*Data are gathered from a residential treatment facility for substance use disorders. Data include item-level responses for all questionnaires listed below. Data are available at initiation of treatment, after one month of treatment, and at treatment discharge.*

**Quality of Life (WHOQOL-BREF)**

The Quality of Life assessment is a 26-item questionnaire that measures general, physical, and psychological health, as well as social relationships and one’s environment. Responses to the questionnaire are on a 5-point Likert scale ranging from 1) Not at all or very dissatisfied to 5) Extremely or Very satisfied.

The Quality of Life measure used in the Patient Health Assessment (PHA) contains no revisions to the original WHOQOL-BREF assessment.

<https://link.springer.com/content/pdf/10.1023/B%3AQURE.0000018486.91360.00.pdf>

Skevington, S. M., Lotfy, M., & O’Connell, K. A. (2004). The World Health Organization’s WHOQOL-Bref Quality of life assessment: Psychometric Properties and results of the international field trial. A report from the WHOQOL Group. *Quality of Life Research*, *13*(2), 299–310. https://doi.org/10.1023/b:qure.0000018486.91360.00

**Thoughts about Change (CSS-5)**

The Thoughts about Change assessment, also known as the Commitment to Sobriety Scale (CSS) contains 5 questions measuring the patient’s commitment to abstinence from alcohol and drug use. These questions assess various aspects of dedication towards alcohol/drug cessation, including the importance of sobriety in the patient’s life, how committed they are to continuing their alcohol/drug use abstinence, and their desire to return to substance use. The questions are rated on a 6-point Likert scale, ranging from 1) Strongly Disagree to 6) Strongly Agree.

The format of the Thoughts about Change measure was not altered from its original reference, the CSS-5.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3840075/>

Kelly, J. F., & Greene, M. C. (2014). Beyond motivation: Initial validation of the commitment to sobriety scale. *Journal of Substance Abuse Treatment*, *46*(2), 257–263. https://doi.org/10.1016/j.jsat.2013.06.010

**Tobacco Use (FTND)**

The Tobacco Use/Dependence assessment is used when the patient confirms prior tobacco or nicotine use within the past month. The measure consists of 7 questions, with the first 6 assessing the patient’s current level of addiction by asking questions such as, “How soon after you wake up do you smoke your first cigarette or inhale your first vape?” or “Do you smoke/vape even when you're ill enough to be in bed most of the day?”. The final question asks the patient to indicate their current level of interest in quitting tobacco use on a scale of 1-5.

The format of the Tobacco Use measure is modeled off of the Fagerström Test for Cigarette Dependence (FTND). The FTND consists of 6 questions, which are the same as the first 6 in the Tobacco Use measure used in the PHA. The final question in the Tobacco Use measure was the only addition made to the referenced assessment.

<https://web.p.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=0&sid=1c08df73-85b0-4263-9d7b-5cfcc105c935%40redis>

Heatherton, T. F., Fagerström, K.O., Frecker, R. C., & Kozlowski, L. T. (1991). The Fagerström Test for Nicotine Dependence: a revision of the Fagerström Tolerance Questionnaire. *British Journal of Addiction*, *86*(9), 1119–1127. https://doi.org/10.1111/j.1360-0443.1991.tb01879.x

**Smokeless Tobacco Dependence**

The Smokeless Tobacco Dependence assessment follows a screener for smokeless tobacco use within the past month. The questionnaire consists of 2 items, the first of which asks for a self-reported level of addiction to smokeless tobacco products, with responses ranging from 1) Not at all addicted to 5) Completely addicted. The second question asks for the patient’s level of interest in quitting smokeless tobacco use on a 1-5 scale.

**Alcohol/Drug Craving (PACS)**

The Alcohol/Drug Craving questionnaire assesses the alcohol/drug cravings the patient has experienced within the past week, excluding any tobacco or nicotine cravings. It consists of 5 items, which assess a variety of craving characteristics, including the frequency and strength of cravings, as well as the amount of time spent thinking about drinking or using drugs. The final question of the measure asks for a self-reported average alcohol and drug craving for the past week. Responses to the questions are on a 0-6 scale ranging from 0) None at all/Never to 6) Strong urge/Nearly all of the time.

The Alcohol/Drug Craving measure is modeled on the Penn Alcohol Craving Scale (PACS). There are no differences between the two assessments.

https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1530-0277.1999.tb04349.x

Flannery, B.A., Volpicelli, J.R., & Pettinati, H.M. (1999). Psychometric properties of the Penn Alcohol Craving Scale. *Alcoholism: Clinical and Experimental Research*, 23(8), 1289–1295. <https://doi.org/10.1097/00000374-199908000-00001>

**Alcohol Abstinence Experiences (AASE)**

The Alcohol Abstinence Experiences measure is a 20-item self-report questionnaire that assesses the patient’s self-confidence in their ability to remain abstinent from alcohol in various situations. These situations range from when experiencing withdrawals to being offered a drink in a social setting, providing a wide variety of scenarios from which patients can report their confidence levels. Responses to the questions are in the form of a 5-point Likert scale ranging from 1) Not at all confident, to 5) Extremely confident, and responses are scored in regard to 4 different subscales: Negative Affect, Social/Positive, Physical, and Craving and Urges.

The Alcohol Abstinence Experiences measure used here is based on the Alcohol Abstinence Self-Efficacy Scale (AASE), with no changes made to the questions asked in the assessment.

https://www.jsad.com/doi/epdf/10.15288/jsa.1994.55.141?role=tab

DiClemente, C. C., Carbonari, J. P., Montgomery, R. P., & Hughes, S. O. (1994). Alcohol Abstinence Self-Efficacy Scale. *Journal of Studies on Alcohol*, *55*(2), 141–148. https://doi.org/10.1037/t04226-000

**Drug Abstinence Experiences (DASE)**

The Drug Abstinence Experience is structured in a similar format to the Alcohol Abstinence Experiences measure but is targeted towards mood-altering substance use within the past year. Patients are first asked to clarify if the answers to the assessment are based on a prescribed, non-abused substance, and then answer the same questions as in the Alcohol Abstinence Experiences measure. The 20 questions are used to evaluate self-reported confidence levels in reference to the four subscales mentioned prior: Negative Affect, Social/Positive, Physical, and Craving and Urges.

The Drug Abstinence Experience assessment is based on the Drug Abstinence Self-Efficacy Scale (DASE), which is an adaptation of the AASE. Both assessments include the same 20 scenarios for assessing confidence levels, however the DASE includes an additional question regarding the patient’s drug of choice. The questionnaire on the DASE was also reframed to ask participants how tempted they would be to use their drug of choice in each of the 20 scenarios. Lastly, the Drug Abstinence Experience assessment used in the PHA was modified to inquire whether the responses to the questionnaire were based on a prescribed, non-abused substance.

<https://journals.sagepub.com/doi/epdf/10.2466/pr0.2000.86.2.529>

Hiller, M. L., Broome, K. M., Knight, K., & Simpson, D. D. (2000). Measuring self-efficacy among drug-involved probationers. *Psychological Reports*, *86*(2), 529–538. https://doi.org/10.2466/pr0.2000.86.2.529

**Emotional Experiences (DERS-18)**

The Emotional Experiences assessment is an 18-item inventory of the patient’s emotional regulation abilities in reference to emotional experiences within the past two weeks. Responses are framed on a 5-point scale, ranging from 1) Almost never (0-10%) to 5) Almost always (91-100%). There are six subscales within this assessment, including awareness, clarity, goals, impulse, nonacceptance, and strategies. The scores on each of these subscales allow for the measurement of emotional dysregulation expressed by the participant.

The Emotional Experiences questionnaire is a replication of the Difficulties in Emotion Regulation Scale (DERS-18) and features no alterations from the original reference.

<https://www2.psych.ubc.ca/~klonsky/publications/DERS18.pdf>

Victor, S. E., & Klonsky, E. D. (2016). Validation of a brief version of the Difficulties in Emotion Regulation Scale (DERS-18) in five samples. *Journal of Psychopathology and Behavioral Assessment*, *38*(4), 582–589. https://doi.org/10.1007/s10862-016-9547-9

**General Health (PHQ-9)**

The General Health assessment consists of 9 items used to measure depressive symptoms in the participant by asking them how bothered they were by the 9 listed problems within the last two weeks. Responses range from 0) Not at all to 3) Nearly every day. The total score of the assessment is an indicator of potential depressive symptoms, with a higher score indicating greater depression severity.

The General Health measure used in the PHA is more commonly known as the 9-item Patient Health Questionnaire (PHQ-9) and is often used in clinical settings to screen for depression severity. There are no differences between the PHQ-9 and the General Health assessment.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/>

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9. *Journal of General Internal Medicine*, *16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

**Anxiety Experiences (GAD-7)**

The Anxiety Experiences measure is a brief 7-item self-report questionnaire that evaluates anxiety symptoms and possible generalized anxiety disorder (GAD). The format of the measure is similar to that of the General Health PHQ-9 assessment, with questions being in reference to experiences within the past two weeks. Additionally, a higher total score is indicative of greater severity of anxiety symptoms. Questions on the assessment target various anxiety symptoms, such as feeling nervous or on edge, having trouble relaxing, and excessive worrying.

The Anxiety Experiences assessment is modeled after the GAD-7 anxiety scale with no alterations from its reference.

<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410326>

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder. *Archives of Internal Medicine*, *166*(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

**Distressing Thoughts and Habits (OCI-R)**

The Distressing Thoughts and Habits measure contains 18 items, each listing an experience certain individuals might experience, such as checking things more often than necessary and getting upset if the arrangement of things is altered. The questionnaire asks respondents to indicate how often they have experienced these habits within the past month on a scale of 0) Not at all to 4) Extremely. The measure aims to score for obsessive-compulsive symptoms and habits.

The questionnaire used in the PHA derives from the Revised Obsessive-Compulsive Inventory (OCI-R) and features no changes in the 18 items included in the assessment. The primary difference between the OCI-R and the Distressing Thoughts and Habits measure is seen within the scoring. The measure used in the PHA is scored by an OCR total, whereas the OCI-R is scored in reference to six subscales, including washing, checking, hoarding, and other obsessive-compulsive symptoms.

<https://psycnet.apa.org/fulltext/2002-08358-015.html>

Foa, E. B., Huppert, J. D., Leiberg, S., Langner, R., Kichic, R., Hajcak, G., & Salkovskis, P. M. (2002). The obsessive-compulsive inventory: Development and validation of a short version. *Psychological Assessment*, *14*(4), 485–496. https://doi.org/10.1037/1040-3590.14.4.485

**Sleep Quality (PSQI)**

The Sleep Quality measure features 9 items, with questions 1-4 asking for the respondent’s usual bedtime, getting up time, hours of sleep per night, and how long it takes to fall asleep. These habits are a self-reported average of the patient’s habits within the past month. Following this, question 5 contains 10 subparts, each asking about possible sleep disruptions and their frequency on a weekly scale in reference to the past month. Items 6-8 ask the patient to detail the frequency of any sleep medication use, trouble staying awake while engaging in daily activities, and issues with keeping up enthusiasm. Patients are then asked to rate their overall sleep quality within the past month on a scale of 0) Very good to 3) Very bad. Lastly, any sleep medications (prescription or over the counter) are noted by the accessor. The measure provides scores for 7 separate components of sleep quality: subjective sleep quality, sleep latency, duration, efficiency, disturbances, use of medication for sleep, and daytime dysfunction. The scores of these components are summed to generate a global score from which sleep quality can be assessed.

The Sleep Quality measure is modeled after the Pittsburgh Sleep Quality Index (PSQI). The primary difference between the two is that the assessment used in the PHA is shortened to only include the items 1-9, while the PSQI goes on to include a final question with multiple subparts that focuses on the respondent’s roommates or bed partners (Shahid et al., 2011).

Shahid, A., Wilkinson, K., Marcu, S., & Shapiro, C. M. (2011). Pittsburgh Sleep Quality Index (PSQI). *STOP, THAT and One Hundred Other Sleep Scales*, 279–283. https://doi.org/10.1007/978-1-4419-9893-4\_67

https://www.sciencedirect.com/science/article/pii/0165178189900474

Buysse, D. J., Reynolds, C. F., Monk, T. H., Berman, S. R., & Kupfer, D. J. (1989). The Pittsburgh Sleep Quality index: A new instrument for psychiatric practice and Research. *Psychiatry Research*, *28*(2), 193–213. https://doi.org/10.1016/0165-1781(89)90047-4

**Pain Intensity & Interference (PROMIS)**

The Pain Intensity & Interference measure assesses the respondent’s pain experiences within the past 7 days. After self-reporting pain locations, patients complete the 7-item questionnaire which focuses on both pain intensity and the level of pain interference in the respondent’s everyday activities. Responses range from 0) No pain or not at all to 5) Very severe or very much.

The Pain Intensity & Interference measure is based on the pain intensity and pain interference short form assessments from the Patient-Reported Outcomes Measurement Information System (PROMIS). The first three items of the measure used in the PHA reflect the PROMIS Pain Intensity Short Form 3a, with no edits made. Items 4-7 of the Pain Intensity & Interference measure are modeled after the PROMIS Pain Interference Short Form 6a. The PROMIS intensity form features 6 items, 4 of which are included in the PHA measure.

<https://www.sciencedirect.com/science/article/pii/S0895435615005466>

Stone, A. A., Broderick, J. E., Junghaenel, D. U., Schneider, S., & Schwartz, J. E. (2016). Promis fatigue, pain intensity, pain interference, pain behavior, physical function, depression, anxiety, and anger scales demonstrate ecological validity. *Journal of Clinical Epidemiology*, *74*, 194–206. https://doi.org/10.1016/j.jclinepi.2015.08.029

**Gambling Experiences (BBGS)**

Gambling Experiences is a 3-item assessment of gambling behaviors during the past 12 months. Responses are in a yes/no format and summed to create a total gambling score, which can be used to screen for potential gambling disorders. Each of the three questions target various symptoms of gambling disorders, namely withdrawal, lying, and social consequences as a result of gambling.

The Gambling Experiences measure follows the structure of the Brief Biosocial Gambling Screen (BBGS), with no changes evident between the reference and the assessment used in the PHA.

<https://journals.sagepub.com/doi/epdf/10.1177/070674371005500204>

Gebauer, L., LaBrie, R., & Shaffer, H. J. (2010). Optimizing DSM-IV-TR classification accuracy: A brief biosocial screen for detecting current gambling disorders among gamblers in the general household population. *The Canadian Journal of Psychiatry*, *55*(2), 82–90. https://doi.org/10.1177/070674371005500204

**Eating Behaviors (EDDS)**

The Eating Behaviors measure contains 21 items and screens for potential eating disorders, such as anorexia nervosa, bulimia nervosa, and binge-eating disorder, as well as any symptoms of disordered eating. Respondents are asked to self-report their behaviors over the past three months. The first 3 items on the questionnaire focus on body-image related habits, and the latter questions primarily ask the patient to detail the frequency of a specific disordered eating habit within the past three months. For questions 13-16, patients are asked to only count instances where disordered behavior occurred directly to counter eating or possible weight gain

The Eating Behaviors assessment is based on the Eating Disorder Diagnostic Scale (EDDS), with minor changes made to the assessment used in the PHA. The PHA measure combines certain items of the EDDS to create a more concise questionnaire. This is seen in items 3 and 4 on the EDDS and item 3 on the PHA measure, where the questions regarding weight and shape influencing self-judgment are combined to a singular question. Additionally, the Eating Behaviors measure only focuses on the past 3 months, whereas the EDDS includes additional questions referencing the past 6 months. Furthermore, the EDDS includes two additional items concerning birth control and menstrual periods which is excluded in the PHA measure. The final difference between the two measures is seen in the inclusion of an item asking for the respondent’s highest weight in the past 3 months in the Eating Behaviors PHA measure.

https://psycnet.apa.org/record/2004-11653-007

Stice, E., Fisher, M., & Martinez, E. (2004). Eating Disorder Diagnostic Scale: Additional Evidence of Reliability and Validity. *Psychological Assessment*, *16*(1), 60–71. https://doi.org/10.1037/1040-3590.16.1.60

**Sexual Behaviors (PATHOS)**

The Sexual Behaviors measure contains 6-items and is utilized for screening and measuring sexual addiction. Responses are given in a yes/no format and are summed to create a total score. The Sexual Behaviors measure is modeled after the PATHOS assessment, which contains the same six questions. Each item focuses on a certain aspect of sexual addiction, namely being preoccupied with sexual behaviors, ashamed, receiving treatment for sexual behaviors, having hurt others as a result of sexual behavior, feeling out of control, and being saddened following sexual behaviors. There were no changes made between the PATHOS assessment and the Sexual Desire measure used in the PHA.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3212607/

Carnes, P. J., Green, B. A., Merlo, L. J., Polles, A., Carnes, S., & Gold, M. S. (2012). PATHOS: A brief screening application for assessing sexual addiction. *Journal of Addiction Medicine*, *6*(1), 29–34. https://doi.org/10.1097/adm.0b013e3182251a28

**Self-Efficacy Experiences (GSE)**

The Self-Efficacy Experiences measure asks participants to reflect over the past month and indicate how true the 10 items listed are. Answers range from 1) Not at all true, to 4) Exactly true, and are added to create a total score. The questions on this measure aim to assess the patient’s self-efficacy in the form of healthy coping and adaptation to stressful events (Schwarzer & Jerusalem, 1995).

The Self-Efficacy Experiences measure used in the PHA is in reference to the General Self-Efficacy Scale (GSE), specifically the 10-item version of the assessment. There were no changes made to the Self-Efficacy Scale from the GSE.

https://www.proquest.com/docview/213828989/fulltextPDF/494F5282449F4FA4PQ/1?accountid=10920

Luszczynska, A., Scholz, U., & Schwarzer, R. (2005). The General Self-Efficacy Scale: Multicultural Validation Studies. *The Journal of Psychology*, *139*(5), 439–457. https://doi.org/10.3200/jrlp.139.5.439-457

**Social Support (MSPSS)**

The Social Support evaluation consists of 12 questions divided into three separate subscales: family, friends, and significant others. The purpose of these questions is to measure the perceived level of social support the respondent receives from each of the three subcategories. This assessment provides scores for the three categories, as well as an average score from which overall social support can be assessed. Responses to assessment items are on a 7-point Likert scale ranging from 1) Very Strongly Disagree to 7) Very Strongly Agree.

The Social Support measure is in reference to the Multidimensional Scale of Perceived Social Support (MSPSS), with no differences between the two.

https://web.s.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=0&sid=3f850da0-def9-429c-8908-313b46e2b028%40redis

Dahlem, N. W., Zimet, G. D., & Walker, R. R. (1991). The multidimensional scale of perceived social support: A confirmation study. *Journal of Clinical Psychology*, *47*(6), 756–761. https://doi.org/10.1002/1097-4679(199111)47:6<756::aid-jclp2270470605>3.0.co;2-l

**Stressful Life Experiences (LEC-5)**

Stressful Life Experiences is a 17-item measure used in only baseline assessments. The measure is structured as a checklist, with each item listing a stressful life event such as natural disaster, or serious injury. Respondents are asked to indicate whether they 1) experienced the life event personally, 2) witnessed it happen to someone else, 3) learned about it happening from a close friend or family member, 4) experienced the event due to their job, 5) are not sure, or 6) the event does not apply to the respondent. The purpose of this assessment is to note any exposure to life events that have the potential to cause Post-Traumatic Stress Disorder (PTSD) or other distress due to traumatic events.

The Stressful Life Experiences measure is modeled after the Life Events Checklist for the DSM-5 (LEC-5). There were no changes made to the items and scoring of the measure used in the PHA from the LEC-5.

<https://journals.sagepub.com/doi/pdf/10.1177/1073191104269954>

Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric Properties of the Life Events Checklist. *Assessment*, *11*(4), 330–341. https://doi.org/10.1177/1073191104269954

**Childhood Experiences (ACE)**

Childhood Experiences is a 17-item measure used in baseline assessments to evaluate exposure to adverse experiences during the first 18 years of life. Responses are structured in a yes/no format, and a total score is created. Adverse childhood experiences listed in the questionnaire cover forms of physical and emotional abuse and neglect, as well as sexual abuse, assault, and other traumatic events.

The Childhood Experiences measure is modeled on the Adverse Childhood Experiences assessment (ACE), which typically contains 10 items. The initial 10 items on the Childhood Experiences measure are a replication of the ACE assessment, and items 11-17 were created to supplement the measure.

<https://www.sciencedirect.com/science/article/pii/S0749379798000178?via%3Dihub>

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8

**Substance Use History**

The Substance Use History questionnaire contains 2 primary items, each with subparts. The first question asks for the respondent to self-report the substances they have ever tried, as well as the age at which they first tried the substance (tobacco, alcohol, or other drugs). Participants are also asked to report the first mood-altering substance they have tried recreationally. The last item asks for the substances the respondent regularly used (tobacco, alcohol, or other drugs), as well as the age at which they began regularly using the substance.

**Stress Responses (PCL-5)**

Stress Responses is a 20-item self-report assessment measuring Post-Traumatic Stress Disorder (PTSD) severity through focusing on the 20 symptoms of PTSD as detailed in the DSM-5. The questionnaire asks participants to detail how bothered they were by the various problems within the past month on a scale from 0) Not at all to 4) Extremely. Use of this assessment can help screen for PTSD and assess symptom severity in respondents.

The Stress Responses measure used in the PHA is also known as the PTSD Checklist for the DSM-5 (PCL-5). There were no changes made to the Stress Responses measure from the PCL-5.

<https://psycnet.apa.org/fulltext/2015-55809-001.pdf>

Bovin, M. J., Marx, B. P., Weathers, F. W., Gallagher, M. W., Rodriguez, P., Schnurr, P. P., & Keane, T. M. (2016). Psychometric Properties of the PTSD Checklist for Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition (PCL-5) in Veterans. *Psychological Assessment*, *28*(11), 1379–1391. https://doi.org/10.1037/pas0000254

**AA/NA Affiliation Scale (AAAS)**

The AA/NA Affiliation Scale is a 10-item questionnaire designed to assess patient involvement in Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) prior to being in treatment. Questions cover topics such as membership of AA or NA, sponsorship, active participation, and general involvement in AA/NA meetings, and are structured in either a yes/no format or short response. The results are scored to create a lifetime meetings and past year meetings calculation, as well as a total score.

The AA/NA Affiliation scale is modeled after the 9-item AA Affiliation Scale (AAAS) but is expanded to include a final question regarding meeting attendance in the past 90 days outside of treatment. Additionally, the scale used in the PHA is modified to include both NA as well as AA, which is reflected in the wording of the items.

<https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/j.1530-0277.1998.tb03691.x>

Humphreys, K., Kaskutas, L. A., & Weisner, C. (1998). The Alcoholics Anonymous Affiliation Scale: Development, Reliability, and Norms for Diverse Treated and Untreated Populations. *Alcoholism: Clinical and Experimental Research*, *22*(5), 974–978. https://doi.org/10.1111/j.1530-0277.1998.tb03691.x

**AA/NA Involvement**

The AA/NA Involvement measure is similar to the previous measure in that it continues to assess respondent involvement in AA/NA. The questionnaire contains 12 items that assess self-reported AA/NA involvement and attendance both within the past year and in general. Scores are measured in reference to an AA Attendance subscale and an AA Involvement subscale.

**Beliefs about AA/NA (TSPEQ)**

The Beliefs about AA/NA measure is a 16-item questionnaire with responses on a 6-point Likert scale from 1) Strongly disagree to 6) Strongly agree. Items are framed as statements regarding attendance and beliefs surrounding AA/NA. Thus, the purpose of this measure is to assess current patient opinions regarding AA/NA involvement and attendance, as well as assess patient expectancies for AA/NA engagement. The measure provides both a positive and negative score.

