EJD Consulting and Associates

BASELINE EVALUATION REPORT

NADA
DRUG & ALCOHOL- MENTAL HEALTH INFORMATION MANAGEMENT PROJECT

for

Network of Alcohol and other Drugs Agencies

September 2009

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EXECUTIVE SUMMARY

In 2008 the Network of Alcohol and Other Drugs Agencies (NADA) received funding under NSW Health's *A New Direction in Mental Health* strategy to undertake an information management project with non-government (NGO) drug and alcohol treatment organisations in NSW.

Titled the NGO Drug and Alcohol (D&A) and Mental Health Information Management Project, the four year project will develop and implement a system for measuring client treatment outcomes related to their drug and alcohol use, mental health and general health and social functioning.

EJD Consulting and Associates was contracted by NADA to independently evaluate the Project. Based on the baseline data collected from 38 NGO D&A agencies in June 2009, the evaluators found that there was a general appreciation of the importance of client data collection, with the vast majority of providers reporting they collected and utilised a broad range of client information, including mental health issues and social and family functioning.

The majority of NGOs reported using client data to fulfil external funding requirements, as well as to assist with internal service and treatment planning. Further, most NGOs reported that their internal information management systems were good or very good. Most indicated however that their data was less useful in terms of assessing client outcomes from past treatments, for consolidating data across different client segments, and for comparing client outcomes with other services.

In general there was strong support for NADA to continue to work with the sector to improve the utility and consistency of data collection, in particular data related to mental health. There was also support for NADA to facilitate opportunities for the sector to have access to quality measurement tools, together with additional training and resources related to improved information management.

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REPORT

1. INTRODUCTION AND PURPOSE OF EVALUATION

In 2008 the Network of Alcohol and Other Drugs Agencies (NADA) received funding under NSW Health's *A New Direction in Mental Health* strategy to undertake an information management project with non-government drug and alcohol treatment organisations in NSW.

The four year project will develop and implement a system for measuring client treatment outcomes related to their drug and alcohol use, mental health and general health and social functioning. A specific focus of the project is on organisations funded by NSW Health.

The title of the Project is the Non Government Organisation (NGO) Drug and Alcohol and Mental Health Information Management Project (hereafter the Project).

In early 2009 NADA contracted EJD Consulting and Associates to design an evaluation framework for the Project. Subsequently EJD Consulting was also contracted to undertake the evaluation proper. The aim of the evaluation is to:

1) Collect and analyse implementation data and stakeholder feedback as part of a continuous improvement, action research model.

2) Prepare a final independent evaluation report on the overall success of the Project in early 2012 to inform future decision making.

What follows is the preliminary evaluation report on the Project containing the baseline data.

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2. BACKGROUND

2.1 About NADA and its Members

NADA is the peak organisation for the non-government drug and alcohol (D&A) sector in NSW. NADA is an incorporated, not-for-profit organisation.

NADA's membership comprises approximately 115 agencies ranging from health promotion, early intervention, treatment, and after-care programs. These agencies are diverse in their approach to service delivery and structure, and make up approximately one third of the D&A sector in NSW.

NADA's aims are to strengthen the NGO D&A sector, to provide leadership and advocacy on D&A policy and service system development, to build networks and information exchanges, and to continue to develop NADA as a quality peak body for the NSW NGO D&A sector.

The D&A and Mental Health Information Management Project is linked to each of these organisational aims, and in particular to the first outcome focused on strengthening the sector.

2.2 Comorbidity and Data Collection

The association between mental health and drug and alcohol misuse in the community is well recognised. In recent years there has been an increasing focus on how best to identify and work with clients presenting with these comorbidity issues.

Increased understanding of comorbidity in the community has benefited the D&A sector with a recognition of the complexities of working with this client group. In many instances this has lead to increases in funding, resources and workforce development though initiatives such as the Commonwealth's *Improved Services for People with Drug and Alcohol Problems and Mental Illness* and the NSW Health's *A New Direction in Mental Health*. Both these initiatives have components that go toward improving data collection systems and treatment outcome measurement.

When done effectively, the collection and use of client outcome data can be used for a variety of purposes including clinical decision-making with clients, service and staff planning, plus service monitoring, quality improvement and reporting purposes. It should be noted however there are resourcing impacts associated with data collection and compliant costs linked to additional reporting.

Across a range of sectors there is recognition that there is significant variation in the way clients are screened, assessed and ultimately treated based on available data in respect to the client's drug and alcohol use, mental health issues or both. For example, it has been assumed that accurate comorbidity and mental health specific client information is not routinely collected by the D&A sector despite the fact that a large proportion of clients have symptoms of mental illness in addition to drug and alcohol use issues.

Numerous screening, assessment and outcome tools are used but the challenge for many service providers is to identify what tools are best suited for them and their clients. There are also questions relating to how to train staff in the effective use of various tools, as well as how to record and use the information collected.

Since 2003-04 there has been an injection of funds from national and state funding agencies aimed at improving service co-ordination and treatment outcomes for individuals with comorbidity issues. Many strategies and pilot initiatives have been developed and implemented that go towards meeting these goals, within government agencies, and also across the NGO sector.

One such strategy, the National Comorbidity Initiative, identified that there is a range of data sets that describe comorbidity and the types of services accessed by this client group, but that the area of assessing client outcomes was not universally well addressed.

Nonetheless at both national and state levels there is a growing focus on the quality of care being delivered to clients. This corresponds to a growing expectation for service providers across all sectors to align their practices with evidence based or evidence informed practice and treatment outcomes.

2.3 Information Management in NGO D&A Sector

In 1999 the NSW Drug Summit endorsed the implementation of a minimum data collection as part of a coordinated strategy to monitor outcomes for D&A services in NSW.

Since 2000, all NSW Health funded agencies have collected and reported on a set of common client and service measures known as the NSW minimum data set (MDS). Some organisations have adopted established tools, such as the Brief Treatment Outcome Measure (BTOM), while others have developed their own data sets for use at a local level.

For the D&A sector as a whole, apart from MDS, there is no standard data, service or outcome measures currently in use. Further, there is also variance in how services collect, record, store and ultimately use the data. For example NADA has identified that some organisations collect only required data items (such as MDS), some collect data in addition to that required for compliance purposes but do not appear to make extensive use of the data, while others use some of the data for their own planning purposes.

These differences across the NGO sector present a number of challenges. For example, it can limit the understanding of the client groups being serviced, what services are being provided, and what the impacts of these services are. It also can affect the sector's capacity to advocate for more appropriate resources and areas of priority.

The variation in data collection and management practices across the sector may be attributed to many factors. This includes the range and level of intensity of services provided, the resources available to collect, store and analyse data, the capacity of staff to identify and use relevant tools, and the levels of understanding as to how data can support the organisation's planning and advocacy.

It is within the context of these diverse information management practices that the current Project has been developed.

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3. ABOUT THE PROJECT

3.1 Origins of the Project

In 2008 NADA received a grant under NSW Health's *A New Direction in Mental Health* strategy to undertake an information management project over a four-year period with non-government D&A treatment organisations in NSW.

The goal of the project is to build the capacity of agencies to assess and measure outcomes for clients with drug and alcohol and mental health issues.

3.2 Aims

The Project aims to improve the measurement of treatment outcomes for clients presenting to non government drug and alcohol NGOs. Specifically the Project aims to:

- Increase the numbers of organisations involved in routine client treatment outcome measurement; and
- Improve sector understanding and use of routine client treatment outcome measure data in drug and alcohol service delivery and planning.

3.3 Objectives

The prime objective of the Project is to develop, trial and implement a system for measuring routine client outcomes with NGO D&A treatment organisations. In particular the Project will deliver:

- A client treatment outcome measuring tool for use by non-government D&A organisations;
- An on-line data collection system for the capture and reporting of client treatment outcomes; and
- Resources to support the use of routine client treatment outcome measures and the on-line data collection system (for example through user guides, a data dictionary, and staff training).

3.4 Timeframes and Target Audiences

The Project commenced in late 2008 and is due to conclude in 2012.

The target group for the project is non-government D&A treatment services in NSW. There will be a specific focus on those organisations funded by NSW Health.

In the first instance, up to ten NSW Health funded NGO D&A services will participate in an initial pilot phase of the Project. Once tools and systems have been trialled and evaluated, a second and final phase of the Project will potentially involve all other Health funded NGO D&A treatment services in NSW.

3.5 Staffing and Management Arrangements

NADA is responsible for the Project's management and implementation and for complying with the Funding and Performance Agreement signed with NSW Health.

Jo Khoo has been appointed the Project Manager within NADA and will be responsible for leading the development and implementation of the Project. The project team will include other NADA staff who will contribute to the Project as needed. Over the four year life of the Project, NADA may contract other personnel to undertake specific tasks associated with Project implementation (for example the independent evaluation- *see Section 4*).

A Project Advisory Group has been formed and is responsible for providing advice and guidance on Project planning and implementation. It comprises a number of NADA member representatives as well as external experts in the areas of research, data management, mental health and D&A policy and service delivery. The Advisory Group will exist for the life of the Project.

