To the Graduate Council:

I am submitting herewith a dissertation written by John George Gardin, II entitled "A Study of the Determinants of Alcoholism Treatment Referral." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

W. S. Verplanck, Major Professor

We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

Vice Provost
and Dean of The Graduate School

A STUDY OF THE DETERMINANTS OF ALCOHOLISM TREATMENT REFERRAL

A Dissertation

Presented for the

Doctor of Philosophy

Degree

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John George Gardin, II

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ABSTRACT

Recent concerns of cost-containment and effectiveness of treatment of alcoholics have emphasized the need to match clients to treatment resources more adequately. Indeed, legislation was passed in Oregon mandating insurance reimbursement for the most appropriate and least costly alcoholism and alcohol abuse treatment. As a result, the Oregon State Health Planning and Development Agency (SHPDA) developed an instrument to assess the appropriate level of care for each client.

This study addressed three hypotheses: (1) The descriptive statements of the SHPDA instrument, as designed and organized, are strongly and positively associated with treatment setting choice; (2) Medically and psychiatrically oriented sets of descriptive statements in the SHPDA instrument will account for more error in predicting treatment setting choices than socially oriented descriptive statements; and (3) Personal characteristics of respondents using the SHPDA instrument will significantly affect choices of treatment setting.

Low response rates yielded a sample that precluded usual statistical tests of significance, leaving only measures of association for use in analysis of results. As a result of the sample size, all results must necessarily be viewed as trends for further investigation.

The first hypothesis was not upheld. Although the SHPDA instrument was designed to reflect a continuum of severity of alcoholic symptoms in its descriptive statements, measures of association of these descriptive statements with level of care were weak at best.

The second hypothesis received some support. Medically and psychiatrically oriented groups of descriptive statements showed relatively stronger measures of association with the level of care chosen when compared to like measures of association for socially oriented groups of descriptive statements.

The third hypothesis was not examined due to inadequate sample size.

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CHAPTER 1

INTRODUCTION

Overview

In the following pages of this chapter the wide variety of alcoholism treatments available will be discussed, including settings, modalities and administering staff. Some support and/or experimental justification will be provided as available for each. This will lead to a discussion of the effectiveness and efficiency of alcoholism treatment, addressing methodological issues as well as research results. What will emerge is the need to match individual alcoholic clients to specific treatments, and the examination of one instrument which has been proposed for that purpose. This instrument will then be used in this study to address our main concerns: Is this instrument, as designed and organized, positively associated with treatment setting choices? Do medically and psychiatrically oriented items in this instrument account for more error in predicting treatment setting choices than socially oriented items? Do personal characteristics of the respondents using this instrument significantly affect choices of treatment setting?

Alcoholism Treatment--The Setting

Various typologies have been proposed as characterizing the wide range of alcoholism treatment settings available. Armor, Polich, and Stambul (1978) among others have suggested that the broadest categorization is that of inpatient versus outpatient care, and they have

defined inpatient care as an overnight stay in a medical facility. However, many individuals have difficulty with this distinction, including the National Institute for Alcohol Abuse and Alcoholism (NIAAA), who chose instead to include all forms of residential care within the category of "inpatient" (National Institute on Alcohol Abuse and Alcoholism, 1982). For purposes of this paper, the NIAAA categorization has been followed. Thus, within the inpatient settings, both hospital and nonhospital facilities were considered.

There are basically two forms of treatment which occur in hospital-based inpatient treatment settings: detoxification and rehabilitation. The former usually consists of a three to seven day stay for purposes of detoxification, evaluation and entry into the rehabilitation program. Drugs are often used during withdrawal, such as Diazepan and Chlordiazepoxide. Once the initial period has passed, evaluation of medical status and use of pharmacotherapy are stressed (Diesenhaus, 1982). Admissions to these programs have been dominated by individuals with fewer years of alcoholic drinking (when compared to non-hospital-based programs) and who have been socially stable (Berry & Boland, 1977; Saxe, Dougherty, Esty, & Fine, 1983). Costs for treatment are routinely reimbursed by insurance companies. The usual four-week treatment program includes educational lectures, family sessions, individual and group counseling, and dietary consultations. Self-help groups, such as Alcoholic Anonymous, are often important adjuncts to treatment. Treatment staff are often a blend of degreed (possessing at least an Associate Arts degree in a related

field) and nondegreed (possessing only a high school diploma or its equivalent), some of whom are recovering alcoholics themselves. This formal level of education is, of course, exclusive of any other training those individual may have received. The treatment team concept is frequently employed, allowing utilization of the specialized skills of physicians, psychologists, social workers, nurses, dieticians, physical therapists, counselors, and others available in the hospital to consult on and participate in the treatment of the individual. It should be noted that hospital-based inpatient programs may be freestanding, housed within a general hospital, or housed within a psychiatric facility.

Non-hospital-based inpatient treatment at the time of this research was again basically of two types: detoxification and rehabilitation. Although detoxification was initially exclusively associated with hospitals and their emergency rooms, non-hospital-based social model detoxification facilities have flourished. Indeed, a survey of state alcohol authorities has shown a tripling of state operated and/or state contracted non-hospital-based detoxification programs since 1975 (Den Hartog, 1982). Although in-house medical assistance was not available in these programs, all had ready access to such support. Most had standing physician's orders for the minor tranquilizers used in hospital-based detoxification programs. Some of the non-hospital-based detoxification facilities were an integral part of a freestanding, non-hospital-based rehabilitation program, but many were state-contracted detoxification facilities with no such direct link to aid in the transition from detoxification to rehabilitation.

Although at the time of this study neither hospital nor non-hospital-based detoxification had been evaluated in a controlled manner so as to assess their effectiveness in aiding the individual in withdrawal, avoiding medical complications, and facilitating referral to treatment, other differences remained. Foremost was the cost. Non-hospital detoxification was significantly less expensive, as one might well imagine. Available data indicated that a significant number of individuals experience no serious medical complications as a result of withdrawal and so may not need a medically oriented detoxification facility (Diesenhaus, 1982).

Non-hospital-housed rehabilitation programs were not usually administratively affiliated with a hospital, and were most commonly nonprofit corporations. There were, however, two types: state-contracted programs and non-state-contracted programs. The former served individuals who tended to have fewer social and/or financial resources and who had been drinking alcoholically for more years. Clients of the latter were typically middle-classed, employed, and socially stable clientele. The usual length of treatment varies, but was typically more than 4 weeks, and frequently averages 60 days. Treatment consisted of a combination of individual and group counseling, educational classes, and family sessions. Nutrition was usually stressed, with clients often involved in meal planning and preparation. Indeed, clients in the state-contracted programs were expected to take an active role in their treatment and were often given responsibility for some program planning, special activities and maintenance of the

facility. Staff within state-contracted programs were a blend of degreed and nondegreed personnel, with various levels of training and experience. They were frequently recovering themselves. Consultation with other professionals was usually available, but in no measure as great as the team concept of the hospital programs nor the non-state-contracted programs. This was especially true of the smaller programs, with fewer financial resources. Indeed, staff within the non-state-contracted programs were more similar to the staff in hospital-based programs. Alcoholics Anonymous was an important adjunct with all of the above.

In the 1980s, hospital-based outpatient care was a newly emerging field. Developed in response to pressures from insurance companies to offer the least costly and most appropriate level of care and to accommodate the needs of clients, many formerly inpatient programs began to offer day-treatment and/or outpatient programs. Day-treatment was essentially an intensive program in which the client did not sleep at the hospital. Clients could participate in therapeutic activities for 5 or more hours per day, 5 days a week. Sometimes they merely join the clients in the inpatient program and sometimes not. Hospital-based outpatient services were much less intensive than day-treatment, amounting to 1 or 2 days per week for 1 to 3 hours per visit. As with most programs, self-help groups such as Alcoholics Anonymous were relied upon extensively.

The private nonprofit sector has traditionally provided outpatient care. In the 1960s and 1970s, alcoholism councils were established

throughout the country as an extension of the National Council on Alcoholism. Initially serving as voluntary information and referral agencies manned by volunteers, the vast majority incorporated and became treatment providers, at least within the state of Oregon, employing trained staff. It was not entirely relevant to explore the reasons for this transformation except to say that often the local mental health authority was more willing to allow the local councils to provide treatment to alcoholic clients. This coupled with a general dissatisfaction with the customary approach of those trained in mental health toward alcoholism treatment only served to foster the development of the councils as treatment agencies. With the passage of a beer and wine tax measure in 1977 in the state of Oregon, which dedicated a portion of those revenues to the treatment and rehabilitation of those suffering from alcoholism, a revenue source emerged within the state which allowed a path of transition from voluntary agencies to ones employing trained staff. Councils have matured greatly in the last decade or two and now routinely employ a combination of degreed and nondegreed staff, with recovering staff in significant numbers. As the treatment was subsidized by the State, the programs operated with sliding fee scales and served even those who could not afford to pay. Clients were typically low to middle class and often mandated to treatment. Large numbers of drunk drivers usually attended these programs, especially since the passage of various drunk driving laws within the state of Oregon which mandated treatment for convicted drunk drivers or made treatment a diversion option from

conviction. Antabuse was a frequent adjunct to treatment and Alcoholics Anonymous was referred to extensively.

Although the State Mental Health Division usually contracted with a council or some similar nonprofit for provision of alcoholism treatment services, in some areas the local mental health program, operated by the County, provided those services directly. Staff in these programs were usually degreed and might or might not be recovering themselves. The actual client profile might be very similar to that described above for the private nonprofits, but the treatment approach could differ significantly in terms of the amount of clinical psychotherapy provided. Other mental health issues were more likely to receive attention, sometimes preceding actual treatment for the individual's alcohol problem.

Alcoholism Treatment--The Modalities

There existed a great variety of modalities available for the treatment of alcoholism, ranging from the physiological to the psychological to the social--and every possible combination of each. In the discussion which follows it is important to recognize that rarely is any one modality or approach delivered in isolation from some other approach. If anything can be said of the treatments available for alcoholics, it must be said that they are extremely eclectic.

Undoubtedly the most commonly used drug in the treatment of alcoholism is disulfiram, trade-named Antabuse. Although disulfiram does not "cure" alcohol craving or dependence, it has been found to

be a valuable tool in aiding the client in an enforced abstinence while other rehabilitative measures are applied. Initially, clients on disulfiram were subject to clinical trials amounting to the ingestion of alcohol following a few days on disulfiram. The resulting reaction, consisting of flushing, nausea, vomiting, respiratory difficulty, and a sudden drop in blood pressure, among other signs, informed the client of the consequences of drinking while taking the drug. This was assumed to dull the clients' desire to drink as long as they were taking disulfiram (Kissin & Begleiter, 1977). The use of clinical trials has declined, as most therapists began to rely upon verbal warnings to deter drinking. Other chemical antagonists have been used, among them citrated calcium cyanamide and metronidozol, in essentially the same manner. Among treatment professionals, these agents are not viewed as treatment, per se, but as an insurance policy while treatment takes place.

Nutritional approaches, while also rarely used in isolation, also have become quite common. Since Williams' (1947) proposal to treat alcoholism with massive doses of vitamins, various approaches have been tried (Williams, 1959; Milam & Ketcham, 1981). Whether one accepts Williams' origin of alcoholism or not, a marked change in caloric intake with special attention to vitamin supplements has become an integral part of many treatment programs.

Many forms of pharmacotherapy have been used in the treatment of alcoholism, limited obviously to medically oriented treatment settings. As alcoholism and depression are often inseparable some

have treated alcoholism with antidepressants (Gibson & Becker, 1973; Solomon, 1982). Given that alcohol is itself a sedative drug, this connection is not altogether surprising. Nonetheless, antidepressants have remained heavily prescribed in some settings. Tricyclic antidepressants and lithium have probably been the most commonly used. Even ignoring the issue of the client's depression being an expected result of the regular ingestion of a sedative (alcohol), there have remained serious questions regarding the use of these drugs (Kissin & Begleiter, 1977; Mendelson & Mello, 1979). Other drugs have been used as well, among them minor and major tranquilizers. The former, although having fallen from favor in many settings due to the cross-tolerance and cross-addiction processes involved, have continued to be grossly overprescribed to alcoholics. It has been jokingly stated that many physicians have treated alcoholics as having a Valium deficiency. Alcohol itself has been recognized as self-medication for some psychotic individuals, who, without alcohol, become severely agitated (Mendelson & Mello, 1979).

Verging on psychological modalities, but obviously related to physiological approaches, is chemical aversion therapy. Utilizing Pavlovian theories, Voegtlin (1940) began using Emetine to induce vomiting in association with alcohol. A conditioned reflex to the taste, sight, and smell of alcoholic beverages is produced, facilitating abstinence. As with the more purely physiological approaches, this technique must be administered under medical supervision as it is potentially hazardous (Baekeland, 1977). Various other behavioral

approaches have been developed over the last 30 years (Nathan, 1978). Often such techniques have been used in combination with other forms of intervention, be they physiological or psychological/social. Blood alcohol level discrimination training has been attempted, under the assumption that alcoholics do not accurately process information about their level of intoxication (Lovibond & Caddy, 1970). In a related manner, alcoholics have watched videotapes of themselves when drunk to enable them to process information which, it is assumed, is not, at the time of drunkenness, available to them. Both methods operate on the belief that alcoholics simply have not learned to manage their alcohol intake, and can do so if taught to.

One of the most widely integrated behavioral approaches within alcoholism treatment programs is relaxation and stress management training. The obvious assumption has been that alcoholics drink to relax. Teaching them viable alternatives to relaxation, usually by means of biofeedback, should assist them in developing substitute relaxation behaviors (Kraft & Al-Issa, 1967). Various imaging and visualization techniques have also been employed.

Behaviorists have also assumed that alcoholics have difficulty expressing their needs and wants, so have developed various assertiveness approaches. Role-playing and behavior rehearsal have been commonly employed in this process (Sobell & Sobell, 1972). More cognitively oriented behaviorists have assumed that if alcoholics can be taught to recognize the thoughts, feelings, and behaviors that precede drinking, appropriate substitute behaviors can be adopted, and drinking avoided (Sobell & Sobell, 1973a, 1973b).

Among nonbehavioral psychological/social approaches, it is safe to say that nothing has not been tried on the alcoholic (Keller, 1983). Individual orthodox psychoanalysis and the majority of psychiatrically oriented therapists have tended to see alcoholism as a manifestation of some underlying personality or emotional disorder, with obvious roots in the client's early childhood. Their methods have been the same with alcoholics as they have been with other psychoneuroses and character disorders, including group and individual therapy (Keller, 1983). Most psychotherapists, however, have emphasized contemporary life problems with their clients, utilizing a variety of specialized therapies to draw the client's attention to their world and their world's stressors (Frank, 1974). Group therapy has been commonly employed, and has often been described as the treatment of choice for alcoholics (Doroff, 1977). Family therapy has also become an integral part of many programs. Much of what happens in treatment is educational in nature, both for the client and their loved ones. An attempt is made to gain the client's and their significant other's recognition of the nature and extent of the client's alcoholism and a willingness to accept and cooperate with treatment.

It has been widely recognized by treatment professionals that much of what occurs in a client's life to maintain long-term quality sobriety will happen after the client leaves treatment. The alcoholic's environment is seen as crucial in this process, and often includes participation in a self-help group such as Alcoholics Anonymous. For those involved in Alcoholics Anonymous, the group provides a network

of individuals who support abstinence and are committed to assisting one another in that process (Hayman, 1966; Jones, 1970).

