Based on

TCU Mapping-Enhanced Counseling Manuals for Adaptive Treatment

As Included in NREPP

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USING CLIENT ASSESSMENTS TO PLAN AND MONITOR TREATMENT (USING CEST GUIDE)

A guide for using the TCU Client Evaluations of Self and Treatment (CEST) in individual or group counseling settings

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(August 2008)

TCU Mapping-Enhanced Counseling manuals provide evidence-based guides for adaptive treatment services (included in National Registry of Evidence-based Programs and Practices, NREPP, 2008). They are derived from cognitive-behavioral models designed particularly for counselors and group facilitators working in substance abuse treatment programs. Although best suited for group work, the concepts and exercises can be directly adapted to individual settings.

When accompanied by user-friendly information about client assessments that measure risks, needs, and progress over time, *TCU Mapping-Enhanced Counseling* manuals represent focused, time-limited strategies for engaging clients in discussions and activities on important recovery topics. These materials and related scientific reports are available as Adobe PDF® files for free download at http://www.ibr.tcu.edu.

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Introduction: Ingredients of Effective Treatment

The delivery of treatment is not always well matched to the needs of clients. Contrary to a one-size-fits-all approach, there is evidence that a deliberate process of *assessment*, *planning*, and *delivery* of tailored interventions is fundamental to treatment effectiveness (Simpson, 1995, 2001, 2004, 2006). *This suggests service providers should adopt a "systems" perspective that emphasizes* ***stages of early engagement and change*** *as signposts for tailoring adaptive therapeutic interventions based on client needs.*

A. How can treatment engagement be established and sustained?

Stronger engagement (i.e., *program participation* and *counseling rapport*) emerges when client problems are addressed by therapists using a positive approach emphasizing problem solving and social skills enhancements – as opposed to a punitive emphasis on program rules and strict compliance requirements (Joe, Broome, Rowan-Szal, & Simpson, 2002). The success of cognitive and behavioral interventions is consistently related to the quality of the counseling relationship, which is reflected in higher client ratings of *treatment satisfaction* as well. Better assessments of client needs and progress are necessary to help monitor and guide this process.

B. How do "adaptive interventions" fit into this picture?

The treatment effectiveness literature widely supports the use of motivational enhancement techniques, cognitive strengths-based counseling, behavioral reinforcement therapy, and social support networking approaches that are prominent in the drug treatment field (National Institute on Drug Abuse, 1999, 2006). Unfortunately, they are not always delivered consistently and strategically during the course of treatment. **Figure 1** lists a collection of TCU interventions that "link" adaptively to various stages of therapeutic progress (Simpson, 2004; Simpson & Joe, 2004). These are described in detail and are available for download (without charge) at the IBR Web site.

The set of TCU interventions are manual-guided and integrated through a unique evidence-based counseling technique called "node-link mapping." Research shows that this cognitive visualization strategy reduces reliance on purely verbal communication (Dansereau, Joe, & Simpson, 1993) and increases attention, focus, and memory for session content (Czuchry, Dansereau, Dees, & Simpson, 1995). *TCU Mapping-Enhanced Counseling* is effective in a variety of settings as shown with a variety of drug treatment outcome measures (Dansereau & Simpson, in press). As explained in the following sections, clinical decisions about which manuals to use, and when, should be guided by client needs and functioning.

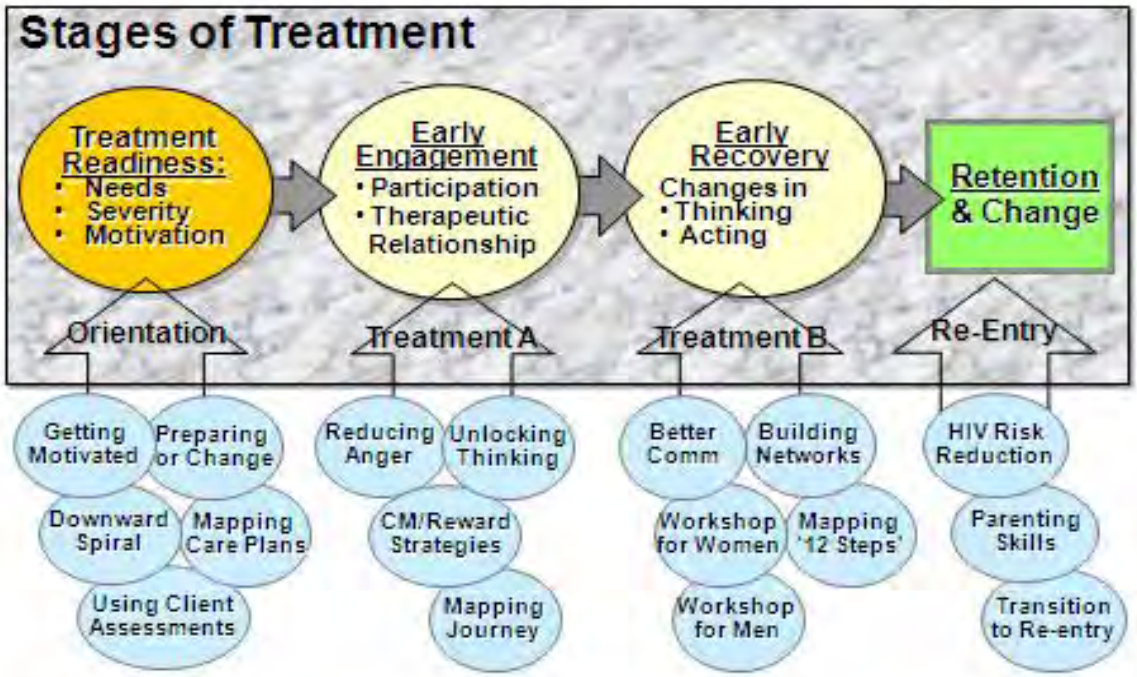


Fig 1. Adaptive TCU interventions for stages of strategic treatment planning.

C. What kinds of measures should be used, and when?

Limited time and resources make it necessary for most treatment providers to use brief screening and assessment instruments for measuring client risks and needs, as well as psychosocial and engagement attributes that have direct (evidence-based) relevance to clinical care decisions.

As illustrated in **Figure 2,** a series of TCU instruments have been developed for addressing these applications (Joe, Broome, Rowan-Szal, Simpson, 2002; Lehman, Greener, & Simpson, 2002; Simpson & Knight, 2007). In particular, the ***Client Evaluation of Self and Treatment (CEST)*** scales capture several crucial psychosocial and readiness dimensions of change and recovery. They can be administered and repeated throughout treatment phases to monitor progress. **Assessment Fact Sheets** also are available (on the IBR Web site) containing interpretive norms, and these resources are revised or expanded as new forms are added to the "menu of options."

The current manual explains the contents, scoring, interpretations, and applications of the CEST measures. Case studies are presented later as examples of their clinical applications. Other TCU assessment instruments are available as well, and can be used to complement information from the CEST. These include *Criminal Thinking Scales (CTS)* and *Family and Friends* scales (but they are not discussed in detail here).

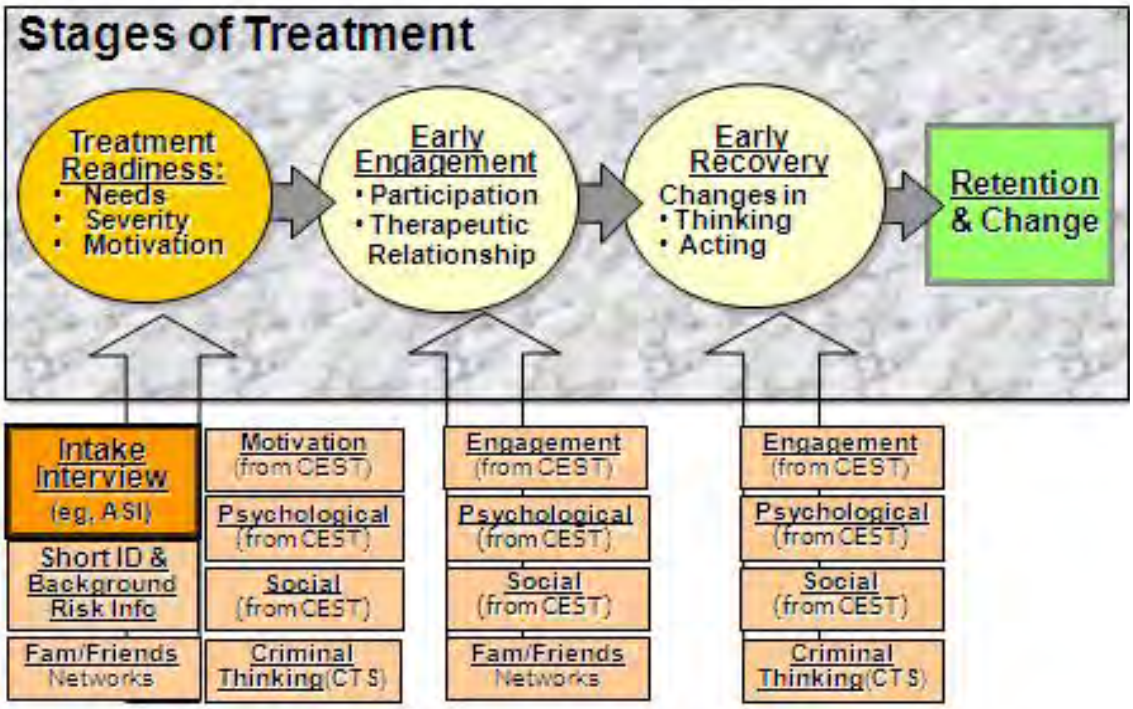


Fig 2. Assessing needs and progress at different stages of treatment.

Part 1: TCU Client Assessment Scales

The **Client Evaluation of Self and Treatment (CEST)** is the primary TCU assessment used to measure and monitor client needs and performance in treatment. It can be self-administered or completed in an interview by program staff. The CEST may be administered as a whole instrument or in shorter versions (discussed later) representing its specific domains.

Numerous clinical assessments are available for measuring these and other relevant client attributes, of course, but an advantage of the TCU forms is that they are brief, mutually integrated, purpose driven, and free. They are copyrighted, but only for the purpose of protecting them from commercial violations or inappropriate modifications.

The CEST includes 16 scales (each defined by 5 to 12 items) representing client motivation and readiness for treatment, psychological and social functioning, and treatment engagement (Joe et al., 2002). Motivation for treatment factors include *desire for help, treatment readiness,* and *treatment needs*, while psychological domains include *self esteem, depression, anxiety, decision making,* and *self efficacy*. Social domains include *hostility, risk taking,* and *social consciousness* (i.e., representing personal acceptance of social norms). Finally, treatment engagement scales include

treatment satisfaction, counselor rapport, and *treatment participation*, along with client perceptions of *peer support* and *social support* (from family members).
When the CEST is used at the beginning of treatment (usually called the CEST-Intake), engagement measures are not included because it is too soon for them to be meaningful. Overall, the measures have proven to be useful for treatment planning as well as monitoring client performance and change during the course of treatment (Simpson, 1995, 2001, 2004, 2006). By averaging scores of clients *within* a treatment unit, the CEST scales also can be used as criteria for evaluating its collective impact.

