NADA
network of alcohol and other drugs agencies

PROGRAM EVALUATION

A guide for the NSW non government alcohol and other drugs sector

ABOUT NADA

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non government alcohol and other drugs sector in NSW. Our vision is a connected and sustainable sector providing quality evidence based programs to reduce alcohol and other drug related harms to NSW communities.

We represent approximately 100 organisational members that provide a broad range of services including health promotion and harm reduction, early intervention, treatment and aftercare programs. Our members comprise of services that are diverse in their structure, philosophy and approach to alcohol and other drugs service delivery. NADA provides a range of programs and services that focus on sector and workforce development, information management, governance and management support, sector representation and advocacy, as well as actively contributing to public health policy.

NADA is governed by a Board of Directors elected from the NADA membership. We are accredited under the Australian Service Excellence Standards.

Further information about NADA and our programs and services is available on the NADA website at www.nada.org.au.

Australian Government
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RESOURCE DEVELOPMENT

The NADA Program Evaluation Guide was developed in partnership with Dr Anni Gethin of Argyle Research & Training.

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- Noffs Foundation
- WHOS (We Help Ourselves)

NADA acknowledges the traditional custodians of country throughout NSW and ACT. Our office is built upon the ancestral lands of the Gadigal people of the Eora nation. We recognise, respect and value the deep and continuing connection of Aboriginal and Torres Strait Islander people to land, community and culture. We pay our respect to Elders past, present and future.

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Contents

GLOSSARY

Baseline data – data collected at a starting point, usually before treatment starts; used to assess client progress

Benchmark – a standard or point of reference against which outcomes may be compared or assessed

Clinically significant – how effective a treatment is in causing change

Data – information collected for use in planning, decision making or evaluation

Evaluation – the objective assessment of a program's design, implementation and results to determine whether the program works as intended, and how well the program works to facilitate change for clients

Follow up data – data collected after participants have completed treatment or a program, weeks, months or years later

Inputs – the resources needed to run a program

Methods – defined ways of collecting data, broadly divided into quantitative and qualitative methods

NADAbase Client Outcomes Management System (COMS) – an online client data management system for recording and reporting on client information, service delivery and treatment outcomes

Outcomes – the changes, benefits, learning or other effects that happen as a result of what the organisation offers or provides

Outcome measure – tools which are used to assess the change which occurs for a client over a period of time, usually between starting and completing treatment

Outputs – the specific, measurable amount of goods/services/facilities produced as a direct result of a program's activities

Procedure – a step by step description of how the evaluation will be/was carried out

Program – a structured and well defined set of interventions and activities designed to improve client outcomes. Programs can run over a set time frame (weeks or months) or continuously. Services can run "closed programs" where clients start and finish together, or allow intake at different points with each client completing the program to their own schedule

Program evaluation – see *Evaluation*

Project – a set of activities focused on producing a clearly defined output (such as a resource or discussion/research paper) or outcome (e.g. improving engagement with a service). Projects differ from programs in that they are usually "one offs" designed to address or investigate a particular issue, information gap or research question

Qualitative – a measure of the quality or qualities of an outcome that uses a narrative rather than numeric value

Quantitative – a numeric measure of an outcome

Research – a systematic investigation used to establish facts and develop conclusions; evaluation is a form of research

Stakeholders – any person or organisation with an interest in the operations of a service provider

Statistically significant – a change in an outcome measure that was highly unlikely to be caused just by chance

Introduction

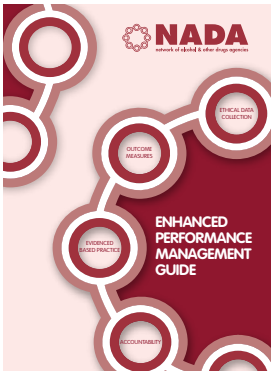
Knowing that their programs make a difference is essential for Alcohol and Other Drugs (AOD) organisations. Evaluation provides the means to assess the impact of AOD programs, and identify areas where they can be improved to increase quality and effectiveness.

Evaluation findings are needed to report to stakeholders and funding bodies, for reporting, benchmarking and to apply for grants. They also form an important engagement tool to be used with clients and staff, providing tangible evidence of a program's value and the impact of participation.

In an environment where programs must demonstrate an evidence base and continuous quality improvement is the norm, evaluation is now the expectation for AOD organisations.

This *Program Evaluation Guide* is part of a suite of practice enhancement tools developed by NADA, including:

- The *NADAbase Client Outcomes Management System (COMS)*, which provides a way for organisations to store and then access data on client information, service delivery and treatment outcomes. Reports from *NADAbase COMS* show how client outcomes change during and following treatment, and so provide the core information needed for evaluation.
- NADA's (2014) *Benchmarking Guide* and (2015) *Enhanced Performance Management Guide* which provide guidance on how to use the findings from evaluations to benchmark against other services and programs, and how to enhance organisational performance, respectively.



The *Program Evaluation Guide* will provide AOD organisations with information and tips on how to conduct an evaluation and set up the necessary support systems to measure the impact of the work they do.

This guide contains:

- an overview of evaluation, its benefits, challenges and how to overcome them
- advice on engaging an external evaluation consultant or university researcher
- information on setting up data and support systems for successful evaluation
- a step by step guide to planning and conducting an evaluation, and reporting evaluation results
- information for organisations looking to enhance their evaluations, including how to use follow up data, client feedback, stories and case studies
- advice on how to develop a "research culture" within your organisation.

1. Evaluation

1.1 WHAT IS EVALUATION?

Evaluation is the objective assessment of a program (or project's) design, implementation and results. It uses a structured process to find out whether a program works as intended, and how well a program works to facilitate change for clients. It is an integral part of planning programs, services and projects (NADA 2015b).

At its most straightforward, evaluation involves identifying what a program is aiming to achieve (e.g. to help clients reduce problematic substance use or reduce high levels of anxiety), then measuring these outcomes for all clients at the start and finish of a program, and, if possible, months, or even years later. The difference between the "before" and "after" measures shows the impact of a program.

Evaluation is a field of research that tends to be laden with confusing jargon, however, whatever terms are used, it is useful to remember that evaluation primarily involves:

- **Describing** the program or project being run, the treatment model and the characteristics of participants
- **Counting** numbers of people, sessions, workshops, etc.
- **Recording** inputs and outputs, client outcome measures, and client and stakeholder feedback.
- **Measuring** the differences in "before" and "after" scores, (and if possible, follow up scores).
- **Communicating** and using findings to drive service improvement.

1.2 TYPES OF EVALUATION

There are a number of types of evaluation that can be selected, depending on the purpose of a program and the focus of the evaluation. When selecting the type of evaluation, it is important that the evaluation processes suit the program being evaluated and the resources available (NADA 2015b).

This resource specifically provides guidance on "outcome evaluation" – assessing the effectiveness of a program in facilitating change for the client group.

Table 1. Evaluation types

Type of evaluation	What it shows
Needs analysis	• Used to make the case for a new service or to inform program design. It is undertaken before developing a program to determine the need within a population and what a program should contain to meet that particular need. • Examines existing service provision and identifies gaps.
Process evaluation	• Examines whether program activities have been undertaken as planned and helps to identify where improvements can be made (e.g. if workshops or training did not run as intended). • Mostly involves counting and checking and usually forms part of an outcome evaluation.
Outcome evaluation	• Examines the effectiveness of a program in facilitating change for the client group, as indicated by changes in client outcome measures.
Impact evaluation	• Examines the overall impact of an intervention on a population. Not usually feasible for AOD programs but can be used to evaluate legal and policy measures – e.g. drink driving laws or strategies to reduce binge drinking.
Economic evaluation	• Determines the costs per unit of change in outcomes for clients. • Used to help choose between different intervention options, and to show "value for money".

1.3 EVALUATION CHALLENGES

There are a number of challenges that organisations can face when embarking on an evaluation, especially when starting out.

Table 2. Evaluation challenges

Challenges	Strategies for success
No idea where to start with the evaluation or confused about aspects of the evaluation, such as what outcome measures to select or how to analyse results	• Seek advice and support from NADA, an external evaluation consultant, another AOD organisation with an established evaluation process, or a university researcher. • Ask an experienced evaluator or university researcher to be part of the evaluation reference group or steering committee. This group can help with the evaluation plan and provide advice and expertise to staff conducting the evaluation. • Consider commissioning the first evaluation, and get advice along the way about how to do it "in house" for future projects.
Evaluation not happening to plan	• Ensure someone is responsible, and that evaluation tasks are part of their work plan. • In small organisations the CEO or manager can drive the evaluation.
Poor data quality	• Put systems in place to minimise errors and improve data quality – see data quality process – below.
Data not collected at the right times – either baseline, program end or follow up	• Conduct regular data checks to ensure all outcome data is collected at intake and again at the end, before clients leave the program. • Collect follow up data when clients attend aftercare, or use incentives to obtain feedback (e.g. vouchers).
Resource constraints – e.g. limited staff capacity	• Involve stakeholders early on and find out what support they can provide. • Start small and targeted: choose only a few key outcome measures.

1.4 GETTING EXTERNAL HELP

There is a wide range of support available to assist organisations with evaluation, both free and on a fee basis. Support can be provided by:

- NADA
- The Community Mental Health Drug and Alcohol Research Network (The CMHDARN Research Network)
- Independent evaluation consultants
- University researchers.

