THE DEVELOPMENT OF AN EVALUATIVE TOOL WHICH ASSESSES EVIDENCE-BASED PRACTICES OF ALCOHOL TREATMENT PROGRAMS IN A RURAL COMMUNITY OF THE INLAND NORTHWEST

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Authorization to Submit Dissertation

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Abstract

This program assessment study had two main functions: (1) to develop an evaluative tool which compared and assessed program mission, content, and theoretical framework of alcohol treatment programs in a rural inland northwest community to evidence-based practices; evaluate client recidivism of these programs; evaluate the population demographics being served in these programs; and (2) make recommendations for program improvement based on evidence-based practices (EBPs).

The Robertello Evaluative Tool (RET) for Evidence-Based Practices in Alcohol Treatment was developed to provide alcohol treatment programs with an effect measurement of EBPs which examine specific program content. The RET assessment was completed with one pilot study program and four other outpatient alcohol treatment programs. The assessment process included completion of the RET by the program facilitators and an interview which was digitally recorded, transcribed, and analyzed. Analysis methods included Likert scale ratings collected in the areas of theoretical frameworks, mission, goals, and objectives, and treatment methods; qualitative data was segmented, coded, and themes were developed. Descriptive statistics and measures of central tendency were calculated for client demographic and recidivism information as available. Each facility was presented with EBP recommendations for implementation. After the pilot study analysis and the field study analysis processes, the RET was modified to ensure accuracy and ease of use.

Analysis of the individual alcohol treatment programs suggested that EBPs in the areas of theoretical frameworks, mission, goals, and objectives, client recidivism and client demographics were not implemented at most facilities. Practitioners need assistance in program planning including the recognition and implementation of EBPs. By using a

successful assessment criterion, alcohol treatment programs can improve program practices and begin to track overall program effectiveness.

Program facilitators reported the RET assessment process was easy to use and accurately reflected issues their facilities had with implementing EBPs. Program facilitators found the Practice Recommendation Summary to be helpful and especially appreciated the examples that were provided to implement the recommendations.

The RET can serve as a foundational tool for the assessment of EBPs in the future by providing individual alcohol treatment providers a resource for transitioning alcohol research and theory into practice.

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CHAPTER ONE

Introduction

Substance abuse, defined as the problematic use of alcohol, tobacco, or drugs, has wide-ranging implications for the individual addict and society (Substance Abuse and Mental Health Services Administration [SAMHSA], Center for Substance Abuse Treatment [CSAT], 2003). As a component of substance abuse, alcohol consumption in itself may not be problematic, but increased alcohol consumption can manifest itself into alcohol abuse and alcoholism (SAMHSA, CSAT, 2003). An alcohol problem is classified as ". . . any problem related to alcohol use that may require some type of intervention or treatment" (SAMHSA, CSAT, 2003, p. 1). Alcohol abuse, or the repeated use of alcohol, is a recognized medical condition defined by ". . . the regular use of alcohol despite recurrent adverse consequences" (SAMHSA, CSAT, 2003). Alcohol abuse usually progresses to alcohol dependence which is characterized by four symptoms: cravings, loss of control, physical dependence, and increased tolerance (Donatelle, 2006). Alcohol abuse and dependence also have serious consequences for the individual and society including negative health effects, financial difficulties, relationship problems, legal implications, as well as societal issues. But because alcohol dependence is a chronic problem, long-term treatment may be difficult to access and complete successfully.

Communities have focused some of their efforts on alcohol prevention programs to stop alcohol abuse before it starts. Alcohol prevention can start in two basic areas. First, controlling the conditions for alcohol to be available can be a deterrent to underage alcohol use and general population alcohol abuse. This includes age requirements for drinking,

regulating outlets and times of sales, and how much people drink in public places. By regulating alcohol sales and strict enforcement of underage alcohol use, many alcohol-related community problems can be avoided, although historically this cannot be the only answer for a community (Institute of Medicine, 2003). Alcohol will still be located and consumed by underage drinkers despite these efforts. Second, prevention efforts through formal education or community education can be beneficial by informing people about the negative effects of alcohol (Burke, 2003). Seriousness of alcohol consumption can also be conveyed through laws and social expectations (Hawkins, Catalano, & Associates, 1992). These forms of prevention are difficult to administer because many social norms promote alcohol use, especially with underage populations.

An equally important aspect of alcohol abuse and dependence includes identifying appropriate treatment strategies and evaluating their effectiveness. Communities often rely on several different treatment modalities including hospitals, physician offices, churches, psychologists or psychiatrists, outpatient care, and others. Treatment methods can also vary from provider to provider, and sometimes treatment is not available when needed. Each community's treatment approaches and their effectiveness need to be assessed in order to ensure appropriate and optimal care is given.

Setting the Problem

Treatment efforts can be approached from a multifaceted perspective in order to serve effected populations and combine efforts in a comprehensive manner. This is the foundation of the biopsychosocial model which promotes approaching addiction treatment from biological, psychological, and social viewpoints (Donatelle, 2006). The National Institute on Drug Abuse (NIDA) (2000) suggests several principles of effective treatment that can be

used by a community to implement and develop a consistent approach to alcohol treatment. The most important concept is the idea that "treatment needs to be readily available". Individuals need to be able to access treatment options at any time and have a variety of local services available. This also leads into the concept that "no single treatment is appropriate for all individuals" (Join Together, 2005, p. 10). Services must be matched to the needs of the client. Each community needs an assortment of treatment venues to best match clients' individual needs. These needs include managing the drug or alcohol abuse, but also other social needs such as medical care, treating co-existing disorders, legal problems, vocational counseling, housing services, and any psychological needs that may exist (Join Together, 2005). The biopsychosocial model also approaches addiction and treatment in a similar way, attributing addiction to a combination of biological or genetic, psychological, and social perspectives. Treatment for alcohol abuse based on the biopsychosocial model uses each of these areas to form a complete treatment approach (Donatelle, 2006). As the client progresses through treatment, the treatment approaches are continually assessed to ensure maximum benefits and possible success for the client.

Overall, providing effective treatment is a comprehensive approach that can be complicated and daunting to implement. Many treatment facilities chose a variety of treatment approaches based on personal preference, familiarity, or ease of use of the method by the provider. These treatment approaches are usually not grounded in a specific theory (Burdine & McLeroy, 1992). Clients' progress may be measured in objectives specific to their individual needs, but the overall theory grounding their alcohol treatment is often not evaluated (J. Pastore, personal communication, January 8, 2007). Because of this "here and there" approach, it is difficult to manage the treatment program, evaluate its success,

determine client outcomes and recidivism, rate a program's strengths and weaknesses, or make recommendations for improvement. Facilities may have a preconceived idea about how their treatment program is functioning, when in reality it is serving their clients in different ways. Furthermore, facilities find it difficult to combine a variety of treatment methods and stay current with new research developments for evidence-based practices (Burke & Early, 2003; Rapp, 2000)

Significance of the Study

For these reasons, treatment programs, their mission statements, and client outcomes should be assessed to determine how programs function in meeting client needs and achieving their intended goals. By assessing a community's alcohol treatment programs, much information can be obtained, including not only the number of alcohol treatment programs available at a given time, but the various treatment approaches used by these programs, and their missions, goals, and objectives. This may clarify what services are offered in a single community and help develop options for different treatment methods. An assessment of a community's overall alcohol treatment program effectiveness can also be measured by evaluating client recidivism. One can also determine how alcohol treatment programs implement and evaluate their treatment approaches and whether those approaches match evidence-based practices. Furthermore, program evaluation leads to a deeper understanding of alcohol-related issues such alcohol-related crime, how to focus treatment efforts in a particular community, and eventually aids a community in developing a more comprehensive, evidence-based approach for alcohol prevention and early intervention efforts.

Problem Statement

The purpose of this program assessment study was to develop an evaluative tool which compares and assesses program mission, content, and theoretical framework of alcohol treatment programs in a rural inland northwest community to evidence-based practices; evaluate client recidivism of these programs; evaluate the population demographics being served in these programs; and make recommendations for program improvement based on evidence-based practices.

Research Questions

The following research questions were used in this program assessment study to develop an evidence-based practice tool for alcohol treatment program evaluation:

1. Assess the number of alcohol treatment programs in a rural inland Northwest community.

    1a. Evaluate the mission, goals, and objectives of the programs.

    1b. Evaluate the theoretical framework of the programs.

    1c. Evaluate the content of the programs.

    1d. Evaluate the population demographics being served in the programs.

    1e. Evaluate the client recidivism of the programs.

2. Compare alcohol treatment programs to evidence-based practices.

3. Develop recommendations for individual program assessment and improvement based on evidence-based practices.

Limitations and Delimitations

This study was delimited by the following conditions:

The study occurred in a very unique area. The community is situated in the Inland Northwest and is considered in a rural area. However, within the community is a large public university, and there is a similar size institution in a bordering state close by.

The study was a mixed-method study including quantitative and qualitative analysis.

The number of providers that were studied is very small (less than ten) due to the size of the community.

The study focused on alcohol treatment programs located within the community.

The community members are very well-educated; this community has a large number of resources that are usually unavailable to a rural area.

This study was limited by the individual characteristics of the community being studied. This area is very unique in that its largest city is the home of a large, public university with approximately 11,000 students, and 3800 employees. The community is located in a rural area, but is adjacent to another similar large, public university in a bordering state. The combination of these two institutions significantly changes the population demographics, as well as available community resources, educational opportunities, and recreational venues. The community's demographics also reveal that its largest city has a predominately Caucasian community, with 23.4% of the city's residents in the 20-24 year old age group (U.S. Census Bureau, 2000a). Approximately 44% of the city's working population is employed in the educational, health, or social services industry. The city's median income is $26,884 with over 22% of the total population earning between $50,000 and $74,999 a year. However, 9.5% of families and 22.4% of individuals in this city live below the poverty level (U.S. Census Bureau, 2000b). This may be due in part to the large number of students that reside within the city limits. Despite this community's

resources, a large number of individuals still experience social and economic hardships in this area. The unique demographics of this population make it difficult to relate this study's findings to other areas, but gives insight into the problem of alcohol treatment which is prevalent in every community, despite economic or education levels and social agendas.

CHAPTER TWO

Introduction

The purpose of this literature review is threefold: to describe program evaluation models and their application in health behavior change theories; to describe a systematic approach to program evaluation within the content of alcohol treatment services; and to review current alcohol treatment practices, alcohol abuse and dependence, and national alcohol use and abuse. Through this information, the reader will better understand how alcohol treatment programs work to decrease alcohol abuse and dependence in our communities, and the guiding principles behind these programs. This will serve as a foundation for designing and implementing an evaluative tool for alcohol treatment programs using evidence-based treatment practices and recommendations.

Program Evaluation Models

Program evaluation is an evolving science. The development of program evaluation as a field of professional practice began to emerge and largely grow in the 1960's as writings from Cronbach, Campbell, Stanley, Stufflebeam, Tyler, and others were published (Stufflebeam, 2001). Through these writings and successive discussions, many evaluation approaches surfaced. Several schools, including the University of Minnesota and the University of Texas, have devoted full curricula to program evaluation, while the National Science Foundation and the Joint Committee Program Evaluation Standards have furthered the field by setting standards for evaluation and continuous examination of evaluation approaches (Stufflebeam, 2001). Stufflebeam (2001) defines evaluation as ". . . a study designed and conducted to assist some audience to assess an object's merit or worth" (p. 11).

In his text *Evaluation Models*, he has classified twenty-two common evaluation approaches into four categories: pseudo evaluations, questions and/or methods-oriented, improvement/accountability-oriented, and social agenda/advocacy approaches (Stufflebeam, 2001).

Assessing and evaluating a program's merit and worth is essential to develop recommendations for improvement when evaluating alcohol treatment programs. The most suited evaluation model for a substance abuse treatment program would ideally be an objective assessment of the program's goals, objectives, and outcomes. Stufflebeam's (2001) review of evaluation models brings to light an evaluation approach that would be nicely suited for substance abuse treatment; the program-theory based evaluation. Stufflebeam characterizes the program-theory based evaluation as a type of question and/or methods-oriented approach. He states: "The main purposes of the theory-based program evaluation are to determine the extent to which the program of interest is theoretically sound, to understand why it is succeeding or failing, and to provide direction for program improvement" (Stufflebeam, 2001, p. 37).

A common theme in program evaluation from a behavior change approach is the examination of the program's mission and theoretical framework. Although this can be one part of a larger program evaluation, it is important enough that some evaluators focus solely on this aspect of evaluation. In the program theory-based evaluation, Stufflebeam (2001) describes ways in which a program's mission and theoretical frameworks can be examined through the following questions: "Is the program grounded in an appropriate, well-articulated, and validated theory? Is the employed theory reflective of recent research? [And] Are the program's beneficiaries, design, operation, and intended outcomes consistent with

the guiding theory?" (pp. 37-38). "Unfortunately, not many program areas in education and the social sciences are grounded in sound theories" (Stufflebeam, 2001, p. 38).

It would be ideal for alcohol treatment programs to be grounded in a sound theoretical basis. Although practitioners may use several different theories as a base for a behavior change program, there are certain behavior change theories that relate to alcohol treatment success. These include the social-cognitive theory (SCT), the theory of reasoned actions (TRA), and the health belief model (HBM) (McKenzie, Neiger, & Smeltzer, 2005). The following paragraphs describe each of these theories and provide a foundation for program evaluation on a clear, theoretical model.

Social Cognitive Theory

Bandura's Social Cognitive Theory is based on the relationship of external stimuli and reinforcement and how those factors, along with internal expectations or subjective measures, can change or modify a particular behavior. SCT is grounded in the concepts of behavioral capability and reinforcement. Behavioral capability is the cognitive and physical ability to perform a behavior change based on self-efficacy. Reinforcement is a positive result of a behavior change, which can come from a facilitator, from watching another person receive positive reinforcement, or through self-reinforcement. An important aspect of the SCT is the idea that people need to believe they can change a behavior, be successful at the behavior change, and that the behavior change will benefit their health in the long-run (McKenzie et al., 2005). In substance abuse treatment, this situation would be ideal for a person who wanted to stop abusing alcohol, but not realistic for in situations where the person didn't believe their substance use was harmful to themselves or that it posed a problem in their lives.

Theory of Reasoned Action

The Theory of Reasoned Action is based on the concept of behavioral intention, or the ". . . individual's subjective perceptions and report of the probability that they will perform the behavior [change] (McKenzie et al., 2005, p. 152)." This means that an individual's ability or desire to change a behavior is based on their attitude toward the behavior, and on subjective norms associated with the behavior. Attitudes about the behavior determine if the individual feels the behavior has positive or negative health outcomes, and also their ability to perform the behavior change successfully. Subjective norms include how society and the individual feel about the specific behavior and if it is important for that person to agree or disagree with society about the value of the behavior (McKenzie et al., 2005). For example, a college student may view excessive alcohol consumption as a "normal" and accepted behavior in their peer group, despite ongoing negative consequences. Because of the perceived value of this behavior, the individual may chose to continue drinking alcohol excessively in order to meet social norms.

Health Belief Model

The Health Belief Model is another value-expectant theory that is used frequently in health behavior change. The HBM hypothesizes a change in behavior is prompted by a combination of one of the following factors: a motivation to change the behavior, a perceived health threat due to the problem behavior, and the belief that implementing a particular health recommendation would reduce the perceived health threat. Oftentimes, individuals experience barriers to behavior change, including lack of self-efficacy to change a behavior, unavailable resources, or lack of knowledge necessary to change a behavior (McKenzie et al., 2005). When implementing the HBM in substance abuse treatment, ideally an individual

would be motivated to change abusive behaviors using prescribed guidelines, and would feel that they had sufficient tools and resources to implement and be successful at the behavior change.

Moving Theory to Practice

Although each of these theories have common elements including the individual's motivation to change and external stimuli that may affect behavior change (including resources and subjective norms), they still must be related to real-life examples to be successful. It is very difficult to apply theory to practice. Burdine and McLeroy (1992) discern why practitioners were not using theory to guide behavior change programs including three primary reasons this was difficult: "(1) the failure of theory to adequately guide practice in specific settings or contexts; (2) the lack of appropriate theories to guide community-oriented interventions; and (3) difficulties in transferring theories from the academic training context to the practice environment" (p. 336).

The first reason that practitioners are not using theory to guide behavior change programs lies in the difficulty for practitioners to relate a behavior change theory targeted toward an individual to a practice setting. For example, some theories examine the prevention side of alcohol studies such as social norms or community problems that practitioners are not able to control. An example of a typical prevention problem is a community's large numbers of alcohol retail outlets or the legal enforcement of underage drinking. The second reason, or the lack of appropriate theories to guide community-oriented interventions, cites how theories are based on social science and are not easily manipulated to work for a specific population. In this case, ethnic and socioeconomic factors play an important role in administering and implementing a behavior change program. The

third statement reflects the ongoing problem that academia is facing by teaching a theory but not the implementation process. Practitioners have little real-world practice on how to move a sound theory into practice. To overcome these issues, practitioners need to be familiar with various theories that may guide behavior change. Although one should be wary about picking and choosing parts from several different theories when implementing a behavior change program, one aspect of a theory may work better than another, and can help the practitioner individualize a program to meet an individual or a community's needs. Practitioners should also examine the applicability of certain theories to the problem they are addressing. This can be done by taking the goals of a proposed program and matching them with the most applicable theories. In this way, a program's goals and objectives are aligned with a particular theory base, and evaluation methods can be more efficient. In turn, a program's success or failure can be measured by comparing the stated goals and objectives and the program outcomes (McKenzie et al., 2005). The evaluator may then question how a program's design or implementation might be changed in order to produce better outcomes. In the case of alcohol treatment programs, recommendations may be made that guide the practitioner toward utilizing evidence-based practices.

A Systematic Approach to Program Evaluation

By employing evidence-based practice recommendations and aspects of the program theory-based evaluation described by Stufflebeam (2001), one should be able to develop a systematic approach to evaluate alcohol treatment programs, their mission, theoretical frameworks, and outcomes in terms of client recidivism. The following list proposes recommended criteria for assessing a program's mission and theoretical framework:

Program Mission and Theoretical Frameworks

The theory or theories used in the program should be well-defined and validated (Stufflebeam, 2001).

The program theory outcomes align with the overall outcomes of the program (McKenzie et al., 2005).

The program mission should be clearly stated and describe the intent of the program (McKenzie et al., 2005).

Program goals should be operationally defined, consisting of measurable objectives. Goals and objectives should be written and referred to in times of program content and client guidance. Programs should be able to measure their objectives by using standardized criteria (McKenzie et al., 2005).

Program Practices and Treatment

The program mission and theory should be implemented through every day practices. This means that the program facilitator will use specific program practices and treatment to try to reach client goals and outcomes. In simpler terms, the mission and theoretical frameworks are the so-called “road-map” for where the practitioner is headed; the program practices and treatment is the actual “trip”. Therefore, program practices and treatment methods should be guided by evidence-based practices, as defined by relevant, peer-reviewed published literature and studies in alcohol treatment research. Alcohol treatment services must also be constantly assessed and modified to ensure appropriate care is given.

Alcohol treatment is available in a variety of venues and forms. Treatment can take place in emergency rooms, hospitals, doctor’s offices, employee assistance programs, inpatient facilities, veterans’ hospitals, recovery support groups, school-based programs,

employee-based programs, outpatient offices, and churches. The National Institute on Drug Abuse [NIDA] (2000) developed a list of scientifically based treatment recommendations in the area of drug and alcohol abuse. These treatment practices can be implemented on a community-level to ensure that substance abuse treatment services are addressing all types of patient needs. The NIDA does not suggest that any one treatment option is the best. All individuals are different and specific treatment methods fit specific individuals. This translates into treatment as a holistic approach and means that treatment should address physical, mental, and emotional needs of the patient (NIDA, 2000). Effective treatment for alcohol abuse should combine a variety of techniques and services including behavioral therapy, medications to reduce alcohol cravings, social services support, physical and mental health services, and self-help (Join Together, 2005). Treatment needs to meet multiple needs of each individual, not just recovery from the addiction process. Although certain forms of treatment have strengths and weaknesses, providing a comprehensive treatment approach guarantees the greatest chance for success.

Program facilitators may use a variety of options to treat clients for substance abuse. To examine if treatment strategies are based on evidence-based practices, and to determine if alcohol treatment program strategies align with theory-based mission and theoretical frameworks, general guidelines for programs should follow at the least this selected criteria outlined in the NIDA's Principles of Drug Addiction Treatment (2000):

Treatment should be comprehensive, addressing all aspect of a client's life, and should combine a variety of services to increase effectiveness. Although detoxification is an important aspect of treatment, this process should be combined with other services. In addition, cognitive and behavioral therapies must be included in treatment (NIDA, 2000;

Longabaugh and Morgenstern, 1999; Marlatt & Gordon, 1985; Larimer et al., 1999; Irwin et al., 1999).

Treatment should be readily available; treatment is a long-term process and multiple episodes of treatment may be needed (SAMHSA, 2000).

Treatment plans should be monitored and amended regularly. This includes aligning individual treatment plans with the overall mission, goals, and objectives of the program (McKenzie et al., 2005).

Treatment (including brief interventions) should include multiple sessions and programs should encourage or require attendance. Involuntary treatment should also include motivational strategies to encourage attendance (SAMHSA, 2000).

Alcohol treatment programs should also have the following emphases:

Treatment services and experiences should address resistance skills and experiences that are meaningful and reflective for the client in order to increase program effectiveness. Risk factors and protective factors for alcohol abuse and dependence should be addressed and managed (DOJ, OJJDP, 2002; SAMHSA, NCAP, 2000; Gerstein, 1984).

Recovering alcohols need to identify with other successful recovering alcoholics for physical and emotional support (Humphreys, 1999; DOJ, OJJDP, 2002; SAMHSA, 2000).

Overall, the systematic approach to program evaluation in the area of alcohol treatment practices should include the foundations presented in evidence-based alcohol treatment research. It is important for the reader to understand the complexities and numerous methods of effective alcohol treatment practices. In the following section, the researcher will review current evidence-based alcohol treatment practices.

A Review of Alcohol Treatment Practices

Introduction

Many options exist for effective alcohol treatment programs to fit the specific needs of an individual or group undergoing treatment, and also to meet the theories and goals of the treatment program. The National Institute on Drug Addiction (NIDA) recommends behavioral therapies (individual or group counseling) as an integral part of an effective treatment plan. Medications may also be an essential element when combined with behavioral therapies to help reduce cravings and manage physical symptoms of withdrawal as well as treat other co-existing disorders (NIDA, 2000). Alcoholics Anonymous (2005b) (AA) and other Twelve-Step Facilitations (Humphreys, 1999; Zemore, Kaskutas, & Ammon, 2004) (TSFs) have also received large attention in recent research for their straightforward approach to alcohol treatment. They offer a type of understanding for the addict by opening communication with former addicts and offering guidance and emotional support.

It is also essential to treat all aspects of the addict's health. Addressing physical health issues, as well as mental, emotional, and psychological aspects of health are important to ensure a complete recovery with a lower chance of relapse (Donatelle, 2006). However, the Project MATCH trial, for example, has not detected any differences among treatment effectiveness (Donovan, Kadden, DiClemente, & Carroll, 2004). Nonetheless, certain programs may still work better for clients with specific characteristics (Donovan et al., 2004). Behavioral therapies, medications used to treat alcoholism, and twelve-step facilitations will be described in-depth in the following paragraphs.

Behavioral Therapies

Behavioral therapy is a large section of alcohol treatment and can include a variety of methods. Behavioral therapies can include counseling, cognitive behavioral therapies, motivational therapies, relapse prevention, brief interventions, and the community reinforcement approach. They are used to address the cause of addiction problems and to develop problem-solving skills to prevent relapse (Join Together, 2006).

Cognitive-Behavioral Coping-Skills Therapy

Cognitive-behavioral coping-skills therapy (CBST), also known as cognitive behavioral therapy, is one method of behavioral therapy that has been used to treat alcohol dependency and other psychiatric disorders. The goal of CBST is to treat the patient by ". . . improving cognitive and behavioral skills for changing problem behaviors" (Longabaugh & Morgenstern, 1999, p. 1). This approach has also been called a broad-spectrum treatment approach because it does not focus solely on the issue of alcohol consumption, but also the maladaptive behaviors associated with drinking. The CBST process is designed to unlearn inappropriate responses and replace them with adaptive behaviors. CBST is the primary treatment method for alcohol dependency in Veterans hospitals and in the academic setting (Longabaugh & Morgenstern, 1999).

The CBST model is based on two core elements: 1) Bandura's social-cognitive theory and 2) employing a form of individual coping skills training to address the patient's deficits. The latter element can be addressed by techniques such as role-playing, the use of teaching tools, and behavioral rehearsal. Researchers have demonstrated that CBST is the first treatment approach to "demonstrate efficacy in reducing drinking in randomized clinical trials" (Longabaugh & Morgenstern, 1999, p. 3). In the last twenty-five years, CBST has

continued to prove itself as an effective approach in changing drinking behaviors, especially when used as a component of a more comprehensive therapy (Longabaugh & Morgenstern, 1999). Research still needs to be completed to find the specific variables in CBST programs that make it effective. CBST may also be more effective with certain patient populations and needs. These include those in high-risk situations, when used as aftercare therapy, in relapse situations, and in patients with personality disorder, deficits in social skills, and severe psychiatric dysfunction.

Motivational Therapies

Motivational therapies are another type of behavioral therapy used to address addiction. Three specific behavioral treatment strategies have been studied recently which target a person's motivation to change problem drinking behaviors. They include brief motivational intervention, motivational interviewing (MI), and motivational enhancement therapy (MET). Brief motivational interviewing uses a harm reduction approach to problem drinking. This treatment is usually provided by a physician or other health care professional. Treatment providers use brief motivational intervention to "advise patients on the need to reduce their alcohol consumption and offer feedback on the effects of the patients' drinking" (DiClemente, Bellino, & Neavins, 1999, p. 88). This is done in an attempt to reduce or stop patient drinking and enhance patient's motivation.

Motivational interviewing is frequently used with less motivated persons. MI is based on the psychological stages of change model and focuses on altering internal motivation. Techniques employed in MI include reflective listening, examining positive and negative results from behavior change, improving self-efficacy, interview and assessment, and eliciting personal motivation statements from the client/patient. This approach avoids

confrontation and negative associations with behavior change that may be used in other treatment methods.

Motivational enhancement therapy combines MI techniques in a shorter, less intense format. MET was originally used in conjunction with Project MATCH, a longitudinal comparative treatment method study. MET consists of four treatment sessions. In the first session personalized feedback is provided and personal ambivalence issues are addressed. In the second session strategies for change are developed and a commitment to change has been established and will be enforced. In the final two sessions, motivation is renewed by reviewing behavioral progress (DiClemente et al., 1999).

Overall, motivational strategies increase treatment success and patient compliance. By increasing internal motivation, a person is more likely to exhibit long-term behavioral changes. But it is difficult to promote internal motivation in a patient. Internal motivators are complex and vary from person to person. What motivates one person may not work for another. This is an important yet still relatively untapped resource for clinicians and researchers to learn about treatment and patient success. More research is needed to examine how motivational therapies be combined with other treatment approaches to enhance results.

Relapse Prevention

Relapse prevention (RP) is another important behavioral therapy that addresses cognitive and behavioral skills to reduce substance use. The relapse prevention model was originally developed by Marlatt and Gordon (1985). The model suggests there are two areas which pose a threat to relapse to substance use: immediate deterrents and covert antecedents. Immediate deterrents can include exposure to high-risk situations, poor coping skills, a distorted perception of the outcomes associated with alcohol use, and the effects of

unsuccessful abstinence. Covert antecedents include lifestyle balance, urges, and cravings, and the addict's response to these occurrences. The relapse prevention model focuses on specific intervention strategies to address each of these issues. This leads to increased self-efficacy and relapse management (Larimer, Palmer, & Marlatt, 1999). Although studies have found RP to be an effective behavioral strategy in treating alcohol abuse (Irwin, Bowers, Dunn, & Wang, 1999), abstinence rates are not higher with RP as compared to other treatment approaches. RP can be an effective component of a comprehensive treatment approach that addresses all levels of addiction.

Brief Interventions

Brief interventions are a short-term behavioral treatment method currently employed in the United States to reduce problem drinking. This treatment is usually developed by specialists to be delivered by allied health care professionals who work with clients or patients who are not problem drinkers. Brief interventions can occur in a physician's office, community mental health agencies, work settings or other venues (Osborn, 2001). The focus is on ". . . changing patient behavior and increasing patient compliance with therapy" (Fleming & Baier Manwell, 1999, p. 129). This technique can be employed to change a variety of health risk behaviors including smoking, diet, and other lifestyle factors. The focus of this treatment is brief individual counseling to reduce risk behaviors. This type of intervention is also described as harm reduction because the focus is not on eliminating the risk behavior entirely as in abstinence, but merely reducing problem drinking behaviors (Fleming & Baier Manwell, 1999). Therefore, this treatment approach is traditionally used for people whose problems are not severe, for example non-alcoholics (Osborn, 2001). Elements of brief interventions combine aspects of motivational enhancement therapy, 12-

step based methods, and cognitive behavioral therapy, but on a short-term basis. There are five essential steps to brief interventions used in the primary care setting (see Appendix A). A brief intervention can be conducted within a five to ten-minute physician's office visit. Unfortunately, health care providers are not always reimbursed for prevention or intervention measures where direct care does not occur, thus decreasing the number of possible brief interventions (Fleming & Baier Manwell, 1999).

Overwhelming research has shown the effectiveness of brief interventions. The World Health Organization (WHO) Brief Intervention Study Group is one of several large population studies that supported brief interventions due to their positive effects on participants. Effectiveness has also been shown to increase with follow-up visits and/or telephone consultations with the health care provider. Brief interventions have been most effective in reducing alcohol-related problems and consumption in nondependent drinkers (Fleming & Baier Manwell, 1999). Osborn states "This review of brief interventions in the treatment of alcohol use disorders attests to their utility and viability as an alternative option to more expensive, intensive, and prolonged forms of traditional treatment" (2001, p. 81).

Another situation which should be noted is the use of brief interventions in patient populations who do not respond to other alcohol treatment referrals. These people may not be in a motivational state of behavior change and may benefit from the interaction a primary care physician can provide on this subject. In this role, and with other patients, physicians can establish trust and emphasize other co-existing medical problems related to excessive alcohol use. Unfortunately alcohol treatment has customarily occurred outside the traditional medical care system, making physicians less likely to perform this type of intervention. Also with the changing face of primary care physicians' offices, multiple people can be involved

in one patient's treatment and care, making it important to educate other health care providers regarding brief intervention strategies (Fleming & Baier Manwell, 1999). Treatment providers of brief intervention strategies should have extensive addictions-related knowledge to be able to accurately answer patient questions and make appropriate referrals if necessary (Osborn, 2001). If these obstacles can be overcome, this treatment technique may receive more research and practical implementation as an alternative and inexpensive treatment for alcohol use (Fleming & Baier Manwell, 1999).

However, there are several questions that still remain unanswered in brief intervention research and implementation. Participants from brief interventions are usually studied through a twelve month period. Researchers need to assess the efficacy of brief interventions after the twelve-month period is over to determine long-term effects of this type of treatment. Additional research should be completed to asses the effects of brief interventions combined with other techniques, especially pharmacological methods, to increase their effectiveness. Studies of brief interventions employing these conditions should be examined to determine the best possible treatment methods for a variety of patient populations.

Community-Reinforcement Approach

The community-reinforcement approach (CRA) is a well-researched yet underutilized approach to alcohol treatment. CRA is another type of behavioral therapy that employs two main goals: "elimination of positive reinforcement for drinking" and "enhancement of positive reinforcement for sobriety" (Miller, Meyers, Hiller-Sturmhofel, 1999, p. 118). Essentially, abstinence will become more rewarding than drinking. CRA therapists use a variety of treatment methods to facilitate these goals. Therapists build patient motivation,

initiate sobriety, analyze patient's drinking patterns, increase positive reinforcement, and practice behavioral rehearsal while establishing a positive, energetic, optimistic atmosphere that may even include a patient's significant others in treatment (Miller et al., 1999). Some therapists may find the constant support and motivational enhancement necessary for this type of treatment difficult to deliver and are not as successful as other therapists at this approach. Other facilities are hindered by CRA's requirement for "immediate" treatment and overloaded treatment sessions in the early stages of treatment. This initial large amount of treatment time can be too much for some facilities or providers to handle, thus making CRA an unfeasible choice for treatment.

CRA has been studied initially in inpatient settings, and more recently in outpatient models for program efficacy. CRA has been found to be highly effective overall. In a University of New Mexico study, "CRA was found to be more successful in suppressing drinking than was a traditional disease-model counseling treatment approach" (Miller et al., 1999, p. 119). CRA also can be used in family therapy successfully because of its inherent role of a person's significant others in establishing positive associations with sobriety. Overall, CRA can be described as ". . . a comprehensive, individualized treatment approach designed to initiate changes in both lifestyle and social environment that will support a client's long-term sobriety" (Miller et al., 1999, p. 120).

Medications

Medications used to treat alcoholism, or used in combinations with other types of therapy, can be very successful (Join Together, 2005). Since alcohol and drugs act directly on the brain, physical withdrawal symptoms may occur 6-48 hours after ceasing to use a substance. This can result in tremors, elevated blood pressure, increased heart rate, and

seizures (Roberts & Koob, 1997). Using medications during the initial phases of detoxification can reduce some of the physical symptoms of withdrawal and help to decrease drug or alcohol cravings.

Several new medications have been developed recently which may block neurotransmitter systems in the development of addiction, and thus the development of alcoholism. This research is based on the theory that some individuals may be genetically predisposed to alcoholism and by stopping chemical reactions in the brain the disease may cease to progress, thereby correcting biological abnormalities (Johnson & Ait-Daoud, 1999). The goal of this type of therapy is to "reduce the desire to drink and promote abstinence" (Johnson & Ait-Daoud, 1999, p. 99).

Naltrexone is a type of medication which targets how dopamine affects a person's motivation, consumption, and cravings. Although the Food and Drug Administration (FDA) has approved naltrexone for the treatment of alcohol dependence, its effectiveness may vary based on the person's genetic proposed predisposition to alcoholism. The higher a person's predisposition to alcoholism, the more effect the medication will have. One major obstacle to naltrexone treatment is patient compliance (Johnson & Ait-Daoud, 1999). This requires increased monitoring efforts on part of the practitioner. Naltrexone may be more appropriate if used in combination with other psychological treatment methods to decrease physiological symptoms of alcohol cravings.

Acamprosate is another medication used to treat alcoholism. It appears to ". . . reduce the intensity of craving after drinking cessation, particularly when the patient is exposed to situations or environments associated with previous alcohol use, where the risk of relapse is greatest" (Johnson & Ait-Daoud, 1999, p. 101). Clinical studies of acamprosate show its

effectiveness in humans in helping to maintain abstinence compared to subjects who only received a placebo tablet (Johnson & Ait-Daoud, 1999).

New medications to treat alcoholism are currently being studied. Different types of medications that may lead to a reduction in alcohol consumption include opioid antagonists and calcium channel antagonists. Also possible combinations of medications are being tested to examine if their effects can be cumulative. Treatment providers in the United States continue to prefer the medication naltrexone to treat alcoholism. Advancements in this research need to examine different subtypes and levels of drinkers to see how different medications affect these people. Dose variance with imaging technologies also need to be tested to determine if the appropriate amounts are being used and their affects on human participants (Johnson & Ait-Daoud, 1999).

Although certain types of medications can be highly successful in the treatment of alcohol addiction, this type of treatment is far more effective if used in conjunction with another treatment method. For example, medications can treat the physical cravings for alcohol, but interpersonal therapies can address emotions and other issues behind alcohol abuse. Without addressing the psychological aspects of addiction, medications only mask the physical symptoms of detoxification. Once the medications are discontinued the addict has a high likelihood of returning to alcohol use or abuse because they cannot handle the psychological struggles that underlie the addiction.

Alcoholics Anonymous and Twelve-step Facilitations

Alcoholics Anonymous (AA) is a popular treatment and relapse prevention approach used by communities worldwide. AA is the most common program among the twelve-step programs, and its design has been mimicked by other treatment facilities. AA is defined as “.

. . a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problems and help others to recover from alcoholism" (Alcoholics Anonymous [AA], 2005). AA is a self-supporting organization with one requirement for membership: a desire to stop drinking. There are an estimated 2,076,935 members worldwide including 1,184,979 members in the U.S. from approximately 52,651 groups (AA, 2005). Although individual AA groups are structured, they rely primarily on the AA members to run meetings, greet new members, and conduct group business. The function of AA groups is described in-depth through the twelve traditions of AA shown in Appendix B. Members of AA work through a 12-step program to continue alcohol treatment and prevention from drinking. The twelve steps are outlined in Appendix C.

The AA program and other twelve-step programs like it appear to be effective in reducing alcohol consumption on a long-term basis during program participation (Humphreys, 1999; Zemore et al., 2004). One particular aspect of the program that is important is the effect of alcoholics helping other alcoholics. This interpersonal engagement is a predictor of individual treatment success. Zemore et al. (2004) have shown that sharing advice, help, and experiences helped alcoholics deal with their own treatment issues. The interpersonal nature of twelve-step programs and the associated anonymity of AA may be the essential elements for success in this type of treatment. AA and other twelve-step facilitations are very accessible and cost-effective for a wide range of people. This has been especially helpful as managed care organizations have begun to limit treatment in facilities (Humphreys, 1999).

Prior to the 1990's, there was limited research on the effectiveness of AA and twelve-step facilitation (TSF) approaches. But fortunately research has recently included AA and

TSFs in longitudinal study designs, comparison groups, and even random treatment conditions. Recent research shows AA and TSFs to be effective treatment methods for a variety of individuals (Humphreys, 1999). Furthermore, AA has strong support from its members, and a large number of people have found success with AA (Humphreys, 1999).

Effects of Alcohol Treatment

The effects of the different methods of alcohol treatment are varied and have produced an ongoing debate in the research field. Questions as to which treatment methods are best, which methods should be used with specific populations, length of treatment, inpatient versus outpatient treatment or alternative treatment settings, and other variables such as co-existing disorders and overall health status, play a role in evaluating treatment options and maintaining best practices in a variety of treatment settings. Recently these debates have been fostered by the changing status of American health care systems and the influx of managed care organizations. Insurance companies want shorter treatment methods with the same results as longer, more costly programs. In contrast, the goal of the practitioner, however, should be to employ evidence-based practices that meet the needs of their clients, despite regulations by private insurance companies or Medicare.

Treatment Success

Alcohol treatment services need to be readily available to the public at the time of need. This ensures that people who need treatment receive it while they are motivated and ready. Treatment does not have to be voluntary to be effective either. Sometimes external motivators, like family, friends, or even the judicial system, can be an effective motivator for completing alcohol treatment (NIDA, 2000).

There are several factors that are proven to impact treatment success. Being female and being married are positively associated with treatment outcomes. There is also a large focus on providing treatment access for females and ensuring that population's success with alcohol treatment (NIDA, 2000). Education levels also affect recovery; higher education levels are positively associated with non-abstinent recovery but negatively associated with abstinent recovery. This means that those with higher education levels are more likely to be able to recover from alcoholism on a non-abstinent basis. Recovery levels can be reduced among those with alcohol or drug-using friends. Dependence severity may also affect recovery by decreasing the chances of abstinence recovery (Dawson et al., 2004).

Alcohol treatment services can also have significant fiscal implications. For example, when evaluating social services, "[c]hildren whose families receive appropriate drug and alcohol treatment are less likely to remain in foster care" (Join Together, 2006, p. 9). Also, families who receive addictions treatment spend less money per month on medical expenses than those not receiving treatment. When reviewing fiscal outcomes in the criminal justice system, recidivism for arrestees has shown major decreases when inmates received addictions treatment; this was also true for adolescent arrestees who received residential treatment. In general, addictions treatment also improves health outcomes for addicts treating co-existing disorders (Join Together, 2006).

Summary

Despite differences in gender, race, socioeconomic status, marital status, or age, alcohol abuse is a disease that affects all people, either directly or indirectly. Although each treatment program or method has its own strengths and weaknesses, using evidence-based practices to provide a complete and individualized program may work best to treat an addict

and their specific risk factors. There is no "perfect fit" when treating alcohol addiction. It is a multifaceted problem that requires a comprehensive treatment approach. Therefore, alcohol treatment providers, whether it be a counselor, family doctor, therapist, or other allied health personnel, need to recognize the needs of each individual and offer treatment services that are flexible to meet each person's needs, within evidence-based practice guidelines.