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4. ABOUT THE EVALUATION

EJD Consulting and Associates was contracted in early 2009 to develop an evaluation framework for the Project. The firm was also contracted to conduct the research and prepared the various components of the staged evaluation to be undertaken between 2009 and 2012.

4.1 Evaluation Aim and Approach

The aim of the Project Evaluation is to:

- Collect and analyse implementation data and stakeholder feedback as part of a continuous improvement, action research model; and
- Prepare a final independent Evaluation Report on the overall success of the Project in early 2012 to inform future decision making.

Using a Results Based Accountability approach, the evaluation will assess the overall success of the Project based on the degree to which a number of agreed indicators and measures have been met. A summary of key measures are included at Attachment 1.

The Project will be assessed on the degree to which it has met a number of broad success factors, including the Project's:

- Efficacy
- Efficiency
- Adequacy
- Appropriateness.

Also included at Attachment 1 are some key questions related to each of the above factors that will be investigated over the course of the Project.

4.2 Evaluation Products

In order to assess how the Project indicators have changed as a result of the Project, the evaluation will gather data at various stages, commencing in mid 2009 and concluding with the final Evaluation report in early 2012. Key products will comprise:

- Baseline Evaluation Report *August 2009*
- Interim Pilot Evaluation Report *Expected: Mid 2010*
- Final Pilot Evaluation Report *Expected: End 2010*
- Interim State-Wide Evaluation Report *Expected: Late 2011*
- Final Evaluation Report *Expected: Early 2012.*

This evaluation report is the Baseline Report based on the methodology described in Section 4.4.

4.3 Stakeholders

The primary Project stakeholders are NADA's members comprising of approximately 115 NGOs (*see Section 2.1*). From a Project evaluation perspective, there will be a specific focus on those members who are D&A specialist organisations funded by NSW Health.

Other stakeholders who will be consulted over the course of the evaluation will include members of the Project Advisory Group comprising:

- NSW Health staff involved in the Project from the Mental Health and Drug and Alcohol Office (MHDAO) and InforMH;
- Relevant research organisations including key staff in the National Drug and Alcohol Research Centre (NDARC), and
- Relevant peak and other NGO organisations including Mental Health Coordinating Council (MHCC), Aboriginal Health and Medical Research Council (AHMRC); and Drug and Alcohol Multicultural Education Centre (DAMEC).

The perspective of clients who have participated in the data gathering processes will also be sought. In addition NADA staff that work on or are linked into the project will provide feedback.

In the first instance emphasis will be given to gathering feedback from the pilot participants (see Section 3.3).

4.4 Methodology

The evaluation methodology is based on an action research-continuous improvement model that will generate a number of reports over the course of the Project.

Between 2009 and 2012 EJD Consulting and Associates will collect and analyse a range of qualitative and quantitative data gathered through:

- Review of all project documentation including establishment papers, correspondence to participant organisations, plus tools and resources developed as part of the project;
- Baseline and follow up written questionnaires completed by pilot NGOs together with other participant organisations;
- Focus groups with NGO staff in the pilot organisations;
- Interviews with relevant NADA project staff, plus staff in relevant NGOs, and with other key stakeholders;
- Feedback from the Project Advisory Committee; plus
- Outcomes of routine NADA and project feedback including via end of training evaluation sheets.

Baseline Methodology

This preliminary baseline report is based on the written questionnaire distributed to 82 NADA member organisations[1] in June 2009.

The comprehensive questionnaire contained a mix of likert scale and open-ended questions related to the Project's development, as well as the key evaluation measures and indicators.

A total of 38 responses were received, representing a 46% response rate.

Included at Attachment 2 is the full data set from the baseline questionnaire.

[1] This number varies from the 115 listed as NADA members as part of this full list accounts for separate programs of the one overarching organisation.

Note: Only those items related to the baseline evaluation issues have been reported on in Section 5.

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5. BASELINE FINDINGS

As described in Section 4.4, the following evaluation findings are drawn from a baseline questionnaires administered in June 2009. Unless otherwise indicated, the number of questionnaire respondents was 38.

5.1 Profile of Respondents

5.1.1 About the Organisations

Respondents covered all categories of NADA member organisations including organisations that provided D&A:

- residential treatment services (63%);
- out-patient counselling, case management or day programs (45%);
- outreach services (42%);
- after-care/ transitional support (37%); plus
- range of other services (26%)[2].

These organisations covered providers with as few as one or two staff members, through to large providers with 150 or more staff members.

The average number of staff per respondent organisations was 21 staff (full and part-time).

[2] Note: Percentages exceed 100% as many organisations offer more than one-type of service types.

5.1.2 About the Clients

The number of clients seen by the respondent organisations ranged from 18 per annum, through to 20,000 per annum. The majority of providers saw between 80 and 500 clients per annum.

When respondents were asked to estimate how many of their organisation's clients were thought to have mental health problem, responses ranged from 18% through to 100%.

The average number of clients with mental health problems was calculated at 72%.

5.2 Intake and Systems Profile

The baseline questionnaires generated data regarding the type of intake processes used by NADA member organisations and the profile of their computer systems (see Questions 10- 19, Attachment 2). Some key findings are as follows (n=38):

- Majority of providers use agency developed intake/ assessment forms (92%), with a significant proportion also using, or only using standardised screening/ assessment measures (45%);
- Majority of providers enter client intake data into their computer systems, with:
    - Majority of these entering all key intake information (70%)
    - Minority entering only some data (30%).

  A small minority of providers (4) primarily kept intake data paper-based;
- All but one provider[3] used a Window based operating system, with 90% of these using Windows XP;
- All but one provider[4] had broadband internet connections;
- The number of computer terminals generally reflected the size of the provider, with the majority of providers having less than 10 terminals (57%)[5];
- Majority of providers used either the NADA online MDS system (55%) and/or Excel (53%) as their computer-based client data software. Other software in use included:

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[3] One provider (11 staff) used a Macintosh based operating system alone.

[4] One provider (small rural provider) used satellite based internet connection.

[5] 27% providers had between 1- and 20 terminals; and 16% had more than 20 terminals.

- SPSS (8%)
- SMART (8%) and
- SAMIS (5%), plus a range of other project based options.

- Majority of providers have the same staff who collect the data from clients also entering the data into the computer systems[6], with only 7 providers reporting different staff enter the data;

  For the majority of providers client data entry was the responsibility of staff working in clinical services (74%) and/or in administration (63%). 9 providers also had management playing a role in client data entry.

- Majority of providers had one position responsible for overseeing client data entry (59%), however a significant proportion (41%) indicated no one individual was responsible.

5.3 Client Data Profile

5.3.1 Type of Data Gathered

Majority of respondent organisations reported their current client data gathering information systems were useful or very useful in respect to:

- current drug and alcohol problems (97%);
- current mental health problems (79%);
- social/ family functioning (71%);
- physical health (79%);
- social economic issues[7] (84%);
- past drug and alcohol treatments and therapies (71%); and
- past mental health treatments and therapies (68%).

Also see mental health data information at Section 5.5.

The one measure which less than half of respondents reported as either useful or very useful related to outcomes of past treatments or therapies in general (47%).

[6] 51% providers had same staff enter all the data; 22% have only some data entered by same staff.

[7] This was defined as including employment, finances, housing, legal issues etc.

When respondents were asked what client information was not currently collected that they felt would be useful to their service a number indicated improved

a) outcome measurement data in general; and
b) mental health information.

Other responses listed included:

- improved medical information (for example HIV, or Hepatitis C status);
- number of hospital admissions or detentions;
- where clients are referred from;
- client expectations of treatment; and
- time required for services.

5.3.2 Service Use of Client Data

Majority of respondent organisations (89%) reported the primary reason for collecting client data was a combination of meeting external funding requirements and internal service and treatment planning purposes. Only one provider indicated it was primarily for funding purposes and to meet external requirements.

Further, the majority of providers reported that they regularly used and reviewed client intake data as part of treatment planning (53%). Only seven providers (18%) rarely used and reviewed client data as part of treatment planning.

The majority of providers also used the same assessment questions or intake tools to measure individual client progress (68%). However only a little over one third of providers (37%) regularly and routinely conducted these assessments on clients.

Of those providers who did reassess, most reported they conducted these at predetermined intervals. The intervals ranged from weekly to every three months. Providers also reported they routinely reassessed when the client exited their service, had a relapse or change of condition, or when clinical staff determined it is timely and relevant.

5.3.3 Assessed Usefulness of Client Data

When respondent organisations were asked to rate the overall value and usefulness of their current client data, a range of views were reported. For example, the majority of providers found their client data useful or very useful in respect to:

- determining the treatment their service will initially deliver (76%);
- measuring client progress over time (68%); and
- demonstrating their organisation's effectiveness (74%).

Positive, though less convincing results were also reported in respect to measuring success of treatment options at exit (60%).

Less than half of the respondent organisations however reported their client data system was useful or very useful in respect to consolidating data across different client categories (47%).