AOD organisations typically seek external advice or commission evaluation services for the following reasons:

- Initial set up or review of an organisation's evaluation process.
- Specific evaluation related issues, such as survey design, selecting outcome measures, data analysis, interpreting results, write up, using recommendations, etc.
- Where an independent external evaluation is required by the funding body, or is commissioned by the AOD organisation to provide an objective and robust review of a service.

The Community Mental Health Drug and Alcohol Research Network
The CMHDARN Research Network is a partnership between NADA, the Mental Health Coordinating Council and the Mental Health Commission of NSW.

It was established to broaden involvement of the community mental health and AOD sector in evidence-led research and to promote the value of research and the use of research evidence in practice. The overall aim of the Network is to improve the quality of service delivery and correspondingly, the outcomes for consumers of community managed services.

For more information visit: www.cmhdaresearchnetwork.com.au

Table 3. Seeking external evaluation advice

Considerations	Guidance
What do we look for in an independent evaluator?	• Experience in the AOD field. • Proven track record in evaluation, statistical analysis and reporting. • Pragmatic researcher: supports an organisation to work with the data and systems they have; finds solutions, rather than creating barriers. • Able to listen to what the organisation wants, and provide guidance as to what an evaluation can provide. • If you are looking to learn about evaluation, ensure that the evaluator is happy to share their knowledge and skills, and support organisational participation.
How much does an external evaluation cost?	• Evaluation consultants charge $1,000 to $1,600 per day (large consulting firms will charge more). • A university professor costs approximately $2,500 per day, a research associate $1,300. • A standard pre and post evaluation, including literature review, data collection, stakeholder feedback, report recommendations and presentation costs approximately: = $25,000 (independent evaluation consultant) = $45,000 (university). • Many universities charge an administration fee however, some university researchers may collaborate for free if they can use the data themselves for research projects and publication.
How is an external evaluation arranged?	• Write an evaluation brief that clearly states: – what you want to find out – a list of likely tasks – what you want produced (e.g. report to funding body) – the timeframe – your budget. • Formally call for expressions of interest or approach a few evaluation consultants and/or university researchers and ask what they can do for your budget.
Is it possible to buy advice on parts of the evaluation?	• Definitely. You can find an evaluator to provide advice on an hourly basis, or for sections of work. • Organisations can also obtain free advice, including from NADA, The CMHDARN Research Network, evaluation consultants or university researchers with whom an organisation has a relationship.
How do we find an external evaluator?	• NADA • Universities • Australasian Evaluation Society • Internet search.

2. Setting up for an evaluation

Ensuring the right data collection systems, staff skills and support processes are in place is critical when setting up an evaluation. In reality, many organisations will have little in the way of evaluation support structures. This should not deter any organisation from evaluating what they are doing. Organisations can improve their evaluation infrastructure over time.

The key systems, skills and support required to undertake an evaluation include:

- a client data and outcomes database
- data quality processes
- client consent processes
- organisational support
- an evaluation steering committee
- evaluation skills and training.

For an overview of the key points to consider when planning and conducting an evaluation refer to the *Program Evaluation Checklist* (available in the supporting documents of the *Program Evaluation Policy* in NADA's (2015b) *Policy Toolkit*).

2.1 CLIENT DATABASE

A client database is used to collect routine client data (i.e. client demographics, length of stay, primary drug of concern, etc.), and client outcome measures through embedded assessment tools (e.g. Severity of Dependence Scale (SDS), Kessler Psychological Distress Scale (K10+), Depression, Anxiety and Stress Scale (DASS), World Health Organisation Quality of Life-8 (WHO QoL-8)). A client database should be capable of producing reports that show aggregated client details and outcomes for particular programs or time periods, and enable the comparison of outcome data at baseline through to program completion.

This *Program Evaluation Guide* is designed to be used with any client data collection system, including *NADAbase COMS* (Client Outcome Management System), RediCASE, customised databases, or generic databases such as Microsoft Access or Excel (when used as a database).

In reality, organisations can be at many different stages in their capacity to record client data and outcomes. Unfortunately it is also not uncommon for organisations to invest in a database, only to find that it cannot provide the kind of reporting they need. *NADAbase COMS* is a good choice for most organisations in the sector. It is specifically designed for AOD organisations and supports a robust set of validated outcome measures.

2.2 DATA QUALITY PROCESSES

An organisation's database is only useful if staff are routinely and accurately entering the correct data at the correct times. Otherwise, it can become a case of "rubbish in, rubbish out". Regularly running through some simple data check procedures can fix most issues. Systems can also be put in place to minimise data errors. For example, data entry fields can be set up to flag obviously incorrect data (e.g. text in numerical fields). Maintaining data integrity is achieved through a combination of regular data checking, and reinforcement with staff of the process of "getting the data entry right". For organisations using *NADAbase COMS*, there is the *Data Quality Check Report* which provides a comprehensive overview of potential data entry errors (e.g. potential duplicate codes) and episodes that may require review (e.g. episodes that have remained open for an extensive period).

Data quality checklist

- ☑ Data is collected for each client as they enter the program
- ☑ All program exits are recorded
- ☑ Data is collected for each client at program completion
- ☑ Data is entered in each demographic field and for each outcome measure
- ☑ The data is accurate (i.e. correct numbers, demographics, drug use statistics, start and exit dates, etc.)
- ☑ Missing fields or incorrect data are reviewed and corrected

2.3 ETHICAL EVALUATION

At the start of any program, organisations are required to obtain client consent for treatment. It is also best practice to obtain consent for client data to be used for reporting and evaluation. This consent can be a simple line added to a standard treatment consent form with a check box. For example:

I consent to my de-identified data being used for external reporting and evaluation purposes. I understand that my name will never be used in reporting, and that no details that could identify me will be reported without my specific consent.

☑ Yes ☐ No

For evaluation consent to be ethical and meaningful, the data of clients who do not consent to their data being used for this purpose must be removed before any external reporting takes place.

If an organisation wants to include case studies or client stories in an evaluation, then a separate consent form needs to be obtained from the client. The form should fully explain to the client what is involved in them telling their story, how they will be identified, and the risks and benefits of participating. Further information on, and templates for, managing client privacy and consent can be found in the *Privacy and Confidentiality Policy* and *Program Management Policy* (and supporting documents) of NADA's (2015b) *Policy Toolkit*.

2.4 ORGANISATIONAL SUPPORT

The organisations with the most effective evaluation processes are those where:

- the entire organisation is committed to evaluating
- findings are used to engage with clients and to improve the organisation's performance
- staff recognise the benefit of evaluation and support the processes involved.

Organisational commitment and support for evaluation involves the following:

- There is a person or people responsible for planning, conducting and writing up the evaluation and for communicating findings (many larger organisations have a research officer or team. In smaller organisations, the most effective way to get an evaluation going can be for the CEO or a senior manager to take responsibility).
- There is management support for the evaluation process.
- There are strategies to get "staff on board". Involving staff throughout the evaluation process (e.g. in planning, monitoring data integrity, and in using and sharing findings) can help to reinforce the value of evaluation. *"When staff can see the impact of the work they do with clients, it is very compelling."* (Program Manager)

2.5 SETTING UP AN EVALUATION STEERING COMMITTEE

An evaluation steering committee will help to keep an evaluation on track and is an excellent way to obtain both expert advice and stakeholder input (including consumer views). This committee should meet (either in person or virtually) at the evaluation planning stage, at least once during the evaluation, and to review the draft final report.

An evaluation steering committee can include:

- an experienced evaluator/researcher
- a senior staff member (with an in-depth understanding of the program being evaluated)
- a person with evaluation experience from another AOD or Mental Health organisation
- a data person (ideally someone from within the organisation)
- a program worker
- a consumer representative (a past client is ideal).

If an evaluation is complex or long term, or if additional data or resources are needed, than consideration should be given to inviting other stakeholders (and others as appropriate) to form part of the evaluation steering committee.

2.6 STAFF TRAINING AND CAPACITY BUILDING

Evaluation is well within the capacity of nearly all AOD organisations, but staff training and mentoring can also be very helpful, especially when setting up evaluation processes, analysing data and writing reports.

NADA supports organisations to collect ethical and useful client outcome data. NADA offers a series of online tutorials that provide members with a self-guided tour on how to use *NADAbase COMS* to effectively collect, extract and report on client outcome data. The CMHDARN Research Network can also support organisations through its mentoring program that connects AOD professionals with an academic mentor.

'But I can't do statistics!'
Data and statistics terrify a lot of people. The reality is that only minimal knowledge of statistics is required to conduct an evaluation. It is sufficient to be able to use basic Excel functions to add, subtract, and work out percentages and averages. Additional support and advice is widely available – and most organisations will have staff with some statistical analysis skills.

Evaluation training is also available and is regularly offered in major cities and regional areas, through organisations such as the Centre for Community Welfare Training and the Australasian Evaluation Society. Even staff who are not involved with the actual evaluation can benefit from understanding the processes involved and how to use the evaluation to improve their practice and engagement with clients.

3. Developing an evaluation plan

3.1 WHAT THE PLAN DOES

An evaluation plan sets up the structure of the evaluation, and describes the program, the participants, methods, outcome measures and data collection timing. Completing each part of the evaluation plan (found in Appendix 1), following the instructions and example text that follow, will provide a solid plan to guide an evaluation. The evaluation plan also sets up a foundation for evaluation reporting: many of the headings and text are used again in the evaluation report.

