TCU Treatment System

Overview of Background and Structure

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An Integrated Approach to Treatment for Addiction

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The "TCU Treatment System" refers to a collection of resources for planning, implementing, and assessing progress in using evidence-based treatment innovations for substance use problems. The system includes (1) manual-guided psychosocial interventions and related life-skills counseling strategies, (2) integrated assessment instruments for measuring client needs and performance, and (3) program management tools to address organizational needs, functioning, and change. Scientific evidence and conceptual models that guide the use of these materials have been presented in relation to treatment process and program change in several hundred publications by the TCU research team.

Real-world partnerships with the national and regional offices of the *Addiction Technology Transfer Centers* (ATTC) network funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal *Bureau of Prisons*, numerous state agencies that oversee treatment services for community and correctional populations, and professional treatment associations—along with several international collaborations—have provided a wealth of opportunities and experience in transferring these resources into applied settings.

TCU interventions and assessments have many commonalities with others in the addiction treatment field. The interventions are unique in regard to their strategic integration using a *general conceptual framework* and uniform inclusion of *cognitive-based graphic tools* (i.e., TCU node-link mapping) to enhance communications and treatment planning. The assessments target both *client-level progress and treatment satisfaction*, as well as *organizational factors* related to program effectiveness and adaptability.

A specialized series of short companion reports are available from our Web site which summarize the conceptual models, interventions, assessments, and treatment monitoring tools included in the *TCU Treatment System*. These reports explain applications of the resources and list citations for the most pertinent scientific publications on which they are based. ✪

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*TCU treatment resources can be downloaded free of charge. See the **Downloads** Web page at **www.ibr.tcu.edu***

How treatment works

Treatment for drug addiction is sometimes viewed as a singular event for correcting an acute problem. In fact, it is much more complicated. Evidence shows there is a structured therapeutic process typically related to client recovery, and that different types of interventions serve to initiate or sustain client progress through stages of change. Medications may assist in this process but are not the "active ingredients" of psychosocial recovery foundations common to virtually all forms of drug addiction treatments.

The *TCU Treatment Model* (Simpson, 2004) is based on research from the addiction and mental health treatment fields that emphasize sequential relationships between needs and motivation for treatment, early engagement, early recovery, length of stay in treatment, and posttreatment outcomes (see **Figure 1** below). Findings demonstrate that a multidimensional index of client problem severity at intake (calculated from drug history and psychosocial functioning indicators) is related to during-treatment performance and follow-up outcomes (Joe, Simpson, Greener, & Rowan-Szal, 2004).

More importantly, repeated assessments throughout treatment show that more favorable scores at each stage increase by at least two-fold the chances of progressing successfully through the subsequent stage (Joe, Simpson, & Broome, 1999; Simpson & Joe, 2004). Findings supporting this model of treatment process come from diverse settings, including those for correctional populations (Simpson, Knight, & Dansereau, 2004).