5.3.4 Perceived Barriers to Improved Client Data

When respondent organisations were asked to assess what if any barriers existed to improving the information gathered on clients a number of responses were provided. These included:

- database and technology constraints related to adding and accessing additional data fields (including on the NADA online MDS system);
- staff time, cost and resourcing impacts;
- privacy and accuracy difficulties associated with client self-reports; plus
- challenges in accessing reliable post-treatment or longitudinal client outcome information.

5.4 Service Capacities

Respondent organisations were asked to rate their service's capacity on a range of measures related the success indicators associated with the Information Management Project overall (*see Attachment 1*).

The majority of providers indicated that overall their service was either good or very good in terms of its appreciation of the value of:

- gathering client assessment data at intake (76%);

- gathering client assessment data at various points in the treatment delivery (66%); and
- accurate and consistent client data collection (68%).

The majority also reported good or very good capacities in respect to their service's:

- overall quality of their client data (63%);
- use of client assessment data in service planning and delivery (60%); and
- capacity to review and report on client outcomes data (58%).

A smaller proportion of respondent organisations however rated their service's capacity good or very good in respect to:

- quality of their information management systems overall (53%); and
- measuring client outcomes after discharge (34%).

Also see assessment of overall sector capacities at Section 5.6.

5.5 Profile of Mental Health Issues

5.5.1 Mental Health Training

Respondent organisations were asked to indicate approximately how many of their current staff who work with clients had some form of mental health training. Approximately:

- 27% of organisations had 20% or less staff trained in mental health, including five organisations (14%) having no staff trained;
- 32% of organisation had between 21% and 50% of staff trained in mental health;
- 22% of organisation had between 51% and 99% of staff trained in mental health; and
- 19% of organisation had all staff trained in mental health.

5.5.2 Treatment and Support Available

When respondent organisations were asked how treatment and support was provided to clients with mental health problems, a range of options were reported as

available, many were available concurrently through the one provider. For example, (in descending order) half or more than of half of all organisations reported that they:

- provided treatment and support through a mental health service with relevant client information shared between providers (68%);
- provided treatment and support in-house via mental health trained professionals (66%);
- referred clients to mental health services for treatment and support separate to their drug and alcohol interventions (66%); and/or
- provided support in-house by staff not formally trained in mental health (50%).

5.5.3 Mental Health Information Gathered

The majority of respondent organisations (82%) reported that mental health information was included as part of their standardised intake form and was routinely asked of all clients. Only two organisations reported that mental health information was only gathered from clients suspected of having a mental health problem.

The majority of respondent organisations reported they used a standardised screening and assessment tool in respect to the mental health of clients (62%). The most common tools in use are[8]:

- Psycheck Screening Tool (used by 29% organisations);
- Kessler-10 (K10) (16% of organisations)
- Depression Anxiety Stress Scales (DASS) (13% of organisations);
- Indigenous Risk Impact Scale (IRIS) (13% of organisations); plus
- SAAP database (5% of organisations)[9].

In terms of the frequency with which mental health assessment information is used by organisations, the majority of respondents indicated that they always used the information to:

- initiate client referrals to other services (70%);
- inform how treatment services are delivered (68%);
- inform how case coordination is provided (68%); and

[8] Note: Most organisations reported using more than one tool.

[9] See Questions 20 and 40 at Attachment 2 for the full set of responses given.

- review client's progress and make adjustments to treatment plans as needed (68%).

Approximately half or less than half of providers however reported they always used mental health client assessment information:

- measure client outcomes over time (51%);
- to review the services overall service delivery and planning (47%); and
- in advocacy or funding submissions (37%).

Roughly a fifth of service providers (22%) also indicated they used mental health assessment information for other purposes such as:

- to assist in family and carer planning;
- for referrals to other medical or support organisations; and
- for internal research, staff development and service monitoring purposes.

5.5.4 Mental Health Service Capacities

Respondent organisations were asked to rate their service's capacity on a range of mental health related measures. The majority of providers indicated their service overall was either good or very good in terms of its:

- knowledge of mental health conditions and symptoms (87%);
- understanding of mental health treatment options (82%);
- confidence in working with mental health clients (79%); and
- skills in working with mental health clients (76%).

5.6 Sector Capacities Overall

Respondent organisations were asked a number of questions related to how their service related to other parts of the NGO drug and alcohol sector. The responses to these questions were far less positive than organisation's assessment of the quality of their own data gathering information and capacities.

For example, only a minority of providers reported their organisation was good or very good at:

- comparing their client outcome data with other services (21%); and
- assessing client outcomes after discharge (34%).

Further, only a small minority of providers felt that the non-government drug and alcohol sector overall was good or very good in terms of its capacity to consolidate and report on client outcomes overall (16%).

5.7 Future Plans and Issues for Consideration

The majority of respondent organisations (88%) indicated that they had plans for improving their service's collection or use of client data in the future. When providers were ask to specify what those plans were, most identified actions that either NADA or the sector as a whole should undertake. These included:

- introducing a standardised data collection tool, incorporating mental health data, for use across sector;
- NADA modifying its online MDS database to include:
    - a simpler, more user-friendly interface
    - the addition of mental health data fields
    - a capacity to better measure client progress and outcomes over time
    - a capacity for users to generate improved data analysis and outcomes reports (while protecting client privacy and confidentiality)
    - a capacity for users to generate simple graphics and charts on outcome data
    - a capacity for the standardised database used by providers to also include client case plans and case notes;
- agreement to adopt standardised computer softwares to improve data comparisons and reporting;
- hosting of sector workshops and information sessions to assist staff:
    - improve their skills and capacities in data collection and data analysis
    - develop a better appreciation of the value and use of accurate client data information in general;
- funding grants to assist staff, including clinical staff, to improve their computer literacy;
- providing access to specialist information and technology experts that could work with providers to:
    - improve their internal data collection systems
    - train staff in use of standardised data collection and outcome measurement tools;

- facilitating opportunities for providers to share their approaches to data collection and analysis and to learn lessons from across the sector; plus
- annual publishing and distribution of client profile and outcome data from across the sector.

A number of providers also noted that the growing requirement for expanding client data collection, analysis and reporting was having financial and staffing impacts on their organisations. Suggestions to address this challenge included:

- providing more funding and staff directly linked to expanded data collection and reporting requirements;
- providing access to specialist staff skilled in information management, as well as able to provide advice on software and hardware updates and maintenance, plus assist with staff training and capacity building (*see above*);
- improving access to independent service model and client outcomes research;
- commissioning more research on longitudinal client outcomes; and
- commissioning more client outcome reports in general.

Finally, some respondents noted that client outcomes can have different meanings and uses depending on the service type, the context or the end-user. This suggested the need to be clear about what is meant by all terminology, and to ensure NADA is mindful about the impacts of any new information management systems and measures, and how it will be used, or potentially used both internally and externally.

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6. CONCLUSION

The questionnaires sent to NGO D&A providers in June 2009, as part of NADA's NGO Drug and Alcohol and Mental Health Information Management Project, generated valuable baseline data.

Based on the 38 responses received, representative of a range of D&A provider types across NSW, the findings demonstrate that providers on the whole are collecting and utilising a broad range of client information, including data related to drug and alcohol use and mental health issues.

The findings indicate a high level of appreciation of the importance of data collection. There is widespread recognition of its value in terms of not only meeting external funding and reporting requirements, but also in respect to improved client service delivery and internal planning purposes.

The majority of respondent organisations rated their service as good or very good in respect to:

- their overall information management systems;
- the quality of their client data overall;
- their use of client data in service planning and delivery; plus
- their knowledge of mental health conditions and understanding of the treatment options available.

There was strong support for incorporating mental health data into the standardised client data gathering systems, including into the NADA online MDS database.

While these positive baseline self-assessments reflect well on the NGO D&A sector as a whole, they do pose a slight challenge to NADA and its Project given its aim to demonstrate measurable improvements in client outcome reporting over time.

Some respondents emphasised the need to consider not just the benefits and opportunities of more consistency in client outcome measurement, but also consideration of some of the implementation challenges. For example, a number of providers were keen for NADA to clarify what was meant by ‘client outcomes’ and to consider the difficulties of effective measurement over time, including post-treatment. Other providers noted the potential risk of client outcome measures being misinterpreted, not just by individual providers, but by external parties as well.

Providers indicated that any common information management systems or shared assessment tools would need to cater for different types of clients, models of treatment and interventions.

The resourcing impacts of expanded data collection were also noted as a challenge.

A focus on client outcome measurement from a quality improvement perspective, rather than from competitive service-against-service perspective was seen as important. For example one provider cautioned against any move to establish so-called service ‘*league tables*‘.

Many of the respondent organisations indicated their strong support for NADA's Information Management Project. They noted that, subject to quality research, effective piloting, and evidence-based evaluation, the outcomes should be highly beneficial to the NGO D&A sector.

Overall the feedback emphasises the need for NADA to closely involve the sector in the Project’s development. It also raises the need to consult with other key stakeholders including clients, mental health experts and funding bodies.

