlighted in blue, then press [Enter]. Touchpad users can point to the needed record and double click to select it. This takes you back to the Entry Form where the fields are filled with the data from that particular record. Press [Alt] [n] to Enter the Detail Form (or click Enter) to make changes to the data associated with that ePTE record.



**4. Locating Transmitted ePTE Records:**

Use the method from item 3 to view transmitted ePTE records. From the Entry Form, press [Alt] [f] (for File) and [t] for Search Transmitted PT&E to see a list of records that have already been transmitted to RTI. Selecting a record from this screen works the same way as it did with un-transmitted records. Use the arrow keys to highlight in blue the record you wish to view, then press [Enter], or double click the record. You can open these records for viewing purposes only. The system displays a pop-up box when you enter the Detail Form reminding you that the record has already been transmitted and asking you if you would like to open it for viewing only. All the fields in the Detail Form are grayed out or read-only, preventing you from making changes. Also, the only available option from the Detail Form is to Cancel, [Alt] [c].

**5. Correcting mistakes on an ePTE that has already been transmitted:**

Please notify your Data Collection Manager as soon as possible if there is a problem with an ePTE you have submitted. You may be asked to contact Headway staff.

**6. Completing an ePTE for up to 2 weeks in which you do not work:**

On the Entry Form, check the "Did Not Work" field. Then go to the Detail Form in order to save the record and make it "Ready to Transmit." If you check "Did Not Work" on the Entry Form, you are not able to enter any Hours or Expenses on the Detail Form.

**7. Completing a record for 3 weeks or more in which you do not work:**

Do not submit an ePTE record if you will not be working for 3 weeks or more. Instead, your Data Collection Manager must send an e-mail message to Headway indicating the dates you will not be working as well as the reason you will not be working. This may occur in a number of situations, such as when you have finished your assignment and will not be working for the remainder of the quarter.

**8. Loading Default Values:**

If you have made changes to the information on the Entry Form and now need to bring your default values back, press [Alt] [t] (for Tools) then [I] (for Load Default Values).

**9. Clearing Default Values on the Entry Form:**

Occasionally, you may want to clear out all default information displayed on the Entry Form to enter information for a new ePTE record. To do this, press [Alt] [t] (for Tools) then [r] (for Refresh).

**10. Changing the Default Values on the Entry Form:**

Occasionally, you may need to change the default values that pre-fill when you begin the ePTE program, including the project number.

- From the Entry Form, press [Alt] [t] (for Tools) and then [v] (for Update Default Values).

The System Default Value Setting Form appears so you can update your personal information. You can make corrections to all values except the RTI ID. If you make updates to your name, address, or phone number, a check mark appears in the "New Name/Address/Phone" field. After you make the updates, press [Alt] [s] (for Save) or click Save. A pop-up box asks if you would like to transmit this change. If so, answer "Yes" to this pop-up box. The next time you transmit to RTI this update information will be sent to RTI and Headway. Be sure to inform your Data Collection Manager of any name/address/phone changes as well.

**11. Changing your RTI ID Number:**

This ID number is the main key to processing your ePTEs (and getting paid!) and should only be changed under very unusual circumstances. To change your RTI ID number, you must acquire a password from your Data Collection Manager. Once you have the password, go to the Entry Form. Press [Alt] [t] (for Tools) and then [i] (for Change ID). The Change RTI ID Form appears:



Enter the updated information and the password, then press [Alt] [o] (for OK) or click "OK." If you have entered this form in error, cancel out by pressing [Alt] [c] (for Cancel) or clicking on "Cancel."

**12. Compact your ePTE Data:**

Occasionally, your Data Collection Manager or Tech Support may recommend that you compact your ePTE data to enhance the system performance and prevent system crashes. Compacting data will be scheduled by the person recommending the process and should not be done on your own. **When the system is compacting data, please wait until it finishes. Do not perform any other task or turn off your computer as this may cause serious problems.**

**13. Accessing the Built-In Help Files:**

From the Entry Form, press [Alt] [h] and then either [b] for Basic Information or [q] for the list of Frequently Asked Questions. You can scroll down the help window by using the **down arrow**. Once you have finished reading the help file, close it by pressing [Alt] [F4].



#### 14. Using the Touchpad:

By design, this ePTE system works fine using the keys, although it has also been designed to be easy to use with a computer mouse. Your laptop has a built in Touchpad, which functions like a mouse.

### 7.6 Submitting Receipts with ePTEs

Most of your time and expense charges can be submitted using the ePTE. Since you should rarely have any expenses, you must check with your Data Collection Manager prior to incurring any expense. In the rare event you should have an expense over \$10.00, prepare and submit a **Headway Expense Report** and include paper receipts to claim reimbursement. Bear in mind how each type/amount of expense is submitted and don't submit the same charge both ways. Every expense will be claimed on EITHER the ePTE OR the Headway Expense Report, but NOTHING will be reported on both of the forms. In other words, you cannot claim the same expense twice.

Follow these steps when using the Headway Expense Report (see *Exhibit 7.3*) to submit receipts:

Accurately record the area number, the project number, Data Collection Manager name and the corresponding week beginning date.

1. **Date Column** – Enter the dates beside each day of the week on the left side.
2. **Total Expenses Column** – Total your daily expenses by adding the amounts in each of the individual expense columns.
3. **Lodging Column** – For this study, you should not have any lodging expenses.
4. **Meals** – Meal expenses should be submitted on your ePTE, NOT on the Headway Expense Report.
5. **Telephone** – For this study, you should not have any telephone expenses since you will receive a project calling card. If needed, reimbursement for adding 3-way calling should be recorded under Miscellaneous Expenses.
6. **Auto Rental** – For this study, you should not have any auto rental expenses.
7. **Miscellaneous** – Document all miscellaneous expenses over \$10.00 for the corresponding day of the week. Record the amount and explain the expense in the Notes section. **Receipts for all miscellaneous expenses over \$10.00 must be submitted with this form.** Remember, expenses over \$10.00 are not recorded on your ePTE.
8. **Notes** – Enter notes as required. For example, all miscellaneous expenses must be explained in the Notes section.
9. When finished, complete the certification area by entering your RTI ID number and the date prepared. Sign your name to "...certify that this statement is true, correct, and complete and that the data collected and submitted are truthful."
10. Keep the pink (bottom) copy for your records.
11. Staple all receipts behind the white copy of the form and mail the original and yellow copies to your Data Collection Manager.

# Exhibit 7.3 Headway Expense Report

## HEADWAY EXPENSE REPORT

RTI Project Number: \_\_\_\_\_

Field Supervisor Area: \_\_\_\_\_

Field Supervisor Name: \_\_\_\_\_

Week Beginning Sunday: \_\_\_\_\_

Year

Day

Month

Day of Week	Date	Total Expenses	Lodging*	Meals	Telephone*	Auto Rental*	Miscellaneous <sup>§</sup>
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
<b>Totals:</b>							

\* All expenses for Lodging, Telephone and Auto Rental must be accompanied by original receipts.  
 § All miscellaneous expenses must be explained in the Notes section. Attach receipts for expenses over \$10.

ID Number: \_\_\_\_\_

Name: \_\_\_\_\_ (Please print)

Address: \_\_\_\_\_ (Number) \_\_\_\_\_ (Street)

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Please check if name or address change

I certify that this statement is true, correct and complete and that the data collected and submitted are truthful.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Approved by: \_\_\_\_\_ Supervisor \_\_\_\_\_ Date \_\_\_\_\_

Notes:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Disposition: Send original and yellow copies to supervisor; retain pink copy for your records.

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## 7.7 Authorization for Expenditures

Before spending any money on project-related business, consult with your Data Collection Manager to obtain authorization. This is to control budget expenditures and make sure the managers have input into all decisions affecting data collection work. Expenses made without prior authorization may be denied reimbursement. So you **must obtain approval prior to making any such expenditures**. You also must obtain and submit receipts for expenses over \$10.00.

## 7.8 FedEx Mailing Procedures

You will need to send various materials or equipment via FedEx. For example, you will use FedEx to send completed, edited SCIDs to RTI within 48 hours of completing the interview. The procedures, while simple, are essential to ensure that your shipment is not lost, arrives promptly, and that the charge is billed properly.

When sending materials via FedEx, place materials in a package suitable for shipping. Your bulk supplies will include these packages, or your local FedEx office can provide you with boxes and envelopes free of charge if you need them. Follow the steps documented in *Exhibit 7.4* to properly complete the FedEx airbill. An example of the pre-printed FedEx airbill that will be provided for you to use for SCID shipments is shown in *Exhibit 7.5*, while *Exhibit 7.6* contains an example pre-printed airbill for equipment shipments to RTI. It is especially important that you use one of the pre-printed FedEx airbills provided. If you need additional airbills, contact your Data Collection Manager to arrange for an additional supply to be sent to you.

### 7.8.1 Proper Handling of FedEx Packages

Project materials and equipment are vulnerable to loss or theft during drop off and delivery. Use the following steps to ensure proper delivery and handling of the package.

- Keep the top copy of the airbill, the "Sender's Copy," so you have a record of the tracking number at the top of the airbill. RTI staff need this number to track the package if it is not delivered on time.
- Peel off the adhesive backing and affix the label to the package, or place the completed FedEx airbill in one of the provided plastic pouches.

Once ready for shipment, consider the best method for giving the package to FedEx. Your options:

1. Arrange for the package to be picked up at your home by calling FedEx at 1-800-GOFEDEX. Since these packages contain confidential information, you **MUST** hand the package directly to an authorized FedEx employee. Do **NOT** leave the package unattended for pickup. Do **NOT** leave the package with a family member to give to FedEx.
2. Take the package to your local FedEx office. You must hand the package directly to an authorized FedEx employee. Do **NOT** ask any non-project person to deliver the package for you.
3. Leave the package in a secure FedEx drop box. Do **NOT** ask any non-project person to deliver the package for you.

While detailed, these FedEx procedures are designed to ensure that all project materials and equipment remain in "reliable hands" while in the field. Always ask if you have any questions.

## Exhibit 7.4 Instructions for Completing a FedEx Airbill

Section #	Instructions	Additional Notes or Explanations
1	Enter the shipping date. Leave the Sender's account number blank. Enter your name, telephone number and address as the sender, if it is not pre-printed.	
2	Notice the preprinted project number, either 0211838.212.006 or 0212682.120.006.  To divide FedEx charges into the 1/3 and 2/3 split, your stack of preprinted airbills is ordered with 1 MHSS airbill followed by 2 EMHSS airbills. Simply use the next airbill in the stack to properly divide the charges.	This preprinted number on the airbill must be marked correctly for RTI to properly process charges. For data security purposes, do NOT add a project name or acronym.
3	For <b>completed SCIDs</b> , use the airbill preprinted for RTI to  For <b>RTI equipment</b> , use the airbill preprinted for RTI Technical Support.	FedEx must have street addresses: no PO boxes.
4a	Verify that the box "FedEx Priority Overnight" is marked (unless otherwise instructed by your supervisor).	This must be marked correctly for RTI to receive the correct, discounted shipping rate.
4b	Leave blank.	
5	Mark the type of package used for the shipment.	"Other" should be marked for NSDUH equipment shipped in RTI packaging. If instructed by your supervisor to use FedEx Pak packing, make sure the appropriate package type is marked.
6	Verify that the "No" box is checked under the question about possible dangerous contents.	
7	Verify that the box "Third Party" is preprinted. Check also that the RTI FedEx account number ( ) is preprinted. Leave the weight/total declared value lines blank.	The standard FedEx coverage meets the project's needs. Additional insurance is not necessary.
8	Mark "Direct Signature" required.	A signature is required since a SCID package contains confidential information while a package to Tech Support contains valuable equipment.



Exhibit 7.6 Completed FedEx Airbill to RTI Technical Support

PULL AND RETAIN THIS COPY BEFORE AFFIXING TO THE PACKAGE. NO POUCH NEEDED.

**FedEx Express US Airbill**      FedEx Tracking Number: **8583 1305 2551**

**1 From** Please print and print last. Sender's FedEx Account Number: **2/28/11**

Date: **2/28/11**      Sender's Name: **Rachel Interviewer**      Phone: **937,478-5050**

Company: **519 Valley Drive**

Address: **Oakwood**      State: **OH**      ZIP: **45409**

**2 Your Internal Billing Reference** **0211838-212-006**

**3 To** Recipient's Name: **TECHNICAL SUPPORT**      Phone: \_\_\_\_\_

Company: **RTI INTERNATIONAL**

Recipient's Address: **1000 PARLIAMENT CT STE 100**

We cannot deliver to P.O. boxes or P.O. ZIP codes.

Address: **DURHAM**      State: **NC**      ZIP: **27703**

City: **DURHAM**      State: **NC**      ZIP: **27703**

Account Number: **/0800/1000/0034147661/6**

**Sender's Copy**

0215

**4a Express Package Service**

**FedEx Priority Overnight**       **FedEx Standard Overnight**

**FedEx 2Day**       **FedEx Express Saver**

**4b Express Freight Service**

**FedEx 1Day Freight**       **FedEx 2Day Freight**

**FedEx 3Day Freight**

**5 Packaging**

**FedEx Envelope\***       **FedEx Pak\***

**FedEx Tube**       **Other**

**6 Special Handling**

**SATURDAY Delivery/NOT Available for FedEx First Overnight, FedEx Express Home, or FedEx 2Day Freight.**

**HOLD Saturday at FedEx Location**

**HOLD Saturday at FedEx Location**

**HOLD Saturday at FedEx Location**

**Yes, this needs to be certified.**

**No**       **Yes**       **Day/Log**

**Signature Required**       **Signature Not Required**

**7 Payment** Bill to:  **Sender**       **Recipient**       **Third Party**       **Credit Card**       **Cash/Check**

**Total Packages**      **Total Weight**      **Total Declared Value\***

\_\_\_\_\_      \_\_\_\_\_      \$ **100.00**

**8 NEW Residential Delivery Signature Options**      If you require a signature, check Direct or Indirect.

**No Signature Required**       **Direct Signature**       **Indirect Signature**

**519**

fedex.com 1.800.GoFedEx 1.800.463.3339

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## 8. QUALITY CONTROL

### 8.1 Introduction

Your ability, preparedness, and willingness to properly perform your data collection tasks following all project protocols are the most important components of the overall quality control process. This chapter discusses the quality control procedures in place to help you do your best job.

### 8.2 Staff Training and Evaluation

During your training session, RTI project staff present you with the information necessary for you to properly perform your job as a clinical interviewer on this study. This includes detailed training on contacting interview respondents as well as a review of administrative procedures. Additionally, staff thoroughly cover the correct procedures for administering the SCID. *Section 8.3* describes procedures for certifying you in SCID administration. Additional information will be provided.

At the close of any in-person training session, you are asked to complete an evaluation form to assess the training program and materials, the trainers, and the training facilities. Following any formal group training conducted via telephone, please submit any feedback via e-mail to your Data Collection Manager. Your feedback on the effectiveness of the various interviewer training programs is an important part of letting us know whether or not the training program was thorough and effective. Your evaluation is also used to improve preparations for future training sessions.

### 8.3 CI Certification

To successfully graduate from training, each CI must complete and pass a rigorous certification interview to demonstrate his/her proficiency as a clinical interviewer. Following the completion of training, each CI will receive an assigned certification respondent, and complete a follow-up interview following all Mental Health Study procedures. Completed certification SCIDs received at RTI will be reviewed in detail by the Clinical Supervisors. Following this careful review, the CI will receive detailed feedback. If needed, the CI will be assigned one or perhaps two additional certification interviews.

MHSS cases may be assigned once a CI has been formally certified.

### 8.4 Supervision and Feedback during Data Collection

Feedback during this study focuses on helping you improve your clinical interviewing skills and on making sure the study runs smoothly. Feedback during data collection includes:

- discussions between you and your Clinical Supervisor concerning your performance while completing the SCID;
- discussions between you and your Data Collection Manager concerning logistical and administrative details, including any suggestions for ways to improve your performance of these tasks; and
- sharing with your Data Collection Manager your ideas and thoughts on ways to improve the study process (suggestions, whether through e-mail or during calls, are always welcome).

Please be receptive when given feedback from project personnel about your performance, as we are all striving to learn and improve.



## **8.5 Ongoing Quality Improvements**

Throughout the year, typically before the start of each quarter of data collection, each CI must successfully complete a detailed inter-rater reliability exercise. Each CI will access an audio recording, listen to the recording, and complete a SCID based on the content of the recording. Details on how to access the file will be provided. After shipping the SCID to RTI, each CI's work will be reviewed with feedback provided individually by a Clinical Supervisor. These reliability exercises are important to maintain the standardization and integrity of the SCID administration process, thus maximizing the quality of the data collected.

**Appendix A**  
**NSDUH Respondent Materials**

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To provide you with further background information on the NSDUH interview process, this appendix contains NSDUH materials and handouts used with respondents by field interviewers. These materials include:

- Question and Answer Brochure
- Summary of the Questionnaire
- Highlights from the 2009 NSDUH
- RTI/SAMHSA Fact Sheet
- Who Uses the Data?

For further information about NSDUH, SAMHSA, and RTI, visit the following websites:

<http://nsduhweb.rti.org>

<http://www.oas.samhsa.gov/nsduh.htm>

<http://www.rti.org>

## Exhibit A.1 Question and Answer Brochure

# National Survey on Drug Use and Health

Answering Your Important Questions



**For more information on  
NSDUH or SAMHSA, contact:**

NSDUH National Study Director  
SAMHSA, Center for Behavioral  
Health Statistics and Quality  
1 Choke Cherry Road  
Room 7-1009  
Rockville, MD 20857

**For more information on  
NSDUH or RTI, contact:**

NSDUH National Field Director  
Research Triangle Institute  
3040 Cornwallis Road  
Research Triangle Park, NC 27709  
1-800-848-4079

**Internet Users:** You may access more  
information about SAMHSA on the World Wide  
Web at:

<http://www.samhsa.gov>

Additional information about RTI is available at:

<http://www.rti.org>

Additional information about the National  
Survey on Drug Use and Health is available at:

<http://insduhweb.rti.org>

V.1.11

### What Is the National Survey on Drug Use and Health (NSDUH)?

The National Survey on Drug Use and Health (NSDUH) is the Federal Government's primary source of national data on the use of alcohol, tobacco, and illicit substances. The survey also contains questions on health, illegal behaviors, and other topics associated with substance use. The study was initiated in 1971 and currently is conducted on an annual basis. This year approximately 70,000 individuals, 12 years old and older, will be randomly selected and asked to voluntarily participate.

The primary objectives of NSDUH are:

- to collect timely data on the magnitude and patterns of alcohol, tobacco, and illegal substance use and abuse;
- to assess the consequences of substance use and abuse; and
- to identify those groups at high risk for substance use and abuse.

#### Sponsored by

Substance Abuse and Mental Health  
Services Administration  
U.S. Public Health Service  
U.S. Department of Health  
and Human Services

#### Conducted by

Research Triangle Institute  
3040 Cornwallis Road  
Research Triangle Park, NC 27709

### Why Should I Participate?

- NSDUH is the primary source of national data on the use of alcohol, tobacco, and illicit substances. By volunteering in this study, you are helping us gather this important information that is needed to make accurate policy decisions.
- Individual residents of selected households, who are randomly chosen and agree to participate, are given a cash payment of \$30 at the end of the interview.
- If selected to participate, you will represent over 4,500 other United States residents. Since our sample is selected based on scientific random sampling, no other household or person can be substituted.
- By participating in this study, you will be assisting with the formation of public policy.

# Answering Your Important Questions about the National Survey on Drug Use and Health

## Exhibit A.1 Question and Answer Brochure (continued)

Answering Your Important Questions about the

### What is the Substance Abuse and Mental Health Services Administration (SAMHSA)?

The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS). SAMHSA was created in 1992 to provide leadership and a Federal focus for the Nation's mental health and substance abuse treatment and prevention programs. NSDUH is used to help facilitate this mission by monitoring the nature and extent of substance use in the United States, as well as the consequences of this use.

### How Does the Government Conduct the Study?

Under a competitive bidding process, SAMHSA selects a survey research organization to administer NSDUH. Currently, Research Triangle Institute (RTI) is under contract to conduct NSDUH through 2011. RTI, which is located in Research Triangle Park, North Carolina, and closely associated with the University of North Carolina, Duke University, and North Carolina State University, is a large, experienced research organization that has conducted NSDUH since 1988.

### How Was I Selected?

A scientific random sample of households is selected throughout the United States. Once selected, no other residence can be substituted for any reason. A professional RTI interviewer makes a personal visit to each household to ask several initial questions. One or possibly two residents of your household may be asked to voluntarily participate in the survey. If you are selected, no other person can be substituted. Since the survey is based on a random sample, you will represent over 4,500 other United States residents.



### How Will the Data Be Used?

Government agencies, private organizations, individual researchers, and the public at large use the data for a number of purposes. For example, the U.S. Public Health Service and state health agencies use data from NSDUH to estimate the need for drug treatment facilities. Other federal, state, and local agencies use the information to support their drug use prevention programs and to monitor drug control strategies.

### What if I Do Not Smoke, Drink or Use Illegal Drugs?

In order to know the percentage of people who do use these substances, we also have to know how many people do not. Therefore, the responses of people who do not use drugs are just as important as those of people who do. You do not need to know anything about drugs to answer the questions. In addition, we ask a number of health-related questions that are relevant for all people.

### How Is the Study Administered?

NSDUH data are collected in the privacy of the participant's home. A professional RTI

interviewer personally visits each selected household to administer the



NSDUH questionnaire using a laptop computer. For some items, the interviewer reads questions and enters the

responses into the computer; however, the participant privately enters most responses directly into the computer. The survey takes approximately 60 minutes to complete.

### What Happens to My Information?

Each computerized interview data file—which is identified only by a code number—is electronically transmitted to RTI on the same day the interview is conducted. The answers then are combined with all other participants' answers, and are coded, totaled, and turned into statistics for analysis. As a quality-control measure, you may receive a telephone call or a letter from RTI to verify that the interviewer did complete the survey with you.

**CONFIDENTIAL**

### Will My Answers Be Kept Confidential?

Both SAMHSA and RTI are committed to assuring complete confidentiality of responses. Our interest is only in the combination of all responses nationwide—not anyone's individual answers. Your full name is never recorded or associated with your answers. The information is only used for statistical purposes and cannot be used for any other purpose. Confidentiality of all answers to questions in this survey is assured under Federal law, the Confidential Information Protection and Statistical Efficiency Act of 2002 (CIPSEA). Any project staff or authorized data user who violates CIPSEA may be subject to a jail term of up to 5 years, a fine of up to \$250,000, or both.

## Exhibit A.2 Summary of the Questionnaire

# *2011 National Survey on Drug Use and Health* Summary of the Questionnaire

You have asked to know more about the *National Survey on Drug Use and Health* and the types of questions the interviewer will ask. Below is a summary of each section of the questionnaire for you to examine. Keep in mind that not everyone will see every question—the questions depend on the participant's own experiences. Furthermore, participants can always refuse to answer any questions during the interview.

### **Demographics**

This section, administered by the interviewer, consists of questions about the participant such as his/her date of birth, race, educational background, and health status.

#### *Sample Questions:*

- ▶ What is the highest grade or year of school you have **completed**?
- ▶ Would you say your health in general is excellent, very good, good, fair, or poor?

### **Computer Practice Session**

In this section, the interviewer shows the participant how to use the laptop computer and lets him/her practice using a short practice session.

### **Cigarettes, Alcohol and Illicit Drugs**

For most of the rest of the interview, the participant answers questions by listening to the questions over the headphones and/or reading the questions on the computer screen, and then entering responses using the computer's keyboard. The participant answers these questions in private, although the interviewer is available to help with any problems using the computer. During this part of the interview, only the participant can hear and see the questions and see his/her responses.

#### Tobacco Products and Alcohol

These sections include questions about whether and how often participants have used cigarettes, chewing tobacco, snuff, cigars, pipe tobacco, and alcoholic beverages such as beer, wine, or liquor.

#### *Sample Questions:*

- ▶ Have you **ever** smoked part or all of a cigarette?
- ▶ How old were you the **first time** you used chewing tobacco?
- ▶ What is your **best estimate** of the number of days you drank alcohol during the past 30 days?

#### Illicit Drugs

The next sections ask about the participant's use or non-use of marijuana, heroin, cocaine, hallucinogens, and inhalants; and prescription pain killers, tranquilizers, stimulants, and sedatives when taken only for their effect. Questions about drug dependence and drug treatment are also included in these sections.

#### *Sample Questions:*

- ▶ Have you **ever**, even once, used marijuana or hashish?
- ▶ How much do people risk harming themselves physically and in other ways when they use **cocaine once a month**?

## Exhibit A.2 Summary of the Questionnaire (continued)

### Adult Social Environment and Mental Health

Participants aged 18 and older receive questions about their social experiences such as: how many times they have moved, their opinions about drug use, and in some cases, their experiences as a parent. Mental health questions cover such topics as depression and treatment for mental health problems.

#### *Sample Questions:*

- ▶ How do you feel about **adults** trying marijuana or hashish once or twice?
- ▶ During the past 12 months, was there any time when you **needed** mental health treatment or counseling for yourself but **didn't get it**?
- ▶ Have you ever in your life had a period of time lasting several days or longer when **most of the day** you felt **sad, empty, or depressed**?

### Youth Experiences and Mental Health

Youth aged 12-17 participating in the survey are also asked questions about their social experiences such as: perceptions about the risks of using certain drugs; whether getting drugs is difficult or easy; feelings about school and peers; and involvement in clubs, sports, and other extracurricular activities. The mental health questions cover such topics as depression and treatment for mental health problems.

#### *Sample Questions:*

- ▶ **During the past 12 months**, in how many different kinds of school-based activities, such as team sports, cheerleading, choir, band, student government, or clubs, have you participated?
- ▶ Have you ever in your life had a period of time lasting several days or longer when **most of the day** you felt **sad, empty, or depressed**?
- ▶ During the past 12 months, did you receive treatment or counseling from a **private therapist, psychologist, psychiatrist, social worker, or counselor** for emotional or behavioral problems that were **not** caused by alcohol or drugs?

### Health Care and Demographic Information

In this section, the laptop is handed back to the interviewer, who asks questions about education, health insurance, and family income information to help in analyzing the data. If necessary, a knowledgeable adult in the household may be asked to help participants answer some of these questions.

The answers to these questions increase the government's knowledge about health care, especially as it may relate to drug use or treatment. This information helps in planning health care services and finding ways to lower the costs of care.

#### *Sample Questions:*

- ▶ How many hours did you work **last week** at all jobs or businesses?
- ▶ **Before taxes and other deductions**, was the total **combined family** income during 2010 more or less than 20,000 dollars?
- ▶ Are you currently covered by private health insurance?

Please feel free to ask the interviewer if you have any other questions about the questionnaire.

*Thank you for your cooperation and help!*



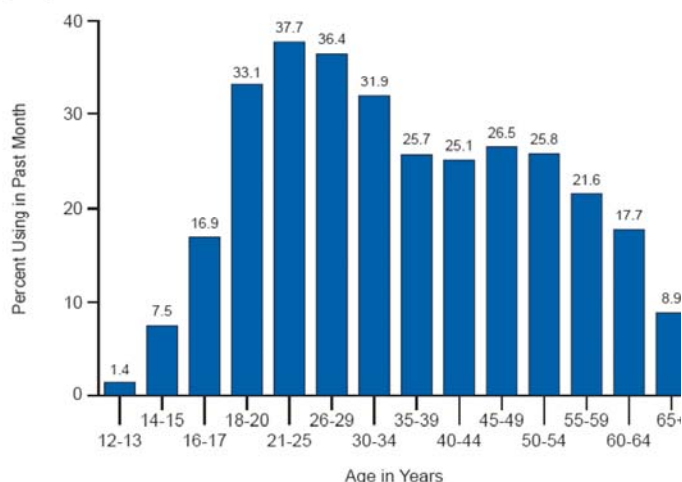
## Exhibit A.3 Highlights from the 2009 NSDUH

### *SELECTED HIGHLIGHTS* from the *2009 National Survey on Drug Use and Health*

#### Tobacco Use

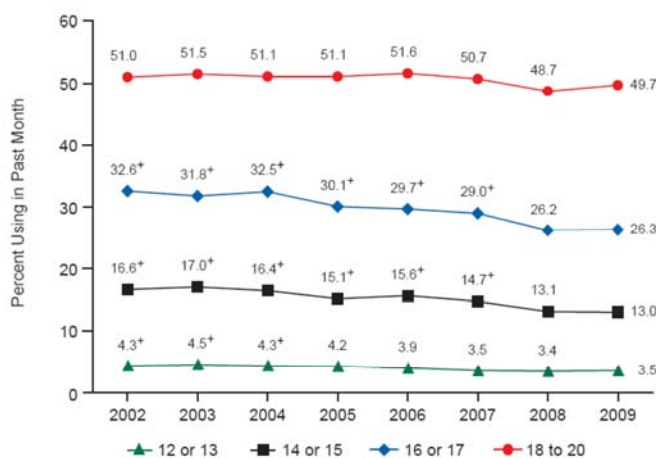
- An estimated 69.7 million Americans reported current use (during the past month) of a tobacco product in 2009, which is 27.7 percent of the population aged 12 and older. About 58.7 million (23.3 percent) smoked cigarettes.
- The graph to the right illustrates past month cigarette use among persons age 12 or older.

Past Month Cigarette Use among Persons Aged 12 or Older, by Age: 2009



#### Alcohol Use

Current Alcohol Use among Persons Aged 12- 20, by Age: 2002-2009



\* Difference between this estimate and the 2009 estimate is statistically significant at the .05 level.

- Slightly more than half of all Americans age 12 or older, 51.9 percent or 130.6 million persons, were current drinkers in the 2009 survey, which is similar to the 129.0 million persons (51.6 percent) reported in 2008.
- Although consumption of alcoholic beverages is illegal for those under 21 years of age, 27.2 percent of this age group (10.4 million) were current drinkers in 2009. The graph on the left displays the current use of alcohol for 12–20 year olds from 2002 through 2009.

#### Illicit Drug Use

- An estimated 21.8 million Americans were current users of illicit drugs in 2009, meaning they used an illicit drug at least once during the 30 days prior to the interview. This estimate represents 8.7 percent of the population 12 years old or older.
- Marijuana is the most commonly used illicit drug, with an estimated 16.7 million current users, or 6.6 percent of the population 12 years old or older, an increase from the 2008 rate of 6.1 percent. Similar to 2008, an estimated 1.6 million persons were current users of cocaine, while 760,000 currently used Ecstasy, an increase from the 555,000 current Ecstasy users reported in 2008.

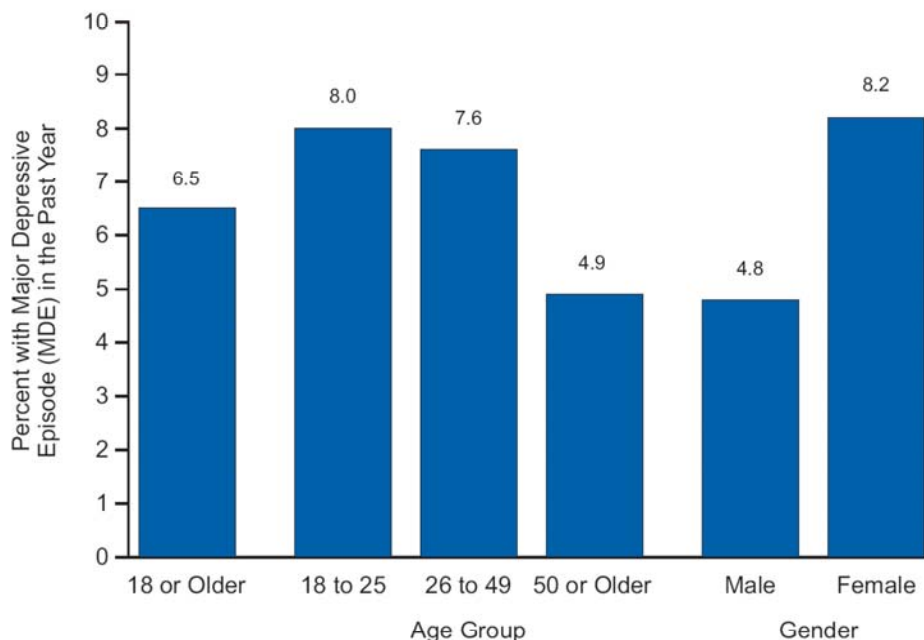
Results from the 2009 National Survey on Drug Use and Health: Summary of National Findings, DHHS/SAMHSA/CBHSQ, September 2010

## Exhibit A.3 Highlights from the 2009 NSDUH (continued)

### Mental Health

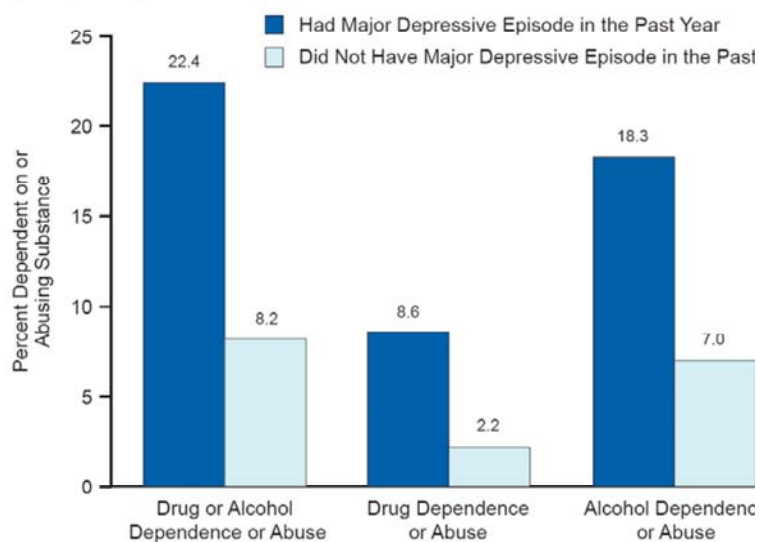
- In 2009, an estimated 14.8 million adults, or 6.5 percent of the population aged 18 or older, had at least one major depressive episode (MDE) in the past 12 months. Among adults, the percentage having MDE in the past year varied by age and gender, as shown in the graph below.

Major Depressive Episode in the Past Year among Adults Aged 18 or Older, by Age and Gender: 2009



Substance Dependence or Abuse among Adults Aged 18 or Older, by Major Depressive Episode in the Past Year: 2009

- Persons with past year MDE were more likely than those without MDE to have used an illicit drug in the past year (29.5 vs. 13.5 percent).
- Similarly, substance dependence or abuse was more prevalent among persons with MDE than among those without MDE (22.4 vs. 8.2 percent), as shown in the graph to the right.



Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings, DHHS/SAMHSA/CBHSQ, 2010

## Exhibit A.4 RTI/SAMHSA Fact Sheet

National Survey on Drug Use and Health

# NSDUH

SAMHSA Fact Sheet

## Substance Abuse and Mental Health Services Administration (SAMHSA)



### About SAMHSA

The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds the NSDUH, is an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS). SAMHSA was created to focus attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders.

SAMHSA is made up of four centers and supporting offices that engage in activities focusing on substance abuse treatment, mental health services, and substance abuse prevention. The Center for Behavioral Health Statistics and Quality (CBHSQ) is the focal point for the collection, analysis, and dissemination of national data on practices and issues related to substance abuse and mental disorders. This center is responsible for the NSDUH, the Drug Abuse Warning Network (DAWN), and the Drug and Alcohol Services Information System (DASIS), among other studies.

### Selected Achievements

**Recovery Month**—Coordinated by SAMHSA's Center for Substance Abuse Treatment, the annual Recovery Month campaign highlights ways to create awareness that alcohol and drug use disorders can be managed effectively when an entire community supports those who suffer from these treatable diseases. Recovery Month promotes the societal benefits of treatment for alcohol and drug use disorders, recognizes the contributions of treatment providers, and highlights the message that recovery from alcohol and drug use disorders is possible. Annual NSDUH findings are presented during Recovery Month activities.

<http://www.recoverymonth.gov>

**Access to Recovery**—The Access to Recovery program, created and administered by SAMHSA, is an ongoing initiative that provides people seeking drug and alcohol treatment with vouchers to pay for a range of appropriate community-based services. Since the program began in 2004, more than \$500 million in funding has been awarded to expand access to substance abuse treatment and recovery support services.

<http://www.atr.samhsa.gov>

**Leading on Mental and Substance Use Disorders**—SAMHSA submitted its landmark report on the long-standing barriers to appropriate treatment and support services for people having both mental and substance abuse disorders to Congress in 2002. Since then, SAMHSA has made significant gains in improving access to treatment for these individuals and continues to work toward further improvements in access and in the quality of services provided. These efforts include identifying and providing funding for effective programs in the prevention and treatment of both disorders, expanding SAMHSA's national registry of treatment programs, and establishing a national prevention and provider cross-training center to address this issue.

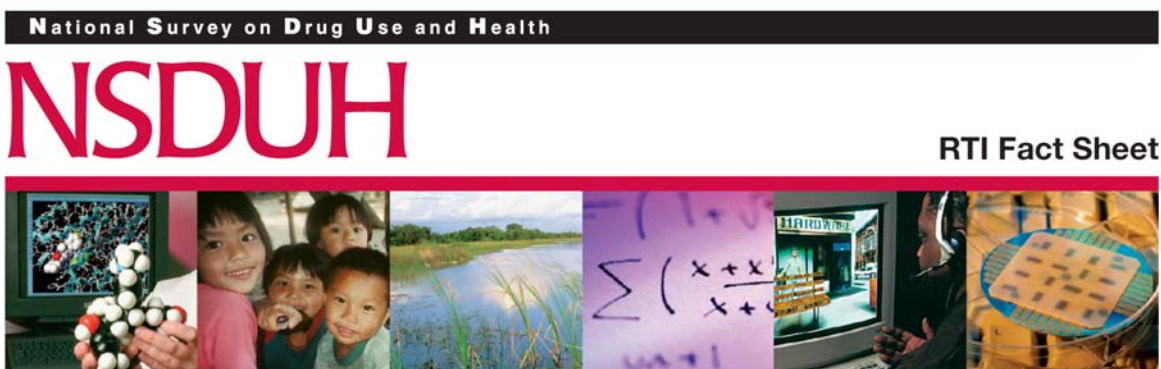
For more information about SAMHSA, contact:



NSDUH National Study Director  
SAMHSA, Center for Behavioral  
Health Statistics and Quality  
1 Choke Cherry Road  
Room 7-1009  
Rockville, MD 20857

<http://nsduhweb.rti.org>  
<http://www.samhsa.gov>

## Exhibit A.4 RTI/SAMHSA Fact Sheet (continued)



## Research Triangle Institute

### About RTI

Research Triangle Institute (RTI) was created in 1958 through joint action by Duke University in Durham, the University of North Carolina at Chapel Hill, and North Carolina State University in Raleigh and has become an independently operating, nonprofit organization dedicated to conducting research that improves the human condition.

RTI is headquartered in the United States, with laboratory and office facilities in Research Triangle Park, North Carolina, and corporate offices and research facilities in California, Georgia, Illinois, Maryland, Massachusetts, Michigan and Washington, DC. RTI also maintains international offices in El Salvador, Indonesia, South Africa, Spain, Sweden, the United Arab Emirates, and the United Kingdom, as well as numerous project locations worldwide.

RTI offers innovative research and technical solutions to governments and businesses worldwide in the areas of surveys and statistics, health and pharmaceuticals, advanced technology, education and training, economic and social policy, international development, energy and the environment. Funds to support RTI's work come from competitively won contracts with and grants from clients in government, industry, and public service.

SAMHSA selected RTI to conduct the NSDUH through 2011. SAMHSA and RTI have worked together on the NSDUH since 1988.

### Selected Achievements

**Taxol® and Camptothecin™**—In the mid-1960s, two pioneering scientists at RTI produced two compounds instrumental in the fight against cancer—Camptothecin and Taxol—which have been responsible for saving the lives of hundreds of thousands of people afflicted with cancer.

**Education Research**—RTI is involved in education research and evaluation projects throughout the United States. In support of a contract awarded by the U.S. Department of Education to the Southern Regional Education Board, RTI has conducted work in the design, implementation, and evaluation of a comprehensive model for school reform in middle and secondary grades, with a focus on improving the quality of education programs and enhancing school and student performance.

**Focus on Childhood Obesity**—Recognizing the serious health and social consequences of obesity in children and adolescents, RTI completed two noteworthy efforts—with the University of North Carolina at Chapel Hill and through a grant from the Centers for Disease Control and Prevention—to explore public opinions about childhood obesity and lifestyle issues that may contribute to this problem. The results of these studies were utilized by policymakers to identify strategies and implement prevention programs where they are most needed.

For more information about RTI, contact:



NSDUH National Field Director  
Research Triangle Institute  
3040 Cornwallis Road  
Research Triangle Park, NC 27709

Phone: 1-800-848-4079  
<http://nsduhweb.rti.org>  
<http://www.rti.org>

RTI International is a trade name of Research Triangle Institute. Taxol®, a word coined by Dr. Monroe Wall of RTI, is a trademark of Bristol-Myers Squibb Company. Camptothecin™ is a trademark of RTI.

## Exhibit A.5 Who Uses the Data?

# National Survey on Drug Use and Health WHO USES THE DATA?

- The **White House Office of National Drug Control Policy** (ONDCP) uses the data to track progress toward goals in the National Drug Control Strategy.
- The **Substance Abuse and Mental Health Services Administration** (SAMHSA), a part of the U.S. Public Health Service, prepares statistical reports on substance use patterns and trends.
- **SAMHSA** uses the data to identify populations and geographic areas with particular substance abuse problems so that federal resources can be used efficiently for prevention and treatment programs.
- The **Partnership for a Drug-Free America** uses the data to design media advertising campaigns for the prevention of substance use and abuse.
- Based on the trends and patterns of substance use evident in the data, the **National Institute on Drug Abuse** (NIDA) develops research programs targeted toward populations and types of drug use problems where the need is greatest.
- **University-based researchers** use the data to conduct research on important substance use issues, such as the risk and protective factors associated with substance use, personal and societal consequences of substance use, and the impact of policy options for dealing with the substance abuse problem.
- **Substance abuse agencies at the state and local level** use the data to assess the potential need for treatment programs and to design programs that fit the needs of populations served.
- **State and local health departments** use the data to assess area substance use problems and to develop appropriate funding strategies and prevention measures.
- The **U.S. Department of Education** uses the data to inform drug use prevention and education programs and provide educational materials for teachers and administrators.
- The **U.S. Department of Transportation** uses the data on driving after alcohol and illicit drug use to develop prevention programs and materials on impaired driving.
- The **Office on Smoking and Health**, a part of the Centers for Disease Control and Prevention (CDC), uses the data to study trends and patterns in youth tobacco use and to develop strategies for reducing youth tobacco use.
- **Newspaper, television, and radio reporters** use the data in their stories on substance use and abuse.

*For additional information on these organizations and their use of NSDUH data, please visit <http://nsduhweb.rti.org> and click on the "Who Uses NSDUH Data" link.*

**Appendix B**  
**Instructions for Completing Paper PT&Es**

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## Instructions for Completing Paper PT&Es

As explained in *Chapter 7*, all clinical interviewers must complete an electronic Production, Time, and Expense (ePTE) report weekly and submit it in order to be paid. In case of computer or system problems and you are not able to access the ePTE system, your Data Collection Manager may instruct you to prepare a paper version called an PT&E. Also, if a submitted ePTE is found to contain errors, a corrected paper report must be submitted.

### 1.1.2 What to Record on an PT&E Report

Step-by-step instructions for completing a paper PT&E report are provided in this section. Refer to *Section 7.5.4* for instructions on daily completion of the ePTE Working Copy (*Exhibit 7.1*) and splitting your hours/expenses between the different data collection project numbers.

An example of a properly completed paper PT&E Report is provided in *Exhibit B.1*. Please refer to the instructions and the example as you are completing your paper PT&Es to be sure you are making all required entries correctly.

The information entered in the first 4 steps listed below defines an individual report.

1. Week Beginning Sunday – At the top of the form, enter the date (month, day, and year) of the Sunday on which the reporting period began. Each reporting period runs for seven days—Sunday through Saturday.
2. RTI Project Number – Enter the appropriate project number.

