THE DESIGN OF AN EVALUATION MODEL FOR AN OUTPATIENT ALCOHOL AND DRUG ABUSE TREATMENT PROGRAM

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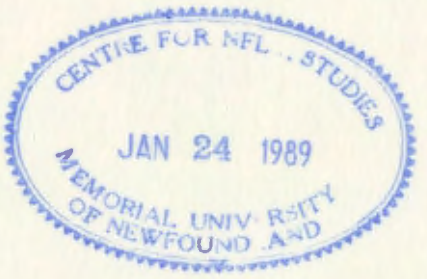
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The Design of an Evaluation Model for an Outpatient Alcohol and Drug Abuse Treatment Program

by

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Abstract

This study presents a treatment outcome evaluation model designed for the Waterford Hospital Addictions Program, St. John's, Newfoundland. Because this program operates under the constraints of limited resources, the researcher endeavored to design a model that enables program personnel to conduct manageable but methodologically sound program evaluation. The following factors guided the development of the proposed model: (a) a review of the state of the art evaluation technology, and (b) a preliminary evaluation of the Addictions Program based on an analysis of present implementation policies and procedures, and on a survey of participants' perceptions of the program. The purpose of the survey was three-fold: (a) to conduct a preliminary evaluation of the effectiveness of the Addictions Program, (b) to provide a basis for selecting measures of treatment outcome success for inclusion in the proposed model, and (c) to determine the usefulness of the questionnaire (Appendix C) for inclusion in the proposed model.

The model includes forms designed to facilitate the gathering and recording of information deemed necessary to demonstrate the impact of the Addictions Program on clients. The rationale for instrumentation and guidelines for implementation are provided.

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The Design of an Evaluation Model for an Outpatient Alcohol and Drug Abuse Treatment Program

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Statement of Problem and Rationale for Study

Although substance abuse treatment is receiving increased focus as a specialized practice area for social workers and other allied health professionals, doubts about the effectiveness of treatment continue. Freeman (1985) proposes several reasons for this: the high dropout rate from treatment programs, high recidivism rates, high relapse rates, and lack of empirical knowledge regarding the effects of varying treatment approaches on specific types of clients. While these factors contribute to a recognized need to evaluate systematically the effectiveness of substance abuse treatment, most clinical programs lack an evaluation component (Whitehead & Ogbourne, 1985).

Historically, evaluation studies in the substance abuse field have been primarily implemented in research rather than clinical programs (Sobell, 1979). The applicability of this research to the evaluation of clinical programs is limited for several reasons: (a) Whereas researchers are primarily concerned with testing and building theory, evaluators of clinical programs are primarily interested in questions directly relevant to a specific program; (b) requirements necessary to satisfy methodological

standards for experimental research are unmanageable for clinical settings; (c) usually, clinicians have limited knowledge of research design, and with their other responsibilities lack the skills and time to implement the type of research common to academic researchers; and (d) typically, such research designs are too expensive for clinical programs. These factors constrain the conduct of program evaluation in clinical settings and point to the need for more reasonable criteria enabling program personnel to conduct simpler but methodologically sound program evaluations (Gottheil et al., 1981; Spicer, 1980; Whitehead & Ogbourne, 1985).

This study is concerned with the Waterford Hospital Addictions Program. This program provides outpatient, combined treatment for alcohol and drug abusers. Social group work is its primary treatment method (see Appendix A for Program Description). Although this program has operated since January, 1982, prior to the present study no systematic attempt has been made to assess its effectiveness. Because the Addictions Program operates under the constraints of limited resources, the purpose of this study is to design a prospective evaluation model that will enable program personnel to conduct manageable but rigorous and systematic treatment outcome studies. Several factors provide the basis for this model: (a) a review of the state of the art evaluation technology, and (b) a

preliminary evaluation of the Addictions Program based on an analysis of present implementation policies and procedures, and on a survey of participants' perceptions of the program.

The possible implications of this study are as follows: (a) The preliminary study may justify the hospital's allocation of staff and space to the program as well as provide a basis for better services to group members; (b) the proposed model may enable evaluation to become an integral component of the Addictions Program, and may identify service needs, suggest intervention strategies, monitor program implementation, and determine the impact of the program on clients; and (c) the proposed model may be adapted for use by other alcohol and/or drug treatment programs.

The Concepts

Evaluation research is defined by Patton (1978) as ... "the systematic collection of information about the activities and outcomes of actual programs in order for interested persons to make judgements about specific aspects of what the program is doing and affecting" (cited in Spicer, 1980).

Process evaluation refers to an evaluation approach that focusses on the activities or treatment components of a program rather than the impact of a program on clients.

Outcome evaluation refers to an evaluation approach which determines the effects or impact of a program on clients.

Prospective evaluation model refers to a model that is preplanned rather than retrospective. This approach allows the collection of adequate baseline information necessary for comparisons of clients' status at intake and following treatment.

Substance abuse treatment refers to the treatment of alcohol and drug abuse.

Review of the Research

Scope of the Substance Abuse Problem

Alcohol and drug abuse are major health and social problems that affect not only the substance abuser but indirectly, the lives of many others. An estimated 12,011 to 15,859 Newfoundlanders are alcoholics (Field, 1986). If this estimate is multiplied by the suggested four or five individuals indirectly affected by each alcoholic (Royce, 1981) there is a possible total of 79,295 Newfoundlanders affected by alcohol abuse. A provincial estimate for total other drug use is not available (Alcohol and Drug Dependency Commission of Newfoundland and Labrador, personal communication, June 17, 1986).

Alcohol and drug abuse impact on individuals in many forms (e.g. child neglect, family violence, divorce, forcible rape, beatings, stabbings, homicides, suicides and traffic accidents) (Emerick & Hansen, 1983). In addition, substance - related problems cost our society millions of dollars through lost work time, damage to property, and utilization of social welfare, medical and other treatment services. The total estimated expenditure attributable or associated with alcohol abuse from 1982-1983 for Newfoundland and Labrador is $56,279,083 (Field, 1986). This estimate includes the following components - health care, criminal justice, social services, lost production,

fire protection and alcoholism prevention and rehabilitation programs. An estimate for total expenditure for other drug use costs is not available (Alcohol and Drug Dependency Commission of Newfoundland and Labrador, personal communication, June 17, 1986).

Despite the vastness of the problem in terms of both monetary and human costs the majority of substance abusers never receive formal treatment for their primary disorder (Estes and Heinemann, 1986). For those that do, only cautious estimates can be made regarding the effectiveness of their treatment because of the lack of methodologically sound program evaluations of substance abuse treatment (Sobell & Sobell, 1982).

Attempts to understand and deal with this complex phenomenon have resulted in various conceptualizations, theories of causality, treatment approaches and evaluation strategies. A review of these developments follows.

Traditional Conceptualizations

Researchers recognize the commonalities between alcohol and drug abuse in terms of etiology, process, and treatment (Miller, 1980). Traditionally, both have been approached using the medical model (Wright, 1985). Therefore, although the following discussion applies specifically to alcohol abuse, these conceptualizations have influenced the drug field and consequently have relevance for both.

Moral model. Until the early twentieth century, alcoholism was conceptualized as a sign of moral weakness rather than a symptom of physical, psychological or social factors. Afflicted individuals were typically dealt with through the legal-judicial system (Maisto & McCollam, 1980; Tarter & Sugerman, 1976).

Medical model. E.M. Jellinek is credited with making the first major attempt at a scientific formulation of the alcoholism syndrome. He is a chief exponent of the disease concept. Caddy (1980) summarized this model as positing alcoholism as a unitary disease, in which all persons so afflicted are substantially the same: They experience a similar progressive deterioration characterized by loss of control over alcohol.

Many theories are subsumed under this model. For example, genetic theories explain alcoholism as an inherited disease. Some biochemical theories posit that certain people are born with a body chemistry that makes them susceptible to becoming addicted to alcohol. Other biochemical theories posit that excessive drinking may cause one's body chemistry to alter, leading to alcoholism (Tarter & Sugerman, 1976; Ward, 1980). With the emergence of the medical conceptualization, the moral model declined and alcoholism became recognized as a medical rather than a legal problem.

Alcoholics Anonymous. Proponents of this model also define alcoholism as a disease. They believe the alcoholic has an allergy to alcohol (disease of the body) combined with a craving for alcohol (disease of the mind). The model posits that the potential alcoholic is both psychologically and biologically different from the nonalcoholic. Drinking alcohol, according to this model, causes alcoholism in the individual who is susceptible to the disease (Caddy, 1980; Ward, 1980).

While the traditional models have substantive differences, they have common assumptions which have influenced treatment and treatment outcome evaluation in the substance abuse field. Pattisson, Sobell and Sobell (1977) summarized these assumptions as follows:

> (a) alcoholism is a distinct entity that can be described and recognized, (b) alcoholics and prealcoholics differ in some essential way from nonalcoholics, (c) alcoholics may sometimes experience a perceived physical craving for alcohol or a strong psychological compulsion to drink, (d) alcoholics gradually develop a process called loss of control over drinking (physical dependence on alcohol), and possibly an inability to stop drinking, and (c) alcoholism is a progressive, permanent and irreversible condition (cited in Maisto & McCollam, 1980).

These assumptions have implications for substance abuse treatment and treatment outcome evaluation: (a) Treatment is designed to deal with the disease rather than with the afflicted individuals, (b) abstinence is considered the only criterion for successful treatment, and (c) improvement in other areas of life functioning is believed unlikely unless abstinence is achieved and vice versa (Maisto & McCollam, 1980).

The most controversial of these issues is the reliance on abstinence as the only successful treatment outcome. Sobell (1978) summarized the implications of this assumption:

> (1) It excludes the possibility of partial improvements. (2) Abstinence has not been consistently related to marked improvements in other areas of life function. (3) Changes in or cessions of drinking behavior are not easily measured because there are no readily available ways to validate this measure. (4) Drinking is a multifaceted behavior; to use a single dichotomous index (sober or drunk) to reflect drinking behavior prohibits evaluation of multiple components of drinking patterns and the relationship of drinking behavior to other outcome variables (cited in Caddy, 1980, p. 156).

Etiology and Treatment

The numerous theories of causality include genetic, biochemical, psychoanalytic, personality, learning, transactional analysis and sociological theories (reviewed in Senesac, 1981; Tarter & Sugerman, 1976). Combinations of these theories may be recognized in the various treatment modalities available to the substance abuser.

Some researchers (Miller, 1980; Tarter & Sugerman, 1976) believe that this multifaceted stance on the etiology of substance abuse is necessary due to two factors: (a) No one theory has been proven to be the correct theory; and (b) although substance abusers present with an array of associated behavioral, familial and vocational problems, etiology and motivation are often unclear.

Treatment modalities include inpatient (or residential) and outpatient settings involving short-term intensive treatment or long-term care (Royce, 1981). Treatment may vary in orientation from individual therapy, family therapy, group therapy, or include a combination of these.

Numerous treatment approaches are practiced within each of these modalities. For example, treatment approaches that are offered primarily as individual therapy include drug therapies, aversion therapies, hypnosis, and psychotherapy (reviewed in Miller, 1980; Royce, 1981).

Family therapy for substance abusers ulilizes many and diverse theoretical models and interventions. For example,

some therapists base their treatment on the premise that substance abuse causes marital discord whereas other therapists view the substance abuse as a consequence of the marital problems (Miller, 1980). Treatment techniques may include confrontation, role playing and role reversal. The therapist aims to help family members recognize how they contribute to the substance abuse process and to teach them alternative behavioral responses which may help break the process (Ward, 1980).

Group therapy, as a treatment approach for substance abusers, has been practiced since the 1940's following World War II, due to a need for a cost-effective method for treating large numbers of individuals. Included among the models for conducting groups are psychodrama, reality therapy, transactional analysis, experiential, educational, and interactional (cited in Miller, 1980). Although there are enormous variations in treatment orientation, a consensus exists amongst professionals on the efficacy of the therapeutic group as an agent of client change (Vannicelli, 1986). In fact, the popular belief is that group therapy represents a superior treatment method for substance abusers (Miller, 1980).

Yet, despite the widespread use of these treatment methods and the good intentions of treatment personnel, at present there are few data to recommend one method over another. Some researchers note little or no empirical

support for alcohol and drug abuse treatment (Miller, 1980). The reason for this is that traditional evaluation methods and techniques usually have not been adequate to document the effectiveness of treatment outcome (Sobell & Sobell, 1982).

Traditional Evaluation Methods

Program evaluation as a specialized function is essentially a post-World War II phenomenon (Schulberg et al., 1969). The increased focus on evaluation within the field of mental health is attributed to mandates requiring health services to become more accountable. The demand for evaluation of clinical treatment services reflects a series of factors including: enormous growth in health care costs, limited resources, increasing demands for services, as well as the ethical obligation to provide knowledgeably appropriate and effective services to meet the special needs of selected populations.

Over the past quarter century many program evaluation models have been developed including goal-attainment, goal-free, transactional, decision-oriented, systems, behavioral, and the CIPP (Context, Input, Process, Product) models (selected models reviewed in Isaac & Michael, 1985; Meenaghan et al., 1982; Senesac, 1981; Schulgberg, 1969).

Traditionally, evaluation models used to evaluate mental health and substance abuse treatment programs were

guided by a "summative" paradigm aimed at evaluating the finished product rather than program processes. Within this client input - treatment - outcome paradigm, the treatment program was the only determinant of client posttreatment functioning examined. This paradigm has since been expanded to include the examination of the relationship between treatment entry, duration and outcome, and (a) specific treatment program components (processes), and (b) extratreatment factors such as clients' family and work settings (Finney & Moos, 1984; Moos & Finney, 1983).

This study is concerned with treatment outcome evaluation. This type of evaluation determines the effects or impact of a program on its clients and may be either summative or formative. In contrast to summative studies, formative studies provide data to program personnel during the course of its operation for the purpose of enhancing program development or improvement (Spicer, 1980).

Within the substance abuse treatment field, traditional program evaluation methods have encountered many problems. To help avoid repeating them a review of these problems is pertinent.

Overview of Methodological Problems in the Study of Treatment Outcome

Between 1942 and 1977, six major critiques of the alcoholism treatment outcome literature were published

(Crawford & Chalupsky, 1977; Emrick, 1974; 1975; Hill & Blane, 1967; Miller et al., 1970; Voegtlin & Lemere, 1942). Goldstein et al. (1984), Sobell (1978), and Voris (1986) reviewed these publications. Maisto and Cooper (1980) reviewed both alcohol and drug abuse treatment outcome evaluation studies. The consensus of these reviewers is that treatment outcome studies of that era were replete with major methodological problems which seriously hampered their validity and generalizability. Among the inadequacies consistently reported are lack of random assignment to control groups, use of retrospective rather than prospective treatment outcome studies, use of insensitive outcome measures, use of questionable data collection methods, and limited follow-up techniques. In recent years researchers have addressed these problems in the hope of formulating more scientific treatment outcome methodologies. These problems are discussed below.

Lack of randomization. Random assignment of subjects to treatment conditions occurred very infrequently in the fields of alcohol and drug abuse. Maisto and Cooper (1980) explained that this limitation has major implications for evaluation research since random assignment" ... assures that differences in group outcome results are not an artifact of pretreatment differences between the groups" (p.2).

Lack of prospective research designs. The lack of proper controls is partly explained by the prevailing tendency to engage in retrospective rather than prospective treatment outcome evaluation studies. Such studies severely limit the researcher's ability to collect adequate baseline data. Therefore it is usually not possible to measure changes in a subject's behavior from pretreatment to posttreatment and follow-up (Sobell, 1978). Often, even demographic data on preattrition clients are not reported. Goldstein et al. (1984) noted that this is of major significance to substance abuse programs because of their often high and selective drop-out rates.

Lack of adequate outcome measures. The field of alcohol and drug abuse has been widely criticized for using inadequate outcome measures (Cohen et al., 1976; Pomerleau & Adkins, 1980; Sobell & Sobell, 1982). Traditionally, the main criterion of treatment outcome in these fields has been drinking and/or drug ingestion behaviors (Maisto & Cooper, 1980). These authors noted that the use of such dichotomous measures as drinking/abstinent or drug-free/addicted restricts the definition of treatment outcome. These absolute measurement scales have not allowed for either interpretation of degrees of treatment success in regard to the drinking and/or drug ingestion behaviors or evaluation of treatment success in other areas of life functioning.

Reliability and validity of outcome data. Traditionally, this issue received limited attention despite the fact that in both the alcohol and drug abuse fields most treatment outcome measures are based on clients' self-reports. In recent years, researchers (e.g. Sobell et al., 1974; Sobell & Sobell, 1975; 1978; Cooper et al., 1980; 1981) have directed their efforts towards establishing the validity and reliability of substance abusers' self-reports (cited in Polich, 1982).

Follow-up of substance abusers. Most alcoholism treatment programs reported follow-up rates below 75% (Hill & Blane, 1967). Reviews of drug abuse literature reveal that follow-up losses varied from 10% to 90% (Cohen et al., 1976; Smart, 1976). Citing the investigations of others (e.g. Backeland et al., 1975; Gearing, 1970; Miller et al., 1970; Moos & Bliss, 1978; Sobell & Sobell, 1976), Maisto and Cooper (1980) noted that the attrition problem in follow-up studies is important because substance abusers who are not easily located at follow-up tend to function worse than those who are more easily located. The authors concluded that high attrition rates tend to positively bias outcome results because the sample typically consists of the better functioning subjects. Therefore, follow-up attrition must be minimized if valid and unbiased outcome results are to be obtained. A review of the state of the art on

evaluation technology in this field indicates advancements which help overcome these problems.

The State of the Art

Over the past two decades scientific research has produced evidence which has resulted in the reformulation of traditional concepts of alcohol and drug abuse as well as significant improvement in treatment outcome evaluation. Sobell and Sobell (1982) attributed these findings to three factors:

The first factor was derived from behaviorally-oriented treatment programs and approaches. This orientation calls for the operational definition and measurement of the behaviors under study, including the drinking and/or drug ingestion behaviors.

The second factor was the emergence of "controlled drinking" treatment outcome reports. This treatment goal necessitated the development of more sensitive and valid outcome measures (e.g., amount of alcohol consumed per day, breath tests and liver function tests)." ... this type of measurement has subsequently allowed for more precise quantification of drinking in the evaluation of all alcohol treatments" p.(295).

The third factor was the reports of differential treatment outcomes with different populations of alcohol abusers. Not only have pretreatment and posttreatment

functioning levels been found to differ among various groups, no correlation between improvement in drinking level and other areas of life functioning has been demonstrated. In fact, Sobell and Sobell (1982) reported totally abstinent alcoholics evidencing deteriorations in other areas of life health and vice versa. They concluded that multiple-outcome measures are needed in order to adequately evaluate treatment programs.

As a consequence of these research developments and the resulting recognition of the limitations of traditional models, multivariate approaches to the study and treatment of alcohol and drug abuse have emerged. Maisto and Cooper (1980) summarized this conceptualization as follows:

> Multidimensional models are based on the premise that drug and alcohol abuse are complex behavioral patterns that (1) have multiple causes, (2) can affect any individual, (3) can be treated by a variety of therapists in a variety of settings with a variety of techniques and (4) treatment can be designed to affect multiple areas of life health (p. 9).

In contrast to traditional models, the multivariate model has the following implications for treatment outcome evaluation studies (Caddy, 1980):

First, this approach advocates the collecting and reporting of outcome data in a manner that allows for assessment of changes in individual patients. This

necessitates using pretreatment and posttreatment comparison measures of treatment outcome, allowing for recognition to be given to degrees of improvement.

Second, the collection of data on multiple measures of treatment outcome (i.e. drinking and/or drug ingestion behaviors as well as behavior in other areas of life functioning such as employment, interpersonal relationships etc.) enhances the validity of treatment outcome evaluation studies by presenting a more complete picture of treatment outcome.

With this conceptualization of substance abuse treatment, improved evaluation measures and techniques have emerged. Many researchers recommend guidelines for methodological requirements ensuring good treatment outcome evaluations (Emrick & Hansen, 1983; Tims & Holland, 1984; Treffert et al., 1976). These recommendations are similar to those developed by Sobell and Sobell (1982). These recommendations and a summary of the authors' explanation of their importance follows:

Plan evaluation prior to study. Planned assessments facilitate obtaining adequate baseline (pretreatment) measures required for valid interpretation of outcome data. Other advantages include: (a) Subjects can be briefed about the follow-up before treatment begins, (b) their compliance with follow-up procedures can be requested, and (c) follow-up tracking data (e.g. addresses, phone numbers,

collateral contacts) and the necessary releases for information can be obtained.

Operationally define subject populations, treatments and outcome measures. Adequate definition of all criterion variables is imperative in order that a study may be replicated and its findings generalized to other populations and treatments. Measures should be continuous and quantifiable (e.g., number of days missed work and number of ounces of ethanol consumed per day).

Obtain representative assessments of pretreatment functioning. Multiple pretreatment measures clearly define the subjects under study, can identify differential levels of pretreatment impairment, can be compared with posttreatment data to assess change, and through statistical measures can be used to determine factors that relate to subjects' successful posttreatment.

Obtain comprehensive tracking information. Barr et al. (1973), Moss and Bliss (1978), and Sobell and Sobell (1978) found that subjects who are difficult to locate for follow-up typically function worse than those who are easily located (cited in Sobell & Sobell, 1982). Comprehensive tracking information can help minimize attrition by enhancing the likelihood of finding subjects for follow-up.

Use outcome measures of known reliability and validity. Although subjects' self-reports have been demonstrated to be reliable and valid overall and suitable

for most purposes, they have not been found to be error free. Consequently it is suggested that researchers use a convergent validity approach when evaluating treatment effectiveness (Sobell & Sobell, 1980). This refers to the collection of data from multiple sources, including subjects' self-reports, multiple collateral informants' reports (e.g. relatives, employers, probation officers), in-field probe breath alcohol test, official records to verify reports of arrests, employment, hospitalizations etc., period liver function tests to assess recent episodes of heavy drinking, and psychological tests for brain damage related to alcohol and/or drug ingestion.

Use multiple measures of treatment outcome that are continuous and quantifiable whenever possible. The advantages of using multiple measures include:
(a) Relationships in posttreatment changes in the substance abuse behavior can be evaluated in the context of other possible changes occurring in a person's life, and
(b) knowledge about the temporal relationships between various aspects of treatment outcome is provided (e.g. do changes in drinking behavior occur before or after changes in interpersonal functioning?). In addition to the substance abuse behavior, other measures of life health functioning are recommended (e.g. vocational, substance-related hospitalizations and arrests, physical health, psychological tests, familial, residential,

interpersonal and emotional). All measures should be quantified and scaled whenever possible.

Use multiple follow-up contacts. Multiple follow-up assessments are advantageous in two ways: (a) They minimize attrition by increasing the likelihood of finding subjects for follow-up, and (b) they avoid some memory problems because information is gathered about a shorter time interval. When multiple follow-up assessments were used a high percentage of subjects found for follow-up was reported (Ersner - Hershfield et al., 1979; Sobell & Sobell, 1978).

Use minimum of 12-to-18-month follow-up interval. The results of several studies (Caddy et al., 1978; Davies et al., 1956; Gerard & Saenger, 1959; Maisto et al., 1980) suggest that posttreatment data must be gathered over a minimum of 12 to 18 months in order to reflect stable functioning (cited in Sobell & Sobell, 1982). A minimum change was found to occur in group data after this time interval. However data for individual subjects continued to change even after 12 to 18 months.

Use appropriate statistical analysis: (a) advanced techniques, (b) control for pretreatment differences, (c) analyze for predictors of treatment outcome. Statistical procedures can indicate whether or not a treatment is effective and suggest which treatment components and pretreatment factors are most related to various outcomes. Multivariate statistical methods are

useful in determining relationships between a set of measures (e.g. drinking behavior, interpersonal behavior, vocational functioning).

Within the framework of the criteria discussed above, Sobell and Sobell (1982) reviewed the state of the art of alcohol treatment outcome evaluation. Their review included 37 treatment outcome studies conducted from 1976 to 1980. Their findings suggest that some methodological advancement is apparent. For example, 56.8% (n=21) of the reviewed studies used two or more information sources to gather outcome data, 29.7% (n=11) used three or more sources and 32.4% (n=12) used subjects' self-reports only. Of the 37 studies 29 used other life health measures in addition to drinking behavior. The mean number of outcome measures used was 3.5. Most studies used a minimum 12-month follow-up and collectively reported locating 78.4% of the subjects for follow-up. Equal interval follow-up data for all subjects in their study was reported by 89.2% (n=30). The mean number of contacts was 5.9. Finally, 30 studies used some level of statistical analysis (e.g. univariate, multivariate or nonparametric) to derive outcome conclusions.

Other researchers looked at both alcohol and drug abuse treatment outcome evaluations (Maisto & Cooper, 1980) as well as substance abuse treatment outcome evaluations in comparison with other mental health interventions (Goldstein et al., 1984). The consensus is that despite advances in

evaluation technology and the increased recognition of the need for methodologically sound treatment outcome evaluations, good evaluation studies continue to be the exception rather than the rule. The drug field employs the least adequate methodologies while outcome evaluations in the alcohol field are comparable with other mental health evaluations (Goldstein et al., 1984).

In all areas, major methodological flaws continue to persist (e.g. inadequate reporting of subjects' sociodemographic characteristics and substance abuse history, limited, if any description of type and amount of treatment provided, lack of adequate assessment prior to treatment, failure to control or account for differential pretreatment status among treatment groups, and the widespread lack of unity among definitions of outcome variables and methods of measurement employed in evaluation studies).

Clearly, treatment outcome evaluation studies in the field of substance abuse lack generalizability due to a host of methodological problems. Such lack of generalizability does not, however, negate the importance of that research in guiding other treatment outcome evaluation efforts. A review of selected outcome evaluation studies is presented to facilitate the informed selection of outcome measures by demonstrating the impact of subject, treatment, and

extratreatment variables on treatment outcome and indicate the interrelationships between these variables.

Factors Affecting Posttreatment Functioning

Many factors influence the recovery - relapse process in the substance abuser. These factors have been grouped into three categories: subject characteristics, treatment characteristics, and extratreatment or life context experiences.

Subject characteristics. Emrick (1973) reviewed alcoholism treatment outcome studies published between 1952 and 1971 (cited in Emrick & Hansen, 1983). He noted that the following subject characteristics predicted a favorable response to treatment whenever a statistically significant relationship was observed:

> higher social class, employed, married, socially active, financially secure, good work adjustment, good marital and family relationships, good social relationships, good "general situation", no or minimal pretreatment arrest history, good physical condition, higher intelligence, good psychological insight, at least moderate self-acceptance, good motivation, previous outpatient treatment, diagnosed "normal", being cooperative during treatment, drinking none or a little during treatment, and having the spouse involved in treatment. Patient characteristics that more often

> than not predicted a negative response to treatment (whenever statistically significant relationships were observed) included having had previous inpatient treatment, being aggressive, having had suicide attempts, having an organic brain syndrome, and having a "sociopathic" personality disorder (pp. 1079-1080).

More recent studies indicating the impact of subject variables on treatment response supported Emrick's findings. For example, studies conducted by Bromet et al., 1977 and Ornstein et al., 1985 demonstrate the influence of subject background characteristics at intake on treatment outcome. Among the sociodemographic variables which Bromet et al. found to be the strongest predictors of positive functioning were being married and having higher socioeconomic status. Among the drinking variables, lower levels of physical impairment and an absence of previous hospitalizations for alcoholism during the three years before admission to the treatment program were most strongly related to favorable posthospital adjustment.

Ornstein et al. (1985) studied the interactions of selected demographic variables with alcoholism treatment outcome. Subjects with positive responses to treatment were found to be older, married and employed at the time of admission to the treatment program, had a longer history of preadmission abstinence, fewer prior hospitalizations, and were more likely to participate in aftercare. However, only

the last two variables were predictive of treatment outcome.

Other studies testify to the impact of a subject's psychiatric severity on treatment outcome (McLelland et al., 1983; Saxon, 1983). For example, McLelland et al. studied a sample of 742 males (460 alcohol-dependent, 282 drug-dependent) treated in one of six programs, varying in scope, location, and intensity. Subjects who showed no improvement overall in any of the six programs were rated high in severity of psychiatric disturbance at admission. Subjects who responded well to treatment in every program were those who rated low in psychiatric severity at admission. The researchers noted that for both the alcohol - and drug - dependent samples, a global rating of subjects' psychiatric severity, estimated at admission, was the best predictor of most outcome measures.

A study conducted by McGuire (1982) illustrates the influence of subjects' drinking history at intake on treatment outcome. McGuire studied drinking drivers who were referred to the courts to one of six different programs with the goal of reducing abuse of alcohol. He found that overall "light drinkers" responded favorably to treatment, regardless of the type whereas "heavy drinkers" responded poorly no matter which of the six programs they entered.

Other researchers have investigated the influence of subjects' cognitive functioning on treatment outcome. Scharfer (1971) and Sobell et al. (1972) asked a series of

questions to alcohol abusers regarding the extent to which they believed their own drinking to be uncontrollable after taking the first drink. On the basis of responses received they concluded that the degree to which subjects believed themselves to be dependent on alcohol might influence their decision to drink to excess after a period of abstinence as a result of self-fulfilling prophecy. Heather et al. (1982) supported this by showing that alcoholics who believed in the slogan "first drink, then drunk" were more likely to be classified as problem drinkers at six month follow-up than those who did not believe the slogan or had not heard it (cited in Heather et al., 1983).

The role of cognitive variables is further demonstrated in studies conducted by Gregson and Taylor (1977), Hester (1981), and Litman et al. (1984). Gregson and Taylor found cognitive impairment to be more predictive of abstinence at six-month follow-up than were variables relating to drinking or psychosocial functioning. Similarly, Hester found that subjects with high levels of cognitive functioning remained in treatment more so than subjects with lower levels of cognitive functioning. Litman et al. (1984) reported that subsequent survivors differed from subsequent relapsers at intake in that they already had knowledge and experience of useful coping behaviors. They concluded that coping behaviors per se were not related significantly to outcome, whereas subjects' reported effectiveness of these coping

behaviors was related significantly to outcome.

In general, specific subject characteristics have proven to be predictive of treatment outcomes. Soloman (1982) suggested that these outcomes may be due to selective bias in treatment received (i.e. because of subject choice or assignment by treatment personnel) rather than inherent differences in treatment response by various client subgroups. She suggested that more consideration be given to matching selected subgroups of subjects to specific treatment modalities and cited evidence favoring specific client-treatment match (Armor et al., 1976; Kissen et al., 1970; McLelland et al., 1981). Although this evidence is not conclusive the assumption that substance abusers differ in their reactions to treatment is increasingly accepted and their differential assessment, much advocated (Gottheil et al., 1981; Pattison, 1979; Skinner, 1981).

Treatment characteristics. Research indicates that type of treatment is not consistently or predictably related to patient improvement (e.g. combined treatment of drug and alcohol abusers versus separate treatment, (Cole et al., 1981); inpatient versus outpatient treatment, (Cole et al., 1981); and individual versus group therapy, (Soleman, 1982). However, studies of process elements demonstrate links between specific treatment program components and client change.

Allison and Hubbard (1985) reviewed the drug abuse treatment process literature and noted the following investigations relating to the influence of program philosophy, policy and goals on treatment process, and therefore on outcomes of treatment: Bratter and Pennacchia (1978) suggested that if program staff believe abstinence to be a realistic goal, clients will be more likely to achieve that goal. Others have recommended individualizing goals and other aspects of treatment (Kaufman, 1978; Peckham, 1977). Iverson and Wenger (1978-1979) reviewed the philosophies of a number of therapeutic communities (residential treatment program for drug abusers) and found that a firm theoretical base for the treatment techniques employed was lacking.

Gallant et al. (1966) identified two elements of an intake procedure in alcoholism clinics as important in reducing patient no-shows and drop-out: (a) a limited time interval (48 hours maximum) between initial patient contact with program and first appointment, and (b) group rather than individual intake sessions.

Gallant et al.'s research is supported by Panepinto et al. (1980) who reported that attendance at an outpatient group orientation by patients discharged from an inpatient alcoholism program increased the likelihood of them remaining in attendance in outpatient treatment for the first four visits.

Leigh et al. (1984) and Olkin and Lemle (1984) reported similar findings. Leigh et al.'s research identified the length of delay between assessment and first appointment as being predictive of dropout. Olkin and Lemle found that attendance at a pre-intake group prior to assignment to an individual intake interview significantly reduced the rate of no-shows for the intake appointment.

Length of time in treatment, regardless of modality, has been shown to be positively related to outcome of substance abuse treatment (Bale et al., 1980; Simpson, 1979; Welte et al., 1981). Based on Simpson's findings that a stay of at least 3 months resulted in better treatment outcome, Allison and Hubbard (1985) speculated that a minimal length of stay in treatment may be required before treatment can have a positive effect.

Finney et al. (1981) suggested that length of stay is not related to outcome in some programs due to their lack of intensity of treatment. Similarly, Bromet et al. (1977) found that the degree of clients' program participation in psychological treatment experiences related positively to treatment outcome.

Counselor characteristics have been studied with respect to impact upon treatment outcome. Some researchers (e.g. de Angel's & Ross, 1978; Longwell et al., 1978; LaSciuto et al., 1970) investigated the effectiveness of professional and nonprofessional and ex-addict counselors

(cited in Allison & Hubbard, 1985). Findings from these studies are not consistent, indicating the need for further research in this area.

Miller et al. (1980) reported that higher degrees of counselor empathy was positively related to treatment outcome. Similarly, Valle (1981) reported better treatment outcome achieved by counselors with higher levels of interpersonal functioning. Leigh et al.'s (1984) study suggested that alcoholism treatment programs can improve attendance by changing certain characteristics or behaviours of treatment personnel (e.g. seeing patients at the scheduled time rather than keeping them waiting indefinitely).

Some studies investigated client perception of their experiences in substance abuse treatment (Moss & Finney, 1980; Wexler & DeLeon, 1983). Moss and Finney reported that participants' perceived quality of alcoholism programs was predictive of six-month outcome, relative to patient characteristics at intake and other treatment factors. Wexler and DeLen reported that clients' retrospective ratings of their satisfaction with treatment, the relevance of specific program components to their personal situation, and the relative importance of treatment upon their lifestyles since leaving drug abuse treatment, were directly related to positive treatment outcome as well as length of stay in treatment.

Clients' perceptions of treatment environments have been related to dropout and participation in aftercare services. Moos et al. (1978) found that dropouts at a Salvation Army alcoholism program perceived their treatment environment as less involving, less supportive, and more disorganized than did those who stayed longer (cited in Finney & Moos, 1984). Pratt et al. (1977) found that alcoholic patients who saw their treatment program as emphasizing autonomy, expression of anger and aggression, and the achievement of insight were more likely to attend aftercare (a reentry group that focused on outpatients' achievements and adjustment to community life) (cited in Finney & Moos, 1984).

Other program attributes that impact on treatment outcome include group size and composition, duration of treatment, staff-client ratios and staff morale (Berman et al., 1984; Joe et al., 1983; Schroeder et al., 1982).

Extratreatment (life context) experiences. Evaluation researchers now recognize that the treatment program is but one temporary microsystem influencing posttreatment functioning. Evaluation studies need to examine extratreatment environmental factors in order to develop more effective interventions in the recovery-relapse process (Finney & Moos, 1984).

Bromet and Moos (1977), Moos et al. (1979), and Finney et al. (1980) examined the relationship between

patients' family environment and treatment outcome. Results of outcome studies of residential alcoholism treatment indicate that patients located in families characterized by more cohesion, limited conflict, and greater emphasis on recreational activities function better after treatment. These relationships persisted six months after treatment when family functioning dimensions were assessed to predict patient functioning at a two-year follow-up (cited in Finney & Moos, 1984).

Work environment has been shown to influence treatment outcome. Ward et al. (1982) found that pretreatment job satisfaction was positively related to outcome among alcoholic patients assigned to reality therapy or self-awareness therapy. Moos and Finney (1983) reported a weak relationship between psychosocial characteristics of patients' work environment and follow-up functioning among alcoholic patients who returned to families after treatment. However, they found that among working individuals not living in families, those who saw their work environment as higher in involvement, cohesion and supervisor support, experienced better treatment outcome.

Other life situations have been shown to be predictive of relapse episodes. Marlatt and Gordon (1979) found that many relapse episodes occur within the first 90 days after treatment and are precipitated by interpersonal conflicts and situations involving social pressure to drink. Moos et

al. (1981) found that negative life events (such as economic or legal problems) were significantly more prevalent among relapsed alcoholics than among recovered alcoholics. Positive life events (such as a promotion or marital reconciliation) were significantly fewer among the relapsed alcoholics. Finney et al. (1980) found that negative life events that occurred during the first six months after treatment were related to complaints of physical symptoms and depression at a two-year follow-up (cited in Billings & Moos, 1983; Moos & Finney, 1983).

Summary

Alcohol and drug abuse are major social and health problems. Attempts to come to grips with these complex phenomena have resulted in numerous conceptualizations, theories of causality, treatment approaches, and evaluation strategies.

Prior to the past decade evaluation studies in this field were replete with major methodological problems which seriously hampered their validity and generalizability. A review of the state of the art of alcohol and drug abuse treatment outcome evaluation indicates that although much improvement is still needed, some methodological advancement is evident. Attempts to standardize methodology across studies are underway. For example, researchers propose minimum criteria for use in treatment outcome studies. New

guidelines recommend the examination of subject, treatment, and extratreatment (life context) variables in relation to posttreatment functioning.

Method

The major goal of this study was to design an evaluation model for the Waterford Hospital Addictions Program. The researcher pursued this goal through several distinct stages.

Three months of experience at the Waterford Hospital enabled the researcher to gain first-hand knowledge of the program first through observation and then by co-leading addiction groups. Opportunities for program-related discussions with program personnel were readily available. This experience later facilitated the assessment of program philosophy and goals, admission criteria, referral procedures, treatment methods, termination procedures, and of ongoing procedures for program data collection.

A review of research in the addictions field focussed on designing a program evaluation model for an addictions program.

A study of program participants' experiences in the Waterford Hospital Addictions Program constituted the final preparatory step to the development of the proposed model.

The purpose of this study was three-fold: (a) to conduct a preliminary evaluation of the effectiveness of the Addictions Program, (b) to provide a basis for selecting measures of treatment outcome success for inclusion in the proposed model, and (c) to determine the usefulness of the

questionnaire (Appendix C) for inclusion in the proposed model.

This study examined the perceptions of group members regarding their experiences in the Addictions Program. Because entry level assessments of clients' phycho-social-physical functioning were not available from existing program records, pretreatment and posttreatment comparisons are not possible. Therefore, the study provides a general impression of the program rather than an accurate assessment of program impact on clients. Respondents' rating of program effectiveness, types and severity of problems, and their treatment priorities have implications for selecting outcome measures for the evalution model.

The population consisted of individuals formally admitted to the program before or during the period, October 7th, 1986 to October 18th, 1986 who attended at least one group meeting during that period. Respondents represented four Waterford Hospital addiction groups. These included the Tuesday Day Group (n=9), Thursday Day Group (n=9), Night Group (n=8), and the Self-help Group (n=8). A fifth group in the Waterford Hospital Addictions Program is a Penitentiary Group. The researcher excluded this group from the study because of administrative difficulties preventing completion of questionnaires.

The Sample. Of the 34 individuals comprising the population, 29 participated in this study. Twenty-five were

in attendance at day or night group meetings during the designated time period when questionnaires were administered. The remaining four were Self-help Group members. Representation from the four addiction groups was as follows: Tuesday Day Group (n=8), Thursday Day Group (n=9), Night Group (n=8), and Self-help Group (n=4).

The Setting. Program facilities include two rooms located in the Ambulatory Care Department of the hospital and a room at Her Majesty's Penitentiary. Participants from the day and night groups completed questionnaires in the group meeting rooms at the hospital. Self-help Group participants usually meet at the hospital but they completed questionnaires individually, outside the hospital.

The Procedure. The researcher instructed the program's clinical director on how to administer the questionnaire. The clinical director pre-tested the questionnaire on three individuals who were current members in the Addictions Program. They completed the questionnaire on the average in one hour. The results of the pre-test did not lead to any major changes in the questionnaire. The researcher then instructed the group leaders on how to administer the questionnaire.

At routine group meetings during the designated time period, group leaders informed day and night group members of the purpose of the study, assured them of confidentiality of individual data and of identity, obtained

written consent (Appendix B) from those agreeing to participate, administered the questionnaire and answered any questions pertaining to it. The procedure was similar for Self-help Group members except that the clinical director approached them on an individual basis and because of scheduling problems, they completed questionnaires independently and outside group meetings.

Memorial University Computing Services programmed the analyses of all data. The Statistical Package for the Social Sciences -X by Nie et al. (1985) was utilized. The analysis excluded missing data by item.

The Questionnaire. The researcher developed the questionnaire (Appendix C) in June, 1986. The ASIST - A Structured Assessment Interview for Selecting Treatment (Addiction Research Foundation, 1984) provided the basis for the majority of questions. The researcher developed the remaining questions in consultation with program personnel.

The questionnaire consists of 10 sections with a total of 60 questions. Questions in the first nine sections are primarily close-ended. They elicit information on the following areas: (a) Accommodation/Marital Family Relationships, (b) Other Social Relationships, (c) Education/employment, (d) Finances, (e) Leisure, (f) Legal Status, (g) Alcohol Use, (h) Other Drug Use, and (i) Health Status. Specific inquiries include respondents' perceptions of their need for help in each functional area,

the overall effect of alcohol/drug use on their level of functioning, and their rating of the adequacy of program time devoted to each problem area.

Questions in the tenth section are primarily open-ended. The focus is on the extent to which the respondents perceive the program as helpful, the adequacy of time available to them (both during group meetings and outside) to talk about personal problems, reasons for missing group meetings, factors promoting continued participation, performance of group leaders and perceived needs for improvement in the program.

Background information includes respondents' sex, age, length of current admission to the program, number of previous admissions, referral source, prior and current treatment for addiction.

Results and Discussion

Description of Study Group

The 29 individuals who comprised the study group represent four Waterford Hospital Addiction Groups: Tuesday Day Group (n=9), Thursday Day Group (n=8), Night Group (n=8), and Self-help Group (n=4). Although these groups espouse the same primary program goals, they differ in their respective program objectives and treatment models (Appendix A).

Generally, program participants' initial group placement is in one of the two Day Groups. The objectives of these groups are to help members (a) to reduce their alcohol/drug consumption and dependency, (b) to recognize the impact of alcohol/drug use on their life health, (c) to identify current coping methods, and (d) to learn better ones. These objectives are achieved by means of group interaction aimed towards increasing members' insight into and awareness of their addiction problems.

The achievement of the Day Group objectives is a requirement for entrance into the Night Group. This group utilizes a psychotherapy model, wherein emphasis is placed on promoting fundamental change in participants' capacity to cope with problems concerning marriage, sexuality etc. Minimal attention is given to the addiction problem.

Following completion of the Night Group, participants may join the Self-help Group. Unlike the other groups, this group is responsible for planning the structure and scheduling of their meetings and is neither lead nor attended by program personnel. The clinical director of the program is consultant to this group.

Program personnel screen individuals for selection for each of these groups.

The inherent differences in the groups may have affected outcome. Therefore, analysis by group is presented for selected variables as well as data for the study group as a whole.

Of the 29 respondents, 24 were male and 5 were female. Most (21) were in their 20's to mid-30's (Table 1).

Table 1

Age of Study Group Participants
(n=29)

Age Category	Frequency	Percent
19-25 years	5	17.2
26-35 years	16	55.2
36-45 years	4	13.8
46+ years	4	13.8
Totals	29	100.0

Twenty-one (72.4%) respondents reported attainment of secondary level education or higher. Thirteen (44.8%) reported completion of some post-high school education (Table 2). Education achievement levels for the group were consistent with existing research showing that a younger cohort is generally more educated than an older one (Armour, Polich & Stambul, 1978).

Table 2

Educational Achievement Levels of Study Group Participants (n=29)

Educational Level	Frequency	Percent
less than high school	8	27.6
high school	8	27.6
some vocational/trade school	6	20.7
vocational/trade school completed	3	10.3
some university	4	13.8
Totals	29	100.0

Table 3 indicates the high rate of unemployment (61.9%) characteristic of this group. Such unemployment is typical of that found in other alcohol/drug user populations (Armour, Polich & Stambul, 1978). However, there is no apparent relationship between employment status and level of

education completed, as in other populations. That is, low academic achievement does not "explain" the high rate of unemployment. Perhaps, the current high rate of unemployment in Newfoundland generally, and in particular amongst young people, accounts for this lack of relationship.

Table 3

Employment Status of Study Group Participants (n=29)

Employment Status	Frequency	Percent
disabled	3	10.3
homemaker	1	3.4
in training program	1	3.4
student	2	7.0
unemployed	11	38.0
employed part-time	3	27.6
employed full-time	8	10.3
Totals	29	100.0

Concurrent with a high rate of unemployment is a low level of income reported by the study group. Given the economic climate described above, it is not surprising that welfare benefits and U.I.C., together, represented the main source of income for 41.3% of respondents(Table 4).

Table 4

Main Source of Income for Study Group Participants (n=29)

Source of Income	Frequency	Percent
employment	10	34.5
savings	1	13.8
U.I.C.	4	38.0
welfare benefits	11	3.4
other	3	10.3
Totals	29	100.0

As Table 5 shows, the majority of respondents were single (75.8%). Most had never married (37.9%) while slightly fewer (34.5%) were separated or divorced.

Table 5

Marital Status of Study Group Participants (n=29)

Marital Status	Frequency	Percent
married/remarried/cohabiting	7	24.1
widowed	1	3.4
separated/divorced	10	34.5
single	11	37.9
Totals	29	100.0

Only 27.6% of respondents were living with family members or relatives. All others were living alone, in an institution or with non-relatives.

Almost half (48.3%) the study group were living in independent accommodations i.e. own house/ apartment/ bedsitter. Approximately 1/4 (24.1%) were living in shelter/ hostel/ institution, and the remainder (27.6%) were living in boarding houses.

The data on marital status, employment status, and residential status reflect the social instability of study group participants. In this respect, they resemble other substance abuse populations described in research i.e. more likely to be divorced or separated, unemployed, and having unstable living arrangements (Polich, et. al., 1978).

Table 6 shows respondents' length of current participation in this program. Participation ranged from two months or less (28./6%) to one year or more (35.8%).

Table 6

Length of Current Participation in Program
(n=28)

No. of Months	Frequency	Percent
> 1-2 months	8	28.6
3-4 months	4	14.3
5-6 months	3	10.7
7-8 months	3	10.7
9-10 months	0	0.0
11+ months	10	35.7
Totals	28	100.0

Current participation represented the first entry into this program for 65.5% of the study group, the second for 27.6%, and the third for the remainder (6.7%).

For 19 (65.5%) respondents, this program represented the only current treatment for addiction. Those receiving additional treatment (34.5%) reported participation in A.A., Salvation Army Harbour Light Program, other treatment at the Waterford Hospital, Emmanual House, and individual counselling.

Eighteen (62.15%) respondents reported prior treatment for their addiction, other than participation in this program. Prior treatment services included A.A., Salvation Army Harbour Light Program, other treatment at the Waterford Hospital, and treatment at local general hospitals.

The findings on the amount and duration of treatment highlight several points: that many respondents participate in this program on a long-term basis, that they often return to it for further treatment, and that they tend to have a history of treatment for their addiction. These factors are consistent with indicators of treatment success (Bale et al., 1980; Polich et al., 1978) and reflect participants' motivation to overcome their addiction problems as well as their committment to the program.

The Waterford Hospital (44.8%) was the greatest single referrer to the program. Other community social agencies, taken together, referred a large percentage (Table 7).

Table 7

Study Participants' Source of Referral to Program (n=29)

Referral Source	Frequency	Percent
Waterford Hospital in-pt service	10	34.5
Waterford Hospital out-pt service	3	10.3
court	1	3.4
other social agencies	10	34.5
self-referred	5	17.2
Total	29	100.0

The primary addiction of individuals in the study group was alcohol. Nineteen (65.5%) respondents reported a need for help with alcohol use, as compared with only nine (31%) who reported a need for help with other drug use. Six (23%) respondents reported a need for help with both alcohol and other drug use (Table 8). Information on the primary addiction of these six respondents was not obtained. In future, the questionnaire should ascertain whether alcohol or other drug use is perceived as the major problem.

Table 8
Study Participants' Type of Addiction
(n=29)

Addiction	Frequency	Percent
alcohol	13	44.8
other drugs	3	10.3
both alcohol and other drug use	6	20.7
neither	7	24.0
Total	29	100

Self-reports on alcohol/drug use indicate some degree of program success. Respondents reported both absolute abstinence and reduction in alcohol/drug use. (Both are often criteria for program success). Nine (31%) respondents reported complete abstinence from alcohol for at least six months immediately preceding completion of questionnaires. During that time period all of these individuals were participating in the program. Other respondents reported varying periods of abstinence from alcohol during the same six month period: 0-30 days (24.1%), 31-60 days (10.3%), 61-90 days (17.2%), and 91-179 days (14.3%).

With regard to other drug use, 12 (41.3%) respondents reported that they have never used drugs (other than

alcohol) for non-medical reasons. Others reported varying lengths of time since last using drugs: 6+ months (24.1%), 2 months (24.1%), and less than 1 month (20.7%).

Seven (24.1%) respondents reported no current need for help with either alcohol or other drug use. One other who reported never having used drugs, reported only a "slight" problem with alcohol use. Similarly, two (6.9%) others reported only "slight" problems with both alcohol and other drug use. If we accept the fact that study group participants were admitted to the Waterford Hospital Addictions Program as prima facie evidence that they were in fact alcohol and/or drug addicted, the severity of the alcohol/drug problem must have been greater than "slight" at the time of entry. Therefore, one might justifiably assume that some degree of improvement has occurred since entry.

The findings on alcohol/drug use are indicative of a successful program. Although it is possible that extratreatment factors contributed to this outcome it is reasonable to assume that participation in this program was a major contributing factor.

Impairment in Psychosocial Functioning: Respondents' Perceptions of the Effects of Alcohol/Drug Use

Tables 9 and 10 clearly indicate that respondents perceived that alcohol/drug use had adversely affected their life functioning in most areas. Half the respondents who

Table 9

Respondents Needing Help: Perception of Overall Effect of Alcohol/Drug use by Functional Area

(n=29)

Functional Area	n needing help	Overall Effect of Alcohol/Drug Use: made worse	had no effect	made better
other social relationships	23	18	2	2
leisure	23	22	0	1
school/employment	20	14	4	0
emotional health	20	20	0	0
alcohol use	19	19	0	0
marital/family relationships	17	16	1	0
finances	16	15	0	0
legal status	13	11	2	0
other drug use	9	9	0	0
physical health	9	9	0	0

Table 10

Respondents Not Needing Help: Perception of Overall Effect of Alcohol/Drug Use by Functional Area

(n=29)

Functional Area	n not needing help	Overall Effect of Alcohol/Drug Use: made worse	had no effect	made better
other drug use	20	5	4	0
physical health	20	19	1	0
legal status	16	7	8	0
marital/family relationships	12	10	1	1
finances	11	6	0	0
alcohol use	10	9	1	0
emotional health	8	7	1	0
school/employment	7	6	2	1
other social relationships	6	3	2	1
leisure	6	5	1	0

reported no need for help with legal status also reported no adverse affects of alcohol/drug use on their legal status. These individuals have probably not to date experienced any addiction-related involvement with the law.

Areas of impairment. Respondents' ratings of their psycho-social-physical functioning reveal the types and severity of their problems and have implications for establishing outcome measures that clients consider important.

Table 11 presents participants' perceptions of need for help. Only respondents who perceive a need for help (having problems with moderate to extreme degrees of impairment) are included in the table. Respondents with problems of a perceived lesser degree (not perceiving a need for help) are not included. All groups reported having all the problems listed, excepting the Self-help Group which did not report accommodation or drug use problems. Overall, the most predominant problems are with social relationships and leisure. The least frequently reported problems were accommodation, drug use, and physical health. No particular patterns of problems are apparent.

A chi-square analysis of the data on school/employment problems did not yield statistically significant results regarding change in problems after six or more months in the program.

Table 11

Participants' Perceptions of Need for Help: Group by Problem Area
n = 29

Problem Area	Total	n of Respondents Needing Help (within groups)			
		Day (Tues.) n=8	Day (Thurs.) n=9	Night n=8	Self-help n=4
other social relationships	23	9	5	1	8
leisure	23	8	6	1	8
school/employment	20	8	5	1	6
emotional health	20	6	6	2	6
alcohol use	19	6	7	2	4
marital/family relationships	17	7	2	1	7
finances	16	6	2	2	6
legal status	13	3	4	1	5
other drug use	9	4	1	0	4
physical health	9	1	3	2	3
living arrangements	7	2	3	0	2

With respect to financial problems by groups, overall the Night Group and Self-help Group reported fewer difficulties than the two day groups. The most predominant financial difficulties were in the areas of recreational/ entertainment and payment of debts (Table 12).

All respondents reported fair to good physical health but indicated emotional health problems to varying degrees (Table 13). The most predominant of these was tension/ anxiety/nervousness (100%). Following closely were problems related to trouble concentrating (86.2%), difficulty sleeping (75.6%), and depression (72.4%).

The Self-help Group reported the fewest number of emotional health problems, with a range of 2-8 per person. The Night Group and Thursday Day Group reported the full range of emotional health problems. Tuesday Day Group followed closely, reporting 13 of the 15 problem areas.

Participants in all groups identified leisure problems as a major area of concern. Table 14 presents the types of leisure activities respondents participated in over the past 6 months. The number of respondents in the Self-help Group was small but they were most involved in the activities. The Night Group participants reported limited participation. Participation in education/interest courses was the least frequently reported leisure activity while watching T.V. was the most popular pastime, overall.