The driving force for client progress towards recovery is a strategic series of interventions, as demonstrated in research that has programmatically tested this model using TCU treatment assessments and interventions. Because of the high frequency of early dropouts and associated costs, greater vigilance for "front end" stages of treatment is crucial. For instance, a few of our most recent experimental studies reaffirm that treatment induction and readiness training improves motivation and early engagement (Czuchry & Dansereau, 2005). Behavioral interventions (e.g., contingency
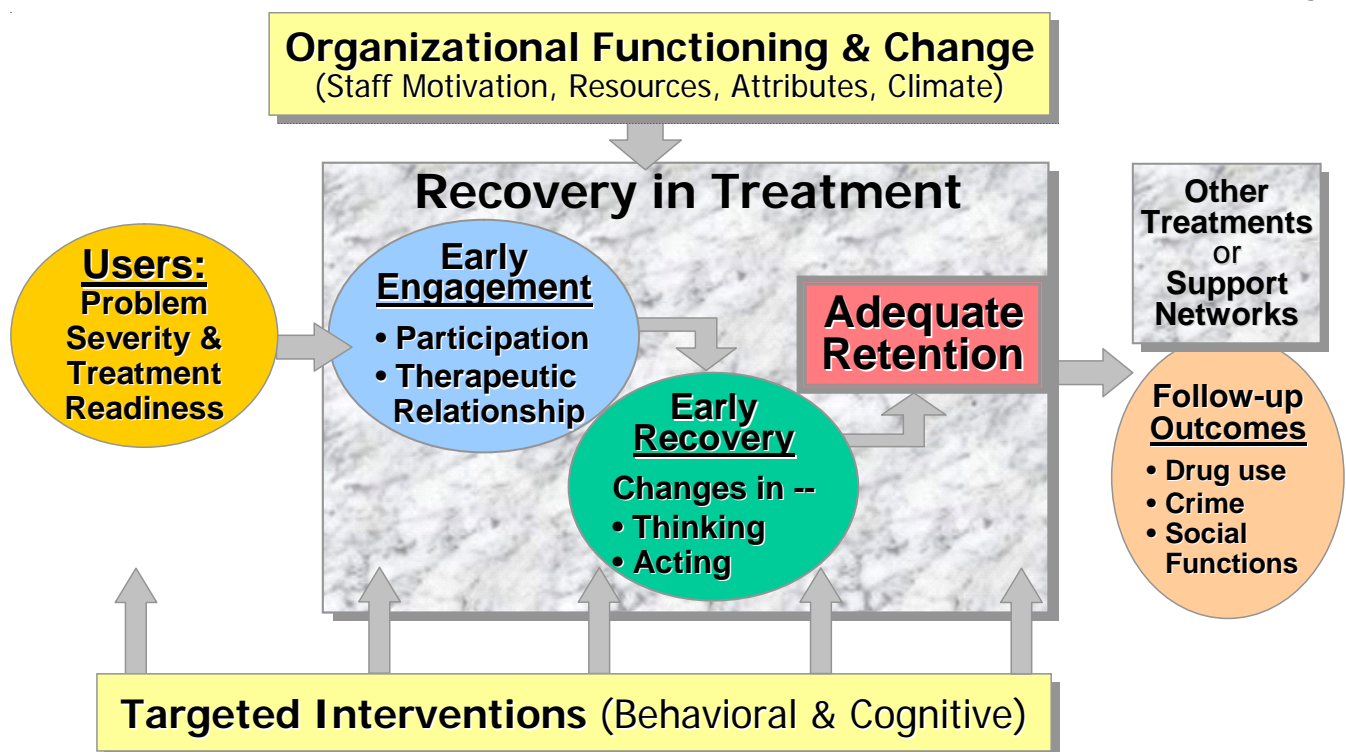
Figure 1. TCU Treatment System components for psychosocial interventions (Simpson, 2002, 2004, 2006).

How treatment and assessments work together

For too long at too many programs, assessments and interventions have been functionally detached. Formal assessments tend to be completed and filed away (or used mainly for research). Interventions tend to be delivered within a uniform schedule instead of responding to particular needs. Pieces of this process operate independently and do not inform each other about impact or deficiencies. Computer-based technologies offer a chance to change the system, but it is like putting together a complicated and expensive puzzle.

Ideally, treatment planning should occur at both the client and program levels. Program directors and clinical supervisors have responsibility for monitoring progress and managing resources for the services system, while individual counselors have responsibility for personalized planning and effective delivery of services. That means that at the program management level, aggregated client records are needed for tracking clinical needs and response patterns (including dynamic changes over time) by using indicators such as client attributes and severity levels, during-treatment functioning, treatment engagement, and retention.

Diagnostic indicators for a program might detect significant shifts in primary drug use, demographic profiles (e.g., gender or age), or referral sources at intake. Likewise, in-treatment functioning of clients might signal needs for new clinical tools that address low readiness for treatment, high levels of client anger or hostility, poor session attendance and counseling rapport, high rates of

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early dropout, etc. Assuming appropriate levels of skills and responsibility, counselors need ready access to an array of "plug-n-play" interventions shown to be effective (i.e., evidence-based) in addressing these issues.

A systems approach therefore suggests that targeted and relevant assessments be obtained and made available for *client-level* treatment planning and monitoring—and that they be used at the *aggregated* level for program planning and monitoring. In principle, innovations needed to address client needs and performance should be identified

and selected based on scientific support, training requirement, and access (including via the internet) to user-friendly intervention tools. Tracking client and program level responses (using the on-going assessments) should inform deci-sions about clinical impact and organizational change following an iterative process.

But this is easier said than done. Architectural plans for the TCU Treatment System follow these blueprints. Assessments of client needs and severity at intake—along with a set of brief scales for motiva-tion, psychological, and social functioning that are repeated during treatment—are tied into our treat-ment process framework, as are interventions shown to impact them. The *Client Evaluation of Self and Treatment* (**CEST**) is central to the monitoring of client functioning (individually and collectively), and it includes scales for therapeutic engagement and social support (see **Figure 2**, next page; Joe et al., 2002). Information from approxi-mately 10,000 clients provides comparative norms and functional thresholds for interpreting records at individual and program levels (see A*ssessment FACT Sheets* on the IBR Web site). Program-wide assess-ment of client samples using the CEST can generate diagnostic profiles on client functioning. Interventions are then identified from TCU resources or elsewhere that are shown to be effective in addressing prominent needs or deficiencies. ✪

How programs manage treatment quality and change

Treatment effectiveness can best be viewed using both a micro and macro perspective—that is, at the client and program levels. Not only is the quality of client treatment planning and care important, as already discussed, but so is the proper placement of clients into the most appropriate level of care. Posttreatment outcomes of clients with low overall problem severity are comparable when treated either in high or low intensity settings (including outpatient and residential options). However, clients with high-severity problems at intake have been shown to have outcomes up to three times better if they received more highly structured residential care (versus low-struc-

ture outpatient care) for at least 3 months (Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999).

The importance of retention on treatment outcomes is well established (Gossop, Marsden, Stewart, & Rolf, 1997; Simpson, Joe, & Brown, 1997), but there are large program variations in overall client engagement and retention levels (Broome, Simpson, & Joe, 1999; Simpson, Joe, Broome, Hiller, Knight, & Rowan-Szal, 1997). Not only are these differences related to quality of clinical planning and delivery, it is becoming more widely acknowledged that organizational climate and functioning are signifi-

cant factors to consider. Programs with better staff communications, cohesion, and resources have records of better clinical care (Lehman, Greener, & Simpson, 2002).

The *TCU Program Change Model* (Simpson, 2002) uses findings from the literature on technology transfer to summarize major organizational influences on program quality and how these are related to institutional change. Evidence clearly points out that dissemination alone for transferring new innovations into practice is seldom effective. Organizations go through stages of change before new ways of doing things
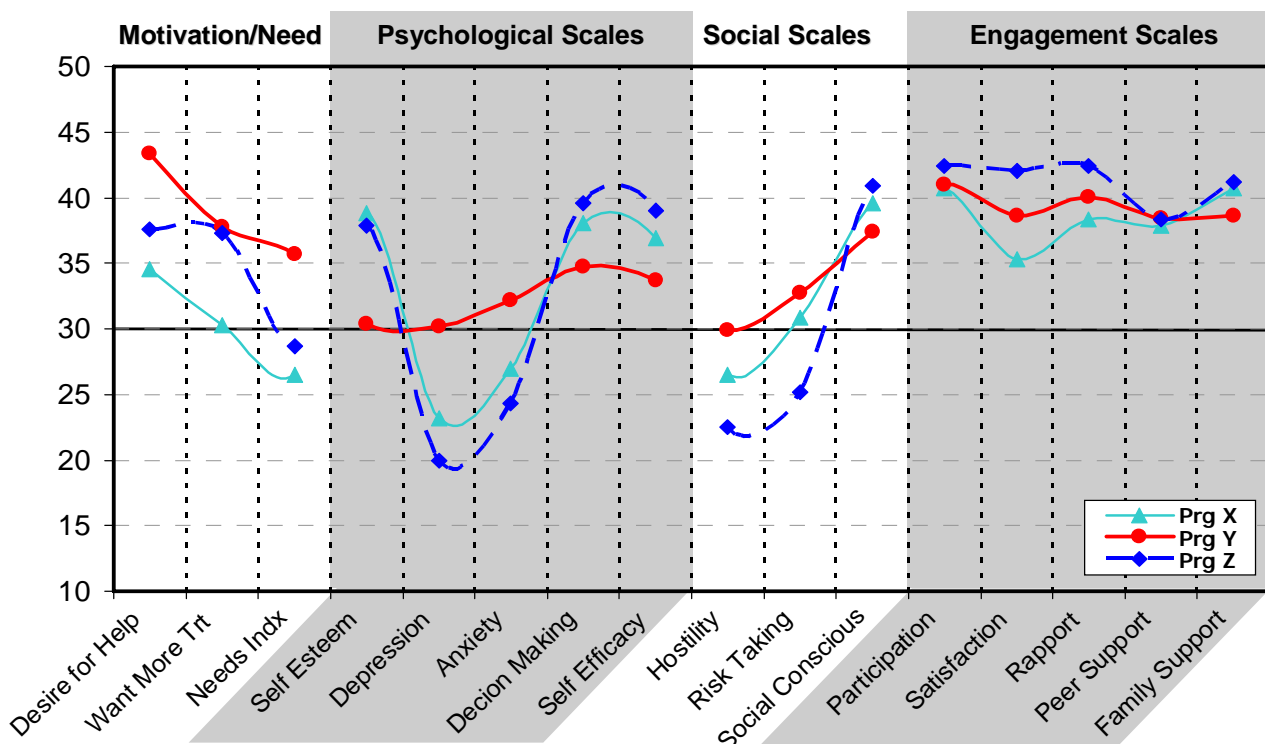
TCU Client Evaluation of Self & Treatment (CEST) Scores