A. How are "client scores" calculated?

CEST scale scores are calculated based on client self-ratings (using 5-point Likert-type items for gauging strength of agree-disagree responses). Answers to items for each scale are averaged and then multiplied by 10. Means range from 10 to 50, with scores above 30 indicating *agreement* (higher scores reflect stronger agreement) and those below 30 indicating *disagreement* (lower scores reflect stronger disagreement).

Scoring results are illustrated in Figure 3 for three scales from the CEST, including *treatment readiness, anxiety,* and *hostility*. Items that define each of these scales are listed below the figure. Assessments collected from 9,833 clients who participated in several TCU studies in recent years are used to interpret the scores. The bar column reports the mean (or average) score on each scale, while the solid and dotted lines give information about "dispersion" or distributions of the scores. More specifically, the 75th and 25th percentiles are shown. The area *between* these lines represents the scores where the middle 50% of respondents fell.

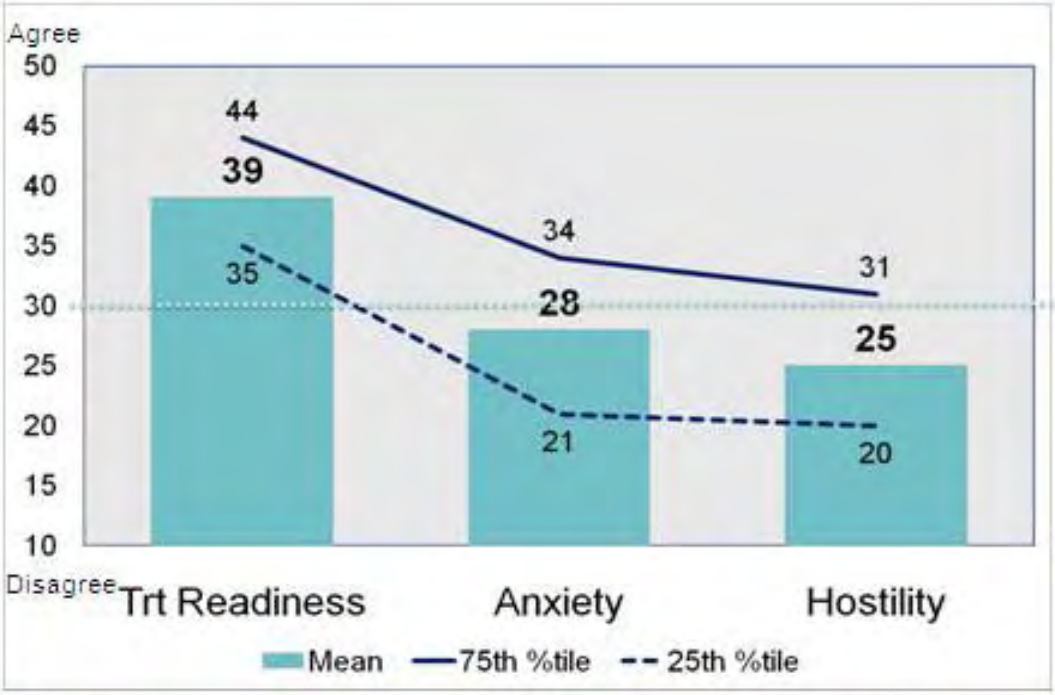


Fig 3. Means and distributions for 3 CEST scales (based on 9,833 clients).

Treatment Readiness (TR), defined by the following 8 items.

- You plan to stay in this treatment program for awhile.
- This treatment may be your last chance to solve your drug problems.
- This kind of treatment program will not be very helpful to you. ®
- This treatment program can really help you.
- You want to be in a drug treatment program now.
- You have too many outside responsibilities now to be in this treatment program. ®
- You are in this treatment program because someone else made you come. ®
- This treatment program seems too demanding for you now. ®

(® indicates the item uses "reverse" wording so its scoring is adjusted accordingly.)

Anxiety (AX), defined by the following 7 items.

- You have trouble sleeping.
- You have trouble concentrating or remembering things.
- You feel afraid of certain things, like elevators, crowds, or going out alone.
- You feel anxious or nervous.
- You have trouble sitting still for long.
- You feel tense or keyed-up.
- You feel tightness or tension in your muscles.

Hostility (HS), defined by the following 8 items.

- You have carried weapons, like knives or guns.
- You feel a lot of anger inside you.
- You have a hot temper.
- You like others to feel afraid of you.
- You feel mistreated by other people.
- You get mad at other people easily.
- You have urges to fight or hurt others.
- Your temper gets you into fights or other trouble.

This information provides a measurement framework for readily identifying clients with "unusually high or low" scores indicative of specific needs of clients. Figure 3 shows the mean score for *treatment readiness* is 39, which is 9 points above the scale's neutral center point of 30. In other words, this score value indicates that clients included in the reference treatment sample (of 9,833) on average reported "moderately high readiness for treatment." The chart also shows that 25% of clients scored above the value of 44, while the lowest 25% of scores fell below 35. For treatment planning, the latter group of low-motivation clients would probably benefit from special interventions for raising treatment understanding and readiness.

With respect to *anxiety*, the mean score was 28, with 25% of scores falling above 34 and another 25% falling below 21. Finally, the scores for *hostility* averaged 25, with 25% of

scores falling above 31 and another 25% falling below 20. As with poor motivation scores, clients in the high anxiety and high hostility groups likewise represent special challenges for treatment programs. Especially difficult are individuals who report *co-occurrences* of these problems.

B. Are these scores reliable and "evidence-based"?

A national sample of over 1,700 clients from 87 programs located across the U.S. was used initially to study reliability and validity of the CEST (Joe et al., 2002). Results from confirmatory factor analysis verified the CEST factor structure, coefficient alpha reliabilities established that the scales had satisfactory levels of internal consistency, and relationships of scales with selected client and program functioning indicators documented their predictive validities. The CEST scales also have been adapted and tested for use in criminal justice populations, using a sample of 3,266 offenders from 26 CJ-based programs located in 6 different states (Garner et al., 2007). It likewise has been used internationally as illustrated by a study of over 1,500 clients from 44 treatment agencies located in England (Simpson, Rowan-Szal, Joe et al., in press).

These studies show consistency in the way client motivation and psychosocial self ratings are associated with indicators of program participation and counseling rapport. Namely, these measures of therapeutic engagement are related directly to higher treatment motivation and readiness scores as well as to better psychosocial functioning profiles (i.e., higher *self esteem, decision making, self efficacy*, and *social consciousness*, along with lower *anxiety, hostility,* and *risk taking*). In turn, stronger therapeutic linkages predict longer treatment retention and better follow-up outcomes. Regression analyses indicate these relationships are substantial, with motivation and psychosocial functioning measures accounting for one-fourth to one-half of the variance in the client engagement (Simpson et al., in press). Within a treatment process framework (Simpson, 2004, 2006), therefore, early interventions designed to improve treatment readiness, mental health, and anger-related problems seem to be highly appropriate.

CAUTION: Although client assessments may be recognized as being "reliable and valid" statistically, they are not necessarily accurate or unbiased for *every client in every situation*. Thoughtful choices are needed about which instruments to use, when, and what they mean for clinical care. "Preparing" clients to complete their assessments carefully and accurately (e.g., with standardized instructions) is crucial. Interpretations and applications should be made in conjunction with other information available. *Clients need to know that results of their assessments can make a big difference in their treatment experiences!*

C. How should scores for an individual client be interpreted?

To make clinical applications for an individual client, of course, it is necessary to know client-level scores on the CEST scales. *For each client and each scale, a score should be interpreted on two dimensions – first, how does its value compare to the neutral center point score of 30, and second, where does the score stand in relation to those of other comparable treatment clients.*

The set of CEST scores for treatment motivation and psychosocial functioning at program intake are of initial interest. Depending on the program and its mission, there may be other client measures selected as well. *They serve to "flag" potential incoming problems such as those related to low readiness for treatment, poor mental health functioning, and risky social tendencies.*

User-friendly feedback charts are essential for counselors to understand these scores efficiently and accurately. Figure 4 illustrates a sample feedback chart for "Pat" that includes scores on eight of the CEST scales. The mean score for each scale is shown using a bar-graph format, and the line graphs (defined by 25th–75th percentile scores) show where the middle 50% of client scores fall.

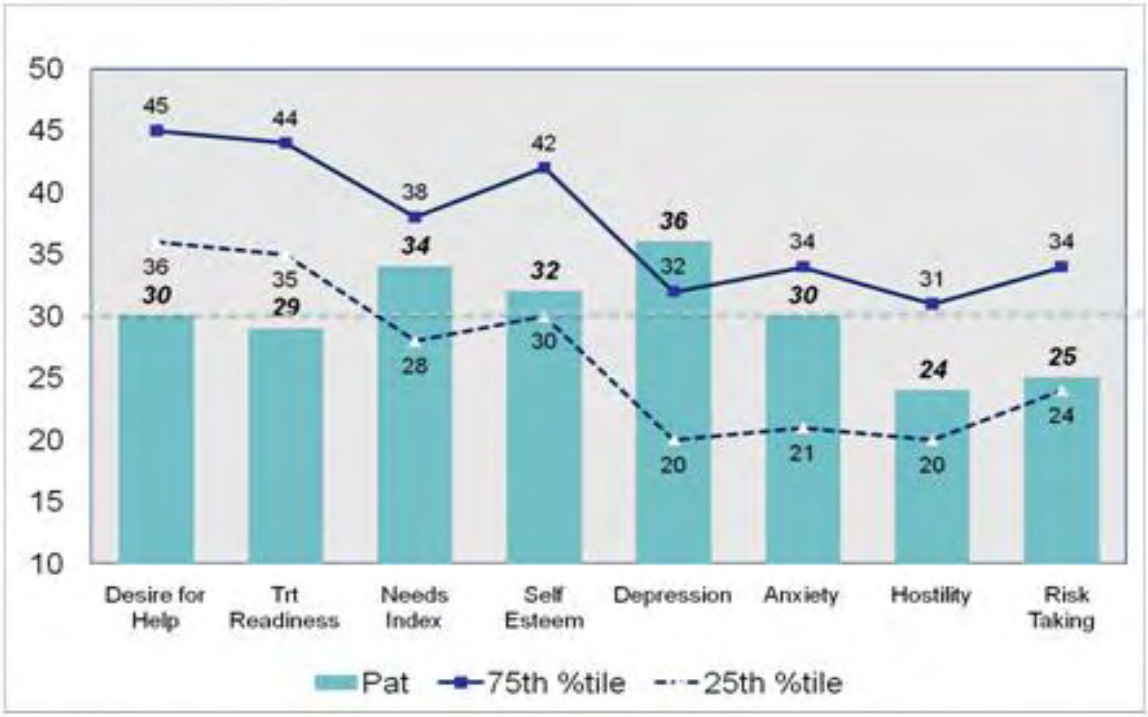


Fig 4. Treatment motivation and psychosocial scores for "Pat."

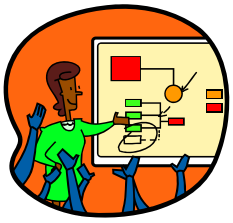
On four of these measures, Pat scored at or very near the neutral midpoint of 30 (i.e., 30 on *desire for help*, 29 on *treatment readiness*, 32 on *self esteem*, and 30 on *anxiety*).