3.2 STRUCTURING YOUR PLAN

3.2.1 INTRODUCTION

The Introduction section provides a summary of the content and structure of the evaluation plan. Here is an example of an Introduction:

> This document provides an evaluation plan for [Name of Program]. It provides details of the program and clients, outlines the evaluation aims and methods, and identifies the evaluation tasks, responsibilities and timeline.
>
> The plan is a living document, and contains records of program inputs and outputs, client profiles and baseline outcomes. This plan forms the foundation for program reporting.

3.2.2 BACKGROUND

It is possible to present evaluation findings without any background discussion or literature review. However, even a brief background section will make for a stronger piece of research, and will help the audience better understand the program and what kind of impact the type of intervention typically has for the client group. It is also helpful for the person or team conducting the evaluation to contextualise their program and evaluation, to know what findings might be expected, and what findings need to be examined more closely.

A Background section can include:

- **Brief history** – including the origins and guiding values of the program.
- **Target client group** – typical participants and why they need this type of intervention.
- **Previous research findings** – on similar programs in Australia and internationally (noting that AOD treatment and outcomes are not necessarily comparable across nations (don't forget to reference your sources)).
- **Gaps in research** – if there has been very little research or it can be shown that the particular program being evaluated is unique, then this should be discussed.
- **Previous results** – from previous evaluations of the program.

3.2.3 THE [PROGRAM]

3.2.3.1 Defining the program

The first step in evaluation is to clearly define the subject of the evaluation. This involves describing the program's **model of care**, its key elements, processes and aims. Advice on articulating a model of care can be found in NADA's (2015a) *Enhanced Performance Management Guide*. A model of care description can be brief, but should include:

- the program's aims (intended outcomes)
- how the agency delivers AOD services to clients
- who the clients are
- the theoretical approach
- the program's duration
- the core interventions
- how service delivery works to facilitate change for clients.

Here is an example of a model of care description:

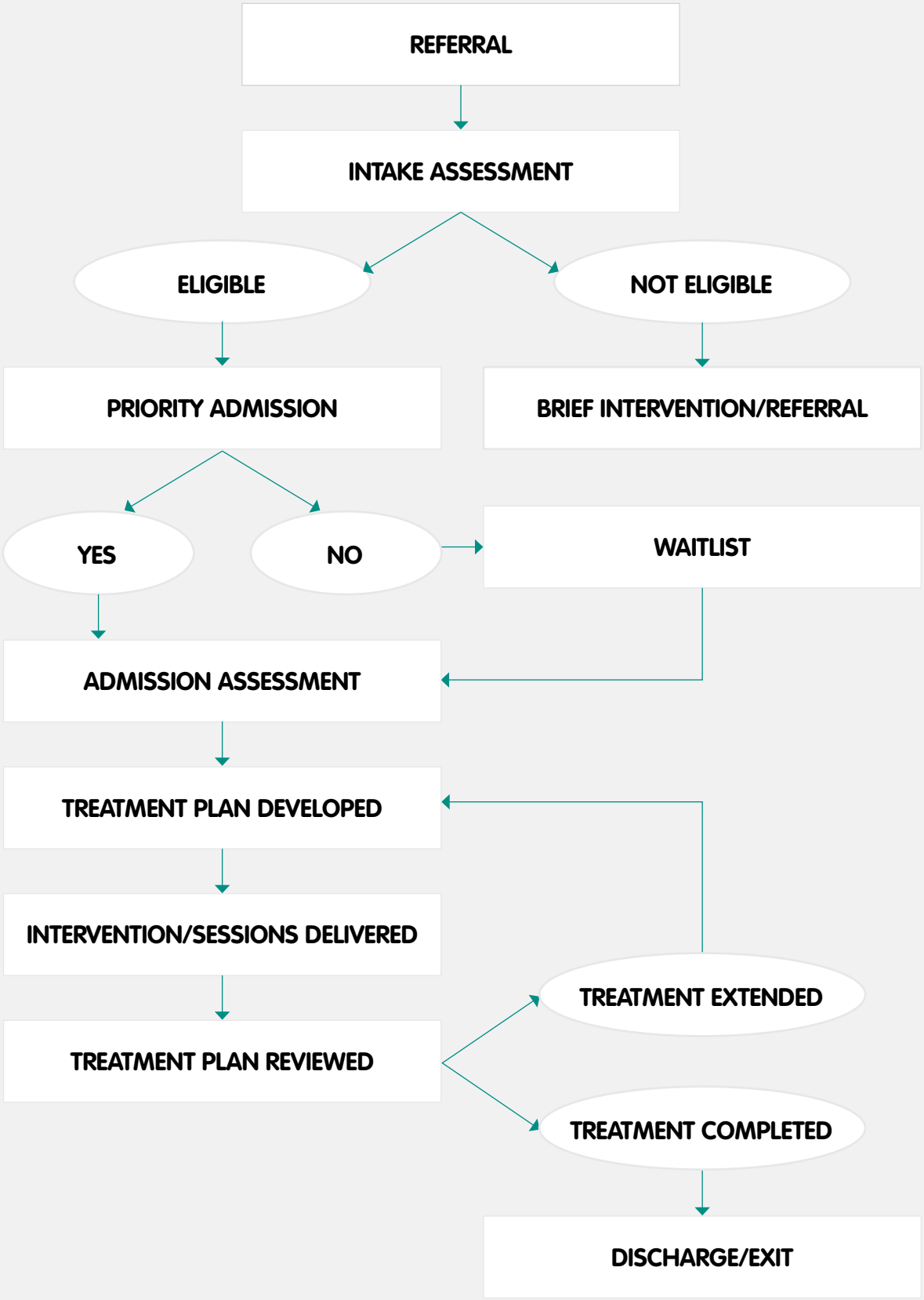
The Cannabis Clinic

This Cannabis Clinic provides free outpatient counselling for people over 16 years of age who are dependent cannabis users, and who would like to reduce or cease their cannabis use. Founded in a harm minimisation approach, the intervention aims to reduce the risks of harm associated with cannabis use, including health, social and legal problems.

One-hour counselling sessions are provided, each week for between three to eight weeks, with further sessions provided if requested by the client. Therapists work to develop a positive and professional therapeutic relationship with clients to support them in achieving their treatment goals. A range of evidence based behavioural treatments are used by therapists in working with clients, including Cognitive Behaviour Therapy (CBT), contingency management and motivational enhancement therapy. [...and briefly describe the elements of these treatments].

It can also be useful to explain the **client journey**, providing a description or map of the steps involved in a client's care, from the client's first point of contact with the service, their participation in the program, through to treatment completion and beyond. The following is a simple flowchart that can be adapted and changed to reflect an organisation's treatment processes. Customer journey mapping tools are also widely available on the internet – look for one that can clearly depicts your client's typical journey, so that it can be readily understood by anyone, even a person who does not have an AOD background.

Figure X. Example client journey



3.2.3.2 Clarifying what the program is aiming to achieve

Defining what a program is aiming to achieve is the most important step in any evaluation (or program plan). If the aims are unclear, it can be very difficult to select appropriate measurement tools or measure program outcomes. There is also a risk that the tool selected will measure outcomes the organisation cannot act upon.

Even very experienced program managers and workers can be unclear or even incorrect about what their program is aiming to do, and what it can be expected to do. Evaluation planning will be far more straightforward if time is spent clarifying who the program is aiming to reach and what difference the program makes (or will make) to this client group.

3.2.3.3 Explaining the causal mechanisms

A **program logic** is a commonly used planning, evaluation and review tool. It shows the intended outcomes of a program, and how the program is theorised to facilitate change for clients (i.e. the logic of "if we do this program, with these clients, and these inputs and outputs, we can expect to get these outcomes").

AOD treatment outcomes

Typically, every AOD program aims to support clients to reduce and/or abstain from AOD use, reduce substance dependence, develop coping skills around recovery and relapse, improve mental health, reduce risky behaviours and improve health and wellbeing. Other outcomes might include improved relationship skills, improved parenting and family functioning, and engagement in education or employment.

Developing a program logic is a highly useful exercise to undertake before embarking on an evaluation: it provides a good "snapshot" of how a program works and enables staff to clearly articulate what the program is aiming to achieve and why it is logical to expect such outcomes. By showing the resources invested, it also provides explicit recognition that services are treating clients with a chronic relapsing condition, and, in some cases, clients with multiple complex needs and permanent debilitating conditions. Intended outcomes should reflect the reality of substance dependence and an organisation's own client group.