Alcoholism Treatment--The Providers

In the early years of alcoholism treatment, those providing the services were mostly nondegreed, recovering individuals operating from an Alcoholics Anonymous perspective or psychiatrists and medical doctors (Keller, 1983). During the 1970s, however, professional groups such as psychologists and social workers began entering the field. Although various national surveys have been conducted to ascertain the types of staff involved in alcoholism treatment, these surveys have often been limited to federally funded programs, thus ignoring all programs not so funded, including most programs based in a general hospital, most freestanding private alcoholism rehabilitation facilities, private physicians' offices, and others. It is this investigator's opinion that providers do not represent or project a cohesive body. It would seem that those with degrees are often viewed with skepticism by those without. Those staff who are recovering often see themselves as somehow elite when compared to nonrecovering staff. Freestanding clinics and programs have employed proportionally more nondegreed, recovering counselors than have community mental health centers, and hospital programs have relied primarily on medical staff (Camp & Kurtz, 1982). There is no empirical evidence regarding the utilization of various occupational groups and their impact on the treatment delivery system.

Alcoholism Treatment--Effectiveness/Methodological Issues

Without exception, the reviewers have decried the poor methodology employed in the studies of alcoholism treatment. Some reviewers, such as Hill and Blaine (1967), even refused to summarize their findings because of those methodological inadequacies. They listed them as follows: lack of prior planning, lack of control groups, inadequate sampling procedures, ill-defined criterion variables, use of unreliable measuring instruments, and insufficient follow-up techniques. Of the 49 studies they reviewed from 1952 to 1963, only 2 met even minimal methodological standards.

Some 8 years later, May and Kuller (1975), in their review of studies appearing between 1965 and 1975, reported an increasing sophistication in evaluation instruments. At the same time they lamented the almost nonexistent improvements in study design. They found a consistent lack of control groups, randomization of subjects and objective measures of behavior change. But perhaps their most incisive critique was their observation of the "lack of consensus as to what constitutes effective outcome and an effective measurement of that outcome for the alcoholic patient" (p. 475).

Crawford and Chalupsky (1977) in their review of 40 studies during approximately the same time period (1968 to 1971) also found improved methodology, but still so poor as to question the integrity of the results. They were especially critical of the following: lack of control groups; inadequate sampling procedures; the lack of concern

with the reliability of the measuring instruments; the lack of pre-treatment baseline data; inaccurate or insufficient collection of data; the absence of specific descriptions of populations and treatments; the failure to relate sample variations to outcome variations; the collapsing of data into coding which precluded inquiring into patient-treatment interactions; rudimentary statistical analysis; and poor reporting of and/or inadequate follow-up techniques. Needless to say, they too had few if any praises for the level of scientific investigation which they found. These methodological shortcomings present in the alcoholism treatment field were perhaps most eloquently summarized by Caddy (1978): "The alcoholism field perhaps offers the most striking example of the failure of treatment agencies or groups to apply even the most basic principles of evaluative research to equally basic treatment evaluation questions" (pp. 151-152).

Each of the shortcomings identified by the above reviewers is a topic in itself. The purpose in highlighting them at this time is to set a stage upon which the following reviews can be critically examined. Even though one or more of these issues impacts each of the following reviews, their inclusion here is important in order to gain a relative perspective of the effectiveness of alcoholism treatment relative to setting and modality.

Alcoholism Treatment--Effectiveness: Literature Reviews

In what is generally regarded as the first review of the alcoholism treatment literature, Voegtlin and Lemere (1942) examined over 100

separate studies appearing in the literature from 1909 to 1940. They attempted to separate psychological from physiological approaches, but their basis for those separations is open to question. For instance, incarceration was viewed as a psychological approach, while treatments involving dietary restriction of salt and water were physiological treatments. Nonetheless, they concluded that there was poor statistical evidence for one treatment over any other and that no treatment, by their review, was shown to be just as effective as any other form of treatment. They did state that some modalities appeared promising. In addition, as would be echoed by many later reviewers, they stated that perhaps treatment for alcoholism is differentially effective for particular populations and that combinations of treatments seemed more effective than unitary approaches.

In his first review, Emrick (1974) examined 271 reports published from 1952 to 1971. He found that 68% of the 13,817 clients examined were improved or abstinent at follow-up. His conclusion was that "once an alcoholic has decided to do something about his drinking and accepts help, he stands a good chance of improving" (p. 534). However, he observed that alcoholics can and do recover equally well with no or minimal treatment, but that their rate of improvement was positively correlated with the amount of treatment received. Although he stopped short of advocating client characteristics as major determinants of treatment outcome, he was insistent that technique variables alone were not powerful determinants of outcome. In 1975, Emrick added 126 studies to his original review, examining psychologically oriented

studies to evaluate treatment versus no-treatment conditions. A major barrier to this enterprise was that very few studies employed no-treatment conditions and none employed controls on patient characteristics. Nonetheless, he concluded, once again, that there was no difference in abstinence or improve-rates between no and minimal treatment, and that more than minimal treatment did make a difference. It is of note that Emrick sorted behaviors other than drinking into content clusters and found that improvement in drinking (i.e., drinking less or abstinent) was positively related to changes in affective/cognitive functioning, employment situations, interpersonal relationships at home, physical condition, legal problems and Alcoholics Anonymous attendance.

In his last review, Emrick (1979) examined 90 studies employing random patient assignment to two or more treatments, and found few differences. He noted that the behavioral approaches, including aversion techniques and systematic desensitization, seemed more efficacious. Brief interventions of nonbehavioral approaches appeared as successful as longer interventions.

In 1975, Baekland, Lundwall and Kissin summarized all of those studies with control groups and statistical analysis which they could find in the literature. Throughout, dropouts were considered as failures. They separately reviewed inpatient, outpatient, psychotherapeutic, drug, and sociocultural treatments and found some evidence for success in each. They concluded that there was no significant difference between inpatient and outpatient treatment. Their most adamantly

stated finding, and one which they stated throughout their review, was that the characteristics of the client, not the treatment, play a dominant role in the outcome of treatment. Higher social economic status clients and those socially stable appeared more likely to benefit from treatment than those of lower social economic status with few social supports. They also stated that Alcoholics Anonymous seemed very effective for a select few, but that it was not representative of all alcoholics.

In Costello's first report (1975a) he analyzed 58 studies appearing in the literature between 1951 and 1973 and in a follow-up report (1975b) analyzed separately 23 of these studies with the longest follow-up period (2 years). Although he attempted no formal synthesis, he did attempt to compare treatment program characteristics to outcome using a cluster analysis technique. Studies were grouped into five categories, from poorest to best, by examination of the percent of successful abstainers and percent of continued problem drinkers. The percentages varied from 12% successful abstainers and 60% problem drinkers to 45% successful abstainers and 44% problem drinkers. His conclusion was that smaller programs using a variety of techniques are more successful. Additionally, those programs employing more stringent patient selection, such as screening out high-risk patients, are more successful. Other factors included as contributing to their success were identified as use of Antabuse, a high level of social case work, family treatment, employer involvement and behaviorally oriented treatment. But the greatest factor of all was, once again, patient

characteristics. In a later update (Costello, Biever, & Baillargeon, 1977) he essentially validated his original findings in that 45% of patients in good programs maintained sobriety and 45% relapsed.

In one of the most controversial studies as of the time of this writing, the so-called Rand Studies followed more than 2,000 patients through a wide variety of treatment settings and assessed their drinking patterns (Armor, Polich, & Stabul, 1978). This report examined patients at 6 months and 18 months after treatments and found 68% and 67% showed improvement, respectively. As a part of the latter group, they identified that 24% were abstinent for more than 6 months, 21% were abstinent for 1 month, and 22% were normal drinkers. This generated intense controversy as it raised the issue of controlled drinking (Emrick & Stilson, 1977; Roizon, 1977; National Council on Alcoholism, 1976). Critics of the study stated it lacked a random selection in its original sample (Tuchfelt, Marcus, & Lipton, 1982), as well as pointing to the fact that 80% of the patients were lost in follow-up. In addition, there was a heavy reliance on self report, and the criteria for normal drinking was not stringent enough.

In the 1981 follow-up report, Polich, Armor, and Braiker contacted more than 900 of the original Rand sample 4 years afterward and interviewed 85% of them. Only 7% were abstinent after 4 years and 15% had died (which is 2.5 times the normal mortality rate). However, while 90% of the patients were drinking with serious problems at admission (one wonders why this was not 100%), only 54% were drinking with serious problems after 4 years. No particular treatment achieved consistently more positive results.

Alcoholism Treatment--Effectiveness: Modality and Setting

Although the issue of the effectiveness of particular treatments for particular patients remains unanswered at the time of this study, various attempts have been made to address this issue. Ritson (1968, 1971) examined 6 month and 12 month outcomes in comparing individual outpatient treatment with group and Alcoholics Anonymous inpatient treatment settings. Although no significant difference was noted, obvious confounding of modalities and settings, plus the lack of random assignment, makes the results of little use. In other studies which have been well received, Edwards and colleagues (Edwards, 1966, 1970; Edwards & Guthrie, 1966, 1967) randomly assigned socially stable patients to either 2 months of intensive outpatient treatment with after care or 8.9 weeks of inpatient treatment with outpatient after care. They found that outpatient treatment was more efficacious on global ratings of improvement, but not until 12 months after the termination of treatment. In apparent contradiction, Wanberg, Horn and Fairchild (1974) found that 2 weeks of inpatient treatment was more effective on drinking behavior 90-100 days after intake than three or more outpatient sessions. It should be noted that Wanberg et al. confined themselves to drinking behavior only, while Edwards (1966, 1970) and Edwards and Guthrie (1966, 1967) examined more global functioning criteria.

Various studies have examined aversive conditioning techniques. Voegtlin (Voegtlin & Boz, 1949) described chemical aversion treatment using Emetine with 496 patients at Schick-Shadel Hospital in Seattle,

Washington. In that sample, 42% were totally abstinent and 60% were abstinent for 1 year following treatment. Likewise, Thimann (1949) reported a 51% abstinent rate. More recently, Wiens, Montague, and Manough (1976), reporting on patients at Raleigh Hills Treatment Center in Portland, Oregon, described a 63% abstinent rate after 1 year. These results have been rather typical of those obtained of aversive conditioning techniques, but they have not gone uncriticized. Nathan and Lipscomb (1979) have pointed out that the results were probably more a function of patient characteristics and self-selection than of the treatment provided. They noted that the clients in these studies were of higher social economic status and more socially stable, and so had a higher probability of success regardless of the treatment provided. In apparent support of this contention, Neuberger, Matarazzo, and Schmitz (1980) examined two samples of patients in 1975 and 1976. They found that 39% of the 1975 and 50% of the 1976 samples were abstinent at 1 year. The importance of this study lies in the fact that the sample included those on Medicare, unemployed, and unmarried. In their 1982 study (Neuberger, Miller, & Schmitz, 1982) they showed that Medicare clients had poor outcomes, with only a 36% abstinent rate after 12 months. They validated other studies in showing 75% abstinent rate for socially stable clients.

Although Emetine-induced nausea was by far the most widely used stimulus, there were other options available in the application of aversive conditioning techniques. Electric shock has been employed to this end, although not very successfully (Nathan & Lipscomb,

1979). Imagined aversive stimuli, although rarely used, has also been attempted (Cautela, 1970).

In perhaps the only other study to generate as much controversy as the Rand reports, Sobell and Sobell (1972, 1973b, 1978) described their Individualized Behavior Therapy for Alcoholics (IBTA). Again, the controversy stems from the issue of controlled drinking as a valid goal for alcoholics. The treatment itself offered a more detailed analysis of an individual's drinking behavior than had been previously employed. Substitute behaviors were then enlisted with the treatment goal of either controlled drinking or abstention. The actual results, in percentages, were not of note. However, they did report that whether or not an individual was assigned to a controlled drinking or abstinent group, they were drinking in a nonproblematic way at follow-up compared to control groups. Sobell and Sobell's work has been seriously challenged by Pendery, Maltzman, and West (1982) who have charged the Sobells with unethical research practices. Their follow-up of the Sobells' original treatment group sharply contradicted the Sobells' findings. In short, Pendery et al. maintained that abstinence is the only realistic and prudent goal for an alcoholic.

Research into the effectiveness of pharmacological treatment of alcoholism has been inconclusive at best. Overall, Brown and Williams (1973) reported negative findings in the use of Chlordiazepoxide in reducing anxiety and depression, but others have shown Chlordiazepoxide superior to placebos (Baekeland, 1977). Tricyclic antidepressants revealed contradictory results (Solomon, 1982), as did

Lithium (Kline, Wren, & Cooper, 1974; Merry, Reynolds, & Bailey, 1976).

In general, research into the effectiveness of alcoholism treatment has been plagued by gross methodological shortcomings. As with all research in the real world, some of these, like random clinical trials, may never be feasible or ethical. However, there appeared to be three areas upon which consensus was obtained: (1) characteristics of a client are the most prognostic of treatment outcome; (2) treatment is better than no treatment; (3) specific treatment modalities and settings are more effective for specific client populations.

Given the above and the marked interest in the 1980s by the United States Government and the insurance industry on cost-containment and cost-effectiveness, it would seem wise to embark upon a course of matching clients to treatments. At the time of this research, there was not sufficient data to adequately describe treatment modalities available. But perhaps it would be possible to match clients to treatment settings. Given the wide range of cost attendant to various settings, this would seem to be reasonable. Yet there have been few attempts to do so. Filstead (1982) has presented a continuum of care conceptual framework within which potential clients can be evaluated and referred for treatment. Stressing that alcoholism and substance abuse clients were not a homogeneous group, he outlined five levels of care: critical medical and/or psychiatric care; alcoholism/substance abuse specialty hospitals; residential, freestanding rehabilitation facilities; alternative living programs; and outpatient

services. He then presented criteria by which patients were sorted into the most appropriate level of care. These 11 criteria were clustered into four groups; medical condition, psychiatric condition alcohol/substance abuse and misuse patterns and consequences; and desire for assistance. Each criterion has been placed on a 5-point rating scale. Although Filstead changed his level of care to correspond to what was available to him in the community, he showed that with the 272 individuals who were evaluated using these criteria, the level of care was significantly related to 7 of his 11 criteria. Those which were not significant were drinking and use patterns, social support systems available, behavioral/social consequences due to drinking, and the patient's willingness to work on his/her problem. Even though not significantly related to level of care, Filstead insisted that they were still clinically relevant in assessing the patient's treatment needs.

Alcoholism Treatment in Oregon--A Political Perspective

During the Oregon State Legislative session of 1983, Senate Bill 522 was enacted, becoming Chapter 601 of Oregon Laws. This Senate Bill made sweeping revisions of the health care delivery system as regards requirements for coverage of mental illness and chemical dependency treatment by insurers. Indeed, so notable were these changes that the Alpha Center, a federally supported health policy research agency, cited this statute as one of the most innovative in our nation as regards health care. In its most general terms, this

statute provides limitations as regards reimbursement so as to facilitate "to the greatest extent possible, (that) the least costly settings for treatment, outpatient services and residential facilities, shall be widely available and utilized except when contraindicated because of individual health care needs" (Chapter 601, Sections 3 and 4, Oregon Laws, 1983). Many of the major changes involved treatment for mental illness and drug dependency other than alcoholism, but for our purposes only that part of the law dealing with alcoholism is addressed.

With the passage of this legislation, specific coverage amounts were identified for outpatient and non-hospital-residential treatment for alcoholism. In addition, any program, "licensed, approved, established, maintained, contracted with or operated by the Mental Health Division" was eligible (Chapter 601, Section 1(3)(4), Oregon Laws, 1983). Previously, no non-hospital-based program was eligible for reimbursement by insurance carriers. As can be imagined, this Bill was opposed by hospital-based programs and received far less than enthusiastic support from insurance companies. This even though, as reviewed above, outpatient and non-hospital-based treatment for alcoholism has been shown to be at least as effective as hospital-based care, and certainly far less expensive. Although the issue of licensure was key during the legislative process, and has continued to be important, especially to the hospital-based programs, the first mechanical issue around which groups polarized was the allowance of cost-containment methods by insurance companies. Basically, insurers could either provide for a lower copayment for residential and

outpatient services than for inpatient care (which has not received wide support) or employ a claims review process to assure appropriateness of both treatment setting and duration. Section 7 of Chapter 601 mandated that the State Health Planning and Development Agency (SHPDA) was to develop a nonbinding set of criteria to serve as a model for insurance companies in screening their clients in this review process. The SHPDA did so, generating the instrument which served as the basis for the questionnaire used in this study (see Appendix A). Their instrument met with fervent opposition by hospital-based programs. In general, they viewed the SHPDA instrument as too objective and inflexible, and wanted a more subjective instrument instead. To that end, the Oregon Medical Association (OMA) and the newly formed Oregon Association of Hospitals (OAH) proposed an alternative set of review criteria. Both the SHPDA and OMA-OAH instruments followed the principles of Chapter 601, especially as regards the policy that hospital-based inpatient care is justified for the treatment of alcoholism only when a medical condition is present which would require 24 hour attention. The OMA-OAH criteria were in use at the time of this study, with the SHPDA criteria being used as a "backup" as deemed necessary by the insurance companies who were using the review option.

Since the SHPDA instrument formed the basis for this study's questionnaire, it was important to examine its structure and intended use in more detail. As stated above, the SHPDA was charged by the Oregon State Legislature with developing model, nonbinding criteria by

which the least costly, most appropriate level of care could be objectively documented for clients seeking insurance reimbursement. The SHPDA thus created an inventory for this purpose. In this inventory, items were grouped into five clusters, consistent with their review of the literature as to pertinent data to be collected in making treatment setting decisions. These clusters were identified as follows: (1) presenting medical situation, including data of a medical nature obtained by direct observation of the client at admission; (2) social and occupational information, obtained by interview of the client and from significant others; (3) personal factors, including recent consequences of alcohol use and mental and emotional history and status, also obtained by interview; (4) medical history containing data regarding both alcohol related and alcohol unrelated physical conditions; and (5) prognostic factors, composed of a wide variety of data from level of motivation to use of other drugs, to alcoholism treatment history.

Each cluster (e.g., medical cluster) was composed of two or more items (e.g., blood alcohol level and vital signs). Each item was followed by 5 to 12 descriptive statements. For most items the series of descriptive statements was arranged in order of increasing severity. The interviewer's task was to check the most appropriate descriptive statement for each item for the client in question.

The intent of the Oregon State Health Planning and Development Agency in arranging the descriptive statements in this manner was to facilitate the use of cutoff points in level of care determinations. Intuitively, this seemed logical as level of care was defined as

outpatient, nonmedical inpatient or medical inpatient--each supposedly more intense than the one preceding it. In this way, descriptive statements of a certain severity would be proscriptive of appropriate level of care. Indeed, cutoff points on each item's continuum of descriptive statements were developed (see Appendix A). It was envisioned that these cutoff points would assist insurance companies in their claims review process.

Conclusion

Although several instruments existed to assess an individual's alcohol problem, aside from Filstead (1983) there was no evidence in the literature of an attempt to relate these instruments to the level of care provided beyond theoretical discussions. Even with Filstead, there was no mention of the skill level or training of the individual doing the evaluation. For an instrument to be usable in this field, it must be shown that it is not subject to wide variation by the evaluator, or it must be limited to certain evaluators with certain training and qualifications. The latter did not seem a reasonable alternative in the alcoholism field. As was shown earlier, providers come from widely diverse levels of training and experience, and each may use criteria for referral in a unique manner.

Given the preceding, three hypotheses emerged as being of interest, and are examined in this paper: (1) the descriptive statements of the SHPDA instrument, as designed and organized, are strongly and positively associated with treatment setting choice; (2) medically and

psychiatrically oriented sets of descriptive statements in the SHPDA instrument will account for more error in predicting treatment setting choices than socially oriented descriptive statements; and (3) personal characteristics of respondents using the SHPDA instrument will significantly affect choices of treatment setting.

CHAPTER 2

METHOD

Overview

The development of the questionnaire used in this study and the selection of respondents is discussed in some detail. Response rates, a major concern in this study, are then addressed, as well as a description of those respondents who did respond. Specific procedural points are addressed, including how respondents were contacted and instructions given to them. Finally, information about the type of statistical tests employed is presented.

The Questionnaire

A questionnaire was developed directly from the SHPDA instrument, so it is important to recall the earlier discussion on its creation and implementation (see Appendix B). The questionnaire used in this study was identical in content and structure to that of the SHPDA instrument. That is, clusters, items and descriptive statements on the SHPDA instrument were transferred directly to the questionnaire. As there were no clients to be evaluated, however, the questionnaire was arranged so that the respondent would decide level of care appropriate for each descriptive statement independently of all other descriptive statements, both in that cluster and outside that cluster. Although treatment setting choices are never made utilizing only one piece of

data, this was the only realistic way of assessing each descriptive statement's relationship to treatment settings.

Personal Data Sheet

For those respondents choosing to participate, a short personal data sheet was sent to them once the completed questionnaire had been received (see Appendix C). The personal data sheet asked only for the respondent's name and basic identifying data, as follows: agency employed by; current position title; length of time in their current position; length of paid experience in alcoholism/addiction treatment; formal degrees obtained; approximate number of hours of specialized training in addictions within the five years prior to this research, excluding that received as part of their formal degree; current certifications or licenses; whether or not the respondent was a recovering alcoholic/addict; and if recovering, how long had they been clean/sober.

Respondents

Lists of all licensed and/or approved alcoholism treatment programs within the state of Oregon were obtained from the Oregon State Mental Health Division, Office of Alcohol and Drug Programs, and the Oregon State Health Planning and Development Agency (SHPDA). Rather than seeking a representative sample, questionnaires were sent to all 145 programs generated from the lists, including 10 hospital-

based programs, 18 community mental health programs (those operated by the county mental health authority), and 117 private, nonprofit programs. The questionnaire was not addressed to any specific person at the programs. However, the cover letter (see Appendix B) was written to the program directors, and not only requested their assistance, but asked that they give the questionnaire to "the person(s) in your agency charged with making initial contact with clients to determine their appropriateness for treatment, and what level of treatment to refer them to." Of the 145 treatment programs contacted, 19 responded. Response rates were noticeably different depending upon the type of program contacted (see Table 1). None of the 10 hospital-based programs responded. Some communicated to this investigator that they felt that if they responded they would somehow be lending support or credibility to the SHPDA instrument, which they had adamantly opposed, as described earlier. Proportionately, almost four times as many county programs responded when compared to responding private nonprofits. Reasons for this significant disparity were not so readily apparent. Some programs stated they did not respond due to their already over-booked schedules, although it was reported that it took only 20 to 30 minutes to complete the questionnaire. At any rate within some programs, more than one individual responded, giving a sample size of 29. It should be noted that there was a biased sample, not only by the lack of hospital-based respondents, but also due to other self-selection factors.

Table 1

Alcoholism Treatment Programs Response Rates

Type of program	Total number	Number responding
Hospital-based	10	0
County health division	18	7
Private nonprofit	117	12
Total	145	19

Procedure

The questionnaire was distributed as indicated above. For those respondents choosing to participate, it was stated that once the initial questionnaire was returned, a short personal data sheet would be mailed to each respondent who had completed the initial questionnaire. This was done to minimize contamination of responses on the questionnaire relative to demographic variables of the respondents.

Instructions on the questionnaire defined four terms for the respondents as follows:

Twenty-four hour program: A treatment program in which the identified patient/client resided until the program was complete. This included short-term detoxification and longer-term rehabilitation stays.

Medical model: Programs which provided direct staffing by medical personnel, such as nurses and physicians. Usually located on or affiliated with a hospital, although not always. Treatment typically

consisted of a combination of pharmacotherapy, individual/group/ family counseling, alcoholism education, AA. Could also include aversive conditioning.

Social model: Programs which did not provide direct staffing by medical personnel, such as nurses and physicians, although consultation with such professionals usually was available. Most often freestanding. Treatment typically consisted of a combination of individual/group/family counseling, alcoholism education, AA. Not designed to treat serious or ongoing medical complications.

Outpatient program: A treatment program in which the individual patient/client resided in the community and came to the treatment facility for services. Visits might range from as infrequently as once per month to as often as several hours per day.

It was the respondent's task to evaluate each descriptive statement and decide which one treatment option would be most appropriate: 24 hour medical model, 24 hour social model, or outpatient. A fourth option, "selection not usually meaningful--no unusual choice indicated," was provided. The respondents were to place one number corresponding to the treatment of choice in a blank to the right of each descriptive statement.

Once the completed questionnaire was received, a follow-up personal data sheet was sent to the respondents to gather information about their length of time in their current position, their length of paid experience in the alcoholism/addiction treatment field, any formal degrees earned, their amount of training in addictions within the last 5 years (exclusive of all formal degrees), certifications or licenses

held, whether or not the respondent was a recovering alcoholic/addict and if so how much time had passed since they last used.

As the completed questionnaires were received, it became obvious that the number of programs responding would be so low as to jeopardize the examination of one or more of this study's hypotheses. Therefore, various steps were considered to enlist the cooperation of nonresponding programs. To this end, many programs were contacted personally by this investigator by phone to encourage their cooperation.

Hypotheses

Three hypotheses were formulated for examination in this study:

1. The descriptive statements of the SHPDA instrument, as designed and organized, are strongly and positively associated with treatment setting choice.
2. Medically and psychiatrically oriented sets of descriptive statements in the SHPDA instrument will account for more error in predicting treatment setting choices than socially oriented sets of descriptive statements.
3. Personal characteristics of respondents using the SHPDA instrument will significantly impact choices of treatment setting.

Analysis of Data

Measures of association were obtained for each of the 22 items with treatment choice as a test of the first hypothesis. As both the

items and treatment choice variables were nominal in nature, the measure of association used was the Guttman G (Freeman, 1965). Values thus obtained were then ranked and displayed in Table 2.

The Guttman G statistic is a coefficient of predictability which describes the degree of association between two nominal scales. It is especially useful in that it imposes no restrictions on the number of classes involved, has no unrealistic assumptions, and is directly interpretable. The value itself is obtained by the following:

$$G_a = \frac{\Sigma f_i - F_d}{N - F_d}$$

where

f_i = the maximum frequency found within each subclass of the independent variable,

F_d = the maximum frequency found among the totals of the dependent variable, and

N = number of cases.

As calculated in this manner, G_a is one-way, or asymmetrical.

To examine the second and third hypotheses, the descriptive statement responses on the questionnaire were tabulated and sorted by the personal data variables. Measures of association were then employed for the various personal data and descriptive statement combinations, yielding Guttman G (Freeman, 1965) values for those combinations of nominal X nominal variables and Theta (Freeman, 1965) values for those combinations of ordinal X nominal variables.

Table 2

Measures of Association for Questionnaire Items and Treatment Choice

Items (by cluster)	Guttman G value
Cluster I: Presenting medical situation	
1. Blood alcohol level	.14
2. Acute symptoms	.30
3. Vital signs	.30
4. Ambulation	.32
5. Seizures--this episode	.27
Cluster II: Social/occuapational context	
6. Social network incentives	.29
7. Social network disincentives	.21
8. Supervision/support available	.19
9. Self-support	.19
Cluster III: Personal context	
10. Recent consequences	.28
11. Mental and emotional status/history	.32
Cluster IV: Medical context	
12. Alcohol-nonrelated medical history	.28
13. Alcohol-related medical history	.28
Cluster V: Prognostic factors	
14. Desire and motivation for help	.16
15. Personal recognition of dependency	.04
16. Recognition/denial by significant other	.11
17. Alcohol use pattern	.28
18. Legally obtained mind-altering drugs use pattern	.24
19. Illegally obtained mind-altering drugs use pattern	.28
20. Alcoholism treatment history	.16
21. Detoxification history	.24
22. Follow-up performance	.14

The Theta statistic is a coefficient of differentiation or nominal-ordinal association and is useful for nominal-ordinal relationships. The value is calculated as follows:

$$R = \frac{\Sigma D_i}{T_2}$$

where

$D_i = /f_b - f_a/$

$f_b - f_a$ = frequency below minus frequency above for each pair of classes in the nominal scale, and

T_2 = obtained by multiplying the total frequency for each nominal class by the totals for each of the other classes two at a time and then summing the products.

Both Guttman G and Theta values are directly interpretable as "a value of X eliminates X% of errors in guessing one variable from the other."

CHAPTER 3

RESULTS

The instrument developed by the Oregon State Health Planning and Development Agency was designed so that most item's descriptive statements ranged from least chronic/severe and/or most prognostic of positive treatment outcome to most chronic/severe and/or least prognostic of positive treatment outcome. The questionnaire used in this study was constructed directly from that instrument. Treatment choices were also arranged numerically from most intense and/or medically oriented, with the additional item of "no usual choice indicated" on the questionnaire. It was thus expected that the descriptive statements within each item would exhibit strong measures of association with the treatment choice indicated. This was formulated as the first hypothesis. But as can be seen from an examination of Table 2, no Guttman G values exceeded .32. Nonetheless, visual inspection of responses to the descriptive statements revealed that consistent treatment choices occurred with some of these descriptive statements, regardless of the personal data obtained for the subject, as would have been expected if the first hypothesis had been upheld. In identifying these descriptive statements, those in which 85% of the respondents made the same treatment setting choice were seen as treated uniformly. This second level of analysis via visual inspection revealed that descriptive statement 10, describing very severe acute symptoms, resulted in respondents choosing hospital-based treatment

regardless of any of the personal data factors of the respondent examined. The same was true of descriptive statements 14 and 15, which once again described very poor vital signs, and descriptive statements 23 and 24, describing severe seizure conditions. Medical history descriptive statements 64 and 71, the former related to and the later not related to alcohol abuse or addiction, and both indicative of severe medical complications, also uniformly resulted in the selection of hospital-based care. And finally, descriptive statement 107, indicative of moderate use of illegal mind-altering drugs, uniformly resulted in the selection of outpatient treatment.

Some socially oriented descriptive statements also resulted in uniform treatment choices by respondents, consistent with the first hypothesis. Descriptive statement 27, assessing social network incentives for treatment, and relating to a situation of moderately good prognosis, uniformly resulted in the selection of outpatient treatment. Likewise, descriptive statements 36 and 37, indicative of very good to good supervision and support resources in the community, both resulted in the uniform selection of outpatient treatment. A strong desire and motivation for treatment, as reflected in descriptive statement 74, also uniformly resulted in outpatient treatment selection.

It was expected that the medically and psychiatrically oriented items and/or descriptive statements would show stronger measures of association with the treatment chosen than those items and/or descriptive statements not so oriented. This was formulated as the second hypothesis. The following items were considered medical and/or

psychiatric in nature in this regard: blood alcohol level, acute symptoms, vital signs, ambulation, and seizures--this episode (from Cluster I--presenting medical situation); mental and emotional status and history (from Cluster III--personal context); alcohol-nonrelated medical history and alcohol-related medical history (from Cluster IV--medical context); and alcohol use pattern, legally obtained mind-altering drugs use pattern, and illegally obtained mind-altering drugs use pattern (from Cluster V--prognostic factors). Similarly, the following criteria were considered social in nature: social network incentives, social network disincentives, supervision and support available, and self-support (from Cluster II--social/occupational context); recent consequences (from Cluster III--personal context); and desire and motivation for help, personal recognition of dependency, recognition/denial by significant other, alcoholism treatment history, detoxification history, and follow-up performance (from Cluster V--prognostic factors). Given these categorizations, 9 of the 11 highest Guttman G values were medically and/or psychiatrically oriented, while 9 of the 11 lowest Guttman G values were socially oriented (see Table 3).

An examination of the third hypothesis was to occur by sorting the descriptive statement responses by the five personal data characteristics which, it was believed, would significantly impact treatment choices. However, the small sample size precluded an examination of this hypothesis.

Table 3

Ranked Association Values for Questionnaire Items and Treatment Choice

Items	Guttman G value
Ambulation (I)*	.32
Mental and emotional status/history (III)	.32
Acute symptoms (I)	.30
Vital signs (I)	.30
Social network incentives (II)	.29
Recent consequences (III)	.28
Alcohol-nonrelated medical history (IV)	.28
Alcohol-related medical history (IV)	.28
Alcohol use pattern (V)	.28
Illegally obtained mind-altering drugs use pattern (V)	.28
Seizures--this episode (I)	.27
Legally obtained mind-altering drugs use pattern (V)	.24
Social network disincentives (II)	.21
Supervision/support available (II)	.19
Self-support (II)	.19
Desire and motivation for help (V)	.16
Alcoholism treatment history (V)	.16
Blood alcohol level (I)	.14
Recognition/denial by significant other (V)	.11
Personal recognition of dependency (V)	.04

*Roman numerals in parentheses following each item identify the cluster to which the item belongs.

CHAPTER 4

DISCUSSION

Throughout the discussion which follows, it must be remembered that the sample size (N = 29) has seriously affected the results. Most notably, probability statements are absent, leaving us only with comparisons of measures of association. But even at the level of comparisons, the small sample size must be kept in mind. In all cases the results must be interpreted not as absolutes, but as indicators suggesting further exploration.

Given the above it was still expected that each of the 22 items on the questionnaire would be strongly associated with the level of care chosen, as stated in the first hypothesis. As shown, no more than 32% of the error associated with predicting the treatment choice was accounted for by any single item. This leads to the suggestion that perhaps the SHPDA instrument is not a valid tool for determining level of care. Minimally it would appear that the vast majority of descriptive statements within the items themselves are not good predictors of level of care when used by this sample of subjects. As was mentioned, several individual descriptive statements (N = 14) are exceptional in this regard, but the remaining 119 descriptive statements are not.

Previous investigators have found and treatment professionals have stated that medical and/or psychiatric symptoms are or should be key determinants in level of care decisions. The second hypothesis

addressed this issue. Some (Filstead, 1982) have stated clearly that these should be the only issues in deciding hospital versus nonhospital care. Even though the SHPDA items individually showed weak levels of association, relative levels of association revealed that indeed medical and psychiatric items were more strongly associated with level of care chosen than other items. In fact, 10 of the 14 descriptive statements which resulted in uniform determinations were contained within medically oriented items. This would suggest that psychologically and socially related items lend themselves to much broader and less predictable treatment choices. Such issues as motivation, level of denial, and social support available have some of the weakest association with treatment choice. Although no one would deny the role these factors play in a client's progress once enrolled in treatment, they do not appear to be discriminatory factors in a choice of treatment settings. Of note is the fact that social network incentives and recent consequences of alcohol and/or substance abuse were the only two nonmedical and/or nonpsychiatric items in the top 11 when all items' associations were rank ordered. This would suggest that these factors may not only have value in relationship to predicting the progress in treatment, but also in determining level of care to be provided. It was also observed that medically oriented descriptive statements appeared to be more uniformly evaluated by respondents in determining level of care. More subjective descriptive statements, such as social supports, personal motivation for treatment, and recognition of dependency, while seen as important by providers in predicting

treatment success, appeared to be very weakly associated with choice of treatment setting.

The examination of descriptive statements by personal data factors relative to the third hypothesis, as discussed earlier, did not occur given the small sample size.

Among all the variances in responses, there were several descriptive statements (14 to be exact) that produced uniform treatment setting choices regardless of the personal data factor examined. Predictably, this uniformity occurred in relation to medically oriented descriptive statements depicting the most severe/chronic symptoms and/or the most prognostic of negative treatment outcome situations. For these descriptive statements, better than 85% of the respondents in the sample all chose hospital-based inpatient treatment. This is entirely consistent with the general belief in the field that hospital-based care should only be applied in the presence of some medical situation which warrants the added expense of that care, all other community resource factors being equal. In contrast, although some more socially oriented descriptive statements produced uniformity in treatment setting choice, this was the exception, not the rule. The direction of this uniformity was at the other end of the criterion involved. In other words, there was some uniformity in choice of outpatient care for clients who exhibited very good to good supervision and support in the community and a high level of personal desire and motivation for treatment. These situations tended to result in referral to an outpatient setting. One generalization, then, open for further

examination, would be that severe medical problems lead to referral to a hospital inpatient setting while some positive social indicators result in a greater likelihood of a referral to outpatient care. In neither situation is the converse true; the lack of medical complications does not appear to result in a uniform recommendation for outpatient care, and negatively prognostic social indicators do not result in a referral to hospital-based inpatient care.

In summary, several interesting effects were observed, but with the understanding that serious sampling problems left the observations as only signposts for further exploration as opposed to having reached a journey's end. Here, it is important to note the following:

1. The results of this study did not support the use of the State Health Planning and Development Agency instrument in its existing structure. There appeared to be little if any consistent association between treatment setting choices and the continuum of severity as expressed in each item's descriptive statements.
2. Relationships between items, however, supported the view that medically and psychiatrically oriented items result in stronger associations with treatment setting choice than do more socially oriented items. This relationship held at the descriptive statement level as well.

Certainly there exists a need for an objective rating of client's presenting symptoms and/or situations so as to aid in referral to the most appropriate treatment setting. This study would suggest that the

issues involved in developing and implementing such a rating may be much more complex and sensitive than would appear to be the case.

Meanwhile, within the state of Oregon, insurers were using the case review method to determine appropriate level of care for reimbursement purposes with the SHPDA instrument being the prime model. This raised some serious points to consider. First, of course, was the fact that this study showed no strong, consistent relationship between the SHPDA items and treatment choices by those participating in the study. One could argue that the limited sample size was a major factor in the absence of such a relationship. But it must be remembered that those participating in this study were most supportive of the use of the SHPDA instrument, and stood to gain the most by its adoption. Those least supportive, namely the hospital-based programs, did not participate. Thus if any subgroup of respondents should have shown the SHPDA instrument in its most positive light, those who did respond should have.

A second issue involved the existing way in which the SHPDA instrument was used, namely "cutoff points." Each item's continuum of descriptive statements was dissected by lines by SHPDA staff. Once the client's symptoms passed a given line, that was indicative of another level of care, or treatment setting choice. Except as regards 14 of the 133 descriptive statements in the SHPDA instrument (as discussed earlier) there was no support in this study for the use of cutoff points. This was especially true as regards non-medically-oriented descriptive statements.

In short, the SHPDA instrument would not, in all probability, do what it was designed to do: aid in the determination of the appropriate level of care for alcoholic clients for insurance reimbursement purposes. What would probably occur, as occurs when any instrument which doesn't work well is forced into a system, was that providers and reviewers would use the instrument to support their own beliefs about level of care rather than objectively evaluating the client before them. Thus the politics which interfered with the participation in the study would continue to interfere in appropriate level of care determinations.

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APPENDICES

APPENDIX A

SPECIFIC MODEL FOR PUBLIC COMMENT, TESTING, REVIEW, AND REVISION: INVENTORY FOR SELECTION AND REVIEW OF APPROPRIATE TREATMENT SETTING WHEN THE TREATMENT PRIORITY IS AN ALCOHOL PROBLEM

SPECIFIC MODEL FOR PUBLIC COMMENT, TESTING, REVIEW, AND REVISION: INVENTORY FOR SELECTION AND REVIEW OF APPROPRIATE TREATMENT SETTING WHEN THE TREATMENT PRIORITY IS AN ALCOHOL PROBLEM

S.M.P.D.A. 10-1-83

Site #: Program #: Date Person Admitted to Current Program if Any: Month Day Year / / Person Code: Persog's Age, Sex: Preparer Code: Based on info. as of: Month Day Year / /83

Instructions: On each scale below, (circle) specific applicable phrases or information and [bracket] the overall level or category statement which best applies. In general, if part of a statement at a higher level is true, bracket that statement (for certain scales, which are indicated, it may be appropriate to [bracket] more than one statement). If, on any particular scale, no specific information can be circled, do not bracket any statement (coding for that scale will be [0], meaning "not available or don't know.") This should occur infrequently and be resolved as soon as possible. The purpose is to inventory the individual's condition and circumstances at this time.

Clusters and Scales	Level 1	Level 2	Level 3	Level 4	Level 5
A. Presenting Medical Situation Cluster					
1. BREATHALIZER (Current Episode)	1. 0.0	2. 0.05 or more	3. 0.10 or more	4. 0.15 or more	5. 0.25 or more
1A. Highest Ever Breathalizer: ____					
2. ACUTE SYMPTOMS (be sure to circle all applicable)	1. No obvious acute medical problems.	2. Cold; mild digestive upset;, etc.	3. Does not keep down fluids, etc.	4. Tremors preventing performances of activities of daily living; abnormal electrolytes, but correctable in less than four hours; history of severe alcohol withdrawal syndrome.	5. Presence of infection requiring systemic antibiotic therapy; persistent postural blood changes; abnormal electrolytes, not correctable in less than four hours; current evidence of severe alcohol withdrawal syndrome
3. VITAL SIGNS	1. Vital signs within normal limits.	2. One vital sign indicates moderate impairment: slightly irregular heart rate: pulse 100 or above; diastolic blood pressure 100 to 120	3. Several vital signs indicate moderate impairment: slightly irregular heart rate; pulse 100 or above; diastolic blood pressure 100 to 120	4. One vital sign indicates severe impairment: grossly irregular heart rate, diastolic blood pressure 120 or more; fever greater than 100.0° F.	5. Several vital signs indicate severe impairment: grossly irregular heart rate; diastolic blood pressure 120 or more; fever greater than 100.0°F.
4. AMBULATION (at present; neuropathy is on scale 13)	1. Normal gait	2. Unsteady, but does not require assistance	3. Unsteady, and requires assistance	4. Cannot walk, except with assistance	5. Cannot walk, even with assistance.
5. SEIZURES (at present; describe history on scales 12 and/or 13)	1. No current evidence of seizure	2. First time seizures	3. More than three seizures this withdrawal	4. Focal seizure	5. New seizure not clearly related to withdrawal.

8. Social and Occupational Context Cluster					
6. SOCIAL NETWORK INCENTIVES (immediately prior to this time) Comments: aspects and members of network described: _____	1. Ongoing relationships with and among significant others exist and the significant others recognize problems, are encouraging treatment, are committed to own involvement in supportive recovery and maintenance activities.	2. Ongoing relationships with and among significant others exist and the significant others recognize problems, appear open to learning to encourage treatment and to be involved in supportive recovery and maintenance activities.	3. Ongoing relationships with and among significant others exist and are of a quality such that brief, intensive intervention could make therapeutic and supportive involvement feasible, but the significant others minimize problems, do not encourage treatment, resist own involvement.	4. Ongoing relationships with and among significant others exist but are currently of a quality that will necessitate substantial, continuing intervention before therapeutic and supportive involvement is feasible, or, relationships exist but have been subjected to recent major change (death, retirement, major illness, of one or several significant others.)	5. Ongoing relationships to and among significant others have not existed for some time or have suddenly terminated, and for all practical purposes, no "natural" significant others now exist.
7. SOCIAL NETWORK DISINCENTIVES (immediately prior to this time) Comments: aspects and members of network described: _____	1. Social network exists, it has positive <u>potential</u> but current relationships in it have neither positive nor negative impact on the alcohol and/or substance abuse.	2. Individual is isolated from others; there are no current ongoing relationships on which to build for therapeutic and supportive involvement.	3. Ongoing relationships to and among significant others exist but are currently of a quality that will necessitate substantial, continuing intervention before therapeutic and supportive involvement is feasible.	4. Ongoing relationships are negative, detrimental, strong; effective continuing intervention does not seem possible. However, the significant others involved are not necessarily abusers.	5. Ongoing relationships enable, encourage, facilitate, abuse; are destructive and counter-therapeutic; the significant others involved, or some of them, are abusers.
8. SUPERVISION AND SUPPORT AVAILABLE (in current "home" living situation)	1. Responsible non-abuser of alcohol and other drugs is available to lend support and encouragement for maintaining treatment objectives nearly all the time, day and night.	2. Responsible non-abuser of alcohol and other drugs is available to lend support and encouragement for maintaining treatment objectives; lives in, but is away for work, school, etc., part of each day; can periodically communicate support, and medication reminders (if needed), at all times, even when away.	3. Responsible non-abuser of alcohol and other drugs is available to lend support and encouragement for maintaining treatment objectives; lives in, but is away for work, school, etc., part of each day; can<u>not</u> periodically communicate support, and medication reminders (if needed), when away.	4. Responsible non-abuser of alcohol and other drugs is available to lend support and encouragement for maintaining treatment objectives; does <u>not</u> live in, but can visit regularly, can periodically communicate support, and medication reminders (if needed), when away.	5. Responsible non-abuser of alcohol and other drugs is not available to lend support and encouragement for maintaining treatment objectives; does not live in, cannot visit regularly, and probably cannot periodically communicate support, or medication reminders (if needed), when away.

9. SELF SUPPORT IN SOCIETY	1. Communication skills, literacy, education, vocational skills, are sufficient to have consistently supported the individual in a defined social/occupational role up to now.	2. Skills have been sufficient to have consistently supported the individual in a defined social/occupational role until the time period immediately preceding this assessment.	3. Skills have been sufficient to have consistently supported the individual in a defined social/occupational role except for a number of episodes or periods apparently precipitated by alcohol or substance use during a time when social/occupational role did not change.	4. Skills have not always been sufficient to have supported the individual in a defined social/occupational role in the past because of externally forced changes in social/occupational role, rather than because of increased alcohol or substance use, but there is reasonable evidence of potential to rehabilitation and/or improve skills to an adequate level within a reasonable time.	5. Whether or not skills have been sufficient to have supported the individual in a defined social/occupational role in the past, there is reasonable evidence that the skills cannot be rehabilitated and/or improved to an adequate level within a reasonable time; prognosis for subsequent independent living is poor, may or may not be braindamaged, may require protected living for rest of life.
9A. SKILL LEVEL INDICATES POTENTIAL FOR UPWARD MOBILITY: Circle YES or NO or ?					
9B. REALISTIC OPPORTUNITIES FOR UPWARD MOBILITY: Circle YES or NO or ?					
C. Personal Context Cluster 10. RECENT CONSEQUENCES (of alcohol and/or substance use)	1. No problems reported in the most recent 12 months by family, employer or legal authorities, etc., because of alcohol or substance use.	2. Family objections in the most recent 12 months to alcohol or substance use; deterioration of hobbies, activities, social life; verbal abuse of family members; embarassing behavior at functions.	3. In the most recent 12 months, threat of divorce; history of separation(s); court referral; arrested and charged with driving under the influence; effects on behavior and/or school work of children; loss of custody of children (for men); loss of friends because of violence or fights.	4. In the most recent 12 months, absenteeism; intoxification on the job; recent or pending divorce; loss of custody of children (for women); history of arrest for violence towards family; history of child abuse and/or neglect.	5. Long-term or recent history of court ordered treatment; incarceration because of alcohol or substance abuse; history of arrest for violence to others; history of loss of job because of drinking or substance abuse.
11. MENTAL AND EMOTIONAL STATUS AND HISTORY	1. Can utilize information in a rational and consistent fashion; no history of psychiatric diagnosis or treatment.	2. No appearance of current mental or emotional disturbance, but history of mental or emotional impairment and/or specific history of insomnia, nervousness, brief outpatient psychiatric treatment, or of self-destructive thoughts.	3. Agitated or belligerent at this time; angry, anxious, or suspicious at this time; and/or history of properly diagnosed depression, anxiety, moodswings, and/or extensive outpatient psychiatric treatment; history of chronic psychiatric condition, now asymptomatic; recent but not current psychiatric diagnosis; or, recent (last 6 months) suicide plan.	4. Confused, poor memory, disoriented to time or place, at this time; or weepy, depressed, or flat affect at this time; or just transferred from, or currently in a psychiatric hospital or ward, as a short term (30 days or less) hospitalization; or history of psychiatric hospitalization, condition currently controlled by medications; or singular suicide attempt.	5. Ongoing hallucinations and/or history of inability to function in society because of psychiatric condition; history of more than one psychiatric hospitalization not related to alcohol or substance abuse; history of residence in a psychiatric institution for six months or more; or emergency room intervention for prior suicide attempt(s). Presence of alcohol-induced brain damage may have been demonstrated.

B. Medical Context Cluster

12. MEDICAL HISTORY AND CONDITION APART FROM ALCOHOL AND/OR SUBSTANCE ABUSE

1. No presenting transient or chronic medical problems or conditions except those primarily traceable to alcohol or other drug use; and is not current smoker.
2. No presenting transient or chronic medical problems or conditions except those primarily traceable to alcohol or other drug use; and is current smoker.
3. Minor transient or chronic problems, not traceable to alcohol or other drug use; and requiring short-term treatment.
4. Marked, but not life-threatening problems such as blindness, deafness, etc., and requiring continuing treatment.
5. Severe, life-threatening, acute medical problems not primarily traceable to alcohol or other drug use.

12A. SPECIFIC HISTORY:

1. History of seizures that are not related to alcohol and/or substance use: Circle YES or NO or ?
2. History of grand mal seizures prior to alcohol abuse: Circle YES or NO or ?
3. If Yes to (1) or (2), ever controlled by medication: Circle YES or NO or ? and specify the medication(s), if known: _____.
4. Under medication most recent 6 months: Circle YES or NO or ? If yes, what medication(s), if known: _____.
5. If Yes to (4), was medication regime consistently followed during most recent 6 months: Circle YES or NO or ?
6. Special dietary needs?

13. MEDICAL HISTORY AND CONDITION RELATED TO ALCOHOL AND/OR OTHER DRUG ABUSE (The underlying issue is not chronicity, but whether something is at an active level of severity such as to require hospitalization and urgent or continuous intervention)

1. No presenting transient or chronic medical problems or conditions traceable to alcohol or other drug use.
2. Minor transient or chronic problems, traceable to alcohol or other drug abuse, such as swelling feet or ankles, sporadic eating, glandular swelling, wine sores; present treatment is being followed and is effective.
3. Transient or chronic problems traceable to alcohol or other drug abuse, such as swelling feet or ankles, sporadic eating, glandular swelling, wine sores; present treatment, if any, is not being followed or is not effective.
4. Marked, but not immediately life-threatening problems, traceable to alcohol or other drug abuse, such as gout; heart disease; lung diseases; liver disease; pancreatic failure; brain damage; skin ulceration.
5. Severe, life-threatening problems primarily traceable to alcohol or other drug use, such as stomach or intestinal bleeding; pancreatitis, alcoholic hepatitis; congestive heart failure; respiratory distress.

13A. SPECIFIC HISTORY:

1. History of seizures that are related to alcohol or other drug use: Circle YES or NO or ?
2. History of grand mal seizures subsequent to alcohol abuse: Circle YES or NO or ?
3. If Yes to (1) or (2), ever controlled by medication: Circle YES or NO or ? and specify the medication(s) if known: _____.
4. Under medication most recent 6 months: Circle YES or NO or ? If yes, what medication(s), if known: _____.
5. If Yes to (4), was medication regime consistently followed during most recent 6 months: Circle YES or NO or ?

E. Prognostic Factors Cluster 14. DESIRE OR MOTIVATION FOR HELP (as expressed and manifest)	1. Individual spontaneously and freely expresses concern about impact of alcohol problem on signficant others in the home and/or occupational situation; has verbalized step-by-step plan for managing self; is following plan; is fully committed to, and performing well, in treatment; is utilizing both "natural" support resources and self-help group involvement.	2. Individual freely expresses concern about impact; has verbalized step-by-step plan for managing self; plan may or may not involve "natural" support resources and/or self-help group involvement; supervision is necessary to maintain performance in treatment; commitment occasionally lapses.	3. Individual expresses concern about impact of problem on others, but this is manifested as "if only I didn't...," without verbalized step-by-step plan for managing self. Wants to do something, but is not firmly committed.	4. Individual does not express concern, but agrees that he/she should, when questioned about it. Is not sure, or has reservations, about treatment.	5. Individual does not express concern, and disagrees that he/she should, when questioned about it. Does not want to do anything about it, has no desire for assistance.
14A. Court Mandated? Circle YES or No.					
15. RECOGNITION OF DEPENDENCY	1. Individual spontaneously and freely, explicitly, but appropriately, tells others that he/she is dependent on alcohol and/or other drugs.	2. Individual spontaneously and freely, explicitly, but inappropriately and/or with excessive frequency, tells others that he/she is dependent on alcohol and/or other drugs.	3. Individual accurately and always identifies self as dependent on alcohol and/or other drugs, but only when asked directly.	4. Individual sometimes identifies self as dependent on alcohol and/or other drugs, when asked directly.	5. When asked directly, individual seldom or never identifies self as dependent on alcohol and/or other drugs.
16. RECOGNITION OR DENIAL AS EXPRESSED BY MOST SIGNIFICANT OTHER	1. Most significant other spontaneously and freely, explicitly, but appropriately, tells others that the individual is dependent on alcohol and/or other drugs.	2. Most significant other spontaneously and freely, explicitly, but inappropriately and/or with excessive frequency, tells others that the individual is dependent on alcohol and/or other drugs.	3. Most significant other accurately and always identifies the individual as dependent on alcohol and/or other drugs, but only when asked directly.	4. Most significant other sometimes identifies the individual as dependent on alcohol and/or other drugs, when asked directly.	5. When asked directly, most significant other seldom or never identifies the individual as dependent on alcohol and/or other drugs.

17. PATTERN OF ALCOHOL USE	1. Abstinent (CPMS "0") during the month prior to this date.	2. Light or moderate drinking on social occasions, usually less than daily (CPMS "1"), without impaired functioning.	3. Moderate Abuse (CPMS "2"): recognizable pattern of excessive use, such as daily, regardless of social occasions; mildly impaired functioning; no signs of withdrawal; occasional binges.	4. Serious Abuse (CPMS "3"): recognizable pattern of excessive use, such as frequent binge drinking, or heavy drinking several times a week; seriously impaired functioning; no signs of withdrawal.	5. Moderate Addiction (CPMS "4"): recognizable pattern of excessive use; seriously impaired functioning; with signs of tolerance and/or withdrawal; blackouts.	6. Serious Addiction (CPMS "5"): recognizable pattern of excessive use; seriously impaired functioning; with signs of tolerance and/or withdrawal, and with prolonged history of addiction; shakes, tremors.	7. Chronic Addiction (CPMS "6"): under the continuous influence of alcohol; morning drinking; highly dysfunctional; experiences severe withdrawal cannot stay alcohol free.
18. PATTERN OF USE OF LEGALLY OBTAINED MIND-ALTERING DRUGS (See List); Specify drug(s): _____ _____ _____ _____ _____	1. No use (CPMS "0") during the month prior to this date.	2. Less than weekly use (CPMS "1").	3. Use once per week (CPMS "2").	4. Use several times per week (CPMS "3").	5. Use daily (CPMS "4"); signs of tolerance and/or withdrawal.	6. Use two to three times daily (CPMS "5"); signs of tolerance and/or withdrawal.	7. Use more than three times daily (CPMS "6"); severe withdrawal; cannot stay drug free.
19. PATTERN OF USE OF MIND-ALTERING DRUGS NOT OBTAINED LEGALLY (Include marijuana) (See List): Specify drug(s): _____ _____ _____ _____ _____	1. No use (CPMS "0") during the month prior to this date.	2. Less than weekly use (CPMS "1").	3. Use once per week (CPMS "2").	4. Use several times per week (CPMS "3").	5. Use daily (CPMS "4"); signs of tolerance and/or withdrawal.	6. Use two to three times daily (CPMS "5"); signs of tolerance and/or withdrawal.	7. Use more than three times daily (CPMS "6"); severe withdrawal; cannot stay drug free.

20. PRIOR ALCOHOL TREATMENT HISTORY (circle all applicable), BY TREATMENT INTENSITY (indicate number of times for each in the boxes)

1. Has never received alcohol treatment, even though may have been referred.
2. Four times per month, or less, participation in treatment; or at least monthly participation in treatment ☐
3. Five to twenty times per month; or at least weekly participation in treatment. ☐
4. One contact per day; or participation at least five times per week in treatment. ☐
5. Dry, supportive living environment combined with self-help (such as A.A., N.A., or equivalent. ☐
6. Residential treatment that provides up to 30 hours per week of structured treatment outside of a Health Division licensed hospital; including general supervision, personal care, counseling, skill building, and episodic or minimal medical attention. ☐
7. Intensive Residential Treatment that provides at least 30 hours per week of structured treatment outside of a Health Division licensed hospital; including general supervision, personal care, intensive counseling and skill building, and episodic or minimal medical attention. ☐
8. Treatment in a Health Division licensed general hospital with direct nursing supervision and with medical attention immediately available as needed, in addition to alcohol treatment. Circle as applicable:
   a. Emergency Room ☐
   b. Medical-Surgical Unit ☐
   c. Alcohol Unit ☐
   d. Psychiatric Unit ☐
9. Treatment in a Health Division licensed specialty hospital with direct nursing supervision and with medical attention immediately available as needed, in addition to alcohol treatment. Circle as applicable:
   a. Alcohol ☐
   b. Polydrug ☐
   c. Psychiatric ☐

20A. Adjunctive therapy with antabuse?

20B. Adjunctive therapy with valium?

20C. Adjunctive therapy with _____?

20D. SELF-HELP MAINTENANCE (A.A., N.A., or equivalent)
1. How many times has individual tried maintenance in normal living environment with A.A., N.A., or equivalent self-help? ☐
2. If this has been tried, how many times did it result in abstinence for a period of six months or more? ☐

21. DETOXIFICATION HISTORY (Reduction of primary withdrawal symptoms; circle all applicable, and indicate number of times for each in the boxes)

1. Has never been treated for this purpose, even though may have been referred.
2. Outpatient basis. ☐
3. Residential (24 hour) basis outside of a Health Division licensed hospital. ☐
4. In a Health Division licensed general hospital circle as applicable:
   a. Emergency Room ☐
   b. Medical-Surgical Unit ☐
   c. Alcohol Unit ☐
   d. Psychiatric Unit ☐
5. In a Health Division licensed specialty hospital; circle as applicable:
   a. Alcohol ☐
   b. Polydrug ☐
   c. Psychiatric ☐

22. FOLLOW-UP PERFORMANCE (most recent episode)

1. No episode, or no episode within last ten years.
2. Participated regularly in aftercare, the prescribed amount of time.
3. Participated intermittently, but adequately, in aftercare, the prescribed amount of time.
4. Participated intermittently, but not adequately, in aftercare, the prescribed amount of time.
5. Did not participate in aftercare for the prescribed amount of time.

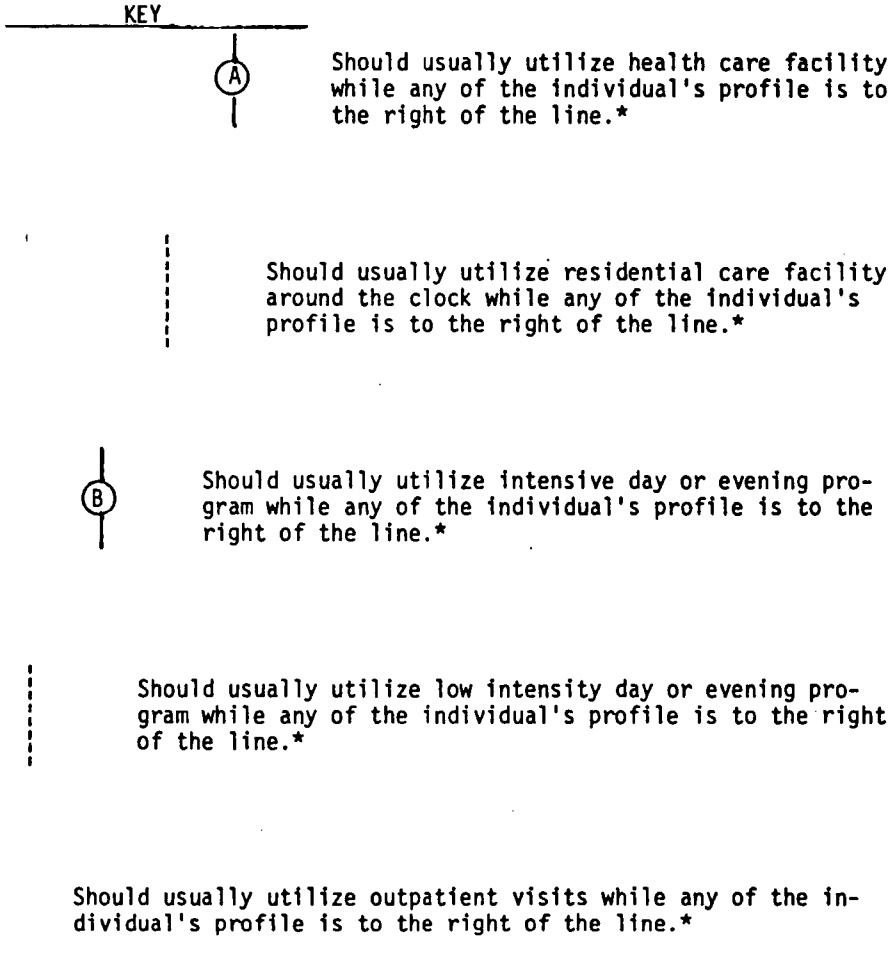
23. AGE OF FIRST INTOXICATION: [ ]

24. AGE BY WHICH REGULAR DRINKING PATTERN WAS ESTABLISHED: [ ]

25. NUMBER OF BLOODLINE RELATIVES WITH ESTABLISHED PATTERNS OF ABUSIVE DRINKING

1. Grandparental generation [ ]
2. Parental generation [ ]
3. Children [ ]
4. Grandchildren [ ]
5. Spouse(s) or consistent living partners [ ]
6. Relatives of (5) [ ]

Specific Example of Possible Reimbursement
Specifications Based on Descriptor Matrix



*Provided that there is an alcohol problem and that prognostic factors, and probable outcome weighed against costs, indicate that treatment should proceed.