	Training/Certification	2011 Data Collection	Ratio
New CI	0212682.120.005	0211838.212.006	1/3
		0212682.120.006	2/3
Returning CI	0211838.212.005	0211838.212.006	1/3
		0212682.120.006	2/3

3. Did Not Work – If you do not work in a given week, you still must complete and submit a PTE report. Mark this box to indicate you did not work, completing the top of the form and the Certification Box in the lower middle of the form.
4. Section A (Date) – This section identifies the days by date over a one-week reporting period. Enter the corresponding date for each day shown.
5. Section B (Production) – Enter the total number of completed interviews (codes 70, 71, and 72). Add the entries in the column at the end of the week and record the total. You are also required to record the QuestID of each interview reported in Column B-1 in the "Notes" section, bottom-right. Make sure to keep up with your PT&E entries daily so you will know what you completed that day.
6. Section C (Time) – Entries should be made for each day you worked. In Column C-1, enter the total number of hours worked during the day as decimals, expressed in hours and portions of an hour to the nearest quarter hour. Show how your hours were spent on project work by distributing the time worked across the various columns as appropriate.



The "time" categories are defined as follows:

- Study/Training – Except for training, this column will not be used. However, if you are authorized to spend time doing additional study, record the time in this column.
- Travel – Use this column for any travel required for your work.
- Contacting/Locating – Record time spent contacting respondents, including time spent making appointments.
- Interviewing – Record time spent administering the questionnaire from start to finish including any initial conversations with the respondent during the interview call.
- Editing – Enter any time spent editing the SCID in this column. Do not include interviewing time here.
- Conference – Record time spent preparing for and in conference with your supervisors, compiling weekly reports or completing incident reports, and any calls with other RTI or research staff such as Technical Support.
- Other – Record time spent performing other allowable project activities such as entering information into the web as well as time spent transferring audio files and preparing FedEx packages. You must include a short description of any "Other" activity in the "Notes" section in the lower right corner of the report.

**TOTAL THE ENTRIES IN ALL THESE COLUMNS AT THE END OF THE WEEK.**

7. Section D (Expenses) – **Check with your Data Collection Manager before incurring any expenses.** With approval, enter the following for each day you work:

- Miles Driven – Record the total miles driven (rounded to the nearest mile) each day on project business (check to make sure that the corresponding travel time is shown in the Travel column). Mileage is reimbursed at the established government mileage reimbursement rate of \$0.51 per mile. Note: This rate is set by the federal government and is subject to change.
- Total Expenses – Record the total amount of eligible expenses for each day.
- Lodging, Meals, Telephone, and Auto Rental – Do not use these columns unless instructed by your Data Collection Manager.
- Miscellaneous Expenses – Record all miscellaneous expenses. You must explain the expense in the Notes. Receipts must be submitted for expenses over \$10.00—remember to get prior approval from your supervisor. Note that parking tickets, traffic tickets, and other fines are not reimbursable expenses.
- Incentives – You will not have any incentive expenses since respondents were paid for the telephone interview at the time of the initial interview.
- Please note the following:
  - Telephone – You will be using a provided calling card for your work and therefore should have no additional telephone charges to report. If needed, reimbursement for adding 3-way calling should be recorded under Miscellaneous Expenses.

8. Certification Section – Complete this section by printing your name, ID number, date, complete mailing address, and telephone number. Then sign and date the form, thereby certifying "that this statement is true, correct, and complete and that the data collected and submitted are truthful." Unsigned forms cannot be processed and will be returned, delaying payment to you.
  
9. Notes – The "Notes" section is for explaining *any* expenses and unusually high time charges to avoid delays in approving your PT&E. Also, record in the Notes section the following information:
  - QuestIDs for all interviews completed during the week.
  - QuestIDs for any breakoff interviews that occurred and were not subsequently completed during the week. Write BRK before the QuestID to indicate it is a breakoff case. You do not need to record breakoffs that result in a completed interview within the same week.
  - Explanations of all time charges under "Other."
  - Explanations of all Miscellaneous expenses (submit receipts for expenses over \$10.00).

**Maintain your PT&E report daily.** Do not rely on your memory to complete it later. You will have photocopies of the ePTE that you can use as a working copy to keep track of your daily time and expenses, *including the QuestID numbers of completed and breakoff interviews*. Then, at the end of your work week, transfer the information to a "real" copy for submission to your supervisor. **DO NOT SUBMIT THE WORKING COPY. IT CANNOT BE PROCESSED AND WILL DELAY YOUR PAYMENT.**

Exhibit B.1 Properly Completed Paper PT&E

Clinical Interviewer WORKING COPY of the ePTE

Data Collection ePTE 08/22/2011 Week Begin 08/22/2011 Travel  Yes  No (circle one) Project # 901 Supervisor Area # 902

Each week record hours in this table, then total at the end of the week. Make corresponding notes as well.

Day of Week	Date	Production			Time						Notes		
		# Comp. Interviews*	Training	Home Study	Travel	Contact Locate	Inter-viewing	Editing	Confer-ence	Other^		Daily Total	
Sun	8/22												
Mon	8/23												
Tues	8/24					0.25						0.25	9994321
Wed	8/25					0.25						0.25	Other: 8/26 + 8/28
Thur	8/26	1				0.25	0.75	0.25		0.50		1.75	audio, web entries, FedEx
Fri	8/27					0.25	2.75	0.50	0.25			0.50	9995432
Sat	8/28	2				1.25	3.50	0.75	0.25	1.00		6.75	9996543
TOTALS		3											

Divide your total hours into the 1/3, 2/3 split. Record the splits in the first row below, then separate the charges between the two charts/codes so the splits and totals are close. Be sure the QuestIDs in the Notes correspond to the interviewing time recorded.

Day of Week	Date	MHSS 1/3: 0211838-212.006			1/3 total: 2.25			EMHSS 2/3: 0212682-120.006			2/3 total: 4.50		
		# Int.*	Travel	Confer-ence	Daily Total	Other^	Inter-viewing	Contact Locate	Travel	Confer-ence	Inter-viewing	Edit	Daily Total
Sun	8/22												
Mon	8/23												
Tues	8/24				0.25							0.25	
Wed	8/25				0.25							0.25	
Thur	8/26	1			0.25	0.75	0.25					1.75	
Fri	8/27							0.25				0.25	0.50
Sat	8/28							0.25				0.25	0.50
TOTALS					0.75	0.75	0.25	0.50	2.25	2	2.75	0.50	4.00
Notes:		9994321			Other 8/26 audio, web, FedEx			9995432			Other 8/28 audio, web, FedEx		

Exhibit B.1 Properly Completed Paper PT&E (continued)



**PRODUCTION, TIME, and EXPENSE REPORT (PT&E)**

under subcontract with  
**headway**  
 RTI International  
 Survey Research Division  
 PO Box 12159  
 Research Triangle Park, NC 27709

Field Supervisor Area: **902**  
 FS Name: \_\_\_\_\_ Week Beginning Sunday **08** / **22** / **2010**  
 Travel Status  Did Not Work

RTI Project Number:  
**0211838-212.006**

A		B		C							D											
Day of Week	Date	Production Number of Completed Interviews	Total Hours Each Day <sup>1</sup>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16			
Sun	22						Contacting/ Locating	Travel	Study/ Training	Interviewing	Editing	Conference	Other <sup>2</sup>	Miles Driven	Total Expenses	Lodging	Meals Actual Expense <sup>3</sup>	Tel./phone	Auto Rental	Misc. <sup>4</sup>	Incentives <sup>5</sup>	
	Mon		0.25																			
	Tues		0.25																			
	Wed		1.75										0.50									
	Thurs	1																				
	Fri																					
	Sat																					
	Totals	1	2.25				0.75		0.75		0.25		0.50									

1. Total hours worked each day in accordance to the request. 2. Hour time allocation to be reported in 0.25 hour increments. 3. Please check if name or address change. 4. Other expenses not included in categories 10-14. 5. Incentives must be attached.

**000999**  
 Name: **A. Professional Interviewer**  
 Address: **1234 Main St**  
 City: **Raleigh** State: **NC** ZIP: **27529**  
 Telephone: **(111) 222-3333**  
 I certify that this information is true, correct and complete and that the data collected and submitted are truthful.  
 Signature: *A. Professional Interviewer* Date: **8/29/2010**  
 Approved by: \_\_\_\_\_ Supervisor

Record # of Interviews Completed During the Week: **9994321**  
 Notes: **Other 8/26 audio, web, FedEx**

Exhibit B.1 Properly Completed Paper PT&E (continued)



RESEARCHWAY

under subcontract with

RTI International  
Survey Research Division  
PO Box 12134  
Research Triangle Park, NC 27709

PRODUCTION, TIME, and EXPENSE REPORT (PT&E)

RTI Project Number:  
0212682-120.006

Field Supervisor Area: 902

FS Name

Week Beginning Sunday

Month: 08

Day: 22

Year: 2010

Travel Status:  Did Not Work

A		B		C							D									
Day of Week	Date	Production	Number of Completed Interviews	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
				Total Hours Each Day	Study/ Training	Travel	Contacting/ Locating	Interviewing	Editing	Conference	Other <sup>1</sup>	Miles Driven	Total Expenses	Lodging	Meals Actual Expense <sup>2</sup>	Telephone	Auto Rental	Misc. <sup>3</sup>	Incentives <sup>4</sup>	
Sun	22																			
Mon	23																			
Tues	24																			
Wed	25																			
Thurs	26						0.25													
Fri	27			0.50			0.25	2.75	0.50	0.25	0.50									
Sat	28		2	4.00			0.50	2.75	0.50	0.25	0.50									
Totals			2	4.50			0.50	2.75	0.50	0.25	0.50									

<sup>1</sup> Record ID numbers in column B-1. Enter total hours worked in the project. If they are different, use the appropriate column. Do not include hours worked on other projects.  
<sup>2</sup> Record ID numbers in column B-1. Enter total miles driven in the project. If they are different, use the appropriate column. Do not include miles driven on other projects.  
<sup>3</sup> Record ID numbers in column B-1. Enter total expenses in the project. If they are different, use the appropriate column. Do not include expenses on other projects.  
<sup>4</sup> Record ID numbers in column B-1. Enter total incentives in the project. If they are different, use the appropriate column. Do not include incentives on other projects.

Record ID: 0009999  
 Name: A. Professional Interviewer  
 Address: 1234 Main ST (Street) State: NC Zip: 27529  
 City: Raleigh (City) State: NC Zip: 27529  
 Telephone: (11) 222 3333 (1) Please check if name or address change  
 I certify this statement is true, correct and complete and that the data collected and submitted are truthful.  
 Signature: A. Professional Interviewer Date: 8/29/2010  
 Approved by: \_\_\_\_\_ Supervisor Date: \_\_\_\_\_

Record ID of Interviews Completed During the Week	Notes
9995432	Other 8/28 audio, web, FedEx
9996543	

## Submitting a Completed Paper PT&E

Keep the gold copy of your paper PT&E for your records and FedEx the original, yellow, and pink copies (with any receipts stapled behind the white copy) to your Data Collection Manager no later than *Monday* of each week for review and signature. Once he/she receives your PT&E, he/she must review, approve, and sign it, and then send the forms to Headway/RTI for processing. All approved PT&Es received at Headway/RTI by 3 p.m. on Tuesday are processed, and checks or direct deposit vouchers are mailed by first-class mail to your home on Friday.

Please be aware that processing PT&Es takes time—sometimes as long as two or three weeks from the time you send the PT&E to your Data Collection Manager to the time you are paid, depending on holidays. Note that direct deposit is available to you, with funds available the Monday following Headway processing.

The following are examples of common errors found on paper PT&Es:

- Unsigned
- Failure to enter the project number (or, failure to enter the correct project number)
- Failure to enter a complete/correct ID Number
- Incorrect totals or no totals in columns and rows
- Breakdown of time not recorded in the proper column or totaled in a column other than the one in which daily entries are recorded.
- Time not rounded to quarter hours and not recorded in decimal form (two decimal points). Do not record time in minutes. Round to the nearest quarter hour:

<b>Time Worked</b>	<b>Incorrect Entry</b>	<b>Correct Entry</b>
1 hour and 15 minutes	1:15	1.25 hrs.
1 hour and 20 minutes	1:20	1.25 hrs.
1 hour and 30 minutes	1:30	1.50 hrs.
1 hour and 40 minutes	1:40	1.75 hrs.
1 and 3/4 hours	1:45	1.75 hrs.

Taking time to double check your work to catch any mistakes will save processing time and allow you to receive payment on time. Legible work helps as well—please write neatly in blue or black ink.

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## **Appendix C**

### **The NSDUH Laptop**



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## **C. THE NSDUH LAPTOP**

### **C.1 Introduction**

This chapter introduces the computer used for the Mental Health Study and serves as a reference whenever you have questions. It contains information about computer terminology and the different components of the Gateway laptop computer as well as tips on computer care and maintenance. If you cannot find an answer to a question, please call your Data Collection Manager.

### **C.2 Welcome to the Gateway E475**

The Gateway E475 Notebook is a powerful laptop computer with many sophisticated functions and uses. RTI and SAMHSA believe in using the best equipment to conduct the NSDUH and have invested thousands of dollars in these laptops.

The laptop computer consists of many different parts including switches, lights, and ports for attaching optional equipment. While you will not use all of these components, take the time to become familiar with the ones you will use.

Your project issued computer bag contains all necessary pieces of equipment to conduct your work tasks. This chapter describes in detail all of the pieces of equipment used, including:

- the laptop unit
- a black power cord/AC adapter that comes in two parts
- headphones
- a telephone handset recording control (used between the handset and the telephone)
- wall jack recording control (used between the telephone and the wall jack of your telephone).

## C.2.1 The Front

- **Power Indicator Light.** This blue light next to the battery indicator light is on when the computer is on and off when the computer is off. If the light is blinking, the computer is in 'stand-by' mode. Press the Power Button again to turn the computer on again.
- **Battery Status Indicator Light.** This light indicates the battery status and is located at the very front of the computer to the left of the latch. You can also see this light when the screen is closed.

Blue—the computer is plugged into an outlet; battery is fully charged.

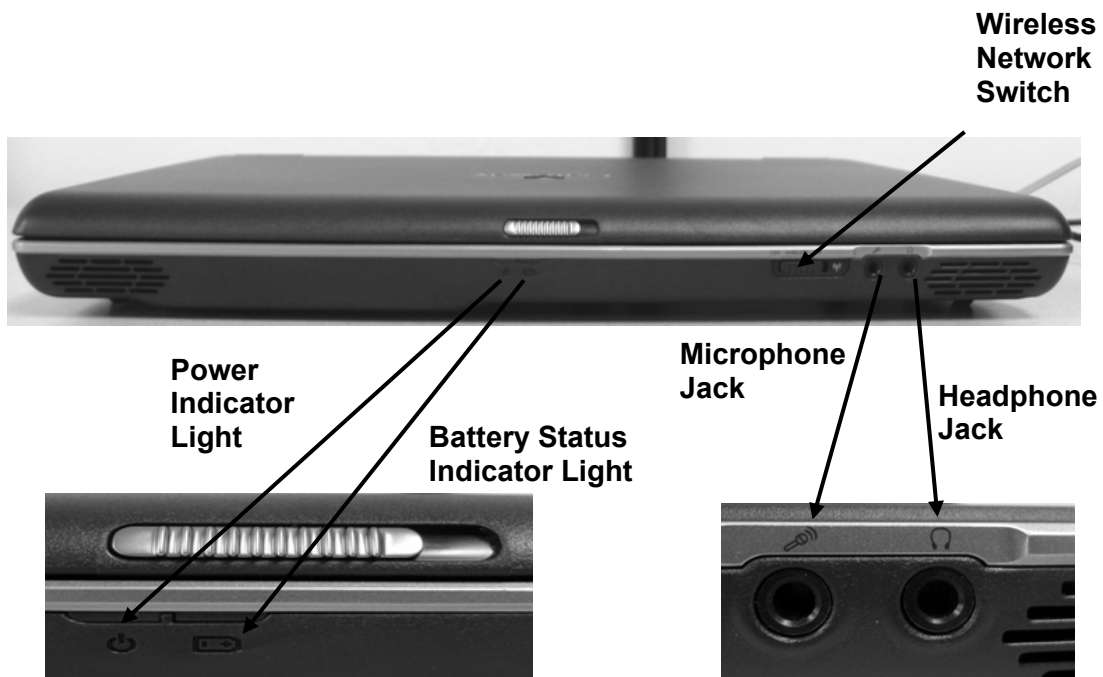
Purple—the computer is plugged into an outlet; battery is charging.

Blinking Red—the battery charge is very low.

Solid Red—there is a battery malfunction. Contact Technical Support for assistance. If the problem prevents you from working inform your Data Collection Manager of the situation.

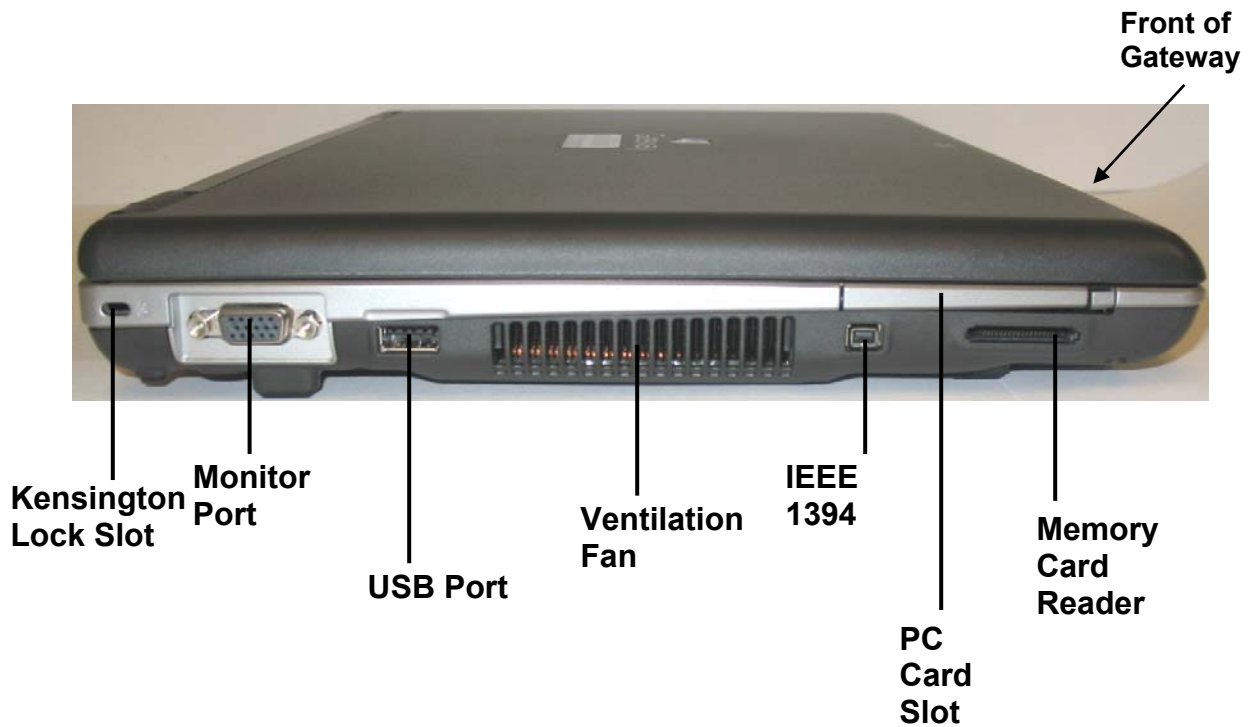
Light is off—the computer is either turned off and not plugged in or turned on but not plugged in so they system is using the battery for power. Either way, the battery is not recharging.

- **Wireless Network Switch.** To access the Internet via a wireless network connection, slide the switch to the right to the 'on' position. If not using wireless, the switch should remain in the 'off' position to avoid causing problems.
- **Microphone and Headphone Jack.** These jacks are labeled to show you where to plug in headphones, speakers, or a microphone. To disable the laptop speakers, *plug the headphones into the Headphone jack, which is to the left of the speaker on the right side.* When connecting the recording control to the laptop, use the microphone jack, which is to the left of the headphone jack.



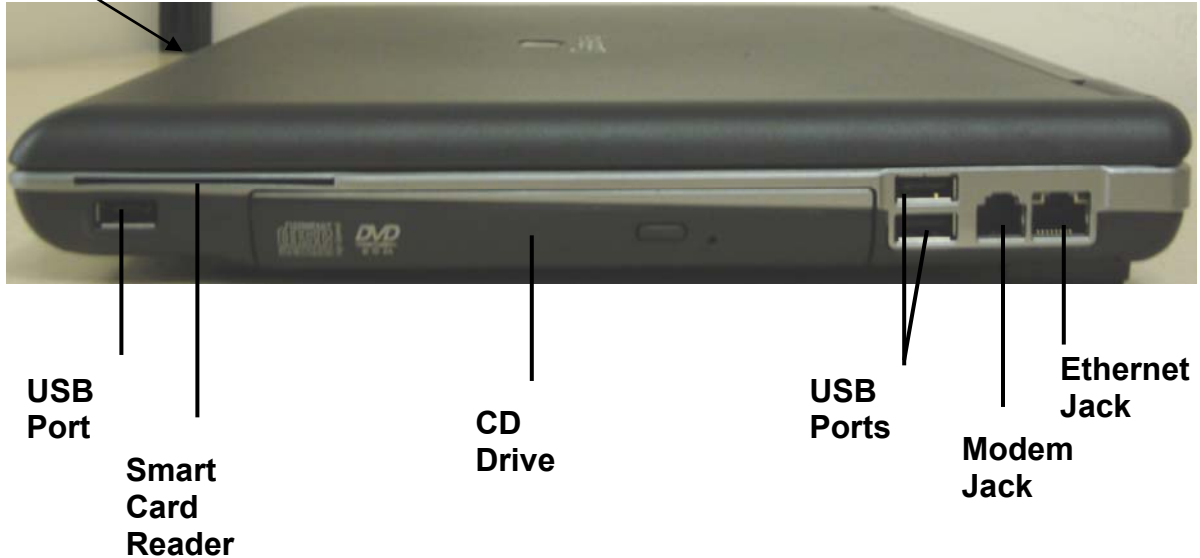
## C.2.2 The Left Side

- USB Port. The USB port will not be used.
- Ventilation Fan. The laptop's ventilation fan helps cool the internal components. If the air vents are blocked, the laptop may become hot enough to harm your skin. Always place the laptop on a flat, sturdy surface, such as a table, and make sure the ventilation fan slots are never blocked as the laptop may overheat and cause permanent damage.
- Kensington Lock slot, Monitor Port, IEEE 1394 Port, PC Card Slot and Memory Card Reader. These features will not be used.



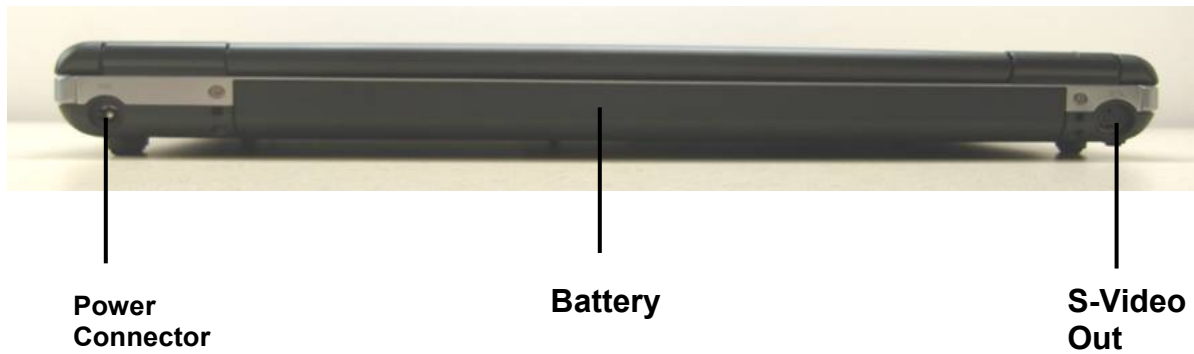
### C.2.3 The Right Side

Front of  
Gateway



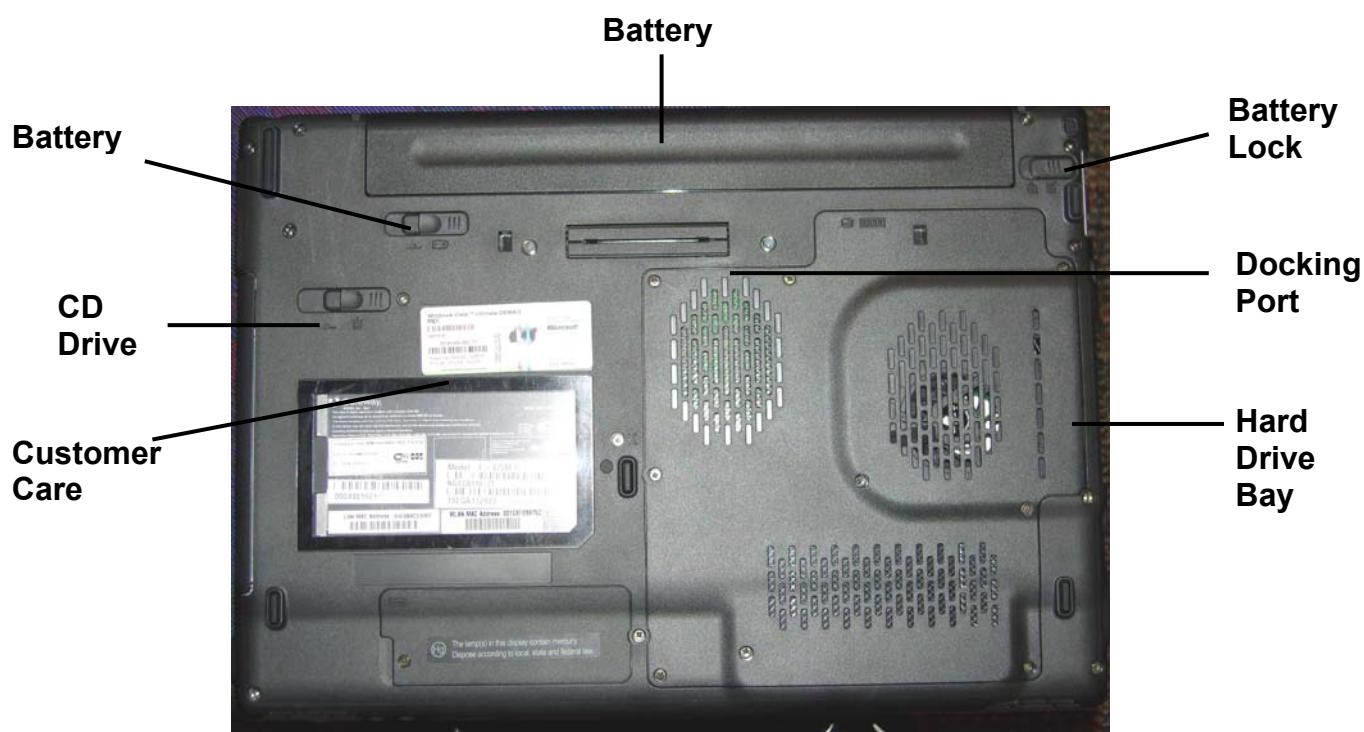
- USB Ports. Additional USB ports will also not be used.
- Smart Card Reader. Not used on NSDUH.
- CD Drive. The CD drive is located on the side of the computer.
- Modem Jack. This port, for connecting a telephone line, is used for a dial-up Internet connection.
- Ethernet Jack. Use this port for a cable or DSL high speed Internet connection.

## C.2.4 The Back



- Power Connector. This socket is for the power cord/AC adapter. Plug the round connector for the AC adapter power cord into this socket.
- Battery. This is where the battery is located in the computer.
- S-Video Out Jack. Not used on NSDUH.

## C.2.5 The Underside



### Front of Gateway

- Battery. This is where the battery is located in the computer.
- Battery Latch. This latch, labeled with a small picture of a battery, releases the battery pack to replace the computer's battery (see *Section C.5*).
- CD Drive Latch. **Do not use this latch**. The CD drive is installed. Do not slide the latch over and remove the CD drive.
- Customer Care (Identification) Label. This label shows the respective serial number and other information for the laptop unit issued to you. There are several other labels (not shown above) on the underside of the computer. On the cover of the closed laptop, you will find an important blue and gray label indicating the laptop belongs to the Federal government. This label is also used for identifying purposes by RTI staff. **DO NOT remove any of these labels**.
- Hard Drive Bay. This is where your hard disk drive is stored. The hard disk is where all the data and computer software programs are stored. **DO NOT attempt to remove the hard disk drive from the bay** unless instructed to do so by Technical Support staff.
- Docking Port. Not used on NSDUH.
- Battery Lock. Used in conjunction with the battery latch to release the battery pack.

### C.2.6 Additional Equipment

You will receive several additional items for use on the Mental Health Study, including headphones and two recording controls.

Connect the headphones to the laptop (refer to *Section C.3.1*) to disable the laptop speakers. This is important for interviewing privacy.



Use one of the recording controls to record the interview. Refer to *Chapter 3* for connection and use instructions.

WALL JACK RECORDING CONTROL		
Phone Service:	Analog	
Control location:	Between wall jack and telephone	
TELEPHONE HANDSET RECORDING CONTROL		
Phone Service:	Digital	
Control location:	Between handset and telephone	

### C.3 Opening the Computer

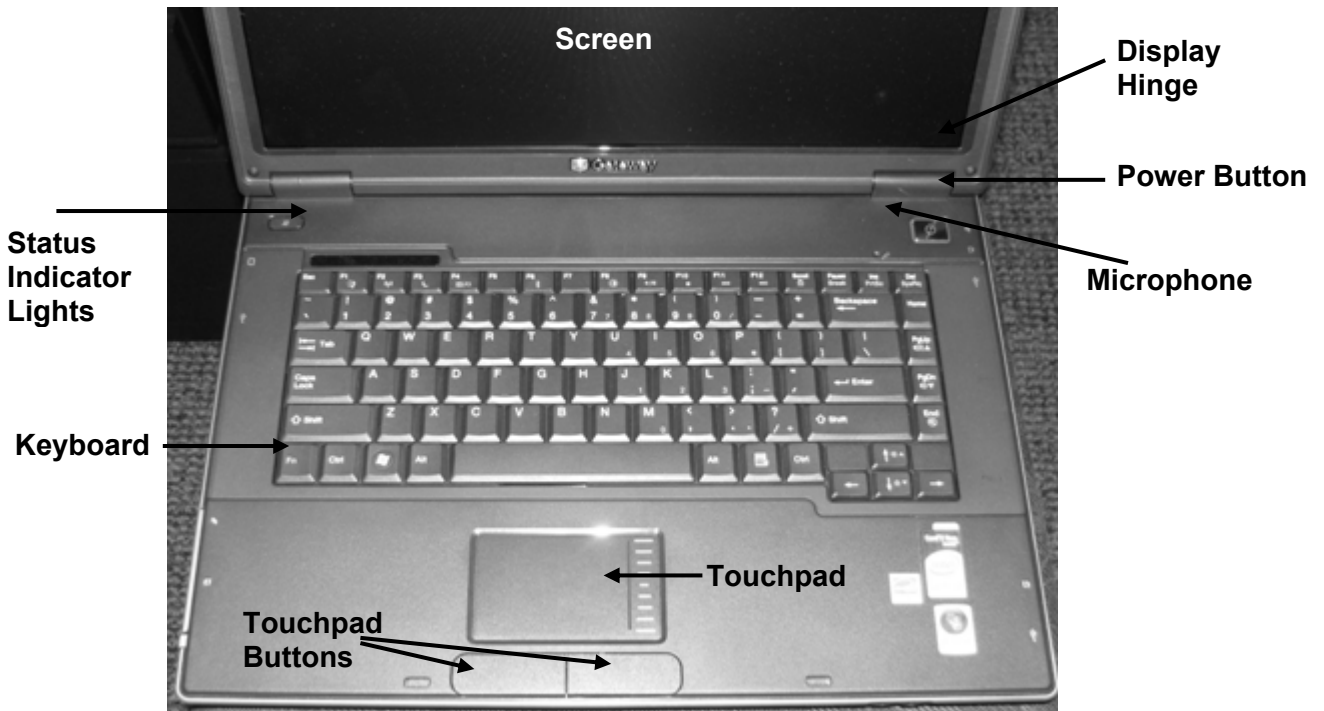
When the computer is opened, the screen and keyboard are displayed.

To open the laptop:

1. With the front of the computer facing you, find the silver latch on the front center of the laptop.
2. Slide the latch to the right and open the cover, displaying the screen.
3. Adjust the screen to a comfortable viewing angle.



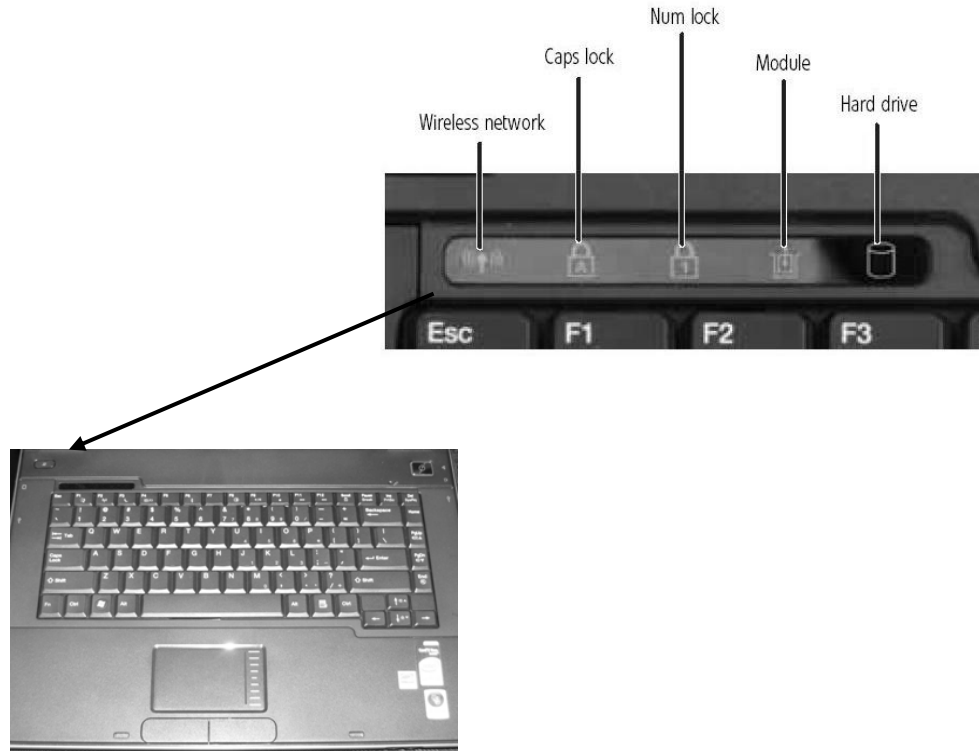
### C.3.1 The Front with the Display Open



- **Screen.** The Liquid Crystal Display (LCD) screen provides clear, bright color with minimal glare.
- **Display Hinges.** These hinges allow you to adjust the angle of the screen for comfortable viewing. To avoid damaging the screen, do not force it back too far.
- **Power Button.** This is the silver button found at the top right of the open laptop above the keyboard. The button glows blue when the computer is on.
- **Microphone.** This will not be used on NSDUH.
- **Touchpad.** This dark gray square below the keyboard acts as a "mouse." *Section C.3.4* contains details about Touchpad use.
- **Touchpad Buttons.** The left and right buttons below the Touchpad act like "mouse" buttons. Again, *Section C.3.4* contains details about Touchpad use.
- **Keyboard.** The keyboard allows you to enter information into the computer. Do not alter the keyboard or surrounding area by adding any labels or stickers or 'cheat sheets' other than the approved and standardized function key labels provided. See *Section C.3.3*.
- **Status Indicator Lights.** The series of indicator lights inform you of the computer's status. For more information about the function of each light, see *Section C.3.2*.

### C.3.2 Status Indicator Lights

The status indicator lights are a row of five lights above the keyboard and visible below the screen when the laptop is open. It looks like this:



- **Wireless Network Light.** This light is blue when the wireless network switch is in the 'on' position.
- **Lock Key Lights.**
  - Caps Lock** This light shows the [Caps Lock] key is on, locking the alphabet keys in uppercase letters. Press the [Caps Lock] key to turn the light off and return to typing in lowercase.
  - Number Lock will not be used.
- **Module Light.** This light is blue when the CD Drive Module is in use. You will not be using this module during interviewing.
- **Hard Drive Light.** This light flashes when the hard drive is in use.

### C.3.3 The Keyboard



The computer keyboard, used to enter information, contains three types of keys: **typewriter keys**, **function keys**, and **special keys**.

**Typewriter keys** type numbers, letters, punctuation and some common symbols (e.g., \$, %, &). Please note the letter "l" and the number "1" are not interchangeable, neither are the letter "O" and the number "0" so be careful when typing.

**Function keys** on the top row, labeled F1 through F12, instruct the computer to carry out special commands.

The **special keys** are all the remaining keys.

- **ENTER KEY.** The most important special key is the [ENTER] key used to indicate that entry of a certain item is completed.
- **SHIFT KEY.** There are two shift keys on the keyboard, on the left and right of the second row from the bottom. They are marked with an up arrow and the word Shift. There is no difference between the left- and right-shift keys. The shift keys can be used in the same ways as the shift keys on a typewriter. If Shift is pressed with [a], an "A" is displayed on the screen, and pressing Shift and [1] simultaneously, displays a "!" on the screen.
- **ALT KEY.** The [Alt] key is located at the bottom corner of the keyboard on either side of the Space bar. It is also used in combination with other lettered keys on the keyboard to activate certain functions.
- **TAB KEY.** The [Tab] key is located on the left side of the keyboard on the third row from the top. It is used to move around the screen to choose an option.
- **ARROW KEYS.** On the lower right corner of the keyboard there are four arrow keys that can help you move to a particular area on the screen.

### C.3.4 Touchpad Use

The Touchpad and Touchpad buttons shown on the previous page work like a computer mouse.

- MOVE:** The dark gray rectangle is a touch sensitive area. Placing your finger gently upon this rectangle and moving your finger around causes the cursor—the arrow on the screen—to move in the same direction as your finger. If you need to move the cursor a large distance, you may run out of room on the Touchpad. Simply lift your finger and move it to a different spot on the Touchpad then continue to move it.
- POINT:** Use your finger on the Touchpad to move the cursor to point to one of the words or boxes or commands shown on the CAI Manager screen.
- PRESS:** With the cursor pointing to a specific word/box/command on the CAI Manager screen, you must tell the computer you want to execute that step. Similar to pressing the Enter key, press the left button below the Touchpad to execute.

Computer linguists simplify the move-point-click steps by using just one word—click. Additionally, you can 'double click,' which means to press the left button twice in succession.

### C.4 Powering the Computer

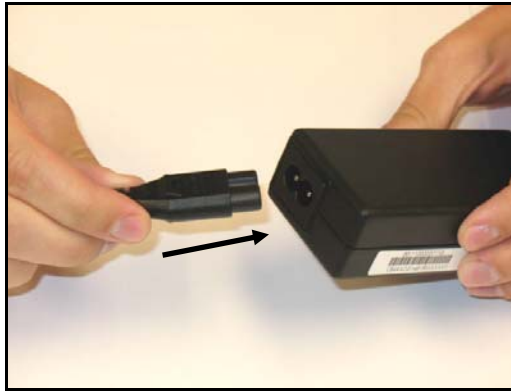
This section contains the necessary information to safely use electricity either from a wall outlet or from a battery to power your laptop. **Whenever possible**, the computer should be plugged into an outlet and should not be using battery power. Plugging in the laptop increases the screen brightness, enabling you to see the screen clearer and conserves battery power.

### C.4.1 Using Electricity/AC Adapter

To plug the unit into an outlet, use the AC adapter power cord. It comes in two parts: (1) a power cord with an electric plug at one end and a connector at the other; and (2) a cord with the adapter "block."

To connect using the AC adapter power cord:

- 1.) Connect the power cord with the electric plug at one end to the AC power block. Use only the power cords that come with the laptop.



- 2.) Plug the complete AC adapter cord into the computer's circular power connector on the back of the laptop. When looking at the back, the connector is on the left side.



- 3.) Connect the other end of the power cord to a live wall outlet. Note: You should always plug the round end of the cord into the laptop first, and then plug the pronged end into the wall.

**Warning! Do not disassemble the AC power block.** It contains dangerous voltages that can cause serious personal injury or death. Contact your Data Collection Manager about returning defective adapters.

## C.4.2 Using Battery Power

The battery that came with your computer arrived partially charged and ready to use; it is already installed in the laptop. To charge it completely, connect the computer to an outlet (see *Section C.4.1*). The battery charges while your laptop is on or off if the cords are properly connected. When the computer is on and plugged into the wall, the battery recharges but at a slower rate than when the computer is off and plugged into an electrical outlet. Therefore, always recharge the battery overnight by turning off the computer, plugging in the power cord, and connecting to a wall outlet.

Although it is best to conduct interviews with the laptop connected to electrical power, the laptop generally can run between 2 to 3 hours on a fully-charged battery. Keep in mind that if not plugged in the battery gradually loses its charge even when you are not using the computer. The battery is fully charged when the battery indicator light is blue. To check the battery status, move the cursor over the plug/battery icon in the system tray in the lower right corner of the screen. When not plugged in, the remaining battery power percentage displays.

### To recharge the battery:

- 1.) Plug the AC adapter power cord into the computer and an outlet, as described in *Section C.4.1*.
- 2.) The battery will begin recharging immediately even if the laptop is running. Check to make sure the battery light is blue or purple, which indicates that the outlet is providing electricity to the computer.

### Warning signs when the battery level is low:

- **System Warning.** The computer emits three short "ding" sounds.

If you hear this sound, your battery is getting very low. You must switch to electrical power as soon as possible. Plug the laptop into an electrical outlet, and proceed.

Do not press the power button to turn off the laptop first—if you do, you may lose information. But it is not necessary nor advisable to shut down the laptop prior to plugging it into electrical power.

When you hear the ding sounds, you must plug in your laptop immediately. The laptop will emit three more "ding" sounds as the battery is nearly empty and then *will* shut itself off automatically. If an outlet is not available or you cannot plug the laptop in for some other reason, stop and save what you are doing, and shut down the laptop.

### C.4.3 Turning the Computer On

Once you have supplied power to your laptop by either using the battery or plugging into an outlet, starting the computer is simple.

To turn it on:

- 1.) Push the latch on the front of the laptop and open the display screen.
- 2.) Press the silver power button on the right of the computer, above the keyboard. *[Note: When you first press the power button, the computer's internal fan begins running. This noticeable noise from the fan may be startling at first, but is a normal function of the computer.]*
- 3.) Wait for the computer to boot up. You will know it is ready when the security password screen appears.



### C.4.4 Turning the Computer Off

When turning off the computer, follow the steps shown below to avoid losing information or damaging the computer's hard disk drive. Do not use the power button to turn off the computer unless instructed to do so by Technical Support staff.

To turn the computer off:

- 1.) Simultaneously press the Ctrl/Alt/Delete keys, then choose Shut Down.
- OR
- 2.) Click the Start button, select Shut Down, then click OK

Wait a moment or two for the computer screen to go blank before closing the display.

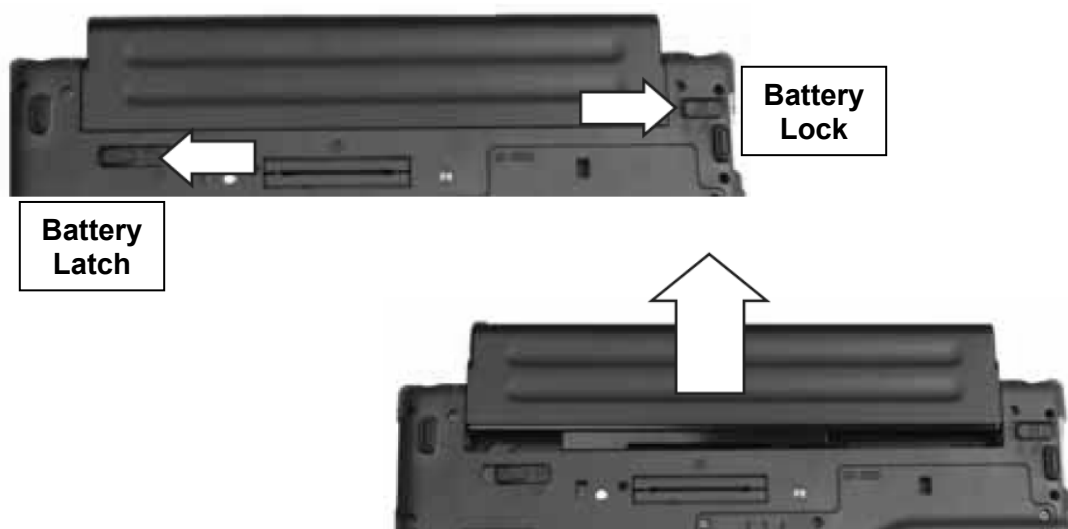
**IMPORTANT:** Do not push the power button at this point or you will turn the laptop on again.