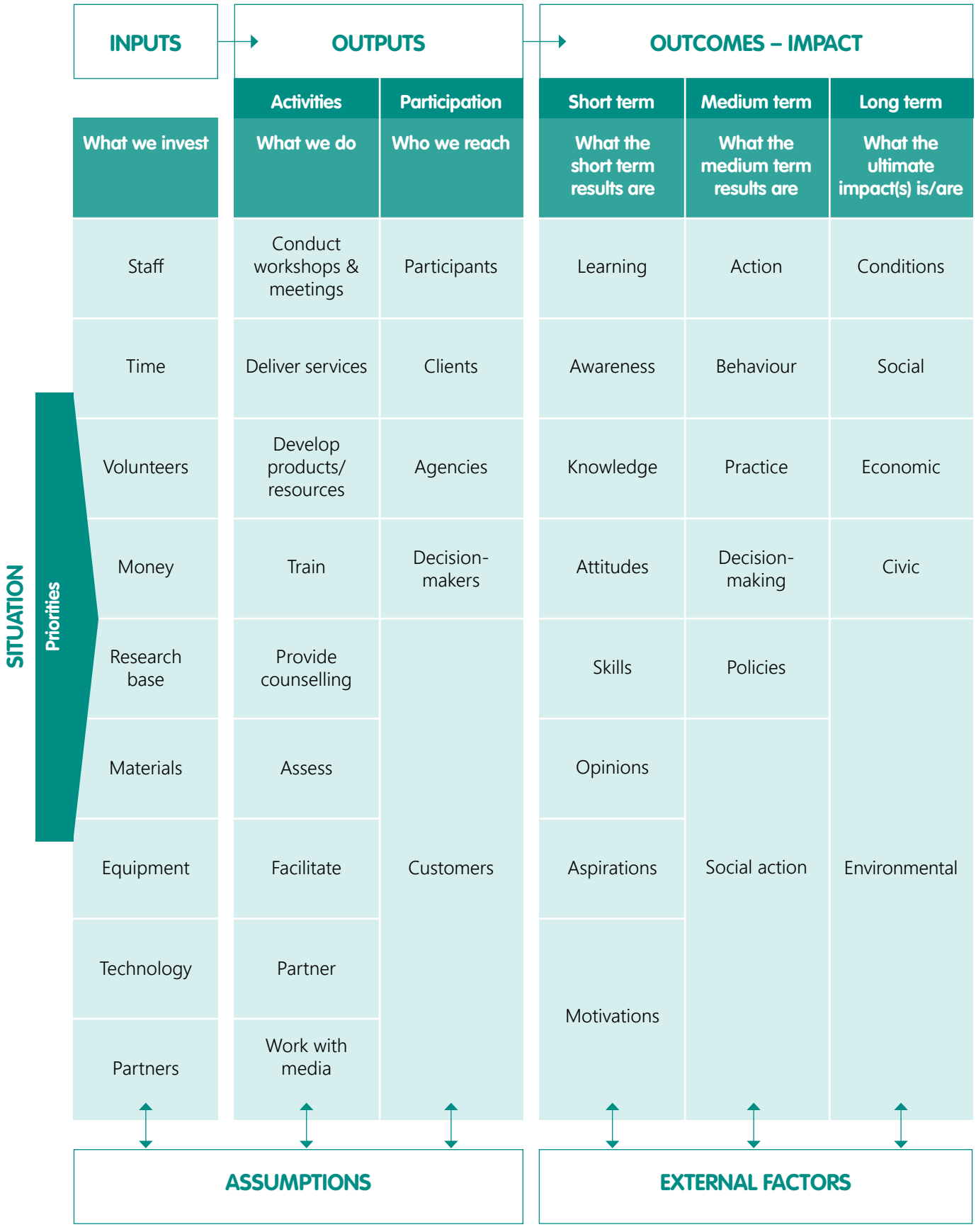
When developing a program logic, start by outlining the intended long term outcomes of the program. Then, outline the outcomes that participants can expect at program completion, and at six and twelve months follow up.

These questions can assist in clarifying a program's outcomes:

- "After being in this program, participants will…?"
- "Six months/a year after program completion, participants will…?"
- "If participants did not do our program, but continued as they were, what would their situation be like?"

The following is an example program logic produced from the University of Wisconsin-Extension (2003).

Figure 1. Program logic example



3.2.4 EVALUATION AIMS

This section provides an overview of the purpose and scope of the evaluation and what the organisation would like to learn from conducting the evaluation.

Here is an example of a "Statement of aims" for a straightforward pre and post evaluation:

> The aims of the evaluation are to identify the short term treatment outcomes of clients who have undertaken the [Program], including changes in substance dependence and mental health and wellbeing. The evaluation also aims to obtain feedback about the quality of the program. From this evaluation we hope to learn:
>
> - the range of improvements in substance dependence and mental health issues clients can expect if they complete the program
> - ways of enhancing our program.

What organisations can potentially learn from an evaluation is wide ranging. For first time evaluators, finding out if their program "makes a difference" is usually sufficient. As staff become more experienced and confident with data collection and analysis, evaluations can be used to answer a range of questions.

Questions that evaluation can answer

- How much of a difference do we make? Is it clinically significant?
- Are there points in the program where clients "get worse"? Why is this? How can we better support clients?
- To what extent are improvements maintained over time? – e.g. What proportion of clients show reductions in substance use and related harms six months after completing the program?
- Who "drops out" of treatment, when and why? What can we do to improve program retention?

3.2.5 INPUTS AND OUTPUTS

Inputs are all the resources needed to run a program. An input table should include:

- The total cost of the program
- Number of staff: full time, part time and casual and total Full Time Equivalent (FTE) hours/week
- Staff positions
- Brief description of facilities (and whether owned or hired)
- Technology and software (if specific to the program)
- Volunteer time
- Any other resources required to run the program.

Here is a template for recording program inputs:

Table X. Program input recording

Input	Data to record
Staff	*List of program staff*
Resources	*Summarise facilities, budget, equipment, etc.*
In kind contributions	*Type of resources and distribution*

Outputs are the specific, measurable amount of goods/services/facilities produced as a direct result of a program's activities. The information needs to be informative enough to show "how much" was delivered, and detail the number of items (e.g. sessions, workshops, etc.), together with an accurate description.

Often reporting is laden with too much detail about outputs. Depending on the requirements of an organisation's funders, it is best to summarise outputs as briefly as possible. One table is usually sufficient, but if the program has a number of distinct elements (for example, production of educational resources and treatment), two or more tables may be needed.

Should we evaluate workshops and training sessions?

Most organisations collect feedback from participants on workshops and training. The result is mostly big piles of paper surveys that may or may not be entered and written up. And, unless the session is really terrible, the feedback will be positive.

Consider asking only a few relevant questions that will help to improve the sessions, and encourage participants to tell you directly, or via an online survey app.

Here is a template for recording program outputs:

Table X. Program output recording

Output	Data to record
Whole residential program	*This is described in detail in "Program description" but is also an output*
Counselling sessions	*Number and duration*
Resources produced	*Type of resources and distribution*

3.2.6 METHODS

The Methods section of an evaluation plan (and evaluation report) has three sections:

- **Participants** (clients who have participated in the program being evaluated)
- **Outcome Measures** (client outcome measures and feedback)
- **Procedure** (when and how data is collected)

3.2.6.1 Participants

The Participants section describes client demographics and presenting issues upon entering the program (baseline). Most of this data is already collected by AOD organisations for Minimum Data Set (MDS) reporting, but, depending on the aims of the program, additional data may need to be collected and reported on (for example, on diagnosed Post Traumatic Stress Disorder (PTSD) or sexual health).

The following subheadings and example text provide guidance on what to include in a Participants section.

Participant demographics at baseline

There were 57 clients who commenced the program; all clients were male, ages ranging from 18 to 47 years, with a median age of 28. Twenty-five percent of clients were of Aboriginal and/or Torres Strait Islander background (n=14), and 17% were from Culturally and Linguistically Diverse (CALD) backgrounds (n=10).

Table X. Participant background characteristics at baseline

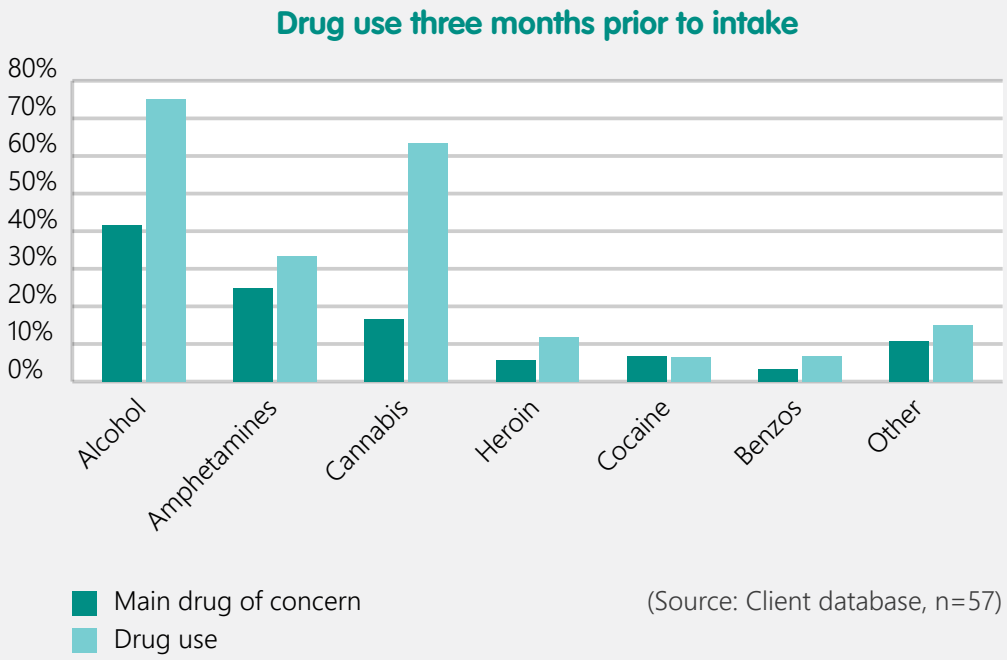
Factor	In program
Gender (male)	100%
Age range=18-47	Ave=28
Aboriginal and/or Torres Strait Islander background	25%
Culturally and Linguistically Diverse background	17%

(Source: Client database, n=57)

Drug use at baseline

Drug use data should include the main drug of concern and any drug use in the period prior to intake. For "single substance" treatment programs it is useful to present the full spectrum of substance use of clients entering the program, even if outcome data is only collected on the one substance. Drug use data is best presented as a chart. For example:

Figure X. Participant main drug of concern and drug use three months prior to intake



(Source: Client database, n=57)

Drug treatment history

Drug treatment data can include whether clients have previously participated in an organisation's program, whether they completed the program or not, and any other drug treatment history. This data can then be categorised by type of treatment, with a percentage of clients who have participated in each type of treatment, as presented in this table, for example:

Table X Participant drug treatment history

Treatment type	%
Counselling	15
Withdrawal management	40
Residential rehabilitation	25
Pharmacotherapy	12
Have not previously accessed drug treatment	8

(Source: Client database, n=57)

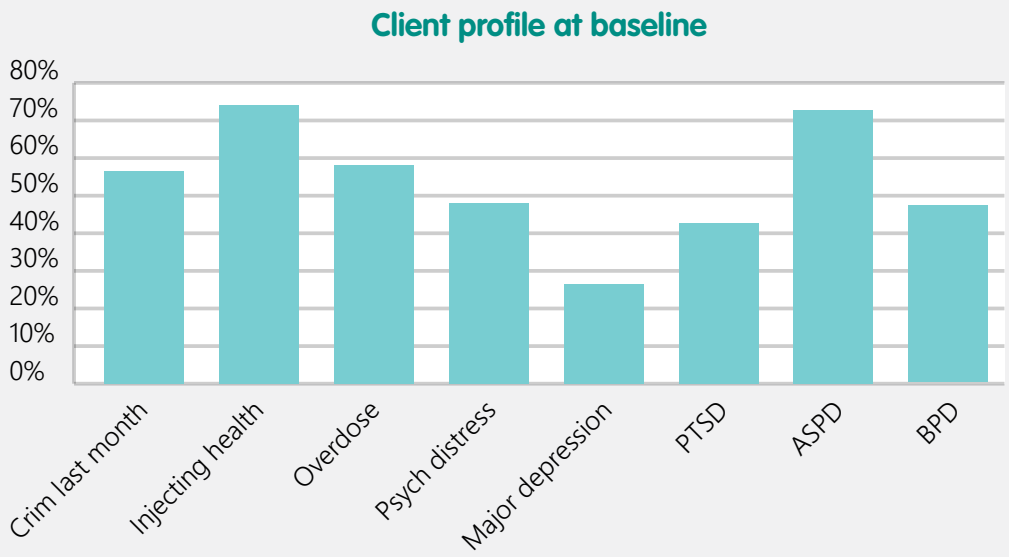
Comorbidity and other issues

Many clients accessing AOD treatment services have a range of issues of concern. It is useful to summarise these issues. For example:

Detailed client profile at baseline:

The majority of the sample (55%) were criminally active in the month preceding interview. Injection-related health problems (74%) and a history of heroin overdose (58%) were commonly reported. There were high degrees of psychiatric comorbidity, with 49% reporting severe psychological distress, 28% having current major depression, 37% having attempted suicide, and 42% having a lifetime history of post-traumatic stress disorder (PTSD). Personality disorders were also prevalent, with 72% meeting criteria for anti-social personality disorder and 47% screening positive for borderline personality disorder. (Ross et al. 2005)

Figure X. Participant profile at baseline



(Source: Client database, n=57)

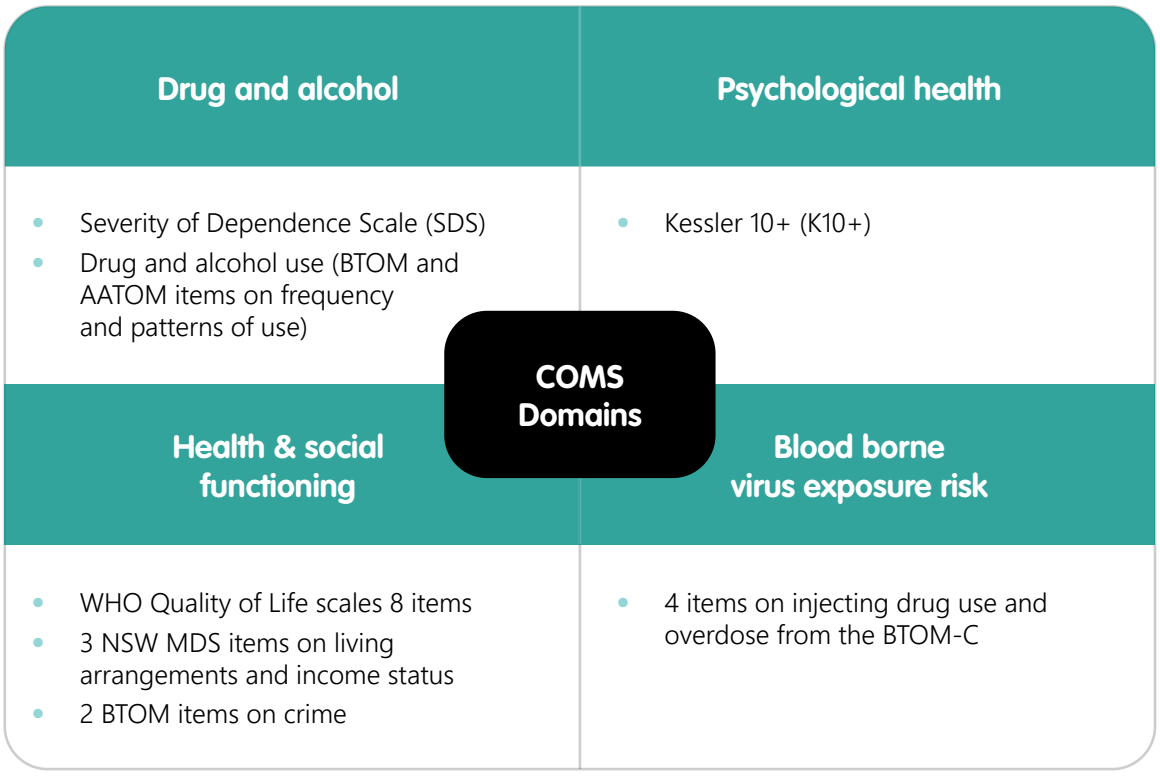
3.2.6.2 Outcome measures

Client outcome measures

Every program is designed to facilitate positive change, or outcomes. These outcomes are identified during program planning and when developing a program logic. Quantitative "outcome measures" are used to measure client progress on a program's intended outcomes.

Selecting measures for typical AOD treatment outcomes is straightforward. *NADAbase COMS* supports a set of validated outcome measures that are relevant, widely used and which were selected following an extensive review process (Deady 2009). For most AOD organisations, the measures within *NADAbase COMS* (as shown in Figure 2) are sufficient to assess the impact of their programs.

Figure 2. NADAbase COMS Screening, Assessment and Outcome Measures (NADA 2015a)



Additional outcome measures that are commonly used include:

- Program retention: Although this is really an "interim outcome", high treatment attrition rates are common for AOD programs, particularly for residential programs; so measuring retention can help to understand why clients drop out and improve retention.
- Substance specific use (for example, in cannabis treatment, cones/day is used).
- Other mental health measures (for example, some organisations use the DASS in preference to the K10+, and/or screen for PTSD, etc.).
- Program specific measures (for example, if a parenting program, then outcome measures of parental responsiveness and functioning can be used).
- Client feedback measures (for example, the Client Satisfaction Questionnaire (CSQ-8)) (Larsden et al 1979).

Here are some questions to consider when selecting outcome measures:

- Does it measure what it's supposed to measure (validity) and do so on a consistent basis (reliability) (World Health Organization 2000)?
- Is the measure suitable for all clients (e.g. CALD)?
- Does it cost to use the measure? Do you need permission or a license to use it?
- Who can administer the measure? Who can interpret results? Do they need special qualifications or training?
- Can the measure be integrated into the client database and aggregate reports produced?

The following table is an example of how to list program outcome measures in the Methods – Outcome Measures section of the evaluation plan. Each measure will have a standard reference that can be found on the official site of that measure, or, if used in a published study, as referenced in the journal article. References for *NADAbase COMS* supported outcome measures can be found in the NADA (2012) *Using the Client Outcomes Management System (COMS)* user guide.

Table X. Outcome measures: [Program] evaluation

Outcome measure	Details	Scoring	Validation
e.g. SDS [Reference]	Self-report that screens for substance dependence.	Add scores for each item. Total score from 0-15. Scores above 3 (4 for young people) may indicate dependence.	Validated across populations and cross culturally as a brief screen.
e.g. K10+ [Reference]	Self-report measure of psychological distress. Can detect anxiety and/or depressive disorder and indicate improving or worsening symptoms.	10-15 Higher scores=greater distress.	Widely used in a range of populations. Validated cross culturally.
e.g. CSQ-8 [Reference]	Client quality feedback.	8-32 Higher scores indicate greater satisfaction.	Widely used across human services programs.