SPECIFIC MODEL FOR PUBLIC COMMENT, TESTING, REVIEW, AND REVISION: INVENTORY FOR SELECTION AND REVIEW OF APPROPRIATE TREATMENT SETTING WHEN THE TREATMENT PRIORITY IS AN ALCOHOL PROBLEM

S.H.P.D.A.
10-1-83

Site #: Program #: Date Person Admitted to Current Program if Any: Month Day Year / / Person Code: Person's Age, Sex: Preparer Code: Based on info. as of: Month Day Year / /83

Instructions: On each scale below, (circle) specific applicable phrases or information and [bracket] the overall level or category statement which best applies. In general, if part of a statement at a higher level is true, bracket that statement (for certain scales, which are indicated, it may be appropriate to [bracket] more than one statement). If, on any particular scale, no specific information can be circled, do not bracket any statement (coding for that scale will be [0], meaning "not available or don't know.") This should occur infrequently and be resolved as soon as possible. The purpose is to inventory the individual's condition and circumstances at this time.

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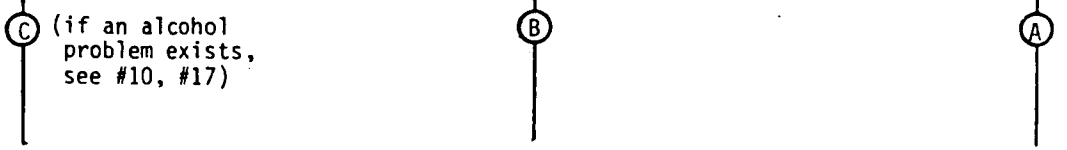

8. Social and Occupational Context Cluster

6. SOCIAL NETWORK INCENTIVES (immediately prior to this time) Comments: aspects and members of network described: _____	1. Ongoing relationships with and among significant others exist and the significant others recognize problems, are encouraging treatment, are committed to own involvement in supportive recovery and maintenance activities.	2. Ongoing relationships with and among significant others exist and the significant others recognize problems, appear open to learning to encourage treatment and to be involved in supportive recovery and maintenance activities.	3. Ongoing relationships with and among significant others exist and are of a quality such that brief, intensive intervention could make therapeutic and supportive involvement feasible, but the significant others minimize problems, do not encourage treatment, resist own involvement.	4. Ongoing relationships with and among significant others exist but are currently of a quality that will necessitate substantial, continuing intervention before therapeutic and supportive involvement is feasible, or, relationships exist but have been subjected to recent major change (death, retirement, major illness, of one or several significant others.)	5. Onguing relationships to and among significant others have not existed for some time or have suddenly terminated, and for all practical purposes, no "natural" significant others now exist.
7. SOCIAL NETWORK DISINCENTIVES (immediately prior to this time) Comments: aspects and members of network described: _____	1. Social network exists, it has positive potential but current relationships in it have neither positive nor negative impact on the alcohol and/or substance abuse.	2. Individual is isolated from others; there are no current ongoing relationships on which to build for therapeutic and supportive involvement.	3. Ongoing relationships to and among significant others exist but are currently of a quality that will necessitate substantial, continuing intervention before therapeutic and supportive involvement is feasible.	4. Ongoing relationships are negative, detrimental, strong; effective continuing intervention does not seem possible. However, the significant others involved are not necessarily abusers.	5. Ongoing relationships enable, encourage, facilitate, abuse; are destructive and counter-therapeutic; the significant others involved, or some of them, are abusers.
8. SUPERVISION AND SUPPORT AVAILABLE (in current "home" living situation)	1. Responsible non-abuser of alcohol and other drugs is available to lend support and encouragement for maintaining treatment objectives nearly all the time, day and night.	2. Responsible non-abuser of alcohol and other drugs is available to lend support and encouragement for maintaining treatment objectives; lives in, but is away for work, school, etc., part of each day; can periodically communicate support, and medication reminders (if needed), at all times, even when away.	3. Responsible non-abuser of alcohol and other drugs is available to lend support and encouragement for maintaining treatment objectives; lives in, but is away for work, school, etc., part of each day; can not periodically communicate support, and medication reminders (if needed), when away.	4. Responsible non-abuser of alcohol and other drugs is available to lend support and encouragement for maintaining treatment objectives; does not live in, but can visit regularly, can periodically communicate support, and medication reminders (if needed), when away.	5. Responsible non-abuser of alcohol and other drugs is not available to lend support and encouragement for maintaining treatment objectives; does not live in, cannot visit regularly, and probably cannot periodically communicate support, or medication reminders (if needed), when away.

(C) (if an alcohol problem exists, see #10, #17)

(B)

(A)

9. SELF SUPPORT IN SOCIETY	1. Communication skills, literacy, education, vocational skills, are sufficient to have consistently supported the individual in a defined social/occupational role up to now.	2. Skills have been sufficient to have consistently supported the individual in a defined social/occupational role until the time period immediately preceding this assessment.	3. Skills have been sufficient to have consistently supported the individual in a defined social/occupational role except for a number of episodes or periods apparently precipitated by alcohol or substance use during a time when social/occupational role did not change.	4. Skills have not always been sufficient to have supported the individual in a defined social/occupational role in the past because of externally forced changes in social/occupational role, rather than because of increased alcohol or substance use, but there is reasonable evidence of potential to rehabilitation and/or improve skills to an adequate level within a reasonable time.	5. Whether or not skills have been sufficient to have supported the individual in a defined social/occupational role in the past, there is reasonable evidence that the skills cannot be rehabilitated and/or improved to an adequate level within a reasonable time; prognosis for subsequent independent living is poor, may or may not be braindamaged, may require protected living for rest of life.
9A. SKILL LEVEL INDICATES POTENTIAL FOR UPWARD MOBILITY: Circle YES or NO or ?					
9B. REALISTIC OPPORTUNITIES FOR UPWARD MOBILITY: Circle YES or NO or ?					
C. Personal Context Cluster 10. RECENT CONSEQUENCES (of alcohol and/or substance use)	1. No problems reported in the most recent 12 months by family, employer or legal authorities, etc., because of alcohol or substance use.	2. Family objections in the most recent 12 months to alcohol or substance use; deterioration of hobbies, activities, social life; verbal abuse of family members; embarassing behavior at functions.	3. In the most recent 12 months, threat of divorce; history of separation(s); court referral; arrested and charged with driving under the influence; effects on behavior and/or school work of children; loss of custody of children (for men); loss of friends because of violence or fights.	4. In the most recent 12 months, absenteeism; intoxification on the job; recent or pending divorce; loss of custody of children (for women); history of arrest for violence towards family; history of child abuse and/or neglect.	5. Long-term or recent history of court ordered treatment; incarceration because of alcohol or substance abuse; history of arrest for violence to others; history of loss of job because of drinking or substance abuse.
11. MENTAL AND EMOTIONAL STATUS AND HISTORY	1. Can utilize information in a rational and consistent fashion; no history of psychiatric diagnosis or treatment.	2. No appearance of current mental or emotional disturbance, but history of mental or emotional impairment and/or specific history of insomnia, nervousness, brief outpatient psychiatric treatment, or of self-destructive thoughts.	3. Agitated or belligerent at this time; angry, anxious, or suspicious at this time; and/or history of properly diagnosed depression, anxiety, moodswings, and/or extensive outpatient psychiatric treatment; history of chronic psychiatric condition, now asymptomatic; recent but not current psychiatric diagnosis; or, recent (last 6 months) suicide plan.	4. Confused, poor memory, disoriented to time or place, at this time; or weepy, depressed, or flat affect at this time; or just transferred from, or currently in a psychiatric hospital or ward, as a short term (30 days or less) hospitalization; or history of psychiatric hospitalization, condition currently controlled by medications; or singular suicide attempt.	5. Ongoing hallucinations and/or history of inability to function in society because of psychiatric condition; history of more than one psychiatric hospitalization not related to alcohol or substance abuse; history of residence in a psychiatric institution for six months or more; or emergency room intervention for prior suicide attempt(s). Presence of alcohol-induced brain damage may have been demonstrated.

(C) (if an alcohol problem exists, see #10, #17)

(B)

(A)

9. Medical Context Cluster **12. MEDICAL HISTORY AND CONDITION APART FROM ALCOHOL AND/OR SUBSTANCE ABUSE**	1. No presenting transient or chronic medical problems or conditions except those primarily traceable to alcohol or other drug use; and is not current smoker.	2. No presenting transient or chronic medical problems or conditions except those primarily traceable to alcohol or other drug use; and is current smoker.	3. Minor transient or chronic problems, not traceable to alcohol or other drug use; and requiring short-term treatment.	4. Marked, but not life-threatening problems such as blindness, deafness, etc., and requiring continuing treatment.	5. Severe, life-threatening, acute medical problems not primarily traceable to alcohol or other drug use.

12A. SPECIFIC HISTORY:
1. History of seizures that are not related to alcohol and/or substance use: Circle YES or NO or ?
2. History of grand mal seizures prior to alcohol abuse: Circle YES or NO or ?
3. If Yes to (1) or (2), ever controlled by medication: Circle YES or NO or ? and specify the medication(s), if known: _____.
4. Under medication most recent 6 months: Circle YES or NO or ? If yes, what medication(s), if known: _____.
5. If Yes to (4), was medication regime consistently followed during most recent 6 months: Circle YES or NO or ?
6. Special dietary needs?

13. MEDICAL HISTORY AND CONDITION RELATED TO ALCOHOL AND/OR OTHER DRUG ABUSE (The underlying issue is not chronicity, but whether something is at an active level of severity such as to require hospitalization and urgent or continuous intervention)	1. No presenting transient or chronic medical problems or conditions traceable to alcohol or other drug use.	2. Minor transient or chronic problems, traceable to alcohol or other drug abuse, such as swelling feet or ankles, sporadic eating, glandular swelling, wine sores; present treatment is being followed and is effective.	3. Transient or chronic problems traceable to alcohol or other drug abuse, such as swelling feet or ankles, sporadic eating, glandular swelling, wine sores; present treatment, if any, is not being followed or is not effective.	4. Marked, but not immediately life-threatening problems, traceable to alcohol or other drug abuse, such as gout; heart disease; lung diseases; liver disease; pancreatic failure; brain damage; skin ulceration.	5. Severe, life-threatening problems primarily traceable to alcohol or other drug use, such as stomach or intestinal bleeding; pancreatitis, alcoholic hepatitis; congestive heart failure; respiratory distress.

13A. SPECIFIC HISTORY:
1. History of seizures that are related to alcohol or other drug use: Circle YES or No or ?
2. History of grand mal seizures subsequent to alcohol abuse: Circle YES or NO or ?
3. If Yes to (1) or (2), ever controlled by medication: Circle YES or NO or ? and specify the medication(s) if known: _____.
4. Under medication most recent 6 months: Circle YES or NO or ? If yes, what medication(s), if known: _____.
5. If Yes to (4), was medication regime consistently followed during most recent 6 months: Circle YES or NO or ?

(C) (if an alcohol problem exists, see #10, #17)
(may need (B) for other reasons)
(A)

E. Prognostic Factors Cluster 14. DESIRE OR MOTIVATION FOR HELP (as expressed and manifest)	1. Individual spontaneously and freely expresses concern about impact of alcohol problem on signficant others in the home and/or occupational situation; has verbalized step-by-step plan for managing self; is following plan; is fully committed to, and performing well, in treatment; is utilizing both "natural" support resources and self-help group involvement.	2. Individual freely expresses concern about impact; has verbalized step-by-step plan for managing self; plan may or may not involve "natural" support resources and/or self-help group involvement; supervision is necessary to maintain performance in treatment; commitment occasionally lapses.	3. Individual expresses concern about impact of problem on others, but this is manifested as "if only I didn't...," without verbalized step-by-step plan for managing self. Wants to do something, but is not firmly committed.	4. Individual does not express concern, but agrees that he/she should, when questioned about it. Is not sure, or has reservations, about treatment.	5. Individual does not express concern, and disagrees that he/she should, when questioned about it. Does not want to do anything about it, has no desire for assistance.
14A. Court Mandated? Circle YES or No.					
15. RECOGNITION OF DEPENDENCY	1. Individual spontaneously and freely, explicitly, but appropriately, tells others that he/she is dependent on alcohol and/or other drugs.	2. Individual spontaneously and freely, explicitly, but inappropriately and/or with excessive frequency, tells others that he/she is dependent on alcohol and/or other drugs.	3. Individual accurately and always identifies self as dependent on alcohol and/or other drugs, but only when asked directly.	4. Individual sometimes identifies self as dependent on alcohol and/or other drugs, when asked directly.	5. When asked directly, individual seldom or never identifies self as dependent on alcohol and/or other drugs.
16. RECOGNITION OR DENIAL AS EXPRESSED BY MOST SIGNIFICANT OTHER	1. Most significant other spontaneously and freely, explicitly, but appropriately, tells others that the individual is dependent on alcohol and/or other drugs.	2. Most significant other spontaneously and freely, explicitly, but inappropriately and/or with excessive frequency, tells others that the individual is dependent on alcohol and/or other drugs.	3. Most significant other accurately and always identifies the individual as dependent on alcohol and/or other drugs, but only when asked directly.	4. Most significant other sometimes identifies the individual as dependent on alcohol and/or other drugs, when asked directly.	5. When asked directly, most significant other seldom or never identifies the individual as dependent on alcohol and/or other drugs.

(C) (if an alcohol problem exists, see #10, #17)

(B)

(A)

17. PATTERN OF ALCOHOL USE	1. Abstinent (CPMS "0") during the month prior to this date.	2. Light or moderate drinking on social occasions, usually less than daily (CPMS "1"), without impaired functioning.	3. Moderate Abuse (CPMS "2"): recognizable pattern of excessive use, such as daily, regardless of social occasions; mildly impaired functioning; no signs of withdrawal; occasional binges.	4. Serious Abuse (CPMS "3"): recognizable pattern of excessive use, such as frequent binge drinking, or heavy drinking several times a week; seriously impaired functioning; no signs of withdrawal.	5. Moderate Addiction (CPMS "4"): recognizable pattern of excessive use; seriously impaired functioning; with signs of tolerance and/or withdrawal; blackouts.	6. Serious Addiction (CPMS "5"): recognizable pattern of excessive use; seriously impaired functioning; with signs of tolerance and/or withdrawal, and with prolonged history of addiction; shakes, tremors.	7. Chronic Addiction (CPMS "6"): under the continuous influence of alcohol; morning drinking; highly dysfunctional; experiences severe withdrawal cannot stay alcohol free.
18. PATTERN OF USE OF LEGALLY OBTAINED MIND-ALTERING DRUGS (See List); Specify drug(s): _____	1. No use (CPMS "0") during the month prior to this date.	2. Less than weekly use (CPMS "1").	3. Use once per week (CPMS "2").	4. Use several times per week (CPMS "3").	5. Use daily (CPMS "4"); signs of tolerance and/or withdrawal.	6. Use two to three times daily (CPMS "5"); signs of tolerance and/or withdrawal.	7. Use more than three times daily (CPMS "6"); severe withdrawal; cannot stay drug free.
19. PATTERN OF USE OF MIND-ALTERING DRUGS NOT OBTAINED LEGALLY (Include marijuana) (See List): Specify drug(s): _____	1. No use (CPMS "0") during the month prior to this date.	2. Less than weekly use (CPMS "1").	3. Use once per week (CPMS "2").	4. Use several times per week (CPMS "3").	5. Use daily (CPMS "4"); signs of tolerance and/or withdrawal.	6. Use two to three times daily (CPMS "5"); signs of tolerance and/or withdrawal.	7. Use more than three times daily (CPMS "6"); severe withdrawal; cannot stay drug free.

C B A

20. PRIOR ALCOHOL TREATMENT HISTORY (circle all applicable). BY TREATMENT INTENSITY (Indicate number of times for each in the boxes)

1. Has never received alcohol treatment, even though may have been referred.
2. Four times per month, or less, participation in treatment; or at least monthly participation in treatment ☐
3. Five to twenty times per month; or at least weekly participation in treatment. ☐
4. One contact per day; or participation at least five times per week in treatment. ☐
5. Dry, supportive living environment combined with self-help (such as A.A., N.A., or equivalent. ☐
6. Residential treatment that provides up to 30 hours per week of structured treatment outside of a Health Division licensed hospital; including general supervision, personal care, counseling, skill building, and episodic or minimal medical attention. ☐
7. Intensive Residential Treatment that provides at least 30 hours per week of structured treatment outside of a Health Division licensed hospital; including general supervision, personal care, intensive counseling and skill building, and episodic or minimal medical attention. ☐
8. Treatment in a Health Division licensed general hospital with direct nursing supervision and with medical attention immediately available as needed, in addition to alcohol treatment. Circle as applicable:
   a. Emergency Room ☐
   b. Medical-Surgical Unit ☐
   c. Alcohol Unit ☐
   d. Psychiatric Unit ☐
9. Treatment in a Health Division licensed specialty hospital with direct nursing supervision and with medical attention immediately available as needed, in addition to alcohol treatment. Circle as applicable:
   a. Alcohol ☐
   b. Polydrug ☐
   c. Psychiatric ☐

20A. Adjunctive therapy with antabuse?

20B. Adjunctive therapy with valium?

20C. Adjunctive therapy with _____?

20D. SELF-HELP MAINTENANCE (A.A., N.A., or equivalent)
1. How many times has individual tried maintenance in normal living environment with A.A., N.A., or equivalent self-help? ☐
2. If this has been tried, how many times did it result in abstinence for a period of six months or more? ☐

21. DETOXIFICATION HISTORY (Reduction of primary withdrawal symptoms; circle all applicable, and indicate number of times for each in the boxes)

1. Has never been treated for this purpose, even though may have been referred.
2. Outpatient basis. ☐
3. Residential (24 hour) basis outside of a Health Division licensed hospital. ☐
4. In a Health Division licensed general hospital circle as applicable:
   a. Emergency Room ☐
   b. Medical-Surgical Unit ☐
   c. Alcohol Unit ☐
   d. Psychiatric Unit ☐
5. In a Health Division licensed specialty hospital; circle as applicable:
   a. Alcohol ☐
   b. Polydrug ☐
   c. Psychiatric ☐

(Literature indicates no clear evidence as to Ⓐ, Ⓑ, Ⓒ appropriateness, but may be indicative of probability of success of treatment in general.)

22. FOLLOW-UP PERFORMANCE (most recent episode)
1. No episode, or no episode within last ten years.
2. Participated regularly in aftercare, the prescribed amount of time.
3. Participated intermittently, but adequately, in aftercare, the prescribed amount of time.
4. Participated intermittently, but not adequately, in aftercare, the prescribed amount of time.
5. Did not participate in aftercare for the prescribed amount of time.

23. AGE OF FIRST INTOXICATION: ☐

24. AGE BY WHICH REGULAR DRINKING PATTERN WAS ESTABLISHED: ☐

25. NUMBER OF BLOODLINE RELATIVES WITH ESTABLISHED PATTERNS OF ABUSIVE DRINKING
1. Grandparental generation ☐
2. Parental generation ☐
3. Children ☐
4. Grandchildren ☐
5. Spouse(s) or consistent living partners ☐
6. Relatives of (5) ☐

(Literature indicates no clear evidence as to (A), (B), or (C) appropriateness, but may be indicative of probability of success of treatment in general.)

APPENDIX B

COVER LETTER AND QUESTIONNAIRE

Douglas County Council on
Alcohol & Drug Abuse Prevention & Treatment

P.O. Box 1121 • 621 W. Madrone • Roseburg, Oregon 97470

(503) 672-2691

October 3, 1984

TO: Program Director

FROM: John Gardin II, B.S.
Executive Director

RE: Attached Questionnaire

The passage of SB 522 during our last Legislative Session will very noticeably affect the way many of us access insurance company reimbursements. This will also directly affect the kind of information required by insurance companies in order for them to appropriately address cost containment issues of SB 522. As you will recall, SB 522 mandates insurance coverage for alcohol treatment, among other forms of substance abuse and mental health treatment, at the least costly, most appropriate level of care. The State Health Planning and Development Agency (SHPDA) was charged with developing model criteria for assessing "appropriate level of care". These model criteria have in fact been developed by SHPDA and have already been adopted by Blue Cross/Blue Shield of Oregon.

The purpose of the present study is to critically examine these criteria as a step towards the development of an instrument which will reasonably assess appropriate level of care. The results of this study will serve at least two purposes:

1. Give you an opportunity to impact the content and form of this instrument, as it, or something like it, will become a necessary part of the insurance billing process; and

2. Allow me to complete my dissertation.

If you are willing to participate, I would ask that you distribute the questionnaire to the person(s) in your agency charged with making initial contact with clients to determine their appropriateness for treatment, and what level of treatment to refer them to. If more than one person performs that duty, feel free to copy the questionnaire and distribute as needed. Once I have received the completed questionnaire, I will be mailing a very short personal data form for the person(s) who completed the questionnaire. Individual responses throughout the study will be strictly confidential.

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Please see that the questionnaire is returned to me by October 26, 1984, at the address below.

The results of this study will be shared with you upon its completion. If you have any questions, please feel free to call me. Thank you in advance for your cooperation.

JG/blm

Please send completed questionnaire(s) to:

John Gardin II, M.S.
Executive Director
ADAPT
P.O. Box 1121
Roseburg, OR 97470

NAME OF INDIVIDUAL COMPLETING QUESTIONNAIRE _____

DATE COMPLETED _____

EMPLOYED BY _____

POSITION TITLE _____

EMPLOYER'S ADDRESS _____

_____

_____

EMPLOYER'S PHONE NUMBER _____

HOME ADDRESS _____

_____

HOME PHONE NUMBER _____

PLEASE CHECK ONE:

The Program I Am Currently Working For Is:

1. ☐ Hospital-based and/or medical-model program, located in or directly affiliated with and supported by a hospital and/or providing medically-oriented treatment with medical personnel.

2. ☐ Non-medical model program, not located in or directly affiliated with or supported by a hospital nor providing medically oriented treatment with medical personnel.

If you checked box #2, please check all of the following that apply:

a. ☐ A Community Mental Health run program. All employees are on the County payroll.

b. ☐ A private non-profit corporation.

c. ☐ A private for profit corporation.

d. ☐ An outpatient program.

e. ☐ A residential program.

In completing this questionnaire, you will need to keep in mind the following definitions:

24-hour program: A treatment program in which the identified patient/client resides until the program is complete. This includes short-term detoxification and longer-term rehabilitation stays.

Medical model: Programs which provide direct staffing by medical personnel, such as nurses and physicians. Usually located in or affiliated with a hospital, although not always. Treatment typically consists of a combination of pharmacotherapy, individual/group/family counseling, alcoholism education, A.A. May also include aversive conditioning.

Social model: Programs which do not provide direct staffing by medical personnel, such as nurses and physicians, although consultation with such professionals usually is available. Most often free-standing. Treatment typically consists of a combination of individual/group/family counseling, alcoholism education, A.A. Not designed to treat serious or ongoing medical complications.

Outpatient program: A treatment program in which the identified patient/client resides in the community and comes to the treatment facility for services. Visits may range from as infrequently as once per month to as often as several hours per day.

With each of the symptom/situations to follow, please decide which one of three treatment options you would usually choose and place the number corresponding to that option in the space to the right of the symptom/situation. If selection among options is not usually meaningful (it may be appropriate to handle the symptom or situation in two or three of the choices instead of one), please so indicate. In all cases, the options will be:

1. 24-hour medical model
2. 24-hour social model
3. Outpatient
4. Selection not usually meaningful - no "usual" choice indicated.

Please refer again to the definitions given above for the treatment modalities.

Here is an example:

Symptom/situation: Red eyes __1__

In the example, if a patient/client came to you for treatment, and, on the basis of red eyes only, you would usually refer him/her to a 24-hour medical model program, then you would place a 1 in the space, as illustrated.

Please complete all items, placing only one (1) number in each space.

1. 24-hour medical model
2. 24-hour social model
3. Outpatient
4. No "usual" choice indicated

[BREATHALIZER - Current Episode]

1. 0.0 _____
2. 0.05 or more _____
3. 0.10 or more _____
4. 0.15 or more _____
5. 0.25 or more _____

[ACUTE SYMPTOMS]

6. No obvious acute medical problems _____
7. Cold; mild digestive upset; etc. _____
8. Does not keep down fluids, etc. _____
9. Tremors preventing performances of activities of daily living; abnormal electrolytes, but correctable in less than four hours; history of severe alcohol withdrawal syndrome _____
10. Presence of infection requiring systemic antibiotic therapy; persistent postural blood changes; abnormal electrolytes, not correctable in less than four hours; current evidence of severe alcohol withdrawal syndrome _____

[VITAL SIGNS]

11. Vital signs within normal limits _____
12. One vital sign indicates moderate impairment: slightly irregular heart rate; pulse 100 or above; diastolic blood pressure 100 to 120. _____
13. Several vital signs indicate moderate impairment: slightly irregular heart rate; pulse 100 or above; diastolic blood pressure 100 to 120. _____
14. One vital sign indicates severe impairment: grossly irregular heart rate, diastolic blood pressure 120 or more; fever greater than 100.0°F. _____

1. 24-hour medical model
2. 24-hour social model
3. Outpatient
4. No "usual" choice indicated

15. Several vital signs indicate severe impairment: grossly irregular heart rate; diastolic blood pressure 120 or more; fever greater than 100.0°F. _____

[AMBULATION - at present]

16. Normal gait _____
17. Unsteady, but does not require assistance _____
18. Unsteady, and requires assistance _____
19. Cannot walk, except with assistance _____
20. Cannot walk, even with assistance _____

[SEIZURES - at present]

21. No current evidence of seizure _____
22. First time seizures _____
23. More than three seizures this withdrawal _____
24. Focal seizure _____
25. New seizure not clearly related to withdrawal _____

[SOCIAL NETWORK INCENTIVES - immediately prior to this time]

26. Ongoing relationships with and among significant others exist and the significant others recognize problems, are encouraging treatment, are committed to own involvement in supportive recovery and maintenance activities. _____
27. Ongoing relationships with and among significant others exist and the significant others recognize problems, appear open to learning to encourage treatment and to be involved in supportive recovery and maintenance activities. _____
28. Ongoing relationships with and among significant others exist and are of a quality such that brief, intensive intervention could make therapeutic and supportive involvement feasible, but the significant others minimize problems, do not encourage treatment, resist own involvement. _____
29. Ongoing relationships with and among significant others exist but are currently of a quality that will necessitate substantial, continuing intervention before therapeutic and supportive involvement is feasible, or, relationships exist but have been subjected to recent major change (death, retirement, major illness, of one or several significant others). _____
30. Ongoing relationships to and among significant others have not existed for some time or have suddenly terminated, and for all practical purposes, no "natural" significant others now exist. _____

1. 24-hour medical model
2. 24-hour social model
3. Outpatient
4. No "usual" choice indicated

[SOCIAL NETWORK DISINCENTIVES - immediately prior to this time]

31. Social network exists, it has positive potential but current relationships in it have neither positive nor negative impact on the alcohol and/or substance abuse. _____

32. Individual is isolated from others; there are no current ongoing relationships on which to build for therapeutic and supportive involvement. _____

33. Ongoing relationships to and among significant others exist but are currently of a quality that will necessitate substantial, continuing intervention before therapautic and supportive involvement is feasible. _____

34. Ongoing relationships are negative, detrimental, strong; effective continuing intervention does not seem possible. However, the significant others involved are not necessarily abusers. _____

35. Ongoing relationships enable, encourage, facilitate, abuse; are destructive and counter-therapeutic; the significant others involved, or some of them, are abusers. _____

[SUPERVISION AND SUPPORT AVAILABLE - in current "home" living situation]

36. Responsible non-abuser of alcohol and other drugs is available to lend support and encouragement for maintaining treatment objectives nearly all the time, day and night. _____

37. Responsible non-abuser of alcohol and other drugs is available to lend support and encouragement for maintaining treatment objectives; lives in, but is away for work, school, etc., part of each day; can periodically communicate support, and medication reminders (if needed), at all times, even when away. _____

38. Responsible non-abuser of alcohol and other drugs is available to lend support and encouragement for maintaining treatment objectives; lives in, but is away for work, school, etc., part of each day; cannot periodically communicate support, and medication reminders (if needed), when away. _____

39. Responsible non-abuser of alcohol and other drugs is available to lend support and encouragement for maintaining treatment objectives; does not live in, but can visit regularly, can periodically communicate support, and medication reminders (if needed), when away. _____

40. Responsible non-abuser of alcohol and other drugs is not available to lend support and encouragement for maintaining treatment objectives; does not live in, cannot visit regularly, and probably cannot periodically communicate support, or medication reminders (if needed), when away. _____

1. 24-hour medical model
2. 24-hour social model
3. Outpatient
4. No "usual" choice indicated

[SELF SUPPORT IN SOCIETY]

41. Communication skills, literacy, education, vocational skills, are sufficient to have consistently supported the individual in a defined social/occupational role up to now. _____

42. Skills have been sufficient to have consistently supported the individual in a defined social/occupational role until the time period immediately preceding this assessment. _____

43. Skills have been sufficient to have consistently supported the individual in a defined social/occupational role except for a number of episodes or periods apparently precipitated by alcohol or substance use during a time when social/occupational role did not change. _____

44. Skills have not always been sufficient to have supported the individual in a defined social/occupational role in the past because of externally forced changes in social/occupational role, rather than because of increased alcohol or substance use, but there is reasonable evidence of potential to rehabilitation and/or improve skills to an adequate level within a reasonable time. _____

45. Whether or not skills have been sufficient to have supported the individual in a defined social/occupational role in the past, there is reasonable evidence that the skills cannot be rehabilitated and/or improved to an adequate level within a reasonable time; prognosis for subsequent independent living is poor, may or may not be braindamaged, may require protected living for rest of life. _____

46. Skill level indicates <u>potential</u> for upward mobility. _____

47. Skill level does <u>not</u> indicate potential for upward mobility. _____

48. There are realistic <u>opportunities</u> for upward mobility. _____

49. There are <u>not</u> realistic opportunities for upward mobility. _____

[RECENT CONSEQUENCES of alcohol and/or substance abuse]

50. No problems reported in the most recent 12 months by family, employer or legal authorities, etc., because of alcohol or substance use.

51. Family objections in the most recent 12 months to alcohol or substance use; deterioration of hobbies, activities, social life; verbal abuse of family members; embarrassing behavior at functions. _____

52. In the most recent 12 months, threat of divorce; history of separation(s); court referral; arrested and charged with driving under the influence; effects on behavior and/or school work of children; loss of custody of children (for men); loss of friends because of violence or fights. _____

1. 24-hour medical model
2. 24-hour social model
3. Outpatient
4. No "usual" choice indicated

53. In the most recent 12 months, absenteeism; intoxification on the job; recent or pending divorce; loss of custody of children (for women); history of arrest for violence towards family; history of child abuse and/or neglect. _____

54. Long-term or recent history of court ordered treatment; incarceration because of alcohol or substance abuse; history of arrest for violence to others; history of loss of job because of drinking or substance abuse. _____

[MENTAL AND EMOTIONAL STATUS AND HISTORY]

55. Can utilize information in a rational and consistent fashion; no history of psychiatric diagnosis or treatment. _____

56. No appearance of current mental or emotional disturbance, but history of mental or emotional impairment and/or specific history of insomnia, nervousness, brief outpatient psychiatric treatment, or of self-destructive thoughts. _____

57. Agitated or belligerent at this time; angry, anxious, or suspicious at this time; and/or history of properly diagnosed depression, anxiety, moodswings, and/or extensive outpatient psychiatric treatment; history of chronic psychiatric condition, now asymptomatic; recent but not current psychiatric diagnosis; or, recent (last 6 months) suicide plan. _____

58. Confused, poor memory, disoriented to time or place, at this time; or weepy, depressed, or flat affect at this time; or just transferred from, or currently in a psychiatric hospital or ward, as a short term (30 days or less) hospitalization; or history of psychiatric hospitalization, condition currently controlled by medications; or singular suicide attempt. _____

59. Ongoing hallucinations and/or history of inability to function in society because of psychiatric condition; history of more than one psychiatric hospitalization not related to alcohol or substance abuse; history of residence in a psychiatric institution for six months or more; or emergency room intervention for prior suicide attempt(s). Presence of alcohol-induced brain damage may have been demonstrated. _____

[MEDICAL HISTORY AND CONDITION APART FROM ALCOHOL AND/OR SUBSTANCE ABUSE]

60. No presenting transient or chronic medical problems or conditions except those primarily traceable to alcohol or other drug use; and is not current smoker. _____

61. No presenting transient or chronic medical problems or conditions except those primarily traceable to alcohol or other drug use; and is current smoker. _____

1. 24-hour medical model
2. 24-hour social model
3. Outpatient
4. No "usual" choice indicated

62. Minor transient or chronic problems, not traceable to alcohol or other drug use; and requiring short-term treatment. _____

63. Marked, but not life-threatening problems such as blindness, deafness, etc., and requiring continuing treatment. _____

64. Severe, life-threatening, acute medical problems not primarily traceable to alcohol or other drug use.

65. Has a history of seizures that are not related to alcohol and/or substance use. _____

66. Has a history of grand mal seizures prior to alcohol abuse. _____

[MEDICAL HISTORY AND CONDITION RELATED TO ALCOHOL AND/OR OTHER DRUG ABUSE]

67. No presenting transient or chronic medical problems or conditions traceable to alcohol or other drug use.

68. Minor transient or chronic problems, traceable to alcohol or other drug abuse, such as swelling feet or ankles, sporadic eating, glandular swelling, wine sores; present treatment is being followed and is effective. _____

69. Transient or chronic problems traceable to alcohol or other drug abuse, such as swelling feet or ankles, sporadic eating, glandular swelling, wine sores; present treatment, if any, is not being followed or is not effective. _____

70. Marked, but not immediately life-threatening problems, traceable to alcohol or other drug abuse, such as gout; heart disease; lung diseases; liver disease; pancreatic failure; brain damage; skin ulceration. _____

71. Severe, life-threatening problems primarily traceable to alcohol or other drug use, such as stomach or intestinal bleeding; pancreatitis; alcoholic hepatitis; congestive heart failure; respiratory distress.

72. Has a history of seizures that are related to alcohol or other drug use. _____

73. Has a history of grand mal seizures subsequent to alcohol abuse. _____

[DESIRE FOR MOTIVATION FOR HELP - as expressed and manifest]

74. Individual spontaneously and freely expresses concern about impact of alcohol problem on significant others in the home and/or occupational situation; has verbalized step-by-step plan for managing self; is following plan; is fully committed to, and performing well, in treatment; is utilizing both "natural" support resources and self-help group involvement. _____

1. 24-hour medical model
2. 24-hour social model
3. Outpatient
4. No "usual" choice indicated

75. Individual freely expresses concern about impact; has verbalized step-by-step plan for managing self; plan may or may not involve "natural" support resources and/or self-help group involvement; supervision is necessary to maintain performance in treatment; commitment occasionally lapses. ____

76. Individual expresses concern about impact of problem on others, but this is manifested as "if only I didn't...," without verbalized step-by-step plan for managing self. Wants to do something, but is not firmly committed. ____

77. Individual does not express concern, but agrees that he/she should, when questioned about it. Is not sure, or has reservations, about treatment. ____

78. Individual does not express concern, and disagrees that he/she should, when questioned about it. Does not want to do anything about it, has no desire for assistance. ____

79. The treatment is Court mandated. ____

80. The treatment is <u>not</u> Court mandated. ____

[RECOGNITION OF DEPENDENCY]

81. Individual spontaneously and freely, explicitly, but appropriately, tells others that he/she is dependent on alcohol and/or other drugs. ____

82. Individual spontaneously and freely, explicitly, but inappropriately and/or with excessive frequency, tells others that he/she is dependent on alcohol and/or other drugs. ____

83. Individual accurately and always identifies self as dependent on alcohol and/or other drugs, but only when asked directly. ____

84. Individual sometimes identifies self as dependent on alcohol and/or other drugs, when asked directly. ____

85. When asked directly, individual seldom or never identifies self as dependent on alcohol and/or other drugs. ____

[RECOGNITION OR DENIAL AS EXPRESSED BY MOST SIGNIFICANT OTHER]

86. Most significant other spontaneously and freely, explicitly, but appropriately, tells others that the individual is dependent on alcohol and/or other drugs. ____

87. Most significant other spontaneously and freely, explicitly, but inappropriately and/or with excessive frequency, tells others that the individual is dependent on alcohol and/or other drugs. ____

88. Most significant other accurately and always identifies the individual as dependent on alcohol and/or other drugs, but only when asked directly. ____

1. 24-hour medical model
2. 24-hour social model
3. Outpatient
4. No "usual" choice indicated

89. Most significant other sometimes identifies the individual as dependent on alcohol and/or other drugs, when asked directly. _____

90. When asked directly, most significant other seldom or never identifies the individual as dependent on alcohol and/or other drugs. _____

[PATTERN OF ALCOHOL USE]

91. Abstinent (CPMS "0") during the month prior to this date. _____

92. Light or moderate drinking on social occasions, usually less than daily (CPMS "1"), without impaired functioning. _____

93. Moderate Abuse (CPMS "2"): recognizable pattern of excessive use, such as daily, regardless of social occasions; mildly impaired functioning; no signs of withdrawal; occasional binges. _____

94. Serious Abuse (CPMS "3"): recognizable pattern of excessive use, such as frequent binge drinking, or heavy drinking several times a week; seriously impaired functioning; no signs of withdrawal. _____

95. Moderate Addiction (CPMS "4"): recognizable pattern of excessive use; seriously impaired functioning; with signs of tolerance and/or withdrawal; blackouts. _____

96. Serious Addiction (CPMS "5"): recognizable pattern of excessive use; seriously impaired functioning; with signs of tolerance and/or withdrawal, and with prolonged history of addiction; shakes, tremors. _____

97. Chronic Addiction (CPMS "6"): under the continuous influence of alcohol; morning drinking; highly dysfunctional; experiences severe withdrawal, cannot stay alcohol free. _____

[PATTERN OF USE OF LEGALLY OBTAINED MIND-ALTERING DRUGS]

98. No use (CPMS "0") during the month prior to this date. _____

99. Less than weekly use (CPMS "1"). _____

100. Use once per week (CPMS "2"). _____

101. Use several times per week (CPMS "3"). _____

102. Use daily (CPMS "4"); signs of tolerance and/or withdrawal. _____

103. Use two to three times daily (CPMS "5"); signs of tolerance and/or withdrawal. _____

104. Use more than three times daily (CPMS "6"); severe withdrawal; cannot stay drug free. _____

1. 24-hour medical model
2. 24-hour social model
3. Outpatient
4. No "usual" choice indicated

[PATTERN OF USE OF MIND-ALTERING DRUGS NOT OBTAINED LEGALLY]

105. No use (CPMS "0") during the month prior to this date. _____

106. Less than weekly use (CPMS "1"). _____

107. Use once per week (CPMS "2"). _____

108. Use several times per week (CPMS "3"). _____

109. Use daily (CPMS "4"); signs of tolerance and/or withdrawal. _____

110. Use two to three times daily (CPMS "5"); signs of tolerance and/or withdrawal. _____

111. Use more than three times daily (CPMS "6"); severe withdrawal; cannot stay drug free. _____

[PRIOR ALCOHOL TREATMENT HISTORY]

112. Has never received alcohol treatment, even though may have been referred. _____

113. Four times per month, or less, participation in treatment; or at least monthly participation in treatment. _____

114. Five to twenty times per month; or at least weekly participation in treatment. _____

115. One contact per day; or participation at least five times per week in treatment. _____

116. Dry, supportive living environment combined with self-help (such as A.A., N.A., or equivalent). _____

117. Residential treatment that provides up to 30 hours per week of structured treatment outside of a Health Division licensed hospital; including general supervision, personal care, counseling, skill building, and episodic or minimal medical attention. _____

118. Intensive Residential Treatment that provides at least 30 hours per week of structured treatment outside of a Health Division licensed hospital; including general supervision, personal care, intensive counseling and skill building, and episodic or minimal medical attention. _____

119. Treatment in a Health Division licensed general hospital with direct nursing supervision and with medical attention immediately available as needed, in addition to alcohol treatment. _____

120. Treatment in a Health Division licensed specialty hospital with direct nursing supervision and with medical attention immediately available as needed, in addition to alcohol treatment. _____

121. Has had adjunctive therapy with Antabuse. _____

122. Has had adjunctive therapy with valium. _____

123. Has had adjunctive therapy with _____. _____

1. 24-hour medical model
2. 24-hour social model
3. Outpatient
4. No "usual" choice indicated

[DETOXIFICATION HISTORY - Reduction of primary withdrawal symptoms]

124. Has never been treated for this purpose, even though may have been referred. _____

125. Outpatient basis. _____

126. Residential (24 hour) basis outside of a Health Division licensed hospital. _____

127. In a Health Division licensed general hospital. _____

128. In a Health Division licensed specialty hospital. _____

[FOLLOW-UP PERFORMANCE - most recent episode]

129. No episode, or no episode within last ten years. _____

130. Participated regularly in aftercare, the prescribed amount of time. _____

131. Participated intermittently, but adequately, in aftercare, the prescribed amount of time. _____

132. Participated intermittently, but not adequately, in aftercare, the prescribed amount of time. _____

133. Did not participate in aftercare for the prescribed amount of time. _____

APPENDIX C

PERSONAL DATA SHEET

I would appreciate your answering the following and returning it to me as soon as possible in the self-addressed, stamped envelope. Please know that all responses are confidential and no individual responses will be identified in this study. Thank you!

1. Name: _____

2. Agency Employed By: _____

3. Current Position Title: _____

4. Length of Time in This Position (check one):

   a ____ Less than 6 months
   b ____ 6 months - 18 months
   c ____ 18 months - 36 months
   d ____ 36 months - 60 months
   e ____ More than 60 months

5. Lenth of Paid Experience in Alcoholism/Addiction Treatment (check one):

   a ____ Less than 6 months
   b ____ 6 months - 18 months
   c ____ 18 months - 36 months
   d ____ 36 months - 60 months
   e ____ More than 60 months

6. Formal Degrees (check all that apply):

   a ____ High School Diploma
   b ____ Associate Arts Degree
   c ____ Bachelor's Degree
   d ____ Master's Degree
   e ____ Doctoral Degree (Ph.D., M.D., etc.)

7. Approximate Number of Hours of Specialized Training in Addictions Within the Last 5 Years (excluding that received as part of your formal degree) (check one):

   a ____ Less than 25 hours
   b ____ 25 - 25 hours
   c ____ 50 - 75 hours
   d ____ 75 - 1000 hours
   e ____ More than 100 hours

8. Check any of the Following Certifications/Licenses You Now Possess:

   a ____ Registered Clinical Social Worker
   b ____ Licensed Practical Nurse
   c ____ Registered Nurse
   d ____ Licensed Clinical Psychologist
   e ____ Licensed Physician
   f ____ Certified Alcoholism Counselor
   g ____ Alcohol and Drug Evaluation Specialist
   h ____ Other (please specify)

   _____

   _____

9. Are You a Recovering Alcoholic/Addict?

   _____ Yes _____ No

10. If You are Recovering, How Long Have You Been Clean/Sober?

    a ____ Less than 6 months
    b ____ 6 months - 12 months
    c ____ 12 months - 24 months
    d ____ 24 months - 36 months
    e ____ More than 36 months

VITA

John Gardin II is currently Executive Director of Douglas County Council on Alcohol and Drug Abuse Prevention and Treatment (ADAPT), a private, nonprofit alcohol and drug abuse program in Roseburg, Oregon. In addition, he is Vice-President and founder of Northwest Correctional Counsultants, Inc., a private consulting firm specializing in services to the Oregon State Corrections Division. Mr. Gardin has served on several boards and task forces within the state of Oregon, and is past president of the Alcohol and Drug Program Directors Association of Oregon. Prior to specializing in alcohol and other-drug abuse problems, Mr. Gardin was intensively involved in the treatment of incestuous families, and coordinated a model program for that purpose.