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GLOSSARY

AOD	Alcohol and drug
BTOM	Brief Treatment Outcome Measure
D&A	Drug and alcohol
GLBT	Gay, lesbian, bi-sexual and transgender
MDS	Minimum data set (NSW Health prescribed minimum set of client and service outcome data information)
Members	NADA member organisations
NADA	Network of Alcohol and Other Drugs Agencies
NGOs	Non-Government organisations
Respondent organisations	Organisations that responded to the baseline Project questionnaire n= 38
Respondents	Refers to individuals who responded to the baseline questionnaire

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ATTACHMENTS

ATTACHMENT 1: Evaluation Criteria and Measures

The following set of evaluation measures was developed by the independent Project evaluators- EJD Consulting and Associates- with input from NADA staff and the Project Advisory Committee (see Section 3.5). They are drawn from the Project Evaluation Framework approved in May 2009.

Key Indicators and Measures

1) Increase in non government D&A organisations':
   - o routine data collection of quality mental health as well as D&A client information;
   - o use of mental health as well as D&A client information in terms of:
     a) treatment services delivered;
     b) type of case coordination provided;
     c) client referrals initiated;
     d) client outcomes measured over time; plus
     e) overall service delivery and planning.

2) Increase in non government D&A staff's:
   - o skills, knowledge and capacity in gathering quality mental health and D&A client information;
   - o understanding of the relevance and application of quality client data to service delivery and planning.

3) Recognition that the Project's tool, data gathering system, and associated activities:
   - o were efficient and effective in improving treatment outcome measurement of clients of the D&A NGO sector;
   - o provided a useful approach for future NGO D&A and mental health information management in NSW.

Success Factors

In order to assess the above indicators the evaluators will gather data and feedback based on the following broad success factors: efficacy, efficiency, adequacy, and appropriateness. What follows are some sample questions related to each factor[10]:

- **Efficacy**
  - *What were the key inputs, outputs and outcomes?*
  - *Was the tool legitimate and appropriate?*
  - *Was the data collected (and the collection and reporting formats) compatible with other data systems?*
  - *Was the data collected useful and did it/ could it assist in improved service delivery and planning?*
  - *How are services, staff and clients better off as a result of the Project?*

- **Efficiency**
  - *Has the time and resources expended been efficient and effective in terms of the results delivered?*
  - *Were the Project's staffing and resources adequate?*
  - *What, if any, barriers or constraints were there in terms of implementing the Project (for e.g. staff access to information/ training, resources, or equipment)?*
  - *Has the communication been effective - to and from NADA?*
  - *What were the tool's client impacts in terms of length and intrusiveness?*
  - *Were the governance arrangements of the Project sufficient?*

[10] Note: These questions are indicative only and primarily reflect the breadth of issues on which feedback will be gathered. They will be modified depending on the respondents and the data collection instruments used.

- **Adequacy**
  - *Did NADA achieve the results expected by themselves, by the project funders and by other stakeholders?*
  - *Was the data reliable and of good quality?*
  - *Was there clear understanding of roles and responsibilities of various parties?*
  - *Was the training and resources adequate from a user's perspective?*
  - *Was there sufficient engagement of key stakeholders (in both the mental health and drug and alcohol fields)?*

- **Appropriateness**
  - *Did the processes and outcomes align with the funding guidelines and stated expectations?*
  - *Could the tool be used by other sectors and stakeholders? If not, why not? Is so, how so?*
  - *Were there any unexpected consequences arising from the Project or its implementation (positive or negative)?*

Stakeholders will also be asked their views of the next steps or areas for improvement at each stage of the evaluation.

* * * *

ATTACHMENT 2: Baseline Questionnaire- Full Data Set

The Project Baseline Questionnaire was distributed to 82 NADA member organisations (non-government drug and alcohol agencies in NSW) in June 2009.

A total of 38 responses were received. Response rate calculated at 46%.

What follows is the full data set of responses (minus all identifying details- Q.1 & 2).

Note: In questions: 3, 9, 10, 13, 18, 20, 21, 22, & 23-n is greater than candidature because in some cases multiple choices were made.

Question 3. Which of the following service type's best describes your services role?

Service Types	**Respondents**	No#
Residential Treatment	1, 3, 4, 5, 6, 7, 8, 9, 10, 13,16, 19, 21, 22, 23, 24, 27, 29, 30, 33, 34, 35, 36, 38	24
Out-patient counselling and case management/ day program	2,3,7, 8, 12, 16, 17, 20, 22, 23, 25, 28, 30, 31, 32, 34, 38	17
After-care/ transitional support	2,3, 4, 6,16, 17, 19, 22, 23, 28, 29, 30, 34, 38	14
Outreach	2,3, 4, 6, 7, 9, 13, 16, 17, 18, 20, 23, 25, 26, 28, 30	16
Other	2, 3, 4, 9, 11, 14, 15, 16, 23, 30, 37	11
n		82

Other Responses (n=11)

2. Health promotion service for GLBT people and people affected by HIV.
3. Homeless
4. Employment Services/Diversion Program
9. Homeless and women and children's rehab
11. Post Rehab living skills program
14. AOD Counselling/Advocacy and Referral
15. Women's Healthcare Centre
16. Primary care D&A
23. Developing new services
30. Needle and Syringe Program, Medical Centre
37. Counselling/Group work outpatient only

Question 4. Approximately how many staff work in your service?
(part and full time)

Code	No# staff
1	10
2	150
3	8
4	35
5	11
6	25
7	7
8	10
9	15
10	8.2
11	2
12	4
13	14
14	1
15	19
16	60
17	7
18	4
19	16
20	3
21	12
22	16
23	12
24	160
25	5
26	8
27	24
28	6
29	14
30	55
31	10
32	5
33	14
34	11
35	12
36	
37	3
38	15

Average 21.35

Question 5. Approximately how many staff in your service work with clients?
(part and full time)

Code	No# Staff w Clients
1	3
2	80
3	8
4	23
5	4
6	20
7	5
8	7
9	14
10	9
11	2
12	4
13	13
14	1
15	17
16	55
17	6
18	4
19	13
20	3
21	11
22	14
23	12
24	100
25	5
26	5
27	22
28	3
29	12
30	40
31	5
32	5
33	13
34	10
35	12
36	
37	3
38	10

Average 15.49

Question 6. Approximately what number of these staff have some form of mental health training?

Code	No# Staff w Training
1	0
2	20
3	5
4	2
5	1
6	10
7	
8	3
9	10
10	3
11	2
12	4
13	14
14	1
15	5
16	50
17	3
18	4
19	0
20	1
21	1
22	8
23	4
24	30
25	4
26	0
27	15
28	2
29	3
30	10
31	4
32	0
33	2
34	1
35	4
36	1
37	3
38	14

Average 6.59

Question 7. Approximately how many clients does your service see annually?

Code	No# Clients p/a
1	8000
2	2000
3	
4	
5	500
6	
7	33
8	120
9	100
10	70
11	
12	150
13	400
14	90
15	5000
16	1000
17	200
18	115
19	60
20	1500
21	18
22	115
23	250
24	500
25	90
26	80
27	120
28	1200
29	200
30	20000
31	1029
32	180
33	85
34	130
35	253
36	80
37	350
38	180

Average 1299.94

Question 8. Approximately what percentage of your clients do you think have some sort of mental health problem?

Code	% Clients w Mental Health Problem
1	70
2	30
3	50
4	85
5	50
6	80
7	75
8	33
9	80
10	95
11	80
12	70
13	75
14	90
15	50
16	100
17	90
18	75
19	95
20	18
21	95
22	90
23	70
24	60
25	95
26	95
27	75
28	75
29	60
30	85
31	85
32	70
33	65
34	60
35	28
36	65
37	80
38	85

Average 71.82%

Question 9. Which of the following best describes how your service provides treatment and support to the clients with mental health problems?

Service Description	
(1)Treatment and Support is Provided by in-house mental health trained professionals	25
(2)Treatment and Support is provide through a mental health service with relevant client information and outcomes shared between our services	26
(3)Clients with mental health issues are referred to or use other services for treatment and support separate to their drug and alcohol treatment whilst with our service	25
(4)Support is provided via our service staff that are not formally trained in mental health but are experienced	19
(5)Our service does not treat clients with mental health problems	1
(6)Other	4
n	100

Other Responses (n=4)

4. A range of training/professional development activities are offered to staff under the current Co morbidity project and have been offered over time for all [service name]'s clinical staff i.e. - Mental Health First Aid, Mental Health/AOD joint training/Psy- check training.

24. Recovery Services has implemented a training program designed to lift the knowledge and skills of all staff to enable them to better work with people with a mental illness.

28. Historically DD interagency monthly about to re-start (being a bit of a gap in meetings) - will be used to identify clients that require dual case management.

29. Minimum Qualification level for all staff is Certificate IV in D&A. This includes minor competency training in mental health & substance use. (per Q6)

Question 10. What operating system does your service use?