(Source: Client database, n=57)

Qualitative and quality measures

Demonstrating that a program is achieving outcomes is important, but organisation's may also want to know what clients think about the quality and usefulness of the program (i.e. has it met their needs, would they recommend the program to their friends, etc.) and whether there is anything they would like to see changed or improved (e.g. accessibility, content, etc.).

Client feedback can be collected using a short survey (standardised or custom designed) or through more extensive methods (e.g. focus group). While client feedback overlaps with outcomes, it is generally not an "outcome measure". By aggregating results over time however, client feedback can be used as an indicator of program quality (and a driver to improve quality when satisfaction is low).

Client feedback should be collected before the program ends, as email and phone follow up of clients who have left the program will return much poorer response rates. When collecting client feedback, the main rule is that feedback should only be collected if the organisation is able to use it for reporting and to improve quality. Other questions to consider when deciding whether to collect client feedback, include:

- Do you have the staffing and resources to collect qualitative data (noting that interviews for case studies are best done by staff not involved in the particular program)?
- Can you address issues of privacy and consent?

Evaluation differs from formal social research in that it is often appropriate and useful to include **client stories** (or "case studies" if more formally written up) or even pictures in reporting. Many funders ask for this kind of information in program reports, and case studies can be good to include in grant applications. Pictures and stories are also great for supplementing program descriptions, and individual stories can be particularly compelling when talking to people about how a program is making a difference.

3.2.6.3 Procedure

The Procedure section explains when client outcome (and feedback) data is collected and how it is collected. At minimum, client outcome data (i.e. SDS, K10+ etc.) needs to be collected at the following intervals:

- **Baseline** – As each client enters the program, as part of their initial assessment.
- **Program completion** – Collected before a client leaves the program, as part of their final review, last counselling session, etc.

Once staff in an organisation are confidently collecting and entering client data at these two points, and the data is being analysed, data can also be collected at the following points:

- During treatment, at halfway, three months, six months or another point.
- At follow up, one month, six months, one year, or two years post treatment.
- On waitlist registration (if after a wait of at least a few weeks, then progress can be compared while waiting to enter the program, with what occurs when actually participating).

How do we get follow up data from our clients once they have left our program?

Offer incentives (e.g. vouchers $30 to $50).

Re-assess all aftercare program participants.

Use social media as a more reliable contact than mobile phone.

Let clients know how important their follow up data is – and that you will be contacting them at a mutually convenient time; that you have realistic expectations and will offer more support if needed.

Here are some questions to consider when determining data collection points:

- What are the benefits to collecting data at a given point? What will it tell you?
- Do you have the staffing and resources to collect additional data?
- What response rate will you get (noting that 80% is gold and 65% is at the bottom of the threshold to be publishable)?
- Do you have client consent processes in place to obtain additional data?

Here is an example of a Procedure section:

> Clients will be assessed at intake and at program completion on each outcome measure. The outcome measurement tools will be administered by program staff using [(e.g. entering data into [name of database]/ completed by the participant)]. Client feedback will be obtained at the end of the program in the last treatment session.
>
> Data will be scored [how?], [by whom? (e.g. automatically in *NADAbase COMS* and/or another database)] and analysed in [name of software (e.g. Excel, SPSS – full version name)] by [name of person responsible]. Baseline and program completion measures will be compared in order to identify any changes in severity of drug dependence, psychological health, and health and social functioning [add/delete outcomes as applicable].
>
> [Add a paragraph if also collecting client stories – when these will be collected and by whom].

The paragraphs above are sufficient for an evaluation plan or report, but it can also be useful to give very specific instructions to staff about how to administer the outcome tools.

3.2.7 EVALUATION RESPONSIBILITY AND TIMELINE

An evaluation will fail if it is no one's responsibility or if the evaluation team does not have sufficient time or support to complete the evaluation. Defining the team, their responsibilities, and allocating time and clarifying evaluation supports are some of the most important steps in an evaluation.

Evaluation responsibilities can be put in a table (as shown below, for example), and inserted into work plans and calendars as necessary. This information is used to inform the project timeline which identifies when key tasks and reports are due. The difference between a good and bad evaluation can come down to timing: adequate time needs to be allocated to collecting data, write up and meeting reporting requirements.

Table X Evaluation responsibilities

Evaluation role	Evaluation tasks	Time needed
Evaluator 1	• Writing plan • Supervising monitoring and data collection • Liaising with stakeholders • Reporting evaluation progress • Writing final report • Communicating findings to staff	• 1 week planning • 1 day a month monitoring • 1 week writing report • 2 days reporting results to stakeholders
Evaluator 2	• Data integrity • Organising data collection • Liaising with stakeholders for external data collection	• 1 week at baseline • 1 week at completion and follow up
Supervisor	• Input to planning • Checking that evaluation is progressing	• Part of existing role
Stakeholder 1	• Provide data • Provide planning input	• ½ day at baseline and final • 2 hours planning meeting
Support 1	• Provide advice on feedback surveys and write up	• 2-hour meeting
Support 2	• Support database reporting	• As needed

4. Reporting: analysing and presenting data

This chapter provides guidance on writing up the evaluation report; it shows how to analyse and present the data an organisation has collected. A generic report structure is used (found in Appendix 2). Sections can be used to communicate results to funders and other stakeholders (e.g. the Executive Summary can be appended to a funding application, the Outcomes section can be used to provide feedback to program staff or clients, etc.).

The headings and text that follow below explain what to retain from the evaluation plan, what to delete and the analysis to add. As with the evaluation plan, this text can be adapted and changed to suit specific programs and evaluations. As the report is written in past tense (you've done the evaluation), some sections will need to have the tense changed.

4.1 STRUCTURING YOUR REPORT

4.1.1 ACKNOWLEDGEMENTS

The evaluation report opens with an acknowledgement of the contribution of those who supported or participated in the evaluation. This can include a collective acknowledgement of the contribution of staff and clients, and an acknowledgement of the expertise and guidance provided by individual steering group committee members and/or other stakeholders.

4.1.2 EXECUTIVE SUMMARY

The Executive Summary pulls together the key elements of the evaluation report and should be around two pages long. It is a valuable means of communicating program outcomes to a wide audience (World Health Organisation 2000). The Executive Summary should briefly describe:

- what the report is about (i.e. program description, evaluation aims etc.)
- what you did (i.e. evaluation methods and procedure)
- what you found (i.e. results)
- what the next steps are (if any) and any recommendations.

4.1.3 INTRODUCTION

The Introduction section briefly describes the program being evaluated, the outcomes being measured and the methods used. For example:

> This report presents the findings of the evaluation of the [Program] as delivered between [point X] and [point Y]. The [Program] is a [brief program description]. Clients included [brief client description]. The [Program] aimed to [brief description of program aims].
>
> Clients attended/participated in the program for [time period/range of time periods]. During the evaluation period [X clients] participated in the program.
>
> The evaluation aimed to identify the [brief description of evaluation aims (e.g. the short term treatment impacts on substance use and dependence, mental health and wellbeing)] of participation in the [Program], and to [(e.g. obtain feedback from clients about the quality of the program)].

The Introduction section also includes a brief outline of what the organisation hoped to learn from the evaluation. For example:

> From the evaluation we hoped to learn:
> - the proportion of our clients who are no longer substance dependent at the end of the program
> - the proportion of our clients who showed reduced symptoms of mental distress
> - how the outcomes from "our program" compare with "program Y", or how "our program as run in previous years" compares with "other comparison".

A brief description on what data was collected, when and how, should also be included in the Introduction section (the Methods section will go into greater detail). For example:

> For this evaluation, client outcome data was collected at baseline, program exit and at three months follow up. Outcome measures included [list measures used]. Output and cost data was also collected. Client feedback was obtained through a custom designed feedback survey. Four clients also provided stories about their experiences of the program.

4.1.4 BACKGROUND

The Background section can be taken from the evaluation plan (if this was not part of the evaluation plan, refer to Section 3.2.2 for guidance on what to include).

4.1.5 THE [PROGRAM]

This section should include the following subheadings:

- **Program description**
- **Program aims**
- **Program logic**

These sections can be taken from the evaluation plan (and updated accordingly).

4.1.6 EVALUATION AIMS

This section outlines what the organisation hoped to learn from the evaluation (and can be taken from the evaluation plan).

4.1.7 INPUTS AND OUTPUTS

These tables can be taken from the evaluation plan (and updated accordingly, recalling that outputs are all the activities involved in delivering the program). If the organisation has not delivered on its contracted outputs, a brief explanation should be included as to why. This information can be used for program improvement and when reporting to funders. Below are examples of how to present input and output reporting.

Program Inputs
The inputs for [Program] involved the following staff and other resources:

Table X. Program input recording

Output	Data to record
Staff	*List of program staff*
Resources	*Summarise facilities, budget, equipment, etc.*
In kind contributions	*Type of resources and distribution*

Program Outputs
During the period of delivering [Program] the following outputs were produced:

Table X. Program output recording

Output	Data to record
Whole residential program	*This is described in detail in "Program description" but is also an output*
Counselling sessions	*Number and duration*
Resources produced	*Type of resources and distribution*

4.1.8 METHODS

4.1.8.1 Participants

This section includes the demographics of clients entering the program (taken from the evaluation plan) and the numbers of participants who commenced and completed the program. A profile of client substance use and presenting issues is also included (reserving analysis for the Results and Discussion sections).

