



SANDAS & DASSA Alcohol and Other Drug Treatment Roundtable

28th June 2016

Summary of Consultation

Background:

SANDAS has been working in partnership with DASSA to investigate the measurement of treatment outcomes in the drug and alcohol sector. DASSA has been working internally to establish some outcomes measures for its services, and SANDAS has been keen to investigate how an interconnected system of outcome measurement across our member organisations and other treatment services might be instigated.

The roundtable event was held to bring together a number of stakeholders to discuss the current approaches to measuring health and social outcomes for people who access alcohol and other drugs treatment in South Australia. Both SANDAS and DASSA recognise that the development of outcomes-based reporting and funding is fraught with challenges. For this reason, we identified that it was important to involve service providers and other stakeholders early in the process.

This event included presentations on developments in other jurisdictions, explored existing practice in SA, sought input from a range of stakeholders on the current situation in SA and facilitated discussion to identify the creation of an effective, robust and meaningful outcomes framework for SA.

Attendance:

The SANDAS & DASSA AOD Treatment Outcomes Roundtable was held on the 28th of June 2016, and had representation from the following organisations:

- Adelaide Primary Health Network
- Baptist Care SA
- Centacare
- Country SA Primary Health Network
- Courts Administration Authority
- Drug and Alcohol Services SA (DASSA)
- Drug ARM
- Hepatitis SA
- Life Without Barriers
- Mission Australia
- National Centre for Education and Training on Addiction (NCETA)
- Northern Area Community and Youth Services
- Northern Health Network

- OARS Community Transitions
- Salvation Army Towards Independence
- SA Network of Drug and Alcohol Services (SANDAS)
- Uniting Communities
- West Coast Youth and Community Support

Also present were the CEO of the Queensland Network of Alcohol and Drug Agencies (QNADA), and Deputy CEO of the NSW Network of Alcohol and Drug Agencies (NADA).

Dr Chris Holmwood – Director – Clinical Consultation Liaison and Standards, DASSA

The event opened with a presentation from Chris Holmwood, who spoke about the process of development of outcomes measures within DASSA and what they are seeking to achieve through the partnership with SANDAS. He explored some of the reasons why we measure outcomes, what DASSA is implementing in its services, and explored the potential usage of the ADAPT tool as an outcome measure.

Chris outlined some basic principles for outcome data which included:

- Data should only be collected for decision making at some level
- Data needs to be built on information already collected and systems already in place to minimise the risk to implementation
- Indicators should be able to be used across government and non-government services.
- Indicators should be useful for clients, clinicians and managers
- Indicators need to be as evidence based as possible
- Indicators need to be able to be benchmarked

Robert Stirling – Deputy CEO, Network of Alcohol and Drug Agencies (NADA)

Robert's presentation covered the creation of [NADABase](#), a database for use by drug and alcohol agencies in NSW for the purposes of general data collection and outcomes measurement. Their process included:

- The establishment of a steering committee
- Review of outcomes tools by an independent researcher
- Baseline survey conducted with NADA membership
- Training focused on organisational culture change
- Evaluation, upgrades and ongoing monitoring

The outcomes tools used by NADABase include the Severity of Dependence Scale (SDS), ATOM, Kessler 10+, WHO-8: EUROHIS Quality of Life Scale, BBV Exposure risk taking scale.

Robert identified many challenges faced by NADA in the process including ongoing technical problems with the database system, provision of adequate ongoing monitoring to ensure members continuously input data and the differences between government and non-government outcomes tools and collection to enable comparable data.

Some of the achievements have included changing cultures within organisations, data is being valued in the sector as a tool to demonstrate the effectiveness of treatment and interest is being generated amongst potential research partners.

Discussions are continuing to further evolve the process including considerations of consumer involvement, ethical data collection and alignment of government and non-government tools.

Rebecca MacBean – CEO, Queensland Network of Alcohol and Drug Agencies (QNADA)

Rebecca's presentation focused upon the process by which the [Queensland Alcohol and Other Drug Treatment Service Delivery Framework](#) was developed. The framework is an overarching document outlining the mission, aims, objectives, values, understandings, established tools, therapeutic approaches, practice principles and standards that inform the Queensland's AOD treatment sector. It was developed through a partnership of policy, sector and workforce development organisations, based on feedback from treatment providers.