Comparisons with other clients, however, indicate Pat's motivation level is unusually low. In addition, self esteem was relative low and anxiety level relatively high. A score of 36 on *depression* was noticeably above the midpoint of 30, and it was very high compared to other clients. The scores for *treatment needs index* (34), *hostility* (24), and *risk taking* (25) deviated by 5 or 6 points from the neutral value of 30, but all fell inside the boundaries describing most clients (i.e., the middle 50%).

In summary, this profile of scores suggest Pat has low treatment readiness and is depressed (along with diminished self esteem), but has no unusual hostility or risk-taking inclinations.

D. Are there other "comparison groups" for interpreting scores?

The comparison group used above to help interpret CEST scores was a large-scale national sample of clients admitted to community-based treatment. Furthermore, the middle 50% of clients (defined by 25th–75th percentiles) was the guide for defining whether scores are comparatively high or low. Other options are available and appropriate to consider, however, as can be found on the IBR Web site (listed under *Assessment Fact Sheets with norms).*



In particular, it might be more informative to use "gender-specific" comparison groups since profiles for males and females differ in significant ways. Gender-specific norms found at the IBR Web site show females in drug treatment generally report higher motivation, depression, and anxiety levels than males, while males tend to score higher on hostility and risk taking. For example, the high boundary score defined by the middle 50% of clients (i.e., the 25th–75th percentiles) for CEST anxiety among females is 37, while for males it is 33. Therefore, a score of 32 on anxiety might be regarded as comparatively high if reported by a male, but not for a female.

Another alternative is to use different definitions of *problem thresholds* for interpreting scores in relation to specific comparison groups. For instance, rather than using the middle 50% of clients to define problem-score thresholds, some programs might prefer to based these definitions on the middle 33% of clients (calculated by using 33rd–67th percentiles). These "cut-off" scores become less extreme and the result is that high, middle, and low categories of scores each will, by definition, include one-third of the sample. Thus, the high (67th percentile) score for anxiety among females now becomes 34 (compared to 37 as the 75th percentile score discussed above) while for males it is 31 (compared to 33 as the 75th percentile score). In other words, the two options set clinical interpretation thresholds at different levels. The consequence is that more clients will be "flagged" as having comparatively extreme (high or low) scores when the

middle 33% of clients (i.e., the 33rd–67th percentiles) are used to define interpretative norms.

Because of the special circumstances surrounding corrections-based treatment samples, scores for offenders in drug treatment programs may be interpreted more accurately if the comparison sample is restricted to correctional settings. Because there are so many subgroup selection criteria that can be applied to define the "ideal" comparison group, however, there are practical limitations to consider – especially as sizes of these subgroups for comparison become very small (and usually more unstable).

The option becoming more appealing and feasible in many settings is to use previous clients admitted into a program as its own comparison group. The advantages are easy to recognize, and as the program-specific database increases in size the opportunities to increase subgroup specificity (defined by gender, age, race, drug, etc.) grows.

E. How often should the CEST assessment be repeated?

The CEST scales were originally selected and designed to be used as "interim" criteria in an on-going assessment process. Indeed, measuring client needs and monitoring change over time is a dynamic process – and it can be *very* challenging.

There is no predetermined or "right" schedule for repeating the CEST, and not all scales are equally important over time. As illustrated earlier (see Figures 1 and 2), assessments often are scheduled to coincide with treatment phases or conceptual steps of the therapeutic plan. For special populations (e.g., adolescents, criminal justice referrals, or mentally ill clients), other measures also may be needed to address treatment needs and progress.

The CEST-Intake scales for motivation and psychosocial functioning – possibly with pretreatment *risk* assessments (selected on the basis of program mission and target clientele) – identify particular areas of high-risk concern for treatment planning. For instance, programs that include an "orientation phase" may give special attention to scores on motivation/readiness and hostility/depression scales. Therapeutic objectives for this phase frequently focus on preparing clients for change as well as improving emotional stability in preparation for formal "treatment phases." Thus, measures of *desire for help*, *treatment readiness*, *hostility*, and *depression* provide indicators (both individually for clients as well as collectively for intact "groups" of clients) of responsiveness. *High-risk clients who do not show positive change on these measures are likely to present challenges in later treatment phases*.

As treatment sessions advance, evidence shows it is important for clients to become engaged therapeutically as measured by program participation and rapport with counseling staff. The pace of change observed is usually varied, however, with some clients engaging rapidly while others progress more slowly or not at all. Client scores of 30 or below on these scales are cause for clinical concern. In group counseling settings such as Therapeutic Communities, the *peer support* measure also is a useful indicator of engagement.

There are no "hard and fast" rules for interpreting changes in client scores. Ideally, high hostility and depression scores at intake as well as low motivation for treatment will tend to moderate and stabilize over the early weeks of care, while engagement levels rise. Score changes of 3-5 points or more by high-risk clients usually signify progress, and this evidence deserves to be used as "positive feedback" to clients as part of treatment planning sessions.

Also note that *some scores may change for the worse*, reflecting treatment-specific issues affecting one or more clients. Negativity in client-counselor matches or in group counseling dynamics may be at play. In other cases, some scales simply become less relevant over time. In particular, the CEST scales for measuring initial motivation and readiness for treatment tend to become less meaningful later, especially as clients begin seeing themselves as making favorable changes. Motivation does not actually become unimportant, of course, it just changes in the way it is manifested. Motivation tends to become more localized around specific issues during treatment, and is captured in part as elements of engagement scores.

Finally, not all scores will change. For highly functioning clients, that is usually good news; for poorly adjusted clients, it is not. The challenge for treatment providers is to establish adaptive solutions that maximize positive changes, sometimes by implementing service innovations.

Part 2: Combining Scores for Program Comparisons

By averaging scale scores across all clients in a treatment unit, comparisons can be made between programs. Certainly not all admissions to any single treatment unit are the same, but there are structural or systems factors (such as referral networks, services specialization, geographic locations) that heavily influences the types of clients most likely to enter specific programs. Information from CEST assessments can help capture and understand differences in types of clients being treated and their profiles of needs.

For example, Figure 5 presents average scores for clients treated in 3 different units of a multi-clinic agency. Program X serves adolescents, Program Y specializes in co-occurring mental health and drug use problems, and Program Z handles mandated court referrals for Driving Under Influence (DUI) offenses. The adolescent program (Prg X) has the lowest motivation scores and the highest levels of hostility and risk taking. The program for co-occurring mental health and drug use problems (Prg Y) includes clients with the highest overall scores on treatment motivation/needs and depression/anxiety. DUI referrals (Prg Z) report modest treatment motivation and the lowest psychosocial dysfunction levels. These program differences have implications for staffing skills and the types of interventions most likely to be effective in each setting.

Fig 5. Treatment motivation and psychosocial scores for 3 programs.

Maybe even more useful are scale score comparisons *across time* within a given program. If based on the same clients assessed at intake and again at the end of a designated treatment phase, the results offer a basis for evaluating general effects of the services provided. Figure 6 summarizes Time 1 to Time 2 data for Program Y, discussed above. The dark bars show program-level mean scores at Time 1, and the lighter bars report Time 2 results. Treatment motivation and needs scores declined while psychological functioning showed improvements. However, there was a rise in hostility levels that suggest problems apparently occurred during treatment and need to be investigated. Specific concerns might focus on whether the interventions being used need modification, or whether negative clinical dynamics involving staff or other clients that may have aroused hostilities.

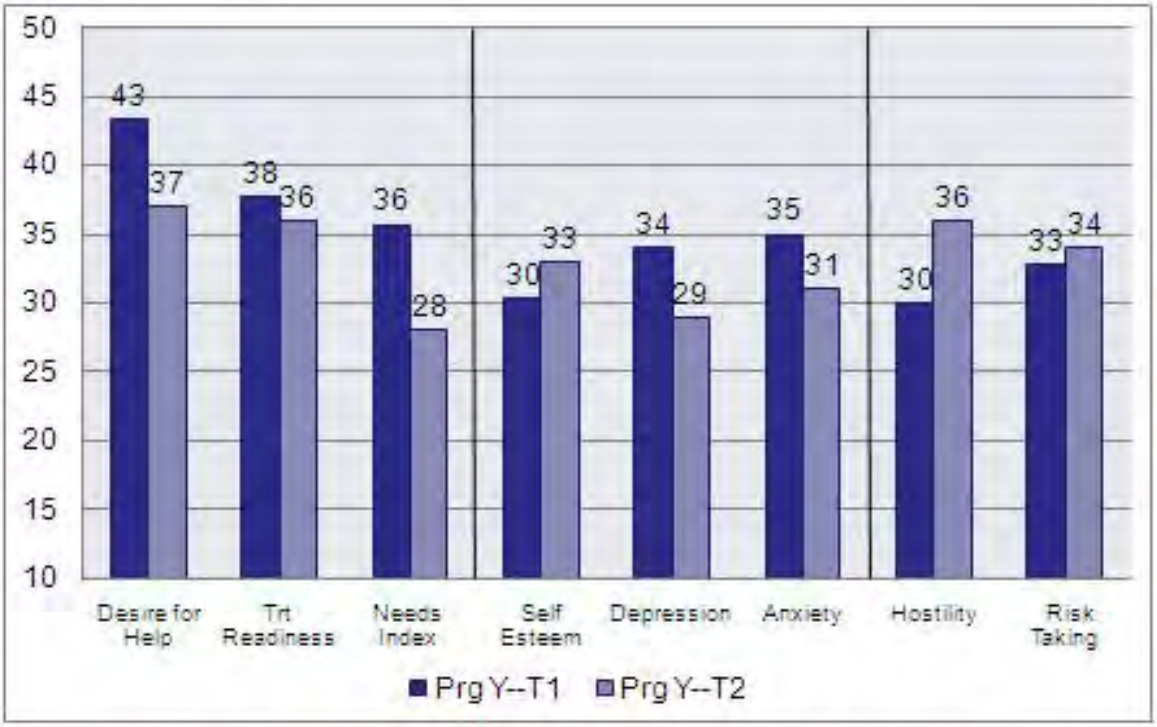


Fig 6. Treatment motivation and psychosocial scores at Times 1 and 2.

Another significant application might be to compare all incoming admissions during 2 consecutive intervals of time in order to examine stability of clientele attributes. Empirical documentation of significant shifts over time in client characteristics can inform and improve leadership decisions involving admission or referral policies, staff training, selection and implementation of new evidence-based interventions or other innovations, and organizational structure.

Part 3: Assessment Alternatives and Methods

There are many client screening and assessment options available to treatment providers. They vary in the amount of client and staff time required for administration, skills required for clinical interpretations, complexity of scoring, availability of norms for clinical applications, costs, etc. Unfortunately, there is no list of ideal instruments that fits the needs of every treatment program. Thoughtful decisions and actions are therefore necessary to select resources and apply them in an adaptive treatment strategy.

The CEST assessment began as a "research tool" almost 20 years ago and has *evolved* as a "clinical tool." Some readers of published treatment evaluation reports might be aware of variations in the scale domains, items included, wording differences, and

answer response formats over the years. This work is culminating in a more standardized clinical version that can be used in diverse community-based therapeutic settings, including residential as well as outpatient programs. However, the CEST is intended to remain flexible, and users are given the right to "customize" its wording or formatting when needed.

Indeed, the expanded use of TCU assessments by treatment services in criminal justice (CJ) settings has led to systematic adjustments, especially for certain items. This new version is renamed the "CJ CEST." Other specialized risks and functioning assessments for CJ clients also have been added, such as the *TCU Drug Screen III* and the *Criminal Thinking Scales (CTS)*.