Alcohol Abuse and Dependence

A pattern of increased consumption of alcohol followed by recurring adverse negative consequences is labeled alcohol abuse (SAMHSA, CSAT, 2003). The clinical diagnosis of alcohol abuse is made when a person exhibits one or more of the following conditions within a 12-month time period: recurrent alcohol use that results in unfulfilled work, school, or home responsibilities, recurrent alcohol use in physically hazardous conditions, recurrent alcohol-related legal problems, or continued alcohol use despite persistent social or interpersonal problems (SAMHSA, CSAT, 2003).

Alcohol abuse usually progresses to alcohol dependence. Dependence on a substance or behavior is a disease that is characterized by four symptoms: cravings, loss of control, physical dependence, and increased tolerance. Alcohol dependence may also be characterized by drinking large amounts of alcohol over a longer period of time than originally intended, unsuccessful attempts to control alcohol use, spending a large amount of time obtaining, consuming, or recovering from the effects of alcohol, altering social or personal activities due to alcohol use, or continued alcohol use despite recurring personal, social, or work problems (American Psychiatric Association [APA], 2000).

Genetics and the environment can influence alcohol dependence. Some people may have inherited genes that predispose them to alcohol dependence (Donatelle, 2006). And people with a family history of alcohol dependence are more likely to have lifetime alcohol dependence than those without such family history (Donatelle, 2006; Roberts & Koob, 1997). Environmental effects may increase or decrease alcohol dependence also. Education, social support, and self-regulating actions may decrease alcohol dependence while exposure to alcohol, friends and family who consume alcohol, and use of alcohol at an early age may increase one's risks (SAMHSA, CSAT, 2003).

Many adverse effects of alcohol abuse and dependence exist including health problems, relationship issues, financial difficulties, and societal issues. Substance abuse is a preventable disease, yet it is the leading cause of death from a preventable health condition. One in four substance abuse-related deaths are caused by alcohol use (Robert Wood Johnson Foundation, 2001). Health conditions such as cirrhosis of the liver and cancers are increased, taxing the nation's healthcare system as well. Exposure to HIV and other sexually transmitted diseases are also increased due to alcohol consumption because of the risk of unsafe sexual practices that can occur (SAMHSA, CSAT, 2003). Other health risks include "a weakened immune system, tuberculosis, coronary heart disease, [and] stroke" (SAMHSA, CSAT, 2003).

Alcohol dependence or episodes of increased alcohol consumption may also lead to unstable societal conditions including violence, aggression, legal issues, and interpersonal disturbances (World Health Organization [WHO], 2005). Driving under the influence of alcohol costs many Americans their lives each year. In 2006, the National Highway Traffic Safety Association [NHTSA] reported 13,470 deaths were the result of alcohol impaired

crashes involving at least one driver with a blood alcohol concentration of 0.08 or higher (Subramanian, 2008). Violence is also correlated with alcohol abuse (WHO, 2005). Communities pay for these problems by funding more police and criminal justice employees to monitor and enforce laws associated with underage alcohol consumption, drinking and driving, and associated violence (Miller et al., 1999). Despite these negative personal and societal consequences, alcohol use still continues.

National Alcohol Use and Abuse

Despite alcohol's adverse effects and prevention efforts targeted at decreasing alcohol use, rates of alcohol consumption are still high. The National Survey on Drug Use and Health (2005) (formerly the National Household Survey on Drug Abuse) is a survey that reports alcohol and illicit drug use for respondents within the last thirty days by number and frequency of drinks. This survey also tracks the percentage of people who reported drinking in the last thirty days by gender and age group. Among people age 12 and older, 51.8% of respondents reported drinking alcohol in the past 30 days. Higher drinking rates were reported among males, young adults aged 18 to 25, and among whites over other ethnic groups (SAMHSA, OAS, 2006). Individuals in these population groups may experience higher rates of alcohol abuse, dependence, or alcohol-related problems in their daily lives and in turn may cause more alcohol-related problems in their community. More than 55 million people, or approximately one-fifth (22.7%) of persons participated in binge drinking within the last 30 days prior to the survey (SAMHSA, OAS, 2006). The National Institute on Alcohol Abuse and Alcoholism National Advisory Council describes binge drinking as:

". . . [A] pattern of drinking alcohol that brings blood alcohol concentration (BAC) to 0.08 gram percent or above. For the typical adult, this pattern corresponds by consuming 5

or more drinks (male), or 4 or more drinks (female), in about 2 hours (National Institutes of Health [NIH], 2004, p. 3). Binge drinking can establish a pattern of risky alcohol consumption, where a person may pose physical or emotional harm to themselves or others. This type of drinker may not be alcohol dependent, but may engage in binge drinking or drinking in dangerous situations. Binge drinking is clearly dangerous for the drinker and for society.

Frequency of alcohol, or the number of days people who reported drinking in the last thirty days, is also important. Persons aged 26 and older had the highest levels of consumption (9 days), followed by 18 to 25-year olds (7 days) and 12 to 17-year olds (5 days). American Indians/Alaska Natives averaged the highest number of drinks per day (approximately 6) than any other ethnic group (SAMHSA, 2006). This statistic may help explain important health problems among American Indians/Alaska Natives that may be present due to alcohol dependence.

The National Survey on Drug Use and Health also examined heavy use of alcohol, defined as ". . . five or more drinks on the same occasion on each of 5 or more days in the past 30 days" (SAMHSA, 2006, p. 27). The number of people who reported heavy drinking in the last thirty days has stayed consistent over the last five years. In 2005, 6.6% of the population age 12 and over reported heavy drinking. This equals approximately 16 million people. These final statistics show that alcohol abuse and alcoholism is not a problem that is going away. Alcohol use and abuse has reached epidemic levels in our country. This problem affects all ages, ethnicities, socioeconomic levels, and gender. Our society must work to decrease alcohol abuse and dependence through effective prevention and treatment strategies.

Conclusion

Alcoholism is a chronic disease that affects all aspects of a person's life, and may have lasting affects on society as well. Prevention programs can be effective in stopping alcohol abuse before it starts, but practitioners still need to focus on people who regularly abuse alcohol. Alcohol treatment is not always effective; people return for multiple treatment episodes and are often left dealing with their personal and health consequences of alcohol use between treatments. Alcohol treatment needs to be more effectively managed by providing practitioners with evidence-based practice guidelines to implement in their treatment programs. This would increase programs' overall effectiveness, and decrease the personal and societal consequences of alcohol abuse and dependence.

In order for this to happen, alcohol treatment programs should be based on well-defined theory that is validated. Program theories and program outcomes need to match and function well together. Programs should have clear missions, goals, and objectives which are quantifiable and easily measured. Overall, treatment should be comprehensive, readily available, including multiple sessions, and treatment programs should be reviewed and amended regularly. Alcohol treatment should include a form of cognitive behavioral therapy, as well as educating the client about resistance skills, risk factors, and protective factors which may influence alcohol use. Addicts should be able to relate their therapy to real-life experiences, including sharing experiences with recovering alcoholics.

In each of these areas, alcohol treatment practices should include evidence-based practices in order to provide the best possible care to people suffering from alcohol abuse or dependence. By developing an evidence-based practice guideline to assess and improve existing alcohol treatment practices, these programs may become more effective and over

time will decrease alcohol abuse and dependence, improving individual's lives and our communities.

CHAPTER THREE

Methodology

Introduction

This program assessment study had two main functions: (1) to develop an evaluative tool which compared and assessed program mission, content, and theoretical framework of alcohol treatment programs in a rural inland northwest community to evidence-based practices; evaluate client recidivism of these programs; evaluate the population demographics being served in these programs; and (2) make recommendations for program improvement based on evidence-based practices (EBPs). The Robertello Evaluative Tool (RET) for Evidence-Based Practices in Alcohol Treatment (see Appendix D) was developed for alcohol treatment program analysis. Using this tool, the researcher also made recommendations for alcohol treatment program improvements based on evidence-based practices. Figure one (1) depicts the procedure that was used to accomplish both purposes:

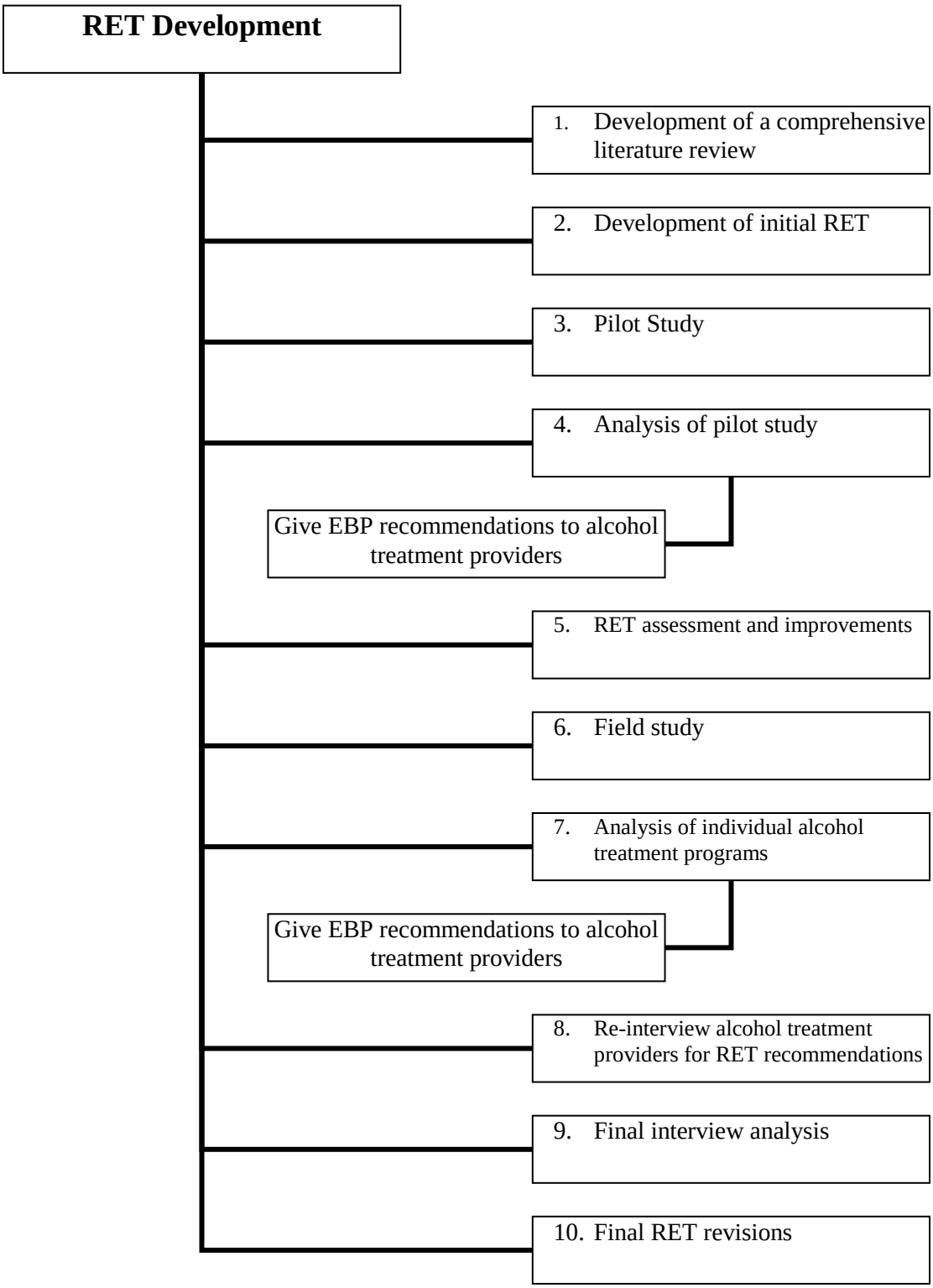

Figure 1. Schematic Representation of the Procedure

Procedure

In this section of the methodology, the procedure depicted in Figure 1 will be explained step-by-step.

Comprehensive Literature Review

First, a comprehensive literature review was completed in the area of alcohol treatment. This included searches of two major databases in the areas of Psychology/Psychiatry, Social Sciences and Medicine to find relevant journal articles and government documents. The only journal articles accessed were from peer-reviewed, refereed journals. Key words used in the searches included “alcohol treatment”, “alcohol prevention”, “evidence-based practices”, “best practices”, “program evaluation”, “social cognitive theory”, “theory of reasoned action”, “health belief model”, and combinations of these terms. Relevant online literature and printed government documents including the National Directory of Drug and Alcohol Abuse Treatment Programs (2005), NIDA’s Principles of Drug Addiction Treatment (2000), the National Survey on Drug Use and Health (2006), SAMHSA’s Treatment Improvement Protocols, the National Survey of Substance Abuse Treatment Services, the Alcohol Epidemiologic Data Directory, SAMHSA’s Services Research Outreach Survey and others were accessed for information on alcohol treatment and evidence-based practices. Documents from the Robert Wood Johnson Foundation and the Join Together program were also reviewed for content. Textbooks in the subjects of program evaluation and health program planning and evaluation were also used to supplement the research.

From this information, the researcher was able to develop an understanding of current alcohol treatment practices, methods of program evaluation, health behavior change theories,

and desired outcomes in alcohol treatment processes. Above all else, a pattern of evidence-based practices emerged from the research which guided the development of this research question. Personal insight and experience was gained about this community's alcohol treatment services through observation of an existing alcohol treatment program and informal interviews with alcohol treatment providers and counselors. From these ideas, the concept of developing an evidence-based practice evaluation tool to assess alcohol treatment programs materialized.

Development of an Initial Evaluation Tool

The second step in the RET development and assessment procedure was the development of a preliminary evaluation tool. The Robertello Evaluative Tool (RET) for Evidence-Based Practices in Alcohol Treatment was modeled after the Join Together Action Kit, Improving the Quality of Drug and Alcohol Treatment (2005) and NIDA's Principles of Drug Addiction Treatment: A Research Based Guide (2006). Principles that have been shown to be effective in reducing substance abuse among large populations in evidence-based studies were also added in the RET for further evaluation (NIDA, 2000; Longabaugh & Morgenstern, 1999; Marlatt & Gordon, 1985; Larimer et al., 1999; Irwin et al., 1999; DOJ, OJJDP, 2002; SAMHSA, NCAP, 2000; Gerstein, 1984; Humphreys, 1999; [DOJ], Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2002). Each principle cited in the RET is referenced within the tool itself. Stufflebeam's (2001) program-theory based evaluation model and health program theory evaluation tools cited in McKenzie et al. (2005) were used as criteria within the RET to evaluate program theory, mission, goals, objectives, and framework. A preliminary version of the RET appears in Appendix D.

The RET for Evidence-Based Practices in Alcohol Treatment was used by alcohol treatment program facilitators and the primary researcher to assess programs on five main criteria: 1) program mission, goals, and objectives, 2) theoretical frameworks, 3) treatment methods, 4) client recidivism, and 5) client demographics. The criteria were compared to evidence-based principles in each specific area.

The instrument was organized in a rubric format. Principles numbered one (1) through ten (10) presented in the rubric were graded using a Likert scale (1=not acceptable, 2= fair, and 3= excellent) to the degree in which it meets the evidence-based practice ideal. Principles eleven (11) and twelve (12) were evaluated on numeric data. A "Points of Practice" section was included beside each principle to aid the alcohol treatment provider in assessing each area. An assessment area was located to the right of each principle for assessment by the program facilitator and the primary researcher. Included in the assessment area was a space to input notes and recommendations about each principle or for use by the primary researcher when gathering information about the program. The RET also included space at the end of the document for notes or summary information.

Pilot Study

The third step in the RET development and assessment procedure was to conduct a pilot study using the initial version of the RET with a sample alcohol treatment program. Prior to the pilot study, approval for this research was obtained from the University of Idaho Human Assurances Committee (see Appendix E). Preceding the study, the researcher also completed the Human Participants Protection Education for Research Teams online course sponsored by the National Institutes of Health (see Appendix F). In this pilot study, the program facilitator of an alcohol treatment program in the sample community used the RET

to evaluate his institution's alcohol treatment programs. The time to complete the RET instrument was approximately thirty minutes to one hour, depending on the amount of information provided by the program facilitator. This population was kept separate from the sample population and was only used for this pilot study.

After the program facilitator completed the self-assessment using the RET, a thirty minute interview was conducted to gain additional information about the program's alcohol treatment practices (including program mission, goals, objectives, content, or other areas of interest). Documents that were relevant to assessing program mission, theoretical framework, program treatment, client recidivism, and client demographics were obtained from each alcohol treatment program coordinator as they were available. No documents were gathered that sacrificed individual patient/client confidentiality. Public documents were gathered that described the various alcohol treatment programs, including general information, intervention strategies, and effectiveness rates. Any other significant documents at the facility that are given to the public for knowledge about the program were gathered.

The program facilitator was also interviewed about the use of the RET, suggestions for improving the RET, and topics or content area that was missing from the RET that may be helpful to other program directors. Possible interview questions are listed in Appendix G.

All interviews were digitally recorded for transcription and analysis purposes. Audiotapes were transcribed by voice recognition software (Dragon Naturally Speaking, version 8.1) and printed for analysis. No identifying information was transcribed about the people who were interviewed. Transcriptions and audiotapes were kept by the primary researcher in a secure location.

Analysis of Pilot Study and Evidence-Based Practice Recommendations

The fourth step in the RET development and assessment procedure is the analysis of the pilot study. Each of the five criteria included in the RET (mission, goals, and objectives; theoretical frameworks, treatment methods, client recidivism, and demographics) were assessed and analyzed individually. Table 1 shows a schematic representation of the RET including the criteria used for assessment, each criteria's assessment techniques, and analysis methods. A more specific account of the analysis procedure will be included later in the Analysis Section of the Methodology.

Criteria	Assessment	Analysis
Program mission, goals, and objectives	• Likert scale • Interview • Document gathering	• Likert rating • Segmenting, coding, and thematic development of interview transcripts • Data triangulation
Theoretical frameworks	• Likert scale • Interview • Document gathering	• Likert rating • Segmenting, coding, and thematic development of interview transcripts • Data triangulation
Treatment methods	• Likert scale • Interview • Document gathering	• Likert rating • Segmenting, coding, and thematic development of interview transcripts • Data triangulation
Client recidivism	• Descriptive statistics	• percentages
Client demographics	• Descriptive statistics	• percentages • measures of variability • measures of central tendency

Table 1. *RET Assessment and Analysis*

A secondary outcome of the pilot study analysis was the development of evidence-based practice recommendations for the alcohol treatment provider. After each section of the RET was analyzed, the RET was presented to the alcohol treatment provider at a second interview with appropriate evidence-based practice recommendations specific to their practice facility added. This interview took approximately twenty minutes. A summary or notes section was also added to the RET as needed to clarify any other issues as necessary.

RET Assessment and Improvements

The fifth step of the RET development and assessment procedure was analyzing the pilot study interview regarding the RET and possible improvements that could be made to the instrument itself or in the overall assessment process. The interview with the alcohol treatment provider from the pilot study was transcribed, segmented, coded, and themes were developed for each area. Analysis of data was analyzed and compared to evidence-based practices and as many suggestions as possible were implemented in the existing RET document.

Field Study

In the sixth step of the RET development and assessment procedure, using the modified RET, a field study occurred within the sample population. The sample population for the field study was organized from the 2005 National Directory of Drug and Alcohol Abuse Treatment Programs, the Substance Abuse and Mental Health Services Association (SAMHSA) online Substance Abuse Treatment Facility Locator (http://dasis3.samhsa.gov/), as well as alcohol treatment providers listed in the local phone book, community newspapers, and other public sources. Initially, seven alcohol treatment programs were contacted to

participate in the study. Of these potential participants, four programs decided to participate. Coordinators of the programs in this community were contacted to participate in this study. Participants signed a written consent waiver prior to participation (see Appendix H). The University of Idaho Human Assurances Committee approved the study prior to participation to protect participants from undue harm (see Appendix E).

First, the alcohol treatment providers assessed their programs on their own using the modified RET. The self-assessment by the program facilitators using the RET took approximately thirty minutes to one hour, depending on the amount of information that was provided. Second, any documents that were relevant to assessing program mission, theoretical framework, program treatment, client recidivism, and client demographics were obtained from each alcohol treatment program coordinator within the community as they were available. No documents were gathered that sacrificed individual patient/client confidentiality. Public documents were gathered that described the various alcohol treatment programs, including general information, intervention strategies, and effectiveness rates. Any other significant documents at the facility that are given to the public for knowledge about the program were gathered.

The alcohol treatment providers were then interviewed about each principle assessed in the RET. Each interview lasted approximately thirty minutes to one hour. All interviews were digitally recorded for transcription and analysis purposes. Audiotapes were transcribed by voice recognition software (Dragon Naturally Speaking, version 8.1) and printed for analysis. No identifying information was transcribed about the people who were interviewed. Transcriptions and audiotapes were kept in a secure location.

Analysis of Individual and Community Alcohol Treatment Programs and Evidence-Based Practice Recommendations

The seventh step of the RET development and assessment procedure was individual and community alcohol treatment program analysis. Analysis of each of the four individual alcohol treatment programs were assessed and were completed using the RET Assessment and Analysis previously presented in Table 1. Recommendations for each individual program were developed within each principle area and documented within the RET. A summary or notes to the RET was also be added if necessary.

After completing the individual assessments, an assessment of overall alcohol treatment evidence-based practice use was completed by examining the individual assessments and noting the use or absence of evidence-based practices. Through gathering data about individual alcohol treatment programs in this community, a list of recommendations was developed that took place on a state and national level to help better serve the needs of people using alcohol treatment services. For each RET principle, the Likert scale ratings of each individual alcohol treatment provider were used to determine the mean and standard deviation of that assessment area. Available statistical information was also gathered from the individual assessments including demographic information about clients served and client recidivism rates. This assessment was written in summary format and will be used in the Discussion section of this document. This information may also be presented to individual alcohol treatment providers upon request.

A secondary outcome of the field study analysis was the presentation of evidence-based program recommendations to the field study participants. Program recommendations

to meet evidence-based practice standards were written within the RET document and given to each program director.

Re-Interview Alcohol Treatment Providers

The eighth step of the RET development and assessment procedure was to re-interview the alcohol treatment providers regarding their experience using the RET, suggestions, problems, and recommendations for the tool itself. This interview lasted approximately twenty to thirty minutes. All interviews were digitally recorded for transcription and analysis purposes. Audiotapes were transcribed by voice recognition software (Dragon Naturally Speaking, version 8.1) and printed for analysis. No identifying information was transcribed about the people who were interviewed. Transcriptions and audiotapes were kept in a secure location.

Final Interview Analysis

The ninth step in the RET development and assessment process was the analysis of the final interviews with the individual alcohol treatment providers. Interview transcriptions were segmented, coded, and themes were developed for each area.

Final RET Revisions

The tenth step in the RET development and assessment process was the implementation of any recommendations for the RET by the field study participants. The interview analysis was compared to evidence-based practices and as many suggestions as possible were implemented in the existing RET document. Any final RET revisions were also completed at this time to encourage the future use of the instrument and to ensure ease of use.

Role of the Researcher in Qualitative Assessment for Program Evaluation

The primary researcher served as complete observer/interviewer during the three interview stages (the pilot study, field study, and re-interview). The researcher had no interaction with alcohol treatment program participants, and did not influence alcohol treatment programs in any way. Data gathered and generated at the conclusion of this study was shared with interviewees at their request. Programs' recommendations were shared with pilot study and field study participants at the conclusion of the study.

The researcher was subject to the bias of interpretation of the various interviews and documents that were gathered. This pre-existing bias occurred from my current level of knowledge about alcohol treatment programs and their effectiveness. My philosophy regarding alcohol treatment and rehabilitation follows the guiding principle that behaviors can be changed if the person is motivated and ready to change. I think that treatment is most successful if it is addressed using a biopsychosocial model which targets all aspects of an individual's behavior, environmental influences, and genetic predispositions. Treatments may consist of any of the following or a combination of approaches including cognitive behavioral therapy, twelve-step facilitation, community reinforcement, and possibly medications used to treat alcoholism if used in combination with other psychological therapy. I think that brief interventions can be used to initiate motivation to change for an individual, but I do not believe that the majority of these programs can have long-lasting effects on alcoholics or alcohol abusers.

Although I do regard certain types of programs as more effective than others, I tried to eliminate this bias by using semi-structured interview questions through the interview process.

Analysis

Data Analysis

In steps four (4) and (7) of the procedure, the RET was used to analyze the pilot study findings and field study findings of alcohol treatment facilities. A basic analysis overview for the five main principles in the RET was presented in Table 1. Below find how each section (1. program mission, goals, and objectives; 2. theoretical frameworks; 3. treatment methods; 4. recidivism; and 5. patient demographics) were analyzed using quantitative and/or qualitative methodology.

Program Mission, Goals, and Objectives

Program mission, goals, and objectives were assessed by multiple methods. Method one (1) used a Likert scale (1=not acceptable, 2=fair, and 3=excellent). A rubric was provided for each principle presented in this section. Based on the criteria set in the rubric, a Likert scale value was given for each of these objectives. Method two (2) was an interview with the program coordinator. Method (3) included document gathering. In analysis of the interview transcripts and the documents, data was segmented, coded, and thematic development occurred. Data was also triangulated for increased validity. The evidence-based principles for this area that were assessed and analyzed with the Likert scale, interviews, and document gathering included:

1) The program mission should be clearly stated and describe the intent of the program (McKenzie et al., 2005., p. 128).

2) Program goals should be operationally defined, consisting of measurable objectives. Goals and objectives should be written and referred to in times of program

content and client guidance. Programs should be able to measure their objectives by using standardized criteria (McKenzie et al., 2005, pp. 129-133).

Theoretical Frameworks

Program theoretical frameworks were assessed by multiple methods. Method one (1) included a Likert scale (1=not acceptable, 2=fair, and 3=excellent). A rubric was provided for each principle presented in this section. Based on the criteria set in the rubric, a Likert scale value was given to these objectives. Method two (2) was an interview with the program coordinator. Method (3) included document gathering. In analysis of the interview transcripts and the documents, data was segmented, coded, and thematic development occurred. Data was also triangulated for increased validity. The evidence-based principles for this area that were assessed and analyzed with the Likert scale, interviews, and document gathering included:

1) The theory or theories used in the program should be well-defined and validated (Stufflebeam, 2001). "Is the employed theory reflective of recent research?" (Stufflebeam, 2001, p. 37).

2) The program theory outcomes align with the overall outcomes of the program (McKenzie et al., 2005).

Treatment Methods

Program treatment methods were assessed by multiple methods. Method one (1) used a Likert scale (1=not acceptable, 2=fair, and 3=excellent). A rubric was provided for each principle presented in this section. Based on the criteria set in the rubric, a Likert scale value was given to these objectives. Method two (2) was an interview with the program

coordinator. Method (3) included document gathering. In analysis of the interview transcripts and the documents, data was segmented, coded, and thematic development occurred. Data was also triangulated for increased validity. The evidence-based principles for this area that were assessed and analyzed with the Likert scale, interviews, and document gathering included:

1) Treatment should be comprehensive, addressing all aspect of a client's life, and should combine a variety of services to increase effectiveness. Although detoxification is an important aspect of treatment, this process should be combined with other services. In addition, cognitive and behavioral therapies must be included in treatment (NIDA, 2000; Longabaugh & Morgenstern, 1999; Marlatt & Gordon, 1985; Larimer et al., 1999; Irwin et al., 1999).

2) Treatment should be readily available; treatment is a long-term process and multiple episodes of treatment may be needed (SAMHSA, 2000).

3) Treatment plans should be monitored and amended regularly. This includes aligning individual treatment plans with the overall mission, goals, and objectives of the program (McKenzie et al., 2005)

4) Treatment (including brief interventions) should include multiple sessions and programs should encourage or require attendance. Involuntary treatment should also include motivational strategies to encourage attendance (SAMHSA, 2000).

5) Treatment services and experiences should address resistance skills and experiences that are meaningful and reflective for the client in order to increase program effectiveness. Risk factors and protective factors for alcohol abuse and dependence should

be addressed and managed (SAMHSA, 2000; DOJ, OJJDP, 2002; SAMHSA, NCAP, 2000; Gerstein, 1984).

6) Recovering alcohols need to identify with other successful recovering alcoholics for physical and emotional support (Humphreys, 1999; [DOJ], Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2002; SAMHSA, 2000).

Client Recidivism

Client recidivism was assessed by collecting descriptive statistics. The evidence-based principles for this area that will be assessed and analyzed include:

1) Program practices should result in low client recidivism or decreased return-to-behavior (SAMHSA, 2000).

Client Demographics

Client demographics were assessed by collecting descriptive statistics. Data including age by groupings, gender, socioeconomic status, and race were collected anonymously. Percentages, mean, standard deviation, and central tendency were calculated as appropriate and available. The evidence-based principles for this area that was assessed and analyzed include:

1) The program should attempt to serve the specific needs of the community and any special population groups (SAMHSA, 2000).

Triangulation

An inherent validation of this type of generated data comes from the fact that professionals in the field of alcohol treatment services were interviewed regarding their current treatment practices. Although the techniques used in alcohol treatment programs

were not identical, there were similarities between interviewees and programs. Interviewees in this situation are a valid and reliable source of information for this subject area. Also, emerging data was similar in language or jargon due to the professional nature of this inquiry. Most of the emerging themes and data that was generated from the interviews and document gathering was terminology commonly used by professionals who work in the area of alcohol treatment services.

When appropriate and available, direct quotes for people who were interviewed were used in analysis and the discussion of the research to eliminate any bias that may happen during translation of interviews or generation of data. Interviewees had the option to review data generated from their interviews. This also served as a method of triangulation for the researcher's bias of preferred practices.

All data was generated over several months time. This allowed for subsequent interviews to clarify material as necessary and allowed the researcher adequate time to analyze data for emerging themes and developments occurring naturally in qualitative analyses.

A Previous Pilot Study

The use of emerging data and similar segments, codes, and themes was evident in a previous pilot study conducted by the researcher evaluating alcohol prevention and early intervention strategies on the campus of Washington State University. In this pilot study, data was generated from two interviews as well as from a variety of documents describing the various alcohol prevention and early intervention programs in this community. Overall, fifty-nine (59) categories and fifteen (15) themes emerged. Of this data, seven (7) categories and three (3) themes were repeated among the research. These categories and themes were

words used to describe intervention techniques, theories, types of assessment, and characteristics of alcohol abusers, among other things. Some of the categories and themes served as areas of focus in the current research project.

CHAPTER FOUR

Results and Analysis

Analysis of Pilot Study

The first time the RET was used to evaluate and assess an alcohol treatment program was during completion of the pilot study. The RET was originally established to assess individual alcohol treatment programs in five main areas: 1) mission, goals, and objectives, 2) theoretical frameworks, 3) treatment methods, 4) client recidivism, and 5) client demographics.

Client Recidivism and Demographics

Due to a re-direction of this research after the committee proposal meeting, changes were implemented in the RET that affected some of the initial assessment areas. The two main changes that occurred pertained to client recidivism and client demographics. In the original version of the RET, an assessment of client recidivism was to occur through a comparison of the alcohol treatment program's recidivism rates to recent reported rates in similar research projects. The pilot study alcohol treatment program did not measure client recidivism, so an assessment of this area was impossible. Due to the various recidivism measures currently reported in the literature, it is unlikely that client recidivism measurements, if available, would be comparable to any data currently available in the literature. It is important, however, that the RET continue to seek self-reports of client recidivism from the alcohol treatment programs in order to stress the importance of collecting and evaluating this data in terms of program effectiveness.

The assessment of client demographics also changed before the pilot study occurred. In the committee proposal meeting it was suggested that the research project be narrowed to focus on a sub-population of alcohol treatment clients in the eighteen to twenty-four year old age group. The initial RET assessment originally included client demographic listings by age. The other demographic areas in the RET estimated factors including gender, socioeconomic status, and race. The pilot study treatment program did not track clients by any demographic measures, so data was unavailable for this population. Again, although some alcohol treatment programs may not measure this type of data, it is important that measurements of gender, socioeconomic status, and race are included in the RET in order to understand how an alcohol treatment program meets the needs of their clients and serves sub-populations in the community.

In the other three areas of assessment, 1) theoretical frameworks, 2) mission, goals, and objectives, and 3) treatment methods, information was collected by the alcohol treatment program facilitator, interview analysis, document gathering, triangulation, and re-interview.

Theoretical Frameworks

Theoretical frameworks were assessed by RET Principles One and Two. Principle One addressed which theory or theories, if any, were primarily used by the alcohol treatment program. The pilot study program facilitator identified social cognitive theory as the main theory employed in alcohol treatment, along with parts of the stages of change model and motivational interviewing techniques. Program goals and their alignment with theory goals were assessed by Principle Two. The pilot study facilitator did differentiate between program goals and theory goals on the written evaluation using the RET. When asked “How difficult is it to match client problems with validated behavior change theories?” he

responded that it was ". . . real straightforward" (lines 99-101). Although later in the interview when asked about program goals and theory goals, the subject identified that he doesn't use program goals; the facility allows clients to work with counselors to set their own individual goals. These goals are not guided by a particular set of guidelines or program influence, except to decrease negative behaviors. The subject also did not note any community resistance when establishing his program beyond the obvious resistance encountered in the college-aged population, which he describes as the "college drinking culture" (line 117).

Mission, Goals, and Objectives

Mission, goals, and objectives were assessed by RET Principles Three and Four. The program facilitator identified three different mission statements during the RET assessment. Although direct quotations of the mission statement are not included in this discussion in order to maintain program confidentiality, none of the mission statements that were offered during the interview process clearly addressed the intent of the program, the population the program serves, or how the program accomplishes its purpose.

Principle Four assessed the pilot study's program goals and objectives. In the written RET assessment, the program facilitator listed the program goals as "contingent on client's goals", and did not list any program objectives. In the interview, the subject stated that he used client-specific goals and objectives, but not in a formal treatment plan (lines 194-201). The subject acknowledged that developing goals and objectives was not a global idea for him; they were solely based on client outcomes and were completely individual (lines 236-244). When asked if he would consider revising his program to include a more global set of

program goals and objectives, he stated "[p]rogram goals to me if we go global . . . seems to melt . . . into a mission statement" (lines 248-249).

After discussing objectives, it was evident that this program facilitator used client-based objectives that were behavioral in nature. The program facilitator gave an example of a common client objective: ". . . between now and the next appointment, why don't you just go check out an AA meeting . . . and maybe journal a little bit and write down some feelings you had or whatever. Come back and we'll process that" (lines 210-212). Although this type of objective is action/behavioral, the measurement is based solely on self-reported data and is very subjective.

Treatment Methods

The RET assessed treatment methods in Principles Five through Ten. Evidence-Based Principle Five describes treatment as a comprehensive model including all aspects of a client's life. The pilot study alcohol treatment program addresses each of these areas in a client's life (family, social, work/employment, financial, and health). This was evident in the interview by the program facilitator's references to various services offered to their clients including health services, together with detoxification, medications, employment, nutritionists, exercise physiologists, recovery groups including AA and NA, and a recovery house offering full-time living opportunities for abstaining clients (lines 273-291 and Pilot Study Document 2). The second part of this Principle assesses what types of treatment services are offered. The pilot study facilitator reported using a combination of cognitive-behavioral, twelve-step facilitation, motivational therapies, individual therapies, group therapy, medication, and detoxification in a set of "wraparound services" offered to clients (line 298).

The availability of treatment services to in-coming clients was assessed in Principle Six. In the written RET self-assessment; the program facilitator noted that most clients are seen for their first appointment over forty-eight hours after initial contact. They track this time period through the use of a time code which is accessible by everyone working at the facility. Multiple treatment methods are available and encouraged for all clients and are not limited by payment methods. This facility accepts a student fee for payment, so the types of payment methods accepted was not an issue.

The evaluation and amendment of the client's treatment plan including the alignment of the treatment plan with the program's mission, goals, and objectives, was assessed in Principle Seven. This facility does not refer to any overarching mission, goals, or objectives when evaluating a client's treatment plan, although the program facilitator acknowledged the concept that ". . . objectives should be moving you towards [a] goal . . . absolutely" (line 350). The program facilitator reported the facility also does not have a formal process in place to review client treatment plans, although in the RET written assessment he cited the APA process as the formal review process. The program facilitator, who is also a clinician, also indicated that he reviews client treatment plans weekly with each client. This facility also has access to a template for a "treatment summary" which includes the ". . . current diagnostic impression of the five axes of DSM-IV criteria: client strengths, major concerns to be addressed, focus and objectives, [and] recommendations for termination" (lines 364-367).

Attendance issues including whether the program encourages attendance, especially in the case of mandatory treatment, was assessed in Principle Eight. The program facilitator reported using "motivational interviewing, rapport building, and behavioral contracts" to encourage attendance (lines 389-390). The behavioral contracts consist of mostly self-

reported behavioral objectives. There is no mandatory treatment at this facility, but there are some clients who are referred for mandatory preliminary evaluations.

Risk and protective factors and the personalization of a treatment program for each client were assessed in Principle Nine. The program facilitator recognizes that the treatment offered in this facility is largely a client-based program, set to meet the clients where they are in the treatment process. Through the written RET self-assessment, the facilitator indicated the program "identifies [risk factors] by the client and therapist" and "develops strategies to reduce" these factors. "Strategies to take advantage of [protective factors]" are also established.

The interaction of clients with other successfully recovering alcoholics was assessed by Principle Ten. This treatment program currently encourages attendance at an outside AA/NA group. Other interactions occur at the program's sponsored Recovery House. Recovery House is a house where recovering alcoholics can live together to provide a safe and supportive environment for the client to transition to a life without substance use. The Recovery House is continuously monitored by staff (Pilot Study Document 2).

Evidence-Based Practice Recommendations for the Pilot Study

The Practice Recommendations Summary of the RET for the pilot study population is located in Appendix I. In this section, the abbreviated Practice Recommendations Summary section is addressed in detail.

The first Practice Recommendation regarded the mission statement for the program. The researcher suggested that the mission statement should be revised so it is global in nature and reflects the intent of the program and the population the program will serve. The program's original mission statement can be modified to form the new mission statement by

using the last two sentences: “At [the pilot study program], we support personal efforts to maintain the health and the reduction of health risks so students can achieve academic, career, and personal success. As well, we support and challenge all members of the [pilot study] community to positively contribute to overall campus health and the reduction of health risk.”

The second Practice Recommendation was to define and develop overarching program goals for the treatment population. Currently, this program has no treatment goals, only client-specific goals relating to individual treatment. Program goals should be global in nature and reflect certain aspects of the treatment program including counseling, assessment, and prevention, among others. Currently in counseling, assessment, and prevention, mission statements can easily become goal statements for those areas. For example, the current mission statement in the Counseling area is “[t]o provide a [one-on-one] service with a chemical dependency professional through [the program] regarding one’s own personal use or concern for someone else’s use”. This statement would serve well as a program goal for counseling. Goal statements should also be developed for treatment methods and environment to address how the program functions for the intended population and how clients can positively change their environment to affect their substance abuse.

The third Practice Recommendation is to develop and implement overarching objectives for the treatment population. Currently, all objectives used in this program are client-specific. Objectives that are program-specific can provide a standard of measurement to gauge the programs’ overall effectiveness. The objectives being used are also action/behavioral in nature. Other forms of objectives can be used to more accurately assess the alcohol treatment program in a variety of ways. Other types of objectives are

process/administrative, learning, environmental, and program. For example, these types of objectives can assess the frequency of sessions, awareness levels about substance use, changes in the environment, and changes in risk and protective factors in the program population.

The fourth area addressed in the Practice Recommendations is the social network available to recovering addicts. Although the use of AA/NA and the Recovery House is excellent, the alcohol treatment program has access to funds and facilities to provide a larger number of groups for recovering addicts to interact with each other. The program facilitator supervises a large number of people who would be ideal in supervising and implementing such groups. Plus, the population this program serves is in the 18-24 year old age group. This population specifically would benefit from the interaction provided in such an environment of their peers. Coincidentally, while reviewing the Practice Recommendations with the pilot study program facilitator, he mentioned that after the initial interview, the alcohol treatment program has begun to offer other social networks for recovering alcoholics in addition to those mentioned. He describes the group as an activity-based group with a focus on field trips other similar experiences.

The final Practice Recommendation is to use existing computer based-files to track client recidivism. Currently this alcohol treatment program does not track client return-to-behavior. By not tracking clients that return for later counseling or existing clients' time-in-treatment, it is difficult to assess the alcohol treatment program's effectiveness in this population. This type of data would be invaluable in order to ensure clients were being served effectively and that behavior change was successful. During the re-interview, the pilot study program facilitator cited time constraints as the major reason for not tracking

client recidivism, stating “we could do that easily . . . I just haven’t taken the time to do it” (lines 124-126).