The Participants section is a good place to include retention reporting if there has been substantial attrition (expected in most residential rehabilitation services), unless retention is a specific focus of the evaluation, in which case it should be discussed separately in the Results and Discussion sections.

Retention data is collected throughout the program. At minimum, reporting needs to include client numbers at both the start and the end of a program. It is useful to also report on retention at different intervals. These intervals are for each organisation to determine, and can be intervals such as two weeks, one month, etc., or at the identified point(s) when clients tend to drop out.

Here is an example of retention reporting:

There were 234 clients who started the [Program] in [Month/Year], comprising 150 men and 84 women. After two weeks (T1), nine clients had left the program, with 96% remaining. At three months (T2), 67 clients had left, with 70% remaining. A total of 100 clients completed the five-month program, or 43% of the original client group. These results, and the differences in retention by gender and age, are shown at Table X.

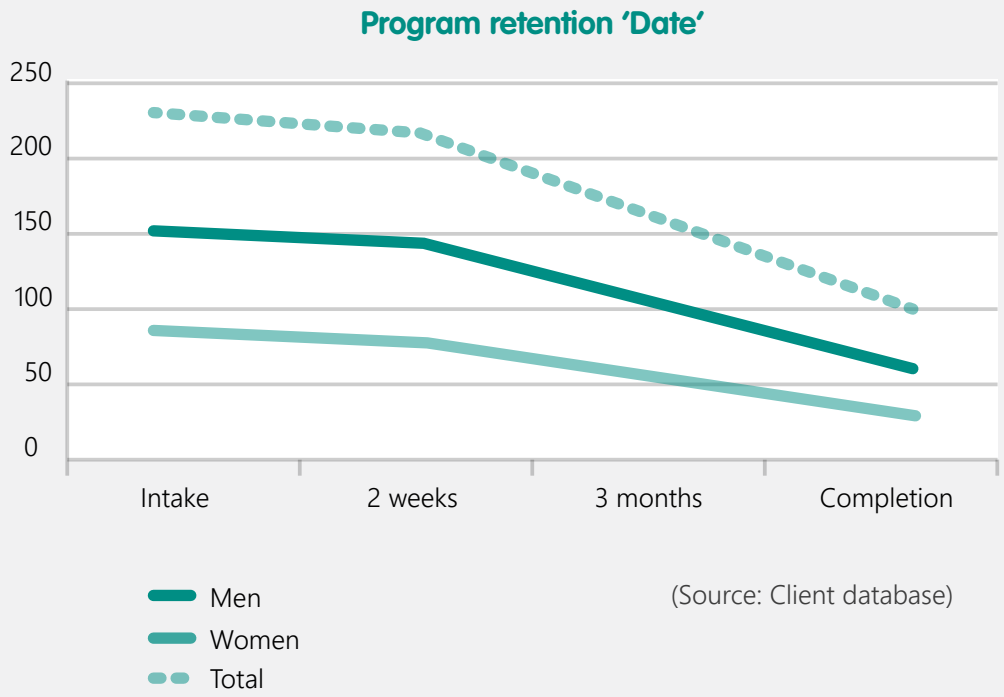
Table X: Retention for [Program] [Date]

Factor	Intake	T1	T2	Completion
Gender				
Male	150	143	104	67
Female	84	82	59	33
Age group				
18-24	77	76	46	30
25-29	80	74	60	29
30-50	77	75	57	41

(Source: Client database)

A graph is also useful to illustrate a decrease in participation over the course of a program (as shown below, for example).

Figure X: Retention for [Program] [Date]



(Source: Client database)

4.1.8.2 Outcome measures

This section can be taken from the evaluation plan (and updated accordingly).

4.1.8.3 Procedure

This section can be taken from the evaluation plan (and updated accordingly).

4.1.9 RESULTS

The Results section examines and describes the changes that have been observed in each outcome measure where data was collected.

4.1.9.2 Analysing quantitative data

Staff are familiar with how scores change on outcome measures for individual clients, given that these are mostly also assessment tools. Program level outcomes analysis simply adds all the individual scores together for each measure (SDS, K10+, WHO QoL-8 etc.), then provides either:

- an average score for all clients on the measure
- a proportion of clients in a category (e.g. 45% of clients were substance dependent as defined on the SDS)
- a proportion of clients who improved on a measure (or proportion who showed a clinically significant improvement).

Sample size: To be meaningful, *n* (number of clients) should be at least 30. Smaller numbers can be still be analysed but are likely to be skewed by large changes for individual clients. If the program has less than 20 clients, it is better to present as a table, and discuss in detail the changes (for example, "five clients showed improvement, six clients remained the same…" etc.). After the program has been run over multiple periods, then, the *n* can be increased by putting all the program data together.

Outcome measure analysis: When analysing outcome data, each outcome measure (e.g. SDS, K10+, WHO QoL-8) needs to be analysed separately (and if a measure has subscales these also need to be analysed separately). Some outcome measures use changes in overall scores (e.g. a lower score can mean a client is showing noticeable improvement, DASS); others use thresholds (e.g. a score over three indicates a person is substance dependent, SDS), and others use subcategories (e.g. proportion of clients at 'very high risk', K10+).

How an organisation presents results is a matter of preference, but the meaning of thresholds and subcategories tends to be clearer to an audience than averages (e.g. "a lower proportion of clients were experiencing a high level of distress" is easier to understand than "our clients showed an average 20% improvement on scores for the K10+"). However, with smaller client numbers or multiple categories within a measure, sometimes changes in average scores are the best option.

Dealing with drop outs: Given the high proportion of clients that drop out of AOD treatment, and that outcomes for those who do not complete treatment are likely to be very different from those who do, it is important to analyse only "paired data". That is, only analyse data for clients where there is both a baseline and completion score.

Analysing follow up data: Clients providing data – say three to six months after the program finished – will also (most often) be much lower again than those completing a program. Follow up data is also best presented by using paired data. This can be done by either comparing the scores of those followed up at the end of the program with their follow up scores, or, alternatively, there can be a separate analysis for the whole follow up group, showing their changes from baseline, completion and follow up.

Step by step guide to outcome analysis

Step 1. Understand the tool being used

Be clear about the outcome measure, what it measures, what changes in scores mean, and any threshold measure (for *NADAbase COMS* supported outcome measures, this information can be found in the NADA (2012) *Using the Client Outcome Management System (COMS)* user manual). Being clear about exactly what the outcome measure is measuring prior to analysing the numbers, will make checking for errors, understanding the results and writing up, a great deal easier. For example:

> The Severity of Dependence Scale (SDS) measures substance dependence; it includes the following psychological aspects: impaired control over drug use, and preoccupation and anxieties about drug use. It includes five items (questions) that are scored on a 4-point scale (0-3). The total score (0-15) is obtained through the addition of the five items. A score of 3 or above is correlated with a diagnosis of current substance dependence as defined in the DSM-V. Higher scores indicate a higher level of substance dependence; lower scores are an indication that the client is less dependent.

Step 2. Obtain paired data

Obtain a set of paired scores for each client for the outcome measure (e.g. baseline (intake) and completion (exit), or exit and follow up). If there are subscales in the outcome measure, obtain the paired scores for each subscale.

Step 3. Check data quality

Check the accuracy of the raw data. This will involve checking that each score is within the range of possible scores for that outcome measure (e.g. 0 to 15 for SDS). If there is missing data at either intake or exit, or scoring errors, see if these can be corrected (e.g. if transcribed incorrectly), otherwise these records need to be excluded from the analysis.

Step 4. Analyse the data

Decide if the outcome is going to be analysed and reported as (i) "change in average scores", (ii) "proportion improved", or (iii) "proportion of clients meeting a threshold or in a category" (it is possible to report both averages and proportions).

The scores on an outcome measure are bad, or showed no change – do we still have to report them?

Yes, because:

Negative direction outcome scores (i.e. clients getting "worse") can be expected across certain domains – for example, once people stop using a substance their anxiety levels can increase.

A proper evaluation does not "cherry pick" results, and showing poor or indifferent outcomes provides an excellent opportunity to find out why, and improve the program.

If an organisation reports poor results, this adds creditability to the reporting of good results.

i) **Average:** Add the paired scores together in each column, and divide each total by *n* (number of clients) to give an average aggregate score at intake and completion. For example:

The average client scores on the SDS were 12.5 at intake but had reduced to 1.5 at program completion.

Table X. Average SDS scores at program intake and completion

Average SDS score	Intake	Completion
Score	12.5	1.5

(Source: [Program] [Date], n=57)

ii) **Proportion improved:** Take all the scores at completion away from the intake scores, to give a third column of figures. Identify all the clients where there is a difference showing improvement (this will be either an increase or decrease in scores, depending on the tool being used). Divide the number of clients who improved by the total number of clients (e.g. 42/57 = 74% of clients improved on [name of outcome measure]).

iii) **Threshold or category:** Determine the proportion (%) of clients at intake who met a threshold or who were in each category. Then do the same for clients at completion.

Step 5. Present the data

Results can all be presented as text, however, most audiences find tables and graphs much easier to understand. For each outcome, a short statement of what the results were can be provided, and illustrated with a table or chart. For example:

Severity of Dependence
Clients showed substantially reduced severity of dependence as measured on the SDS. Average client scores on the SDS were 12.5 at intake but had reduced to 1.5 at program completion. In addition, only 5% of clients met the clinical definition for dependence at program completion (score of 3 or above on the SDS scale), compared to 85% at intake.

Table X. Average SDS scores at program intake and completion

Average SDS score	Intake	Completion
Score	12.5	1.5

(Source: [Program] [Date], n=57)

Alternatively, a general statement can be made. For example:

Average scores improved for all client outcome measures, with clients showing reduced severity of dependence, reduced mental distress and improved quality of life [Table X]. In addition, clients showed decreased risk taking behaviour [Table X].

These results seem weird! They are saying something that we didn't observe in our clients.

If results seem odd, then go back and check the data. Has it been entered correctly? Has the correct scale been used? Have pairs been matched and no "orphan baseline data" included?

Are there extreme outliers? If so, check with program staff that these were accurate (sometimes drug use can be exaggerated at baseline). And consider re-analysing without the outliers.

4.1.9.2 Client feedback and stories

A feedback survey with a **client rating** scale (e.g. CSQ-8) will provide a single number which is the average of all the client scores, or a "quality snapshot". This can also be reported in a sentence. For example:

"Clients mostly reported a good level of satisfaction with the program, with an average client score of 26.4 on the CSQ-8 program quality survey (scale 8-32)."

Client stories can also be placed throughout the report and, as covered earlier, they are a compelling way of showing how a program is making a difference.

4.1.10 BENCHMARKING

"Benchmarking is the process of identifying and implementing the best of improved practices by selecting and comparing aspects of service practice and performance against the best" (NADA 2014). Outcome measure results can be used in a benchmarking process. This enables an organisation to see how the impact of their program compares to that of other similar programs, and if not performing as well, to determine ways of improving quality and effectiveness.

The Benchmarking section compares outcome results to those from earlier evaluations, other sites of the same organisation, or by similar organisations running similar programs (e.g. another therapeutic community, or another counselling program, or outcomes that have been reported in the literature). For examples and further guidance, refer to the NADA (2014) *Benchmarking Guide*.

4.1.11 DISCUSSION

The Discussion section is where the results are analysed, compared to other evaluations and an assessment made as to whether the program is meeting its objectives. It is also where recommendations are made to improve the program and where suggestions are made for future evaluation questions and research projects. No new results or information should appear in the Discussion section.

Before starting to write the Discussion, it is helpful to read the discussion section in other papers writing up AOD program evaluations. These can be found in journals such as *Drug and Alcohol Review* or *Addiction* or other AOD or mental health research journals.

The Discussion section starts with a restatement of the evaluation aims and what the organisation hoped to learn. Each aim and area for learning should be discussed separately and include what the results showed (although don't just repeat what has already been stated) and what was learnt.

If there is comparative data or the outcomes are being used to benchmark, explain how the results compare to those of previous evaluations or other services. Are they about what would be expected? Are they much better, or worse?

The Discussion section can also include anything else that was learnt from the evaluation, even if this was not expected. It is also useful to write a statement about what the evaluation observed about program retention, if relevant.

The implications of the evaluation are then discussed, and "next steps" outlined. This can include:

- What the organisation will change or improve as a result of the evaluation, if anything (these can then be the basis for recommendations).
- Plans for follow up data collection (for example, in six months, or from clients using an aftercare program).
- Further evaluation and research questions.

The Discussion concludes with a statement that summarises the evaluation findings and the implications of the findings for the organisation and client group.

5. Getting the most out of your evaluation

5.1 EVALUATION FINDINGS AS AN ENGAGEMENT TOOL

Being able to demonstrate that a program makes a difference is a powerful engagement tool for both clients and staff. Communicating about the evaluation as it is being conducted and presenting the findings as they emerge acts as a constant reminder of the value of evaluation. Staff can see that the work they do with clients is effective, and/or that there are areas where things might need to be done differently (which reinforces the need for accurate and timely data entry). For current and potential clients, a summary of the impacts of the program can show that the program "does work", is something they would like to do, or encourages them to renew their engagement with the program.

5.2 USING EVALUATION FINDINGS IN FUNDING APPLICATIONS

An established evaluation process combined with enhanced performance management systems shows potential funders that an organisation is committed to evidence based practice and continuous quality improvement.

The following sections can be extracted from evaluations and included in funding applications:

- program logic
- evaluation findings – i.e. program impacts
- benchmarking: How the impacts of a particular program compare with other similar programs
- how findings have been used to improve practice.

5.3 BUILDING A RESEARCH CULTURE

Building a culture of research and evaluation has a number of benefits for organisations. Establishing a strong research culture involves taking all the steps in setting up an organisation for effective evaluation, running good evaluations and using the results. It also involves networking with other practitioner researchers (see The CMHDARN Research Network) and developing relationships with universities and academics to undertake further research.

When an organisation undertakes an evaluation, a whole range of questions may emerge about how the program works, and can help to identify barriers to effectiveness and how these might be overcome. AOD organisations with well-developed research cultures are able to take these questions and use them as a driver for expanded evaluations or specific research projects. They then engage with universities or academic researchers to conduct the research.

Some of the research topics that AOD organisations have undertaken research on include:

- Why do some clients do better than others?
- What impact does trauma have on substance dependence?
- What proportion of our clients have cognitive impairment, and how does that impact on their treatment/how can we design our interventions for people with cognitive impairment?
- Why do anxiety levels increase dramatically for some clients when they are abstinent?
- Are there effective treatments for PTSD that we can offer our clients?

6. Evaluation templates, tools and resources

6.1 EVALUATION PLAN TEMPLATE

1 Title

2 Introduction

Summarise the purpose of the evaluation plan

3 Background

Briefly describe the program's background i.e. brief history, target group, research findings and gaps, etc.

4 The [Program]

4.1 Program description

Describe the program's model of care and map the client journey

4.2 Program aims

Outline what the program is aiming to achieve

4.3 Program logic

Use a program logic model to explain causal mechanisms

5 Evaluation aims

Provide an overview of the purpose and scope of the evaluation and what the organisation hopes to learn

6 Program inputs and outputs

Record (and maintain) program input and output tables

7 Methods

7.1 Participants

Profile client demographics and presenting issues upon entering the program

7.2 Outcome measures

7.2.1 Client outcome measures

List quantitative measures

7.2.2 Qualitative and quality measures

List client feedback measures

7.3 Procedure

Describe how and when outcome measure data will be collected

8 Evaluation responsibility and timeline

Outline evaluation tasks, people responsible and include a project timeline

6.2 EVALUATION REPORT TEMPLATE

1 Title

2 Acknowledgements
Acknowledge the contribution of those who participated in the evaluation process

3 Executive summary
Summarise key elements i.e. aims, methods, procedure, results, findings and next steps (if any)

4 Introduction
Summarise the purpose of the evaluation report

5 Background
Briefly describe the program's background i.e. brief history, target group, research findings and gaps, etc.

6 The [Program]

6.1 Program description
Describe the program's model of care and map the client journey

6.2 Program aims
Outline what the program is aiming to achieve

6.3 Program logic
Use a program logic model to explain causal mechanisms

7 Methods

9.1 Participants
Profile client demographics and the number of clients who commenced and completed the program

9.2 Outcome measures

9.2.1 Client outcome measures
List quantitative measures

9.2.2 Qualitative and quality measures
List client feedback measures

9.3 Procedure
Describe how and when outcome measure data was collected

8 Evaluation aims
Provide an overview of the purpose and scope of the evaluation and what the organisation hoped to learn

9 Program inputs and outputs
Update program input and output tables (and if contracted outputs were not met, briefly explain why)

10 Results

Describe how quantitative changes have been observed (or not) and supplement with tables, charts and qualitative data as appropriate

11 Benchmarking

Describe how outcomes compared to those of other programs or from earlier evaluations

12 Discussion

Discuss findings, recommendations and next steps (if any)

6.3 TOOLS AND RESOURCES

Evaluation resources

The Evaluation Toolbox provides a "how to" guide for evaluating behaviour change programs:
http://evaluationtoolbox.net.au/

The Program Development and Evaluation site from the University of Wisconsin-Extension is an online "discovery space" that aims to grow a culture of ongoing program development and evaluative thinking:
http://www.uwex.edu/ces/pdande/index.html

Outcome measures

Training and support on how to use NADA's Client Outcome Management System is available online:
http://tutorial.nada.org.au/

The full report on the Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Setting be accessed at:
http://www.drugsandalcohol.ie/18266/1/NADA_A_Review_of_Screening,_Assessment_and_Outcome_Measures_for_Drug_and_Alcohol_Settings.pdf

A summary table of outcome measures from this review can be accessed at:
http://www.nada.org.au/media/7708/summarytableofoutcomemeasures.pdf

NADA practice enhancement tools

NADA's practice enhancement tools including the Enhanced Performance Management and Benchmarking guides can be accessed online:
http://nada.org.au/resources/nadapublications/resourcestoolkits/

Research networking and mentoring

The Community Mental Health Drug and Alcohol Research Network (The CMHDARN Research Network) can help link organisations with an academic mentor:
http://www.cmhdaresearchnetwork.com.au/

Finding an evaluator

Australasian Evaluation Society
http://www.aes.asn.au/

Ethics training and resources

Praxis Australia
http://www.praxisaustralia.com.au/

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