Besides choices about which assessment scales are best suited for a treatment system, it is necessary to consider procedural issues. When and where will the assessments be administered, who will collect and manage the information, and are assessments to be completed with paper-and-pencil, computer-aided, or optically-scanned methods?

It should be emphasized that implementation of new assessments or other treatment innovations is a stage-based process (Simpson, 2002, in press; Simpson & Flynn, 2007). Institutional policies and timing, staff skills and commitments, administrative and clinical leadership, financial and technical resources, and organizational climate all influence its success and sustainability. Their importance should not be underestimated.

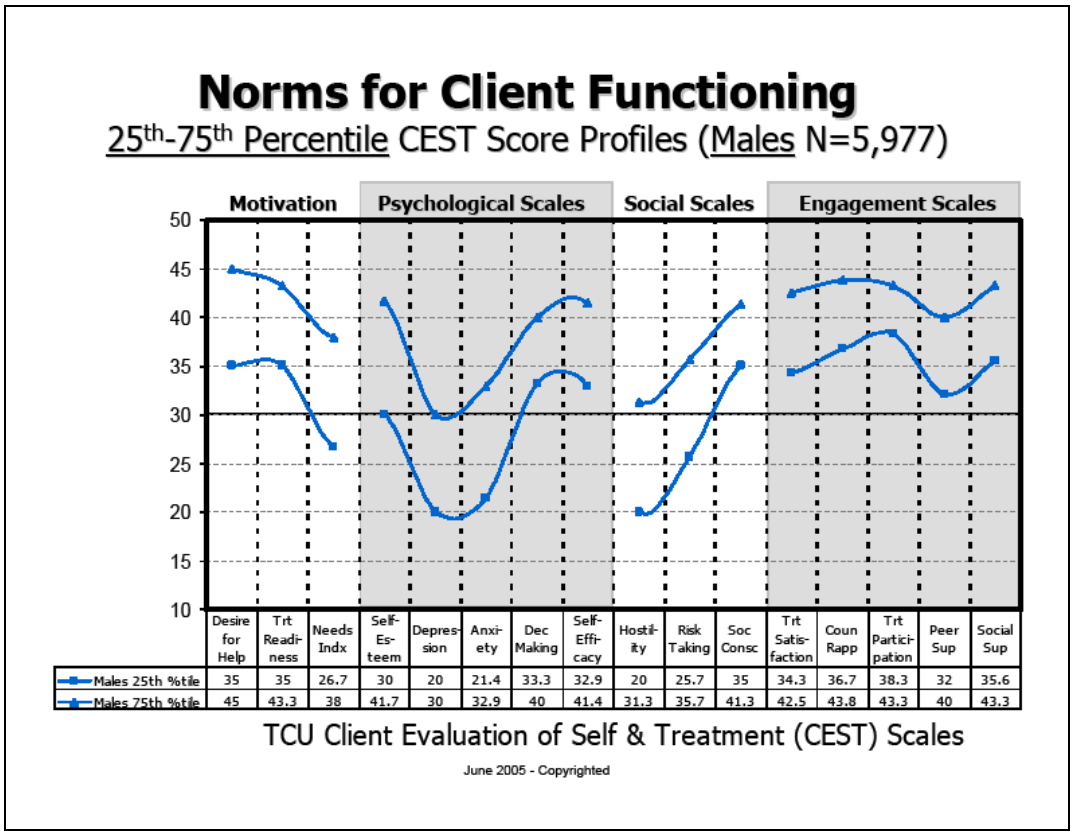
A. Where are the "latest versions" of TCU assessments?

The CEST as well as other TCU assessments can be reviewed and downloaded (as PDF files) at the IBR Web site, listed under "**Forms**" on the Homepage. Linked to the information on each form is an *administration version* as well as a *Scoring Guide* that shows items grouped according to its parent scale and how to calculate scores.

There are two general categories of assessments – Community Treatment Forms and CJ Treatment Forms. In addition, there are specialized forms developed for previous treatment evaluations of programs for adolescents, women with children, correctional residential and outpatient services, and outpatient methadone maintenance. Open permission is granted to use of these forms.

B. How are "comparison-group norms" accessed?

A variety of comparison-group norms are available (as downloadable PDF files) at the IBR Web site, found under "**Assessment Fact Sheets (with norms)**" in the **Evidence** section of the Homepage. Examples of these charts are shown on the next page.


Norms for Client Functioning
25th-75th Percentile CEST Score Profiles (Males N=5,977)
Motivation
Psychological Scales
Social Scales
Engagement Scales
50
45
40
35
30
25
20
15
10
Desire for Help
Trt Readi-ness
Needs Indx
Self-Es-teem
Depres-sion
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Dec Making
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Soc Consc
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Peer Sup
Social Sup
Males 25th %tile 35 35 26.7 30 20 21.4 33.3 32.9 20 25.7 35 34.3 36.7 38.3 32 35.6
Males 75th %tile 45 43.3 38 41.7 30 32.9 40 41.4 31.3 35.7 41.3 42.5 43.8 43.3 40 43.3
TCU Client Evaluation of Self & Treatment (CEST) Scales
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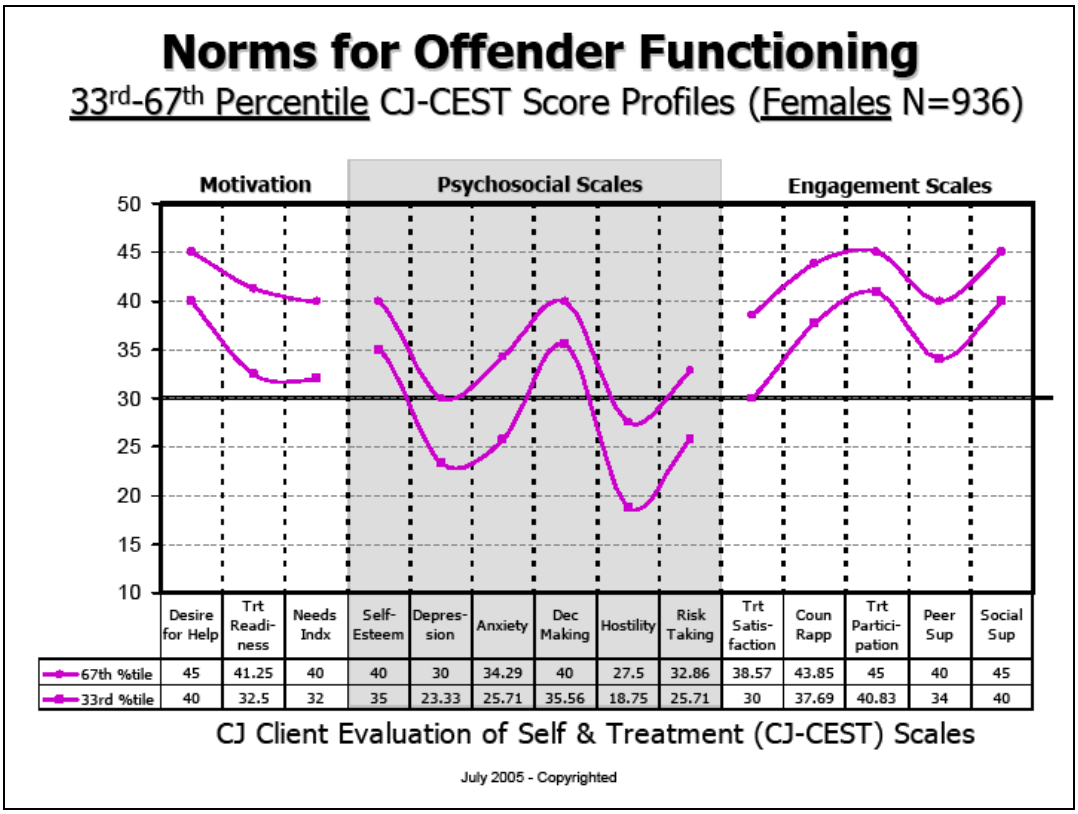
Norms for Offender Functioning
33rd-67th Percentile CJ-CEST Score Profiles (Females N=936)
Motivation
Psychosocial Scales
Engagement Scales
50
45
40
35
30
25
20
15
10
Desire for Help
Trt Readi-ness
Needs Indx
Self-Esteem
Depres-sion
Anxiety
Dec Making
Hostility
Risk Taking
Trt Satis-faction
Coun Rapp
Trt Partici-pation
Peer Sup
Social Sup
67th %tile 45 41.25 40 40 30 34.29 40 27.5 32.86 38.57 43.85 45 40 45
33rd %tile 40 32.5 32 35 23.33 25.71 35.56 18.75 25.71 30 37.69 40.83 34 40
CJ Client Evaluation of Self & Treatment (CJ-CEST) Scales
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For the CEST and CJ CEST forms, norms have been calculated for clients treated in community-based or CJ programs that participated in TCU research projects anytime during the past decade. These include normative profiles calculated for *total samples* as well as *male and female subsamples* using both 25-75 and 33-67 percentile thresholds. The first example above shows CEST norms for males in community-based programs using 25-75 percentiles. The second chart shows CJ CEST norms for females in CJ programs using 33-67 percentiles.

By selecting and printing a chart for the preferred comparison group, users can use it as a template for marking client results directly onto the chart and interpreting scores. Examples of how this might be carried out and used as part of individual or group counseling sessions with clients are described later in case studies, presented in Part 4.

C. Are "optical scanning" options available?

Because of the growing interest in using optical scanning technology for efficiently obtaining and applying assessment results, many of the TCU assessments are being converted into an "**automated data capture**" (**ADC**) system. The Spring 2008 edition of the *IBR Research Reports* newsletter (Vol. 17, No. 1, available on the IBR Web site under "Newsletters" on the Homepage) summarizes details on our Web site about hardware requirements and scoring software available (at no charge) from the IBR.

In brief, converting TCU assessments into ADC forms involves a 3-step process, as illustrated in reference to the CJ CEST. **First**, the CJ CEST scales were grouped into 4 sections so that the total items for each one would fit onto a single (1-sided) page formatted for ADC. These include the *Motivation and Needs* section, the *Psychological Functioning* section, the *Social Functioning* section, and the *Treatment Engagement* section. (Along the right margin, respondent information is recorded for date of administration and program identification.)

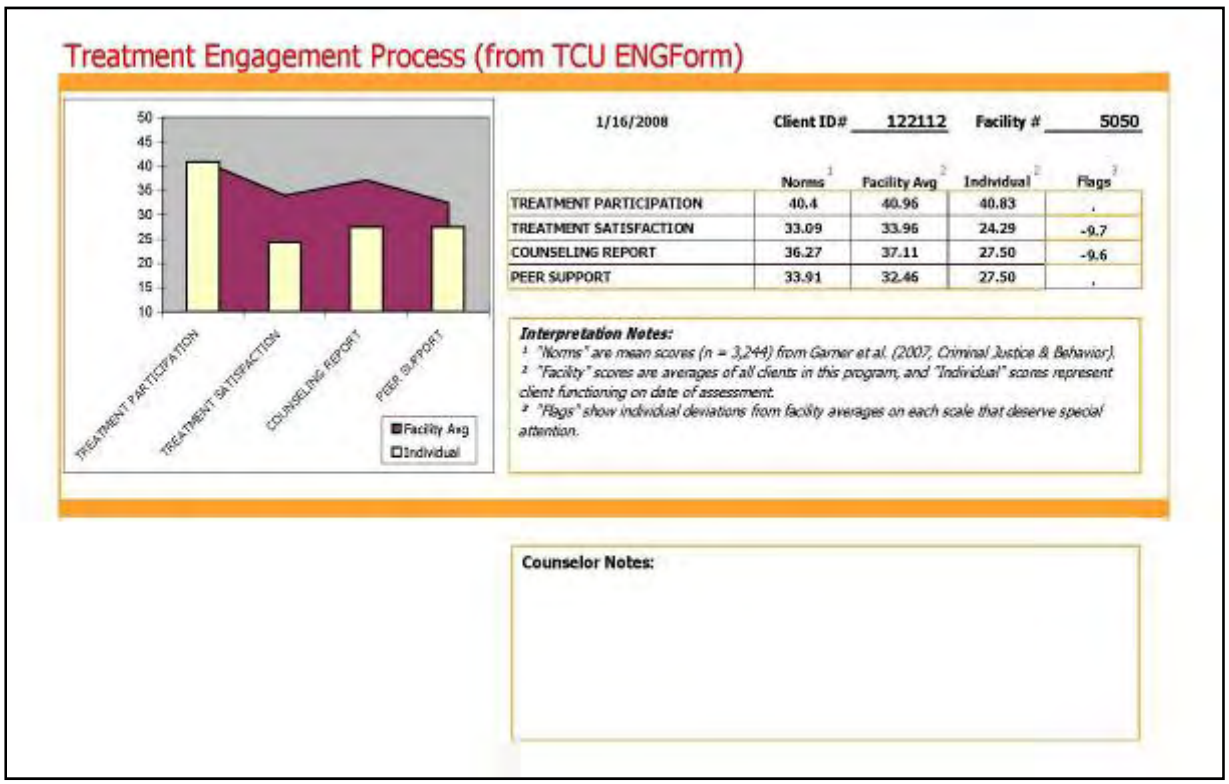
Second, an item-scoring program was prepared for reading and scoring items using an optical reader.

Third, a program was prepared to sum item scores, calculate scale scores, and generate feedback on results.

Having rapid (preferably in real-time) and easy-to-use results from client assessments are crucial to for making adaptive treatment decisions. Therefore, the TCU ADC Forms can generate immediate results to counselors in a combined graphic and tabular format, illustrated below for the *Treatment Engagement* assessment.

Feedback reports show clients scores in a bar graph which overlays a line graph representing comparison-group norms. In addition, tabular records give specific scores for "national norms," "facility norms," and the client score. In the far right-hand column, deviant scores are "flagged" (defined by variances of 5-points or more from *facility norms*) in order to call out counselor attention to the results. A box for counselor response and narrative clinical notes is located at the bottom of the report.

A similar reporting format is followed for other TCU assessments, and the "inventory" of these forms is growing.



Treatment Engagement Process (from TCU ENGForm)

1/16/2008 Client ID# 122112 Facility # 5050

	Norms [1]	Facility Avg [2]	Individual [2]	Flags [3]
TREATMENT PARTICIPATION	40.4	40.96	40.83	.
TREATMENT SATISFACTION	33.09	33.96	24.29	-9.7
COUNSELING REPORT	36.27	37.11	27.50	-9.6
PEER SUPPORT	33.91	32.46	27.50	.

Interpretation Notes:

[1] *"Norms" are mean scores (n = 3,244) from Garner et al. (2007, Criminal Justice & Behavior).*

[2] *"Facility" scores are averages of all clients in this program, and "Individual" scores represent client functioning on date of assessment.*

[3] *"Flags" show individual deviations from facility averages on each scale that deserve special attention.*

Counselor Notes:

Part 4: Clinical Applications of CEST Scores

One of the many "disconnects" that can happen sometimes between substance abuse treatment providers and their clients involves talking with clients about assessment results. Clients often have low expectations of being asked to be involved in discussing or interpreting score results and using them in the treatment planning process. Providers often believe clients are not capable or motivated enough to put effort into treatment planning and that clients may be resistant or defensive about assessment. The purpose of this section is to illustrate how CEST scores can be used to empower clients and provide a foundation for an effective working relationship between client and counselor.

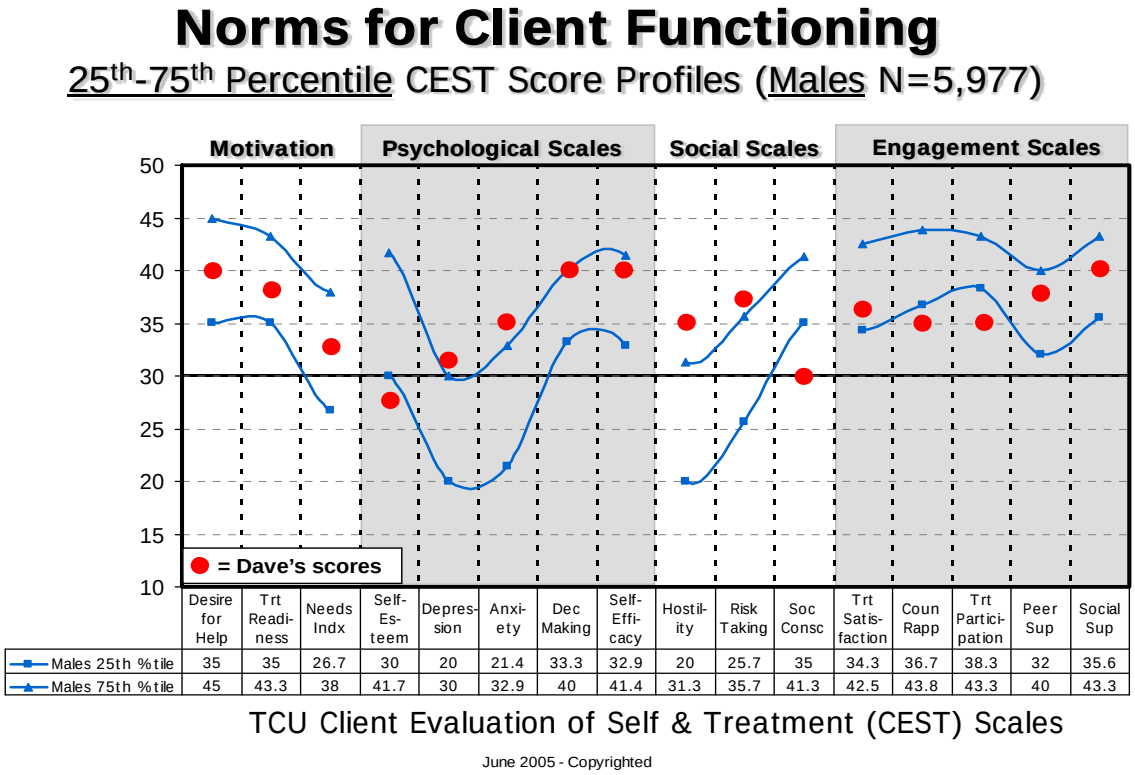
We approach CEST results not as a "diagnosis" of the client, but rather as an indicator of attitudes, perceptions, and experiences the client reports. These attitudes, perceptions, and experiences help shed light on areas of focus or interest for treatment planning. If the CEST is being administered several times during a treatment stay (for example at intake, at mid-point, and at discharge), then the results can also be used comparatively to talk with clients about progress in specific areas, to explore client changes in attitudes and perceptions, or to help make plans for aftercare services.

Using CEST scores for individual treatment planning

Take a look at the example of a CEST scores for an individual client below. Let's say his name is "Dave."

Desire for Help	40	Hostility	35
Treatment Readiness	38	Risk-taking	37
Treatment Needs	33	Social Consciousness	30
Self-Esteem	27	Treatment Satisfaction	36
Depression	32	Counselor Rapport	35
Anxiety	35	Treatment Participation	35
Decision-making	40	Peer Support	37
Self-Efficacy	40	Social Support	40

For ease of review, Dave's scores for the various CEST scales were charted onto a graph template featuring national norms based on a comparative sample of male clients in treatment, as shown below:



Dave had been in the program about 3-weeks when the CEST assessment was administered to help with treatment planning. On his CEST graph you can notice the following at a glance:

> *Dave is about average on his desire for help and readiness for treatment services, and reports a mid-range of things he needs from treatment. He indicates that his self-esteem is lower than average compared to the national sample and his feelings of depression and anxiety are somewhat higher. He reports high average ratings for decision-making and self-efficacy. We can also see that Dave reports high level of hostility and risk-taking and lower social consciousness. He is low average for treatment satisfaction, rapport with staff, and participation, and high average for peer and social support.*

Dave's CEST results reveal some encouraging information – he's as motivated as the next guy to seek treatment, he reports adequate decision-making and belief in himself, and he seems to be getting along with his peers in treatment and reports having social support his treatment efforts. Dave may have endorsed statements on the CEST such as "You need help in dealing with your drug use," "You want to be in a drug treatment program now," "You think about probable results of your actions," "You can do just

about anything you really set your mind to do," "Other clients in this program are helpful to you," and "You have people close to you who motivate and encourage your recovery."

His CEST also reveals areas that would likely benefit from targeted interventions to help Dave complete treatment successfully. In particular, Dave reports levels of hostility that are higher than expected ("You're temper gets you into fights and other trouble"), also more comfort with risks ("You like to take chances"). General social conventions are less strongly endorsed than in the national sample ("You feel honesty is required in every situation"). And of particular note, after 3 weeks in the program, he appears to not be engaging fully in treatment as evidenced by low ratings of treatment satisfaction ("This program is organized and well-run"), rapport with staff ("You are motivated and encouraged by your counselor"), and participation ("You always participate actively in your counseling sessions").

The first step in using CEST results to help inform treatment planning involves reviewing the CEST graph with the client. This review is best approached from a collaborative framework – presenting the results on the graph as items of interest and curiosity and inviting the client to join in a conversation about what he/she views as most relevant and important to address in treatment. In addition, based on treatment engagement scores, the counselor can ask questions to better understand the client's outlook about the program and explore any concerns the client has identified. The highlights and agreements from this meeting with the client are then used to complete a treatment plan.

In most programs, the treatment plan is prepared using the organization's approved format. Treatment plans generally include a statement about the client's presenting concerns, along with targeted goals for treatment, measurable objectives for those goals, and recommendations for treatment activities to facilitate or support those goals.

Here is sample CEST review session, using "Dave" as our client.

After using the first few minutes of the session to welcome Dave and engage him in a brief "check-in," the counselor directs the focus toward reviewing the CEST and engaging Dave in thinking about the results.

CO: *One thing that some clients have found strange in the past is that they are often asked to complete pages and pages of questionnaires as part of their treatment, but then they never get to see the results*.

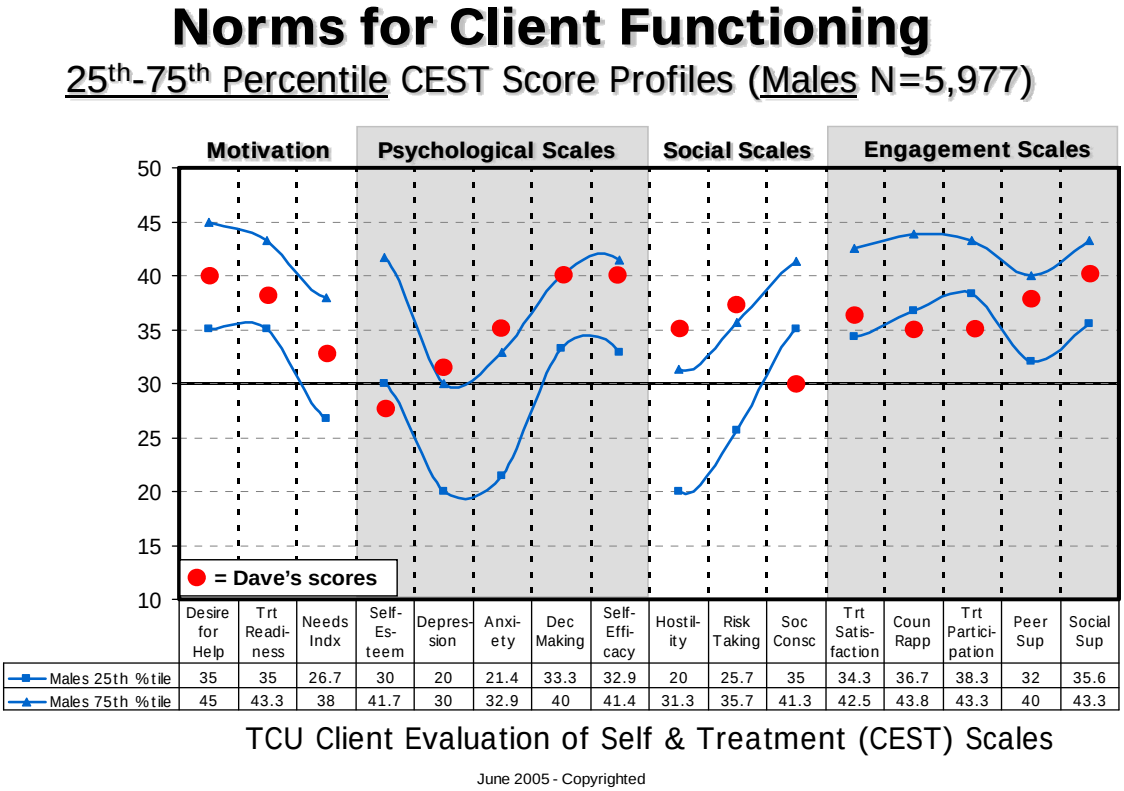
DAVE: *Yeah – it can feel like being a lab rat.*

CO: *Right. Well today I want to review your results for the CEST. You completed a set of these surveys a few weeks ago. The results are calculated and written out on a graph, which we can review together.*

DAVE: (Laughing). *So now you have a chart showing just how crazy I am.*

CO: *Of course! The guys with the nets are waiting right outside. Actually, your CEST results are more about things that relate to your treatment here. We can use the CEST to get an idea of how to arrange your treatment stay and plan out areas of possible focus for you. If nothing else, it just gives you and me a chance to talk about getting the most out of what this program has to offer.*

CO: (After giving Dave a copy of his graph, or moving his seat around so that Dave can look on to his copy). *Dave, let me "translate" this chart for you first, so you can get oriented around all the lines and squiggles.*



	Desire for Help	Trt Readi-ness	Needs Indx	Self-Es-teem	Depres-sion	Anxi-ety	Dec Making	Self-Effi-cacy	Hostil-ity	Risk Taking	Soc Consc	Trt Satis-faction	Coun Rapp	Trt Partici-pation	Peer Sup	Social Sup
Males 25th %tile	35	35	26.7	30	20	21.4	33.3	32.9	20	25.7	35	34.3	36.7	38.3	32	35.6
Males 75th %tile	45	43.3	38	41.7	30	32.9	40	41.4	31.3	35.7	41.3	42.5	43.8	43.3	40	43.3

TCU Client Evaluation of Self & Treatment (CEST) Scales

June 2005 - Copyrighted

DAVE: *What do the 75 and 25 mean?*

CO: *Think of them as high and low averages. For our charts we use a national average for comparison, based on some published numbers for nearly 6,000 male clients in treatment across the country that also took the CEST. So the top bar – the "75" represents the highest average of all those people, and the bottom bar – the "25" represents the lowest average. You'll see as I explain it, for some of the elements we are looking for high scores and for some, low scores.*

CO: (Continuing) *Your scores have been charted using the small round dots.*

DAVE: *Looks like I'm all over the board on this one.*

CO: *Let's walk through it and see what you think. In the area of motivation, your results show you are about in the middle, in terms of wanting help for your drug use and being ready to stay committed to a program. You are also in the middle in your opinion about what you need from treatment.*

DAVE: *I've been trying to work some steps since I took this a few weeks ago. I think I'm more aware than ever of staying clean this time. I've just got to stick with it.*

CO: *So, a few weeks ago you were "average" in being motivated to stick with it, and now, today, you're sensing that your motivation is stronger.*

DAVE: *Guess it just takes time.*

CO: *The next area looks at some psychological areas. Yours shows that you reported feeling somewhat higher levels of depression and anxiety than average and you reported lower levels of self-esteem. Naturally, these things are often inter-related – feeling sad and anxious all the time can have an impact on how good we feel about ourselves.*

DAVE*: I think I've been nervous all my life. Jumpy. And I do get really down because I end up worrying about all kinds of things that bother me and that I can't do anything about. Like my ex-wife and my kids. I've felt like I mess up everything I touch since I don't know when. It makes me mad at the world sometimes.*

CO*: And that's normal, right. We feel bunched up and sad, we feel like we mess things up, so naturally, we can feel angry about everything. So one solution, and one thing that maybe this program can help with, is to find ways to reduce the tension, the sadness, the anger, and create a future where these things aren't a burden.*

DAVE: *Maybe…*

CO: *Well, the next thing your chart seems to be showing us is that, you do believe that if you set your mind to it, you can do most anything. It also shows that you are above average in thinking through decisions and making plans. So how does that influence your "maybe?"*

DAVE: *I do believe that kind of stuff, about doing what you set out to do, but I have to tell you that a lot of that up until now was about dealing dope and staying ahead of the law.*

CO: *So that was up until now. How about now?*

DAVE: (After a pause). *I've got to think about that one, but I get your point. It's like someone said in group – we can use all of our street skills toward new thinking and new acting. And I know that. I know that.*

CO: *Somehow, you sense the truth in that and you're waiting to see how you will use it.*

DAVE: (Nods)

CO: *This next section of the chart deals with things like taking risks, angry feelings, and conforming to social expectations. As you can see, you scored somewhat higher on anger and hostility and risk taking, and lower on social conformity*.

DAVE: *I do have a temper. I took a DV charge about 5 years ago after a fight with my ex-wife got out of hand. In terms of taking risks, well all I can say is buying and selling dope over a 10 year span is all about taking risks. And for this one* (pointing to social consciousness), *I've always thought that a lot of society's so-called rules are really hypocritical. Now again, I've heard the guys in group say that survival on the street means forgetting the rules. And that means we have to pay extra attention to relearning some of the rules of regular society, so we can get jobs and stay clean. That sort of thing.*

CO: *I'm going to have to start going to this group of yours*.

DAVE: *It's pretty good. I listen more than I talk, but I do think about some of the things the other guys talk about.*

CO: *This next part of the chart that deals with how you have been getting along in treatment so far seems to reflect this. You are a little above the middle average in terms*

of your involvement with other clients (peers – like fellow group members). And you seem to have a good amount of support from family and friends outside of treatment.

DAVE: *That would be mainly my mother and sisters, plus a couple of people I grew up with. They have been trying for years to get me to change. Of course, I never let them know how involved in dealing I really was. They think I'm on probation for possession.*

CO: *They have stood by you all the way, never really knowing how deeply involved you were at one time.*

DAVE: *And I do like the groups here. Like I said – mostly to listen.*

CO: *Hmm. Maybe that's what your treatment participation score is showing us. It's a bit on the low side of average. I'm also interested in your ratings of satisfaction with the program and with the counseling staff. These are lower than average.*

DAVE: *I was pretty chapped about one of the counselor's attitudes here. I thought he was being rude to me and he never listened and ended up assigning me to a group I couldn't attend because of my work and transportation schedule. That idiot left last week. I like the new counselor much better. She at least listens to me and tries to work with me, in terms of my work schedule.*

CO: *Scheduling and the time that we offer certain groups has been a challenge for you and your new counselor is helping you get a handle on that. Any other thoughts about your ratings of satisfaction with the program and staff?*

DAVE: *Sometimes things run a little slow. It took a week for someone to give me a referral for a job program. But, hey, overall, your program here seems to be a good one. I'm just happy to have a new counselor. I think my attitude is getting better.*

CO: *One of the things we do with the CEST is to ask you to complete it again after you have been in treatment a few more months. Then we can sit down and compare your scores with a graph showing where you are now, and where you are then.*

DAVE: (Laughing) *Before and after, huh?*

CO: *Yeah. You'll lose 20 pounds, grow a full head of hair, and develop 6-pack abs. What I'd like to do now is talk with you and outline some recommendations, based on the CEST, for areas to focus on over the next few months of treatment. Before we move on to that, do you have any questions about the information we just reviewed?*

The next step would be to use areas identified in the CEST to inform a plan for treatment in the coming months. In Dave's case, it might include group or individual interventions to address anxiety and low moods, anger and cognitive distortions ("thinking errors"), and increasing participation in treatment.

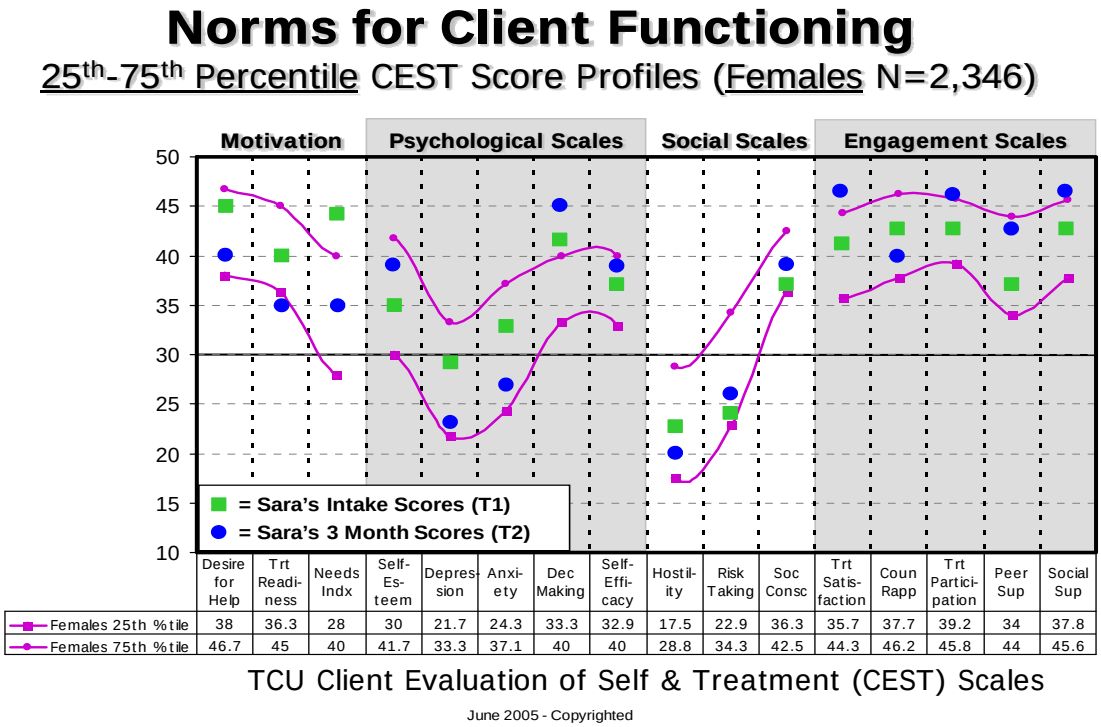
To illustrate how a review of CEST scores with Dave might be worked into a treatment plan we have included a sample of a basic plan at the end of this section.