RET Assessments and Improvements

There are seven main areas in the RET that were changed after the pilot study in order to better assess alcohol treatment programs. This section discusses changes made under the specific twelve evidence-based principles found in the RET with comparisons of the initial version of the RET and the revised version changes in italics. The complete revised version of the RET is included in Appendix J.

Principle One

Theoretical frameworks of the alcohol treatment program are assessed by Principle One. Principle One states: “The theory or theories used in the program should be well-defined and validated (Stufflebeam, 2001). ‘Is the employed theory reflective of recent research?’ (Stufflebeam, 2001, p. 37).” In the ideal listed for this principle, it lists “[u]se of the Social Cognitive Theory (SCT), Theory of Reasoned Action (TRA), Health Belief Model (HBM), combination, or other validated health behavior change theory” as an ideal. But in the Points of Practice section for Principle One, it does not ask directly which, or if any, of these theories is used. It prompts the program facilitator to evaluate the alcohol treatment program’s theoretical basis in terms of cognitive, behavioral, and reinforcement/motivational aspects. The Points of Practice section should also include each specific theory (SCT, TRA, HBM, combination, or other) as a choice for evaluators. The initial RET version of Principle One Points of Practice is shown in Figure 2; the revised version of the RET Principle One Points of Practice with the changes in italics is shown in Figure 3.

POINTS OF PRACTICE
▪ What are the main points of the theory basis for the alcohol treatment program? Cognitive aspects? Behavioral aspects? Reinforcement/motivation? Other? Notes: ▪ SCT is grounded in the concept of behavioral capability and reinforcement; a cognitive capacity to perform a behavior and self-efficacy; reinforcement is used – through self, others, or a positive result of the behavior change. ▪ TRA is based on behavioral intention, the individual's attitude toward behavior change, and subjective norms associated with the behavior. ▪ HBM states that change is promoted by one or more of the following: motivation, a perceived health threat, and the belief that change would decrease the perceived health threat; individuals need to overcome barriers to change and practice increasing self-efficacy.

Figure 2. RET Principle One Original Text

POINTS OF PRACTICE
▪ What are the main points of the theory basis for the alcohol treatment program? Cognitive aspects? Behavioral aspects? Reinforcement/motivation? Other? *Which theory most closely aligns with the alcohol treatment program (circle your response)?* *SCT* *TRA* *HBM* *combination* *other (please list)* _____ Notes: ▪ SCT is grounded in the concept of behavioral capability and reinforcement; a cognitive capacity to perform a behavior and self-efficacy; reinforcement is used – through self, others, or a positive result of the behavior change. ▪ TRA is based on behavioral intention, the individual's attitude toward behavior change, and subjective norms associated with the behavior. ▪ HBM states that change is promoted by one or more of the following: motivation, a perceived health threat, and the belief that change would decrease the perceived health threat; individuals need to overcome barriers to change and practice increasing self-efficacy.

Figure 3. RET Principle One Revisions

Principle Two:

In this section, a more clear delineation is needed between program goals and theory goals. One of the Ideals listed in Principle Two states "[p]rogram goals and theory goals align." The Points of Practice section asks the evaluator "[d]o program goals (PG) and theory goals (TG) match?" and includes space to list both sets of goals. But as the pilot study program facilitator was interviewed, it was evident that the difference between program goals and theory goals were unclear on two levels. First, the definitions of program and theory goals seem to be obscure based on our interview. He did not understand the difference between the two terms in relation to a health program planning model. Second, he did not understand why an alcohol treatment program should identify goals on a program level. He stated in the initial interview ". . . we don't have real strict program goals. We let the client identify their own goals" (lines 102-103).

It would be advantageous to define the terms "program goals" and "theory goals" in the Points of Practice section of Principle Two so program evaluators have a better understanding of the terminology before assessing this section. Figure 4 shows the initial RET version of Principle Two Points of Practice; Figure 5 shows the revised version of the RET Principle Two Points of Practice with the changes in italics.

POINTS OF PRACTICE
▪ Are the client's problem(s) applicable to the theories being used? ▪ Do the program goals (PG) and theory goals (TG) match? PG = TG = ▪ Is there interference with the program or theory goals inherent in the community or in social norms? ▪ List any social norms that may be problematic: ▪ Is there community support for your program?

Figure 4. RET Principle Two Original Text

POINTS OF PRACTICE
Program goals: Specific goals that apply to each alcohol treatment program that guide its direction and treatment focus. *Theory goals: Specific goals of a health behavior change theory that involve motivation, reinforcement, intention, or other areas that must be addressed to successfully employ the program.* ▪ Are the client's problem(s) applicable to the theories being used? ▪ Do the program goals (PG) and theory goals (TG) match? PG = TG = ▪ Is there interference with the program or theory goals inherent in the community or in social norms? ▪ List any social norms that may be problematic: ▪ Is there community support for your program?

Figure 5. RET Principle Two Revisions

Principle Three

In Principle Three under the Points of Practice section, the "parts of the mission statement" and the related questions (intent of the program, population served, and how) should be listed before the Mission Statement. In the pilot study, after reviewing the RET the program evaluator had completed, it seemed that the program facilitator answered the "parts of the mission statement" section separately, relating the questions to the entire program. By reversing these two areas, it should be evident to program facilitators that a mission statement should include certain aspects (intent of the program, population served, and how). The initial RET version of Principle Three Points of Practice is shown in Figure 6; the revised version of the RET Principle Three Points of Practice with the changes in italics is shown in Figure 7.

POINTS OF PRACTICE
Mission Statement: **Parts of the mission statement** Intent of program: Population served: How: Program Philosophy (if different):

Figure 6. RET Principle Three Original Text

POINTS OF PRACTICE
Parts of the mission statement *Intent of program:* *Population served:* *How:* *Program Philosophy (if different):* *Mission Statement:*

Figure 7. RET Principle Three Revisions

Principle Four

In Principle Four the Assessment Criteria should be amended under level one (not acceptable) to include the statement "no program goals or objectives". In the case of the pilot study and as it may be in the case of other alcohol treatment programs, there were not any formal goals or objectives relating to the program itself. The initial RET version of

Principle Four Assessment is shown in Figure 8; the revised version of the RET Principle Four Assessment with the changes in italics is shown in Figure 9.

ASSESSMENT	
1=not acceptable	▪ The program goals are not global; they do not include who will be affected and what will change as a result of the program; many aspects of the program are not represented by the program goals. ▪ The program objectives do not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives are not realistic in the program setting; objectives should be modified to better suit the clients and strengths of the program.

Figure 8. RET Principle Four Original Text

ASSESSMENT	
1=not acceptable	▪ The program goals are not global; they do not include who will be affected and what will change as a result of the program; many aspects of the program are not represented by the program goals. ▪ The program objectives do not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives are not realistic in the program setting; objectives should be modified to better suit the clients and strengths of the program. ▪ *No program goals or objectives.*

Figure 9. RET Principle Four Revisions

Principle Six

In in Principle Six's Points of Practice section, the term "other" should be included under methods of payments currently accepted. A comparison of Principle Six is shown in Figures 10 and 11.

POINTS OF PRACTICE
▪ On average, how many hours/days after initial contact are patients seen for their first appointment (circle your response)? 1-4 hours 4-12 hours 12-24 hours 24-36 hours 36-48 hours Over 48 hours ▪ Which methods of payment do you currently accept (circle all that applies)? Medicaid/Medicare Private insurance State insurance Military insurance Self payment Are multiple treatment episodes available for returning clients?

Figure 10. RET Principle Six Original Text

POINTS OF PRACTICE
▪ On average, how many hours/days after initial contact are patients seen for their first appointment (circle your response)? 1-4 hours 4-12 hours 12-24 hours 24-36 hours 36-48 hours Over 48 hours ▪ Which methods of payment do you currently accept (circle all that applies)? Medicaid/Medicare Private insurance State insurance Military insurance Self payment *Other* Are multiple treatment episodes available for returning clients?

Figure 11. RET Principle Six Revisions

Principle Eleven

As stated previously, client recidivism rates cannot be matched to any existing data available in the literature due to the variability in measurement of this information. Under the Ideal for Principle Eleven, the following statement should change from "[c]lient recidivism rates should be below the national average for existing alcohol treatment programs" to "programs should strive for a low recidivism rate and an overall decrease in

client's return-to-behavior". A comparison of the original RET and the revised RET is seen in Figures 12 and 13 with the changes in italics.

EVIDENCE-BASED PRINCIPLE 11:
Client recidivism rates should be below the national average for existing alcohol treatment programs. Program practices should result in low client recidivism or decreased return-to-behavior.

Figure 12. RET Principle Eleven Original Text

EVIDENCE-BASED PRINCIPLE 11:
Programs should strive for a low recidivism rate and an overall decrease in client's return-to-behavior.

Figure 13. RET Principle Eleven Revisions

Principle Twelve

Since the focus of this research study has changed to a more specific population of eighteen to twenty-four year olds, the Assessment section in Principle Twelve will not include program estimates by age. A comparison of the original RET and the revised RET is seen in Figures 14 and 15.

ASSESSMENT
Program population estimates: age groups: under 18: 18-24: 24-36: 37-49: 50-65: 65 and over: gender: SES: race: **To be completed by program evaluator** Community estimates: Notes/Recommendations:

Figure 14. RET Principle Twelve Original Text

ASSESSMENT
Program population estimates: Gender: SES: Race: **To be completed by program evaluator** Community estimates: Notes/Recommendations:

Figure 15. RET Principle Twelve Revisions

Analysis of Individual Alcohol Treatment Programs

Seven alcohol treatment programs were contacted to participate in the study. Four of the programs were located in the original geographic region proposed for this study. However, only two programs in this area agreed to participate, so the region was expanded to include two neighboring counties with similar socioeconomic and demographic variables. Three additional alcohol treatment centers were contacted in this region; of these facilities, two agreed to participate in the study. In total, four of the seven alcohol treatment programs that were contacted participated in this study. Usually a participation rate of four out of seven programs would not be ideal, but in this case-study approach, it was considered acceptable to examine each treatment facility on an individual basis. To ensure anonymity, the alcohol treatment programs are referred to as Program A, Program B, Program C, and Program D. Each alcohol treatment program was analyzed in five main areas: 1) theoretical frameworks, 2) mission, goals, and objectives, 3) treatment methods, 4) client recidivism, and 5) client demographics. In Appendix K find the five main assessment areas and the corresponding evidence-based principles for each area. The RET was re-ordered for ease of use after the first two interviews based on feedback given by the participants. In Appendix K, notice how the order of the principles in the RET changed.

After describing the five assessment areas for each facility, the evidence-based practice recommendations for each facility are summarized.

Analysis of Program A

Theoretical Frameworks

RET Principles One and **Two** were used to assess theoretical frameworks. In **Principle One**, Program A facilitator indicated she used cognitive, behavioral, and motivation components in their treatment program. She cited the use of Moral Recognition Therapy (MRT), rewards and sanctions, and Motivational Interviewing (MI). She also stated the use of a cognitive self-change group that is included in the client's individualized treatment plan. However, each of these areas is considered treatment techniques, not necessarily theories. After reviewing concepts of the SCT, HBM, and TRA suggested in the RET, she identified her program as most closely aligning with aspects of SCT. When asked how difficult it is to match client problems with validated behavior change theories, Program A facilitator indicated that the process is highly "internalized" (Interview A, line 76). As she further described the process, she said that these practices were an integral part of her training. She does feel that it is sometimes difficult to transmit this information to other less experienced counselors because she is highly reliant on her personal foundation of knowledge of the treatment process.

Program A facilitator reported that some community resistance existed to the theory used in the program. This has been displayed through the lack of financial assistance in new treatment endeavors (Interview A, lines 92-94). An example of community resistance was during the program's attempts at incorporating components for treatment that are outside of the traditional realms of therapy such as exercise or socialization. Although these activities are only part of a treatment method and the community resistance is not to the program as a

whole, it is still discouraging to experience. However, many different treatment techniques could be used to relay the same information.

Program Mission, Goals, and Objectives

Principles Three and **Four** were used to assess the program mission, goals, and objectives. Program A facilitator provided copies of the mission statement, performance and measurement of goals, objectives, services provided, and philosophy. A direct quotation of Program A's mission statement is not included in this discussion in order to maintain program anonymity.

The mission statement provided for Program A was lengthy but descriptive. Although the mission statement could be revised to be more concise, it described the intent of the program, the client population, and how the program functions.

It was, during the discussion of goals and objectives, obvious that although Program A facilitator used measurable objectives with clients in their individualized treatment plan, the program did not have any over-arching goal or objective statements that pertained to substance abuse treatment (Interview A, lines 155-179). She did mention later in the interview that it had actually been a goal of the program ". . . to increase family involvement a little bit" (Interview A, lines 249-250). The goal was not written along the other program goals or objectives, and like the other goal statements, there were no measurable criteria for the statement. Areas that should be supplemented include additional goal statements and corresponding objectives focusing on education, treatment, and other client-related services.

No goals or objectives directly pertain to treatment; it is difficult to determine whether all counselors are using the same treatment methods. The staff meets weekly to review clients' individualized treatment plans and all counselors are supervised by the

program facilitator (Interview A, lines 181-200). This creates more work for the program supervisor as well as uncertainty with some of the less experienced counselors by not having a defined set of goals and objectives that are established for the program. Evaluating client treatment and services is difficult if no measurable objectives exist. The program facilitator indicated that she tends to rely on their reputation in the community to communicate their treatment practices and methods (Interview A, lines 227-232).

Treatment Methods

Principles Five through **Ten** are used to assess treatment methods. Program A facilitator indicated in **Principle Five** that family, social, work/employment, financial, and health aspects are all addressed during substance abuse treatment. Counselors are to use cognitive behavioral, motivational therapies, individual therapies, and group therapy. Clients are advised to attend AA meetings regularly. Counselors refer clients for medication needs and detoxification services.

Principle Six is used to assess the availability of treatment. Program A counselors usually respond to clients' requests for treatment services after a 48-hour period following the initial request. Program A facilitator acknowledged this amount of time between contact and scheduling an appointment is not ideal, but attributes the situation to inadequate staffing and/or finances to increase staffing, and counselors' heavy client loads. Ideally, treatment should be readily available, including setting appointments in a timely manner, or at the least, assessing the immediate needs of a client before their first appointment (SAMHSA, 2000).

Most forms of payment including Medicaid/Medicare, private insurance, state insurance, military insurance, self-payment, and other forms are accepted for fee payment. Program A facilitator reported that most forms of insurance and Medicaid/Medicare are

insufficient in allowing an adequate number of treatments or hours of treatment per year. However, the client can usually be switched to a different payment method, so it has not been difficult to extend a client's treatment services.

Principle Seven is used to assess the monitoring and amendment of treatment services including the process and timeline involved in treatment plan reviews. Counselors are to follow state regulations that require a 90-day review of individualized treatment plans, although they do informally review all clients' treatment weekly at staff meetings. However, written records of these weekly reviews do not exist. Treatment plans are also reviewed to determine if the clients are meeting their individual goals and objectives.

Principle Eight is used to assess the use of multiple treatment sessions, client motivation, and risk and protective factors in the treatment process. At this facility, all clients are advised to attend multiple treatment sessions, including those clients completing brief interventions. For client motivation, Program A facilitator discussed the common sanctions in place for mandatory clients. Although she realizes that the sanctions are enough motivation for clients to attend their sessions, it does not always motivate them to do actively participate in treatment. To encourage more dynamic participation, she describes using "role playing" in the group setting, personally encouraging them, or ". . . getting other members to help them" (Interview A, lines 384-385). She and her counselors use other methods of motivation for voluntary clients including positive reinforcement and role modeling. Occasionally, financial concerns about payment are used as motivators if a client is not regularly attending sessions. She mentioned that the group members often take pride in attending their group sessions, and even being there early. The older members tend to motivate and encourage the newer members.

Principle Nine is used to assess the use of resistance skills in order to increase program effectiveness. Program A facilitator reported that counselors in this program use the client's initial assessment to personalize which resistance skills to address (Interview A, lines 427-430). They also address risk factors and protective factor in individual and group counseling in the form of education, brainstorming, refusal skills, and relapse prevention work (Interview A, lines 433-435). She discussed the difference between risk factors for alcoholics versus intravenous drug users, and reported that obvious differences exist in the way risk factors are addressed for those two very different groups of addicts. By understanding the different types of risk and protective factors addicts encounter, treatment can become more meaningful for the clients. Clients may also form strong bonds with their counselors and therefore relate positively to treatment.

Principle Ten is used to assess the use of twelve-step facilitation in treatment. At Program A, in almost all of their treatment programs, twelve-step participation is encouraged. Although twelve-step recovery is not done at the facility, several community options are available including AA, NA, and Celebrate Recovery, a faith-based twelve-step group. Even in cases such as AA, state guidelines for drug court participants limit the amount of interaction between recovering addicts. Recovering alcoholics can still communicate and support each other by telephone, in the same type of scenario as in AA or NA. Recovering alcoholics also have a chance to communicate during group contact. Group situations create a diverse environment including recovery addicts at all levels of sobriety.

Client Recidivism

Principle Eleven was written to gather recidivism information. Program A facilitator reported no formal information collection of recidivism. After completing the RET, Program

A facilitator decided to contact the drug court coordinator for data on recidivism. Based on her knowledge, no information for the county is collected. From her own calculations, she determined that the re-arrest rate for alcohol-related crimes was approximately 8% and the estimated recidivism rate (in terms of return-to-behavior) was approximately 40% of the drug court population, not including minimal usage. Minimal usage can be described as a return-to-behavior which resulted in minimal consequences for the addict, usually estimated at one drink per week. Since relapse prevention is such an important skill to gain during recovery, clients meet in a process group at least once a week where relapse prevention topics are presented and discussed. Topics include triggers for substance use, coping strategies, reinforcement, and other topics identified as important by the group members (Interview A, lines 539-561).

Client Demographics

Principle Twelve is used to gather information about patient demographics, sub-populations, and minority or special needs. Program A offers a women's treatment group, and previously the counselors have done an education group for 18-19 year olds and older juvenile clients to discuss their alcohol treatment issues. It is difficult to accommodate minority populations with special group sessions because of the small minority population present in this treatment program (Interview A, lines 562-570). Program A facilitator estimates the treatment population is representative of the community in terms of gender, race, age, and socioeconomic status, although there is no formal data to verify this information. Program A facilitator estimated the percentage of clients re-arrested in this area who returned to the facility was 8%. She also estimated 40% of the drug court population has experienced a return-to-behavior.

A summary of the information gained about Program A in each RET Principle is listed in Table 2. Table 2 also includes Likert scale ratings and each Principle's corresponding assessment area. Principles Eleven and Twelve which corresponded to client recidivism and demographics do not receive Likert scale ratings.

Table 2

Program A Ratings by RET Principle

RET Principle	Likert Scale Rating	Assessment Area
1	3	Treatment
2	2	Treatment
3	3	Treatment
4	2	Treatment
5	3	Treatment
6	2	Treatment
7	2	Theoretical frameworks
8	2	Theoretical frameworks
9	3	Mission, goals, and objectives
10	3	Mission, goals, and objectives
Total Score	**25**	

Note 1: Ratings are totaled for an overall score which reflects evidence-based practices.

Possible range of total scores between 10 and 30.

Note 2: Likert scale ratings are 3=excellent, 2=fair, and 1=not acceptable.

Practice Recommendations Summary

The Practice Recommendations Summary portion of the RET for Program A is located in Appendix L. The first evidence-based practice recommendation for this facility is to revise the mission statement to reflect the global nature of the program and the philosophy of the services offered. The current mission statement reflects the administrative aims of the facility, but does not clearly address who the client is and how their needs will be met. The following mission statement was suggested after reviewing Program A's existing literature, including several goal statements:

> The mission of [Program A] is to improve the quality and availability of mental health and substance abuse treatment options by providing high quality and affordable education and treatment to all people regardless of gender, sexual orientation, financial status, religion, or ethnicity.

The second evidence-based practice recommendation for Program A is a revision of the program's goal statements. The two existing goal statements, much like the mission statement, are focused on administrative outcomes. The first goal statement also had bulleted items listed, which could be re-written into two goal statements with the former bulleted text serving as objective statements. Another suggestion is to diversify goal statements by addressing client outcomes, for example, add goal statements for prevention, treatment, counseling, and/or education. Program A facilitator indicated, to help orient new staff to current program practices, a need to better outline treatment services (lines 193-199). The information provided by a mission statement, goals, and objectives would be beneficial for staff and clients alike.

The third evidence-based practice recommendation is to diversify objective statements to include not only administrative objectives, but also learning, action/behavioral, environmental, and program objectives, which would help measure success. These objectives could also guide program facilitation to define and make useful treatment techniques and theoretical principles for everyday practice.

The fourth evidence-based practice recommendation is to increase program assessment and evaluation in several areas through the use of computer software. Program A facilitator expressed an interest in tracking the time-after-initial-contact until a client's first appointment, but tracking is limited presently because of staffing numbers. Appropriate evaluative and assessment software could track the time, date, and topics of phone conversations and determine how quickly clients were accessing treatment services. Computer software could also generate weekly progress report templates. Program A facilitator noted that weekly progress reports could be generated after staff meetings to increase the quality of care a client receives (lines 334-336). Currently the staff meets to discuss clients' needs, but no formal report is kept in the clients' file. A weekly progress report could help staff discuss and remember details about the clients' needs, progress, and treatment plan.

The final evidence-based treatment recommendation is to begin tracking recidivism and patient demographics. This data could help assess the programs' effectiveness and aid in the implementation of minority population groups during treatment.

Analysis of Program B

Theoretical Frameworks

Principles One and **Two** are used to assess theoretical frameworks. **Principle One** aids the program facilitator in defining and choosing a theoretical framework for treatment. Program B facilitators had difficulty defining their theoretical basis for the alcohol treatment program. After reviewing the Points of Practice section, they thought their practice most resembled the theoretical frameworks found in the SCT and some areas of the HBM, which they referred to as the Stages of Change model. However they did not think the 18-25 year old age group related well to the beginning stages of the HBM; most specifically the perceived health threat and the belief that behavior change could impact a perceived health threat. They did use latter aspects of the theory which apply to overcoming barriers to change and increasing self-efficacy. Program B employs several cognitive aspects in their treatment program which align closely with SCT.

Principle Two is used to assess how the theoretical framework of the program aligns with program goals. Program B facilitators had not identified a theoretical framework for treatment, so assessing whether their treatment practices aligned with a specific theory was difficult for them. Although, during the interview each separate treatment program offered at this facility was noted to have specific treatment goals. Those goals could be aligned with theoretical frameworks presented in SCT. Program B facilitators did indicate some interference with program goals may exist from the social norms present in the community. They described this social norm as the “partying college atmosphere” (Interview B, line 121). The large undergraduate population present in this community may present social difficulties for recovering alcoholics.

Mission, Goals, and Objectives

Principles Three and **Four** were used to assess mission, goals, and objectives. Program B did not have a mission statement, although they had a philosophy statement and corresponding objectives. State guidelines require outpatient alcohol treatment programs have a philosophy statement and objectives. The philosophy statement, goals and objectives for this facility are not discussed in detail in order to maintain confidentiality. Program B facilitators also indicated that specific goals and objectives exist for each individual treatment program area also (Program B, lines 193-195).

Program B facilitators understood during the interview the purpose of having a philosophy statement, goals, and objectives at the program level as well as in the client's individualized treatment plan. One Program B facilitator gave an example of a common goal and objective used in treatment (Interview B, lines 279-282):

> [S]o the problem might be that they don't have relationships or activities that are conducive to recovery. The goal would be that they develop relationships and some recreational or social activities that are conducive to recovery. So then the approaches might be attend 2 AA meetings a week to get some people in their life that don't drink or use, and get a sponsor.

This approach was also evident in Program B's treatment plan format which included space to add: (a) patient biopsychosocial problem, (b) a long-term or short-term patient treatment goal, (c) approaches to resolve the problem, (d) person(s) responsible to resolve the problem, (e) estimated completion date, (f) the date the problem was resolved, and (g) an area to include the summary of progress toward the goal and approaches (Program B, Document 2).

Overall, Program B's philosophy, goals, and objectives are closely aligned with evidence-based principles. The drawback was the lack of a mission statement, which, according to state guidelines, is not necessary for outpatient treatment programs. Otherwise, Program B appears to be moving in the right direction towards evidence-based principles within the current structure of their treatment program.

Treatment Methods

Principles Five through **Ten** are used to assess treatment methods. **Principle Five** is used to assess the types of treatment methods available. Program B uses a combination of services including: cognitive-behavioral, twelve-step facilitation, motivational therapies, and individual and group therapies. A focus on family, social, work/employment, financial, and health aspects of the client's life is present in Program B's treatment plan. Individual therapy addresses any of these areas of the client's life that needs more personal attention.

Principle Six is used to assess the accessibility of treatment by measuring the time between a client's initial contact and the first appointment and the methods of payment the facility accepts. Program B usually schedules clients for their first appointment after 48 hours following initial contact, unless the client is ". . . in crisis (Interview B, line 352)". The counselors can get a preliminary idea by phone about the client's emotional needs. This program also does not have a wait list, so they feel comfortable with the idea that they can schedule a client immediately if necessary.

For payment, Program B accepts private insurance and self-payment. Program B receives no state funding, and because no physician is on-site, Medicare is not accepted. If it is necessary, clients with such needs are referred to other local facilities.

Principle Seven is used to assess the monitoring and amending of treatment plans and the timeframe in which that occurs. Client treatment plans are reviewed according to state guidelines which require one review every 20 hours during intensive outpatient treatment, one review per month in outpatient treatment during the first 3 months, and one review every three months thereafter. Program B facilitators state that informal review or discussion about clients can happen between counselors, but it is not formally written as part of the client's file. Amending treatment plans occurs if the need arises during an individual counseling session. Program goals or objectives are not revised regularly.

Principle Eight is used to assess the strategies to increase or maintain attendance with mandatory and voluntary clients. For mandatory clients, general external motivators such as: 1) status reports that are sent to a client's probation officer, 2) "no show" fees, or 3) a follow-up call or letter. Some positive strategies are also used such as giving homemade cookies or pizza. Intrinsic or internal motivation strategies appear not to be used with mandatory or with voluntary clients. Some form of internal motivation was taking place with clients, which was expressed by a more positive association with the treatment process as the treatment progressed. However, no definition of change could be offered as to was happening. By providing intrinsic motivation to the client by building trusting relationships, encouragement, reinforcement, and focusing on positive results from a successful behavior change, this program may have increase success.

Principle Nine is used to assess how the alcohol treatment program affects individualized risk and protective factors. Program B facilitators indicated that the terms risk and protective factors were used more frequently as societal descriptors in prevention. When discussing risk and protective factors in terms of treatment, they used the terms strengths and

weaknesses instead. Clients' strengths and weaknesses were addressed in individual therapy, group therapy, relapse prevention group, and intensive outpatient treatment. For example, a potential trigger for addictive behavior was identified, then the clients' thoughts, thinking, and behavior about the trigger were addressed (Interview B, lines 601-608). Strengths and weaknesses are discussed with clients in terms of the six ASAM dimensions: "acute intoxication and/or withdrawal potential; biomedical conditions and complications; emotional, behavioral or cognitive conditions and complications; readiness to change; relapse, continued care or continued problem; and recovery environment" (Interview B, Document 3).

Principle Ten is used to assess the interaction clients have with successfully recovering alcoholics. Twelve-step facilitation is not offered as part of Program B, although counselors encourage clients to participate in community twelve-step facilitation programs such as AA or NA. Structured, supervised interactions are provided with recovering alcoholics during the intensive outpatient treatment program.

Client Recidivism

Client recidivism is assessed by using **Principle Eleven**. Client recidivism is not measured. The resources to measure that type of data is not available and since the population they serve is between 18 and 25 years of age and highly transient, the ability to track these clients is very low. Program B facilitators did not have any estimates on the percentage of clients who have returned to addictive behavior.

Client Demographics

Client demographics are assessed by using **Principle Twelve**. Estimates of Program B's current client population are: 80% male, 20% female; 96% of clients have insurance or self-pay; 80% are white, 2% Asian, 6% other or multicultural; and 70.7% are between ages 20 and 25. To accommodate special groups or minority populations, and due to low enrollment numbers, minority clients are not offered specialized treatment, although there is some history of clients with special needs before, including clients with a hearing impairment and language barriers.

A summary of the information gained about Program B in each RET Principle including Likert scale ratings given for each Principle and each corresponding assessment area is seen in Table 3. Principles Eleven and Twelve which corresponded to client recidivism and demographics do not receive Likert scale ratings.

Table 3

Program B by RET Principle

RET Principle	Likert Scale Rating	Assessment Area
1	2	Treatment
2	3	Treatment
3	1	Treatment
4	3	Treatment
5	3	Treatment
6	3	Treatment
7	2	Theoretical frameworks
8	2	Theoretical frameworks
9	3	Mission, goals, and objectives
10	3	Mission, goals, and objectives
Total Score	**25**	

Note 1: Ratings are totaled for an overall score which reflects evidence-based practices. Possible range of scores between 10 and 30.

Note 2: Likert scale ratings are 3=excellent, 2=fair, and 1=not acceptable.

Practice Recommendations Summary

The Practice Recommendations Summary of the RET for Program B is located in Appendix M. The first evidence-based practice recommendation for Program B was to draft a mission statement to reflect elements of social cognitive theory and the health belief model currently used in the facility's existing programs. Currently, their philosophy statement describes chemical addiction and definitions for diagnoses. A mission statement reflecting elements of theories that are being used in the alcohol treatment program does provide including interventions, client outcomes, and overarching program goals.

The second evidence-based practice recommendation was to revise existing goal and objectives statements. The objective statements currently found in Program B literature may be better as goal statements. These statements also match the theoretical foundations presented in the Health Belief Model and Social Cognitive Theory, which would work well with the previous recommendation to draft a mission statement aligned with these same theories.

The third evidence-based practice recommendation was a continuation of the previous recommendation in the area of objectives. Objective statements should be added to address all aspects of the program, from administrative outcomes to client-based outcomes. By setting defined, measureable objectives in several areas, the program facilitator could then determine the successfulness of the alcohol treatment programs offered and if the conditions of the objectives have been achieved.

The fourth evidence-based practice recommendation was to increase the use of intrinsic motivation and to rely less on ever-present extrinsic motivators to prompt client behavior change. For any behavior change to be successful, the client must have intrinsic

motivators such as a change in attitudes, beliefs, or opinion. Although this type of change may not always be possible, the program facilitator should increase intrinsic motivation in order to ensure a decrease in return-to-behavior. Although, in any facility which accepts mandated clients (such as those from the criminal justice system), the inherent extrinsic motivators may far outweigh the intrinsic factors at the time of treatment. However, by recognizing and offering intrinsic motivators, the client may make a connection sometime in the future.

The last evidence-based practice recommendation for Program B was to track client recidivism, which would measure program success and give future insight to any return-to-behavior.

Analysis of Program C

As a precursor to Program C analysis, certain information regarding this interview process is necessary. Program C facilitator received the RET and its corresponding instructions approximately two weeks before the interview. At the interview, Program C facilitator admitted to not reading or completing any of the RET. She wanted however to proceed with the interview, although she had not provided any information about the treatment program. When asked to provide information to supplement the interview, she declined to share any written information about the program. Program C facilitator was aware that the interview and analysis process was anonymous, and also signed a Human Assurances Committee Consent Form prior to beginning the interview. The information gained for Program C was severely limited and therefore analysis and recommendations may not accurately reflect its content.

Another important factor to consider when reading this analysis is that the RET was revised prior to this interview. The order of the RET Principles were changed to ensure ease-of-use of future program facilitators completing the instrument. The same RET principles were used to address the five main areas of the instrument (theoretical frameworks; mission, goals, and objectives; treatment methods; client recidivism; and client demographics), but the RET principle ordering did change. Refer to Table 9 for details about how the Principles changed order.

Theoretical Frameworks

Principles Nine and **Ten** are used to assess theoretical frameworks. Program C facilitator indicated the alcohol treatment education program is based on Kernberg's work in psychodynamic therapy. Referring to this theory, she stated "I actually think that really dove-tails with the cognitive behavioral stuff that we're required to do and it's just part of how I do therapy, so that's just been our approach" (Interview C, lines 219-221). Kernberg's work in psychodynamic therapy seems to function more as a treatment method than an overarching program theory. Program C facilitator did identify with SCT because of some of its cognitive components. Other aspects of SCT to which she identified with include "contingency management" and "reinforcement" (Interview C, lines 226 and 228).

The TRA and HBM were briefly reviewed for the program facilitator. After describing aspects of TRA, she replied "we avoid that like the plague. We don't care what they're going to do, we just care what they're doing now" (Interview C, lines 234-235). She also said that she did not identify Program C with the HBM/Stages of Change. She felt her clients could not identify with this theory because of their lack of perception of possible health threats which is inherent to this theory.

Principle Ten is used to assess Program C's goals and their alignment with the program theory. Program C facilitator permitted a viewing of the mission statement, although she would not provide a copy of this program literature. When asked specifically about the use of program goals, Program C facilitator reported the mission statement was the primary source of program guidance. It does not appear this program has any over-arching theory which guides its implementation. Program C has a "manualized part" that they are required by the state to incorporate, otherwise they just try to ". . . connect with the person" (Interview C, lines 271-272).

Mission, Goals, and Objectives

Principles Eleven and **Twelve** are used to assess the program mission, goals, and objectives. Program's C mission statement is not included in this review in order to maintain anonymity. The program's mission statement was largely based on Christian scripture, and did not describe the intent of the program, treatment philosophy, or intended beneficiaries. When asked to summarize the intent of the program, Program C facilitator responded "we celebrate recovery" (Interview C, line 356). A mission statement should be a broad account of who the program will serve and what services the program will provide; the current mission statement should be clearer in describing its addiction treatment services.

Program C facilitator did not provide any goal statements for the program. She asked if program goal statements were the same as a treatment plan. She continued by listing some things in which every client is asked to participate during treatment. Program C expects their clients to be ". . . involved in the community, less dependent on treatment, more dependent on community resources like the recovery community, like churches, like medical providers"

(Interview C, lines 369-372). At another point during the interview, she stated there were some goals she had for the clients (Interview C, lines 61-79):

1. ". . . get a sponsor within two weeks"

2. ". . . work the steps before advancing in each phase"

3. ". . . attend three times a week of the matrix model and the MRT, groups, CST, and [complete] step work as well"

4. ". . . attend a minimum of three local Christian churches"

5. ". . . submit to random urinalysis" (lines 76-77)

6. ". . . breathalyzer testing [twice a week] for each client".

Program C also did not have a specific list of program objectives of which the researcher was aware. The program facilitator did provide a checklist of behaviors, similar to the goals listed above, that each client was to complete during each phase of treatment (phases one, two, and three). These checklists included items such as: "get a sponsor within two weeks", "call your sponsor daily for two weeks", "complete steps 1-5 with your sponsor", [attend] 3 AA meetings a week", "[attend] weekly individual sessions", "attend church", and "remain abstinent from all substances", among other items (Program C, Document 1). This document provided a blueprint for treatment for each of the three phases by including the titles of weekly group sessions. Topics included subjects such as relapse prevention, motivation, and triggers (Program C, Document 1).

Assessing the community support for a treatment program can be a valuable way to show if the program if effective in reaching members of the community in target populations. When asked about community resistance, Program C facilitator began discussing advertising dollars. She may have misunderstood the question, as she continued to discuss how she does

not do any advertising for her program and she spends her advertising money supporting other programs in the community. When asked if she felt support for the program at the criminal justice level, she responded that initially there was little support from the probation officers for this program, but now they seem to be big supporters (Interview C, lines, 332-345).

Treatment Methods

Principles One through **Six** were used to assess treatment methods. Program C focuses on all aspects of a clients' recovery including family, social, work/employment, financial, and health. Program C facilitator reported addressing ". . . cognitive behavioral, motivational therapies, individual therapy, and group therapy" (Interview C, lines 12-13). Program C participants are also required to participate in "community-based twelve-step meetings" (Interview C, line 14). Although during the interview, the cognitive behavioral components were stressed by the program facilitator, no evidence was found that targeted these areas during the treatment program. Behavioral checklists were a large part of the treatment program, but cognitive components did not seem to correspond to these checklists.

Principle Two is used to assess the availability of treatment in terms of time and financial accessibility. Program C facilitator reported that all clients are seen immediately, within one to four hours. Clients usually attend multiple treatment sessions. Private insurance, state insurance, and self-payment, are all accepted, however, most clients receive funding from block grants from the state.

Principle Three is used to assess the monitoring and amendment of client treatment plans. Program C follows state guidelines for outpatient treatment programs which require a 90-day written review in addition to weekly progress notes for each client. The treatment

plan review does not compare whether the client's individualized treatment plan aligns with the program mission, goals, or objectives.

Principle Four is used to assess motivational strategies that encourage success with mandated and voluntary clients. Approximately 80% of the clients are mandated from the criminal justice system. Program C facilitator reported using motivational interviewing techniques. She also acknowledged using external motivators such as criminal justice repercussions to motivate clients to attend and participate. When asked how she motivates voluntary clients, she said she uses the facility's reputation as motivation. She reported that this facility is known as a place where change can happen for an individual, and they count on the client knowing this before entering treatment.

Principle Five is used to assess the use of risk and protective factors in the treatment process. Program C facilitator reported that her impression of risk and protective factors only applied to prevention work, not the treatment process. The following excerpt from the interview illustrated her concept of risk and protective factors (Interview C, lines 132-141):

> Today I saw, we have a homeless kid who has never worked before and he got a job clearing off snow from RVs or something. And he didn't have the clothing he needed to do that job, so we went and got him the Carhart stuff; you know things that will help him to be successful . . . that's what we do pretty much all the time for our clients. We figure out what they need and we give them the tools they need, either through us or through voc rehab, and then they're much more likely to be successful, they feel like someone cares and we do care.

Although this example of how Program C aids their clients is informative, it does not address the cognitive processes in addiction recovery or the use of risk and protective factors and their importance in the recovery process.

Principle Six is used to assess the program's structured interaction with recovering alcoholics. Currently Program C requires clients complete the twelve-step process in a community-based AA program. Through this process, clients have constant interaction with other recovering alcoholics as peers and mentors. They also have contact with recovering alcoholics during group presentations. Program C facilitator describes the interactions as frequent during non-group times, for example, when a person offers transportation or other help to someone else. Although it is important to have time discussing the recovery process with other addicts, it is also important that this interaction be supervised by a licensed professional who can monitor the contact for appropriateness.

Client Recidivism

Principle Seven is used to assess client recidivism. Program C does not formally track the program's recidivism rate. Program C facilitator reported an estimated return-to-behavior rate of 4-8%.

Client Demographics

Principle Eight is used to assess client demographics and how the program functions in meeting the needs of sub-populations. All data collected from Program C are estimated by the Program C facilitator. Program C is comprised of 100% male clients. Approximately 20% of Program C's current participants are non-intravenous drug users; a large portion of those clients are in the 18-25 year old age category. Program C facilitator estimates 4-6% of

program participants have been re-arrested. Otherwise, client demographics are not tracked. No previous history of accommodation for special populations was mentioned.

A summary of the information gained about Program C in each RET Principle including Likert scale ratings given for each Principle and the corresponding assessment area is seen in Table 4. Principles which correspond to client recidivism and demographics do not receive Likert scale ratings and are not included.

Table 4

Program C Ratings by RET Principle

RET Principle	Likert Scale Rating	Assessment Area
1	1	Treatment
2	3	Treatment
3	2	Treatment
4	2	Treatment
5	1	Treatment
6	2	Treatment
9	1	Theoretical frameworks
10	1	Theoretical frameworks
11	2	Mission, goals, and objectives
12	1	Mission, goals, and objectives
Total Score	**16**	

Note 1: Ratings are totaled for an overall score which reflects evidence-based practices. Possible range of scores between 10 and 30.

Note 2: Likert scale ratings are 3=excellent, 2=fair, and 1=not acceptable.

Practice Recommendations Summary

The Practice Recommendations Summary of the RET for Program C is located in Appendix N. In this section, the abbreviated Practice Recommendations Summary section will be addressed in detail.

The first evidence-based practice recommendation is that this program should be based on a clear, validated theoretical basis. Through the interview and analysis process, some theoretical components were identified that may be present in the alcohol treatment program including Social Cognitive Theory and psychodynamic therapy; specifically reinforcement and self-efficacy. In order to establish parameters for measuring programs outcomes and success, a theoretical basis must be established to ground the program. From this basis, a mission statement, goals, and objectives which align with the program's foundation can be established.

The second and third evidence-based practice recommendation for this program involves establishing over-arching goals for the entire program and diversifying the existing program objectives. Currently, there are no program goals in place. The program objectives are entirely behavioral in nature and are list-oriented. By incorporating goals and objectives which meet the program's underlying themes of reinforcement and self-efficacy, program's success could be assessed easier.