Table 12

Respondents with Financial Problems: Group by Type of Problem
n = 29

Problem Area	Total	n of Respondents Needing Help (within groups)			
		Day (Tues.) n=8	Day (Thurs.) n=9	Night n=8	Self-help n=4
recreation/entertainment	11	5	1	1	4
payment of debts	11	4	2	1	4
clothing purchases	9	4	1	1	3
medical/dental services	9	4	0	1	4
transportation	7	4	1	0	2
alcohol/drug purchases	7	3	1	0	3
rent/mortage	6	1	2	0	3
alimony/child support	5	1	1	1	2
food purchases	5	2	1	0	2

Table 13

Respondents with Emotional Health Problems: Group by Type of Health Problem

Type of Problem	n of Respondents Needing Help (in groups) Total (%)	Day (Tues.) n=8	Day (Thurs.) n=9	Night n=8	Self-help n=4
tension/anxiety/ nervousness	29(100)	9	8	4	8
trouble concentrating	25(86.2)	9	7	2	7
difficulty sleeping	22(72.4)	7	7	2	6
depression	21(72.4)	8	5	0	8
loneliness	19(65.5)	7	5	2	5
feeling inferior to others	19(65.5)	9	4	1	5
uncontrollable thoughts/ impulses	18(62.1)	7	3	s	6
feelings of preoccupation/ forgetfulness	18(62.1)	7	5	0	6
difficulty eating	17(58.6)	7	4	0	6
amnesia	17(58.6)	8	5	0	4
irrational fears/phobias	14(48.3)	7	4	1	2
feeling people are against you	13(44.8)	4	4	1	4
feeling aggressive/violent towards others	13(44.8)	5	3	1	4
thoughts of suicide	10(34.5)	5	2	0	3
sexual problems	8(27.6)	3	2	0	3

Table 14

Leisure Activities Identified by Respondents: Group by Type of Activity

Type of Activity	Total (%)	n of Respondents (within groups) Day (Tues.) n=8	Day (Thurs.) n=9	Night n=8	Self-help n=4
watching T.V.	22(75.9)	7	6	4	5
hobbies/crafts	15(51.7)	5	3	3	4
sports/recreation	15(51.7)	3	4	2	6
socializing	13(44.8)	6	1	3	3
community groups/activities	12(41.4)	5	2	2	3
religion/religious activities	9(31.0)	3	2	3	1
eduction/interest courses	7(24.1)	4	0	1	2

Discussion on Psychosocial Functioning: Respondents' Perceptions of the Effects of Alcohol/Drug Use.

Whether impairment in psychosocial functioning in substance abusers helps cause the substance abuse or is a consequence of it, is not known with certainty. However, a consensus exists amongst researchers regarding the basic characteristics of the disorder once it is established (Armour et al., 1980). These include problems in the following areas: marital/ family relationships, other social relationships, living arrangements, education/ employment, finances, leisure, legal status, and health status. These factors constitute the core of substance abuse problems. Hence they are useful indicators of the damage done by alcohol/drug use as well as the severity of the alcohol/drug problem.

Examination of psychosocial variables identified in this study group reveals impairment across the full spectrum of 11 functional areas. The range per individual is 3-11. Because respondents' psychosocial functioning at the time of entry into this program is unknown, an assessment of the extent to which they have improved in these areas is not possible, but the fact that respondents reported a large number of problems for which the program offers help indicates the relevence of the program.

Criteria for evaluating psychosocial rehabilitation must include the extent to which individuals have become

reintegrated into the community in terms of improvement in employment/education status, income, residential status, interpersonal relationships and the development of healthier coping skills to equip individuals to deal more effectively with stress (Armour, et. al., 1980). The data on the adverse effects of alcohol/drug use on psychosocial functioning, as perceived by study group participants, (Tables 9 & 10) indicate the need for assessing the level of impairment in these areas at the time of entry to the program.

Respondents' Perceptions Of Program Effectiveness

Respondents' reports of their thoughts and feelings regarding their experiences in the Waterford Hospital Addictions Program provide a basis for evaluating program effectiveness and for obtaining information directed towards improving the program.

Perceived adequacy of the amount of time spent on problems by the program. Respondents reported their perceptions of the adequacy of time spent on selected areas of psychosocial functioning. Overall, respondents who reported no need for help were satisfied with the amount of time spent on most problems. A notable exception is apparent in the area of finances where only about 36% of those who reported no need for help were satisfied with the amount of time spent on this subject. An equal percentage

of the study group perceived the amount of time as being too little, and the remainder did not respond to this question.

Table 15 indicates that more than half of all respondents who reported a need for help with social relationships, leisure, alcohol use, other drug use, and emotional health also reported satisfaction with the amount of time spent on these problems. The problem for which the highest number of respondents reported an adequate amount of time is alcohol use. Problems for which there is the highest reported dissatisfaction with time spent included marital/family relationships, school/employment, and finances.

Table 15 provides a general overview of respondents' perceptions of the adequacy of time spent on various problems, and Table 16 presents similar data differentiated by group. The Night Group and Self-help Group reported more satisfaction with adequacy of time, overall, than the two day groups. The day groups reported inadequacy of time in the areas of marital/family relationships, school/ employment, and finances. Less than half of respondents who reported a need for help with these problems were satisfied with the amount of time spent on them by the program. It should be noted that almost all respondents who reported an inadequate amount of time indicated too little time rather than too much. All four groups consistently reported a high

Table 15

Respondents' Perceptions of Adequacy of Time Spent on Problems:
Adequacy by Type of Problem

Type of Problems	n of respondents	Adequacy of Time: too little	adequate	too much
other social relationships	23*	7	13	0
leisure	23	8	13	0
school/employment	20	9	8	0
emotional health	20	3	11	0
alcohol use	19	2	13	2
marital/family relationships	17	6	7	0
finances	16	6	7	0
legal status	13	1	8	1
other drug use	9	0	5	2

* Number of respondents do not correspond to column total under Adequacy of Time since some respondents did not answer all questions.

Table 16

Respondents' Perception of Adequacy of Time Spent on Problems: Group by Problem Area

Problem Area	Is Amount of Time Spent Adequate?							
	Day (Tues.) (n=8)		Day (Thurs.) (n=9)		Night (n=9)		Self-Help (n=4)	
	Yes	No	Yes	No	Yes	No	Yes	No
alcohol use	7	0	6	3	6	1	4	0
legal status	6	1	4	4	5	1	4	0
other drug use	6	1	8	1	3	0	3	0
emotional health	5	0	4	3	4	1	4	0
marital/family relationships	4	2	3	4	7	1	3	1
other social relationships	4	2	5	4	6	1	3	1
leisure	4	2	4	5	6	2	4	0
school/employment	3	3	4	4	5	2	2	1
finances	3	3	5	3	3	2	2	1

degree of satisfaction with the amount of time spent on discussion of alcohol and other drug use.

Perceived needs for improvement. In gauging participants' perceptions of needs for improvement in the treatment program, the questionnaire enquired whether or not there are problem areas that the program was not dealing with that respondents would have liked to be given attention. Of the 29 respondents, only three responded affirmatively to this question. All three pointed to the need to include discussion on sexual problems.

Information on what respondents liked least about this program reveals that the most predominant criticism concerns the location of the program. Two factors were noted: (a) the stigma associated with a psychiatric facility, and (b) the fact that the Waterford Hospital is not in a central location.

Other criticisms included the following: that there was too much discussion on family problems, that the groups met only once a week, and that some members participated too little.

Fourteen respondents reported that they had not attended all scheduled group meetings. Nine respondents gave reasons for missing meetings. The most frequently reported reason related to conflicting commitments e.g. work or medical (n=5). Other reasons given were: transportation

problems (n=1); illness, fatigue (n=2); and indulgence in alcohol/drugs (n=1).

The replies of 27 respondents regarding whether or not enough time was available to them during group meetings to discuss personal problems were as follows: affirmative (23, 79.3%), and negative (4, 13.8%).

Twenty-seven respondents replied as to whether or not enough time was available outside group meetings (from professional staff) to talk about personal problems and receive help. Less than half (48.3%) responded affirmatively. Thirteen (44.8%) respondents indicated a desire for further opportunity to talk about personal problems.

Finally, respondents rated how well they perceive group leaders to be doing their jobs. The response categories to this question were "excellent", "good", "fair" and "poor". Of the 28 respondents answering this question, 20 (69%) answered "excellent" and 8 (27.6%) answered "good".

Factors promoting continued participation in the program. Considerable overlap exists between responses regarding factors promoting continued participation and what respondents liked best about the program. Participants saw the program as helpful in three ways: resolution of their addiction problem, the emotional support provided, and the opportunity to share experiences with others who had similar problems.

One respondent reported that continued attendance was promoted by referral by the Division of Child Welfare. The one respondent referred to this program by the court did not perceive the source of referral as a significant factor in promoting his/her continued participation.

Participants' perceptions of the overall impact of the program. Twenty-eight respondents rated the degree to which they felt this program was helping or harming them in dealing with their addiction problem. Eighteen (62.1%) indicated that the program was helping "alot" and 10 (34.5%) indicated that the program was helping "some". Twenty-two (75.9%) respondents reported that the program had "not at all" harmed them. Three (10.3%) reported the extent of harm as "not much", and one (3.4%) reported that it had harmed "some".

Respondents gave their opinions regarding how many other group members they believed to be improving because of the treatment they were receiving from this program. Of the 28 responses obtained, 8(27.6%) indicated "alot", 8(27.6%) indicated "quite a few", 10 (34.5%) indicated "some", and 2(6.9%) indicated "don't know".

Finally, all respondents reported that they would recommend this program to others with addiction problems.

Discussion on Respondents' Perceptions of Program Effectiveness

Overall, findings point to a favorable perception of the Waterford Hospital Addictions Program on the part of study group participants.

The data on perceived adequacy of time spent on problems highlight several points. First, since the primary focus of substance abuse treatment programs is the alcohol/drug consumption, it is noteworthy that all participating groups consistently reported satisfaction with the amount of time the program spends on discussion of alcohol/drug use.

Also, the areas of dissatisfaction (i.e. marital/family relationships, school/employment, and finances) highlighted in this analysis are reported primarily by the Day Group participants rather than Night and Self-help Group participants. A possible explanation for this may relate to the intended purposes of the different groups. The focus of the day groups is helping participants recognize the impact of alcohol/drug abuse on life problems and helping them identify current methods of coping with these problems. On the other hand, the focus of the Night and Self-help Groups is "... fundamental change in a person's coping style and to develop more positive ego strengths. Change in these areas are aimed at achieving long lasting results" (Program Description, Appendix A, p. 103). The data suggest that some day group participants may desire a more advanced

approach to their addiction problem. This in turn may suggest a need for a better understanding on the part of some participants regarding the purposes of their groups or perhaps a need for program personnel to re-examine the appropriateness of decisions to place particular individuals in the day groups.

The data on perceived needs for improvement reflect a high degree of respondent satisfaction regarding program content, opportunity during group meetings to talk about and receive help with problems, and performance of group leaders. Negative comments primarily reflect factors external to the treatment program e.g. reasons given by respondents for not attending all scheduled group meetings. No respondent indicated that reasons for missing were in any way related to his/her dissatisfaction with the group meetings.

The criticism most closely associated with the program is its location. Since changing the site of the program may not be feasible, possibly some attention should be given to dispelling the negative feelings resulting from the program's association with a psychiatric facility. Perhaps, this issue could be addressed during the orientation to the program i.e. the Educational Seminar (Program Description, Appendix A, p. 101).

Responses pertaining to the amount of time available to respondents outside group meetings suggest that possibly

more referrals for additional service, either within the hospital or to outside resources, should be undertaken.

The data pertaining to factors promoting continued participation in the program reflects the inherent power of a therapeutic group. These factors point to the benefits of group therapy as have been documented by a number of writers. Anderson (1982), for example, noted the opportunity for a safe atmosphere in which clients can "ventilate feelings, compare attitudes and behavior with others, ... and understand factors that contribute to and maintain their [alcohol/drug] problem and to deal more effectively with them when they arise" (p. 28). The data suggest that study group participants believed that the Waterford Hospital Addictions Program provides such an atmosphere for group members.

In summary, this analysis indicates that this program is highly valued by study group participants. The absence of initial entry assessments precludes the possibility of determining reported changes in benefits over time. In order to accomplish this an evaluation model that compares clients' functioning before and after treatment, using objective follow-up methods, is required.

The Model

This model is primarily intended to facilitate the gathering and recording of information deemed necessary to demonstrate the impact of the Waterford Hospital Addictions Program on clients. In addition, it may provide the basis for timely and relevant feedback for program development and planning. Because this program operates under the constraints of limited resources, the researcher endeavored to design a model that is manageable but methodologically sound. Hence, this model represents a compromise between the state of the art evaluation technology and an expeditious procedure.

The researcher adapted the recommended forms and procedures from (a) Sobel, L.C. (1979), and (b) Addiction Research Foundation (1984). The model also includes original standardized instruments developed by other researchers. If used conscientiously, these forms and procedures generate information that provides the basis for a methodologically sound program evaluation.

However, present recommendations cannot be considered permanent. Changes in the Addictions Program and/or new research developments may necessitate revisions of the material in future.

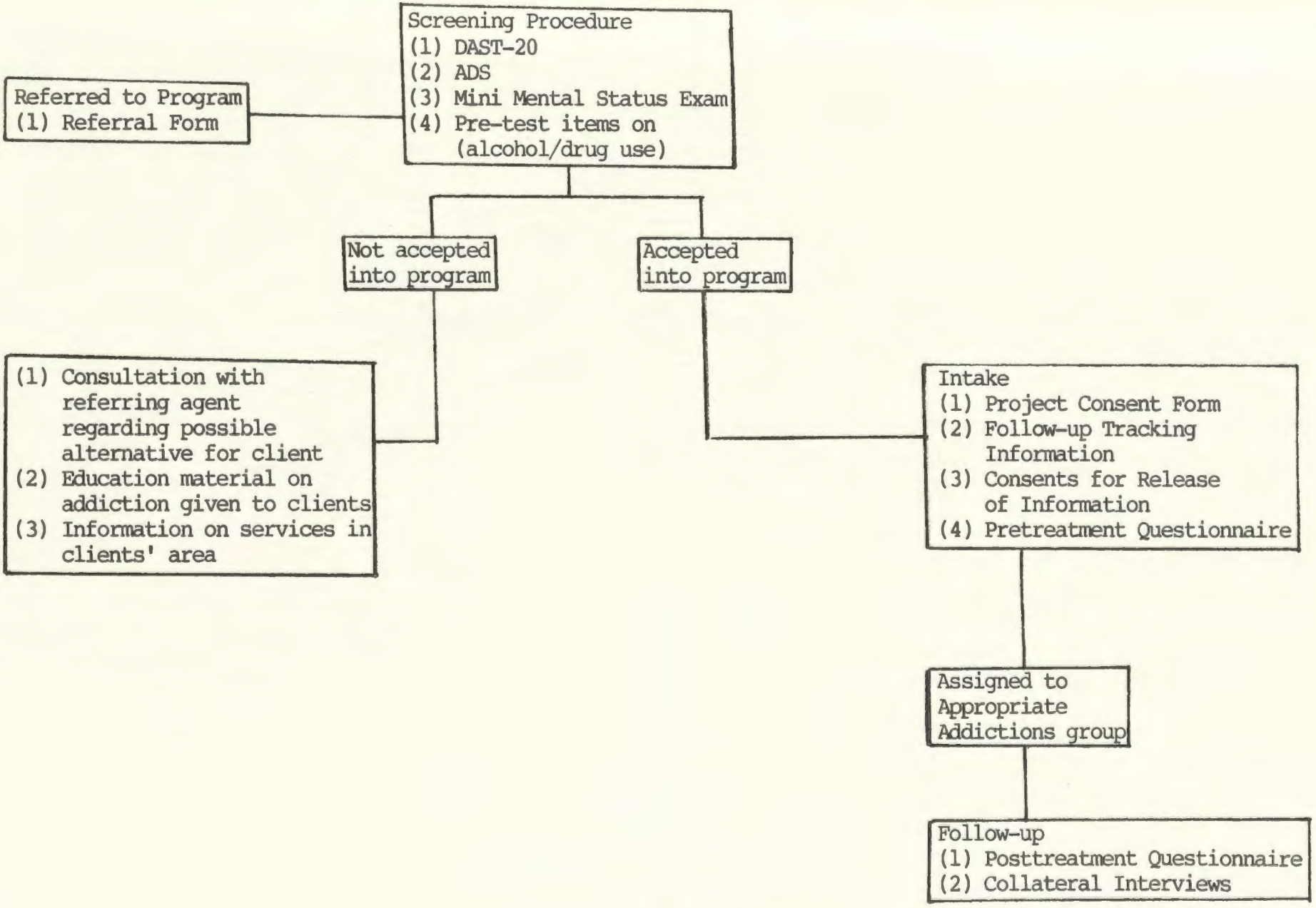


Figure 1: Flow Chart:
From Referral to Program to Follow-up

Evaluation of Program Goals

Goal statements provide the basis for selecting measures of a program's major desired outcomes. To serve this purpose, goal statements must be clearly stated so that they can be operationalized into outcome measures which describe the behavior that program participants should evidence after treatment as proof of goal attainment (Morris & Fitz-Gibbon, 1986).

In consultation with program personnel, the researcher restated the goals of the Waterford Hospital Addictions Program (Program Description, Appendix A, p. 98). The revised goal statements represent what program personnel agree the program should accomplish:

1. Reduction of clients' level of consumption and dependency on alcohol/drugs.
2. Reduction of clients' social impairment.
3. Reduction of clients' psychological impairment.

This model includes forms designed to measure the attainment of these primary program goals. Appendix D outlines the development of these forms, the assessment areas covered therein, and the proposed indicators of goal attainment.

Selection of Subjects

It is not necessary and possibly not feasible to include all individuals who participate in the Waterford

Hospital Addictions Program in an evaluation project. Therefore, decisions must be made regarding the number and types of clients appropriate for inclusion. Options for selecting a study sample include the following:

1. The study population may include all prospective clients referred to the Addictions Program during a designated time period (e.g. September 1, 1988 to December 31, 1988). Those admitted during that time period may comprise the study sample.

2. A variation of option one is a random selection of a study sample from a population of clients referred to the program during a designated time period (e.g. every second person admitted during the time period September 1, 1988 to December 31, 1988).

3. Depending on the information sought, other selection criteria may relate to particular sub-populations (e.g., alcoholics, drug abusers, polydrug abusers, males, females, particular age groups, etc.).

Data Collection Instruments

To ensure that information is collected in a systematic, usable manner, this evaluation model includes forms providing for the collection of pertinent data at selected times (i.e., intake, treatment, and follow-up). This section presents a description of the intended

purpose(s) of these forms and guidelines for their administration.

Referral Form (Appendix E). This form is the initial contact form and records basic demographic and referral data. The estimated completion time is three to five minutes. Ideally, it is completed on all clients referred to the Addictions Program, whether they are accepted or not. It is recommended that the Referral Form be left at appropriate places in the Waterford Hospital in-patient and out-patient services to facilitate its completion on all individuals referred by these sources. With respect to telephone calls from prospective clients or other referral sources, completion of this form might be limited to those individuals committing themselves to undergo the programs's screening procedure.

Alcohol Dependence Scale (ADS) (Appendix F). This scale assesses the severity of the alcohol dependence syndrome, withdrawal symptoms, obsessive-compulsive drinking style, diagnosis and prognosis. It is initially used as a screening tool to provide an objective measure of clients' suitability for the Additions Program. Also, if administered at follow-up it provides an index of treatment outcome. It usually takes 10 minutes to complete. Appendix F provides instructions on the administration, scoring and interpretation of ADS.

Drug Use Questionnaire (DAST-20) (Appendix G). This instrument assesses clients' involvement with drugs (other than alcohol) during the 12 month pretreatment interval and indicates the severity of the drug problem. It is initially completed during the screening interview as an added objective measure of clients' appropriateness for the program. Also, this instrument provides an index of treatment outcome, if administered at follow-up. It usually takes approximately 10 minutes to complete. Appendix G provides instructions on the administration, scoring and interpretation of DAST-20.

Mini Mental Status Exam (Appendix H). This standardized questionnaire assesses clients' mental health. Similar to the ADS and DAST-20 instruments, this instrument offers considerable potential as a diagnostic tool and is therefore administered during the screening interview. Also, this questionnaire provides an objective measure of treatment outcome when used at follow-up. It usually takes approximately 10 minutes to complete. Appendix H provides guidelines on the administration, scoring and interpretation of the Mini Mental Status Exam.

Consent Statement (Appendix I). This form explains the purpose and goals of the evaluation study and informs clients of all procedures to be used. Consenting clients must understand and sign this form at the intake interview, prior to participation in the evaluation study.

Tracking Information Form (Appendix J). Researchers stress the importance of minimizing follow-up attrition (Review of the Research, p. 16). The collection of appropriate data at intake is essential to track and maintain contact with clients throughout the evaluation project. The referral and pretreatment forms together record the necessary descriptive information on clients (e.g. names, addresses, phone numbers, and current vocational and residential information) as well as the names of institutions or agencies with which clients have had contact over the past 12 months. With clients' permission these places may be contacted to request records regarding clients' behavior.

The intended purpose of the Tracking Information Form is to record the names, addresses and phone numbers of two or three individuals (e.g. relatives or friends) most likely to know the whereabouts of the clients. Along with facilitating continued contact with clients, these collateral sources provide a basis for corroborating information received from clients. This is important since although clients' self-reports have been demonstrated to be reliable and valid overall, they have not been found to be error free. To ensure the reliability and validity of clients' self-reports, the collection of data from multiple sources is recommended (Review of the Research, p. 21).

Collaterals are contacted, if necessary, in order of clients' preference.

The Tracking Information Form is completed at the intake interview.

Release of Information (Appendix K). The clients' signature on this form gives permission to evaluation personnel to contact specific institutions or agencies for information regarding the clients' association with same. A Release of Information form is signed for each agency contacted regarding a client. Hence, the number completed varies for different clients.

Release of Information forms will likely pertain to hospitalizations, jail incarcerations, and treatment centers in which the client received services during the 12 month pretreatment interval. They are mailed as soon as possible after the intake interview.

The Release of Information Form(s) are completed at the intake interview.

Pretreatment Questionnaire (Appendix L). An interview format, at intake, is the intended mode of administration for this questionnaire. Assessment areas covered include demographics, accommodation/marital family relationships, other social relationships, education/employment, finances, leisure, legal status, alcohol/drug use, and health status. The questions pertain to clients' functioning in these areas over the 12 month pretreatment interval. All clients are

asked the same questions and in the same order as they appear on the form. Approximately 60-70 minutes is estimated for the administration of this questionnaire.

This questionnaire may be completed at intake. However, consideration may be given to administering only the Alcohol/Drug Use section (7.1-7.22) during the screening interview. Interpretation guidelines for the alcohol consumption question (7.9) are those used im the ASIST - A Structured Addictions Assessment Interview for Selecting Treatment (Addiction Research Foundation, 1984). The alcohol/drug use items, together with the three standardized instruments (ADS, DAST-20 and Mini Mental Status Exam) enable program personnel to make decisions regarding who should and should not be admitted to the Addictions Program based on an objective rather than a solely subjective assessment.

Collateral Letter (Appendix M). Sobell (1979) explained the utility and reasons for this letter as follows:

> This letter is sent to all collaterals designated by the client and should be mailed within a week after the pretreatment interview. This letter explains the (1) client's voluntary participation in the project, (2) procedures used in the project, and (3) overall purpose and reasons for the project. About a week after the collateral letters are sent, the evaluator should

> telephone the collaterals about the nature of the project. The timing of this first call is critical and should occur shortly after the letter is sent. The goal of this call is to insure that the collateral understands and feels comfortable with the interview procedures before the first follow-up interview is conducted. The client's signature on this letter is intended to communicate to the collateral his/her agreement and cooperation with the project (p. 14).

It may not be feasible or necessary to contact all collaterals designated by all clients. Consideration may be given to contacting collaterals on a random basis (e.g. collaterals designated by every third client). Collateral letters are not sent if they are not to be followed-up by collateral interviews. Therefore, decisions pertaining to this matter must be made prior to beginning the evaluation. The names of collateral sources are, nonetheless, requested of all clients for tracking purposes.

Posttreatment Questionnaire (Appendix N). The assessment areas covered in this form are the same as those contained in the pretreatment questionnaire. Hence, clients' pretreatment functioning can be compared with their posttreatment functioning. This provides the basis for an assessment of group change as well as individual client change from pretreatment to posttreatment.

An additional component to this questionnaire is a Client Satisfaction Scale (Attkisson et al., 1985). This scale elicits program participants' perceptions of the Addictions Program and its impact on client change.

This questionnaire is administered to clients at all follow-up contacts.

Collateral Follow-up Interview (Appendix O). This form is intended as a means for corroborating information received from clients. Therefore, two or three collaterals designated by the clients are interviewed and asked questions very similar to those asked of the clients in the posttreatment follow-up questionnaire.

The frequency of follow-up contacts with collaterals depend on the time and resources available to program personnel for evaluation purposes. Ideally, collaterals are contacted for follow-up with the same frequency as clients. However, even a minimum of follow-up contacts with collaterals help to determine the validity and reliability of clients' self-reports.

Whenever possible, these interviews may be conducted by telephone.

Follow-up Progress Notes (Appendix P). This form is intended to record all follow-up activities pertaining to a specific client during his/her participation in the evaluation project. Transactions may include the dates of the intake interview and the forms completed during that

interview, the date when Release of Information Forms and Collateral Letters are mailed, and the dates and purpose(s) of any calls to clients, collaterals or other agencies. Also, any significant information received from clients or others (e.g. new addresses, new telephone numbers, hospitalizations, arrests, reasons for missing scheduled meetings) may be recorded. If used conscientiously, this form provides a checklist of completed treatment outcome evaluation activities and possibly some important outcome data.

Attendance Record (Appendix Q). This form records clients' attendance at or absence from all group meetings occurring during the timeframe of the evaluation project. It is completed by group leaders at every group meeting. This information provides indication of each client's degree of participation in the Addictions Program.

Time Intervals for Follow-up Contacts

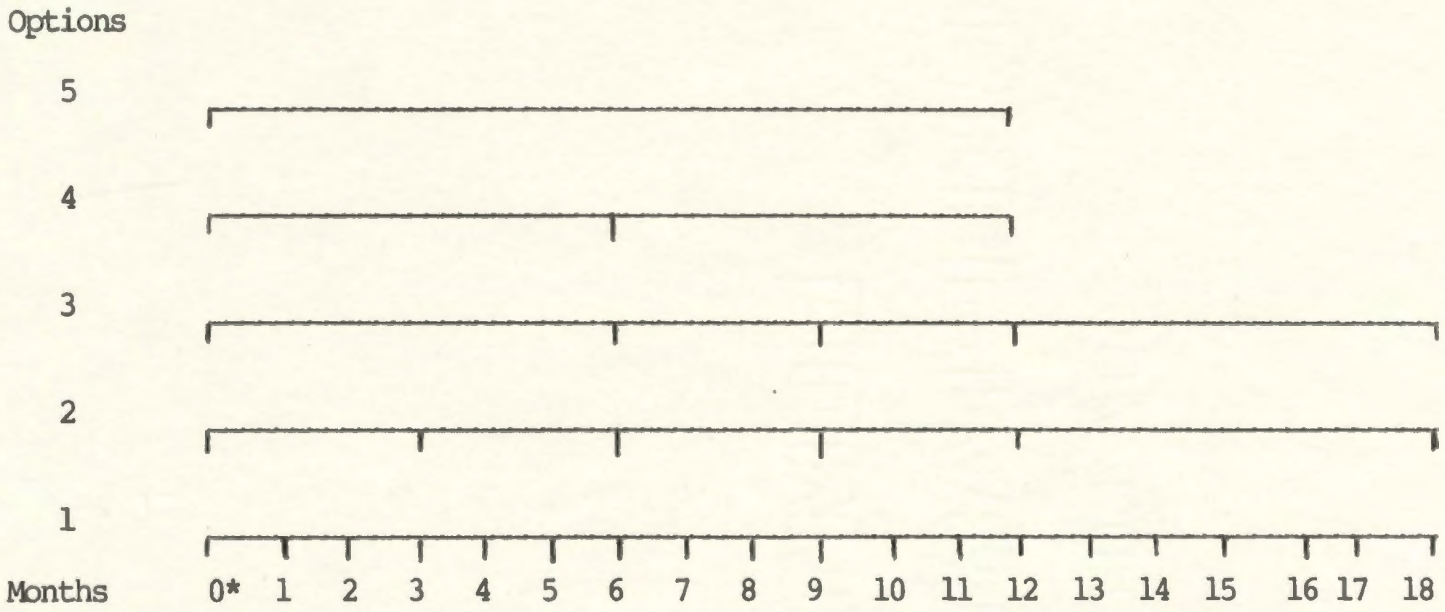
A minimum of 12 to 18 months posttreatment follow-up is recommended in order to reflect stable client functioning. Multiple follow-up contacts with clients and collaterals during the follow-up period minimize attrition by increasing the likelihood of finding clients for follow-up (Review of the Research, p. 22). Decisions pertaining to the number of follow-up contacts and the time framework of the research depend on the time and resources available to program

personnel for evaluation purposes. Figure two presents suggested options for the time framework of the evaluation project.

Option one suggests a time framework in which follow-up contacts with both clients and collaterals occur monthly for 18 months posttreatment.

Multiple follow-up contacts enable inquires about a shorter time interval thereby minimizing memory problems and the likelihood of losing clients for follow-up. The frequent follow-up contacts with collaterals provide a good basis for determining the reliability and validity of clients' self-reports. However, this option demands much evaluation time.

Within the time framework suggested in option two all clients are contacted at the designated times (i.e. 3, 6, 9, 12 and 18 months). However, collaterals may be contacted on a random basis (e.g. one collateral designated by every third client). Although not as comprehensive as option one, this option has the following advantages: (a) The 18 month posttreatment time interval provides a good basis for determining stable client functioning, (b) the collateral contacts provide some basis for determining the validity and reliability of clients' self-reports, and (c) the earlier contacts (i.e. 3 and 6 months) facilitate the tracking of clients for later follow-up contacts. Since the number of follow-up contacts suggested in this option are considerably



* The Pretreatment Questionnaire is administered at intake in all five options. Zero (0) represents intake.

Figure 2: Options for Follow-up Contacts

fewer than suggested in option one, the required evaluation time is considerably less.

The advantages and disadvantages of option three are similar to those noted for option two. However, because the three month follow-up contact is excluded success in tracking potentially hard-to-locate clients is reduced.

Option four fulfills the minimum 12 month follow-up interval. The six month follow-up contact provides some opportunity to track potentially hard-to-locate clients. Also, limited follow-up contacts with collaterals (if undertaken) provide some basis for determining the reliability and validity of clients' self-reports.

Multiple follow-up contacts are not a feature of option five. Consequently, opportunities to minimize attrition and to avoid memory problems by inquiring about shorter time intervals are lost. However, the administration of the pretreatment questionnaire at intake and the posttreatment questionnaire 12 months posttreatment entry provides the basis for comparing pretreatment functioning with posttreatment functioning. Also, contacts with collaterals shortly after intake and again at the 12 month follow-up point, provides some basis to determine the reliability and validity of clients' self-reports.

Conclusion

The staff of the Waterford Hospital Addictions Program is interested in knowing the impact the program is having on clients but lack the resources to implement sophisticated treatment outcome studies. Therefore, the researcher endeavored to design an evaluation model that enables program personnel to conduct simpler but methodologically sound program evaluation. The proposed model includes the following components:

1. The use of standardized instruments as screening tools provide objective measures of clients' suitability for the Addictions Program by assessing the severity of their alcohol/drug problem and their mental health. These questionnaires also provide an index of treatment outcome if administered at follow-up.

2. The proposed model is prospective rather than retrospective and provides the basis for the collection of data on multiple measures of clients' functioning at more than one point in time (i.e. before, during and after treatment), thus enabling comparisons of clients' status before and after treatment.

3. Key variables are measured by continuous and quantifiable indicators of behaviour demonstrated by program participants before, during, and after treatment. For example, number of ounces of alcohol consumed, number of

school/job-related problems, and number of addiction-related legal problems.

4. Multiple measures of treatment outcome broaden the definition of program success. Rather than relying only on the abstinent/no abstinent criteria, changes in other areas of life health are measured (e.g., interpersonal relationships, education/employment, finances, leisure, legal status, and health status).

5. Comprehensive tracking information increases the likelihood of locating subjects for follow-up, thus minimizing attrition.

6. The collection of data from multiple sources, including clients' self-reports, collateral informants' reports and official police, employment and hospital records increases the validity and reliability of clients' self-reports.

7. Multiple follow-up contacts (a) minimize attrition by increasing the likelihood of finding subjects for follow-up, and (b) avoid some memory problems because information is gathered about a shorter time interval.

8. A minimum 12-18 month follow-up interval helps to ensure that posttreatment data reflect stable client functioning.

Although the primary concern of the proposed model is determining the effects of the Addictions Program on clients, it may also provide the basis for timely and relevant feedback for program development and planning.

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APPENDIX A

Appendix A

Waterford Hospital Addictions Program
Program Description*

Preamble:

An Addictions Program has been successfully operating since January, 1982 through the Ambulatory Care Department of Waterford Hospital. It is an out patient treatment service which offers assistance to individuals who are addicted to drugs or alcohol. The program is co-ordinated by a social worker and is staffed by social workers and nurses. A psychiatrist is available as a consultant to staff and as a resource in the assessment and treatment of individuals in crisis.

The program has the following components:

Core Program

I. Educational Seminar (1/2 day seminar)
II. Day Groups, Interactional Insight Awareness Model
III. H.M. Penitentiary Day Group, Educational and Interactional Insight Awareness Model
IV. Night Group, Psychotherapy Model
V. Referral to Specialized Services

Maintenance Program

I. Self-help Group
II. Drop-in Group

Philosophy of Addictions Program:

The program is based on the premise that alcohol/drug addiction is a problem that impacts on everyday living, and is also influenced by the way a person handles everyday life. Therefore, treatment must address a variety of issues about the individual's addiction and lifestyle.

Furthermore, this program is designed on the basis of a recognition that any individual can develop the ability to gain control over an addiction. However, such control can only be achieved if the person requires support and treatment in order to gain the desired control.

* Selected portions of the Program Description for the Waterford Hospital Addictions Program, December, 1985.

The causes of addiction remain unclear and controversy about levels of addiction continues. Therefore, this treatment approach does not advocate abstinence for all participants. It is more reasonable to assist participants to set goals which they can work to achieve. For some the goal will be controlled drinking, for others abstinence. In all cases, other goals will be in place regarding methods of coping with life.

It is generally known that overcoming an addiction is a difficult and lengthy process. Therefore, this program does not expect quick and lasting results. Instead it accepts that a person may be involved in the core program for as long as two years. An individual can participate in the maintenance component for an indefinite period of time. The availability of long-term treatment and support is seen as essential to reducing the effects of addiction.

Goals of Program:

The program is not designed to meet all the needs of people with addictions problems. It does attempt to help members achieve the following:

(1) Identify the dimensions of their problems with alcohol, street drugs and/or prescription medications.

(2) Reduce their dependency and/or control their addiction.

(3) Identify their individual coping patterns in relation to their problems.

(4) Adopt new and healthier ways of coping with life and life problems.

(5) Build their self-esteem and learn to communicate effectively.

Theoretical Base:

The complexity of addiction problems demands a multiplicity of approaches. In order to provide various treatment as well as other support on a long-term basis, group therapy has been chosen as the model of therapy.

This model allows group members to relate to one another in a therapeutic manner while drawing on the expertise of the therapists. This approach is preferred because it combines the efforts of the professionals with the efforts of the addicted person's peers. This combination enhances peer learning, and provides role models to the group. It also gives people an opportunity to share their difficulties and their ideas in an environment where everyone is taking similar risks. Thus it is a relatively safe place (I. Yalom 1975).

The specific approaches employed within the group therapy model are outlined below.

1. Client-Centered Therapy

   This approach emphasizes the client's importance as an individual who deserves positive regard, warmth and empathy. The therapist strives to provide these by building a relationship which respects the individual as being more than his/her problem (Carl Rogers 1951).

2. Rational-Emotional Therapy

   The patient's self-defeating ideas are the target for work with this approach. Attempts are made to replace these ideas with more realistic and positive ways of living and renewing life. A "person's self-talk" is explored and modified, and irrational ideas are confronted. The result should be a person who possesses a set of ideas which allow a satisfactory level of functioning. (Albert Ellis 1973).

3. Reality Therapy

   This is a "common sense" approach to behaviour change which stresses the "here and now". The patient is helped to focus on current problems and accept responsibility for making changes. (W. Glasser, 1965).

4. Behaviour Therapy

   This approach requires that the patient define goals in behavioural terms. The means of achieving the goals are then established and certain rewards are attached to progress towards the desired end. All goals and the behaviours which lead to them must be clearly measurable. (Skinner 1973, Wolfe 1973).

Criteria for Group Member Selection:

Any person who is 16 years of age or older may be selected for the program if they meet the following criteria:

1. Group members must be physically/psychologically dependent on or have an addiction problem with one or more of the following: alcohol, prescription drugs, street drugs.

2. Group members must be capable of participating in a group experience; they must be free from major intellectual, psychotic, or mental impairments.

3. Group members must indicate some motivation or desire to change.

4. Members must be committed to attend at least one group therapy session per week and sign a written agreement regarding participation.

5. Members must agree to abide by the rules and policies which govern the operation of the program.

Referral Procedure:

1. Referrals are accepted for all in-patient units, the Ambulatory Care Service of Waterford Hospital, and from community agencies. Pertinent information must be made available at time of referral.

2. A screening process is carried out by a staff person from the program. This involves determining that the prospective member is willing to attend sessions and will have access to sessions after discharge. If neither of these criteria is met an assessment is not completed. The program staff consults with the referring agent regarding possible alternatives for the client. Also, the client is given a package of materials on addictions which contains a list of resources in his/her area.

3. Prospective group members who meet the screening criteria are interviewed for assessment purposes prior to acceptance into the program.

4. Prospective group members must complete a pre-test questionnaire.

5. Group members must sign a written agreement to respect the confidential nature of all information exchanged during the group sessions.

6. Members must attend at lease one introductory educational seminar during their initial weeks in the program.

7. Prospective group members are assigned to an appropriate group as determined by group leaders.

8. All prospective group members who are not accepted into the Program yet who need immediate follow-up are referred to appropriate services.

9. All group members have the opportunity to be referred to the Program more than once, yet a waiting period may be necessary in view of past performances in the program. This will rest upon the discretion of the group leader assessing the individual.

Termination Procedure:

1. All group members who miss two consecutive group sessions, without legitimate reason, will meet with one of the group leaders to discuss their interest in continuing with the Program.

2. All group members who miss four group sessions without legitimate reason, will be terminated from the Program. Whenever possible an interview will be held to discuss this action.

3. All members attending groups who are considered inappropriate for the groups will be interviewed privately and informed that they must terminate involvement in the program.

Drop-in Procedure:

A drop-in group session is available once per month to those members who prematurely terminated from the program. The last day and night groups of each month are the designated drop-in sessions. Members can attend these sessions without notifying staff. They will be given opportunity to inform the group of their situation since leaving the program. They may be seen following the session to determine their interest in re-entering the program.

Description of Program:

Core Program

I. Educational Seminar (1/2 day)

This seminar is held once per month for all new members who have been referred during the month. The staff person presents information on addictions and the addiction program. Participants are involved in group discussion on the material presented and/or their concerns about entering the program.

II. Day Groups (Tuesday and Thursday Mornings at 11:00-12:30) - (Time Limit One Year Interactional Insight Awareness Model

Format: These groups meet weekly. They are open-ended in structure so that new members can be accepted into the groups as spaces become available. Size is limited to 12 people.

Participants: Members have participated in the educational seminar and may have attended other treatment programs. They may be in-patients or out-patients and they have been assessed prior to entering the program. Members are assigned to a specific group and cannot attend others without the approval of staff.

Content: The day groups are oriented to helping members:

- to recognize how their addiction/dependency is affecting their lives;

- identify their life problems and methods of coping with these;

- reduce and/or control their dependency on alcohol/drugs.

Members work to achieve these objectives by interacting with each other in a manner which promotes feedback and confrontation. Sharing information on problems related to dependency or addiction is coupled with feedback to produce an increase in members' insight, and an awareness of alternatives for coping with their problems.

Leaders: Groups are co-led, when possible, by social workers and nurses. Co-leaders are present to guide discussion and help the group handle the expression of hostilities, defense mechanisms and transference.

III. Penitentiary Addictions Group (Tuesday, 2:00-3:45)

Educational and Interactional Insight Awareness Model

Format: This group meets weekly and is open-ended in structures so that new members can be accepted as spaces become available. Size is limited to 12 people.

Participants: All members are inmates of the H.M. Penitentiary. They have completed application for admission to the program and have been accepted by the staff as being appropriate for the group.

Contents: This group strives to help members:

- recognize how their addiction/dependency affects their lives, and particularly how it contributes to their illegal activities;

- identify their life problems and methods of coping with these;

- reduce and/or control their dependency on alcohol/drugs;

- provide members with basic information regarding addiction and the effects of drug/alcohol use.

This group uses the same methods employed in the Day Group. However, these is naturally a great emphasis on topics which relate to coping while involved with the justice system. At times topics are pre-determined and movies and slides are used. However, members' concerns usually dictate the focus of any session.

Group Leaders: This group is co-led by a classification officer and a social worker. Leaders guide the discussion and help the group handle any difficult issues which arise.

Leaders also assume responsibility for assessing the members' progress and facilitating their transfer to the Day or Evening Groups when they show an interest.

IV. Night Group (Tuesday Evening - 7:30-9:30) - (Time Limit - One Year)

Psychotherapy Model

Format: This group meets weekly and is open-ended in structure. Size is limited to 12 people.

Participants: All members have participated in the Day Groups, Penitentiary Group or other community services. They have maintained sobriety or cessation of drug use. These members show an ability to tolerate direct confrontation, develop insight and take action on their problems.

These people are highly motivated to problem-solve and alter their lifestyles. They are generally feeling positive about themselves and thus have energy to deal with complex problems concerning their marriage, personal abilities, etc. They usually have community supports.

Content: The primary purposes of this group are: to cause fundamental change in a person's coping style and to develop more positive ego strengths. Change in these areas are aimed at achieving longlasting results.

This group has only a minimal focus on addiction problems. The major emphasis is placed on identifying problem areas, including personal characteristics, which require attention and developing abilities to address the issues. Members explore all the dimensions of the problems and with support from the group they discover options for dealing with these. Eventually members are able to cope with less support and the newly learned skills become incorporated into the person's character.

Group Leaders: This group is co-led by two social workers. Leaders act as role models and facilitators. They are basically non-directive and participate in order to assist members to refine the skills they have already developed.

The leaders also assist members to terminate from the group and move to other supportive services if required.

V. Referral to Specialized Services

Many people who enter the program have problems which require specialized treatment outside the group setting. These people are referred to appropriate services within or outside the Hospital.

Maintenance Program:

Group members who reach their time limits in the Core Program can transfer to the Maintenance Program. At the time of transfer members' goals are reviewed and they are helped to select a maintenance component appropriate to their needs. They may choose to use services outside the hospital or they may choose to use groups in the Maintenance Program. These are as follows:

(i) Self-help Group

This group is comprised of members who have completed their involvement with the night group. They plan the structure and schedule of their meetings but they have access to a staff person if the need arises for consultation.

(ii) Drop-in Group

The last day and night group of each month is designated as a "drop-in group". Members who have discontinued involvement in the program are able to attend a session. They are given an opportunity to discuss their progress and/or problems. Staff will see "drop-ins" following the session if there appears to be a need for further intervention.

APPENDIX B

APPENDIX B

Consent Statement

The staff of the Waterford Hospital Addictions Program is interested in hearing how you feel about this program. The information you provide may be very helpful in determining how well the program is working and how we can make it better. The attached questionnaire covers personal questions about you and your experiences in the Addictions Program. There are no right or wrong answers to these questions; instead answers should reflect your thoughts, feelings and personal situation.

All information we gather will be kept strictly confidential. Findings will be reported in summary form so that no one can be identified.

You are free not to answer any questions you choose, or not participate at all, and it will in no way prejudice the services you receive from this program now or in the future.

If you decide to participate in this study we wish to thank you for your time and cooperation.

Any questions I have about participation have been answered and I give my consent to participate.

_____ _____

(signature) (date)

_____ _____

(witness) (date)

APPENDIX C

APPENDIX C

A STUDY OF PROGRAM PARTICIPANTS EXPERIENCES IN THE WATERFORD HOSPITAL ADDICTIONS PROGRAM

1. ACCOMMODATION, MARITAL/FAMILY RELATIONSHIPS

THE FOLLOWING QUESTIONS ARE ABOUT YOUR ACCOMMODATION, AND YOUR FAMILY/MARITAL RELATIONSHIPS.

1.1 WHAT IS YOUR PRESENT ACCOMMODATION?

OWN HOUSE/APARTMENT.....1 [ ]
BOARDING HOUSE.....2 [ ]
SHELTER/HOSTEL.....3 [ ]
INSTITUTION.....4 [ ]
OTHER.....5 [ ]
SPECIFY_____

1.2 WITH WHOM ARE YOU LIVING?

WITH MATE.....1 [ ]
WITH CHILD/REN.....2 [ ]
WITH OTHER FAMILY.....3 [ ]
WITH FRIENDS.....4 [ ]
ALONE.....5 [ ]
INSTITUTION.....6 [ ]
OTHER.....7 [ ]
SPECIFY _____

1.3 HOW WOULD YOU DESCRIBE YOUR LIVING ARRANGEMENT?

UNSATISFACTORY.....1 [ ]
SOMEWHAT SATISFACTORY.....2 [ ]
NEUTRAL.....3 [ ]
SOMEWHAT SATISFACTORY.....4 [ ]
SATISFACTORY.....5 [ ]

1.4 WHAT IS YOUR CURRENT MARITAL STATUS?

MARRIED, NEVER DIVORCED.....1 [ ]
REMARRIED.....2 [ ]
COHABITING.....3 [ ]
WIDOWED.....4 [ ]
SEPARATED.....5 [ ]
DIVORCED.....6 [ ]
SINGLE.....7 [ ]

1.5 WHAT DO YOU FEEL HAS BEEN THE OVERALL EFFECT OF ALCOHOL/DRUG USE ON YOUR MARITAL/FAMILY RELATIONSHIPS?

MADE THEM MUCH WORSE.....1 [ ]
MADE THEM WORSE.....2 [ ]
HAD NO EFFECT.....3 [ ]
MADE THEM BETTER.....4 [ ]
MADE THEM MUCH BETTER.....5 [ ]

1.6 HOW WOULD YOU RATE YOUR NEED FOR HELP WITH MARITAL/FAMILY PROBLEMS?

NO REAL PROBLEM, HELP NOT NEEDED.....1 [ ]
SLIGHT PROBLEM, HELP PROBABLY NOT NEEDED.....2 [ ]
MODERATE PROBLEM, SOME HELP NEEDED.....3 [ ]
CONSIDERABLE PROBLEM, HELP NEEDED.....4 [ ]
EXTREME PROBLEM, HELP ESSENTIAL.....5 [ ]

1.7 HOW WOULD YOU RATE THE AMOUNT OF TIME SPENT ON MARITAL/FAMILY PROBLEMS BY THIS PROGRAM?

NOT ENOUGH.....1 []
TOO MUCH.....2 []
SATISFACTORY.....3 []
UNABLE TO COMMENT. HAVE NOT ATTENDED ENOUGH GROUP MEETINGS.....4 []

2. OTHER SOCIAL RELATIONSHIPS

THE FOLLOWING QUESTIONS ARE ABOUT OTHER SOCIAL RELATIONSHIPS.

2.1 DO YOU HAVE MANY FRIENDS?

NO.....1 []
YES.....2 []

2.2 HAVE YOU BEEN HAVING PROBLEMS WITH YOUR FRIENDS?

NO.....1 []
YES.....2 []

IF YES, WHAT KIND OF PROBLEMS HAVE YOU BEEN HAVING? (E.G. STANDING UP FOR YOUR RIGHTS, STARTING CONVERSATIONS, LOSING YOUR TEMPER).

_____

2.3 WHAT DO YOU FEEL HAS BEEN THE OVERALL EFFECT OF ALCOHOL/DRUG USE ON YOUR RELATIONSHIPS WITH FRIENDS AND OTHER PEOPLE?

MADE THEM MUCH WORSE.....1 []
MADE THEM WORSE.....2 []
HAD NO EFFECT.....3 []
MADE THEM BETTER.....4 []
MADE THEM MUCH BETTER.....5 []

2.4 HOW WOULD YOU RATE YOUR NEED FOR HELP WITH YOUR PROBLEM WITH FRIENDS AND OTHER PEOPLE?

NO REAL PROBLEM, HELP NOT NEEDED.....1 []
SLIGHT PROBLEM, HELP PROBABLY NOT NEEDED.....2 []
MODERATE PROBLEM, SOME HELP NEEDED.....3 []
CONSIDERABLE PROBLEM, HELP NEEDED.....4 []
EXTREME PROBLEM, HELP ESSENTIAL.....5 []

2.5 HOW WOULD YOU RATE THE AMOUNT OF TIME SPENT ON PROBLEMS WITH FRIENDS AND OTHER PEOPLE BY THIS PROGRAM?

NOT ENOUGH.....1 []
TOO MUCH.....2 []
SATISFACTORY.....3 []
UNABLE TO COMMENT. HAVE NOT ATTENDED ENOUGH GROUP MEETINGS.....4 []

3. EDUCATION/EMPLOYMENT

THE FOLLOWING QUESTIONS ARE ABOUT YOUR EDUCATION/EMPLOYMENT STATUS.

3.1 WHAT IS THE HIGHEST EDUCATION LEVEL YOU HAVE COMPLETED?

LESS THAN HIGHSCHOOL.....1 []
HIGH SCHOOL.....2 []
SOME VOCATIONAL/
TRADE SCHOOL.....3 []
VOCATION/TRADE SCHOOL
COMPLETED.....4 []
SOME UNIVERSITY.....5 []
UNIVERSITY COMPLETED.....6 []

3.2 WHAT IS YOUR PRESENT EMPLOYMENT STATUS?

NOT IN THE LABOUR FORCE.....1 []
HOMEMAKER.....2 []
STUDENT.....3 []
IN RETRAINING PROGRAM.....4 []
UNEMPLOYED.....5 []
EMPLOYED FULL-TIME.....6 []
EMPLOYED PART-TIME.....7 []

3.3 IF YOU ARE UNEMPLOYED, HOW MANY WEEKS HAVE YOU BEEN UNEMPLOYED?

WEEKS.....1 _____

3.4 HAVE ANY OF THE FOLLOWING SCHOOL/EMPLOYMENT PROBLEMS OR CHANGES HAPPENED TO YOU IN THE PAST SIX MONTHS/ PRIOR TO THE PAST SIX MONTHS?

	HAS OCCURRED IN PAST SIX MONTHS		HAS OCCURRED PRIOR TO PAST SIX MONTHS	
	NO	YES	NO	YES
PROMOTION	[]	[]	[]	[]
LAYOFF	[]	[]	[]	[]
RETIREMENT	[]	[]	[]	[]
LATENESS/ABSENTEEISM	[]	[]	[]	[]
ACCIDENTS	[]	[]	[]	[]
DECREASE IN GRADES/PRODUCTIVITY	[]	[]	[]	[]
DRINKING/DRUG TAKING AT SCHOOL ON THE JOB	[]	[]	[]	[]
VERBAL WARNING FROM SCHOOL/ UNION/EMPLOYER	[]	[]	[]	[]
WRITTEN REPRIMAND	[]	[]	[]	[]
SUSPENSION/LOSS OF PAY	[]	[]	[]	[]
JOB DEMOTION	[]	[]	[]	[]
EXPLUSION/DISMISSAL	[]	[]	[]	[]
RESIGNATION	[]	[]	[]	[]

3.5 WHAT DO YOU FEEL HAS BEEN THE OVERALL EFFECT OF ALCOHOL/DRUG USE ON YOUR SCHOOL/EMPLOYMENT SITUATION?

MADE THEM MUCH WORSE.....1 []
MADE THEM WORSE.....2 []
HAD NO EFFECT.....3 []
MADE THEM BETTER.....4 []
MADE THEM MUCH BETTER.....5 []

3.6 HOW DO YOU RATE YOUR NEED FOR HELP WITH SCHOOL/EMPLOYMENT PROBLEMS?

NO REAL PROBLEM, HELP NOT NEEDED.....1 []
SLIGHT PROBLEM, HELP PROBABLY NOT NEEDED.....2 []
MODERATE PROBLEM, SOME HELP NEEDED.....3 []
CONSIDERABLE PROBLEM, HELP NEEDED.....4 []
EXTREME PROBLEM, HELP ESSENTIAL.....5 []

3.7 HOW WOULD YOU RATE THE AMOUNT OF TIME SPENT ON SCHOOL/EMPLOYMENT PROBLEMS BY THIS PROGRAM?

NOT ENOUGH.....1 []
TOO MUCH.....2 []
SATISFACTORY.....3 []
UNABLE TO COMMENT. HAVE NOT ATTENDED ENOUGH GROUP MEETINGS.....4 []

4. FINANCES

THE FOLLOWING QUESTIONS ARE ABOUT YOUR FINANCIAL STATUS.

4.1 WHAT HAS BEEN YOUR MAIN SOURCE OF INCOME IN THE PAST SIX MONTHS?

EMPLOYMENT.....1 []
UNEMPLOYMENT INSURANCE BENEFITS.....2 []
SPOUSE.....3 []
PENSION.....4 []
WELFARE BENEFITS.....5 []
SAVINGS.....6 []
OTHER.....7 []
SPECIFY_____

4.2 IN THE PAST SIX MONTHS HAVE YOU EXPERIENCED ANY FINANCIAL DIFFICULTIES?

NO. IF NO, MOVE TO SECTION 5, LEISURE.....1 []

YES. IF YES, COMPLETE 4.3 - 4.6.....2 []

4.3 WHICH OF THE FOLLOWING AREAS ARE CAUSING YOU FINANCIAL DIFFICULTIES?

	NO	YES
FOOD PURCHASES	1[]	2[]
ACCOMMODATION (RENT/MORTAGE)	1[]	2[]
CLOTHING PURCHASES	1[]	2[]
TRANSPORTATION	1[]	2[]
MEDICAL/DENTAL SERVICES	1[]	2[]
RECREATION/ ENTERTAINMENT	1[]	2[]
ALIMONY/CHILD SUPPORT	1[]	2[]
ALCOHOL/DRUG PURCHASES	1[]	2[]
PAYMENT OF DEBTS	1[]	2[]

APPROX DEBTS _____

OTHER 1[] 2[]

SPECIFY_____

4.4 WHAT DO YOU FEEL HAS BEEN THE OVERALL EFFECT OF ALCOHOL/DRUG USE ON YOUR FINANCIAL SITUATION?

MADE IT MUCH WORSE.....1 []
MADE IT WORSE.....2 []
HAD NO EFFECT.....3 []
MADE IT BETTER.....4 []
MADE IT MUCH BETTER.....5 []

4.5 HOW WOULD YOU RATE YOUR NEED FOR HELP WITH FINANCIAL PROBLEMS?

NO REAL PROBLEM, HELP NOT NEEDED.....1 []
SLIGHT PROBLEM, HELP PROBABLY NOT NEEDED.....2 []
MODERATE PROBLEM, SOME HELP NEEDED.....3 []
CONSIDERABLE PROBLEM, HELP NEEDED.....4 []
EXTREME PROBLEM, HELP ESSENTIAL.....5 []

4.6 HOW WOULD YOU RATE THE AMOUNT OF TIME SPENT ON FINANCIAL PROBLEMS BY THIS PROGRAM?

NOT ENOUGH.....1 []
TOO MUCH.....2 []
SATISFACTORY.....3 []
UNABLE TO COMMENT. HAVE NOT ATTENDED ENOUGH GROUP MEETINGS.....4 []

5. LEISURE

THE FOLLOWING QUESTIONS ARE ABOUT YOUR LEISURE TIME ACTIVITIES.

5.1 OVER THE PAST SIX MONTHS, IN WHICH OF THE FOLLOWING ACTIVITIES HAVE YOU PARTICIPATED?

	NO	YES
COMMUNITY GROUPS/ACTIVITIES	1[]	2[]
HOBBIES/CRAFTS	1[]	2[]
SPORTS/RECREATION	1[]	2[]
WATCHING T.V	1[]	2[]
ATTENDING EDUCATION/INTEREST COURSES	1[]	2[]
SOCIALIZING	1[]	2[]
RELIGION/RELIGIOUS ACTIVITIES	1[]	2[]
OTHER ACTIVITIES	1[]	2[]

SPECIFY_____

5.2 WHAT DO YOU FEEL HAS BEEN THE OVERALL EFFECT OF ALCOHOL/DRUG USE ON YOUR PARTICIPATION IN LEISURE ACTIVITIES?

MADE IT MUCH WORSE.....1 []
MADE IT WORSE.....2 []
HAD NO EFFECT.....3 []
MADE IT BETTER.....4 []
MADE IT MUCH BETTER.....5 []

5.3 HOW WOULD YOU RATE YOUR NEED FOR HELP WITH LEISURE PROBLEMS?

NO REAL PROBLEM, HELP NOT NEEDED.....1 []
SLIGHT PROBLEM, HELP PROBABLY NOT NEEDED.....2 []
MODERATE PROBLEM, SOME HELP NEEDED.....3 []
CONSIDERABLE PROBLEM, HELP NEEDED.....4 []
EXTREME PROBLEM, HELP ESSENTIAL.....5 []

5.4 HOW WOULD YOU RATE THE AMOUNT OF TIME SPENT ON LEISURE PROBLEMS BY THIS PROGRAM?

NOT ENOUGH.....1 []
TOO MUCH.....2 []
SATISFACTORY.....3 []
UNABLE TO COMMENT. HAVE NOT ATTENDED ENOUGH GROUP MEETINGS.....4 []

6. LEGAL STATUS

THE FOLLOWING QUESTIONS ARE ABOUT YOUR LEGAL STATUS

6.1 OVER THE PAST SIX MONTHS HAVE YOU HAD ANY LEGAL PROBLEMS?

YES.....1 []
NO.....2 []

6.2 WHAT DO YOU FEEL HAS BEEN THE OVERALL EFFECT OF ALCOHOL/DRUG USE ON YOUR LEGAL STATUS?

MADE IT MUCH WORSE.....1 []
MADE IT WORSE.....2 []
HAD NO EFFECT.....3 []
MADE IT BETTER.....4 []
MADE IT MUCH BETTER.....5 []

6.3 HOW WOULD YOU RATE YOUR NEED FOR HELP WITH LEGAL PROBLEMS?

NO REAL PROBLEM, HELP NOT NEEDED.....1 []
SLIGHT PROBLEM, HELP PROBABLY NOT NEEDED.....2 []
MODERATE PROBLEM, SOME HELP NEEDED.....3 []
CONSIDERABLE PROBLEM, HELP NEEDED.....4 []
EXTREME PROBLEM, HELP ESSENTIAL.....5 []

6.4 HOW WOULD YOU RATE THE AMOUNT OF TIME SPENT ON LEGAL PROBLEMS BY THIS PROGRAM?

NOT ENOUGH.....1 []
TOO MUCH.....2 []
SATISFACTORY.....3 []
UNABLE TO COMMENT. HAVE NOT ATTENDED ENOUGH GROUP MEETINGS.....4 []

7. ALCOHOL USE

THE FOLLOWING QUESTIONS ARE ABOUT YOUR USE OF ALCOHOL.

7.1 WHAT IS THE LONGEST PERIOD OF TIME, IN DAYS, THAT YOU HAVE ABSTAINED IN THE PAST SIX MONTHS?

..... _____

7.2 WHAT DO YOU FEEL HAS BEEN THE OVERALL EFFECT OF ALCOHOL ON YOUR LIFE?

MADE IT MUCH WORSE.....1 []
MADE IT WORSE.....2 []
HAD NO EFFECT.....3 []
MADE IT BETTER.....4 []
MADE IT MUCH BETTER.....5 []

7.3 HOW WOULD YOU RATE YOUR NEED FOR HELP WITH YOUR DRINKING?

NO REAL PROBLEM, HELP NOT NEEDED.....1 []
SLIGHT PROBLEM, HELP PROBABLY NOT NEEDED.....2 []
MODERATE PROBLEM, SOME HELP NEEDED.....3 []
CONSIDERABLE PROBLEM, HELP NEEDED.....4 []
EXTREME PROBLEM, HELP ESSENTIAL.....5 []

7.4 HOW WOULD YOU RATE THE AMOUNT OF TIME SPENT ON PROBLEMS WITH ALCOHOL USE BY THIS PROGRAM?

NOT ENOUGH.....1 []
TOO MUCH.....2 []
SATISFACTORY.....3 []
UNABLE TO COMMENT. HAVE NOT ATTENDED ENOUGH GROUP MEETINGS.....4 []

8. OTHER DRUG USE

THE FOLLOWING QUESTIONS ARE ABOUT YOUR USE OF DRUGS, OTHER THAN ALCOHOL. THESE INCLUDE STREET DRUGS AND PRESCRIPTION DRUGS.

8.1 HOW LONG HAS IT BEEN SINCE YOU LAST USED DRUGS (FOR NON-MEDICAL REASONS)?

LESS THAN 24 HOURS AGO.....1 []
BETWEEN 1 - 2 DAYS AGO.....2 []
BETWEEN 3 - 7 DAYS AGO.....3 []
MORE THAN ONE WEEK AGO.....4 []

IF MORE THAN 1 WEEK AGO, SPECIFY NUMBER OF DAYS OR MONTHS ...____

8.2 WHAT DO YOU FEEL HAS BEEN THE OVERALL EFFECT OF DRUG USE ON YOUR LIFE?

MADE IT MUCH WORSE.....1 []
MADE IT WORSE.....2 []
HAD NO EFFECT.....3 []
MADE IT BETTER.....4 []
MADE IT MUCH BETTER.....5 []

8.3 HOW WOULD YOU RATE YOUR NEED FOR HELP WITH DRUG USE?

NO REAL PROBLEM, HELP NOT NEEDED.....1 []
SLIGHT PROBLEM, HELP PROBABLY NOT NEEDED.....2 []
MODERATE PROBLEM, SOME HELP NEEDED.....3 []
CONSIDERABLE PROBLEM, HELP NEEDED.....4 []
EXTREME PROBLEM, HELP ESSENTIAL.....5 []

8.4 HOW WOULD YOU RATE THE AMOUNT OF TIME SPENT ON PROBLEMS WITH DRUG USE BY THIS PROGRAM?

NOT ENOUGH.....1 []
TOO MUCH.....2 []
SATISFACTORY.....3 []
UNABLE TO COMMENT. HAVE NOT ATTENDED ENOUGH GROUP MEETINGS.....4 []

9. HEALTH STATUS

THE FOLLOWING QUESTIONS ARE ABOUT YOUR HEALTH.

9.1 HOW WOULD YOU RATE YOUR HEALTH OVER THE PAST SIX MONTHS?

GOOD.....1 []
FAIR.....2 []
POOR.....3 []

9.2 HAVE YOU RECEIVED TREATMENT/ MEDICAL SUPERVISION FOR ANY MEDICAL CONDITION OVER THE PAST SIX MONTHS?

NO 1[] YES 2[]

IF YES, SPECIFY _____

9.3 WHAT DO YOU FEEL HAS BEEN THE OVERALL EFFECT OF ALCOHOL/DRUG USE ON YOUR PHYSICAL HEALTH?

MADE IT MUCH WORSE.....1 []
MADE IT WORSE.....2 []
HAD NO EFFECT.....3 []
MADE IT BETTER.....4 []
MADE IT MUCH BETTER.....5 []

9.4 HOW WOULD YOU RATE YOUR NEED FOR HELP WITH PHYSICAL HEALTH PROBLEMS?

NO REAL PROBLEM, HELP NOT NEEDED.....1 []
SLIGHT PROBLEM, HELP PROBBABLY NOT NEEDED.....2 []
MODERATE PROBLEM, SOME HELP NEEDED.....3 []
CONSIDERABLE PROBLEM, HELP NEEDED.....4 []
EXTREME PROBLEM, HELP ESSENTIAL.....5 []

9.5 HAVE YOU EXPERIENCED ANY OF THE FOLLOWING EMOTIONAL HEALTH PROBLEMS OVER THE PAST SIX MONTHS?

	NO	YES
TENSION/ANXIETY/NERVOUSNESS	1[]	2[]
DIFFICULTY EATING/CHANGE IN EATING PATTERNS	1[]	2[]
DIFFICULTY SLEEPING/CHANGE IN SLEEP PATTERNS	1[]	2[]
DEPRESSION	1[]	2[]
LONELINESS	1[]	2[]
IRRATIONAL FEARS/PHOBIAS	1[]	2[]
TROUBLE CONCENTRATING	1[]	2[]
FEELING PEOPLE ARE AGAINST YOU/ARE TRYING TO HARM YOU	1[]	2[]
FEELING INFERIOR TO OTHERS	1[]	2[]
HAVING UNCONTROLLABLE THOUGHTS/IMPULSES	1[]	2[]
FEELING AGGRESSIVE/VIOLENT TOWARD OTHERS	1[]	2[]
HAVING THOUGHTS OF SUICIDE	1[]	2[]
HAVING SEXUAL PROBLEMS	1[]	2[]
FEELING PREOCCUPIED/FORGETFUL	1[]	2[]
AMNESIA/TROUBLE REMBERING PAST EVENTS	1[]	2[]
OTHER PROBLEMS	1[]	2[]

SPECIFY _____

9.6 HAVE YOU RECEIVED PROFESSIONAL HELP FOR EMOTIONAL HEALTH PROBLEMS OVER THE PAST SIX MONTHS, OTHER THAN THIS PROGRAM?

NO 1[] YES 2[]

IF YES, PLEASE COMPLETE THE FOLLOWING:

	NUMBER OF ADMISSIONS OR OUTPT. APPOINTMENTS	LENGTH OF INVOLVEMENT IN WEEKS	LOCATION/ DATES OF TREATMENTS
1. IN-PATIENT MEDICAL OR PSYCHIARTY	_____	_____	_____
2. OUT-PATIENT PSYCHIARTY/	_____	_____	_____
3. OTHER	_____	_____	_____

9.7 WHAT DO YOU FEEL HAS BEEN THE OVERALL EFFECT OF ALCOHOL/DRUG USE ON YOUR EMOTIONAL HEALTH?

MADE IT MUCH WORSE.....1 []
MADE IT WORSE.....2 []
HAD NO EFFECT.....3 []
MADE IT BETTER.....4 []
MADE IT MUCH BETTER.....5 []

9.8 HOW WOULD YOU RATE YOUR NEED FOR HELP WITH EMOTIONAL HEALTH PROBLEMS?

NO REAL PROBLEM, HELP NOT NEEDED.....1 []
SLIGHT PROBLEM, HELP PROBABLY NOT NEEDED.....2 []
MODERATE PROBLEM, SOME HELP NEEDED.....3 []
CONSIDERABLE PROBLEM, HELP NEEDED.....4 []
EXTREME PROBLEM, HELP ESSENTIAL.....5 []

9.9 HOW WOULD YOU RATE THE AMOUNT OF TIME SPENT ON EMOTIONAL HEALTH PROBLEMS BY THIS PROGRAM?

NOT ENOUGH.....1 []
TOO MUCH.....2 []
SATISFACTORY.....3 []
UNABLE TO COMMENT. HAVE NOT ATTENDED ENOUGH GROUP MEETINGS.....4 []

10. GENERAL INFORMATION

IF YOU HAVE ATTENDED FOUR OR MORE GROUP MEETINGS PLEASE ANSWER ALL QUESTIONS IN THIS SECTION. IF YOU HAVE ATTENDED LESS THAN FOUR GROUP MEETINGS SKIP QUESTIONS 1 TO 11 IN THIS SECTION. INSTEAD PLEASE ANSWER QUESTIONS 12 TO 20.

10.1 HOW MUCH DO YOU FEEL THIS PROGRAM IS HELPING OR HARMING YOU IN DEALING WITH YOUR ADDICTION PROBLEM?

HELPING

ALOT.....1 [ ]
SOME.....2 [ ]
NOT MUCH.....3 [ ]
NOT AT ALL.....4 [ ]

HARMING

ALOT.....1 [ ]
SOME.....2 [ ]
NOT MUCH.....3 [ ]
NOT AT ALL.....4 [ ]

10.2 ARE YOU RECEIVING ENOUGH HELP DURING GROUP SESSIONS TO TALK ABOUT YOUR PERSONAL PROBLEMS AND RECEIVE HELP WITH THEM?

YES.....1 [ ]
NO.....2 [ ]
DON'T NEED ANY HELP.....3 [ ]
DON'T WANT ANY HELP.....4 [ ]

10.3 ARE YOU RECEIVING ENOUGH TIME OUTSIDE GROUP SESSIONS (FROM THE PROGRAM STAFF OR OTHER COUNSELLORS) TO TALK ABOUT YOUR PERSONAL PROBLEMS AND RECEIVE HELP WITH THEM?

YES.....1 [ ]
NO.....2 [ ]
DON'T NEED ANY HELP.....3 [ ]
DON'T WANT ANY HELP.....4 [ ]

10.4 SINCE STARTING THE PROGRAM, HAVE YOU ATTENDED ALL SCHEDULED GROUP MEETINGS?

YES 1[ ] NO 2[ ]

IF NO, WHY DID YOU MISS THOSE MEETINGS YOU MISSED?

_____

10.5 WHAT IS IT ABOUT THIS GROUP THAT PROMPTS YOU TO KEEP ATTENDING?

_____

10.6 IN YOUR OPINION, HOW MANY OTHER GROUP MEMBERS ARE IMPROVING BECAUSE OF THE TREATMENT THEY RECEIVE FROM THIS PROGRAM?

ALOT.....1 [ ]
QUITE A FEW.....2 [ ]
SOME.....3 [ ]
NOT MANY.....4 [ ]
DON'T KNOW.....5 [ ]

10.7 ARE THERE ANY PROBLEM AREAS THAT THIS PROGRAM IS NOT DEALING WITH THAT YOU WOULD LIKE TO HAVE IT DEAL WITH?

IF YES, SPECIFY _____

10.8 WHAT DO YOU LIKE BEST ABOUT THIS PROGRAM?

_____

10.9 WHAT DO YOU LIKE LEAST ABOUT THIS PROGRAM?

_____

10.10 HOW WELL ARE YOUR GROUP LEADERS DOING THEIR JOBS?

EXCELLENT.....1 []
GOOD.....2 []
FAIR.....3 []
POOR.....4 []

10.11 WOULD YOU RECOMMEND THIS PROGRAM TO OTHERS WITH ADDICTION PROBLEMS?

_____

10.12 HOW OLD ARE YOU?

..... _____

10.13 YOUR SEX?

MALE .....1 []
FEMALE .....2 []

10.14 HOW MANY TIMES HAVE YOU BEEN ADMITTED TO THIS PROGRAM?

..... _____

10.15 WHEN DID YOUR CURRENT ADMISSION TO THIS PROGRAM START?

..... _____

10.16 WHO REFERRED YOU TO THIS PROGRAM FOR YOUR CURRENT ADMISSION?

WATERFORD HOSPITAL IN-PATIENT SERVICE .....1 []
WATERFORD HOSPITAL OUT-PATIENT SERVICE .....2 []
THE COURT .....3 []
OTHER SOCIAL AGENCY IN THE COMMUNITY .....4 []
SELF-REFERRED .....5 []

10.17 AT PRESENT I ATTEND:

DAY GROUP: TUESDAY .....1 []
DAY GROUP: THURSDAY .....2 []
NIGHT GROUP: TUESDAY .....3 []
PENITENTIARY GROUP .....4 []
SELF-HELP GROUP .....5 []

10.18 PRIOR TO YOUR CURRENT ADMISSION TO THIS PROGRAM DID YOU RECEIVE TREATMENT FOR YOUR ADDICTION PROBLEM?

NO.....1 []
YES.....2 []
SPECIFY_____

10.19 AT THE PRESENT TIME ARE YOU RECEIVING TREATMENT FOR YOUR ADDICTION PROBLEM OTHER THAN THIS PROGRAM?

NO.....1 []
YES.....2 []
SPECIFY_____

10.20 ADDITIONAL COMMENTS.

_____

APPENDIX D

APPENDIX D

Interpretation - Pretreatment Questionnaire, Posttreatment Questionnaire and Collateral Interview

The ASIST - A Structured Addictions Assessment Interview for Selecting Treatment (Addiction Research Foundation, 1984) provided the basis for these questionnaires. The intended purpose of the ASIST is to facilitate the collection and recording of client information deemed relevant to making individually tailored referral decisions. This includes a comprehensive assessment into nine areas of the client's life.

The researcher adapted the ASIST for use in a study of the perceptions of participants regarding their experiences in the Waterford Hospital Addictions Program. Similar to the ASIST, the adapted questionnaire, although less detailed, covers nine life areas.

The researcher further revised the adapted ASIST form for use as the Pretreatment Questionnaire in the proposed model. Several factors guided the revisions: (a) the relevancy of questions to the local scene; (b) the relevancy of questions to the examination of program impact in relation to major desired outcomes; and (c) the need for brevity, because of the limited resources available to program personnel for evaluation purposes. The researcher made all revisions to the original ASIST questionnaire in consultation with program personnel.

The Pretreatment Questionnaire is intended to obtain baseline information on individuals entering treatment at the Waterford Hospital Addictions Program. A slightly modified form serves as a Posttreatment Questionnaire. The questions included mirror those asked in the Pretreatment Questionnaire. The parallel nature of the items permits a comparison of clients' status at intake with status following treatment.

A standardized Client Satisfaction Questionnaire (Attkisson et al., 1984) enables client participation in the evaluation of the Addictions Program.

A Collateral Interview provides a supplement to clients' Posttreatment Questionnaire. The questions included, although fewer, are similar to those asked in the Posttreatment Questionnaire. The data generated from the resource persons - individuals likely to be familiar with clients' progress since starting treatment - can be used to determine the validity and reliability of information obtained from clients.

The nine assessment areas covered in these forms are Accommodation, Marital/Family Relationships, Other Social Relationships, Education/Employment, Finances, Leisure, Legal Status, Alcohol/Drug Use and Health Status. The information sought under these headings includes the following:

1. Socio-demographic characteristics

2. Nature and extent of alcohol and drug abuse and dependence

3. Previous and current treatment for addiction(s)

4. Physical and emotional health status

5. Extent of clients' social support systems

6. Leisure profile

7. Legal situation

8. Identification of problem areas

9. Assessment of clients' need for help

10. Assessment of the overall effect of alcohol/drug use on clients' lives.

Pretreatment and posttreatment comparisons of clients' profile in each life area provide the basis for measuring the attainment of the three primary program goals. These are outlined below.

Goal one: Reduction of clients' level of consumption and dependency on alcohol/drugs. Alcohol/Drug Use (Section 7) is covered in all three questionnaires and is intended to measure any change over time in clients' level of alcohol/drug consumption. Other forms, ADS - Alcohol Dependency Scale (Appendix D) and DAST - Drug Abuse Screening Test (Appendix E), respectively measure any change over time in clients' level of alcohol and drug dependency.

Goal two: Reduction of clients' social impairment. Indicators of the attainment of this goal include the following:

1. Improved employment status. This is measured by comparing the number of clients employed posttreatment as compared with pretreatment. See, Education/Employment, Section 3.

2. Fewer school/job-related problems (e.g. layoffs, dismissals, decrease in grades/productivity) posttreatment as compared with pretreatment. See Education/Employment, Section 3.

3. Improved financial status. This is measured by comparing (a) the number of clients in receipt of social assistance and U.I.C. posttreatment as compared with pretreatment, and (b) clients' gross monthly/annual income posttreatment as compared with pretreatment. See Finances, Section 4.

4. Improved residential status. This is measured by comparing the number of clients living in independent accommodations i.e. own house/apt./bedsitter or private boarding house and the number of clients living in group quarters (e.g. Emmanuel House, hostels, institution) posttreatment as compared with pretreatment. Also, an assessment of clients' living situation in terms of with whom they are living (e.g. alone, with non-relatives or family) posttreatment as compared with pretreatment provides

further basis for assessing clients' social stability. See Accommodation, Marital/Family Relationships, Section 7.

5. Fewer addiction-related legal problems (e.g. fewer arrests) posttreatment as compared with pretreatment. See Legal Status, Section 6.

6. Fewer addiction-related health problems (e.g. fewer outpatient/hospital treatments) posttreatment as compared with pretreatment. See Health Status, Section 8.

7. Improved interpersonal relationships. This is measured by the extent of reported difficulties in interpersonal relationships posttreatment as compared with pretreatment. See Accommodation/Marital Family Relationships, Section 1 and Other Social Relationships, Section 2.

Goal three: Reduction of clients' psychological impairment is determined by the number of emotional health problems posttreatment as compared with pretreatment. See Health Status, Section 8. Also, the Mini Mental Status Exam (Appendix F) provides a further objective measure of clients' mental health status.

Client satisfaction. At follow-up clients' perception of their treatment program is measured by a standardized Client Satisfaction Questionnaire - Attkisson et al., 1984. (Posttreatment Questionnaire, Appendix M).

APPENDIX E

APPENDIX E

Waterford Hospital Addictions Program
Referral Form

1. _____
First Middle Last

2. D.O.B. _____ 3. Sex [] Male [] Female

4. Current Address: (Not hospital or prison): _____

_____

_____

_____ Phone Number: _____

5. Permanent Address: (if different from current address): _____

_____

_____ Phone Number: _____

6. Current Marital Status:
[] Single, never married [] Married
[] Cohabiting [] Separated
[] Divorced [] Widowed

7. Highest level of education completed:
[] less than highschool [] High School
[] Some Vocational/Trade School
[] Vocational/Trade School Completed
[] Some University [] University Completed.

8. Current employment status:
   [ ] Homemaker [ ] Student [ ] Disabled
   [ ] Retired [ ] Unemployed [ ] Employed part-time
   [ ] Employed full-time.

9. Referral Source:
   [ ] Waterford Hospital In-patient Service
   [ ] Waterford Hospital Out-patient Service
   [ ] Other community source
   Specify _____

THIS SECTION IS COMPLETED BY ADDICTION PROGRAM PERSONNEL:

10. Status of service: [ ] New [ ] Readmission

11. Screened by: _____ Date _____

12. Action Taken:
   (a) [ ] Accepted into program
   [ ] Day-Tuesday
   [ ] Day-Thursday
   [ ] Night Group
   [ ] Penitentiary
   [ ] Self-help

   (b) [ ] Not accepted into program
   [ ] Reason _____
   _____

13. Consents to participate in evaluation project
   [ ] Yes [ ] No

14. Additional Comments: (Use this space to indicate no-shows for screening interviews etc.)

_____

_____

_____

_____

_____

APPENDIX F

APPENDIX F

NAME: _____ DATE: _____

ALCOHOL USE QUESTIONNAIRE (ADS)

The questions in this booklet are about your use of alcohol during the *past 12 months*.

INSTRUCTIONS

1. **Carefully read each question and the possible answers provided. Answer each question by circling the ONE choice that is most true for you.**
2. **The word "drinking" in a question refers to "drinking of alcoholic beverages."**
3. **Take as much time as you need. Work carefully, and try to finish as soon as possible. Please answer ALL questions.**

If you have difficulty with a question or have any problems, please ask the questionnaire administrator.

PAGE ONE

These questions refer to the past 12 months

1. How much did you drink the last time you drank?

   a. Enough to get high or less
   b. Enough to get drunk
   c. Enough to pass out

2. Do you often have hangovers on Sunday or Monday mornings?

   a. No
   b. Yes

3. Have you had the "shakes" when sobering up (hands tremble, shake inside)?

   a. No
   b. Sometimes
   c. Almost every time I drink

4. Do you get physically sick (e.g. vomit, stomach cramps) as a result of drinking?

   a. No
   b. Sometimes
   c. Almost every time I drink

5. Have you had the "DT's" (delirium tremens) - that is, seen, felt or heard things not really there; felt very anxious, restless, and overexcited?

   a. No
   b. Once
   c. Several times

PAGE TWO

6. When you drink, do you stumble about, stagger, and weave?

   a. No
   b. Sometimes
   c. Often

7. As a result of drinking, have you felt overly hot and sweaty (feverish)?

   a. No
   b. Once
   c. Several times

8. As a result of drinking have you seen things that were not really there?

   a. No
   b. Once
   c. Several times

9. Do you panic because you fear you may not have a drink when you need it?

   a. No
   b. Yes

10. Have you had blackouts ("loss of memory" without passing out) as a result of drinking?

    a. No, never
    b. Sometimes
    c. Often
    d. Almost every time I drink

PAGE THREE

11. Do you carry a bottle with you or keep one close at hand?

    a. No
    b. Some of the time
    c. Most of the time

12. After a period of abstinence (not drinking), do you end up drinking heavily again?

    a. No
    b. Sometimes
    c. Almost every time

13. In the past 12 months, have you passed out as a result of drinking?

    a. No
    b. Once
    c. More than once

14. Have you had a convulsion (fit) following a period of drinking?

    a. No
    b. Once
    c. Several times

15. Do you drink throughout the day?

    a. No
    b. Yes

PAGE FOUR

16. After drinking heavily, has your thinking been fuzzy or unclear?

    a. No
    b. Yes, but only for a few hours
    c. Yes, for one or two days
    d. Yes, for many days

17. As a result of drinking, have you felt your heart beating rapidly?

    a. No
    b. Once
    c. Several times

18. Do you almost constantly think about drinking and alcohol?

    a. No
    b. Yes

19. As a result of drinking have you heard "things" that were not really there?

    a. No
    b. Once
    c. Several times

20. Have you had weird and frightening sensations when drinking?

    a. No
    b. Once or twice
    c. Often

PAGE FIVE

21. As a result of drinking have you "felt things" crawling on you that were not really there (e.g. bugs, spiders)?

    a. No
    b. Once
    c. Several times

22. With respect to blackouts (loss of memory):

    a. Have never had a blackout
    b. Have had blackouts that last less than a hour
    c. Have had blackouts that last for several hours
    d. Have had blackouts that last for a day or more

23. Have you tried to cut down on your drinking and failed?

    a. No
    b. Once
    c. Several times

24. Do you gulp drinks (drink quickly)?

    a. No
    b. Yes

25. After taking one or two drinks, can you usually stop?

    a. Yes
    b. No

ADS-25

THE ADMINISTRATION, SCORING AND INTERPRETATION OF ADS*

Administration: give the ADS-25 questionnaire to the client and instruct him/her to carefully consider each question and circle the answer that most accurately reflects his/her response.

The assessment worker should be available to answer any questions that the client may have while completing the questionnaire:

Scoring: When the client has completed the questionnaire use the table entitled ADS Scoring Key to determine the value of the circled responses to each question. The raw score is obtained by adding the scores for all 25 questions.

Interpretation: Use the ADS Interpretation Guide table for the suggested interpretation of the client's score. It is recommended that this information should be discussed with the client during the assessment summary portion of the interview.

* Addiction Research Foundation (1984). A structured addictions assessment interview for selecting treatment. In Assessment handbook including ASSIST. Ontario, Canada.

ADS SCORING KEY

Item	Option	Score	Item	Option	Score	Item	Option	Score
1	a	0	10	a	0	19	a	0
	b	1		b	1		b	1
	c	2		c	2		c	2
2	a	0	11	a	0	20	a	0
	b	1		b	1		b	1
				c	2		c	2
3	a	0	12	a	0	21	a	0
	b	1		b	1		b	1
	c	2		c	2		c	2
4	a	0	13	a	0	22	a	0
	b	1		b	1		b	1
	c	2		c	2		c	2
							d	3
5	a	0	14	a	0	23	a	0
	b	1		b	1		b	1
	c	2		c	2		c	2
6	a	0	15	a	0	24	a	0
	b	1		b	1		b	1
	c	2						
7	a	0	16	a	0	25	a	0
	b	1		b	1		b	1
	c	2		c	2			
				d	3			
8	a	0	17	a	0			
	b	1		b	1			
	c	2		c	2			
9	a	0	18	a	0			
	b	1		b	1			

ADS INTERPRETATION GUIDE

ADS Raw Score	SUGGESTED INTERPRETATION
0	No evidence of alcohol dependence was reported by the client.
1 - 13 (1st quartile)	Low Level of alcohol dependence. Such dependence as exists is probably psychological, rather than physical. Controlled drinking strategies may be of use if there are no contraindications. Clients are more likely to comply with controlled drinking and reject abstinence goals. Check for seriousness of intentions to comply with treatment.
14 - 21 (2nd quartile)	Moderate Level of alcohol dependence. Psychosocial problems related to drinking are likely. Psychological dependence may still be characteristic, but look for increasing signs of physical dependence, and withdrawal symptoms. Controlled drinking strategies may be considered if there are no contraindications. Clients may be more likely to comply with controlled drinking and reject abstinence goals.

22 - 30 (3rd quartile)	Substantial Level of alcohol dependence. Physical dependence is likely. Physical disorders and psychosocial problems related to alcohol abuse are probable. Abstinence treatment goals should be very seriously considered. Clients may be more likely to recognize that abstinence is the only way to improve.
31 - 47 (4th quartile)	Severe Level of alcohol dependence. Physical dependence is highly likely. Serious physical disorders related to drinking, such as liver disease, are likely. Abstinence is probably the only reasonable treatment goal. Clients should generally agree with total abstinence as the focus of treatment.

APPENDIX G

Name:_____ Date:_____

DRUG USE QUESTIONNAIRE (DAST-20)

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

	These questions refer to the past 12 months.	Circle Your Response	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Have you abused prescription drugs?	Yes	No
3.	Do you abuse more than one drug at a time?	Yes	No
4.	Can you get through the week without using drugs?	Yes	No
5.	Are you always able to stop using drugs when you want to?	Yes	No
6.	Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
7.	Do you feel bad or guilty about your drug use?	Yes	No
8.	Does your spouse (or parents) complain about your involvement with drugs?	Yes	No
9.	Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10.	Have you lost friends because of your use of drugs?	Yes	No
11.	Have you neglected your family because of your use of drugs?	Yes	No
12.	Have you been in trouble at work because of drug abuse?	Yes	No
13.	Have you lost a job because of drug abuse?	Yes	No
14.	Have you gotten into fights when under the influence of drugs?	Yes	No
15.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16.	Have you been arrested for possession of illegal drugs?	Yes	No
17.	Have you experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19.	Have you gone to anyone for help for a drug problem?	Yes	No
20.	Have you been involved in a treatment program specifically related to drug use?	Yes	No

THE ADMINISTRATION, SCORING AND INTERPRETATION OF DAST-20*

DAST-20

Administration: In addition to handing the client a copy of the DAST, please provide him/her with the following information regarding the test:

- the 20 questions are concerned with your involvement with drugs only, not alcoholic beverages. Drugs refer to psychoactive substances.
- read each question carefully, and then circle either the "yes" or "no" answer. In cases where either seems appropriate, circle the answer which best describes your response.

Scoring: When the client has completed the questionnaire, score the answers according to the Scoring Scheme for DAST - 20. The DAST score which is determined by totalling the scores for all items will indicate the severity of the client's drug problem.

Interpretation: The DAST total score orders individuals along a continuum with respect to their degree of problems or consequences related to drug abuse. As the DAST score increases there is a corresponding rise in the level of drug problems reported. A low score does not necessarily mean that the client is free of drug problems. One must consider the length of time the client has been using drugs, the client's age, level of consumption, source of the referral and other data collected during the assessment in order to interpret the DAST score.

* Addiction Research Foundation (1984). A structured addictions assessment interview for selecting treatment. In Assessment handbook including ASSIST. Ontario, Canada.

A DAST score of 6 or greater is suggested for case identification purposes.

DAST SCORE	DEGREE OF PROBLEMS RELATED TO DRUG ABUSE
0	None Reported
1 - 5	Low Level
6 - 10	Moderate Level
11 - 25	Substantial Level
16 - 20	Severe Level

SCORING SCHEME FOR D.A.S.T.- 20

Question #	Answer	Score
1	Yes	1
	No	0
2	Yes	1
	No	0
3	Yes	1
	No	0
* 4	Yes	1
	No	0
* 5	Yes	1
	No	0
6	Yes	1
	No	0
7	Yes	1
	No	0
8	Yes	1
	No	0

* Note reversal of scoring in these two items.

Question #	Answer	Score
9	Yes	1
	No	0
10	Yes	1
	No	0
11	Yes	1
	No	0
12	Yes	1
	No	0
13	Yes	1
	No	0
14	Yes	1
	No	0
15	Yes	1
	No	0
16	Yes	1
	No	0
17	Yes	1
	No	0
18	Yes	1
	No	0
19	Yes	1
	No	0
20	Yes	1
	No	0

APPENDIX H

MINI MENTAL STATUS EXAM*

Suggested Introduction. I am now going to ask you some questions that we ask everybody routinely. Some of them may seem easy, others are harder. Just think about each and answer as best you can. Some questions may repeat things you have already told me, if so, please just answer them again.

		MAX	CLIENT SCORE
32.	What is the date? _____ year _____ season _____ date _____ day _____ month (prompt: Can you tell me the...)	/5/	/ /
33.	Where are we? _____ state _____ county _____ town _____ hospital _____ floor (prompt: Can you tell me the name of this...)	/5/	/ /
34.	I would like to test your memory, ok? (One second apart say: "Here are some words: elephant, table, blue.") Can you repeat these words? _____ elephant _____ table _____ blue	/3/	/ /
	Repeat until all 3 are recalled. Count trials required _____. (Max 6) If client cannot recall all 3, memory cannot be tested later. When all 3 are recalled, say "OK, now I will ask you them later."		
35.	a) I would like you to count backwards for me. Begin at 100 and count backwards subtracting seven (7) at a time. (Stop after 5 subtractions.) Check: _____ 93 _____ 86 _____ 79 _____ 72 _____ 65	/5/	/ /
	b) Note: If client cannot do serial 7's ask: Spell WORLD backwards. D L R O W		
36.	Can you remember the words I gave you earlier? _____ elephant _____ table _____ blue	/3/	/ /
37.	Show client a) wrist watch (point to it) What is this? _____ b) pencil (point) And what is this? _____ (Check correct)	/2/	/ /
38.	Repeat this after me please. "No ifs, ands or buts." _____ (Check correct)	/1/	/ /

* Folstein, M.F., Folstein, S.E., & McHugh, P.R. (1975). Mini mental status: A practical method for grading cognitive state of patients for clinicians. Journal of Psychiatric Research, 12, 189-198.

	MAX	CLIENT SCORE
39. (Give client a piece of blank paper.) Say, "Take a paper in your right hand, fold it in half, and put it on the floor."	/3/	/ /
Hand _____ Fold _____ Floor _____		
40. (Do not say instruction out loud.) Show client card: "Close your eyes." Ask: I want you to read this and then do what it says. (Check correct) (Score only if client closes eyes).	/1/	/ /
41. (Give client blank paper) Ask client: Can you write down a sentence for me? (Do not dictate, it must be spontaneous). (Check correct) _____	/1/	/ /
42. Show Card of 2 intersecting pentagons to client. Give client paper and ask: Can you copy this, exactly as you see it please? (Check correct) _____	/1/	/ /
TOTAL SCORE:	/30/	/ /

DECISION: RULE OUT OBS

GUIDELINES: — Score $>$ 25 - NORMAL (MEAN FOR NORMALS 27.6)

— 20-25 - IMPAIRED - QUESTIONABLE

— $<$ 20 - SEVERE, USUALLY FUNCTIONAL PSYCHOSIS, OBS, DEMENTIA.

(NOTE: IN ETOH ABUSE - IMPAIRMENT COULD BE RELATED TO CURRENT INTOXICATION OR WERNICKE'S - REPEAT EXAM AFTER HOSPITALIZATION, DECREASE ACUTE PHASE AND TREATMENT.)

APPENDIX I

APPENDIX I

Waterford Hospital Addictions Program Evaluation Project

Consent Statement

The staff of the Waterford Hospital Addictions Program is interested in learning how well the program is working and how it can be made better. To obtain this information we are requesting group members' participation in an evaluation project.

If you decide to participate, we will be asking you questions about your use of alcohol and/or other drugs and how it has affected various areas of your life (e.g. jobs., family, health). This information will first be collected in a pretreatment interview lasting approximately _____. We will also ask you to sign some blank release of information forms so that we can collect records from other agencies you have used throughout the year.

To carry out our purpose, we will be in contact with you for the next _____ months. During this _____ month period follow-up contacts will be made _____. They will be made
(fill in intended contact schedule)
by telephone, by mail, or in a personal interview. At those times we will be asking you to give us information similar to that asked in the pretreatment interview (e.g. alcohol/ drug use, jobs, family, health).

We may also want to talk to other people who know you in order to hear how they think the Addictions Program is affecting you. Therefore, we will ask you for the names of some collateral sources - friends, spouse, employer, relatives - who can provide us with some information about your use of alcohol and/or other drugs and about other areas of your life health. These questions are like the ones we will be asking you when we contact you. Also, we may obtain records from various agencies which may be able to supply us with further information (e.g. hospital and arrest records).

All the information we gather will be kept strictly confidential. It will be seen only by the people directly involved in the conduct of this project. Findings will be reported in summary form so that no one can be identified.

Your participation is this project is voluntary. You are free to not answer any questions you choose, or to withdraw this consent and to discontinue participation at any time. This will in no way prejudice the services you receive from this program now or in the future.

If you decide to participate, your information will help us to evaluate the effectiveness of the Addictions Program and your progress as an individual in this program. Also, it may help us to understand and help other people with problems similar to yours.

Thank you.

Any questions I have about participation have been answered and I give my consent to participate.

_____	_____
Date	Signature of Volunteer
_____	_____
Date	Signature of Witness

APPENDIX J

APPENDIX J

Waterford Hospital Addictions Program
Tracking Information Form

Re: _____

Collateral Information Sources (e.g. spouse, other relatives, friends, employer, probation officer). In order of clients' preference.

(1) Full Name: _____

Relationship: _____

Address: _____

Phone Number: _____

(2) Full Name: _____

Relationship: _____

Address: _____

Phone Number: _____

(3) Full Name: _____

Relationship: _____

Address: _____

Phone Number: _____

(4) Full Name: _____

Relationship: _____

Address: _____

Phone Number: _____

APPENDIX K

APPENDIX K

Waterford Hospital Addictions Program
Release of Information

Re: _____
Date of birth: _____
Address: _____
_____

I give my permission to _____
Name of person, organization or

_____
agency

_____
Address
to release all information pertaining to me to the Waterford Hospital Addictions Program. This information is needed to aid in my clinical treatment and/or evaluation.

I have been advised that I may withdraw this consent at any time and unless an earlier date is specified, this consent will be in effect for _____ months.

_____ _____
Signature of client Date

_____ _____
Signature of witness Date

APPENDIX L

APPENDIX L

Waterford Hospital Addictions Program

Pretreatment Questionnaire

Assessment Areas Covered:	Demographics, accommodations, marital and family relationships, other social relationships, education, employment, finances, leisure, legal status, alcohol use, drug use, and health
Administration:	Self-administered or interviewer - administered (approximately 60-70 minutes), at intake. Consideration may be given to administering the Alcohol/Drug Use section during the screening interview. This may aid decision-making regarding appropriate admissions.
Design Features:	68 items; multiple-choice, yes/no, and completion Gquestions
Abstract:	The researcher adapted this questionnaire from the ASIST - A Structured Addictions Assessment Interview for Selecting Treatment (Addiction Research Foundation, 1984). It is intended to obtain baseline information on individuals entering treatment at the Waterford Hospital Addictions Program. The pretreatment data represents clients' functioning during the 12 month pretreatment interval.

Pretreatment Questionnaire

1. ACCOMMODATION, MARITAL/FAMILY RELATIONSHIPS

THE FOLLOWING QUESTIONS ARE ABOUT YOUR ACCOMMODATION, AND YOUR FAMILY/MARITAL RELATIONSHIPS.

1.1 WHERE ARE YOU LIVING NOW?

OWN HOUSE.....1 []
RENTED HOUSE/APARTMENT/BEDSITTER .....2 []
BOARDING HOUSE.....3 []
SHELTER/HOSTEL/ COMMUNITY CARE.....4 []
INSTITUTION.....5 []
OTHER.....6 []
SPECIFY_____

1.2 HOW LONG HAVE YOU LIVED THERE?

IF LESS THAN ONE YEAR GIVE THE NUMBER OF MONTHS.1 [][]
NUMBER OF YEARS.....2 [][]

1.3 WHO ARE YOU LIVING WITH?

WITH SPOUSE OR PARTNER.....1 []
WITH CHILDREN.....2 []
WITH OTHER RELATIVES.....3 []
WITH FRIENDS.....4 []
WITH OTHERS (NOT RELATIVES OR FRIENDS.....5 []
ALONE.....6 []
OTHER.....7 []
SPECIFY_____

1.4 HOW LONG HAVE YOU HAD THIS LIVING ARRANGEMENT?

IF LESS THAN ONE YEAR GIVE THE NUMBER OF MONTHS.1 [][]
NUMBER OF YEARS.....2 [][]

1.5 WHAT IS YOUR CURRENT MARITAL STATUS?

SINGLE, NEVER MARRIED.....1 []
MARRIED.....2 []
COHABITING.....3 []
SEPARATED.....4 []
DIVORCED.....5 []
WIDOWED.....6 []

1.6 HOW LONG HAVE YOU HAD THIS MARITAL STATUS?

IF LESS THAN ONE YEAR GIVE THE NUMBER OF MONTHS.1 [][]
NUMBER OF YEARS.....2 [][]

1.7 DO YOU HAVE MARITAL/FAMILY PROBLEMS NOW?

NO.....1 []
YES.....2 []

1.8 IF YES, HOW DO YOU RATE YOUR NEED FOR HELP WITH MARITAL/FAMILY ROBLEMS?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 []
MODERATE PROBLEM HELP NEEDED.....2 []
SEVERE PROBLEM, HELP ESSENTIAL.....3 []

2. OTHER SOCIAL RELATIONSHIPS

THE FOLLOWING QUESTIONS ARE ABOUT OTHER SOCIAL RELATIONSHIPS.

2.1 AT PRESENT DO MOST OF YOUR FRIENDS OR PEOPLE YOU SPEND TIME WITH ABUSE OF HAVE PROBLEMS WITH ALCOHOL/DRUGS?

NO.....1 []
YES.....2 []
50/50 EQUAL.....3 []
DON'T KNOW.....4 []

2.2 DO YOU HAVE ANY FRIENDS WHOM YOU CAN COUNT ON FOR HELP WITH YOUR PROBLEMS?

NO.....1 []
YES.....2 []

2.3 IN THE PAST TWELVE MONTHS HAVE YOU BEEN HAVING PROBLEMS WITH YOUR FRIENDS?

NO.....1 []
YES.....2 []

IF NO, PLEASE MOVE TO SECTION 3, EDUCATION/EMPLOYMENT.

2.4 IF YES, WHAT KIND OF PROBLEMS HAVE YOU BEEN HAVING?

CONTROLLING TEMPER .....1 []
GETTING ALONG WITH FRIENDS..2 []
BEING UNDERSTOOD BY FRIENDS.3 []
BEING INFLUENCED TO USE ALCOHOL/DRUGS.....4 []
OTHER .....5 []

SPECIFY _____

2.5 IF YES, HOW DO YOU RATE YOUR NEED FOR HELP WITH YOUR PROBLEMS WITH YOUR FRIENDS?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 []
MODERATE PROBLEM, HELP NEEDED.....2 []
SEVERE PROBLEM, HELP ESSENTIAL.....3 []

3. EDUCATION/EMPLOYMENT

THE FOLLOWING QUESTIONS ARE ABOUT YOUR EDUCATION/EMPLOYMENT STATUS.

3.1 WHAT IS THE HIGHEST EDUCATION LEVEL YOU HAVE COMPLETED?

LESS THAN HIGH SCHOOL.....1 []
HIGH SCHOOL.....2 []
SOME/COMMUNITY COLLEGE/ TRADE SCHOOL.....3 []
TRADE SCHOOL GRADUATE.....4 []
SOME UNIVERSITY.....5 []
UNIVERSITY GRADUATE.....6 []

3.2 ARE YOU EMPLOYED NOW?

NO.....1 []
YES, PART TIME .....2 []
YES, FULL TIME .....3 []

IF YES, PLEASE MOVE TO QUESTION 3.5.

IF NO, PLEASE ANSWER THE FOLLOWING QUESTIONS.

3.3 HOW LONG HAVE YOU BEEN OUT OF WORK?

LESS THAN 3 MONTHS.....1 []
3-7 MONTHS.....2 []
8-12 MONTHS.....3 []
MORE THAN ONE YEAR.....4 []

3.4 WHAT IS THE MAIN REASON FOR BEING OUT OF WORK? (CHOOSE ONE ANSWER)

TEMPORARILY LAID OFF.....1 []
NOT EMPLOYED AND LOOKING FOR WORK.....2 []
NOT EMPLOYED AND NOT LOOKING FOR WORK.....3 []
STUDENT.....4 []
POOR HEALTH/DISABLED.....5 []
RETIRED.....6 []
HOMEMAKER.....7 []
IN-HOSPITAL.....8 []
IN-JAIL.....9 []
DRINKING/USING DRUGS.....10 []
OTHER.....11 []
SPECIFY _____

3.5 IF YOU HAVE BEEN EMPLOYED OR ATTENDING SCHOOL AT ALL IN THE PAST TWELVE MONTHS HAVE ANY OF THE FOLLOWING SCHOOL/EMPLOYMENT PROBLEMS OR CHANGES HAPPENED TO YOU?

	NO	YES
PROMOTION	[]	[]
LAYOFF	[]	[]
RETIREMENT	[]	[]
LATENESS/ABSENTEEISM	[]	[]
ACCIDENTS	[]	[]
DECREASE IN GRADES/ PRODUCTIVITY	[]	[]
DRINKING/DRUG TAKING AT SCHOOL/ON THE JOB	[]	[]
VERBAL WARNING FROM SCHOOL/ UNION/EMPLOYER	[]	[]
WRITTEN REPRIMAND	[]	[]
SUSPENSION/LOSS OF PAY	[]	[]
JOB DEMOTION	[]	[]
EXPLUSION/DISMISSAL	[]	[]
RESIGNATION	[]	[]

3.6 DO YOU HAVE SCHOOL/EMPLOYMENT PROBLEMS NOW?

NO.....1 []
YES.....2 []

3.7 IF YES, HOW DO YOU RATE YOUR NEED FOR HELP WITH SCHOOL/EMPLOYMENT PROBLEMS?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 []
MODERATE PROBLEM, HELP NEEDED.....2 []
SEVERE PROBLEM, HELP ESSENTIAL.....3 []

4. FINANCES

THE FOLLOWING QUESTIONS ARE ABOUT YOUR FINANCIAL STATUS.

4.1 WHAT HAS BEEN YOUR MAIN SOURCE OF INCOME IN THE PAST TWELVE MONTHS?

EMPLOYMENT.....1 []
UNEMPLOYMENT INSURANCE BENEFITS.....2 []
SPOUSE.....3 []
PENSION.....4 []
WELFARE BENEFITS.....5 []
SAVINGS.....6 []
OTHER.....7 []
SPECIFY_____

4.2 WHAT WAS YOUR TOTAL PERSONAL INCOME OVER THE PAST TWELVE MONTHS? INCLUDE ONLY YOUR INCOME AND NOT THAT OF ANYONE ELSE IN YOUR HOUSEHOLD.

_____

4.3 DO YOU HAVE FINANCIAL PROBLEMS NOW

NO.....1 []
YES.....2 []

4.4 IF YES, HOW DO YOU RATE YOU NEED FOR HELP WITH FINANCIAL PROBLEMS?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 []
MODERATE PROBLEM, HELP NEEDED.....2 []
SEVERE PROBLEM, HELP ESSENTIAL.....3 []

5. LEISURE

THE FOLLOWING QUESTIONS ARE ABOUT YOUR LEISURE TIME ACTIVITIES.

5.1 DO YOU HAVE MUCH SPARE TIME?

NO.....1 []
YES.....2 []

5.2 IN YOUR SPARE TIME, DO YOU PARTICIPATE IN ANY OF THE FOLLOWING ACTIVITIES ON A REGULAR BASIS?

	NO	YES
COMMUNITY GROUPS/ACTIVITIES	1[]	2[]
HOBBIES/CRAFTS	1[]	2[]
SPORTS/RECREATION	1[]	2[]
WATCHING T.V	1[]	2[]
ATTENDING EDUCATION/ INTEREST COURSES	1[]	2[]
SOCIALIZING OR BEING WITH FRIENDS	1[]	2[]
RELIGION/RELIGIOUS ACTIVITIES	1[]	2[]
SITTING ALONE, DOING NOTHING	1[]	2[]
OTHER ACTIVITIES	1[]	2[]

SPECIFY_____

5.3 DO YOU HAVE LEISURE PROBLEMS NOW?

NO.....1 []
YES.....2 []

5.4 IF YES, HOW DO YOU RATE YOUR NEED FOR HELP WITH YOUR LEISURE PROBLEMS?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 []
MODERATE PROBLEM HELP NEEDED.....2 []
SEVERE PROBLEM, HELP ESSENTIAL.....3 []

6. LEGAL STATUS

6.1 DO YOU HAVE ANY LEGAL PROBLEMS AT PRESENT?

NO.....1 []
YES.....2 []

6.2 IF YES, ARE YOU AWAITING
TRIAL/HEARING/SENTENCING....1 []
ON SUSPENDED SENTENCE.....2 []
ON PROBATION/PAROLE.....3 []
IN JAIL.....4 []

6.3 HAVE YOU EVER HAD ANY ALCOHOL/DRUG RELATED DRIVING CHARGES?

NO.....1 []
YES.....2 []

6.4 IF YES, HOW MANY IN THE PAST TWELVE MONTHS?.....[][]

EVER.....[][]

6.5 HAVE YOU HAD ANY OTHER ALCOHOL/DRUG-RELATED CHARGES?

NO.....1 []
YES.....2 []

6.6 IF YES, HOW MANY IN THE PAST TWELVE MONTHS?

_____

WHAT WAS (WERE) THE NATURE OF THE CHARGE(S)?

_____

6.7 IF ARRESTED OR JAILED IN THE PAST TWELVE MONTHS, PLEASE INDICATE THE FOLLOWING:

NAME OF JAIL OR CORRECTIONAL FACILITY:_____

ADDRESS:_____

NUMBER OF DAYS JAILED:_____

DATES OF ARRESTS OR INCARCERATIONS:_____

6.8 IF YOU HAVE LEGAL PROBLEMS NOW, HOW DO YOU RATE YOUR NEED FOR HELP WITH YOUR LEGAL PROBLEMS?

LITTLE OR NO PROBLEM,
HELP NOT NEEDED.....1 []
MODERATE PROBLEM,
HELP NEEDED.....2 []
SEVERE PROBLEM,
HELP ESSENTIAL.....3 []

7. ALCOHOL/DRUG USE

7.1 DO YOU HAVE A PROBLEM WITH ANY OF THE FOLLOWING?

ALCOHOL.....1 []
PRESCRIPTION DRUGS.....2 []
STREET DRUGS.....3 []
ALL OF THE ABOVE.....4 []

7.2 WHICH IS THE MAJOR PROBLEM FOR YOU?

ALCOHOL.....1 []
PRESCRIPTION DRUGS.....2 []
STREET DRUGS.....3 []

IF ALCOHOL USE IS NOT A PROBLEM FOR YOU, PLEASE MOVE TO QUESTION 7.15.

THE FOLLOWING QUESTIONS ARE ABOUT YOUR USE OF ALCOHOL.

7.3 OVER THE PAST TWELVE MONTHS WHAT IS THE LONGEST NUMBER OF DAYS IN A ROW YOU DRANK? (CHECK ONE)

DID NOT DRINK.....1 []
1-2 DAYS AT A TIME.....2 []
3-7 DAYS AT A TIME.....3 []
8-14 DAY AT A TIME.....4 []
15 DAYS AND OVER.....5 []
(SPECIFY NUMBER) _____
CONTINUOUSLY (I.E. DAILY)...6 []

7.4 DURING THE PAST 28 DAYS ON HOW MANY DAYS DID YOU HAVE AT LEAST ONE DRINK?

_____ DAYS.

7.5 DURING THE PAST TWELVE MONTHS HOW MANY DAYS IN A ROW DID YOU USUALLY ABSTAIN? (CHECK ONE)

DID NOT ABSTAIN.....1 []
1-2 DAYS AT A TIME.....2 []
3-7 DAYS AT A TIME.....3 []
8-14 DAY AT A TIME.....4 []
15 DAYS AND OVER.....5 []
(SPECIFY NUMBER) _____
CONTINUOUSLY (I.E. DAILY)...6 []

7.6 WHAT IS THE LONGEST PERIOD OF TIME, IN DAYS, THAT YOU HAVE ABSTAINED IN THE PAST TWELVE MONTHS?

_____ DAYS

7.7 HOW MANY DAYS AGO DID THIS ABSTINENCE END?

DAYS.....1 []
STILL ABSTINENT.....2 []

7.8 HOW OLD WERE YOU WHEN YOUR DRINKING FIRST STARTED TO CAUSE PROBLEMS (WITH YOUR HEALTH, FAMILY ETC.)?

_____

7.9 THE FOLLOWING QUESTIONS ARE ABOUT YOUR DRINKING PATTERNS DURING A "TYPICAL" 28 DAY PERIOD OVER THE PAST TWELVE MONTHS.

	AMOUNT (OZS)	TYPE OF BEVERAGE	STANDARD DRINKS	NUMBER OF TIMES PER TYPICAL 28 DAY PERIOD	PRODUCT
A. WHAT IS THE MAXIMUM AMOUNT YOU HAVE HAD ON ANY ONE DAY?	(_____)	(_____)	_____	X _____	=_____
	(_____)	(_____)	_____	X _____	=_____
B. HOW MUCH DO YOU DRINK ON YOUR "USUAL" DRINKING DAYS?	(_____)	(_____)	_____	X _____	=_____
	(_____)	(_____)	_____	X _____	=_____
C. HOW MUCH DO YOU DRINK ON YOUR "OTHER" DRINKING DAYS	(_____)	(_____)	_____	X _____	=_____
	(_____)	(_____)	_____	X _____	=_____
D. NUMBER OF DAYS OF COMPLETE ABSTINENCE	.....			_____	
E. SUM OF PRODUCTS (A TO C)	.....			_____	

THE MEAN NUMBER OF STANDARD DRINKS PER DAY EQUALS THE SUM OF THE PRODUCTS (E) DIVIDED BY 28: (E/28) = (_____/28) = [][]

F. WHAT IS YOUR USUAL BODY WEIGHT? .....LBS. [][][]
Kg [][]

7.10 HOW LONG HAVE YOU BEEN CONSUMING ALCOHOL AT THIS LEVEL?

IF LESS THAN ONE YEAR, GIVE NUMBER OF MONTHS.....[][]
NUMBER OF YEARS.....[][]

7.11 WHAT IS THE LONGEST PERIOD OF TIME THAT YOU HAVE GONE WITHOUT A DRINK SINCE YOU BEGAN HAVING PROBLEMS ASSOCIATED WITH DRINKING?

IF LESS THAN ONE YEAR, GIVE NUMBER OF MONTHS.....[][]
NUMBER OF YEARS.....[][]

7.12 HOW LONG AGO DID YOU HAVE YOUR LAST DRINK?

HOURS.....[][][]
DAYS.....[][][]
MONTHS.....[][][]

7.13 HOW WOULD YOU RATE YOUR NEED FOR HELP WITH YOUR DRINKING?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 []
MODERATE PROBLEM, HELP NEEDED.....2 []
SEVERE PROBLEM, HELP ESSENTIAL.....3 []

THE FOLLOWING QUESTIONS ARE ABOUT YOUR USE OF DRUGS (OTHER THAN ALCOHOL).

7.14 HAVE YOU EVER USED DRUGS (OTHER THAN ALCOHOL) FOR NON-MEDICAL REASONS?

NO.....1 []
YES.....2 []

IF NO PLEASE MOVE TO SECTION 8, HEALTH STATUS.

IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS.

7.15 HOW MANY DAYS IN THE PAST 28 DAYS HAVE YOU USED DRUGS FOR NON-MEDICAL REASONS? (WRITE IN ZERO(0) IF DRUGS HAVE NOT BEEN USED AT ALL IN THE PAST 28 DAYS).

DAYS.....[][][]

7.16 DURING THE PAST TWELVE MONTHS WHEN YOU WERE USING DRUGS, HOW MANY DAYS IN A ROW DID YOU USE THEM?

1-2 DAYS AT A TIME.....1 []
3-7 DAYS AT A TIME.....2 []
8-14 DAY AT A TIME.....3 []
15 DAYS AND OVER.....4 []
(SPECIFY NUMBER) _____
CONTINUOUSLY (I.E. DAILY)...5 []

7.17 HAVE YOU EVER USED THESE DRUGS IN COMBINATION WITH ALCOHOL?

NEVER.....1 []
SELDOM.....2 []
SOMETIMES.....3 []
USUALLY.....4 []
ALWAYS.....5 []

7.18 HOW LONG HAS IT BEEN SINCE YOU LAST USED ANY OF THESE DRUGS?

LESS THAN 24 HOURS AGO.....1 []
BETWEEN 1-2 DAYS.....2 []
BETWEEN 3-7 DAYS.....3 []
MORE THAN 1 WEEK AGO.....4 []
IF MORE THAN 1 WEEK AGO.....5 []
(SPECIFY NUMBER OF DAYS) _____

THE FOLLOWING QUESTION IS ABOUT YOUR TREATMENT HISTORY FOR ALCOHOL/DRUG USE.

7.19 DID YOU RECEIVE TREATMENT FOR YOUR ALCOHOL/DRUG PROBLEM(S) DURING THE PAST TWELVE MONTHS?

NO.....1 []
YES.....2 []

7.20 IF YES, PLEASE INDICATE THE FOLLOWING:

	TYPE OF TREATMENT		NUMBER OF ADMISSIONS OR OUTPT. APPOINTMENTS	LOCATION	LENGTH/ DATES OF TREATMENTS
1.	IN-PATIENT	1[]	_____	_____	_____
2.	OUT-PATIENT	2[]	_____	_____	_____
3.	DETOX	3[]	_____	_____	_____
4.	RESIDENTIAL	4[]	_____	_____	_____
5.	SELF-HELP GROUPS	5[]	_____	_____	_____
6.	OTHER (SPECIFY)	6[]	_____	_____	_____

7.21 AT THE PRESENT TIME ARE YOU RECEIVING TREATMENT FOR YOUR ALCOHOL/DRUG PROBLEM(S) OTHER THAN THIS PROGRAM.

NO.....1 []
YES.....2 []

SPECIFY _____

7.22 HOW DO YOU RATE YOUR NEED FOR HELP WITH DRUG USE?

LITTLE OR NO PROBLEM,
HELP NOT NEEDED.....1 []
MODERATE PROBLEM,
HELP NEEDED.....2 []
SEVERE PROBLEM,
HELP ESSENTIAL.....3 []

8. HEALTH STATUS

THE FOLLOWING QUESTIONS ARE ABOUT YOUR HEALTH.

8.1 HOW WOULD YOU RATE YOUR HEALTH OVER THE PAST TWELVE MONTHS?

GOOD.....1 []
FAIR.....2 []
POOR.....3 []

8.2 HAVE YOU BEEN TREATED FOR PHYSICAL HEALTH PROBLEMS OVER THE PAST TWELVE MONTHS?

NO.....1 []
YES.....2 []

8.3 IF YES, PLEASE INDICATE THE FOLLOWING:

NATURE OF THE PROBLEM(S):

_____

NUMBER OF TIMES TREATED AS AN OUTPATIENT OR PRIVATE PATIENT:

_____

NUMBER OF HOSPITAL ADMISSIONS:

_____

TOTAL NUMBER OF DAYS HOSPITALIZED:

_____

NAME OF HOSPITAL: _____

ADDRESS: _____

DATES: _____

8.4 DO YOU HAVE PHYSICAL HEALTH PROBLEMS NOW?

NO.....1 []
YES.....2 []

8.5 IF YES, HOW WOULD YOU RATE YOUR NEED FOR HELP WITH PHYSICAL HEALTH PROBLEMS?

LITTLE OR NO PROBLEM,
HELP NOT NEEDED.....1 []
MODERATE PROBLEM,
HELP NEEDED.....2 []
SEVERE PROBLEM,
HELP ESSENTIAL.....3 []

8.6 HAVE YOU EXPERIENCED ANY OF THE FOLLOWING EMOTIONAL HEALTH PROBLEMS OVER THE PAST TWELVE MONTHS?

	NO	YES
TENSION/ANXIETY/ NERVOUSNESS	1[]	2[]
DIFFICULTY EATING/ CHANGE IN EATING PATTERNS	1[]	2[]
DIFFICULTY SLEEPING/ CHANGE IN SLEEP PATTERNS	1[]	2[]
DEPRESSION	1[]	2[]
LONELINESS	1[]	2[]
IRRATIONAL FEARS/PHOBIAS	1[]	2[]
TROUBLE CONCENTRATING	1[]	2[]
FEELING PEOPLE ARE AGAINST YOU/ ARE TRYING TO HARM YOU	1[]	2[]
FEELING INFERIOR TO OTHERS	1[]	2[]
HAVING UNCONTROLLABLE THOUGHTS/ IMPULSES	1[]	2[]
FEELING AGGRESSIVE/ VIOLENT TOWARD OTHERS	1[]	2[]
HAVING THOUGHTS OF SUICIDE	1[]	2[]
HAVING SEXUAL PROBLEMS	1[]	2[]
FEELING PREOCCUPIED/FORGETFUL	1[]	2[]
AMNESIA/TROUBLE REMEMBERING PAST EVENTS	1[]	2[]
OTHER PROBLEMS	1[]	2[]

SPECIFY_____

8.7 HAVE YOU RECEIVED HELP FOR EMOTIONAL HEALTH PROBLEMS OVER THE PAST TWELVE MONTHS, OTHER THAN THIS PROGRAM?

NO.....1 []
YES.....2 []

8.8 IF YES, PLEASE INDICATE THE FOLLOWING:

NATURE OF THE PROBLEM(S):

_____

NUMBER OF TIMES TREATED AS AN OUTPATIENT OR PRIVATE PATIENT:

_____

NUMBER OF HOSPITAL ADMISSIONS:

_____

TOTAL NUMBER OF DAYS HOSPITALIZED:

_____

NAME OF HOSPITAL: _____

ADDRESS: _____

DATES: _____

8.9 DO YOU HAVE EMOTIONAL HEALTH PROBLEMS NOW?

NO..... 1[]
YES..... 2[]

8.10 IF YES, HOW DO YOU RATE YOUR NEED FOR HELP WITH EMOTIONAL HEALTH PROBLEMS?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 []
MODERATE PROBLEM, HELP NEEDED.....2 []
SEVERE PROBLEM, HELP ESSENTIAL.....3 []

9. OVERALL EFFECT OF ALCOHOL/DRUG USE

9.1 WHAT DO YOU FEEL HAS BEEN THE OVERALL EFFECT OF ALCOHOL/DRUG USE ON THE FOLLOWING AREAS OF YOUR LIFE OVER THE PAST TWELVE MONTHS? (CHECK THE STATEMENT WHICH BEST DESCRIBES THE EFFECT OF YOUR ALCOHOL/DRUG USE ON EACH PROBLEM AREA).

PROBLEM AREA	OVERALL EFFECT OF ALCOHOL/DRUG USE		
	MADE IT BETTER	HAD NO EFFECT	MADE IT WORSE
ACCOMMODATION.....	1[]	2[]	3[]
MARITAL/FAMILY RELATIONS.	1[]	2[]	3[]
OTHER SOCIAL RELATIONS...	1[]	2[]	3[]
EDUCATION/EMPLOYMENT.....	1[]	2[]	3[]
FINANCES.....	1[]	2[]	3[]
LEISURE.....	1[]	2[]	3[]
LEGAL STATUS.....	1[]	2[]	3[]
PHYSICAL HEALTH.....	1[]	2[]	3[]
EMOTIONAL HEALTH.....	1[]	2[]	3[]

APPENDIX M

APPENDIX M

Waterford Hospital Addictions Program

Collateral Letter

Date _____

Dear _____

I am allowing this interviewer to contact you and to ask you questions about my behavior. We appreciate your cooperation with us.

Sincerely,

_____

Re:

The above named person has given us your name so we may contact you about his/her progress. This person is participating in the Waterford Hospital Addictions Program. Program staff are interested in learning how well the program is working and how it might be improved. To obtain this information we are conducting a treatment outcome evaluation project. This person is voluntarily participating in this project.

To carry out our purpose, we will be conducting follow-up interviews with this person and possibly with you over the next _____ months. During that period we will probably be contacting you _____ (indicate intended follow-up _____ (schedule). We want to find out how s(he) is doing after going to a treatment program. Therefore, we will be asking you questions about this person's drinking and/or drug taking behavior and how it has affected various areas of his/her life (e.g. jobs, family, and any new arrests or hospitalizations for drinking or drug related problems). We will also be asking this person similar questions about his own functioning during this follow-up period. The follow-up interviews only take about 10 minutes and we can talk with you by phone or in person, whichever is most convenient for you. We will be getting in touch with you shortly.

Your cooperation is this project is both needed and extremely valuable in helping us to evaluate the effectiveness of the Waterford Hospital Addictions Program and to understand people who abuse alcohol and/or drugs. If you decide to participate, all information that you share will be kept strictly confidential. We thank you for your

time in this matter and look forward to contacting you. Please feel free to contact us if you have any questions about this letter or if you have any objections to being interviewed. The number is _____.

Yours sincerely,

_____

APPENDIX N

APPENDIX N

Waterford Hospital Addictions Program

Posttreatment Questionnaire

Assessment Areas Covered:	Demographics, accommodations, marital and family relationships, other social relationships, education, employment, finances, leisure, legal status, alcohol use, drug use, health, and client satisfaction
Administration:	Self-administered (approximately 70-75 minutes), at follow-up, with the exception of question 7.8. It is recommended that this question, if included, be completed in a personal interview.
Design Features:	80 items; multiple-choice, yes/no, and completion questions.
Abstract:	This questionnaire is intended to obtain information on clients' functioning after treatment in the Waterford Hospital Addictions Program. The questions included closely parallel those asked in the Pretreatment Questionnaire. This permits a comparison of clients' status at intake to their status following treatment. A standardized questionnaire is also incorporated: Attkisson et al's (1984) Client Satisfaction Questionnaire. The major purpose for this is to enlist client participation in the evaluation of the Addictions Program. This Posttreatment Questionnaire is intended to enquire about the time interval between the date of the last follow-up contact (or since client started the Addictions Program in the case of the first contact) and the date of the current follow-up contact. Program personnel will decide the interval for which posttreatment data is collected, as well as the frequency of follow-up contacts during that interval. Because the addiction groups are open and not time limited it is likely that when follow-up commences (e.g. 3, 6, 12 months after clients' entrance into the program) many clients will still be participating in the program while others will have terminated.

Posttreatment Questionnaire

1. ACCOMMODATION, MARITAL/FAMILY RELATIONSHIPS

THE FOLLOWING QUESTIONS ARE ABOUT YOUR ACCOMMODATION, AND YOUR FAMILY/MARITAL RELATIONSHIPS.

1.1 IN THE LAST _____ MONTHS HAVE YOU MOVED AT ALL?

NO.....1 [ ]
YES.....2 [ ]

1.2 IF YES, HOW MANY TIMES HAVE YOU MOVED?

1.3 WHERE ARE YOU LIVING NOW?

OWN HOUSE.....1 [ ]
RENTED HOUSE/APARTMENT/BEDSITTER .....2 [ ]
BOARDING HOUSE.....3 [ ]
SHELTER/HOSTEL/ COMMUNITY CARE.....4 [ ]
INSTITUTION.....5 [ ]
OTHER.....6 [ ]
SPECIFY_____

1.4 HOW LONG HAVE YOU LIVED THERE?

IF LESS THAN ONE MONTH GIVE THE NUMBER OF WEEKS...1 [ ][ ]
NUMBER OF MONTHS.....2 [ ][ ]

1.5 WHO ARE YOU LIVING WITH?

WITH SPOUSE OR PARTNER.....1 [ ]
WITH CHILDREN.....2 [ ]
WITH OTHER RELATIVE.....3 [ ]
WITH FRIENDS.....4 [ ]
WITH OTHERS (NOT RELATIVE OR FRIENDS.....5 [ ]
ALONE.....6 [ ]
OTHER.....7 [ ]
SPECIFY_____

1.6 HOW LONG HAVE YOU HAD THIS LIVING ARRANGEMENT?

IF LESS THAN ONE MONTH GIVE THE NUMBER OF WEEKS..1 [ ][ ]
NUMBER OF MONTHS.....2 [ ][ ]

1.7 WHAT IS YOUR CURRENT MARITAL STATUS?

SINGLE, NEVER MARRIED.....1 [ ]
MARRIED.....2 [ ]
COHABITING.....3 [ ]
SEPARATED.....4 [ ]
DIVORCED.....5 [ ]
WIDOWED.....6 [ ]

1.8 HOW LONG HAVE YOU HAD THIS MARITAL STATUS?

IF LESS THAN ONE YEAR GIVE THE NUMBER OF MONTHS.1 [ ][ ]
NUMBER OF YEARS.....2 [ ][ ]

1.9 DO YOU HAVE MARITAL/FAMILY PROBLEMS NOW?

NO.....1 [ ]
YES.....2 [ ]

1.10 IF YES, HOW DO YOU RATE YOUR NEED FOR HELP WITH MARITAL/FAMILY PROBLEMS?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 [ ]
MODERATE PROBLEM, HELP NEEDED.....2 [ ]
SEVERE PROBLEM, HELP ESSENTIAL.....3 [ ]

2. OTHER SOCIAL RELATIONSHIPS

THE FOLLOWING QUESTIONS ARE ABOUT OTHER SOCIAL RELATIONSHIPS.

2.1 AT PRESENT DO MOST OF YOUR FRIENDS OR PEOPLE YOU SPEND TIME WITH ABUSE OF HAVE PROBLEMS WITH ALCOHOL/DRUGS?

NO.....1 [ ]
YES.....2 [ ]
50/50 EQUAL.....3 [ ]
DON'T KNOW.....4 [ ]

2.2 DO YOU HAVE ANY FRIENDS WHOM YOU CAN COUNT ON FOR HELP WITH YOUR PROBLEMS?

NO.....1 [ ]
YES.....2 [ ]

2.3 IN THE LAST _____ MONTH HAVE YOU BEEN HAVING PROBLEMS WITH YOUR FRIENDS?

NO.....1 [ ]
YES.....2 [ ]

IF NO, PLEASE MOVE TO SECTION 3, EDUCATION/EMPLOYMENT.

2.4 IF YES, WHAT KIND OF PROBLEMS HAVE YOU BEEN HAVING?

CONTROLLING TEMPER .....1 [ ]
GETTING ALONG WITH FRIENDS..2 [ ]
BEING UNDERSTOOD BY FRIENDS.3 [ ]
BEING INFLUENCED TO USE ALCOHOL/DRUGS.....4 [ ]
OTHER .....5 [ ]
SPECIFY_____

2.5 IF YES, HOW DO YOU RATE YOUR NEED FOR HELP WITH YOUR PROBLEMS WITH YOUR FRIENDS?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 [ ]
MODERATE PROBLEM, HELP NEEDED.....2 [ ]
SEVERE PROBLEM, HELP ESSENTIAL.....3 [ ]

3. EDUCATION/EMPLOYMENT

THE FOLLOWING QUESTIONS ARE ABOUT YOUR EDUCATION/EMPLOYMENT STATUS.

3.1 HAVE YOU RETURNED TO SCHOOL IN THE LAST _____ MONTHS?

NO.....1 [ ]
YES.....2 [ ]

3.2 HAVE YOU BEEN EMPLOYED AT ALL DURING THE PAST _____ MONTHS?

3.3 ARE YOU WORKING NOW?

NO.....1 [ ]
YES, PART-TIME.....2 [ ]
YES, FULL-TIME.....3 [ ]

3.4 IN THE LAST 28 DAYS, IF CURRENTLY EMPLOYED, DID YOU MISS WORK AS A RESULT OF YOUR DRINKING OR DRUG USE?

NO.....1 [ ]
YES.....2 [ ]
IF YES, HOW MANY DAYS _____

3.5 IF YOU ARE NOT WORKING, WHAT IS THE MAIN REASON FOR BEING OUT OF WORK? (CHOOSE ONE ANSWER)

TEMPORARILY LAID OFF.....1 []
NOT EMPLOYED AND LOOKING FOR WORK.....2 []
NOT EMPLOYED AND NOT LOOKING FOR WORK.....3 []
STUDENT.....4 []
POOR HEALTH/DISABLED.....5 []
RETIRED.....6 []
HOMEMAKER.....7 []
IN-HOSPITAL.....8 []
IN-JAIL.....9 []
DRINKING/USING DRUGS.....10 []
OTHER.....11 []
SPECIFY_____

3.6 IF THE LAST _____ MONTHS HAVE ANY OF THE FOLLOWING SCHOOL/EMPLOYMENT PROBLEMS OR CHANGES OCCURRED?

	NO	YES
PROMOTION	[]	[]
LAYOFF	[]	[]
RETIREMENT	[]	[]
LATENESS/ABSENTEEISM	[]	[]
ACCIDENTS	[]	[]
DECREASE IN GRADES/ PRODUCTIVITY	[]	[]
DRINKING/DRUG TAKING AT SCHOOL/ON THE JOB	[]	[]
VERBAL WARNING FROM SCHOOL/ UNION/EMPLOYER	[]	[]
WRITTEN REPRIMAND	[]	[]
SUSPENSION/LOSS OF PAY	[]	[]
JOB DEMOTION	[]	[]
EXPLUSION/DISMISSAL	[]	[]
RESIGNATION	[]	[]

3.7 DO YOU HAVE SCHOOL/EMPLOYMENT PROBLEMS NOW?

NO.....1 []
YES.....2 []

3.8 IF YES, HOW DO YOU RATE YOUR NEED FOR HELP WITH SCHOOL/EMPLOYMENT PROBLEMS?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 []
MODERATE PROBLEM, HELP NEEDED.....2 []
SEVERE PROBLEM, HELP ESSENTIAL.....3 []

4. FINANCES

THE FOLLOWING QUESTIONS ARE ABOUT YOUR FINANCIAL STATUS.

4.1 WHAT HAS BEEN YOUR MAIN SOURCE OF INCOME OVER THE PAST _____ MONTHS?

EMPLOYMENT.....1 []
UNEMPLOYMENT INSURANCE BENEFITS.....2 []
SPOUSE.....3 []
PENSION.....4 []
WELFARE BENEFITS.....5 []
SAVINGS.....6 []
OTHER.....7 []
SPECIFY_____

4.2 WHAT WAS YOUR TOTAL PERSONAL INCOME (REPORTABLE) OVER THE PAST _____ MONTHS? INCLUDE ONLY YOUR INCOME AND NOT THAT OF ANYONE ELSE IN YOUR HOUSEHOLD.

_____

4.3 DO YOU HAVE FINANCIAL PROBLEMS NOW

NO.....1 []
YES.....2 []

4.4 IF YES, HOW DO YOU RATE YOU NEED FOR HELP WITH FINANCIAL PROBLEMS?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 []
MODERATE PROBLEM, HELP NEEDED.....2 []
SEVERE PROBLEM, HELP ESSENTIAL.....3 []

5. LEISURE

THE FOLLOWING QUESTIONS ARE ABOUT YOUR LEISURE TIME ACTIVITIES.

5.1 DO YOU HAVE MUCH SPARE TIME?

NO.....1 []
YES.....2 []

5.2 IN YOUR SPARE TIME, DO YOU PARTICIPATE IN ANY OF THE FOLLOWING ACTIVITIES ON A REGULAR BASIS?

	NO	YES
COMMUNITY GROUPS/ ACTIVITIES	1[]	2[]
HOBBIES/CRAFTS	1[]	2[]
SPORTS/RECREATION	1[]	2[]
WATCHING T.V	1[]	2[]
ATTENDING EDUCATION/ INTEREST COURSES	1[]	2[]
SOCIALIZING OR BEING WITH FRIENDS	1[]	2[]
RELIGION/RELIGIOUS ACTIVITIES	1[]	2[]
SITTING ALONE, DOING NOTHING	1[]	2[]
OTHER ACTIVITIES	1[]	2[]

SPECIFY_____

5.3 DO YOU HAVE LEISURE PROBLEMS NOW?

NO.....1 []
YES.....2 []

5.4 IF YES, HOW DO YOU RATE YOUR NEED FOR HELP WITH YOUR LEISURE PROBLEMS?

LITTLE OR NO PROBLEM,
HELP NOT NEEDED.....1 []
MODERATE PROBLEM
HELP NEEDED.....2 []
SEVERE PROBLEM,
HELP ESSENTIAL.....3 []

6. LEGAL STATUS

I WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR LEGAL STATUS

6.1 DO YOU HAVE ANY LEGAL PROBLEMS AT PRESENT?

NO.....1 []
YES.....2 []

6.2 IF YES, ARE YOU AWAITING
TRIAL/HEARING/SENTENCING....1 []
ON SUSPENDED SENTENCE.....2 []
ON PROBATION/PAROLE.....3 []
IN JAIL.....4 []

6.3 HAVE YOU HAD ANY ALCOHOL/DRUG RELATED DRIVING CHARGES IN THE LAST _____ MONTHS?

NO.....1 []
YES.....2 []

6.4 IF YES, HOW MANY?

_____

6.5 HAVE YOU HAD ANY OTHER ALCOHOL/DRUG-RELATED CHARGES IN THE LAST _____ MONTHS?

NO.....1 []
YES.....2 []

6.6 IF YES, HOW MANY?

_____

WHAT WAS (WERE) THE NATURE OF THE CHARGE(S)?

_____
_____

6.7 IF ARRESTED OR JAILED IN THE PAST _____ MONTHS, PLEASE INDICATE THE FOLLOWING:

NAME OF JAIL OR CORRECTIONAL FACILITY: _____

ADDRESS: _____

NUMBER OF DAYS JAILED: _____

DATES OF ARRESTS OR INCARCERATIONS:

_____

6.8 IF YOU HAVE LEGAL PROBLEMS NOW, HOW DO YOU RATE YOUR NEED FOR HELP WITH YOUR LEGAL PROBLEMS?

LITTLE OR NO PROBLEM,
HELP NOT NEEDED.....1 []
MODERATE PROBLEM,
HELP NEEDED.....2 []
SEVERE PROBLEM,
HELP ESSENTIAL.....3 []

7. ALCOHOL/DRUG USE

7.1 DO YOU HAVE A PROBLEM WITH ANY OF THE FOLLOWING?

ALCOHOL.....1 []
PRESCRIPTION DRUGS.....2 []
STREET DRUGS.....3 []
ALL OF THE ABOVE.....4 []

7.2 WHICH IS THE MAJOR PROBLEM FOR YOU?

ALCOHOL.....1 []
PRESCRIPTION DRUGS.....2 []
STREET DRUGS.....3 []

IF ALCOHOL USE IS NOT A PROBLEM FOR YOU, PLEASE MOVE TO QUESTION 7.15.

THE FOLLOWING QUESTIONS ARE ABOUT YOUR USE OF ALCOHOL.

7.3 OVER THE LAST _____ MONTHS WHAT IS THE LONGEST NUMBER OF DAYS IN A ROW YOU DRANK? (CHECK ONE)

DID NOT DRINK.....1 []
1-2 DAYS AT A TIME.....2 []
3-7 DAYS AT A TIME.....3 []
8-14 DAY AT A TIME.....4 []
15 DAYS AND OVER.....5 []
(SPECIFY NUMBER) _____
CONTINUOUSLY (I.E. DAILY)...6 []

7.4 DURING THE PAST 28 DAYS ON HOW MANY DAYS DID YOU HAVE AT LEAST ONE DRINK?

_____ DAYS.

7.5 DURING THE PAST _____ MONTHS HOW MANY DAYS IN A ROW DID YOU USUALLY ABSTAIN? (CHECK ONE)

DID NOT ABSTAIN.....1 []
1-2 DAYS AT A TIME.....2 []
3-7 DAYS AT A TIME.....3 []
8-14 DAY AT A TIME.....4 []
15 DAYS AND OVER.....5 []
(SPECIFY NUMBER) _____
CONTINUOUSLY (I.E. DAILY)...6 []

7.6 WHAT IS THE LONGEST PERIOD OF TIME, IN DAYS, THAT YOU HAVE ABSTAINED IN THE PAST _____ MONTHS?

_____ DAYS

7.7 HOW MANY DAYS AGO DID THIS ABSTINENCE END?

DAYS.....1 []
STILL ABSTINENT.....2 []

7.8 THE FOLLOWING QUESTIONS ARE ABOUT YOUR DRINKING PATTERNS DURING A "TYPICAL" 28 DAY PERIOD OVER THE PAST _____ MONTHS.

		AMOUNT (OZS)	TYPE OF BEVERAGE	STANDARD DRINKS	NUMBER OF TIMES PER TYPICAL 28 DAY PERIOD	PRODUCT
A.	WHAT IS THE MAXIMUM AMOUNT YOU HAVE HAD	(_____)	(_____)	_____	X _____	=_____
	ON ANY ONE DAY?	(_____)	(_____)	_____	X _____	=_____
B.	HOW MUCH DO YOU DRINK ON YOUR "USUAL"	(_____)	(_____)	_____	X _____	=_____
	DRINKING DAYS?	(_____)	(_____)	_____	X _____	=_____
C.	HOW MUCH DO YOU DRINK ON YOUR "OTHER"	(_____)	(_____)	_____	X _____	=_____
	DRINKING DAYS	(_____)	(_____)	_____	X _____	=_____
D.	NUMBER OF DAYS OF COMPLETE ABSTINENCE	.....			_____	
E.	SUM OF PRODUCTS (A TO C)	.....			_____	

THE MEAN NUMBER OF STANDARD DRINKS PER DAY EQUALS
THE SUM OF THE PRODUCTS (E) DIVIDED BY 28: (E/28) = (_____/28) = [][]

F. WHAT IS YOUR USUAL BODY WEIGHT? .....LBS. [][][]
Kg [][]

7.9 WHAT IS THE LONGEST PERIOD OF TIME THAT YOU HAVE GONE WITHOUT A DRINK IN THE LAST _____ MONTHS?

IF LESS THAN ONE MONTH, GIVE
NUMBER OF DAYS.....[][]
NUMBER OF MONTHS.....[][]

7.10 HOW LONG AGO DID YOU HAVE YOUR LAST DRINK?

HOURS.....[][][]
DAYS.....[][][]
MONTHS.....[][][]

7.11 HOW WOULD YOU RATE YOUR NEED FOR HELP WITH YOUR DRINKING?

LITTLE OR NO PROBLEM,
HELP NOT NEEDED..... 1[]
MODERATE PROBLEM,
HELP NEEDED..... 2[]
SEVERE PROBLEM,
HELP ESSENTIAL..... 3[]

THE FOLLOWING QUESTIONS ARE ABOUT YOUR USE OF DRUGS (OTHER THAN ALCOHOL).

7.12 HAVE YOU EVER USED DRUGS (OTHER THAN ALCOHOL) FOR NON-MEDICAL REASONS?

NO.....1 []
YES.....2 []

IF NO PLEASE MOVE TO SECTION 8, HEALTH STATUS.

IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS.

7.13 HOW MANY DAYS IN THE PAST 28 DAYS HAVE YOU USED DRUGS FOR NON-MEDICAL REASONS? (WRITE IN ZERO(0) IF DRUGS HAVE NOT BEEN USED AT ALL IN THE PAST 28 DAYS).

DAYS.....[][][]

7.14 OVER THE PAST _____ MONTHS, WHEN YOU WERE USING DRUGS, HOW MANY DAYS IN A ROW DID YOU USE THEM?

1-2 DAYS AT A TIME.....1 []
3-7 DAYS AT A TIME.....2 []
8-14 DAY AT A TIME.....3 []
15 DAYS AND OVER.....4 []
(SPECIFY NUMBER) _____
CONTINUOUSLY (I.E. DAILY)...5 []

7.15 HOW LONG HAS IT BEEN SINCE YOU LAST USED ANY OF THESE DRUGS?

LESS THAN 24 HOURS AGO.....1 []
BETWEEN 1-2 DAYS.....2 []
BETWEEN 3-7 DAYS.....3 []
MORE THAN 1 WEEK AGO.....4 []
IF MORE THAN 1 WEEK AGO.....5 []
(SPECIFY NUMBER OF DAYS) _____

THE FOLLOWING QUESTION ARE ABOUT YOUR TREATMENT HISTORY FOR ALCOHOL/DRUG USE.

7.16 DID YOU RECEIVE TREATMENT FOR YOUR ALCOHOL/DRUG PROBLEM(S) DURING THE PAST _____ MONTHS, OTHER THAN THIS PROGRAM?

NO.....1 []
YES.....2 []

7. 17 IF YES, PLEASE INDICATE THE FOLLOWING:

	TYPE OF TREATMENT		NUMBER OF ADMISSIONS OR OUTPT. APPOINTMENTS	LOCATION	LENGTH/ DATES OF TREATMENTS
1.	IN-PATIENT	1[]	_____	_____	_____
2.	OUT-PATIENT	2[]	_____	_____	_____
3.	DETOX	3[]	_____	_____	_____
4.	RESIDENTIAL	4[]	_____	_____	_____
5.	SELF-HELP GROUPS	5[]	_____	_____	_____
6.	OTHER (SPECIFY)	6[]	_____	_____	_____

7.18 AT THE PRESENT TIME ARE YOU RECEIVING TREATMENT FOR YOUR ALCOHOL/DRUG PROBLEM(S) OTHER THAN THIS PROGRAM.

NO.....1 []
YES.....2 []
SPECIFY_____

7.19 HOW DO YOU RATE YOUR NEED FOR HELP WITH DRUG USE?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 []
MODERATE PROBLEM, HELP NEEDED.....2 []
SEVERE PROBLEM, HELP ESSENTIAL.....3 []

8. HEALTH STATUS

THE FOLLOWING QUESTIONS ARE ABOUT YOUR HEALTH.

8.1 HOW WOULD YOU RATE YOUR HEALTH OVER THE PAST _____ MONTHS?

GOOD.....1 []
FAIR.....2 []
POOR.....3 []

8.2 HAVE YOU BEEN TREATED FOR PHYSICAL HEALTH PROBLEMS OVER THE PAST _____ MONTHS?

NO.....1 []
YES.....2 []

8.3 IF YES, PLEASE INDICATE THE FOLLOWING:

NATURE OF THE PROBLEM(S):

_____

NUMBER OF TIMES TREATED AS AN OUTPATIENT OR PRIVATE PATIENT:

_____

NUMBER OF HOSPITAL ADMISSIONS: _____

TOTAL NUMBER OF DAYS HOSPITALIZED:

_____

NAME OF HOSPITAL: _____

ADDRESS: _____

DATES: _____

8.4 DO YOU HAVE PHYSICAL HEALTH PROBLEMS NOW?

NO.....1 []
YES.....2 []

8.5 IF YES, HOW WOULD YOU RATE YOUR NEED FOR HELP WITH PHYSICAL HEALTH PROBLEMS?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 []
MODERATE PROBLEM, HELP NEEDED.....2 []
SEVERE PROBLEM, HELP ESSENTIAL.....3 []

8.6 HAVE YOU EXPERIENCED ANY OF THE FOLLOWING EMOTIONAL HEALTH PROBLEMS OVER THE PAST _____ MONTHS?

	NO	YES
TENSION/ANXIETY/ NERVOUSNESS	1[]	2[]
DIFFICULTY EATING/ CHANGE IN EATING PATTERNS	1[]	2[]
DIFFICULTY SLEEPING/ CHANGE IN SLEEP PATTERNS	1[]	2[]
DEPRESSION	1[]	2[]
LONELINESS	1[]	2[]
IRRATIONAL FEARS/PHOBIAS	1[]	2[]
TROUBLE CONCENTRATING	1[]	2[]
FEELING PEOPLE ARE AGAINST YOU/ ARE TRYING TO HARM YOU	1[]	2[]
FEELING INFERIOR TO OTHERS	1[]	2[]
HAVING UNCONTROLLABLE THOUGHTS/ IMPULSES	1[]	2[]
FEELING AGGRESSIVE/ VIOLENT TOWARD OTHERS	1[]	2[]
HAVING THOUGHTS OF SUICIDE	1[]	2[]
HAVING SEXUAL PROBLEMS	1[]	2[]
FEELING PREOCCUPIED/FORGETFUL	1[]	2[]
AMNESIA/TROUBLE REMEMBERING PAST EVENTS	1[]	2[]
OTHER PROBLEMS	1[]	2[]

SPECIFY_____

8.7 HAVE YOU RECEIVED HELP FOR EMOTIONAL HEALTH PROBLEMS OVER THE PAST _____ MONTHS, OTHER THAN THIS PROGRAM?

NO.....1 []
YES.....2 []

8.8 IF YES, PLEASE INDICATE THE FOLLOWING:

NATURE OF THE PROBLEM(S):

_____

NUMBER OF TIMES TREATED AS AN OUTPATIENT OR PRIVATE PATIENT:

_____

NUMBER OF HOSPITAL ADMISSIONS:

_____

TOTAL NUMBER OF DAYS HOSPITALIZED:

_____

NAME OF HOSPITAL:

_____

ADDRESS:

_____

DATES:

_____

8.9 DO YOU HAVE EMOTIONAL HEALTH PROBLEMS NOW?

NO..... 1[]
YES..... 2[]

8.10 IF YES, HOW DO YOU RATE YOUR NEED FOR HELP WITH EMOTIONAL HEALTH PROBLEMS?

LITTLE OR NO PROBLEM, HELP NOT NEEDED.....1 []
MODERATE PROBLEM, HELP NEEDED.....2 []
SEVERE PROBLEM, HELP ESSENTIAL.....3 []

9. OVERALL EFFECT OF ALCOHOL/DRUG USE

9.1 WHAT DO YOU FEEL HAS BEEN THE OVERALL EFFECT OF ALCOHOL/DRUG USE ON THE FOLLOWING AREAS OF YOUR LIFE OVER THE PAST _____ MONTHS? (CHECK THE STATEMENT WHICH BEST DESCRIBES THE EFFECT OF YOUR ALCOHOL/DRUG USE ON EACH PROBLEM AREA).

PROBLEM AREA	OVERALL EFFECT OF ALCOHOL/DRUG USE		
	MADE IT BETTER	HAD NO EFFECT	MADE IT WORSE
ACCOMMODATION.....	1[]	2[]	3[]
MARITAL/FAMILY RELATIONS.	1[]	2[]	3[]
OTHER SOCIAL RELATIONS...	1[]	2[]	3[]
EDUCATION/EMPLOYMENT.....	1[]	2[]	3[]
FINANCES.....	1[]	2[]	3[]
LEISURE.....	1[]	2[]	3[]
LEGAL STATUS.....	1[]	2[]	3[]
PHYSICAL HEALTH.....	1[]	2[]	3[]
EMOTIONAL HEALTH.....	1[]	2[]	3[]

10. CLIENT EVALUATION OF SERVICES*

CIRCLE YOUR ANSWER

10.1 HOW WOULD YOU RATE THE QUALITY OF SERVICE YOU HAVE RECEIVED?

4	3	2	1
EXCELLENT	GOOD	FAIR	POOR

10.2 DID YOU GET THE KIND OF SERVICE YOU WANTED?

1	2	3	4
NO, DEFINITEY NOT	NO, NOT REALLY	YES, GENERALLY	YES, DEFINITELY

* Attkisson et al., (1984). Client Satisfaction Questionnaire. Availability Source: C. Clifford Attkisson, Ph.D., Professor of Medical Psychology, University of California, San Francisco, Box 33-C, 401 Parnassus Avenue, San Francisco.

10.3 TO WHAT EXTENT HAS OUR PROGRAM MET YOUR NEEDS?

4	3	2	1
ALMOST ALL OF MY NEEDS HAVE BEEN MET	MOST OF MY MEEDS HAVE BEEN MET	ONLY A FEW OF MY NEEDS HAVE BEEN	NONE OF MY NEEDS HAVE BEEN MET

10.4 IF A FRIEND WERE IN NEED OF SIMILAR HELP, WOULD YOU RECOMMEND OUR PROGRAM TO HIM OR HER?

1	2	3	4
NO, DEFINITEY NOT	NO, NOT REALLY	YES, GENERALLY	YES, DEFINITELY

10.5 HOW SATISFIED ARE YOU WITH THE AMOUNT OF HELP YOU HAVE RECEIVED?

1	2	3	4
QUITE DISSATIFSIED	INDIFFERENT OR DISSATISFIED	MOSTLY SATISFIED	VERY SATISFIED

10.6 HAVE THE SERVICES YOU RECEIVED HELP YOU TO DEAL MORE EFFECTIVELY WITH YOUR PROBLEM?

4	3	2	1
YES, THEY HELPED A GREAT DEAL	YES, THEY HELPED SOMEWHAT	NO, THEY REALLY DIDN'T HELP	NO, THEY SEEMED TO MAKE THINGS WORSE

10.7 IF AN OVERALL, GENERAL SENSE, HOW SATISFIED ARE YOU WITH THE SERVICE YOU HAVE RECEIVED?

4	3	2	1
VERY SATISFIED	MOSTLY SATISFIED	INDIFFERENT OR MIDLY DISSATISFIED	QUITE DISSATISFIED

10.8 IF YOU WERE TO SEEK HELP AGAIN, WOULD YOU COME BACK TO OUR PROGRAM?

1	2	3	4
_____	_____	_____	_____
NO, DEFINITELY NOT	NO, I DON'T THINK SO	YES, I THINK SO	YES DEFINITELY

10.9 ADDITIONAL COMMENTS

_____

_____

APPENDIX 0

APPENDIX O

Waterford Hospital Addictions Program

Collateral Follow-up Interview

Assessment Areas Covered:	Demographics, accommodations, marital and family relationships, other social relationships, education, employment, finances, leisure, legal status, alcohol use, drug use, and health
Administration:	Self-administered or interviewer - administered (approximately 15 minutes), at follow-up
Design Features:	39 items; multiple-choice, yes/no, and completion questions.
Abstract:	This questionnaire is intended to determine the validity and reliability of clients' self-reports. Therefore questions included, although fewer, parallel those asked in the Posttreatment Questionnaire. The questions are meant to inquire about the time interval between the date of the last follow-up contact (or since client started the Addictions Program in the case of the first contact) and the date of the current follow-up contact. Program personnel will decide the frequency of follow-up contacts with collateral sources.

COLLATERAL FOLLOW-UP INTERVIEW

DATE OF LAST FOLLOW-UP CONTACT: _____

DATE OF CURRENT FOLLOW-UP CONTACT: _____

Interview was conducted:

By phone ..... 1[]
In person ..... 2[]
By letter ..... 3[]
Other (specify) ..... 4[]

1. What is your relationship to subject?

Spouse ..... 1[]
Mother ..... 2[]
Father ..... 3[]
Adult child (>18 years) ..... 4[]
Roommate..... 5[]
Brother/Sister ..... 6[]
Uncle/Aunt ..... 7[]
Grandmother ..... 8[]
Grandfather ..... 9[]
Nephew/Niece .....10[]
Cousin .....11[]
Other relative (specify .....12[]
Employer .....13[]
Fellow employee .....14[]
Probation/Parole Officer .....15[]
Friend .....16[]
Other (specify) .....17[]

2. About how often do you usually see/get together with subject?
NOTE: IF no specific number can be given, code as follows:

Daily ..... 1[]
_____ per week ..... 2[]
Number of days
_____ per month .....3 []
Number of days
Other..... 4[]
Specify _____

1. ACCOMMODATION, MARITAL/FAMILY RELATIONSHIPS

1. HAS SUBJECT'S LIVING ARRANGEMENTS CHANGED RECENTLY? (PROBE FOR CHANGES IN ACCOMMODATIONS, MARITAL/FAMILY RELATIONSHIPS).

_____

2. OTHER SOCIAL RELATIONSHIPS

2.1 AT PRESENT, DO MOST OF SUBJECT'S FRIENDS OR PEOPLE S(HE) SPENDS TIME WITH ABUSE OR HAVE PROBLEMS WITH ALCOHOL/DRUGS?

NO.....1 []
YES.....2 []
50/50 EQUAL.....3 []
DON'T KNOW.....4 []

2.2 IN THE PAST _____ MONTHS HAS SUBJECT BEEN HAVING PROBLEMS WITH HIS/HER FRIENDS?

NO.....1 []
YES.....2 []
DON'T KNOW.....3 []

2.3 IF YES, WHAT KIND OF PROBLEMS HAVE S(HE) BEEN HAVING?

CONTROLLING TEMPER.....1 []
GETTING ALONG WITH FRIENDS..2 []
BEING UNDERSTOOD BY FRIENDS.3 []
BEING INFLUENCED TO USE ALCOHOL/DRUGS.....4 []
OTHER.....5 []
SPECIFY _____
_____

3. EDUCATION/EMPLOYMENT

3.1 HAS SUBJECT BEEN EMPLOYED AT ALL IN THE PAST _____ MONTHS?

YES.....1 []
NO.....2 []
DON'T KNOW.....3 []

3.2 IS SUBJECT EMPLOYED NOW?

NO.....1 []
YES, PART-TIME.....2 []
YES, FULL-TIME.....3 []
DON'T KNOW.....4 []

3.4 IN THE LAST _____ MONTHS, IF SUBJECT HAS BEEN EMPLOYED DID S(HE) LOSE A JOB BECAUSE OF ALCOHOL/DRUG USE?

NO ..... 1 []
YES ..... 2 []
DON'T KNOW ..... 3 []

3.5 IF SUBJECT IS NOT EMPLOYED NOW, HOW LONG HAS S(HE) BEEN OUT OF WORK?

_____ 1 []

DON'T KNOW.....2 []

4. FINANCES

4.1 WHAT HAS BEEN THE SUBJECT'S MAIN SOURCE OF INCOME OVER THE PAST _____ MONTHS?

EMPLOYMENT.....1 []
UNEMPLOYMENT INSURANCE BENEFITS.....2 []
SPOUSE.....3 []
PENSION.....4 []
WELFARE BENEFITS.....5 []
SAVINGS.....6 []
OTHER.....7 []
SPECIFY_____
DON'T KNOW.....8 []

5. LEISURE

5.1 IN YOUR OPINION, DOES SUBJECT HAVE MUCH SPARE TIME?

NO.....1 []
YES.....2 []
DON'T KNOW.....3 []

5.2 IN HIS/HER SPARE TIME, DOES SUBJECT PARTICIPATE IN ANY OF THE FOLLOWING ACTIVITIES ON A REGULAR BASIS?

	NO	YES	DON'T KNOW
COMMUNITY GROUPS/ ACTIVITIES	1[]	2[]	3[]
HOBBIES/CRAFTS	1[]	2[]	3[]
SPORTS/RECREATION	1[]	2[]	3[]
WATCHING T.V	1[]	2[]	3[]
ATTENDING EDUCATION/ INTEREST COURSES	1[]	2[]	3[]
SOCIALIZING	1[]	2[]	3[]
RELIGION/RELIGIOUS ACTIVITIES	1[]	2[]	3[]
SITTING ALONG, DOING NOTHING	1[]	2[]	3[]
OTHER ACTIVITIES	1[]	2[]	3[]

SPECIFY _____

6. LEGAL STATUS

6.1 HAS SUBJECT HAD ANY PROBLEMS WITH THE LAW OVER THE PAST _____ MONTHS?

NO.....1 []
YES.....2 []
DON'T KNOW.....3 []

6.2 IF YES, WHAT WAS (WERE) THE NATURE OF THE PROBLEM(S)?

_____

6.3 IS SUBJECT CURRENTLY ON PROBATION, PAROLE, OR IN JAIL?

	YES	NO	DON'T KNOW
ON PROBATION	1[]	2[]	3[]
ON PAROLE	1[]	2[]	3[]
IN JAIL	1[]	2[]	3[]

7. ALCOHOL/DRUG USE

7.1 DOES SUBJECT HAVE A PROBLEM WITH ANY OF THE FOLLOWING NOW?

ALCOHOL.....1 []
PRESCRIPTION DRUGS.....2 []
STREET DRUGS.....3 []
ALL OF THE ABOVE.....4 []

NOTE: IF RESPONDENT INDICATES THAT ALCOHOL USE IS NOT A PROBLEM FOR SUBJECT MOVE TO QUESTION 7.7. IF IT IS A PROBLEM ASK THE FOLLOWING QUESTIONS.

7.2 AS FAR AS YOU KNOW DID SUBJECT DRINK AT ALL IN THE PAST _____ MONTHS?

NO.....1 []
YES .....2 []
DON'T KNOW.....3 []

7.3 AS FAR AS YOU KNOW HOW LONG AGO DID SUBJECT HAVE HIS/HER LAST DRINK?

_____

7.4 IF THE SUBJECT DRANK IN THE LAST MONTH, HOW MANY DAYS DID S(HE) DRINK?

_____

7.5 AS FAR AS YOU KNOW WHAT IS THE LONGEST PERIOD OF TIME, IN DAYS, THAT SUBJECT HAS ABSTAINED OVER THE PAST _____ MONTHS?

_____ DAYS.....1 []
DON'T KNOW.....2 []

7.6 IN YOUR OPINION, WHICH OF THE FOLLOWING STATEMENTS BEST DESCRIBES SUBJECT'S DRINKING OVER THE PAST _____ MONTHS?

INCREASED.....1 []
REMAINED THE SAME.....2 []
DECREASED.....3 []
DON'T KNOW.....4 []

NOTE: IF RESPONDENT INDICATES THAT DRUG USE IS NOT A PROBLEM FOR SUBJECT MOVE TO SECTION 8, HEALTH STATUS. IF IT IS A PROBLEM, ASK THE FOLLOWING QUESTIONS.

7.7 HOW LONG HAS IT BEEN SINCE SUBJECT LAST USED DRUGS FOR NONMEDICAL REASONS?

LESS THAN 24 HOURS AGO.....1 []
BETWEEN 1-2 DAYS.....2 []
BETWEEN 3-7 DAYS.....3 []
MORE THAN 1 WEEK AGO.....4 []
IF MORE THAN 1 WEEK AGO.....5 []
(SPECIFY NUMBER OF DAYS) _____

7.8 IN YOUR OPINION, WHICH OF THE FOLLOWING STATEMENTS BEST DESCRIBES SUBJECT'S DRINKING OVER THE PAST _____ MONTHS?

INCREASED.....1 []
REMAINED THE SAME.....2 []
DECREASED.....3 []
DON'T KNOW.....4 []

7.9 HAS THE SUBJECT RECEIVED TREATMENT FOR HIS/HER ALCOHOL/DRUG PROBLEM(S) OVER THE PAST _____ MONTHS, OTHER THAN THIS PROGRAM?

NO.....1 []
YES.....2 []
DON'T KNOW.....3 []

8. HEALTH STATUS

8.1 HAS SUBJECT EXPERIENCED ANY SERIOUS PHSYICAL OR EMOTIONAL HEALTH PROBLEMS OVER THE PAST _____ MONTHS?

YES ..... 1 []
NO..... 2 []
DON'T KNOW ..... 3 []

8.2 IF YES, BRIEFLY EXPLAIN

_____

8.3 HAS SUBJECT BEEN TREATED FOR PHYSICAL OR EMOTIONAL HEALTH PROBLEMS OVER THE PAST _____ MONTHS?

NO.....1 []
YES.....2 []
DON'T KNOW.....3 []

THANK YOU VERY MUCH. WE APPRECIATE YOUR COOPERATION.

APPENDIX P

APPENDIX P

Waterford Hosptial Addictions Program
Progress Notes

APPENDIX Q

APPENDIX Q

Waterford Hospital Addictions Program
Attendance Record

Group: Tuesday Day [] Thursday Day [] Night [] Self-help [] Penitentary []

Names	January*					February					March					April					May					June				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
______	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]
______	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]
______	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]
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______	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]

* Use check (✓) to indicate present and A to indicate absent.

This form may be adapted to record dates of weekly meetings. For example, June, week 3 may be noted as June 16th.

Names	July					August					September					October					November					December				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
____________	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]
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____________	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]
____________	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]