Using CEST scores across time for monitoring and aftercare

When the CEST is collected at several time points across a treatment episode, subsequent meetings can focus on changes in the four domain areas captured by the CEST. For both progress reports and aftercare planning, a review of two different CEST time points would result in a written plan or recommendation. In the case of progress reports, CEST results are used as an adjunct to updating individual treatment plans. In the case of reviewing the CEST as part of the discharge process, the results might be used to inform recommendations for aftercare.

For ease of discussion, let's consider another client, "Sara." The client's scores for the various CEST scales were as follows and were charted onto the graph template Sara's scores shortly after intake (T1) and her score after 3 months in treatment (T2). In this case, Sara's program used a national sample of female clients for comparison.

	T1 / T2		**T1 / T2**
Desire for Help	45 / 40	Hostility	23 / 20
Treatment Readiness	40 / 35	Risk-taking	24 / 26
Treatment Needs	44 / 35	Social Consciousness	37 / 39
Self-Esteem	35 / 39	Treatment Satisfaction	42 / 47
Depression	29 / 23	Counselor Rapport	43 / 40
Anxiety	33 / 27	Treatment Participation	43 / 46
Decision-making	42 / 45	Peer Support	37 / 43
Self-Efficacy	37 / 39	Social Support	43 / 47



In looking at changes in CEST scores, a 5-point spread is usually considered to reflect significant change. For the purposes of using the results as feedback for progress reports, updated plans, or aftercare plans, a shift of 3-4 points would reflect "moderate" change, while a 1-2 point difference would reflect that things are about the same.

Sara's CEST results between Intake (T1) and 3 months (T2) show that she is reporting some changes in her motivation, with reductions in perceptions of need for help ("Your life has gone out of control," and readiness ("This treatment program seems too demanding for you"). Sara's largest change is in her sense of treatment needs. This pattern is often seen as clients move from early recovery to mid-treatment and may be due to client's feeling better and not longer experiencing the sense of "urgency" to enter treatment that characterizes many clients at intake.

Sara also reports some improvements in self-esteem ("You wish you had more respect for yourself") and depression ("You worry or brood a lot"), with her largest psychological change reflecting a strong reduction in reported anxiety ("You feel tense or keyed up").

Sara's decision-making scores remain high ("You think of several different ways to solve a problem") as does her sense of self-efficacy ("What happens in the future mostly depends on you"). Hostility ("You get mad at other people easily") and risk-taking ("You like the fast life") are toward the low end and mostly unchanged. Likewise, Sara's social consciousness ("You feel people are important to you") is high at both time points.

In her third month of treatment, Sara is reporting a significant increase in her satisfaction with treatment ("You can get plenty of personal counseling at this program") and a slight decrease in rapport with staff ("Your counselor is easy to talk to"). She also reports increases in her participation in treatment (""You have made progress with you drug/alcohol problems"), interactions with other clients ("There is a sense of family in this program"), and support from significant others ("You have good friends that do not use drugs").

After reviewing these results with Sara, following the flow and tone outlined in the sample session with "Dave," an updated treatment plan can be crafted (or an aftercare plan if the client is headed for discharge). Based on the changes in the two time points for Sara described above, the following areas might be the focus for further treatment or aftercare planning:

Relapse prevention review: Explore changes in motivation; re-examine triggers
Twelve-step/support group participation: Reinforce recovery and motivation
Managing stress /anxiety: Reinforce progress; support changes made to date
Communication skills: Help with client/counselor relationship; reduce anxiety

Using CEST scores in group counseling

As can be seen in the discussion of using CEST scores in individual sessions with the client, a major benefit these results offer is the opportunity for feedback, discussion, collaboration, and planning.

We have developed a more simplified way of using clients' CEST scores as a springboard for group work. The graphs and charts described previously have a more "clinical" feel to them, and in a one-on-one setting the client and counselor have more time to focus and discuss. This approach may be too complicated for working in groups, where members have divergent needs and dynamics are much different.

The CEST worksheet shown below (***Your CEST Scores***) was developed to help translate scores into a simpler format for group work. The counselor prepares a worksheet for each group member based on his/her CEST results and uses the information to conduct one or more groups

It should be said upfront that preparing CEST results for the preliminary group will require a bit of extra work on the part of the counselor. However, subsequent group sessions can flow from the information and clients can be encouraged to use the results for personal goal setting and working on salient issues.

Client ID _____

Your CEST Scores

Motivation

Desire for help

(*You need help in dealing with your drug use*)

Readiness

(*This treatment program can really help you*)

Treatment Needs

(*You need more individual counseling sessions*)

Social

Hostility

(*You have urges to fight or hurt others*)

Risk-taking

(*You like the fast life*)

Social views

(*You feel honesty is required in every situation*)

Psychological

Self Esteem

(*You have much to be proud of*)

Depression

(*You feel hopeless about things)*

Anxiety

(*You feel tense of keyed up*)

Decision-making

(*You think about the results of your actions*)

Self-confidence

(*You can do just about anything you set your mind to do)*

Engagement

Treatment rating

(*You're satisfied with this program*)

Rapport

(*You trust your counselor(s)*

Participation

(*You attend counseling sessions*)

Peer support

(*There is a sense of family in this program)*

Social support

(*You have people close to you that encourage your recovery)*

How you see yourself and treatment

Preparation for CEST group activity

To prepare for the preliminary group, the counselor fills out a ***Your CEST Scores*** worksheet (shown above) for each participant, using his or her CEST results.

Next to each scale description on the worksheet, there is a space for the counselor to enter a designation of the client's score. However, rather than raw numbers, these scores are "translated" into designations that represent "not a problem," "about average," or "maybe a problem area for you." This legend is presented below.

+ = *Probably not a problem and may be a strength you can draw on*

o = *About where most people are; may or may not be a problem or need focus*

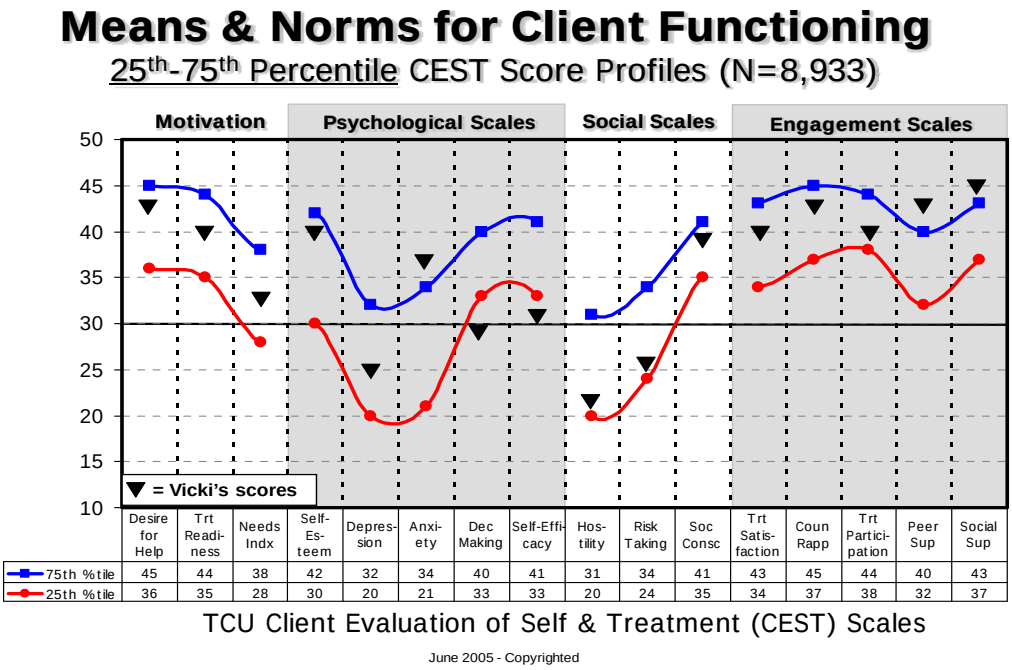
– = *An area that probably needs improvement and may be a problem*

These designations are arrived at by comparing the individuals' scores with the average for the reference group. As discussed previously, the reference group can be a national sample or all clients within the program.

Using the fictional case study of "Vicki" below, we outline how to use CEST scores and graphs to complete each client's ***Your CEST Scores*** worksheet.

Vicki's CEST Scores

Desire for Help	43	Hostility	22
Treatment Readiness	40	Risk-taking	26
Treatment Needs	33	Social Consciousness	39
Self-Esteem	40	Treatment Satisfaction	40
Depression	25	Counselor Rapport	43
Anxiety	37	Treatment Participation	40
Decision-making	29	Peer Support	43
Self-Efficacy	31	Social Support	45



Based on the above information for Vicki, the counselor would prepare a ***Your CEST Scores*** worksheet for the client that looks like this:

Client ID _____

Your CEST Scores

Motivation

Desire for help (+)
(*You need help in dealing with your drug use*)

Readiness (o)
(*This treatment program can really help you*)

Treatment Needs (o)
(*You need more individual counseling sessions*)

Social

Hostility (+)
(*You have urges to fight or hurt others*)

Risk-taking (+)
(*You like the fast life*)

Social views (+)
(*You feel honesty is required in every situation*)

Psychological

Self Esteem (+)
(*You have much to be proud of*)

Depression (+)
(*You feel hopeless about things*)

Anxiety (–)
(*You feel tense of keyed up*)

Decision-making (–)
(*You think about the results of your actions*)

Self-confidence (–)
(*You can do just about anything you set your mind to do*)

Engagement

Treatment rating (+)
(*You're satisfied with this program*)

Rapport (+)
(*You trust your counselor(s)*)

Participation (o)
(*You attend counseling sessions*)

Peer support (+)
(*There is a sense of family in this program*)

Social support (+)
(*You have people close to you that encourage your recovery*)

How you see yourself and treatment

Keeping in mind that the desired direction for some scales is high (desire for help, self, esteem, peer support) and for others, low (depression, hostility, anxiety), Vicki's CEST scores worksheet reflects that her desire for help is not a problem and maybe a strength she can draw on (+), and her readiness for treatment and treatment needs are about average (0), reflecting these may or may not be areas for growth. Vicki's self-esteem is not a problem (+), as reflected by its higher score, nor is depression (+), as reflected by its lower score. However, she shows a high anxiety score (-), reflected on the worksheet as an area she needs to work on. Similarly, decision-making and self-efficacy (self-confidence) are lower than we would like to see (-), meaning these also may be areas of treatment focus. Vicki's hostility and risk-taking are low, meriting a "plus" symbol (+) on the worksheet as these areas are not a problem for Vicki (the preferred direction is low), and may indeed be strengths. The rest of the scales reflect generally high scores in the desired direction (+), with the exception of treatment participation at mid-range or average (0).

