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ADMINISTRATION MANUAL FOR THE TREATMENT SERVICES REVIEW "TSR"

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INTRODUCTION

The Treatment Services Review (TSR) is a brief (5 - 10 minute) structured interview designed to provide information on the type, amount and efficacy of services provided (directly or indirectly) to a

substance abuse patient by his treatment program. The interview is designed for administration by a trained technician on a weekly basis. The treatment services are divided into seven problem areas typically found among substance abusers, which may be addressed during the course of rehabilitation by most programs. These include medical condition, employment/support, alcohol and drug use, legal status, family relations and psychiatric function.

The TSR is designed for use in conjunction with the Addiction Severity Index (ASI). The ASI is also a structured interview designed to assess the type and severity of problems in substance abusers prior to and following treatment. The ASI is therefore designed to evaluate the treatment problems of a substance abuse patient at the start of treatment and to serve as the basis for the initial treatment plan. Since the ASI can be readministered following treatment, it offers the opportunity for the treatment evaluator to assess whether and to what extent there has been change in the patient's problems by the completion of treatment and at subsequent follow-up points.

Thus, while the ASI provides a valid measure of the substance abuser, there has been no standardized method for measuring the treatment process itself or the degree to which the various services provided by treatment programs are associated with patient improvement. The TSR was therefore developed to fill the need for:

1) an ongoing record of the number and types of services provided to substance abuse patients during treatment. This is seen as necessary for cost-effectiveness determinations and as a means of monitoring the proportion of the patient population that actually receives the available services.

2) a during treatment evaluation of the extent to which the problems identified at admission are actually addressed over the course of treatment; and the rate at which these identified problems show change during treatment.

GENERAL ISSUES

It should be recognized that in this attempt to measure the nature, amount and efficacy of treatment services, it was necessary to choose between competing perspectives in several important areas and these bear discussion as a means of justifying the particular questions employed in each of the problem areas.

It is possible to measure the nature of treatment offered within a program in several ways. Some have performed detailed interviews with treatment providers and treatment directors and others have measured the activities of a treatment program during selected time periods ranging from a day to a month. These measures provide an indication of the treatment philosophy of a program, the services available and the activities performed; and all of these are important. In the TSR we have elected to measure the treatment provided by a treatment program through weekly interviews with individual patients within the program.

While it is recognized that this offers only one, possibly biased perspective, we feel it is potentially the most reliable data available and offers several measurement advantages. First, we felt that the patient is the best source of information on the types and amounts of treatment actually received. For this reason, we selected a time period (past week) that promotes easier recall and more reliable data. Further, the interview is divided into problem areas that correspond to those areas initially assessed through patient interviews at admission by the ASI. Data from this instrument indicates that these problems can be evaluated reliably and accurately through the structured interview process and we felt that the same techniques (often the same questions) could be repeated during the course of treatment. Second, it is possible through repeated interview with the patient to measure changes (in type, amount and intensity)of the treatment provided and the effects of that treatment on the patient. Finally, just a patient populations are characterized by summarizing data from individual patients, we felt it would be possible to characterize treatment activity at the treatment program level by summarizing treatment activity for the individual patients in treatment.

GENERAL DIRECTIONS

THE INTERVIEW PROCESS

This form is designed to be administered by a careful, considerate interviewer with a sincere interest in recording the current status of the patient and the number and types of services that he/she has received. The demeanor of the interviewer is very important in obtaining valid results and care should be taken to develop an early and lasting rapport with the patient since these interviews will likely be repeated several times during treatment. It should be noted that an interview format was selected over a questionnaire format because of the advantages of being able to specify the meaning of each question, the ability to probe as a means of insuring patient understanding and because an interview conveys a more personal and important status to information than a questionnaire. Thus, despite the slight additional expense in staff time, we feel the weekly interview offers increased quality of information.

Beginning the Interview - Prior to the start of the first weekly interview and at the initiation of each subsequent interview the interviewer should assure the patient that:

1) the interview will take only a few minutes

2) you want him/her to try to recall as accurately as possible

3) the answers are important and that he/she should feel free to take their time to give the best estimates possible

4) they can ask for further clarification for each question

5) their answers will be confidential (i.e., not divulged to the clinical staff)

Judging an accurate response - There are two major reasons for a response to be inaccurate: failure to understand and a desire to misrepresent. There are means to address each of these within the interview process.

Failure to understand is a common cause of error in interviews particularly if the patient is impaired in any way (distracted with medication concerns, in pain or withdrawal discomfort, cognitively compromised). The interviewer must judge the level of understanding in the early responses to the questions and should make an appropriate adjustment. The patient may be asked to try to concentrate more. This should of course be done tactfully and supportively, reminding the patient that the interview is short and that you are "....not very far from the end".

If this is not successful, the interview can be postponed to accommodate a temporary inconvenience. This may enable better concentration and more valid data at a later date. In this case the patient should be reminded that you will return or recontact him/her and that while you are happy to accommodate him/her, the information is important and necessary to obtain.

In the event that the patient cannot concentrate or cannot understand the questions despite a reasonable level or repetition and rephrasing the **interview should be discontinued in a supportive manner and the data discarded.** There is no point in collecting data that are potentially inaccurate and confused. An interviewer's primary responsibility is to maintain the integrity and validity of the data. It is therefore a service to the evaluation process if these type of data are not included.