An important step in the development of the framework was the clear identification of what is meant by 'Drug and Alcohol Treatment'. That is, what kinds of things could the provision of treatment reasonably be expected to impact, and what it could not. What outcomes should the treatment sector be held accountable for when providing treatment, and what outcomes fall outside the scope of what can be used as a measure of effective program delivery?

The measurement of client outcomes was a particular challenge during the development due to the complex nature of the AOD client group and the requirements of different services. The framework identifies a number of outcome measures that services seemed to have a general consensus on.

These are:

- Changes in amount and/or frequency of drug use
- Changes in risky behaviour
- Changes in social and emotional wellbeing
- Changes in mental health
- Changes in physical health
- Increased knowledge of health / AOD risks and harms
- Increased life skills
- Changes in self esteem

The framework also identifies domains for which it is difficult or problematic to establish the impact of AOD treatment. These are:

- Ability to comply with legal or statutory directives
- Changes in housing/accommodation
- Changes to participation in education / training / work
- Changes in criminal / offending behaviour

The next step for the Queensland partnership is the development of a Treatment Outcomes Framework, and this work is currently in progress.

Services Roundtable

Each attendee at the event was given the opportunity to speak briefly on what their organisation was already doing in outcomes measurement, any particular challenges they may be facing and what their interest is in attending the event. A summary of information shared follows.

Many organisations are already using standardised tools as a part of assessment and outcomes measurement. Those identified included ATOP, Kessler 10, AUDIT, ASSIST, SDS, ADAPT, IRIS, PROMS, PREMS, WHOQoL, DASS, MMS, GAS, TCUDS, Eureka and the LEQ (see appendix for definitions and links to tools). Qualitative data collected from clinician's observations are also used by some organisations to demonstrate outcomes. One service also conducted a criminogenic needs assessment as their client group was primarily offenders. Some services identified moving towards a Results Based Accountability framework, observing that some funding bodies have begun to use this framework in funding contracts.

For some organisations, decisions about what to measure and what data to collect was driven by funding pressure, the need to meet KPIs set by funding bodies, and to secure ongoing funding for the program. For smaller organisations, the loss of a single program can threaten the ongoing viability of service provision in a single location.

Many organisations identified regular monitoring and review of outcomes as a significant challenge, due to the complex and sometimes transient nature of the client group. One organisation estimated that at least 80% of their clients would have a baseline measure, but that outcomes data measured against the baseline was collected in approximately 20% of clients. Most would like to measure outcomes at regular intervals during and post-treatment, but find it difficult to find resources to enable this to happen.

Participants mentioned the importance of any outcomes measures having clinical utility, ensuring that any collected data can be fed back to the client in ways that are meaningful and assist ongoing treatment planning and strengthen the therapeutic relationship. Ethical data collection was also cited as being important, so that there were clear reasons for collecting particular data items, and that the process of collection did not place a burden on the client or create a barrier in the therapeutic relationship.

Most organisations have mechanisms in place to collect client experience outcomes as well as clinical ones. These included annual client surveys, satisfaction surveys on exit, session rating scales and consumer forums. A simple session rating mechanism was also in use by one organisation for measuring outcomes of therapeutic groups, which had been problematic due to the often sporadic nature of group attendance.

Treatment services that sit within larger organisations identified that the requirements of the larger body can sometimes present difficulties with data systems and outcomes measurements. The specific data needs of the individual program needed to sit within the data needs of the broader organisations and this created complexity and added cost for system design and IT requirements. At times there was not consideration or understanding of individual program needs by the parent body.

Not all organisations present were treatment providers but had an interest in treatment models, outcomes measurement, data collection and program evaluation such as NCETA, the Courts

Administration Authority and the Primary Health Networks (as commissioning bodies of AOD services).

Two consumers were also supported to participate through DASSA's Community Engagement Program and provided valuable input from a consumer perspective. Most organisations agreed that more work needs to be done to determine what is important and useful to consumers and carers when measuring outcomes.

Small Group Workshops

Participants were then divided into four small groups and asked to discuss the following questions, and feedback to the larger group. The questions posed to the group were:

- What do we want to do with the data?
 - Therapeutic purposes?
 - Local service management purposes?
 - Sector wide monitoring/planning?
- What clinical outcomes would be useful for these purposes?
- What resources might be required for setting up a system?
- What barriers might there be?
- What could we build on that is already present?

The questions generated discussion that was broad and at times drifted into tangents which were considered important to explore by the groups. The feedback generated from these discussions is summarised below.

Outcomes measurement was seen to have a therapeutic purpose if it enables workers to feedback an individual's progress in a meaningful way. Outcomes tools that produced a 'score' that could be tracked or a visual tool (such as the ADOM 'spiderweb') were considered to be useful in this way. Outcomes tools also needed to be culturally appropriate in order to be meaningful to Aboriginal and Torres Strait Islander or Culturally and Linguistically Diverse clients. Language that is inclusive of Lesbian, Gay, Bi-sexual, Transgender and Intersex clients was also considered to be important.

From a local service management perspective, outcomes data can be used for staff and program accountability, identify professional development and clinical supervision needs, opportunities to explore treatment effectiveness in alternative settings, continuous improvement and quality accreditation processes, compliance and KPI reporting to funding bodies. It was also thought that outcomes data could also be used by organisations to build a case for taking an effective program and attaining funding to replicate its delivery in another region.

Outcomes measures could also be used to inform sector wide service planning (enabling funding bodies to build on what already exists) and identify key gaps in service provision, geographically or where service diversity is limited. The data could also be used to inform benchmarks in service provision.

There were many barriers identified by the groups, including the restrictive nature of some measures and how this is sometimes unhelpful when working with complex clients. It was suggested

that a small set of 'mandatory' measures be identified (data that must be collected for all clients), which may be embellished by a set of 'voluntary' measures that are only used for clients for which they are relevant.

Participants reiterated the importance of clearly identifying the purposes of alcohol and other drug treatment, so as not to be held accountable for outcomes that are difficult to impact through treatment, difficult to measure with reliability, or difficult to attribute to the provision of treatment.

Barriers created by confidentiality requirements that restrict information sharing between organisations are difficult to overcome. Many saw the benefit of enabling assessments or outcomes to be shared but agreed that the client needed to maintain control over how their data is shared. The use of a unique client identifier to track an individual's progress through the system was also thought to be useful.

Some organisations expressed that the organisational culture change necessary could create a barrier, and the need to create individual worker 'buy in' was important. There was also concern that data could be used by funding bodies to compare services to each other, an inappropriate comparison given the diversity of service types and target groups.

All participants agreed that perhaps the biggest barrier to setting up an effective system was a lack of funds to provide the necessary staff time and IT equipment. Several organisations operate without significant administration hours or in-house IT support and sometimes on equipment that is outdated. Clinical staff are often time poor, having limited time for data entry.

It was felt that any proposed system needed to be web-based, not requiring the complex local installation of software or data transfer. Outcomes tools used needed to be simple, preferably ones that were already well known and in use.

Finally, it was expressed that the development of outcomes measures needed to be a somewhat iterative process, that it was important to 'get it right', rather than to rush into selecting tools and building a database. Further consultation with treatment providers, consumers, research bodies and funding providers was needed, and a system developed that was considered useful and not onerous for all stakeholders. Ultimately, the system needs to be able to reflect the "success" of the treatment sector, in order to continue the case for increased investment into effective, evidence based services.

Where to from here?

SANDAS and DASSA will consider the information gathered as part of this consultation and identify priority actions for a working group, to be established in the coming weeks, involving key stakeholders and representatives from treatment organisations. It is anticipated that the group will meet on a regular basis to progress actions resulting in the development of an Outcomes Measurement Framework for drug and alcohol treatment in South Australia.

Further opportunity will be provided for those who attended the roundtable, and for treatment organisations who were not able to send representatives, to feed into this process, either through follow up consultations or online surveys.

Some preliminary work will be done with DASSA's Community Participation Program to ensure there is strong client and community input into this process.

For further information on the event, or to provide additional feedback, please contact:

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Appendix – Definitions and links to Outcomes Tools mentioned

ADAPT	-	Addiction Dimensions for Assessment and Personalised Treatment
ADOM	-	Alcohol and Drugs Outcome Measure
ASSIST	-	Alcohol, Smoking and Substance Involvement Screening Test
ATOP	-	Australian Treatment Outcomes Profile
AUDIT	-	Alcohol Use Disorders Identification Test
DASS	-	Depression Anxiety Distress Scales
GAS	-	Goal Attainment Scale
IRIS	-	Indigenous Risk Impact Screen
Kessler 10	-	Kessler Psychological Distress Scale
LEQ	-	Life Effectiveness Questionnaire
MMS	-	Modified Mini-Screen
PREMS	-	Patient Reported Experience Measures
PROMS	-	Patient Reports Outcomes Measures
SDS	-	Severity of Dependence Scale
WHOQOL	-	World Health Organisation Quality of Life