



MATE

Measurements in the Addictions for Triage and Evaluation

Development of an instrument assessing patient characteristics in substance abuse treatment

Final report

ZonMw/Resultaten Scoren-project nr 31000068

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Preface

This report presents the results of the studies conducted as part of ZonMw/Resultaten Scoren-project nr 31000068 “Measurements in the Addictions for Triage and Evaluation. Development of an instrument assessing patient characteristics in substance abuse treatment”.

It presents the data collected on MATE version 1.0 and describes the developments since then. They resulted in the composition of MATE 2.0, that is a final version that can be used in actual practice and is available at <http://www.mateinfo.eu>.

More information can be obtained from the authors.

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1 Introduction

The aim of substance abuse treatment is to improve or sustain the physical, social and mental health of people that are dependent on alcohol and/or drugs. Professional substance abuse treatment centers in the Netherlands are required to deliver integral services, that is the whole range of care and cure for a great variety of patients. The task of substance abuse treatment is strongly supported by good measurement of the physical, social and mental characteristics of their (potential) patients. The instruments currently available are insufficient in doing so. This project aims at constructing and testing a new instrument to be used 1) as assessment of problem and needs in all the domains relevant in substance abuse treatment and 2) as framework for the application of existing instruments for more refined measuring of a selected series of domains, relevant for matching, patient allocation, and treatment evaluation in the addictions.

This project follows up on the 2002-2003 ZON-Mw project nr 31000045 / 96040690 project 'Developing specifications for the measuring of patient characteristics in substance abuse treatment', that concluded that measurement in the field of substance abuse treatment is not well developed, nor in the array of available instruments, nor in the discipline of application (Broekman & Schippers, 2003). They presented also a survey among field workers and concluded that there is a need for the development of a more mature and more economical instrument for matching and patient allocation, and for monitoring and treatment evaluation. It can be expected that such an instrument will provide treatment staff with more adequate information about the functioning of their patients and will support making rational and transparent decisions about whom to give what kind and how much treatment. The willingness to use an uniform instrument is due to the grown awareness of the importance of data-driven patient allocation. This is among other things caused by the need of the relatively large Dutch substance abuse treatment centers, which have to provide a broad, comprehensive variety of services for all people with substance abuse problems in a region.

Broekman and Schippers' (2003) inventory of current practices of assessment in Dutch substance abuse treatment revealed that the Addiction Severity Index (ASI; McLellan, et al., 1992) and the EuropASI (of which there are more versions around) are the only instruments used in more than one institution. The ASI, developed in the early '80s, was described as a 'first generation' instrument that functioned for the Dutch substance abuse treatment as an important and worthwhile tool that stimulated the systematic registration and filing of patient characteristics, which until then was fairly nonexistent. However, there are many problems with the instrument. These problems are practical as well as conceptual and psychometrical and laid out in detail by Verheul and Van den Brink (2001) and Schippers and Broekman (2004). The (Europ)ASI is composed as an ad hoc compilation of items that are not derived from a clear conceptual framework. It does not produce validated, reliable and normalized scores for each of its seven domains following scoring instructions from test developers. Although the *Interviewer Severity Ratings* do give a summary score for each domain, they are ratings themselves, conceptually unclear and unreliable. The computed *Composite Scores* have inherent problems, and the modified computed indexes (*CI*s and *Eis*) are mere ad hoc clusters

of items based on psychometrically sophisticated factor analytic studies, that cannot, however, make up for the inherent deficiencies of ASI as a measurement instrument. Furthermore, it was revealed that, besides serving as a sophisticated problem checklist, in the practice of Dutch substance abuse treatment centers, only the *Severity Ratings* are used in a way that has an actual influence on the practice, i.e. for matching and patient allocation. The originators of the ASI (McLellan et al., 1992) are developing a new version of the ASI, but decided to do so on their own and rejected a joint enterprise in this respect (Verheul & Van den Brink, 2001). Translating this to-be-expected version, that probably will require a series of adaptations in order to be functional in Dutch and other European countries, was expected to take years. We therefore concluded that it is a worthwhile task to develop an instrument ourselves. Given the conceptual, functional and psychometric shortcomings of the current ASI, we decided not to revise this instrument, but to undertake the endeavor of constructing a fully new one, based on specifications derived from the needs of professional substance abuse treatment services.

1.1 Aim of the research project and sub-projects

The aims of the research projects as formulated in the funding request are the development and test of an instrument for 1) the assessment of needs (problem experiences and needs for treatment) in people with alcohol and/or drug abuse (and gambling), and 2) the framing of existing or adapted instruments for more refined diagnosing and assessing needs in selected, relevant domains, and, eventually, monitoring clinical outcomes and linking substance abuse treatment to the justice field. Further, the cooperation of other institutions and research groups had to be stimulated by the separate organization and funding of three sub-projects. Originally, the following sub-projects have been proposed: 1) validating the implementation of an existing or adapted sub-scale on the general domain: somatic illnesses; 2) validating the new instrument with a recently developed measuring instrument for juridical clients; and 3) testing the use of the new instrument for monitoring treatment outcome.

Ad 1) The first sub-project was given form by implementing and testing the new instrument in a HIV-infectious risk group of heavy drug users who are monitored regularly by the GGD in Amsterdam. The Amsterdam Cohort Study among drug users (ACS), is a prospective open cohort study which started in 1985. Main aims of the ACS are to study the epidemiology of HIV infection and AIDS, other sexual transmitted diseases, and blood borne infections among drug users. The study group mainly consists of long-term drug users, primarily users of heroine, methadone and cocaine. We tested whether the instrument is feasible, reliable, and valid in this group.

Ad 2) The second sub-project, concerning the measuring of the feasibility in a population of judicial clients, has been given form by participating and combining this sub-project with a project commissioned by the SVG (Stichting Verslavingsreclassering GGZ-Nederland), to develop and test a form of 'vroegdiagnostiek', a case-finding and treatment planning instrument to support and guide clients from the judicial context into addiction treatment facilities.

Ad 3) In preparing the third subproject it became clear that monitoring had to be preceded by the construction of algorithms for the assessments and estimations of indicators and dimensions to be used in referral and triage decisions in the intake and treatment processes, that could be tested later on. So, this sub-project was effectuated by developing such algorithms.

Therefore, the aims of this ZonMw/Resultaten Scoren-project are as follows:

- 1) Development of an instrument for the assessment of needs (problem experiences and needs for treatment).
- 2) Framing of existing or adapted instruments for more refined diagnosing and assessing needs in selected, relevant domains, and, eventually, monitoring clinical outcomes in people with alcohol- and/or drug abuse (and gambling).
- 3) Testing the feasibility of the instrument in an intake population of a general substance abuse treatment center.
- 4) Assessing the reliability and the validity of a selection of modules of the instrument in a population of heavy users.
- 5) Developing and testing the feasibility of a measuring instrument for judicial clients.
- 6) Developing and calibrating a set of algorithms for the assessments and estimations of indicators and dimensions to be used in referral and triage decisions in the intake and treatment processes.

We will present the results of the project separately for each of these aims in the following chapters.

2 Development of the instrument

2.1 Specifications of a new instrument

As a result of the former ZonMw project and in cooperation with a Steering Committee of Dutch expert of academicians and clinical experts¹ the authors formulated a series of specifications (Broekman & Schippers, 2003). In general, they concluded that a new instrument should be

1. Functionally related to the practical needs of substance abuse treatment;
2. Acceptable for the assessed individuals and measuring both needs and compensations;
3. Derived from a clear conceptual schema;
4. Internationally compatible and based on the best well developed (sub)instruments.

Ad 1.) Assessing patient characteristics at the intake in substance abuse treatment serves a series of functions. Next to administrative purposes, a distinction can be made between triage; case finding (screening); diagnostics; and monitoring and evaluation. Given the societal task of Dutch community-based substance abuse treatment centers, almost monopolistic providing treatment services to large regional populations, Broekman and Schippers (2003) suggested that the new instrument should focus in the first place on *triage*. Triage for matching and patient allocation is the rough indicating whether a person experiences problems, and whether or not treatment should be offered. For triage to treatment intensity, a protocol has been developed and disseminated nationally (DeWildt et al., 2002), that has been actually implemented a number of years ago in a series of centers. In the intake process, triage is not restricted to treatment intensity trajectories, but includes also decisions whether the patient should be allocated to any or more specialized services, like somatic and psychiatric treatment, and all kind of social services, for example for basic conditions as housing, financing, and self-care, and for psychological help in relationships, getting education, spiritual help etc. *Case finding* refers to the identification of the occurrence of disorders other than the primary complaint, and without a full diagnosis of the disorder. In the intake process cases of psychiatric and some somatic disorders have to be identified in order to be diagnosed further in a next phase in the treatment process. *Diagnosing* at intake can be restricted to the disorders that are core business of substance abuse treatment: dependency and abuse. Further, the instrument should be feasible for *monitoring and evaluation* to measure changes. For measuring change dimensional scoring is required, using continuous scales, rather than diagnostic instruments with a dichotomous outcome ('case' vs 'no case').

Ad 2.) The new instrument should be as short and parsimonious as possible. It should pose simple, self-evident questions and should return outcomes that are understandable for lay persons as well. Important is that not only shortages and disabilities are assessed, but compensations (resources, strengths) as well. Finally, we found that the instrument should cover life areas that can be important for individuals, but are less commonly referred to in professional treatment (eg spirituality).

¹ The steering group consisted of Prof dr Wim van den Brink; Dr Maarten Koeter (AIAR); Dr Vincent Hendriks (PARC); Prof dr Cor de Jong (NISPA); Prof dr Dike van der Mheen (IVO); Prof dr Guus van Heck (KUB).

Ad 3.) Broekman and Schippers (2003) concluded that the new instrument should be based on a comprehensive and conclusive list of relevant domains for the addictions. In particular the measuring of personal and social functioning meeting that requirement is lacking, as they conclude from a critical review of a series of often used instruments that they present in their report.

A firm foundation for the assessment of patient characteristics can be found in the WHO family of classifications consisting of the International Classification of Diseases (ICD) and the International Classification of Functioning (ICF). The ICF is a comprehensive classification system designed to capture aspects of human functioning in the context of a health condition. The ICF was endorsed for international use by the World Health Assembly in May 2001. The system consists of a hierarchy of classifications for each of its domains: Body Functions and Structures, Activities and Participation, and Environmental Factors. Codes can be recorded for each classified item within a domain to indicate the extent of a 'problem' with any of these aspects of functioning. Environmental Factors can be recorded as being either barriers to, or facilitators of a person's functioning. The WHO ICD/ICF as a backbone will guarantee also that the new instrument will match with developments in neighboring areas in health care, such as general and social psychiatry, and internal medicine. The ICF is also one of the pillars of the newly introduced indication process for the first compartment of Dutch health care, which roughly spoken could be characterized as the care part (AWBZ), whereas the second compartment could be characterized as the cure part of the health care system. Regional agencies organized at local authority level (so called RIOs) are responsible for the independent determination of indication that is required in order to be able to claim care in the first compartment. Based on assessment of current functioning guided by the ICF, it is decided what kind of help and the amount of help the person is entitled to get. In the second compartment the WHO-ICD, plays a crucial role, not directly in determining need, but by linking diagnosis to fixed costs. The WHO-ICD and -ICF will gain in importance and impact and it is therefore logical and sensible to use it as the framework for the domains of assessment in the field of substance abuse treatment as well, operating in both compartments. Together, they provide a framework and language for information about health and functioning, to enable communication about health and health care in common terms, across various disciplines and between countries. Domains relevant for the field of substance abuse treatment can be derived from these classifications. Arguments for the adoption of the WHO classification for the new instrument are given more in depth by Broekman and Schippers (2003).

Ad 4.) Broekman and Schippers (2003) observed that professional substance abuse treatment services are gradually stepping out of the relative isolated position in the (mental) health field that they took for decades. The new instrument should be feasible to be used in settings both in and outside the substance abuse treatment field with data understandable broadly. This is in accordance with the need to use the new instrument for research purposes. Therefore, it should make use as much as possible of instruments that are generally accepted by academicians in the field of general (mental) health treatment. Further, the instrument should have an appeal in other countries, in particular in Europe. Developing an instrument just for national needs is not cost-effective, and the product would be out of place in the long run. They therefore suggested not to build one all-in-one purpose instrument (like the ASI), but

to compose a flexible, modular set of instruments. The search for existing instruments has been successful, with the exception of an instrument to measure personal and social functioning according to the ICF. The selection of instruments of existing instruments has been done according to the following specifications:

- Psychometrically solid as is evidenced in international published empirical studies;
- As short and sensible (Feinstein, 1987) as possible;
- Accessible in the public domain.

The last point implies, for ideological and practical reasons, that the modules should be free from copyrights, like the new instrument itself.

2.2 Modules of the new instrument and arguments for inclusion

Considering that the main purposes of the proposed instrument (better: set of instruments) are: triage and monitoring/evaluation, and considering its proposed international compatibility, the new instrument is launched under the name: MATE, acronym for, in Dutch, *Meten van Addicties voor Triage en Evaluatie* and in English, *Measurements in the Addictions for Triage and Evaluation*.

Arranging the modules of the MATE according to the functions they serve, these are the following.

2.2.1 For the function of triage to medical and psychiatric diagnostics

The instrument should be able to help deciding whether medical and/or psychiatric diagnosis and treatment is needed. Many patients in substance abuse treatment have co-occurring mental disorders that needs treatment. Proper diagnosis of these should be part of the treatment planning process. It is a dilemma, however, where to position this diagnostics. There are arguments not to position psychiatric diagnostics (other than for dependency and abuse) in the intake process. The first argument is that proper diagnostics should be done after a certain period of detoxification, since many symptoms disappear as a consequence of stopping the alcohol and/or drug use. Further, assessing patient characteristics in the intake mostly is done by staff not trained as psychiatrists. We concluded that psychiatric diagnostics (other than for dependency and abuse) should be positioned in a phase after initial assessment of patient characteristics at intake. Therefore, the instrument is restricted to the support of the decision whether or not more in depth psychiatric and medical diagnostics and subsequent treatment is needed. For that reason case finding is restricted to psychiatric comorbidity *in general*, and not indicating particular disorders. In this respect we let the function of evaluation and monitoring prevail over the function of case finding of psychiatric disorders (other than dependency and abuse). For this reason we preferred instruments with dimensional scales (given that they allow for dichotomous outcomes as well) above instruments that are primarily build to give categorical outcomes.

In preparing for the decision (triage) whether or not to refer for in-depth comorbid psychiatric and somatic diagnostics, the MATE assesses firstly whether the person is, or has recently been, in psychiatric or psychological treatment, and whether psycho-pharmaceuticals are already prescribed. Further, whether the person currently is in medical treatment or is in clear need of such, including prescribed medications.

Finally a series of *symptoms* are assessed, that occur in disorders that either are rather common (anxiety, depression, personality disorders), or are less prevalent, but so serious that they should not be missed (hallucinations, delusions, suicidal tendency). For the first we selected case finding instruments, for the second, we selected separate items.

The instruments that are included in the MATE are presented in Table 1.

2.2.2 For the function of triage to program services

Substance abuse treatment consists of a series of program services, provided in addition to and in support of the treatment of addictive behaviors. Whether or not special services should be provided to the patient, and which services, must be derived from an assessment of the personal and social functioning. As a consequence of not having an instrument available measuring functioning according to the specification mentioned before, a new instrument had to be devised. We choose to construct an interview based on the ICF classification system. This interview aims to measure selected aspects of the *participation and activities* of the person and the *environmental factors* positively or negatively influencing this functioning. From the selected chapters in the ICF, interview questions are formulated that allow the ratings of:

- The limitation in performance that can be observed in the person;
- The amount of professional support the person already receives;
- The need for help that is currently observed by the interviewer, including the availability of such help;
- The need for help as perceived by the interviewed person;
- The barriers to or facilitators in the environment of the person.

For the selection of the domains from the ICF chapters *participation and activities* and *environmental factors*, an expert group has been consulted and domains are selected that considered to be of relevance for general purposes and for selection program services in particular. The MATE evaluates a selection ('core set') from these domains and factors. The core set was selected on the basis of the relevance for persons with (possible) chronic psychological problems. The set consists of 19 domains from component d. of the ICF 'Activities and participation' and four factors from component e., the 'Environmental factors' that influence activities and participation. These domains were selected because they are deemed important to people who are assessed in the mental health care and substance use disorder treatment. A full presentation of the items in the MATE-interview based on the ICF domains is presented in MATE vs 1.02, in appendix 1. The component 'Activities and participation' is measured in MATE module 7, and 'Environmental factors' in module 8. Since these two modules in the MATE are based on a set of items in the ICF and assess the needs of the person, this part of the MATE has been given a separate name: the MATE-ICN (ICF Core set & Needs for care; in Dutch: MATE-IKZ: ICF Kernset en Zorgbehoefte). MATE-ICN was compiled by the authors with the help of an expert team of clinicians and academicians.

2.2.3 For the function of triage to treatment intensity

According to the intake module developed by Resultaten Scoren (DeWildt et al, 2002), four dimensions in patient characteristics are defined as in particular important for the function of *triage* to treatment intensity, based on available evidence in the literature. These dimensions are:

1. Severity of the dependency;
2. Social and personal functioning;
3. Psychiatric co-morbidity.

Table 1 Overview of modules in MATE^a

Classification system	Domain	Concept	Instrument
ICD/DSM	Substance-related disorders	» Use	» UseGrid
		» Dependence	» ICD/DSM-dependence criteria
		» Abuse	» DSM-criteria
		» Craving	» OCDS (Obsessive Compulsive Drinking Scale -adapted)
	Psychiatric Comorbidity	» Anxiety and depressive symptoms	» HADS (Hospital Anxiety Depression Scale) ^b
		» Psychotic symptoms	» Observation items
		» Suicidality	» MATE-interview
		» Personality disorders	» SAPAS (Standardised Assessment of Personality – Abbreviated Scale)
	Physical comorbidity	» Physical complaints, symptoms	» MAP-HSS (Maudsley Addiction Profile – Health Symptoms Scale)
	ICF	Personal and social functioning	» Participation and Activities, external factors, assistance & support, subjective and objective needs	» MATE-ICN
» General Assessment of Functioning (GAF)			» MATE-score
No system	Treatment History	» Number of adequate and regularly finished treatments	
	Motivation for treatment	» Motivation for Treatment scale	» MfT (Motivation for Treatment)
	Criminality	» Relation criminal behavior and psychoactive drugs use	» MATE-crimi interview (NEXUS)

^a For a full overview of the arguments and references of the modules in the MATE, see MATE Manual and Protocol (Schippers, Broekman, & Buchholz, 2007).