Operating System	No#
Windows XP	34
Windows Vista	6
Mac OS X	3
Other	0
n	43

Code	Q10. OS
1	Windows XP
2	Windows XP
3	Windows Vista
4	Windows XP/Windows Vista
5	Mac OS X
6	Windows XP
7	Windows Vista
8	Windows XP
9	Windows XP
10	Windows XP
11	Windows XP
12	Windows XP
13	Windows XP/Windows Vista/Mac OS X
14	Windows XP
15	Windows XP
16	Windows XP/Mac OS X
17	Windows XP
18	Windows XP
19	Windows XP
20	Windows XP
21	Windows XP/Windows Vista
22	Windows XP
23	Windows XP
24	Windows XP
25	Windows XP
26	Windows XP
27	Windows XP
28	Windows XP
29	Windows XP
30	Windows XP

31	Windows XP
32	Windows XP
33	Windows XP
34	Windows XP
35	Windows XP
36	Windows XP
37	Windows Vista
38	Windows XP

Question 11. What kind of internet connection does your service have?

Internet Connection Type	No#
Dial-up	0
Broadband	37
Other	1
n	38

Other Responses (n=1)

36. Satellite

Question 12. Approximately how many computers does your service use?

No# Computers	No#
Less than 10	21
Between 10 and 20	10
More than 20	5
Other	1
n	37

Code	No# Computers
1	Less than 10
2	More than 20
3	Less than 10
4	More than 20
5	Between 10-20
6	Between 10-20
7	Less than 10
8	Less than 10
9	Between 10-20
10	Less than 10
11	
12	Less than 10
13	Less than 10
14	Less than 10

15	Between 10-20
16	More than 20
17	Less than 10
18	Other
19	Less than 10
20	Less than 10
21	Less than 10
22	Between 10-20
23	Less than 10
24	More than 20
25	Less than 10
26	Less than 10
27	Between 10-20
28	Less than 10
29	Less than 10
30	More than 20
31	Between 10-20
32	Less than 10
33	Between 10-20
34	Less than 10
35	Less than 10
36	Between 10-20
37	Less than 10
38	Between 10-20

Other Responses (n=1)

18. MOS has 5; MCS has 56

Question 13. What sort of computer software/package is used in your service for compiling or analysing client data?

Software/Computer Package	No#
NADA online MDS system	21
Microsoft Excel or similar	20
Microsoft Access or similar	14
SPSS	3
Other	17
n	75

Other Responses (n=17)

1. SAAP Database
2. Varies between branches and divisions. AOD unit use NADA system
4. ADIS
5. Filemaker Pro
7. SMART
9. SMART
14. Excel one In House
20. Internal database
23. SAMIS
24. SAMIS
26. SMART (SAAP/ NDCA)
28. MERIT database
29. EPI Info
30. NMDS, Filemaker Pro, Best Practice
36. Communicare
37. MATISSE

Question 14. Does client intake data get entered into the computer system?

Answer	No#
Yes	23
Only Some	10
No	4
Other	0
n	37

Code	Client Data Entered Into Computer System?
1	Yes
2	No
3	Yes
4	Only Some
5	Yes
6	Yes
7	Yes
8	Only Some
9	Yes
10	No
11	
12	Only Some
13	Yes

14		Yes
15		Only Some
16		Yes
17		Yes
18		Only Some
19		Yes
20		Yes
21		Only Some
22	Yes	
23		Yes
24		Yes
25		No
26		Yes
27		Yes
28		Yes
29		Only Some
30		Yes
31		Yes
32		Only Some
33		Yes
34		Yes
35		Only Some
36		No
37		Only Some
38		Yes

Question 15. Approximately how many staff in your service are responsible for collecting information from clients?

Code	No# Staff Collecting Info
1	7
2	80
3	8
4	15
5	4
6	18
7	4
8	8
9	12
10	10
11	
12	4
13	14
14	1
15	17
16	10
17	1
18	4
19	4
20	3
21	11
22	10
23	6
24	160
25	6
26	5
27	9
28	3
29	12
30	25
31	5
32	5
33	7
34	8
35	4
36	5
37	3
38	10
n=	38
Average (2dp) 14.00	

Question 16. Approximately how many staff in your service are responsible for <u>entering client data</u> into a computer system?

Code	No# Date Enterers
1	7
2	60
3	8
4	10
5	5
6	18
7	2
8	2
9	1
10	1
11	
12	4
13	3
14	2
15	1
16	20
17	1
18	4
19	4
20	3
21	1
22	10
23	6
24	160
25	2
26	1
27	6
28	1
29	2
30	20
31	6
32	5
33	3
34	8
35	3
36	5
37	3
38	3
n=	38

Average (2dp) 10.84

Question 17. Are the staff that collect data from clients the same as the staff who enter the client data into the computer system?

Answer	No#
Yes	19
Only Some	8
No	7
Other	2
n	37

Code	15+16 Same?
1	Yes
2	Yes
3	Yes
4	3
5	Yes
6	Yes
7	Yes
8	Yes
9	Yes
10	Only Some
11	
12	Yes
13	Other
14	Only Some
15	Only Some
16	No
17	Yes
18	Yes
19	Yes
20	Yes
21	No
22	Only Some
23	Yes
24	Yes
25	Other
26	Only Some
27	No
28	No
29	No
30	Yes
31	Only Some
32	Yes
33	Yes
34	Yes

35	Yes
36	Yes
37	No
38	Only Some

Other Responses (n=2)

13. All staff responsible for collecting data, only three of whom enter it electronically

25. We also have an Intake worker for the whole of [service name] that does initial assessment and documents information

Question 18. Which areas of your organisation are primarily responsible for entering client data into the computer?

Answer	No#
Management	9
Admin	24
Clinical	28
Other	1
n	62

Code	Data Entry Area
1	Clinical
2	Administration, Clinical
3	Administration, Clinical
4	Administration, Clinical
5	Administration
6	Administration, Clinical
7	Management, Clinical
8	Administration, Clinical
9	Management, Administration, Clinical
10	Management
11	
12	Management, Administration, Clinical
13	Clinical
14	Clinical
15	Administration
16	Administration, Clinical
17	Administration
18	Clinical
19	Clinical
20	Clinical
21	Administration
22	Clinical
23	Administration, Clinical

24	Management, Admin, Clinical
25	Management, Clinical
26	Other
27	Management, Admin, Clinical
28	Administration
29	Administration
30	Administration, Clinical
31	Administration, Clinical
32	Clinical
33	Administration, Clinical
34	Management, Administration, Clinical
35	Management, Administration
36	Administration, Clinical
37	Clinical
38	Administration, Clinical

Other responses (n=1)

26. Team leader

Question 19. Do you have one position in your service that oversees client data entry?

Answer	No#
Yes	22
No	15
n	37

Yes; Specifications

1. Office Manager
2. Managing director
9. Clinical Team Leader
17. Receptionists
18. Co-ordinator
19. Team Leader and Manager
20. Service coordinator
21. Admin
23. Team Leader
24. Clinical team leaders
26. Team leader
27. Research and Program Development Officer
28. Admin Officer
29. Support Worker
30. IT Support Coordinator

31. Admin
32. ME (manager)
33. IMP – stats package personal
35. Intake officer
36. Dep CEO
38. Service director

Question 20. Which of the following best describes the screening/assessment measures or forms of intake/early assessment?

Answer	No#
Agency developed intake/assessment form	35
Standardised screening/assessment measure	17
n	42

Specifications:

8. SAAP risk assessment, clinical interview schedule

13. Audit, K10, sev, dependince, OTI Psycheck, and some agency developed, beck

14. Mental Health – A1 assessment of Current Presentation

16. DASS, K10, IRIS

18. BTOM, Self Report Questionnaire (SRQ)

20. Psycheck

23. Severity of dependence, other tools developed by Wollongong University

24. ASI, K10, DASS

27. AUDIT, DUDIT, BSCQ, BSI

28. Psycheck, MERIT database tools

29. GHQ, SF12, DTCQ, Crime Questionnaire

30. Psycheck

33. K10, ATOM, Psycheck, IRIS

Question 21. Which of the following statements best describes the main reason for client data collection in your service?

Answer	No#
Combination of meeting external/funding requirements and internal service and treatment planning purposes	34
Primarily for funding purposes and to meet external requirements	1
Primarily for internal service and treatment planning purposes	7
Primarily for use in individual client treatment	3
Other	0
n	45

Question 22. Which of the following statements best describes the utility of client intake data in your service?

Answer	No#
Regularly used and reviewed as part of treatment planning	20
Occasionally used and reviewed as part of treatment planning	8
Rarely used and reviewed as part of treatment planning- primarily for external reporting	7
Other	3
n	38

Other responses (n=3)

18. Regularly used in setting up case plan; case plan reviewed on a regular basis

26. Occasionally used to highlight / justify / explain / support case management carried out by our service

31. Informing early intervention and other program development

Question 23.

A) Do you use the same assessment questions/intake tools at other stages in treatment to measure client progress?

Answer	No#
Yes Regularly	14
Yes Occasionally	12
Only rarely	4
No	6
Other	5
n	41

Other responses (n=5)

5. More detailed assessments occur to identify broader AOD and other bio-psychosocial issues i.e. Case Management and Assessment History

6. At milestones in treatment

18. We have recently started using Psycheck which requires routine completion of assessments

26. We carry out support plan reviews with clients at least once every 3 months

31. Informing early intervention and other program development

B) ***Please provide details of how regularly and for what purpose you re-assess clients using common assessment questions/intake tools***

2. There is no set schedule for re-assessing clients. This is done at the discretion of clinical staff to review progress.

3. Clients are reassessed three times during the course of their stay using common assessment questions as part of three routine Case Management sessions.

4. Treatment Planning

6. For clinical review and for health outcome measures of progress

8. Fortnightly to measure depression and anxiety

9. When signs or symptoms are observed or at case plan review

10. Tracking progress, care planning, identifying social stressors and reviewing D&A history.

12. We use the BTOM assessment for clients at initial Assessment, then do Self-evaluation of Quality of Life pre, during and post case management or group process

13. approx 3 monthly as clients enter the next stage of treatment, then post treatment 3 6 12 month (new)

14. When it seems that clients use or life has changed in a measureable way

15. For ATOD clients we assess at the commencement of counselling, mid way and exit. maximum sessions is 12, groups will similarly usually have an intake process with assessment, followed by exit assessment.

16. Change of Program

17. At the end of treatment, if new issue comes up, screen

18. See above re Psycheck. We complete the BTOM at baseline and follow up at 3 to 6 months

19. More detailed clinical assessments and risk assessments both ongoing through treatment

20. Case work reviews

23. We review client data weekly, and review our service delivery monthly

24. Fortnightly, to assess treatment effectiveness in achieving treatment / case goals.

25. We aim to constantly check in with young people about how they are going and how things are progressing for them, and then determine what else they need. We assess changes in drug use and changes to mental health concerns and explore what has supported change.

27. AUDIT, DUDIT, BSCQ, BSI

29. Questions are done at intake then 4, 8 & 12 months to check outcomes

31. Moving towards this in our service with outcome monitoring tools

33. Intake, ½ way (8 weeks), completion (16 weeks), inform therapy, case management, funding bodies, research

34. Client 'penalty points' and counsellor input is used at weekly clinical meetings to monitor rehabilitation

35. Fortnightly

36. Every 3 months, to check treatment efficiency/ plan programs

37. When clients relapse, or exit and re-enter service

38. Every 4 weeks, improvement and planning

Question 24. What information is <u>not</u> currently being <u>collected</u> from clients that would be useful to your service?

1. Would like to focus more on collecting info of client progress and outcome throughout treatment

2. Follow up data at regular intervals after client has exited the program

4. Outcome Data

5. No

7. All relevant information in gathered

8. None that I am aware of

9. Clear client outcomes ranging from complete abstinence, health outcomes, housing social and in all life domains etc…

10. All necessary information is collected, though the assessment format is under review to produce a more user-friendly version

11. Some Medical data i.e. HIV, Hep C

12. Through care information ie. regular follow up post treatment / group to assess client's progress and Quality of Life

14. Income Source, Housing type, Relationship

15. Where clients are referred from is often discussed, but not collected and mapped. this would be useful.

17. For NADA, mental health info would be great

18. None. But we have information that we collect and are not able to use effectively due to lack of appropriate electronic recording and reporting tools.

21. Lack of integrated client information including complete case notes, history, case management, intake and exit, financial records, etc

23. Not sure our data collection is extensive

24. No comment - although there must be something

25. The NADA database that we use to collate data collection does not allow us to capture mental health stats. Given that we work with Dual Diagnosis it would be helpful to capture these stats on a database.

27. Number of hospital admissions (mental health) number of detentions: this data has just commenced collection.

28. Time required for services - not currently reflected in data collection, Staff time spent on data collection Measurement/Data collection for group work

29. Standard assessment tools to facilitate better treatment planning

31. Mental disorders- diagnosed and other, non-diagnosed mental health problems, engagement in treatment with Psychiatrist/ Mental Health Team, Previous individual or family history

32. Clients expectations of treatment

37. Full address

Question 25. Are there any <u>barriers</u> to adding this information into your client intake forms or data management systems?

1. Limited Clinical Staff: Under-resourcing

2. Our intake forms have been in use for only 3 months, and information gaps have yet to present themselves. New intake questions can be added to our intake forms as required. Recording and using this data may be problematic, however. We currently use NADA's NMDS online tool, however our access to the information we enter is limited, and it would require the assistance of Kevin at NADA for information beyond what is produced in the reporting function of the NADA tool. Ideally, we would have greater access to this information. In addition, information that we collect beyond what is contained in the NMDS (e.g. sexuality data) cannot be recorded along with MDS information. As I understand it, this means that we will need to set up a separate database to record the information that is not part of the MDS, which is inefficient.

3. Availability of Data. Access to clients post treatment

4. Identifying specifics which we want to measure and the most appropriate good practice model or tool relating to that/resources

5. No

8. No

9. The clients are often not honest in responses, leave early or become un-contactable. Case workers are resistant to additional administrative burden and it is viewed as what is the data used for, it is just archived when the client leaves.

10. No, the Form is currently under review

11. Throughcare information i.e. Regular follow up post treatment / group to assess client's progress and Quality of Life

12. Time, resources, lack of appropriate system

14. Should be able to be included

15. The constraints of the data base currently does not allow for the mapping of this information

18. None

21. Yes, size required needs development of new software

22. No

24. There would be no barriers as we have our own system

25. We rely on our internal intake forms and data management to capture this information. It just feels like we are doubling up the work given we cannot enter this information into our NADA database.

27. Capturing information about clients who exit treatment prior to concluding treatment episode, hard to talk to them about why they are disengaging from treatment.

28. Hunter New England area services and compatibility with their tools and systems

29. There will probably be a cost factor to upgrade these

32. Clients require time to process their own role in treatment. By then they are engaged and conditions have changed

33. Data management system (except for MDS) is on excel file

36. Time and costs

37. Many clients are uncomfortable disclosing private details

How useful do you think your services current information systems are in terms of gathering client's details?

26. Current drug and alcohol problems

Answer	No#
Very Useful	20
Useful	17
Neutral	1
Not particularly useful	0
Not useful at all	0
n	38

27. Current mental health problems

Answer	No#
Very Useful	18
Useful	12
Neutral	4
Not particularly useful	4
Not useful at all	0
n	38

28. Social/family functioning

Answer	No#
Very Useful	13
Useful	14
Neutral	7
Not particularly useful	4
Not useful at all	0
n	38

29. Physical health

Answer	No#
Very Useful	17
Useful	13
Neutral	4
Not particularly useful	4
Not useful at all	0
n	38

30. Socio-economic issues

Answer	No#
Very Useful	16
Useful	16
Neutral	2
Not particularly useful	4
Not useful at all	0
n	38

31. Past drug and alcohol treatments

Answer	No#
Very Useful	15
Useful	12
Neutral	5
Not particularly useful	4
Not useful at all	2
n	38

32. Past mental health treatments or therapies accessed by the client

Answer	No#
Very Useful	12
Useful	14
Neutral	6
Not particularly useful	4
Not useful at all	2
n	38

33. Outcomes of part treatments or therapies accessed by the client

Answer	No#
Very Useful	10
Useful	8
Neutral	12
Not particularly useful	6
Not useful at all	2
n	38

34. Determining the treatment your service will initially deliver

Answer	No#
Very Useful	15
Useful	14
Neutral	5
Not particularly useful	3
Not useful at all	1
n	38

35. Measuring client progress over time

Answer	No#
Very Useful	7
Useful	19
Neutral	8
Not particularly useful	2
Not useful at all	2
n	38

36. Measuring success of treatment options at exit

Answer	No#
Very Useful	11
Useful	12
Neutral	6
Not particularly useful	7
Not useful at all	2
n	38

37. Consolidating information across different client categories

Answer	No#
Very Useful	8
Useful	10
Neutral	11
Not particularly useful	8
Not useful at all	1
n	38

38. Demonstrating your organisation's effectiveness

Answer	No#
Very Useful	9
Useful	19
Neutral	4
Not particularly useful	6
Not useful at all	0
n	38

Question 39. Which of the following statements best describes how your service gathers data on client's mental health status?

Answer	No#
Mental health information is part of our standardised intake form and is routinely asked of all clients	31
Mental health information is part of our standardised intake form and is asked only of clients suspected of having a mental health condition	2
Mental health information is only gathered as part of a general case history	0
No we Generally do not gather information on the clients mental health condition	0
Other	5
n	38

Code	Q39. Gathering Method
1	Mental health information is part of our standardised intake form and is routinely asked of all clients
2	Other
3	Other
4	Mental health information is part of our standardised intake form and is routinely asked of all clients
5	Mental health information is part of our standardised intake form and is routinely asked of all clients
6	Mental health information is part of our standardised intake form and is routinely asked of all clients
7	Mental health information is part of our standardised intake form and is routinely asked of all clients
8	Mental health information is part of our standardised intake form and is routinely asked of all clients
9	Mental health information is part of our standardised intake form and is routinely asked of all clients
10	Mental health information is part of our standardised intake form and is routinely asked of all clients
11	Mental health information is part of our standardised intake form and is routinely asked of all clients
12	Mental health information is part of our standardised intake form and is routinely asked of all clients
13	Mental health information is part of our standardised intake form and is routinely asked of all clients
14	Mental health information is part of our standardised intake form and is routinely asked of all clients
15	Mental health information is part of our standardised intake form and is routinely asked of all clients
16	Mental health information is part of our standardised intake form and is asked only of clients suspected of having a mental health condition
17	Mental health information is part of our standardised intake form and is routinely asked of all clients
18	Mental health information is part of our standardised intake form and is routinely asked of all clients
19	Mental health information is part of our standardised intake form and is routinely asked of all clients
20	Other
21	Mental health information is part of our standardised intake form and is routinely asked of all clients
22	Mental health information is part of our standardised intake form and is routinely asked of all clients
23	Mental health information is part of our standardised intake form and is routinely asked of all clients
24	Mental health information is part of our standardised intake form and is routinely asked of all clients
25	Mental health information is part of our standardised intake form and is routinely asked of all clients
26	Mental health information is part of our standardised intake form and is routinely asked of all clients

27	Mental health information is part of our standardised intake form and is routinely asked of all clients
28	Mental health information is part of our standardised intake form and is routinely asked of all clients
29	Mental health information is part of our standardised intake form and is asked only of clients suspected of having a mental health condition
30	Mental health information is part of our standardised intake form and is routinely asked of all clients
31	Other
32	Other
33	Mental health information is part of our standardised intake form and is routinely asked of all clients
34	Mental health information is part of our standardised intake form and is routinely asked of all clients
35	Mental health information is part of our standardised intake form and is routinely asked of all clients
36	Mental health information is part of our standardised intake form and is routinely asked of all clients
37	Mental health information is part of our standardised intake form and is routinely asked of all clients
38	Mental health information is part of our standardised intake form and is routinely asked of all clients

Other Responses (n=5)

2. A variety of intake forms are used across [service name's] branches and the [project name]. All staff with some level of client contact are currently being trained to understand and administer the K10 and SDS and to make appropriate referrals on the basis of mental health issues which are identified using these tools. All clients of the AOD Program in Sydney and Hunter are assessed using K10. This program assumes that its clients probably do have some degree of mental health issues and investigates accordingly.

3. General health questionnaire

20. Clients with AOD issues are assessed for mental health issues

31. Intake form currently under revision to include mental health, mental health info is gathered in assessment form

32. Mental health issues are identified in the process of identifying strengths

Question 40. Please list what, if any, <u>standardised mental health assessment measures</u> are used in your organisation?

1. Questions for SAAP Database
2. As above
3. As above
4. Mental Health assessment as part of MOU with ACT Mental Health/Psy-check
5. Psycheck+ GP+ Psychologist
6. Psycheck, Becks Scales, SF36, CIDI
7. See above
8. Beck depression inventory
9. Mental state examination, Suicide risk assessment, Kessler-10, Psycheck Screening Tool, Self Reporting Questionnaire, DASS-21, (PC-PTSD), TSQ, Psychosis Screener, IRIS.
10. Trialling Psycheck/ all clients have psychological assessment with psychologist

12, 13, 14, 16, 17 & 18. See above

19. Risk Assessment only ‘

20. Psycheck

21. None

23. The tools are included in our internal system which are similar to the dsm 4 and developed in consultation with Wollongong UNI

24. As above

27. BSI (Brief Symptoms Inventory) also the mini mental state exam.

28. See above

29. Mental Health State Exam

30. Psycheck

31. Currently introducing K10 at assessment, one month, and on completion of treatment group and day programs currently use standardised mental health assessment measures at commencement and completion of program. Evaluation surveys use various tools such as K6 or K10, SF36, general health and wellbeing questionnaire

32. Psycheck

33. Now starting IRIS, Psycheck, DASS21 with this to be used in questions 42-48 from now on if approved by board

36. Psycheck, IRIS, DASS (if previously suggested by Ax), BTOM

37. See above

38. See above

Question 41. Are these mental health assessment <u>tools used</u> on all or only some clients?

Answer	No#
All Clients	21
Some Clients	9
Other	4
n	34

Code	Q41. 40 all or some?
1	All Clients
2	Other
3	All Clients
4	All Clients
5	All Clients
6	All Clients
7	All Clients
8	Some Clients
9	Some Clients
10	All Clients
11	All Clients
12	Some Clients
13	All Clients
14	Some Clients
15	
16	All Clients
17	All Clients
18	Other
19	All Clients
20	Other
21	
22	All Clients
23	All Clients
24	All Clients
25	Some Clients
26	
27	All Clients
28	All Clients
29	Some Clients
30	Some Clients
31	Other
32	Some Clients
33	All Clients
34	Some Clients
35	

36	All Clients
37	All Clients
38	All Clients

Other Responses (n=4)

2. All AOD Program clients, currently only some other clients. This will increase following the rollout of mental health awareness training, and training in use of SDS and K10).

18. Vast majority of clients

20. Clients with AOD issues are assessed for mental health issues

31. Proposed to use on all clients

Mental health client assessment information is used...

42. to inform how <u>treatment services</u> are delivered

Answer	No#
Always	25
Occasionally	8
Rarely	2
Never	1
Don't Know	1
n	37

43. to inform how case coordination is provided

Answer	No#
Always	25
Occasionally	9
Rarely	2
Never	0
Don't **Know**	1
n	37

44. to initiate client referrals to other services

Answer	No#
Always	26
Occasionally	11
Rarely	0
Never	0
Don't Know	0
n	37

45. to review client's progress and make adjustments to treatment plans as needed

Answer	No#
Always	25
Occasionally	11
Rarely	1
Never	0
Don't Know	0
n	37

46. To measure client outcomes over time

Answer	No#
Always	19
Occasionally	10
Rarely	6
Never	2
Don't Know	0
n	37

47. To review your overall service delivery and planning

Answer	No#
Always	17
Occasionally	12
Rarely	4
Never	2
Don't Know	1
n	36

48. In advocacy or funding submissions

Answer	No#
Always	14
Occasionally	12
Rarely	7
Never	4
Don't Know	1
n	38

Question 49. Do you use your client's mental health assessment information for any other purposes?

Answer	No#
Don't know	0
No	28
Yes	8
n	36

Specifications (n=8)

3. To determine how Family and Carer's may be included in treatment planning and Exit Planning

8. for referral to appropriate specialist including Medical Practitioners and Black dog

17. Internal Reports to area manager

24. Internal research in relation to incidence and type of mental illness and therefore, staff training and service development.

25. We notice trends and patterns and are able to respond to community needs.

28. For management committee reports, training other services - used as case information, etc

30. Staff Supervisor

31. Evaluation of client outcomes is included for group/day programs but not formally measured in counselling/treatment

How would you currently rate your service's capacity based on the following qualities?

50. Overall Knowledge of mental health conditions and symptoms

Answer	No#
Very Good	10
Good	23
Neutral	5
Poor	0
Very Poor	0
Don't Know	0
n	38

51. Overall understanding of mental health treatment options

Answer	No#
Very Good	11
Good	20
Neutral	7
Poor	0
Very Poor	0
Don't Know	0
n	38

52. Confidence in working with clients with mental health issues

Answer	No#
Very Good	8
Good	22
Neutral	8
Poor	0
Very Poor	0
Don't Know	0
n	38

53. Overall skills in working with clients with mental health issues

Answer	No#
Very Good	16
Good	13
Neutral	6
Poor	3
Very Poor	0
Don't Know	0
n	38

54. Appreciation of the value of gathering client assessment data at intake

Answer	No#
Very Good	16
Good	13
Neutral	6
Poor	3
Very Poor	0
Don't Know	0
n	38

55. Appreciation of the value of gathering client assessment data at various points in the treatment delivery

Answer	No#
Very Good	11
Good	14
Neutral	7
Poor	6
Very Poor	0
Don't Know	0
n	38

56. Appreciation of the value of accurate and consistent client data collection

Answer	No#
Very Good	10
Good	16
Neutral	10
Poor	1
Very Poor	0
Don't Know	1
n	38

57. Use of client assessment data in service planning and delivery

Answer	No#
Very Good	7
Good	16
Neutral	13
Poor	2
Very Poor	0
Don't Know	0
n	38

58. Services capacity to measure client outcome after discharge

Answer	No#
Very Good	3
Good	10
Neutral	13
Poor	7
Very Poor	4
Don't Know	1
n	38

59. Overall the quality of your client data

Answer	No#
Very Good	5
Good	19
Neutral	10
Poor	4
Very Poor	0
Don't Know	0
n	38

60. Overall the quality of your information management systems

Answer	No#
Very Good	6
Good	14
Neutral	13
Poor	5
Very Poor	0
Don't Know	0
n	38

61. Overall your services capacity to review and report on client outcomes data

Answer	No#
Very Good	5
Good	17
Neutral	11
Poor	5
Very Poor	0
Don't Know	0
n	38

62. Capacity of your service to use client outcomes data in advocacy and funding submissions

Answer	No#
Very Good	4
Good	15
Neutral	12
Poor	5
Very Poor	0
Don't Know	2
n	38

63. Capacity of your service to compare its client outcome data with other services

Answer	No#
Very Good	4
Good	4
Neutral	15
Poor	9
Very Poor	2
Don't Know	4
n	38

64. Capacity of the NGO drug and alcohol sector to consolidate and report on client outcomes overall

Answer	No#
Very Good	1
Good	5
Neutral	17
Poor	8
Very Poor	3
Don't Know	4
n	38

Questions 65. Do you have any plans for <u>improving</u> your service's collection or use client data?

Answer	No#
Don't know	3
No	1
Yes	32
n	36

Question 66. Do you have any suggestions for how your service could be assisted to <u>improve its client data collection or its client information management systems overall?</u>

2. NADA's database is currently the best way we have to record the data we collect. In the context of the collection of client clinical data, expansion of NADA database to have the flexibility to add new non-MDS data fields, and the flexibility to produce more detailed reports than is currently possible.

3. Will Take Advice

4. Assistance in the development of a data collection model with appropriate standardised measurement tools which will identify progress and outcomes

5. More staff

6. More funding for health outcomes follow up and access to researchers who can conduct independent assessment of outcomes

7. Not at this time

8. Standardised computer program used by all agencies

9. A streamlined online system that is easy to use and provides simple user friendly reports while protecting client privacy and confidentiality.

10. Assistance would be valued if it helped in developing a system that takes into consideration some of the commonly used indicators

11. Currently using Matisse and manual collections. We would like to see a data base covering all areas including case plans and case notes electronically.

12. Workshops on using specific data systems / user friendly versions

13. Shared experiences of others tools

14. I would love you guys to design a simple, user friendly database as the current one is quite weird to use and I honestly don't find it very good to use. use the KISS principle. Keep It Short and Simple or Keep It Simple Stupid.

15. The computer literacy of a number of staff is particularly poor. Funding grants for computer training would assist; as would fund grants for updating computer equipment.

A course on the benefits and ease of statistics and client information data collection would also be beneficial. Management can go on and on about the importance of data but often staff will be overwhelmed and believe it is not in their skill set. With very little effort, but increased appreciation for the value of it, it can be in their skill set.

16. Advice on data collection that is standard and links with state-wide data collection and is not overly onerous

18. See 65

19. Evaluation tools for treatment in service and groups

20. Guidance by specialist information & technology person - assistance to develop and review simple rating tools (0-10) for client and worker to use together to measure outcomes - to use with the service outcomes database

21. Specialised funding to assist NGO's to access data collection systems already in use

23. Not really as this is driven by existing systems.

25. It would be helpful to know what other services do and how they capture both AOD & mental health stats and information... No point re-inventing the wheel!!!!

27. Additional training for staff on use of Excel would be great, continued support to fund research specific positions within services will allow for accurate information to be collected and use for treatment planning and demonstrating program effectiveness.

28. Variance of services provided by NGOS, tools used and clients - difficult to get a sector-wide view. How do you compare what happens in a residential vs. community facility?

29. Our biggest problem is centred on 'knowing what questions to ask' & for what purpose. There is a clear difference between collecting 'assessment' info to check if a service can meet the client's needs & 'screening' a client for info that can be used for treatment planning or to measure progress/outcomes.

30. Training, Supervision and Support

31. Human resource capacity to assist with measuring client outcomes independently. [Service name] has previous experience with this during involvement with the BTOM project whereby an external researcher undertook pre, during, and post treatment outcome measures

32. Hopefully filling in a form such as this will assist in the development of a system that could be used as a single point, C.I.M.S

33. Yes a data base, flexible for each services' tools they use

37. Very interested in learning new ways to improve follow-up/outcomes system

38. Administrative, eg. database will assist greatly

Question 67. Do you have any suggestions for how the NGO drug and alcohol sector should proceed with client outcome measurements?

4. Identify (based on current evidence) model/tool, Pilot across a range of NGO AOD services i.e. residential/counselling services, Determine effectiveness, and Develop package

6. Yes, agree on standard outcome measures and provided dedicated funding to measure these outcomes through longitudinal follow up.

7. Not at this time

Provide opportunities for collation of data in a non competitive, confidential environment with ready access to results for all contributors, results to be aggregated as well as individual service data.

9. See above

12. Would be great to include Quality of Life measures in client outcomes. also to support agencies to do follow-up and through care

13. Create a simple adjunct to the current online data collection that allows for the production of pretty graphics on outcome data

14. As above

15. Short courses for staff on the value of client outcome measurements and how they've been utilised to the benefit of organisations and the sector.

16. firstly invite a debate on the 'usefulness' of measuring outcomes given that this is a widely variable topic and good outcomes can be subjective in nature. tracking clients over time is problematic and it can be difficult to link treatment interventions to outcomes

17. Incorporation of mental health data

18. See 65

20. Develop generic outcome measurement tools (appropriate to type of service provision) and facilitate training in the use of these

21. Certainly outcome measurements are only effective until completion of program due to lack of funding for support after exit

24. This is complex area due to the transient nature of the client group. Also, what "outcome" would be measured? - for a significant number of clients change is a process that occurs over a period of time after multiple treatment episodes, with at times multiple treatment providers.

25. Need to be really clear and articulate what we mean by "outcome measurement".

29. Data collection &/or Information management are unique & specialised areas, any assistance, particularly around 'what kinds or what types' of information or systems could be easily used by NGO's would help greatly.

31. As above – client outcomes to be measured as a matter of core business to inform client treatment and program planning.

32. Identification of measureable outcomes in consultation with funding bodies and consumers as a starting point

33. Standardisation – through need to avoid league table publications, comparisons

36. Let’s have a conference where we all agree on what to measure and how we will record it and how we will send it to the stakeholders, there is too much reporting in different formats.

37. Workshopping/Brainstorming/Training to hear how other organisations collate and measure outcomes

38. Orientation to significance

Question 68. Do you have any suggestions on how to improve the NGO sector's information management overall?

4. Improved access for ACT NGO staff to network/attend training/information sessions with other NGO's and NADA

6. Equip services to have timely access and control of information relating to their own service and ready access to de-identified aggregated information for the sector

7. Not at this time

9. As above

11. Develop as standard data collection tool

12. Standardise data collection right across NGO's

13. As above

14. As above

16. make it standard, user friendly and regularly publish data

18. See 65

21. If we were provided with information re types of client information systems already available, how accessible, capacity, average costs etc it would free NGO's from the time and costs required in researching themselves as many NGO's would have similar needs

24. Funding bodies should standards their data reporting requirements.

25. Its great to see that both mental health and AOD are being addressed together.

27. It would be great to have this information collated annually and feedback to service providers.

29. This is a great start.

30. Training – inter-sector (MH and AOD), Collaboration and shared training of information management systems, training and support

31. Information technology, ongoing maintenance and updates

32. Forums for discussing the above question. Ask the sector what the ideal information management system will look like and how they will contribute to achieving it

37. Linked information- where all client relevant info is linked in one system, this would assist referrals etc.

38. Orientation to significance

Question 69. Do you have any <u>other comments?</u>

1. Currently use [service name]Support Goals Scaling System

2. Further information on specific improvements to the functionality of the NADA NMDS could be provided by our 2 Sydney-based AOD/co-morbidity clinical staff, however both are currently on annual leave or sick leave. Please be in touch if you'd like some further information from these staff. Thanks Jo.

9. I think Nada should have overall responsibility for the development and management of the abovementioned system as this could then be used on a larger scale with advocacy to Govt.

14. As pointed out above it would be wonderful to have a user friendly database (one that you done need an IT Degree to use effectively) for client work as well as being able to print off graphs and figures for funding bodies etc. I know you should be able to do this with current one but this doesn't seem to work well and I am normally very good with computer systems. I find current database frustrating and trying.

16. This process is taking longer than expected and little progress seems to have been made. our organisation is looking for advice around issues of data collection and IM yet it is not clear what is going to come out of this project.

18. N.B. There is too great a differentiation between the options "always" and "occasionally" in Q42 to Q48. An accurate response to many of the questions would be "most of the time"

28. Service gap - need to up skill government health services to work with clients in withdrawal, clinical liaison within rural areas. Provide money to specialist NGOS to provide education - clinical cluster. Service gaps - under-supply of post-residential care (transition and aftercare). Not just community based counselling - more support for employment, living skills

29. Keep up the good work.

31. Needs to take into consideration the range of treatment providers and treatment types (out-client, outreach, group/day programs, therapeutic communities, residential and rehabilitation services, aftercare). Consider data collection for episodes of health promotion and early intervention in regards to drug and alcohol and mental health (there is currently no consistent data collection and this would be a good opportunity to start somewhere).

* * * *