The third evidence-based practice recommendation is to diversify program objectives into different categories which also correspond to the previous recommendation. By diversifying objective statements used in the alcohol treatment program, specific program outcomes could be established to measure and evaluate program success. It also provides a

solid foundation for the alcohol treatment program to dispel any myths that this program is based solely on the completion of certain behavioral tasks.

The fourth evidence-based practice recommendation for this program is to ensure interactions with recovering alcoholics/addicts are structured and/or supervised. Currently, the program provides minimal structured or supervised interactions between program participants and recovering alcoholics. The interactions that do take place include a group session educational component describing Alcoholics Anonymous to clients. Non-structured interactions which are being promoted include working through the AA steps, providing transportation to active clients, personal favors, and other similar situations. Although revering alcoholics may be able to offer insight on topics such as relapse prevention skills or maintenance strategies, this type of advice should be monitored by a licensed counselor who can properly disseminate the information. Misinformation during any stage of treatment can be detrimental to a client's recovery, and should be monitored closely.

The fifth evidence-based practice recommendation for this program includes increasing intrinsic motivators while decreasing the focus on extrinsic motivators. This facility in particular is highly reliant on extrinsic motivators offered by the criminal justice system. Without these parameters in place, the clinicians indicated that it was difficult to find ways to otherwise motivate their clients (Interview C, lines 345-348). Obviously, clients should take ownership of their recovery, and intrinsic motivators promote that idea. This can be encouraged through promoting healthy lifestyle changes, positive attitudes, or a change in perspective about substance use or abuse.

Analysis of Program D

Theoretical Frameworks

RET Principles Nine and **Ten** were used to assess theoretical frameworks. Program D facilitator indicated the counselors use selected part of both Stages of Change/Health Belief Model and SCT. Program D facilitator had not identified any program areas with a specific theory before. The program theory was also not identified in any literature available to the counselors or clients. Program D facilitator did not think it was difficult to match individual client goals and objectives with the theoretical basis she identified for the program. She did, however, indicate that the process may be trial-and-error: ". . . you try different methods with different people and learn the hard way" (Interview D, lines 322-323).

Program D facilitator described some community resistance to her program. The resistance is related to the location of the treatment center and the presence of treatment clients in that part of the community. The main issue is the location of the facility in a residential area and its proximity to a childcare center. Program D's staff are very careful to monitor clients who are registered sexual offenders to avoid any interaction with children at the childcare facility. By separating the two groups and not allowing any interactions in common facility areas such as hallways or the parking lot, adult clients are restricted and have no contact with juvenile clients. Other community resistance exists as neighbors to the facility have called the police for noise complaints and other minor disturbances (Interview D, lines 329-350).

Program D facilitator also describes the resistance from the local probation officers to alcohol treatment programs in general; she believes this exists because of the different theoretical backgrounds of the two groups. She said (Interview D, lines355-358):

> . . . they do their job well which is to make sure society is safe and that those that are offending get penalized, and we on the other hand recognize that but we want to help them change and not just necessarily throw them in jail . . . [s]o there is that kind of clash because our theories are different.

Program D facilitator also identified some community social norms which may have affected the treatment process. She describes the community as ". . . a rough and tumble kind of town" (Interview D, lines 378-379) where alcohol use is socially accepted. She states that some drugs such as methamphetamines, cocaine, and heroine are not as socially accepted, and alcoholics tend to view themselves as "better" addicts than those people addicted to the harder drugs (Interview D, lines 382-386).

Mission, Goals, and Objectives

Principles Eleven and **Twelve** were used to assess mission, goals, and objectives. Program D facilitator provided program literature that listed the mission, goals, objectives, and treatment services as well as procedural statements for the program. The mission statement was not included in order to maintain anonymity; however, it described the program population, but not what the program provided in terms of services.

Following the mission statement were seven "Procedure" statements, four goal statements, and four objective statements. These statements were also not included to maintain anonymity. Program D facilitator did not write these statements. Actually, when discussing these documents during the interview, she stated "And if I were to write those I would have written them differently" (Interview D, line 412). She suggested a possible goal statement would be ". . . to continue to offer treatment to those that area suffering no matter of any discrimination" (Interview D, lines 415-416). She added concepts about measuring

treatment against best practices and allowing for staff continuing education opportunities. Program D facilitator also did not agree with the objective statements offered in the Program literature, noting that the statements were not measurable statements. She thought the statements were too selective and not inclusive of all treatment systems. Currently, Program D does employ individual goal and objective statements for clients, but these statements are not based on any over-arching program theory.

Treatment

Principles One through **Six** were used to assess program treatment. Principle One is used to assess how the treatment process addresses all aspects of a client's life and what services are offered at the facility. Program D facilitator reported she and her counselors use a "holistic approach" to treatment which includes the six dimensions of treatment (Interview D, line 7). Program D offers cognitive behavioral, motivational therapies, individual therapy and group therapy. The counselors strongly encourage community twelve-step programs, and they refer to outside sources for medication and detoxification needs.

Principle Two is used to assess the availability of treatment and payments accepted by the facility. Program D usually is able to make an appointment for a client within twenty-four to thirty-six hours after a client's initial contact with the facility. They have been able to shorten that period to twelve to twenty-four hours when it is necessary. Program D accepts the following payment methods: private insurance, state insurance, and self-payment. They also have many Medicaid clients who are accessing state substance abuse funding. Program D facilitator reports difficulty in obtaining payments from insurance companies, especially when multiple treatment sessions are required. Insurance companies also limit the number of

visits per year after the deductible is met. She indicated that most clients who have problems with their insurance often resort to self-payment to continue treatment.

Principle Three is used to assess how treatment plans are reviewed and amended. Program D facilitator thoroughly reviews client treatment plans with the staff. As part of the treatment review process, she 1) meets with clinicians on a daily basis to discuss clients' charts, 2) reviews weekly and updates clients' treatment plans, 3) does random audits of two to three client charts per week, on average, focusing on the client's specific treatment plans, and 4) meets monthly with all the clinicians to review clients' charts (Interview D, lines 68-88).

Principle Four is used to assess the use of multiple treatment sessions and motivational strategies used to encourage attendance. Although Program D facilitator already discussed the problems she sometimes encounters with insurance payments for multiple treatments, she is usually able to help clients continue with treatment for as long as necessary. Program D facilitator relies on external motivators to encourage attendance with mandated clients. To help encourage their participation while they're attending treatment, Program D facilitator uses ". . . motivational interviewing techniques" and relies on non-confrontational communication (Interview D, line 118). She feels challenged to build trust and respect between clients and counselors, but building that trust is an integral part to treatment (Interview D, lines 123-126). Program D facilitator does find it difficult to motivate clients that are self-referred. Without the underlying external motivator of jail time or fines, it is hard to reach those clients. Helping her staff build client trust, respect, and dialogue, and by using other internal motivators, attendance and success of treatment with non-mandated clients may increase.

Principle Five is used to assess the use of individual risk and protective factors to maximize the effectiveness of the treatment program. Program D facilitator addresses risk and protective factors during group sessions and focuses on any areas which need attention during individual treatment. This information, though different for each client, may vary from counselor to counselor as they approach the client's needs. For example (Interview D, lines 146-151):

> I'm going to give you a decisional balance. This is the behavior you're talking about that maybe you want to change – that you don't do self-care. What are the good things and bad things about changing that behavior, and the good things and bad things about not changing that behavior, and then let's talk about when you come back next week . . . what you put on that list . . . and come up with some interventions and strategies for you to start working on. So a lot of the time it's kind of spur of the moment and you just give them an assignment.

In discussing protective factors with clients, Program D facilitator focuses on the positive aspects of that behavior. The counselors at Program D use role playing, refusal skills, communication skills, anger management, and case management.

Principle Six is used to assess how interactions with recovering alcoholics are used in the treatment program. Meth-matrix program from Hazelton is used to structure interactions with recovering alcoholics. A sponsorship night is used where recovering addicts come to the facility to talk about different community twelve-step program that are available. Although twelve-step facilitation cannot be required by most clients according to

state guidelines, drug court clients are required to demonstrate documented attendance of three AA or NA meetings per week.

Client Recidivism

Program D does not currently track client recidivism, although the program facilitator is very interested in tracking that information. Recidivism data shared include: 1. starting at the beginning of the fiscal year, keep track of the number of clients they assess, 2. what level of treatment those people are assigned to, 3. how long clients are in each phase of treatment, 4. the clients' attendance records, and 5. the number of clients who drop out of treatment (Interview D, lines 205-208). Some roadblocks to gaining this information has been lack of time and lack of knowledge of how to access such data without it becoming too cumbersome. Program D facilitator thinks recidivism tracking is something that is ". . . really lacking in this field", but she does not feel she has the tools to complete the task (Interview D, line 226). By tracking program recidivism rates, the program could measure its successfulness on several different levels.

Client Demographics

Program D does not formally collect any information about client demographics. Program D facilitator estimates the facility currently treats100 clients; 60% women and 40% men. She states her biggest population are ". . . twenty-five to thirty [year-old] . . . women opiate addicts" (Interview D, lines 246-247). She estimates the eighteen to twenty-five year old age group represents 25% of the total treatment population at this facility. She estimates the number of minority clients is representative of the minority community population. The majority of her clients are in the lower socioeconomic status. For an opportunity to allow

women and men to meet separately, Program D currently offers male and female gender responsive groups. Otherwise, she does not feel there are enough members in other sub-populations to warrant offering other special groups. Program D facilitator did mention that she wanted to eventually separate younger clients (juveniles through early twenties) into their own group to meet age specific treatment needs and treatment strategies.

The information gained about Program D in each RET Principle is summarized in Table 5. Likert scale ratings are included for each Principle and the corresponding assessment area. Principles which correspond to client recidivism and demographics do not receive Likert scale ratings and are not included.

Table 5

Program D Ratings by RET Principle

RET Principle	Likert Scale Rating	Assessment Area
1	3	Treatment
2	3	Treatment
3	3	Treatment
4	2	Treatment
5	3	Treatment
6	3	Treatment
9	2	Theoretical frameworks
10	2	Theoretical frameworks
11	2	Mission, goals, and objectives
12	3	Mission, goals, and objectives
Total Score	**26**	

Note 1: Ratings are totaled for an overall score which reflects evidence-based practices. Possible range of scores between 10 and 30.

Note 2: Likert scale ratings are 3=excellent, 2=fair, and 1=not acceptable.

Practice Recommendations Summary

The Practice Recommendations Summary of the RET for Program D is located in Appendix O. In this section, the abbreviated Practice Recommendations Summary section is addressed in detail.

The first evidence-based practice recommendation for Program D is to add goal and objective statements that reflect current theoretical practices of this program. Although Program D does not formally align with a particular theoretical base, it is evident through the completion of the RET and the interview aspects of the Stages of Change theory and SCT are used. These components can easily be identified in the program goals and objectives. Current goal statements are ambiguous and lack direction. Objective statements also need diversification and to be criterion-based. The four objective statements are administrative objectives and do not address any client outcomes. Program evaluation is difficult using these types of objectives because they are not measureable.

The second evidence-based practice recommendation for Program D is to increase intrinsic motivators and decrease extrinsic motivators, especially with mandatory clients. Treating mandatory clients, it is easy to rely on punitive measures to ensure client attendance and compliance. However, to increase intrinsic motivation and therefore increase client success, counselors must focus on positive associations with treatment and building trust. Adding a positive focus to treatment and giving clients a different perspective about their recovery, it may trigger positive associations with treatment. This intrinsic focus also helps self-referred clients who may need extra motivation for continued attendance and success.

The final evidence-based practice recommendation for Program D is to track program demographics and recidivism. Tracking demographics will show trends to warrant offering

groups treat sub-populations. Tracking program recidivism offers invaluable data about program success and return-to-behavior.

Final Interview Analysis

Each program was presented with an Evidence-Based Practice Recommendation Summary and RET including Likert scale grades for each Principle. At that time, each program facilitator was interviewed about the RET process including their responses towards the individual program recommendations summary and any feedback they had about the research project.

Program A Final Interview Analysis

The Practice Recommendation Summary was presented to Program A facilitator. Program A facilitator thought the RET assessment process was very clear and easy to understand. She said she would recommend the RET to other treatment professionals for assessment. A benefit she noted in the assessment process was the ability to get an objective viewpoint of the program in relation to evidence-based practices (Interview A part 2).

While reading the Practice Recommendation Summary, Program A facilitator noticed the recommendation to revise the program's current mission statement. She appreciated the suggested revision for the mission statement and commented that the included revision was helpful (Interview A part 2). While discussing philosophy, mission, goal, and objective statements, Program A facilitator mentioned the lack of emphasis on those aspects of the treatment program during the yearly state review process. During an annual review, Program A facilitator stated (Interview A part 2, lines 43-56):

> . . . they look at [philosophy and objectives] when they come in. [W]e just went through the recertification process. You know they look at that but … they pay more attention to some of the other things … I honestly think they just sort of look to make sure we have it.

When asked if she was ever given any feedback about Program A's philosophy or objective statements, she stated "I got no feedback on it. I never got any feedback on it. Ever." (Interview A part 2, line 60).

Program A facilitator only had one question about the Recommendations Summary. She did not feel that the RET accurately assessed the amount of intrinsic motivation techniques employed by the counselors or staff. Perhaps this area wasn't documented or communicated in the assessment. She acknowledged that counselors must take opportunities to intrinsically motivate their clients when available (Interview A part 2).

Program A facilitator agreed with the other Practice Recommendations presented including tracking client recidivism, increasing documentation during staff meetings, and diversifying objective statements.

She recognized that tracking client recidivism could be useful to the program. She noted however, that tracking recidivism, due to time and financial constraints, has been difficult for the facility.

She also agreed with the recommendation to document weekly staff meetings. Although at the time of the assessment, Program A counselors had not been documenting discussion about clients at their weekly staff meetings even though it was a state requirement. Before their annual review, Program A facilitator realized they were not meeting the state's

criteria in this area, and she worked to amend the situation. She developed staff notes counselors can use during the meetings to track discussions about client progress.

Program A facilitator understood the necessity to diversify program objectives to quantify all areas of the treatment program; not exclusively the administrative areas. She reviewed the sample objective statements provided in the Recommendation Summary. She also noted the recommendation to quantify objective statements. She compared the measurement criteria of program objective statements to the requirement of client treatment plans and objectives.

Overall, Program A facilitator thought the RET assessment process and recommendations were useful and appropriate for the facility. She stated: "[a]ctually, there were no big surprises. That's probably about where I would rate us" (Interview A part 2, line 146).

Program B Final Interview and Analysis

The Practice Recommendation Summary was presented with both Program B facilitators were present. Program B facilitators did not have any questions or concerns about any of the recommendations; in fact, they had some positive feedback for some of the sections. They indicated it was helpful to read the recommendation about the use of intrinsic motivators during treatment. Basically, through building client trust and communication, this section recommended increasing intrinsic motivators and gave a short example. One Program B facilitator regarded the recommendation as helpful, stating ". . . to have it put into words of 'that's an intrinsic motivator' really is helpful. So it's almost more the words applying to things that we're doing helps a lot" (Interview B part 2, lines 148-149).

One of Program B facilitators also noted was helpful was the recommended revision of the mission statement and the inclusion of a suggested new mission statement was helpful (Interview B part 2, lines 140-143):

> I really like, and you could tell us to write a mission statement, but then you write an example. That really helps us. But it seems to me that I would be much more inclined to want to incorporate that if I didn't have to go, 'okay, now what do I have to think about?' So that I find very helpful.

Both Program B facilitators agreed the RET assessment process was helpful to them as clinicians. They also said they would be willing to recommend the RET assessment process to other clinicians or repeat the assessment after revising some of their treatment practices.

Program C Final Interview and Analysis

During the first interview, Program C facilitator was dismissive about the importance of the research project and the benefits it may have been to the treatment program. Program C facilitator was unprepared at the time of the interview; she had not read or completed the RET prior to the interview and did not have any documentation available to facilitate the assessment process.

When the Practice Recommendation Summary was presented at the second interview, Program C facilitator reacted defensively and was dismissive about the assessment results. She disagreed with the accuracy of the assessment and did not understand that the assessment was based on the information she provided initially. She presented several arguments against the information provided in the summary which directly contrasted information she had

provided in the first interview. Because of these discrepancies, it is impossible to assess if the RET assessment of Program C was accurate.

As she read the assessment, the main areas Program C facilitator disagreed with were: 1. the use of cognitive aspects in treatment, 2. the treatment planning process including the use of mission, goals, and objectives, 3. the use of Stages of Change/Health Belief Model as a theoretical basis for the program, and 4. the amount of structured interaction with recovering alcoholics.

In the first interview, when asked about cognitive aspects of treatment, Program C facilitator listed some required components of treatment that were behavioral in treatment. Some examples she gave were attending AA meetings, finding a sponsor, among others. None of the examples she gave were cognitive in nature. Program C facilitator reported in the second interview that several cognitive models were used during the treatment process including the Matrix model, CSC, and MRT (Interview C part 2, lines 75-76).

Program C was rated "not acceptable" in the areas of program mission, goals, and objectives in the Practice Recommendations Summary. Although Program C facilitator shared the mission statement briefly during the first interview, goals and objectives were not assessed. There was no evidence that clients' treatment plans aligned with the facility's overall mission, goals, or objectives. There was also no reference to client objectives in terms of treatment outcomes. When reviewing this material, Program C facilitator indicated counselors at this program do not complete treatment planning on their own. Counselors' treatment planning is supervised by a clinical supervisor, including the formation of client goals and objectives. Program C facilitator also stated that "our treatment planning is weak"

(Interview C part 2, line 72), although she still argued about the low rating the Program C was given for this assessment area.

In the first interview, Program C facilitator did not identify her program with a particular theoretical base, although she referred to her training in psychodynamic therapy. After reviewing SCT with Program C facilitator, she indicated some aspects of this model aligned with treatment processes currently being used at this facility. She did not, however, associate any of Program C's treatment methods or approaches with Stages of Change/HBM. She indicated clients would not identify with this theory because, according to the theory, the client must first believe in a perceived health threat before progressing with the behavior change process. In the second interview, Program C facilitator stated "[a]ll we use are motivational strategies. We base everything in the stages of change" (Interview C part 2, line 85).

Program C was rated as "not acceptable" in the area of providing structured interactions with recovering alcoholics to increase treatment effectiveness in the Practice Recommendation Summary. When asked about this type of interaction in the first interview, Program C facilitator referenced several situations outside of the treatment setting where recovering alcoholics had contact with current clients. But even when asked directly, there was no indication that the interactions between these people were supervised or structured. During the second interview, Program C facilitator mentioned some areas where there is structured interaction including ". . . 12-step panels . . . which include AA . . . we just really emphasize those. We have more involvement from successfully recovering people than I've ever known" (Interview C part 2, lines 241-245).

Each of these areas presented direct contrasts to the information acquired through the first interview. The information in the interview was not sufficient alone to assess Program C. Without a completed RET prior to the start of the interview, the assessment should not have taken place. It is impossible at this point to know if the RET functioned correctly in assessing this alcohol treatment program or if the information gained in the second interview was an accurate reflection of the program practices.

Program D Final Interview and Analysis

When the Practice Recommendations Summary was presented to Program D facilitator, she did not have any major discrepancies about the information. She agreed with the first recommendation to revise program mission and goal statements using some existing program literature as the basis. As the topic changed to revising program objective statements to match the aforementioned mission and goal statements, she replied: “I don't think were documenting [objectives] in as much detail with the general population as we have to with our drug court clients because it's a requirement” (Interview D Part 2, lines 63-64). Alcohol treatment programs must adhere to certain standards for court-appointed clients, but self-referred clients are always held to as high of a standard. In this case, client objectives are not always documented clearly.

The second evidence-based practice recommendation was to increase the use of intrinsic motivators. Program D facilitator agreed that an improvement in this area would be beneficial. She offered another possible measurement of intrinsic motivation: the client’s attendance at treatment services (Interview D Part 2). Although this would be an intrinsic measure for some clients, it would not apply to drug court clients whose attendance is monitored and sanctioned by the court system. Outside influence to attend treatment sessions

would be characterized as an extrinsic motivator. Often alcohol treatment programs have a difficult time using intrinsic motivators when extrinsic motivators are so ever-present in court-ordered treatment requirements. A suggestion on increasing intrinsic motivation was to focus on the positive changes that occur in a person's life due to a decrease in substance abuse, such as health improvements or relationships. Counselors should be opportunistic when clients meet objectives which reinforce positive outcomes. These recommendations also centered on the foundation of engaging and maintaining positive, healthy relationships with clients.

Program D facilitator was encouraged at the recommendation to begin measuring client recidivism. She wants to immediately improve, but felt she needed feedback to get started. In the Practice Recommendations Summary and during the final interview, the following ideas were presented to begin recidivism tracking: monitoring how many clients are in treatment including which phase of treatment they are in, monitoring the number of treatment sessions each client has in each phase of treatment, monitoring the length of time a client is in treatment before relapse, and tracking re-arrests rates by county. After brainstorming and discussing the possible data she could track, she reported that the task seemed more manageable (Interview D Part 2). She is considering developing a recidivism tracking protocol to test in the next few months before the new fiscal year begins in July. After July, she could implement the program to begin tracking recidivism data within the program.

Overall, Program D facilitator was pleased with the assessment process and recommendations presented for the facility. She stated (Interview D Part 2, lines 158-161):

> It was helpful. I thought it was an excellent tool I have something I can touch and read and look at and go 'okay this is where we want to go' and how we're going to do it. Yeah, it's been fun actually to have somebody objective come in and look at what are we doing...we're on the right track it sounds like. That's good.

Final RET Revisions

Evidence-based suggestions taken during the final interviews with all Program facilitators were implemented in the RET to form a final version. The full RET revised version is included in Appendix P. A detailed list of the revisions and rationale is below:

1. The purpose section of the RET more clearly defines the goal of the tool to assess alcohol treatment programs against evidence-based practices, and lists the five assessment areas: theoretical frameworks; mission, goals, and objectives; treatment; client recidivism; and client demographics. This will help program facilitator understand the purpose of the tool as an external assessment and the areas which will be assessed.

2. In the Instructions section the following sentence was added: "[a]n interview will be scheduled to discuss the RET and your assessment for each Principle". Presently program facilitators have few tools to help them understand these critical assessment areas, thus the RET gives a clear direction and map as to how to assess the implementation of evidence-based practices. The corollary interview after preliminary assessment by the program facilitators is to help facilitate understanding of the RET assessment process and to guarantee completion of the tool.

3. A statement encouraging program facilitators to contact the researcher at any point during the assessment process with questions was added at the end of the first page.

4. An estimate of the time the program facilitator should allot for the completion of the RET was added. Because program facilitators are giving freely of their time, respect should be given through a succinct state of time that should be allotted for completion. .

5. In Principle One under Assessment 2, the criteria was amended to include "although cognitive aspects are included, behavioral therapy has a great focus during treatment". This added statement helps delineate the difference between programs which use cognitive therapies and those which do not, as well as offering discussion of cognitive therapies not incorporated into typical treatment.

6. In Principle Two under Points of Practice, the following question was added: "Does the facility help facilitate payment for comparable services for clients who cannot pay for treatment?" This added question allows for situations where the clients' may be met by another local facility, and where this situation would be in the clients' best financial interests.

7. In Principle Two under Assessments 1 and 2, the criteria was changed to include the option for facilities to make payment provisions for clients.

8. In Principle Three under Points of Practice, the question about treatment plan reviews is defined as weekly or bi-weekly and the reviews must be written, not an informal oral review about client treatment. This rewrite helped facilities differentiate between whether they do informal, oral reviews about clients' progress.

9. In Principle Three under Points of Practice, the question "[i]s there a program review process?" was amended to include the phrase ". . . which examines program mission,

goals, and objectives?" This statement was needed to clarify what program facilitators should be reviewing in terms of program literature.

10. In Principle Four, the previous term "involuntary clients" was replaced with the terms "court-directed/ordered clients" to avoid confusion with involuntary clients who have been entered into a residential treatment facility.

11. In Principle Six the interaction with recovering alcoholics was amended to include the condition "structured" and in assessment, this was also changed to "supervised interaction". These changes will help differentiate between facilities that supervise interactions and those which encourage community interaction which is not supervised by a counselor, group, or other activity.

12. In Principle Seven the Ideal was revised to state "[c]lient recidivism should be tracked and used as a measure of overall program effectiveness". The previous Ideal for this Principle suggested the program facilitator compare recidivism rates to a national recidivism data. This type of measurement was impossible due to the variance of recidivism measures and the lack of consistent national data. With the revised statement, facilitators can track their own recidivism data and track their progress as outlined in their goals and objective statements.

13. In Principle Eight under Points of Practice, the list of client special needs was amended to include "medical needs", which then permits facilities to more accurately assess other types of client specialization.

14. In Principle Nine in the Ideal statement, the Health Belief Model was changed to Health Belief Model/Stages of Change. This theory is known by both names, and in this

study program facilitators knew what the Stages of Change theory was but did not recognize the Health Belief Model.

15. In Principle Nine in the Assessment criteria, the excellent criterion was changed to include "[t]he theoretical basis is a recognized part of the alcohol treatment program". Likewise, the fair rating criterion was changed to "[t]he theoretical basis is present but may not have been identified by the program facilitator". This change accounts for programs which have treatment practices that happen to align with a specific theoretical base, although the theory is not known by the program facilitator.

16. In Principle Ten in the Assessment criteria, the not acceptable rating was amended to include the statement "[t]he program does not include specific goal statements". Some programs in this study did not have goal statements, yet were not penalized in this section because the criteria did not specifically ask for the inclusion of goal statements.

17. In Principle Twelve in the Assessment criteria under the excellent rating, the criteria was amended to include the statement "all aspects of the program are represented by the program's goals including theoretical frameworks". This change ensures that theory is an over-arching part of the alcohol treatment program and is discussed throughout the program literature.

Cost Analysis

The direct costs of evaluating each alcohol treatment program, including the pilot study, and generating each program's evidence-based practice recommendations, were approximately eighty hours of work. This work included interview transcription, analysis, document gathering and analysis, and generating the Practice Recommendations Summary.

CHAPTER FIVE

Discussion

Introduction

In this section, the program evaluation process is discussed including problems which occurred during the evaluation process. First, the development of the RET is explained including the rationale for its development and assessment format. Measures of accuracy and reliability that were integrated are also discussed. Second, this discussion will highlight how the RET was modified for ease of use by participants and inherent limitations of this type of assessment. Third, the outcomes of the program assessment and the implementation of evidence-based practices in theoretical frameworks, mission, goals, and objectives, treatment, client recidivism, and client demographics are also be examined. Finally, the discussion closes with an examination of the RET's role in bridging the gap between research and practice.

Issues with Program Evaluation

Program evaluation has philosophic and program issues which must be addressed during the assessment process. Researchers and participants must be clear about the purpose of the evaluation and any potential benefits subsequent to participation. The research process must be clearly developed and communicated to ensure all information collected is accurate and reflective of the project. Miscommunications can also play a role in the assessment process; researchers must limit potential miscommunications by addressing any potential issues such as purpose and outcomes of the assessment, time commitments, and data

collection procedures. Overall, because of the dynamics of the assessment process, a description of issues that occurred during program evaluation is warranted.

As noted in the American Evaluation Association's Guiding Principles for evaluation practice, defining the purpose of an assessment is an essential component of any evaluation process.. The first Principle urges evaluators to ". . . conduct systematic, data-based inquiries about whatever is being evaluated" (Stufflebeam et al., 2000, p. 445), and develop the foundation of the relationship and responsibilities of the evaluators and participants in the evaluation process. Stufflebeam et al. (2000, p. 445) summarized this principle:

> This principle is supported by three normative statements. These charge evaluators to meet the highest available technical standards pertaining to both quantitative and qualitative inquiry. Evaluators are also charged to work with their clients to ensure that the evaluation employs appropriate procedures to address clear, important questions. The evaluators are charged further to communicate effectively, candidly, and in sufficient detail critique the evaluation's procedures, strengths, weaknesses, limitations, and underlying value and theoretical assumptions and also make defensible interpretations of findings.

In this study, program facilitators needed to understand that the purpose of the RET was to provide an assessment of the program's implementation of evidence-based practices and recommendations to current program practices.

During the assessment process, Program C facilitator did not have adequate understanding: (1) about the research process, (2) of how the process was to be facilitated, or (3) her role in the assessment to provide information about the program for analysis, even

though this information was conveyed to her prior to the start of the assessment, and in the first and second interviews (Interview D, Parts 1 and 2). Potential inaccurate results of Program C's implementation of evidence-based practices were the consequence of not taking the time to complete the RET prior to the interview. The other program facilitators actively participated in the written and interview portion of the assessment process. Therefore they were able to more accurately answer questions about the program and provide additional information that was helpful in the assessment process.

Miscommunications between evaluators and program facilitators, stakeholders, or other participants, may occur. In assessment, these miscommunications about the underlying reasons for program evaluation and participation are commonplace. Evaluators may enter the evaluation process with a hidden bias or agenda. Likewise participants may have their own mistaken reasons for their involvement. Participants may be using the evaluation process to fulfill grant requirements, postpone a major program decision, or to gain public recognition or media attention (Worthen, Sanders, & Fitzpatrick, 1997). All of these factors may skew the participants' or evaluators' perceptions of the evaluation process and even potential results. For example, Program C facilitator saw the evaluation process as an opportunity prove the worth of her program when the process was intended to offer an external, formative assessment of the program's implementation of evidence-based practices.

Communication between evaluators and participants can also be problematic. Oftentimes evaluators are chosen by policymakers, but the bulk of the interaction during the evaluation process is with other people involved in the program implementation or the participants themselves. The participants may have a preconceived notion about the

evaluation, its process, or purpose. Little communication between program stakeholders and facilitators may exist which makes the evaluation process more difficult.

Evaluators face issues with the assessment process in all types of situations. In order to avoid these issues in future use of the RET, the evaluation process should be described in detail to the program facilitators. Participants must also understand the time and commitment to sharing program information for the use of the assessment, and be willing to dedicate an adequate amount of time to the assessment process. These concepts were addressed prior to the interview process, however, problematic issues concerning the RET assessment process were limited to one unprepared Program facilitator; the use and description of the tool and its purpose were well-known to all participants and in general was effective.

Development of an Evaluative Tool

The development of an evaluative tool to assess evidence-based practices in alcohol treatment was warranted by the literature review. Although many evidence-based practices exist, dissemination of evaluative information to practitioners in a format which is easy to implement in everyday practice is difficult. Formative program theory evaluation ". . . helps programs respond to increasing demands for monitoring and performance measurement" (Stufflebeam et al., 2000, p. 211). In this case, use of the RET helps alcohol treatment program facilitators assess programs in terms of evidence-based practices. Although one would think the use of evidence-based practices is wide-spread, the opposite is the reality. Alcohol treatment program facilitators, like many other allied health professionals, have a difficult time managing staff, clientele, and a facility, much less researching current evidence-based practice literature. Program accountability, including effectiveness and

practices, are becoming increasingly important; especially when the program has an evident public factor such as alcohol treatment. Substance abuse programs in particular are subject to community scrutiny because their effectiveness has a direct impact on the community members where the program resides. For this reason, program facilitators must take every possible assurance that evidence-based practices are implemented when possible.

The RET was designed to be a formative program evaluation contingent on program facilitator involvement. Facilitator involvement in the evaluation process is essential for three reasons:

1. Program facilitators can identify areas that need improvement during the evaluation process,

2. This evaluation model keeps the program facilitators focused on the main points of evaluation, in this case, evidence-based practices, and

3. Data generated through this program assessment can be used by the program facilitators to improve long-term program effects (Stufflebeam, Madaus, & Kellaghan, 2000). This evaluation design, along with the use of a program-theory based evaluation model, were particularly important to strengthen the construct validity of the instrument.

Throughout the RET assessment processes, program facilitators were able to identify evidence-based practices being used in their programs, and assess the level to which these practices were implemented. By using an assessment rubric, each evidence-based principle in the RET was assessed by the program facilitator and the researcher. Elements of the principles were assessed through the interview process, and supplemental information was provided. This gave a more reliable assessment of actual program processes than a researcher-only or facilitator-only viewpoint. Also, having the input of a subject-matter

specialist in the area of alcohol treatment who was impartial to the program assessment also strengthened the instrument design. An added measure of reliability within the instrument was through the multiple assessments of the major content areas (theoretical frameworks; mission, goals, and objectives; and treatment) in two or more evidence-based principles. This also ensured the most useful and consistent information surfaced during the assessment process.

The RET was revised to ensure ease of use for program facilitators after Program A and Program B assessments were completed. The major revision to the RET which most greatly affected program facilitators was the ordering of principles. During Program A and Program B's assessments, the RET principles were ordered in what could be described as a top-down approach. From this viewpoint, alcohol treatment programs were being assessed starting with the most broad areas of the program, and as the assessment progressed, the focus of the evaluation narrowed. Specifically, the RET assessment originally began with theoretical frameworks, followed by mission, goals, and objectives, treatment, recidivism, and client demographics. The principle order was changed to mimic the practitioner's viewpoint. The principles were re-ordered to assess treatment practices first, then client recidivism and demographics, followed by mission, goals, and objectives and theoretical frameworks. This helped program facilitators more easily accept the RET and built confidence with the instrument as they progressed. Although the criteria for evaluation remained the same, the format made the tool easier to use and understand. Program facilitators must want to use the RET and invest time in the assessment process; this part of the RET development is essential to its future success with this professional population.

Interpretation of results appears to show that evidence-based practices, especially in the areas of theoretical frameworks and mission, goals, and objectives have not been applied. Although the field of alcohol treatment is abundant with evidence-based practice literature and resources which discuss the implementation of evidence-based practices, an evaluation tool which assesses programs' use of evidence-based practices at the individual level appears to be needed. The program theory evaluation process was the most appropriate choice for this content area.

Alcohol treatment is a highly detailed subject with many variables affecting treatment outcomes. This perhaps explains the absence of an evidence-based practice evaluation tool at the individual program level. However, alcohol treatment programs need to be assessed on a theoretical basis, as in a program theory evaluation, before knowing definitely whether the program is effective and how to replicate it (Stufflebeam et al., 2000). Although the RET does assess program content in term of treatment, each evidence-based principle is grounded in theory and literature citing previous successful outcomes.

Finally, the RET serves as a formative program evaluation, meaning that it gives an interim measure of an alcohol treatment programs' outcomes, which is due to the longevity of the programs' outcomes (Stufflebeam et al., 2000). By providing a formative evaluation standard using evidence-based practices, program facilitators can maintain focus on the guiding principles essential in alcohol treatment.

Limitations

The integral piece of the evaluation and implementation process is one which cannot be accounted for in this study. After the Practice Recommendations Summary and RET feedback is disseminated to program facilitators, it then becomes their responsibility to

implement the recommendations. Unfortunately, unless there is an external motivator, the RET recommendations may never be fully realized in the alcohol treatment program. Program facilitators, in their responsibility to be accountable to their clients, the community, and their professional standards, must impose this standard upon themselves to improve program practices. Stufflebeam et al. (2000, p. 230) describe this process and potential pitfalls of program theory evaluation:

> Common ways in which program theory is seen to be useful is in helping program developers and staff to improve program design before or during implementation, helping them to identify gaps in their logic and additional program activities that are required, and providing program staff with a mental map for reflecting on their work and prioritizing activities. While such outcomes are very satisfying for evaluators, they raise the very real danger that the activity will end there. Developing program models is hard and time-consuming work and once they have been developed there is often considerable pressure to stop and allow the program staff to get back to work. But to get the most benefit from program theory we cannot afford to stop here. The evaluation work remains to be done.

Program Analysis Summary

Summarized below are the five major assessment areas of the RET in each of the individual alcohol treatment programs including: theoretical frameworks; mission, goals, and objectives; treatment; client demographics; and client recidivism; and discussion of the prevailing areas in which alcohol treatment programs are not implementing evidence-based practices.

In Table 6, each alcohol treatment programs' Likert scale scores can be seen in the areas of theoretical frameworks; mission, goals, and objectives; and treatment; the program's total score; and the mean scores for each assessment area.

Table 6

Likert Ratings Summary of Assessment Areas by Program

	A	*B*	*C*	*D*	*Mean*	*Standard Deviation*
Theoretical Frameworks	5	5	2	4	4.0	1.41
Mission, Goals, & Objectives	5	4	3	5	4.25	0.957
Treatment	15	16	11	17	14.75	2.63
Total Scores	**25**	**25**	**16**	**26**	**23.0**	

Note 1: Ratings are totaled for an overall score which reflects evidence-based practices. Possible range of total scores is between 10 and 30. A score of 10 equals a "not acceptable" rating; a score of 20 equals a "fair" rating; a score of 30 equals an "excellent" rating.

Note 2: Possible range of theoretical frameworks scores and Mission, Goals, and Objectives scores are between 2 and 6. A score of 2 equals a "not acceptable" rating; a score 4 of equals a "fair" rating; a score of 6 equals an "excellent" rating.

Note 3: Possible range of treatment scores are between 6 and 18. A score of 6 equals a "not acceptable" rating; a score 12 of equals a "fair" rating; a score of 18 equals an "excellent" rating.

As evident by Table 6, mean scores for the alcohol treatment programs are slightly higher than a "fair" rating in the area of mission, goals, and objectives, and below "fair" in the area of theoretical frameworks. The mean score of 14.75 in the treatment area is between

"fair" and "excellent". With the overall exception of Program C, the programs assessed exhibited high scoring in terms of evidence-based practices. However, these scores do not confirm complete compliance with evidence-based practice implementation at all levels, which was especially evident in the areas of theoretical frameworks and missions, goals, and objectives. Notice the difference in ratings for each program by assessment area and not only the program's total score. The majority of the programs had total scores ranging between "fair" and "excellent", with the exception of Program C. At first glance, these scores may indicate an above average program with the majority of program areas meeting current evidence-based practices. But what has been evident in this research study is that alcohol treatment programs are lacking in the same two specific areas: 1. theoretical frameworks and 2. mission, goals, and objectives.

Theoretical Frameworks & Mission, Goals, and Objectives

In general health behavior change theories, program planning and implementation including the design, management, and measurement involved in mission, goals, and objectives, are an integral part of a successful behavior change program. In the assessments of these four alcohol treatment programs, the above seems to be an after-thought. These program facilitators appear not to be using existing mission, goal, or objective literature as tools to help measure program success or align counselors with a unified theoretical approach to treatment.

More importantly, mission, goals, and objectives are in at least some part, required by state agencies supervising these programs. The Washington Administrative Code [WAC] 388-805-140 requires outpatient treatment facilities to "[e]stablish the philosophy and overall objectives for the treatment services" (Washington State Legislature, 2008). In addition, the

WAC section 388-805-350 requires “each service provider [to] develop and implement policies and procedures for outcomes evaluation, to monitor and evaluate program effectiveness and patient satisfaction for the purpose of program improvement”. Likewise the Idaho Administrative Code [IAC] requires outpatient treatment facilities to include a mission statement, goals, and objectives for their programs. The IAC 16.06.03-040 defines how each program should describe their written plan for services (Idaho Department of Administration, 2007):

> **01. Contents.** The plan shall contain:
>
> **a.** The mission statement, goals and objectives developed by the governing body in accordance with Subsection 031.02 for these rules.
>
> **b**. Goals and objectives that identify the annual and the long-range needs of the program.
>
> i. Goals and objectives are specified for each facility.
>
> ii. The objectives are written so that performance can be measured.
>
> **c**. A description of the process for developing, adopting and implementing goals and objectives.
>
> **d**. Client population served, including age groups and other relevant characteristics.
>
> **e**. The hours and days the program provides services.
>
> **f**. The intake or admission process, including how the initial contact is made with the client and the family or significant others.
>
> **g**. The client assessment and evaluation procedures used by the program.

Although each of the facilities did have the necessary philosophy, mission, goal, or objective statements required by their state, each one, without exception, was poorly written and did not serve to describe or assess the program in any way. These statements were simply contained in the program literature but did not serve any purposeful function.

McKenzie et al. (2005) describe a mission statement as ". . . a short narrative that describes the general focus of the program" (p. 128). A mission statement should describe the intent of the program, and possibly indicate the philosophy behind the program. A mission statement should also lead naturally into the development and implementation of goals and objectives. This process should facilitate the measurement of objectives and consequently program success in those areas (McKenzie et al., 2005). For example, program D's mission statement identifies the program population, but it does not address how the program will be delivered. Program D's mission statement only states it will ". . . deliver services" (Interview D, Document 1). It does not even briefly describe the content or theory pertaining to those services. Program D, however, did have seven statements listed after the mission statement identified as "Procedure". These statements, as explained in the Program D analysis, would function better as goal statements for the program. Although these statements do describe how the program will be delivered, a well-written mission statement should not need to be followed by numerous other statements for clarity.

Another example of the lack of planning for philosophy, mission, goals, and objectives is apparent in Program A's four-part mission statement. This mission statement further states that the goals listed in the mission are to be reviewed at the corporate annual meeting. In this example, the Program A facilitator did not even realize the apparent error in combing goal statements into the mission statement. These two areas need to be separated in

order to facilitate a clear understanding of the program, the population being served, and how the program will function. Goal statements can be used to identify ways the program will function, its theoretical basis, or basic treatment premises. Unfortunately, oftentimes the Program facilitator does not have the experience or the desire to learn about program planning methods, and does not take the time to establish a clear foundation for the program through the use of philosophy, mission, goals, or objectives.

A larger issue is the lack of guidance, direction and supervision that program facilitators have in the writing and implementation of program philosophy, mission, goals, and objectives. Each type of statement has a direct purpose in the planning and implementation of a program. Neither the program facilitators nor the state evaluators seem to care or do not understand the importance of the application of these statements; only that they are present in the program literature. This indifference towards philosophy, mission, goals, and objectives, was noted in the second interview with Program A facilitator. Program A had just undergone an annual state practice review, and Program A facilitator discussed the evaluator's lack of concern about the statements which guide and represent the treatment program. Program A facilitator indicated that the state evaluators only check to see if the alcohol treatment program has current mission, goal, and objective statements (those three areas are required for that particular state's outpatient programs). The evaluators never offer revisions or recommend amending the existing statements. Program A facilitator indicated she would not know where to get information about editing or supplementing philosophy, mission, goal, or objective statements (Interview A part 2).

Just as important to the program planning process as philosophy, mission, goals, and objectives are, the underlying theoretical basis to these statements are also significant. Each

alcohol treatment program should be grounded in a proven theory. Evidence from the RET suggests the use of SCT, HBM/Stages of Change, TRA, or a combination of these theories as an evidence-based approach for theoretical frameworks. It is necessary to use a validated behavior change theory or combination of theories to guide an alcohol treatment program. D'Onofrio (1992, p. 394 as cited in McKenzie et al., 2005) explains the crucial need for a theoretical framework:

> Theory is not a substitute for professional judgment, but it can assist health educators in professional decision making. Insofar as the application of theory to practice strengthens program justification, promotes the effective and efficient use of resources, and improves accountability, it also assists in establishing professional credibility.

Although there are many advantages to using validated theories in an alcohol treatment program, some roadblocks do exist. Program facilitators do not seem comfortable applying theory to practice, or even reviewing programs in terms of possible theoretical foundations. For example, Program B facilitators had the most problem with the program assessment in the areas pertaining to theory. They felt as if they were lacking knowledge about theory before beginning the assessment, and reported looking on the Internet for examples about theories described in the RET. They accredited this lack of knowledge to the length of time since they have been in graduate school or college. As some different evidence-based theories were discussed throughout Interview B, the program facilitators began to identify parts of their program with different aspects of SCT and HBM. But without guidance it was very difficult to determine a theoretical basis for the program or implement any of the theoretical components. This was evident in Programs A and D also;

they identified aspects of SCT and HBM, although did not realize the program aspects they were applying were aligned with these theories.

Practitioners and program facilitators need practice in identifying and implementing program theory into alcohol treatment. Especially when observing programs which receive state funding, program facilitators must use validated measures to ensure behavior change and therefore program success.

By employing a validated behavior change theories, program facilitators have direction in their program in the face of resistance. An evidence-based theory provides guidelines and resources to help the program facilitator encourage the behavior change process. Without this in place, program facilitators may waste resources and chance a decrease in program effectiveness by implementing an approach based on trial and error, opinion, and prior experience alone (Stufflebeam et al., 2000; McKenzie et al., 2005).

In order to improve alcohol treatment programs at a very basic level, a program philosophy, mission, goals, and objectives should be created and grounded in evidence-based theoretical frameworks. This research defines a need at the state level to facilitate the creation and implementation of program planning guidelines which would follow an evidence-based practice foundation. Practitioners should be offered a clear and simple format to define existing alcohol treatment programs. The end result would be alcohol treatment programs with a sound theoretical and treatment basis, designed with an evaluation process primed through mission, goals, and objectives. By establishing this measurement and assessment criteria, programs could have more accurate evaluations and will more effectively meet the needs of the treatment population and as the community.

Treatment

For the most part, programs exhibited implementation of evidence-based practices in their treatment programs. Five areas in particular existed where most programs were rated as excellent or fair, including: the use of comprehensive treatment, multiple treatment episodes, risk and protective factors, structured interaction with recovering alcoholics, and extrinsic motivators.

Each of the programs offered comprehensive treatment focused on all areas of a clients' life: family, social, work/employment, financial, and health; and offered individualized counseling to address any issues in those areas which needed more attention. All programs also offered and encourage the use of multiple treatment episodes. Risk and protective factors were addressed by all programs except Program C. The other program facilitators discussed these factors with clients using a variety of strategies including role-playing, motivational interviewing, and during individualized counseling sessions. Structured interaction with recovering alcoholics was a required aspect of the programs in all instances, although Program C also relied heavily on non-structured interactions between program participants and recovered alcoholics. All programs had evidence of extrinsic motivation, which is especially simple to facilitate with mandated clients. Extrinsic motivators are ever-present in court sanctions and treatment requirements.

The areas in treatment which did not always match evidence-based practice guidelines were the availability of treatment, use of intrinsic motivators, and the review and amendment of client treatment plans. Part of the availability of treatment which was assessed was the amount of time between a clients' first contact with the treatment facility and their initial appointment. This time varied between programs, with Program C reporting

the lowest time, approximately less than four hours. Most facilities reported times between twelve and twenty-four hours or longer due to lack of staffing. Program facilitators overwhelming felt they met the needs of clients in terms of treatment availability because of lack of wait lists, and screening clients with critical needs. In this instance, a client who presents as a critical patient would be seen ahead of others.

All programs in this study needed assistance identifying and implementing the use of intrinsic motivators during treatment. Program facilitators found it difficult to focus on intrinsic motivators when extrinsic motivators are ever-present with this treatment population. The review and amendment of treatment plans was also an area of concern. Facilities reported non-structured reviews of client treatment plans, with formal, written reviews happening approximately every two weeks, or whenever they are required by the state. Although program facilitators were meeting state guidelines, client treatment plans should be monitored and amended when changes occur. Counselors should be attentive to modifications that must occur as the client progresses through treatment.

Client Recidivism and Demographics

Another surprising result of the alcohol treatment programs' analyses was the realization that no program actively tracked recidivism rates. From a purely quantitative framework, the tracking and comparison of recidivism data could benefit existing alcohol treatment programs by demonstrating program effectiveness.

Recidivism can be difficult to assess, particularly with this population. First, the eighteen to twenty-five year old client can be transient and sometime unreliable. Second, it can be difficult to obtain data from the substance abuse client population due to possible incarceration, abuse issues, and general inconsistencies in self-reported data. But there is an

indefinite amount of information that can be gathered from a single facility. For example, a basic measurement tracking a clients' return-to-treatment in terms of time between treatment periods and length of treatment episodes would demonstrate an overall effectiveness measure. In a rural area such as this community where there are very few substance abuse treatment facilities, this type of measurement may be easy to obtain. Another important measurement is the number of drug-court offenders in treatment and any subsequent treatment episodes they may attend. This information is usually tracked through the county or state, but it would be beneficial for treatment facilitators to have access to this information for program effectiveness assessments.

Tracking return-to-behavior is more difficult depending on the description of the term. Practitioners question whether return-to-behavior should include brief relapses that do not result in harm to the individual, family, or society in general, or if all relapses should be accounted for. The measurement of client relapse is especially difficult once the client has successfully completed treatment. Although some studies have followed clients up to twelve months post-treatment, it is difficult to obtain information without the premise of regular communication through the treatment process.

Using any definition, recidivism data is an invaluable tool for tracking program success. Recidivism data can be used to determine which treatment methods are more effective with different populations based on age, gender, race, socioeconomic variables, and countless others. Collecting such data can give information about the program community and potential barriers to treatment and is not a variable to be overlooked or dismissed.

Client demographics have also been overlooked by program facilitators. With knowledge about client demographics, programs can begin to offer treatment based on

specific client needs, such as gender-specific treatment groups, or groups defined by age or race. Currently, the Center for Substance Abuse Treatment [CSAT] has developed Treatment Improvement Protocols [TIPs] which offer evidence-based practice guidelines for the treatment of substance abuse. These guidelines match specific client needs and demographic profiles. For example, TIPs are currently available in the following focus areas: adolescents, clients with HIV/AIDS, clients with physical and cognitive disabilities, older adults, and pregnant women, among many others.

There were two examples of gender-based treatment groups in this study. Program C was a facility which treated only male clients (Interview B). Program D facilitator indicated that she had recently begun gender-responsive treatment groups for male-only and female-only clients. She indicated these groups were very informational for the clients because they were able to discuss gender-related issues with clients of the same gender (Interview D). Another type of client accommodation was seen in Program B. Program B facilitators explained that they have offered special services for clients in the past, including providing interpreters for clients who did not speak English. Unfortunately, this was even problematic, as the interpreters used were often family members of the person seeking treatment.

Other facilities did not offer any defined services for minority clients or treatment groups defined by prevailing client characteristics. The reason given for not offering these treatment groups was a lack of diversity in existing client populations. Each program gave estimates of client populations by race, gender, and age, although this data was not validated. The program facilitators estimated that their client populations were representative of the demographics present in the surrounding area.

Despite the lack of diversity in client populations, program facilitators should still focus on meeting the specific needs of clients. By tracking demographic information, program facilitators will be aware of any trends in client demographics, and can begin to implement services based on clients' characteristics.

Bridging the Gap between Research and Practice

The development of an evaluative tool to assess alcohol treatment programs against evidence-based practices is a crucial step in the transition from theory to practice. Information should be shared between practitioners, theorists and researchers in the improvement of alcohol treatment. Lamb, Greenlick, and McCarty (1998) outline the different perspectives of researchers, policymakers, and practitioners in the struggle to implement evidence-based practices. "Researchers perceive that many research-developed innovations have improved the treatment of drug abuse" [and] ". . . that patient outcomes would be significantly improved if these, and other research-tested modalities, were fully utilized in treatment" (Lamb et al., 1998, p. 30). On the other hand, treatment providers are searching for information pertinent to their daily delivery of services, and regard research topics as irrelevant. In contrast, policymakers view research literature as inaccessible, with an over-abundance of information at all levels except cost-effectiveness (Lamb et al., 1998). A significant time-lag appears to exist with all information in the research setting, and programs appear not to benefit immediately from participation at the research level. Oftentimes the cost of a research initiative is more than enough ammunition to fight implementation. Lastly, consumers are ridden with a different set of concerns about treatment. Their needs focus on treatment accessibility, cost, treatment choices, the

integration of treatment with medical or social services, and other issues. Few client advocates exist in the area of alcohol treatment (Lamb et al., 1998).

The RET takes some of these important issues from all aspects and has structured them in a concise assessment tool. Written from a research perspective, use of the RET helps define and evaluate evidence-based practices in alcohol treatment. All evidence-based principles are referenced from multiple sources. The design of the RET is based on several successful models in alcohol treatment research. From the practitioner's perspective, use of the RET assesses concepts important to daily practice in the treatment sections. The RET was written for use by practitioners, and amended to include language familiar to individuals in the practice setting. It also includes notes and descriptors to clarify information. By implementing the interview process after RET completion, any additional questions a practitioner may have about the RET can be answered. The Practice Recommendations Summary given to the practitioners following program analysis is extremely helpful to bridge the gap between theory and practice by giving program facilitators written guidelines for evidence-based practice recommendations.

For policymakers, use of the RET provides a succinct tool to help evaluate multiple aspects of a treatment program with suggestions for program evaluation. Policymakers are often concerned with program effectiveness, and using the RET would provide feedback on assessing an existing alcohol treatment program and establishing assessment criteria. For this group, the RET would also reduce the influx of information present in the literature to a well-defined, manageable segment. Finally, in reviewing consumer needs, use of the RET would help evaluate program practices which are relevant to consumer accessibility. These include available payment methods, time between initial contact and first appointment,

specialized services for minority populations, and treatment services. By assessing these areas, the RET would help increase the focus on the need for effective, accessible treatment.

Although the creation of an evaluative tool in this area is essential to possibly improving program practices, strategies need to be discussed to capitalize on the integration of this tool at the research, practice, and policy levels. An obvious answer to the question of implementation at the program level is to compensate program facilitators for their time and involvement in the assessment process. Although this study could not support that type of endeavor, possible funding is available through grants, subsidies, and other funding opportunities at the state and national level. Another important strategy to consider is the purposeful collaboration of researchers and practitioners. Efforts to communicate and share information at both ends of this spectrum must happen for a significant change in alcohol treatment practices to occur. In addition to this concept, it is also noteworthy to acknowledge the contribution of every individual in the alcohol treatment area, including researchers, practitioners, and policymakers, to the improvement of this field.

Conclusion

Overall, the assessment process offered by the RET has been successful. The development of the RET has taken feedback from five program facilitators to aid in an effective, usable measurement of program practices. The limitations of this study lie in the implementation of the evidence-based practice recommendations by the program facilitators. Apparently, practitioners need an evaluative tool to help them assess and amend treatment deficiencies in the areas of theoretical frameworks, mission, goals, and objectives, client recidivism and demographics. Correct use of the RET makes an important stride toward that aim by moving alcohol treatment research and theory into practice.

CHAPTER SIX

Conclusion

The purpose of this chapter is to provide recommendations for future research and present a proposal to re-examine the foundations of alcohol treatment practice at the state level. Possible improvements for this study and other similar studies in the future are also offered.

Prior to the outset of this project, questions were apparent about the effectiveness of alcohol treatment programs and the guiding principles underlying their development. These questions were developed from preliminary research in program assessment and alcohol treatment methods and after discussion with various community members and policymakers in the area of alcohol treatment services. After further inquiry into program design and implementation, the following initial pre-proposal questions surfaced:

1. How do alcohol treatment programs function?

2. Do alcohol treatment programs utilize evidence-based practices?

3. How do alcohol treatment programs measure program outcomes and effectiveness?

Those questions brought about this research proposal and dissertation to develop an evaluative tool to assess alcohol treatment programs against evidence-based practices, and to assess programs' effectiveness in terms of client recidivism.

Recommendations for Future Research

Interpretation of this study's results point to the need for evidence-based practice assessments at the individual program level. From this study, certain recommendations seem prudent. Future research should focus on assessing evidence-based practice implement in a

larger metropolitan community, or perhaps state-wide. A larger study with a more diverse population of treatment centers would offer a more global perspective of alcohol treatment program practices. Findings of the present study cannot be generalized because of the existing demographics and treatment population which is specific to this community. Without first conducting a large-scale investigation, it is impossible to generalize results pertaining to specific treatment outcomes to a general alcohol treatment population. However, some of the information from this study which pertains to programs' use of mission, goals, and objectives, as well as theoretical frameworks, may be correlated to other programs in other areas. Program planning and implementation information is not specific to the community demographics or study population; therefore, it is easier to translate this information to other alcohol treatment programs. A second recommendation is development of a plan for program facilitators to implement evidence-based practices and ensure continual program improvement. In order to promote the research-practitioner continuum and distribution of knowledge between practitioners and researchers, promotion in this area is needed. Implementation of evidence-based practices appears to be restricted by time and finances. Exploration of methods includes state guidelines requiring the implementation of evidence-based practices.

Re-Examining the Foundations of Alcohol Treatment Practice

Implementation of RET assessment at the state level is a larger continuation of this research project . Although state guidelines are based on evidence-base practices, the full implementation of these practices and success of individual treatment programs are often not measured. Practitioners need a succinct evaluation tool which assesses the fundamental principles of alcohol treatment.

Implementing statewide assessment using the RET presents additional benefits which traditional state assessments do not offer. Not only does use of the RET provide a practice recommendation summary, but use also offers suggestions for recommendation implementation specific to that program. The RET offers individualized attention and facilitates communication between program facilitators and policymakers. The use of the RET can also commence an initiative for alcohol treatment program recidivism tracking that has been unprecedented in typical treatment settings.

Possible Improvements

As previously reported, this research project would benefit from a larger number of participants in a more diverse setting. Implementation of the final revision of RET would also offer a more informative study, focusing not on the deficiencies of the instrument but on the strengths and weaknesses of the programs' themselves. Another area of possible improvement is the ability to access more quantitative data to supplement any findings from the RET, which appears to be lacking in the treatment facilities studied. Future studies may be more selective about possible treatment populations and may be able to account for this prior to participation.

Summary

In conclusion, utilization of the RET appears to offer an effective measurement of the use of evidence-based practices in alcohol treatment. Albeit, research should not end there. The implementation of evidence-based practices and overall program effectiveness should be the goal of researchers, policymakers, and practitioners alike. Stufflebeam (2000) noted the most difficult problem in program evaluation is not the evaluation process itself, but the

responsibility of others to continue a project in which you dedicated your time, energy, and ideals.

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APPENDIX A: Primary Care Interventions and Descriptions

Steps	Descriptions
"Assessment and direct feedback"	Includes the health care providers' assessment of alcohol use through different techniques (CAGE Questionnaire, patient questioning, etc.) and expression of concern for the problem drinking.
"Negotiation and goal setting"	The patient and provider come to an agreement regarding how to reduce alcohol consumption and appropriate goals.
"Behavioral modification techniques"	The provider addresses high risk situations where the target behavior may occur, how the patient can handle these situations, and possible support systems.
"Self-help-directed bibliotherapy"	The provider gives the patient appropriate brochures or information regarding alcohol use and behavioral modification techniques.
"Followup and reinforcement"	Follow-up appointments are established and may include telephone or other communication to reinforce positive behavior.

(Fleming & Baier Manwell, 1999, p. 129).

APPENDIX B: Twelve Traditions of Alcoholics Anonymous

Traditions of AA	Statement
1	“Our common welfare should come first; personal recovery depends upon A.A. unity.”
2	“For our group purpose there is but one ultimate authority — a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.”
3	“The only requirement for A.A. membership is a desire to stop drinking.”
4	“Each group should be autonomous except in matters affecting other groups or A.A. as a whole.”
5	“Each group has but one primary purpose to carry its message to the alcoholic who still suffers.”
6	“An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.”
7	“Every A.A. group ought to be fully self-supporting, declining outside contributions.”
8	“Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.”
9	“A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.”
10	“Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.”
11	“Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.”
12	“Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.”

(Alcoholics Anonymous, 1990, p. 53)

APPENDIX C: Twelve Steps of Alcoholics Anonymous

Steps	Definition
1	“We admitted we were powerless over alcohol — that our lives had become unmanageable.”
2	“Came to believe that a Power greater than ourselves could restore us to sanity.”
3	“Made a decision to turn our will and our lives over to the care of God as we understood Him.”
4	“Made a searching and fearless moral inventory of ourselves.”
5	“Admitted to God, to ourselves and to another human being the exact nature of our wrongs.”
6	“Were entirely ready to have God remove all these defects of character.”
7	“Humbly asked Him to remove our shortcomings.”
8	“Made a list of all persons we had harmed and became willing to make amends to them all.”
9	“Made direct amends to such people wherever possible, except when to do so would injure them or others.”
10	“Continued to take personal inventory and when we were wrong promptly admitted it.”
11	“Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.”
12	“Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.”

(Alcoholics Anonymous, 1990, p. 52)

APPENDIX D: The Robertello Evaluative Tool (RET) for Evidence-Based Practices in Alcohol Treatment

Purpose: The goal of this tool is to assess current alcohol treatment program practices, mission, goals, and objectives in the field of alcohol treatment studies. The focus of this assessment is on alcohol treatment programs that serve the 18-25 year old age group. Upon completion of this tool, the alcohol treatment program facilitator will receive Evidence-Based Practice (EBP) suggestions and recommendations that can be implemented in their existing alcohol treatment program.

Instructions: Since this tool is used to assess alcohol treatment program practices, mission, goals, and objectives, answer each question as it applies to the alcohol treatment program as a whole, not individually.

There are twelve (12) evidence-based principles presented in this evaluative tool. Each principle includes ideals, points of practice, and an assessment section. After reading each evidence-based principle and corresponding ideals, use the points of practice section to informally evaluate the alcohol treatment program which targets 18-25 year old clients. Then use the criteria listed in the assessment rubric to rate the program. You can also place any notes or recommendations in this section for future reference. The primary researcher will collect and evaluate the RET after it is completed and assess any other information available from the alcohol treatment program that is applicable to this assessment.

After a final interview and assessment by the primary researcher, the RET and any EBP recommendations generated will be returned to the alcohol treatment program facilitator for possible implementation.

EVIDENCE-BASED PRINCIPLE 1:
The theory or theories used in the program should be well-defined and validated (Stufflebeam, 2001). "Is the employed theory reflective of recent research?" (Stufflebeam, 2001, p. 37).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Use of the Social Cognitive Theory (SCT), Theory of Reasoned Action (TRA), Health Belief Model (HBM), combination, or other validated health behavior change theory.	▪ What are the main points of the theory basis for the alcohol treatment program? Cognitive aspects? Behavioral aspects? Reinforcement/motivation? Other? Notes: ▪ SCT is grounded in the concept of behavioral capability and reinforcement; a cognitive capacity to perform a behavior and self-efficacy; reinforcement is used – through self, others, or a positive result of the behavior change. ▪ TRA is based on behavioral intention, the individual's attitude toward behavior change, and subjective norms associated with the behavior. ▪ HBM states that change is promoted by one or more of the following: motivation, a perceived health threat, and the belief that change would decrease the perceived health threat; individuals need to overcome barriers to change and practice increasing self-efficacy.	Grade / Criteria 3=excellent: ▪ The program shows clear use of a validated health behavior change theory or combination of theories. 2=fair: ▪ The program shows partial use of a validated health behavior change theory. Incorporation of specific theory components is needed in order for proper assessment and vision for the program. 1=not acceptable: ▪ At this time the program does not use a validated health behavior change theory as a basis. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 2:
The program theory outcomes align with the overall outcomes of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The client's problem(s) are applicable to the theories being used. ▪ Program goals and theory goals align. ▪ There is no known interference between program or theory goals inherent in the community or socially.	▪ Are the client's problem(s) applicable to the theories being used? ▪ Do the program goals (PG) and theory goals (TG) match? PG = TG = ▪ Is there interference with the program or theory goals inherent in the community or in social norms? ▪ List any social norms that may be problematic: ▪ Is there community support for your program?	Grade / Criteria 3 — ▪ The clients problems are applicable to the theories being used ▪ Program goals and theories align ▪ There is community support for the program ▪ There is no known interference between program theory or goals and the community 2 — ▪ Clients problems may match the program theories being used or some changes could be made to better match the client's problems with a proper theoretical base ▪ Program goals and theories do not align but can be modified to match ▪ There is some community interference between the program and social norms or community expectations 1 — ▪ Clients problems do not match the program theories being used; program theories must change to meet the client's needs ▪ Program goals and theories do not align ▪ This program is meeting significant community interference; the program theories and goals need to be re-evaluated Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 3:
The program mission should be clearly stated and describe the intent of the program (McKenzie et al., 2005., p. 128).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Mission should clearly describe the intent of the program including who the program will affect and what the program will provide. ▪ Mission may include the program philosophy. ▪ Mission should be broad in nature.	Mission Statement: **Parts of the mission statement** Intent of program: Population served: How: Program Philosophy (if different):	Grade / Criteria 3=excellent: The mission statement is a broad account of who the program will affect and what the program will provide. 2=fair: The mission statement is should be re-worded to more accurately describe program participants and the effects of the program; or the mission statement is too specific in its wording. 1=not acceptable: The mission statement may have too narrow a focus and does not describe accurately the intent of the program Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 4:
Program goals should be operationally defined, consisting of measurable objectives. Goals and objectives should be written and referred to in times of program content and client guidance. Programs should be able to measure their objectives by using standardized criteria (McKenzie et al., 2005, pp. 129-133).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ A goal is defined as ". . . a broad timeless statement of a long-range program purpose" (Deeds, 1992, p. 36). ▪ An objective should include small steps that, if completed, will lead to completion of the program goals. ▪ Objectives include short term and long term outcomes.	List program goals: ▪ Goals can be written in incomplete sentences, but should include **who** will be affected and **what** will change as a result of the program. ▪ Goals should be global in nature. ▪ Goals should include all aspects or components of a program. List program objectives: Does each objective include: ▪ A measurable outcome? ▪ The conditions under which the outcome will be observed (or when the change will occur)? ▪ The criterion measurement of the outcome? ▪ The population? ▪ Is each objective realistic?	Grade / Criteria 3=excellent: ▪ All program goals are global and include who will be affected and what will change as a result of the program; all aspects of the program are represented by the program goals. ▪ All program objectives include measurable outcomes, conditions, criterion, and population and is realistic in the program setting. 2=fair: ▪ Some to all program goals are global and may or may not include who will be affected and what will change as a result of the program; some aspects of the program are not represented by the program goals. ▪ Program objectives may or may not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives may not be realistic in the program setting. 1=not acceptable: ▪ The program goals are not global; they do not include who will be affected and what will change as a result of the program; many aspects of the program are not represented by the program goals. ▪ The program objectives do not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives are not realistic in the program setting; objectives should be modified to better suit the clients and strengths of the program. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 5:

Treatment should be comprehensive, addressing all aspect of a client's life, and should combine a variety of services to increase effectiveness. Although detoxification is an important aspect of treatment, this process should be combined with other services. In addition, cognitive and behavioral therapies must be included in treatment (NIDA, 2000; Longabaugh & Morgenstern., 1999; Marlatt & Gordon, 1985; Larimer et al., 1999; Irwin et al., 1999).

IDEAL	POINTS OF PRACTICE	ASSESSMENT	
▪ Treatment should address all aspects of a client's life including relationships (family and social), work/employment, financial needs, health, and others. ▪ Treatment should include a variety of services including but not limited to the following: cognitive behavioral approach, TSFs, motivational therapies, individual therapy, group therapy, medications, etc. ▪ If detoxification is used it must be combined with other services. ▪ Cognitive and behavioral therapies must be included in treatment.	Does treatment include focus on the following aspects of the individual's life: ▪ family ▪ social ▪ work/employment ▪ financial ▪ health Which of the following treatment services are offered (circle all that applies)? ▪ cognitive behavioral ▪ twelve-step facilitation ▪ motivational therapies ▪ individual therapy ▪ group therapy ▪ medications ▪ detoxification	Grade	Criteria
		3=excellent	▪ Treatment addresses all aspects of the client's life. ▪ Treatment includes a variety of services and uses cognitive and behavioral therapies. ▪ Detoxification, if used, is combined with other services.
		2=fair	▪ Treatment needs to be modified to better address all aspects of the client's life. ▪ Treatment may or may not use a wide variety of services; cognitive and behavioral therapies is included in treatment. ▪ Detoxification, if used, is combined with other services.
		1=not acceptable	▪ Treatment does not addresses all aspects of a client's life. ▪ Treatment only uses one or two; treatment does not include cognitive and behavioral therapies. ▪ Detoxification, if used, is not combined with other services.
		Notes/Recommendations:	

EVIDENCE-BASED PRINCIPLE 6:
Treatment should be readily available; treatment is a long-term process and multiple episodes of treatment may be needed (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment is accessible; patients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment services are available if necessary.	▪ On average, how many hours/days after initial contact are patients seen for their first appointment (circle your response)? 1-4 hours 4-12 hours 12-24 hours 24-36 hours 36-48 hours Over 48 hours ▪ Which methods of payment do you currently accept (circle all that applies)? Medicaid/Medicare Private insurance State insurance Military insurance Self payment ▪ Are multiple treatment episodes available for returning clients?	See below

Grade	Criteria
3=excellent	▪ Treatment is accessible; clients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment episodes are available if necessary.
2=fair	▪ Treatment is accessible; over 75% of patients are scheduled between 24-48 hours following initial contact. ▪ State and government insurances are accepted for payment; some private insurance are also accepted. ▪ Multiple treatment episodes are available if necessary.
1=not acceptable	▪ Treatment is not accessible; fewer than 50% of clients are scheduled between 24-48 hours following initial contact. ▪ Self-payment and private insurance are the only forms of payment currently accepted. ▪ Multiple treatment episodes are not available unless through self-payment.

Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 7:
Treatment plans should be monitored and amended regularly. This includes aligning individual treatment plans with the overall mission, goals, and objectives of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment plans are amended regularly (weekly basis or less). ▪ Programs are amended to meet mission, goals, and objectives.	▪ Do you have a process currently in place that allows weekly reviews (or less) of treatment plans? Yes No ▪ Are treatment plans periodically reviewed to ensure they meet program missions, goals, and objectives specific to the individual? Yes No ▪ Is there a program review process? Yes No	

Grade	Criteria
3=excellent	▪ There is currently a formal process of treatment review and amendment that occurs weekly (or more often); and the process includes a review of program mission, goals, and objectives.
2=fair	▪ There is currently a formal process of treatment review and amendment that occurs once to twice a month; and the process may include a review of program mission, goals, and objectives.
1=not acceptable	▪ There is not currently a formal process of treatment review and amendment that occurs or it occurs less than once a month. ▪ The review process does not include a review of program mission, goals, or objectives.

Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 8:
Treatment (including brief interventions) should include multiple sessions and programs should encourage or require attendance. Involuntary treatment should also include motivational strategies to encourage attendance and participation (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ All treatments should include multiple sessions. ▪ Facilities should encourage attendance through motivational strategies.	▪ Do all treatment programs require multiple sessions (including brief interventions)? Yes No ▪ What strategies are used to increase or maintain attendance? ▪ What strategies are used to encourage participation during involuntary treatment?	Grade / Criteria 3=excellent: ▪ All treatment programs include multiple sessions; if brief interventions are used, multiple sessions are required. ▪ Attendance is encouraged through motivational strategies. ▪ Participation is encouraged for involuntary program participants. 2=fair: ▪ Treatment programs (including brief interventions) are flexible and may include multiple sessions. ▪ Attendance is encouraged through motivational strategies when it meets program goals. ▪ Participation may be encouraged for involuntary program participants. 1=not acceptable: ▪ Treatment programs do not include multiple sessions unless requested by the client. ▪ If brief interventions are used, only one session is required. ▪ Attendance is not encouraged through motivational strategies. ▪ Participation is recommended but not encouraged for involuntary program participants. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 9:
Treatment services and experiences should address resistance skills and experiences that are meaningful and reflective for the client in order to increase program effectiveness. Risk factors and protective factors for alcohol abuse and dependence should be addressed and managed (DOJ, OJJDP, 2002; SAMHSA, NCAP, 2000; Gerstein, 1984).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should be personalized to address individual risk and protective factors including scenarios, idea generating, and role-playing if appropriate.	How is each aspect of treatment addressed? ▪ Individual risk factors ▪ Individual protective factors	Grade / Criteria 3=excellent: ▪ Individual risk factors and individual protective factors are addressed with the use of demonstrating scenarios, idea generating, and role-playing, or other clinically approved methods. 2=fair: ▪ Individual risk factors and/or individual protective factors are addressed with the use of clinically approved methods. 1=not acceptable: ▪ Neither individual risk factors nor individual protective factors are addressed. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 10:

Recovering alcohols need to identify with other successful recovering alcoholics for physical and emotional support (Humphreys, 1999; [DOJ], Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2002; SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT	
▪ Treatment should include exposure to successful recovering alcoholics supervised by the program facilitator.	▪ Does the program include structured exposure to successfully recovering alcoholics? Yes No ▪ Is twelve-step facilitation (i.e. Alcoholics Anonymous) encouraged for voluntary participation? Yes No	Grade	Criteria
		3=excellent	▪ The program provides opportunity for structured interaction supervised by the program facilitator between program participants and successful recovering alcoholics. ▪ The program encourages outside twelve-step facilitation participation.
		2=fair	▪ When available, the program provides opportunity for interaction between program participants and successful recovering alcoholics; interaction may or may not be structured or supervised. ▪ The program does not encourage or discourage outside twelve-step facilitation participation.
		1=not acceptable	▪ The program does not provide opportunity for structured interaction between program participants and successful recovering alcoholics. ▪ The program does not encourage outside twelve-step facilitation participation.

Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 11:
Program practices should result in low client recidivism or decreased return-to-behavior (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Client recidivism rates should be below the national average for existing alcohol treatment programs.	▪ What methods are used to track client recidivism? ▪ How is client recidivism addressed by the program facilitator?	Please list current the program recidivism rate: Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 12:
The program should attempt to serve the specific needs of the community and any special population groups (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The program participant population matches the overall community demographics. ▪ The treatment program can be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.	▪ Does the program track the participant population? (If yes, list tracking variables.) Yes No ▪ Can the program be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.? Yes No List examples:	Program population estimates: age groups: under 18: 18-24: 24-36: 37-49: 50-65: 65 and over: gender: SES: race: **To be completed by program evaluator** Community estimates: Notes/Recommendations:

APPENDIX E: Idaho Human Assurances Committee Approval

Federalwide Assurance: FWA00005639
Federal Assigned IRB #: 00000843
UI Assigned Number: 07-045

MEMORANDUM

TO: Kimberly Robertello
1940 NW Arcadia Drive
Pullman, WA 99163

FROM: Steve Meier, Chair
Human Assurances Committee

DATE: June 13, 2007

SUBJECT: Approval of "The Development of an Evaluative Tool Which Assesses Evidence-Based Practices of Alcohol Treatment Programs in a Rural Community of the Inland Northwest"

On behalf of the Human Assurances Committee at the University of Idaho, I am pleased to inform you that the above-named proposal is approved as offering no significant risk to human subjects. This approval is valid for **one year** from the date of this memo. Should there be a significant change in your proposal, it will be necessary for you to resubmit it for review. Thank you for submitting your proposal to the Human Assurances Committee.

Steve E. Meier
SEM/ed

APPENDIX F: Human Participant Protection Education for Research Teams (NIH)

Completion Certificate

This is to certify that

KIMBERLY ROBERTELLO

has completed the **Human Participants Protection Education for Research Teams** online course, sponsored by the National Institutes of Health (NIH), on 02/01/2006.

This course included the following:

- key historical events and current issues that impact guidelines and legislation on human participant protection in research.
- ethical principles and guidelines that should assist in resolving the ethical issues inherent in the conduct of research with human participants.
- the use of key ethical principles and federal regulations to protect human participants at various stages in the research process.
- a description of guidelines for the protection of special populations in research.
- a definition of informed consent and components necessary for a valid consent.
- a description of the role of the IRB in the research process.
- the roles, responsibilities, and interactions of federal agencies, institutions, and researchers in conducting research with human participants.

National Institutes of Health
http://www.nih.gov

APPENDIX G: Interview Questions for the Pilot Study

General Questions

1. How familiar were you with evidence-based practice literature in alcohol treatment studies before participating in this study?
2. How would you evaluate the accuracy of the Robertello Evaluation Tool (RET) to assess your alcohol treatment programs' (ATP's) implementation of evidence-based practices?
3. How would you rate the overall ease of use of the RET?
4. What things in the RET were difficult to answer or account for?

Questions based on the Evidence-Based Principles

Principle 1

1. How many of the theories mentioned in Principle 1 (SCT, TRA, or HBM) do you use? (Please list.) Which other theories do you use?
2. If you use a combination of several theories, how have you been assessing their implementation in the practice of alcohol treatment?

Principle 2

3. How difficult is it to match client problems with validated behavior change theories?
4. If applicable, how do you address any community resistance to alcohol treatment program or theory goals?

Principle 3

5. If the program has both a mission and philosophy statement, how does each one function in terms of the overall plan of the alcohol treatment program?

Principle 4

6. How do ATPs use goals and objectives to measure client outcomes?
7. How would you evaluate the RET to facilitate an accurate assessment of the ATP's goals and objectives?

Principle 5

8. Which aspects of a client's life (family, social, work/employment, financial, or health) does the ATP focus on primarily? Which areas need an increased focus (if any)?
9. Of the following list of treatment services (cognitive behavioral, twelve-step facilitation, motivational therapies, individual therapy, group therapy, medication, or detoxification), which treatment service(s) does the ATP focus? Which treatment services are not offered by the ATP? What is the rationale behind this decision?

Principle 6

10. How does your facility document treatment access (the time it takes between a client's first contact with the facility and attending a session/appointment)?
11. Does the facility have any difficulty with certain forms of payment?

Principle 7

12. If applicable, describe the process for review/amendment of client treatment plans.
13. If applicable, describe the program review process.
14. What documentation supports these processes?

Principle 8

15. If multiple sessions are not used consistently, provide the rationale for this.

16. What differences in the motivational strategies are there between voluntary and involuntary clients (if any)?

Principle 9

17. How do you personalize the ATP for the client?

Principle 10

18. If applicable, how is time with other recovering alcoholics structured during the ATP?
19. If applicable, how is twelve-step facilitation used in this ATP?

Principle 11

20. How does your ATP measure recidivism?
21. How do you collect the recidivism data?

Principle 12

22. What special needs do you focus on with this sub-population (18-25 year-olds)?
23. If applicable, how can this ATP be specialized to meet other minority or special group needs?

APPENDIX H: Consent Form

The Development of an Evaluative Tool Which Assess Evidence-Based Practices of Alcohol Treatment Programs in a Rural Community of the Inland Northwest
Primary Researcher: Kimberly Robertello

The University of Idaho Human Assurance Committee has approved this project.

My name is Kimberly Robertello and I am currently conducting research in alcohol treatment services for my doctoral dissertation at the University of Idaho. This study will assess alcohol treatment services available to the Inland Northwest and the nature of these services. Data for this research will be obtained through audiotape interview. Each subject will be asked to participate in no more than two interviews lasting approximately 30-60 minutes. Transcriptions of audio interviews will be kept in a secure location and confidentiality will be maintained throughout the research process. The research process will begin in May 2007 and continue through November 2007.

By signing this consent form, you agree to be interviewed by Kimberly Robertello, the primary researcher. The researcher will not attempt to interview alcohol treatment program participants at any time. Participation is not mandatory, and you can withdrawal from participation in this study at any time with no repercussions. Participation in this research project will not yield any financial benefits. At the completion of this study, participants will have access to any conclusions made by the study, which could benefit alcohol treatment programs by providing alcohol treatment program facilitators evidence-based practice guidelines and suggestions for implementation. Participation in this study and information obtained in the interview process will remain confidential and will not be used to alter funding or other benefits to any alcohol treatment programs. Any new information developed during the course of the research which may relate to your willingness to participate or continue participation in the project will be provided to you as soon as it is available. If you chose to withdrawal from the research project at any time, please contact the primary researcher or faculty sponsor listed below to verify your termination of participation in the project. The participants have no personal risk by participating in this study. The participant can request transcripts of their interview for review during the course of the research project or a compilation of data at the culmination of the research project by contacting the primary researcher. The participant will receive a compilation of proposed evidence-based practice recommendations suitable for implementation in their alcohol treatment program at the conclusion of this study.

I, _____, consent to the interview process for research regarding alcohol treatment services in the Inland Northwest. I understand my rights as a participant and they have been explained to me prior to participation. I may receive a copy of this consent form upon request. Questions regarding the research or interview process should be directed to Kimberly Robertello.

Participant's Signature _____ Date _____

Researcher's Signature _____ Date _____

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APPENDIX I: Pilot Study Practice Recommendations Summary

Pilot Study

Overall Score: 22/30
30=excellent
20=fair
10=not acceptable

Understanding the RET Assessment:
The assessment consists of two areas: a Practice Recommendation Summary (PRS) and a detailed assessment of the each of the twelve principles presented in the RET.

Practice Recommendations Summary:

- Revise the mission statement for the program so it reflects the global nature of the program and the philosophy of the services offered.

- Define program goals that are overarching for the treatment population.

- Objectives for the treatment population can be written to address specific areas of Counseling, Assessment, and Prevention.

  Currently, objectives are client-specific and tend to be action/behavioral in nature. This alcohol treatment program would benefit from developing objectives that are overarching for the treatment population that can serve as a "pathway" for treatment. Process/administrative and outcome/program objectives can be used by program facilitators to guide the direction of the program. Learning and action/behavioral objectives can be used by the client during the treatment process. Environmental objectives can be used to address the nonbehavioral causes of a health problem (ex. alcohol abuse) that are present socially, physically, and/or psychologically. Objectives should also be measurable in order to accurately assessment program impact. See the table below for suggestions for implementation of different types of objectives:

TYPE OF OBJECTIVE	**EXAMPLES OF PROGRAM OUTCOMES**
Process/administrative objective	Number of sessions held
Learning objective	Change in awareness about alcohol use
Action/behavioral objective	Alcohol consumption decreased or eliminated
Environmental objective	Change in the environment
Program objective	Decrease in risk factor for alcohol use/abuse

- Increase the social network available for recovering addicts.

  The use of Alcoholics Anonymous/Narcotics Anonymous, the Recovery House, and one other recovery group were mentioned as ways for addicts to interact with other addicts. This population has a great potential to interact successfully with other recovering addicts in a

structured environment that can be facilitated by your support staff (i.e. Graduate students). Use this resource to supplement your program and continue to meet the needs of this population of young adults.

- Use your available resources (computer-based files) to track client recidivism.

  This data is invaluable to effectively evaluate and assess the alcohol treatment program's success. With the type of population you serve, the data can also be used potentially for longitudinal study research. Most alcohol treatment research available tracks clients for twelve months post-treatment. You have access to this population for much longer time periods which gives you the potential for significant research findings.

EVIDENCE-BASED PRINCIPLE 1:
The theory or theories used in the program should be well-defined and validated (Stufflebeam, 2001). "Is the employed theory reflective of recent research?" (Stufflebeam, 2001, p. 37).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Use of the Social Cognitive Theory (SCT), Theory of Reasoned Action (TRA), Health Belief Model (HBM), combination, or other validated health behavior change theory.	▪ What are the main points of the theory basis for the alcohol treatment program? Cognitive aspects? Behavioral aspects? Reinforcement/motivation? Other? Notes: ▪ SCT is grounded in the concept of behavioral capability and reinforcement; a cognitive capacity to perform a behavior and self-efficacy; reinforcement is used – through self, others, or a positive result of the behavior change. ▪ TRA is based on behavioral intention, the individual's attitude toward behavior change, and subjective norms associated with the behavior. ▪ HBM states that change is promoted by one or more of the following: motivation, a perceived health threat, and the belief that change would decrease the perceived health threat; individuals need to overcome barriers to change and practice increasing self-efficacy.	<table><tr><td>Grade</td><td>Criteria</td></tr><tr><td>3=excellent</td><td>▪ The program shows clear use of a validated health behavior change theory or combination of theories.</td></tr><tr><td>2=fair</td><td>▪ The program shows partial use of a validated health behavior change theory. Incorporation of specific theory components is needed in order for proper assessment and vision for the program.</td></tr><tr><td>1=not acceptable</td><td>▪ At this time the program does not use a validated health behavior change theory as a basis.</td></tr></table> Notes/Recommendations: GRADE=3 There is clearly a sound theoretical basis for the program, but the theoretical framework is not identified in any of the program literature. I would suggest adding this to the mission statement or program goals.

EVIDENCE-BASED PRINCIPLE 2:
The program theory outcomes align with the overall outcomes of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The client's problem(s) are applicable to the theories being used. ▪ Program goals and theory goals align. ▪ There is no known interference between program or theory goals inherent in the community or socially.	▪ Are the client's problem(s) applicable to the theories being used? ▪ Do the program goals (PG) and theory goals (TG) match? PG = TG = ▪ Is there interference with the program or theory goals inherent in the community or in social norms? ▪ List any social norms that may be problematic: ▪ Is there community support for your program?	Grade / Criteria 3=excellent: ▪ The clients problems are applicable to the theories being used ▪ Program goals and theories align ▪ There is community support for the program ▪ There is no known interference between program theory or goals and the community 2=fair: ▪ Clients problems may match the program theories being used or some changes could be made to better match the client's problems with a proper theoretical base ▪ Program goals and theories do not align but can be modified to match ▪ There is some community interference between the program and social norms or community expectations 1=not acceptable: ▪ Clients problems do not match the program theories being used; program theories must change to meet the client's needs ▪ Program goals and theories do not align ▪ This program is meeting significant community interference; the program theories and goals need to be re-evaluated Notes/Recommendations: GRADE=2 It is evident that you understand the need for program theory as is relates to practice, although there is no evidence of program theory goals or objectives that serve as a "pathway" through treatment. Some of the content you have in place can serve as your program goals, and it does follow aspects of the SCT and stages of change. Overall, the program would run more smoothly if these aspects were defined for all program facilitators. Also, see the Recommendation Summary.

EVIDENCE-BASED PRINCIPLE 3:
The program mission should be clearly stated and describe the intent of the program (McKenzie et al., 2005., p. 128).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Mission should clearly describe the intent of the program including who the program will affect and what the program will provide. ▪ Mission may include the program philosophy. ▪ Mission should be broad in nature.	Mission Statement: **Parts of the mission statement** Intent of program: Population served: How: Program Philosophy (if different):	Grade / Criteria 3=excellent: The mission statement is a broad account of who the program will affect and what the program will provide. 2=fair: The mission statement is should be re-worded to more accurately describe program participants and the effects of the program; or the mission statement is too specific in its wording. 1=not acceptable: The mission statement may have too narrow a focus and does not describe accurately the intent of the program. Notes/Recommendations: GRADE=2 The mission statement should be revised to reflect the global nature of the program as it relates to the theories that currently guide your practice. See the Recommendation Summary for suggestions for the program mission statement. Also, use the ADCAPS website and the mission statement to relay information to potential clients about the nature of the program.

EVIDENCE-BASED PRINCIPLE 4:
Program goals should be operationally defined, consisting of measurable objectives. Goals and objectives should be written and referred to in times of program content and client guidance. Programs should be able to measure their objectives by using standardized criteria (McKenzie et al., 2005, pp. 129-133).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ A goal is defined as ". . . a broad timeless statement of a long-range program purpose" (Deeds, 1992, p. 36). ▪ An objective should include small steps that, if completed, will lead to completion of the program goals. ▪ Objectives include short term and long term outcomes.	List program goals: ▪ Goals can be written in incomplete sentences, but should include **who** will be affected and **what** will change as a result of the program. ▪ Goals should be global in nature. ▪ Goals should include all aspects or components of a program. List program objectives: Does each objective include: ▪ A measurable outcome? ▪ The conditions under which the outcome will be observed (or when the change will occur)? ▪ The criterion measurement of the outcome? ▪ The population? ▪ Is each objective realistic?	See table below

Grade	Criteria
3=excellent	▪ All program goals are global and include who will be affected and what will change as a result of the program; all aspects of the program are represented by the program goals. ▪ All program objectives include measurable outcomes, conditions, criterion, and population and is realistic in the program setting.
2=fair	▪ Some to all program goals are global and may or may not include who will be affected and what will change as a result of the program; some aspects of the program are not represented by the program goals. ▪ Program objectives may or may not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives may not be realistic in the program setting.
1=not acceptable	▪ The program goals are not global; they do not include who will be affected and what will change as a result of the program; many aspects of the program are not represented by the program goals. ▪ The program objectives do not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives are not realistic in the program setting; objectives should be modified to better suit the clients and strengths of the program.

Notes/Recommendations: GRADE=1
Currently there are no program goals or objectives, only objectives specific to the client as an individual. Continue to use client-specific goals and objectives to track individual treatment, but over-arching program goals and objectives should be added to guide the alcohol treatment program. See the Recommendation Summary for suggestions for goals and objectives categories.

EVIDENCE-BASED PRINCIPLE 5:

Treatment should be comprehensive, addressing all aspect of a client's life, and should combine a variety of services to increase effectiveness. Although detoxification is an important aspect of treatment, this process should be combined with other services. In addition, cognitive and behavioral therapies must be included in treatment (NIDA, 2000; Longabaugh & Morgenstern., 1999; Marlatt & Gordon, 1985; Larimer et al., 1999; Irwin et al., 1999).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should address all aspects of a client's life including relationships (family and social), work/employment, financial needs, health, and others. ▪ Treatment should include a variety of services including but not limited to the following: cognitive behavioral approach, TSFs, motivational therapies, individual therapy, group therapy, medications, etc. ▪ If detoxification is used it must be combined with other services. ▪ Cognitive and behavioral therapies must be included in treatment.	Does treatment include focus on the following aspects of the individual's life: ▪ family ▪ social ▪ work/employment ▪ financial ▪ health Which of the following treatment services are offered (circle all that applies)? ▪ cognitive behavioral ▪ twelve-step facilitation ▪ motivational therapies ▪ individual therapy ▪ group therapy ▪ medications ▪ detoxification	Grade / Criteria 3=excellent: ▪ Treatment addresses all aspects of the client's life. ▪ Treatment includes a variety of services and uses cognitive and behavioral therapies. ▪ Detoxification, if used, is combined with other services. 2=fair: ▪ Treatment needs to be modified to better address all aspects of the client's life. ▪ Treatment may or may not use a wide variety of services; cognitive and behavioral therapies is included in treatment. ▪ Detoxification, if used, is combined with other services. 1=not acceptable: ▪ Treatment does not addresses all aspects of a client's life. ▪ Treatment only uses one or two; treatment does not include cognitive and behavioral therapies. ▪ Detoxification, if used, is not combined with other services. Notes/Recommendations: GRADE=3 The treatment services available to clients are excellent. All aspects of the client's life are addressed in the treatment process.

EVIDENCE-BASED PRINCIPLE 6:
Treatment should be readily available; treatment is a long-term process and multiple episodes of treatment may be needed (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment is accessible; patients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment services are available if necessary.	▪ On average, how many hours/days after initial contact are patients seen for their first appointment (circle your response)? 1-4 hours 4-12 hours 12-24 hours 24-36 hours 36-48 hours Over 48 hours ▪ Which methods of payment do you currently accept (circle all that applies)? Medicaid/Medicare Private insurance State insurance Military insurance Self payment ▪ Are multiple treatment episodes available for returning clients?	See assessment table below

Grade	Criteria
3=excellent	▪ Treatment is accessible; clients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment episodes are available if necessary.
2=fair	▪ Treatment is accessible; over 75% of patients are scheduled between 24-48 hours following initial contact. ▪ State and government insurances are accepted for payment; some private insurance are also accepted. ▪ Multiple treatment episodes are available if necessary.
1=not acceptable	▪ Treatment is not accessible; fewer than 50% of clients are scheduled between 24-48 hours following initial contact. ▪ Self-payment and private insurance are the only forms of payment currently accepted. ▪ Multiple treatment episodes are not available unless through self-payment.

Notes/Recommendations: GRADE=2
Continue to track client scheduling and work to improve time-after-initial-contact for appointments. Your screening methods seem to be working for high-risk clients at this time. There are no issues with payment or multiple treatment sessions. Continue to ensure the population is aware of the availability of treatment services offered through appropriate advertising and awareness campaigns.

EVIDENCE-BASED PRINCIPLE 7:
Treatment plans should be monitored and amended regularly. This includes aligning individual treatment plans with the overall mission, goals, and objectives of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment plans are amended regularly (weekly basis or less). ▪ Programs are amended to meet mission, goals, and objectives.	▪ Do you have a process currently in place that allows weekly reviews (or less) of treatment plans? Yes No ▪ Are treatment plans periodically reviewed to ensure they meet program missions, goals, and objectives specific to the individual? Yes No ▪ Is there a program review process? Yes No	See below

Grade	Criteria
3=excellent	▪ There is currently a formal process of treatment review and amendment that occurs weekly (or more often); and the process includes a review of program mission, goals, and objectives.
2=fair	▪ There is currently a formal process of treatment review and amendment that occurs once to twice a month; and the process may include a review of program mission, goals, and objectives.
1=not acceptable	▪ There is not currently a formal process of treatment review and amendment that occurs or it occurs less than once a month. ▪ The review process does not include a review of program mission, goals, or objectives.

Notes/Recommendations: GRADE=1
Although client goals/objectives are reviewed at each treatment session, the review is not formal and objectives are not directly measured (except by self-report). Treatment plans should follow a formal review process and the overall treatment program should be reviewed for compliance with program mission, goals, and objectives on a regular basis.

EVIDENCE-BASED PRINCIPLE 8:

Treatment (including brief interventions) should include multiple sessions and programs should encourage or require attendance. Involuntary treatment should also include motivational strategies to encourage attendance and participation (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ All treatments should include multiple sessions. ▪ Facilities should encourage attendance through motivational strategies.	▪ Do all treatment programs require multiple sessions (including brief interventions)? Yes No ▪ What strategies are used to increase or maintain attendance? ▪ What strategies are used to encourage participation during involuntary treatment?	See nested table below

Grade	Criteria
3=excellent	▪ All treatment programs include multiple sessions; if brief interventions are used, multiple sessions are required. ▪ Attendance is encouraged through motivational strategies. ▪ Participation is encouraged for involuntary program participants.
2=fair	▪ Treatment programs (including brief interventions) are flexible and may include multiple sessions. ▪ Attendance is encouraged through motivational strategies when it meets program goals. ▪ Participation may be encouraged for involuntary program participants.
1=not acceptable	▪ Treatment programs do not include multiple sessions unless requested by the client. ▪ If brief interventions are used, only one session is required. ▪ Attendance is not encouraged through motivational strategies. ▪ Participation is recommended but not encouraged for involuntary program participants.

Notes/Recommendations: GRADE = 3 This program uses appropriate strategies to encourage attendance including motivational interviewing, rapport building, and behavioral contracts. Brief interventions are used in the prevention aspect of the program which was not reviewed in this process. Involuntary participation is not applicable for this program.

EVIDENCE-BASED PRINCIPLE 9:

Treatment services and experiences should address resistance skills and experiences that are meaningful and reflective for the client in order to increase program effectiveness. Risk factors and protective factors for alcohol abuse and dependence should be addressed and managed (DOJ, OJJDP, 2002; SAMHSA, NCAP, 2000; Gerstein, 1984).

<table>
<tr><th>IDEAL</th><th>POINTS OF PRACTICE</th><th>ASSESSMENT</th></tr>
<tr>
<td>▪ Treatment should be personalized to address individual risk and protective factors including scenarios, idea generating, and role-playing if appropriate.</td>
<td>How is each aspect of treatment addressed?
▪ Individual risk factors

▪ Individual protective factors</td>
<td>
<table>
<tr><th>Grade</th><th>Criteria</th></tr>
<tr><td>3=excellent</td><td>▪ Individual risk factors and individual protective factors are addressed with the use of demonstrating scenarios, idea generating, and role-playing, or other clinically approved methods.</td></tr>
<tr><td>2=fair</td><td>▪ Individual risk factors and/or individual protective factors are addressed with the use of clinically approved methods.</td></tr>
<tr><td>1=not acceptable</td><td>▪ Neither individual risk factors nor individual protective factors are addressed.</td></tr>
</table>
Notes/Recommendations: GRADE=3
Strategies to increase protective factors and decrease risk factors can also be added to program objectives and client objectives. The focus should be on personalizing these for the client. In our discussion, it seemed like the focus was on the different strategies used to decrease risk factors and increase protective factors, not on the actual outcome.
</td>
</tr>
</table>

EVIDENCE-BASED PRINCIPLE 10:
Recovering alcohols need to identify with other successful recovering alcoholics for physical and emotional support (Humphreys, 1999; [DOJ], Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2002; SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should include exposure to successful recovering alcoholics supervised by the program facilitator.	▪ Does the program include structured exposure to successfully recovering alcoholics? Yes No ▪ Is twelve-step facilitation (i.e. Alcoholics Anonymous) encouraged for voluntary participation? Yes No	Grade / Criteria 3=excellent: ▪ The program provides opportunity for structured interaction supervised by the program facilitator between program participants and successful recovering alcoholics. ▪ The program encourages outside twelve-step facilitation participation. 2=fair: ▪ When available, the program provides opportunity for interaction between program participants and successful recovering alcoholics; interaction may or may not be structured or supervised. ▪ The program does not encourage or discourage outside twelve-step facilitation participation. 1=not acceptable: ▪ The program does not provide opportunity for structured interaction between program participants and successful recovering alcoholics. ▪ The program does not encourage outside twelve-step facilitation participation. Notes/Recommendations: GRADE=2 Supplement current programs as listed in the Recommendations Summary. The program facilitator mentioned three structured groups currently available (Recovery House, AA/NA, and one other group).

EVIDENCE-BASED PRINCIPLE 11:
Program practices should result in low client recidivism or decreased return-to-behavior (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Client recidivism rates should be below the national average for existing alcohol treatment programs.	▪ What methods are used to track client recidivism? ▪ How is client recidivism addressed by the program facilitator?	Please list current the program recidivism rate: Notes/Recommendations: Recidivism is not being currently tracked by this program. The opportunity to track client recidivism with this population and resources (file management program) is in place. Client recidivism can also serve as an assessment of program effectiveness in measuring program goals and objectives. See other notes in the Recommendations Summary.

EVIDENCE-BASED PRINCIPLE 12:
The program should attempt to serve the specific needs of the community and any special population groups (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The program participant population matches the overall community demographics. ▪ The treatment program can be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.	▪ Does the program track the participant population? (If yes, list tracking variables.) Yes No ▪ Can the program be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.? Yes No List examples:	Program population estimates: age groups: under 18: 18-24: 24-36: 37-49: 50-65: 65 and over: gender: SES: race: **To be completed by program evaluator** Community estimates: This program serves the 18 to 24 year old population and a few members outside that age group. Notes/Recommendations: The program facilitator is aware of client needs and special group circumstances and appropriate training (multicultural competencies) are in place. The program may consider adding group meetings based on specific populations (i.e. gender, race, SES, sexuality).

APPENDIX J: The Revised Robertello Evaluative Tool (RET) for Evidence-Based Practices in Alcohol Treatment

Purpose: The goal of this tool is to assess current alcohol treatment program practices, mission, goals, and objectives in the field of alcohol treatment studies. The focus of this assessment is on alcohol treatment programs that serve the 18-25 year old age group. Upon completion of this tool, the alcohol treatment program facilitator will receive Evidence-Based Practice (EBP) suggestions and recommendations that can be implemented in their existing alcohol treatment program.

Instructions: Since this tool is used to assess alcohol treatment program practices, mission, goals, and objectives, answer each question as it applies to the alcohol treatment program as a whole, not individually.
There are twelve (12) evidence-based principles presented in this evaluative tool. Each principle includes ideals, points of practice, and an assessment section. After reading each evidence-based principle and corresponding ideals, use the points of practice section to informally evaluate the alcohol treatment program (which targets 18-25 year old clients). Then use the criteria listed in the assessment rubric to rate the program. You can also place any notes or recommendations in this section for future reference. The primary researcher will collect and evaluate the RET and assess any other information available from the alcohol treatment program that is applicable to this assessment.
After a final interview and assessment by the primary researcher, the RET and any EBP recommendations generated will be returned to the alcohol treatment program facilitator for possible implementation.

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EVIDENCE-BASED PRINCIPLE 1:

The theory or theories used in the program should be well-defined and validated (Stufflebeam, 2001). "Is the employed theory reflective of recent research?" (Stufflebeam, 2001, p. 37).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Use of the Social Cognitive Theory (SCT), Theory of Reasoned Action (TRA), Health Belief Model (HBM), combination, or other validated health behavior change theory.	▪ What are the main points of the theory basis for the alcohol treatment program? Cognitive aspects? Behavioral aspects? Reinforcement/motivation? Other? Which theory most closely aligns with the alcohol treatment program (circle your response)? SCT TRA HBM combination other (please list) _____ Notes: ▪ SCT is grounded in the concept of behavioral capability and reinforcement; a cognitive capacity to perform a behavior and self-efficacy; reinforcement is used – through self, others, or a positive result of the behavior change. ▪ TRA is based on behavioral intention, the individual's attitude toward behavior change, and subjective norms associated with the behavior. ▪ HBM states that change is promoted by one or more of the following: motivation, a perceived health threat, and the belief that change would decrease the perceived health threat; individuals need to overcome barriers to change and practice increasing self-efficacy.	Grade / Criteria 3=excellent: ▪ The program shows clear use of a validated health behavior change theory or combination of theories. 2=fair: ▪ The program shows partial use of a validated health behavior change theory. Incorporation of specific theory components is needed in order for proper assessment and vision for the program. 1=not acceptable: ▪ At this time the program does not use a validated health behavior change theory as a basis. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 2:
The program theory outcomes align with the overall outcomes of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The client's problem(s) are applicable to the theories being used. ▪ Program goals and theory goals align. ▪ There is no known interference between program or theory goals inherent in the community or socially.	Program goals: Specific goals that apply to each alcohol treatment program that guide its direction and treatment focus. Theory goals: Specific goals of a health behavior change theory that involve motivation, reinforcement, intention, or other areas that must be addressed to successfully employ the program. ▪ Are the client's problem(s) applicable to the theories being used? ▪ Do the program goals (PG) and theory goals (TG) match? PG = TG = ▪ Is there interference with the program or theory goals inherent in the community or in social norms? ▪ List any social norms that may be problematic: ▪ Is there community support for your program?	Grade / Criteria 3: ▪ The clients problems are applicable to the theories being used ▪ Program goals and theories align ▪ There is community support for the program ▪ There is no known interference between program theory or goals and the community 2: ▪ Clients problems may match the program theories being used or some changes could be made to better match the client's problems with a proper theoretical base ▪ Program goals and theories do not align but can be modified to match ▪ There is some community interference between the program and social norms or community expectations 1: ▪ Clients problems do not match the program theories being used; program theories must change to meet the client's needs ▪ Program goals and theories do not align ▪ This program is meeting significant community interference; the program theories and goals need to be re-evaluated Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 3:
The program mission should be clearly stated and describe the intent of the program (McKenzie et al., 2005., p. 128).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Mission should clearly describe the intent of the program including who the program will affect and what the program will provide. ▪ Mission may include the program philosophy. ▪ Mission should be broad in nature.	**Parts of the mission statement** Intent of program: Population served: How: Program Philosophy (if different): Mission Statement:	Grade / Criteria 3=excellent: The mission statement is a broad account of who the program will affect and what the program will provide. 2=fair: The mission statement is should be re-worded to more accurately describe program participants and the effects of the program; or the mission statement is too specific in its wording. 1=not acceptable: The mission statement may have too narrow a focus and does not describe accurately the intent of the program Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 4:
Program goals should be operationally defined, consisting of measurable objectives. Goals and objectives should be written and referred to in times of program content and client guidance. Programs should be able to measure their objectives by using standardized criteria (McKenzie et al., 2005, pp. 129-133).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ A goal is defined as ". . . a broad timeless statement of a long-range program purpose" (Deeds, 1992, p. 36). ▪ An objective should include small steps that, if completed, will lead to completion of the program goals. ▪ Objectives include short term and long term outcomes.	List program goals: ▪ Goals can be written in incomplete sentences, but should include **who** will be affected and **what** will change as a result of the program. ▪ Goals should be global in nature. ▪ Goals should include all aspects or components of a program. List program objectives: Does each objective include: ▪ A measurable outcome? ▪ The conditions under which the outcome will be observed (or when the change will occur)? ▪ The criterion measurement of the outcome? ▪ The population? ▪ Is each objective realistic?	Grade / Criteria 3=excellent: ▪ All program goals are global and include who will be affected and what will change as a result of the program; all aspects of the program are represented by the program goals. ▪ All program objectives include measurable outcomes, conditions, criterion, and population and is realistic in the program setting. 2=fair: ▪ Some to all program goals are global and may or may not include who will be affected and what will change as a result of the program; some aspects of the program are not represented by the program goals. ▪ Program objectives may or may not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives may not be realistic in the program setting. 1=not acceptable: ▪ The program goals are not global; they do not include who will be affected and what will change as a result of the program; many aspects of the program are not represented by the program goals. ▪ The program objectives do not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives are not realistic in the program setting; objectives should be modified to better suit the clients and strengths of the program. ▪ No program goals or objectives. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 5:

Treatment should be comprehensive, addressing all aspect of a client's life, and should combine a variety of services to increase effectiveness. Although detoxification is an important aspect of treatment, this process should be combined with other services. In addition, cognitive and behavioral therapies must be included in treatment (NIDA, 1999; Longabaugh et al., 1999; Marlatt & Gordon, 1985; Larimer et al., 1999; Irwin et al., 1999).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should address all aspects of a client's life including relationships (family and social), work/employment, financial needs, health, and others. ▪ Treatment should include a variety of services including but not limited to the following: cognitive behavioral approach, TSFs, motivational therapies, individual therapy, group therapy, medications, etc. ▪ If detoxification is used it must be combined with other services. ▪ Cognitive and behavioral therapies must be included in treatment.	Does treatment include focus on the following aspects of the individual's life: ▪ family ▪ social ▪ work/employment ▪ financial ▪ health Which of the following treatment services are offered (circle all that applies)? ▪ cognitive behavioral ▪ twelve-step facilitation ▪ motivational therapies ▪ individual therapy ▪ group therapy ▪ medications ▪ detoxification	Grade / Criteria 3=excellent: ▪ Treatment addresses all aspects of the client's life. ▪ Treatment includes a variety of services and uses cognitive and behavioral therapies. ▪ Detoxification, if used, is combined with other services. 2=fair: ▪ Treatment needs to be modified to better address all aspects of the client's life. ▪ Treatment may or may not use a wide variety of services; cognitive and behavioral therapies is included in treatment. ▪ Detoxification, if used, is combined with other services. 1=not acceptable: ▪ Treatment does not addresses all aspects of a client's life. ▪ Treatment only uses one or two; treatment does not include cognitive and behavioral therapies. ▪ Detoxification, if used, is not combined with other services. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 6:
Treatment should be readily available; treatment is a long-term process and multiple episodes of treatment may be needed (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment is accessible; patients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment services are available if necessary.	▪ On average, how many hours/days after initial contact are patients seen for their first appointment (circle your response)? 1-4 hours 4-12 hours 12-24 hours 24-36 hours 36-48 hours Over 48 hours ▪ Which methods of payment do you currently accept (circle all that applies)? Medicaid/Medicare Private insurance State insurance Military insurance Self payment Other ▪ Are multiple treatment episodes available for returning clients?	See assessment table below

Grade	Criteria
3=excellent	▪ Treatment is accessible; clients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment episodes are available if necessary.
2=fair	▪ Treatment is accessible; over 75% of patients are scheduled between 24-48 hours following initial contact. ▪ State and government insurances are accepted for payment; some private insurance are also accepted. ▪ Multiple treatment episodes are available if necessary.
1=not acceptable	▪ Treatment is not accessible; fewer than 50% of clients are scheduled between 24-48 hours following initial contact. ▪ Self-payment and private insurance are the only forms of payment currently accepted. ▪ Multiple treatment episodes are not available unless through self-payment.

Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 7:
Treatment plans should be monitored and amended regularly. This includes aligning individual treatment plans with the overall mission, goals, and objectives of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment plans are amended regularly (weekly basis or less). ▪ Programs are amended to meet mission, goals, and objectives.	▪ Do you have a process currently in place that allows weekly reviews (or less) of treatment plans? Yes No ▪ Are treatment plans periodically reviewed to ensure they meet program missions, goals, and objectives specific to the individual? Yes No ▪ Is there a program review process? Yes No	See nested table below

Grade	Criteria
3=excellent	▪ There is currently a formal process of treatment review and amendment that occurs weekly (or more often); and the process includes a review of program mission, goals, and objectives.
2=fair	▪ There is currently a formal process of treatment review and amendment that occurs once to twice a month; and the process may include a review of program mission, goals, and objectives.
1=not acceptable	▪ There is not currently a formal process of treatment review and amendment that occurs or it occurs less than once a month. ▪ The review process does not include a review of program mission, goals, or objectives.

Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 8:
Treatment (including brief interventions) should include multiple sessions and programs should encourage or require attendance. Involuntary treatment should also include motivational strategies to encourage attendance and participation (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ All treatments should include multiple sessions. ▪ Facilities should encourage attendance through motivational strategies.	▪ Do all treatment programs require multiple sessions (including brief interventions)? Yes No ▪ What strategies are used to increase or maintain attendance? ▪ What strategies are used to encourage participation during involuntary treatment?	See below

Grade	Criteria
3=excellent	▪ All treatment programs include multiple sessions; if brief interventions are used, multiple sessions are required. ▪ Attendance is encouraged through motivational strategies. ▪ Participation is encouraged for involuntary program participants.
2=fair	▪ Treatment programs (including brief interventions) are flexible and may include multiple sessions. ▪ Attendance is encouraged through motivational strategies when it meets program goals. ▪ Participation may be encouraged for involuntary program participants.
1=not acceptable	▪ Treatment programs do not include multiple sessions unless requested by the client. ▪ If brief interventions are used, only one session is required. ▪ Attendance is not encouraged through motivational strategies. ▪ Participation is recommended but not encouraged for involuntary program participants.

Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 9:

Treatment services and experiences should address resistance skills and experiences that are meaningful and reflective for the client in order to increase program effectiveness. Risk factors and protective factors for alcohol abuse and dependence should be addressed and managed (DOJ, OJJDP, 2002; SAMHSA, NCAP, 2000; Gerstein, 1984).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should be personalized to address individual risk and protective factors including scenarios, idea generating, and role-playing if appropriate.	How is each aspect of treatment addressed? ▪ Individual risk factors ▪ Individual protective factors	Grade / Criteria 3=excellent: ▪ Individual risk factors and individual protective factors are addressed with the use of demonstrating scenarios, idea generating, and role-playing, or other clinically approved methods. 2=fair: ▪ Individual risk factors and/or individual protective factors are addressed with the use of clinically approved methods. 1=not acceptable: ▪ Neither individual risk factors nor individual protective factors are addressed. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 10:

Recovering alcohols need to identify with other successful recovering alcoholics for physical and emotional support (Humphreys, 1999; [DOJ], Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2002).

IDEAL	POINTS OF PRACTICE	ASSESSMENT	
▪ Treatment should include exposure to successful recovering alcoholics supervised by the program facilitator.	▪ Does the program include structured exposure to successfully recovering alcoholics? Yes No ▪ Is twelve-step facilitation (i.e. Alcoholics Anonymous) encouraged for voluntary participation? Yes No	Grade	Criteria
		3=excellent	▪ The program provides opportunity for structured interaction supervised by the program facilitator between program participants and successful recovering alcoholics. ▪ The program encourages outside twelve-step facilitation participation.
		2=fair	▪ When available, the program provides opportunity for interaction between program participants and successful recovering alcoholics; interaction may or may not be structured or supervised. ▪ The program does not encourage or discourage outside twelve-step facilitation participation.
		1=not acceptable	▪ The program does not provide opportunity for structured interaction between program participants and successful recovering alcoholics. ▪ The program does not encourage outside twelve-step facilitation participation.
		Notes/Recommendations:	

EVIDENCE-BASED PRINCIPLE 11:
Programs should strive for a low recidivism rate and an overall decrease in client's return-to-behavior (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Client recidivism rates should be below the national average for existing alcohol treatment programs.	▪ What methods are used to track client recidivism? ▪ How is client recidivism addressed by the program facilitator?	Please list current the program recidivism rate: Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 12:
The program should attempt to serve the specific needs of the community and any special population groups.

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The program participant population matches the overall community demographics. ▪ The treatment program can be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.	▪ Does the program track the participant population? (If yes, list tracking variables.) Yes No ▪ Can the program be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.? Yes No List examples:	Program population estimates: Gender: SES: Race: **To be completed by program evaluator** Community estimates: Notes/Recommendations:

APPENDIX K: First and Second Version of the RET

RET First Version Principle Order (Pilot Study, Programs A & B)	Assessment Area	RET Second Version Principle Order (Programs C& D)	Assessment Area
Evidence-Based Principle 1: The theory or theories used in the program should be well-defined and validated. Is the employed theory reflective of recent research?	Theoretical frameworks	**Evidence-Based Principle 1**: Treatment should be comprehensive, addressing all aspect of a client's life, and should combine a variety of services to increase effectiveness. Although detoxification is an important aspect of treatment, this process should be combined with other services. In addition, cognitive and behavioral therapies must be included in treatment.	Treatment methods
Evidence-Based Principle 2: The program theory outcomes align with the overall outcomes of the program.	Theoretical frameworks	**Evidence-Based Principle 2**: Treatment should be readily available; treatment is a long term process and multiple episodes of treatment may be needed.	Treatment methods
Evidence-Based Principle 3: The program mission should be clearly stated and describe the intent of the program.	Mission, goals, and objectives	**Evidence-Based Principle 3**: Treatment plans should be monitored and amended regularly. This includes aligning individual treatment plans with the overall mission, goals, and objectives of the program.	Treatment methods
Evidence-Based Principle 4: Program goals should be operationally defined,	Mission, goals, and objectives	**Evidence-Based Principle 4**: Treatment (including brief interventions) should include multiple sessions and programs	Treatment methods

RET First Version Principle Order (Pilot Study, Programs A & B)	**Assessment Area**	**RET Second Version Principle Order (Programs C& D)**	**Assessment Area**
consisting of measurable objectives. Goals and objectives should be written and referred to in times of program content and client guidance. Programs should be able to measure their objectives by using standardized criteria.		should encourage or require attendance. Involuntary treatment should also include motivational strategies to encourage attendance and participation.	
Evidence-Based Principle 5: Treatment should be comprehensive, addressing all aspect of a client's life, and should combine a variety of services to increase effectiveness. Although detoxification is an important aspect of treatment, this process should be combined with other services. In addition, cognitive and behavioral therapies must be included in treatment.	Treatment methods	**Evidence-Based Principle 5**: Treatment services and experiences should address resistance skills and experiences that are meaningful and reflective for the client in order to increase program effectiveness. Risk factors and protective factors for alcohol abuse and dependence should be addressed and managed.	Treatment methods
Evidence-Based Principle 6: Treatment should be readily available; treatment is a long-term process and multiple episodes of treatment may be needed.	Treatment methods	**Evidence-Based Principle 6**: Recovering alcohols need to identify with other successful recovering alcoholics for physical and emotional support.	Treatment methods
Evidence-Based Principle 7:	Treatment methods	**Evidence-Based Principle 7**: Programs should strive for a	Recidivism

RET First Version Principle Order (Pilot Study, Programs A & B)	**Assessment Area**	**RET Second Version Principle Order (Programs C& D)**	**Assessment Area**
Treatment plans should be monitored and amended regularly. This includes aligning individual treatment plans with the overall mission, goals, and objectives of the program.		low recidivism rate and an overall decrease in client's return-to-behavior.	
Evidence-Based Principle 8: Treatment (including brief interventions) should include multiple sessions and programs should encourage or require attendance. Involuntary treatment should also include motivational strategies to encourage attendance and participation.	Treatment methods	**Evidence-Based Principle 8**: The program should attempt to serve the specific needs of the community and any special population groups.	Client Demo-graphics
Evidence-Based Principle 9: Treatment services and experiences should address resistance skills and experiences that are meaningful and reflective for the client in order to increase program effectiveness. Risk factors and protective factors for alcohol abuse and dependence should be addressed and managed.	Treatment methods	**Evidence-Based Principle 9**: The theory or theories used in the program should be well defined and validated. Is the employed theory reflective of recent research?	Theoretical frameworks

RET First Version Principle Order (Pilot Study, Programs A & B)	**Assessment Area**	**RET Second Version Principle Order (Programs C& D)**	**Assessment Area**
Evidence-Based Principle 10: Recovering alcohols need to identify with other successful recovering alcoholics for physical and emotional support.	Treatment methods	**Evidence-Based Principle 10**: The program theory outcomes align with the overall outcomes of the program.	Theoretical frameworks
Evidence-Based Principle 11: Programs should strive for a low recidivism rate and an overall decrease in client's return-to-behavior.	Client recidivism	**Evidence-Based Principle 11**: The program mission should be clearly stated and describe the intent of the program.	Mission, goals, and objectives
Evidence-Based Principle 12: The program should attempt to serve the specific needs of the community and any special population groups.	Client demo-graphics	**Evidence-Based Principle 12**: Program goals should be operationally defined, consisting of measurable objectives. Goals and objectives should be written and referred to in times of program content and client guidance. Programs should be able to measure their objectives by using standardized criteria.	Mission, goals, and objectives

APPENDIX L: Program A Practice Recommendation Summary

Program A

Overall Score: 25/30
30=excellent
20=fair
10=not acceptable

Understanding the RET Assessment:
The assessment consists of two areas: a Practice Recommendation Summary (PRS) and a detailed assessment of the each of the twelve principles presented in the RET.

Practice Recommendations Summary:

- Revise the mission statement for the facility so it reflects the global nature of the program and the philosophy of the services offered.

A suggested revised mission statement is written below:

The mission of Program A is to improve the quality and availability of mental health and substance abuse related treatment options by providing high quality and affordable education and treatment to all people regardless of gender, sexual orientation, financial status, religion, or ethnicity.

- Revise goals to match social cognitive theory (SCT) and health belief model (HBM) principles currently used in the treatment portion of your program. Diversify goals to include client-specific outcomes.

Diversify current goal statements by addressing client outcomes. A common way to facilitate this is to write goal statements in the areas of prevention, treatment, counseling, and/or education. This would serve as a blueprint of services for incoming clients and new employees.

- Diversify objective statements to include all types of potential program outcomes. Continue to revise and renew objectives as previous objectives are met and implemented.

Currently, Program A has four objectives that are process/administrative objectives, meaning they are focused on measuring counselor performance or data. Begin to use learning, action/behavioral, environmental, and program objectives to help define and guide your practice and treatment facilitation. See the table below for specific examples:

TYPE OF OBJECTIVE	EXAMPLES OF PROGRAM OUTCOMES
Process/administrative objective	Number of sessions held
Learning objective	Change in awareness about alcohol use
Action/behavioral objective	Alcohol consumption decreased or eliminated
Environmental objective	Change in the environment
Program objective	Decrease in risk factor for alcohol use/abuse

"Increase family involvement" was a topic that you stated in our interview that you wanted to include in your objective measurements. This is a good example of a program objective. An option to quantify this objective is "Increase family involvement to substance-abuse clients by implementing one family counseling session per month to each recovery group". Another area of focus that was discussed during the interview was increasing the use of motivational techniques with voluntary clients and increasing the use of motivational techniques (other than legal consequences) with court-ordered clients. These types of objectives would also help define the techniques you employ from SCT and HBM.

- Increase use of existing computer software or implement new software to aid your facility in several specific areas.

Use current computer programs or update systems to track and improve time-after-initial-contact. I realize that for this facility that this is in part a staffing issue and that the problem may be resolved after a staff position re-hiring occurs later this year. Software can also be used to create formal written weekly progress reports generated after staff meetings or during client sessions to increase the quality of patient care.

- Begin to track recidivism and patient demographics within your facility.

This data is invaluable to effectively evaluate and assess your alcohol treatment program's success. Tracking your client population (possibly using computer software) in terms of demographic variables (ethnicity, gender, socioeconomic status, etc.) may also aid in the implementation of sub-population groups to serve clients with specialized needs.

EVIDENCE-BASED PRINCIPLE 1:
The theory or theories used in the program should be well-defined and validated (Stufflebeam, 2001). "Is the employed theory reflective of recent research?" (Stufflebeam, 2001, p. 37).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Use of the Social Cognitive Theory (SCT), Theory of Reasoned Action (TRA), Health Belief Model (HBM), combination, or other validated health behavior change theory.	▪ What are the main points of the theory basis for the alcohol treatment program? Cognitive aspects? Behavioral aspects? Reinforcement/motivation? Other? Notes: ▪ SCT is grounded in the concept of behavioral capability and reinforcement; a cognitive capacity to perform a behavior and self-efficacy; reinforcement is used – through self, others, or a positive result of the behavior change. ▪ TRA is based on behavioral intention, the individual's attitude toward behavior change, and subjective norms associated with the behavior. ▪ HBM states that change is promoted by one or more of the following: motivation, a perceived health threat, and the belief that change would decrease the perceived health threat; individuals need to overcome barriers to change and practice increasing self-efficacy.	Grade / Criteria 3=excellent: ▪ The program shows clear use of a validated health behavior change theory or combination of theories. 2=fair: ▪ The program shows partial use of a validated health behavior change theory. Incorporation of specific theory components is needed in order for proper assessment and vision for the program. 1=not acceptable: ▪ At this time the program does not use a validated health behavior change theory as a basis. Notes/Recommendations: Grade=3

EVIDENCE-BASED PRINCIPLE 2:
The program theory outcomes align with the overall outcomes of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The client's problem(s) are applicable to the theories being used. ▪ Program goals and theory goals align. ▪ There is no known interference between program or theory goals inherent in the community or socially.	▪ Are the client's problem(s) applicable to the theories being used? ▪ Do the program goals (PG) and theory goals (TG) match? PG = TG = ▪ Is there interference with the program or theory goals inherent in the community or in social norms? ▪ List any social norms that may be problematic: ▪ Is there community support for your program?	Grade / Criteria 3=excellent: ▪ The clients problems are applicable to the theories being used; ▪ Program goals and theories align; ▪ There is community support for the program; ▪ There is no known interference between program theory or goals and the community 2=fair: ▪ Clients problems may match the program theories being used or some changes could be made to better match the client's problems with a proper theoretical base; ▪ Program goals and theories do not align but can be modified to match; ▪ There is some community interference between the program and social norms or community expectations 1=not acceptable: ▪ Clients problems do not match the program theories being used; program theories must change to meet the client's needs; ▪ Program goals and theories do not align; ▪ This program is meeting significant community interference; the program theories and goals need to be re-evaluated Notes/Recommendations: Grade = 2. Currently the program theories aren't well defined in the program literature, but their use is apparent. To improve in this area, the recommended revisions in the areas of mission, goals, and objectives will help.

EVIDENCE-BASED PRINCIPLE 3:
The program mission should be clearly stated and describe the intent of the program (McKenzie et al., 2005., p. 128).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Mission should clearly describe the intent of the program including who the program will affect and what the program will provide. ▪ Mission may include the program philosophy. ▪ Mission should be broad in nature.	Mission Statement: **Parts of the mission statement** Intent of program: Population served: How: Program Philosophy (if different):	Grade / Criteria 3=excellent: The mission statement is a broad account of who the program will affect and what the program will provide. 2=fair: The mission statement is should be re-worded to more accurately describe program participants and the effects of the program; or the mission statement is too specific in its wording. 1=not acceptable: The mission statement may have too narrow a focus and does not describe accurately the intent of the program. Notes/Recommendations: Grade = 3. Slight re-wording will make this statement more concise and easier to understand. See PRS.

EVIDENCE-BASED PRINCIPLE 4:
Program goals should be operationally defined, consisting of measurable objectives. Goals and objectives should be written and referred to in times of program content and client guidance. Programs should be able to measure their objectives by using standardized criteria (McKenzie et al., 2005, pp. 129-133).

<table>
<tr><th>IDEAL</th><th>POINTS OF PRACTICE</th><th>ASSESSMENT</th></tr>
<tr>
<td>▪ A goal is defined as ". . . a broad timeless statement of a long-range program purpose" (Deeds, 1992, p. 36).
▪ An objective should include small steps that, if completed, will lead to completion of the program goals.
▪ Objectives include short term and long term outcomes.</td>
<td>List program goals:

▪ Goals can be written in incomplete sentences, but should include who will be affected and what will change as a result of the program.
▪ Goals should be global in nature.
▪ Goals should include all aspects or components of a program.

List program objectives:

Does each objective include:
▪ A measurable outcome?
▪ The conditions under which the outcome will be observed (or when the change will occur)?
▪ The criterion measurement of the outcome?
▪ The population?
▪ Is each objective realistic?</td>
<td>
<table>
<tr><th>Grade</th><th>Criteria</th></tr>
<tr><td>3=excellent</td><td>▪ All program goals are global and include who will be affected and what will change as a result of the program; all aspects of the program are represented by the program goals.
▪ All program objectives include measurable outcomes, conditions, criterion, and population is realistic in the program setting.</td></tr>
<tr><td>2=fair</td><td>▪ Some to all program goals are global and may or may not include who will be affected and what will change as a result of the program; some aspects of the program are not represented by the program goals.
▪ Program objectives may or may not include measurable outcomes, conditions, criterion, and population.
▪ The program objectives may not be realistic in the program setting.</td></tr>
<tr><td>1=not acceptable</td><td>▪ The program goals are not global; they do not include who will be affected and what will change as a result of the program; many aspects of the program are not represented by the program goals.
▪ The program objectives do not include measurable outcomes, conditions, criterion, and population.
▪ The program objectives are not realistic in the program setting; objectives should be modified to better suit the clients and strengths of the program.</td></tr>
</table>
Notes/Recommendations: Grade = 2. Not all areas of the program are represented in the objectives; mainly administrative objectives are specified. Diversify objectives statements (see PRS).
</td>
</tr>
</table>

EVIDENCE-BASED PRINCIPLE 5:

Treatment should be comprehensive, addressing all aspect of a client's life, and should combine a variety of services to increase effectiveness. Although detoxification is an important aspect of treatment, this process should be combined with other services. In addition, cognitive and behavioral therapies must be included in treatment (NIDA, 2000; Longabaugh & Morgenstern., 1999; Marlatt & Gordon, 1985; Larimer et al., 1999; Irwin et al., 1999).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should address all aspects of a client's life including relationships (family and social), work/employment, financial needs, health, and others. ▪ Treatment should include a variety of services including but not limited to the following: cognitive behavioral approach, TSFs, motivational therapies, individual therapy, group therapy, medications, etc. ▪ If detoxification is used it must be combined with other services. ▪ Cognitive and behavioral therapies must be included in treatment.	Does treatment include focus on the following aspects of the individual's life: ▪ family ▪ social ▪ work/employment ▪ financial ▪ health Which of the following treatment services are offered (circle all that applies)? ▪ cognitive behavioral ▪ twelve-step facilitation ▪ motivational therapies ▪ individual therapy ▪ group therapy ▪ medications ▪ detoxification	Grade / Criteria 3=excellent: ▪ Treatment addresses all aspects of the client's life. ▪ Treatment includes a variety of services and uses cognitive and behavioral therapies. ▪ Detoxification, if used, is combined with other services. 2=fair: ▪ Treatment needs to be modified to better address all aspects of the client's life. ▪ Treatment may or may not use a wide variety of services; cognitive and behavioral therapies is included in treatment. ▪ Detoxification, if used, is combined with other services. 1=not acceptable: ▪ Treatment does not addresses all aspects of a client's life. ▪ Treatment only uses one or two; treatment does not include cognitive and behavioral therapies. ▪ Detoxification, if used, is not combined with other services. Notes/Recommendations: Grade = 3. The treatment services available to clients are excellent. All aspects of the client's life are addressed in the treatment process.

EVIDENCE-BASED PRINCIPLE 6:
Treatment should be readily available; treatment is a long-term process and multiple episodes of treatment may be needed (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment is accessible; patients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment services are available if necessary.	▪ On average, how many hours/days after initial contact are patients seen for their first appointment (circle your response)? 1-4 hours 4-12 hours 12-24 hours 24-36 hours 36-48 hours Over 48 hours ▪ Which methods of payment do you currently accept (circle all that applies)? Medicaid/Medicare Private insurance State insurance Military insurance Self payment ▪ Are multiple treatment episodes available for returning clients?	See assessment table below

Grade	Criteria
3=excellent	▪ Treatment is accessible; clients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment episodes are available if necessary.
2=fair	▪ Treatment is accessible; over 75% of patients are scheduled between 24-48 hours following initial contact. ▪ State and government insurances are accepted for payment; some private insurance are also accepted. ▪ Multiple treatment episodes are available if necessary.
1=not acceptable	▪ Treatment is not accessible; fewer than 50% of clients are scheduled between 24-48 hours following initial contact. ▪ Self-payment and private insurance are the only forms of payment currently accepted. ▪ Multiple treatment episodes are not available unless through self-payment.

Notes/Recommendations: Grade = 2. Work to improve time-after-initial-contact for appointments through call tracking, computer software, or any other available method. Currently a variety of options are available for payment and clients are routinely seen for multiple treatment episodes.

EVIDENCE-BASED PRINCIPLE 7:

Treatment plans should be monitored and amended regularly. This includes aligning individual treatment plans with the overall mission, goals, and objectives of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment plans are amended regularly (weekly basis or less). ▪ Programs are amended to meet mission, goals, and objectives.	▪ Do you have a process currently in place that allows weekly reviews (or less) of treatment plans? Yes No ▪ Are treatment plans periodically reviewed to ensure they meet program missions, goals, and objectives specific to the individual? Yes No ▪ Is there a program review process? Yes No	See assessment table below

Grade	Criteria
3=excellent	▪ There is currently a formal process of treatment review and amendment that occurs weekly (or more often); and the process includes a review of program mission, goals, and objectives.
2=fair	▪ There is currently a formal process of treatment review and amendment that occurs once to twice a month; and the process may include a review of program mission, goals, and objectives.
1=not acceptable	▪ There is not currently a formal process of treatment review and amendment that occurs or it occurs less than once a month. ▪ The review process does not include a review of program mission, goals, or objectives.

Notes/Recommendations: Grade = 2. Currently staff meets to review client treatment, although the process is not formal in that there may not be a written documentation of the meetings. Develop a written tool to track these progress meetings. After revising mission, goals and objectives as suggested in the PRS, you may be able to address these aspects during treatment reviews more easily also.

EVIDENCE-BASED PRINCIPLE 8:

Treatment (including brief interventions) should include multiple sessions and programs should encourage or require attendance. Involuntary treatment should also include motivational strategies to encourage attendance and participation (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ All treatments should include multiple sessions. ▪ Facilities should encourage attendance through motivational strategies.	▪ Do all treatment programs require multiple sessions (including brief interventions)? Yes No ▪ What strategies are used to increase or maintain attendance? ▪ What strategies are used to encourage participation during involuntary treatment?	See nested table below

Grade	Criteria
3=excellent	▪ All treatment programs include multiple sessions; if brief interventions are used, multiple sessions are required. ▪ Attendance is encouraged through motivational strategies. ▪ Participation is encouraged for involuntary program participants.
2=fair	▪ Treatment programs (including brief interventions) are flexible and may include multiple sessions. ▪ Attendance is encouraged through motivational strategies when it meets program goals. ▪ Participation may be encouraged for involuntary program participants.
1=not acceptable	▪ Treatment programs do not include multiple sessions unless requested by the client. ▪ If brief interventions are used, only one session is required. ▪ Attendance is not encouraged through motivational strategies. ▪ Participation is recommended but not encouraged for involuntary program participants.

Notes/Recommendations: Grade = 2. Continue to encourage participation as discussed in the PRS.

EVIDENCE-BASED PRINCIPLE 9:
Treatment services and experiences should address resistance skills and experiences that are meaningful and reflective for the client in order to increase program effectiveness. Risk factors and protective factors for alcohol abuse and dependence should be addressed and managed (DOJ, OJJDP, 2002; SAMHSA, NCAP, 2000; Gerstein, 1984).

<table>
<tr><th>IDEAL</th><th>POINTS OF PRACTICE</th><th>ASSESSMENT</th></tr>
<tr>
<td>▪ Treatment should be personalized to address individual risk and protective factors including scenarios, idea generating, and role-playing if appropriate.</td>
<td>How is each aspect of treatment addressed?
▪ Individual risk factors

▪ Individual protective factors</td>
<td>
<table>
<tr><td>Grade</td><td>Criteria</td></tr>
<tr><td>3=excellent</td><td>▪ Individual risk factors and individual protective factors are addressed with the use of demonstrating scenarios, idea generating, and role-playing, or other clinically approved methods.</td></tr>
<tr><td>2=fair</td><td>▪ Individual risk factors and/or individual protective factors are addressed with the use of clinically approved methods.</td></tr>
<tr><td>1=not acceptable</td><td>▪ Neither individual risk factors nor individual protective factors are addressed.</td></tr>
</table>
Notes/Recommendations: Grade = 3. Strategies to increase protective factors and decrease risk factors can also be added to program objectives and client objectives.
</td>
</tr>
</table>

EVIDENCE-BASED PRINCIPLE 10:

Recovering alcohols need to identify with other successful recovering alcoholics for physical and emotional support (Humphreys, 1999; [DOJ], Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2002; SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should include exposure to successful recovering alcoholics supervised by the program facilitator.	▪ Does the program include structured exposure to successfully recovering alcoholics? Yes No ▪ Is twelve-step facilitation (i.e. Alcoholics Anonymous) encouraged for voluntary participation? Yes No	Grade / Criteria 3=excellent: ▪ The program provides opportunity for structured interaction supervised by the program facilitator between program participants and successful recovering alcoholics. ▪ The program encourages outside twelve-step facilitation participation. 2=fair: ▪ When available, the program provides opportunity for interaction between program participants and successful recovering alcoholics; interaction may or may not be structured or supervised. ▪ The program does not encourage or discourage outside twelve-step facilitation participation. 1=not acceptable: ▪ The program does not provide opportunity for structured interaction between program participants and successful recovering alcoholics. ▪ The program does not encourage outside twelve-step facilitation participation. Notes/Recommendations: Grade = 3. Continue to encourage interaction when it is appropriate.

EVIDENCE-BASED PRINCIPLE 11:
Program practices should result in low client recidivism or decreased return-to-behavior (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Client recidivism rates should be below the national average for existing alcohol treatment programs.	▪ What methods are used to track client recidivism? ▪ How is client recidivism addressed by the program facilitator?	Please list current the program recidivism rate: Notes/Recommendations: Recidivism is not being currently tracked by this program. Client recidivism can serve as an assessment of program effectiveness in measuring program goals and objectives. See other notes in the PRS.

EVIDENCE-BASED PRINCIPLE 12:
The program should attempt to serve the specific needs of the community and any special population groups (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The program participant population matches the overall community demographics. ▪ The treatment program can be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.	▪ Does the program track the participant population? (If yes, list tracking variables.) Yes No ▪ Can the program be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.? Yes No List examples:	Program population estimates: age groups: under 18: 18-24: 24-36: 37-49: 50-65: 65 and over: gender: SES: race: **To be completed by program evaluator** Community estimates: The program serves a population proportionate to the local population. Notes/Recommendations: Begin tracking client demographic variables to ensure all minority and special population groups' needs are being met. (See PSR.)

APPENDIX M: Program B Practice Recommendation Summary

Program B

Overall Score: 25/30
30=excellent
20=fair
10=not acceptable

Understanding the RET Assessment:
The assessment consists of two areas: a Practice Recommendation Summary (PRS) and a detailed assessment of the each of the twelve principles presented in the RET.

Practice Recommendations Summary:

- Add a mission statement to help better describe your program. Use aspects of the Health Belief Model/Stages of Change and Social Cognitive Theory to help describe your program.

Currently, Program B has a philosophy statement which describes chemical addictions and diagnoses. This philosophy statement is in accordance with Washington Administrative Code for chemical dependency outpatient treatment centers. It may be helpful, however, to create a mission statement which briefly describes program services, who the program will affect, and what the program will provide in terms of types of interventions, client outcomes, and overarching program goals. *This type of statement may already exist for individual treatment programs that are currently being facilitated in this organization.*

- Modify philosophy and objectives section.

You can also add goal and objective statements to describe goal you (as a practitioner) have for your program. For example, you may have goals or objectives related to continuing education experiences, client recidivism, etc. See the next recommendation listed (under process/administrative objectives) for some more examples.

- Diversify objective statements to include all types of potential program outcomes. See the table below for specific examples:

TYPE OF OBJECTIVE	**EXAMPLES OF PROGRAM OUTCOMES**
Process/administrative objective	Number of sessions held; response time for clients
Learning objective	Change in awareness about alcohol use
Action/behavioral objective	Alcohol consumption decreased or eliminated
Environmental objective	Change in the environment
Program objective	Decrease in risk factor for alcohol use/abuse

- Increase use of internal motivators and decrease use of external/punitive motivators.

Focus on the positive changes that may take place in a person's life due to a decrease in substance abuse. Some of these changes can be tracked through individual objective statements, especially those related to health status (i.e. number of drinks per day). Use the opportunities presented when clients are working towards/meet objectives to reinforce positive outcomes that are internally driven. Examples of internal motivators would be a change in health status and changes in attitudes or beliefs. Another important foundation to increasing internal motivators would be to engage and maintain positive and healthy relationships with your clients. This will add value to any reinforcing statements you make and interactions with your clients.

- Begin to track recidivism and patient demographics within your facility.

This data is invaluable to effectively evaluate and assess the alcohol treatment program's success. Tracking your client population in terms of demographic variables (ethnicity, gender, socioeconomic status, etc.) may also aid in the implementation of sub-population groups to serve clients with specialized needs.

EVIDENCE-BASED PRINCIPLE 1:
The theory or theories used in the program should be well-defined and validated (Stufflebeam, 2001). "Is the employed theory reflective of recent research?" (Stufflebeam, 2001, p. 37).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Use of the Social Cognitive Theory (SCT), Theory of Reasoned Action (TRA), Health Belief Model (HBM), combination, or other validated health behavior change theory.	▪ What are the main points of the theory basis for the alcohol treatment program? Cognitive aspects? Behavioral aspects? Reinforcement/motivation? Other? Notes: ▪ SCT is grounded in the concept of behavioral capability and reinforcement; a cognitive capacity to perform a behavior and self-efficacy; reinforcement is used – through self, others, or a positive result of the behavior change. ▪ TRA is based on behavioral intention, the individual's attitude toward behavior change, and subjective norms associated with the behavior. ▪ HBM states that change is promoted by one or more of the following: motivation, a perceived health threat, and the belief that change would decrease the perceived health threat; individuals need to overcome barriers to change and practice increasing self-efficacy.	<table><tr><td>Grade</td><td>Criteria</td></tr><tr><td>3=excellent</td><td>▪ The program shows clear use of a validated health behavior change theory or combination of theories.</td></tr><tr><td>2=fair</td><td>▪ The program shows partial use of a validated health behavior change theory. Incorporation of specific theory components is needed in order for proper assessment and vision for the program.</td></tr><tr><td>1=not acceptable</td><td>▪ At this time the program does not use a validated health behavior change theory as a basis.</td></tr></table> Notes/Recommendations: Grade = 2. The program does use HBM and SCT. Make sure the use of these theories is reflected in program literature including mission, goals, and objectives. All the material is in there, it just needs to be "relocated" to the correct place (i.e. mission statements, objective statements) as described in the PRS.

EVIDENCE-BASED PRINCIPLE 2:
The program theory outcomes align with the overall outcomes of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The client's problem(s) are applicable to the theories being used. ▪ Program goals and theory goals align. ▪ There is no known interference between program or theory goals inherent in the community or socially.	▪ Are the client's problem(s) applicable to the theories being used? ▪ Do the program goals (PG) and theory goals (TG) match? PG = TG = ▪ Is there interference with the program or theory goals inherent in the community or in social norms? ▪ List any social norms that may be problematic: ▪ Is there community support for your program?	Grade / Criteria 3=excellent: ▪ The clients problems are applicable to the theories being used ▪ Program goals and theories align ▪ There is community support for the program ▪ There is no known interference between program theory or goals and the community 2=fair: ▪ Clients problems may match the program theories being used or some changes could be made to better match the client's problems with a proper theoretical base ▪ Program goals and theories do not align but can be modified to match ▪ There is some community interference between the program and social norms or community expectations 1=not acceptable: ▪ Clients problems do not match the program theories being used; program theories must change to meet the client's needs ▪ Program goals and theories do not align ▪ This program is meeting significant community interference; the program theories and goals need to be re-evaluated Notes/Recommendations: Grade = 3. As stated in the PRS, all the components are here; just some minor reorganization is needed.

EVIDENCE-BASED PRINCIPLE 3:
The program mission should be clearly stated and describe the intent of the program (McKenzie et al., 2005., p. 128).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Mission should clearly describe the intent of the program including who the program will affect and what the program will provide. ▪ Mission may include the program philosophy. ▪ Mission should be broad in nature.	Mission Statement: **Parts of the mission statement** Intent of program: Population served: How: Program Philosophy (if different):	Grade / Criteria 3=excellent: The mission statement is a broad account of who the program will affect and what the program will provide. 2=fair: The mission statement is should be re-worded to more accurately describe program participants and the effects of the program; or the mission statement is too specific in its wording. 1=not acceptable: The mission statement may have too narrow a focus and does not describe accurately the intent of the program. Notes/Recommendations: Grade = 1. Review the PRS for this section. Add a mission statement that looks at a broad account of your services, etc. The current philosophy statement defines chemical dependency. It goes on to describe the types of interventions Program B uses in alcohol treatment (coping skills, groups, etc.). As stated before, this information is valuable in describing your program, but by creating a mission statement, you can more accurately reflect your theoretical base for treatment.

EVIDENCE-BASED PRINCIPLE 4:
Program goals should be operationally defined, consisting of measurable objectives. Goals and objectives should be written and referred to in times of program content and client guidance. Programs should be able to measure their objectives by using standardized criteria (McKenzie et al., 2005, pp. 129-133).

IDEAL	POINTS OF PRACTICE	ASSESSMENT	
▪ A goal is defined as ". . . a broad timeless statement of a long-range program purpose" (Deeds, 1992, p. 36). ▪ An objective should include small steps that, if completed, will lead to completion of the program goals. ▪ Objectives include short term and long term outcomes.	List program goals: ▪ Goals can be written in incomplete sentences, but should include **who** will be affected and **what** will change as a result of the program. ▪ Goals should be global in nature. ▪ Goals should include all aspects or components of a program. List program objectives: Does each objective include: ▪ A measurable outcome? ▪ The conditions under which the outcome will be observed (or when the change will occur)? ▪ The criterion measurement of the outcome? ▪ The population? ▪ Is each objective realistic?	Grade	Criteria
		3=excellent	▪ All program goals are global and include who will be affected and what will change as a result of the program; all aspects of the program are represented by the program goals. ▪ All program objectives include measurable outcomes, conditions, criterion, and population and is realistic in the program setting.
		2=fair	▪ Some to all program goals are global and may or may not include who will be affected and what will change as a result of the program; some aspects of the program are not represented by the program goals. ▪ Program objectives may or may not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives may not be realistic in the program setting.
		1=not acceptable	▪ The program goals are not global; they do not include who will be affected and what will change as a result of the program; many aspects of the program are not represented by the program goals. ▪ The program objectives do not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives are not realistic in the program setting; objectives should be modified to better suit the clients and strengths of the program.
		Notes/Recommendations: Grade = 3. After revising your program philosophy statement as described in the PRS, you will meet these guidelines for goal statements. Objectives for each specific program were well-written.	

EVIDENCE-BASED PRINCIPLE 5:

Treatment should be comprehensive, addressing all aspect of a client's life, and should combine a variety of services to increase effectiveness. Although detoxification is an important aspect of treatment, this process should be combined with other services. In addition, cognitive and behavioral therapies must be included in treatment (NIDA, 2000; Longabaugh & Morgenstern., 1999; Marlatt & Gordon, 1985; Larimer et al., 1999; Irwin et al., 1999).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should address all aspects of a client's life including relationships (family and social), work/employment, financial needs, health, and others. ▪ Treatment should include a variety of services including but not limited to the following: cognitive behavioral approach, TSFs, motivational therapies, individual therapy, group therapy, medications, etc. ▪ If detoxification is used it must be combined with other services. ▪ Cognitive and behavioral therapies must be included in treatment.	Does treatment include focus on the following aspects of the individual's life: ▪ family ▪ social ▪ work/employment ▪ financial ▪ health Which of the following treatment services are offered (circle all that applies)? ▪ cognitive behavioral ▪ twelve-step facilitation ▪ motivational therapies ▪ individual therapy ▪ group therapy ▪ medications ▪ detoxification	Grade / Criteria 3=excellent: ▪ Treatment addresses all aspects of the client's life. ▪ Treatment includes a variety of services and uses cognitive and behavioral therapies. ▪ Detoxification, if used, is combined with other services. 2=fair: ▪ Treatment needs to be modified to better address all aspects of the client's life. ▪ Treatment may or may not use a wide variety of services; cognitive and behavioral therapies is included in treatment. ▪ Detoxification, if used, is combined with other services. 1=not acceptable: ▪ Treatment does not addresses all aspects of a client's life. ▪ Treatment only uses one or two; treatment does not include cognitive and behavioral therapies. ▪ Detoxification, if used, is not combined with other services. Notes/Recommendations: Grade = 3. The treatment services available to clients are excellent. All aspects of the client's life are addressed in the treatment process.

EVIDENCE-BASED PRINCIPLE 6:
Treatment should be readily available; treatment is a long-term process and multiple episodes of treatment may be needed (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment is accessible; patients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment services are available if necessary.	▪ On average, how many hours/days after initial contact are patients seen for their first appointment (circle your response)? 1-4 hours 4-12 hours 12-24 hours 24-36 hours 36-48 hours Over 48 hours ▪ Which methods of payment do you currently accept (circle all that applies)? Medicaid/Medicare Private insurance State insurance Military insurance Self payment ▪ Are multiple treatment episodes available for returning clients?	See assessment table below

Grade	Criteria
3=excellent	▪ Treatment is accessible; clients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment episodes are available if necessary.
2=fair	▪ Treatment is accessible; over 75% of patients are scheduled between 24-48 hours following initial contact. ▪ State and government insurances are accepted for payment; some private insurance are also accepted. ▪ Multiple treatment episodes are available if necessary.
1=not acceptable	▪ Treatment is not accessible; fewer than 50% of clients are scheduled between 24-48 hours following initial contact. ▪ Self-payment and private insurance are the only forms of payment currently accepted. ▪ Multiple treatment episodes are not available unless through self-payment.

Notes/Recommendations: Grade = 3. Although your facility does not have the most options available for payment, you go above and beyond in making sure potential clients can find services that meet their payment options. Client scheduling can be improved, but it would require extra hours and staffing that your facility can not afford at this time.

EVIDENCE-BASED PRINCIPLE 7:

Treatment plans should be monitored and amended regularly. This includes aligning individual treatment plans with the overall mission, goals, and objectives of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment plans are amended regularly (weekly basis or less). ▪ Programs are amended to meet mission, goals, and objectives.	▪ Do you have a process currently in place that allows weekly reviews (or less) of treatment plans? Yes No ▪ Are treatment plans periodically reviewed to ensure they meet program missions, goals, and objectives specific to the individual? Yes No ▪ Is there a program review process? Yes No	See nested table below

Grade	Criteria
3=excellent	▪ There is currently a formal process of treatment review and amendment that occurs weekly (or more often); and the process includes a review of program mission, goals, and objectives.
2=fair	▪ There is currently a formal process of treatment review and amendment that occurs once to twice a month; and the process may include a review of program mission, goals, and objectives.
1=not acceptable	▪ There is not currently a formal process of treatment review and amendment that occurs or it occurs less than once a month. ▪ The review process does not include a review of program mission, goals, or objectives.

Notes/Recommendations: Grade = 2. Make sure client goals and objectives align with program goals and objectives. Although review and amendment does not happen weekly, it does occur when needed or prompted by the client.

EVIDENCE-BASED PRINCIPLE 8:

Treatment (including brief interventions) should include multiple sessions and programs should encourage or require attendance. Involuntary treatment should also include motivational strategies to encourage attendance and participation (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ All treatments should include multiple sessions. ▪ Facilities should encourage attendance through motivational strategies.	▪ Do all treatment programs require multiple sessions (including brief interventions)? Yes No ▪ What strategies are used to increase or maintain attendance? ▪ What strategies are used to encourage participation during court-ordered treatment?	See nested table below

Grade	Criteria
3=excellent	▪ All treatment programs include multiple sessions; if brief interventions are used, multiple sessions are required. ▪ Attendance is encouraged through motivational strategies. ▪ Participation is encouraged for involuntary program participants.
2=fair	▪ Treatment programs (including brief interventions) are flexible and may include multiple sessions. ▪ Attendance is encouraged through motivational strategies when it meets program goals. ▪ Participation may be encouraged for court-ordered program participants.
1=not acceptable	▪ Treatment programs do not include multiple sessions unless requested by the client. ▪ If brief interventions are used, only one session is required. ▪ Attendance is not encouraged through motivational strategies. ▪ Participation is recommended but not encouraged for court-ordered program participants.

Notes/Recommendations: Grade = 2. Increase intrinsic/internal motivators for clients as described in the PRS.

EVIDENCE-BASED PRINCIPLE 9:
Treatment services and experiences should address resistance skills and experiences that are meaningful and reflective for the client in order to increase program effectiveness. Risk factors and protective factors for alcohol abuse and dependence should be addressed and managed (DOJ, OJJDP, 2002; SAMHSA, NCAP, 2000; Gerstein, 1984).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should be personalized to address individual risk and protective factors including scenarios, idea generating, and role-playing if appropriate.	How is each aspect of treatment addressed? ▪ Individual risk factors ▪ Individual protective factors	Grade / Criteria 3=excellent: ▪ Individual risk factors and individual protective factors are addressed with the use of demonstrating scenarios, idea generating, and role-playing, or other clinically approved methods. 2=fair: ▪ Individual risk factors and/or individual protective factors are addressed with the use of clinically approved methods. 1=not acceptable: ▪ Neither individual risk factors nor individual protective factors are addressed. Notes/Recommendations: Grade = 3.

EVIDENCE-BASED PRINCIPLE 10:

Recovering alcohols need to identify with other successful recovering alcoholics for physical and emotional support (Humphreys, 1999; [DOJ], Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2002; SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should include exposure to successful recovering alcoholics supervised by the program facilitator.	▪ Does the program include structured exposure to successfully recovering alcoholics? Yes No ▪ Is twelve-step facilitation (i.e. Alcoholics Anonymous) encouraged for voluntary participation? Yes No	Grade / Criteria 3=excellent: ▪ The program provides opportunity for structured interaction supervised by the program facilitator between program participants and successful recovering alcoholics. ▪ The program encourages outside twelve-step facilitation participation. 2=fair: ▪ When available, the program provides opportunity for interaction between program participants and successful recovering alcoholics; interaction may or may not be structured or supervised. ▪ The program does not encourage or discourage outside twelve-step facilitation participation. 1=not acceptable: ▪ The program does not provide opportunity for structured interaction between program participants and successful recovering alcoholics. ▪ The program does not encourage outside twelve-step facilitation participation. Notes/Recommendations: Grade = 3.

EVIDENCE-BASED PRINCIPLE 11:
Program practices should result in low client recidivism or decreased return-to-behavior (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Client recidivism rates should be below the national average for existing alcohol treatment programs.	▪ What methods are used to track client recidivism? ▪ How is client recidivism addressed by the program facilitator?	Please list current the program recidivism rate: Notes/Recommendations: Recidivism is not being currently tracked by this program. Client recidivism can serve as an assessment of program effectiveness in measuring program goals and objectives. See other notes in the PRS.

EVIDENCE-BASED PRINCIPLE 12:
The program should attempt to serve the specific needs of the community and any special population groups (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The program participant population matches the overall community demographics. ▪ The treatment program can be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.	▪ Does the program track the participant population? (If yes, list tracking variables.) Yes No ▪ Can the program be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.? Yes No List examples:	Program population estimates: age groups: under 18: 18-24: 24-36: 37-49: 50-65: 65 and over: gender: SES: race: **To be completed by program evaluator** Community estimates: The program serves a population proportionate to evidence-based treatment literature estimates (dominantly male population), and a high number of 18-25year olds which is reflective of this area and substance abuse issues present. Notes/Recommendations: Begin tracking client demographic variables to ensure all minority and special population groups' needs are being met. (See PSR.)

APPENDIX N: Program C Practice Recommendation Summary

Program C

Overall Score: 16/30
30=excellent
20=fair
10=not acceptable

Understanding the RET Assessment:
The assessment consists of two areas: a Practice Recommendation Summary (PRS) and a detailed assessment of the each of the twelve principles presented in the RET.

Practice Recommendations Summary:
This information was gathered only through the interview process. The RET was not completed prior to the interview, and very few documents were given to the researcher to verify additional program information. Some or all of these points may be clarified using existing program resources not available to the researcher.

- Identify the program with a clear theoretical basis to ensure accountability and a measurement of program success.

Currently the program does tend to relate to some aspects of the social cognitive theory (in particular, behavioral capacity and reinforcement, and self-efficacy). The program facilitator also stated in our interview that she identifies with psychodynamic therapy, although direct contrasts to the specific aims of psychodynamic therapy were presented throughout the interview, leading to the conclusion that there was no definite overarching theory for this program. Obviously this can present difficulties; practitioners may be disseminating differing information, the public may not have a clear view of the program's purpose in the community, assessment is difficult without first establishing a clear theoretical basis, etc.

- Incorporate program goals and specific objectives to help ensure program direction and success.

Current program objectives are entirely behavioral in nature and list-oriented. There are no overarching program goals to orient the program or measure program practices. Therefore, current program objectives do not relate to anything in the program literature. Furthermore, it seems that the rationale of the program is based solely on completion of certain behavioral components.

- Diversify objective statements to include all kinds of potential program outcomes.

Currently, treatment methods focus on behavioral checkpoints and accountability to ensure compliance. Also begin to focus on cognitive skills to aid in the recovery process. Objective statements to assess administrative functions are also important in measuring program success. See the table below for specific examples:

TYPE OF OBJECTIVE	EXAMPLES OF PROGRAM OUTCOMES
Process/administrative objective	Number of sessions held; response time for clients
Learning objective	Change in awareness about alcohol use
Action/behavioral objective	Alcohol consumption decreased or eliminated
Environmental objective	Change in the environment
Program objective	Decrease in risk factor for alcohol use/abuse

- Ensure interactions with recovering alcoholics/addicts also include structured, supervised interactions.

Although the informal time clients spend with recovered alcoholics/addicts is important in completing their step-work, their place in the treatment process should not replace the role of formal counseling and structured interactions. Recovering alcoholics/addicts may be very helpful in regulated group environments discussing topics such as relapse prevention, motivational strategies, and the like, but may not always offer sound treatment advice, and their interactions should be monitored.

- Increase the use of internal/intrinsic motivation.

A substance abuse program cannot rely on extrinsic motivators (or punitive motivators) as the sole means of encouraging healthy behaviors. If this is the case, the client does not "own" the behavior, but is only "going through the motions" of treatment in order not to be punished. In this type of facility, it is difficult to focus on other forms of motivation when the primary reason for attendance is to avoid punishment. By focusing on the positive changes that may take place in a person's life due to a decrease in substance abuse, some cognitive reinforcement may take place. Some of these changes can be tracked through individual objective statements, especially those related to health status (i.e. number of drinks per day). Use the opportunities presented when clients are working towards/meet objectives to reinforce positive outcomes that are internally driven. Examples of internal motivators would be a change in health status and changes in attitudes or beliefs. Another important foundation to increasing internal/intrinsic motivators would be to engage and maintain positive and healthy relationships with clients. This will add value to any reinforcing statements you make and future interactions with clients.

- Begin to track recidivism and patient demographics within your facility.

This data is invaluable to effectively evaluate and assess the alcohol treatment program's success. This information may possibly be obtained from BPA as reporting standards for the state are currently being amended and will take effect in July 2008.

EVIDENCE-BASED PRINCIPLE 1:

Treatment should be comprehensive, addressing all aspect of a client's life, and should combine a variety of services to increase effectiveness. Although detoxification is an important aspect of treatment, this process should be combined with other services. In addition, cognitive and behavioral therapies must be included in treatment (NIDA, 1999; Longabaugh et al., 1999; Marlatt & Gordon, 1985; Larimer et al., 1999; Irwin et al., 1999).

IDEAL	POINTS OF PRACTICE	ASSESSMENT	
▪ Treatment should address all aspects of a client's life including relationships (family and social), work/employment, financial needs, health, and others. ▪ Treatment should include a variety of services including but not limited to the following: cognitive behavioral approach, TSFs, motivational therapies, individual therapy, group therapy, medications, etc. ▪ If detoxification is used it must be combined with other services. ▪ Cognitive and behavioral therapies must be included in treatment.	Does treatment include focus on the following aspects of the individual's life: ▪ family ▪ social ▪ work/employment ▪ financial ▪ health Which of the following treatment services are offered (circle all that applies)? ▪ cognitive behavioral ▪ twelve-step facilitation ▪ motivational therapies ▪ individual therapy ▪ group therapy ▪ medications ▪ detoxification	Grade	Criteria
		3=excellent	▪ Treatment addresses all aspects of the client's life. ▪ Treatment includes a variety of services and uses cognitive and behavioral therapies. ▪ Detoxification, if used, is combined with other services.
		2=fair	▪ Treatment needs to be modified to better address all aspects of the client's life. ▪ Treatment may or may not use a wide variety of services; cognitive and behavioral therapies is included in treatment. ▪ Detoxification, if used, is combined with other services.
		1=not acceptable	▪ Treatment does not addresses all aspects of a client's life. ▪ Treatment only uses one or two; treatment does not include cognitive and behavioral therapies. ▪ Detoxification, if used, is not combined with other services.
		Notes/Recommendations: Grade=1 Treatment currently does not focus on the cognitive aspect of therapy, only behavioral components.	

EVIDENCE-BASED PRINCIPLE 2:
Treatment should be readily available; treatment is a long-term process and multiple episodes of treatment may be needed (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment is accessible; patients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment services are available if necessary.	▪ On average, how many hours/days after initial contact are patients seen for their first appointment (circle your response)? 1-4 hours 4-12 hours 12-24 hours 24-36 hours 36-48 hours Over 48 hours ▪ Which methods of payment do you currently accept (circle all that applies)? Medicaid/Medicare Private insurance State insurance Military insurance Self payment Other ▪ Are multiple treatment episodes available for returning clients?	See assessment table below

Grade	Criteria
3=excellent	▪ Treatment is accessible; clients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment episodes are available if necessary.
2=fair	▪ Treatment is accessible; over 75% of patients are scheduled between 24-48 hours following initial contact. ▪ State and government insurances are accepted for payment; some private insurance are also accepted. ▪ Multiple treatment episodes are available if necessary.
1=not acceptable	▪ Treatment is not accessible; fewer than 50% of clients are scheduled between 24-48 hours following initial contact. ▪ Self-payment and private insurance are the only forms of payment currently accepted. ▪ Multiple treatment episodes are not available unless through self-payment.

Notes/Recommendations: Grade=3
This facility does a good job contacting and scheduling patients immediately.

EVIDENCE-BASED PRINCIPLE 3:

Treatment plans should be monitored and amended regularly. This includes aligning individual treatment plans with the overall mission, goals, and objectives of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment plans are amended regularly (weekly basis for inpatient treatment and bi-weekly for outpatient treatment). ▪ Programs are amended to meet mission, goals, and objectives.	▪ Do you have a process currently in place that allows weekly reviews (or less) of treatment plans? Yes No ▪ Are treatment plans periodically reviewed to ensure they meet program missions, goals, and objectives specific to the individual? Yes No ▪ Is there a program review process? Yes No	See assessment table below

Grade	Criteria
3=excellent	▪ There is currently a formal process of treatment review and amendment that occurs weekly or bi-weekly (depending on the setting); and the process includes a review of program mission, goals, and objectives.
2=fair	▪ There is currently a formal process of treatment review and amendment that occurs once to twice a month; and the process may include a review of program mission, goals, and objectives.
1=not acceptable	▪ There is not currently a formal process of treatment review and amendment that occurs or it occurs less than once a month. ▪ The review process does not include a review of program mission, goals, or objectives.

Notes/Recommendations: Grade=2

Treatment review does follow the state guidelines, but does not currently include a review of mission, goals, and objectives as they relate to a client's progress.

EVIDENCE-BASED PRINCIPLE 4:

Treatment (including brief interventions) should include multiple sessions and programs should encourage or require attendance. Court-directed/ordered treatment should also include motivational strategies to encourage attendance and participation (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ All treatments should include multiple sessions. ▪ Facilities should encourage attendance through motivational strategies.	▪ Do all treatment programs require multiple sessions (including brief interventions)? Yes No ▪ What strategies are used to increase or maintain attendance? ▪ What strategies are used to encourage participation during mandated treatment?	See nested table below

Grade	Criteria
3=excellent	▪ All treatment programs include multiple sessions; if brief interventions are used, multiple sessions are required. ▪ Attendance is encouraged through motivational strategies. ▪ Participation is encouraged for mandated program participants.
2=fair	▪ Treatment programs (including brief interventions) are flexible and may include multiple sessions. ▪ Attendance is encouraged through motivational strategies when it meets program goals. ▪ Participation may be encouraged for mandated program participants.
1=not acceptable	▪ Treatment programs do not include multiple sessions unless requested by the client. ▪ If brief interventions are used, only one session is required. ▪ Attendance is not encouraged through motivational strategies. ▪ Participation is recommended but not encouraged for involuntary program participants.

Notes/Recommendations: Grade=2

This program does not offer much encouragement other than punitive measures.

EVIDENCE-BASED PRINCIPLE 5:
Treatment services and experiences should address resistance skills and experiences that are meaningful and reflective for the client in order to increase program effectiveness. Risk factors and protective factors for alcohol abuse and dependence should be addressed and managed (DOJ, OJJDP, 2002; SAMHSA, NCAP, 2000; Gerstein, 1984).

<table>
<tr><th>IDEAL</th><th>POINTS OF PRACTICE</th><th>ASSESSMENT</th></tr>
<tr>
<td>▪ Treatment should be personalized to address individual risk and protective factors including scenarios, idea generating, and role-playing if appropriate.</td>
<td>How is each aspect of treatment addressed?
▪ Individual risk factors

▪ Individual protective factors</td>
<td>
<table>
<tr><td>Grade</td><td>Criteria</td></tr>
<tr><td>3=excellent</td><td>▪ Individual risk factors and individual protective factors are addressed with the use of demonstrating scenarios, idea generating, and role-playing, or other clinically approved methods.</td></tr>
<tr><td>2=fair</td><td>▪ Individual risk factors and/or individual protective factors are addressed with the use of clinically approved methods.</td></tr>
<tr><td>1=not acceptable</td><td>▪ Neither individual risk factors nor individual protective factors are addressed.</td></tr>
</table>
Notes/Recommendations: Grade=1
The program facilitator did not give any indication that risk and protective factors were being reviewed with clients as part of the treatment process.
</td>
</tr>
</table>

EVIDENCE-BASED PRINCIPLE 6:

Recovering alcoholics need to identify with other successful recovering alcoholics for physical and emotional support (Humphreys, 1999; [DOJ], Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2002).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should include exposure to successful recovering alcoholics supervised by the program facilitator.	▪ Does the program include structured exposure to successfully recovering alcoholics? Yes No ▪ Is twelve-step facilitation (i.e. Alcoholics Anonymous) encouraged for voluntary participation? Yes No	See nested table below

Grade	Criteria
3=excellent	▪ The program provides opportunity for structured interaction supervised by the program facilitator between program participants and successful recovering alcoholics. ▪ The program encourages outside twelve-step facilitation participation.
2=fair	▪ When available, the program provides opportunity for interaction between program participants and successful recovering alcoholics; interaction may or may not be structured or supervised. ▪ The program does not encourage or discourage outside twelve-step facilitation participation.
1=not acceptable	▪ The program does not provide opportunity for structured interaction between program participants and successful recovering alcoholics. ▪ The program does not encourage outside twelve-step facilitation participation.

Notes/Recommendations: Grade=2

Interactions should be structured and/or supervised. See PSR for more details.

EVIDENCE-BASED PRINCIPLE 7:
Programs should strive for a low recidivism rate and an overall decrease in client's return-to-behavior (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Client recidivism rates should be below the national average for existing alcohol treatment programs.	▪ What methods are used to track client recidivism? ▪ How is client recidivism addressed by the program facilitator?	Please list current the program recidivism rate: No information available. Notes/Recommendations: See PSR for details.

EVIDENCE-BASED PRINCIPLE 8:
The program should attempt to serve the specific needs of the community and any special population groups (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The program participant population matches the overall community demographics. ▪ The treatment program can be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.	▪ Does the program track the participant population? (If yes, list tracking variables.) Yes No ▪ Can the program be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.? Yes No List examples:	Program population estimates: Gender: 100% male SES: Race: **To be completed by program evaluator** Community estimates: The program serves a population proportionate to evidence-based treatment literature estimates (dominantly male population), and a high number of 18-25year olds which is reflective of this area and substance abuse issues present. Notes/Recommendations: See PRS for details.

EVIDENCE-BASED PRINCIPLE 9:
The theory or theories used in the program should be well-defined and validated (Stufflebeam, 2001). "Is the employed theory reflective of recent research?" (Stufflebeam, 2001, p. 37).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Use of the Social Cognitive Theory (SCT), Theory of Reasoned Action (TRA), Health Belief Model (HBM), combination, or other validated health behavior change theory.	▪ What are the main points of the theory basis for the alcohol treatment program? Cognitive aspects? Behavioral aspects? Reinforcement/motivation? Other? Which theory most closely aligns with the alcohol treatment program (circle your response)? SCT TRA HBM combination other (please list) _____ Notes: ▪ SCT is grounded in the concept of behavioral capability and reinforcement; a cognitive capacity to perform a behavior and self-efficacy; reinforcement is used – through self, others, or a positive result of the behavior change. ▪ TRA is based on behavioral intention, the individual's attitude toward behavior change, and subjective norms associated with the behavior. ▪ HBM states that change is promoted by one or more of the following: motivation, a perceived health threat, and the belief that change would decrease the perceived health threat; individuals need to overcome barriers to change and practice increasing self-efficacy.	<table><tr><td>Grade</td><td>Criteria</td></tr><tr><td>3=excellent</td><td>▪ The program shows clear use of a validated health behavior change theory or combination of theories.</td></tr><tr><td>2=fair</td><td>▪ The program shows partial use of a validated health behavior change theory. Incorporation of specific theory components is needed in order for proper assessment and vision for the program.</td></tr><tr><td>1=not acceptable</td><td>▪ At this time the program does not use a validated health behavior change theory as a basis.</td></tr></table> Notes/Recommendations: Grade=1 It is difficult to assess a program without a clear theoretical basis. See PRS for details.

EVIDENCE-BASED PRINCIPLE 10:
The program theory outcomes align with the overall outcomes of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The client's problem(s) are applicable to the theories being used. ▪ Program goals and theory goals align. ▪ There is no known interference between program or theory goals inherent in the community or socially.	Program goals: Specific goals that apply to each alcohol treatment program that guide its direction and treatment focus. Theory goals: Specific goals of a health behavior change theory that involve motivation, reinforcement, intention, or other areas that must be addressed to successfully employ the program. ▪ Are the client's problem(s) applicable to the theories being used? ▪ Do the program goals (PG) and theory goals (TG) match? PG = TG = ▪ Is there interference with the program or theory goals inherent in the community or in social norms? ▪ List any social norms that may be problematic: ▪ Is there community support for your program?	Grade / Criteria 3=excellent: ▪ The clients problems are applicable to the theories being used ▪ Program goals and theories align ▪ There is community support for the program ▪ There is no known interference between program theory or goals and the community 2=fair: ▪ Clients problems may match the program theories being used or some changes could be made to better match the client's problems with a proper theoretical base ▪ Program goals and theories do not align but can be modified to match ▪ There is some community interference between the program and social norms or community expectations 1=not acceptable: ▪ Clients problems do not match the program theories being used; program theories must change to meet the client's needs ▪ Program goals and theories do not align ▪ This program is meeting significant community interference; the program theories and goals need to be re-evaluated Notes/Recommendations: Grade=1 The only information available about this program was the list of behaviors expected from clients for each phase of the program (ex. attend AA meetings). There is no program theory evident and no goals were presented. See PRS for details.

EVIDENCE-BASED PRINCIPLE 11:
The program mission should be clearly stated and describe the intent of the program (McKenzie et al., 2005., p. 128).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Mission should clearly describe the intent of the program including who the program will affect and what the program will provide. ▪ Mission may include the program philosophy. ▪ Mission should be broad in nature.	**Parts of the mission statement** Intent of program: Population served: How: Program Philosophy (if different): Mission Statement:	Grade / Criteria 3=excellent: The mission statement is a broad account of who the program will affect and what the program will provide. 2=fair: The mission statement is should be re-worded to more accurately describe program participants and the effects of the program; or the mission statement is too specific in its wording. 1=not acceptable: The mission statement may have too narrow a focus and does not describe accurately the intent of the program Notes/Recommendations: Grade=2 The mission statement does not describe the population being treated or how the program functions (other than through Christian beliefs). See PRS.

EVIDENCE-BASED PRINCIPLE 12:
Program goals should be operationally defined, consisting of measurable objectives. Goals and objectives should be written and referred to in times of program content and client guidance. Programs should be able to measure their objectives by using standardized criteria (McKenzie et al., 2005, pp. 129-133).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ A goal is defined as ". . . a broad timeless statement of a long-range program purpose" (Deeds, 1992, p. 36). ▪ An objective should include small steps that, if completed, will lead to completion of the program goals. ▪ Objectives include short term and long term outcomes.	List program goals: ▪ Goals can be written in incomplete sentences, but should include **who** will be affected and **what** will change as a result of the program. ▪ Goals should be global in nature. ▪ Goals should include all aspects or components of a program. List program objectives: Does each objective include: ▪ A measurable outcome? ▪ The conditions under which the outcome will be observed (or when the change will occur)? ▪ The criterion measurement of the outcome? ▪ The population? ▪ Is each objective realistic?	Grade / Criteria 3=excellent: ▪ All program goals are global and include who will be affected and what will change as a result of the program; all aspects of the program are represented by the program goals. ▪ All program objectives include measurable outcomes, conditions, criterion, and population and is realistic in the program setting. 2=fair: ▪ Some to all program goals are global and may or may not include who will be affected and what will change as a result of the program; some aspects of the program are not represented by the program goals. ▪ Program objectives may or may not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives may not be realistic in the program setting. 1=not acceptable: ▪ The program goals are not global; they do not include who will be affected and what will change as a result of the program; many aspects of the program are not represented by the program goals. ▪ The program objectives do not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives are not realistic in the program setting; objectives should be modified to better suit the clients and strengths of the program. ▪ No program goals or objectives. Notes/Recommendations: Grade=1 Although existing program objectives are measureable, they do not represent several aspects of the program. See PRS for details.

APPENDIX O: Program D Practice Recommendation Summary

Program D

Overall Score: 26/30
30=excellent
20=fair
10=not acceptable

Understanding the RET Assessment:
The assessment consists of two areas: a Practice Recommendation Summary (PRS) and a detailed assessment of the each of the twelve principles presented in the RET.

Practice Recommendations Summary:

- Add goal and objective statements that reflect current theoretical practices of this program.

Currently the program has a mission statement followed by seven procedure statements. These statements could easily be used as goal statements, although they tend to focus on administrative needs. You also have goal and objective statements listed on a separate page with the same type of focus. These statements can be re-worded to include concepts about the program's theoretical basis (Stages of Change, etc.) and should also include measureable objective statements. An example is: Encourage clients to participate in three community AA meetings weekly. The chart below gives examples of objective statements that can be used to represent different program areas:

TYPE OF OBJECTIVE	**EXAMPLES OF PROGRAM OUTCOMES**
Process/administrative objective	Number of sessions held; response time for clients
Learning objective	Change in awareness about alcohol use
Action/behavioral objective	Alcohol consumption decreased or eliminated
Environmental objective	Change in the environment
Program objective	Decrease in risk factor for alcohol use/abuse

- Increase the use of intrinsic motivators and decrease use of external/punitive motivators.

Focus on the positive changes that may take place in a person's life due to a decrease in substance abuse. Some of these changes can be tracked through individual objective statements, especially those related to health status (i.e. number of drinks per day). Use the opportunities presented when clients are working towards/meet objectives to reinforce positive outcomes that are intrinsic. Examples of intrinsic motivators would be a change in health status and changes in attitudes or beliefs about substance abuse. Another important foundation to increasing intrinsic motivators would be to engage and maintain

positive, healthy relationships with your clients. This will add value to interactions you have with your clients and any reinforcing statements you make.

- Begin to track recidivism and patient demographics in your facility.

This data is invaluable to effectively evaluate and assess the alcohol treatment program's success. Tracking your client population in terms of demographic variables (ethnicity, gender, socioeconomic status, etc.) may also aid in the implementation of sub-population groups to serve clients with specialized needs. This will become easier as the state begins to track clients that are state-funded.

EVIDENCE-BASED PRINCIPLE 1:

Treatment should be comprehensive, addressing all aspect of a client's life, and should combine a variety of services to increase effectiveness. Although detoxification is an important aspect of treatment, this process should be combined with other services. In addition, cognitive and behavioral therapies must be included in treatment (NIDA, 1999; Longabaugh et al., 1999; Marlatt & Gordon, 1985; Larimer et al., 1999; Irwin et al., 1999).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should address all aspects of a client's life including relationships (family and social), work/employment, financial needs, health, and others. ▪ Treatment should include a variety of services including but not limited to the following: cognitive behavioral approach, TSFs, motivational therapies, individual therapy, group therapy, medications, etc. ▪ If detoxification is used it must be combined with other services. ▪ Cognitive and behavioral therapies must be included in treatment.	Does treatment include focus on the following aspects of the individual's life: ▪ family ▪ social ▪ work/employment ▪ financial ▪ health Which of the following treatment services are offered (circle all that applies)? ▪ cognitive behavioral ▪ twelve-step facilitation ▪ motivational therapies ▪ individual therapy ▪ group therapy ▪ medications ▪ detoxification	Grade / Criteria 3=excellent: ▪ Treatment addresses all aspects of the client's life. ▪ Treatment includes a variety of services and uses cognitive and behavioral therapies. ▪ Detoxification, if used, is combined with other services. 2=fair: ▪ Treatment needs to be modified to better address all aspects of the client's life. ▪ Treatment may or may not use a wide variety of services; cognitive and behavioral therapies is included in treatment. ▪ Detoxification, if used, is combined with other services. 1=not acceptable: ▪ Treatment does not addresses all aspects of a client's life. ▪ Treatment only uses one or two; treatment does not include cognitive and behavioral therapies. ▪ Detoxification, if used, is not combined with other services. Notes/Recommendations: Grade = 3 Treatment addresses all aspects of a client's life and includes cognitive and behavioral aspects.

EVIDENCE-BASED PRINCIPLE 2:
Treatment should be readily available; treatment is a long-term process and multiple episodes of treatment may be needed (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment is accessible; patients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment services are available if necessary.	▪ On average, how many hours/days after initial contact are patients seen for their first appointment (circle your response)? 1-4 hours 4-12 hours 12-24 hours 24-36 hours 36-48 hours Over 48 hours ▪ Which methods of payment do you currently accept (circle all that applies)? Medicaid/Medicare Private insurance State insurance Military insurance Self payment Other ▪ Are multiple treatment episodes available for returning clients?	See nested table below

Grade	Criteria
3=excellent	▪ Treatment is accessible; clients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment episodes are available if necessary.
2=fair	▪ Treatment is accessible; over 75% of patients are scheduled between 24-48 hours following initial contact. ▪ State and government insurances are accepted for payment; some private insurance are also accepted. ▪ Multiple treatment episodes are available if necessary.
1=not acceptable	▪ Treatment is not accessible; fewer than 50% of clients are scheduled between 24-48 hours following initial contact. ▪ Self-payment and private insurance are the only forms of payment currently accepted. ▪ Multiple treatment episodes are not available unless through self-payment.

Notes/Recommendations: Grade = 3. Treatment is readily available. The program helps clients with any insurance issues that may arise.

EVIDENCE-BASED PRINCIPLE 3:
Treatment plans should be monitored and amended regularly. This includes aligning individual treatment plans with the overall mission, goals, and objectives of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment plans are amended regularly (weekly basis for inpatient treatment and bi-weekly for outpatient treatment). ▪ Programs are amended to meet mission, goals, and objectives.	▪ Do you have a process currently in place that allows weekly reviews (or less) of treatment plans? Yes No ▪ Are treatment plans periodically reviewed to ensure they meet program missions, goals, and objectives specific to the individual? Yes No ▪ Is there a program review process? Yes No	Grade / Criteria 3=excellent: ▪ There is currently a formal process of treatment review and amendment that occurs weekly or bi-weekly (depending on the setting); and the process includes a review of program mission, goals, and objectives. 2=fair: ▪ There is currently a formal process of treatment review and amendment that occurs once to twice a month; and the process may include a review of program mission, goals, and objectives. 1=not acceptable: ▪ There is not currently a formal process of treatment review and amendment that occurs or it occurs less than once a month. ▪ The review process does not include a review of program mission, goals, or objectives. Notes/Recommendations: Grade = 3. Treatment plans are reviewed weekly (or less) and random "spot checks" are done to ensure optimal care is given.

EVIDENCE-BASED PRINCIPLE 4:

Treatment (including brief interventions) should include multiple sessions and programs should encourage or require attendance. Court-directed/ordered treatment should also include motivational strategies to encourage attendance and participation (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ All treatments should include multiple sessions. ▪ Facilities should encourage attendance through motivational strategies.	▪ Do all treatment programs require multiple sessions (including brief interventions)? Yes No ▪ What strategies are used to increase or maintain attendance? ▪ What strategies are used to encourage participation during involuntary treatment?	See nested table below

Grade	Criteria
3=excellent	▪ All treatment programs include multiple sessions; if brief interventions are used, multiple sessions are required. ▪ Attendance is encouraged through motivational strategies. ▪ Participation is encouraged for mandated program participants.
2=fair	▪ Treatment programs (including brief interventions) are flexible and may include multiple sessions. ▪ Attendance is encouraged through motivational strategies when it meets program goals. ▪ Participation may be encouraged for mandated program participants.
1=not acceptable	▪ Treatment programs do not include multiple sessions unless requested by the client. ▪ If brief interventions are used, only one session is required. ▪ Attendance is not encouraged through motivational strategies. ▪ Participation is recommended but not encouraged for mandated program participants.

Notes/Recommendations: Grade = 2. Increase the use of intrinsic motivation techniques with mandated clients. See PRS for details.

EVIDENCE-BASED PRINCIPLE 5:
Treatment services and experiences should address resistance skills and experiences that are meaningful and reflective for the client in order to increase program effectiveness. Risk factors and protective factors for alcohol abuse and dependence should be addressed and managed (DOJ, OJJDP, 2002; SAMHSA, NCAP, 2000; Gerstein, 1984).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should be personalized to address individual risk and protective factors including scenarios, idea generating, and role-playing if appropriate.	How is each aspect of treatment addressed? ▪ Individual risk factors ▪ Individual protective factors	Grade / Criteria 3=excellent: ▪ Individual risk factors and individual protective factors are addressed with the use of demonstrating scenarios, idea generating, and role-playing, or other clinically approved methods. 2=fair: ▪ Individual risk factors and/or individual protective factors are addressed with the use of clinically approved methods. 1=not acceptable: ▪ Neither individual risk factors nor individual protective factors are addressed. Notes/Recommendations: Grade = 3. The Program Facilitator gave specific examples of how this is incorporated into treatment.

EVIDENCE-BASED PRINCIPLE 6:
Recovering alcoholics need to identify with other successful recovering alcoholics for physical and emotional support (Humphreys, 1999; [DOJ], Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2002).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should include exposure to successful recovering alcoholics supervised by the program facilitator.	▪ Does the program include structured exposure to successfully recovering alcoholics? Yes No ▪ Is twelve-step facilitation (i.e. Alcoholics Anonymous) encouraged for voluntary participation? Yes No	Grade / Criteria 3=excellent: ▪ The program provides opportunity for structured interaction supervised by the program facilitator between program participants and successful recovering alcoholics. ▪ The program encourages outside twelve-step facilitation participation. 2=fair: ▪ When available, the program provides opportunity for interaction between program participants and successful recovering alcoholics; interaction may or may not be structured or supervised. ▪ The program does not encourage or discourage outside twelve-step facilitation participation. 1=not acceptable: ▪ The program does not provide opportunity for structured interaction between program participants and successful recovering alcoholics. ▪ The program does not encourage outside twelve-step facilitation participation. Notes/Recommendations: Grade = 3. Structured interaction with recovering alcoholics occurs in group settings.

EVIDENCE-BASED PRINCIPLE 7:
Programs should strive for a low recidivism rate and an overall decrease in client's return-to-behavior (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Client recidivism rates should be below the national average for existing alcohol treatment programs.	▪ What methods are used to track client recidivism? ▪ How is client recidivism addressed by the program facilitator?	Please list current the program recidivism rate: Data not available. Notes/Recommendations: See PRS for ideas to implement recidivism tracking.

EVIDENCE-BASED PRINCIPLE 8:
The program should attempt to serve the specific needs of the community and any special population groups (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The program participant population matches the overall community demographics. ▪ The treatment program can be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.	▪ Does the program track the participant population? (If yes, list tracking variables.) Yes No ▪ Can the program be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.? Yes No List examples:	Program population estimates: Gender: 60% women, 40% men SES: lower SES population Race: Estimates this is similar to the community distribution. **To be completed by program evaluator** Community estimates: Notes/Recommendations: This program accomdates special populations when able (ex. Gender responsive group).

EVIDENCE-BASED PRINCIPLE 9:
The theory or theories used in the program should be well-defined and validated (Stufflebeam, 2001). "Is the employed theory reflective of recent research?" (Stufflebeam, 2001, p. 37).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Use of the Social Cognitive Theory (SCT), Theory of Reasoned Action (TRA), Health Belief Model (HBM), combination, or other validated health behavior change theory.	▪ What are the main points of the theory basis for the alcohol treatment program? Cognitive aspects? Behavioral aspects? Reinforcement/motivation? Other? Which theory most closely aligns with the alcohol treatment program (circle your response)? SCT TRA HBM combination other (please list) _____ Notes: ▪ SCT is grounded in the concept of behavioral capability and reinforcement; a cognitive capacity to perform a behavior and self-efficacy; reinforcement is used – through self, others, or a positive result of the behavior change. ▪ TRA is based on behavioral intention, the individual's attitude toward behavior change, and subjective norms associated with the behavior. ▪ HBM states that change is promoted by one or more of the following: motivation, a perceived health threat, and the belief that change would decrease the perceived health threat; individuals need to overcome barriers to change and practice increasing self-efficacy.	<table><tr><td>Grade</td><td>Criteria</td></tr><tr><td>3=excellent</td><td>▪ The program shows clear use of a validated health behavior change theory or combination of theories.</td></tr><tr><td>2=fair</td><td>▪ The program shows partial use of a validated health behavior change theory. Incorporation of specific theory components is needed in order for proper assessment and vision for the program.</td></tr><tr><td>1=not acceptable</td><td>▪ At this time the program does not use a validated health behavior change theory as a basis.</td></tr></table> Notes/Recommendations: Grade = 2. Incorporate a description of the program's overarching theory into mission, goals, and objectives statements. See PRS for details.

EVIDENCE-BASED PRINCIPLE 10:
The program theory outcomes align with the overall outcomes of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The client's problem(s) are applicable to the theories being used. ▪ Program goals and theory goals align. ▪ There is no known interference between program or theory goals inherent in the community or socially.	Program goals: Specific goals that apply to each alcohol treatment program that guide its direction and treatment focus. Theory goals: Specific goals of a health behavior change theory that involve motivation, reinforcement, intention, or other areas that must be addressed to successfully employ the program. ▪ Are the client's problem(s) applicable to the theories being used? ▪ Do the program goals (PG) and theory goals (TG) match? PG = TG = ▪ Is there interference with the program or theory goals inherent in the community or in social norms? ▪ List any social norms that may be problematic: ▪ Is there community support for your program?	Grade / Criteria 3=excellent: ▪ The clients problems are applicable to the theories being used ▪ Program goals and theories align ▪ There is community support for the program ▪ There is no known interference between program theory or goals and the community 2=fair: ▪ Clients problems may match the program theories being used or some changes could be made to better match the client's problems with a proper theoretical base ▪ Program goals and theories do not align but can be modified to match ▪ There is some community interference between the program and social norms or community expectations 1=not acceptable: ▪ Clients problems do not match the program theories being used; program theories must change to meet the client's needs ▪ Program goals and theories do not align ▪ This program is meeting significant community interference; the program theories and goals need to be re-evaluated Notes/Recommendations: Grade = 2. Incorporate program theories to match what is currently happening with clients in treatment now.

EVIDENCE-BASED PRINCIPLE 11:
The program mission should be clearly stated and describe the intent of the program (McKenzie et al., 2005., p. 128).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Mission should clearly describe the intent of the program including who the program will affect and what the program will provide. ▪ Mission may include the program philosophy. ▪ Mission should be broad in nature.	**Parts of the mission statement** Intent of program: Population served: How: Program Philosophy (if different): Mission Statement:	Grade / Criteria 3=excellent: The mission statement is a broad account of who the program will affect and what the program will provide. 2=fair: The mission statement is should be re-worded to more accurately describe program participants and the effects of the program; or the mission statement is too specific in its wording. 1=not acceptable: The mission statement may have too narrow a focus and does not describe accurately the intent of the program Notes/Recommendations: Grade = 3. The mission statement describes the program accurately.

EVIDENCE-BASED PRINCIPLE 12:
Program goals should be operationally defined, consisting of measurable objectives. Goals and objectives should be written and referred to in times of program content and client guidance. Programs should be able to measure their objectives by using standardized criteria (McKenzie et al., 2005, pp. 129-133).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ A goal is defined as ". . . a broad timeless statement of a long-range program purpose" (Deeds, 1992, p. 36). ▪ An objective should include small steps that, if completed, will lead to completion of the program goals. ▪ Objectives include short term and long term outcomes.	List program goals: ▪ Goals can be written in incomplete sentences, but should include **who** will be affected and **what** will change as a result of the program. ▪ Goals should be global in nature. ▪ Goals should include all aspects or components of a program. List program objectives: Does each objective include: ▪ A measurable outcome? ▪ The conditions under which the outcome will be observed (or when the change will occur)? ▪ The criterion measurement of the outcome? ▪ The population? ▪ Is each objective realistic?	Grade / Criteria 3=excellent: ▪ All program goals are global and include who will be affected and what will change as a result of the program; all aspects of the program are represented by the program goals. ▪ All program objectives include measurable outcomes, conditions, criterion, and population and is realistic in the program setting. 2=fair: ▪ Some to all program goals are global and may or may not include who will be affected and what will change as a result of the program; some aspects of the program are not represented by the program goals. ▪ Program objectives may or may not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives may not be realistic in the program setting. 1=not acceptable: ▪ The program goals are not global; they do not include who will be affected and what will change as a result of the program; many aspects of the program are not represented by the program goals. ▪ The program objectives do not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives are not realistic in the program setting; objectives should be modified to better suit the clients and strengths of the program. ▪ No program goals or objectives. Notes/Recommendations: Grade = 2. Diversify program goals and objectives to include all aspects of the program. See PRS for details.

APPENDIX P: Final RET Revisions

Purpose: The goal of this tool is to assess current alcohol treatment programs against evidence-based practices in five main areas: theoretical frameworks; mission, goals, and objectives; treatment; client recidivism; and client demographics. The focus of this assessment is on alcohol treatment programs that serve the 18-25 year old age group. Upon completion of this tool, the alcohol treatment program facilitator will receive Evidence-Based Practice (EBP) suggestions and recommendations that can be implemented in their existing alcohol treatment program.

Instructions: Answer each question as it applies to the alcohol treatment program as a whole, not for individual clients.

There are twelve (12) evidence-based principles presented in this evaluative tool. Each principle includes ideals, points of practice, and an assessment section. After reading each evidence-based principle and corresponding ideals, use the points of practice section to informally evaluate the alcohol treatment program (which targets 18-25 year old clients). Then use the criteria listed in the assessment rubric to rate the program. You can also place any notes or recommendations in this section for future reference. An interview will be scheduled to discuss the RET and your assessment for each Principle. Afterwards, the primary researcher will collect and evaluate the RET and assess any other information available from the alcohol treatment program that is applicable to this assessment. After a final interview and assessment by the primary researcher, the RET and any EBP recommendations generated will be returned to the alcohol treatment program facilitator for possible implementation. The researcher will review any EBP recommendations and possible implementation techniques with the program facilitator.

Please feel free to contact me with any questions about the instrument as you proceed. This evaluation should take approximately one hour, but more time may be necessary for a more thorough assessment.

Contact Information:

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EVIDENCE-BASED PRINCIPLE 1:

Treatment should be comprehensive, addressing all aspect of a client's life, and should combine a variety of services to increase effectiveness. Although detoxification is an important aspect of treatment, this process should be combined with other services. In addition, cognitive and behavioral therapies must be included in treatment (NIDA, 1999; Longabaugh et al., 1999; Marlatt & Gordon, 1985; Larimer et al., 1999; Irwin et al., 1999).

IDEAL	POINTS OF PRACTICE	ASSESSMENT	
▪ Treatment should address all aspects of a client's life including relationships (family and social), work/employment, financial needs, health, and others. ▪ Treatment should include a variety of services including but not limited to the following: cognitive behavioral approach, twelve-step facilitations (TSFs), motivational therapies, individual therapy, group therapy, medications, etc. ▪ If detoxification is used it must be combined with other services. ▪ Cognitive and behavioral therapies must be included in treatment.	Does treatment include focus on the following aspects of the individual's life: ▪ family ▪ social ▪ work/employment ▪ financial ▪ health Which of the following treatment services are offered (circle all that applies)? ▪ cognitive behavioral ▪ twelve-step facilitation ▪ motivational therapies ▪ individual therapy ▪ group therapy ▪ medications ▪ detoxification	Grade	Criteria
		3=excellent	▪ Treatment addresses all aspects of the client's life. ▪ Treatment includes a variety of services and uses cognitive and behavioral therapies. ▪ Detoxification, if used, is combined with other services.
		2=fair	▪ Treatment needs to be modified to better address all aspects of the client's life. ▪ Treatment may or may not use a wide variety of services; although cognitive aspects are included, behavioral therapy has a greater focus during treatment ▪ Detoxification, if used, is combined with other services.
		1=not acceptable	▪ Treatment does not address all aspects of a client's life. ▪ Treatment only uses one or two methods; treatment does not include cognitive and behavioral therapies. ▪ Detoxification, if used, is not combined with other services.
		Notes/Recommendations:	

EVIDENCE-BASED PRINCIPLE 2:
Treatment should be readily available; treatment is a long-term process and multiple episodes of treatment may be needed (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment is accessible; patients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances. ▪ Multiple treatment services are available if necessary.	▪ On average, how many hours/days after initial contact are patients seen for their first appointment (circle your response)? 1-4 hours 4-12 hours 12-24 hours 24-36 hours 36-48 hours Over 48 hours ▪ Which methods of payment do you currently accept (circle all that applies)? Medicaid/Medicare Private insurance State insurance Military insurance Self payment Other ▪ Does the facility help facilitate payment for comparable services for clients who cannot pay for treatment? ▪ Are multiple treatment episodes available for returning clients?	Grade / Criteria 3=excellent: ▪ Treatment is accessible; clients are scheduled between 24-48 hours following initial contact. ▪ A variety of options are accepted for payment including several different insurances or payment provisions are made. ▪ Multiple treatment episodes are available if necessary. 2=fair: ▪ Treatment is accessible; over 75% of patients are scheduled between 24-48 hours following initial contact. ▪ State and government insurances are accepted for payment; some private insurance are also accepted; payment provisions are made occasionally. ▪ Multiple treatment episodes are available if necessary. 1=not acceptable: ▪ Treatment is not accessible; fewer than 50% of clients are scheduled between 24-48 hours following initial contact. ▪ Self-payment and private insurance are the only forms of payment currently accepted. ▪ Multiple treatment episodes are not available unless through self-payment. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 3:
Treatment plans should be monitored and amended regularly. This includes aligning individual treatment plans with the overall mission, goals, and objectives of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment plans are amended regularly (weekly basis for inpatient treatment and bi-weekly for outpatient treatment). ▪ Programs are regularly amended to meet mission, goals, and objectives.	▪ Do you have a process currently in place that allows written weekly or bi-weekly reviews of treatment plans? Yes No ▪ Are treatment plans periodically reviewed to ensure they meet program missions, goals, and objectives specific to the individual? Yes No ▪ Is there a program review process which examines program mission, goals, and objectives? Yes No	Grade / Criteria 3=excellent: ▪ There is currently a formal process of treatment review and amendment that occurs weekly or bi-weekly; and the process includes a review of program mission, goals, and objectives. 2=fair: ▪ There is currently a formal process of treatment review and amendment that occurs once a month; the process may include a review of program mission, goals, and objectives. 1=not acceptable: ▪ There is not currently a formal process of treatment review and amendment that occurs or it occurs less than once a month. ▪ The review process does not include a review of program mission, goals, or objectives. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 4:

Treatment (including brief interventions) should include multiple sessions and programs should encourage or require attendance. Court-directed/ordered treatment should also include motivational strategies to encourage attendance and participation (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ All treatments should include multiple sessions. ▪ Facilities should encourage attendance through motivational strategies.	▪ Do all treatment programs require multiple sessions (including brief interventions)? Yes No ▪ What strategies are used to increase or maintain attendance? ▪ What strategies are used to encourage participation during court-directed/ordered treatment?	Grade / Criteria 3=excellent: ▪ All treatment programs include multiple sessions; if brief interventions are used, multiple sessions are required. ▪ Attendance is encouraged through motivational strategies. ▪ Participation is encouraged for court-directed/ordered program participants. 2=fair: ▪ Treatment programs (including brief interventions) are flexible and may include multiple sessions. ▪ Attendance is encouraged through motivational strategies when it meets program goals. ▪ Participation may be encouraged for court-directed/ordered program participants. 1=not acceptable: ▪ Treatment programs do not include multiple sessions unless requested by the client. ▪ If brief interventions are used, only one session is required. ▪ Attendance is not encouraged through motivational strategies. ▪ Participation is recommended but not encouraged for court-directed/ordered program participants. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 5:

Treatment services and experiences should address resistance skills and experiences that are meaningful and reflective for the client in order to increase program effectiveness. Risk factors and protective factors for alcohol abuse and dependence should be addressed and managed (DOJ, OJJDP, 2002; SAMHSA, NCAP, 2000; Gerstein, 1984).

<table>
<tr><th>IDEAL</th><th>POINTS OF PRACTICE</th><th>ASSESSMENT</th></tr>
<tr>
<td>▪ Treatment should be personalized to address individual risk and protective factors including scenarios, idea generating, and role-playing if appropriate.</td>
<td>How is each aspect of treatment addressed?
▪ Individual risk factors

▪ Individual protective factors</td>
<td>
<table>
<tr><th>Grade</th><th>Criteria</th></tr>
<tr><td>3=excellent</td><td>▪ Individual risk factors and individual protective factors are addressed with the use of demonstrating scenarios, idea generating, and role-playing, or other clinically approved methods.</td></tr>
<tr><td>2=fair</td><td>▪ Individual risk factors and/or individual protective factors are addressed with the use of clinically approved methods.</td></tr>
<tr><td>1=not acceptable</td><td>▪ Neither individual risk factors nor individual protective factors are addressed.</td></tr>
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Notes/Recommendations:
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EVIDENCE-BASED PRINCIPLE 6:

Recovering alcoholics need to identify with other successful recovering alcoholics in a structured environment for physical and emotional support (Humphreys, 1999; [DOJ], Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2002).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Treatment should include exposure to successful recovering alcoholics supervised by the program facilitator.	▪ Does the program include structured exposure to successfully recovering alcoholics? Yes No ▪ Is twelve-step facilitation (i.e. Alcoholics Anonymous) encouraged for voluntary participation? Yes No	Notes/Recommendations:

Grade	Criteria
3=excellent	▪ The program provides opportunity for structured interaction supervised by the program facilitator between program participants and successful recovering alcoholics. ▪ The program encourages outside twelve-step facilitation participation.
2=fair	▪ When available, the program provides opportunity for interaction between program participants and successful recovering alcoholics; interaction may or may not be structured or supervised. ▪ The program does not encourage or discourage outside twelve-step facilitation participation.
1=not acceptable	▪ The program does not provide opportunity for structured interaction between program participants and successful recovering alcoholics; contact may be unsupervised. ▪ The program does not encourage outside twelve-step facilitation participation.

EVIDENCE-BASED PRINCIPLE 7:
Programs should strive for a low recidivism rate and an overall decrease in client's return-to-behavior (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Client recidivism should be tracked and used as a measure of overall program effectiveness.	▪ What methods are used to track client recidivism? ▪ How is client recidivism addressed by the program facilitator?	Please list current the program recidivism rate: Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 8:
The program should attempt to serve the specific needs of the community and any special population groups (SAMHSA, 2000).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The program participant population matches the overall community demographics. ▪ The treatment program can be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, etc.	▪ Does the program track the participant population? (If yes, list tracking variables.) Yes No ▪ Can the program be specialized to meet the needs for minority or special groups based on age, race, gender, socioeconomic status, medical needs, etc.? Yes No List examples:	Program population estimates: Gender: SES: Race: **To be completed by program evaluator** Community estimates: Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 9:
The theory or theories used in the program should be well-defined and validated (Stufflebeam, 2001). "Is the employed theory reflective of recent research?" (Stufflebeam, 2001, p. 37).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Use of the Social Cognitive Theory (SCT), Theory of Reasoned Action (TRA), Health Belief Model (HBM)/Stages of Changes (SOC), a combination, or other validated health behavior change theory.	▪ What are the main points of the theory basis for the alcohol treatment program? Cognitive aspects? Behavioral aspects? Reinforcement/motivation? Other? Which theory most closely aligns with the alcohol treatment program (circle your response)? SCT TRA HBM/SOC combination other (please list) _____ Notes: ▪ SCT is grounded in the concept of behavioral capability and reinforcement; a cognitive capacity to perform a behavior and self-efficacy; reinforcement is used – through self, others, or a positive result of the behavior change. ▪ TRA is based on behavioral intention, the individual's attitude toward behavior change, and subjective norms associated with the behavior. ▪ HBM/SOC states that change is promoted by one or more of the following: motivation, a perceived health threat, and the belief that change would decrease the perceived health threat; individuals need to overcome barriers to change and practice increasing self-efficacy.	<table><tr><td>Grade</td><td>Criteria</td></tr><tr><td>3=excellent</td><td>▪ The program shows clear use of a validated health behavior change theory or combination of theories. The theoretical basis is a recognized part of the alcohol treatment program.</td></tr><tr><td>2=fair</td><td>▪ The program shows partial use of a validated health behavior change theory. Incorporation of specific theory components is needed in order for proper assessment and vision for the program. ▪ The theoretical basis is present but may not have been identified by the program facilitator.</td></tr><tr><td>1=not acceptable</td><td>▪ At this time the program does not use a validated health behavior change theory as a basis.</td></tr></table> Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 10:
The program theory outcomes align with the overall outcomes of the program (McKenzie et al., 2005).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ The client's problem(s) are applicable to the theories being used. ▪ Program goals and theory goals align. ▪ There is no known interference between program or theory goals inherent in the community or socially.	Program goals: Specific goals that apply to each alcohol treatment program that guide its direction and treatment focus. Theory goals: Specific goals of a health behavior change theory that involve motivation, reinforcement, intention, or other areas that must be addressed to successfully employ the program. ▪ Are the client's problem(s) applicable to the theories being used? ▪ Do the program goals (PG) and theory goals (TG) match? PG = TG = ▪ Is there interference with the program or theory goals inherent in the community or in social norms? ▪ List any social norms that may be problematic: ▪ Is there community support for your program?	Grade / Criteria 3=excellent: ▪ The clients' problems are applicable to the theories being used. ▪ Program goals and theories align. ▪ There is community support for the program. ▪ There is no known interference between program theory or goals and the community. 2=fair: ▪ Clients' problems may match the program theories being used or some changes could be made to better match the client's problems with a proper theoretical base. ▪ Program goals and theories do not align but can be modified to match. ▪ There is some community interference between the program and social norms or community expectations. 1=not acceptable: ▪ Clients' problems do not match the program theories being used; program theories must change to meet the client's needs. ▪ Program goals and theories do not align. ▪ The program does not include specific goal statements. ▪ This program is meeting significant community interference; the program theories and goals need to be re-evaluated. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 11:
The program mission should be clearly stated and describe the intent of the program (McKenzie et al., 2005., p. 128).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ Mission should clearly describe the intent of the program including who the program will affect and what the program will provide. ▪ Mission may include the program philosophy. ▪ Mission should be broad in nature.	**Parts of the mission statement** Intent of program: Population served: How: Program Philosophy (if different): Mission Statement:	Grade / Criteria 3=excellent: The mission statement is a broad account of who the program will affect and what the program will provide. 2=fair: The mission statement is should be re-worded to more accurately describe program participants and the effects of the program; or the mission statement is too specific in its wording. 1=not acceptable: The mission statement may have too narrow a focus and does not describe accurately the intent of the program. Notes/Recommendations:

EVIDENCE-BASED PRINCIPLE 12:
Program goals should be operationally defined, consisting of measurable objectives. Goals and objectives should be written and referred to in times of program content and client guidance. Programs should be able to measure their objectives by using standardized criteria (McKenzie et al., 2005, pp. 129-133).

IDEAL	POINTS OF PRACTICE	ASSESSMENT
▪ A goal is defined as ". . . a broad timeless statement of a long-range program purpose" (Deeds, 1992, p. 36). ▪ An objective should include small steps that, if completed, will lead to completion of the program goals. ▪ Objectives include short term and long term outcomes.	List program goals: ▪ Goals can be written in incomplete sentences, but should include **who** will be affected and **what** will change as a result of the program. ▪ Goals should be global in nature. ▪ Goals should include all aspects or components of a program. List program objectives: Does each objective include: ▪ A measurable outcome? ▪ The conditions under which the outcome will be observed (or when the change will occur)? ▪ The criterion measurement of the outcome? ▪ The population? ▪ Is each objective realistic?	Grade / Criteria 3=excellent: ▪ All program goals are global and include who will be affected and what will change as a result of the program; all aspects of the program are represented by the program goals including the program's theoretical framework. ▪ All program objectives include measurable outcomes, conditions, criterion, and population and is realistic in the program setting. 2=fair: ▪ Some to all program goals are global and may or may not include who will be affected and what will change as a result of the program; some aspects of the program are not represented by the program goals. ▪ Program objectives may or may not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives may not be realistic in the program setting. 1=not acceptable: ▪ The program goals are not global; they do not include who will be affected and what will change as a result of the program; many aspects of the program are not represented by the program goals. ▪ The program objectives do not include measurable outcomes, conditions, criterion, and population. ▪ The program objectives are not realistic in the program setting; objectives should be modified to better suit the clients and strengths of the program. ▪ No program goals or objectives. Notes/Recommendations: