Mid-Ohio Psychological Services, Inc.

Alcohol and Other Drug (AOD) Treatment Review

04/15/2010

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Program Background

When MOPS first opened in 1992, staff at MOPS recognized the important impact that AOD treatment needs placed on the functioning of the clients that we service. AOD services have historically been viewed as both an integral component of overall mental health treatment services, as well as a collection of services unto themselves. An AOD assessment has been integral to the overall assessment of every client who has received services at MOPS since the agency's inception.

On 7/15/2003 MOPS became certified by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) in response to the ever increasing need for AOD services in Fairfield County. At that time, an initial AOD program was developed with explicit treatment expectations for persons who had a primary AOD diagnosis. On 5/31/2006 MOPS relinquished our certification with ODADAS as the result of unnecessary administrative cost associated with maintaining the certification, but the program expectations remained for persons who were receiving mental health services and had an AOD diagnosis.

MOPS initially developed a Standard of Care (SOC) for most client populations in 2007 and have been progressively enhancing this SOC since that time. The SOC for AOD clients was initially developed in 2007 and critically reviewed and enhanced in 2008. The SOC for AOD services at MOPS can be found in Appendix A of this document.

Methodology

In order to better understand the care that persons who experience abuse/dependence with alcohol and other drugs while at MOPS, an extensive program review occurred in January and February 2010. Fifty random cases were sampled for a case review out of a list of 480 MOPS clients identified that had an AOD diagnosis during their course of care from 12/01/2008 to 12/01/2009. Each case file was reviewed utilizing the *AOD Chart Review Form* (See Appendix B). Additionally, service utilization was captured from the agency's *Clinical Information System*. This data was then entered into a database, utilizing a "normalized" data structure for most fields. The data was then analyzed utilizing *Statistical Package for the Social Sciences* V8.0 (SPSS). Because no client identifying information was reported in this service evaluation and because this service evaluation is being conducted exclusively for internal quality improvement, specific permission from clients to be included in this study was not deemed necessary.

Results

Between 12/1/2008 and 12/1/2009, 2,643 clients were seen throughout MOPS, with 480 (18.16%) of these individuals having an AOD diagnosis as one of their three primary diagnosis. As can be seen in Figure 1, the mean age for the clients with an AOD diagnosis was 29.8, ranging from 15 to 68. The distribution is positively skewed, with the majority of clients being in their 20's.

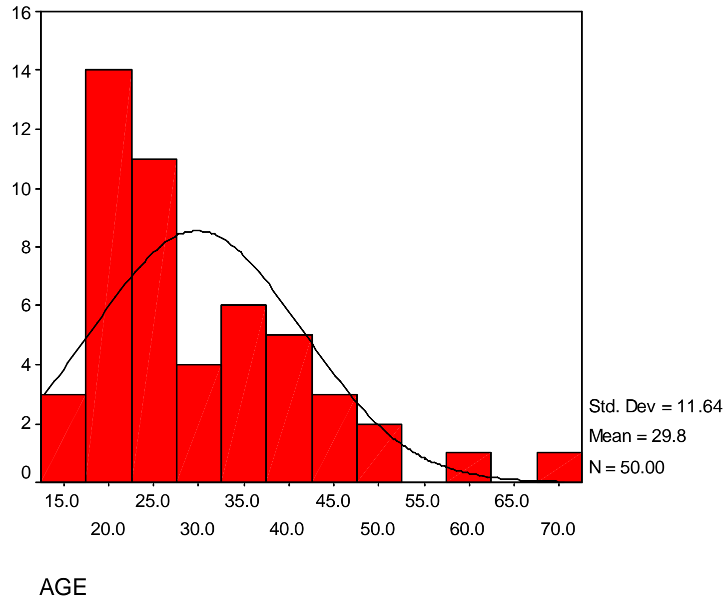

Figure 1--Sample Age Distribution

As can be seen in Figure 2, 58% of the sample was Female, while 42% of the sample was Male.

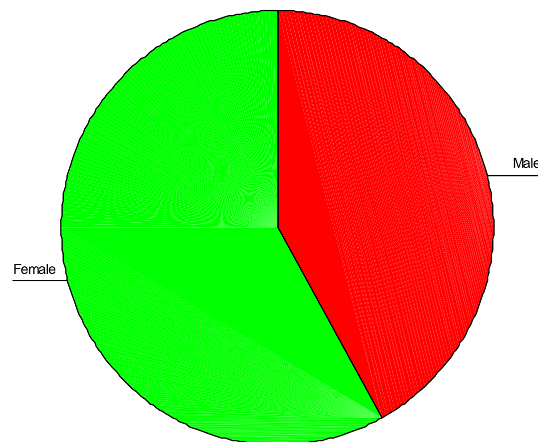

Figure 2--Gender

Of the 47 clients who are adults in this sample, 48.9% were single, 25.5% were married, 23.4% divorced, and 2.1% were widowed (see Figure 3). Cumulatively, 74.5% were not married at the time of intake. The vast majority of the clients (85.7%) were not living with family members (parents/siblings/spouses) at the time they entered care.

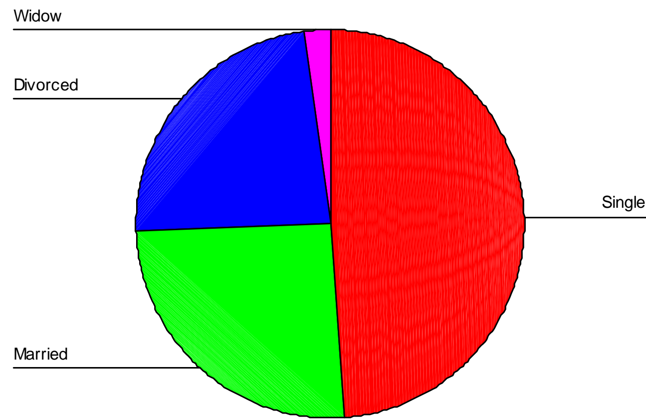

Figure 3 Marital Status

Most (74.5%) of the adult clients had children. Of those that had children, the mean number of children was 2.29 (range of 1 to 5).

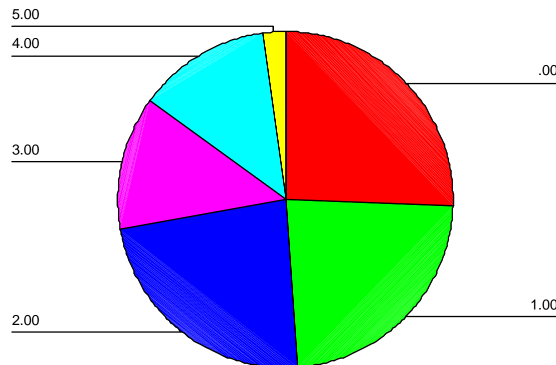

Figure 4--Number of Children

Of those adults with children (n=35), 20% had children in some placement other than their own home or a family member's home, with a total of 14 kids being in "placement". Of those adults with children, 65.7% of them had children living with them at the time of entering treatment (for a total of 44 kids living with someone actively dealing with AOD issues). Using this data as a base rate, it is estimated that of the clients receiving services at MOPS during this review period, approximately 384 children are living with a parent who is involved with treatment as the result of substance abuse.

Seventy percent of the sample was from Fairfield County (see Figure 5)—a slighlty higher perportion of clients then the general MOPS client population (approxiamately 55%).

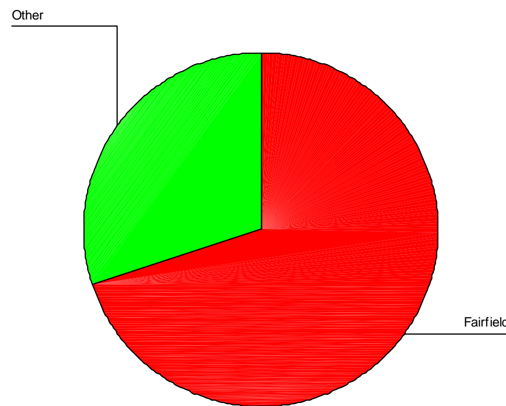

Figure 5--County

The vast majority (82%) of the clients received Medicaid to pay for the serivce, while only 6% paid for the service themselves and 10% received services on a sliding scale (see Figure 6).

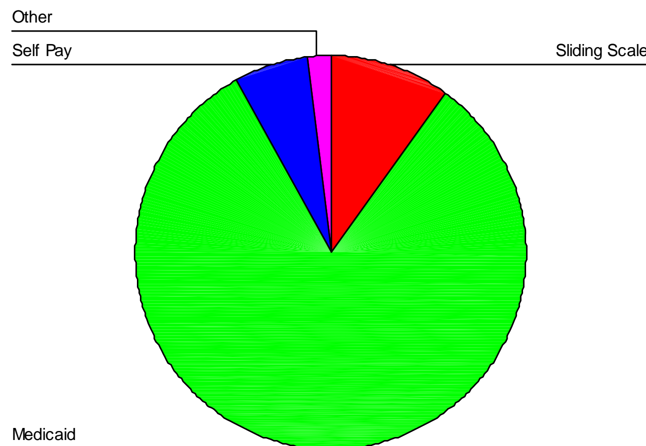

Figure 6--Payment Source

Clients were referred for serivces from a range of places, with the largest number of clients coming from Fairfield County Job and Family Services (22%), Self Refferred (20%), and “Other Sources” (18%). Approximately 28% of the clients came from a court, while approxiatmely 26% of the clients came from various Children Services agencies. Relatively few clients were referred by medical providers (6%)

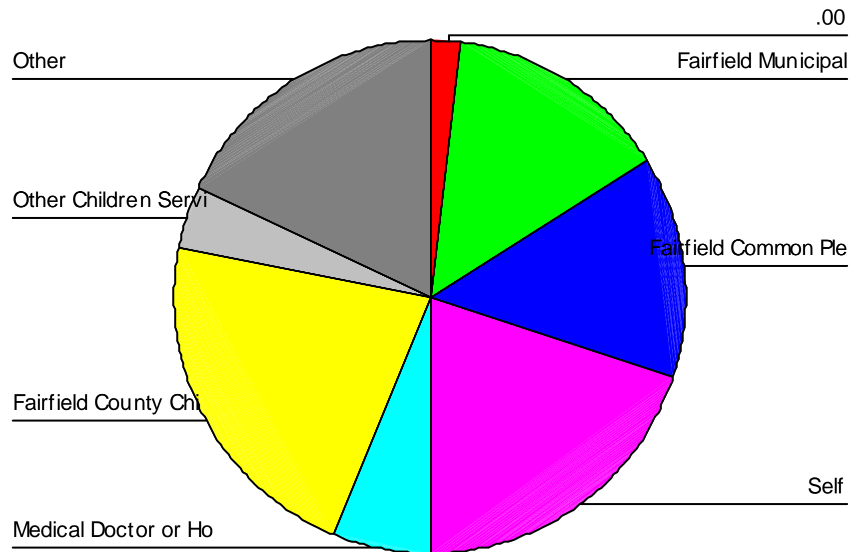

Figure 7--Referral Source

Sixty-eight percent of the clients had either current or prior involment with the criminal justice system. Fifty percent of the clients receiving AOD services were invovled with a criminal offense leading to their involvment in treatment services. The majority of these offenses were AOD specific, with four clients being referred for Driving Under the Influence and 12 clients being charged with other AOD related offenses (ie. Drug Abuse, Possession, Underage Consumption, Disorderly Conduct, etc.). Thirty-six percent of the offenses were not AOD specific, including offenses such as Theft, Domestic Violence, Assault, Resisting Arrest, and Receiving Stolen Property. Most of the client who were involved with the court system concurrent with the treatment episode also had a prior arrest record (52% of the clients currently involed with the court) while 32% of the clients who were not currently involved with the court had prior involvment with the criminal justice system. In all, 42% of the clients had prior involvment with the court, with a range of 1-10 prior offenses.

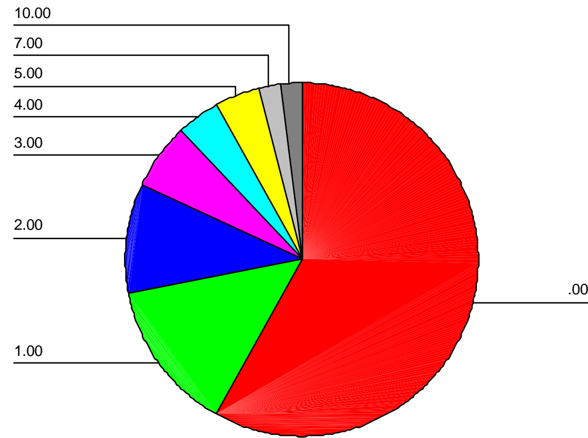

Figure 8--Number of Prior Offenses

As can be seen in Figure 9, the mean age that clients began using alcohol or illicit substances was 14.2 (range of 7 to 21). This is genearlly consistent with national statistics regarding the age of first usage.

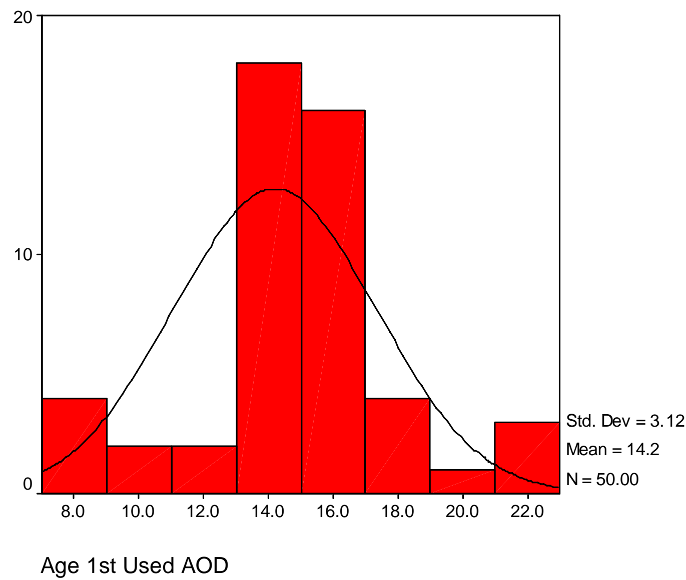

Figure 9-- Age 1st Used

The vast majority of the clients were not working at the time of intake for treatment (80%) and did not have a history of stable employment (82%).

Only 2% of the clients were estimated to function Above Average in intelligence while 54% were viewed as functioning in the Below Average range of intelligence. Fifty percent of the clients had a history of learning problems.

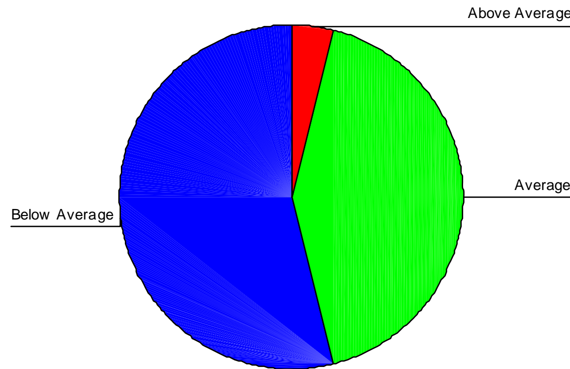

Figure 10--Intelligence Level

Fifty-eight percent of the clients had a prior mental health diagnosis, with he most common prior diagnosis being Depression.

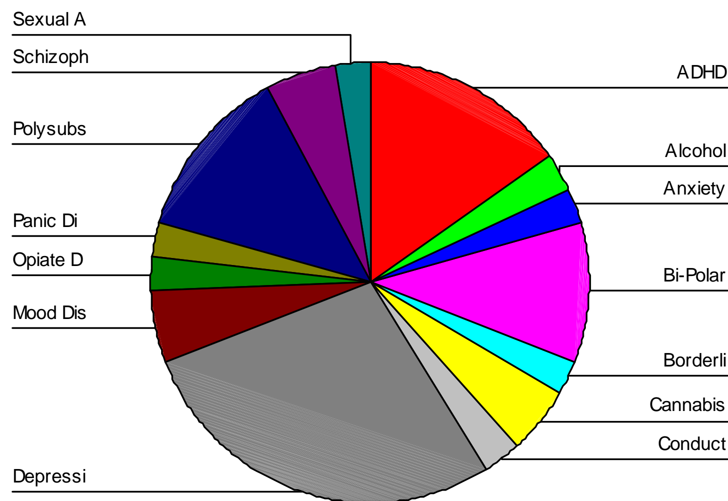

Figure 11 Prior Diagnosis

The majority (52%) of clients who currently have an AOD diagnosis, have this diagnosis as their current primary diagnosis.

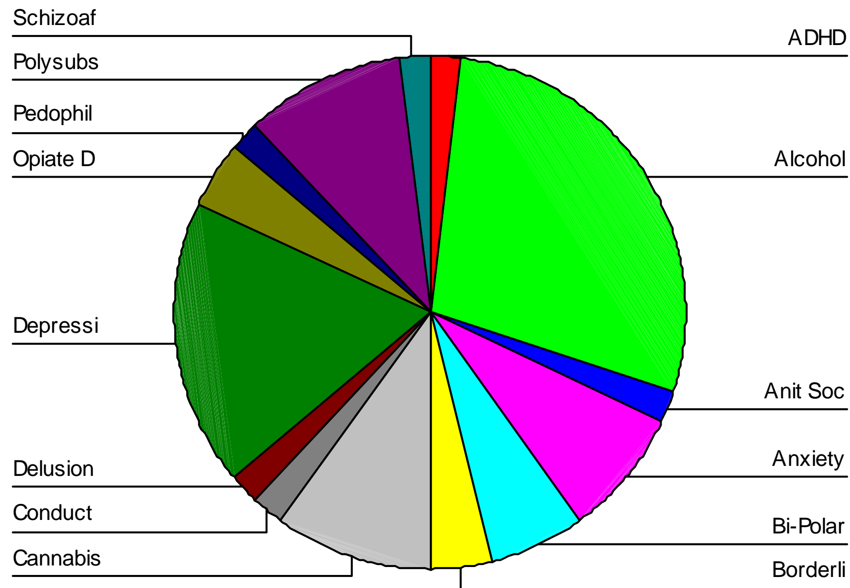

Figure 12--Primary Diagnosis

Seventy-four percent of the clients had three or more AOD Diagnosis. Of those clients with a clearly defined drug of preference, the majority (50%) identified Alcohol as their drug of choice, with Marijuana following with 28.6% of clients identifing it as their drug of choice and 11.9% identifying prescription medicaition as their drug of choice.

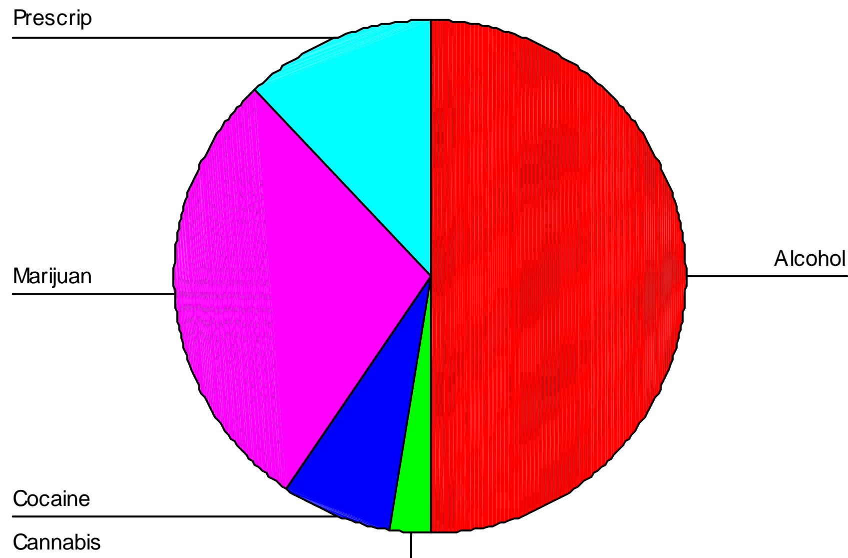

Figure 13--Drug of Choice

Twenty-six percent of the clients had a prior AOD treatment history. Of those clients with a prior outpatient AOD history, the mean number of treatment episodes was 1.25 with a range from 1 to2. Only 6% of the clients had previously particpated in residential AOD treatment and 2% had participated in Detoxification treatment.

Only 20% of the cases had AOD defined as the Standard Of Care that the client was being treated for, in spite of the fact that essentially every client that has an AOD diagnosis should have AOD defined as at least one of the SOC applied to the case. In only 24% of the cases was the SASSI administerd and none of the cases was the SOCRATES administered, in spite of these instruments being defined as critical assessment tools in the AOD SOC. In only 3% of the cases was documentation evident that the client had been referred to 12 Step Programing, 10% of the cases was documentation evident that the client participated in Drug Education, and only 8% of the cases was documentation evident tha the client completed the Worksheets defined in the AOD SOC as critical for intervention.

In the 10 cases where the AOD SOC was defined, only 30% of the time was the SASSI administered and none of the cases indicated that the SOCRATES was administered. Only 10% of the cases was the client referred to 12 Step Programming, 50% of the time the client participated in Drug Education, and only 20% of the time did the client participate in completing the worksheets outlined in the SOC.

Participation in services by service type during the client's entire length of care for the entire sample can be seen in the following table:

	Minimum	Maximum	Mean	Standard Deviation
Individual	0	311	22.42	50.59
Group	0	44	2.80	9.27
CSP	0	480	30.06	89.79
Medication	0	67	3.70	12.50
Length of Stay (Months)	1	87	12.44	17.75

When looking at only those clients who have terminated from treatment (n=29), the service breakdown is as follows:

	Minimum	Maximum	Mean	Standard Deviation
Individual	0	40	7.07	10.15
Group	0	9	.86	2.43
CSP	0	20	1.90	4.46
Medication	0	4	.24	.79
Length of Stay (Months)	1	36	6.00	8.43

The vast majority of clients terminated treatment by simply dropping out of care(44.8%). Only 6.9% of the clients completed services "successfully" as defined by a planned termination with all of the treatment goals having been met.

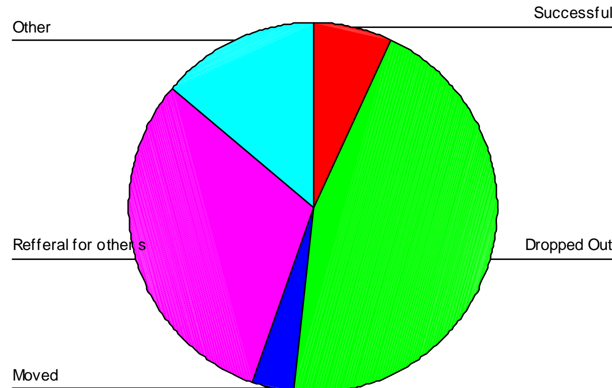

Figure 14--Nature of Termination

For the 58% of the cases that have terminated, the mean length of time since termiation was 7.5 months. Only 3.4% of the cases have a known relapse since termination (although it should be noted that little effort has been made to follow up with clients to verify relapse).