The Beliefs about AA/NA measure was made in reference to the 12-Step Participation Expectancies Questionnaire (TSPEQ). The TSPEQ originally has 39 items and the measure used in the PHA includes 16 of these. The Beliefs about AA/NA measure does cover the 10 subscales within the TSPEQ: social support, structured time, increased motivation, skill learning, positive/negative emotional reactions, social concerns, spirituality concerns, social influences, and attendance barriers (Kahler et al., 2006).

https://www.jsad.com/doi/epdf/10.15288/jsa.2006.67.538?role=tab

Kahler, C. W., Kelly, J. F., Strong, D. R., Stuart, G. L., & Brown, R. A. (2006). Development and initial validation of a 12-step participation expectancies questionnaire. *Journal of Studies on Alcohol*, *67*(4), 538–542. https://doi.org/10.15288/jsa.2006.67.538

**Spiritual Experiences (Brief R-COPE)**

The Spiritual Experiences measure includes 14 items regarding spiritual coping experiences in the past 30 days. Participants are asked to indicate the frequency of each experience, ranging from 0) Not at all to 3) Nearly every day, and scores reflect positive and negative spiritual coping. Following the 14 items, respondents identify their current religious affiliation.

Spiritual Experiences is based on the Brief Religious Coping (Brief R-COPE) assessment, with the only difference between the two being the inclusion of identification of religious affiliation in the Spiritual Experiences measure.

<https://www.mdpi.com/2077-1444/2/1/51>

Pargament, K., Feuille, M., & Burdzy, D. (2011). The BRIEF RCOPE: Current psychometric status of a short measure of religious coping. *Religions*, *2*(1), 51–76. https://doi.org/10.3390/rel2010051

**Treatment Perspectives**

The Treatment Perspectives measure features 22 total items and is divided into two parts. Responses on part one are formatted on a 5-point Likert scale from 1) Completely agree to 5) Completely disagree, and part two features an additional N/A option. Questions concern patient beliefs surrounding past behaviors as well as their current treatment plan.

**Mindfulness Inventory (MAAS)**

The Mindfulness Inventory contains 15 statements expressing a lack of active awareness and mindfulness in everyday experiences, and responses indicate frequency on a scale of 1) Almost Always to 6) Almost Never. A total mindfulness score is then generated to assess self-awareness and attention to the present.

The Mindfulness Inventory is modeled after the Mindfulness Attention Awareness Scale (MAAS) and features no alterations from the original reference.

<https://psycnet.apa.org/fulltext/2003-02410-012.pdf>

Brown, K. W., & Ryan, R. M. (2003). The Benefits of Being Present: Mindfulness and Its Role in Psychological Well-Being. *Journal of Personality and Social Psychology*, *84*(4), 822–848. https://doi.org/10.1037/0022-3514.84.4.822

**Impression of Change (PGIC)**

The Impression of Change measure contains a single item asking the respondent to describe the change in their emotions, activity, symptoms, limitations, and overall quality of life in reference to their substance use disorder since beginning treatment. The responses range from 1) No change or condition worsened to 7) A great deal better.

The Impression of Change measure is in reference to the Patient Global Impression of Change (PGIC) assessment and contains no alterations from the original questionnaire.

<https://rmdopen.bmj.com/content/rmdopen/1/1/e000146.full.pdf>

Rampakakis, E., Ste-Marie, P. A., Sampalis, J. S., Karellis, A., Shir, Y., & Fitzcharles, M.-A. (2015). Real-life assessment of the validity of patient global impression of change in fibromyalgia. *RMD Open*, *1*(1). https://doi.org/10.1136/rmdopen-2015-000146

**Additional Data Include:**

* **Basic demographics (age, gender, education)**
* **Duration of sobriety prior to treatment**
* **Length of stay in treatment**
* **Treatment dropout**
* **Specific SUDs (e.g., alcohol use disorder)**