A step-by-step general outline for a preliminary session to review CEST results as a group activity follows.

General Outline for CEST Group

1. Begin the group by telling participants they are receiving some feedback based on the CEST forms they completed as part of their paperwork.

> *Not too long ago, you completed some forms called the CEST. These surveys measured your ideas and experiences in four areas of treatment – motivation, psychological, social, and becoming involved in the treatment program. Today you will have a chance to review your own results and see how your scores compare with averages around the country. This will also give you some ideas about what to focus on during treatment.*

2. Give each group member a copy of their *Your CEST Scores* worksheet, along with handout *Understanding Your CEST Scores*. (The handout and worksheet templates are included at the end of this section.) Walk clients through an overview of their CEST scores worksheet.

Your feedback worksheet shows your scores in 4 areas related to treatment – motivation, psychological, social, and engagement. One the CEST, you reported how you see yourself and what you think about being in treatment. Each of the 4 areas has different components. For example, you can see that self-esteem, anxiety, and depression are part of the psychological area.

Your feedback sheet assigns either a "plus," a "zero," or a "minus" to how you scored on each of the components.

Your handout explains what each of these mean. A "plus" means that you are doing well in this area, that it is probably not a problem, and likely strength of yours. A "zero" means your scores were about average. This would be areas you may or may not need to focus on. And a "minus" means your scores showed this might be an area you want to focus on, maybe take some action to work on it.

Continue to walk the group participants through each of the scales on the worksheet, giving examples of what is meant:

Let's walk through the worksheet so you can understand your score in each of the areas. The Motivation box is made up of "desire for help," "readiness," and "treatment needs." This would be reflected in things like – "You need help in dealing with your drug use," or "This treatment program is where I need to be right now."

The Psychological box has different areas about how you feel and how you think about things. "Self esteem" refers to feeling at ease with yourself, not being so hard on yourself. "Depression" shows what you reported about your moods. "Anxiety" is an indicator of how tense or nervous you report feeling. ""Decision-making" and "self confidence" get at how you tend to think about plans, making decisions, following through, and also how much you believe that you can do things when you set your mind to do them.

The Social box looks at different areas of how you operate in society or with other people. "Hostility" is a score on your reports of how hot-headed or inclined to get into fight you are. "Risk-taking" looks at your sense of recklessness or taking chances. And "social views" is a score of your beliefs in basic social values.

The Engagement box does not contain a diamond ring. Engagement here refers to how involved you report being in treatment. This includes a "treatment rating," which is your overall satisfaction with your program, "rapport," which reflects how well you get along with your counselors and other staff, and "participation," which refers to how actively you are taking part in groups, counseling, guidance, and other aspects of treatment. The "peer support" area is your report of how you get along with your fellow clients in this program and "social support" is your report of having supportive family and friends you can call on and trust.

3. Give participants some time to review their charts and make note of areas that might be strengths and areas that might need focus as part of treatment

Take a few minutes to look at your chart. Pay attention to areas where you are doing well, and also look at areas that you may want to work on. Use your own judgment on areas with a "zero" score, in terms of identifying things to work on.

4. Distribute copies of the CEST Score Planner worksheets (included at the end of this section). Instruct participants to complete the planner using their scores.

Now that you have had a chance to look over your worksheets, let's take a few minutes to think about how the scores might relate to treatment. Look over your scores and take a few minutes to complete a worksheet on what your scores show as areas of focus, based on having a "minus" sign or a "zero," if in your judgment there might be some work to do there. Use the boxes on the left to list your problem areas and the boxes on the right to make a few notes about changes or improvements you would like to make in those areas while you are here in treatment.

5. Once participants have completed the planning sheets, lead a general processing and discussion segment, based on the activity. Some of the following questions may be used as discussion starters.

Discussion questions:

What is your overall opinion of your CEST scores? Do you agree with what the scores say about how you see yourself and this program?

What was your most surprising score?

What scores are in agreement with what other people may have talked to you about before?

What makes some of these areas, like motivation, self-esteem, depression, important for treatment goals?

How can treatment itself help with some of these areas?

Based on what you wrote on your planning sheet, what came up as an important area for you to focus on? [Follow-up question for respondent]: *What did you write down that you wanted to change or improve in that area?*

How will you know when you have been successful in addressing some of your "problem" areas?

6. Thank participants and end group in usual manner. Allow them to keep their scores and planning sheets and encourage them to continue thinking about what they plan to work on.

Resources and References

Handouts and Templates Referenced in Part 4: Clinical Applications of CEST Scores

EXAMPLE

Initial Treatment Plan

Plan completed within 30 calendar days of initial appointment with input from the following:

Client: Dave D. Case # 26273967

Date Referred: 2/22/08 Date Plan Developed: 3/20/08

Case Manger: Abel Counselor

Treatment/ Evaluation History:
Previous treatment: 2x (mandated residential; outpatient)
Completed intake: 2/25/08
Completed drug history assessment: 2/25/08
Completed CEST (all domains): 3/10/08
CEST review with client: 3/15/08

Treatment issue(s) as identified by client and therapist:

Anxious feelings and low moods
Anger and cognitive distortions ("criminal thinking")
Increase participation in treatment

List goal(s) of therapy and methods to verify goal achievement:

1. Improve coping skills for mood management: Attend counseling services; attend intervention group on changing thinking patterns; changes on CEST @ 6 months

2. Explore anger/impulse control: Develop awareness of patterns of loss of control; attend intervention group on anger control; changes on CEST @ 6 months

3. Increase treatment participation: Develop incentive plan for participation as part of individual counseling; communication skills group; changes on CEST @ 6 months

Anticipated frequency of contact: 1 session per week for individual counseling; 1 recovery group per week; 1 targeted intervention group per week

Recommendations: Client was open and engaged during the review of his initial CEST assessment. He has identified several roadblocks to engagement during his first few weeks and reports he is feeling more positive about the program and participation.

Client ID _____

Your CEST Scores

Motivation

Desire for help

(*You need help in dealing with your drug use*)

Readiness

(*This treatment program can really help you*)

Treatment Needs

(*You need more individual counseling sessions*)

Social

Hostility

(*You have urges to fight or hurt others*)

Risk-taking

(*You like the fast life*)

Social views

(*You feel honesty is required in every situation*)

Psychological

Self Esteem

(*You have much to be proud of*)

Depression

(*You feel hopeless about things)*

Anxiety

(*You feel tense of keyed up*)

Decision-making

(*You think about the results of your actions*)

Self-confidence

(*You can do just about anything you set your mind to do)*

Engagement

Treatment rating

(*You're satisfied with this program*)

Rapport

(*You trust your counselor(s)*

Participation

(*You attend counseling sessions*)

Peer support

(*There is a sense of family in this program)*

Social support

(*You have people close to you that encourage your recovery)*

How you see yourself and treatment

Understanding Your CEST Scores

Your CEST Score worksheet gives you a general idea of how your CEST scores compared to those of other people in alcohol or drug treatment.

There are 4 areas on your CEST Score sheet:

Motivation *– These areas look at your motivation and how strongly you believe you need to be in treatment*

Psychological *– These areas look at general psychological issues such as anxiety or depression*

Social *- These areas look at how you get along with other people and in social settings*

Engagement *– These areas look at your general satisfaction with and participation in your treatment program*

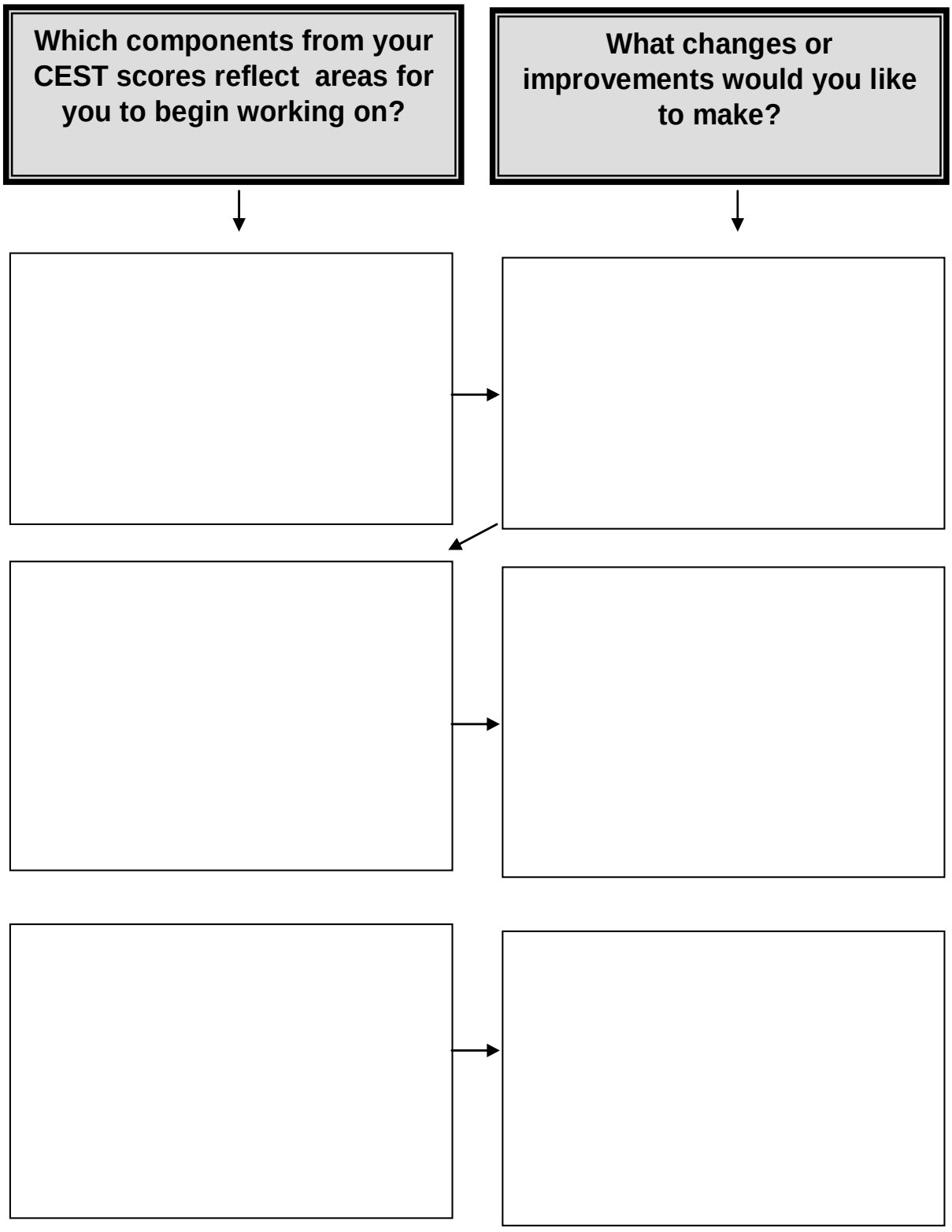
You can read your scores for each area using the legend below:

+ *= Probably not a problem and may be a strength you can draw on*

O *= About where most people are; may or may not be a problem or need focus*

– *= An area that probably needs improvement and may be a problem*

CEST Score Planner



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