## C.5 Reseating/ Replacing the Battery Pack

If your battery is not charging correctly (either it is not charging at all or not holding a charge long), you can try to reseat the battery pack by taking it out and putting it right back in. In rare instances, a problem with the battery pack may require that it be replaced. Check with Technical Support staff for assistance.

To reseat or replace the battery pack:

- 1.) Turn the computer off.
- 2.) Close the computer's screen until it clicks shut and turn the computer over.
- 3.) Unplug the computer if it is plugged into an outlet.
- 4.) Slide the battery lock to the unlocked position, then slide the battery release latch. Slide the battery carefully out of the laptop.



- 5.) Place the battery pack (either the current one or a new one) into the battery bay until it "snaps" into place. Slide the battery lock to the locked position. Replacement battery packs are supplied by Technical Support.
- 6.) Turn the computer right side up, plug the computer back into electrical power, and then open the cover.
- 7.) Press the power button to turn the computer on.



## C.6 Care of the Laptop

The laptop is an expensive piece of equipment that needs to be properly cared for so that it operates correctly. Take time now to read and follow these instructions to save time and effort later.

### C.6.1 Exposure to the Elements

- **Keep the computer away from sources of extreme heat or cold.** Extreme temperatures can damage the computer. Do not place or use the computer close to a heater or air conditioner. **Store the computer in temperatures between 40 F and 95 F.** If the computer has been exposed to extreme temperatures, allow enough time for it to return to room temperature before use.
- **Avoid areas with high concentrations of dust and dirt.** These can clog the internal mechanisms of the computer and the keyboard.
- **Use the computer where it will have adequate ventilation.** Like many household appliances, the computer requires air circulation to keep it from overheating during use. While the circulation required is minimal, be sure you have not covered the computer's air vents during use.
- **Do not eat, drink, or smoke when using the computer.** Exposing the computer to food particles, liquids, or smoke may damage the computer permanently.

### C.6.2 Screen, Keyboard, and Body Care

- **Do not set anything on the computer keyboard.** Accidentally closing the screen with something on the keyboard (such as a pencil), damages the computer screen.
- **Do not place heavy objects on the computer when it is closed.**
- When moving or transporting the computer, take special care not to bump it into objects. The more jolts the computer receives, the sooner it is likely to malfunction. **A single shock can potentially damage the computer permanently.**
- Always use the carrying case when taking the computer anywhere. The case is not only convenient for carrying the computer; it also helps protect it from damage.
- **Never pick up the computer by the screen.** The computer screen is the weakest part of the machine. Picking the computer up by the screen when it is open risks serious damage.
- **Never spray any liquid directly onto the computer.** To clean your computer, use a clean, damp cloth. You should apply a small amount of water or a gentle cleaning solution to the cloth and not spray it directly onto the computer. If you spill liquids on the computer, wipe off the liquids and allow the computer to dry thoroughly before using it again. Failure to do so will likely result in damage to the machine.
- **Use only water to clean the screen.** Other cleaning solutions can damage the screen despite advertisers' claims.

## C.7 Cables, Ports, and Card Slots on the Laptop

- **Do not use frayed or otherwise damaged cables.** When connecting or disconnecting a cable, hold the cable only by its connector—the plug—not by the cord. If you notice a damaged cable, promptly contact Tech Support for a replacement.
- **Never force a connector into a port if the connector and port do not join easily.** Make sure the connector matches the port and that it is properly aligned before you attach it, sliding it straight into and out of the port. Attaching/detaching a cable at an angle will likely cause damage. Also take care not to mistakenly insert any other objects that do not belong (such as pens, pencils, etc) into any ports or openings.
- **When transporting your laptop, always disconnect any cables or cords.**

## C.8 Traveling with your Computer

### C.8.1 Air Travel

- When traveling by air with the laptop, **you can safely put your equipment through airport security devices that do not harm laptop computers.** If the security device is not marked that it is safe for computers, ask. If airport security personnel will not guarantee the safety of your laptop, hand it to the Security Guard, who will follow their standard protocol for checking computer equipment.
- **Never allow anyone to check your computer unless they have presented official airport security identification.** Beware of imposters who might try to trick unwary travelers into allowing them access to or control of their computers or other valuable items. Also, beware of two-person or larger teams working to get between you and your computers. Keep your laptop close to your body at all times. Do not set it down or let someone take it from you without proper identification. Another suggestion is to put your personal carry-on items through the scanning machine first, sending your laptop through last as you walk through the detection equipment. Doing so helps keep your computer equipment close to you.
- **Never check your laptop in your luggage.** Expensive electronic equipment should **always** be taken on the airplane as carry-on luggage. If it is checked with the rest of your luggage, the chances of it being stolen or damaged are *tremendous*.

### C.8.2 Automobiles

- Never store your computer in the trunk of your car for any length of time. Doing so might expose it to extreme temperatures that can cause serious harm or permanent damage.
- Never leave your computer alone in the car where it is visible at all. This is an invitation to a thief to break into your car and steal it. Remember, you are responsible for returning your equipment to RTI when your data collection duties are over.

## C.9 Your Responsibility

By understanding and following the care instructions given, you can take proper care of the equipment entrusted to you. The equipment issued to you is **your** responsibility. It is expected you will take the necessary precautions to ensure its safety and wellbeing. Additionally, the equipment is assigned to you only for your use as an interviewer on this project.

When you receive your equipment, you complete and sign an Equipment Assignment and Receipt Form, referred to as an EARF (see *Exhibit C.1*). The notices at the top on the form contain important information. You must read each of these notes carefully and sign indicating you have read and understand the information.

- The first note acknowledges your receipt of the equipment and concerns use of and alterations to the equipment. You agree not to install, or attempt to install, any other software or programs on the equipment unless you are specifically told to do so by Technical Support staff. Also, you are not to alter or attempt to alter the existing programs. Additionally, if requested by project management or Headway, you are to return project equipment immediately to the appropriate person(s) designated by your Data Collection Manager.
- The second important notice concerns your responsibility for caring for the equipment. You are expected and legally responsible for taking appropriate care of the equipment, following the care guidelines listed in this appendix and taking steps to ensure the safety of your equipment. What does that mean? Basically, be careful! Don't repeatedly jam cords into connectors causing damage. Don't leave your computer in your car in plain sight. It is important that you follow the guidelines and be sensible when working with your equipment.

While it is understood that an occasional accident or event out of your control may occur, Headway has specific consequences for theft, loss, or damage beyond repair, including disciplinary steps and required repayment of the approximate value of the equipment for repeated problems. These consequences are documented in the Headway Equipment Policy included with your hire packet.

- The next two notices acknowledge your receipt of the Headway Equipment Policy, confirm you have reviewed the policy, and that by signing you agree to the terms stated in the EARF and to adhere to the Headway Equipment Policy at all times.
- The last notice at the top of the EARF emphasizes the importance of keeping track of your government-issued equipment and lists the federal penalties for loss.

When you receive equipment and sign the EARF, you assume full and legal responsibility for taking reasonable and appropriate steps to safeguard this equipment against damage, loss, or theft. Should you experience loss or theft of your equipment or damage requiring repair, Headway will implement the disciplinary steps as documented in the Headway Equipment Policy, beginning with a letter of documentation.

Also, you are only to use the equipment provided to you for your work on the Mental Health Study. Do not add other software or games or even play music in the laptop CD drive. Use in this way is likely to cause problems with the specially designed computer programs. Should you attempt to alter the programs or load other software, you will be subject to Headway disciplinary procedures, beginning at the

Written Advisory (warning) stage (see the Headway Equipment Policy for more details).

SAMHSA has provided you with excellent equipment for your use on NSDUH. You are responsible for the proper handling and care of this equipment. Swapping of equipment with other staff is not allowed under any circumstances.

## Exhibit C.1 Equipment Assignment and Receipt Form (EARF)

### National Survey on Drug Use and Health

Project 0211838; Contract No. HHSS283200800004C

#### **EQUIPMENT ASSIGNMENT AND RECEIPT FORM - HEADWAY**

**Directions: Read this Equipment Agreement carefully. Verify that each piece of equipment issued to you is properly identified on this form. Sign and date within each box for items checked out.**

I acknowledge receipt of the following equipment which is in working order and new/like new condition. I understand that all equipment provided to me is the property of the United States Government and is to be used only for NSDUH project business purposes. I agree that while this equipment is in my possession, I will not in any way alter the software that was installed by RTI, unless specifically instructed to do so by RTI staff. I agree not to install any software on this equipment that is not supplied by RTI. Additionally, upon request by project management or Headway, I will return all equipment immediately to the appropriate person(s) as designated by my Field Supervisor. I understand that failure to return project-related equipment will result in disciplinary action, legal action, and/or payroll deductions.

Furthermore, I understand that I am fully and legally responsible for taking reasonable and appropriate steps to safeguard this equipment against damage, loss, or theft. In the event that equipment becomes damaged, lost or stolen, I will notify project management and Headway immediately, and in the event of theft, I will cooperate with any police investigation.

I acknowledge and confirm that I have received a copy of Headway's Equipment policy. I have reviewed this policy and directed any questions pertaining to the policy to my immediate supervisor or a member of the onsite team at RTI. I agree to adhere to the policy at all times. I further understand that if this agreement is not upheld in any manner that disciplinary actions will be taken immediately.

This agreement is binding and shall supersede all other agreements whether in writing or verbal and shall be governing terms and conditions where a conflict may exist between the terms and conditions of this agreement and the terms and conditions of other agreements or forms. As certified by my signature below, I hereby affirm that I have read, understand, and agree to the above terms and conditions, as well as to the Headway Equipment Policy.

**NOTICE:** The computer and the other equipment which will be provided to you for your use on this project are the property of the United States Government and must be returned immediately upon the completion of the assignment or upon termination of your employment for any reason. Failure to return the equipment is conversion of United States Government property and is a federal crime under the provisions of Article II, Section 641 of the United States code which provides that any person who embezzles, steals, purloins, or knowingly converts to his use or the use of another, or without authority sells, conveys, or disposes of anything of value of the United States shall be fined in an amount up to \$10,000 or imprisoned not more than 10 years or both. Any person failing to return equipment will be reported to the Federal Bureau of Investigation and local law enforcement authorities.

Signature \_\_\_\_\_

Date \_\_\_\_\_

CHECKED OUT TO: (Print Name) \_\_\_\_\_

ID # \_\_\_\_\_

Place Label Here

#### **iPAQ Kit** (check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> iPAQ (2011 Value = \$192) | Govt. ID # _____                             |
| <input type="checkbox"/> AC Adapter                | <input type="checkbox"/> Spare Pens (2)      |
| <input type="checkbox"/> Car Charger               | <input type="checkbox"/> iPAQ Canvas Case    |
| <input type="checkbox"/> Rechargeable Battery Pack | <input type="checkbox"/> Mini-USB Cables (2) |
| <input type="checkbox"/> Storage Card              |  |

Signature \_\_\_\_\_

Date \_\_\_\_\_

#### **Laptop Kit** (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Laptop (2011 Value = \$620) | Govt. ID # _____                            |
| <input type="checkbox"/> AC Adapter                  | <input type="checkbox"/> Phone Cords (2)    |
| <input type="checkbox"/> Headphones                  | <input type="checkbox"/> Phone Cord Coupler |
| <input type="checkbox"/> Black Extension Cord        | <input type="checkbox"/> Laptop Case        |
| <input type="checkbox"/> CD Drive                    |   |

Signature \_\_\_\_\_

Date \_\_\_\_\_

#### **Other Equipment** (check all that apply)

- |   |                  |
|---|------------------|
| <input type="checkbox"/> Printer (2011 Value = \$153)   | Govt. ID # _____ |
| <input type="checkbox"/> Monitor (2011 Value = \$125)   | Govt. ID # _____ |
| <input type="checkbox"/> Projector (2011 Value = \$461) | Govt. ID # _____ |
| <input type="checkbox"/> Other _____                    |                  |

Signature \_\_\_\_\_

Date \_\_\_\_\_

Prepared/Assigned By: TSG Staff: \_\_\_\_\_ Date \_\_\_\_\_

RTI – NSDUH Technical Support Group, 1000 Parliament Court, Suite 100, Durham, NC 27703

Disposition: Original to RTI project files, yellow to Headway files, retain pink copy for your records.

08/10

# **Appendix D**

## **SCID Specifications**

## **Acknowledgements**

Material presented in this appendix has been adapted from the User's Guide for the Structured Clinical Interview for DSM-IV-TR Axis I Disorders (Research Version) by Michael B. First, M.D., Miriam Gibbon, M.S.W., Robert L. Spitzer, M.D., and Janet B. W. Williams, D.S.W.

## I. Overview

Before systematically inquiring about the presence or absence of particular DSM-IV criterion items, the SCID begins with an open-ended Overview of the present illness and past episodes of psychopathology. The Overview provides an opportunity for the respondent to describe his/her current situation in his/her own words. It also provides the interviewer the opportunity to collect certain types of information that may not be covered in the course of assessing specific diagnoses (e.g., prior treatment, social and occupational functioning, context of the development of the psychopathology). By the end of the interview, the interviewer should have gathered enough information to formulate a tentative differential diagnosis.

The Overview does not assume a chief complaint (current problem); it inquires about current and past emotional problems and any treatment that the respondent may have ever had. If the respondent has never had any kind of psychiatric treatment, two kinds of questions are particularly important for locating periods of possible lifetime mental disorders: 1) Has there ever been a time when the respondent was unable to go to work or school? And 2) When, in his/her life was the respondent most upset?

When asking about a history of past treatment and it becomes clear that the respondent has had a particularly complicated history, it may be useful to turn to the Life Chart, located at the end of the Overview. This chart provides a framework for recording past treatment history in a chronological fashion.

In the Overview, respondents are asked about all past treatments, including medications. The interviewer should be sure to question a respondent about any medications that were prescribed that do not seem appropriate for the condition described. This often gives a clue to problems that the respondent has not mentioned. For example, a respondent who describes only chronic depression, but was treated with lithium in the past, may describe a possible manic episode when asked why lithium was prescribed. (Of course, a prescribed medication should NOT be used to justify a diagnosis without documentation that the disorder actually met criteria, since medication is sometimes prescribed inappropriately.) Be sure to get a list of ALL psychotropic medications taken in the past 12 months, not just currently. Obtain the dosage, frequency, and any changes in dosage of all medications. Ask what symptoms or disease a medication is prescribed to treat. Many medications are prescribed for very different disorders



(e.g., Depakote for both seizures and mania; Paxil for both the pain of fibromyalgia and depression); dosages often differ depending on the symptoms being treated. Additionally, be aware of any medical conditions that may also impact mood (e.g., hypothyroidism). If not already discussed, capture when it was first discovered.

### **Important Coding Issues:**

- **Education** – "Part College" = completed at least one year of college. Trade schools (hair dressing, auto mechanics, etc.) and certificate programs do not count as college.
- **Work History** – Do not be limited by the past 6 months. Get a snapshot of the stability of their work history. If a Respondent is a student, ask about grades and any changes in grades. (If presently a C student, is that typical?)
- **Inability to Work or Go To School** – If a Respondent indicates that they are on disability, confirm what the disability is (mental or physical), and when it was first diagnosed. Also ask how this disability impacts them today (symptoms/functioning).
- **Psychopathology** – Any treatment, even a single session, would be coded 3. Use the "Life Chart" page to capture the chronology of treatment. Since it is not always understood as treatment, ask specifically if s/he has ever received medication to help their mood, nerves or to help them sleep. Note: treatment for drug and or alcohol use is NOT coded here.
- **Most-upset/Feeling the best** – Do not take "Don't know" for an answer. Pause and encourage.  
Best – is a clue for possible mania.
- **Alcohol/Drug use** – After assessing past year use, also get an idea of life-time use. (e.g., "When were you using the most?" "Have you ever used?")
- **Current Social Functioning** – Important for assessing the GAF and will require follow-up questions. Does current functioning represent a change? If no or few friends are reported, why? Is this typical or a change in functioning? How does she feel about this?

## **II. Screening Module**

The Overview is followed by a set of nine screening questions. These questions are taken from the body of the SCID and are typically the initial questions asked by the SCID for the disorders being screened. These screening questions may help reduce the potential effects of a "negative response bias" that may be especially problematic in the later sections of the SCID.

Because of the structure of the SCID, there is a tendency for the respondent to notice that a 'yes' answer to the initial probe question in a section results in follow-up questions, whereas a 'no' answer results in a skip to the next section. This leads to some respondents giving 'no' answers as a way of speeding the interview along. By asking these questions up front, and using answers to these questions in the determination of whether a section should be skipped, response bias may be minimized.

In the Screening Module, you are to ask the questions without any follow-up elaboration. You will have the opportunity to ask the respondent additional follow-up questions later, in the section of the SCID in which the disorder is being considered. Therefore, when the respondent gives a positive response to one of these screening questions, you should explain, "We'll talk more about that later." A 'no' answer should be coded as a 1, an equivocal response as a 2, and a 'yes' response should be coded a 3. All screening questions should be asked, answered, and coded before proceeding further in the SCID.

### **Important Coding Issue:**

- If you should decide to go into a section based on information obtained later in the interview despite an answer of "No" (coded 1) here, be sure to change the Screening code to either a 2 or 3.

## **III. Module A. Mood Episodes**

This module begins with ratings for Past Year and Lifetime Major Depressive Episodes, followed by Past Year and Lifetime Manic Episodes, and Dysthymic Disorder. Lifetime Major Depressive Episode is only assessed if the criteria for Past Year Major Depressive Episode are not met. Likewise, Lifetime Major Manic Episode is only assessed if the criteria for Past Year Manic Episode are not met. If the criteria for either Past Year or Lifetime Mania are met, then the Dysthymia section is NOT administered. Note that in this version of the SCID, Module A is the only module in which lifetime symptoms assessed. Also, remember that behavioral referents are important for all symptoms.

## **A. Major Depressive Episode**

### *Criterion A:*

*Establishing the Minimum Two Week Duration:* When you begin to ask about a possible Major Depressive Episode, first determine whether there has been a two-week period of depressed mood and/or loss of interest (either in the past year or before the past year). If there is some doubt about whether the duration of the depressed mood is truly two full weeks, inquire about the specific symptoms anyway, because it often turns out that a respondent who minimizes a problem when first asked may, on further reflection, recall that he/she was, in fact, symptomatic for a full two weeks. For example, let's say a respondent reports being depressed for several months during his junior year of college. Try to pinpoint a two-week interval as follows: "I know it's hard to be precise, but I need to focus on a two week period when it was the worst. Were you depressed during the fall semester of your junior year, or in the spring? Respondent answers "spring." Was it before or after spring break?" "How close was it to finals?" etc.

*Establishing Co-occurrence of Symptoms during the Same Two-Week Period:* In those situations in which the respondent reports more than one major depressive episode in the period in question, you should establish which of the episodes was "the worst" and subsequent questions should focus on the worst two-week period during that "worst" episode. It is recommended that you use holidays, seasons, or other life events (e.g., birthdays, graduation) as "landmarks" in trying to narrow down the two-week period in which the depression was the worst. The process of carefully reviewing the respondent's past also serves to transform the time period from an abstraction to a more vivid memory so that reporting of specific symptoms is more likely to be valid.

*Bereavement/GMC/Substance Ruleouts:* Do not assume that a period of depression may be complicated by either a death or drug use will "fall out" at either Criteria D (due to substance use/general medical condition) or Criteria E (bereavement). There are two reasons for this: 1. In the case of bereavement, if the symptoms lasted longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation, then the episode would be classified as a Major Depressive Episode (and not "Simple Bereavement"); 2. Even if the symptoms are better characterized as Simple Bereavement, or a Mood Disorder due to GMC/Substance Use, and a diagnosis of MDE is not given, the symptoms will nonetheless affect the GAF (for Past Year

episodes) and thus need to be reported on and documented. When a respondent reports multiple episodes of depression, some of which are complicated by Bereavement/GMC/Substance Use, consider first assessing the episode NOT complicated by these factors even if it was not the "worst" episode. If the respondent does not meet criteria for the "clean" episode, then go back and ask about the worst episode even if it is complicated.

**Common Pitfalls:** One of the most common errors in this section is the failure of the interviewer to ensure that each symptom was present for "most of the day, nearly every day." It is strongly recommended that you specifically ask, "Was that true for most of the day, nearly every day, during this period?" after each symptom, even to the point of tedium, since there is no other way to be sure this duration requirement is met. Do not assume that if the first several symptoms were present for most of the day, nearly every day, that the rest will also have this pattern. Note that item A(9) does not have to be present every day—recurrent suicidal ideation or a single instance of suicide attempt warrants a rating of 3. Further, all symptoms, including low mood and anhedonia, must be present during the SAME 2-week period.

A second common pitfall is to forget to ask about the second half of an item when the respondent answers "no" to the first part. For example item A(7) can be rated 3 if EITHER worthlessness OR excessive or inappropriate guilt has been present. If the respondent denies feelings of worthlessness, then do NOT code the item a 1 but follow-up that question with an inquiry about excessive or inappropriate guilt.

A third issue is how to count symptoms that occur in the context of a co-morbid general medical condition. General medical conditions may present with the same symptoms as characterize a depressive episode (e.g., weight loss, insomnia, fatigue). Should they be attributed to the depression or the medical condition? The rule in DSM-IV is to consider such symptoms as part of the depressive episode UNLESS they are clearly attributable to the medical condition. For example, insomnia related to frequent nocturnal coughing spells in a person with bronchitis should not count toward A(4). Similarly, symptoms should not count toward Major Depressive Episode if they are better accounted for by another disorder. For example, weight loss due to refusal to eat food because of the delusion that the food is poisoned should not be rated a 3.

A final issue is whether to consider as part of a depressive episode symptoms that have been present prior to the onset of the episode (e.g., chronic insomnia). Such symptoms count toward a diagnosis of Major Depressive Episode only if they have become appreciably worse

during the depressive episode. For example, if an individual who usually takes 30 minutes to fall asleep finds that it has been taking two hours to fall asleep since the episode began it would make sense to rate item A(4) as present for the episode.

*Criterion A(1):* Depressed mood may be acknowledged directly ("I've been feeling depressed") or by one of its many synonyms (sad, blue, tearful, "down in the dumps," "I can't stop crying"). Depressed mood in a Major Depressive Episode can be distinguished from "ordinary" (i.e., nonpathological) depression only by virtue of its persistence and severity. To count toward this criterion, the respondent's depressed mood must have been present for most of the day, nearly every day, for at least two weeks. Note that depressed mood in an adolescent may present as irritable mood.

*Criterion A(2):* Although the cardinal symptom of a Major Depressive Episode is depressed mood, it may be diagnosed in the absence of a subjective feeling of depression. Some respondents, particularly those with severe presentations, have lost the capacity to feel sadness. Others may have a cognitive style or come from a cultural setting in which feelings of sadness are downplayed. For such respondents, loss of interest or pleasure counts as a "depressive equivalent" and can be substituted for depressed mood when defining the two-week interval that applies to criteria A(3)-A(9). Evidence of this symptom may be that the respondent reports a general diminishing of pleasure (e.g., nothing makes me happy anymore) or specifies examples such as no longer reading books, watching TV, going to the movies, socializing with friends or family, or having sex. When rating this item, note that complete loss of interest or the ability to experience pleasure is not necessarily required for a rating of 3—evidence that there is a significant reduction in the ability to experience pleasure will suffice. Note: a loss of interest that is not due to mood is not coded 3. For example, a loss of interest in playing soccer because the respondent is now playing tennis or because he moved and that sport is not available, or loss of interest in gardening because it is now winter (too cold for gardening), would not qualify as anhedonia.

*Criterion A(3):* This item is rated 3 if there has been a significant change in appetite, either up or down, OR a significant change in weight during the two-week target period. Note that the first part of this item focuses on appetite and not on the amount of food consumed; thus a rating of 3 should be made only if the respondent acknowledges a significant change in his/her appetite for food. Since this is a compound item requiring a change in either appetite or weight, one need inquire about weight change only if there is no significant change in appetite. (Be

forewarned, however, that significant changes in weight without corresponding appetite changes suggest the possibility that a general medical condition may be responsible for the change in weight.) Note: weight gain or loss is over a one month period (not 2-weeks).

*Criterion A(4):* Insomnia may be manifested in many different ways, any one of which can count for this item. These include difficulty falling asleep, waking up a number of times in the middle of the night, and awakening much earlier than is normal for that person, with an inability to fall back asleep. Hypersomnia is sleeping much more than is normal for the person. Note that it is difficult and potentially not very meaningful to establish an absolute definition of the number of hours of sleep that constitute insomnia or Hypersomnia because of wide variability in individuals' need for sleep. However, as a rule of thumb, sleeping two hours more or less than is typical on a daily basis would constitute Hypersomnia or insomnia. Note that Hypersomnia should not be coded for someone who stays in bed for most of the day but is not sleeping. Also, if a respondent is taking a sleep medication, and thus sleeping ok; for coding, do not assume that the respondent would have a sleep problem if he/she were not on the medication. So, do not code it a 3 unless the respondent has actually reported sleep troubles during the episode.

*Criterion A(5):* Psychomotor agitation and retardation refer to changes in motor activity and rate of thinking (i.e., noticeably slowed or rapid speech and/or thinking and/or slowed or restless body movement). While many depressed respondents describe a subjective feeling of being restless or slowed down, this item should not be counted unless the symptoms are visibly apparent to an outside observer (e.g., the subject is either pacing and unable to sit still or seems to move in slow motion). There must be a convincing behavioral description of past agitation or retardation that was observed by others. Distinguish the feelings of being slowed down by psychomotor retardation (e.g., "I feel like I'm walking through a vat of molasses) from feelings of having no energy, which are coded in the next item.

*Criterion A(6):* Respondents with this symptom may report feeling tired all the time, "running on low power," "feeling weak," or totally drained after minimal physical activity. When a respondent complains about not feeling like doing anything, differentiate between lack of energy and loss of interest or motivation, which may also be present.

*Criterion A(7):* Be careful in rating this item since subjects who are depressed but do not have the full syndrome of Major Depressive symptoms often acknowledge feeling bad about themselves or feeling guilty. The actual item requires a more severe disturbance in self-

perception – either feelings of worthlessness OR excessive or inappropriate guilt. If, after asking a respondent how he/she feels about him/herself, you get an "I feel bad" or "I don't like myself," it is often helpful to present the respondent with the actual item (e.g., "How bad does that get? So bad that you feel worthless?") The worthlessness should be fairly global, and not just related to a precipitating stressor (e.g., if a breakup with a significant other precipitated the depression, worthlessness that is only related to the respondent's perception of herself as a girlfriend would not be coded as a 3). Similarly, while respondents often report feeling guilty about the negative impact their problems have on others ("I feel so guilty to be such a burden."), such feelings are often not excessive or inappropriate. A true positive response requires evidence of exaggerated and inappropriate guilt (e.g., "I feel like I've ruined my family forever").

*Criterion A(8):* Cognitive impairment in depression is sometimes severe enough to resemble dementia. With less severe, but still significant, impairment, an individual may be unable to concentrate on any activity (e.g., watching TV, reading a newspaper) due to an inability to filter out brooding thoughts. Interviewers should note that the impairment caused by this symptom may vary depending on the individual's baseline. For example, a theoretical mathematician may still be able to watch TV but no longer be able to concentrate on mathematical proofs—in such an instance, a rating of 3 would be warranted. Note that the second half of this item taps a different type of impairment (i.e., indecisiveness). A respondent suffering from this symptom may report feeling paralyzed by even simple decisions, like which clothes to wear for the day or what to eat for lunch.

*Criterion A(9):* This is the only symptom that does not have to be present nearly every day for at least two weeks to warrant a rating of 3. Any recurrent suicidal thoughts or behavior or any single suicide attempt is sufficient, as well as frequent thoughts such as: "I'd be better off dead" or "My family would be better off if I were dead." If there are current suicidal thoughts, it is imperative that you explore the seriousness of these thoughts and takes appropriate action. If a respondent reports any such thoughts, it is imperative that you ask when the respondent last had these thoughts, and especially if any occurred in the past two weeks (see Distressed Respondent Protocol in **Section 5.7.4**). Self-mutilating behavior (cutting, burning, etc.) without suicidal intent that is only an expression of anger or frustration or is done with the aim of controlling anxiety, is coded 1. Chronic passive thoughts of death that are no worse during this period than any other would be coded 2. If this symptom is coded 3, then the GAF must be at 50 or below (serious symptoms).

*Criterion C: Clinical Significance:* DSM-IV has added this "clinical significance" criterion to most disorders to emphasize the requirement that a symptom pattern must lead to impairment or distress before being considered a diagnosable mental disorder. Do not assume – Ask!

*Criterion D:* This criterion instructs you to consider and rule out a general medical condition or a substance as an etiological factor.

*Criterion E: Ruling Out Simple Bereavement:* At this point in the SCID, a depressive episode lasting at least two weeks has been identified. If, however, that depressive episode is considered to be a normal and expectable reaction to the death of a loved one, it is not diagnosed as a Major Depressive Episode, but would instead be Bereavement. Therefore, the judgment required in this item is whether the depressive reaction has crossed the line (in terms of persistence and severity) from Bereavement to Major Depressive Disorder. DSM-IV provides two guidelines for diagnosing Major Depressive Disorder rather than Bereavement: 1) if the depressive symptoms (i.e., at least 5, most of the day, nearly every day) have persisted for at least two months following the loss, or 2) if certain depressive symptoms that are particularly uncharacteristic of Bereavement are present (e.g., suicidal ideation, psychomotor retardation, etc.). Note that this is one of those double negative items, ("Yes, we have NO Bereavement"), and a 1 is coded if it IS Bereavement.

**Coding Note:** A12/A13 ("PAST YEAR MAJOR DEPRESSIVE EPISODE STARTED:") Record the month and year that the depressive episode started, NOT when the 2-week period that was being assessed began.

## **B. Manic Episode**

The issues for rating Past Year Manic Episode and Lifetime Manic Episode are the same as with Past Year and Lifetime Major Depressive Episode. Remember that if criteria are met for Past Year Manic Episode, there is no need to ask about Lifetime Manic Episode. Also recall that if in those situations in which the respondent reports more than one manic episode in the period in question, establish which of the episodes was "the worst" and subsequent questions should focus on the worst period during that "worst" episode. Use holidays, seasons, or other life events (e.g., birthdays, graduation) as "landmarks" in trying to narrow down the two-week period in which the depression was the worst. The process of carefully reviewing the respondent's past also serves to transform the time period from an abstraction to a more vivid memory so that



reporting of specific symptoms is more likely to be valid. For all symptoms, get behavioral referents. The symptoms during this period must present differently from "normal."

*Criterion A: Elevated or Irritable Mood:* This criterion requires a persistently elevated, expansive or irritable mood. Respondents often describe periods of irritability that are clearly not associated with a Manic Episode. Most commonly, such periods are either Major Depressive Episodes with irritability as an associated feature, or chronic irritability that is a symptom of a personality disturbance. However, if there is any question whether the irritability might be part of a Manic Episode, continue to ask all the manic questions in order to make a judgment as to whether the irritability is a symptom of a Manic Episode or is better accounted for by another condition.

*Criterion A: One Week Duration:* The criteria set for Manic Episode has a minimum duration of one week.

*Criterion B:* For all of the B items, it is imperative that examples be obtained. The examples should be quite convincing. For each symptom, it is useful to assess whether other people noticed the symptom and commented on it. While the symptom does not *need* to have been commented upon to warrant a 3, such comments do bolster confidence in the rating.

*Criterion B(1):* It is important to remember that in order to count a B symptom toward a diagnosis of a Manic Episode, the symptom must be present during the period of elevated or irritable mood and must be persistent and clinically significant. Therefore, merely being more self-confident than usual would not warrant a rating of 3. There must be grandiosity or inflated self-esteem that is clearly not justified by a realistic evaluation.

*Criterion B(2):* The respondent should report getting by on 2 (or more) hours less sleep than usual in order to justify a rating of 3 on this item. The prototypic individual feels that he or she does not need sleep at all. While some individuals may report waking up and not feeling tired, more commonly the individual describes feeling very driven or "wired" and cannot calm down enough to sleep. It may be useful to probe what they are doing when they are not sleeping.

*Criterion B(3):* The increase in talkativeness is manifested in both the rate and amount of speech. The speech often has a driven quality, as if there is so much to say and not nearly enough time to say it. If present during the interview, it may be very difficult for you to interrupt the respondent's monologue. It may be useful to ask the respondent whether other people *commented* that they had trouble interrupting the respondent or getting a word in edgewise.

*Criterion B(4):* Flight of ideas involves thoughts that are loosely connected, with the respondent jumping from one topic to another very quickly, with only the slightest thread of thematic connection between topics. In some cases, the connection may be based on sound rather than meaning (clang association). It is useful to use the phrase "racing thoughts" and ask the respondent whether he/she would describe the thoughts as "racing."

*Criterion B(5):* Distractibility refers to an inability to filter out extraneous stimuli while attempting to focus on a particular task. For example, the respondent may have trouble focusing on the questions because of being distracted by a police siren on the street, and may need to jump up from the interview to investigate what is going on outside. The extraneous stimuli should be *external* and *irrelevant*.

*Criterion B(6):* As a consequence of elevated mood, increased energy or increased self esteem, the person may become involved in more activities than usual. Typical "manic" activities involve calling friends at all hours of the night, writing lots of letters, beginning new creative projects. Alternatively, the increase in activity may be more diffuse and be manifested as psychomotor agitation (e.g., being unable to sit still). Similar to the psychomotor agitation in the MDE section, other people must have noticed and commented on the agitation in order to warrant a rating of 3.

*Criterion B(7):* In the pursuit of pleasure, excitement or thrills, the person may engage in activities that are uncharacteristic of them, without regard to possible negative consequences. Typical examples include lavishly spending large sums of money on luxury items, gifts for others, or expensive vacations, driving too fast, or engaging in reckless or unsafe sexual behavior. Note that the SCID question (i.e., "did you do anything that could have caused trouble for you or your family?") is relatively non-specific in that it will pick up any behavior that reflects poor insight or judgment. This item should be coded 3 ONLY if the behavior is extremely pleasurable and the respondent is acting without regard for the potential painful consequences. For example, problematic behavior occurring in response to a command hallucination or delusion (e.g., accosting strangers with the news that doomsday is approaching) would not warrant a rating of 3.

*Criterion B (3/4 out of 7):* Note that the number of items required to meet criterion B depends on whether criterion A was coded 3 in absence of euphoric mood (i.e., irritable mood

only). If euphoric mood has been present, then only three B criteria need to have been present. Irritable mania requires a minimum of four items to help differentiate it from irritable Major Depressive episodes. Make a note in the SCID if this item is coded 1 with three symptoms present, but mood is irritable.

*Criterion D:* As indicated in this criterion, the symptoms in a Manic Episode must be sufficiently severe so as to cause marked impairment, require hospitalization, or include psychotic features.

*Criterion E:* This criterion instructs you to consider and rule out a general medical condition or a substance as an etiological factor.

### **C. Dysthymic Disorder**

*Criterion A:* The purpose of this item is to determine whether or not the respondent has had a depressed mood for more than 50% of the past two years (or for the two years before the date an MDE occurred in the past year). If a respondent reports being depressed for a significant portion of her life, a depressed state may seem "normal" and therefore go under-reported. Be alert for this type of situation and use additional probes as necessary.

*Criterion B:* Items 2, 3, 4 and 5 are identical to the corresponding items for Major Depressive Episode, except that they need not occur nearly every day for at least two weeks. All of the symptoms may be intermittent, but must be present more than half of the days in the two-year period under consideration. Item 4 is set at a lower threshold, in that it requires only low self-esteem, and not a feeling of worthlessness or inappropriate guilt. Be sure to obtain behavioral referents for each physical symptom even if MDE has been assessed. Also, be watchful for discrepancies between report of MDE symptoms and those reported here. Note that all symptoms must be present more than half of the days in the two-year period under consideration when depressed, and not present or significantly different at other times.

*Criterion C:* In order to ensure the chronic nature of Dysthymic Disorder and to differentiate Dysthymic Disorder from recurrent minor depression, make sure the respondent never had any significant (i.e., more than two months) depression-free periods. If the respondent gives a pretty convincing description of constant low-lying depression, and then says there have been 2 month periods w/o symptoms, be sure to ask questions around this (e.g., what were those symptom free months like? How was your mood? Sleep? etc.).

*Criterion D:* As discussed above, whether a chronic depressed mood represents Dysthymic Disorder or Major Depressive Disorder in Partial Remission depends on the severity of the symptoms and the initial onset of the depression. If the disorder begins with a two-year period of depression that is less severe than a Major Depressive Episode, the diagnosis of Dysthymic Disorder is appropriate. If no such two-year period can be documented, the depression is better accounted for by a diagnosis of Major Depressive Disorder in Partial Remission with a prolonged depressive prodrome.

*Criterion F:* This item rules out depressive periods that occurred exclusively during the course of a chronic Psychotic Disorder.

#### **IV. Module B/C. Psychotic Screen**

This module is used to determine whether a psychotic symptom has been present during the past year; but it does not include enough detail to make a complete differential diagnosis. Do not assume that an experience described is "normal." Probe and get details about how frequently it occurs, what meaning the respondent gives to the experience, and how common the experience is in the context of the respondent's culture. Be aware of cultural norms that are different from your own.

##### **A. Rating Delusions**

A delusion is a false personal belief based on incorrect inference about external reality that is fully sustained despite what almost everyone believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., the belief in some cultures that one can communicate with a dead person). When you are unfamiliar with the beliefs characteristic of the individual's cultural or religious background, consultation with someone who is familiar with the respondent's culture may be required to avoid over-diagnosis of delusions.

A delusion involves impairment in the ability to make logical inferences—the way conclusions are drawn from observations of the person's environment or self (e.g., phone hang-

ups indicate that the person is being spied on). In rating each type of delusion, you must differentiate a delusion (which would warrant a rating of 3) from a strongly held "overvalued" idea (which would warrant a rating of 2). In deciding whether a belief is false and fixed enough to be considered a delusion, first determine that a serious error in inference and reality testing has occurred and then determine the strength of the conviction. It may be helpful to ask the respondent to talk at length about his/her conviction because it is only in the specific details that the errors of inference become apparent. In evaluating the strength of the delusional conviction, the interviewer should present alternative explanations (e.g., is it possible that the phone hang-ups are due to people dialing a wrong number?). A delusional respondent may acknowledge the possibility of these explanations, but still hold firm to his/her own belief. Some respondents with a longstanding history of psychotic disorder have developed insight into the "psychotic" nature of their delusions. Such a symptom would still be considered "psychotic" as long as, at some earlier point, the symptom was experienced as real. For example, a respondent may report that his chronic conviction that people at work are plotting against him is a result of his longstanding Schizophrenia. This would be coded as a delusion if the respondent reports that initially he was convinced the plot was real.

The next set of ratings documents the type of delusion, based on content. Note that for a particular delusion, more than one rating may apply. For example, a respondent who believes the FBI is after him because he can control other people's minds would have both persecutory and grandiose types of delusions coded 3.

*Delusion of Reference:* This question has a relatively high false positive rate. Ask for specific examples that establish the psychotic nature of the belief. Most people have at some time felt that other people were talking about them, particularly if they have some obvious physical abnormality or act in a way that makes them stand out. It is therefore important to differentiate realistic perceptions, social anxiety or transient suspiciousness from a fixed false belief. A homeless man who dresses in rags and has no place to take a shower may realistically believe that people are moving away from him on the subway, but if he believes that today's headlines are a cryptic reference to his personal life, the interviewer should rate this item a 3.

*Persecutory Delusion:* Take care to differentiate an exaggerated, possibly valid, perception (e.g., by a boss, a teacher, an ex-spouse, a drug dealer) from real persecutory

delusion. There may be cases in which it is impossible to know whether the persecution is real or delusional.

*Grandiose Delusion:* It is sometimes hard to tell where an inflated perception of one's talents ends and where a grandiose delusion begins. A taxi driver who believes he will write a best-selling novel may be mistaken, but not necessarily delusional. If, however, he tells the interviewer that Steven Spielberg has been calling, begging for movie rights to his novel, he has probably stepped over the line into delusion. Questioning him about his evidence for the belief is a good way to clarify the issue.

*Somatic Delusion:* In assessing this symptom, it is necessary to take into account the respondent's understanding of anatomy and physiology. An uneducated person may have a primitive explanation of symptoms, for example, believing that stomach pains are caused by a grasshopper hopping around inside of him. His willingness to entertain an alternative explanation indicates that the belief is not a delusion. Another example of a false positive would be a respondent with physical symptoms who doubts an internist's reassurance that she has no medical illness. If the respondent is willing to entertain the possibility that her beliefs are exaggerated, then the diagnosis would be Hypochondriasis. A respondent who dismisses such reassurances out of hand is more likely to have a somatic delusion.

*Other Delusions:* Other types of delusions that do not easily fit into one of the specified types are coded here.

## **B. Rating Hallucinations**

*Auditory Hallucinations:* Auditory hallucinations should be differentiated from delusions of reference, in which the respondent hears actual voices (on the street, etc.) and interprets them self-referentially. Evidence that they are, in fact, hallucinations might be that they occur when the respondent is alone. This item should be coded 3 only if hallucinations are judged to be clinically significant, (i.e., recurrent or persistent). Hearing one's name being called and finding no one there is an example of a hallucination that is not clinically significant. A hallucination (the experience of a sensory perception without stimulation of the relevant sensory organ) should also be distinguished from an illusion, which is a misperception of an actual stimulus (e.g., misinterpreting a shadow as the figure of a man).

## **V. Module D. Mood Disorders**

This module is for recording Mood Disorder Diagnoses (other than Dysthymic Disorder, Mood Disorder Due to a General Medical Condition, and Substance-Induced Mood Disorder). The diagnoses covered in this module include Bipolar I Disorder and Major Depressive Disorder. The task in this module is to evaluate whether the specific criteria for Mood Disorders are met based on information gathered in Module A. If any symptom in either the MDE or Mania sections is coded 3, then D1 would also be coded 3.

## **VI. Module E. Anxiety Disorders**

### **A. Posttraumatic Stress Disorder (PTSD)**

The evaluation of PTSD begins with a screen that first reviews the individual's lifetime history of exposure to severely traumatic experiences and then determines whether any of these traumatic experiences have been re-experienced in the form of dreams, flashbacks, intrusive thoughts, or strong reactions when in situations that are reminiscent of the trauma. If so, the interviewer should proceed with the evaluation of PTSD, focusing on the event identified in the screen. If more than one traumatic experience is reported, ask the respondent to choose the one that seems to have affected him/her the most during the past year. If, during the evaluation of PTSD for this particular stressor, it becomes clear that the criteria for PTSD are not being met, determine whether one of the other stressors might in fact have had a greater impact on the individual during the past year, and then reevaluate the criteria in relation to this different stressor.

*Criterion A(1):* In evaluating whether a stressor qualifies as a potential source of PTSD, both the type of stressor ("actual or threatened death or serious injury or threat to the physical integrity of self or others") and the context of exposure ("experienced, witnessed, or confronted with") should be considered. In DSM-IV, stressors are limited to events that pose a threat to life, limb, or physical integrity. Stressors that, while distressing, are not life-threatening (e.g., being humiliated by a boss at the office) do not warrant a rating of 3 for this item. Although the prototypic stressor for PTSD is a wartime combat experience, the concept has been expanded to include other life threatening experiences like being the victim of a serious crime, accident, or disaster. The phrase "threat to physical integrity" includes all experiences of sexual assault or sexual molestation, not just those in which the victim perceives a threat of violence. The context

of the exposure includes having one's life threatened; having the direct personal experience seeing someone else being threatened, injured or killed; or hearing the news of a loved one being hurt. It is not meant to include more indirect and impersonal experiences such as hearing a news report of a catastrophe occurring to strangers. Similarly, the expected death of a loved one of natural causes at an advanced age does not qualify as a PTSD stressor.

It is very important to get a description of the event and some details of what happened. Be respectful/show empathy, but don't assume that the respondent cannot talk about it. Do not begin by giving the respondent permission to not answer (e.g., "you do not have to answer these questions if you don't want to"). While it is true that respondents do not need to answer anything they are uncomfortable answering, you should administer the module with the assumption that the respondent will answer. Getting some details will be essential in assessing the Criteria B, C, and D.

*Criterion A(2):* This criterion requires that the person be profoundly affected by the stressor and react to it with extreme feelings of "fear, helplessness, or horror." It is possible that the respondent says he/she had no emotion initially; he/she may have been in shock. If this is the case, assess if he or she felt differently as a later time.

*Criterion B:* The re-experiencing of the traumatic event can occur spontaneously (intrusive memories, flashbacks, or dreams) or can be triggered by a wide variety of stimuli that remind the person of the traumatic event. For example, smoke from a campfire may produce profound terror in someone who has been trapped in a house fire. Flashbacks to wartime may be triggered by loud noises, seeing war movies, or tropical rainstorms. In some cases, the trigger may be a symbolic representation of the actual stimulus (e.g., a policeman for a concentration camp survivor). Occasionally, it may be difficult to differentiate a flashback from a psychotic experience. In contrast to psychotic symptoms, the sense that one is reliving a traumatic experience in PTSD is transient, self-limited, and understandable in the context of the exposure to the prior stressor. Note that the re-experiencing must be persistent—a few nightmares or intrusive memories don't satisfy this criterion. Therefore assessing the frequency for each symptom is essential. Clinical judgment must be used in assessing significance; however, a symptom that is present less than monthly would not likely warrant a rating of 3. Further, the cues or triggers for both emotional distress and physiological reactivity must be linked to the traumatic event. It is important to elicit examples of the symptoms and to ask additional probes



as necessary. Remember, for B(1), the thoughts must be intrusive/distressing, not just memories of or thoughts about the trauma. For B(2), be sure to ask about the content of the dream. Again, it must be distressing (not just "another dream"). The dream must also be related to the traumatic event. It is important to note that B(3) is a rare symptom – flashbacks are not merely "strong" memories of the event. There must be some sense of reliving the experience. Finally, for B(4) and B(5), information must be gathered regarding what the cue or trigger was and how the respondent reacted. A preference to not watch the TV news because of reporting of similar events would not be coded 3.

*Criteria C and D:* These criteria include symptoms that are much less specific than those in A and B, and are seen in many other disorders. Many people, for instance, try to avoid talking or thinking about bad things that have happened to them, whether or not the bad things were traumatic. Diminished interest, detachment, a restricted range of affect, insomnia, difficulty concentrating, etc., may be symptoms of a Depressive Disorder or of a Personality Disorder. It is important to clarify that the symptoms in C and D developed after the trauma. (In the case of a childhood trauma, it is impossible to know what the person would be like had he or she not had the experience. Following the SCID principle that one does not make a diagnosis without the evidence, we would be hesitant to diagnose PTSD in an adult who has had symptoms as long as he or she can remember.) Again, the symptoms must be present in the past year, have developed after experiencing the trauma and be persistent since that time. In terms of gathering additional information, remember that for C(2), the person/thing being avoided must be directly related to the traumatic event. For C(4), recall that, as in anhedonia, the diminished interest must not merely represent a change of interest or decrease of interest due to other factors.

*Criterion F:* This criterion instructs you to assess if the symptoms are clinically significant.

## **B. Panic Disorder**

Prior to assessing the presence of Panic Disorder, have the respondent describe in detail what happens when he/she has a panic attack.

*Criterion A(1):* The term "panic attack" is often incorrectly used by respondents to describe any escalating anxiety, but the hallmark of a true panic attack is the sudden and intense onset of symptoms. The physical symptoms and terror are often overwhelming, and initial panic

attacks may lead a person to seek emergency care because of concerns that he/she may be having a heart attack. Since the term "panic attack" is liberally used, make sure you have the respondent describe what they mean by this expression prior to assessing any of the criteria.

The presence of a panic attack is not necessarily indicative of Panic Disorder since panic attacks can occur in the context of a number of Anxiety Disorders. For example, if a person with a snake phobia goes on a hike and has a panic attack after accidentally stepping on a snake, this would not warrant an additional diagnosis of Panic Disorder. By definition, at least two of the panic attacks in Panic Disorder must have been "unexpected." Only one of the panic attacks must have occurred in the past year.

Assessing whether a panic attack was "unexpected" may be difficult because respondents with Panic Disorder commonly (and mistakenly) believe that there is a cause-and-effect relationship between the situations in which the attacks have developed and the attacks themselves. For example, a respondent who experienced several unexpected attacks while shopping may assume that it was the experience of being in a crowded store that led to the attacks and therefore not consider the attack to be "unexpected." In such a situation, use the follow-up question, "Have you ever had a panic attack when you didn't expect to at all?" or "When you were in the store, right before you had your first attack, were you already feeling anxious or were you feeling okay?" For some individuals, attacks occur following a frightening thought, such as worrying that something will happen to them or a loved one. Such attacks should still be regarded as "unexpected" because the concept of "unexpected" refers to the absence of a clear association between an environmental stimulus and the occurrence of the panic attack. Common sense will lead you not to include as "unexpected" panic attacks that occur in response to unexpected but realistic dangers, such as being mugged. Similarly, panic attacks that occur in response to delusions about being harmed should not be regarded as "unexpected."

*Criterion A(2):* The diagnosis of Panic Disorder requires that at least one of the panic attacks be clinically significant. The three subparts of this criterion present three different ways in which clinical significance may be manifested: either persistent worry about the implications of the attack (e.g., that the attack means the respondent is going crazy or suffering from a medical illness), worry about having additional attacks, or a change in lifestyle (most commonly, avoidance of situations or activities or modifications to accommodate the attack, like always

being near an exit, sitting on the aisle of a theatre, etc.). Respondents who have had panic attacks but are not particularly bothered by them would warrant a rating of 1 for this item.

*Criteria for Panic Attack:* In DSM-IV, panic attack is defined using a free-standing criteria set that is not part of the criteria set for Panic Disorder per se. The SCID embeds the evaluation of whether the discrete episode of symptoms constitutes a true panic attack or, rather, just a limited symptom attack (i.e., less than 4 symptoms) in the evaluation of Panic Disorder. Before presenting the 13 symptoms of a panic attack to the respondent, the interviewer is instructed to first inquire about the most recent panic attack in an open-ended way (i.e., "when was the last bad one? What was the first thing you noticed?" etc.) This allows the respondent an opportunity to describe the attack in his or her own words, which is helpful in determining whether the experience has the qualities of a true panic attack. This method is also helpful in encouraging the respondent to focus on a single specific attack when endorsing the characteristic symptoms. Note that if fewer than four symptoms are endorsed, the interviewer should ask if the respondent has had other attacks in the past year during which there were more symptoms. If so, the interviewer should go back and reapply the list of 13 symptoms to this most severe attack and then confirm that such attacks have occurred repeatedly.

This requirement that the symptoms reach a peak within ten minutes is to differentiate a panic attack from slowly escalating anxiety. In fact, panic attacks often peak within seconds, and almost always within a few minutes. Although most panic attacks subside within an hour, some individuals may continue to have symptoms and a high level of anxiety for hours after the peak.

*Criterion C:* This criterion instructs you to consider and rule out a general medical condition or a substance as an etiologic factor for the panic attacks. Remember to carefully assess caffeine intake, and remember that caffeine is present in a variety of foods and over-the-counter medications like Anacin. Although substance use may be associated with the initial onset of panic attacks, a substance use etiology should be considered when subsequent panic attacks occur **ONLY** in the context of substance use.

Do not pre-judge the impact of substances or medical conditions. Caffeine and other stimulants, hypoglycemia and hyperthyroidism all can bring on similar symptoms (a more complete list is in the SCID). For some people *any* amount of caffeine can bring on panic-like symptoms.

Merely asking if the respondent sees a connection between the symptoms and these other factors is not sufficient to code this item. A temporal and consistent relationship must be established.

*Criterion D:* This criterion asks you to consider whether the panic attacks are better accounted for by another mental disorder. This judgment depends on determining whether the panic attacks are cued by an anxiety-provoking stimulus arising in the context of another disorder. For example, consider an individual with longstanding Social Phobia who has a panic attack while speaking in front of a large group of people. Since the panic attack was triggered by exposure to an anxiety-provoking situation (e.g., speaking in public) it is considered to be better accounted for by the Social Phobia. Similarly, if someone with Posttraumatic Stress Disorder develops a panic attack when exposed to a stimulus that reminds the person of the traumatic stressor, then the attack would not be considered a symptom of Panic Disorder. Note that this criterion does NOT set up a strict hierarchy between Panic Disorder and other mental disorders (i.e., DSM-IV does not instruct you to never diagnose Panic Disorder if the attacks occur during another disorder). Instead, clinical judgment is required to determine whether the other disorder "better accounts for" the panic attacks. You may need to set aside the evaluation of this criterion pending completion of the remainder of the SCID, if it seems likely that another disorder which accounts for the panic attacks may be present.

*Criterion B: Agoraphobia:* Some individuals with Panic Disorder manage to grit their teeth and suffer panic attacks without developing any avoidance, but most begin to associate certain situations with their panic attacks and consequently avoid those situations (or else endure them only with great anxiety). This avoidance may range from simply not driving a car because a person is afraid of having a panic attack while driving, all the way to never leaving home because one is afraid of having an attack in a place that's not "safe." The key here is fear of a situation where help may not be available *in the event of a panic attack or panic like symptoms*. The fear is of having the panic-like symptoms, not of the situation.

*Criterion B(1):* To rate this item 3, the respondent should report that a situation is avoided because of fears that a panic attack is more likely to develop in that situation or that escape from the situation may be difficult or embarrassing in case of having a panic attack. In some cases, the respondent may not be aware of the reason certain situations are avoided. If the avoidance develops soon after the onset of panic attacks, you may infer that the avoidance is related to the panic attacks.

*Criterion B(2):* Note that a rating of 3 can still be appropriate for a respondent who is able to force him/herself to go into the agoraphobic situations so long as there is either marked distress or the need for a companion to accompany the person. Really pull for the clinical significance of the avoidance and effect on functioning. A respondent who leaves the house everyday to go to work, but who feels uncomfortable in crowds would not be considered agoraphobic.

*Criterion B(3):* This criterion is similar to Criterion D in Panic Disorder in that it reminds you to consider whether the fear and avoidance may be better characterized as part of another mental disorder. Two of the most difficult boundaries are with Specific Phobia and Social Phobia. Typically, Agoraphobia involves avoidance of a cluster of situations, reflecting the general unpredictability of panic attacks. In contrast, Specific Phobia tends to be limited to one consistently-feared situation. Furthermore, the onset of Agoraphobia is related to the onset of panic attacks, whereas Specific Phobias tend to be either lifelong or related to a traumatic experience. Determining whether avoidance of social situations is related to Social Phobia or to fear of developing a panic attack in a social situation (which would warrant a diagnosis of Agoraphobia) generally depends on determining the temporal relationship between the onset of panic attacks and the social avoidance. If an individual develops social avoidance only AFTER the onset of panic attacks, then Agoraphobia is the most appropriate diagnosis. An individual with longstanding social avoidance who develops panic attacks when in social situations would better be considered to have Social Phobia. Note that this criterion does NOT preclude making a diagnosis of BOTH Panic Disorder with Agoraphobia and another disorder characterized by avoidance in the same individual (e.g., an individual with a long-standing dog phobia since childhood who develops unexpected panic attacks in situations without the presence of dogs).

### **C. Agoraphobia without History of Panic Disorder**

This disorder is analogous to Panic Disorder with Agoraphobia, but the concern is about panic-like symptoms as opposed to full-blown panic attacks. In Panic Disorder with Agoraphobia, there is anxiety about being in places or situations from which escape may be difficult or embarrassing in the event of having a *panic attack*. In this condition, the anxiety is focused on being in places or situations from which escape may be difficult or embarrassing in the event of

having *panic-like symptoms* (either a specific uncontrollable symptom like a loss of bowel control or else subthreshold versions of panic attacks known as "limited symptom attacks").

*Criterion A:* When assessing this criterion, it is important to establish that the anxiety and/or avoidance are related to concerns about having panic-like symptoms and not for other reasons (e.g., a person having anxiety about going outside because he/she lives in a dangerous neighborhood).

*Criterion B:* This criterion, which requires that criteria have never been met for Panic Disorder, has been omitted from the SCID since this criterion has already been met by virtue of the branching logic that skips this disorder if criteria have been met for Panic Disorder.

*Criterion C:* The type of anxiety or avoidance seen in this condition would rarely be associated with a substance or general medical condition (except as discussed in criterion D). Nonetheless, DSM-IV requires you to rule out these etiologies.

*Criterion D:* Individuals with general medical conditions often restrict their activities and avoid situations because of concerns that the symptoms of the general medical condition may be disabling or embarrassing. This criterion clarifies that this diagnosis may be appropriate if the amount of anxiety or avoidance is unreasonable given the severity of the general medical condition. For example, avoiding driving for several weeks following a severe heart attack would not warrant a diagnosis of AWOPD, whereas being housebound for two years following a mild heart attack might warrant a diagnosis.

#### **D. Social Phobia**

*Criterion A:* There is a wide range of social triggers that may qualify for this criterion—what they all have in common is that the respondent fears acting in a way that will be humiliating or embarrassing. Some people are afraid of any kind of scrutiny—they choose to work by themselves, won't go to parties, or out on dates because they are extremely self-conscious, and believe that others will judge them to be foolish, stupid, or inept. (This is often a lifelong pattern and these individuals usually also have Avoidant Personality Disorder.) Other socially phobic people are comfortable in many relationships, but uncomfortable about various situations in which they are required to "perform." This more circumscribed form of Social Phobia includes

traditional performance situations like public speaking or playing a musical instrument, as well as other behaviors that are only a performance in the person's mind: fears of urinating in a public bathroom, writing in front of others, or eating in front of others. Individuals with performance anxiety have no problem performing the behavior when alone (e.g., giving a speech in front of a mirror). In all cases, a rating of 3 requires that the focus of the anxiety is concern about being humiliated or embarrassed by the scrutiny of others. Avoidance of a behavior because of concerns that the person's own high standards will not be met (as in Obsessive-Compulsive Personality Disorder) would not warrant a rating of 3.

Because concerns about public speaking are so ubiquitous, it is important not to rate this criterion as a 3 for public speaking unless it is clear that the person's concerns are excessive and do not diminish with practice.

Remember, these need to be reactions that have occurred in the past year – not just sometime in the past. Also, be sure to get examples to support the criterion "marked and persistent fear."

*Criterion B:* The question "*Have you always felt anxious...*" is intended to assess the consistency of the reaction on every exposure to the feared situation; not an intermittent presence since childhood. This criterion should be rated 1 if the anxiety and avoidance are erratically expressed (i.e., fear of speaking in one class, but no fear of speaking in a different class with the same number of people).

*Criterion C:* This criterion helps to set the boundary between Social Phobia and the social avoidance that is characteristic of many psychotic disorders. In a psychotic disorder, the social avoidance is usually associated with a delusional belief (e.g., persecutory delusion) that the respondent believes justifies his/her social anxiety or avoidance.

*Criterion D:* This two-part criterion underscores that avoidance of social situations is not a required part of this disorder. A diagnosis of Social Phobia may also apply to those who force themselves to go to parties, give talks, or go on job interviews, but feel anxious while doing it.

*Criterion E (also in Specific Phobia):* A diagnosis of Social or Specific Phobia is not made unless avoidance, anticipatory anxiety, or distress is clinically significant (i.e., interferes with functioning, with social activities, or with relationships, or there is marked distress ABOUT

having the phobia). Thus, for example, a public speaking phobia in a plumber who is almost never called upon to address groups is unlikely to meet the criterion, as is a snake phobia in someone who rarely leaves New York City. Too, claims that promotions would have occurred had the respondent been more at ease socially (or better at public speaking) would not generally meet the criterion; the critical difference being the low level of skill or ease versus a true phobia. Some individuals who seriously constrict their lives to avoid social (or other phobic) situations may report a lack of distress since their phobias are never activated. A rating of 3 may still be justified if you make a clinical judgment that the phobia has a significant negative impact on their functioning. Note: Most potential diagnoses of phobias sink or swim on this criterion.

*Criterion G:* Phobias are rarely caused by the direct physiological effects of a substance or general medical condition.

*Criterion H:* DSM-IV excludes a diagnosis of Social Phobia for individuals with medical or psychiatric conditions who may understandably avoid social situations because they are embarrassed about their symptoms. Such individuals, especially those who overreact to their condition or disability, may deserve a diagnosis of Anxiety Disorder NOS (which would be recorded on page X.4 in the Interviewer Debriefing Module, if appropriate).

## **E. Specific Phobia**

The criteria B, C, D, and E are the same as in Social Phobia.

*Criterion A:* The hallmark characteristic of a phobia is that the fear is way out of proportion to the degree of danger posed by the object or situation. Be sure to obtain good evidence of "marked and persistent fear that is excessive or unreasonable..." by eliciting behavioral referents.

*Criterion G:* Specific Phobia is, in a sense, residual to other disorders with stimulus triggered anxiety. For example, although fear and avoidance of contamination may meet criteria for a "dirt phobia," if the fear and avoidance occurs as part of a contamination obsession and hand washing compulsion in Obsessive Compulsive Disorder, then an additional diagnosis of Specific Phobia is not made.



It should be noted that a diagnosis of Specific Phobia can be made along with one of these other disorders if the fear and avoidance are unrelated to the other disorder. For example, a person with Panic Disorder may avoid many different situations or activities because of fear of a panic attack, but may also have specific phobias that are unrelated to the Panic Disorder. It is up to you to get enough information to judge whether, in addition to agoraphobia, there are fears (e.g., of dogs, of spiders) that are unrelated.

## **F. Obsessive Compulsive Disorder**

*Obsessions, Criterion A:* The most common diagnostic problem is distinguishing true obsessions from other repetitive distressing thoughts, like excessive worries about realistic concerns, depressive ruminations, and delusions. Obsessions have an intrusive, inappropriate, and "ego-alien" quality and are experienced by the respondent as something different and stranger than the worries or preoccupations that characterize Generalized Anxiety Disorder or a normal reaction to life's unpredictability. The recurrent, intrusive, and anxiety-provoking thought while driving, that one ran over a small child without realizing it is an obsession.

Spending an equal amount of time worrying about one's retirement is more likely to be an aspect of Generalized Anxiety Disorder. Unlike obsessions, depressive ruminations and delusions are generally not perceived as intrusive or inappropriate, but are understood by the respondent as a valid form of concern, even if he/she realizes that the concern is excessive and tries to stop thinking about it.

In those situations when the differential diagnosis is particularly challenging, it may be useful to remember the fact that obsessions and compulsions usually go together (in fact, 90% of the time according to the DSM-IV OCD field trial). Therefore, in trying to distinguish between an OCD obsession and other repetitive thoughts, the clinching point may be whether compulsions are also present.

### **Important Interviewing/ Coding Issues:**

- All four aspects of Obsessions (A1- A4) must be coded 3 in order to meet the diagnosis.
- A1 (E79) - these thoughts are more than recurrent - they must also be experienced as intrusive and inappropriate.

*Compulsions, Criterion A:* Compulsions are distinguished from other forms of repetitive behaviors by the underlying motivation for the behavior—to reduce or prevent the anxiety associated with an obsession. For example, hand washing alleviates anxiety triggered by the obsession that one is contaminated; repeating a prayer exactly 36 times is meant to counteract the distress caused by having an obscene thought. Determining that the behavior is intended to reduce the anxiety accompanying an obsession is very helpful in differentiating a compulsion from other repetitive behaviors like tics and stereotypes. The most common compulsions are behaviors like hand washing, repetitive touching or picking up and replacing an object over and over again, or mental acts such as counting or repeating a word or phrase over and over.

**Important Interviewing/ Coding Issues:**

- All four aspects of Obsessions (E79-E82) must be coded 3 in order to meet the diagnosis.
- E79 - these thoughts are more than recurrent - they must also be experienced as intrusive and inappropriate.
- E80 - worrying about safety when living in a rough neighborhood is not what we are looking for here
- E84/85 In assessing these items, be sure to ask the respondent what would happen if he/she were prevented from doing the behavior. Washing one's hands to prevent the spread of germs (especially in a health-care setting) would not typically qualify (useful probes: does the respondent do so more than others do? Is this standard of washing typical in this setting?)

*Criterion B:* This symptom (on page E.30) is to be assessed if the respondent meets criteria for either Obsessions or Compulsions. If the respondent meets criteria for both Obsessions and Compulsions, then these questions are to apply to both sets of symptoms. The prototypal individual with OCD is aware that his/her obsessions and compulsions are unreasonable (e.g., that it is ridiculous to be concerned about contamination from germs that might arise from touching newspapers). Over time, some individuals with OCD lose insight as to the excessive nature of their obsessive concerns or compulsive behaviors and may in a later stage of the illness describe the obsessions or compulsions as being reasonable.

For such individuals, it is essential to establish whether at some time in the past (usually early in the course of the illness) the obsessions and compulsions were regarded as unreasonable (e.g., when the hand washing first started, did you feel that you were washing your hands much more

than you should or than really made sense?). For those individuals who no longer recognize that the obsessions or compulsions are not reasonable, the specifier "With Poor Insight" may be noted.

*Criterion C:* This criterion requires that the obsessions or compulsions be clinically significant. Note the standard DSM-IV clinical significance criterion also includes a phrase indicating that the obsessions or compulsions may be "time consuming (take more than an hour a day)." This clause allows you to conclude that impairment is present even in the face of respondent's lack of concern about the behavior or the realization that it is useful.

*Criterion D:* An additional diagnosis of OCD should not be given along with another mental disorder if the repetitive thoughts or behaviors can be considered to be features of the other mental disorder. Most of the examples of symptoms of other disorders that are given in the SCID do not really meet the test of "intrusive and inappropriate." For example, when a patient with Anorexia Nervosa is preoccupied with measuring the exact number of calories in the food she eats, she may agree only that it is excessive, not foolish. However, if the obsessions or compulsions are clearly symptoms of another disorder, the interviewer may skip out of the diagnosis of OCD without spending a lot of time deciding whether the symptoms are "intrusive and inappropriate" or just "excessive." (Of course, Anorexia does not protect someone against OCD; the individual with Anorexia may also have hand washing rituals that are unrelated to her eating disorder, and therefore be given both diagnoses.)

*Criterion E:* OCD is rarely due to a GMC/Substance.

**Common Pitfall:** Newer interviewers may become obsessively concerned with the precise meaning of each word in the definitions and assign a diagnosis to a respondent who does not deserve it. Many people have some obsessive thoughts or compulsive behavior, but OCD is a severe and relatively infrequent condition.

### **Important Interviewing/Coding Issues: Hoarding**

- According to the DSM-IV, if hoarding symptoms are extreme (e.g., if symptoms are accompanied by excessive collecting or buying or stealing of items that are not needed or for which there is no available space), then a diagnosis of OCD is considered. Therefore, severe cases of hoarding discovered in this study will be captured by OCD.

- Symptoms of hoarding include persistent difficulty discarding or parting with possessions, regardless of the value others may attribute to these possessions, due to strong urges to save items and/or distress associated with discarding. These symptoms result in the accumulation of a large number of possessions that fill up and clutter active living areas of the home or workplace to the extent that their intended use is no longer possible (or would if without third-party intervention) and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).
- Epidemiological studies suggest that hoarding occurs in 2-5% of the population and can lead to substantial distress and disability, as well as serious public health consequences that warrant consideration as a mental disorder. Recent media coverage (e.g., television shows) will likely increase public awareness and self-reported hoarding in this study; however, because we do not ask specifically about hoarding in this study, respondents will not report hoarding unless it is accompanied by some insight (i.e. recognizes that hoarding-related beliefs and behaviors [pertaining to difficulty discarding items, clutter, or excessive acquisition] are problematic)..

### **G. Generalized Anxiety Disorder (GAD)**

*Criterion A:* This describes the person who may be known by acquaintances as a "worry wart" or a "nervous Nellie." The anxiety or worry is not focused on one or two issues, but is panoramic. "Nellie" worries about the safety of her children, the possibility of being late for an appointment, what to wear to a party, whether her job is in jeopardy, whether there are jellyfish in the water, etc. She worries much of the time, and everyone she knows thinks it is excessive.

*Criterion B:* Recognizing that the worry is excessive, a person with this problem will often tell him/herself to cut it out, and try to think about something else, but will find him/herself drifting inexorably back to whatever worry is preoccupying him/her at the time.

*Criterion F(2):* Generalized anxiety is more commonly an associated feature of a Mood or Psychotic Disorder than it is indicative of Generalized Anxiety Disorder. This criterion is presented out of the DSM-IV order in order to allow the interviewer to skip out of the evaluation of GAD if the

anxiety is a feature of another disorder. However, if the period of generalized anxiety clearly precedes the onset of a Mood or Psychotic Disorder, then both diagnoses can be given.

*Criterion C:* Note that, like the generalized anxiety, some of these symptoms must also be present "more days than not" for a period of at least six months.

*Criterion D:* Anxiety and worry are important components of many mental disorders. An additional diagnosis of GAD is appropriate only if there are additional symptoms of anxiety and worry that are not part of the other disorder.

*Criterion E:* This criterion helps to set the boundary between the clinically significant anxiety in GAD and "normal" (e.g., "walking worried"). The anxiety and worry should be considered clinically significant only if they are sufficiently severe to cause marked distress or impairment in functioning.

*Criterion F:* This criterion instructs the interviewer to consider and rule out a general medical condition or a substance as an etiological factor.

### **Important Interviewing/Coding Issues:**

- Many times a respondent will say "yes" to this at the screener but deny symptoms at the start of the module. Be sure to follow up and ask what he/she was referring to earlier
- If a respondent gives several examples of things he/she worries about, and then says "no" to a 6 month period of time, be sure to follow up and ask how much time he/she does spend worrying. We encourage getting a percentage of time spent worrying regardless of whether the respondent says "yes" or "no" to a 6 month period. You may consider going through the section if the worrying is close to, but less than 50%.
- This 6 month period of worry does NOT need to represent a change for the respondent. Some respondents interpret the question as asking whether there has been a time when he/she worried more than his/her normal level of worry.
- Be sure to assess that the symptoms are present when worrying, and not present when not worrying. Similar to Dysthymia, be aware of chronic fatigue, concentration and sleep problems that may or may not be associated with this anxiety.
- Criterion D (E104) – While it is certainly possible to have both GAD and another Axis I disorder (including another anxiety disorder), use your clinical judgment to assess if one

diagnosis is a better fit than having both – if the symptoms described are better accounted for by another diagnosis.

## **VII. Module F. Eating Disorders**

### **A. Anorexia Nervosa**

*Criterion A:* You must assess the respondent's lowest weight in the past year, highest weight in the past year, and current weight. It is also necessary to obtain the respondent's height. Although abnormally low weight is necessary for a rating of 3, it is not sufficient. There must be evidence that the person is underweight because of a "refusal" to maintain a normal body weight. The determination as to whether the person's weight is being maintained at a significantly-below-normal level is a clinical judgment. The "below 85%" threshold is merely a guideline and is not intended to be a strict cut-off. Determining "expected" weight ranges can be done by calculating whether the "body mass index" (BMI) [i.e., weight in kilograms/(height in meters)<sup>2</sup>] is less than **17.5**. A quick link to a BMI calculator can be found at: <http://www.nhlbisupport.com/bmi/>. A chart is also included at the end of this Appendix.

*Criterion B:* This criterion expresses the reason for refusal to maintain a normal weight: an intense (and unreasonable) fear of becoming fat that persists despite the abnormally low weight.

*Criterion C:* This criterion includes three forms of characteristic distorted thinking, the presence of any one of which would warrant a rating of 3: 1) a marked distortion in the way body size and shape are experienced (e.g., the person is emaciated but still describes a body part that seems "flabby" and needs further reduction); 2) body shape and weight is the central factor in determining self-esteem; and 3) denial of the extent and danger of weight loss.

*Criterion D:* Irregular periods do not count – there must be a time during which at least three consecutive periods have been missed. Since birth control pills (BCPs) may artificially regulate a menstrual cycle, if someone is having menstrual activity and is on BCP, they are viewed as having met the amenorrhea criterion because the criterion just does not apply. (Same for men and for prepubertal girls.)

## **B. Bulimia Nervosa**

*Criterion A:* Episodic bursts of binge eating must be distinguished from a pattern of generalized overeating and from isolated episodes of overeating that are context-specific (e.g., at an all-you-can-eat restaurant or a celebration in which there is unlimited food). Binge eating occurs during a discrete period of time, involves consuming a huge number of calories, and is characterized by the sense of having lost control. Although the person may have a feeling of gratification or a reduction in anxiety during the binge, afterwards he/she typically feels uncomfortable, guilty, disgusted, or ashamed. The type of food consumed during binges varies, but usually includes sweet, high calorie treats such as ice cream or cake. Because some respondents may report having had "binges" involving relatively small amounts of food (e.g., eating three cookies), it is important to inquire specifically about the quantity and type of food consumed. Be sure to obtain a concrete example of what the respondent typically eats within a 2-hour period. For instance, if a respondent reports eating "a bag of chips," ask about the size of the bag as well. A good rule of thumb is that an amount equivalent to two full sized meals is considered enough for a "binge." A respondent must report both a lack of control and a large amount of food consumed.

*Criterion B:* Binge eating by itself is not sufficient to make the diagnosis. It must be accompanied by inappropriate compensatory mechanisms intended to counteract the effects of binges. The most common of these compensatory behaviors is some form of purging (self-induced vomiting or laxative abuse). Less common compensatory behaviors include fasting, excessive exercise, and manipulation of insulin doses by diabetics. If a respondent reports that he/she is exercising a lot, one might need to probe to determine whether the exercise is in response to a binge, or just a general way of life. Individuals are often very embarrassed about both their binge eating and their compensatory mechanisms (particularly those related to purging). Such information is therefore not volunteered and emerges only with direct questioning.

*Criterion C:* The minimum frequency of twice a week applies both to the binges and to the compensatory mechanisms, with the presumption that these generally occur together. The binges must be of the level assessed in Criterion A.

*Criterion D:* This criterion is similar to Criterion C in Anorexia Nervosa and describes the cognitive distortions that are invariably present.

## VIII. Module G. Intermittent Explosive Disorder

In order to rate a 3 for this disorder, the respondent must have had several (*at least two*) discrete episodes during the past year in which aggressive impulses were grossly out of proportion to any precipitating factors. These aggressive episodes should not be better accounted for by a Personality Disorder, a Psychotic Disorder, a Mood Episode, or Attention-Deficit/Hyperactivity Disorder.

### **Important Interviewing/Coding Issues:**

- Be sure to get an actual description of a specific recent incident. What was the context? What was the nature of the damages and/or injuries (how severe?) How frequently does this type of thing occur?
- If the behavior is verbal threats, rather than physical violence, the threats must be severe.
- Typically, individuals report a sense of remorse after the fact.
- For the question "Was this on purpose or was it really beyond your control?" reporting that it was beyond the respondent's control would be coded 3.
- Be aware of cultural differences in the acceptance of violence in assessing this disorder.

## IX. Module H. Substance Use Disorders

This module contains ratings for the Substance Use Disorders (Dependence and Abuse), which covers problems caused by the respondents' pattern of use of substances. The SCID separates the evaluation of Alcohol from other substances because it is legal, more widely used than other substances, and most users do not have a problem with it.

### **A. Alcohol Use Disorders**

The Alcohol Use Disorders section begins with a series of screening questions to determine whether the respondent's pattern of alcohol use is substantial enough to warrant a detailed evaluation of Alcohol Dependence and Abuse or if the respondent's use of alcohol is insignificant and does not require further assessment. Because respondents often minimize (or underestimate) their drinking habits, do NOT skip the Alcohol section unless the respondent reported drinking fewer than 6 drinks during the past 12 months. Because the definition of Alcohol Abuse requires *recurrent* problems associated with alcohol, infrequent heavy drinking



may still warrant a diagnosis of Alcohol Abuse. If this threshold level of alcohol use is met, establish clear patterns of alcohol use during the past 12 months:

- Typical pattern(s) – the preferred drink (e.g., beer), the amount(s) typically consumed (e.g., 6 12-oz beers), and the frequency of drinking episodes (e.g., 3 nights/wk).
- Heaviest pattern(s) – the same information as above, in addition to the period of time the heaviest pattern occurred during the past 12 months.

### **Important Interviewing/Coding Issues:**

- Ask about the pattern of use again – do not rely on the information obtained earlier in the overview.
- Do not skip the probes on the bottom half of page H1. Information obtained here is useful in assigning the GAF. Get details. If someone objected to their drinking, ask why. Especially ask these questions if the respondent seems to be minimizing his/her use or the effect of his/her use. Imagine a respondent who says he does not have a problem with alcohol, but his spouse is always arguing with him about his use. Why? What does she say?
- The focus on the heaviest period helps prevent the respondent from averaging their usage over the entire year (or minimizing significant events). Remember, however, we are assessing the entire year.
- Questions in the module primarily focus on the period of heaviest drinking. However, if the respondent gives a negative response, also open up the question to the whole year. This is especially important if the period of heaviest drinking was short.
- Use clinical judgment in determining whether a period of time is significant. For example, it is doubtful that a respondent's use would warrant a diagnosis of Dependence for symptoms only occurring during a two week period. However, symptoms that lasted a month or longer may warrant a diagnosis. Use clinical judgment and take the answers to the heaviest period in context.

### **1. Alcohol Dependence**

The criteria have been re-ordered from the DSM-IV in order to make them more user-friendly.

*Criterion A(3):* The intent of this item is to capture the respondent's failed attempts to put some limits on his/her drinking, e.g., "I'll just have a few beers and then go home" or "I'll stop at the bar for only half an hour." Note that the breaking of these self-imposed limits (e.g., the respondent ends up drinking a couple of six-packs, or staying in the bar for hours) must occur OFTEN in order to be coded 3. There is something of a paradox inherent in the evaluation of this item (and criterion A(4) as well). In order to qualify for these items, the individual must have developed enough insight about having a substance problem to want to control its use. These items are therefore impossible to evaluate in someone who has a very heavy pattern of use but denies any need to control or cut down use.

It is important to note that this symptom is not the same as 'drinking more than one usually does.' The respondent must be putting a limit on him/herself and then going past the limit. Obtain both a description of the amount the respondent planned to consume (or the amount of time he/she planned to use) and how much (or how long) he/she actually drank. As the behavior must occur OFTEN to be coded a "3," it is necessary to assess how frequently this occurred.

*Criterion A(4):* This item describes unsuccessful attempts to cut down or control drinking over a longer period of time... weeks, months, or years, as opposed to planning for an evening's drinking. Successful attempts to cut down do NOT count towards this symptom. However, successful efforts preceded by several unsuccessful efforts would count. A report that "I may have a problem" is not sufficient to qualify as "persistent desire to cut down." More probes would be necessary.

*Criterion A(5):* This item covers the ways in which drinking may become a central focus of the respondent's life. As a rule of thumb, two evenings a week is not a "great deal of time"; five evenings a week is, and in between probably justifies a rating of 2.

*Criterion A(6):* The prototype for this item is the street corner alcoholic who has essentially given up all activities except those associated with drinking. It may also be applied, for example, to an amateur athlete who has stopped doing sports because of drinking, or a person who has stopped seeing all his good friends and now hangs out with a group of heavy drinkers. If a respondent drinks because he doesn't want to socialize (i.e., his alcohol use is not causing him to cut down on important activities; rather he is drinking because he doesn't want to do those activities) he would not receive a code of 3 on this symptom. A respondent would have to have

given up participating in order to drink instead to receive a code of 3. If alcohol is used as a way to avoid an unpleasant activity the symptom would receive a code of 1 or 2.

*Criterion A(7):* This item is meant to tap a pattern of compulsive alcohol use and does not refer merely to the adverse physical or psychological consequences of drinking. In order to qualify for a rating of 3 on this item, a respondent must understand that the physical or psychological problems are due to the drinking, and still be unable to stop or cut down significantly. Examples of physical problems include cirrhosis or esophageal bleeding due to excessive drinking; examples of psychological problems include alcohol-induced pugnacity that leads to frequent fights and blackouts. The most frequent noxious physical effect of alcohol is a hangover. When hangovers are severe and frequent, and the respondent continues to drink, a coding of 3 is justified on this item.

*Criterion A(1):* Anyone who drinks at all develops tolerance from the time of adolescent experimenting with alcohol. This item is meant to capture those whose tolerance increased markedly from the time they began drinking fairly regularly to some later time (e.g., "I used to get drunk on 3 beers. Now I can drink 2 six-packs and not be drunk."). It will often be necessary to ask additional probes for this symptom in particular: First, orient the person to the period of time when he/she 'first started drinking regularly' (which is defined as the time when he/she first started drinking at least once per month). Obtain an estimate of how much the respondent needed to feel the effect back then, and during his/her period of heaviest use in the past year. Tolerance is defined as an increase of at least 50%, with a minimum threshold of four drinks. Be aware of respondents who say they have less tolerance now than when they first started drinking. They may be comparing now to a time of heavy drinking, rather than when they first started. Finally, be sure the respondent is answering *not* how much they do drink, but how much it takes to feel the effect.

*Criterion A(2):* Withdrawal is indicated by the development of the characteristic substance-specific withdrawal syndrome shortly after stopping or decreasing the amount of alcohol. In some cases, the individual never allows the withdrawal syndrome to develop because he/she starts drinking in anticipation of the onset of withdrawal symptoms. Read the list of withdrawal symptoms one at a time.

## **2. Alcohol Abuse**

*Criterion A(1):* A rating of 3 for this item requires specific evidence that it was the effects of the alcohol use (i.e., either intoxication, withdrawal, or "hangover") that resulted in the respondent's failure to fulfill a major role obligation on at least two occasions. If the level of drinking is significant and the respondent denies any ill effects, explore if others had to cover for the respondent or compensated for him/her.

*Criterion A(2):* A common error in rating this item is to be over-inclusive and assume that any level of alcohol use in a situation that requires alertness would qualify. This item should be rated a 3 only when the drinking caused sufficient impairment to create a physically hazardous condition (e.g., driving or hunting while intoxicated). Although getting drunk and walking home through a dangerous neighborhood or having unprotected sex with someone one doesn't know very well while intoxicated is certainly risky, neither would warrant a rating of 3—the intent of this item is to rate behavior that puts the respondent in immediate danger because his/her coordination or cognition is impaired by drinking. Recurrent for driving under the influence is 3 or more times.

*Criterion A(3):* This item should be rated 3 only if legal problems are a direct consequence of the effects of alcohol (e.g., arrest for violent behavior resulting from intoxication). A "Minor in Possession" (MIP) does not count for this symptom.

*Criterion A(4):* This item is difficult to evaluate when the interpersonal conflict is possibly attributable to a relational problem rather than to a problem with the individual's alcohol use. For example, arguments about occasional non-problematic drinking that are initiated by a spouse who believes any drinking is evil would not warrant a rating of 3.

## **B. Non-Alcohol Substance Use Disorders**

The non-alcohol substance dependence and abuse section is perhaps the most complex part of the SCID because it allows for the simultaneous rating of Dependence and Abuse for 8 different classes of substances. In order to minimize the number of questions that must be asked about each substance, the SCID inquires about the level of drug use for each class to determine whether the Dependence and Abuse questions need to be asked. Read the full drug list to the

respondent and circle the names of all drugs the respondent reports having used in the past year. For all drugs used in the past year, determine the period of heaviest use and the typical and heaviest patterns of use (quantity, frequency) during the past 12 months. For prescription drugs used in the past year, determine whether and how often these drugs have been taken non-medically (i.e., took more of the medication than was prescribed; took the medication for a period longer than was prescribed; used the prescribed medication in a recreational manner [for the feeling or effect only]; used a drug that was not prescribed to him or her [e.g., stolen from a family member, purchased on the street]). Symptoms of Dependence and Abuse are assessed for each drug class for which the threshold level of use has been met. For cannabis, the threshold is at least 6 times in the past year, for prescription drugs, the threshold is nonmedical use at least twice in the past 12 months, and for all other drugs, the threshold is at least twice in the past year. Begin with the drug class meeting the threshold level of use that is highest on the list, query all Dependence and Abuse symptoms for that class, and repeat this process until all other drug classes meeting the threshold level of use have been queried.

**Important Interviewing/Coding Issues:**

- Most of the points in the Alcohol section (*Section IX.A* above) apply here as well.
- If the medication is prescribed, be sure to ask about the amount prescribed, and the amount used. Ask whether they ever took the medication for the effect/high.
- Do get pattern of use: typical and heaviest.

**1. Non-Alcohol Substance Dependence**

*Criterion A(3):* The intent of this item is to capture the respondent's failed attempts to put some limits on his/her drug use, e.g., "I'll just have one joint tonight." Note that the breaking of these self-imposed limits (e.g., the respondent ends up smoking three joints) must occur OFTEN in order to be coded 3. There is something of a paradox inherent in the evaluation of this item (and criterion A(4) as well). In order to qualify for these items, the individual must have developed enough insight about having a substance problem to want to control its use. These items are therefore impossible to evaluate in someone who has a very heavy pattern of use but denies any need to control or cut down use.

It is important to note that this symptom is not the same as using 'more than one usually does.' The respondent must be putting a limit on him/herself and then going past the limit. Obtain both a description of the amount the respondent planned to consume (or the amount of time he/she planned to use) and how much (or how long) he/she actually used. As the behavior must occur OFTEN to be coded a "3," it is necessary to assess how frequently this occurred.

*Criterion A(4):* This item describes unsuccessful attempts to cut down or control drug use over a longer period of time...weeks, months, or years, as opposed to planning for an particular evening's decision to use drugs. Successful attempts to cut down do NOT count towards this symptom. However, successful efforts preceded by several unsuccessful efforts would count. A report that "I may have a problem" is not sufficient to qualify as "persistent desire to cut down." More probes would be necessary.

*Criterion A(5):* This item covers the ways in which drug use may become a central focus of the respondent's life. It is especially variable across classes of drugs because of differences in cost, availability, legality, and the typical pattern of use of the particular substance. For example, the high cost, daily need, and relative unavailability of opioids is much more likely to result in an individual becoming totally preoccupied with the daily task of procuring them. In contrast, this item is less likely to apply to inhalants because of their low cost, wide availability in stores, and the typical pattern of intermittent use. As a rule of thumb, two evenings a week spent smoking pot is not a "great deal of time"; five evenings a week is, and in between probably justifies a rating of 2.

*Criterion A(6):* The prototype for this item is a heroin addict who has essentially given up all activities except those associated with procuring and using heroin. However, it may also be applied, for example, to an amateur athlete who has stopped doing sports because of using drugs, or a person who has stopped seeing all his good friends and now hangs out with a group of heavy drug users. If a respondent uses because he doesn't want to socialize (i.e., his substance use is not causing him to cut down on important activities; rather he is using drugs because he doesn't want to do those activities) he would not receive a code of 3 on this symptom. A respondent would have to have given up participating in order to use drugs instead to receive a code of 3. If drugs are used as a way to avoid an unpleasant activity the symptom would receive a code of 1 or 2.

*Criterion A(7):* This item is meant to tap a pattern of compulsive use of the substance and does not refer merely to the adverse physical or psychological consequences of using that substance. In order to qualify for a rating of 3 on this item, a respondent must understand that the physical or psychological problems are due to the substance use, and still be unable to stop or cut down significantly. Examples of physical problems include serious damage to the nasal mucosa from sniffing cocaine or exacerbation of asthma during smoking excessive amounts of marijuana. Examples of psychological problems include cocaine-induced paranoia, or panic attacks precipitated by marijuana.

*Criterion A(1):* The development of tolerance occurs most frequently with amphetamine, cocaine, nicotine, opioids, and sedatives (especially barbiturates). Tolerance for many drugs (e.g., cocaine, barbiturates, heroin) is usually apparent to the respondent. For drugs like marijuana, where the quality of the drug varies markedly, it may not be possible to establish tolerance. It will often be necessary to ask additional probes for this symptom in particular: First, orient the person to the period of time when he/she 'first started using the substance regularly' (which is defined as the time when he/she first started using at least once per month). Obtain an estimate of how much the respondent needed to feel the effect back then, and during his/her period of heaviest use in the past year. Tolerance is defined as an increase of at least 50%. Be aware of respondents who say they have less tolerance now than when they first started. They may be comparing now to a time of heavy use, rather than when they first started. Finally, be sure the respondent is answering *not* how much they do use, but how much it takes to feel the effect.

*Criterion A(2):* Withdrawal is indicated by the development of the characteristic substance-specific withdrawal syndrome shortly after stopping or decreasing the amount of the drug. In some cases, the individual never allows the withdrawal syndrome to develop because he/she starts using in anticipation of the onset of withdrawal symptoms. The severity and clinical significance of the withdrawal syndrome varies by class of substance. Characteristic withdrawal syndromes are most apparent with sedatives and opioids. Criteria sets are also provided for withdrawal from amphetamine and cocaine. Although withdrawal symptoms sometimes occur, no specific criteria sets are provided for withdrawal from cannabis, hallucinogens, inhalants, or PCP.

## 2. Non-Alcohol Substance Abuse

*Criterion A(1):* A rating of 3 for this item requires specific evidence that the effects of the substance use resulted in the respondent's failure to fulfill a major role obligation on at least two occasions. If the level of use is significant and the respondent denies any ill effects, explore if others had to cover for the respondent or compensated for him/her.

*Criterion A(2):* A common error in rating this item is to be over-inclusive and assume that any level of substance use in a situation that requires alertness would qualify. This item should be rated a 3 only when the substance use caused sufficient impairment to create a physically hazardous condition (e.g., driving or hunting while intoxicated). Although getting stoned and walking home through a dangerous neighborhood or having unprotected sex with someone one doesn't know very well while intoxicated is certainly risky, neither would warrant a rating of 3—the intent of this item is to rate behavior that puts the respondent in immediate danger because his/her coordination or cognition is impaired by substance use. Recurrent for driving under the influence is 3 or more times.

*Criterion A(3):* This item should be rated 3 only if legal problems are a direct consequence of the effects of the substance (e.g., arrest for violent behavior resulting from intoxication). Legal problems resulting from procurement or possession of illicit substances do not count because these are so much a function of local laws, attitudes, and enforcement policies.

*Criterion A(4):* This item is difficult to evaluate when the interpersonal conflict is possibly attributable to a relational problem rather than to a problem with the individual's substance use. For example, arguments about occasional non-problematic substance use that are initiated by a spouse who believes that even minimal drug use is evil and depraved would not warrant a rating of 3.

## X. Adjustment Disorder

In most cases, this module is skipped during the administration of the SCID because another more specific diagnosis has already been made. Consider this module only if there is a past year problem described in the overview, but no Axis I disorder has been identified by the SCID to account for it. The border between Adjustment Disorder and ordinary problems of life



may be clarified by the notion that Adjustment Disorder implies that the severity of the disturbance is sufficient to justify clinical attention or treatment.

### **Important Interviewing/Coding Issues:**

- A diagnosis of Adjustment Disorder can be assigned even if another past year diagnosis is present.
- There must be a precipitating event for this disorder to be diagnosed.
- This is the one section that can be coded without actually asking the questions – however it is always better to get more information and confirm.
- It is possible to have on-going stressors – thus the symptoms would persist for more than 6 months. The key here is whether the symptoms persist for more than 6 months *after the stressor or its consequences cease*. The prototypical example of this type of event is post-divorce.

## **XI. End of Interview**

The Global Assessment of Functioning (GAF) scale is contained in this section of the SCID. The GAF scale is designed to measure psychological, social, and occupational functioning. For this study, we will be rating the GAF based on the respondent's worst point during the past year. A score of 100 is assigned to a hypothetical healthiest patient and a score of 1 is assigned to the most ill patient. GAF scores should reflect two components: symptom severity and functioning. Ratings are based on the component that reflects the greatest level of impairment during the past year, rather than an average of the two components. Most respondents will receive a score somewhere between 100 and 1.

There are 4 steps to be followed in determining the appropriate GAF score for a respondent.

Step 1: Starting at the top of the scale, look at each decile and ask yourself, "is either the respondent's symptom severity or functioning worse than what is specified in this range?"

Step 2: If the answer to that question is yes, move down to each subsequent decile until the description for that range matches the respondent's level of symptom severity or functioning (whichever is worse).

Step 3: Double check that the appropriate range has been selected by looking at the range below the one selected and determining that the description for that range is more severe in terms of both symptom severity and functioning than is true for the respondent.

Step 4: Determine the specific number within the 10-point range that is most appropriate for the respondent. This is done by thinking of a hypothetical continuum of persons falling within the chosen range and deciding where the respondent falls on that continuum.

Review your notes about the respondent and ask any additional questions necessary to enable a confident assignment of a GAF score before reading the end of interview script to the respondent and ending the interview. This last point cannot be stressed enough.

## **XII. Interviewer Debriefing**

Complete the questions in this section within an hour of having completed the interview. The answers to these questions provide information about threats to the validity of the data gathered during the interview as well as documentation about unusual situations that may have occurred during the interview session (e.g., the respondent became distressed or showed signs of cognitive impairment, or the respondent was frequently distracted throughout the interview session). This information will be used to determine whether the interview data should be included in the data set to be analyzed or whether the data should be discarded.

## Short Blessed Test (SBT) Administration and Scoring Guidelines

*A spontaneous self-correction is allowed for all responses without counting as an error.*

SB-1. "What year is it now?"

Acceptable Response: The exact year must be given. An incomplete but correct numerical response is acceptable (e.g., 01 for 2001).

SB-2. "What month is it now?"

Acceptable Response: The exact month must be given. A correct numerical answer is acceptable (e.g., 12 for December).

--- "Please repeat this phrase after me: John Brown, 42 Market Street, Chicago."

It is important to carefully read the phrase and give emphasis to each item of the phrase. There should be a one second delay between individual items. The trial phrase should be re-administered until the respondent is able to repeat the entire phrase without assistance or until a maximum of three attempts. If the respondent is unable to learn the phrase after three attempts, a "C" should be recorded. This indicates the respondent could not learn the phrase in three tries.

Whether or not the trial phrase is learned, say "Good, now remember that name and address for a few minutes."

SB-3. "About what time is it?"

This is scored as correct if the time given is within plus or minus one hour. If the respondent's response is vague (e.g., "almost 1 o'clock), they should be prompted to give a more specific response.

SB-4. "Please count backwards from 20 to 1."

The instructions should be read as written. If the respondent skips a number after 20, an error should be recorded. If the respondent starts counting forward during the task or forgets the task, the instructions should be repeated and one error should be recorded. The maximum number of errors is two.

SB-5. "Please say the months of the year in reverse order."

The instructions should be read as written. To get the respondent started, the interviewer may state "Start with the last month of the year. The last month of the year is \_\_\_\_\_." If the respondent cannot recall the last month of the year, the interviewer may prompt this test with "December"; however, one error should be recorded. If the respondent skips a month, an error should be recorded. If the respondent starts saying the months forward upon initiation of the task, the instructions should be repeated and no error recorded. If the respondent starts saying the months forward during the task or forgets the task, the instructions should be repeated and one error recorded. The maximum number of errors is two.

SB-6. "Please repeat the phrase I asked you to repeat before."

The respondent should state each item verbatim. The address number must be exact (i.e. "4200" would be considered an error for "42"). For the name of the street (i.e. Market Street), the thoroughfare term is not required to be given (ie. Leaving off "drive" or "street") or to be correct (ie. Substituting "boulevard" or lane") for the item to be scored correct.

These guidelines are based on the administration experience of faculty and staff of the Memory and Aging Project, Alzheimer's Disease Research Center, Washington University School of Medicine, St. Louis (John C. Morris, MD, Director & PI; [morrisj@abraxas.wustl.edu](mailto:morrisj@abraxas.wustl.edu)). They have been modified.

# Body Mass Index Chart

BMI	Height (in)																		
	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76
Wgt. (lbs)	4'10"	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"
100	21	20	20	19	18	18	17	17	16	16	15	15	14	14	14	13	13	13	12
105	22	21	21	20	19	19	18	18	17	16	16	16	15	15	14	14	14	13	13
110	23	22	22	21	20	20	19	18	18	17	17	16	16	15	15	15	14	14	13
115	24	23	23	22	21	20	20	19	19	18	18	17	17	16	16	15	15	14	14
120	25	24	23	23	22	21	21	20	19	19	18	18	17	17	16	16	15	15	15
125	26	25	24	24	23	22	22	21	20	20	19	18	18	17	17	17	16	16	15
130	27	26	25	25	24	23	22	22	21	20	20	19	19	18	18	17	17	16	16
135	28	27	26	26	25	24	23	23	22	21	21	20	19	19	18	18	17	17	16
140	29	28	27	27	26	25	24	23	23	22	21	21	20	20	19	19	18	18	17
145	30	29	28	27	27	26	25	24	23	23	22	21	21	20	20	19	19	18	18
150	31	30	29	28	27	27	26	25	24	24	23	22	22	21	20	20	19	19	18
155	32	31	30	29	28	28	27	26	25	24	24	23	22	22	21	20	20	19	19
160	34	32	31	30	29	28	28	27	26	25	24	24	23	22	22	21	21	20	20
165	35	33	32	31	30	29	28	28	27	26	25	24	24	23	22	22	21	21	20
170	36	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21
175	37	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23	22	21
180	38	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23	22
185	39	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23
190	40	38	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23
195	41	39	38	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24
200	42	40	39	38	37	36	34	33	32	31	30	30	29	28	27	26	26	25	24

## **Addendum 1: Skype User Guide**



# 2011 NATIONAL SURVEY ON DRUG USE AND HEALTH

## Mental Health Surveillance Study Clinical Interviewer Skype User Guide

Contract No. HHSS283200800004C

Project No. 0211838

Prepared for:

Substance Abuse and Mental  
Health Services Administration  
Rockville, Maryland 20857

Prepared by:

Research Triangle Institute

June 2011





## SKYPE USER GUIDE

To enhance quality, the Mental Health Surveillance Study (MHSS) is changing to use Skype for audio recording interviews. Skype is an Internet phone provider which allows users to make voice calls from a computer via an Internet connection. This guide outlines all procedures specific to the use of Skype on the MHSS and should be used in conjunction with your 2011 MHSS *Clinical Interviewer Handbook*. For reference, *Exhibit 1* summarizes the steps involved for using Skype on the Mental Health Study.

### A. Equipment

To conduct and record interviews through Skype, use the provided Skype headset. The cushioned headset expands/contracts to fit comfortably. The position of the microphone also adjusts.

The headset attaches to the computer through any of the USB ports on either the left or right side of the laptop and can be connected at any time prior to use. The blue symbol on the left earpiece glows blue when connected.

Use the volume control buttons on the left earpiece (the side with the microphone) and press either the + button at the top or the – button at the bottom to adjust the volume.



### B. Skype Account

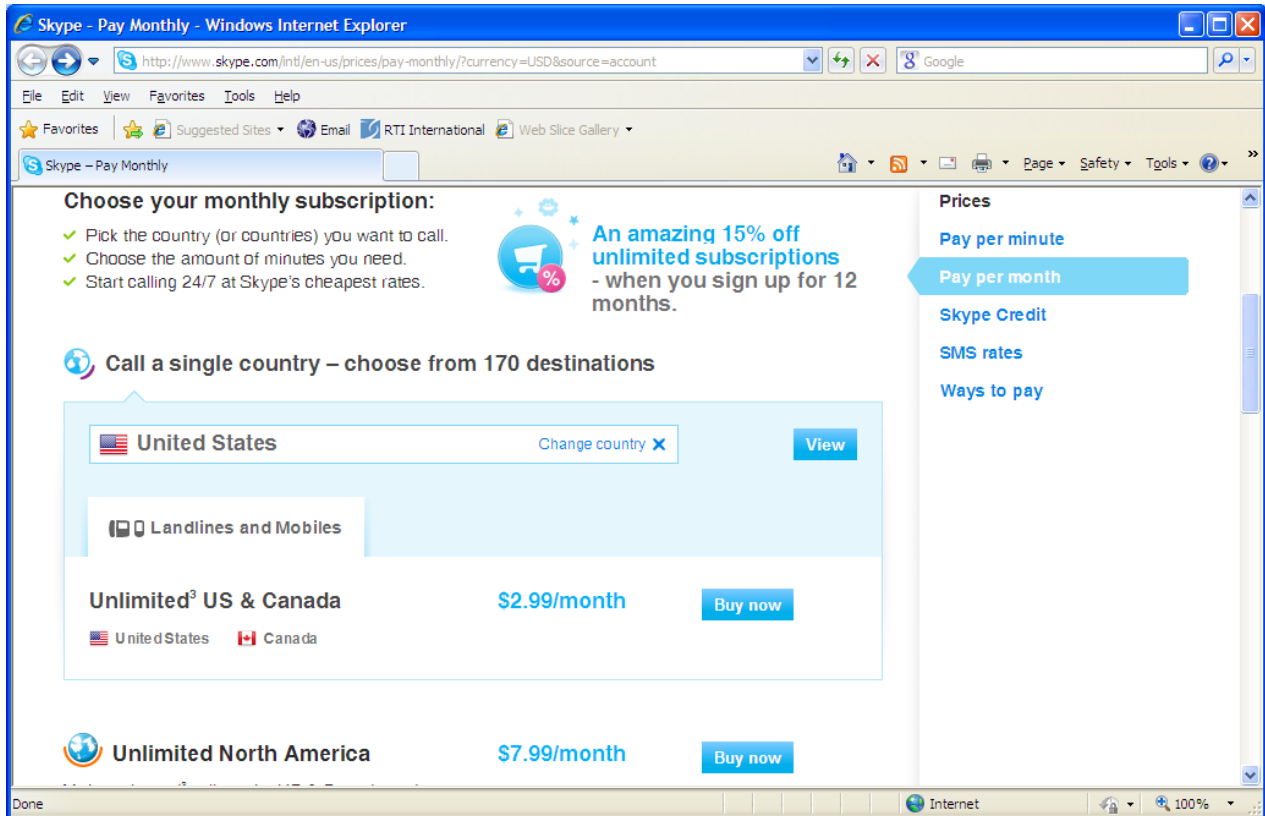
Placing calls to respondents and recording interviews can be done using a Skype account you will create for your MHSS work. Please note this account should only be used for MHSS work-related calls and should be closed upon the termination of your work on the project. If you have an existing Skype account, you must create another account that is reserved for MHSS work.

#### B.1 Account Set-Up

While connected to the Internet, first attach your Skype headset then use the Skype link on the desktop to open Skype. Follow the prompts to establish a Skype account, keeping the following in mind:

- Use your MHSS work email address as the basis of your MHSS Skype user name (i.e. clinical.interviewer038). If your user name has already been used, add a leading zero (i.e. clinical.interviewer0038).
- Pay attention to the check boxes on the first few introductory screens:
  - Uncheck the "Yes, send me Skype news and promotions" box on the initial 'Create a new Skype account' screen
  - Leave the check box checked for "Sign me in when Skype starts" on the 'Set up your Skype profile' screen
  - Uncheck the "Show welcome screen at start-up" box on the 'Welcome' screen
- Under the Account menu option, click 'See subscriptions' in the middle of the screen

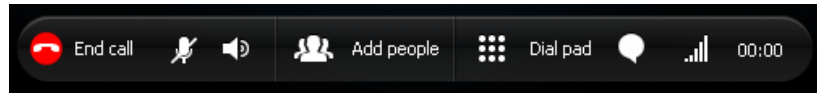
- Sign up for the monthly Unlimited USA and Canada subscription. The charge should be 2.99 per month, charged in 3 month blocks. (Do not select the 12 month payment option.)



- Charge the Skype subscription fees to your personal credit card, then submit the expense for reimbursement on your next ePTE (see **Section E** for details).

Note: The 'unlimited' subscription does have limits which should not interfere with your work (maximum of 6 hours per day, 10,000 minutes per month (over 166 hours), no more than 50 numbers called per day). If you expect to reach a limit during an interview, use the telephone recording system. Note calls to other Skype users or to toll free numbers (800, 877, etc.) do not count towards your limits.

**OPTIONAL:** You could use Skype to call RTI managers/supervisors if you wish. Call the RTI 800 number, and when the recorded voice answers, click the 'Dial pad' on the call menu and enter '1'.



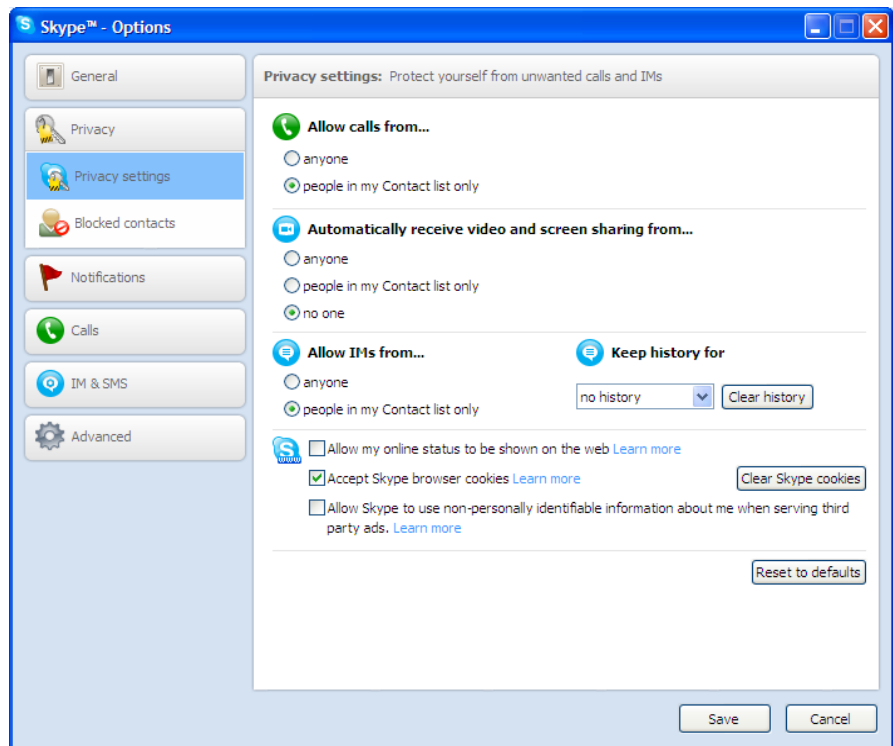
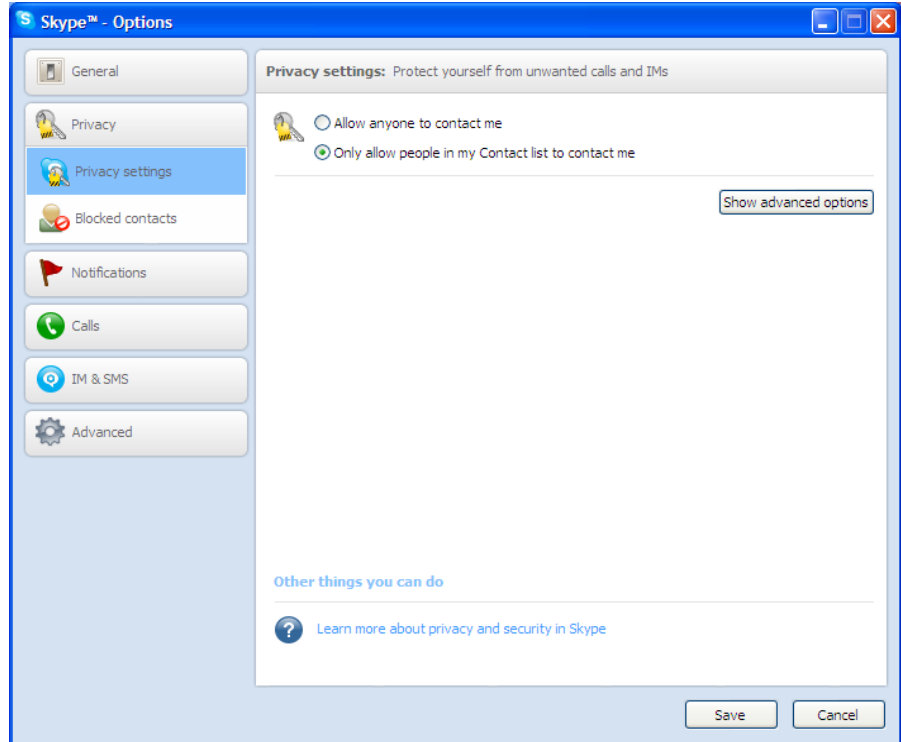
As the voice asks for the extension, enter the 5 digit extension for the person you are calling. Note the '1' will still display on the dial pad but does not affect the call routing. Refer to **Exhibit 1.1** in your **CI Handbook** for contact information.

Once your account is set up, make several test calls to ensure Skype is working properly. Skype also provides a free 'Sound Test Service' to test Skype.

## B.2 Account Settings

Use the following instructions to update the settings of your account.

1. On the Main Skype page, click the **Skype** menu (found on the row with Skype, Contacts, Conversation, etc), then click **Privacy**.
2. Change the main privacy setting to "Only allow people in my Contact list to contact me," as shown.
3. Click "Show Advanced Options."
4. Alter your Privacy settings to match the image below. **Be sure to select "no history"** from the drop down list on the right side of the screen. Click Save when finished.

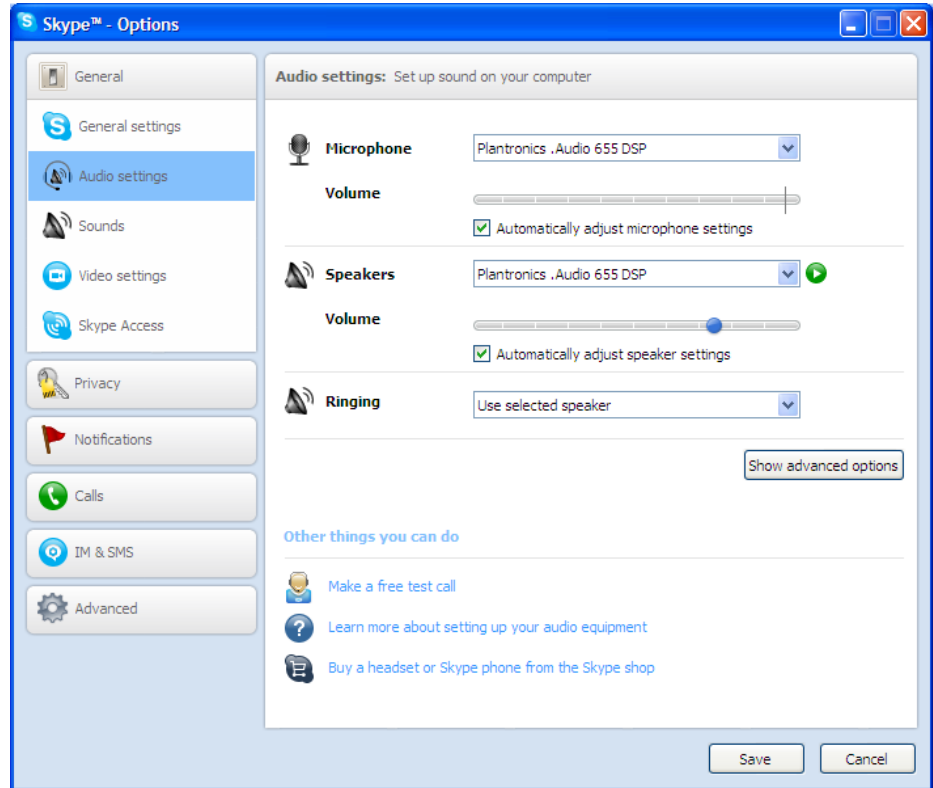


Following these instructions carefully helps **preserve privacy for you and your respondents**.

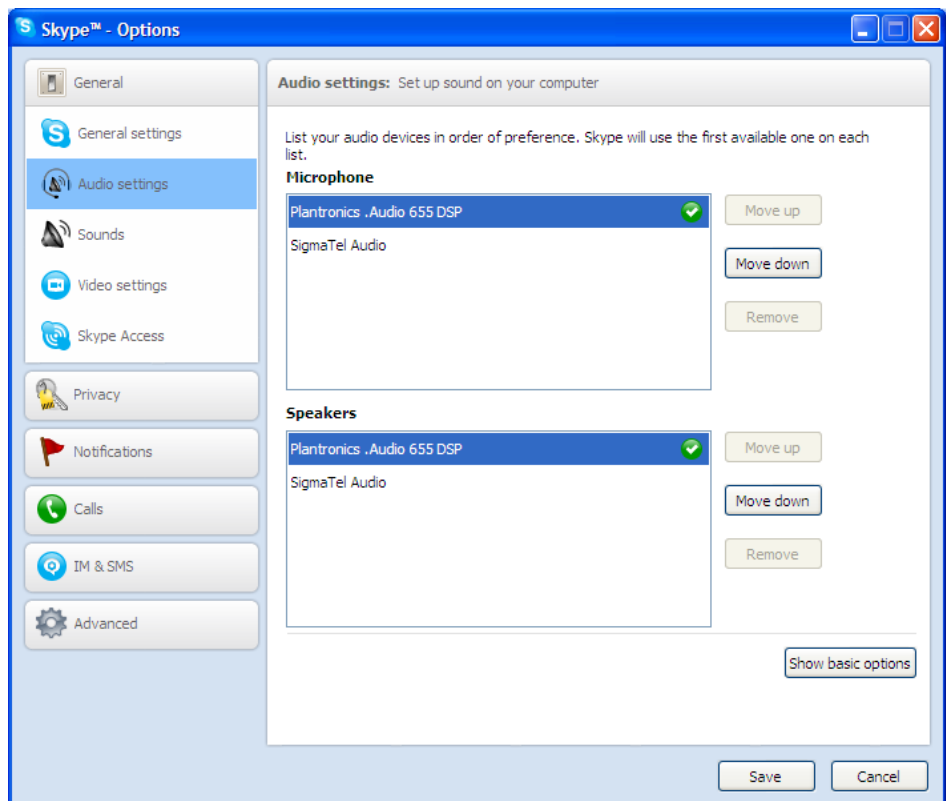
5. On the Main Skype page, click the **Call** menu (found on the row with Skype, Contacts, Conversation, etc), then click **Audio Settings**.

6. Check that your settings match those shown in the image to the right.

7. Click "Show Advanced Options."



8. Alter your Audio settings to match the image below. Be sure the Plantronics option is listed first for both the microphone and the speakers. Click Save when finished.



### B.3 Caller ID

By calling through an Internet phone provider, your caller ID may appear in a number of different formats, such as "unknown," "0000123456," or "external call unknown number." Skype does allow changes to the caller ID display if you use a cell phone number or a Google voice number, but not if you use a land line. Also, there is no guarantee what number actually might appear.

Understandably, respondents may hesitate to answer a call with a vague caller ID. If the respondent doesn't answer your Skype call, consider using your usual telephone (home/office/cell) and the SAMHSA calling card.

- If the respondent can complete the interview at that time, you must be ready with your equipment and supplies. Tell the respondent you will call right back, stating the caller ID may be different. You can then call again using Skype in order to record the interview.
- If you are setting an appointment, inform the respondent when you call again for the appointment, the caller ID may be different.

Contact your Data Collection Manager with any questions about caller ID.

### B.4 Calling with Skype

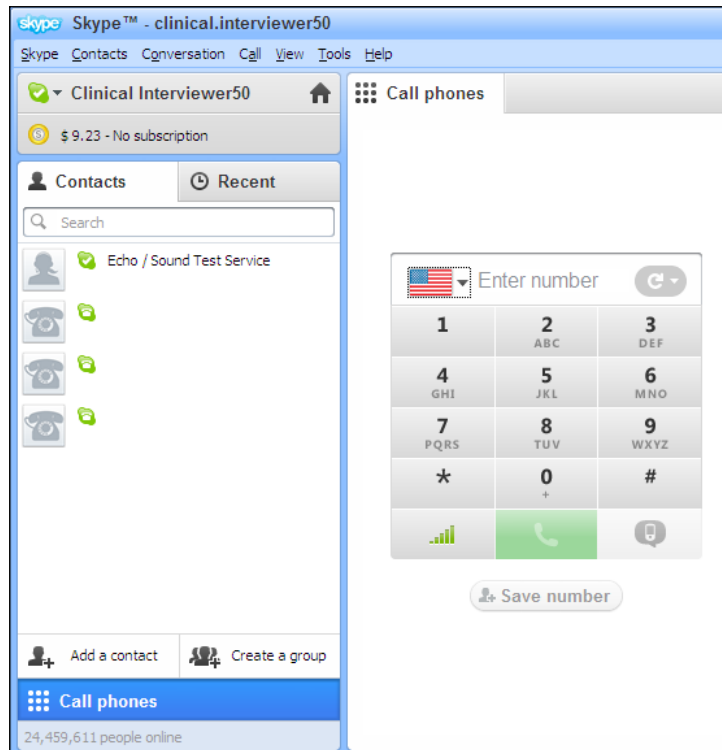
To dial a respondent's number, use the "Call phones" option at the bottom of the Skype page. **DO NOT enter a respondent number as a contact in Skype.** The respondent's name and number are confidential information to be protected. Dial the number using the 'keypad' on the screen, or to enhance speed and accuracy, copy and paste the number from the CMS or MH Case Manager. Highlight the number, press Ctrl c, then click the "Enter number" space at the top of the Skype keypad, and press Ctrl v. The green phone button at the bottom of the keypad illuminates bright green; click to dial the number.

Be sure to **delete the number from the keypad when finished.** With a number entered, the gray shape to the right of the number becomes an X. Click the X to delete the number.

The setting for "No History" as explained in **Section B.2** should remove the records of any prior calls made. If needed, use the "Clear history" button shown on the Privacy Settings screen.

You may choose to use your Skype account for other work related calls, such as to a Clinical Supervisor or your Data Collection Manager. Feel free to enter their names and numbers as Contacts within Skype.

Be sure the volume setting through Skype is maximized for recording purposes. While completing a test call, use the volume/speaker icon (shown in the image below to the right of the mute microphone icon)



to ensure the Skype volume is all the way up. You may adjust the volume to a comfortable level for the headset using the volume up/down buttons on the left earpiece of the headset.

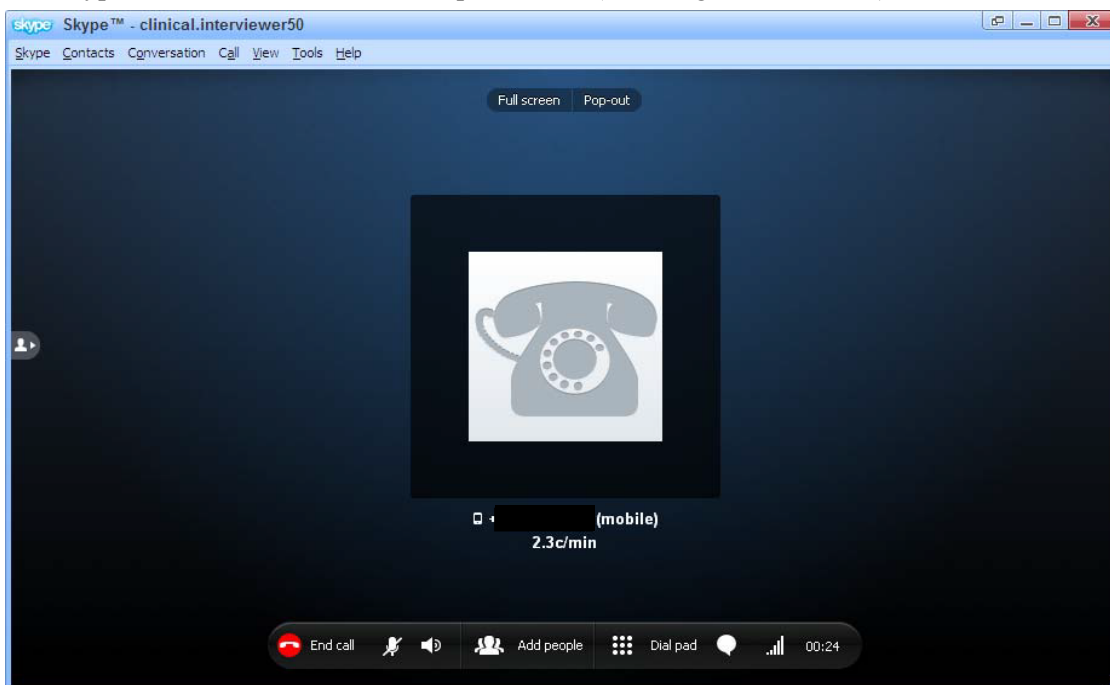
## B.5 Three Way Calling with Skype

Although rare, you may need to participate in a three-way conference call through Skype with the respondent and an emergency care representative. Recall MHSS has a very detailed Distressed Respondent Protocol described in the separate Distressed Respondent Protocol Booklet. Scenario 2, with its elevated risk of harm to self or suicide, asks the respondent to remain on the line while you contact emergency care services in the respondent's area.

Skype does allow multiple parties to participate in a call using its conference call feature. Unlike telephone three-way calling, you cannot put the respondent on hold to converse privately with the emergency care representative before linking the respondent and the representative.

To conference call through Skype, follow these steps:

1. Mute the microphone so the respondent cannot hear you (after following the scenario script and explaining your plans): Wiggle the mouse to display the tool bar at the bottom of the Skype screen, then click the microphone icon (to the right of 'End call') to mute the call.



2. Call the appropriate emergency care representative using your usual telephone (home/office/cell) and the SAMHSA calling card. Follow the scenario script to explain the situation to the representative. Obtain the name of the person and explain you will hang up and call again.
3. Reconnect the respondent's call by clicking the mute microphone icon again to unmute.
4. Click "Add people" and call the same emergency care representative.
5. Stay on the line while the representative and the respondent talk to maintain their connection.

Be sure you have another phone available when interviewing in Skype. Although this situation rarely occurs, you must be prepared and able to handle it properly should it happen.

## B.6 Ending Skype

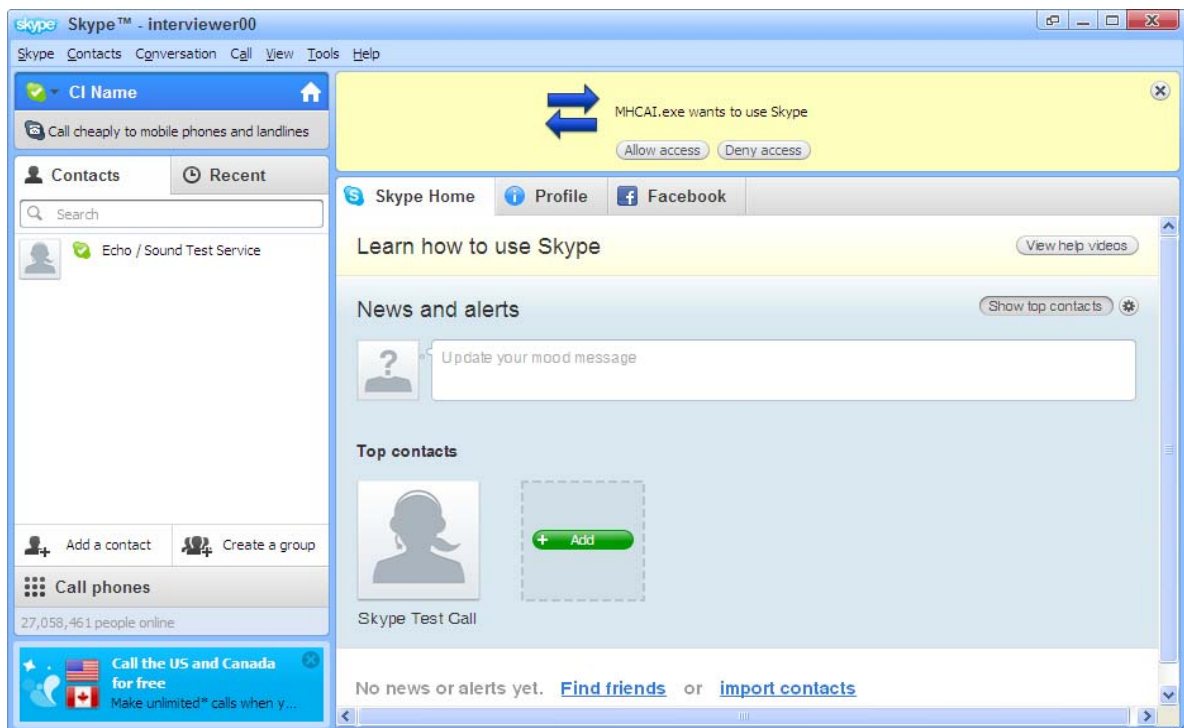
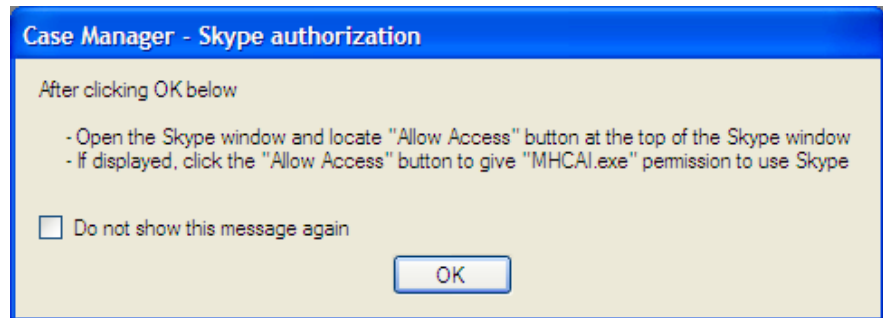
When finished with Skype, be sure to Sign Out (through the Skype menu on the main page) or Quit (right click the Skype icon in the system tray). Selecting Close or clicking the red X only closes the window; it does not end your Skype session. Be sure to Sign Out to clear your call history and end Skype.

## C. MH Case Manager

The MH Case Manager allows you to record interviews using either Skype or the telephone and a recording control device, with the preferred method being Skype. The first time you open the program with Skype already open, the Case Manager prompts you to allow access to Skype.

Click OK.

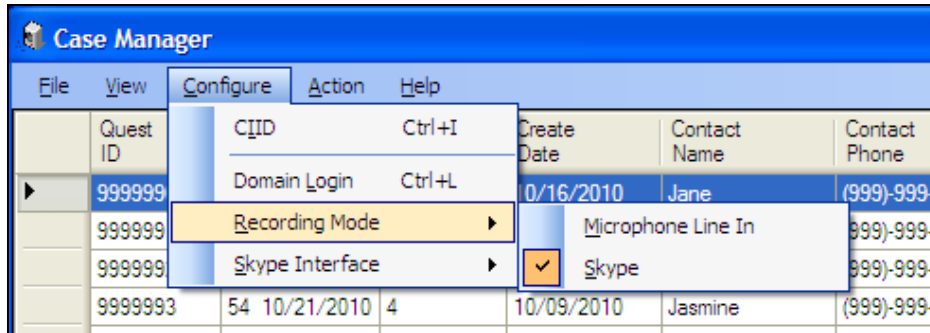
Then, within Skype, click the "Allow Access" button in the yellow space at the top of the screen.







## C.1 Configure MH Case Manager

To select your recording method, click "Configure" from the menu. From the drop down list, highlight "Recording Mode" then select either "Microphone Line In" or "Skype." Note Skype is the initial setting, so you only need to change it to record a telephone interview. Be sure to change it back to Skype when finished.



An icon in the lower right corner of the MH Case Manager allows you to check the configuration at a glance. For Skype, the icon displays as a blue S,  while the telephone recording icon displays as a green microphone.  If the Skype program is completely shut down or unavailable on your laptop, the Skype S shows as gray instead of blue.

## C.2 Recording the Interview with Skype

While connected to the Internet, have the MH Case Manager open and the case selected. Start Skype as needed (the Case Manager should already start Skype for you). You can arrange the two windows on your laptop screen to easily view and use both programs.

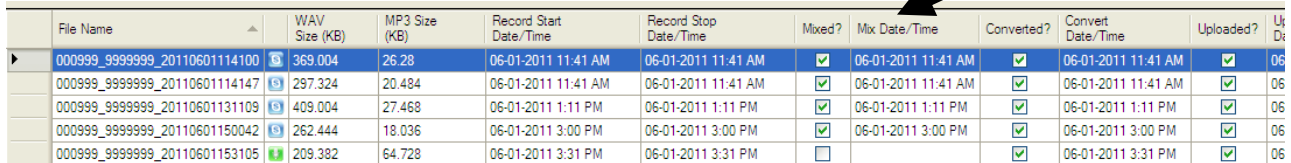
Complete your test call by first clicking "Recording Test" and then dialing the number through Skype. Note the "Start Recording" button in the Recording Test box **does not turn green** until the actual connection is made. So, if you call your cell phone voice mail as your test call, once the connection is made and your voice mail message starts to play, be ready to click "Start Recording." You will miss recording the first few seconds of the message, but that is not a problem.

When you call a respondent, again, the "Start Recording" button will be grayed out and not turn green until the connection is made. Since you wait to begin recording until the respondent provides permission during the introduction process, the slight delay is not a problem.

When finished recording, click "Stop Recording." Take care to not accidentally click too early.

### C.3 Uploading Files

Uploading completed recordings remains the same straightforward process. While connected to the Internet, click "Upload." There is one MH Case Manager difference to note: At the bottom of the screen, Skype files display a "Mixed" check box along with a "Mixed Date/Time." These items will be blank for telephone recordings.



File Name	WAV Size (KB)	MP3 Size (KB)	Record Start Date/Time	Record Stop Date/Time	Mixed?	Mix Date/Time	Converted?	Convert Date/Time	Uploaded?	Uk Di
000999_9999999_20110601114100	369.004	26.28	06-01-2011 11:41 AM	06-01-2011 11:41 AM	<input checked="" type="checkbox"/>	06-01-2011 11:41 AM	<input checked="" type="checkbox"/>	06-01-2011 11:41 AM	<input checked="" type="checkbox"/>	06
000999_9999999_20110601114147	297.324	20.484	06-01-2011 11:41 AM	06-01-2011 11:41 AM	<input checked="" type="checkbox"/>	06-01-2011 11:41 AM	<input checked="" type="checkbox"/>	06-01-2011 11:41 AM	<input checked="" type="checkbox"/>	06
000999_9999999_20110601131109	409.004	27.468	06-01-2011 1:11 PM	06-01-2011 1:11 PM	<input checked="" type="checkbox"/>	06-01-2011 1:11 PM	<input checked="" type="checkbox"/>	06-01-2011 1:11 PM	<input checked="" type="checkbox"/>	06
000999_9999999_20110601150042	262.444	18.036	06-01-2011 3:00 PM	06-01-2011 3:00 PM	<input checked="" type="checkbox"/>	06-01-2011 3:00 PM	<input checked="" type="checkbox"/>	06-01-2011 3:00 PM	<input checked="" type="checkbox"/>	06
000999_9999999_20110601153105	209.382	64.728	06-01-2011 3:31 PM	06-01-2011 3:31 PM	<input type="checkbox"/>		<input checked="" type="checkbox"/>	06-01-2011 3:31 PM	<input checked="" type="checkbox"/>	06

Additionally, a blue Skype icon or a green microphone icon displays in the 3<sup>rd</sup> column indicating the recording method for the file. The case information bar for uploaded, unselected cases displays white.

#### Exhibit 1 MHSS Skype Call Summary Steps

Set Up Tasks	Reference
Establish Skype account	Section B.1
Update Skype privacy settings	Section B.2
Configure MH Case Manager for Skype	Section C.1

Respondent Call Tasks	Reference
Prepare materials	CI Handbook, Chapter 4
Prepare equipment <ul style="list-style-type: none"> <li>- Laptop connected to Internet</li> <li>- Skype headset attached</li> <li>- MH Case Manager open and case selected</li> <li>- Skype open</li> </ul>	Section A
Complete test recording	Section C.2
Call respondent using 'regular' calling method (if can do interview now, call back with Skype)	Section B.3
For an interview appointment, call using Skype	Section B.4
Record interview	Section C.2
Delete number from Skype keypad when finished	Section B.4
Upload file	Section C.3
Complete all other documentation steps	CI Handbook, Chapter 6

## D. Trouble Shooting

In testing, Skype has proven reliable and user-friendly while greatly enhancing the quality of the interview audio recordings. However, problems may arise. Keep the following in mind:

- **Monitoring Call Quality:** While there are no specific steps necessary for you to monitor call or recording quality, please contact your Data Collection Manager if you encounter any problems. If there are any issues with the quality of your submitted recordings, a supervisor will contact you.
- **Avoiding Interrupted Recordings:** A particular laptop setting disables the 'Tap' feature on the Touchpad. This avoids the inadvertent brush of the Touchpad that generates a tap/click on the "Stop Recording" button during an ongoing interview. Please do not change this setting.
- **Avoiding Dropped Calls:** We hope this will occur rarely, but dropped calls may happen. Sometimes it depends on the quality of the Internet connection. If your wireless has occasional breaks in service, perhaps try an Ethernet connection which can be more stable.
- **Handling Dropped Calls:** Should you experience a dropped call, try to call the respondent again quickly, using a telephone as needed. Explain you had an equipment issue; you'll try to resolve it quickly and then will call them back. If your Internet returns quickly, call back through Skype to complete the interview. If the issue cannot be resolved quickly (maybe a storm induced power outage) call the respondent to set an appointment.
- **Avoiding Skype Overload:** When using Skype, minimize the number of open applications on your laptop. Clearly you must have the MH Case Manager open along with Skype, and it can be helpful to have the CMS open as well. If you encounter a distressed respondent situation and need to use the SAMHSA website and/or the National 911 Registry, those applications can also be used in conjunction with Skype. Remember the laptop should only be used for MHSS work-related tasks.
- **Conducting an Interview without Skype:** As needed, use the telephone audio recording method described in *Chapter 3* of your *CI Handbook* to record an interview. Change the MH Case Manager configuration to Microphone Line In (see *Section C.1*). Handbook page 3-1 describes the use of separate headphones to disable the laptop speakers and allow you to listen to the test recording. Do NOT use separate headphones, and do NOT use the Skype headset. Instead, mute the laptop speakers following a successful test recording call. When finished interviewing, unmute the speakers and change the configuration back to Skype.
- **Conducting an Interview without Internet:** If you need to conduct an interview without any Internet access, refer to the above bullet and also page 3-10 of your *CI Handbook*.

Should you have any issues using Skype, please contact your Data Collection Manager. The managers need to know what issues you are facing and are glad to provide assistance. They may direct you to contact the project's Technical Support Group (TSG) at

## **E. Administrative**

Please note the following information for handling administrative details related to Skype.

### **E.1 Subscription Reimbursement**

As mentioned, you will charge the 3 month Skype subscription fee to your personal credit card. To be reimbursed, record the expense on your next ePTE. You don't have to wait for the charge to appear on your credit card bill, since you know the total.

- Record the total amount in the expense section on the back of your CI ePTE Working Copy.
- Divide the expense into the 1/3 and 2/3 split. Refer to *Chapter 7* of your *CI Handbook* as needed.
- Keep in mind expenses over \$10 must be submitted on a Headway Expense Report. Given the current Skype rate for a 3 month subscription, this should not be an issue.

Some credit cards may charge a small fee (0.30 or so) for processing an international payment (recent Skype charges were processed through a Luxembourg location). Such a fee would be a reimbursable expense.

### **E.2 Subscription Renewal**

As the end of your 3 month Skype subscription nears, you will be notified by Skype. Unless otherwise directed, renew your subscription for an additional 3 months. Charge a personal credit card, and then claim the expense on an ePTE as explained above.

Remember this account should only be used for MHSS work-related calls, and should be closed upon the termination of your work on the project.

As always, if you have questions about or issues with using Skype, contact your Data Collection Manager.

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## **Addendum 2: Distressed Respondent Protocol Booklet**



# **2012 NATIONAL SURVEY ON DRUG USE AND HEALTH**

## **Mental Health Surveillance Study Distressed Respondent Protocol Booklet**

Contract No. HHSS283201000003C

Project No. 0212800

Prepared for:

Substance Abuse and Mental  
Health Services Administration  
Rockville, Maryland 20857

Prepared by:

Research Triangle Institute

March 2012



## Quick Reference Guide

### Distressed Respondent Situation Contacts:

Call:	Phone Number:

### National Lifeline Number:

### Locating a Respondent's Address:

1. Navigate to the CMS "Case Status" link
2. Locate the QuestID/Case Data information for the case
3. Click "Click Here" in the Address column on the far right

### SAMHSA Mental Health Services Referral Information:

<http://mentalhealth.samhsa.gov/databases/>  
(link on your laptop's Desktop)

### Using the National 911 Registry (see page DRP-10 for details):

1. Use the County Search desktop link:  
<http://www.naco.org/Counties/Pages/CitySearch.aspx> and enter either the respondent's City or ZIP code to find the county
2. Use the 911 Registry file from either the desktop link or the CMS
3. Use the corresponding Region tab to locate the state and county
4. Locate the 24 hour number, selecting the most appropriate number for the R's address

### 3 Way Calling:

#### SKYPE

1. Mute microphone for respondent call
2. Using another telephone, contact the emergency care representative, explain the situation, obtain their name, and indicate you will call again. End the call
3. Unmute the respondent call
4. Through Skype, add the emergency care representative to the call (Add people)
5. Stay on the line to maintain the connection between the respondent and the representative

### OWN PHONE (record the steps for your phone here)

- 1.
- 2.
- 3.

# MHSS DISTRESSED RESPONDENT PROTOCOL

## Distressed Respondents

Due to the sensitive nature of portions of the SCID interview, you may encounter a respondent who becomes upset during the interview. In situations where you feel that based on indirect and direct statements made by the respondent that he or she has had suicidal or homicidal thoughts within the past two weeks or is otherwise distressed, use the Distressed Respondent Protocol (see *Exhibit A*) to determine the proper course to follow. So that it is always readily available, this Protocol is printed at the back of each SCID booklet. The first page of the protocol lists issues to be aware of before, during, and following the interview as you interact with the respondent. Although you may be qualified, you are NOT to provide counseling or other services. For your work on this study, you must follow the approved protocol.

The chart at the bottom of the first page lists various scenarios you may encounter and refers to the more detailed instructions on the following pages. Deciding which scenario to use is a judgment call for you to make based on your interactions with the respondent.

In certain scenarios and in ANY case where you are unsure of the proper scenario or correct approach, you are to consult with project staff to determine the best course of action for the situation. The Clinical Supervisors ( ), who are licensed psychologists, will act primarily as a sounding board for you. If there is a question about what action to take in response to your interactions with a respondent, you will discuss the situation with one of the Clinical Supervisors, and the Clinical Supervisor will make the final decision as to what action, if any, should be taken beyond documenting the situation. These steps are for your protection and are required by RTI's IRB.

In accordance with the Distressed Respondent Protocol or after consulting with one of the Clinical Supervisors ( ), you may need to call an emergency psychiatric care provider (e.g., crisis center, inpatient hospital) or 911 in the respondent's area so emergency help can be dispatched to the respondent's location as needed. Obtain referral information for the respondent's area from the SAMHSA website (<http://mentalhealth.samhsa.gov/databases/>) and the national 911 database (see *Exhibit B*).

When calling an emergency psychiatric care provider, use 3-way calling to keep the respondent on the line while you call. Be familiar with and practice using 3-way calling prior to initiating any interviews so you can perform this operation smoothly, if needed. Note: with 3-way calling, once the respondent is speaking with the other person, you must **remain on the line** in order to maintain their connection.

Once speaking with an emergency psychiatric care representative or 911 in the respondent's area, use the script in the Distressed Respondent Protocol to explain the situation, and provide the respondent's name, telephone number, and, if needed, the address reported by the respondent (if known) as well as the respondent's home address (if the respondent reports a different location). To protect respondent confidentiality, when possible, only share information required to properly assist the respondent. The emergency care representative or 911 dispatcher will need the entire address to send assistance.

To report the respondent's address to the emergency psychiatric care representative or 911 dispatcher:

- ask the respondent for the address of his/her current location; and
- obtain the respondent's home address from the CMS. From the CMS, access the case (through the Case Status link), and click as directed in the Address column to display the address for the QuestID. To protect confidentiality the address is not provided as assignment information, but is readily available should you need it in an urgent situation.

While you are not to participate in the conversation between the respondent and the emergency care representative, do pay attention to be sure the respondent receives instructions for how to receive emergency services. If the emergency care representative is not able to provide services to protect the safety of the respondent, call 911 in the respondent's area. Note the protocol includes these instructions to ensure proper handling of each respondent's situation. If an emergency care representative asks you to stay on the line with the respondent while the rescue team arrives, do not complete the interview. Rather, keep the conversation casual and light, avoiding topics that may be upsetting to the respondent.

When finished with any distressed respondent situation, be sure to document both the situation and your response by completing an online Incident Form accessible through the Main Page of the CMS. See *Exhibit C* for the types of incident information to enter. **Proper documentation of all distressed respondent situations is critically important** to protect respondents' rights. For non-emergency situations (Scenarios 1, 3, 5), contact \_\_\_\_\_ to consult with them about the course of action that may need to be taken to protect the respondent or other possible victims. If you have questions about what to include in an Incident Report, or if you want to debrief about the case, you may also call \_\_\_\_\_. Additionally, you must contact \_\_\_\_\_ immediately for any cases for which imminent danger is or may possibly be involved (Scenarios 2 and 4) to receive supervision and debrief. If it is an urgent situation and \_\_\_\_\_ is unavailable within 15 minutes, try the next person on the list, and so on. In addition to the study contact summary printed in the inside cover of this handbook, the chart below lists these contacts:

Call:	Cell Phone Numbers:

Please note that \_\_\_\_\_ do not have clinical training. Calling one of them is important to alert project staff that the Distressed Respondent Protocol has been enacted and you are attempting to contact the Clinical Supervisors ( \_\_\_\_\_ ).

The study's IRB approval rests on following these carefully developed procedures exactly.

## Exhibit A Distressed Respondent Protocol

### Specific Guidelines

If respondents report any of the issues listed below during any interactions with the recruiter or clinical interviewer, including before, during, or after a telephone screening or interview, the staff member will immediately refer to the scenario chart below and follow the instructions provided. Details of all incidents will be documented on the case management system and reported to project management staff immediately.

- Has had **any suicidal thoughts in the past two weeks (p. A.3)**, including
  - passive suicidal thoughts (i.e. thoughts or wishes about his/her death **in the absence of** thoughts about specific ways s/he could die or attempt suicide, plans for how s/he could die or attempt suicide, or intention of dying or attempting suicide) **[SCENARIO 1]** or
  - active suicidal thoughts (i.e. thoughts or wishes about his/her death **combined with** thoughts about specific ways s/he could die or attempt suicide, plans for how s/he could die or attempt suicide, the intention of dying or attempting suicide, the means to carry out that plan, and will not promise you that s/he will not hurt him/herself) **[SCENARIO 2]**
- Has had **any homicidal thoughts in the past two weeks**, including
  - passive homicidal thoughts (i.e. thoughts or wishes about seriously harming someone else **in the absence of** thoughts about specific ways in which s/he could seriously harm another person, plans for how s/he could seriously harm another person, intentions of seriously harming another person) **[SCENARIO 3]** or
  - active homicidal thoughts (i.e. thoughts or wishes about seriously harming someone else **combined with** thoughts about specific ways s/he could seriously harm another person, plans for how s/he could seriously harm another person, the intention of seriously harming another person, and the means to carry out that plan) **[SCENARIO 4]**

Scenario Chart		
Scenario Number	Individual at Risk of Harm	Imminent Danger?
1	Self	No
2	Self	Possible / Yes
3	Other(s)	No
4	Other(s)	Possible / Yes
5	No risk of harm; respondent is agitated or upset	No

**Exhibit A Distressed Respondent Protocol (continued)**

Scenario Number	Individual at Risk of Harm	Imminent Danger?
1	Self	No
<b>STEPS</b>		
<p><b>A. COMPLETE SCREENING/INTERVIEW AND THEN READ TO R:</b> When you agreed to participate in this interview, I promised that I would not tell anyone what you have told me unless it was necessary to protect you or other people. You told me earlier that you have recently had thoughts or wishes about your death or dying.</p> <p><b>B.</b> Do you have a doctor, counselor, or someone you can talk to about how you are feeling now?</p> <p><b>IF YES:</b> I strongly suggest that you contact this person immediately so you can talk to him or her about how you have been feeling, especially about the thoughts you've been having about death and dying. Would you be willing to do that?</p> <p><b>IF YES:</b> Okay. There is also a national Lifeline hotline you can call where counselors are available to talk at any time of the day or night. Their toll-free number is 1-800-273-8255. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>IF NO:</b> I strongly suggest that you contact the national Lifeline hotline at 1-800-273-8255. Lifeline has counselors available 24-hours a day to talk to you about how you are feeling. They may also help you locate (additional) mental health services in your area. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away. If you are not able to get to an emergency room immediately, you should call 911 for assistance. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>C. WHEN CALL IS COMPLETED, CALL <span style="float: right;">IF YOU HAVE</span> QUESTIONS OR WOULD LIKE TO DEBRIEF. FILL OUT ONLINE INCIDENT REPORT.</b></p>		

**Exhibit A Distressed Respondent Protocol (continued)**

Scenario Number	Individual at Risk of Harm	Imminent Danger?
2	Self	Possible / Yes
<b>STEPS</b>		
<p><b>A. END SCREENING/INTERVIEW AND THEN READ TO R:</b> When you agreed to participate in this interview, I promised that I would not tell anyone what you have told me unless it was necessary to protect you or other people. You told me earlier that you are thinking about harming yourself. Can you promise me that you will not harm yourself today?</p> <p><b>IF NO: GO TO STEP B.</b></p> <p><b>IF YES:</b> Do you have a doctor, counselor, or other professional you can talk to about how you are feeling?</p> <p><b>IF YES:</b> I strongly suggest that you contact this person so you can talk to him or her about how you have been feeling, especially about the thoughts you've been having about death and dying. Would you be willing to do that?</p> <p><b>IF YES:</b> Okay. There is also a national Lifeline hotline you can call where counselors are available to talk at any time of the day or night. Their toll-free number is 1-800-273-8255. Lifeline has counselors available 24-hours a day to talk to you about how you are feeling. They may also help you locate (additional) mental health services in your area. I strongly suggest you contact counselors at Lifeline. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away. If you are not able to get to an emergency room immediately, you should call 911 for assistance. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>IF NO:</b> I strongly suggest that you contact the national Lifeline hotline at 1-800-273-8255. Lifeline has counselors available 24-hours a day to talk to you about how you are feeling. They may also help you locate (additional) mental health services in your area. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away. If you are not able to get to an emergency room immediately, you should call 911 for assistance. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>B.</b> I strongly suggest that we contact emergency care services in your area, such as a crisis center or nearby hospital. I am going to look-up that number. Can you remain on the line while I do that? It may take a few minutes.</p> <p><b>IF NO:</b> Okay, if I don't connect you with the local emergency care provider, then I will need to call the provider myself to see if they can send someone to you who can provide the care you need in order to keep you safe. I'll call you back to let you know what I find out.</p> <p><b>C. FIND THE NEAREST EMERGENCY PSYCHIATRIC SERVICES USING THE SAMHSA WEBSITE</b> (<a href="http://mentalhealth.samhsa.gov/databases/">http://mentalhealth.samhsa.gov/databases/</a>). <b>SEARCH FOR <u>INPATIENT MH TREATMENT</u> USING THE R'S CURRENT ZIP CODE.</b></p>		

**SCENARIO 2 (Continued)**

**D. CALL THEIR LOCAL INPATIENT PSYCHIATRIC CARE FACILITY OR CRISIS CENTER AND READ THIS STATEMENT:**

I work for RTI International, a research company in North Carolina, and we are conducting a research study. During an interview with a respondent, the respondent told me that (he/she) is thinking about killing or harming (himself/herself) and I am concerned about (his/her) safety. I can give you additional information about the research study, if you would like. I can also provide you with the respondent's contact information.

**IF ASKED FOR NSDUH OVERVIEW:** This study, part of the National Survey on Drug Use and Health sponsored by the United States Public Health Service, is designed to test procedures for use in future NSDUH surveys. Questions ask about various mental health issues such as depression, anxiety, post traumatic stress disorder, and substance dependence. Please note that this information was obtained through the respondent's participation in a research study. We went through appropriate informed consent procedures, during which I told the respondent that if (he/she) told me something that caused me to be concerned about (his/her) well-being, I would report that to someone else who could help or intervene. Given the context in which the information was obtained, however, we cannot guarantee that the participant understood the questions nor that (he/she) provided truthful responses. Do you have any questions about the study? **ANSWER QUESTIONS.**

**E. GIVE R FIRST NAME, TELEPHONE NUMBER, AND ADDRESS (IF KNOWN) TO LOCAL EMERGENCY CARE REPRESENTATIVE. IF THEY ARE UNABLE TO PROVIDE SERVICES THAT ENSURE THE R'S SAFETY, SEARCH FOR THE R'S LOCAL EMERGENCY NUMBER USING THE NATIONAL 911 DATABASE.**

**F. IF R NOT ON THE OTHER LINE, END CALL WITH THE EMERGENCY CARE PROVIDER OR LOCAL 911 DISPATCHER AND ATTEMPT TO CONTACT R AGAIN WITH AN UPDATE.**

**IF R ON THE OTHER LINE, CONNECT R TO EMERGENCY CARE REPRESENTATIVE OR LOCAL 911 DISPATCHER AND STAY ON THE LINE; IF YOU HANG-UP, THEIR CONNECTION WILL ALSO END.**

**G. YOU MAY STAY ON THE LINE TO WAIT FOR THE RESCUE TEAM TO ARRIVE. IF SO, DO NOT CONTINUE THE INTERVIEW. KEEP THE DISCUSSION LIGHT AND AVOID EMOTIONAL TOPICS. DEMONSTRATE EMPATHIC LISTENING BUT REFRAIN FROM COUNSELING OR PRACTICING PSYCHOLOGY.**

**H. WHEN CALL IS COMPLETED, CALL \_\_\_\_\_ TO DEBRIEF. IF SHE DOES NOT RETURN CALL WITHIN 15 MINUTES, CALL \_\_\_\_\_ TO DEBRIEF. IF NEITHER ONE OF THEM IS AVAILABLE, CONTACT \_\_\_\_\_ TO NOTIFY ONE OF THEM ABOUT THE INCIDENT. FILL OUT ONLINE INCIDENT REPORT.**

**Exhibit A Distressed Respondent Protocol (continued)**

Scenario Number	Individual at Risk of Harm	Imminent Danger?
3	Other(s)	No
<b>STEPS</b>		
<p><b>A. COMPLETE SCREENING/INTERVIEW AND THEN READ TO R:</b> When you agreed to participate in this interview, I promised that I would not tell anyone what you have told me unless it was necessary to protect you or other people. You told me earlier that you have recently had thoughts or wishes about seriously harming someone else. Do you have a doctor, counselor, or someone you can talk to about how you are feeling now?</p> <p><b>IF YES:</b> I strongly suggest that you contact this person immediately so you can talk to him or her about how you have been feeling, especially about the thoughts you've been having about seriously harming someone else. Would you be willing to do that?</p> <p><b>IF YES:</b> Okay. There is also a national Lifeline hotline you can call where counselors are available to talk at any time of the day or night. Their toll-free number is 1-800-273-8255. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>IF NO:</b> I strongly suggest that you contact the national Lifeline hotline at 1-800-273-8255. Lifeline has counselors available 24-hours a day to talk to you about how you are feeling. They may also help you locate (additional) mental health services in your area. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away. If you are not able to get to an emergency room immediately, you should call 911 for assistance. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>B. WHEN CALL IS COMPLETED, CALL _____ TO DEBRIEF. IF DIRECTED BY ONE OF THEM, FOLLOW SCENARIO 4 FOR POSSIBLE IMMINENT DANGER TO OTHERS. FILL OUT ONLINE INCIDENT REPORT.</b></p>		



**Exhibit A Distressed Respondent Protocol (continued)**

Scenario Number	Individual at Risk of Harm	Imminent Danger?
4	Other(s)	Possible / Yes
<b>STEPS</b>		
<p><b>A. END SCREENING/INTERVIEW AND END CALL.</b></p> <p><b>B. SEARCH FOR THE R'S LOCAL EMERGENCY NUMBER USING THE NATIONAL 911 DATABASE.</b></p> <p><b>C. CALL THEIR LOCAL 911, AND READ THIS STATEMENT:</b> I work for RTI International, a research company in North Carolina, and we are conducting a research study. During an interview with a respondent, the respondent told me that (he/she) is thinking about killing or harming another individual. I am concerned about this individual's safety. I can give you additional information about the research study, if you would like. I can also provide you with the respondent's contact information.</p> <p><b>IF ASKED FOR NSDUH OVERVIEW:</b> This study, part of the National Survey on Drug Use and Health sponsored by the United States Public Health Service, is designed to test procedures for use in future NSDUH surveys. Questions ask about various mental health issues such as depression, anxiety, post traumatic stress disorder, and substance dependence. Please note that this information was obtained through the respondent's participation in a research study. We went through appropriate informed consent procedures, during which I told the respondent that if (he/she) told me something that caused me to be concerned about (him/her) harming someone else, I would report that to someone else who could help or intervene. Given the context in which the information was obtained, however, we cannot guarantee that the participant understood the questions nor that (he/she) provided truthful responses. Do you have any questions about the study?</p> <p><b>ANSWER QUESTIONS.</b></p> <p><b>D. GIVE R FIRST NAME, TELEPHONE NUMBER, ADDRESS (IF KNOWN), AND VICTIM'S IDENTIFYING INFORMATION TO LOCAL 911 DISPATCHER. END CALL.</b></p> <p><b>E. WHEN CALL IS COMPLETED, CALL _____ TO DEBRIEF. IF SHE DOES NOT RETURN CALL WITHIN 15 MINUTES, CALL _____ TO DEBRIEF. IF NEITHER ONE OF THEM IS AVAILABLE, CONTACT _____ TO NOTIFY ONE OF THEM ABOUT THE INCIDENT. FILL OUT ONLINE INCIDENT REPORT.</b></p>		

**Exhibit A Distressed Respondent Protocol (continued)**

Scenario Number	Individual at Risk of Harm	Imminent Danger?
5	No risk of harm; respondent is agitated or upset	No
<b>STEPS</b>		
<p><b>A. END SCREENING/INTERVIEW AND THEN READ TO R:</b> I know these questions are very personal, and they seem to be upsetting you. Do you have a doctor or someone you can talk to about how you are feeling?</p> <p><b>IF YES:</b> I suggest that you call that individual immediately so that she or he can help you talk about and work through how you are feeling. There is also a national Lifeline hotline you can call where counselors are available to talk at any time of the day or night. Their toll-free number is 1-800-273-8255. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>IF NO:</b> I suggest that you contact the national Lifeline hotline at 1-800-273-8255. Lifeline is a 24-hour hotline that you could call to discuss this with a counselor. They may also help you locate (additional) mental health services in your area. If you feel that this is an emergency now or later, you should go to a hospital emergency room right away or call 911 for assistance. <b>THANK R FOR THEIR PARTICIPATION IN THE STUDY AND END CALL.</b></p> <p><b>B. WHEN CALL IS COMPLETED, CALL <span style="float: right;">IF YOU HAVE ANY</span> QUESTIONS OR NEED TO DEBRIEF. FILL OUT ONLINE INCIDENT REPORT.</b></p>		

## Exhibit B 911 Registry Search Steps

For Scenarios 2 and 4, you may need to contact a local 911 service in the respondent's area. To locate a number for the local area, we have contracted with NENA, the National Emergency Number Association, to provide a copyrighted listing of local service providers within the United States.<sup>2</sup>

Follow these steps to locate a local 911 number:

1. Locate the address of the respondent from the CMS
2. Use the County Search desktop link: <http://www.naco.org/Counties/Pages/CitySearch.aspx> and enter either the City or ZIP code to find the corresponding county
3. Open the national 911 Registry file (link found on CMS or on your desktop). The file contains the following information:
  - Public Safety Answering Point (PSAP) Name
  - County
  - PSAP Address (Street, Community, State, ZIP)
  - 24 hour Phone Number
  - Second 24 hour Phone Number
  - PSAP Service Area Description
4. Locate the state and the corresponding Region tab to use (the listing below sorts by Region while the INDEX tab in the file shows States in alphabetical order)

Region	States Included
Northeast	Connecticut, Delaware, Massachusetts, Maryland, Maine, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Virginia, Vermont, Washington, DC, West Virginia
Southeast	Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas
Central	Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
West	Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

5. Scroll to the appropriate state and county (alphabetized in the second column)

<sup>2</sup> Copyright 2005-2006 by National Emergency Number Association (NENA) and its providers, all Rights Reserved. Not to be copied, used or distributed in any manner, except in accordance with a license agreement between the user and NENA.

## Exhibit B 911 Registry Search Steps (continued)

6. Locate the 24 hour number for 911 services for the county and the respondent's address. Keep in mind the following:
  - Many counties have multiple local 911 numbers: Select the most appropriate number. For example, Anne Arundel County in Maryland has a number for the city of Annapolis and another number for the rest of the county.
  - Densely populated areas may list many individual numbers for the various cities/municipalities within the county. Use the respondent's city to narrow down the choices. If the city is not listed separately, try the county number.
  - The last column in the file contains a description of the service area. This may also help in selecting a number.
  - Some addresses may be physically located in one county, yet the closest 911 provider may be just across the county (or even state) line. Should this happen, the dispatcher answering your call should provide the better/closer number or even be able to transfer your call.
  - Rarely, a PSAP requested that their local number be suppressed in the file so the 24 hour number column appears blank. If this occurs, locate a nearby number. Perhaps there is another listing for the county to try. If not, try to find a nearby county: consider the ZIP code of the address and try to find another listing for that state with a similar ZIP code. If that doesn't work, try another number in the state, requesting assistance in determining the correct number.
  - Do your best to determine the correct number. Even if the number is not exact, you'll have access to a nearby number close to the proper location, and those responders should be able to direct you to the proper number.

Periodically, the 911 Registry file will be updated and posted to the CMS. Your Data Collection Manager will send an email when an updated file is available, with a reminder to copy the file from the CMS and save it to your desktop to ensure you have the most current version.

If you have any questions about accessing or using the 911 Registry, please contact your Data Collection Manager.

## Exhibit C Incident Report Form

Incident Report Form	
When completing the Incident Report Form, <b>DO NOT</b> include identifying information such as the respondent's name or address *required fields	
Project Title:	National Survey on Drug Use and Health (NSDUH): Mental Health Surveillance Study
*Date of Incident:	5 / 20 / 2011
*Scenario	Select
*Respondent's Location:	
*Participant's QuestID :	
*Describe in detail the nature and timing of this incident:	6000 characters remaining
<div style="border: 1px solid black; height: 40px;"></div>	
If Report or Referral was made to an outside agency:	
Date and time of report/referral:	MM/DD/YYYY [ ] / [ ] / [ ] HH:MM AM/PM [ ] : [ ] N/A
Agency and person who took report/referral:	
Current disposition of situation:	1000 characters remaining
<div style="border: 1px solid black; height: 40px;"></div>	
<input type="button" value="Save"/> <input type="button" value="Submit Report"/> <input type="button" value="Reset"/> <input type="button" value="Cancel"/>	

Be sure the Incident Report contains essential details for understanding the incident and the actions taken to handle the distressed respondent, including:

- The scenario number that was used,
- The nature and extent of the suicidal thoughts (Scenario 1, Scenario 2), homicidal thoughts (Scenario 3 and Scenario 4), or emotional distress (Scenario 5),
- Information considered in the risk assessment to include any risk factors (e.g., respondent could not contract for safety) and protective factors (e.g., respondent denied a plan, has no history of attempts, respondent is under the care of a psychiatrist),
- What actions were taken to resolve the situation (e.g., referred respondent to Lifeline, connected respondent with the local crisis center, contacted \_\_\_\_\_ for supervision), and  
Any unforeseen circumstances that arose (e.g., respondent hung-up before script was read.

**Appendix E: Mental Health Surveillance Study  
Field Interviewer Handbook**



# 2012 NATIONAL SURVEY ON DRUG USE AND HEALTH

## MHSS Field Interviewer Handbook

Contract No. HHSS283201000003C

Project No. 0212800

Prepared for:

Substance Abuse and Mental  
Health Services Administration  
Rockville, Maryland 20857

Prepared by:

Research Triangle Institute

October 2011

Field Interviewer: \_\_\_\_\_

FI ID No: \_\_\_\_\_





# 2012 NATIONAL SURVEY ON DRUG USE AND HEALTH

## Mental Health Surveillance Study Field Interviewer Handbook

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October 2011

# Research Triangle Institute

## MISSION

To improve the human condition by turning knowledge into practice.

## VISION

To be the world's leading independent research organization, recognized for solving critical social and scientific problems.

## VALUES

**Integrity** - We perform with the highest ethical standards of individual and group honesty. We communicate openly and realistically with each other and with our clients.

**Excellence** - We strive to deliver results with exceptional quality and value.

**Innovation** - We encourage multidisciplinary collaboration, creativity and independent thinking in everything we do.

**Respect for the Individual** - We treat one another fairly, with dignity and equity. We support each other to develop to our full potential.

**Respect for RTI** - We recognize that the strength of RTI International lies in our commitment, collectively and individually, to RTI's vision, mission, values, strategies and practices. Our commitment to the Institute is the foundation for all other organizational commitments.

**Fiscal Responsibility** - We operate with financial integrity and transparency. We are accountable for cost competitiveness and continuing financial responsibility.

**Objectivity** - Our work is independent of undue influences by political, economic, or other factors. We maintain the highest level of scientific objectivity in our work.

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# 1. INTRODUCTION TO THE STUDY

The Mental Health Surveillance Study (MHSS) is a special research study being conducted as part of the 2012 National Survey on Drug Use and Health (NSDUH). This handbook outlines all procedures specific to the Mental Health Surveillance Study and should be used in conjunction with your 2012 NSDUH *FI Manual* and *FI Computer Manual*.

## 1.1 Overview of the Mental Health Surveillance Study

The Mental Health Surveillance Study (also referred to as the Mental Health Study throughout this handbook) was first conducted as part of the 2008 NSDUH. This study is designed to assess the NSDUH's Mental Health module questions by:

- collecting data from all adult interview respondents through a Mental Health module within the initial NSDUH interview; and
- recruiting and completing in-depth follow-up telephone interviews with selected adult respondents.

The follow-up telephone interviews will be completed with respondents aged 18 and older who complete the initial NSDUH interview using an abbreviated version of the Structured Clinical Interview for DSM-IV Axis I Disorders, also known as the SCID. The goal is to complete 1,500 follow-up telephone interviews in 2012.

As field interviewers (FIs) on the MHSS, you are responsible for completing the screening and the initial NSDUH interview. For selected interview respondents, you will use special recruitment scripts displayed in the initial interview to recruit the respondent for the follow-up telephone interview. The follow-up telephone interview will be conducted by a set of specially trained telephone interviewers.

## 1.2 Organization

The MHSS management structure is the same as the 2012 NSDUH data collection management structure. You will report to your field supervisor (FS) for NSDUH and Mental Health Study work.

## 1.3 Schedule

The MHSS uses the same quarterly schedule as the 2012 NSDUH. Data collection will take place in all four quarters of 2012.

## 1.4 Sample

The Mental Health Study is being conducted in all 50 states and Washington, DC. All NSDUH FIs will take part in this special study.

The MHSS sample is embedded within the 2012 NSDUH sample. A sub-sample of English-speaking respondents aged 18 or older who complete the initial NSDUH interview will be selected to complete the follow-up telephone interview in English. Persons aged 12 to 17 years old and respondents who complete the initial NSDUH interview in Spanish are not eligible for the follow-up interview.



The target number of completed follow-up telephone interviews for 2012 is 1,500, or approximately 375 follow-up interviews per quarter. If an interview respondent is selected for the follow-up interview, special recruitment scripts will display during the back-end CAPI portion of the initial interview. Under no circumstances should you mention the possibility of a follow-up interview to the respondent before this time.

### **1.5 Use of the Mental Health Study Handbook**

This handbook provides a detailed description of the additional tasks you are required to complete for this study. It outlines all procedures and materials that are specific to the MHSS, so it should be used in combination with your *FI Manual* and *FI Computer Manual*. Adherence to prescribed procedures and duties is critical to the success of the Mental Health Study. This handbook should be carefully studied as you prepare for fieldwork, and referred to during data collection as questions arise. Keep it in your laptop bag so it is available for reference while working. Take care to not show respondents the handbook; it is for your use only.

You may, however, have questions or encounter field situations for which you do not find an answer in this handbook. When in doubt about any field situation, contact your FS.

### **1.6 Field Interviewer Responsibilities**

With every scientific survey, there are many necessary components that contribute to the overall success of the research. You are responsible for one of the most important aspects of the research: making sure the NSDUH interview is administered properly according to survey procedures.

Specifically, you are responsible for:

- completing the screening and initial NSDUH interview;
- following the recruitment scripts to recruit selected respondents for the follow-up telephone interview;
- transmitting each day that you work (Your timely transmission is crucial due to the tight schedule for completion of the follow-up interview.); and
- adhering to the current NSDUH data collection standards you are already well acquainted with, as well as the procedures described in this handbook.

It is imperative that you follow all procedures and protocols as you are working the MHSS. You have already signed a NSDUH Data Collection Agreement Form from Headway—that agreement is binding for the Mental Health Study as well. If you have any questions about this, discuss them with your FS.

## 2. EQUIPMENT AND MATERIALS

### 2.1 Introduction

For the screening and initial NSDUH interview, you will utilize your NSDUH equipment and materials. However, for respondents that have been selected for a follow-up interview, there are several additional materials you will use. You must use the correct version of the materials as appropriate during the MHSS. You will also need to be familiar with terminology specific to the Mental Health Study.

### 2.2 Equipment

The equipment for the MHSS will be the same equipment used for your NSDUH assignment. No changes have been made to the iPAQ screening program for the Mental Health Study. The NSDUH interview has been programmed so that the recruitment scripts for the follow-up interview will appear in the back-end CAPI portion when necessary.

#### 2.2.1 Technical Support Procedures

Technical support for the MHSS will be provided by the Technical Support Group (TSG). For any technical issues, call your FS first, then, if necessary, call . Refer to *Section 8.5* in your *FI Computer Manual* for guidelines on contacting Technical Support.

### 2.3 Terminology

Terminology specific to the Mental Health Study is defined in this section. These terms will be used throughout the handbook, as well as during training and data collection activities. It is important that all members of the project (e.g. FIs, FSs, Technical Support personnel, etc.) understand and utilize these terms when discussing Mental Health Study data collection activities.

**Mental Health Surveillance Study (or Mental Health Study, or MHSS)**: Nationwide study first conducted in 2008 and continuing this year to assess the NSDUH's Mental Health module questions. This study collects data from all adult interview respondents through a Mental Health module within the initial NSDUH interview, and through in-depth follow-up telephone interviews with selected adult respondents. For additional information refer to *Chapter 1*.

**Initial Interview**: The NSDUH interview conducted with respondents, including respondents selected for the Mental Health Study follow-up interview. After completion of the initial interview, this will be your last contact with the respondent. Refer to *Chapter 3* for details.

**Follow-up Interview**: The follow-up telephone interview conducted with selected respondents who complete the initial interview. A telephone interviewer will complete the follow-up interview, which will ask questions about various mental health and other related issues.

**Recruitment Scripts**: After completing the initial interview, for selected respondents you will read a script programmed in the back-end portion of the interview that describes the follow-up interview to the respondent. These series of screens are referred to as "recruitment scripts" and it is the first time the follow-up interview is introduced to the respondent. *Section 3.4* contains the recruitment scripts.

## 2.4 Materials

In addition to the NSDUH materials used during the initial interview, for respondents selected for the follow-up interview there are several special Mental Health Study materials. These materials are described in this chapter as well as their location and color scheme. The use of each material will be discussed throughout this handbook.

The Mental Health Study materials include a statement about the respondent having been "randomly chosen for this special study" without providing sample size details. Zero, 1 or 2 residents from a household may be selected to complete the follow-up interview. Additionally, the materials indicate the follow-up interview questions focus on various mental health issues such as depression, anxiety, post traumatic stress disorder, and substance dependence rather than tobacco, alcohol, and drug use or non-use.

It is important to be organized and make sure you have everything you need when you go to the field to work, including enough money to cover NSDUH and Mental Health Study incentive payments. To assist you with materials organization, you will be given individual packets of Mental Health Study materials with your bulk supplies. Each packet will contain one copy of each Mental Health Study material in a large envelope for use during the recruitment scripts. These materials are the Follow-up Study Description, Follow-up Interview Payment Receipt, and Reminder Card. Keep two of these Mental Health Study materials packets in your laptop bag. After you use a packet of materials with a respondent selected for the follow-up interview, ask your FS to order a replacement packet. You should have two packets of materials at all times.

It is important that information about the follow-up interview be introduced when it is intended, during the back-end CAPI portion of the initial interview. **Under no circumstances should you mention this possibility to the respondent before this time.** This is why using the correct materials is so important. For example, if the Follow-up Interview Payment Receipt was used for the initial NSDUH interview, the information within the material would not be accurate for the initial interview.

Mental Health Study materials have not been translated into Spanish, because there will be no Spanish follow-up interviews completed on the Mental Health Study. All selected respondents must be able to complete the initial interview in English. If the initial interview is completed in Spanish, the respondent will not be eligible for the follow-up interview and the recruitment scripts will not appear.

At the conclusion of data collection, as directed by your FS, make arrangements to properly dispose of any remaining Mental Health Study materials by shredding and then either recycling or trashing the shredded documents.

### 2.4.1 Screening

There are no special Mental Health Study procedures or materials for the screening because it is not until the end of the initial interview that a respondent is selected and recruited to take part in the follow-up interview. Therefore, no changes have been made to the screening program for the Mental Health Study.

## 2.4.2 Initial Interview

The initial interview utilizes the 2012 NSDUH materials. However, for a respondent selected for the follow-up interview, there are several additional items you will use when reading the recruitment scripts. Listed below are the Mental Health Study materials you will use exclusively for the recruitment process. The table gives additional information about each material such as the color, the modification made to the form from the main study version, and the handbook exhibit number.

Mental Health Study Material	Color	Location	Modification	Exhibit #
<b>Follow-up Study Description</b>	Blue	Mental Health Study Materials Packet	<ul style="list-style-type: none"> <li>• Title refers to follow-up interview</li> <li>• Description of study</li> <li>• Used during recruit process for follow-up interview at the end of the initial interview</li> </ul>	<b>Exhibit 2.1</b>
<b>Follow-up Interview Payment Receipt</b>	Blue, 3 ply	Mental Health Study Materials Packet	<ul style="list-style-type: none"> <li>• Title refers to follow-up interview</li> <li>• Given to the respondent along with the \$30 payment after they agree to participate in the follow-up interview</li> </ul>	<b>Exhibit 2.2</b>
<b>Reminder Card</b>	Blue	Mental Health Study Materials Packet	<ul style="list-style-type: none"> <li>• Includes contact days &amp; times as a reminder for the respondent</li> </ul>	<b>Exhibit 2.3</b>

## Exhibit 2.1 Follow-up Study Description



**U.S. Public Health Service  
Center for Behavioral Health  
Statistics and Quality**

### **Follow-up Study Description**

You have been randomly chosen for this special study for the 2012 National Survey on Drug Use and Health. This study, sponsored by the United States Public Health Service, will ask questions about various mental health issues such as depression, anxiety, post traumatic stress disorder and substance dependence. Although there is no benefit to you personally, knowledge gained from this study will improve our ability to describe and understand mental health issues in the United States.

If you agree to participate in this follow-up interview, your first name and telephone number will be collected but will be used only for re-contact purposes. Your name and telephone number will not be included on the interview forms on which your answers will be written, or on any interview audio files that might be recorded. While the interview has some personal questions, federal law protects the privacy of your answers and requires us to keep all of your answers confidential. Any data that you provide will only be used by authorized personnel for statistical purposes according to the Confidential Information Protection and Statistical Efficiency Act of 2002. The only exception to this promise of confidentiality is if you tell the interviewer that you intend to seriously harm yourself or someone else; in this situation RTI may need to notify a mental health professional or other authorities.

The interview will be conducted over the phone and takes on average an hour to complete. Your participation is voluntary. You may consider some of the questions to be sensitive in nature and some of the questions also may make you feel certain emotions, such as sadness. Remember that you can refuse to answer any questions that you do not want to answer, and you can stop the interview at any time. If you become upset at any time during the interview and wish to speak to a mental health professional about how you are feeling, the interviewer can again provide you with the toll-free hotline numbers that are printed on your payment receipt from the first interview. **If you agree to complete the interview, you will receive \$30 today.**

If you have questions about the study, call the Project Representative at . If you have questions about your rights as a study participant, call RTI's Office of Research Protection at (a toll-free number). You can also visit our project Website: <http://nsduhweb.rti.org/> for more information.

Thank you for your cooperation and time.

, Project Officer  
Center for Behavioral Health Statistics and Quality  
Substance Abuse and Mental Health Services Administration (SAMHSA)  
U.S. Public Health Service  
Department of Health and Human Services

**Exhibit 2.2 Follow-up Interview Payment Receipt**

# Follow-up Interview Payment Receipt

**United States Public Health Service**

and

**Research Triangle Institute**

**thank you for agreeing to participate in a special study for the  
2012 National Survey on Drug Use and Health.**

In appreciation of your participation in this important study, you are eligible to receive a \$30 cash payment. Since maintaining the confidentiality of your information is important to us, your name will not be entered on this form. However, the interviewer must sign and date this form to certify you received (or declined) the cash payment.

_____	_____	_____ - _____
Interviewer	Date	Case ID
<input type="checkbox"/> Accepted Cash Payment		<input type="checkbox"/> Declined Cash Payment

If you ever feel that you need to talk to someone about mental health issues, you can call the National Lifeline Network. Counselors are available to talk at any time of the day or night and they can give you information about services in your area.

1-800-273-TALK or 1-800-273-8255  
1-888-628-9454 (Spanish)  
<http://suicidepreventionlifeline.org/>

If you ever feel that you need to talk to someone about drug use issues, you can call the Substance Abuse and Mental Health Services Administration's Treatment Referral Helpline. This is a 24-hour service that will help you locate treatment options near you.

1-800-662-HELP or 1-800-662-4357  
1-800-487-4889 (TDD)  
<http://findtreatment.samhsa.gov>

Disposition: Top copy to Respondent, yellow to Field Supervisor, pink to Field Interviewer.

**Exhibit 2.3 Reminder Card**



We appreciate you taking time for this important study and look forward to speaking with you soon.

Your suggested contact days and times are:

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Time							



Research Triangle Institute  
 Research Triangle Park, NC 27709-2194



## 3. INITIAL INTERVIEW

### 3.1 Introduction

There are many necessary components that contribute to the overall success of every scientific study. You are responsible for one of the most important aspects of the Mental Health Study—making sure the initial NSDUH interview is administered properly according to established survey procedures. This chapter discusses the steps required to complete the initial interview and administer the recruitment scripts for the follow-up interview when they appear on the laptop screen.

### 3.2 Initial Interview

For research purposes, it is essential to treat all interview respondents in the same manner. The initial interview is the same for all NSDUH respondents. Adult respondents completing the initial interview in English may be randomly selected for participation in the Mental Health Study. For selected respondents, they will be asked to complete an additional follow-up telephone interview (also in English) after the initial interview is completed (see *Chapter 1*). Since you will not know which respondents will be selected for the follow-up interview until the recruitment scripts appear, it is crucial that you have and use the correct forms during the initial interview. Reference *Section 2.4.2* for a list of exclusive Mental Health Study materials used to complete the follow-up interview recruitment process.

### 3.3 Incentive Procedures

Respondents receive a \$30 cash payment for completing the initial interview. The procedures for providing the initial incentive payment are the same, including the use of the Interview Payment Receipt. However, selected interview respondents who agree to complete the follow-up telephone interview will be given an additional \$30 when prompted by the recruitment scripts at the end of the initial interview. Therefore, there is the possibility of paying a selected respondent a total of \$60 during your interview encounter. Always be sure you have enough incentive money with you in case a respondent is selected and agrees to complete the follow-up interview. Since a household may have two selected respondents, you must have enough incentive money on hand (\$120) to pay incentives to both respondents. As needed, replenish your supply by visiting a bank or ATM before contacting another household. See *Section 3.4* for more information.

### 3.4 Recruitment Process

The recruitment scripts are the first opportunity for you to tell the respondent about the possibility of participating in a follow-up interview and receiving an additional \$30 for their agreement to participate. For information on how to answer respondent questions about the follow-up interview, see *Chapter 4*.

The beginning of the recruitment process, where you introduce the follow-up interview to the respondent, is done in a standardized way through a series of back-end CAPI screens. You must read these recruitment scripts verbatim.



The recruitment process begins after you pay the respondent for the initial interview (INCENT01). The next screen (RECRUIT1) introduces the study to the respondent and gives a brief explanation of the process, including the time frame for the follow-up interview and the additional cash payment. You will also give the respondent a copy of the Follow-up Study Description which provides more information on the telephone interview. It is imperative to give the correct version of the study description at this point to make sure the respondent receives all necessary information for making an informed decision about participation.

For respondents who agree to participate, enter "1" on this screen. The next screen to appear is shown on page 3-6.

Forms Answer Navigate Options

You have been randomly selected to participate in one additional study for the U. S. Public Health Service. This interview will ask questions about mental health issues. It will be conducted over the telephone and will take about an hour. Participation in this interview is voluntary and all of your answers will be kept confidential.

**HAND FOLLOW-UP STUDY DESCRIPTION TO RESPONDENT.** Please read this statement. It describes the survey and the legislation that assures the confidentiality of any information you provide.

If you agree to participate, I will pay you an additional \$30 today. Within the next two weeks, a different interviewer will call you to explain more about the interview and to schedule a convenient time to complete it. If you wish, you may complete the full interview when the interviewer calls.

**IF ASKED "WHY WAS I SELECTED?"** (You have been randomly chosen for this special study for the National Survey on Drug Use and Health. This study, sponsored by the U.S. Public Health Service, will ask questions about various mental health issues. Knowledge gained from this study will improve our ability to describe and understand mental health issues in the United States.)

1. RESPONDENT AGREES TO RECONTACT  
 2. RESPONDENT DOES NOT AGREE TO RECONTACT  
 3. RESPONDENT IS NOT AVAILABLE DURING THE SPECIFIED TIME PERIOD

RECRUIT1

If the respondent agrees to participate but is not available during the specified time period (within the next two weeks), enter "3" on the RECRUIT1 screen and the next screen appears—RECRT4WK. This screen informs the respondent an interviewer will be available to complete the interview within the next four weeks to accommodate their schedule.

Telephone interviewers have up to four weeks to complete the follow-up interview. However, our preference is to complete the follow-up interview with the respondent in the first two weeks. This screen allows respondents who are not available during the first two weeks to participate if they will be available during the four week time period. Never suggest the option of completing the follow-up interview within four weeks rather than two weeks until seeing this screen.

Forms Answer Navigate Options

To accommodate your schedule, an interviewer will be available to call you about this study and schedule a convenient time to complete the interview within the next four weeks.

1. RESPONDENT AGREES TO RECONTACT

2. RESPONDENT DOES NOT AGREE TO RECONTACT

3. RESPONDENT IS NOT AVAILABLE DURING THE SPECIFIED TIME PERIOD

RECRT4WK

If the respondent refuses to participate in the follow-up interview, do your best to address any questions the respondent has at that time to try to persuade him/her to participate. However, if the respondent continues to refuse, you are not to make a return visit to the DU to try to convert the follow-up interview refusal. An initial refusal to the follow-up interview is considered a final refusal. In this situation, enter "2" on either the RECRUIT1 or RECRT4WK screens as appropriate, and the next screen, REFFEAS, will appear asking the respondent why they do not want to participate. This has an open-ended answer field which allows you to enter up to 100 characters of text. Enter the answer clearly and concisely.

Eforms Answer Navigate Options

**Since this additional study is designed to help us improve future NSDUH surveys, it is important to understand why people might not want to participate. Would you please tell me why you do not want to participate?**

REFFEAS

The next screen, THANKR2, appears where you should politely thank the respondent for his/her time and go on to finish the FI debriefing questions and wrap-up the interview just as you normally do.

Forms Answer Navigate Options

**Thank you for your time. I just need to finish a few questions on my own to show that I did the interview. This will only take a few minutes.**

**BE SURE YOU HAVE YOUR SHOWCARD BOOKLET, CALENDAR, QC ENVELOPE W/ FORM, AND PAYMENT RECEIPT COPIES.**

**PRESS [ENTER] TO CONTINUE.**

THANKR2

If the respondent is available and agrees to complete the follow-up interview, enter "1" on the RECRUIT1 or RECRT4WK screens and you will be routed to the RECRUIT2 screen shown below. Here you obtain the respondent's first name and telephone number so the telephone interviewer will be able to contact the respondent for the follow-up interview.

To enter the respondent's contact information, simply type the appropriate information into the field, starting with the first name, and press **[ENTER]** after each entry to move to the next field. If you need to back up to a previous field, press the up and down arrows on the keyboard to move to the correct field. Additional information about the first name or telephone number provided by the respondent should be entered in the Notes field.

It is extremely important to get the correct phone number for the respondent as this encounter will be the last opportunity for face-to-face contact with this person. Therefore, to ensure you collect accurate contact information, ask the respondent to repeat the telephone number given. You are also instructed to read the contact information you have entered into the computer back to the respondent for confirmation as needed.

Follow the script to ask the respondent for an additional contact number, entering this information in the Notes. Include a comment describing the type of number, such as cell phone or work phone.

The screenshot shows a software window titled "Eforms Answer Navigate Options". The main content area has a yellow background and contains the following text:

**Since another interviewer will be completing the second interview, may I have your first name and phone number so the interviewer can call you?**

**ENTER FIRST NAME ONLY AND PHONE NUMBER.**

**To check that I entered the number correctly, please repeat the phone number.**

**CONFIRM NUMBER. AS NEEDED, READ THE CONTACT INFORMATION ENTERED TO THE RESPONDENT AND CONFIRM IT IS CORRECT.**

**Is there another number where the telephone interviewer could contact you about the second interview?**

**IF YES: RECORD PHONE NUMBER AND TYPE (CELL, WORK, ETC) IN THE NOTES FIELD. REPEAT ABOVE STEPS TO CONFIRM THE NUMBER. YOU MAY ENTER UP TO 50 CHARACTERS.**

**IF NO: CONTINUE.**

**PRESS [ENTER] TO CONTINUE.**

At the bottom of the window, there is a form with three fields:

<b>RECRUIT2 - FIRST NAME</b>	<input type="text"/>
<b>PHONE NUMBER</b>	<input type="text" value="( ) - -"/>
<b>NOTES</b>	<input type="text"/>

Next, you will obtain the best days and times to contact the respondent within the next two or four weeks (dependent upon the respondent's recorded availability) on the RECRUIT3 screen. Previously, the RECRUIT1 or RECR4WK screen indicated that the first telephone call would be to schedule a convenient time to complete the full interview, but the respondent can complete the interview at that time as well. This statement should clarify that the times they are providing for re-contact are not necessarily firm interview appointment times but rather times for the telephone interviewer to contact them to schedule a mutually convenient time for the follow-up interview.

You may need to probe for several good days and times. For example, if a respondent says the best time to reach him is on Sundays after 5 pm, enter this information and then ask what other days and times would be convenient. Telephone interviewers are available on evenings and weekends as well as during weekdays to accommodate the respondent's schedule. As needed, share this information with the respondent to obtain additional days and times to contact them.

Once you enter the best days and times for re-contact, read the information you typed into the laptop back to the respondent to confirm you have entered it correctly. Then, you are instructed to complete a Reminder Card and hand it to the respondent. Under the listed days on the card, write the times the respondent provided for contact. Give the card to the respondent to use as a reminder of the suggested days and times they may be contacted about the follow-up interview, then read the text informing them that the interviewer may try to reach them at other times as well.

Please also let me know the best days and times when you will be available in the next two weeks. I will give this information to the interviewer, and he or she will try to contact you during one of these times.

**ENTER BEST DAYS/TIMES. AS NEEDED, PROBE FOR ADDITIONAL BEST DAYS/TIMES.  
READ THE INFORMATION ENTERED TO THE RESPONDENT AND CONFIRM IT IS CORRECT.**

**COMPLETE A REMINDER CARD AND HAND TO THE RESPONDENT.**

I have entered these days and times in the computer and recorded them on this card. Please note the interviewer may try to reach you at other times as well.

**INTERVIEWER NOTE: ADDITIONAL INFORMATION REGARDING THE BEST DAYS OR TIMES PROVIDED BY THE RESPONDENT SHOULD BE ENTERED IN THE NOTES FIELD. YOU MAY ENTER UP TO 50 CHARACTERS.**

**TELEPHONE INTERVIEWERS ARE AVAILABLE EVENINGS AND WEEKENDS.**

**PRESS [ENTER] TO CONTINUE.**

<b>RECRUIT3 - BEST DAYS</b>	
<b>BEST TIMES</b>	
<b>NOTES</b>	

An example of the RECRUIT3 screen referencing the four week time period is shown below. This screen will appear for respondents who indicate they are available during the four week time period on RECR4WK.

The screenshot shows a software window titled 'Forms Answer Navigate Options'. The main content area has a yellow background and contains the following text:

**Please also let me know the best days and times when you will be available in the next four weeks. I will give this information to the interviewer, and he or she will try to contact you during one of these times.**

**ENTER BEST DAYS/TIMES. AS NEEDED, PROBE FOR ADDITIONAL BEST DAYS/TIMES.  
READ THE INFORMATION ENTERED TO THE RESPONDENT AND CONFIRM IT IS CORRECT.**

**COMPLETE A REMINDER CARD AND HAND TO THE RESPONDENT.**

**I have entered these days and times in the computer and recorded them on this card. Please note the interviewer may try to reach you at other times as well.**

**INTERVIEWER NOTE: ADDITIONAL INFORMATION REGARDING THE BEST DAYS OR TIMES PROVIDED BY THE RESPONDENT SHOULD BE ENTERED IN THE NOTES FIELD. YOU MAY ENTER UP TO 50 CHARACTERS.**

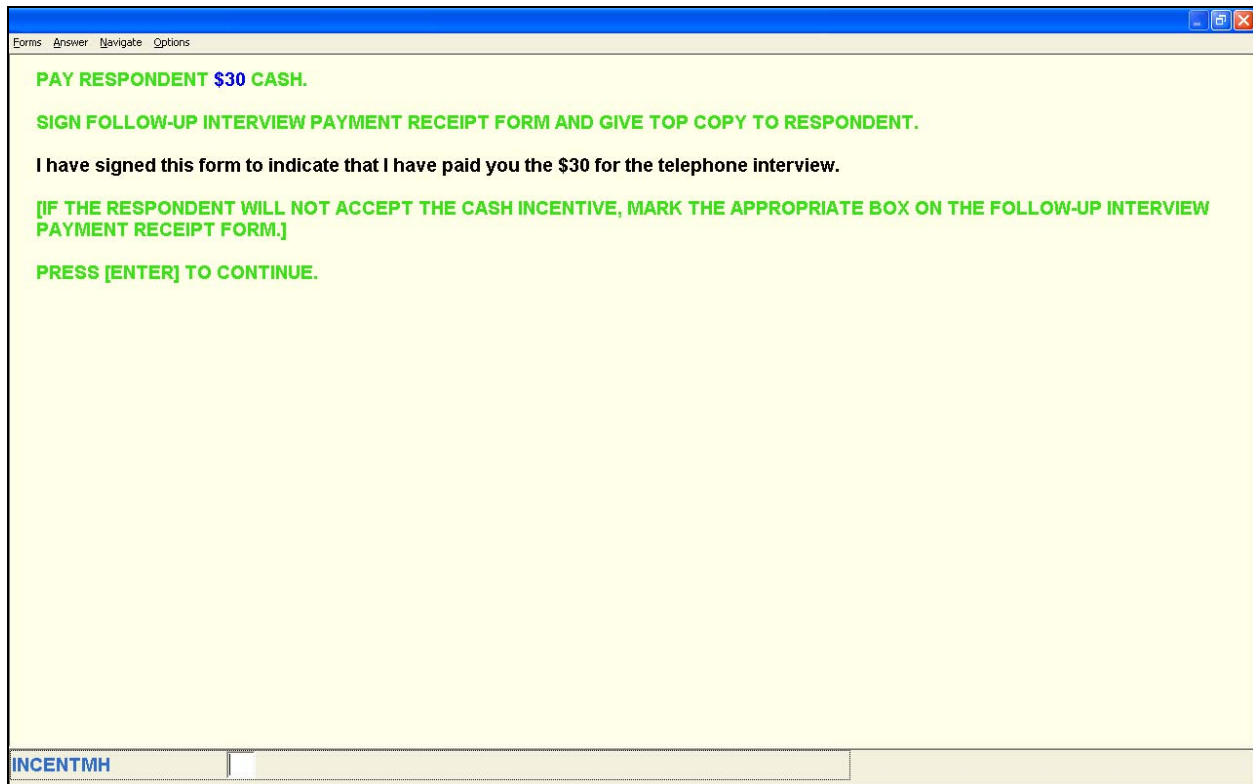
**TELEPHONE INTERVIEWERS ARE AVAILABLE EVENINGS AND WEEKENDS.**

**PRESS [ENTER] TO CONTINUE.**

At the bottom of the window, there is a form with three input fields:

<b>RECRUIT3 - BEST DAYS</b>	<input type="text"/>
<b>BEST TIMES</b>	<input type="text"/>
<b>NOTES</b>	<input type="text"/>

Next, the INCENTMH screen will appear. At this point you should pay the respondent the additional \$30 for the follow-up telephone interview and sign the Follow-up Interview Payment Receipt, reading the scripted text and following the instructions on the screen. This screen is similar to the earlier incentive screen that directs you to pay the respondent for completion of the initial interview. As with the initial interview payment, it is imperative to follow the instructions in the order listed and to read the text verbatim. As stated earlier, you must have enough incentive money on hand (\$120) in case two respondents are selected for the follow-up interview.



The screenshot shows a computer window titled "Forms Answer Navigate Options". The main content area has a yellow background and contains the following text in green:

- PAY RESPONDENT \$30 CASH.**
- SIGN FOLLOW-UP INTERVIEW PAYMENT RECEIPT FORM AND GIVE TOP COPY TO RESPONDENT.**
- I have signed this form to indicate that I have paid you the \$30 for the telephone interview.**
- [IF THE RESPONDENT WILL NOT ACCEPT THE CASH INCENTIVE, MARK THE APPROPRIATE BOX ON THE FOLLOW-UP INTERVIEW PAYMENT RECEIPT FORM.]**
- PRESS [ENTER] TO CONTINUE.**

At the bottom left of the window, the text "INCENTMH" is displayed in blue.



After paying the respondent the \$30 for the follow-up interview, end the recruitment process by reading the THANKR2 screen. At this point, you should thank the respondent for his/her time and then finish any the remaining interview tasks, including the FI debriefing questions.

Forms Answer Navigate Options

Thank you for your time. I just need to finish a few questions on my own to show that I did the interview. This will only take a few minutes.

BE SURE YOU HAVE YOUR SHOWCARD BOOKLET, CALENDAR, QC ENVELOPE W/ FORM, AND PAYMENT RECEIPT COPIES.

PRESS [ENTER] TO CONTINUE.

THANKR2

If you would like to review or practice completing the recruitment process, a list of Mental Health Study initial interview practice cases can be found in *Exhibit 3.1*.

### 3.5 Transmit Each Day You Work

After completing the initial interview and returning home, you must transmit to RTI. Telephone interviewers work on a very tight schedule in order to complete the follow-up interview within the four-week deadline and preferably within the first two weeks. Once the follow-up interview information is received at RTI, the case is assigned to a telephone interviewer within 24 hours. Please note that depending on when the case is transmitted, the telephone interviewer may not be able to call the respondent the very next day.

### **Exhibit 3.1 Mental Health Study Initial Interview Practice Cases**

The following cases may be used for Mental Health Study practice. Each case has one practice interview denoted (Interview A). This chart includes all the information you need to complete the interview.

Please note: These cases will advance from the CONFIRM screen in the front-end Demographics to Question Q124 which asks about the number of telephones in the respondent's household. This will allow you to easily practice the recruitment portion of the interview.

<b>CASE ID</b>	<b>QUEST ID</b>	<b>QUALITY CONTROL ID</b>
ZZ10010025A	9995482	X10-0008
ZZ10010027A	9996016	X10-0016
ZZ10010029A	9995491	X10-0024
ZZ10010031A	9996025	X10-0032
ZZ10010033A	9995507	X10-0040
ZZ10010034A	9996034	X10-0057
ZZ10010035A	9995516	X10-0065
ZZ10010036A	9996043	X10-0073
ZZ10010037A	9995525	X10-0081
ZZ10010039A	9996052	X10-0099

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## 4. OBTAINING PARTICIPATION

### 4.1 Answering Respondent Questions

When answering a respondent's questions, at any phase—screening or initial interview, it is important that nothing you say affect the respondent's answers.

One of the most important protocols of the Mental Health Study is that respondents not know about the possibility of a follow-up telephone interview until the recruitment screens appear at the end of the initial interview. **NEVER** mention the follow-up interview until you see the recruitment scripts. **NEVER** use the possibility of an additional interview payment of \$30, while trying to persuade the respondent to complete the screening or initial interview.

What can you say to the respondent about the follow-up interview? If the respondent asks you why he/she has been selected to complete an additional interview, it's important to convey the purpose provided in the recruitment scripts and Follow-up Study Description:

**"You have been randomly chosen for this special study for the National Survey on Drug Use and Health. This study, sponsored by the U.S. Public Health Service, will ask questions about various mental health issues. Knowledge gained from this study will improve our ability to describe and understand mental health issues in the United States."**

It would be useful to memorize this statement in case a respondent asks you about this. This scripted response is also provided on the RECRUIT1 screen (*Exhibit 4.1*). However, only offer this information if the respondent questions you. It is important to respond using these words as opposed to something else that seems neutral, but may be biasing. We do not want the respondent to feel they were selected for the follow-up interview because of the answers they provided during the initial interview. Therefore, it is important to emphasize the respondent was randomly chosen for the follow-up interview.

Like the text of the Follow-Up Study Description, the above response refers to a 'special study' instead of the Mental Health Study, as the name may raise concerns for some respondents. Use the terms 'special study,' 'telephone interview,' 'follow-up study,' or 'important study' with respondents.

If a respondent asks why a different interviewer has to contact them by phone for the next interview, tell the respondent:

**"A different interviewer is required to do the second interview because they have been specifically trained on the follow-up interviewing process."**

If a respondent expresses concerns that they only have a cell phone as a method of contact or to complete the follow-up interview, explain the telephone interviewer will call them to set up a convenient time to complete the interview, such as during the evening or on the weekend when cell phone minutes are often free. The telephone interviewer can also arrange to call them at an alternate phone number for the follow-up interview, such as a work number, rather than their cell phone.

For more information about answering respondent questions, including questions related to telephone use, see *Exhibit 4.4*.

## 4.2 Refusals

If a respondent refuses to participate in either the initial interview or follow-up interview, address the respondent's questions and concerns using your knowledge and the appropriate study materials.

### 4.2.1 Initial Interview Refusals

For initial interview refusals, do your best to convert the respondent using the appropriate study materials (see *Chapter 2*). Once again, **NEVER** mention the possibility that if the respondent completes this interview, he/she can also do a follow-up telephone interview for an additional \$30 incentive. Although every FI should strive for good response rates, it is more important that the correct Mental Health Study protocols are followed.

### 4.2.2 Follow-up Interview Refusals

If the respondent completes the initial interview, but refuses to agree to complete the follow-up interview, address any questions the respondent has at that time, but do not return to the DU to try to convert the follow-up interview refusal. An initial refusal to the follow-up interview is considered a final refusal.

During the recruitment process, the objection by the respondent may take place while on the RECRUIT1 (*Exhibit 4.1*) or RECRT4WK (*Exhibit 4.2*) screens. If you are unable to convert the respondent's refusal, enter "2—RESPONDENT DOES NOT AGREE TO RECONTACT."

A respondent may also decide against participating while on a later recruitment screen, perhaps while providing a phone number or best days or times. In this situation, press F9 as needed to return to RECRUIT1, and enter "2—RESPONDENT DOES NOT AGREE TO RECONTACT."

You will then be routed to the REFFEAS (*Exhibit 4.3*) screen which prompts you to ask the respondent why he/she does not want to participate. This question has an open-ended answer field and will allow up to 100 characters of text. Be as clear and concise as possible.

Remember, even if the respondent refuses the follow-up interview, you must enter a code 70 into the iPAQ after completing the initial interview. You do not need to enter additional ROCs for the follow-up interview as that information is gathered in the recruitment screens. Your work on the case is considered complete after finishing the initial interview and attempting to recruit the respondent for the follow-up interview.

## 4.3 Other Non-response

Be familiar with how to handle these types of non-response.

### 4.3.1 Respondent Unavailable

A respondent may not be able to complete the follow-up interview when you read the RECRUIT1 (*Exhibit 4.1*) or RECRT4WK (*Exhibit 4.2*) screens because they are unavailable during the specified time frame—that is, within two or four weeks, respectively. In this situation, enter "3—RESPONDENT IS NOT AVAILABLE DURING THE SPECIFIED TIME PERIOD." Again, even if the respondent is unavailable to complete the follow-up interview, you must enter the code 70 into the iPAQ after completing the initial interview.

### 4.3.2 No Phone Access

If a respondent would like to participate but does not have access to a phone, probe to see if there is another phone number where they could be reached. As needed, suggest a cell or work phone, but do NOT mention specific locations such as a neighbor, friend or relative. If the respondent is not able to provide a phone number to contact them, explain that in order to participate in the study they must be able to complete the follow-up interview by telephone. At the RECRUIT1 screen, enter "2—RESPONDENT DOES NOT AGREE TO RECONTACT." Next, at the REFFEAS screen, enter a brief response to document the respondent does not have access to a phone. Only for situations where the respondent does not have access to a phone, you are not required to read the REFFEAS screen to the respondent.

## Exhibit 4.1 RECRUIT1 Screen

Forms Answer Navigate Options

You have been randomly selected to participate in one additional study for the U. S. Public Health Service. This interview will ask questions about mental health issues. It will be conducted over the telephone and will take about an hour. Participation in this interview is voluntary and all of your answers will be kept confidential.

**HAND FOLLOW-UP STUDY DESCRIPTION TO RESPONDENT.** Please read this statement. It describes the survey and the legislation that assures the confidentiality of any information you provide.

If you agree to participate, I will pay you an additional \$30 today. Within the next two weeks, a different interviewer will call you to explain more about the interview and to schedule a convenient time to complete it. If you wish, you may complete the full interview when the interviewer calls.

**IF ASKED "WHY WAS I SELECTED?"** (You have been randomly chosen for this special study for the National Survey on Drug Use and Health. This study, sponsored by the U.S. Public Health Service, will ask questions about various mental health issues. Knowledge gained from this study will improve our ability to describe and understand mental health issues in the United States.)

1. RESPONDENT AGREES TO RECONTACT

2. RESPONDENT DOES NOT AGREE TO RECONTACT

3. RESPONDENT IS NOT AVAILABLE DURING THE SPECIFIED TIME PERIOD

RECRUIT1

## Exhibit 4.2 RECRT4WK Screen

The screenshot shows a web browser window with a blue title bar. The address bar contains the text "Forms Answer Navigate Options". The main content area has a yellow background and contains the following text:

**To accommodate your schedule, an interviewer will be available to call you about this study and schedule a convenient time to complete the interview within the next four weeks.**

Below this text are three radio button options:

- 1. RESPONDENT AGREES TO RECONTACT**
- 2. RESPONDENT DOES NOT AGREE TO RECONTACT**
- 3. RESPONDENT IS NOT AVAILABLE DURING THE SPECIFIED TIME PERIOD**

At the bottom of the screen, there is a navigation bar with the text "RECRT4WK" on the left and several empty input fields on the right.



### Exhibit 4.3 REFFEAS Screen

The screenshot shows a web browser window with a blue title bar. The address bar contains the text "Forms Answer Navigate Options". The main content area has a yellow background and contains the following text: "Since this additional study is designed to help us improve future NSDUH surveys, it is important to understand why people might not want to participate. Would you please tell me why you do not want to participate?". At the bottom of the window, there is a navigation bar with the word "REFFEAS" on the left and a search input field on the right.

#### Exhibit 4.4 Respondent Questions and Responses

Respondent Question	FI Response
"What types of questions will the interviewer ask me?"	"The study asks questions about various mental health issues such as depression, anxiety, post traumatic stress disorder and substance dependence."
"How long will the telephone interview last?"	"The interview takes about an hour."
"Why was I selected for an additional study?"	<p>"You have been randomly chosen for this special study for the National Survey on Drug Use and Health."</p> <p>OR</p> <p>"You were randomly chosen to participate in this special study. The computer program makes the selection and I have no idea who will be chosen until it appears on the screen."</p>
"Why must there be a different interviewer? I'd like to do the interview now."	"A different interviewer is required to do the second interview because they have been specifically trained on the follow-up interviewing process."
"How will the interviewer's phone number display on Caller ID?"	"Each interviewer's phone number will be different. It will not show up as an RTI number since the interviewers work in different locations across the country."
"Why is my participation so important?"	"You are important because knowledge gained from the study will improve our ability to describe and understand mental health issues in the U.S."
<p>"Why am I getting \$60 when my brother only got \$30 for the interview?"</p> <p>(for 2 person households where only one person is selected for the Mental Health Study)</p>	"You were randomly chosen and agreed to participate in this special study for the National Survey on Drug Use and Health. Since the selection process is random, only a limited number of people will be asked to complete the additional interview."
<p>"Can I complete the interview in Spanish?" (or any other language)</p> <p>(for bilingual respondents who complete the initial interview in English, but would like to complete the follow-up interview in Spanish or another language)</p>	"For this study, you must be able to complete the entire interview in English."

**Exhibit 4.4 Respondent Questions and Responses (continued)**

Respondent Question	FI Response
"Why do you need a second phone number?"	"Providing a second phone number assists the interviewer in contacting you about the follow-up interview. While we prefer to have a second phone number available, you are not required to give us another number."
"I don't have a phone. Can I still do the interview?"	"To participate in this study, you must be able to complete the interview by telephone. Is there another phone number where we could reach you?"  (See <b>Section 4.3.2</b> for more information)
"I only have a cell phone with very limited minutes."	"The telephone interviewer will call you to set up a convenient time to complete the interview, such as during the evening or on the weekend when cell phone minutes are often free."  OR  "The telephone interviewer can call you at an alternate number for the interview, such as a work number."
"Can I do the interview on my cell phone as I drive to work?"	"The telephone interviewer would not want you to be distracted while driving, but can arrange for another convenient time to complete the interview that works for your schedule."
"How many people are chosen to complete the (telephone) interview?"	"Our goal is to complete 1,500 interviews this year."
"I don't want to do an interview over the phone for hour. Can someone interview me in person?"	"A different interviewer is required because they have been specifically trained on the follow-up interviewing process. There are a limited number of these interviewers available, and they are only able to complete the interview by telephone."

## 5. ADMINISTRATIVE PROCEDURES

### 5.1 Introduction

Your documentation and reporting of field activities allows you, your FS, and the RTI project management staff to closely monitor NSDUH and Mental Health Study data collection efforts. Changes, additional procedures, and important clarifications are noted below.

### 5.2 Project Charge Code

All Mental Health Study field work should be charged to the 2012 NSDUH project number, which is 0212800-001.106.002.

### 5.3 Completing and Submitting Weekly ePTE

You should maintain an ePTE working copy that combines NSDUH and Mental Health Study hours, miles, and expenses. There is no need for you to keep separate records of charges. In the Notes field of the ePTE where you list the Case IDs of completed initial interviews, add an "MH" in parentheses to the end of Case IDs that generated a follow-up interview. You must transmit a complete and accurate ePTE report each week by 10:30 pm (EST) on Sunday from your laptop. For general ePTE questions, refer to *Chapter 11* of your *FI Manual*.

### 5.4 PT&E Summary Data

Enter your weekly PT&E Summary Data in your iPAQ so that your entry includes NSDUH and Mental Health Study work. You should not enter or transmit weekly PT&E Summary Data separately for the Mental Health Study.

### 5.5 Incentive Advances

You are responsible for paying respondents cash incentives and monitoring your incentive funds on a weekly basis. You will not be issued a separate incentive advance for the Mental Health Study. Instead, pay respondents who agree to the follow-up interview using your 2012 NSDUH Incentive Advance.

You are required to pay all selected interview respondents who agree to the follow-up interview in cash. Therefore, when cashing the Headway incentive check, request that it be dispensed in ten and twenty dollar bills. A respondent who is selected and agrees to be contacted for a follow-up telephone interview has the opportunity to receive a total of \$60 at the completion of the initial interview via two separate incentive payments.

A respondent who completes the initial interview receives \$30 for the completion of that initial interview. If they then agree to be re-contacted for the follow-up telephone interview, they receive an additional \$30 cash incentive. Refer to *Chapter 3* of this handbook for more details. Headway reimburses all incentives paid based on the total amount of incentives entered in Column 16 of your ePTE. As a result, your incentive cash amount will always equal the original amount. A summary of incentives paid must be included in the Notes section of the ePTE, as well as an explanation for any case in which the respondent refused to accept the cash incentive, including the CaseID. For example, the correct way to

summarize incentives paid for 6 completed NSDUH interviews, one of which yielded a follow-up interview would be: "6 int. @ \$30, 1 MH @\$30." See *Exhibit 5.1* for an example of a properly completed ePTE working copy, including a follow-up interview.

### **1.1.1 5.5.1 Incentive Advance Balance Sheet**

Keeping track of incentive advances received, incentive payments made to respondents and reimbursements from Headway requires careful and detailed records. Use the Incentive Advance Balance Sheet to help you keep a record of incentive payments and Headway reimbursements (see *Exhibit 11.6* in the *FI Manual*). Your Headway Advance Balance Booklet contains instructions on how to monitor your incentive advance money and also a supply of blank Incentive Advance Balance Sheets. Additionally, instructions for repaying incentive advance balances are included in *Section 11.7.3* in the *FI Manual*.

## **5.6 Transmitting to RTI**

Each day you work, be sure to transmit to RTI. It is essential that all NSDUH work is received on a timely basis, but even more so for the Mental Health Study because of the deadline for completion of the follow-up interviews. Telephone interviewers must complete the follow-up interview within four weeks, and preferably within the first two weeks. This tight schedule means you must transmit each night you work to ensure information about the follow-up interview is received promptly at RTI.

Exhibit 5.1 Properly Completed ePTE Working Copy

WORKING COPY of the ePTE

Data Collection ePTE  
 Week Begin 1 / 08 / 2012  
 Travel Yes (circle one) No  
 Project # 0212800-001.106.002  
 Supervisor Area # Kristen Effess  
 999

Day of Week	Date	Production # Comp. Interviews*	Time							Notes			
			Training	Home Study	Travel	Contact Locate	Inter-viewing	Editing	Confer-ence		Other^ (include Trans Time)	Daily Total@	
Sun	1-08											XX10010035A	
Mon	1-09	2			1.00	4.00	2.50				0.25	7.75	XX11140306B
Tues	1-10												XX10010048A (MH)
Wed	1-11	1			1.00	3.00	1.50			0.75	0.25	6.50	XX11140021A
Thur	1-12												XX11144A028A
Fri	1-13												XX10010116B
Sat	1-14	3			1.25	1.00	4.50				0.25	7.00	Other time on 1-09, 1-11, and 1-14 for transmitting
<b>TOTALS</b>		<b>6</b>			<b>3.25</b>	<b>8.00</b>	<b>8.50</b>			<b>0.75</b>	<b>0.75</b>	<b>21.25</b>	6 int @ \$30 1 MH @ \$30 \$0.44 expense on 1-15 for postage

Day of Week	Date	Expense										Total Expense@	
		Miles Driven	Lodging#	Meal Expenses	Tele- phone#	Auto Rental#	Miscellaneous\$	Incentive!					
Sun	1-08												
Mon	1-09	50									60	0	
Tues	1-10												
Wed	1-11	60									60	0	
Thur	1-12												
Fri	1-13												
Sat	1-14	75								0.44	90	\$0.44	
<b>TOTALS</b>		<b>185</b>								<b>0.44</b>	<b>210</b>	<b>\$0.44</b>	

NOTE: Remember to note your Total Hours, Total Miles Driven, & Total Expenses for entry into the iPAQ PT&E Summary

DAILY NOTES SPACE:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Odometer START		40,100		40,210			40,350
Odometer STOP		40,150		40,270			40,425
Time START		11:00 am		2:00pm			10:00am
Time STOP		2:30 pm		7:30pm			2:00pm
Time START		3:00 pm					5:30pm
Time STOP		7:00 pm					8:15pm

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## 6. QUALITY CONTROL

### 6.1 Introduction

The importance of quality work at every point in the process of collecting research data cannot be emphasized enough. As interviewers, you are the direct link in the flow of information for the survey and you must carefully perform the screening and interview procedures as instructed so the results are of the highest possible quality.

### 6.2 Data Quality Reminders

The Mental Health Study protocols must be followed precisely to ensure the validity of this special study. If you focus on the data quality reminders listed below, you should be able to complete your work successfully and without data quality problems.

1. Use the correct field materials for the initial interview and recruitment scripts (refer to *Chapter 2* as needed).
2. Read all screens verbatim. Since you will be recruiting so few respondents for the follow-up interview, you may be initially surprised when the recruitment scripts appear. Simply trust the instrument and read the screens verbatim following all the instructions. The screens tell you exactly what to do each step of the way.
3. Never mention the possibility of a follow-up interview until scripted in the back-end CAPI of the initial interview.

### 6.3 Verification

The Mental Health Study procedures for verification are the same as the 2012 NSDUH.

### 6.4 Ongoing Training

This handbook should be carefully studied as you prepare for fieldwork each quarter in 2012, and referred to during data collection as questions arise. Keep it in your laptop bag so it is available, but be careful to not show it to respondents, either on purpose or accidentally.

You will complete a separate iLearning course before the start of each quarter in 2012 as a refresher and further training on Mental Health Study procedures. You must store your iLearning CD in a safe place at home. Do not store the CD in your laptop bag or car as damage could easily occur.

As always, should you have any questions about the study not covered in this handbook, be sure to ask your FS.



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## **Appendix F: New Clinical Interviewer Training Agenda**



## 2011 MENTAL HEALTH SURVEILLANCE STUDY: NEW CLINICAL INTERVIEWER TRAINING AGENDA

<b>DAY 1</b>	<b>8:15 – 5:00</b>	<b>Objective:</b> Introduce the study, the equipment and systems used
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- 8:15 – 9:15      **1. INTRODUCTION TO THE STUDY (1 hour)**
- Staff introductions, including ice breaker
  - Review training schedule, training courtesies
  - Introduction to the handbook
  - Explanation of NSDUH, MHSS/EMHSS
    - VIDEO – MHSS Recruitment Process [5 minutes]
  - Overview of CI responsibilities; certification process
- 9:15 – 10:00      **2. INTRODUCTION TO THE EQUIPMENT (1 hour, 15 minutes)**
- Issue equipment, sign EARFs
  - Overview of the Laptop (hardware, software)
  - Calling card
  - Computer Set Up
  - RTI Webmail (and practice)
- 10:00 – 10:15      BREAK**
- 10:15 – 10:45      **2. INTRODUCTION TO THE EQUIPMENT, cont.**
- CMS introduction
  - Audio Recording (Demo with recording equipment)
  - Care of Laptop, Technical Support Procedures
- 10:45 – 11:00      **3. CASE ASSIGNMENT & CMS FUNCTIONS (15 minutes)**
- CMS functions
  - Receiving case assignment information
- 11:00 – 12:00      **4. CONTACTING RESPONDENTS (1 hour, 45 minutes)**
- Respondents' rights and confidentiality
  - Review materials
  - Contacting the Respondent
  - Introducing the Study
- 12:00 – 1:00      LUNCH**
- 1:00 – 1:45      **4. CONTACTING RESPONDENTS, cont.**
- Interviewing the Respondent
  - Nonresponse

- 1:45 – 2:30      **5. DOCUMENTING RESULTS (45 minutes)**
- Use and importance of Record of Calls (ROCs)
  - Status Codes
  - Documenting ROCs, including comments
  - Practice entering codes for various scenarios into CMS
  - Status Code Exercises
- 2:30 – 3:00      **8. GENERAL CLINICAL INTERVIEWING SKILLS (30 minutes)**
- TASK: Trainer will review probing, open-ended questions, anchoring, rating, ranking, etc.
- CI MATERIAL: Blank SCID (for notes)
- CI HANDOUT: SCID Documentation Handout
- 3:00 – 3:15      BREAK**
- 3:15 – 3:30      **6. DISTRIBUTION OF MATERIALS (15 minutes)**
- Distributing materials
  - Transfer of Audio Recordings
  - Shipment of SCID; preparing FedEx Shipments
- 3:30 – 5:00      **7. ADMINISTRATIVE PROCEDURES (1 hour, 30 minutes)**
- ePTE Procedures (enter default values, practice with ePTE system, prepare ePTE for trip to training, exercises for dividing charges)
  - Reporting to Data Collection Manager
  - Reporting to Clinical Supervisor
  - End of Day, review homework assignment
- 6:00 – 8:00      "VIRTUAL" CLINICAL INTERVIEWER LAB** (Trainers on call to assist with homework)
- HOMEWORK:** Practice recording and uploading audio files  
Carefully review Chapter 5 and Appendix D of Handbook

<b>DAY 2</b>	<b>8:15 – 5:00</b>	<b>Objective:</b> Focus on interviewing skills and operational definitions of each symptom
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8:15 – 9:00	<p><b>8. SCID TRAINING - OVERVIEW</b> (Lecture/Demonstration)</p> <p><u>TASK:</u> Trainer will review the SCID Overview followed by a demonstration with CS as respondent and the new CI's conducting the interview in a round-robin.</p> <p><u>TRAINER MATERIAL:</u> SCID #1 with responses for demonstration</p> <p><u>CI MATERIAL:</u> Blank SCID (for notes and recording responses)</p> <p>NOTE: The above task and materials list applies to all Lecture/Demonstrations during Day 2.</p>
9:00 – 9:05	<b>SCID Screening</b> (Lecture/Demonstration)
9:05 – 10:00	<b>Module A – Depression</b> (Lecture/Demonstration)
<b>10:00 – 10:15</b>	<b>BREAK</b>
10:15 – 10:40	<b>Module A (cont.) – Mania and Mood D/O Due to GMC/Substance</b> (Lecture/Demonstration)
10:40 – 11:05	<b>Module A (cont.) – Dysthymia</b> (Lecture/Demonstration)
11:05 – 11:35	<b>Module B/C – Psychotic Screen, Module D – Mood Differential</b> (Lecture/Demonstration)
11:35 – 12:00	<b>Module E – Anxiety Disorders: PTSD</b> (Lecture/Demonstration)
<b>12:00 – 1:00</b>	<b>LUNCH</b>
1:00 – 2:15	<b>Module E – Anxiety Disorders cont.: Other Anxiety Disorders</b> (Lecture/Demonstration)
2:15 – 2:40	<b>Module F – Eating Disorders</b> (Lecture/Demonstration)
2:40 – 2:50	<b>Module G– Intermittent Explosive Disorder</b> (Lecture/Demonstration)
<b>2:50 – 3:05</b>	<b>BREAK</b>
3:05 – 3:45	<b>Module H – Substance Use Disorders</b> (Lecture/Demonstration)
3:45 – 3:55	<b>Module J – Adjustment Disorder</b> (Lecture/Demonstration)
3:55 – 4:15	<b>Module K – End of Interview (GAF)</b> (Lecture)

4:15 – 4:45

**Exercise: GAF Scoring (Practice)**

TASK: Individual Practice GAF scoring for 6 cases

TRAINER HANDOUT: GAF Scoring Exercise

CI HANDOUT: GAF Scoring Exercise

4:45 – 5:00

**End of Day – Wrap-up**

TASK: Answer questions. Hand out homework

CI MATERIAL: Homework handouts (GAF)

6:00 – 7:00

**CLINICAL INTERVIEWER LAB (Optional)**

**HOMEWORK:**

**HOMEWORK: GAF SCORING**

TASK: Read 24 vignettes and practice GAF scoring

TRAINER HANDOUT: GAF Practice Exercise for Trainers (with GAF Answers in the back)

CI HANDOUT: GAF Practice Exercises

<b>DAY 3</b>	<b>8:15 – 5:00</b>	<b>Objective:</b> Review the structure of the SCID, skip patterns and putting it all together
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- 8:15 – 8:30      **Review of Agenda and Day 2**  
TASK: Collect GAF homework from CIs. Other trainers will grade responses and return to CIs later in the day
- 8:30 – 8:50      **Review of SCID Structure (Lecture)**  
CI MATERIAL: Blank SCID (from Day 1 for notes)
- 8:50 – 9:50      **10. HANDLING UNUSUAL SITUATIONS (1 hour)**
- Cognitive impairment protocol and reporting
  - Distressed Respondents
- 9:50 – 10:05      **BREAK**
- 10:05 – 10:15      **Calibration & Inter-rater Reliability (Lecture)**
- 10:15 – 11:45      **Exercise: Independent Rating of Recorded SCID**  
INDEPENDENT RATING/GROUP CALIBRATION EXERCISE  
TASK: Group will independently score a 90-minute real SCID interview (Q4 2010 IR Calibration Interview 4013551), followed by a 45-minute discussion of how the symptoms were coded.  
TRAINER/CI MATERIAL: Blank SCID
- 11:45 – 12:45      **LUNCH**
- 12:45 – 1:30      **Exercise: Group Calibration (Discussing SCID Ratings)**  
TASK: Group will discuss how the symptoms were coded.  
TRAINER MATERIAL: Answer Sheet for Calibration Exercise  
CI MATERIAL: Independently coded SCID
- 1:30 – 1:45      **Module K – End of the Interview (continued) and Module X – Interviewer Debriefing Section (Lecture)**
- 1:45 – 2:00      **Threats to Validity (Lecture)**
- 2:00 – 3:00      **Full Interview Exercise #1**  
TASK: CIs will work in pairs to practice administering entire SCID. Trainers will float and provide supervision.  
TRAINER/RESPONDENT MATERIAL: SCID #2 script for Full Interview 1  
CI MATERIAL: Blank SCID
- 3:00 – 3:15      **BREAK**



- 3:15 – 4:15      **Full Interview Exercise #2**  
TASK: CIs will work in pairs to practice administering the entire SCID.  
Trainers will float and provide supervision.  
TRAINER/RESPONDENT MATERIAL: SCID #3 script for Full Interview 2  
CI MATERIAL: Blank SCID
- 4:15 – 4:45      **Review – Practice Interviews #1 and #2 (Lecture)**
- 4:45 – 5:00      **End of Day – Wrap-up**  
CI HANDOUT: Script/Answer Sheet for Full Interview Exercises #1 and #2  
CI HANDOUT: Graded GAF Practice Exercises and Answer Sheet
- 6:00 – 7:00      **CLINICAL INTERVIEWER LAB (Optional)**
- HOMEWORK:**      Review materials from Days 2 and 3  
Prepare any written questions for Day 4

<b>DAY 4</b>	<b>8:15 – 4:15</b>	<b>Objective:</b> Practice the entire interview process – from case assignment to shipment
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8:15 – 8:30	<b>REVIEW OF DAY 3</b> <ul style="list-style-type: none"> <li>• Answer questions</li> </ul>
8:30 – 9:30	<b>Review of GAF Scoring Homework</b> <u>HOMEWORK #1: GAF SCORING</u> <u>TASK:</u> Review GAF scores to the 24 vignettes <u>TRAINER HANDOUT:</u> GAF Practice Exercise for Trainers (with GAF Answers in the back)
9:30 – 10:00	<b>9. SCID PAIRED MOCK (4 hours, 45 minutes)</b> CIs go through the entire process of getting the case, making an appointment, conducting the interview, packaging SCID for shipment, etc. Trainers will float and provide supervision. <u>RESPONDENT MATERIAL:</u> SCIDs #4 and #5 for Paired Mocks 1 and 2 <u>CI MATERIAL:</u> Blank SCID
10:00 – 10:15	<b>BREAK</b>
10:15 – 12:00	<b>9. SCID PAIRED MOCK, cont.</b> <ul style="list-style-type: none"> <li>• Paired Mock exercise (continued)</li> </ul>
12:00 – 1:00	<b>LUNCH</b>
1:00 – 2:30	<b>9. SCID PAIRED MOCK, cont.</b> <ul style="list-style-type: none"> <li>• Paired Mock exercise (continued)</li> </ul>
2:30 – 2:45	<b>BREAK</b>
2:45 – 3:45	<b>9. SCID PAIRED MOCK, cont.</b> <ul style="list-style-type: none"> <li>• Review of Mock SCIDs (Lecture)</li> </ul> <u>CI HANDOUT:</u> Script/Answer Sheet for Paired Mock Exercises
3:45 – 4:15	<b>11. WRAP-UP (30 minutes)</b> <ul style="list-style-type: none"> <li>• Summary/Answer CI Questions</li> <li>• Reminder to practice with equipment/materials and review the handbook prior to beginning work</li> <li>• Review of Certification process; handout information, schedule</li> <li>• Training evaluation and distribute training checks</li> </ul>

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## **Appendix G: SCID Editing Form**



## 2012 MENTAL HEALTH SURVEILLANCE STUDY (MHSS)

# SCID EDITING FORM

CI Name: \_\_\_\_\_ Type of Review \_\_\_\_\_ Full \_\_\_\_\_ Part \_\_\_\_\_  
 Quest ID: \_\_\_\_\_ CS Name \_\_\_\_\_  
 Date of Interview: \_\_\_\_\_ Date of review/edit: \_\_\_\_\_  
 Feedback given by: \_\_\_\_\_ Date of Feedback: \_\_\_\_\_

Summary of case (demographics, dx's, salient points, GAF)

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√ = ok/went into section    + = very good    - = see comments below

OV	MDE-py	MDE-it	Manic – py	Manic – it	Dysthymia	Psychotic	Mood Diff	PTSD	Panic	Social	Specific	OCD	GAD	Anorexia	Bulimia	IED	Alcohol	Drugs	Adjustment	GAF	End of Interview	

Adequate notes	Missed codes	Proper codes	Proper probes	Rapport w R	Dealt w/ emotions properly	Asked question verbatim	Got description in R's own words	Behavioral referents	Right amt of information	Resolved contradictions	Medical or substance etiologies	Correct time period	Differentiated bet symptoms easily confused	Leading questions	Distressed respondent	Completed scid / followed skips

Note both strengths and areas to develop. Use examples from interview.

### KEY

Adequate notes = provided adequate notes to support ratings; Adjustment = Adjustment Disorder Module; Alcohol = Alcohol Use Disorders Module; Anorexia = Anorexia Nervosa Module; Asked question verbatim = asked the initial questions verbatim; Behavioral referents = obtained examples to support endorsed symptoms; Bulimia = Bulimia Nervosa Module; Completed scid / followed skips = properly administered the SCID; Correct time period = anchored the respondent in the correct time periods; Dealt w/ emotions properly = properly responded to respondent's emotions; Differentiated symptoms easily confused = properly differentiated symptoms that overlap; Distressed respondent = properly followed the Distressed Respondent Protocol; Drugs = Non-Alcohol Substance Use Disorders Module; Dysthymia = Dysthymic Disorder Module; End of interview = read End of Interview script (K.4); GAD = Generalized Anxiety Disorder Module; GAF = Global Assessment of Functioning Scale; Got description in R's own words =

documented symptoms in the respondent's own words; IED = Intermittent Explosive Disorder Module; Leading questions = did not ask leading questions; Manic – It = Manic Episode-Lifetime Module; Manic – py = Manic Episode-Past Year Module; MDE-It = Major Depressive Episode-Lifetime Module; MDE-py = Major Depressive Episode-Past Year Module; Medical or substance etiologies = ruled out disorders due to general medical conditions, substance use, or medication; Missed codes = did not circle all codes; Mood Diff = Mood Differential Module; OCD = Obsessive-Compulsive Disorder Module; OV = Overview Module; Panic = Panic Disorder Module; Proper codes = properly coded the data; Proper probes = asked proper follow-up questions; Psychotic = Psychotic Screening Module; PTSD = Posttraumatic Stress Disorder Module; Rapport w R = established and maintained rapport with respondent; Resolved contradictions = asked follow-up probes to resolve conflicting information; Right amt of information = obtained the right amount of information to have confidence in data; Social = Social Phobia Module; Specific = Specific Phobia Module.

## **Appendix H: SCID Technical Editing**



SCID Technical Editing Guide.....H-1  
SCID Failed Edit Worksheet.....H-15

# **2012 NATIONAL SURVEY ON DRUG USE AND HEALTH**

## Mental Health Surveillance Study SCID Technical Editing Guide

January 2012

## 2012 MENTAL HEALTH SURVEILLANCE STUDY (MHSS)

### SCID Technical Edit Guide

Technical Editors should check all variables as specified. should be notified of any inconsistencies or cases in which conditions are not true.

When Technical Editing is complete, a code 89 should be entered into CMS system (<https://nsduhweb.rti.org/nsduhFT/login.cfm>) and your name and the date should be recorded on the cover of the SCID booklet in the fields marked “Edited by:” and “Date Edited”

#### A. CHECK FRONT COVER

1. On front cover of SCID booklet, check that all information is correctly filled in:

Var Name	# of Characters	Range	Description
<b>Interviewer ID:</b>	6	000998 – 680447	If blank or not the right number of characters, this can be found in the CMS and should be filled in correctly
<b>QuestID:</b>	7	2000000 – 9969999	If blank or not the right number of characters, contact QUESTID is.
<b>Date of Interview:</b>	6	MM/DD/YY	If blank, this can be found in the CMS (it is the date of event 70, 71, or 72) and should be filled in
<b>Date Shipped to RTI:</b>	6	MM/DD/YY	If blank, this can be found in the CMS (it is the date of event 80) and should be filled in
<b>Date Received at RTI:</b>	6	MM/DD/YY	If blank, this can be found in the CMS (it is the date of event 81) and should be filled in
<b>Clinical QC by:</b>	20	Unrestricted	This should be the name or initials of the Clinical Supervisor who reviewed the SCID. If blank, this can be found in the CMS (it is the name associated with events 86 and 87) and should be filled in
<b>Date of Clinical QC:</b>	6	MM/DD/YY	If blank, this can be found in the CMS (it is the date of event 87) and should be filled in
<b>Edited by:</b>	20	Unrestricted	This should be filled in with the technical editor’s name
<b>Date Edited:</b>	6	MM/DD/YY	This should be filled in with the date the Technical Edit is completed.

## B. CHECK REQUIRED FIELDS

1. Check that all required variables have been filled.

Var Name	Range	Description
ISTH	0–12	Interview Start Time – Overview Hour
ISTM	00–59	Interview Start Time – Overview Minute
AMPM1	AM, PM	
OV1	1, 2, 8	Respondent's sex
OV2	MM/DD/YYYY, 88/88/8888	Respondent's date of birth
OV3	1–5, 8	Marital status
OV4	1–8, 88	Education (highest level completed)
OV5	1, 3, 8	Treatment for emotions [IF OV5=1, SKIP to OV6]
OV5a	1-4, 8	History of mental health treatment
OV6	0–5, 8	Number of hospitalizations [IF OV6=0, SKIP to OV7a]
OV6a	1-2, 8	History of hospitalizations [IF OV6a≠2 skip to OV7a]
OV6b	Open text	Reason(s) for Psychiatric Hospitalization(s) - Past Year
OV7a	Open text	Psychotropic medications taken in the past year – NOT currently
OV7b	Open text	Psychotropic medications taken in the past year - currently
EOI1	0–100	Global Assessment of Functioning (GAF) Scale; 0= inadequate information <b>(located at end of SCID behind End of Interview tab).</b>
IDS1	1, 3, 8	Distressed Respondent Protocol used <b>(located at end of SCID behind Interview Debriefing tab)</b>
IDS3	1, 3, 8	Short Blessed Scale used [If IDS3 = 1, SKIP to IDS5]
IDS4a	0-28, 88	Score on Short Blessed
IDS5	1, 3, 8	Primary support group problems
IDS6	1, 3, 8	Social environment problems
IDS7	1, 3, 8	Educational problems
IDS8	1, 3, 8	Occupational problems
IDS9	1, 3, 8	Housing problems
IDS10	1, 3, 8	Economic problems
IDS11	1, 3, 8	Health care access problems
IDS12	1, 3, 8	Criminal justice problems
IDS13	1, 3, 8	Life-threatening illness – self
IDS14	1, 3, 8	Life-threatening illness – family
IDS15	1, 3, 8	Other psychosocial/environment problems
IDS16	1–5, 8	Comprehension Rating
IDS18	1–5, 8	Cooperation Rating
IDS20	1–5, 8	Privacy Rating
IDS22	1–5, 8	Global Validity Rating
IDS24	1, 3, 8	Potential disorders not assessed [IF IDS24 = 1; SKIP to IDS26]
IDS24a	1-4, 8	Rule-out disorder present
IDS26	1–5, 8	CS: Global Validity Rating
IDS28	1, 3, 8	CS: Potential disorders not assessed [IF IDS28=1; SKIP IDS28a and IDS29]
IDS28a	1-4, 8	Rule-out disorder present

## C. CHECK SCREENING VARIABLES FOR CONSISTENCY

1. On “Screening-Page 1” and “Screening-Page 2” check variables S1-S9:

Var Name	Range	Description	Consistency Check
<b>S1</b>	1–3, 8	Panic attacks in past year	if S1=1 then E28=1; if S1=2 or 3 then E28=3
<b>S2</b>	1–3, 8	Fear of leaving the house, being alone in past year	if E52=3 or <b>BLANK</b> then E53=Blank (ignore S2) else; if S2=1 then E53=1; if S2=2 or 3 then E53=3
<b>S3</b>	1–3, 8	Fear of being around others in past year	if S3=1 then E60=1; if S3=2 or 3 then E60=3
<b>S4</b>	1–3, 8	Fear of flying, blood, being enclosed in past year	if S4=1 then E70=1; if S4=2 or 3 then E70=3
<b>S5</b>	1–3, 8	Bothered by illogical/repeated thoughts in past year	if S5=1 then E78=1; if S5=2 or 3 then E78=3
<b>S6</b>	1–3, 8	Compulsive behavior in past year	if S6=1 then E83=1; if S6=2 or 3 then E83=3
<b>S7</b>	1–3, 8	Nervous/anxious Past Year	if S7=1 then E93=1; if S7=2 or 3 then E93=3
<b>S8</b>	1–3, 8	Underweight	if S8=1 then F1=1; if S8=2 or 3 then F1=3
<b>S9</b>	1–3, 8	Out of control eating	If F7=3 then F8=blank, else if S9=1 then F8=1; if S9=2 or 3 then F8=3

## D. CHECK SKIP PATTERNS

For these variables check to see if the conditions stated in the “Skip Logic” column are true. For example, if variable A2 has a 1 circled, then variables A3 through A17 should be blank. If they are not all blank, then write down the name of the variable on the failed edit worksheet that has a response entered and the variable from which the skip originated (listed in the first column tables that follow). So if for example, A2 = 1 and you look through an notice A5 also has a 1 circled then you should write the following in the columns. You do not have to write anything in the notes column. Example:

Variable Name (Skip begins)	Var Name (Should be blank)	Notes
A2=1	A5=1	

### 1. MODULE A: MOOD EPISODES

Var Name	Range	Description	Skip Logic
<b>A2</b>	1–3, 8	A2- Loss of interest or pleasure	if A1≠ 3 and A2≠ 3 then A3–A17=BLANK
<b>A10</b>	1, 3, 8, 9	Criteria A met	if A10=1 then A11–A17=BLANK
<b>A11</b>	1–3, 8, 9	Clinically significant distress or impairment	if A11=1 or 2 then A12–A17=BLANK
<b>A14</b>	1, 3, 8, 9	Primary Mood Episode (not due to substance or GMC)	if A14=1 then A15–A17=BLANK
<b>A15</b>	1, 3, 8, 9	At least 1 episode not simple bereavement	if A15=1 then A16 and A17=BLANK

Var Name	Range	Description	Skip Logic
A16	1, 3, 8, 9	Past Year Major Depressive Episode	if A16=1 then A17=BLANK; if A16=3 then A17=2 digit number and A18–A34=BLANK
A19	1–3, 8, 9	A2 - Loss of interest or pleasure	if A18≠ 3 and if A19≠ 3 then A20–A34=BLANK
A27	1, 3, 8, 9	Criteria A met	if A27=1 then A28–A34=BLANK
A28	1–3, 8, 9	Clinically significant distress or impairment	if A28=1 or 2 then A29–A34=BLANK
A30	1, 3, 8, 9	Primary Mood Episode (not due to substance or GMC)	if A30=1 then A31–A34=BLANK
A31	1, 3, 8, 9	At least 1 Episode not Simple bereavement	if A31=1 then A32–A34=BLANK
A32	1, 3, 8, 9	Lifetime Major Depressive Episode	if A32=1 then A34=BLANK
A35	1–3, 8	A1 - Abnormally elevated, expansive or irritable mood	if A35=1 then A36–A50=BLANK
A36	1–3, 8	A2 – Irritability/elevated mood at least 1 week	if A36=1 or 2 then A37–A50=BLANK
A44	1, 3, 8, 9	Criteria B met	If A44=1 then A45–A50=BLANK
A45	1–3, 8, 9	Criteria D met	If A45=1 or 2 then A46–A50=BLANK
A48	1, 3, 8, 9	Criteria E met	If A48=1 then A49 and A50=BLANK
A49	1, 3, 8, 9	Manic Episode past year	If A49=1 then A50=BLANK; if A49=3 then A50 has a response and A51–A80=BLANK
A51	1–3, 8, 9	Criteria A	If A51=1 then A52–A65=BLANK
A52	1–3, 8, 9	Criteria A2 – lasting one week or more	If A52=1 or 2 then A53–A65=BLANK
A60	1, 3, 8, 9	Criteria B	If A60=1 then A61–A65=BLANK
A61	1–3, 8, 9	Criteria D	If A61=1 or 2 then A62–A65=BLANK
A63	1, 3, 8, 9	Criteria E- Primary Mood	If A63=1 then A64–A65=BLANK
A64	1, 3, 8, 9	Manic Episode criteria met	If A64=1 then A65=BLANK; if A64=3 then A65 has a response and A66–A80=BLANK
A66	1–3, 8, 9	Criteria A met	If A66=1 then A67–A80=BLANK
A73	1–3, 8, 9	Criteria B met	If A73=1 then A74–A80=BLANK
A74	1, 3, 8, 9	Criteria C met	If A74=1 then A75–A80=BLANK
A75	1, 3, 8, 9	Criteria D met	If A75=1 then A76–A80=BLANK
A77	1, 3, 8, 9	Criteria F met	If A77=1 then A78–A80=BLANK
A78	1, 3, 8, 9	Criteria G met	If A78=1 then A79 and A80=BLANK
A79	1–3, 8, 9	Criteria H - Clinically significant distress or impairment	If A79=1 then A80=BLANK

## 2. MODULE B/C: PSYCHOTIC SCREENING

Var Name	Range	Description	Skip Logic
BC1	1–3, 8	Delusion of Reference	if BC1=1 or 2 then BC2=BLANK
BC3	1–3, 8	Persecutory Delusion	if BC3=1 or 2 then BC4=BLANK
BC5	1–3, 8	Grandiose Delusion	if BC5=1 or 2 then BC6=BLANK
BC7	1–3, 8	Somatic Delusion	if BC7=1 or 2 then BC8=BLANK
BC9	1–3, 8	Other Delusions	if BC9=1 or 2 then BC10=BLANK
BC11	1–3, 8	Auditory Hallucinations	if BC11=1 or 2 then BC12–BC14=BLANK
BC15	1–3, 8	Visual Hallucinations	if BC15=1 or 2 then BC16=BLANK
BC17	1–3, 8	Tactile Hallucinations	if BC17=1 or 2 then BC18=BLANK
BC19	1–3, 8	Other hallucinations, e.g. gustatory, olfactory	if BC19=1 or 2 then BC20=BLANK

## 3. MODULE D: MOOD DISORDERS

Var Name	Range	Description	Skip Logic
D1	1, 3, 8	No Clinically Significant Mood SXS	if D1=1 then D2–D9=BLANK
D2	1, 3, 8, 9	History of 1+ Manic or Mixed Episodes	if D2=1 then D3–D5=BLANK
D3	1, 3, 8, 9	At least 1 Manic/Mixed Episode Not due to GMC/Substance Use	if D3=1 then D4–D5=BLANK
D4	1, 3, 8, 9	Bipolar I Disorder	if D4=1 then D5=BLANK; if D4=3 then D5 is filled in and D6–D9=BLANK
D6	1, 3, 8, 9	At least 1 MDE Not due to GMC/Substance Use	if D6=1 then D7–D9=BLANK
D7	1, 3, 8, 9	At least 1 MDE Not accounted for by Schizoaffective Disorder	if D7=1 then D8 and D9=BLANK
D8	1, 3, 8, 9	Major Depressive Disorder	if D8=1 then D9=BLANK

## 4. MODULE E: ANXIETY DISORDERS

### a. Post Traumatic Stress Disorder

Var Name	Range	Description	Skip Logic
E1	1, 3, 8	Traumatic Events	if E1=1 then E2–E27=BLANK
E2	1, 3, 8, 9	Presence of Upsetting Memories	if E2=1 then E3–E27=BLANK
E3	1–3, 8, 9	A1 - Event involved actual/threatened death or serious injury	if E3=1 then E4–E27=BLANK
E4	1–3, 8, 9	A2 - Response involved fear/helplessness, horror	if E4=1 then E5–E27=BLANK
E10	1, 3, 8, 9	Criteria B met	if E10=1 then E11–E27=BLANK
E18	1, 3, 8, 9	Criteria C met	if E18=1 then E19–E27=BLANK
E24	1, 3, 8, 9	Criteria D met	if E24=1 then E25–E27=BLANK
E25	1–3, 8, 9	E - Duration of disturbance > 1 month	if E25=1 then E26 and E27=BLANK
E26	1–3, 8, 9	F - Clinically significant distress/impairment	if E26=1 then E27=BLANK

b. Panic Disorder

Var Name	Range	Description	Skip Logic
E28	1, 3, 8	S1 - Panic Disorder - Screening Question 1	if E28=1 then E29–E51=BLANK
E29	1–3, 8, 9	A1 - Recurrent/unexpected panic attacks	if E29=1 then E30–E51=BLANK
E30	1–3, 8, 9	A2- one month + concern about panic attacks	if E30=1 then E31–E51=BLANK
E31	1–3, 8, 9	Panic attack symptoms developed abruptly	if E31=1 then E32–E51=BLANK
E45	1, 3, 8, 9	Qualified Panic Attack - At least 4 symptoms and E31=3	if E45=1 then E46–E51=BLANK
E46	1, 3, 8, 9	C - Primary Anxiety Disorder	if E46=1 then E47–E51=BLANK
E47	1, 3, 8, 9	D – Panic Attacks not due to other mental disorder	
E47a	1, 3, 8, 9	Panic Disorder	If E47a=1 then E48-E51=BLANK
E48	1–3, 8, 9	B1 - Presence of Agoraphobia	if E48=1 then E49–E59=BLANK
E49	1–3, 8, 9	B2 - Avoidance of Agoraphobic situations	if E49=1 then E50–E59=BLANK
E50	1, 3, 8, 9	B3- Agoraphobia Not due to other disorder	if E50=1 then E51–E59=BLANK

c. Agoraphobia without Panic Disorder (AWOPD)

Var Name	Range	Description	Skip Logic
E52	1, 3, 8, 9	Past Year Panic Disorder Criteria Met	if E52=3 then E53–E59=BLANK
E53	1, 3, 8, 9	S2 – AWOPD – Screening Question 2	if E53=1 then E54–E59=BLANK
E54	1–3, 8, 9	A1 - Presence of Agoraphobia	if E54=1 then E55–E59=BLANK
E55	1–3, 8, 9	A2 - Agoraphobic situations avoided	if E55=1 then E56–E59=BLANK
E56	1, 3, 8, 9	A3 - Avoidance not due to other mental disorder	if E56=1 then E57–E59=BLANK
E57	1, 3, 8, 9	Criteria A met	if E57=1 then E58 and E59=BLANK
E58	1, 3, 8, 9	C - Primary Anxiety Disorder (not due to GMC/Substance)	if E58=1 then E59=BLANK

d. Social Phobia

Var Name	Range	Description	Skip Logic
E60	1, 3, 8	S3 – Social Phobia – Screening Question 3	if E60=1 then E61–E69=BLANK
E61	1–3, 8, 9	A – Fear of social performance situation	If E61=1 then E62–E69=BLANK
E62	1–3, 8, 9	B - Exposure to social situation provoke anxiety	if E62=1 then E63–E69=BLANK
E63	1–3, 8, 9	C- Recognize excessive fear	if E63=1 then E64–E69=BLANK
E64	1–3, 8, 9	D - Avoid social or performance situations	if E64=1 then E65–E69=BLANK
E65	1–3, 8, 9	E - Avoidance/anxiety interfere with functioning	if E65=1 then E66–E69=BLANK
E66	1, 3, 8, 9	G- Primary Anxiety Disorder (not due to substance/GMC)	if E66=1 then E67–E69=BLANK



<b>E67</b>	1–3, 8, 9	Phobia not due to other disorder	if E67=1 then E68 and E69=BLANK
<b>E68</b>	1–3, 8, 9	H - Phobia unrelated to GMC	if E68=1 then E69=BLANK

e. Specific Phobia

<b>Var Name</b>	<b>Range</b>	<b>Description</b>	<b>Skip Logic</b>
<b>E70</b>	1, 3, 8	S4 – Specific Phobia – Screening Question 4	if E70=1 then E71–E77=BLANK
<b>E71</b>	1–3, 8, 9	A - Excessive/unreasonable fear	if E71=1 then E72–E77=BLANK
<b>E72</b>	1–3, 8, 9	B - Exposure to phobic stimulus induce anxiety	if E72=1 then E73–E77=BLANK
<b>E73</b>	1–3, 8, 9	Criteria B met	if E73=1 then E74–E77=BLANK
<b>E74</b>	1–3, 8, 9	D - Avoidance of phobic situation (Criteria D)	if E74=1 then E75–E77=BLANK
<b>E75</b>	1–3, 8, 9	E - Avoidance/anxiety interfere with functioning	if E75=1 then E76 and E77=BLANK
<b>E76</b>	1, 3, 8, 9	G - Symptoms not due to other disorder	if E76=1 then E77=BLANK

f. Obsessive Compulsive Disorders (OCD)

<b>Var Name</b>	<b>Range</b>	<b>Description</b>	<b>Skip Logic</b>
<b>E78</b>	1, 3, 8	S5 – Obsessions – Screening Question 5	if E78=1 then E79–E82=BLANK
<b>E79</b>	1–3, 8, 9	A1 - Intrusive thoughts, images, impulses causing anxiety	if E79=1 then E80–E82=BLANK
<b>E80</b>	1–3, 8, 9	A2 - Intrusive thoughts are not excessive worries	if E80=1 then E81 and E82=BLANK
<b>E81</b>	1–3, 8, 9	A3 - Ignore/repress intrusive thoughts. Images, impulses	if E81=1 then E82=BLANK
<b>E83</b>	1, 3, 8	S6 – Compulsions – Screening Question 6	if E83=1 then E84 and E85=BLANK
<b>E86</b>	1, 3, 8	Presence of obsession or compulsion	if E86=1 then E87–E92=BLANK
<b>E87</b>	1–3, 8, 9	B - Recognize obsessions/compulsions excessive	if E87=1 then E88–E92=BLANK
<b>E89</b>	1–3, 8, 9	C - Obsessions/compulsions interfere with normal functioning	if E89=1 then E90–E92=BLANK
<b>E90</b>	1, 3, 8, 9	D - Obsessions/compulsions not related to Axis I Disorder	if E90=1 then E91 and E92=BLANK
<b>E91</b>	1, 3, 8, 9	E - Primary Anxiety Disorder (not due to Subst/GMC)	if E91=1 and E92=BLANK

g. Generalized Anxiety Disorder (GAD)

<b>Var Name</b>	<b>Range</b>	<b>Description</b>	<b>Skip Logic</b>
<b>E93</b>	1, 3, 8	S7 – GAD – Screening Question 7	If E93=1 then E94–E107=BLANK
<b>E94</b>	1–3, 8, 9	A - Excessive anxiety past 6 months	if E94=1 then E95–E107=BLANK
<b>E95</b>	1–3, 8, 9	B - Difficult to control worry past 6 months	if E95=1 then E96–E107=BLANK
<b>E96</b>	1, 3, 8, 9	Does Not Co-occur with Mood, psychotic disorder	if E96=1 then E97–E107=BLANK
<b>E103</b>	1–3, 8, 9	Criteria C met	if E103=1 then E104–E107=BLANK
<b>E104</b>	1, 3, 8, 9	D - SX Not related to Axis 1 disorder	if E104=1 then E105–E107=BLANK
<b>E105</b>	1–3, 8, 9	E - Clinically significant distress/impairment	if E105=1 then E106 and E107=BLANK
<b>E106</b>	1, 3, 8, 9	F - Primary Anxiety Disorder (not due to Subst/GMC)	if E106=1 then E107=BLANK

## 5. MODULE F: EATING DISORDERS

Var Name	Range	Description	Skip Logic
<b>F1</b>	1, 3, 8	S8 – Anorexia Nervosa – Screening Question 8	if F1=1 then F2–F6=BLANK
<b>F2</b>	1–3, 8, 9	A - Low body weight	if F2=1 then F3–F6=BLANK
<b>F3</b>	1–3, 8, 9	B - Fear of gaining weight while underweight	if F3=1 then F4–F6=BLANK
<b>F4</b>	1–3, 8, 9	C - Distorted body image	if F4=1 then F5 and F6=BLANK
<b>F5</b>	1–3, 8, 9	D – Amenorrhea (if OV=1 (Male R) F5 will be blank	if F5=1 then F6=BLANK
<b>F7</b>	1, 3, 8	Criteria Met for Anorexia	if F7=3 then F8–F15=BLANK
<b>F8</b>	1, 3, 8, 9	S9 – Bulimia Nervosa – Screening Question 9	if F8=1 then F9–F15=BLANK
<b>F9</b>	1–3, 8, 9	A2 - No control over eating	if F9=1 then F10–F15=BLANK
<b>F10</b>	1–3, 8, 9	A1 - Binge eating	if F10=1 then F11–F15=BLANK
<b>F11</b>	1–3, 8, 9	B - Behavior to prevent weight gain (vomit, laxative)	if F11=1 then F12–F15=BLANK
<b>F12</b>	1–3, 8, 9	C - Binge eating & compensatory behavior bi-weekly past 3 month	if F12=1 then F13–F15=BLANK
<b>F13</b>	1–3, 8, 9	D - Self-evaluation based on body image	if F13=1 then F14 and F15=BLANK
<b>F14</b>	1, 3, 8, 9	E - Does not Co-occur with Anorexia	if F14=1 then F15=BLANK

## 6. MODULE G: IMPULSE CONTROL DISORDERS

Var Name	Range	Description	Skip Logic
<b>G1</b>	1–3, 8	A - Serious Assaultive acts	if G1=1 then G2–G4=BLANK
<b>G2</b>	1–3, 8, 9	B - Extreme aggressiveness	if G2=1 then G3 and G4=BLANK
<b>G3</b>	1–3, 8, 9	C - SX due to other disorder	if G3=1 then G4=BLANK

## 7. MODULE H: SUBSTANCE USE DISORDERS

Var Name	Range	Description	Skip Logic
<b>H1</b>	1, 3, 8	Drank 6 + drinks in Past year	if H1=1 then H2–H14=BLANK
<b>H15</b>	1, 3, 8	Sedatives - Hypnotics- Anxiolytics	if H15=1 then H24, H32, H40, H48, H56, H64, H72, H80, H88, H96, H104, H112, H120=BLANK
<b>H16</b>	1, 3, 8	Stimulants	if H16=1 then H25, H33, H41, H49, H57, H65, H73, H81, H89, H97, H105, H113, H121=BLANK
<b>H17</b>	1, 3, 8	Opioids	if H17=1 then H26, H34, H42, H50, H58, H66, H74, H82, H90, H98, H106, H114, H122=BLANK
<b>H18</b>	1, 3, 8	Cannabis	if H18=1 then H27, H35, H43, H51, H59, H67, H75, H83, H91, H99, H107, H115, H123=BLANK
<b>H19</b>	1, 3, 8	Heroin	if H19=1, then H28, H36, H44, H52, H60, H68, H76, H84, H92, H100, H108, H116, H124=BLANK
<b>H20</b>	1, 3, 8	Cocaine	if H20=1, then H29, H37, H45, H53, H61, H69, H77, H85, H93, H101, H109, H117, H125=BLANK

Var Name	Range	Description	Skip Logic
H21	1, 3, 8	Hallucinogens/PCP	if H21=1, then H30, H38, H46, H54, H62, H70, H78, H86, H94, H102, H110, H118, H126=BLANK
H22	1, 3, 8	Inhalants	if H22=1, then H31, H39, H47, H55, H63, H71, H79, H87, H95, H103, H111, H119, H127=BLANK
H23	1, 3, 8	Past Year Drug Use	if H23=1 then H24–H127=BLANK

## 8. MODULE J: ADJUSTMENT DISORDER

Var Name	Range	Description	Skip Logic
J1	1, 3, 8	Disturbance in Past Year not meeting other Axis 1 criteria	if J1=1 then J2–J8=BLANK
J2	1–3, 8, 9	A - Symptoms due to identifiable stressor within 3 months of onset	if J2=1 then J3–J8=BLANK
J3	1–3, 8, 9	B - Clinically significant distress/impairment	if J3=1 then J4–J8=BLANK
J4	1, 3, 8, 9	C- Not due to other Axis I or II disorder	if J4=1 then J5–J8=BLANK
J5	1, 3, 8, 9	D - Symptoms not due to Bereavement	if J5=1 then J6–J8=BLANK
J6	1–3, 8, 9	E - Symptoms do not persist for 6+ months	if J6=1 then J7 and J8=BLANK
J7	1, 3, 8, 9	Adjustment Disorder	if J7=1 then J8=BLANK

## E. CHECK SYMPTOM CRITERIA & DIAGNOSTIC VARIABLES TO ENSURE CONDITIONS MET FOR CODE 3

### 1. MODULE A: MOOD EPISODES

#### a. Past Year and Lifetime Major Depressive Episode

Var Name	Range	Description	Conditions
A10	1, 3, 8, 9	Symptom A Criteria Past Year MDE	A10=3 if at least 5 of A1–A9=3 and (A1=3 or A2=3)
A16	1, 3, 8, 9	Past Year Major Depressive Episode	A16=3 if A10=3 and A11=3 and A14=3 and A15=3
A27	1, 3, 8, 9	Symptom A – Lifetime MDE	A27=3 if at least 5 of A18–A26=3 and (A18=3 or A19=3)
A32	1, 3, 8, 9	Lifetime Major Depressive Episode	A32=3 if A27=3 and A28=3 and A30=3 and A31=3

b. Past Year and Lifetime Manic Episode

Var Name	Range	Description	Conditions
<b>A44</b>	1, 3, 8, 9	Criteria B – Manic Past Year met if manic mood, then at least 3 of A37-A43=3; if only irritable mood (A44a=3), then 4 of A37-A43=3.	A44=1 if fewer than 3 of A37–A43=3 or if 3 of A37–A43=3 and A44a=3
<b>A49</b>	1, 3, 8, 9	Criteria A, B, D, E Manic Past Year	A49=3 if A35=3 and A36=3 and A44=3 and A45=3 and A48=3
<b>A60</b>	1, 3, 8, 9	Criteria B - Lifetime Manic - met if manic mood, then at least 3 of A53-A59= 3; if only irritable mood (A60a=3), then 4 of A53-59 = 3.	A60=1 if fewer than 3 of A53–A59=3 or if 3 of A53–A59=3 and A60a=3
<b>A64</b>	1, 3, 8, 9	Lifetime Manic Episode	A64=3 if A51=3 and A52=3 and A60=3 and A61=3 and A63=3

c. Dysthymic Disorder

Var Name	Range	Description	Conditions
<b>A73</b>	1–3, 8, 9	Criteria B met	A73=3 if at least 2 of A67–A72=3
<b>A80</b>	1, 3, 8, 9	Dysthymic Disorder	A80=3 if A66=3 and A73=3 and A74=3 and A75=3 and A77=3 and A78=3 and A79=3

2. MODULE B/C: PSYCHOTIC SCREENING

Var Name	Range	Description	Conditions
<b>BC21</b>	1, 3, 8	Primary Psychotic symptom present	BC21=3 if (BC1=3 and BC2=3) or (BC3=3 and BC4=3) or (BC5=3 and BC6=3) or (BC7=3 and BC8=3) or (BC9=3 and BC10=3) or (BC11=3 and BC12=3) or (BC15=3 and BC16=3) or (BC17=3 and BC18=3) or (BC19=3 and BC20=3)

3. MODULE E: ANXIETY DISORDERS

Var Name	Range	Description	Conditions
<b>E10</b>	1, 3, 8, 9	Criteria B PTSD	E10=3 if at least 1 of E5–E9=3
<b>E18</b>	1, 3, 8, 9	Criteria C PTSD	E18=3 if at least 3 of E11–E17=3
<b>E24</b>	1, 3, 8, 9	Criteria D PTSD	E24=3 if at least 2 of E19–E23=3
<b>E27</b>	1, 3, 8, 9	Post-traumatic stress disorder in past year	E27=3 if E3=3 and E4=3 and E10=3 and E18=3 and E24=3 and E25=3 and E26=3
<b>E45</b>	1, 3, 8, 9	Qualified Panic attack	E45=3 if at least 4 of E32–E44=3 and E31=3
<b>E47a</b>	1, 3, 8, 9	Panic Disorder	E47a=3 if E29=3 and E30=3 and E45=3 and E46=3 and E47=3

<b>E51</b>	1, 3, 8, 9	Panic Disorder with Agoraphobia in past year	E51=3 if E48=3 and E49=3 and E50=3
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<b>Var Name</b>	<b>Range</b>	<b>Description</b>	<b>Conditions</b>
<b>E52</b>	1, 3, 8, 9	Past Year Panic Disorder Criteria Met	E52=3 if E51=1 or 2 or 3
<b>E57</b>	1, 3, 8, 9	Criteria A met	E57=3 if E54=3 and E55=3 and E56=3
<b>E69</b>	1, 3, 8, 9	Social Phobia in past year	E69=3 if E61=3 and E62=3 and E63=3 and E64=3 and E65=3 and E66=3 and E67=3 and E68=3
<b>E77</b>	1, 3, 8, 9	Specific Phobia Past Year	E77=3 if E71= 3 and E72=3 and E73=3 and E74=3 and E75=3 and E76=3
<b>E103</b>	1–3, 8, 9	Criteria C met	E103=3 if at least 3 of E97–E102=3
<b>E107</b>	1, 3, 8, 9	Generalized Anxiety Disorder	E107=3 if E94=3 and E95=3 and E96=3 and E103=3 and E104=3 and E105=3 and E106=3

#### 4. MODULE F: EATING DISORDERS

<b>Var Name</b>	<b>Range</b>	<b>Description</b>	<b>Conditions</b>
<b>F6</b>	1, 3, 8, 9	Anorexia Nervosa Past Year	F6=3 if F2=3 and F3=3 and F4=3 and (F5=3 or F5=Blank and OV1=1)
<b>F15</b>	1, 3, 8, 9	Bulimia Nervosa Past Year	F15=3 if F9=3 and F10=3 and F11=3 and F12=3 and F13=3 and F14=3

#### 5. MODULE G: IMPULSE CONTROL DISORDERS

<b>Var Name</b>	<b>Range</b>	<b>Description</b>	<b>Conditions</b>
<b>G4</b>	1, 3, 8, 9	Intermittent Explosive Disorder Past year	G4=3 if G1=3 and G2=3 and G3=3

#### 6. MODULE H: SUBSTANCE USE DISORDERS

<b>Var Name</b>	<b>Range</b>	<b>Description</b>	<b>Conditions</b>
<b>H9</b>	1, 3, 8, 9	Alcohol Dependence	H9=3 if at least 3 of H2–H8=3
<b>H14</b>	1, 3, 8, 9	Alcohol Abuse	H14=3 if at least 1 of H10–H13=3
<b>H23</b>	1, 3, 8, 9	Past Year Threshold Substance Use	H23=3 if at least one of H15–H22=3
<b>H80</b>	1, 3, 8, 9	Sedatives - hypnotics- anxiolytics	H80=3 if at least 3 of H24, H32, H40, H48, H56, H64, H72=3
<b>H81</b>	1, 3, 8, 9	Stimulants	H81=3 if at least 3 of H25, H33, H41, H49, H57, H65, H73=3
<b>H82</b>	1, 3, 8, 9	Opioids	H82=3 if at least 3 of H26, H34, H42, H50, H58, H66, H74=3
<b>H83</b>	1, 3, 8, 9	Cannabis	H83=3 if at least 3 of H27, H35, H43, H51, H59, H67, H75=3

<b>H84</b>	1, 3, 8, 9	Heroin	H84=3 if at least 3 of H28, H36, H44, H52, H60, H68, H76=3
<b>H85</b>	1, 3, 8, 9	Cocaine	H85=3 if at least 3 of H29, H37, H45, H53, H61, H69, H77=3
<b>Var Name</b>	<b>Range</b>	<b>Description</b>	<b>Conditions</b>
<b>H86</b>	1, 3, 8, 9	Hallucinogens/PCP	H86=3 if at least 3 of H30, H38, H46, H54, H62, H70, H78=3
<b>H87</b>	1, 3, 8, 9	Inhalants	H87=3 if at least 3 of H31, H37, H47, H55, H63, H71, H79=3
<b>H120</b>	1, 3, 8, 9	Sedatives - Hypnotics- Anxiolytics	H120=3 if at least 1 of H88, H96, H104, H112=3
<b>H121</b>	1, 3, 8, 9	Stimulants	H121=3 if at least 1 of H89, H97, H105, H113=3
<b>H122</b>	1, 3, 8, 9	Opioids	H122=3 if at least 1 of H90, H98, H106, H114=3
<b>H123</b>	1, 3, 8, 9	Cannabis	H123=3 if at least 1 of H91, H99, H107, H115=3
<b>H124</b>	1, 3, 8, 9	Heroin	H124=3 if at least 1 of H92, H100, H108, H116=3
<b>H125</b>	1, 3, 8, 9	Cocaine	H125=3 if at least 1 of H93, H101, H109, H117=3
<b>H126</b>	1, 3, 8, 9	Hallucinogens/PCP	H126=3 if at least 1 of H94, H102, H110, H118=3
<b>H127</b>	1, 3, 8, 9	Inhalants	H127=3 if at least 1 of H95, H103, H111, H119=3

## 7. MODULE J. ADJUSTMENT DISORDER

<b>Var Name</b>	<b>Range</b>	<b>Description</b>	<b>Conditions</b>
<b>J7</b>	1, 3, 8, 9	Adjustment Disorder	J7=3 if J2=3 and J3=3 and J4=3 and J5=3 and J6=3

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**Mental Health Surveillance Study (MHSS)**

**SCID Failed Edit Worksheet**

Quest ID: \_\_\_\_\_ Technical Editor: \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Interviewer: \_\_\_\_\_ Clinical Supervisor: \_\_\_\_\_

**A. Check Front Cover**

	Interviewer ID
	Quest ID
	Date of Interview
	Date Shipped to RTI

	Date Received at RTI
	Clinical QC by
	Date of Clinical QC

**B. Check Required Fields – Problem is missing or out of range**

	OV1
	OV2
	OV3
	OV4
	OV5
	OV5a
	OV6
	OV6a
	OV6b
	OV7a
	OV7b
	EOI1 (End of interview, GAF)

	IDS1
	IDS3
	IDS4a
	IDS5
	IDS6
	IDS7
	IDS8
	IDS9
	IDS10
	IDS11
	IDS12
	IDS13
	IDS14

	IDS15
	IDS16
	IDS18
	IDS20
	IDS22
	IDS24
	IDS24a
	IDS26
	IDS28
	IDS28a

**C. Required Fields & Check screening variables for consistency – problem is inconsistency**

	S1
	S2
	S3

	S4
	S5
	S6

	S7
	S8
	S9



**D. Check Skip Patterns - Legitimate Skip but data is present**

Variable Name (Skip begins)	Variable Name (Should be blank, but response is circled. Include what response is written on SCID)	Notes

**E. Check for symptom Criteria & Diagnostic Variables to ensure conditions met for code 3.**

	A10
	A16
	A27
	A32
	A44
	A49
	A60
	A64
	A73
	A80

	E45
	E47a
	E51
	E57
	E69
	E77
	E103
	E107

	H82
	H83
	H84
	H85
	H86
	H87
	H120
	H121
	H122
	H123
	H124
	H125
	H126
	H127

	BC21
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	F6
	F15

	G4
--	----

	E10
	E18
	E24
	E27

	H9
	H14
	H80
	H81

	J7
--	----

## **Appendix I: Clinical Interview Current Status Report**



Total Number of Cases Not Keyed      112    23      120    24      100    19      118    22    450    22

Current Clinical Interview Status Codes	Quarter 1	%	Quarter 2	%	Quarter 3	%	Quarter 4	%	Total	%
00: Initialized -- Not worked	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
50: Appointment for Follow-Up Interview	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
51: R Unavailable	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
52: Ring No Answer, Busy	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
53: Machine/Voicemail: No Msg	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
54: Machine/Voicemail: Left Msg	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
56: Breakoff (Partial Interview)	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
57: Refusal	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
59: Other, Specify	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
70: Interview Completed, Audio Recorded	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
71: Interview Completed, No Audio (Refusal)	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
72: Interview Completed, No Audio (Technical Problem)	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
73: Breakoff (Partial Interview)	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
74: Unable to Contact after Repeated Calls	77	15.49	75	15.03	64	11.99	81	14.92	297	14.33
75: Final - Phone Number Problem	4	0.80	17	3.41	6	1.12	6	1.10	33	1.59
76: Final - Refusal	3	0.60	4	0.80	2	0.37	3	0.55	12	0.58
77: Final - Other (Specify)	0	0.00	1	0.20	2	0.37	1	0.18	4	0.19
79: Case reworked - R not selected	3	0.60	3	0.60	0	0.00	0	0.00	6	0.29
80: Materials Shipment (SCID)	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
81: SCID Received at Regent	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
82: SCID Received at Editing	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
83: Not Ready for Editing - Audio file expected but not uploaded	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
84: Ready for Editing - No audio file captured (code 71 or 72)	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
85: Ready for Editing - Audio file uploaded	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
86: Editing in Progress	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
87: Editing Complete	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
88: SCID Delivered to Technical Editing	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
89: Technical Editing Complete	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
90: 90 SCID Not Keyed - Reason Unspecified	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
90.1: Respondent-Induced Break-off	9	1.81	16	3.21	9	1.69	7	1.29	41	1.98
90.2: Comprehension Problems - Language Barrier	0	0.00	0	0.00	1	0.19	0	0.00	1	0.05
90.3: Respondent Distress	4	0.80	1	0.20	2	0.37	4	0.74	11	0.53
90.4: Cognitive Impairment - Short Blessed administered and failed	2	0.40	3	0.60	4	0.75	9	1.66	18	0.87
90.5: Cognitive Impairment suspected but not captured by the short blessed - Short Blessed administered and passed, yet invalid for other reasons	5	1.01	0	0.00	2	0.37	2	0.37	9	0.43
90.6: Data of Questionable Validity (e.g., insufficient data, denial of symptoms, inconsistent report)	2	0.40	0	0.00	7	1.31	5	0.92	14	0.68
90.7: Interviewer error (e.g. Improper scoring of the Short Blessed, failure to follow protocol)	3	0.60	0	0.00	1	0.19	0	0.00	4	0.19
95: Keyed	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
96: Keying Verified	385	77.46	379	75.95	434	81.27	425	78.27	1623	78.29
<b>Current Clinical Supervisor Review Codes</b>										
40: Not Selected for Clinical Supervisor Full Audio Review	345	92.99	327	93.16	368	88.25	357	91.07	1397	91.25
41: Selected for Clinical Supervisor Full Audio Review - Pending	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
42: Clinical Supervisor Full Audio Review, In Progress	0	0.00	1	0.28	2	0.48	2	0.51	5	0.33
43: Clinical Supervisor Full Audio Review, Completed, no problems	19	5.12	16	4.56	36	8.63	23	5.87	94	6.14
44: Clinical Supervisor Full Audio Review, Completed with Minor Problems	6	1.62	7	1.99	11	2.64	10	2.55	34	2.22
45: Clinical Supervisor Full Audio Review, Completed with Major Problems	1	0.27	0	0.00	0	0.00	0	0.00	1	0.07
<b>Total (Codes 40 through 45)</b>	<b>371</b>	<b>100</b>	<b>351</b>	<b>100</b>	<b>417</b>	<b>100</b>	<b>392</b>	<b>100</b>	<b>1531</b>	<b>100</b>