Misrepresentation is common among substance abusers and can be a major problem to any evaluation effort. Misrepresentation will be increased if the patient feels:

1) his answers are not confidential (from the treatment staff as well as outside individuals and organizations)

2) that there are "right" and "wrong" answers
3) that the interviewer would be shocked, disapproving or sympathetic to a particular set of answers

4) that his answers will somehow affect the nature or amount of services available to him.

The level of misrepresentation can be reduced by paying careful attention to these factors during the interviewing process. Prior to the start of the interview and regularly during the interview

itself, the patient should be reminded of the purpose of the interview, that there are no right or wrong answers and that the information will not be divulged to treatment staff. Further, throughout the process the interviewer should maintain an interested and supportive but **non-reactive** demeanor. When the nature of the response to a particular question suggests a lack of candor the interviewer should calmly remind the patient that the information is confidential and that you are simply interested in the services received during the past week.

It is important to note that some proportion of patients will not respond to these efforts to build trust and to maintain candid responses. Misrepresentation can usually be spotted in the manner in which the question(s) are answered. When this is the case and the patient appears to be falsifying answers **to a few items in a specific problem area, place an X** in the block(s) to indicate that the question was asked but that the response(s) was not acceptable. An interview should be continued until the interviewer feels that **more than a few items are inaccurate - in which case the interview should be terminated and the data discarded.** Again, there is no value to inaccurate data and its inclusion will impair the evaluation process.

What is a Significant Problem? - In two sections of the TSR (Family and Psychiatric) the patient is asked the number of days that he/she has experienced a "significant problem." Though we have tried to define and delimit the parameters of a "significant problem" it should be recognized at the outset that this will ultimately be a matter of judgment for the patient and the interviewer.

The word "significant" is included in each of the problem areas in an attempt to reduce the total number of possibly problematic situations that could confront a patient, to just those that could clearly warrant some type of intervention. Thus, in its most basic sense, a significant problem is one that could generally be regarded as a potential target of some form of intervention.

Trivial problems in each of the seven areas and ones that are generally temporary in nature and subject to improvement (in most cases) without intervention should not be counted. Again this will require judgment on the part of the interviewer but some degree of subjectivity can be reduced by following these guidelines during the questioning:

1) emphasize the word significant in the question - suggest in each case that you are interested in issues that re "...really **problems - ones that you might need some kind of help for."**

2) when in doubt probe for the nature of the problems reported by the patient. Record these in the comments section.

3) if in doubt and the patient maintains that the issue is a "significant problem" to him/her, accept the statement and go on to consider the remainder of the items.

Many of the problems that will be reported are due to the direct effects of alcohol or drugs and this will clearly be the only reason for their occurrence. These problems should be categorized **only under the alcohol and drug section** (e.g. the person who reports his withdrawal cramps as a significant medical problem). Sometimes it is helpful to ask the patient **"If you were to eliminate your use of drugs/alcohol would you still have (have had) this problem?"** This type of question will help to get at the important points to be used in making a decision to count or not to count a reported problem:

1) would there have been a problem (then or in the near future) without the influence of alcohol and drugs?

2) would a successful intervention that reduced or eliminated the alcohol/drug problem permit a return to a satisfactory situation in the affected area?

It is more likely that the problems that are reported will be a combination of alcohol/drug and other problem areas and will not be clearly one or the other. Obviously these are more difficult to judge appropriately (e.g. the outpatient who has gotten drunk and hit his wife - thus being thrown out of his home). The interviewer should probe carefully in these cases asking for the complete set of circumstances and antecedents. In the above case, if the outpatient had not had prior family problems (i.e. getting along with his wife, etc.) then this problem would likely be characterized as an alcohol problem - under the view that he would have continued satisfactory family life had he not

gotten drunk **and** that a successful intervention for the alcohol problem **alone** will enable a return to an acceptable family situation. However, if in the above case the outpatient had found the family and home life unacceptable regardless of the alcohol use, it would **have been** considered a family problem - under the view that despite the clear involvement of alcohol, he could not have gone on in his family/home situation for much longer regardless of the alcohol and further, that improvement in the alcohol problem **alone** would not alleviate the family situation.

Again, these are judgments that require some probing. In the event that no clear determination can be made, count the problem in the area that it has been reported.

What is a "Significant Discussion" with a treatment provider? - Again, the word "significant" has been included to eliminate frivolous or superficial conversations that only marginally address the problem area. In general, the significance of a discussion is not measured exclusively by the **length** of the conversation but by its **impact** on the patient. The subjectivity involved in this area will be reduced by employing the following guidelines:

1) emphasize the word "significant" in the question - suggest in each case that you are interested in discussions that are **"...directed at solving or helping the problems identified - a discussion that made you think, that changed the way you look at a problem, that gave you new idea or insight."**

2) when in doubt probe for the nature of the discussions reported by the patient. Record these in the comments section of each problem area.

3) if still in doubt and the patient maintains that the discussion was "significant" to him/her, accept the statement and go on to consider the remainder of the items.

Often a session with a treatment provider will cover a range of problem areas. **Please note** that a single discussion could have "significant" impact on several of the patient's problems and if this is the case, this **single discussion should be counted in each of the areas in which it actually had "significant impact.** For example, a counseling session that lasted an hour challenged the patient's perceptions of his family problems, provided support, encouragement and suggestions for his efforts to remain drug free and developed a plan for seeking employment **should be counted three times** as a significant discussion in the areas of drug use, employment and family problems Again, it will be important to probe the content of the sessions and solicit the patient's impression of the significance of each content.

An additional issues is the determination of exactly who the patient had a discussion/session with. Especially in the early days of treatment, it is possible that a patient will not know the title or name of each staff member. Thus, while the patient may say he had a discussion with a "nurse" it may actually have been a social worker or a physician. The interviewer is expected to use judgment in probing for accurate answers to these questions. If it is not possible to be sure whether the patient had a discussion with a counselor or a physician then the fact that a discussion occurred should be recorded under the "Significant discussion" section under the individual session. **However, the interviewer should not guess with whom the discussion actually occurred.** It is equally possible that a patient may report "talking to my counselor one day last week - I don't remember which day and I'm not sure what we talked about." In this case, despite some certainty that a conversation actually occurred - there is not evidence that the content had a significant impact on any problem area and this discussion **should not be counted** in any problem area.

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Please Note: In the case of group discussions, these should only be counted if the patient reports that the group session has had an impact on his/her problem. **It is not necessary for a patient to discuss his/her own problems.** Further, it is not absolutely necessary for the patient to say anything during group (although this is one way of probing for impact and significance) for the session to have had an impact. The interviewer should assess, through probes, whether the patient felt the group session had an impact on his/her problem but should accept his/her report of whether it was a "significant discussion" in most cases. If the patient attended a discussion group pertaining to a problem that he/she didn't have (e.g.. an alcoholic attending group therapy or discussions about drug abuse) **and** it didn't' pertain to his problem - then **do not count** this as a significant discussion.

In some cases the patient will indicate that he/she had a significant discussion about a legitimate treatment issue with a family member or a fellow patient (particularly in inpatient settings). Clearly, these discussions can be very therapeutic and the patient should not be made to feel that they are secondary in importance. **However,** to count these kinds of discussions on this form would introduce substantial additional variability into an already judgment-laden situation. For this reason we have decided to **count only those discussions that involve a treatment provider** from a recognized treatment or intervention organization. One exception to this is a significant discussion with an AA, NA or CA sponsor. These discussions will be counted since the sponsor is recognized as having a clear role in the patient's recovery and those interactions can often have substantial impact on that recovery.

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What is an "in-program" versus an "out-program" service? - In all areas of the TSR the patient is asked to report whether the services received were from his "program" or were from some other agency, organization or individual. The reason behind these questions is simple. If we want to determine if services received are correlated with problem improvement then it will be necessary to include the total number and types of services received, regardless of the source. It is however, important to note that out-program services should only be counted if they are from a service organization or individual associated with a service organization - not simply friends or relatives that discuss the patient's problems with him.

This distinction usually will not apply in an impatient or residential program but can be an important distinction for outpatient programs that evaluate and refer of clients to different types of services. The following points will be helpful in making this judgment.

Program Definition - The "program" should be considered **all** of the units, wards, clinics, etc. that fall under the **same department** (usually psychiatry or family medicine) and **practice coordinated care primarily for the problems of substance dependence.** Thus, under this definition, inpatient and outpatient substance abuse treatment clinics under the same medical department could be considered as one "program" even if one treats primarily alcohol dependence and the other treats primarily drug dependence. However, notice that while an inpatient drug abuse treatment unit located within a medical hospital could be considered part of the same "program" as an outpatient alcohol treatment unit (if administered by the same general management) even though they are literally miles away; the cardiac care unit of that hospital in which that inpatient drug treatment unit is located would not be considered part of the "program" even though it is located only a few yards from the substance abuse unit.

It is recognized that these additional guidelines will not solve all of the questions regarding program definitions. These are guidelines that we have found helpful and each facility is urged to agree on the actual units, wards, sections, etc. that will be defined as the "program" at that facility". This strategy of **adopting a single local convention** regarding the program definition is the best way of avoiding confusion. Thus it will be an important part of training for each potential interviewer to be aware of the local convention regarding "program" definition.

What services does the "Program" get credit for providing? Obviously all services provided by the personnel employed in a treatment program or on the property of the program are automatically

credited to that program. However, many programs refer patients outside the treatment setting for one-time-only evaluation services (e.g.. psyche testing, X-ray, employment evaluation) as well as some ongoing services (employment training, psychotherapy, AA). For the sake of convention, we have decided to report as "program services" those services that are contracted or paid for by the program, regardless of whether they are on program property. For example, many programs will employ a laboratory service to analyze urine samples, or a psychologist to do educational or personality testing, or a counselor to run an off-site AA program. All of these and other similar examples will be counted as "In-Program" services. Services which are received by the patient that are paid for by separate funds (e.g.. city, state, NIAAA, HEW, etc.) including the patient's personal costs or his insurer's costs, will be counted as "Out-Program services. It is important to note that these will be considered "Out-Program" services even if they were referred or initiated by the program - since the program does not pay for them.

IN SUMMARY

The **"program"** includes all units, wards, clinics:

a) providing substance abuse treatment (alcohol or drug)

b) under the same departmental administration

"In-Program" services are:

a) all those provided on site(s)

b) all those paid for by the program, regardless of site

When in doubt, please adopt standard, local conventions for how these services will be counted.

SPECIFIC DIRECTIONS BY PROBLEM AREA

PLEASE NOTE: THERE SHOULD BE NO BLANKS ON THE COMPLETED FORM. EACH QUESTION SHOULD HAVE EITHER A VALID RESPONSE OR THE LETTER "X" TO SIGNIFY AN INVALID RESPONSE (DUE TO EITHER A FAILURE TO COMPREHEND OR SUSPECTED MISREPRESENTATION)

Demographic Data

Name - Please print the full name of the patient, starting with the last name.

Date - Month/Day/Year

Interviewer - Please print the interviewer's name or local code number

I.D.# - Please print the local identification number for the patient in this space.

Week # - Please print the week of treatment that you are **measuring** not the day of the week you are asking questions.

Days Attending Program - Self explanatory

Medical Problems

1. Days of physical medical problems - Ask the patient to tell you the number of days he/she experienced any type of **physical** medical problems during the past week. These would include pain, disease, disability, etc. Only significant problems that were truly bothersome to the patient should be counted. Temporary, insignificant problems from colds, flu or sore muscles should not be counted. **Do not count** days of problems that were due simply to alcohol and/or drug withdrawal effects. **Do not count** days of psychiatric or emotional problems as these will be discussed in other sections of the TSR.

2. Days hospitalized - Ask the patient for the number of **days** in which he/she was treated as an inpatient to a hospital or medical setting. Please note that this item requires that the patient be admitted to the hospital, not just a medical appointment at a clinic or wart in an inpatient setting. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

3. Days received a medication as prescribed - It should be stressed that this medication should be for **physical** medical problems only - detoxification, antagonist or maintenance medications are recorded in the alcohol/drug sections while psychiatric medications are recorded in the psychiatric section. Multivitamins should not be counted. Further, the medication must be both prescribed and actually taken. Record the number of times the medication was actually taken, not just the number of times it was prescribed. Please note that it is not necessary to count the number of different prescriptions or drugs taken nor the number of times per day the medication was taken as prescribed. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

General Notes for questions 4 to 6:

a) these questions refer to the **number of times** during the past week - **not the number of days.** Multiple medications or sessions per day should be recorded in each case.

b) Often a program will **refer** a patient to another facility or section of the facility for medical care (to an admission physician or to a medical specialist such as a radiologist - **these visits should be counted here.** Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

c) Admission physicals should be counted in this section under the category of person(s) that administered the exam.

d) HIV (AIDS) testing and counseling sessions **should be** counted in this section as medical treatments; and recorded under the type(s) of practitioners who provided the service.

4. Times seeing a physician - It should be emphasized that these visits should be for the purpose of obtaining care for a physical medical problem - not simply beginning a detoxification or maintenance treatment. If the physician is a psychiatrist but is providing medical care for a physical problem, that visit should be recorded here. If the session was also devoted to psychiatric issues and this was also a significant part of the visit, this should be counted again in the psychiatric section. Note: HIV/AIDS counseling and testing sessions performed by the physician should be counted here.

5. Times seeing a nurse, nurse-practitioner or physician's assistant - same rules apply as for physician. It should be emphasized that these visits should be for the purpose of obtaining care for a physical medical problem - not simply obtaining a medication dosage (see question 5).

6. Significant discussion - Record the number of times participating in a discussion that was pertinent to the patient's medical problems including HIV/AIDS concerns with program members **other than the medical staff**. These discussions should be recorded separately for individual sessions (with a member of the program staff) and group sessions. Discussions recorded here should **not** include medical personnel since visits to these individuals will be recorded in questions 4 and 5.

Only discussions with staff from the program or another service organization should be recorded: i.e., not family and friends that he/she has talked with.

Employment/Support Problems

1. Days paid for working - Include all days that the patient was paid for working. Each paid employment day should be counted regardless of whether the patient worked only part-time (less than 8 hours). If a patient was on paid vacation or approved and paid sick leave, these days should also be counted as work days since they were earned through employment. Finally, employment days should also be counted even if the job was informal (under the table) - that is work with small businesses or individuals that would not be recorded on formal pay records. This does not mean the commission of illegal acts.

2. Days of education or training - Record all days the patient spent in an approved or official education or training program - one that would lead to a degree or certificate. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

General Notes for questions 3 to 5:

a) these questions refer to the **number of times** during the past week - **not the number of days.** Multiple meetings or sessions per day should be recorded in each case.

b) Often a program will **refer** a patient to another facility or section of the facility for employment counseling and/or skill training - **these visits should be counted here.** Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

3. Training, education, employment - These visits should be restricted to just those that were for the purposes of getting a job or the training/education that would lead to a new or better job. Record those visits to a staff member or agency whose primary duties are dedicated to employment counseling and other employment or educational services (employment specialist) separately from visits to a general counselor or social worker who would perform a full range of services for the patient.

4. Unemployment compensation benefits - These visits should be restricted to just those that were for the purpose of obtaining social service benefits to compensate the patient other than through employment. Welfare, disability compensation, temporary housing, emergency relief, social security compensation visits should all be counted here. Record those visits to a staff member or agency whose primary duties are primarily dedicated to benefits counseling (benefits specialist) separately from visits to a general counselor or social worker who would perform a full range of services for the patient.

5. Significant discussion - Record the number of times participating in a discussion that was pertinent to the patient's employment problems with program members **other than employment counseling/skill development staff.** These discussions should be recorded separately for individual sessions and group sessions. Discussions recorded here should not include employment/training personnel since visits to these individuals will be recorded in questions 3 and 4.

Only discussions with staff from the program or another service organization should be recorded i.e., not family and friends that he/she has talked with.

Alcohol Problems

1. Days drinking - Record all days that the patient drank any alcohol, regardless of the amount.

2. Days intoxicated - Record just those days that the patient reports having been intoxicated ("getting a buzz", "getting high").

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Please Note: this question will require probing in the event that the patient is tolerant to alcohol and/or if the patient has used drugs and alcohol together. A tolerant (dependent) alcoholic may correctly say that he/she did not get high or drunk, simply because of the tolerance. If this is the case, <u>we have adopted the convention that three or more drinks in one hour will be recorded as intoxication.</u>

In the case of joint use of the alcohol and drugs the interviewer should, with the help of the patient, try to determine the source of the intoxication. <u>If it remains unclear after probing, the intoxication should be counted in both the drug and alcohol sections.</u>

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3. <u>Days spent in inpatient treatment</u> - Record the number of days spent in any type of inpatient treatment for an alcohol problem. **Note:** Patients may have been treated as an inpatient for both alcohol and drug problems. If so, <u>their inpatient status should be recorded **both** under the alcohol and drug sections.</u> On the other hand, if a patient is an inpatient at a combined alcohol and drug program and he/she has only an alcohol problem, his/her status should be recorded only under the alcohol section. **Note:** many patients receive alcohol treatment as part of **primary** treatment for psychiatric or medical problems. Days counted here should be counted <u>only</u> if the primary treatment focus for the ward or program was substance abuse. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

4. <u>Detoxification Medication</u> - The medications should be for the purpose of detoxification - to reduce withdrawal symptoms and to increase the safety/comfort of the withdrawal process. Medications prescribed to address sleep and/or mood disorders that accompany the withdrawal process <u>may be counted.</u> However, probe to determine if these medications have simply been continued to address a more prolonged problem of anxiety or sleep disturbance. <u>Multivitamins</u>, though often given for detoxification supplementation, <u>should not be counted.</u> Typically, the medications used will be benzodiazepines (usually Serax or Librium) and the course of the medication regimen for detoxification is generally 3 to 7 days following termination of alcohol. Use of different medications or a longer course of medication is usually (not always) indicative of a different problem and may be recorded elsewhere (i.e., medical or psychiatric). Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

5. <u>Medication to Prevent Drinking</u> - These medications are almost always prescribed following the detoxification period and are designed to produce an unpleasant (headache, vomiting) reaction when alcohol is ingested. By far the most frequently prescribed "blocking" or "antagonist" medication is Disulfiram or Antabuse. Calcium carbimide may also be prescribed. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

6. <u>Blood Alcohol Test</u> Count the number of times the patient has had his blood alcohol measured using a breathalyzer or other technique. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

General Notes for questions 7 to 10

a) <u>these questions refer to the **number of times** during the past week -**not the number of days.**</u> Multiple meetings or sessions per day <u>should be recorded</u> in each case.

b) <u>Often a program will refer a patient to another facility or section of the facility</u> for AA, 12 Steps or even medication - these visits (<u>if they have been based on referrals from the treatment program</u>) should be counted here. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

7. <u>Alcohol Education</u> - This is a session with the <u>primary purpose</u> of providing medical and/or psychological education about alcohol and its effects. AA, group therapy, and 12-Step meetings <u>should **not** be counted here</u> since their purpose is much broader. Film sessions regarding the problems of alcoholic such as denial, relapse, etc. may be counted here.

8. AA and 12-Steps - These meetings should be counted together since they have largely the same purpose. Remember, AA and 12-Step meetings that are not located on the treatment program are still counted.

9. Relapse Prevention - Relapse prevention meetings refer to the use of specific behavioral and cognitive techniques designed to prepare the patient for situations that will trigger the desire to drink in the natural environment. In order to be counted here, the meeting or session must be devoted to these techniques rather than simply a discussion of the natural environment following treatment.

It should be noted that many programs hold generic relapse prevention meetings for **both** alcohol and drug problems/patients since the problems of readjustment are quite similar. **If** the relapse prevention meeting is generic in nature **and** the patient in question has only one of the two problems (drug or alcohol then his visit should be counted in only one place on the TSR (**either alcohol question 9 or drug question 9**. If the meeting is generic and the patient has problems with both drugs and alcohol, then the visit should be counted in both places on the TSR.

10. Significant Discussion - Record the number of times participating in a discussion that was pertinent to the patient's alcohol problems with program members **other than in the meetings and sessions recorded in items 7 to 9**. These discussions should be recorded separately for individual sessions and group sessions and for In-Program Vs Out-Program visits. Discussions recorded here can be with any staff member but should **not** include the sessions counted in items 6 to 8 since visits to these individuals will have been recorded in those items). Only discussions with staff from the program or another service organization should be recorded, i.e., not family and friends that he/she has talked with. Note: significant discussions with the patient's AA sponsor should be counted here.

Drug Problems

1. Days of drug use - Record all days that a subject used an illicit drug or a prescription drug in a non-prescription manner - that is in an abuse manner.

2. Days spend in **inpatient** treatment - Record the number of days spent in any type of inpatient treatment for a drug problem. **Note:** Patients may have been treated as an inpatient for **both** alcohol and drug problems. If so, their inpatient status should be recorded **both** under the alcohol and drug sections. On the other hand, if a patient is an inpatient at a combined alcohol and drug problem and he/she has only a drug problem, his/her status should be recorded only under the drug section. **Note:** Many patients receive drug abuse treatment as part of **primary** treatment for psychiatric or medical problems. Days counted here should be counted only if the primary treatment focus for the ward or program was substance abuse. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

3. Detoxification Medication - The medications should be for the purpose of detoxification - to reduce withdrawal symptoms and to increase the safety and/or discomfort of the withdrawal process. Medications prescribed to address sleep and/or mood disorders that accompany the withdrawal process may be counted. However, probe to determine if these medications have simply been continued to address a more prolonged problem of anxiety; or sleep disturbance. Multivitamins, though often given for detoxification supplementation, should not be counted. Typically the medications used with be methadone or Clonidine (for opiate detoxification), Phenobarbital (for barbiturate detoxification) or Desipramine (for cocaine detoxification).

The course of the medication regimen for detoxification is generally 3 to 7 days following termination of the drug. Use of different medications is usually (not always) indicative of a different problem and may be recorded elsewhere (i.e., medical or psychiatric). Please note: some of the same medications that are used to detoxify are also used in maintenance (e.g., methadone, desipramine) be sure to probe for the nature of the medication use - record maintenance medications in Item 3. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

4. Maintenance Medication - These are medications designed to stabilize a patient's moods and reduce craving for the problematic drug. The two most widely used maintenance medications are methadone and LAAM for opiate maintenance. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

5. Medication to Block Drug Effects - These medications are almost always prescribed following the detoxification period and are designed to reduce the desire for drugs or to block their reinforcing effects. By far, the most frequently prescribed "blocking" or "antagonist" medication is naltrexone or Trexan for opiate use, Desipramine for cocaine use and Sertraline for benzodiazepine use. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

6. Drug Screening Test - Count the number of times the patient has had his/her recent drug use measured using a urine test, blood test or (sometimes) a hair analysis. **NOTE:** HIV/AIDS screening tests should be counted in the medical section. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

General Notes for questions 7 to 10:

a) These questions refer to the **number of times** during the past week **-not the number of days.** Multiple meetings or sessions per day should be recorded in each case.

b) Often a program will refer a patient to another facility or section of the facility for NA, CA or even medication - **these visits** (if they have been based on referrals from the treatment program) **should be counted here.** Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program."

7. Drug Education - This is a session with the primary purpose of providing medical and/or psychological education about drug use and its effects. NA, CA and group therapy meetings should not be counted here since their purpose is much broader. Film sessions regarding the problem of drug users such denial, relapse, etc. should be counted here.

8. NA and CA - Narcotics Anonymous and Cocaine Anonymous meetings should be counted together since they have largely the same purpose. Remember, NA and CA meetings that are not located at the treatment program are still counted; further, if they are conducted by program personnel or personnel hired by the program for that purpose - they are counted at In-Program meetings.

9. Relapse Prevention - Relapse prevention meetings refer to the use of specific behavioral and cognitive techniques designed to prepare the patient for situations that will trigger the desire to use drugs in the natural environment. In order to be counted here the meeting or session must be devoted to these techniques rather than simply a discussion of the natural environment following treatment.

It should be noted that many programs hold generic relapse prevention meetings for both alcohol and drug problems/patients since the problems of readjustment are quite similar. If the relapse (drugs or alcohol) then his visit should be counted in only one place on the TSR (either alcohol question 9 or drug question 9). If the meeting is generic and the patient has problems with both drugs and alcohol, then the visit should be counted in both places on the TSR.

10. Significant Discussion - Record the number of times participating in a discussion that was pertinent to the patient's drug problem with any program members other than in the meetings and sessions recorded in Items 7 to 9 since visits to these individuals will have been recorded in those items.

Only discussions with staff from the program or another service organization should be recorded, i.e., not family and friends that he/she has talked with.

Legal Problems

1. Days incarcerated - Enter the number of days the patient spent in jail, detention center, holding area or police lockup. This does not mean simple arrest, it means being held or incarcerated for at least the majority of a day and/or overnight.

2. Days of illegal activity - Enter the number of days the patient engaged in crime for **profit.** Do no count simple drug possession or use. However, do include any crimes committed for the purpose of obtaining drugs.

General Notes for question 3:

a) This question refers to the **number of times** during the past week - **not the number of days.** Multiple meetings or sessions per day should be recorded in each case.

b) Often a program will refer a patient to another facility or section of the facility for legal counseling - these visits should be counted here. Use the general guidelines for determining whether the visits or services were "In-Program" or "Out-Program".

3. Contacts with justice system - Many substance abuse patients have a range of legal problems confronting them concurrent with treatment. Often, treatment programs will assist the patient or indirectly to take care of them.

Record under In-Program, the times a program staff person contacted any member of the legal system (police, lawyer, parole/probation, court officer, etc.) for the purpose of assisting the patient with a legal matter. These visits should be broken down by the nature of the contact - letter, phone call, visit.

Record under Out-Program, any contact with the legal system made either by the patient (unaccompanied by a program employee) or by a member of some other organization or agency.

4. Significant Discussions - Record the number of times participating in a discussion that was pertinent to the patient's legal or criminal problems with treatment or service providers other than in the meetings and sessions recorded in item 3. These discussions should be recorded separately for individual sessions and group sessions for In-Program Vs Out-Program discussions).

Family/Social Problems

General Introduction - The family and social problems section of the TSR (and the ASI) are among the most difficult to standardize due to the inherent complexity of the situations, the interactions of alcohol and drugs and the different normative situations faced by the patients. For example, the definition of who is a family member is by no means uniform. Often, a patient will have been raised by; and feel close to a step-parent, grandparent, aunt or even a neighbor - sometimes not seeing his/her biological parents until well into their teenage years. The marital relationships can be even more difficult to judge, as in the case where a patient is married to one woman, has been living with another for an extended period of time, but has become recently involved sexually with another. As a general rule, a family member will be someone with whom the patient has had a long standing, supportive, reciprocal relationship. This will not be restricted to blood or marital relatives.

A second issue is the definition of a problem. A large number of patients will report being separated from a loved one and being depressed about it. For the purposes of this form, we will count this as an emotional problem (in the psychiatric section) and we will restrict our definition of family/social problems to those problems that arise through contact or interaction. This means that a patient cannot have a "problem" with a family member during the past week unless they have had some interaction. Obviously, this will be very difficult to judge in those cases where the patient has been ejected from his home due to family problems but because of this has been out of the family environment over the past week. If the patient has tried to make contact and this was refused or rebuffed, the this should be counted in this section. If no attempt at contact was made, then we have taken the position not to record a family problem and the problematic moods and feelings that the patient is experiencing are best recorded under the psychiatric section. Of course, this is not intended as the "correct" definition of family/social problems. Many other equally tenable definitions could have been used. We have opted this definition since it is amenable to measurement and is consistent with the ASI definition in the family/social section.

1. Days of problems - Be sure to stress that you are interested in the number of days the patient had problems in **getting along with** family members, friends, and acquaintances (e.g., neighbors, co-workers, etc.). Do not count loneliness and boredom here (see below). Stress that these should be significant problems, not simply misunderstanding or a brief, cross word. Do not include problems that were related directly to the use of, or withdrawal from, alcohol or drugs - these problems should be counted under the alcohol and drug sections. In general, if the problem would have occurred except for the drug/alcohol problem, then It should not be counted here. Please follow the guidelines specified in the Introduction of the manual.

2. Days of loneliness/boredom - Record the number of days that the patient experienced significant periods of loneliness (the inability to connect with other people, to make or keep friends) and/or periods of boredom where the patient had nothing meaningful or interesting to do. Inactivity and lack of personal contact are not sufficient to be counted as loneliness or boredom - these periods should be bothersome or problematic for the patient. Stress that you are interested in extended parts of the day, not merely short periods within a generally satisfactory day of activities.

General Notes for questions 3 and 4:

a) These questions refer to the **number of times** during the past week - **not the number of days.** Multiple meetings or sessions per day should be recorded in each case.

b) Often a session in this area will cover more than one topic (e.g., marital, family and social relationships) - these visits should be counted for each of the areas where there has been a significant impact on the patient (Please see guidelines in the Introduction of this manual).

c) Patients and their families are often referred outside the program for services of this nature (marital therapy, couples counseling, counseling about a problem child, etc.) Please record these sessions separately for In-Program and Out-Program locations.

3. Family sessions: **Family present** - Please record each session or discussion that the patient had with a treatment provider that focused on the family or marital problems of the patient; and which included a member of the patient's family. This could include the full family or simply couples therapy. Record those visits to a staff member or agency **whose duties are primarily dedicated to family or couples counseling** (usually a social worker, psychologist or nurse with special training and experience in family therapy issues) separately from visits to a general counselor who would perform a full range of services for the patient.

4. Family sessions: **Family not present** - Please record each session or discussion that the patient had with a treatment provider that focused (at least in part) on the family or marital problems of the patients; but did not include a family member of the patient's family. That is, a session in which the patient talked about his family problems but the family members were not present. Record those visits to a staff member or agency **whose duties are primarily dedicated to family or couples counseling** (usually a social worker, psychologist or nurse with special training and experience in family therapy issues) separately from visits to a general counselor who would perform a full range of services for the patient.

Psychiatric/Emotional Problems

1. Days of problems - Be sure to stress that you are interested in the number of days the patient had significant emotional problems or "problems with your nerves". These problems would generally be depression, anxiety, cognitive confusion (i.e., getting your mind to do what you want it to), seeing or hearing things that aren't there, trouble controlling violent tendencies. Stress that these should be significant problems, not simply a brief period of emotional discomfort. Try to have the patient separate these reported problems from the emotional changes and mood swings that often occur associated with the use of, or withdrawal from, alcohol or drugs - these problems should be counted under the alcohol and drug sections. In general, if the problem would not have occurred except for the drug/alcohol problem, then it should not be counted here. Please follow the guidelines specified in the Introduction section of the manual.

2. Days hospitalized - Record the number of days the patient spent as an inpatient on a ward or program where the primary treatment was for psychiatric/psychological problems. **Note:** Many patients receive psychiatric treatment as part of **primary** treatment for alcohol, drug or medical problems. Days counted here should be counted only if the primary treatment focus for the ward or program was psychiatric illness. Please record these sessions separately for In-Program and Out-Program locations.

3. Psychological testing - Record the number of times the patient was given either performance-based or paper and pencil testing for emotional or cognitive problems. This will not include vocational or educational training - just tests designed to qualify emotional or cognitive function. IQ testing that occurs in the context of an employment or pre-employment evaluation should not be recorded here. However, if IQ testing is recommended in the context of a psychological evaluation of cognitive competence, it should be counted here. Please record these sessions separately for In-Program and Out-Program locations.

4. Psychiatric medication - Record the number of days any prescribed psychotropic medication was actually taken for symptoms such as depression, anxiety or hallucinations. The hallucinations. The question is designed to document the incidence of symptoms severe enough to warrant medication in the opinion of a physician, therefore, **the medication must have been prescribed** currently for the disorder in question - use of a previously prescribed medication or for a different reason should not be counted. **Note:** also that the days the medication was **actually taken** should be recorded, not just the number of days the medication was prescribed. Please record these sessions separately for In-Program and Out-Program locations.

General Notes for questions 5 to 7

a) These questions refer to the **number of times** during the past week - **not the number of days.** Multiple meetings or sessions per day should be recorded in each case.

b) Often a session in this area will cover more than one topic (e.g., psychological and family problems) - these visits should be counted for each of the areas where there has been a significant impact on the patient (Please see guidelines in the Introduction of this manual).

c) Patients are often referred outside the program for services of this nature (individual counseling, psychological testing, evaluation for medication, etc.) Please record these sessions separately for In-Program and Out-Program locations.

5. Relaxation training. Biofeedback - Record the number of sessions that the subject practiced or rehearsed a form of behavioral therapy for relaxation such as biofeedback or relaxation training. The patient must have actually performed the therapy for it to be counted. While for many patients, prayer has a relaxing quality - this should not be counted here.

6. Behavior modification - Record the number of sessions that the subject practiced or rehearsed a form of behavioral therapy designed to provide insight to the patient's behavior, to illustrate common behavioral problems, etc. The patient must have actually performed the therapy for it to be counted. This item is designed to record behavioral treatments/therapies designed to address psychological problems, not simply alcohol/drug problems, therefore, behavioral sessions devoted to relapse prevention should not be counted here - but should be counted in the alcohol/drug sections. Record those visits to a staff member or agency **whose specialized duties are primarily dedicated to psychiatric counseling or therapy** (usually a psychiatrist, social worker, psychologist or nurse with special training and experience in psychotherapy) separately from visits to a general counselor who would perform a full range of services for the patient.

7. Significant discussion - Record the number of times participating in a discussion that was pertinent to the patient's psychological/emotional problems with treatment providers **other than** in the meetings and sessions recorded in items 2 to 5. These discussions should be recorded separately for individual sessions and group sessions for In-Program and Out-Program visits.

Other Services Addendum to the TSR

This section of services and activities (as well as others that could be of local interest) may be included as an addendum to the standard TSR. The questions included here are not part of the standard form although they may be of use in specific applications.

How many **times** in the past week have you:	IN-PROG	OUT-PROG
1. Received a session of recreation (active movement or play)?	__/__	__/__
2. Received a session where arts, crafts or hobbies were being taught?	__/__	__/__
3. Attended an event (sporting or entertainment event) not associated with alcohol/drug use?	__/__	__/__
4. Attended a patient government or organization meeting? (for example, an AA/NA organizational meeting)	__/__	__/__

General Notes:

a) These questions refer to the number of **times** during the past week - not the number of days. Multiple meetings or sessions per day should be recorded in each case.

b) Often sessions will cover more than one topic - these visits should be counted for each of the areas where there has been a significant impact on the patient. (Please see guidelines in the Introduction to this manual).

c) Patients are often referred outside the program for services of this nature (recreational activities, etc.). Please record these sessions separately for In-Program and Out-Program locations.

1. Recreation sessions - This item is designed to record the number of active sessions of recreation received by the patient - for In-Program and Out-Program. These should be scheduled sessions by a treatment provider or in the context of rehabilitation services provided by an agency or program. It is not simply a record of the number of basketball games played during the week.

2. Hobbies and crafts - Record the number of passive or sedentary recreation sessions received by the patient - e.g., hobbies, arts and crafts, etc. These should be scheduled sessions by a treatment provider or in the context of rehabilitation services provided by an agency or program. It is not simply a record of the number of times the patient practiced his favorite hobby on his own.

3. Entertainment - Please record the number of entertainment events attended by the patient as part of an organized rehabilitation program. These should be organized outings by a treatment provider or in the context of rehabilitation services provided by an agency or program. It is not simply a record of the number of times the patient attended an entertainment event on his own.

4. Patient government - Please record the number of patient government sessions attended by the patient. These should be meetings run by the patients in which the business of the treatment community or the patient population is the focus of the meeting. These will almost always be inpatient sessions but it is possible that patient government sessions can be part of outpatient treatments as in the case of NA or AA **organizational meetings** (sharing and chairing sessions).