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Research Summary

Focus on Treatment Assessment

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Assessing Clients and Programs for Treatment Performance Monitoring and Evaluation

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Drug treatment programs are accountable to service consumers as well as funding sources. Pressures therefore continue to mount for "core performance indicators" that efficiently gauge and document quality of treatment outcomes. Related expectations are for "optimal matching of clients to services." These issues revolve around decisions and procedures for collecting the *right* information.

The **DATAR** (Improving Drug Abuse Treatment Assessment and Research) project was initiated at TCU in 1989, with funding from NIDA, to study treatment process and evaluate therapeutic enhancement strategies. After developing comprehensive information systems for assessing and evaluating clients with opiate addictions entering outpatient methadone treatment programs, our focus broadened to treatments for correctional populations as well as to women with children. More recently, another phase of the DATAR project (now named Transferring Drug Abuse Treatment and Assessment Resources) has been funded by NIDA to study technology transfer, particularly the influences of organizational structure and climate. At issue is a widely shared interest in improving the measurable effectiveness and efficiency of drug treatment.[1] Recognizing that clients enter treatment with varying psychosocial needs and skill deficiencies (in addition to the presenting problems of drug dependence), specialized interventions and manual-driven psychoeducational curricula have been developed in DATAR to help treatment staff provide services appropriate to the needs of clients. These include the development of a cognitive strategy for information processing (*node-link mapping)* and targeted group education materials on topics such as treatment induction, assertiveness and relationship skills for women and men, recovery and aftercare training, parenting skills, and cessation of cocaine use.[2] The expanded use of new evidence-based treatment interventions depends on several factors, including organizational readiness for change, resources, and dynamics (including staff attributes and institutional climate). New research is in progress to help understand these issues more fully.

The TCU Treatment Process Model (see **Figure** p. 2) and its related assessment system have been

See **Treatment Monitoring**, page 2.

Obtaining Forms

The data collection instruments described in this Research Summary can be downloaded without cost from our Internet Web site at www.ibr.tcu.edu. (Select "Forms" from the homepage and then "Core Set of Forms.") Lists of related publications, project descriptions, counseling manuals, and other information can also be found there.

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developed, revised over time, and adapted as needed for special treatment settings. Scores of studies have focused on fundamental ingredients of effective treatment using this data system.[3] Based on this body of work, recommendations are summarized in this research summary for using a **core set of client assessments** to measure client needs and performance throughout treatment (see below); also described are **optional client assessments** developed for specialized applications (p. 3), a **brief screening instrument** to assess drug use severity and need for treatment (p. 4), and **organizational assessments** that focus on counseling staff and organizational attributes (p. 4). All TCU assessments are available to download from our Web site for noncommercial use *at no cost*. ■

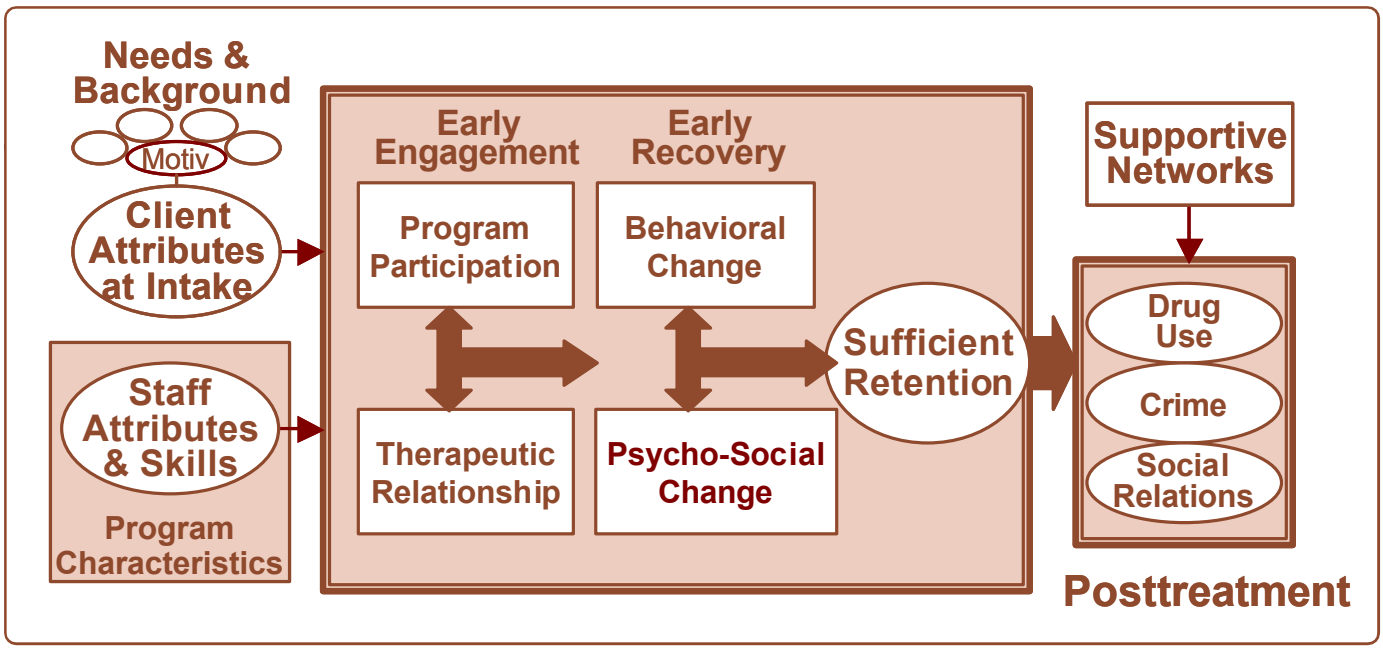

Figure. TCU Treatment Model used to guide assessment strategy.

Core Assessment Instruments for Measuring Client Needs and Progress in Treatment

Our treatment process and outcome research findings[4,5] and experience in adapting assessments to field settings have guided the development of the core set of recommended assessment instruments described below. They capture the information frequently required for administrative reporting by treatment providers as well as the key clinical dimensions found to be related to treatment planning, service delivery, and client progress. Although designed for high efficiency (in terms of time and resources required) and direct comparability across diverse treatment settings, other specialized assessments (like those described later) or modular add-ons may be needed in some instances (e.g., to address co-occurring mental disorders). To benefit from new technology, these core instruments are being adapted for optical scan and computerized administration (along with standard feedback reports for clinical applications, performance documentation, and program management). Progress in these efforts will continue to be reported in scientific articles and quarterly IBR Newsletters available at our Web site.

The **Brief Intake (BI)** is administered by a counselor within 24 hours of program entry and includes background and psychosocial information, a brief history of illegal drug use, and assessments of alcohol, cocaine, opioid, and cannabis abuse based on DSM-IV criteria (30 minutes).

The **Comprehensive Intake (CI)** is administered by a counselor 1 to 3 weeks after admission and has very

broad coverage for needs assessment and treatment planning (90 minutes).

The **Client Evaluation of Self at Intake (CESI)** is a self-rating form completed by the client at the time of admission, usually immediately following the Brief Intake (15 minutes). It includes short scales for treatment motivation (problem recognition, desire for help, treatment readiness), psychological functioning (i.e., self-esteem, depression, anxiety, and decision-making), and social functioning (i.e., childhood problems, hostility, risk-taking, and social conformity). These scales also provide a baseline for monitoring client performance and psychosocial changes during treatment. [A *Scoring Guide* is available for explaining procedures for identifying and scoring items in each scale.]

The **Client Evaluation of Self and Treatment Form (CEST)** includes most of the same psychosocial scales completed at intake (i.e., in the CESI) plus several new scales to measure treatment engagement (25 minutes). Besides motivation, psy-chological, and social functioning, self-ratings also are obtained on treatment needs, services received, treatment satisfaction, counseling rapport, treatment participation, peer support, and (outside) social support — all representing indicators shown to predict outcomes during and following treatment. [A *Scoring Guide* is available for explaining procedures for identifying and scoring items in each scale.][6]

The **Tracking Record (TR)** organizes program reports on client services and transactions, and is completed monthly by agency staff. It contains information concerning counseling session attendance, medications prescribed, urinalysis results, and ancillary services provided. (Time to complete this form varies, depending on agency record-keeping procedures.)

The **Discharge Report (DR)** documents dates and reasons for leaving treatment (2 minutes).

Optional Client Assessment Instruments

Several additional data collection instruments have been developed for specialized applications and treatment settings addressed as part of TCU research projects (e.g., outpatient methadone, correctional outpatient and residential, women and children, and adolescent programs). They augment the generic set of core instruments described above, and all are available as specialized assessments with language adjusted to particular project needs and treatment settings. Data collection occurs during the admission process, throughout treatment, at discharge, and at follow-up.

The **Intake Interview (II)** is administered face-to-face, usually several days after program admission and the client has time to reach medical stabilization and cognitive focus. It is comprehensive and includes sections on sociodemographic background, family and peer relations, health and psychological status, criminal involvement, in-depth drug use history, and an AIDS-risk assessment (90 minutes).

The **Urinalysis Report (UR)** records presence or absence of nine commonly used illegal drugs based on analysis of urine specimens collected at intake and throughout treatment.

The **During-Treatment Performance (DTP)** instrument is completed by the counselor (usually in an individual session) and addresses major behavioral criteria such as social/family functioning, employment, criminal involvement, drug use, and AIDS-risky behavior for the past 1-3 months. Questions are consistent with the intake assessment (25 minutes).

The **Individual Session Record (by Counselor)** describes the length and type of session as well as the issues addressed (5 minutes). Its companion form, the **Individual Session Record (by Client),** is a 5-item questionnaire eliciting the client's reaction to the session (2 minutes).

The **Group Session Record (by Counselor)** describes the length and type of session as well as issues addressed (5 minutes). Its companion from, the **Group Session Record (by Client),** is a 5-item questionnaire eliciting the client's reaction to the session (2 minutes).

The **Counselor Rating of Client (CRC)** is completed by the counselor to describe client functioning and therapeutic strategies used in the preceding 1-3 months (5 minutes).

The **Follow-up Interview (FI)** is administered by a trained interviewer in a face-to-face session held at a designated time after discharge from treatment. It includes questions consistent with the intake assessment, but also addresses functioning and outcome measures based on the posttreatment period (90 minutes).

Screening Clients for Treatment Admission

The **TCU Drug Screen (TCUDS)** is self-administered and serves to quickly identify individuals with a history of heavy drug use or dependency (based on the DSM and the NIMH Diagnostic Interview Schedule) and therefore would be eligible for treatment options (5-10 minutes). It is particularly useful and widely used in criminal justice settings, especially for offenders eligible for treatment as an alternative to regular incarceration.

Organizational Assessment Instruments

In the face of competing demands on staff time and resources, treatment programs often are reluctant to make operational changes, even to incorporate new evidence-based treatment innovations, unless forced by new regulations or otherwise convinced that significant benefits will accrue. More information is therefore needed on types of training programs want and factors that influence important organizational decisions and behaviors. This type of research has gained recent interest in the drug treatment field and requires assessments of treatment structure and organizational attributes, such as those listed below.

The **Program Training Needs (PTN)** survey for program directors is organized into 6 domains reflecting program background, program needs, training needs, pressure to change, diagnostics and billing, and organizational environment. The parallel form for clinical staff focuses on facilities and climate, satisfaction with training, preferences for training content, preferences for training strategy, barriers to training, and computer resources (15 minutes).

The **Program Identification (PID)** form is completed by a program or clinical director to help "classify" a facility in relation to therapeutic modality, setting, and array of services offered (20 minutes). Major sections focus on characteristics of the program, clients, and staff, along with a summary of pertinent program changes and organizational stability.

The **Organizational Readiness for Change (ORC)** assessment is self-administered by program staff (one version is designed for counseling staff, and another for program directors or supervisors). *Motivational factors* addressed include program needs, training needs, and pressures for change, while *resources* are evaluated in regard to office facilities, staffing, training, computer equipment, and e-communications. *Organizational dynamics* include scales on staff attributes (growth, efficacy, influence, adaptability, and clinical orientation) and climate (mission, cohesion, autonomy, communication, stress, and flexibility for change). [25 minutes; a *Scoring Guide* is available for explaining procedures for identifying and scoring items in each scale.] ■

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[1] Simpson, D. D., Joe, G. W., Dansereau, D. F., & Chatham, L. R. (1997). Strategies for improving methadone treatment process and outcomes. *Journal of Drug Issues*, *27*(2), 239-260.

[2] Bartholomew, N. G., & Simpson, D. D. (2002, September). *Research summary: Focus on intervention manuals for counselors*. Institute of Behavioral Research, Texas Christian University. (Available from **Newsletters Section** of IBR Web site.)

[3] Simpson, D. D. (2002, September). *Research summary: Focus on treatment process and outcomes*. Institute of Behavioral Research, Texas Christian University. (Available from **Newsletters Section** of IBR Web site.)

[4] Simpson, D. D. (1997). Effectiveness of drug abuse treatment: A review of research from field settings. In J. A. Egertson, D. M. Fox, & A. I. Leshner (Eds.), *Treating drug abusers effectively*. Cambridge, MA: Blackwell Publishers of North America.

[5] Simpson, D. D. (2001). Modeling treatment process and outcomes. *Addiction*, *96*(2), 207-211.

[6] Joe, G. W., Broome, K. M., Rowan-Szal, G. A., & Simpson, D. D. (2002). Measuring patient attributes and engagement in treatment. *Journal of Substance Abuse Treatment, 22*(4), 183-196. ■

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TCU assessment forms are available for non-commercial use *at no charge*.