^b This instrument is replaced in MATE 2.0 by the Depression Anxiety Stress Scale (DASS), because the HADS turned out to be copyright protected.

Further, treatment history (the number of times the person has been treated before for this affliction) plays a role, enabling a stepped care approach. The MATE assesses the number of adequate and regularly finished treatments of the prevalent addictive behaviors provided in the last five years.

All four dimensions can be derived from the items of the MATE. The paradigms to do so, and the decision tree to recommend treatment intensity, will be explicated in a later section.

2.2.4 For the function of monitoring and evaluation

To monitor alcohol and drug consumption (and gambling behavior), firstly, the MATE assesses the use and ways and patterns of use of psychoactive drugs and gambling, both current in the previous period and lifetime, including the primary substance used (or gambling) in a problematic way. This assessment does not include cognitions, reasons for use, or functionality of use, which are considered pieces of diagnostic information, important for treatment modality and planning, but not for triage to treatment intensity. For measuring consumption, a use-grid has been assembled, based on the list of psychoactive drugs included in the ICD-based Composite Index Diagnostic Inventory (CIDI; WHO, 1997). For measuring the craving for the prevalent drug, that can be taken as a sign for addiction severity, a self report questionnaire is selected. The instrument included measuring physical complaints can be used for monitoring change as well. To monitor symptoms of mental dysfunction, scales are included for anxiety and depression. This scale is used to indicate for further diagnostics on these disorders as well.

The selected instruments for all these modules are presented in Table 1 and in the copy of the MATE (vs 1.02) in appendix 1.

2.2.5 For the function of assessment in judicial patients

Of particular interest for patients referred through the judicial system, two additional modules are optionally included in the MATE. Firstly, one module is added to measure to what extent criminal behavior and drug abuse are interwoven ('nexus'). Secondly, because many of these patients do not present themselves voluntarily to treatment, a module is added measuring treatment motivation. In a separate section will be explicated how these instruments were developed and selected. We name this extended version the MATE-crimi. See chapter 8 for further explanation.

2.3 Developmental stages of the MATE

The specifications and a first draft of the MATE were presented to the Steering Committee and discussed in a meeting in June 2004. After their comments have been elaborated, version 0.93 was composed and presented to key professionals and counselors in the Dutch substance abuse treatment center TACTUS. As a pilot project testing its feasibility and adequacy, this version was being filled out by five interviewers, assessing 28 patients. The results of the pilot were reported by Broekman and Schippers (2004). This report was evaluated by and discussed with the steering committee in a meeting in October 2004. The conclusions of that meeting were worked through and led to the composition of MATE version 1.0, including a pilot version of a manual and protocol for administering. The version (slightly but insignificantly changed later on) that is used in the psychometric studies to be presented here is version 1.02w, which is attached as appendix 1. All details on these phases of the project can be found in the mentioned reports.

The study reported here took place in the period 2005-2006. In this period also the pilot version of the manual and protocol for applying the MATE has been elaborated and extended. A concept version of the underlying final report has been discussed in the third and last Steering Committee meeting in February 2007. The conclusions from the study led to a series of changes that are elaborated in the MATE version 2.0. This version was published together with a final version of the MATE Manual and Protocol (Schippers, Broekman, & Buchholz, 2007). MATE 2.0 has been presented on a national conference in April 2007 and is now available without restrictions.

3 Feasibility, item descriptives and modifications of the instrument

In line with the positive experiences piloting the MATE, TACTUS decided in 2005 to implement the MATE as a regular intake instrument for triage and patient placement of all their patients entering the center. An introductory training was composed, and intake assessors were introduced to the instrument and the protocol.

We answered the following questions:

1. What are the experiences of the MATE assessors as far as usefulness, time needed for filling out, acceptability and understandability of the patients is concerned?
2. How do patients of TACTUS score on the modules of the MATE?

3.1 Feasibility

In the TACTUS center, a total number of 29 counselors were introduced to the MATE and were involved as triagists (of whom eleven applied five or more MATE's). In the period October 2005 till October 2006 a total of 1175 patients were assessed. This is an approximate 60% of all the patients entering the center in that period. After this period, the application of the MATE continued to be routine. From approximately 15% (n=172) of the records in the TACTUS registration system almost all MATE data were missing. We also excluded records on patients not having a substance abuse problem (mainly gamblers), resulting in 945 for reviewing the feasibility and adequacy of the instrument. As can be seen in Appendix 2, containing the descriptives of the MATE-items, the number of missing data on individual items are limited. Also less than 5% of all scores could not be calculated. The only exception is Mate score SZ1.1 Craving, with 6,5% missing data. These are probably due to the relative difficulty of the items in this self-report questionnaire. The time needed for administering the MATE has not been observed in this study. However, in the project piloting the MATE-crimi (see chapter 8), we assessed that the mean administration time for the MATE-crimi which has two additional modules, was 80 minutes, ranging from 40 minutes to 150 minutes which gives some support to the unsystematically reported experiences that it takes 45 minutes to 1 hour to complete the standard MATE in regular practice. We did not include a measurement instrument for the feasibility of the instrument, therefore, we cannot give a detailed account of the perception of working with the instrument. However a relevant observation is that all triagists, who were not in particular selected for their willingness or special capacities, worked with the MATE without any recognizable resistance applied the instrument in their routine activities. They felt that the data collected with the MATE support the processes of triage and patient placement. Further, in general, the data have enough variability and there are relatively few missing data. The practicality is further confirmed by the decision of the substance abuse treatment center to continue the use of the instrument. Thus although even some of the advantages for use in practice (like the automated calculation of relevant factors) were not yet available, the center decided to continue the application. Our conclusions are that the MATE has been well accepted by the TACTUS staff and personnel and is adopted as their standard instrument.

3.2 Item descriptives

In Appendix 2 the descriptives (mean, median, sd, minimum, maximum, n) of the individual MATE items for each module are presented for the total group of subjects. The mean and n are also presented according to primary problem substance. About half the patients (ca 25% female) have alcohol as their main problem, with a mean number of over 13 years of problematic use. Positive scores on items that give indication for further psychiatric or medical consultation are not quite prevalent, ranging from 6% with a serious illness to 14% having delusions. A large majority is dependent on any or more substances.

On the HSS (module 5) the most prevalent complaint is tiredness/lack of energy. Percentage of people with positive scores on the eight personality items in module 6 range from 25 (In general, do you depend on others a lot?) to 63 (Are you normally a worrier?). The mean limitation score on the MATE-ICN items (0-4) varies from .17 (Ensuring one's physical comfort.) to 1.8 (Handling stress or crisis.).

3.3 Conclusions and version changes

Experiences with the feasibility of the MATE vs 1.0 in the study conducted in TACTUS and in the GGD Amsterdam revealed some shortcomings. From the way the MATEs were rolled out, and from comments received during the pilots, a number of elements to be improved were identified. The wording of module 2, on medication and on indication for psychiatric/psychological inquiry was confusing in some respects. In the MATE-ICN, a major critic was at the lack of a specific domain on parent-child interactions. An item referring to this was missed and has been added to the new version.

Module 3. History of substance use disorder treatment had a misleading layout and has been made more simple. The distinction between treatments that were regular ended or not has been left out. The item on d5702b *Protect oneself from health risks* was badly formulated and was changed. In general all wordings, headings, and instructions on the assessment form were critically inspected and many details were improved. Also the scoring form for the MATE scores was newly designed.

4 Factor structure of the MATE-ICN

The data sampled in the TACTUS population (N=945) made it possible to validate the factor structure of the MATE-ICN. On conceptual grounds we wanted to test whether it was warranted to identify a factor to score the disability in basic functioning, like self-care, feeding, housing, etc, since such a score is needed for the algorithm to referral to level of care (as will be discussed in chapter 9.) Further, and mainly for exploring purposes, for example to relate disability scores with other characteristics of the patients, we want to test whether the MATE-ICN items can be seen as one factor, and interpret a sum score as a total disability score.

Table 2 Factor structure of the MATE-ICN determined by testing the fit of models derived from factor analysis.

Model		Chi-square (df)	GFI	AGFI	CFI	TLI	RMSEA
1a	One factor all 18 items	735.875 (135)	0.915	0.892	0.844	0.823	0.069
1b	One factor 16 items	526.299 (104)	0.931	0.910	0.876	0.857	0.066
2a	One general factor + 1 domain factor 16 items	426.306 (97)	0.943	0.921	0.903	0.880	0.060
2b	One general factor + 2 domain factors 16 items	353.396 (93)	0.955	0.934	0.923	0.901	0.054

Confirmatory factor analysis was conducted using the Analysis of Moment Structures (AMOS) version 6. We tested four models.

These were: one factor solution including all 18 items. Since two items lack enough variance (defined as > 85% scoring in one of the extreme categories): d5700 Ensuring physical comfort, and d930 Religion & spirituality, we tested the model without those two (model 1a) and excluded them in all other models. Further, we tested a model of one general factor and the hypothesized basic-limitations factor. Eventually, we tested model 4, with one underlying factor and two domain factors, since the relational items seems to cover a cluster associated items.

The following indices were used to assess model fit: the goodness-of-fit index (GFI), the adjusted goodness-of-fit index (AGFI), the comparative fit index (CFI), the Tucker–Lewis Index (TLI), and the root mean square error of approximation (RMSEA). There are no definitive cut-off points for acceptable model fit when using these indices, but the following criteria are frequently used to indicate the goodness of fit for a particular model: GFI > 0.90; AGFI > 0.80; CFI > 0.90, TLI > .90, and RMSEA < .05. For all models, item errors were uncorrelated. Before CFA EM-based (expectation maximization) imputations were calculated for missing values (% missing values in the range of 1.6% to 6.1%).

The factor models tested and accompanying fit indices are shown in Table 2. χ^2 goodness of fit analyses for all models were highly statistically significant ($p < 0.001$), indicating that a proportion of the total variance was unexplained by each model. Examination of the fit indices revealed that the best fit to the data was offered by model 2b. Fit could be improved somewhat by postulating a third factor on which the two Major Life Areas items d810-850 and d870 as well as the recreational item d920 load. But improvement of fit was only small and interpretation of the factor weak due to two negative factor loadings. Because of this, we prefer the model 2b solution, and find it to have an acceptable fit.

The preferred model 2b and the loadings of each of the MATE-ICN items on the factors is presented in Figure 1. The current study found that for the MATE-ICN a model with one general factor and two domain factors to fit reasonable well and to be in line with the proposed models. We realize this is a preliminary analysis on a first database built up with the MATE. We expect more to come and that might give reason to changes in the future. For now, a structure with one general factor and two domain factors seems to be fitting the data.

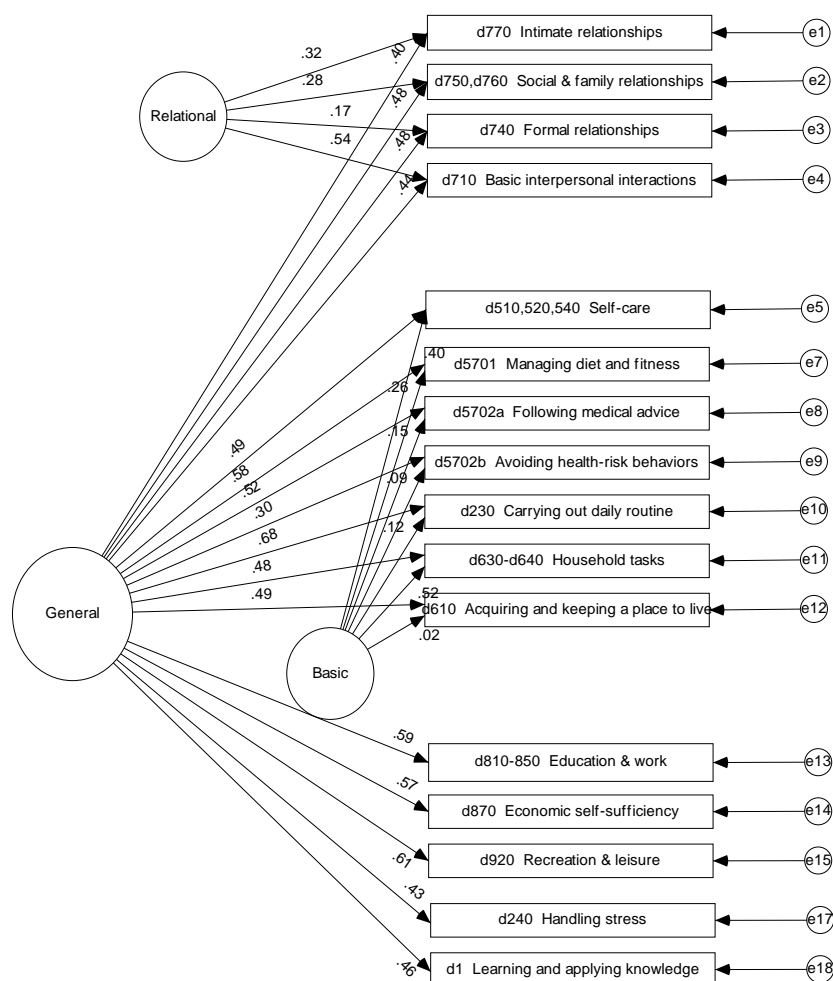


Figure 1. Factor structure of the MATE-ICN – A first analysis.

5 Structure of the MATE

5.1 The MATE-scores

The ten modules of the MATE 1.0 lead to a total number of 19 MATE-scores. Most of them are directly derived from the instruments included.

For the MATE-ICN they are selected on the basis of the analyses presented in chapter 4). This led to three scale scores: Limitations – Total; Limitations – Basic; and Limitations – Relational.

As to the amount of care and support the person receives, the positive and negative influences on the recovery of the person and the number of domains that require care, we do not presume any factors to be underlying these concepts. Therefore, we take the sum scores (for the care and support already provided, weighted by the amount) as a scores that reflect these factors.

In conclusion, the MATE-ICN provides seven scores, namely:

- S7.1 Limitations - Total
- S7.2 Limitations - Basic
- S7.3 Limitations - Relational
- S7.4 Care & support
- S8.1 Positive external influence
- S8.2 Negative external influence
- S8.3 Need for care.

The MATE scores are the following (The first number between brackets refers to the module of the MATE, the second to the respective MATE-score derived from that module).

1. *Characteristics of physical comorbidity [S2.1]* We derive a score for Characteristics of physical comorbidity [S2.1] from the presence of the following phenomena: clearly gives an unhealthy physical impression, exhibits signs of intoxication/withdrawal, has an acute or contagious disease and/or is pregnant.
2. *In psychiatric or psychological treatment [S2.2]* We derive a score for In psychiatric or psychological treatment [S2.2] from taking prescribed medication for psychological problems or receiving recent psychiatric-psychological treatment
3. *Characteristics of psychiatric comorbidity [S2.3]* We derive a score for Characteristics of psychiatric comorbidity [S2.3] from the presence of the following phenomena: suicidal tendencies, hallucinations, illusions and confusion. The score is given for the number of phenomena, with a double score for suicidal plan.
4. *Dependence [S4.1]* For a diagnosis of dependency in respect of the primary substance a score is given that is the sum of the first seven items of module 4. According to the DSM-IV dependency exists from threshold value 3 (American Psychiatric Association, 1994).
5. *Abuse [S4.2]* According to the DSM-IV abuse exists when one of the last four items of module 4 is answered positively. According to the DSM-IV abuse exists from threshold value 1 (American Psychiatric Association, 1994).
6. *Severity dependence/abuse [S4.3]* The score for Severity dependence/abuse [S4.3] is determined by the number of positive answers to items 2 - 9 and 11 of module 4 (Langenbucher et al., 2004).
7. *Physical complaints [S5.1]* The score for Physical complaints [S5.1] is determined by the sum of the scores for the items in module 5 (Marsden et al., 1998).
8. *Personality [S6.1]* The score for Personality [S6.1] is determined by the number of positive answers to items in module 6

(item 3 in reverse) (Moran et al., 2003). From threshold value 4 there is an indication for personality disorders (Germans, personal communication).

9. *Limitations - Total [S7.1]* We define the score for Limitations - Total [S7.1] as the sum of the limitation scores on the 19 items in module 7.

10. *Limitations - Basic [S7.2]* We define the score for Limitations - Basic [S7.2] as the sum of the scores on eight items: d610 Place to live; d630-d640 Household tasks; d510,520,540 Self care; d5700 Ensuring one's physical comfort; d5701 Managing diet and fitness; d5702a Treatment compliance; d5702b Protect oneself from health risks; d230 Carrying out daily routine.

11. *Limitations - Relational [S7.3]*² We define the score for Limitations - Relational [S7.3] as the sum of the scores on the five limitation items: d770 Intimate relationships; d750,d760 Informal relationships, d740 Formal relationships; d710 Basic interpersonal interactions.

12. *Positive external influence [S8.1]* We define the score for Positive external influence [S8.1] as the sum of the scores on three items: e310-e325+ Partner etc.; e550+ Legal factors; e598+ Other factors.

13. *Negative external influence [S8.2]* We define the score for Negative external influence [S8.2] as the sum of the scores on five items: e310-e325- Partner etc.; Loss of relationship; e460- Societal attitudes ; e550- Legal factors; e598- Other factors.

14. *Care & support [S7.4]* We define the score for Care & support [S7.4] as the sum of the scores on the eight Care & support items in module 7.

15. *Need for care [S8.3]* We define the score for Need for care [S8.3] as the number of affirmative answers on the questions for care need either by the interviewer or by the person being assessed.

16. *Craving [SZ1.1]* The score for Craving [SZ1.1] is determined by the sum of the five items in module 9 (DeWildt et al., 2005).

17,18 and 19. are the three scores derived from the HADS (module Z2., to be replaced by four scores derived from the DASS in MATE version 2.0).

5.2 Means, percentiles and intercorrelations of the MATE-scores

Table 3 presents the scores in this population of the 19 MATE-scores derived from the MATE-interview version 1.02 including the three scores derived from module Z2: the HADS (Depression', 'Anxiety', and 'Total' score). This instrument will be replaced in version 2.0 by the DASS. The rationale for some of the scores is presented in the MATE Manual and Protocol (Schippers, Broekman, & Buchholz, 2007).

In the table scores for percentiles 25, 50, 75, 80, 85, 90, 95 are given. The MATE-scores are reasonably well spread, also in the upper percentiles, where differentiation is of importance. Means and medians (percentile 50) are relatively close in most scales, meaning that the sum scores are well interpretable. Almost none of the scores reaches its maximum value at the 95th percentile, so in general no ceiling effects are expected. Exceptions are S2.2 that consists only of 2 items but does not have primarily the function of a severity score and the S4 scores: dependence, abuse and severity of dependence/abuse. S4.3 reaches its maximum at the percentile 90, so it can not

² In version 2.0 an item based on the ICF d7600 Parent-child relationships has been build in in the MATE-ICN and is part of this MATE-score .

differentiate the severity of dependence/abuse between subjects in the upper 10% of this population.

Table 3 MATE scores, means and percentiles

MATE Scores (range)	N	Mean	Percentiles						
			25	50	75	80	85	90	95
S2.1 Characteristics of physical comorbidity (0 – 4)	942	.32	0	0	0	1	1	1	2
S2.2 In psychiatric or psychological treatment (0 – 2)	909	.66	0	0	1	1	2	2	2
S2.3 Characteristics of psychiatric comorbidity (0 – 5)	941	.49	0	0	1	1	1	2	2
S4.1 Dependence (0 – 7)	943	4.32	3	5	6	6	7	7	7
S4.2 Abuse (0 – 4)	942	2.04	1	2	3	3	3	4	4
S4.3 Severity dependence/abuse (0 – 9)	943	5.57 ^v	4	6	8	8	8	9	9
S5.1 Physical complaints (0 – 40)	945	11.72	5	11	17	19	20	22	26
S6.1 Personality (0 – 8)	940	3.36	2	3	5	5	6	6	6
S7.1 Limitations - Total (0 – 72)	932	14.58	6	12	21	23	26	29	36
S7.2 Limitations - Basic (0 – 32)	918	4.67	1	3	7	8	9	11	16
S7.3 Limitations - Relational (0 – 16)	929	3.65	1	3	6	6	7	9	10
S7.4 Care & support (0 – 28)	945	2.00	0	0	3	4	4	6	9
S8.1 Positive external influence (0 – 12)	928	4.18	3	4	6	6	7	7	8
S8.2 Negative external influence (0 – 20)	928	3.91	1	3	6	7	8	9	11
S8.3 Need for care (0 – 19)	933	4.27	1	3	6	7	8	9.6	12
SZ1.1 Craving (0 – 20)	885	7.13	3	7	10	11	13	15	17
SZHADS.1 HADS Depression (0 – 21)	907	7.01	3	7	10	11	12	13	16
SZHADS.2 HADS Anxiety (0 – 21)	903	8.61	5	8	12	13	14	15	17
SZHADS.3 HADS Total (0 – 42)	907	15.61	9	15	22	24	25	27	30

To give an overview of the relations between these scores, the correlation matrix is of the MATE scores is presented in Table 4.

Characteristics of psychiatric and physical comorbidity and being in psychiatric or psychological treatment are correlated only marginally with other MATE-scores, indicating that they represent independent indicators. Abuse and dependence severity are understandably high interrelated, but not too high to make the differentiation of no relevance.

The limitations scores, derived from the MATE-ICN are somewhat, but not too high interrelated. The total limitation score is relatively high correlated with most other MATE-scores, indicating it is a good overall measure of limitations in general. The Limitations - Basic and Limitations - Relational scores are highly correlated with Limitations - Total, because their items are also part of Limitations - Total. Limitations - Basic and Limitations - Relational are moderately correlated (0.50) which gives support to the computation of both scales separately.

The total score on the HADS correlates highest with Physical complaints (0.61) Personality (0.53) and Limitations - Total (0.52).

Table 4 Table 4 Correlations of the 19 MATE-scores (N=945)

	S2.1	S2.2	S2.3	S4.1	S4.2	S4.3	S5.1	S6.1	S7.1	S7.2	S7.3	S7.4	S8.1	S8.2	S8.3	SZ1.1	SZHADS.1	SZHADS.2	SZHADS.3
S2.1 Characteristics of physical comorbidity	1.00																		
S2.2 In psychiatric or psychological treatment	0.02	1.00																	
S2.3 Characteristics of psychiatric comorbidity	0.24	0.16	1.00																
S4.1 Dependence	0.12	0.14	0.22	1.00															
S4.2 Abuse	0.04	0.00	0.16	0.50	1.00														
S4.3 Severity dependence/abuse	0.10	0.11	0.22	0.92	0.75	1.00													
S5.1 Physical complaints	0.30	0.19	0.37	0.45	0.21	0.41	1.00												
S6.1 Personality	0.13	0.22	0.30	0.32	0.16	0.29	0.41	1.00											
S7.1 Limitations - Total	0.31	0.12	0.33	0.33	0.31	0.35	0.45	0.47	1.00										
S7.2 Limitations - Basic	0.34	0.03	0.30	0.27	0.30	0.31	0.41	0.34	0.88	1.00									
S7.3 Limitations - Relational	0.16	0.12	0.27	0.25	0.23	0.27	0.32	0.44	0.76	0.50	1.00								
S7.4 Care & support	0.21	0.09	0.13	0.08	0.08	0.08	0.14	0.14	0.43	0.41	0.23	1.00							
S8.1 Positive external influence	-0.12	0.01	-0.08	-0.05	-0.04	-0.06	-0.14	-0.05	-0.17	-0.17	-0.13	-0.03	1.00						
S8.2 Negative external influence	0.17	0.01	0.25	0.24	0.23	0.25	0.25	0.29	0.56	0.51	0.41	0.30	0.00	1.00					
S8.3 Need for care	0.29	0.07	0.29	0.28	0.25	0.29	0.35	0.40	0.83	0.73	0.62	0.39	-0.08	0.67	1.00				
SZ1.1 Craving	0.21	0.06	0.23	0.49	0.27	0.46	0.43	0.32	0.47	0.42	0.31	0.18	-0.13	0.31	0.42	1.00			
SZHADS.1 HADS Depression	0.20	0.23	0.31	0.37	0.21	0.35	0.52	0.43	0.50	0.42	0.38	0.13	-0.20	0.28	0.42	0.44	1.00		
SZHADS.2 HADS Anxiety	0.20	0.25	0.35	0.41	0.18	0.36	0.59	0.54	0.46	0.35	0.37	0.15	-0.11	0.34	0.40	0.49	0.66	1.00	
SZHADS.3 HADS Total	0.22	0.27	0.36	0.43	0.21	0.39	0.61	0.53	0.52	0.42	0.41	0.16	-0.17	0.34	0.45	0.51	0.91	0.91	1.00

^{NB} Correlations <.30 are printed in grey

6 Reliability of the MATE-ICN

Two studies were undertaken to test the reliability of the MATE-ICN, one in a cohort of drug users at the GGD Amsterdam and one as part of the above mentioned larger study in the population of TACTUS.

6.1 GGD Amsterdam cohort study

As a test for the reliability and feasibility in a group of drug users, the MATE-ICN (module 7 & 8 of the MATE on functioning, needs assessment and external factors) was introduced in the GGD Amsterdam as part of the Amsterdam Cohort Study (ACS; an open cohort study of ca N=500, since 1985; www.amsterdamcohortstudies.org). All 229 participants visiting the study site between August and November 2005 were requested. From them, 224 filled out the HADS (anxiety and depression scale) and 170 were interviewed with the MATE-ICN. They received a reward of €12 for the interview. The MATE-ICN was administered by two interviewers (the researchers of the GGD project).

6.1.1 Method and analyses

Data from the Amsterdam GGD study have been reported by Kat (2006) and in a study on the validity of the SF-36 (Buchholz, in preparation). For this report, data have been used that were sampled to evaluate the reliability of the interviews. Coding 30 audio-taped interviews by the two researchers revealed the following results. (The need for care items were not rated again because questioning this item depends on answers already given and thus it can not be scored independently).

6.1.2 Results: Reliability of the MATE-ICN: GGD data

Table 5 presents the intraclass correlations of the two raters, rating audio tapes of MATE-ICN interviews of 30 individuals.

Table 5 Table 5 Interrater reliability Intraclass Correlation Coefficients ICCs MATE-ICN in the GGD study (N=30)

MATE Score	ICC	95% CI	
		L	U
[S7.1] Limitations - Total	.92	.85	.96
[S7.2] Limitations - Basic	.80	.62	.90
[S7.3] Limitations - Relational	.88	.76	.94
[S7.4] Care & support	.75	.55	.87
[S8.1] Positive external influence	.82	.67	.91
[S8.2] Negative external influence	.91	.82	.95
[S8.3] Need for care	NA	NA	NA

Table 6 Inclusion in reliability and validity study TACTUS: Primary problem

Study participation	Main problem on first contact												Total		
	Alcohol		Opioids		Stimulants		Cannabis		Other substance		Addictive behaviors		Not known		
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	
TACTUS population in general ^a	1105	40.8	318	11.7%	328	12.1%	265	9.8%	46	1.7%	194	7.2%	454	16.8%	2710
Inclusion/excl. not interviewed	195	56.2	17	4.9	44	12.7%	50	14.4%	7	2.0%	21	6.1%	13	3.7%	347
Inclusion/exclusion interviewed	99	62.3	5	3.1	21	13.2%	22	13.8%	3	1.9%	5	3.1%	4	2.5%	159

^a All clients in care by TACTUS in one year except those who were asked for inclusion.

6.2 TACTUS reliability and validity study

This study was adjacent to the routine sampling of MATE's. The MATE-ICN and a series of concurrent instruments were (re-) administered shortly after the first, regular MATE-interview in a sample of 159 patients entering TACTUS in the period May 2005-May 2006 (planned number to be included 150).

6.2.1 Method: Recruitment and representativity

Regular MATE interviewers in TACTUS with an experience of more than five MATEs monthly were requested to include patients according to a set of inclusion criteria, like physically able for a second visit, speaking Dutch reasonably, and not to be treated acutely. In total 506 inclusion forms were filled out (roughly estimated 25% of the yearly population), selected on basis of the availability of recruiting personnel. Of them 347 were **not** eligible for the second administration, and 159 patients (75% male) were successfully included. Since more than half of those that were eligible could not be interviewed, we observed the reasons for not-inclusion. Main reasons are 'no time or not interested' (32%), 'practical problems in planning second interview' (26%) or no complete first MATE-interview (20%). Approximately 75% in the TACTUS population were men and 25% female. The sample was not biased to gender. Table 6 shows the sample is biased to primary problem substance. Subject with opioids are underrepresented and subjects with alcohol or cannabis as primary problem are overrepresented.

6.2.2 Method: Instruments and interviewers

In the first interview, by the TACTUS intake staff, the full MATE was applied. The staff was experienced in doing intakes, but did only receive limited introduction to the MATE. The administration of the second interview was done within two weeks (range between first and second interview 1-21 days, median 7, mean 8 days), after the initial MATE by special hired and trained interviewers. Five interviewers participated, two of them doing 85% of the interviews (none of these were part of the intake staff doing first interviews during the study period). In the second interview, among other instruments, the MATE-ICN (modules 7&8: *Activities & Participation*, and *External factors*) was readministered.

6.2.3 Results: Reliability of the MATE-ICN: TACTUS data

Table 7 presents the intraclass correlations of the test-retest data, with the different raters at T1 and T2 (N=159).

Table 7 Test-retest combined with interraterreliability Intraclass Correlation Coefficients ICCs in the TACTUS study (=159)

MATE Score	ICC	95% CI	
		L	U
[S7.1] Limitations - Total	.73	.65	.80
[S7.2] Limitations - Basic	.69	.60	.77
[S7.3] Limitations - Relational	.51	.38	.62
[S7.4] Care & support	.34	.20	.48
[S8.1] Positive external influence	.38	.23	.51
[S8.2] Negative external influence	.52	.40	.63
[S8.3] Need for care	.60	.49	.70

6.2.4 Conclusion on the reliability of the MATE-ICN

Based on the GGD-data the interrater reliabilities of the MATE-ICN scale scores are good to excellent (ICC from .78 to .92). The GGD data were collected in rather well controlled conditions: two raters rating the same interview. The TACTUS field study took place in real life uncontrolled conditions with many raters. Patient were interviewed and rated twice by different independent interviewers. Furthermore, there was a median time lag between these interviews of eight days. The reliabilities of the MATE-ICN scores in the TACTUS data are therefore lower (ICC from .34 to .73). In particular the reliabilities of the ratings of the domains of Care & support and the external influences are low.

Besides the relatively low level of training that was given to the counselors, the main reason for this is the lack of helping devices in rating the disability and the level of support. We therefore decided to conceptualize formulations to circumscribe every of the five (0-4) rating categories in each of the 19 domains and 5 influencing factors of the MATE-ICN. Based on the experiences in administering the MATE and on hearings with experienced intake staff members in different centers, so-called anchor points were formulated, that are build in MATE version 2.0. The process of creation, feasibility and psychometrics of these helping devices falls beyond the scope of this report and will be discussed later.

7 Validity of a selection of MATE modules

7.1 Method: Instruments and interviewers

The method of the TACTUS reliability and validity study is described in par 6.2.1 and par. 6.2.2. In the second interview, next to a readministration of the MATE-ICN the following instruments were administered:

1. WHODAS-II
2. WHOQOL-Bref
3. CIDI

7.2 Results: Cross-validating the MATE-ICN with the WHODAS

The World Health Organization Disability Assessment Schedule II (WHODAS II) assesses day to day functioning in six activity domains. Results provide a profile of functioning across the domains, as well as an overall disability score. The instrument with a Guide to its Use was initially published by WHO in 1988 to provide a simple tool for assessing disturbances in social adjustment and behaviour. It is available in different formats and in many languages. We applied the 36 item interview version in Dutch. Although a general release was announced already in 2001, this still has not been effectuated; probably because compatibility of the WHODAS II with the ICF-categories is not fully satisfactory. Nevertheless, a cross-validation of the WHODAS and the MATE-ICN is indicated. We correlated the three domains on limitation of the MATE-ICN with the six domains in the WHODAS-II in the TACTUS sample (N = 159).

Table 8 Pearson correlations of MATE-ICN scores on limitations and particular domains of the WHODAS

Domains	1	2	3	4	5a	5b	6	
WHODAS								
	Understanding and communicating	Getting around	Self Care	Getting along with people	Household activities	Work or School activities	Participation in society	
MATE-ICN								
	Limitations - Total	.58	.26	.58	.58	.50	.32	.67
	Limitations - Basic	.46	.20	.54	.42	.49	.25	.57
	Limitations - Relational	.44	.23	.35	.61	.37	.22	.53

As can be seen in Table 8, correlations of MATE-ICN factors and the WHODAS domain 2 (Getting around) and domain 5b (Work or school) are relatively low. This is to be expected, because these two domains are not (Mobility) or hardly (Work and education) represented in the MATE-ICN. Other, expected, correlations (in bold) are reasonably high, with a total MATE-ICN score correlating mean .58 with the other WHODAS factors. The factor Limitations-Basic correlates ca .50 with Self Care, Household activities, and Participation in society. The factor Limitations-Relational correlates >.50 with the domains Getting along with people and Participation in society.

The MATE-ICN reasonably corresponds with rating on the WHODAS, in the domains they share. Unfortunately, the WHO did not

release an instrument that is based on the ICF, so more intercorrelations can not be evaluated.

7.3 Results: Cross-validating the MATE-ICN with the WHOQOL-Bref

The World Health Organization Quality of Life (WHOQOL) is an international cross-culturally comparable quality of life assessment instrument. It assesses individual's perceptions in the context of their culture and value systems, and their personal goals, standards and concerns (WHO, 1993; Murphey et al, 2000). The shorter (BREF) version of the instrument comprises 26 items, which measure the following broad domains: physical health, psychological health, social relationships, and environment. The construct of quality of life (QOL) is based on the biopsychosocial model, which forms the theoretical background of the ICF. Therefore, a measure of QOL can serve as a construct for validation of the MATE-ICN. Thus, the three scales of the MATE-ICN were related to these WHOQOL-BREF domains and is evaluated by us in the sample of N = 159.

Table 9 Pearson correlations of MATE-ICN scores on limitations and particular domains of the WHOQOL-BREF

MATE-ICN \ WHOQOL	WHOQOL			
	Physical health	Psychological health	Social relationships	Environment
Limitations - Total	-.65	-.71	-.59	-.64
Limitations - Basic	-.59	-.63	-.56	-.60
Limitations - Relational	-.44	-.52	-.44	-.43

As can be seen in Table 9, the correlations of the MATE-ICN and the WHOQOL domains are high. Since high scores on the WHOQOL-Bref indicate high QOL but high scores on the MATE-ICN indicate high limitations in functioning, these associations are negative. The relation between Limitations-Relational and Social Relationships are moderate, possibly related to the ambiguity on this 3-item factor in the WHOQOL-BREF, containing the item "Satisfied with conditions of your living place?". The factors Limitation-Basic and Limitation-Total do relate satisfactory with the WHOQOL-Bref factors.

7.4 Results: Cross-validation MATE-Scores on psychiatric comorbidity with the CIDI

From 148 of the 159 patients who have been taken a second interview, psychiatric diagnoses were measured with the CIDI. Half of them (N=73) had one or more diagnoses. Just to describe the comorbidity in this population, we give an overview of the 129 diagnoses observed in these 73 patients in Table 10.

Table 10 Current diagnoses (4-week prevalence) in TACTUS retest population (n=73)

	n	%
296.21 Major Depressive Disorder, Single Episode, Mild	3	2.4
296.22 Major Depressive Disorder, Single Episode, Moderate	8	6.3
296.23 Major Depressive Disorder, Single Episode, Severe Without Ps	19	15.1
296.31 Major Depressive Disorder, Recurrent, Mild	2	1.6
296.32 Major Depressive Disorder, Recurrent, Moderate	2	1.6
296.33 Major Depressive Disorder, Recurrent, Severe Without Psychot	1	.8
296.41 Bipolar I Disorder, Most Recent Episode Manic, Mild	4	3.2
296.42 Bipolar I Disorder, Most Recent Episode Manic, Moderate	6	4.8
298.8 Brief Psychotic Disorder	3	2.4
300.01 Panic Disorder Without Agoraphobia	1	.8
300.02 Generalized Anxiety Disorder	15	11.9
300.21 Panic Disorder With Agoraphobia	6	4.8
300.22 Agoraphobia Without History of Panic Disorder	7	5.6
300.23 Social Phobia	11	8.7
300.29A Specific phobia, animal type	2	1.6
300.29B Specific phobia, blood- injection-injury type	5	4.0
300.29N Specific phobia, natural environment type	2	1.6
300.29S Specific phobia, situational type	5	4.0
300.3 Obsessive-Compulsive Disorder	6	4.8
300.4 Dysthymic Disorder	8	6.3
307.51 Bulimia Nervosa	1	.8
309.81 Posttraumatic Stress Disorder	9	7.1
Total	126	100.0

As can be seen in this table mood disorders (42%) and anxiety disorders (48%). Form the large majority. We should take into account however, that our sample is somewhat biased..The number of persons with any depression or anxiety disorder or with the combination of both, is presented in Table 11.

Table 11 Number of psychiatric diagnoses in TACTUS retest population

	n	%
None	75	50.7
Depression	22	14.9
Depression and Anxiety	19	12.8
Anxiety	31	20.9
Other	1	.7
Total	148	100.0

That is, all but one patient with at least one disorder, can be classified as having an anxiety disorder, or a depression, or both. To validate the MATE-scores that are related to psychiatric disorders (S2.2 In psychiatric or psychological treatment, S2.3 Characteristics of psychiatric comorbidity, SZHADS.3 HADS Total, and S6.1 Personality) and, for descriptive purposes, with the MATE-ICN Limitations Total score, we break these scores down for each these CIDI-categories. See Table 12.

As can be seen in this table, all scores increment from the category of no diagnosis to the category of depression or anxiety, to the category of the combination of both depression and anxiety. So the MATE scores that are related to psychiatric disorders reflect the differences between these diagnostic categories.

Using the HADS scores for anxiety and depression separately, we calculated the sensitivity and specificity of the HADS scores are,

Table 12 MATE-Scores of patients with CIDI psychiatric diagnoses

MATE-scores	CIDI-diagnosis		None		Depression		Anxiety		Dep and Anx	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
[S2.2] In psychiatric or psychological treatment 0 - 2	.59	.78	.71	.78	.60	.82	.93	.70		
[S2.3] Characteristics of psychiatric comorbidity 0 - 5	.23	.59	.36	.85	.78	1.42	1.06	1.30		
[SZHADS.3] HADS Total 0 - 42	11.89	6.64	18.09	6.86	22.10	9.71	22.94	7.22		
[S6.1] Personality 0 - 8	2.78	1.79	3.33	1.77	3.59	1.90	4.61	1.50		
[S7.1] Limitations - Total 0 - 72	10.63	6.93	14.82	8.99	16.19	10.47	20.72	13.26		

with the CIDI diagnoses as criterion. In Figures 2 to 4 we present the ROC curves for those patients with a CIDI depression diagnosis, and anxiety diagnosis or any of them.

As can be seen figure 4, the area under the curve representing the sensitivity and specificity of the HADS total score for those with either an anxiety or a depression scores is around .80. This is satisfying, meaning that discriminative power of this measure is good enough to be used in practice. The areas under the curve for the HADS score on depression, or for anxiety with a CIDI diagnosis in these respective categories is relatively low, meaning that the HADS cannot well be used for specific statements.

Given that we decided in the mean time not to include the HADS in MATE vs 2.0 (for other reasons than its psychometric quality) suggestions for the use of scores on the HADS for clinical purposes is not warranted in this report.

7.5 Conclusions

The scores derived from the MATE-ICN have a reasonable correspondence with the scores on related domains in the WHODAS. The same is true for the WHOQoL-BREF. We conclude that the MATE-ICN covers these domains in a respectable way and that the instrument can be used to assess important aspects of human functioning. As far as psychiatric comorbidity is concerned, in our not fully representative retest sample, about half the patients do have at least one psychiatric diagnosis according to the CIDI. Mood and anxiety disorders form the far majority. As to the validation of the use of the MATE to give an indication of psychiatric comorbidity we conclude that the MATE-scores that relate to psychiatric comorbidity have outcomes that are in line with the diagnosing done with the CIDI as far as anxiety and depression is concerned. Having a diagnosis in one or both of these categories is reflected in higher MATE-scores. Using MATE-scores to support clinical decisions referring patients for further diagnosing and assessment of psychiatric comorbidity, and for matching patients to different treatment intensity levels seems to be warranted.

ROC Curve AUC : .74

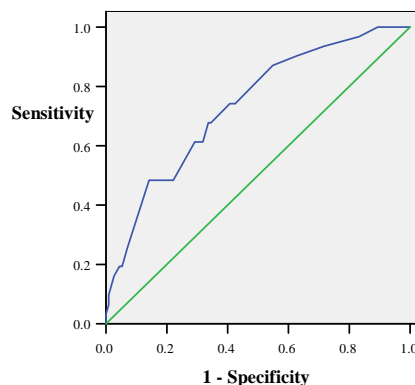


Figure 2. ROC curve HADS anxiety scale for patients with a CIDI anxiety disorder (N=31)

ROC Curve AUC: .63

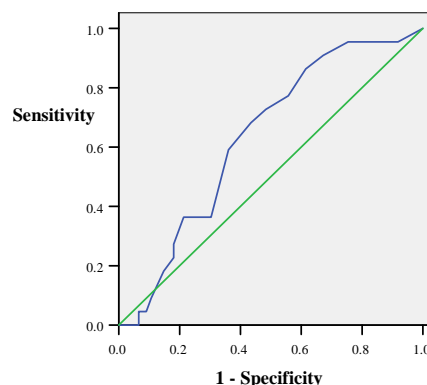


Figure 3. ROC curve HADS depression scale for patients with a CIDI depressive disorder (N=22)

ROC Curve AUC: .80

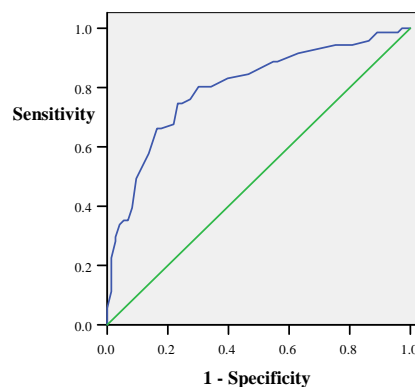


Figure 4. ROC curve HADS total scale for patients with any CIDI disorder (N=71)

8 Developing and testing the feasibility of an assessment instrument for judicial clients

In a separate project, the Stichting Verslavingsreclassering GGZ-Nederland (SVG) granted the authors a research project to develop an instrument for case-finding ('vroegdiagnostiek') and treatment planning, to support and guide judicial clients from the judicial context into addiction treatment. The project is part of the policy of the Ministry of Justice to prevent recidivism, among others by treating selected clients for their addiction. This instrument should follow up judicial persons screened with the RiSc, an instrument developed by the Ministry of Justice.

Since the MATE was considered a good base for such an instrument, it was decided that the ZonMw/Resultaten Scoren project reported here could well provide a substantial contribution to the SVG-project. Consequently, the MATE-crimi was developed and tested. The activities and results of the SVG-project were reported separately by Broekman et al. (2005). This report is not attached, but we cite from the summary the following.

After an introduction in chapter 1, Chapter 2 presents the specifications of the instrument based on the procedures and decisions made in the processes followed by the rehabilitation service personnel ('reclasseringswerkers'). It was proposed to apply the MATE as instrument for matching clients to substance disorder treatment services in analogue to the matching procedures of non-judicial clients. In addition to that, the MATE-crimi should assess the motivation for treatment (not granted in this population) and to assess in how far criminal behavior was interwoven with the (excessive) use of alcohol or drugs.

Chapter 3 describes the development of these two added modules in the MATE-crimi. Since we found no feasible instrument available in the literature, the NEXUS was developed, an interview with eleven elements to assess in how far criminal behavior was interwoven with the (excessive) use of alcohol or drugs. A 24-item self report questionnaire, the Motivation for Treatment (MfT) was selected as the second additional module. The MATE-crimi was applied in 94 judicial clients, in four different substance abuse treatment centers. The results are presented in chapter 4.

Chapter 5 describes the experiences in applying the MATE-crimi in practice and develops a model-procedure for using it as instrument for case-finding and guidance. We concluded that the MATE-crimi is well applicable in actual practice, and provides information feasible for guiding clients into the addiction treatment services. The data gathered with the MATE-crimi are well interpretable and have reasonable variance. The NEXUS and the MfT deserve further study of the reliability and validity. The last chapter presents a proposal for such a study.

9 Developing and calibrating a set of algorithms for indicators and dimensions to be used in referral and triage decisions

The last-sub project took up the task to develop and test algorithms for the assessments and estimations of indicators and dimensions to be used in referral and triage decisions in the intake and treatment processes.

As mentioned before, a manual-based guideline for matching and referral has been developed (DeWildt et al., 2002). This intake module comprises of the following components: (1) semi-structured assessment of patient characteristics, including treatment history; (2) assessment of four key indicators, to be used in an algorithm, based on the stepped care concept; (3) patient matching to one of four levels of care according to the algorithm or to an overruling clinical justification; (4) treatment referral according to component 3.

The intake module identifies the following four levels of intensity of care (LOC):

1. Brief Outpatient Treatment (level 1): At this level, a brief cognitive-behavioural intervention is offered, ranging from four to six sessions, either individually or in a group, over an eight-week period. When needed, pharmacotherapy is added.
2. Outpatient Treatment (level 2): Main element at this level is a standard cognitive-behavioral intervention, ranging from ten to twelve sessions, either individually or in a group, over a six-months period. In addition, depending on the patient's needs, additional interventions are offered, such as training in social skills or treatment for anxiety disorders. Additional pharmacotherapy is recommended.
3. Day treatment or Residential Treatment (level 3): Day treatment and residential treatment (both with a maximum length of three months) offer similar types of services. A broad spectrum of interventions is offered including 20-25 (group)sessions of CBT. The principal difference between day and residential treatment is that the former does not have the 24-hr structure of a residential program. Additional pharmacotherapy is recommended.
4. Care (level 4): Unlike the other LOCs, which focuses on abstinence or a significant reduction in substance use, this level aims primarily at harm reduction. The number of sessions or time frame is not defined *ex ante*. A patient can be treated in either an outpatient or inpatient setting.

In the module, an algorithm based on a decision tree is presented to enable triage. The decision tree, as prescribed by the intake module is presented in Figure 2. Each of the dimensions relevant for triage (treatment allocation indicators: severity of the addiction, psychiatric impairment; and social disintegration) has to be scored as either HIGH or LOW. Further, treatment history, the fourth factor that is used for applying the stepped care concept, is based on the number of previous treatment episodes. A treatment episode is defined as a professionally guided attempt by the patient to change his or her addictive behaviour. In order to be considered as a treatment episode, the patient should have participated in at least one session of an outpatient level of care or one day in a day treatment or residential level of care. Treatment completion is not required. In the decision tree, the number of previous addiction treatments is categorized as 0-1, 2, 3-5, or more than 5.

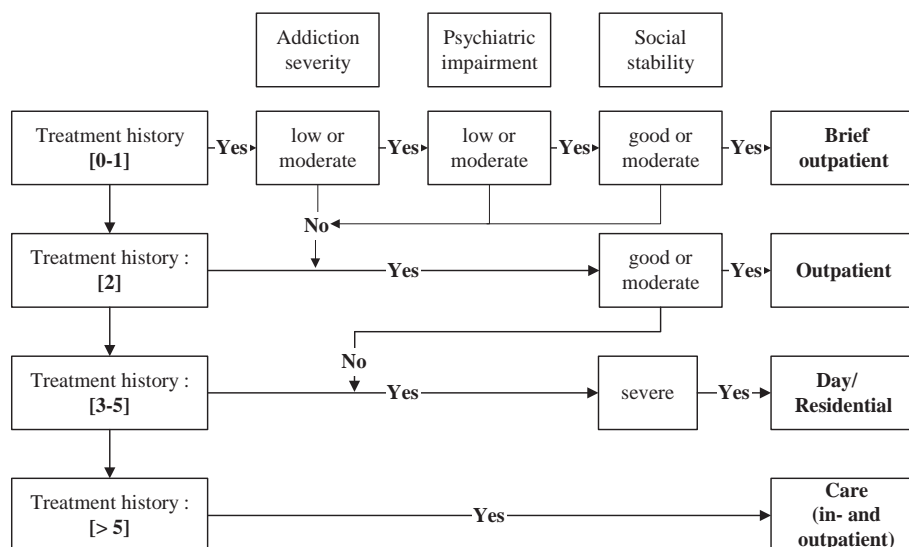


Figure 2 Guidelines for matching and referral Reproduced from Merckx et al.(2007).

Many Dutch substance abuse treatment centers modeled their intake procedure after the intake module by DeWildt et al. (2002), but two of the larger centers adopted the module fully and match almost all their patients according to the decision tree. The feasibility of this matching procedure in these centers has been evaluated and presented by Merckx et al. (2007). They conclude that, besides a number of problems, the application of this manual based stepped care matching procedure is feasible and warrants further development.

As is presented in chapter 3, one of the specifications of the composition of the MATE is the feasibility for triage to treatment intensity. When the MATE is able to support the matching decision process, applying the instrument might be useful in overcoming a weak element in the current intake processes as observed by Merckx et al.: the availability of the information at the right moment during the often hectic intake processes.

9.1 Developing the algorithms

Therefore, in this sub-project, we evaluated how the dimensions-scores could be derived from the items of the MATE. We build algorithms to calculate the dichotomous scores on each of the three dimensions and the score on the treatment history on the basis of the following considerations.

Addiction severity can be derived from: either a) a relatively high and frequent consumption of psychoactive drugs, and/or b) a consent with a high number of items in the DSM- dependency and abuse section (WHO, 1997) and/or c) a very high score on the craving for the main problem drug.

The *psychiatric impairment* (severity of psychic symptoms) can be derived from either a) suicidal ideation, or any of the following symptoms: hallucinations, delusions and confusion, and/or b) currently being (or recently having been) in treatment for psychosocial complaints, and/or a high score on the symptom list for anxiety and depression.

Social disintegration can be derived from either substantial problems in the areas of basic life conditions (housing, feeding, clothing etc) and/or b) substantial negative external factors in the environment, influencing the person's health.

In Figure 3 is graphically depicted how the four dimensions scores are composed.

The circles at the left represent the dimensions involved in the paradigm for triage. The three severity scores can be HIGH or LOW, Treatment History can be 1-4. The rectangles at the right are the elements for the calculation of the dimension scores. A positive score on ANY element gives a positive score on the dimension. (Element scores are combined in the arrows as OR). Elements score dichotomously (HIGH/NOT HIGH or YES/NO). This dichotomy is derived from a continuous score, which is the sum of the MATE-items described in the rectangle. Ranges and cut-off points (CP) are presented in the figure as well.

9.2 Calibrating the algorithms

The number of patients scoring positively on each of the items and each of the elements (at the left) according to these algorithms have been calculated in the population of 945 patients from TACTUS of which MATEs were available. These numbers are presented at the right and left sides of the rectangles respectively. The numbers around the arrows present the number of patients that gets a positive severity score on the basis of that element only. Above the circles, the number of patients scoring positively on the dimension is presented.

The number of patients given a HIGH score on each of the dimensions in this TACTUS population has been compared to the number of patients with a positive score on each of the dimensions observed by Merckx et al. (2007). In that study ASI-severity scores were sampled in the 2003 year cohort of the Jellinek en Brijder. The percentages of patients scoring high on each of these dimensions are quite comparable to the percentages we find in the TACTUS population, applying MATE-dimensions scores. We can conclude that the algorithms we suggest will not lead to matching decisions that, in terms of numbers of patients, will dramatically deviate of those in the other centers. The question whether the same patients are selected with both instruments is still open, and, eventually of course the question whether the right patients are matched to the right level of care. These questions have to be studied in new research.

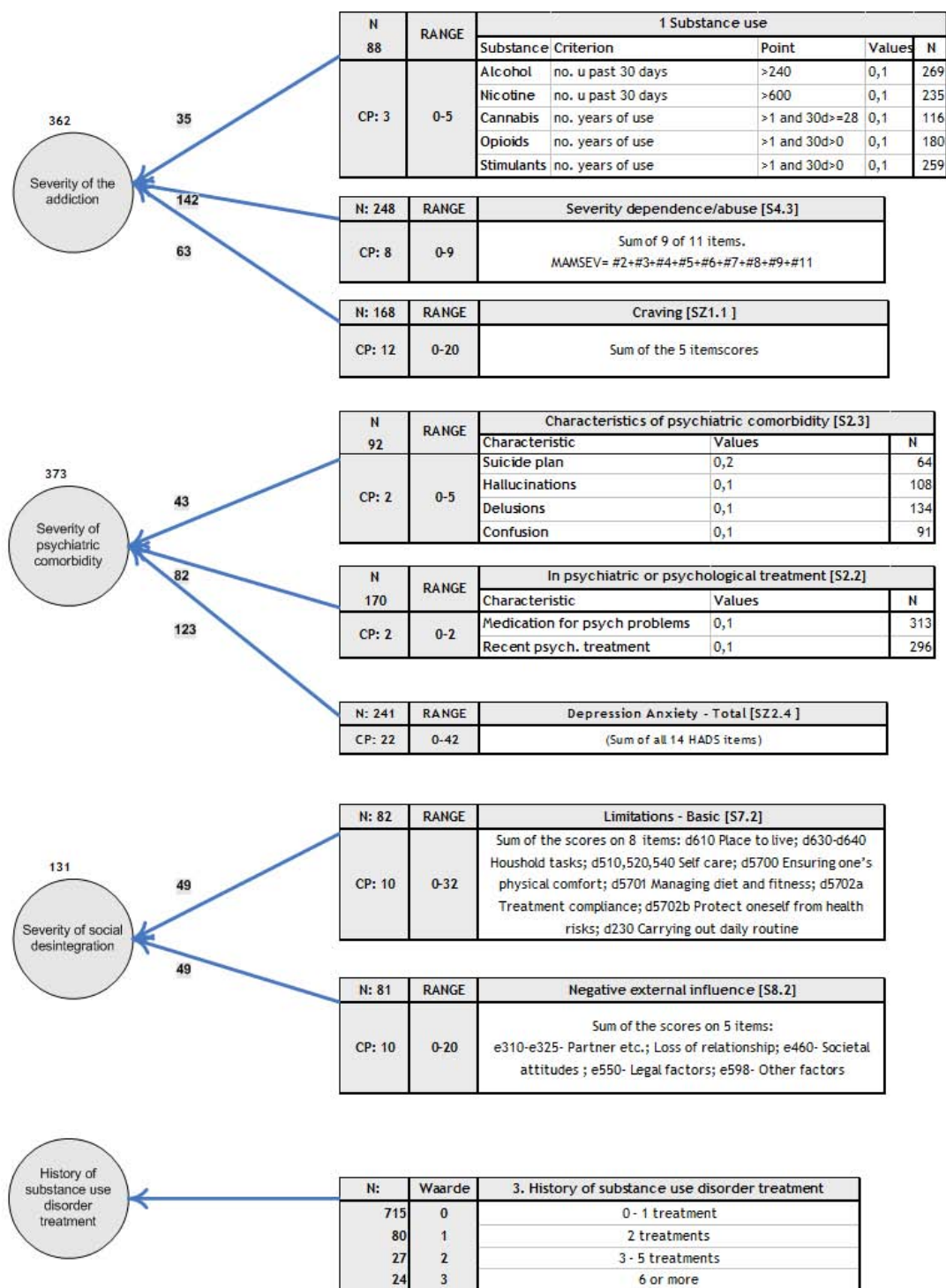


Figure 5. Algorithm for calculating dimension scores based on MATE-scores

9.3 Conclusions

We succeeded in building algorithms to calculate scores for the dimensions used in the decision tree of the intake module that has been followed fully or partly is used in several large substance abuse treatment centers. For the TACTUS-population these algorithms lead to matching and decision to levels of care in numbers that are quite comparable with those in routine care in centers that, with other instruments, do also use this paradigm. This give rise to the assumption that this algorithm might be well applicable in practice. It is highly recommended that the algorithm is tested in routine care.

The actual application however, will be conditioned upon the availability of electronic support. It is therefore a positive sign that both

TACTUS and JellinekMentrum decided to build the algorithm in their electronic patient file systems.

10 General conclusions

This project aimed at developing and testing an instrument to assess the characteristics of patients in the intake of substance abuse treatment centers, according to the specifications formulated in an earlier ZonMw project. These specifications demanded that the new instrument should be: functionally related to the practical needs of substance abuse treatment; acceptable for the assessed individuals and measuring both needs and compensations; derived from a clear conceptual schema; internationally compatible, and based on the best well developed (sub)instruments.

In general, we succeeded in composing and testing such an instrument, or better, set of instruments. A paper version of the instrument, together with a manual and a protocol with detailed instructions for the application, was published and presented on a well-visited national conference. The instrument, named MATE, contains a series of ten modules, of which two are to be self reported and the other are interviews. The MATE version 2.0 produces 20 MATE-scores.

The derivation from a clear conceptual scheme was assured by the strong connection that we made to the WHO classification systems and instruments. International compatibility is best demonstrated by the interest the instrument has aroused by researchers from the University of Muenster and the German national Institut für Therapieforschung in Munich, who, in cooperation with the authors, succeeded in raising funds for a translation of the MATE in German and subsequent testing in a German population. The results of this project will be published later this year.

The functionality for the substance abuse treatment field was demonstrated in a test in a large Dutch treatment center (TACTUS), that piloted the application with success: The instrument was found feasible and helpful in the routine of matching and referral of patients having been taken in by the center. This demonstrated the acceptability of the instrument by patients and interviewing staff. Experiences in the field led to a series of adaptations of the tested version, and this led to MATE version 2.0. The practical functionality is further demonstrated in the potential of the instrument to derive scores that are transparent and ready to use in a paradigm for matching and referral that is used in daily routine in several Dutch treatment centers. The embedding of the instrument in the electronic information systems supporting the treatment which, that is undertaken by a few institutions, will enhance the practical functionality.

The general feasibility was further demonstrated by the feasibility of using the MATE as a diagnostics tool for judicial clients by rehabilitation staff of the judicial system.

Composing the MATE meant that we had to include a fully new instrument on measuring the limitations in functioning and the needs for professional care and support of people with a mental disorder. This instrument, the MATE-ICN (two modules of the ten-module MATE) has been tested thoroughly in this study. Analysis of its structure reveals a model with two domain factors (basic and relational) and a general limitations factor. Further, the actual care and support received, and the needs for care considered to be necessary for the MATE-ICN domains leads to scores that can be used in actual practice, as do the positive and negative external influences.

The interrater reliability of the MATE-ICN instrument is excellent, although the test-retest (by different raters) has not been proven to be excellent yet. The detailed set of instructions in the MATE

protocol, together with individual anchor points outlined for every option in the answers on the items that are formulated for version 2.0, can be expected to improve the reliability of the scores. Cross-validating the MATE-ICN with the WHODAS and the WHOQOL reveals a good level of correspondence with the relevant domains and subscales.

In general, the MATE is able to assess the critical and important characteristics needed for guiding people into treatment, thereby improving the transparency and rationality in evaluating these treatments and supporting the delivery of the right amount and mode of treatment to those that need them.

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Appendix 1: MATE 1.02w

Ingevuld
door: 

Datum
assessment

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Client
nummer


--	--	--	--	--

MATE

versie 1.02w December 2005

1. Middelen: Gebruik	2
2. Indicaties psychiatrisch / medisch consult	3
3. Verslavingsbehandelingsgeschiedenis	3
4. Middelen: Afhankelijkheid & Misbruik	4
5. Lichamelijke klachten	5
6. Persoonlijkheid	6
7. Activiteiten & Participatie, Hulp & Ondersteuning	7
8. Externe factoren van invloed op het herstelproces	10
9. Middelen: Verlangen	11
10. Angst en Depressie	12

L
Z
30 dagen
T

Symbol of typografie	Instructie / uitleg
	In het algemeen geldt dat vragen niet letterlijk gesteld hoeven te worden. De interviewer beoordeelt en is vrij in de manier waarop de informatie verkregen wordt. Indien de benodigde informatie met zekerheid bekend is, dan kunt u het antwoord invullen zonder de vraag te stellen. Uitzonderingen zijn die gevallen waar een L(etterlijk) of een Z(elfinvullijst) in de kantlijn staat.
(etterlijk)	Stel de vragen letterlijk. Geef alleen uitleg als absoluut noodzakelijk of als de vraag duidelijk verkeerd begrepen wordt.
(elfinvullijst)	De persoon vult de vragenlijst zelfstandig in. Als dit niet mogelijk is, help de persoon dan door de vragen voor te lezen.
(ijdvak)	Tijdvak voor de beoordeling.
[Voorbeeld vraag, toelichting]	Tussen haakjes staat schuingedrukt een voorbeeldvraag die gebruikt kan worden om het betreffende item bij de persoon uit te vragen
[BEOORDELING]	Tussen haakjes staat in hoofdletters een beoordelingsinstructie, kenmerken waarop de beoordelaar kan letten of andere verklarende tekst voor de beoordelaar
<u>onderstreepte tekst</u>	Geeft kernbegrip(pen) van de vraag aan. Kan bij eventueel doorvragen gebruikt worden.
[—MIDDEL—]	Vul primaire probleem(stof) in
Ja Nee	<u>Omcirkel</u> Ja als juist of ja, Nee als onjuist of nee
.....	Schrijf antwoord op
.....	Geef geschreven toelichting (vrije tekst)

1. Middelen: Gebruik

Stof		Aantal dagen gebruikt laatste 30 dagen	Aantal eenheden op een kenmerkende dag waarop gebruikt wordt		Totaal aantal jaren gebruik van minstens 2-3 keer per week NB ook invullen als de laatste 30 dagen geen enkele dag gebruikt is
		Bijvoorbeeld: Iedere dag: 30 Een keer per week: 4 Drie dagen: 3 Een dag: 1 Niet: 0 Gedurende slechts 1 week iedere dag: 7		Standaard eenheid (bij drugs bij voorkeur in grammen, anders in de gesuggereerde eenheid)	
Alcohol	Gewoonlijk gebruik		.....	.....	Standaard glazen
	Alleen deze categorie ook invullen als er sprake is van <i>afwisselend gebruik</i> bijvoorbeeld hoger gebruik in het weekend		Hoger gebruik	
Nicotine	Sigaretten, shag, sigaren, pijp, snuifpruimtabak		.....	.....	Sigaretten, sjekkies, sigaren
Cannabis	Hasjiesj, Marihuana, Weed		.....	.....	Joints, stickies
Opiaten	Methadon		.....	.....	mg
	Heroïne		.....	.....	Shots, roken, snuifjes
	Overige opiaten zoals Codeïne, Darvon, Demerol, Dilaudid, Morfine, MSContin, Opium, Palfium, Percodan		.....	.....	Shots, roken, snuifjes, pillen
Cocaïne	Crack, gekookte (base) coke		.....	.....	Pijpjes
	Cocaïne, snuifcokes		.....	.....	Wikkels, snuifjes, shots
Stimulantia	Amfetamines, Khat, Pepmiddelen, Ponderal, Ritaline, Speed		.....	.....	Pillen, snuifjes, shots, pijpjes
Ecstasy/XTC	MDMA of andere psychedelische amfetaminen zoals MDEA, MDA of 2CB.		.....	.....	Pillen
Andere middelen	Bijvoorbeeld: Psychedelica, Inhalantia, Popper. Omschrijf: .....		.....	.....
Sedativa	Barbituraten, Kalmeringsmiddelen, Slaapmiddelen, Tranquilizers, Dalmadorm, Librium, Mogadon, Normison, Rohypnol, Seresta, Temesta, Valium, Xanax		.....	.....	Pillen
Gokken	Waar(op)(mee) .....		.....	.....	€ uitgegeven Euro's, bruto
Ooit middelen gespoten: <input type="checkbox"/> Ooit gespoten <input type="checkbox"/> Spuut nog <input type="checkbox"/> Nooit gespoten					
De primaire problemstof is de stof waarvan het gebruik door de persoon en de beoordelaar als het meest problemen veroorzakend wordt ervaren. Als dit onduidelijkheden oplevert, kies dan in de volgorde (1) Opiaten of Cocaïne, (2) Alcohol, (3)Overige drugs en sedativa, (5) Cannabis. Als nicotinegebruik of gokken de aanmeldklacht is, dan is dat de probleem(stof).					
[—MIDDEL—] [Primaire Problemstof/Probleem]=			.....	

2. Indicaties psychiatrisch / medisch consult

		Huidige voorgeschreven medicatie		Voorgeschreven door: (huisarts, psychiater, internist, longarts e.d.)	
Huidig		[Gebruikt u medicatie voor verslaving?]	Ja	Middel(en) (bijvoorbeeld alcamprostaat, methadon naltrexon):	
			Nee	.....	.....
		Voorgeschreven voor ziekte/klacht:			
Huidig		[Gebruikt u medicatie voor psychische / psychiatrische problemen?]	Ja		
			Nee	.....	.....
12 maanden		[Gebruikt u overige medicatie?]	Ja		
			Nee	.....	.....
Is er op het moment of recente (afgelopen jaar) sprake van psychiatrische of psychologische behandeling?				Is er afstemming met deze behandeling geregeld?	
Ja				Ja	
Nee.....				Nee.....	
Kenmerk	Vraag / observatie				
Suïcidaal risico	Wens. [Heeft u de afgelopen maand gewenst dat u dood was of gedacht dat u beter af was als u dood was?]			Ja	Nee
	Plan, uitvoering. [Heeft u de afgelopen maand plannen gemaakt om uzelf te doden of het geprobeerd?]			Ja	Nee
Psychotische kenmerken	Hallucinaties. [Ziet, of hoort u wel eens dingen die andere mensen niet kunnen zien of horen?]			Ja	Nee
	Wanen. [EXTREME ACHTERDOCHT] [Denkt u wel eens dat andere mensen tegen u samenspannen?]			Ja	Nee
[VERWARDHEID]	[MAAKT EEN VERWARDE, GEDESORIËNTEERDE INDRUK, IS VERGEETACHTIG]			Ja	Nee
[LICHAMELIJKE GEZONDHEID]	[ONGEZONDE INDRUK, ZEER BLEEK OF OPGEBLAZEN GELAAT, BLOEDUITSTORTINGEN, MOEILIJK LOPEN, OEDEEM BENEN, STERKE VERMAGERING OF ZEER DIKKE BUIK, ABSCESSEN, KRABEFFECTEN]			Ja	Nee
[INTOXICATIE/ ONTWENNINGSV ERSCHIJNSELEN]	[TRILLEN, COÖRDINATIESTOORNISSEN, LALLENDE SPRAAK, ONZEKERE GANG, PSYCHOMOTORE VERTRAGING OF AGITATIE, INSULTEN, ERNSTIG ZWETEN, BRAKEN, PUPILAFWIJKINGEN]			Ja	Nee
Lichamelijke ziekte	Ziekte die medisch consult vereist, zoals Hepatitis, HIV			Ja	Nee
Zwanger				Ja	Nee

3. Verslavingsbehandelingsgeschiedenis

Eerdere behandelingen gericht op verslaving afgelopen 5 jaar Gericht op verslavingsgedrag, uitgevoerd door een professional en waarbij veranderafspraken over middelengebruik zijn gemaakt Geen methadononderhoud, kale detox, crisisopname e.d.			
Aantal eerdere behandeling (afgelopen 5 jaar)	Regulier afgesloten		Toelichting
	Ja	Nee	
Aantal ambuland/deeltijd	.....	.....	.....
Aantal klinisch	.....	.....	.....

4. Middelen: Afhankelijkheid & Misbruik

CIDI nummer	Vraag	Antwoord	
	[—MIDDEL—] = <i>☞</i>		
L12B	Heeft u in de afgelopen 12 maanden gemerkt dat u <u>veel meer</u> [—MIDDEL—] nodig begon te hebben <u>om hetzelfde effect te bereiken</u> of dat <u>dezelfde hoeveelheid minder effect had</u> dan voorheen?	Ja	Nee
L14A+B	Heeft u in de afgelopen 12 maanden het <u>verlangen gehad om te stoppen</u> of <u>zonder succes geprobeerd te stoppen of minderen</u> met [—MIDDEL—]?	Ja	Nee
L15A	Heeft u in de afgelopen 12 maanden <u>veel tijd besteed aan het gebruik, verkrijgen, of bijkomen van de effecten van</u> [—MIDDEL—]?	Ja	Nee
L16B	Heeft u in de afgelopen 12 maanden <u>vaak</u> [—MIDDEL—] <u>in grotere hoeveelheden of langer gebruikt dan u van plan was,</u> of <u>het vaak moeilijk gevonden te stoppen met het gebruik van</u> [—MIDDEL—] voor u 'dronken' of high was?	Ja	Nee
L17A+B	Voelde u zich in de afgelopen 12 maanden <u>ziek of onwel bij het stoppen of minderen</u> met [—MIDDEL—] of <u>gebruikte u</u> [—MIDDEL—] of een sterk gelijkend middel <u>om deze gevoelens te voorkomen?</u>	Ja	Nee
L18B + L19B	Ging u in de afgelopen 12 maanden <u>door met het gebruik van</u> [—MIDDEL—] <u>terwijl u wist dat het gezondheidsproblemen of emotionele of psychische problemen bij u veroorzaakte?</u>	Ja	Nee
L20	Heeft u in de afgelopen 12 maanden <u>belangrijke activiteiten opgegeven</u> of sterk verminderd <u>om</u> [—MIDDEL—] <u>te kunnen verkrijgen of gebruiken</u> - activiteiten als sport, werk, of omgaan met vrienden of familie?	Ja	Nee
L8	<u>Belemmerde</u> het gebruik van [—MIDDEL—] u in de afgelopen 12 maanden vaak <u>in uw werkzaamheden</u> op school, in uw baan of thuis?	Ja	Nee
L10	Zijn er in de afgelopen 12 maanden periodes geweest waarin u [—MIDDEL—] <u>gebruikte in situaties waarin u gewond kon raken</u> - bijvoorbeeld bij het fietsen, autorijden of varen, het bedienen van een machine of iets dergelijks?	Ja	Nee
L9A	Heeft het gebruik van [—MIDDEL—] in de afgelopen 12 maanden <u>geleid tot problemen met de politie?</u>	Ja	Nee
L9	<u>Ging u in de afgelopen 12 maanden door met het gebruik van</u> [—MIDDEL—] <u>terwijl u wist dat dat problemen met uw familie, vrienden, op uw werk, op school voor u veroorzaakte?</u>	Ja	Nee

Voortdurend

Vaak

Soms

Zelden

Helemaal niet

5. Lichamelijke klachten

L	In de laatste 30 dagen, hoe vaak had u:	30 dagen				
		Helemaal niet	Zelden	Soms	Vaak	Voortdurend
I	Gebrek aan eetlust	0	1	2	3	4
	Vermoeidheid / gebrek aan energie	0	1	2	3	4
	Misselijkheid	0	1	2	3	4
	Maagpijn	0	1	2	3	4
	Kortademigheid / benauwdheid	0	1	2	3	4
	Pijn in de borst	0	1	2	3	4
	Pijnlijke gewrichten / stijfheid	0	1	2	3	4
	Spierpijn	0	1	2	3	4
	Doof of tintelend gevoel in armen en benen	0	1	2	3	4
	Trillen / beven	0	1	2	3	4

6. Persoonlijkheid

L

Gewoonlijk, in het algemeen

Alleen “Ja” scoren als het *in het algemeen, vaak, normaliter* is. Als het alleen geldt in bijzondere omstandigheden, bij specifieke personen of in specifieke situaties, dan “Nee” scoren.

H

	Ja, zeker	Nee
Heeft u in het algemeen moeite met het maken en behouden van vrienden?	Ja	Nee
Zou u zichzelf als een typische eenling beschrijven?	Ja	Nee
Heeft u in het algemeen vertrouwen in andere mensen?	Ja	Nee
Heeft u gewoonlijk moeite uw zelfbeheersing te bewaren?	Ja	Nee
Bent u impulsief van aard?	Ja	Nee
Maakt u zich gewoonlijk snel zorgen?	Ja	Nee
Hebt u in het algemeen de neiging sterk op anderen te leunen?	Ja	Nee
Bent u in het algemeen een perfectionist?	Ja	Nee

7. Activiteiten & Participatie, Hulp & Ondersteuning

De ICF (International Classification of Functioning, Disability and Health) maakt een onderscheid tussen de uitvoering van activiteiten en participatie en het vermogen om dat te doen. In deze MATE-ICF dient de uitvoering beoordeeld te worden; niet het vermogen, dat wil zeggen: beoordeel of de persoon iets doet of dat er met hulp van buiten iets gedaan wordt, beoordeel niet of de persoon het zelf, al dan niet met hulp, zou kunnen.

De uitvoering kan ondersteund worden door externe factoren of hulpleverende instanties. Iemand die bijvoorbeeld zelf niet het vermogen bezit zelf(standig) huishoudelijk taken te verrichten maar bij wie de huishoudelijk taken wel met hulp van anderen uitgevoerd worden, moet dus gescoord worden als "geen beperking in de uitvoering". Bij hulp & ondersteuning moet gescoord worden dat de persoon bijvoorbeeld veel hulp daarbij ontvangt.

De codering van 0 (geen) tot 4 (volledig) in de beperking en de ondersteuning is niet precies gedefinieerd. Als algemene richtlijn kan gegeven worden:

0	1	2	3	4
0-4%	5-24%	25-49%	50-95%	96-100%

In deze figuur wordt weergegeven dat 0 (geen) en 4 (volledig) maar een klein stukje op de meetlaat innemen, namelijk, ieder 5%, 0 aan de kant van geen beperking en 4 aan de kant van de meeste beperking. Het moet dus behoorlijk duidelijk zijn dat er geen (0) of volledige (4) beperking is wil dat gescoord kunnen worden.

2 (Matig) loopt niet verder dan de helft van de volledige schaal. Dat wil zeggen dat de beperking minder is dan 50% van de mogelijke beperking in de uitvoering. Beoordeelt u de moeilijkheden met de uitvoering groter dan de helft maar niet volledig, dan scoort u 3.

De volgende tabel geeft ook enkele aanwijzingen om de mate van beperking te scoren. Hier is de score (getal) vertaald in een bewoording voor de mate van beperking (geen tot volledig), een getal dat de duur aangeeft (percentage van tijd van $\leq 5\%$ tot $> 90\%$, een term voor de intensiteit (niet merkbaar tot volledige ontwrichting van het dagelijks leven) of de frequentie (nooit tot continu).

Score	ICF mate van beperking	Tijdsduur	Intensiteit	Frequentie
0	Geen	$\leq 5\%$	Niet merkbaar	Nooit
1	Licht	$< 25\%$	Dragelijk	Zelden
2	Matig	$\geq 25\%$	Verstoort dagelijks leven	Soms
3	Ernstig	$> 50\%$	Gedeeltelijke ontwrichting van dagelijks leven	Vaak
4	Volledig	$> 95\%$	Volledige ontwrichting van dagelijks leven	Continu

De gecodeerde informatie is altijd in de context van een gezondheidsprobleem. Informatie die iemands keuze weergeeft maar geen verband houdt met een probleem met het functioneren in samenhang met een gezondheidsprobleem, moet niet worden gecodeerd.

Bij HULPBEHOEFTE dient aangegeven te worden of U (de beoordelaar) hulp of extra hulp nodig acht bij de uitvoering van de betreffende activiteit of participatie, of de persoon zelf (extra) hulp nodig acht en, als een van beide ja is, de eigen instelling bereid en in staat is die hulp te verlenen.

7. Activiteiten & Participatie, Hulp & Ondersteuning

30 dagen

ICF Component d: Activiteiten & Participatie en Component e: Hulp & ondersteuning van diensten		Beperking in uitvoering / Heeft moeite met	Hulp & ondersteuning van institutionele diensten	Hoeveelheid Hulp & Ondersteuning	HULP BEHOEFTE					
HOOFD STUK		0: Geen 1: Licht 2: Matig 3: Ernstig 4: Volledig	KRIJGT DE PERSOON HULP OF ONDERSTEUNING VAN	0: Geen 1: Licht 2: Matig 3: Aanzienlijk 4: Volledig	Vindt u dat er (extra) hulp nodig is?	Vindt persoon zelf dat er (extra) hulp nodig is?	Eigen instelling in staat en bereid deze hulp te geven?			
	HEEFT DE PERSOON MOEILIKHEDEN MET									
TUSSENMENSELIJKE INTERACTIES EN RELATIES	Het aangaan en onderhouden van relaties: <i>[Heeft u moeilijkheden met]</i>		NVT							
	<u>d770</u> intieme relaties <i>[partner]</i>						Ja	Ja	Ja
	<u>d750, d760</u> informele relaties <i>[familie/vrienden]</i>						Nee	Nee	Nee
	<u>d740</u> formele relaties <i>[werkgevers, zorgverleners e.d.]</i>								
	<u>d710</u> Contact maken met en omgaan met andere mensen in het algemeen. <i>[Vindt u het moeilijk om contact met andere mensen te maken en met andere mensen om te gaan?]</i>						NVT	Ja Nee	Ja Nee
BELANGRIJKE LEVENSGEBIEDEN	<u>d810-850</u> Het volgen van een opleiding of het hebben en uitvoeren van werk.	.....	<u>e5850, e5900</u> Heeft de persoon ondersteuning hierbij, zoals werktoeleiding, arbeidsbemiddeling	.....	Ja Nee	Ja Nee	Ja Nee	
	<u>d870</u> Economische zelfstandigheid. <i>[Komt u geld tekort voor uw dagelijks levensonderhoud?]</i>	.....	<u>e5700</u> Ontvangt de persoon hierbij hulp zoals budgettering (NB: een uitkering is geen hulp)	.....	Ja Nee	Ja Nee	Ja Nee	
MAATSCHAPPELIJK, SOCIAAL EN BURGERLIJK LEVEN	<u>d920</u> Recreatieve activiteiten of vrijetijdsbesteding. <i>[Heeft u moeite om iets leuks te doen in uw vrije tijd, bijvoorbeeld om te sporten, ontspanning te zoeken, uitgaan, uitstapjes e.d.?]</i>	.....	NVT		Ja Nee	Ja Nee	Ja Nee		
	<u>d930</u> Activiteiten in het kader van religie of spiritualiteit. <i>[Ervaart u moeilijkheden met het meedoen aan religieuze of spirituele bijeenkomsten of in het samen met anderen zoeken naar betekenis van het leven?]</i>	.....	NVT		Ja Nee	Ja Nee	Ja Nee		
HUISHOUDEN	<u>d610</u> Verwerven en behouden van woonruimte. <i>[Heeft u gebrek aan onderdak? Zijn er problemen met huisvesting?]</i>	.....	<u>e5250</u> Heeft de persoon hier hulp bij van bijvoorbeeld woonvoorzieningen, sociaal pensioen?	.....	Ja Nee	Ja Nee	Ja Nee	
	<u>d630-d640</u> Uitvoeren van huishoudelijke taken, zoals het bereiden van maaltijden, het huishouden doen, inkopen doen. <i>[Heeft u moeite met het uitvoeren van huishoudelijke taken?]</i>	.....	<u>e5750</u> Heeft de persoon hier hulp bij van bijvoorbeeld thuiszorg?	.....	Ja Nee	Ja Nee	Ja Nee	

MATE-ICF component d: Activiteiten & participatie + component e: Externe Factoren (ontwerp MATE)
MATE versie 1.02w December 2005 Meten van Addicties voor Triage en Evaluatie ZonMw project 3100068

7. Activiteiten & Participatie, Hulp & Ondersteuning

ICF Component d: Activiteiten & Participatie en Component e: Hulp & ondersteuning van diensten		Beperking in uitvoering / Heeft moeite met	Hulp & ondersteuning van institutionele diensten	Hoeveelheid Hulp & Ondersteuning	HULP BEHOEFTE		
HOOFD STUK	HEEFT DE PERSOON MOEILIKHEDEN MET	0: Geen 1: Licht 2: Matig 3: Ernstig 4: Volledig	KRIJGT DE PERSOON HULP OF ONDERSTEUNING VAN	0: Geen 1: Licht 2: Matig 3: Aanzienlijk 4: Volledig	Vindt u dat er (extra) hulp nodig is?	Vindt persoon zelf dat er (extra) hulp nodig is?	Eigen instelling in staat en bereid deze hulp te geven?
30 dagen	ZELFVERZORGING						
	d510,520,540 Persoonlijke verzorging, hygiëne of verzorging van kleding. [OBSERVEER PERSOON]		e5750				
	d5700 Zelfbescherming tegen kou, donkerte, vocht. [HEEFT PERSOON VEILIGE SLAAPPLAATS, KLEEDT ZICH VOLDOENDE BESCHERMEND]		Maakt de persoon gebruik van hulp bij zelfverzorging, bijvoorbeeld thuiszorg?		Ja	Ja	Ja
	d5701 Voedzaam eten en drinken en onderhouden van lichamelijke conditie. [Heeft u problemen met voldoende eten en drinken en voor uw lichamenlijk conditie te zorgen?]				Nee	Nee	Nee
	d5702a Verkrijgen en opvolgen van adviezen en behandeling van de gezondheidszorg. [Laat u zich voldoende vaak onderzoeken en adviseren door de gezondheidszorg? Ervaart u moeilijkheden met het volgen van de adviezen en behandelingen?]		e5800 Heeft de persoon regelmatige en goede contacten met de gezondheidszorg?		Ja	Ja	Ja
	d5702b Verhoeden van gezondheidsschade dat zich uit in riskant gezondheidsbedreigend gedrag, zoals gebruik van vuile of gebruikte spuiten, riskant seksueel gedrag, riskant gedrag in het verkeer. [Gebruikt u wel eens vuile spuiten, heeft u wel eens onbeschermd seksueel contact met wisselende partners, begeeft u zich wel eens onder invloed in het verkeer?]		NVT				
	ALGEMENE TAKEN EN EISEN						
	d230 Het hebben van een dagritme en het uitvoeren van dagelijkse routinehandelingen. [Heeft u moeite met het maken van een dagindeling of problemen met reserveren van tijd voor en plannen van de afzonderlijke activiteiten gedurende de dag?]		e5750 Maakt de persoon gebruik van voorzieningen voor dagbesteding?		Ja	Ja	Ja
	d240 Het omgaan met stress of crisissituaties. [Heeft u moeite om met stress of druk om te gaan als er veel van u gevraagd wordt of de situatie moeilijk is?]		NVT		Ja	Ja	Ja
	LEREN EN TOEPASSEN VAN KENNIS						
	d1 Iets leren, toepassen van het geleerde, denken, oplossen van problemen en beslissen. [HEEFT DE PERSOON MOEITE NIEUWE VAARDIGHEDEN TE LEREN OF KENNIS OP TE DOEN EN TOE TE PASSEN?] [KAN VEROORZAAKT WORDEN DOOR LAGE INTELLIGENTIE MAAR OOK DOOR COGNITIEVE STOORNISSEN OF EMOTIONELE STOORNISSEN] [GEEF UW ALGEMENE INDRUK]		NVT		Ja	Ja	Ja

MATE-ICF component d: Activiteiten & participatie + component e: Externe Factoren (ontwerp MATE)
MATE versie 1.02w December 2005 Meten van Addicties voor Triage en Evaluatie ZonMw project 3100068

9

8. Externe factoren van invloed op het herstelproces

30 dagen

ICF Component e: Externe factoren		INVLOED OP HERSTEL	HULP BEHOEFTE			
HOOFDSTUK	ITEM	0: Geen 1: Licht 2: Matig 3: Aanzienlijk 4: Volledig	SPECIFICATIE (VRIJE TEKST):	Vindt u dat er (extra) hulp nodig is?	Vindt persoon zelf dat er (extra) hulp nodig is?	Eigen instelling in staat en bereid deze hulp te geven?
ONDERSTEUNING EN RELATIES	e310-e325 Zijn er in de sociale omgeving van de persoon mensen die steunend zijn en een positieve invloed hebben op het herstelproces?	+	/.....			
	Zijn er in de sociale omgeving van de persoon mensen die een negatieve invloed hebben op het herstelproces (denk aan contacten die middelengebruik stimuleren)?	-	/.....	Ja	Ja	Ja
	Heeft de persoon <i>het laatste jaar</i> een belangrijke relatie verloren, bijvoorbeeld door dood of scheiding, en heeft dat verlies een negatieve invloed op het herstelproces?	-	/.....	Ja	Ja	Ja
ATTITUDES (NEGATIEVE)	e460 Speelt algemeen maatschappelijke negatieve bejegening van verslaafden een negatieve rol in het herstelproces van de persoon?	-	/.....	Ja	Ja	Ja
				Nee	Nee	Nee
DIENSTEN, SYSTEMEN EN BELEID (OVERIGE)	e550 Persoon is verwickeld in juridische zaken die een positieve invloed hebben op het herstelproces (heeft juridische hulp, heeft een reclasseringsambtenaar, komt in aanmerking voor een bevorderende maatregel).	+	/.....			
	Persoon is verwickeld in juridische zaken die een negatieve invloed hebben op het herstelproces (wordt opgejaagd, et cetera).	-	/.....	Ja	Ja	Ja
				Nee	Nee	Nee
	e598 Zijn er andere positieve externe factoren van invloed op het herstelproces?	+	/.....			
	Zijn er andere negatieve externe factoren van invloed op het herstelproces?	-	/.....	Ja	Ja	Ja
				Nee	Nee	Nee

9. Middelen: Verlangen

Z

De volgende vragen gaan over gedachten en gevoelens over [—MIDDEL—] en over het wel gebruiken en niet gebruiken van [—MIDDEL—].

De vragen gaan uitsluitend over de afgelopen, laatste 7 dagen. Beantwoord de vragen dus op grond wat u de **laatste week** heeft gedacht, gevoeld en gedaan. Omcirkel het cijfer voor het antwoord dat het meest op u van toepassing is.

[—MIDDEL—] = *z*.....

7 dagen

-
- 1 Als u niet gebruikt, hoeveel van uw tijd wordt in beslag genomen door gedachten, ideeën, impulsen of beelden die met gebruiken te maken hebben?
- o Geen.
 - 1 Minder dan 1 uur per dag.
 - 2 1-3 uur per dag.
 - 3 4-8 uur per dag.
 - 4 Meer dan 8 uur per dag.
-
- 2 Hoe vaak treden deze gedachten op?
- o Nooit.
 - 1 Minder dan 8 keer per dag.
 - 2 Meer dan 8 keer per dag, maar het grootste deel van de dag treden deze gedachten niet op.
 - 3 Meer dan 8 keer per dag en vrijwel alle uren van de dag.
 - 4 Het aantal keren dat ik deze gedachten heb is niet te tellen en er gaat vrijwel geen uur voorbij zonder er aan te denken.
-
- 3 Als u niet gebruikt, hoe vervelend of storend zijn deze gedachten, ideeën, impulsen of beelden die te maken hebben met gebruiken?
- o Niet vervelend of storend.
 - 1 Enigszins vervelend, maar niet te vaak en niet al te storend.
 - 2 Nogal vervelend, regelmatig en storend, maar nog wel te hanteren.
 - 3 Vervelend, vaak en erg storend.
 - 4 Zeer vervelend, bijna voortdurend en zeer storend.
-
- 4 Hoeveel moeite doet u, als u niet gebruikt, om deze gedachten tegen te gaan of te negeren of om uw gedachten als ze bij u opkomen ergens anders op te richten. (Het gaat erom aan te geven hoeveel moeite u doet, niet of het u lukt of niet).
- o Als ik zulke gedachten al heb, doe ik altijd moeite ze tegen te gaan.
 - 1 Ik doe meestal moeite om zulke gedachten tegen te gaan.
 - 2 Ik doe soms moeite om zulke gedachten tegen te gaan.
 - 3 Ik doe geen moeite om ze tegen te gaan, maar ik geef er met tegenzin aan toe.
 - 4 Ik geef me volledig en uit vrije wil over aan deze gedachten.
-
- 5 Hoe sterk is de drang om [—MIDDEL—] te gebruiken?
- o Ik heb geen drang om [—MIDDEL—] te gebruiken.
 - 1 Ik heb enige drang om [—MIDDEL—] te gebruiken.
 - 2 Ik heb een sterke drang om [—MIDDEL—] te gebruiken.
 - 3 Ik heb een zeer sterke drang om [—MIDDEL—] te gebruiken.
 - 4 De drang om [—MIDDEL—] te gebruiken is overweldigend.

10. Angst en Depressie

Z Onderstreep het antwoord dat het beste weergeeft hoe U zich gedurende de **laatste week** gevoeld heeft

T
7 dagen

1. Ik voel me gespannen

Meestal

Vaak

Af en toe, soms

Helemaal niet

2. Ik geniet nog steeds van de dingen waar ik vroeger van genoot

Zeker zo veel

Niet zo veel als vroeger

Weinig

Haast helemaal niet

3. Ik krijg een soort angstgevoel alsof er elk moment iets vreselijks zal gebeuren

Heel zeker en vrij erg

Ja, maar niet zo erg

Een beetje, maar ik maak me er geen zorgen over

Helemaal niet

4. Ik kan lachen en de dingen van de vrolijke kant zien

Net zoveel als vroeger

Niet zo goed als vroeger

Beslist niet zoveel als vroeger

Helemaal niet

5. Ik maak me vaak ongerust

Heel erg vaak

Vaak

Af en toe maar niet te vaak

Alleen soms

6. Ik voel me opgewekt

Helemaal niet

Niet vaak

Soms

Meestal

7. Ik kan rustig zitten en me ontspannen

Zeker

Meestal

Niet vaak

Helemaal niet

8. Ik voel me alsof alles moeizamer gaat

Bijna altijd

Heel vaak

Soms

Helemaal niet

9. Ik krijg een soort benauwd, gespannen gevoel in mijn maag

Helemaal niet

Soms

Vrij vaak

Heel vaak

10. Ik heb geen interesse meer in mijn uiterlijk

Zeker

Niet meer zoveel als ik zou moeten

Waarschijnlijk niet zoveel

Evenveel interesse als vroeger

10. Angst en Depressie

	11. Ik voel me rusteloos en voel dat ik iets te doen moet hebben			
	Heel erg	Tamelijk veel	Niet erg veel	Helemaal niet
I 7 dagen	12. Ik verheug me van tevoren al op dingen			
	Net zoveel als vroeger	Een beetje minder dan vroeger	Zeker minder dan vroeger	Bijna nooit
	13. Ik krijg plotseling gevoelens van panische angst			
	Zeer vaak	Tamelijk vaak	Niet erg vaak	Helemaal niet
	14. Ik kan van een goed boek genieten~ of van een radio- of televisieprogramma			
	Vaak	Soms	Niet vaak	Heel zelden

Appendix 2: Descriptives of MATE 1.02w items

** Module 1. Substance use.

Primary Problem substance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Alcohol	491	52.0	52.9	52.9
	2 Opioids	148	15.7	15.9	68.8
	3 Stimulants	126	13.3	13.6	82.3
	4 Cannabis	137	14.5	14.7	97.1
	5 Other substance	19	2.0	2.0	99.1
	6 Addictive behaviors	8	.8	.9	100.0
	Total	929	98.3	100.0	
Missing	98 Not known	9	1.0		
	System	7	.7		
	Total	16	1.7		
Total		945	100.0		

Item statistics

Age

	Primary Problem substance				
	1 Alcohol	2 Opioids	3 Stimulants	4 Cannabis	Total
Median	44.00	41.00	30.00	24.00	39.00
Mean	43.23	41.46	31.49	25.35	38.60
Minimum	18	16	18	15	15
Maximum	75	58	56	44	75
Range	57	42	38	29	60

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
Alcohol - years of (lifetime)	12.79	10.00	10.312	1	56	706
Nicotine - years of (lifetime)	20.77	20.00	10.925	1	52	773
Cannabis - years of (lifetime)	11.99	10.00	8.755	1	46	392
Methadone - years of (lifetime)	14.12	14.00	8.622	1	33	139
Heroin - years of (lifetime)	14.89	15.00	9.414	1	35	174
Other opioids - years of (lifetime)	7.93	5.00	8.766	1	30	14
Crack - years of (lifetime)	10.15	8.50	7.915	1	38	174
Cocaine - years of (lifetime)	6.48	5.00	5.661	1	28	127
Stimulants - years of (lifetime)	5.95	4.00	5.721	1	35	92
Ecstasy XTC - years of (lifetime)	6.19	5.00	5.799	1	28	54
Other substances - years of (lifetime)	7.27	2.00	9.443	1	30	30
Sedatives - years of (lifetime)	8.94	4.00	9.733	1	39	140
Gambling - years of (lifetime)	7.31	4.00	8.986	1	39	35

Item statistics

	Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
Alcohol - years of (lifetime)	13.51	469	16.42	81	9.58	74	6.51	59	12.82	683
Nicotine - years of (lifetime)	23.68	380	25.07	143	16.37	107	10.13	112	20.85	742
Cannabis - years of (lifetime)	12.66	88	16.52	90	13.16	62	8.10	135	12.03	375
Methadone - years of (lifetime)	12.38	13	15.02	111	7.89	9	1.50	2	14.09	135
Heroin - years of (lifetime)	10.17	18	16.34	127	11.74	19	3.50	2	14.99	166
Other opioids - years of (lifetime)	7.75	4	8.11	9					8.00	13
Crack - years of (lifetime)	9.19	21	11.44	90	7.52	50	12.67	3	9.98	164
Cocaine - years of (lifetime)	5.84	25	8.00	22	6.31	59	4.25	12	6.31	118
Stimulants - years of (lifetime)	6.37	19	6.88	17	6.16	32	4.31	16	6.00	84
Ecstasy XTC - years of (lifetime)	5.57	14	6.80	5	5.26	19	4.10	10	5.27	48
Other substances - years of (lifetime)	2.78	9	11.50	10	3.80	5	5.50	2	6.54	26
Sedatives - years of (lifetime)	7.98	47	10.57	60	6.31	13	8.14	7	9.04	127
Gambling - years of (lifetime)	7.50	12	7.13	8	11.75	4	5.29	7	7.45	31

** Module 2. Indicators for psychiatric / medical consultation

ipm001 Medicines for addiction prescribed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	723	76.5	77.9	77.9
	1 Yes	205	21.7	22.1	100.0
	Total	928	98.2	100.0	
Missing	System	17	1.8		
Total		945	100.0		

ipm003 Medicines for psych problems prescribed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	612	64.8	66.2	66.2
	1 Yes	313	33.1	33.8	100.0
	Total	925	97.9	100.0	
Missing	System	20	2.1		
Total		945	100.0		

ipm005 Other medicines prescribed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	583	61.7	63.0	63.0
	1 Yes	343	36.3	37.0	100.0
	Total	926	98.0	100.0	
Missing	System	19	2.0		
Total		945	100.0		

ipm007 Current or recent (last year) psychiatric of psychological treatment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	628	66.5	68.0	68.0
	1 Yes	296	31.3	32.0	100.0
	Total	924	97.8	100.0	
Missing	System	21	2.2		
Total		945	100.0		

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
ipm009 Suicide risk Wish.	.31	.00	.461	0 No	1 Yes	940
ipm010 Suicide risk Plan.	.07	.00	.252	0 No	1 Yes	941
ipm011 Psychotic symptoms. Hallucinations.	.11	.00	.319	0 No	1 Yes	942
ipm012 Psychotic symptoms. Delusions.	.14	.00	.350	0 No	1 Yes	941
ipm013 Confusion	.10	.00	.296	0 No	1 Yes	939
ipm014 Physical health	.14	.00	.352	0 No	1 Yes	938
ipm015 Intoxication-withdrawal symptoms	.11	.00	.310	0 No	1 Yes	940
ipm016 Physical disease	.06	.00	.241	0 No	1 Yes	935
ipm017 Pregnancy	.00	.00	.058	0 No	1 Yes	889

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
ipm009 Suicide risk Wish.	.31	487	.32	148	.30	125	.26	137	.31	897
ipm010 Suicide risk Plan.	.05	488	.11	148	.10	125	.06	137	.07	898
ipm011 Psychotic symptoms. Hallucinations.	.09	489	.12	148	.21	125	.09	137	.11	899
ipm012 Psychotic symptoms. Delusions.	.11	488	.10	148	.26	125	.19	137	.14	898
ipm013 Confusion	.07	486	.14	148	.09	125	.10	137	.09	896
ipm014 Physical health	.14	487	.25	148	.11	124	.07	136	.14	895
ipm015 Intoxication-withdrawal symptoms	.11	489	.15	148	.08	124	.06	137	.10	898
ipm016 Physical disease	.05	483	.18	148	.03	125	.00	137	.06	893
ipm017 Pregnancy	.00	457	.01	136	.00	121	.01	132	.00	846

**** Module 4. Substance dependence and abuse.**

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
mam001 Tolerance L12B	.55	1.00	.498	0 No	1 Yes	943
mam002 Quit/Cut down L14A+B	.80	1.00	.402	0 No	1 Yes	940
mam003 Time spent L15A	.54	1.00	.499	0 No	1 Yes	940
mam004 Larger/longer L16B	.71	1.00	.453	0 No	1 Yes	941
mam005 Withdrawal L17A+B	.46	.00	.499	0 No	1 Yes	939
mam006 Physical/psych problems L18B + L19B	.83	1.00	.377	0 No	1 Yes	939
mam007 Reduced activities L20	.43	.00	.495	0 No	1 Yes	942
mam008 Role impairment L8	.51	1.00	.500	0 No	1 Yes	938
mam009 Hazardous use L10	.53	1.00	.499	0 No	1 Yes	940
mam010 Legal problems L9A	.25	.00	.432	0 No	1 Yes	940
mam011 Social problems L9	.76	1.00	.428	0 No	1 Yes	943

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
mam001 Tolerance L12B	.55	491	.46	147	.59	125	.56	137	.54	900
mam002 Quit/Cut down L14A+B	.78	489	.70	147	.88	125	.87	137	.80	898
mam003 Time spent L15A	.47	489	.52	147	.60	124	.69	137	.53	897
mam004 Larger/longer L16B	.74	490	.57	147	.74	124	.71	137	.71	898
mam005 Withdrawal L17A+B	.40	490	.68	147	.46	125	.41	135	.45	897
mam006 Physical/psych problems L18B + L19B	.82	489	.80	146	.85	124	.86	137	.83	896
mam007 Reduced activities L20	.36	490	.43	147	.54	125	.55	137	.43	899
mam008 Role impairment L8	.46	487	.55	146	.56	125	.58	137	.51	895
mam009 Hazardous use L10	.50	490	.41	147	.62	125	.67	136	.53	898
mam010 Legal problems L9A	.24	489	.29	146	.34	125	.14	137	.25	897
mam011 Social problems L9	.76	491	.65	147	.86	125	.77	137	.76	900

**** Module 5. Physical complaints.**

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
IkI001 Poor appetite	1.42	1.00	1.378	0 Never	4 Always	944
IkI002 Tiredness/fatigue	2.13	2.00	1.351	0 Never	4 Always	944
IkI003 Nausea (feeling sick)	.84	.00	1.145	0 Never	4 Always	944
IkI004 Stomach pains	.86	.00	1.169	0 Never	4 Always	945
IkI005 Difficulty breathing	1.34	1.00	1.383	0 Never	4 Always	945
IkI006 Chest pains	.75	.00	1.101	0 Never	4 Always	944
IkI007 Joint/bone pains	1.30	1.00	1.429	0 Never	4 Always	945
IkI008 Muscle pains	1.01	.00	1.275	0 Never	4 Always	942
IkI009 Numbness/tingling	.93	.00	1.254	0 Never	4 Always	944
IkI010 Tremors/shakes	1.15	1.00	1.312	0 Never	4 Always	945

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
IkI001 Poor appetite	1.38	490	1.70	148	1.21	126	1.43	137	1.41	901
IkI002 Tiredness/fatigue	2.02	491	2.34	148	2.06	126	2.20	136	2.10	901
IkI003 Nausea (feeling sick)	.80	490	.97	148	.72	126	.85	137	.82	901
IkI004 Stomach pains	.78	491	1.01	148	.87	126	.86	137	.84	902
IkI005 Difficulty breathing	1.23	491	1.73	148	1.30	126	1.21	137	1.32	902
IkI006 Chest pains	.68	491	.86	148	.87	126	.73	136	.74	901
IkI007 Joint/bone pains	1.38	491	1.49	148	1.05	126	1.03	137	1.30	902
IkI008 Muscle pains	.95	489	1.26	148	1.02	126	.91	137	1.01	900
IkI009 Numbness/tingling	.89	490	1.15	148	.95	126	.82	137	.93	901
IkI010 Tremors/shakes	1.18	491	1.01	148	1.07	126	1.15	137	1.13	902

**** Module 6. Personality.**

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
per001 In general, do you have difficulty making and keeping friends?	.31	.00	.462	0 No	1 Yes	939
per002 Would you normally describe yourself as a loner?	.41	.00	.492	0 No	1 Yes	940
per003 In general, do you trust other people?	.39	.00	.489	0 Yes	1 No	940
per004 Do you normally lose your temper easily?	.28	.00	.449	0 No	1 Yes	938
per005 Are you normally an impulsive sort of person?	.56	1.00	.497	0 No	1 Yes	937
per006 Are you normally a worrier?	.63	1.00	.484	0 No	1 Yes	939
per007 In general, do you depend on others a lot?	.26	.00	.438	0 No	1 Yes	938
per008 In general, are you a perfectionist?	.51	1.00	.500	0 No	1 Yes	940

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
per001 In general, do you have difficulty making and keeping friends?	.29	490	.33	148	.33	125	.32	133	.31	896
per002 Would you normally describe yourself as a loner?	.40	491	.50	148	.41	125	.37	133	.41	897
per003 In general, do you trust other people?	.33	491	.47	148	.45	125	.49	133	.39	897
per004 Do you normally lose your temper easily?	.24	490	.24	148	.31	125	.45	132	.28	895
per005 Are you normally an impulsive sort of person?	.47	490	.62	147	.69	124	.68	133	.56	894
per006 Are you normally a worrier?	.63	490	.62	148	.70	125	.58	133	.63	896
per007 In general, do you depend on others a lot?	.25	491	.18	147	.33	124	.27	133	.25	895
per008 In general, are you a perfectionist?	.54	491	.49	148	.48	125	.50	133	.52	897

**** Module 7. Activities & Participation, Care & Support (MATE-ICN).**

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
iap001 d770 Intimate relationships	1.19	.00	1.378	0 None	4 Complete	929
iap002 d750,d760 Social & family relationships	1.07	.00	1.280	0 None	4 Complete	928
iap003 d740 Formal relationships	.70	.00	1.146	0 None	4 Complete	927
iap007 d710 Basic interpersonal interactions	.69	.00	1.107	0 None	4 Complete	930
iap011 d810-850 Education & work	1.41	1.00	1.542	0 None	4 Complete	925
iap016 d870 Economic self-sufficiency	1.22	.00	1.467	0 None	4 Complete	930
iap021 d920 Recreation & leisure	1.08	.00	1.336	0 None	4 Complete	928
iap025 d930 Religion & spirituality	.14	.00	.545	0 None	4 Complete	889
iap029 d610 Acquiring and keeping a place to live	.65	.00	1.264	0 None	4 Complete	924
iap034 d630-d640 Household tasks	.64	.00	1.108	0 None	4 Complete	921
iap039 d510,520,540 Self-care	.27	.00	.689	0 None	4 Complete	901
iap040 d5700 Ensuring physical comfort	.17	.00	.690	0 None	4 Complete	918
iap041 d5701 Managing diet and fitness	.75	.00	1.137	0 None	4 Complete	915
iap046 d5702a Following medical advice	.53	.00	.956	0 None	4 Complete	900
iap051 d5702b Avoiding health-risk behaviors	.66	.00	1.080	0 None	4 Complete	906
iap052 d230 Carrying out daily routine	1.06	.00	1.322	0 None	4 Complete	887
iap057 d240 Handling stress	1.82	2.00	1.395	0 None	4 Complete	919
iap061 d1 Learning and applying knowledge	.73	.00	1.134	0 None	4 Complete	920

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
iap001 d770 Intimate relationships	1.20	484	1.41	145	1.07	125	1.00	133	1.18	887
iap002 d750,d760 Social & family relationships	.92	484	1.15	145	1.10	124	1.39	133	1.06	886
iap003 d740 Formal relationships	.59	484	.96	145	.80	123	.66	133	.69	885
iap007 d710 Basic interpersonal interactions	.59	484	.82	145	.74	126	.86	133	.69	888
iap011 d810-850 Education & work	1.09	483	2.17	145	1.61	122	1.46	133	1.39	883
iap016 d870 Economic self-sufficiency	.81	484	1.97	145	1.63	126	1.41	133	1.20	888
iap021 d920 Recreation & leisure	.94	483	1.59	144	1.06	126	.99	133	1.07	886
iap025 d930 Religion & spirituality	.08	460	.32	142	.07	117	.17	129	.13	848
iap029 d610 Acquiring and keeping a place to live	.43	484	1.26	143	.94	124	.42	131	.64	882
iap034 d630-d640 Household tasks	.58	482	1.01	142	.42	123	.61	132	.63	879
iap039 d510,520,540 Self-care	.25	471	.51	142	.13	120	.19	129	.27	862
iap040 d5700 Ensuring physical comfort	.12	480	.55	143	.15	123	.00	131	.17	877
iap041 d5701 Managing diet and fitness	.63	480	1.16	142	.61	120	.75	133	.73	875
iap046 d5702a Following medical advice	.41	467	.97	143	.63	120	.33	131	.52	861
iap051 d5702b Avoiding health-risk behaviors	.56	474	.70	142	.70	122	.88	130	.65	868
iap052 d230 Carrying out daily routine	.88	465	1.32	138	1.18	116	1.28	129	1.05	848
iap057 d240 Handling stress	1.83	480	1.78	141	1.81	124	1.90	133	1.83	878
iap061 d1 Learning and applying knowledge	.62	480	.97	143	.88	123	.77	133	.73	879

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
iap012 e5850,e5900 Amount of care provided for d810-850	.78	.00	1.295	0 None	4 Complete	499
iap017 e5700 Amount of care provided for d870	.92	.00	1.403	0 None	4 Complete	469
iap030 e5250 Amount of care provided for d610	.97	.00	1.546	0 None	4 Complete	266
iap035 e5750 Amount of care provided for d630-d640	.44	.00	.998	0 None	4 Complete	311
iap042 e5750 Amount of care provided for d500+	.42	.00	.997	0 None	4 Complete	385
iap047 e5800 Amount of medical care	1.18	1.00	1.263	0 None	4 Complete	277
iap053 e5750 Amount of care provided for d230	.44	.00	1.049	0 None	4 Complete	423

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
iap012 e5850,e5900 Amount of care provided for d810-850	.79	213	.78	111	.59	71	1.05	78	.80	473
iap017 e5700 Amount of care provided for d870	.97	179	.92	106	1.08	76	.63	80	.92	441
iap030 e5250 Amount of care provided for d610	.82	103	1.38	74	.87	38	.71	34	.98	249
iap035 e5750 Amount of care provided for d630-d640	.54	153	.36	70	.23	30	.35	43	.44	296
iap042 e5750 Amount of care provided for d500+	.35	175	.62	98	.48	42	.19	53	.42	368
iap047 e5800 Amount of medical care	.98	117	1.47	81	1.18	38	.79	24	1.15	260
iap053 e5750 Amount of care provided for d230	.35	185	.80	85	.35	60	.21	71	.42	401

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
iap006 D770+ Task of the institute	.46	.00	.498	0	1 Yes	927
iap010 d710 Task of the institute	.21	.00	.411	0	1 Yes	928
iap015 d810 Task of the institute	.21	.00	.407	0	1 Yes	923
iap020 d870 Task of the institute	.19	.00	.390	0	1 Yes	928
iap024 d920 Task of the institute	.27	.00	.442	0	1 Yes	927
iap028 d930 Task of the institute	.02	.00	.156	0	1 Yes	888
iap033 d610 Task of the institute	.13	.00	.334	0	1 Yes	924
iap038 d630 Task of the institute	.11	.00	.314	0	1 Yes	919
iap045 D500+ Task of the institute	.20	.00	.397	0	1 Yes	891
iap050 d5702a Task of the institute	.16	.00	.367	0	1 Yes	899
iap056 d230 Task of the institute	.27	.00	.444	0	1 Yes	887
iap060 d240 Task of the institute	.49	.00	.500	0	1 Yes	918
iap064 d1 Task of the institute	.18	.00	.388	0	1 Yes	921

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
iap006 D770+ Task of the institute	.42	484	.59	145	.46	124	.44	132	.45	885
iap010 d710 Task of the institute	.17	482	.36	145	.21	126	.24	133	.22	886
iap015 d810 Task of the institute	.12	481	.57	145	.20	122	.13	133	.21	881
iap020 d870 Task of the institute	.09	483	.49	145	.21	126	.18	132	.19	886
iap024 d920 Task of the institute	.22	482	.44	144	.24	126	.26	133	.26	885
iap028 d930 Task of the institute	.01	459	.08	142	.01	117	.03	129	.02	847
iap033 d610 Task of the institute	.06	484	.39	143	.14	124	.07	131	.13	882
iap038 d630 Task of the institute	.08	480	.29	142	.08	123	.06	132	.11	877
iap045 D500+ Task of the institute	.14	465	.48	141	.18	115	.11	132	.20	853
iap050 d5702a Task of the institute	.10	467	.45	143	.16	119	.06	131	.16	860
iap056 d230 Task of the institute	.21	465	.47	138	.23	116	.31	129	.27	848
iap060 d240 Task of the institute	.49	479	.59	141	.46	124	.48	133	.50	877
iap064 d1 Task of the institute	.14	481	.36	143	.19	123	.18	133	.19	880

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
iap004 D770+ Need for care Professional	.47	.00	.499	0	1	929
iap008 d710 Need for care Professional	.22	.00	.411	0	1	928
iap013 d810 Need for care Professional	.29	.00	.453	0	1	923
iap018 d870 Need for care Professional	.26	.00	.438	0	1	928
iap022 d920 Need for care Professional	.28	.00	.449	0	1	927
iap026 d930 Need for care Professional	.02	.00	.155	0	1	889
iap031 d610 Need for care Professional	.16	.00	.371	0	1	924
iap036 d630 Need for care Professional	.13	.00	.335	0	1	920
iap043 D500+ Need for care Professional	.21	.00	.408	0	1	891
iap048 d5702a Need for care Professional	.15	.00	.356	0	1	899
iap054 d230 Need for care Professional	.29	.00	.455	0	1	887
iap058 d240 Need for care Professional	.55	1.00	.498	0	1	919
iap062 d1 Need for care Professional	.21	.00	.404	0	1	921

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
iap004 D770+ Need for care Professional	.46	484	.52	145	.47	125	.44	133	.47	887
iap008 d710 Need for care Professional	.17	482	.30	145	.23	126	.29	133	.22	886
iap013 d810 Need for care Professional	.21	481	.56	145	.31	122	.25	133	.29	881
iap018 d870 Need for care Professional	.14	483	.51	145	.33	126	.31	132	.26	886
iap022 d920 Need for care Professional	.24	482	.43	144	.24	126	.28	133	.28	885
iap026 d930 Need for care Professional	.01	460	.06	142	.01	117	.03	129	.02	848
iap031 d610 Need for care Professional	.10	484	.36	143	.22	124	.11	131	.16	882
iap036 d630 Need for care Professional	.11	481	.25	142	.08	123	.12	132	.13	878
iap043 D500+ Need for care Professional	.16	465	.43	141	.19	115	.17	132	.21	853
iap048 d5702a Need for care Professional	.10	467	.38	143	.16	119	.07	131	.15	860
iap054 d230 Need for care Professional	.23	465	.43	138	.28	116	.35	129	.29	848
iap058 d240 Need for care Professional	.55	480	.55	141	.52	124	.56	133	.55	878
iap062 d1 Need for care Professional	.16	481	.33	143	.21	123	.23	133	.21	880

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
iap005 D770+ Need for care Client	.36	.00	.480	0	1	928
iap009 d710 Need for care Client	.17	.00	.379	0	1	928
iap014 d810 Need for care Client	.25	.00	.432	0	1	923
iap019 d870 Need for care Client	.23	.00	.423	0	1	928
iap023 d920 Need for care Client	.26	.00	.436	0	1	927
iap027 d930 Need for care Client	.02	.00	.156	0	1	888
iap032 d610 Need for care Client	.15	.00	.356	0	1	924
iap037 d630 Need for care Client	.11	.00	.313	0	1	919
iap044 D500+ Need for care Client	.18	.00	.380	0	1	891
iap049 d5702a Need for care Client	.14	.00	.344	0	1	899
iap055 d230 Need for care Client	.26	.00	.442	0	1	887
iap059 d240 Need for care Client	.50	.00	.500	0	1	919
iap063 d1 Need for care Client	.18	.00	.384	0	1	921

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
iap005 D770+ Need for care Client	.35	484	.36	145	.40	124	.35	133	.36	886
iap009 d710 Need for care Client	.14	482	.19	145	.21	126	.25	133	.17	886
iap014 d810 Need for care Client	.17	481	.50	145	.29	122	.22	133	.25	881
iap019 d870 Need for care Client	.13	483	.44	145	.31	126	.29	132	.23	886
iap023 d920 Need for care Client	.23	482	.37	144	.22	126	.26	133	.26	885
iap027 d930 Need for care Client	.01	459	.06	142	.00	117	.03	129	.02	847
iap032 d610 Need for care Client	.09	484	.31	143	.22	124	.09	131	.14	882
iap037 d630 Need for care Client	.09	480	.20	142	.07	123	.11	132	.11	877
iap044 D500+ Need for care Client	.14	465	.34	141	.14	115	.15	132	.17	853
iap049 d5702a Need for care Client	.10	467	.34	143	.14	119	.06	131	.14	860
iap055 d230 Need for care Client	.22	465	.36	138	.23	116	.33	129	.26	848
iap059 d240 Need for care Client	.51	480	.47	141	.47	124	.50	133	.50	878
iap063 d1 Need for care Client	.15	481	.26	143	.19	123	.21	133	.18	880

**** Module 8. Environmental factors influencing recovery (MATE-ICN).**

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
ief001 e310-e325+ Support and relationships Postive influence	2.56	3.00	1.272	0 None	4 Complete	927
ief002 e310-e325- Support and relationships Negative influence	1.35	1.00	1.425	0 None	4 Complete	925
ief006 Loss of relationship with negative influence	.85	.00	1.313	0 None	4 Complete	924
ief010 e460- Societal attitudes Negative influence	.50	.00	1.042	0 None	4 Complete	912
ief014 e550+ Legal factors Positive influence	.31	.00	.863	0 None	4 Complete	901
ief015 e550- Legal factors Negative influence	.40	.00	1.002	0 None	4 Complete	918
ief019 e598+ Other factors Positive influence	1.27	.00	1.513	0 None	4 Complete	918
ief020 e598- Other factors Negative influence	.77	.00	1.277	0 None	4 Complete	916

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
ief001 e310-e325+ Support and relationships Postive influence	2.66	485	2.43	144	2.48	124	2.44	133	2.56	886
ief002 e310-e325- Support and relationships Negative influence	1.05	484	1.76	143	1.65	124	1.69	133	1.34	884
ief006 Loss of relationship with negative influence	.82	484	1.10	143	.86	124	.77	132	.87	883
ief010 e460- Societal attitudes Negative influence	.37	475	1.20	143	.40	124	.27	132	.49	874
ief014 e550+ Legal factors Positive influence	.28	467	.38	143	.40	121	.33	129	.32	860
ief015 e550- Legal factors Negative influence	.31	480	.71	144	.46	123	.28	130	.39	877
ief019 e598+ Other factors Positive influence	1.31	480	1.26	144	1.44	124	1.15	130	1.29	878
ief020 e598- Other factors Negative influence	.71	480	1.06	143	.87	122	.64	130	.78	875

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
ief005 e310-e325 Task of the institute	.26	.00	.439	0	1 Yes	648
ief009 Loss of relationship Task of the institute	.16	.00	.367	0	1 Yes	705
ief013 e460 Task of the institute	.09	.00	.292	0	1 Yes	788
ief018 e550 Task of the institute	.20	.00	.401	0	1 Yes	848
ief023 e598 Task of the institute	.39	.00	.488	0	1 Yes	841

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
ief005 e310-e325 Task of the institute	.22	372	.43	106	.21	72	.28	71	.26	621
ief009 Loss of relationship Task of the institute	.11	360	.40	120	.17	90	.06	99	.16	669
ief013 e460 Task of the institute	.06	423	.29	108	.10	111	.02	115	.09	757
ief018 e550 Task of the institute	.16	452	.36	127	.21	116	.18	120	.20	815
ief023 e598 Task of the institute	.30	433	.61	131	.42	116	.43	122	.39	802

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
ief003 e310-e325 Need for care Professional	.26	.00	.438	0	1	Yes 648
ief007 Loss of relationship Need for care Professional	.15	.00	.359	0	1	Yes 706
ief011 e460 Need for care Professional	.11	.00	.309	0	1	Yes 788
ief016 e550 Need for care Professional	.23	.00	.420	0	1	Yes 849
ief021 e598 Need for care Professional	.41	.00	.492	0	1	Yes 841

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
ief003 e310-e325 Need for care Professional	.24	372	.33	106	.18	72	.32	71	.26	621
ief007 Loss of relationship Need for care Professional	.12	360	.33	120	.16	90	.06	100	.16	670
ief011 e460 Need for care Professional	.08	423	.27	108	.12	111	.03	115	.10	757
ief016 e550 Need for care Professional	.19	453	.36	127	.27	116	.20	120	.23	816
ief021 e598 Need for care Professional	.32	433	.56	131	.47	116	.51	122	.41	802

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
ief004 e310-e325 Need for care Client	.23	.00	.421	0	1	Yes 648
ief008 Loss of relationship Need for care Client	.12	.00	.329	0	1	Yes 706
ief012 e460 Need for care Client	.10	.00	.306	0	1	Yes 788
ief017 e550 Need for care Client	.21	.00	.411	0	1	Yes 849
ief022 e598 Need for care Client	.33	.00	.470	0	1	Yes 841

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
ief004 e310-e325 Need for care Client	.20	372	.35	106	.17	72	.28	71	.23	621
ief008 Loss of relationship Need for care Client	.09	360	.28	120	.13	90	.05	100	.13	670
ief012 e460 Need for care Client	.07	423	.28	108	.12	111	.03	115	.10	757
ief017 e550 Need for care Client	.17	453	.37	127	.24	116	.18	120	.21	816
ief022 e598 Need for care Client	.25	433	.47	131	.40	116	.38	122	.33	802

**** Module Z.1. Craving.**

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
mve001 How much of your time when you are not using is occupied by ideas, thoughts, impulses, or images related to drinking?	1.55	1.00	1.266	0 Symptom not present	4 Symptom severe'	891
mve002 How frequently do these thoughts occur?	1.38	1.00	1.208	0 Symptom not present	4 Symptom severe'	887
mve003 How much distress or disturbance do these ideas, thoughts, impulses, or images related to using cause you when you are not using?	1.37	1.00	1.300	0 Symptom not present	4 Symptom severe'	875
mve004 How much of an effort do you make to resist these thoughts or try to disregard or turn your attention away from these thoughts as they enter your mind when you are not using?	1.32	1.00	1.273	0 Symptom not present	4 Symptom severe'	885
mve005 How strong is the drive to use?	1.51	1.00	1.190	0 Symptom not present	4 Symptom severe'	886

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
mve001 How much of your time when you are not using is occupied by ideas, thoughts, impulses, or images related to drinking?	1.32	477	1.89	133	1.47	118	1.98	126	1.53	854
mve002 How frequently do these thoughts occur?	1.17	474	1.69	133	1.34	117	1.74	126	1.36	850
mve003 How much distress or disturbance do these ideas, thoughts, impulses, or images related to using cause you when you are not using?	1.12	465	1.79	132	1.33	116	1.77	126	1.35	839
mve004 How much of an effort do you make to resist these thoughts or try to disregard or turn your attention away from these thoughts as they enter your mind when you are not using?	1.19	474	1.63	132	1.13	117	1.54	125	1.30	848
mve005 How strong is the drive to use?	1.29	474	1.96	133	1.34	116	1.91	126	1.50	849

** Module HADS Depression, Anxiety.

Item statistics

	Mean	Median	Std. Deviation	Minimum	Maximum	N
ads001 I feel tense or "wound up."	1.55	1.00	.925	0 Symptom not present	3 Symptom severe'	907
ads002 I still enjoy the things I used to enjoy.	1.18	1.00	1.024	0 Symptom not present	3 Symptom severe'	909
ads003 I get a sort of frightened feeling as if something awful is about to happen.	1.09	1.00	1.127	0 Symptom not present	3 Symptom severe'	904
ads004 I can laugh and see the funny side of things.	.90	1.00	.889	0 Symptom not present	3 Symptom severe'	908
ads005 Worrying thoughts go through my mind.	1.39	1.00	1.015	0 Symptom not present	3 Symptom severe'	907
ads006 I feel cheerful.	1.02	1.00	.935	0 Symptom not present	3 Symptom severe'	910
ads007 I can sit at ease and feel relaxed.	1.40	1.00	.965	0 Symptom not present	3 Symptom severe'	908
ads008 I feel as if I am slowed down.	1.36	1.00	.936	0 Symptom not present	3 Symptom severe'	909
ads009 I get a sort of frightened feeling like "butterflies" in the stomach.	.88	1.00	.896	0 Symptom not present	3 Symptom severe'	905
ads010 I have lost interest in my appearance.	.76	.00	1.013	0 Symptom not present	3 Symptom severe'	908
ads011 I feel restless as if I have to be on the move.	1.59	2.00	.952	0 Symptom not present	3 Symptom severe'	907
ads012 I look forward with enjoyment to things.	1.10	1.00	1.032	0 Symptom not present	3 Symptom severe'	906
ads013 I get sudden feelings of panic.	.68	.00	.898	0 Symptom not present	3 Symptom severe'	898
ads014 I can enjoy a good book or radio or TV program.	.68	.00	.936	0 Symptom not present	3 Symptom severe'	905

Item statistics

	problem Primary Problem substance									
	1 Alcohol		2 Opioids		3 Stimulants		4 Cannabis		Total	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
ads001 I feel tense or "wound up."	1.55	482	1.34	136	1.64	118	1.60	132	1.54	868
ads002 I still enjoy the things I used to enjoy.	1.06	484	1.31	135	1.24	119	1.30	132	1.16	870
ads003 I get a sort of frightened feeling as if something awful is about to happen.	1.08	479	1.13	136	1.04	118	1.05	132	1.08	865
ads004 I can laugh and see the funny side of things.	.84	483	.99	136	.88	118	.95	132	.89	869
ads005 Worrying thoughts go through my mind.	1.37	482	1.51	136	1.42	118	1.30	132	1.39	868
ads006 I feel cheerful.	.98	484	1.05	136	.97	119	1.14	132	1.02	871
ads007 I can sit at ease and feel relaxed.	1.33	482	1.44	136	1.50	119	1.46	132	1.39	869
ads008 I feel as if I am slowed down.	1.30	484	1.50	136	1.34	118	1.39	132	1.35	870
ads009 I get a sort of frightened feeling like "butterflies" in the stomach.	.80	480	.99	136	.95	119	.97	131	.88	866
ads010 I have lost interest in my appearance.	.69	483	1.03	136	.73	119	.73	131	.75	869
ads011 I feel restless as if I have to be on the move.	1.57	483	1.47	136	1.66	119	1.71	131	1.59	869
ads012 I look forward with enjoyment to things.	1.10	481	1.04	136	1.00	119	1.15	131	1.09	867
ads013 I get sudden feelings of panic.	.66	479	.74	133	.74	117	.58	131	.67	860
ads014 I can enjoy a good book or radio or TV program.	.59	481	.74	136	.75	118	.82	131	.67	866