Figure 2. Client psychosocial and engagement functioning profiles (mean scores) for 3 treatment programs.

Brief overview reports for the TCU Treatment System

Descriptions of specific resources are given in the following reports, and they include more details on interventions and assessments (available for downloading at www.ibr.tcu.edu, labeled "Research Summaries").

Focus on Conceptual Frameworks –
1. TCU Treatment Model
2. TCU Program Change Model

Focus on Interventions –
1. Manuals for Counseling
2. Mapping Tools for Counseling Strategies
3. Contingency Management as a Counseling Strategy
4. Treatment Readiness and Induction Training

Focus on Assessments –
1. Assessments of Client Needs and Functioning
2. TCU Drug Screen
3. Assessments of Organizational Needs and Functioning

Focus on Special Issues –
(In preparation)
1. Brief Interventions for Offender Populations
2. Evidence for the Brief Interventions

Continued from previous page.

become "normal." Like clients moving towards recovery in treatment, program readiness for change and resource levels influence this process for adopting new innovations. On-going decisions about their implementation are guided by perceived needs for and satisfaction with the new resources and related training for using them. Reaching the level of full-scale practice with new procedures depends heavily on organizational functioning, tolerance, and active support.

TCU assessments include the ***Organizational Readiness for Change* (ORC)** which has been developed and tested (see Lehman et al., 2002) for measuring organizational functioning. It focuses on staff perceptions about adequacy of program resources, counselor attributes, work climate (e.g., mission, communication, cohesion, stress), and motivation or pressures for program changes. By combining information obtained using both the ORC (from staff) and the CEST (from clients), a *performance and needs report* on unit functioning is useful for diagnosing programmatic strengths, needs, and barriers to change. Repeating this assessment process over time can be used to evaluate progress.

Stage-based evaluations of how innovations get translated into practice have become a central focus of the TCU research team. A related aspect of this process are new efforts to find practical approaches to computing costs for services and studying how these financial considerations are related to the effectiveness of clinical services and organizational functioning. ✪

TCU Treatment Model, continued from page 2.

management, see Rowan-Szal, Bartholomew, Chatham, & Simpson, 2005) and cognitive techniques (e.g., node-link mapping, see Newbern, Dansereau, Czuchry, & Simpson, 2005) improve treatment engagement indicators—participation and therapeutic relationship—as well as retention.

In programs without effective induction, planning, or early engagement strategies, many clients never receive what might be *superior* interventions tentatively scheduled for later. Like links in a chain, the quality of all elements of treatment delivery must be insured to maintain its overall integrity. Within this stage-based framework, it can be argued that effectiveness of discrete interventions is most properly evaluated on the basis of their *interim* impact on client performance rather than judging them only by examining long-range outcomes (also see McLellan, McKay, Forman, Cacciola, & Kemp, 2005).

Deliberate planning, monitoring, and "on-time" delivery of specific program interventions is fundamental to improving treatment effectiveness. In addition to the evidence for stage-specific interventions as noted above, we have found their aggregated or collective use proportionately increases posttreatment outcome performance (Rowan-Szal, Chatham, Greener, Joe, Payte, & Simpson, 2004). ✪

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