Service Efficacy

The avalable data appears insufficient to report on service efficacy with any real validity due to the lack of aggressive followup to assess relapse as well as the overall lack of compliance with the agency SOC. Based on the extreemly limited data, it does appear that even treatement services that did not comply with the agency SOC were generally much more effective in treating AOD conditions than base rates reported in national studies which reflect a relapse rate of approximately 80%. Further, the average cost of treatment during the life of the case was approximately $935, below the average expense for treatment for most other populations.

Recommendations

Based on the current program evaluation, the following recommendations are forwarded to the clinical supervisory staff:

- All staff should be trained in AOD treatment services
    - Clearly a significant proportion of clients serviced at MOPS experience AOD treatment needs—permeating throughout the treatment populations. As a result, all staff should receive at least a rudimentary level of training in AOD services.
- All staff should be required to review the agency SOC, with specific additional training provided to ensure that staff understand and can apply the SOC
    - The current program eveluation clearly indicates that, although a reasonable AOD SOC has been developed, the vast majority of clinicians either are not familure with the SOC or simply failed to comply with the SOC. Certainly, staff can not use a SOC that they are unfamilure with.
- Supervisory staff should closely monitor all treatment plans, identifying clients who have an AOD diagnosis and ensure that appropriate interventions are being utilized consistent with the agency AOD SOC
    - Ongoing monitoring for complaince with the AOD SOC is viewed as necessary to facilitate utilization of the SOC on a consistent basis the the AOD populations. Clincial Supervisors viewed as being in the best postion to facilitate this ongoing monitoring and re-education of clinical staff as needed.
- Specific follow up should be conducted to assess the maintenance of sobriety at 6 months and one year after termination.
    - It is impossible to validly assess treatment efficacy without accurate information about relapse. Given the reality that many clients will simply “disappear” from treatment, it is important to at least attempt to capture this data. Six months and one year are viewed as reasonable time frames to seek followup data, with an estimation that even with aggressive followup, less than 50% of clients will make this data available.
- A brief program evaluation should be conducted in one year to assess the agency’s ability to implement the changes noted above.

- Program evaluation has very little purpose if it does not lead to improved client care. The above recommendations should result in specific behavioral change on the part of the clinical staff and a brief program evaluation should be implemented, assessing at least the degree to which clinicians are complying with the SOC.

Appendix A
AOD Standards of Care

Assessment

In addition to the assessment tools used for a "general" program enrollment, the following assessment tools are to be utilized (assuming the client is able to read the instruments and is developmentally capable of taking the instruments):

The Substance Abuse Subtle Screening Inventory (SASSI) is to be administered during the assessment procedure for all AOD cases. The SASSI is a psychological screening measure that helps identify individuals who have a high probability of having a substance use disorder. The SASSI Institute (2001) reported that the Adult SASSI-3 identifies substance dependence with an overall empirically tested accuracy of 93%, and also indicates issues such as defensive responding, level of insight and awareness of the effects of substance misuse, evidence of emotional pain, and relative risk of involvement with the legal system. Copies of the SASSI are located in the "testing drawer" in each of the MOPS sites.

The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) is to be administered during the assessment procedure and for at least the next three ISP reviews. The SOCRATES is designed to assess client motivation to change substance use behavior, and is made up of three scales: Problem Recognition, Ambivalence, and Taking Steps. Miller and Tonigan (1996) found the SOCRATES to be an important predictor of long-term substance treatment outcomes.

When working with AOD clients, it is also very important to understand what they have done in the past to manage their usage and to identify what has been helpful and what has not been helpful for them in the past. Aid in assessing these dynamics, the Sobriety Maintenance Skills interview should be conducted.

Use of Collaterals

As part of the assessment procedure, clients will be asked to sign releases of information to obtain collateral information from sources such as previous mental health and AOD treatment providers, medical doctors, hospitals (if the client has required hospitalization for psychiatric or substance-related reasons), and other systems involved in the client's case (probation officers, Children's Services case managers, etc). Once this information is obtained, the clinician can rule out medical complications and/or mental and emotional issues occurring co-morbidly with the substance use issues. In addition, the staff nurse will review each client's

physical health information, and referrals for physical examinations and/or psychopharmacological evaluations can be given if necessary.

Other Assessment Considerations

Assessment of client readiness for change will continue throughout the program. Therapists and clients will monitor the progress of homework assignments as well as attendance and participation in 12-step meetings. In addition, therapists will communicate with referral sources to obtain collateral information necessary to determine progress in creating changes.

Physiological tools such as drug screens will give another indicator as to the client progress in creating and maintaining sobriety. MOPS will not directly conduct physiological tests, but will request findings from tests conducted by other entities. Finally, the SOCRATES instrument will be administered in each of the first three levels of treatment as a formal evaluation of client motivation level changes.

In addition to client motivation, the cognitive abilities of each client will determine the specific treatment interventions for that client. During the assessment procedure, clients will be tested for academic achievement levels. This information, along with the client presentation during the clinical interview, will help clinicians decide if cognitive deficits will be a factor in treatment. For clients with lower cognitive functioning (such as clients diagnosed with Borderline Intellectual Functioning), concrete behavioral interventions with more external motivations (such as wanting to avoid further legal system involvement) will be utilized. Conversely, clients with higher cognitive functioning will have goals related to creating discrepancies between behavior and personal values and creating a conceptual shift that will create internal motivations for change. In general, if a client is diagnosed with Mental Retardation, he/she will not be appropriate for this program. Achievement testing and clinical interview questions will help determine if cognitive deficits are present. If these tools are not sufficient to determine cognitive abilities, intelligence testing can be utilized if there is need for further data to validate the diagnosis.

Mid-Ohio Psychological Services provides general outpatient AOD services. If a client requires more intensive services (detoxification, residential treatment, inpatient treatment, or intensive outpatient services), referrals will be made for clients and/or referral sources. Clients will be informed about the limitations of general outpatient services during the assessment procedure.

Intervention

The Three-Dimensional Model Applied in Treatment

As mentioned at the conclusion of the literature review, Mid-Ohio Psychological Services will utilize a “three dimensional model” to AOD treatment. The content in this program will attempt to facilitate movement through the Stages of Change, assessing and personalizing the program to accommodate cognitive differences, and address treatment content which is consistent with research on effective AOD programs.

Facilitating Stages of Change

As participants progress toward treatment goals at each level of the program, there are interventions that may help clients cognitively create increased readiness for change. In general, therapists will assist clients in the following ways:

1. Expressing empathy, which will be created through techniques such as reflective listening and normalizing ambivalence.

2. Developing discrepancies, which will be created through techniques such as helping the client argue for change and creating discrepancies between behavior and personal values.

3. “Rolling with resistance”, which will be created through techniques such as not arguing for change or opposing resistance, inviting new perspectives and assisting client with finding answers.

4. Supporting self-efficacy, which will be created through techniques such as recognizing that the client’s belief in change is a key motivator for change, monitoring client response to change and client self-fulfilling prophecies.

Managing Cognitive Differences

As mentioned earlier, each client’s cognitive level will be assessed prior to the initiation of treatment. Each client will be given informational material early in treatment, and will be expected to fill out homework assignments as the program progresses. If clients are having difficulties with these requirements, clinicians will assist them in session as necessary. If additional sessions are necessary to work on homework assignments, clients can arrange with clinicians for this to occur. It will be important for clinicians to monitor how well clients understand treatment concepts, as the program is designed to utilize the topics learned when each client develops a relapse prevention plan. If clients continue to have difficulties in spite of additional assistance, adjustments can be made to the program to integrate a more skills-based approach.

Additional Client Treatment Needs

Clinicians will assist clients in taking the broad concepts of AOD treatment, and personalizing it to for the unique needs of the client. If any co-morbid mental or emotional disorders are present, clinicians will address these issues as part of treatment. There typically will not be a need for clients to seek additional services outside of this agency for this reason. As clients progress in the program, it is possible that additional treatment issues may arise, and treatment plans can be amended to address these issues. Each client will be treated as an individual, and each client works with the clinician to create treatment plans.

The Content of Treatment

Each level of treatment will recognize the behaviors and unique therapeutic challenges that participants will face. These include the following:

Stage	**Behaviors**	**Therapeutic Challenge**
Precontemplation	No intent to change, under-awareness, pros outweigh cons, no self-efficacy, demoralized by past failed attempts, coercion, denial, resistance	Teach clients about effects of substance abuse and risks associated with their use, help build client sense of self and identify barriers to recovery.
Contemplation	Thinking about making a change, information seeking, evaluating pros and cons, no concrete change effort enlisted	Teach clients about effects of substances of abuse and risks associated with their use, enhance motivation for change.
Preparation	Developing concrete strategies and solutions, time line for change is within one month, tentative actions may be taken, aware of lessons in	Enhance motivation for change and help participant make behavioral plans to support impending change.

	past failed attempts, links Contemplation to Action via determination	
Action	Active engagement in behavior change (<6 months), skills acquisition, employing strategies to control behavior and behavioral contexts, transtheoretical	Identify relapse triggers, help participant recognize symptoms of impending relapse.
Maintenance	Sustaining gains, avoiding/preventing relapse, termination when confident and secure in maintaining change	Ensure stability of change and help participant identify and cope with any personal issues that might be a threat to recovery program.

The goals at each level of treatment are as follows:

Level One- Precontemplation

G1) Client will gain knowledge about substance abuse

O1) Increased recognition of basic costs of substance abuse and destructive behaviors, as evidenced by completion of self-assessment of behaviors

G2) Create awareness of impact of substance usage

O2) Process denial, resistance, and ambivalence issues, as evidenced by higher SOCRATES scores and client self-report of consideration of change

G3) Assess desire for community-based support

O3) Attend at least 6 “Lead” meetings within 30 days

Level Two- Contemplation

G1) Create awareness of impact of substance usage

O1) Process denial, resistance, and ambivalence issues, as evidenced by higher SOCRATES scores and client self-report of consideration of change

G2) Assess readiness for community-based support

O2) Attend at least 8 12-step meetings within 30 days, ½ of which will be “Lead” meetings, increase in client self-report of desire to learn more about 12-step process

G3) Client will evidence increased knowledge about substance abuse

O3) Increased insight into substance abuse, as evidenced by obtaining passing score on identification test

Level Three- Preparation

G1) Enter and maintain sobriety

O1) No instances of substance use or criminal behavior, as evidenced by random drug screens, contact with probation officers/ case workers, and client self-report, eliminate immediate triggers (substances in immediate area)

G2) Create community-based support

O2) Attendance at least two 12-step meetings per week, ½ of which will be “Discussion” meetings, obtain a self-help sponsor and maintain weekly contact, increased willingness to utilize “dry faces, dry places” concept in creating personal environment

G3) Completion of “step” assignments

O3) Satisfactory completion of worksheets detailing Steps one through four of the 12 steps

G4) Create commitment for change

O4) Increased ability to provide self-motivational statements during interview, increase in self-efficacy in regards to making change SOCRATES scores which indicate higher level of readiness for change

Level Four- Action

G1) Maintain sobriety

O1) No instances of substance use or criminal behavior, as evidenced by random drug screens, consultation with probation officers/case workers and client self-report, increase in implementation of coping skills other than substances

G2) Maintain community-based support

O2) Attendance at least two 12-step meetings per week, maintain weekly contact with self-help sponsor

G3) Completion of relapse prevention assignments

O3) Satisfactory completion of relapse prevention worksheets, increased ability to identify high risk situations, direct and remote linkages, and support system during sessions

Level Five- Maintenance (Mastery level or following relapse)

G1) Maintain sobriety

O1) No instances of substance use or criminal behavior, as evidenced by random drug screens, consultation with probation officers/case workers and client self-report, increase in implementation of coping skills other than substances for at least six months

G2) Maintain community-based support

O2) Attendance at one 12-step meeting per week and give at least one "Lead", maintain weekly contact with self-help sponsor

G3) Process relapse prevention issues

O3) Increased ability to avoid high-risk situations, increase in appropriate coping skills for direct and remote linkages, and increased utilization of support system per client report and consultation with probation officers/case workers

Specific interventions will be utilized to carry out these goals for each level. As mentioned earlier, each client's cognitive functioning level will be taken into account in creating treatment interventions. In addition to the simplification of questions on homework assignments, clinicians will work with clients who are having difficulties with the comprehension of treatment concepts and educational materials. However, all clients will be expected to complete assignments, regardless of cognitive functioning levels.

During the first two levels of treatment (Precontemplation and Contemplation), clients are to be provided education regarding the drug(s) of choice. Educational materials will be provided on alcohol, cannabis, cocaine, amphetamines, hallucinogens, barbiturates, narcotics, and inhalants. Clients will be

formally evaluated on their knowledge of their drug(s) of choice, and these evaluations will be utilized as part of the process of moving into Level Three. Also, clients will be expected to attend 12 step meetings at these levels. At Level One, clients will have 30 days to attend six "Lead" meetings, and at Level Two, clients will have 30 days to attend eight meetings, ½ of which will be "Lead" meetings. Attendance at these meetings will be utilized as evidence of motivation levels, as well as determining if the client is learning introductory material that will be helpful later in the program. Clients will be expected to provide written verification of attendance at these meetings.

Once clients progress into Level Three (Preparation), they will require information on other important issues related to recovery. The educational resources will include symptoms and warning signs that can lead to relapse, as well as short-term relapse prevention planning. A more thorough and complete relapse prevention plan will be created in Level Four treatment. Additional information will be given on the process of recovery, hangovers, having good times without substances, cravings and withdrawal symptoms, information on viral hepatitis, an introduction to the twelve steps. This information will be utilized according to the presenting needs of each client. If needed, other educational materials can be added. In addition, clients will be completing homework assignments that personalize each of the first four of the 12 steps to their addiction (Worksheets 1, 2, 3, 4). Clients will also be expected to attend 12-step meetings twice a week, avoid criminal behavior, and obtain a self-help sponsor during this level in order to progress to Level Four.

Once clients have moved into Level Four (Action), they will be expected to utilize the concepts they have learned in order to create a formalized Relapse Prevention Plan. Clients will be provided information regarding high-risk situations and direct and remote linkages to these situations. Clients will also be completing a series of Relapse Prevention assignments (Worksheets 1, 2, 3, 4, 5). In these assignments, clients will be asked to identify high-risk situations, past destructive events, historically dysfunctional feelings and thought patterns, behavioral coping skills for these feelings and thought patterns, identifying supportive versus enabling environments, and testing the coping skills in the community. Clients are expected to continue with attendance at 12-step meetings, avoid criminal behavior, and maintain regular contact with their self-help sponsors.

Clients at Level Five will have different expectations than one another. Mandated clients can graduate from the program on a satisfactory level if they leave after completing Level Four. If a mandated client wishes to continue in the program voluntarily, he/she may finish the program on a "Mastery Level" with completion of Level Five, and a period of sobriety of greater than six months. This will indicate that the client has received "maximum medical benefit" from the program. Former clients who have completed Level Four and who have relapsed will be revisiting concepts from Levels Three and Four in order to determine the reasons behind relapse, and the relapse prevention plan will be amended if necessary. However, clients will not be expected to do the specific homework assignments again. The specific interventions at this level will be decided upon by the client, but each client will be expected to maintain weekly attendance at 12-step meetings and will give a "Lead" during at least one meeting, refrain from criminal activity and substance use, utilize appropriate coping skills for high risk situations, and identify current and potential linkages to these situations.

Communication with Interested Parties During the Treatment Process

In addition to treatment interventions and client participation in program criteria, outside systems/ caregivers will be an important part of the program process. Prior to initiating the program, therapists will communicate with referral sources to obtain any specific treatment recommendations that these sources believe need to be addressed. Therapists will strive to maintain regular contact with persons involved in the client treatment when appropriate. These persons can include court personnel, Children's Services caseworkers, and treatment providers from any referring agencies. If a client has been referred by an outside entity, the participant will be required to sign a release of information allowing for communication with that entity as long as the client is in the program.

Mid-Ohio Psychological Services will provide periodic reports to referral agencies of treatment progress and client behavior. This can be in the form of informal telephone conversations or in person contact, or in more formalized forms such as treatment summaries or letters. In providing this communication, the rules of confidentiality will be adhered to by the therapist

Termination

Discharge Criteria

Clients will be discharged from the Alcohol and Drug Treatment program under the following conditions:

1. Successful mastery of the goals and objectives identified in the Individual Service Plan through Level 5 treatment

2. Minimal completion of the requirements identified in the Individual Service Plan through Level 4 or Level 5 treatment

3. Being administratively discharged, having completed some of the treatment goals identified on the Individual Service Plan

4. Unwillingness to participate in goals and objectives identified in the Individual Service Plan in Level 1 treatment, thus indicating continued unwillingness to consider making changes

5. Administratively discharged for disciplinary reasons such as being disruptive during therapy sessions or complete unwillingness to participate in treatment goals and objectives at any level of care

Upon discharge from the Alcohol and Drug Treatment program, a summary will be sent to referral sources indicating goals completed while participating in the program, level of treatment identified upon discharge, and motivation levels identified during treatment. This information will be based upon the client's participation in the program, the client motivation

levels at discharge, the client's established program of relapse prevention at the time of discharge, and a comparison to other individuals who have previously abused the client's drug of choice.

Program Evaluation

An integral component of the AOD program is an ongoing program evaluation component. This program evaluation will assess the fidelity to "best practice" concepts and will assess the efficacy of the treatment.

Periodic reviews of specific programs at Mid-Ohio Psychological Services are completed as part of the Quality Assurance reports generated by this agency. In future reviews of the AOD program, one important aspect to be assessed is whether the program is being implemented according to the "best practice" of the profession. This includes issues such as quality and thoroughness of data gathered during the initial assessment and screening of each client, identification and adjusting to the special needs a client may present with, and whether the program is operating under the ethical constructs of non-malfeasance, beneficence and autonomy/least restrictive environment.

In order to assess the issue of "best practice", future program reviews will need to focus on two areas. First, an internal peer review can focus on various aspects of the programs implementation. This can include completeness of intake information, selected issues during treatment, and completion of the core components of the program. These issues can help answer the question of whether the program staff operates in a faithful manner to "best practice" in carrying out the AOD program.

The second area to address is whether the program functions according to accepted treatment protocols. As evidenced in the first portion of this report, this program has been created utilizing research-based theoretical orientations. Future reviews can focus on whether the program is being implemented according to these orientations.

Assessing Efficacy of Treatment

Outcomes and Cost Effectiveness of Treatment

Another important measure of program effectiveness which can be addressed in future program reviews is whether the AOD program is being implemented and generating outcomes

that will satisfy both internal and external evaluators of the program. At an internal level, cost effectiveness reports can determine how the cost of treatment for individual clients is related to the cost of treatment in similar outpatient programs, as well as comparisons to other options for clients (incarceration, inpatient rehabilitation, intensive outpatient rehabilitation, etc).

Self-Report

While the general goals of the program will be similar for all participants, clients will be communicating with clinicians regarding the effectiveness of specific interventions throughout the course of the program. In addition, clients will be self-reporting progress on sobriety during treatment, as well as identifying potential high-risk situations and linkages to these situations. This information will be utilized during treatment to help clients maintain safety while in recovery. Clinicians will utilize this information to determine progress on the understanding of treatment concepts.

Addressing Client Needs

During the assessment procedure, clients will communicate needs for treatment. These will include needs related to mental and emotional health as well as substance-related needs. During each level of treatment clients will be encouraged to communicate whether needs are being met and treatment plans can be amended as additional client needs arise. Because treatment is client-centered, successful completion of a treatment goal indicates that a client need has been satisfied.

Client Satisfaction Surveys

Upon completion and/or termination from this program, clients will be asked to give feedback on the effectiveness of treatment. This confidential survey (See Appendix G) will provide this agency with information regarding a variety of treatment issues. The results of this survey will not be communicated with referral sources or used by clinicians to measure client compliance with treatment. Rather, this information will be utilized as part of future program quality assurance reviews.

Referral Source Surveys

Communication with referral sources is an important aspect of this program. Periodically these sources will be asked to provide feedback on several issues, including whether the program is fulfilling the needs of these referral sources. It is important to note that this structured program is being created at this time because of the perception that additional AOD services are needed in Fairfield County, and these perceptions were initiated by an initial referral source survey conducted by Mid-Ohio Psychological Services in the spring of 2005.

Follow-up Contact After Client "Termination"

Once clients have completed or terminated from the AOD program, there will be opportunities to follow-up with clients to assess if they are continuing with recovery, and to assess if any additional services will be necessary to better ensure sobriety. Clients are to leave contact information during final sessions, and clients will be contacted within 60 days to obtain this follow-up information. In keeping with agency policy, clients will also be notified in writing approximately six months following termination, and are invited at that time to re-engage in services if necessary. If clients choose to not respond, their cases will then be closed. After that time, clients may return for treatment, but must have another diagnostic intake in order to obtain updated psychosocial and AOD information.

Clients will be discharged from the Alcohol and Drug Treatment program under the following conditions:

1. Successful mastery of the goals and objectives identified in the Individual Service Plan through Level 5 treatment

2. Minimal completion of the requirements identified in the Individual Service Plan through Level 4 or Level 5 treatment

3. Being administratively discharged, having completed some of the treatment goals identified on the Individual Service Plan

4. Unwillingness to participate in goals and objectives identified in the Individual Service Plan in Level 1 treatment, thus indicating continued unwillingness to consider making changes

5. Administratively discharged for disciplinary reasons such as being disruptive during therapy sessions or complete unwillingness to participate in treatment goals and objectives at any level of care

Upon discharge from the Alcohol and Drug Treatment program, a summary will be sent to referral sources indicating goals completed while participating in the program, level of treatment identified upon discharge, and motivation levels identified during treatment. This information will be based upon the client's participation in the program, the client motivation levels at discharge, the client's established program of relapse prevention at the time of discharge, and a comparison to other individuals who have previously abused the client's drug of choice.

APPENDIX B

AOD Chart Review

Client Name: ___________________________ Chart ID:______________________

Gender: M/F Age at Intake: ________ County of Residence:_____________

Marital Status: ________ Living with spouse at time of treatment: Y/N

Number of Children:________ # in Home:_________ # in Placement:__________

Payment source: Grant(Sliding Scale) Medicaid Self Pay

Referral Source: ____

Index Offense(s): ____

Prior AOD related offenses: ___________

History of stable employment: Y/N

Currently employed: Y/N

Estimated IQ range: __________ History of Learning Problems: Y/N

Prior MH Diagnosis: ____

Current MH Dx:

Primary

Secondary

Tertiary

Testing Administered: SASSI Y/N SOCRATES Y/N

Referrals to 12 Step Program: Y/N Drug Education: Y/N

Use of structured AOD Worksheets: Y/N

Successful completion of program: Y/N

Nature of termination:

Successful/ Dropped Out/ Kicked Out/ Moved/ Referral for other services

Prior AOD treatment: Y/N

Episodes of

Residential: ________ Detox:_________ IOP:________ OP:__________

Age of first use of Alcohol/Illicit Substance: ___________

Drug of Choice: ____________________ Poly Substance Use: Y/N

Sessions during this treatment episode:

____ Individual ____ Group ____ CSP ____ Medication

Length of treatment episode in months: ____________________

Current SOC for AOD: Y/N

Length of time since program completion in months: ___________________

Any known relapsed: Y/N

Any subsequent offenses: Y/N

List subsequent offenses: