Client Data and Health Outcome Reporting for the NSW NGO Specialist AOD Treatment Sector: Final Project Report

June 2020

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non government alcohol and other drugs sector in NSW.

NADA's goal is to lead as a member driven peak body, building sustainable non government alcohol and other drug organisations to reduce alcohol and drug related harms to individuals, families and communities in NSW.

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INTRODUCTION

Report summary

NADA provides the central data repository for NSW non government specialist Alcohol and Other Drugs (AOD) treatment services through the NADA client data information system - NADAbase. This is an important role to support the sector in the collection and reporting of client data as part of data requirements to Government, KPIs, internal continuous quality improvement, and as a valuable tool to work with individual clients.

The Client Data and Health Outcome Reporting for the NSW NGO Specialist AOD Treatment Sector Project (hereafter referred to the NADAbase Expansion Project) has delivered against the intended project areas:

i) enhancement and expansion to NADAbase for improved monitoring and reporting functionality;
ii) improvements to practice outcomes, research and evaluation through expanding data options to the NSW NGO AOD sector;
iii) evidence that there is alignment of NADAbase Client Outcomes Measurement System with the NSW Health COQI measures to enable state-wide consistency and reporting.

Recommendations from the NADAbase Independent Evaluation

The independent evaluation of NADAbase conducted by University of Wollongong offers a snapshot of how NADAbase is being used by its members and provides direction for future NADAbase improvements (see Appendix 1). Most respondents found NADAbase useful and highlighted the value of many tools included within it for Routine Outcome Monitoring (ROM) and reporting requirements. Feedback was also collected from respondents who disagreed with or were neutral about the utility of NADAbase. These latter responses were linked with concerns about the utility of specific measures, repetition of data collection by the service and A desire for additional training support for using NADAbase.

Recommendation 1: Improve the quality of the data being collected within the NGO sector through additional data quality checks available in NADAbase dashboard (e.g., simple value denoting proportion of COMS assessments completed by the service). **COMPLETED**

Recommendation 2: A feature be added to NADAbase to allow users to leave feedback in 'real-time'

Recommendation 3: In collaboration with member services, NADA should routinely review the measures used within the NADAbase. It is important to note that there are strengths to the sector by collecting the same measures across services (e.g., benchmarking, examining sector-wide trends).

Recommendation 4: Revise current resources on NADAbase training to be more targeted to the needs of different staff within the AOD sector and develop resources that help to improve the *attitudes* of workers and management regarding the use of NADA COMS to inform client care. **COMMENCED**

Recommendation 5: Revise NADAbase data dictionary to include more simplified documentation to allow easier access to the resource by AOD workers without technical expertise. **COMMENCED**

***Recommendation 6*:** NADA to review the current data download functions and consider approaches to streamline and simply the data export. **COMMENCED**

***Recommendation 7*:** Add importing and exporting guide to existing NADAbase data dictionary or create an additional resource. **COMPLETED**

BACKGROUND

The Drug and Alcohol and Mental Health Information Management (DAMHIM) Project was funded by NSW Health in 2008, and aimed to develop and implement a system for measuring outcomes of treatment in non government alcohol and other drugs (AOD) organisations. The resulting Client Outcome Measures System (COMS) database included domains for psychological health, drug and alcohol use and overall health and social functioning. The selection of the outcomes data set was informed by; a consultation process conducted with the NADA membership in 2009; a research review of screening, assessment and outcome measures for use in drug and alcohol settings; and input from the project's expert advisory committee. Standardised measures that were selected as part of the outcomes data set include:

- Kessler-10 Plus
- World Health Organisation Quality of Life Scale - 8
- Severity of Dependence Scale
- Drug and alcohol use questions taken from the Brief Treatment Outcome Measure (BTOM) and the Australian Alcohol Treatment Outcome Measure (AATOM)

These measures included in the NADA client data information system – NADAbase, are identified as gold standard measures in the summary of concurrent validity comparison items in the validation and implementation of the Australian Treatment Outcomes Profile (ATOP)[1]. The ATOP is the client treatment outcome measure currently implemented in the government alcohol and other drug service system with Local Health Districts.

Since the pilot process commenced in 2010 COMS data has been used by NADA member organisations in treatment and care planning, organisation and program development, quality improvement, planning and policy development and sector wide advocacy. Today the combined client outcomes and minimum data set data collection database – NADAbase, provides a central repository for non government specialist AOD treatment services data for NADA member organisations. NADA, as custodians of this client data, has a central role in the support of member organisations in the collection and reporting of client data to their individual clients, for the purposes of organisational improvements and to stakeholders/funders.

For NADA to continue to provide up to date technological support and data reporting features as part of a process of continuous technical and program planning improvement, further investment is required. NADA has a robust plan for future improvements to NADAbase in order that it remain current, responsive and user friendly.

In line with the *System Enablers* priority of the *NSW Health Alcohol and other Drugs Strategic Plan* the substantial enhancement of NADAbase was designed to strengthen monitoring, research and evaluation capacity across the specialist NGO AOD treatment sector in NSW and contribute to the expertise and professionalism of the NGO AOD workforce.

[1] Ryan et al. (2014). Validation and implementation of the Australian Treatment Outcomes Profile in specialist drug and alcohol settings. *Drug and Alcohol Review*. 2014 Jan;33(1):33-42

KEY PROJECT OUTCOMES

NADA Member, Consumer and Stakeholder Consultation

NADA established an expert steering committee that ensured links with the COQI project, guidance from the Centre for Population Health and input from NADA members. Key NADA members, some of whom had been involved in the original COMS project and key research stakeholders were also part of this committee.

As part of the enhancement processes NADA developed a comprehensive Communication Strategy and Consultation Plan that involved feedback via a number of different platforms through development, testing and implementation:

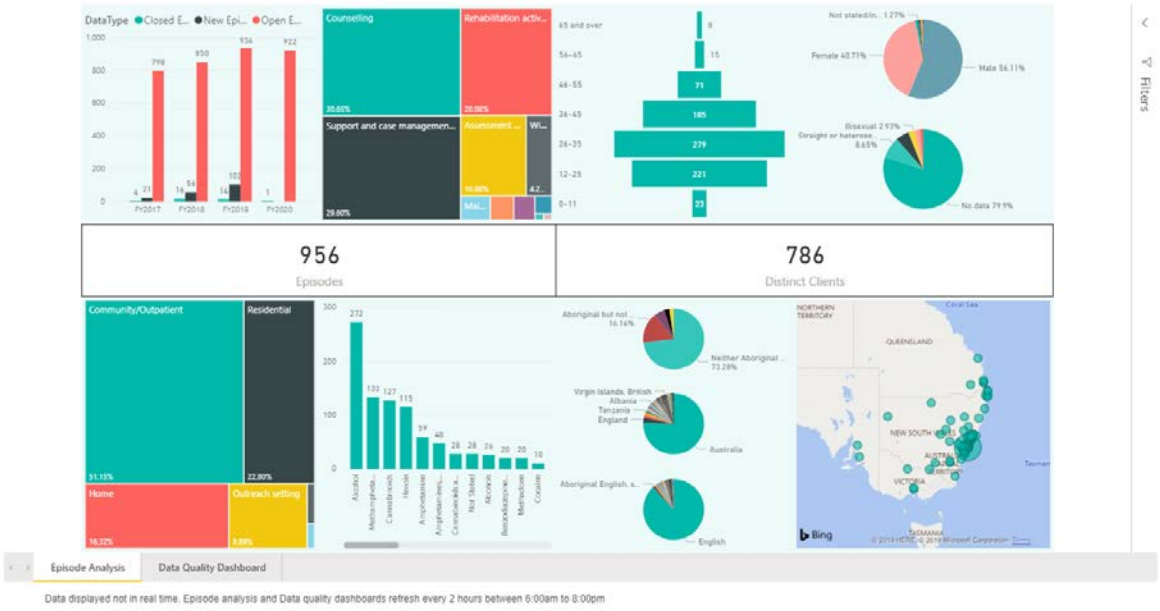
- The Project Steering Committee
- The NADA Practice Leadership Group
- The Women's AOD Services Network
- The Youth AOD Services Network
- The NADA Board member (as sector representatives)
- Consumer Networks
- The RADD working group

Enhance NADAbase

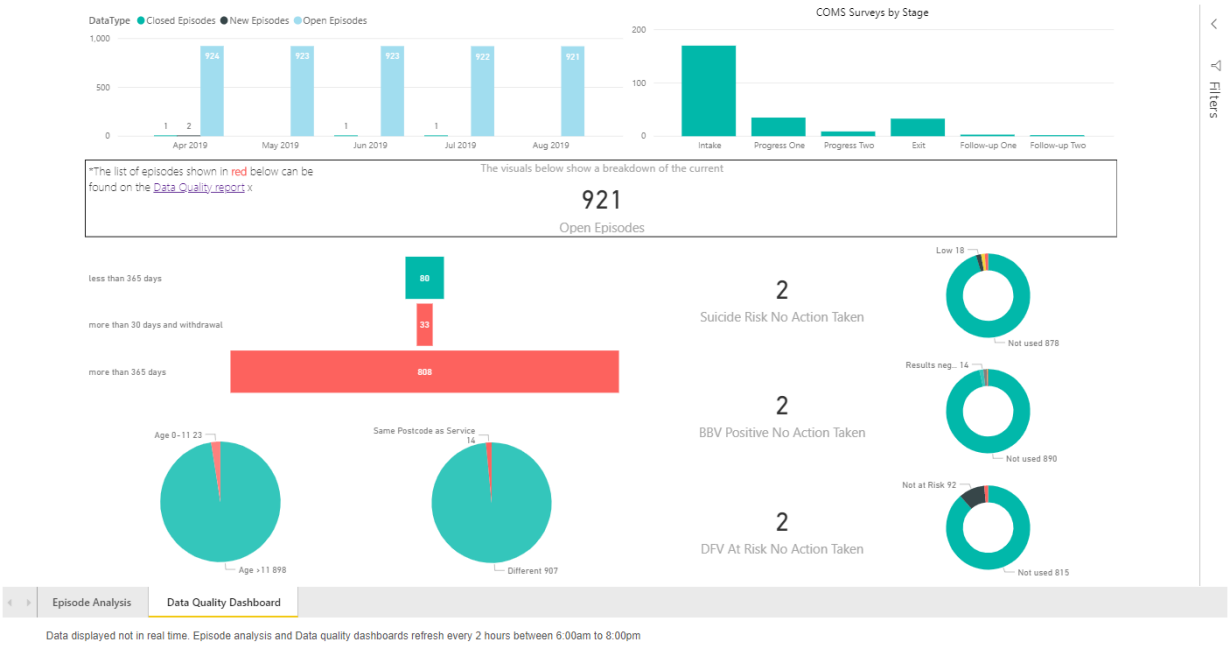
Interactive dashboards (x 2) that provide each NADAbase User Organisations to see at a glance their client data analysed in a number of unique ways as well as a data quality dashboard to assist with the monitoring of data accuracy and quality – in real-time and updated every 2 hours.

These dashboards were designed to improve client and worker engagement with the data and promotes ethical data collection – i.e. Data that is used for improved service provision rather than warehousing.

Episode analysis dashboard



Data quality dashboard



Improvements in data reports at the client and organisational level – based on feedback from the RADD working group and NADA members.

Inclusion of additional demographic questions:

- Gender and Sexuality questions
- Questions regarding children in the care of those seeking treatment

Expansion of NADAbase

Expansion of NADAbase has been conducted in a variety of areas in consultation with NADA members, the COQI group, consumers and Ministry of Health representatives with the following outcomes:

Cultural questions:

Consultation was conducted with Aboriginal Community Controlled organisations (ACCOs) via the Network for Aboriginal Residential and Healing Drug and Alcohol Network (NARHDAN) – now incorporated and named the Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN) to explore the addition of outcome questions specific to cultural identity. Initially inclusion of the Growth and Empowerment Measure (GEM) was examined as it was developed using information gathered from Aboriginal participants of effective empowerment programs. However, ADARRN made the decision in August 2019 to include a different set of specific cultural questions for ACCOs, namely the EQ-5D and two questions relating to cultural identity that have been incorporated into NADAbase for their use.

NADA also conducted consultations with DAMEC regarding the potential for additional questions regarding CALD populations, but no conclusions have been reached about what those questions might be at this time.

Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs)
PROMs assess health status and health-related quality of life from the patient/service user perspective. PREMs are designed to capture a person's perception of their experience of their health care or health service.[2] Currently NADAbase does not include PREMS measures and it is not the most appropriate platform given the implications of linking client records with their feedback. However, The PREMS working group led by NUAA and SESLHD did not reach a conclusion on a PREM and so NADA will await a decision from the Ministry of Health (MoH) in this regard before inclusion and implementation.

Nicotine Dependence
The Fagerström Test for Nicotine Dependence is the most commonly used measure of nicotine dependence[3] and NADA explored the possibility of its inclusion into the COMS. As a result of consultation with key Smoking Cessation consultants a brief from of the Nicotine Dependence scale has been included in NADAbase COMS.

Complexity Rating Scale
The Complexity Rating Scale is a tool designed to provide AOD clinicians with a practical tool which helps summarise the biopsychosocial and economic factors which may be a risk to clients achieving good outcomes from Drug and Alcohol treatment. The Complexity Rating Scale has not been agreed upon for inclusion and is not currently routinely used in the Government sector and therefore it has been decided not to include this measure in NADAbase at this time.

Blood Borne Virus and Sexual Health Screeners
In consultation with Hepatitis NSW and sexual health practitioners NADA has now included Blood Borne Virus (BBV) and sexual health questions as part of the NADAbase suite of screeners, with scripted suggestions for how to ask these questions and links to education and training for staff.

Suicide Risk Screener
Having completed a range of workforce capacity building initiatives regarding assessing suicide risk, NADA has now included a suicide risk screener to NADAbase with accompanying scripts, links and training videos to support NADA members to ask and respond appropriately to suicide risk.

Domestic and Family Violence Screener
NADA in collaboration with the Women's Network and experts in the field of domestic and family violence have developed a screener with accompanying links and scripts to support NADA members to explore the experience of DFV with their female clients. NADA intends to expand on this work and will review the screener in coming months to ensure it is inclusive of people from the LGBTI community.

[2] https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0003/253164/Overview-What_are_PROMs_and_PREMs.pdf

[3] Heatherton TF, Kozlowski LT, Frecker RC, Fagerstrom K. The Fagerstrom Test for Nicotine Dependence: a revision of the Fagerstrom Tolerance Questionnaire. British Journal of Addiction 1991;86:1119-1127.

Implementation and capacity building

The NADAbase Expansion Project delivered on the following capacity building activities to support and encourage NADA members in their collection, use and reporting of their client data:

- Introduction to NADAbase training events
- NADAbase training (one on one with services)
- NADAbase Screener training (one on one with services, or through "Working with women engaged in AOD treatment and Responding to Domestic Violence" workshops)
- Administering COMS training (one on one with services)
- NADAbase Administrator training (online tutorial)
- NADAbase Dashboard tutorials and webinars
- NADAbase Administrators Forum
- NADA Outcomes Forum

In addition, the NADAbase Data Dictionary was completed and Specifications for Importers to NADAbase were developed and desktop published.

Research and Project Evaluation

ATOP Mapping

ATOP mapping report (Appendix 2) was completed and feedback was provided to the Steering Committee in 2018.

Data Snapshots

Have continued to be produced and are available on the NADA website. The Dashboards have included snapshot data and NADA will continue to merge the NADAbase snapshot query into Power BI in order to be able to produce these reports independently. Work is also being undertaken to assist NADA members to have an improved function of exporting data two Excel for analysis.

NADAbase Expansion Project Evaluation

The NADAbase Expansion Project was independently evaluated by a team led by A/Prof Peter Kelly, University of Wollongong (UoW). The survey was designed to examine drug and alcohol workers attitudes and experiences regarding their use of the NADA COMS and NADAbase more broadly. Furthermore, the project explored the barriers and facilitators of routine outcome measurement in the NSW drug and alcohol treatment sector (see Appendix 1). NADA reviewed the evaluation and identified recommendations – which have informed the NADAbase workplan and are detailed at the summary of this report.

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APPENDIX 1

University of Wollongong Report: An Independent Evaluation of the User Experiences of NADAbase

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NADAbase Worker Survey

Routine outcome monitoring (ROM) is the practice by which alcohol and other drug, and mental health workers measure and track changes in client functioning over time[1-3]. It is typically completed by asking clients to complete self-report measures where they rate their functioning (e.g. depression, substance use, quality of life). These tools are considered an important component of individual client care, with evidence that the use of ROM improves treatment adherence and enhances client outcomes[3-5]. From an organisational perspective, ROM is considered a core component of quality assurance approaches. It provides an opportunity for services to monitor their ongoing performance[6,7] and conduct quality assurance projects[8,9].

Despite the evidence to support the benefits of routine outcome assessments, workers tend to use ROM infrequently as part of their routine care. Barriers to using ROMs as part of routine care include increased time demands on clinicians and administrative staff, a lack of clinician training on how to integrate ROM into clinical practice; clinicians' concerns regarding the clinical utility of ROM data, and poor return rates of questionnaires completed by clients[10]. The literature suggests the tendency and frequency that a worker uses ROMs is tethered to the value that they place on the measure itself and the ease of using the ROMs (e.g. time taken, logistics of entering data etc).

NADAbase

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non-government alcohol and other drugs sector in NSW. Based on a comprehensive literature review[11], NADA developed a ROM tool to be used by service providers within NSW (i.e. Client Outcome Measurement System, COMS). The NADA COMS collects information on participant's substance use (i.e. Severity of Dependence Scale, items from the Australian Alcohol Treatment Outcome Measure – frequency and number, risky injecting practices), psychological distress (i.e. Kessler-10), and quality of life (i.e. EUROHIS Quality of Life Scale). The standard COMS survey is currently 51-items in length and takes about 15-minutes to administer. NADA has developed a central data repository, called NADAbase, where NADA members enter both the COMS surveys

and State and National Minimum Data Sets (NMDS). NADA members are encouraged to regularly complete the NADA COMS with individual clients throughout their treatment process, although the frequency with which COMS surveys are completed varies between NADA members[12]. Screening measures (e.g. suicide, domestic violence) and other additional items (e.g. sexuality, child in care) have more recently been included within the NADAbase.

The current project

The aim of the current project was to examine drug and alcohol workers attitudes and experiences regarding their use of the NADA COMS and NADAbase more broadly. The project will examine the barriers and facilitators of routine outcome measurement in the NSW drug and alcohol treatment sector.

Method

NADAbase COMS

NADA represents over 100-member organisations that provide a broad range of services including AOD health promotion, early intervention, treatment, and after-care programs. To improve the use of routine and well-validated outcome assessments within the NGO sector, NADA developed the NADAbase Client Outcomes Management System (COMS) in 2009. This followed extensive consultation with service users, NADA members (e.g. clinicians and management), academic researchers, and a comprehensive literature review[11].

Participants

Participants were 84 staff members who were working at specialist non-government alcohol and other drug treatment facilities. As presented in Table 1, the survey was completed by a combination of direct client support staff (44%), managers (38%), administrative staff (10%) and other support staff (8%). On average, participants had been working in the AOD treatment field for 8-years. Participants predominately worked across residential (41%), community (32%), and outreach (21%) settings. As the term 'participants' is often

used in the AOD field to refer to clients, we have used the term 'workers' throughout this report to avoid any confusion.

Procedure

An anonymous online survey was developed (Survey Monkey) by the research team. NADA distributed an email invitation to people working across the sector to participate in the project. This included information on the project and informed consent procedures. Three reminder emails were also sent. Data was collected between October 2019 and December 2019. The survey took approximately 15 minutes to complete.

Table 1.

Worker demographics (N = 84)

	N	%	M	SD
Gender				
Male	29	34.5		
Female	54	64.3		
Prefer not to say	1	1.2		
Primary work role				
Administration	8	9.5		
Direct client services/Client support	37	44.0		
Management	32	38.1		
Other (research, harm minimization, crisis accommodation)	7	8.3		
Employment duration (years)				
Current position			5.01	4.75
Currently organization			6.38	5.73
Within AOD sector			9.88	8.42
Total years employed			22.44	12.76
Service delivery setting				
Residential	34	40.5		
Community/Outpatient	27	32.1		
Home	1	1.2		
Outreach	18	21.4		
Other (research, combination)	4	4.8		
Main service provided				

Counselling	26	31.0
Rehabilitation activities	27	32.1
Support and case management only	20	23.8
Information and education only	1	1.2
Other (aftercare, research, data entry, combination)	10	11.9
Service NADAbase use		
Direct user	54	64.3
Importer	23	27.4
Unsure	3	3.6
Non-user	3	3.6
Direct and Importer	1	1.2

Measures

The survey is included as an appendix (see appendix 1). The survey included 5 sections.

1. Demographics and work history: This included gender, primary work role, length of time working in the position and sector, and current work setting. Workers were also asked to "describe how your service currently uses the NADAbase" and "Do you use the NADAbase dashboards" (yes or no). If workers reported they didn't use the dashboard, they were subsequently asked "why do you not use the dashboards?".
2. Use of NADA COMS: Workers were asked specific questions about how COMS were used at their service (see Table 4 for items) and they were asked to reflect on "how helpful" they found the COMS (see Table 5 for items). These items were adapted from Ryan et al.[13] To examine how workers use the COMS to support client care, they were asked a series of questions that related to their clinical practice (e.g. "I have asked the clients that I work with to complete the COMS", see Table 6 for the items). Workers were asked to rate,

on a 5-point scale (Not useful, Slightly useful, Moderately useful, Very useful, Extremely useful), their perceived "value" of each of the measures used in the NADA Coms (see Table 7 for items). Workers also had the option of reporting that their "service does not use this measure" or "I am not familiar with this measure". Workers were also asked to indicate if any further assessment measures should be included (yes or no). If they reported yes, they were asked to identify which ones

3. Screeners: Workers were asked to rate, on a 5-point scale (Not useful to Extremely useful), their perceived "value" of each of the screeners in the NADAbase (i.e. domestic violence, suicide, and Blood borne virus and sexual health). Workers also had the option of reporting that their "service does not use this screener" or "I am not familiar with this screener". Workers were also asked to indicate if any further screeners that should be included (yes or no). If they reported yes, they were asked to identify which ones.
4. Additional items: Workers were asked to rate, on a 5-point scale (Not useful to Extremely useful), their perceived "value" of the additional items that have been included in the NADAbase (i.e. gender question, sexuality question, children in care question). Workers also had the option of reporting that their "service does not use these additional items or "I am not familiar" with these additional items. Workers were also asked to indicate if any further measures that should be included (yes or no). If they reported yes, they were asked to identify which ones.
5. Open ended questions: Workers were asked two open ended questions. "What do you see as the advantages of using NADA COMS" and "Do you have any final comments about the NADAbase?". Analysis combined these questions to identify the strengths and challenges with using the current NADA COMS and NADAbase.

Statistical analysis

The analysis was descriptive and presents means (standard deviations), percentages and sample sizes. There was a relatively large proportion of managers (38%) and direct client staff (44%) who completed the survey. Post hoc analysis was conducted to examine if there were any differences between these groups. However, across almost all of the items, there were no significant differences. Consequently, comparisons

between Management and direct client staff are not presented. Likewise, due to the limited sample sizes no sub-group analyses are reported.

Results

NADAbase use across the sector

Workers were asked to describe the way that the NADAbase is currently used within their service. Of the workers who reported using the NADAbase (i.e. management, direct client staff), responses largely represented two themes: (1) *to support individual client care* and (2) to *support reporting and quality assurance*. For example, when describing its use to support client care, workers reported:

> *"it gives me an understanding of how my client is progressing in most aspects of their lives"* (direct client staff, Residential setting), and
>
> *"We us them in session with clients to identify how and where change is experienced by clients. Often it allows us to identify areas of the client's life that has changed in positive ways and pinpoint where there is still room for improvement as identified by the client"* (Direct client staff, Outreach setting).

When describing the *reporting and quality assurance* aspects, workers reported the NADAbase was used to "track trends across the organisation" (Direct client staff, residential setting) and to support "reporting responsibilities" (Direct client staff, community/outpatient setting).

Dashboard

The NADAbase Dashboard is an online, graphical representation of the data that is being collected across an individual service. It was formally introduced to the NADAbase in 2018. Fifteen percent (n = 12) of the respondents reported that they were not familiar with the dashboard. Six of these workers were from services that were direct importers. A further 29% of respondents reported not using the dashboard. Qualitative responses indicated that these respondents did either not see it being useful in their current role ("No need currently"), that they had not received training or had not been "shown how to". As alluded to by some respondents, this might be a reflection of the relatively recent introduction of the upgrade to the

dashboard. Some respondents indicated that their service was using an alternative system (i.e. "we have our own ones that are more specific and comprehensive to our client group"). Other respondents saw the dashboard as being more applicable for management ("my management might, but I do not"). However, as specified by one manager:

> *"Because our services have varying funding streams and our Nadabase programs are not set up per funder, but per activity type, the dash boards do not assist me when it comes to reporting. The dash boards do provide interesting information more generally though".*

Fifty-six percent of respondents reported that they do use the dashboard function in the NADAbase. Of those workers who reported using the NADAbase dashboard, it was indicated to be 'very useful' or 'extremely useful' for 43% of workers. The largest majority of workers reported that it was 'moderately useful' (49%, see Table 1).

Table 2

Perceived usefulness of dashboards as a percentage for workers who reported using the dashboard

	Not or slightly useful (%)	Moderately useful (%)	Very or extremely useful (%)
Dashboard	8.9%	48.9%	42.2%

Client Outcome Measures (COMS)

As highlighted in Table 4, there was a proportion of participants who either did not use any of the COMS or only used selected measures. The measure that was used the least frequently was the Nicotine Dependence Scale (38% were did not use or were unfamiliar with the measure). This is a relatively new measure in the NADAbase (introduced in 2018), suggesting that services have not implemented this as part of routine practice.

Table 3

Use of NADAbase COMS (%)

	Use (%)	Do not use (%)	Unfamiliar with measure (%)
Kessler-10	80.5	15.6	3.9
Substance Dependence Scale	81.8	11.7	6.5
EUROHIS Quality of Life	80.4	13.0	6.5
Blood Borne Virus Risk	68.8	22.1	9.1
Nicotine dependence	62.3	29.9	7.8

Respondents who reported using the COMS were asked a further series of questions specifically examining the use of the COMS at their service. As reported in Table 4, the large majority of people tended to 'Agree' or 'Strongly agree' that it is "a requirement of the service that clients are requested to complete the COMS" (78%), that there is a "strong culture" regarding the use of the COMS (65%), sufficient time is "allocated to administer the COMS" (64%) and that the use of the COMS is "well supported" at their workplace (69%). Twenty-two percent or respondents reported that they 'strongly agree' or 'agree' that the only reason they use the COMS is because "my organization expects me to".

Table 4

Perceptions of service utilization of Client Outcome Measures (COMS) within the NADAbase for people who reported using COMS (%)

	Disagree or Strongly Disagree (%)	Neutral (%)	Agree or Strongly Agree (%)
It is a requirement of our service that clients are requested to complete the COMS	9.7	12.5	77.8
At my service there is a strong culture of using the COMS	9.7	25.0	65.3
At my service time is allocated to administer the COMS	15.3	20.8	63.9
At my service the use of COMS is well supported	9.7	20.8	69.4
Client feedback from the COMS is discussed during team consultations/meetings	22.2	37.5	40.3
The only reason I use the COMS is because my organization expects me to	45.8	31.9	22.2

Note. Only workers who reported using the COMS were included in this table.

Respondents who reported using the COMS were asked a further series of questions examining perceptions regarding the usefulness of the COMS. As detailed in Table 5, 64% of workers reported that they 'agreed or strongly agreed' that the COMS adds value to their work. Whilst a relatively small proportion disagreed with the various helpfulness statements (range: 6% to 16.6%), there was a relatively high proportion who were 'neutral' across all of the items.

Table 5

Perceived helpfulness of Client Outcome Measures (COMS) used in the NADAbase as a percentage for people who reported using COMS (%)

	Disagree or Strongly Disagree (%)	Neutral (%)	Agree or Strongly Agree (%)
They are easy to administer	10.4	28.4	61.2
They are appropriate	6.0	29.9	64.2
They are useful in identifying problem areas or difficulties	10.4	37.3	52.2
The format and style is easy to understand and follow	13.4	31.3	55.2
The length is appropriate for use in routine practice	16.4	28.4	55.2
They are useful for helping me develop case plans	11.9	37.3	50.7
They are appropriate for my setting	13.4	28.4	58.2
I am happy to use the COMS as part of my regular client reviews	9.0	32.8	58.2
The tools help me to track client progress	7.5	25.4	67.2
I use the results from the outcome measures to help adjust my work with clients	11.9	29.9	58.2
Overall, I have found the COMS to be of value in my work	10.4	25.4	64.2

Note. Only workers who reported using the COMS were included in this table.

For those workers who reporting using the COMS, they were asked how they applied the COMS as part of their routine care. As described in Table 6, a relatively high proportion of workers reported asking their clients to complete the COMS 'always or most of the time' (69%). Of concern is the smaller proportion of workers who 'always or most of the time' review the results of the COMS report (49%), discussed the COMS report with clients (40%), or used the results to plan sessions (39%). Systematic implementation of ROM was defined as a rating of ''always'' or ''most of the time'' on all four items; ''asked the clients that I work with to complete the COMS, ''I have reviewed the results of the COMS report'', ''I have discussed the results of the COMS report with the clients I work with" and ''I have used the results taken from the COMS report when planning a session''. Just over a quarter of workers (27%) reported that they used a systematic approach to using ROM over the past 6-months.

Table 6

Application of COMS used in the NADAbase with clients as a percentage (%)

	Rarely to none of the time (%)	A little (%)	Always or most of the time (%)
I have asked the clients that I work with to complete the COMS	20.9	10.4	68.7
I have reviewed the results of the COMS report produced by NADAbase	25.4	25.4	49.3
I have discussed the results of the COMS report with the clients I work with	29.9	29.9	40.3
I have used the results taken from the COMS report when planning a session	29.9	31.3	38.8

Note. Only workers who reported using the COMS were included in this table.

Workers who reported using the COMS were asked to reflect on the value of each of the measures included within the COMS. Table 7 presents the results from respondents who reported using the COMS. The large proportion of respondents reported the Kessler-10 (74%), Substance Dependence Scale (64%) and EUROHIS Quality of Life scale (68%) to be 'very useful' or 'extremely useful'. The usefulness of the remaining items tended to be rated lower, with under 50% of respondents reporting that these measures are 'very useful' or 'extremely useful' (Blood Borne Risk Exposure items, 43%; Nicotine Dependence, 46%).

Table 7

Perceived value of COMS for people who reported using COMS (%)

	Not or slightly useful (%)	Moderately useful (%)	Very or extremely useful (%)
Kessler-10	8.1	17.7	74.2
Substance Dependence Scale	11.1	25.4	63.5
EUROHIS Quality of Life	6.5	25.8	67.7
Blood Borne Virus Risk	22.6	34.0	43.4
Nicotine dependence	20.8	33.3	45.8

Note. Only workers who reported using the COMS were included in this table.

Screeners

Workers were asked to reflect on the value of each of the screening items that have been included in the NADAbase. As highlighted in Table 8, between 59% (Domestic Violence Screener) and 73% (Blood Borne Virus and Sexual Health Screener) of respondent's report using the screeners.

Table 8

Use of NADAbase screeners (%)

	Use Screener (%)	Do not use Screener (%)	Unfamiliar with Screener (%)
Domestic Violence Screener	59.4	29.7	10.9
Suicide Screener	68.8	23.4	7.8
Blood Borne Virus and Sexual Health Screener	73.4	20.3	6.3

For just those participants who reported using screeners, they were asked to report their perceived value of using each of the screeners. The suicide screener was considered to be the most useful screener, with 59% of workers reporting that it is 'extremely or very useful' (see Table 9).

Table 9

Perceived value of screeners used in the NADAbase for people who reported using screeners (%)

	Not or slightly useful (%)	Moderately useful (%)	Extremely or very useful (%)
Domestic Violence Screener	21.1	36.8	42.1
Suicide Screener	11.4	29.5	59.1
Blood Borne Virus and Sexual Health Screener	21.3	34.0	44.7

Note. Only workers who reported using the Screeners were included in this table.

Additional items

Workers were asked to reflect on the value of each of the 'additional items' that have been included in the NADAbase. As highlighted in Table 10, between 80% (Children in care question) and 84% (Gender question and Sexuality Question) of respondent's report using the additional items.

Table 10

Use of additional items (%)

	Use Screener (%)	Do not use Screener (%)	Unfamiliar with Screener (%)
Gender question	84.4	7.8	7.8
Sexuality question	84.4	7.8	7.8
Children in care question	79.7	10.9	9.4

The perceived value of the additional items was relatively low, particularly for the gender questions and sexuality question, with 35% and 39% percent of workers respectively reporting that these items were 'not or slightly useful'.

Table 11

Perceived value of additional items used in the NADAbase for people who reported using additional items (n%)

	Not or slightly useful (%)	Moderately useful (%)	Extremely or very useful (%)
Gender question	35.2	33.3	31.5
Sexuality question	38.9	35.2	25.9
Children in care question	17.6	39.2	43.1

Measures and screeners recommended by respondents for addition to the NADAbase

Respondents were asked an open-ended question to identify "what else should be included" in the COMS. Twenty-two percent of respondents (n = 17) reported that there were additional items that they would like to see. For example, five people reported that they would like to see the Australian Treatment Outcome Profile (ATOP) included and two identified the Substance Use Recovery Evaluator (SURE). Individual respondents identified a range of other measures including the Alcohol Use Disorders Identification Test (AUDIT), Cannabis Use Disorders Identification Test (CUDIT), Drug Use Disorders Identification Test (DUDIT), Alcohol and Drug Outcome Measure (ADOM), Depression, Anxiety and Stress Scale (DASS-42), and the Client Satisfaction Questionnaire (CSQ-8). Other domain areas included scales for gambling, suicidality, behavior rating, and treatment outcomes after treatment exit. One worker specifically requested:

> *"a measure that includes medico/social/legal outcomes: e.g. addressing chronic health conditions & STI checks, paying off problem debt, and resolving outstanding legal issues".*
>
> Whilst another worker identified the need for a more comprehensive and detailed assessment:
>
> *"Type of mental health issues, (e.g. anxiety, depression) 2. Length of diagnosed mental health issues 3. History of diagnosed mental health issues in family 4. Length and extent of substance use history 5. Frequency and duration of previous admissions to AoD recovery programs 6. Longest period of abstinence 7. Most helpful strategies remaining abstinent". Other areas respondents identified were: HIV*

status, Hepatitis C and B status. One respondent reported that it would be helpful to have an option to complete the Substance Dependence Scale for "additional drugs of concern".

Another respondent requested:

"Chronic and acute medical conditions (mental and physical): how service has addressed? Medication check - what meds is the client taking, have they been reviewed? Problem debt: amount on intake, amount on exit. Legal problems: nature and number, resolution. Housing issues -on intake and exit. Dental issues - on intake and exit. These outcome measures demonstrate the holistic and case management support provided by services."

Workers were also asked to identify if there were any other screeners they felt should be included in the NADAbase. These included the inclusion of screeners for violence and aggression.

Training and support

As highlighted in Table 12, workers tended to find the NADAbase easy to use, the reports are helpful, and that NADA is a good source of knowledge. Fifteen percent of workers reported that they 'disagree or strongly disagree' that an appropriate amount of training was available to use the NADAbase. With such a high proportion of people who reported 'neutral' for the item "I find the NADAbase tutorials helpful', it is likely that these workers were either not aware of the training tutorials or have not accessed them.

Table 12

Perceptions regarding training and support received for NADAbase users and ease of use of the NADAbase (n%)

	Disagree or Strongly Disagree (%)	Neutral (%)	Agree or Strongly Agree (%)
I received an appropriate amount of training to use the NADAbase	15.0	31.7	53.3

I find the NADAbase tutorials helpful	2.0	46.9	51.0
I find the online NADAbase system easy to use	3.3	24.6	72.1
I find the reports that NADAbase provide useful	3.6	20.0	76.4
NADA is a source of support/knowledge in relation to data collection and reporting	5.0	18.3	76.7

Advantages and challenges of using the NADAbase within the sector

Workers were asked two open ended questions in the survey. "What do you see as the advantages of using COMS" and "Do you have any final comments about the NADAbase?". As responses to these two items tended to overlap, analysis has focused on identifying the areas of strength with using NADAbase, as well as the perceived challenges with using the NADAbase.

Strengths

1. Supporting client care: Clearly the most common strength reported by workers was the value that the NADAbase provides to client care. Numerous qualitative responses were provided that highlighted different aspects of client care that were positively impacted on by the use of the measures and the broader database. At a clinician level, it was described that the NADAbase is "very helpful as a screening tool", it helps to "assess" a client's "current situation", it is used to "inform care plans", and "track how a client is going" across the treatment process. Workers also highlighted how the tools can be useful for clients. For example, one participant reported that:

   > *"It has been helpful to see the client's journey on a scale to work with the client. We sometimes meet with the clients and use the COMS outcome to help the client see their outcome in the past months."*

   Likewise, another participant reported:

"Gives client information they might not have considered previously - their dependence level, the amount they consume, the number of days they use and the number of days when they are unable to work. Gives clients direct feedback about their mood, particularly if they have not previously had any mental health assessments or treatment. Gives clients direct information about change in their circumstances."

2. Higher level planning and reporting: Organisations commented on the usefulness of the NADAbase in "reporting to government". For example, one participant reported that it "makes reporting APD NMDS data to funders straight forward". Managers described using it to provide a broader picture of "client progress" and using it to inform the implementation of "further program strategies to increase improvement for clients in areas where there is not improvement".

3. Ease of use: Workers reported that the NADA COMS "is a quick easy to use tool", that is "well accepted by clients" and is a "useful conversation starter". Another participant reported that the "COMS is a set of standardised outcome measures that are easy to implement and can be used across the sector". Likewise, another participant reported: "The tool is easy to use and easy to interpret, which is important as we have different case workers with different level of experience, knowledge etc." Throughout the survey workers were very complimentary of the NADA staff and support (e.g. "The NADAbase team are very helpful and have been invaluable to our organisation", "Thanks for providing a great system and wonderful support").

Challenges

1. Importers to the NADAbase: Workers reported using their own bespoke systems at their services and importing their data into the broader database. For example, one participant reported that:

"It's hard to answer these questions as COMS is a small part of our system of reporting outcomes, prems and proms. We don't log into NADAbase to do it. Even though we use it, we access it through our tailored software package specific to our organisation".

Subsequently, workers working at services where data was imported into the NADAbase tended to see lessor value in the NADAbase (e.g. they didn't use the dashboard or reports). For example, some workers questioned the resources spent in maintaining the NADAbase: "Is the NADAbase a good investment for a sector that has such a broad range of needs? We don't know anyone without their own data management system". Whilst other workers hoped that the NADAbase might "grow into a full client management system into the future".

2. Exporting reports and data: Some workers described some technical challenges with using the NADAbase. Services looking to use the data for more advanced evaluation or research purposes described difficulties with the data exports. For example, one participant reported:

   "My main role is to use the data collected by the other staff for research purposes. My main struggle with the NADABASE is how data is extracted into Excel. It is not analysis friendly, when needing to do statistics in SPSS. It takes many hours of cleaning the data so that variables are in the correct format. Perhaps work more closely with people who export and analyse the data to find out how the NADAbase could be better structured at the backend".

   Another participant reported difficulties with uploading data to the NADAbase:

   "The NADAbase import process for organisations with bespoke systems seems archaic. Comma delimited text files - although simple in terms of data format- is a pain to handle on a monthly basis. Maybe an API could be developed in the future to allow automated data transfer?"

A challenge reported by several workers was the variety of information and reports required by different funding bodies. Whilst some reporting functions in the NADAbase met their needs, often greater flexibility in reporting requirements was needed.

3. Training and organisational support: Although not the case for all workers, there were some people who identified the need for their own "further training". Likewise, workers acknowledged the high turnover rates in the field and the need to provide "ongoing" training for the sector. Ideally this training would include "how to administer the screen(s) or how to utilise the information in treatment planning". Some workers commented that there had been a lack of organisational support for the use of the NADAbase (e.g. "We haven't been encouraged to use it much").

4. Appropriateness of the measures: As highlighted above, workers reported some hesitation with some of the measures being used. For example, one participant suggested "Ditch the screening - services do this themselves, and the real interest is in outcomes." Likewise, another participant reported: "Screeners from the site are not used at all and we are unsure why NADA provides them?" Other workers advocated for the use of measures not currently included in the NADAbase:

   > *"I have suggested the addition of the SURE, as this is the outcome measure we are currently using. The SURE captures information across a range of areas in one measure and also has the advantage of being developed by consumers and so uses much more considered language than some other measures."*

   A couple of workers reported limitations with the SDS (e.g. "SDS is a bit useless and confusing for resi rehab", "I don't find the SDS helpful as an outcome measure as insight into use improves and motivation for change increases, their scores actually get 'worse'"). However, another participant requested that the use of the SDS be expanded:

   > *"I'd love to see the capacity to complete and SDS for more than one drug of concern. Many clients are polydrug users and it would be useful to track their sense of dependency on more than one substance, particularly if that changes from one to another over time."*

5. Work setting and client characteristics: Several workers reported challenges with using the NADAbase within "outreach" settings. For example, one participant reported that "it is too time consuming to

undertake multiple surveys when working in an outreach setting. Surveys would first have to be completed on paper and then transferred into NADAbase". Additionally, multiple workers highlighted "literacy issues" with using the NADAbase assessments.

Summary and conclusions

The purpose of the current project was to examine the experience of AOD workers in using the NADA COMS, and more broadly the NADAbase, to support AOD service delivery. The survey included a combination of open-ended qualitative questions and quantitative surveys. Overall, the report provides a picture of the use of the NADAbase across the sector, drawing on views from managers and direct client care staff.

Limitations

There are a number of limitations to consider when reviewing the results from this survey. The sample size is relatively small as only 84 people completed the online survey. It is possible that the results from this survey do not represent the broader views of the sector. A further limitation is that the survey only examined self-reported behaviours from the workers perspective. Future evaluation would benefit from examining the 'actual' practices of workers and the perspectives of clients attending these services. Another limitation is potential confusion by workers regarding the terminology within the NADAbase. As indicated in the qualitative interviews, workers often confused the difference between the NADAbase and the NADA COMS. Likewise, it was common for workers to use the terms 'screeners' and 'measures' interchangeably. The terms used to describe the screeners are quite generic (e.g. Suicide Risk Screener). It is possible that workers confused the use of the screeners within the NADAbase to the screeners that are used at individual sites. This may have potentially increased the proportion of people who indicated using these screeners. None the less, the survey does capture the views of both managers and direct client staff and is well represented by workers working across residential and outpatient settings. Likewise, there was diversity in responses, providing a range of perspectives on the NADAbase.

Summary of findings

Overall, the results of the survey indicated that AOD workers see the value of using ROM to inform both individual client care and to assist with broader service activities (e.g. planning, reporting to funding bodies). This was most apparent in the qualitative aspects of the project, where workers gave numerous examples of where they have used the COMS to improve their practice and inform individual client care. The most widely used measures in the NADAbase are the K10, SDS and the EUROHIS Quality of Life Scales (over 80% of workers surveyed indicated that they used these measures). These three measures were also the most highly endorsed in terms of 'value' to the AOD workers. In contrast, the screeners and 'additional items' were less used and tended to be more likely to be rated as 'not or slightly useful'. It is possible that this is the result of these measures being more recently introduced and not being fully integrated within services. They are also more likely to be important under specific contexts (e.g. a client who identifies a gender other than male or female, a person who is at risk of domestic violence).

As reported in the broader literature[10], encouraging workers to continue to use ROM as part of ongoing care is a challenge. In the current study, 69% of workers reported that they 'always or most of the time' ask clients to complete COMS (see Table 6). However, less than half of workers reported that they 'always or most of the time' review the results of the COMS (49%), discuss the results of the COMS report with client (40%), or use the results from the COMS report when planning sessions (39%). More concerning is that only 27% of workers reported that they systematically used NADA COMS during the past 6-months (i.e. asked participants to complete NADA COMS, reviewed the results, discussed the results with clients, and used the results to inform treatment planning). It is potentially very de-motivating for clients if they go to the trouble of completing an outcome measure, but they never get feedback about it or it is never reviewed by the worker. There are clearly some challenges for the sector in improving the use of ROM to support ongoing client care. It is likely that the NADAbase is best integrated in those services where it is highly supported by management and the results are routinely reviewed as part of ongoing client care (e.g. team meetings). Likewise, workers that hold more positive attitudes towards the use of ROM are more likely to implement it systematically as

part of their work. As part of the NADA base tutorials, it may be useful to develop resources that help to improve the attitudes of workers regarding ROA. Similar approaches have been demonstrated to work within the Australian mental health sector[14].

As highlighted in the *challenges* section of the results, workers identified a number of areas for improvement within the NADAbase. Workers who reported using their own bespoke data management systems tended to see less of a value with using the NADAbase. There were requests from multiple workers to expand the NADAbase to provide more flexible reports and potentially a more comprehensive client management system. Likewise, workers also reported challenges with working with the excel files downloaded from the NADAbase (i.e. "It is not analysis friendly") and uploading data into the system. Whilst a strength of the NADA COMS is that it is "easy to use and easy to interpret", several workers reported a lack of training and support in using it as part of their routine care. It is possible that these workers were not aware of the NADAbase tutorials, with only a very small proportion of workers (2%) indicating that these tutorials were not helpful. There was some suggestion from workers that different or additional measures should be included within the NADAbase. For example, the Australian Treatment Outcome Profile was suggested by 5 people and 2 people suggested the Substance Use Recovery Evaluator (SURE). There was a diverse range of other measures suggested. There are strengths to the sector with collecting the same measures across services (e.g., benchmarking, examining sector wide trends). Any changes to the current measures should be well considered by NADA and the broader sector.

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APPENDIX 2

ATOP Mapping Report

NADA
network of alcohol and other drugs agencies

NADAbase and ATOP Mapping

July 2018

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non government alcohol and other drugs sector in NSW.

NADA's goal is to lead as a member driven peak body, building sustainable non-government alcohol and other drug organisations to reduce alcohol and drug related harms to individuals, families and communities in NSW.

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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 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 after-care 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.

Preparation of this position paper

This paper was prepared by Associate Professor Peter Kelly, School of Psychology, University of Wollongong. The report was informed by interviews with staff from NADA (Dr Suzie Hudson, Ms Cassandra McNamara) and the ATOP Project leads (Prof. Nick Lintzeris, Ms Jennifer Holmes, Ms Kristie Mammen). It also included involvement in the NADAbase Expansion Project Steering Committee and a review of the research literature.

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1. Overview of the ATOP and the NADAbase

The following provides a brief description of the development and makeup of the ATOP and the NADAbase.

1.1 Australian Treatment Outcome Profile (ATOP)

The Treatment Outcome Profile (TOP) was established in the United Kingdom (UK) as a brief tool to monitor substance dependence treatment (Marsden et al., 2008). A validation study was conducted that examined its use across 63 treatment agencies in the UK that included opioid substitution treatment, psychosocial interventions, in-patient detoxification, and residential rehabilitation (N = 1021; Marsden, et al., 2008). The authors concluded that the instrument was reliable and valid in these settings. Domains measured by the TOP include substance use, injecting risk behaviour, education and employment, criminal behaviour, accommodation, psychological health, physical health, and quality of life. The TOP is completed as a clinician delivered interview and takes about 15-minutes to complete. The TOP does not include a total score across all items, rather, it includes a series of individual items that capture aspects of these broad domains (see appendix for the scale).

The ATOP is an adaptation of the Treatment Outcome Profile (TOP) measure. Development of the ATOP was led by the ATOP Project Team, a group of researchers, and senior clinicians working in Australian alcohol and other drug treatment services (Ryan et al., 2013). The purpose of this group was to establish a brief and reliable measurement tool that was appropriate for an Australian setting. The ATOP retains the core components of the TOP, however, it has several significant differences (see Ryan, et al., 2013). This included refining the drug use categories to be more applicable to an Australian setting (e.g. removing 'crack' from the list of substances) and simplifying the criminal activity questions to improve reliable reporting (see Luty, Varughese, & Easow, 2018). Following client and clinician

feedback regarding “ease of comprehension and reporting” of the psychological, physical and quality of life items (Ryan, et al., 2013), a decision was also made to change the rating scale for these three items. The TOP used a 21-item scale (0 to 20) and the ATOP uses an 11-item rating scale (0 to 10). Like the TOP, the ATOP does not include a total score. It includes a series of individual items that can be used be used to ‘screen’ or track changes across time. This means that researchers or clinicians can either use the complete measure or select individual items as clinically appropriate. The ATOP is 24-items in length (see appendix).

The ATOP Project Team have now published a series of studies validating the ATOP for use in an Australian treatment setting. This included examining its use in outpatient opioid treatment settings (N = 131; Ryan, et al., 2013) and amongst a cross sectional sample of people aged 50 years or older (n = 69 attending opioid substitution therapy, n = 30 attending counselling; Lintzeris et al., 2016). The psychometric properties of the ATOP were broadly consistent with the results found in the initial TOP validation study (Lintzeris, et al., 2016; Marsden, et al., 2008; Ryan, et al., 2013). The Ryan study included a small qualitative component that examined clinician ratings of the utility and acceptability of the ATOP (N = 20; Ryan, et al., 2013). The highest rated items were “the ATOP is appropriate for my client population group” (85% “strongly or somewhat agree”), “the format and style of the ATOP are easy to understand and follow” (85% “strongly or somewhat agree”), and “the ATOP was easy to administer” (80% “strongly or somewhat agree”). The lowest rated items were “the ATOP was useful in identifying important problems the client had (45% “strongly or somewhat agree”) and “I would be happy to use the ATOP as part of regular client reviews (45% “strongly or somewhat agree”).

In addition to the research examining the TOP (e.g. Dalton, Crowley, Crouch, & Kelly, 2016; Delgadillo et al., 2015; Eastwood et al., 2018; Luty, et al., 2018; Marsden et al., 2014; Marsden et al., 2009; Marsden et al., 2012; Marsden, et al., 2008; McClure, Acquavita,

Dunn, Stoller, & Stitzer, 2014), there are now a series of papers that have used the ATOP within an Australian setting (Allsop et al., 2017; Barker et al., 2016; Bathish et al., 2017; Dore, Sinclair, & Murray, 2016; Lintzeris, et al., 2016; Mitchell, Kutin, Daley, Best, & Bruun, 2016; Ryan, et al., 2013; Savic, Barker, Best, & Lubman, 2014). Interviews with The ATOP Project Team indicated that the ATOP is now used throughout government provided alcohol and other drug services in NSW. At the time of interviewing the ATOP Project Team, data was not available on the extent to which the ATOP was being 'routinely' used across these services. However, this data is currently being collected within the NSW Health data management system and the ATOP Project Team are in the process of analysing this data.

1.2 NADAbase

As reported on the NADA website, NADA developed a project in 2008 to improve the use of routine outcome assessment measurement within the NSW non-government alcohol and other drug treatment sector. A steering committee was established that included representation from the NADA membership, NSW Ministry of Health, and external experts in the areas of research, data management, mental health and drug and alcohol policy and service delivery. The first stage in the development of this project was the completion of a comprehensive literature review on the use of routine outcome assessment measures in the alcohol and other drug treatment sector (Deady, 2009). The TOP was reviewed as part of this process for possible inclusion as a routine outcome measure within the non-government sector.

Following the literature review, and in consultation with the steering committee, NADA developed the Client Outcomes Management System (COMS). This system was designed to broadly measure key domains in the field:

(1) Drug and alcohol use;

(2) Psychological health;

(3) Physical health and social functioning; and

(4) Blood borne virus exposure risk.

A requirement for a measure to be selected for the NADA COMS was that it was brief, had strong psychometric properties, and was routinely used in health settings (NADA, 2012). The NADA COMS included the Kessler-10 scale (K10; 14 items), Substance Dependence Scale (SDS; 6 items), the World Health Organisation EUROHIS quality of life scale (EQoL; 8-items) and items taken from the Brief Treatment Outcome Monitoring tool (see appendix for a detailed description of these items). In total, the NADA COMS is 51-items in length, can be completed as a self-report measure, and takes approximately 15-minutes for participants to complete (NADA, 2012, p. 1246). The NADAbase is an online database, maintained by NADA, that stores the NADA COMS and the Minimum Data Set for the NGO sector. The NADAbase produces individual client reports that the clinician can review with their clients (NADA, 2012). Likewise, service providers are able to download reports and data from the online system. As part of the NADAbase Expansion Project, three additional screening measures have been included within the NADAbase. These include a suicide screener, domestic violence screener, and a 'blood-borne virus and sexual health screener' (see appendix).

A report detailing data collected within the NADAbase has been published (N = 3682; Kelly, Deane, Baker, & Keane, 2014). This included providing a snapshot of the client profile of people attending treatment, as well as using reliable and clinically significant change to examine rates of client progress amongst people attending residential programs. As of the 30th June 2017, The NADA COMS had been completed by over 20,000 unique clients attending NGO alcohol and other drug treatment services in NSW (NADA Snapshot Report 2016 to 2017). Reports from NADA indicate that in the previous finalcinial year 83 services

used the NADA COMS. The most recent NADAbase Snapshot indicates that of those participants who complete a NADA COMS at baseline and stay for at least 90-days, 73% complete a second NADA COMS assessment, and 42% complete a third NADA COMS assessment (NADA Snapshot Report 2016 to 2017). Due to the large numbers of clients who have completed NADAbase assessments, sub-analysis of specific client population groups within the NADAbase has started to be conducted. For example, a recent publication used latent profile analysis to examine the polysubstance use of people who inject methamphetamine (N = 827; Kelly et al., 2017). Likewise, service providers have started to use the NADAbase to benchmark their program activities (Kelly et al., 2018b).

2. Comparison between the ATOP and NADAbase

The following section provides a comparison of the ATOP with the items and scales included within the NADAbase. It is important to note that the NADAbase includes an extended range of items that cover domains not included in the ATOP (e.g. substance dependence, suicide screening, tobacco dependence, blood-borne virus and sexual health). However, this review focuses on the items covered by the ATOP and the extent to which they match or overlap with the items in the NADAbase.

2.1 Substance use frequency: A very widely used measure of substance use and substance use outcomes is the calculation of the total days of use within a designated time period. This approach is generally improved when it is completed using the Timeline Follow Back procedures (Sobell, Brown, Leo, & Sobell, 1996; Sobell & Sobell, 1992). In both the ATOP and NADAbase, clients are asked to report the number of days they have used (past 28-days) for specific drug types (e.g. heroin, alcohol, amphetamines). Within the literature, the substance use items from the TOP are the most commonly reported 'outcome' measures. For example, the developers of the TOP have used these substance use items to measure the effectiveness of inpatient withdrawal and residential rehabilitation (Eastwood, et al., 2018) and the effectiveness of community treatments for heroin and cocaine (Marsden, et al., 2009). It is important to note that the frequency of substance use is not likely to be very relevant for people who are attending longer-term controlled environments (e.g. residential rehabilitation programs). For both the ATOP and the NADAbase, the quality of the data collected will largely depend on how well the timeline follow back procedures are followed.

2.2 Injecting risk behaviour: The ATOP and NADAbase are very similar in the way that they measure injecting behaviour (i.e. injecting frequency and the use of unsafe injecting

procedures). The main difference is that the ATOP is focused on total days injected in the past 28-days, whilst the NADAbase just identifies when the person last injected (e.g. last three months, never injected). The focus on the past 28-days is likely to be a useful way to track changes in injecting frequency at follow-up time points. However, frequency of injecting drug use is also likely to be highly correlated with the number of days that each person has used specific substances (e.g. heroin, amphetamines). There is also variability in the way that unsafe injecting procedures are asked (i.e. single question for ATOP, NADAbase separates sharing needles and sharing other drug use equipment into two questions). From a treatment perspective, both the ATOP and NADAbase are measuring the same constructs. It is not clear what additional value measuring total days "injected" in the past 28 days would serve for the NADAbase (as it is likely to be highly correlated with days of substance use). The literature review did not identify any articles using the TOP or ATOP that used this item to report changes in clients behaviours. However, NADA could consider including this additional item if it was viewed as being important.

<u>The ATOP asks two questions about injecting drug use:</u>

- Total days "injected" in the past 28 days
- Total days "inject with equipment used by someone else" in the past 28 days

<u>NADAbase asks three questions about injecting behaviour taken from the BTOM:</u>

- When did you last inject/hit up any drug?
    - In the last three months
    - More than three but less than twelve months ago
    - Twelve months ago or more
    - Never injected

- Not stated inadequately described

- How many times in the last 3 months did you use a needle or syringe after someone else had already used it (including your sex partner and even if it was cleaned)?
  - More than ten times
  - Six to ten times
  - Three to five times
  - Twice
  - Once
  - Never

- In the last 3 months did you share any spoons, filters, water, tourniquets, drug solution/mix, or swabs with anyone else? (please circle) Y/N

Education and employment: Both the ATOP and NADAbase measure the domains of education and employment. The NADAbase does not currently include a specific measure of total days of work or education during the proceeding 28-days. From a treatment perspective, both the ATOP and NADAbase are measuring the same constructs. Like the injecting risk behaviour items, the literature review did not identify any articles using the TOP or ATOP that used the days employed or days engaged in education to report changes in clients behaviours. However, NADA could consider including this additional item if it was viewed as being important.

<u>The ATOP includes two questions about employment and education:</u>

- "Days of paid work" in the past 28-days

- "Days at school, tertiary education, vocational training" in the past 28-days

The NADAbase includes 4 items that measure aspects of employment and education:

- Principal Source of Income:
    - Full-time employment
    - Part-time employment
    - Temporary benefit (e.g. sickness, unemployment)
    - Pension (e.g. aged, disability)
    - Student allowance
    - Dependent on others
    - Retirement fund
    - No income
    - Other
    - If other, please specify _____
    - In the last four weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings?_____days (K10)

    - [Aside from those days], in the last four weeks, HOW MANY DAYS were you able to work or study or manage your day to day activities, but had to CUT DOWN on what you did because of these feelings?_____days (K10)

    - Have you enough money to meet your needs? (EQoL)
        - Not at all
        - A little

- Moderately
- Mostly
- Completely

2.3 Crime: The TOP included a series of questions examining criminal involvement (e.g. shoplifting, selling drugs, committing assault). However, after concerns with the valid reporting of these behaviours, the ATOP was reduced to two items (Luty, et al., 2018; Ryan, et al., 2013). Both the ATOP and NADAbase ask questions about arrests. From a clinical utility perspective, they are serving very similar functions. NADAbase obtains more detail regarding the frequency of arrests and when the offences were allegedly committed. The ATOP includes a question on 'violent' behaviour, which might be a clinically useful question for clinicians to ask.

<u>The ATOP includes two questions about crime:</u>

- "Have you been arrested" in the previous 28-days (yes or no)
- "Have you been violent (including DV) towards someone" in the past 28-days (yes or no)

<u>The NADAbase also includes two questions about crime taken from the BTOM:</u>

- How many times in the past three months have you been arrested?_____times
- How many of these arrests were for offences allegedly committed in the past three months?_____arrests

Accommodation: Both the ATOP and NADAbase collect similar information in this domain. Both identify homelessness. The ATOP specifically asks about 'risk of eviction',

whilst the NADAbase asks about overall 'satisfaction' with living conditions (taken from the EQoL). Likewise, both assessments collect information on whether the person has been living with children during the proceeding period. An advantage of the items used in the NADAbase are that they could potentially be used to classify different types of homelessness and help to track people moving in and out of homelessness (e.g. people moving from primary to secondary homelessness). For example, Chamberlain and MacKenzie's identified "primary", "secondary" and "tertiary" types of homelessness (Chamberlain & Mackenzie, 2016, p. 291). Primary homelessness accords with rooflessness and include persons without conventional accommodation (i.e. no usual residence/homeless). Secondary homelessness refers to persons who move frequently from one form of temporary shelter to another and have no usual address (e.g. crisis/short-term accommodation, hostel, shelter/refuge). Tertiary homelessness includes persons who live in boarding houses on a medium to long-term basis defined as 13 weeks and longer (e.g. boarding house). From a clinical utility perspective, both the ATOP and the NADAbase are measuring the same domains (i.e. homelessness, risk of homelessness, usual accommodation).

The ATOP includes three items:

- Have you been homeless? (Yes or No)
- Have you been at risk of eviction? (Yes or No)
- Have you, at any time in the past four weeks, been a primary caregiver or living with any child/children (Yes or No)

The NADA COMS includes three items:

- Living Arrangement:
    - Rented house or flat (public or private)

- Privately owned house or flat
- Boarding house
- Hostel
- Psychiatric home/hospital
- Alcohol/other drug treatment residence
- Shelter/refuge
- Prison/detention centre
- Caravan on serviced site
- No usual residence/homeless
- Other
- If other, please specify _____

- Usual Accommodation:
  - Alone
  - Spouse/partner
  - Alone with child(ren)
  - Spouse/partner with child(ren)
  - Parent(s)
  - Other relative(s)
  - Friend(s)
  - Friend(s)/parent(s)/relative(s) and children
  - Other
  - If other, please specify _____
- How satisfied are you with the conditions of your living place? (EQoL)
  - Very dissatisfied

- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very satisfied

Domestic violence: Both the ATOP and NADAbase provide a measure of domestic violence. The ATOP includes a single item that captures 'violence' towards the person. The NADAbase also includes an item on violence towards the person, that is more specifically focused on family or relationship violence (see below). The screener also examines ongoing risks to the person and other family members (see appendix for complete screener).

<u>The ATOP includes a single item measuring DV:</u>

- "Has anyone been violent (including DV) towards you"? (Yes or No)

<u>The NADA base includes a comprehensive 7-item screener. An example item focused on violence is included below:</u>

- In the last 12 months, has someone in your family or someone you were in a relationship with pushed, hit, kicked, punched, grabbed you around the neck or otherwise hurt you?

  ☐ Yes

  ☐ No

  ☐ Don't wish to say

  ☐ Did not ask

2.4 Health and quality of life measures: The TOP and the ATOP include three items that measure psychological health, physical health and quality of life. Outside of the substance use frequency items used in both the ATOP and NADAbase (see 2.1), these three items are what are most commonly reported in the academic literature (Barker, et al., 2016; Bathish, et al., 2017; Best et al., 2016; Dalton, et al., 2016; Mitchell, et al., 2016; Savic, et al., 2014). However, there is limited published research on the use of these items examining longitudinal change (Dalton, et al., 2016).

2.4.1 **Psychological health:** Both the ATOP and NADA COMS include a measure of psychological health.

The ATOP includes a single item that broadly measures "anxiety, depression, problem emotions and feelings".

- "Clients rating of psychological health status (anxiety, depression and problem emotions and feelings)". This item is rated on a 11-point scale from 0 (Poor) to 10 (Good).

The NADAbase uses the *Kessler-10 Plus* to measure psychological distress *(K10; Kessler et al., 2003)*. The K10 Plus is composed of the original 10-items from the K10. These items are rated on a 5-point scale (1 = 'None of the time', 5 = 'All of the time') and they provide a total summed score that indicate the level of psychological distress. Items predominantly measure symptoms associated with depression (e.g. "In the last four weeks, about how often did you feel hopeless) and anxiety (e.g. "In the last four weeks, about how often did you feel nervous"). The K10 has been widely used in population-based research and has been demonstrated to have good psychometric qualities (Andrews & Slade, 2001; Kessler, et al.,

2003). Previous evaluations of the use of the K10 within the NADA COMS has found it to have high internal consistency (α = .91). The K10 is one of the most widely used measures of psychological distress internationally and there is a large body of published data reporting its use. In the original validation study of the ATOP, the psychological health status item was validated against the K-10 as the "gold standard' measure. A moderate to strong correlation was found (r = .59; Ryan, et al., 2013), suggesting that they are measure similar constructs.

2.4.2 **Physical health:**

The ATOP and NADA COMS include a very similar measure of global physical health. Both items ask the person to rate their over "health". The main difference between these items is the rating scale used (see below). It is very likely that these two items would be significantly correlated.

The ATOP includes a single item measuring physical health status:

- "Clients rating of physical health status (extent of physical symptoms and bothered by illness). This item is rated on a 11-point scale from 0 (Poor) to 10 (Good).

NADA COMS also includes a single item that measures physical health status:

- How satisfied are you with your health? (item 2 of the EQoL)
    - Very dissatisfied
    - Dissatisfied
    - Neither satisfied nor dissatisfied
    - Satisfied
    - Very satisfied

2.4.3 Quality of life:

The NADAbase uses the EUROHIS Quality of Life Scale (EQoL). The EQoL is an 8-item, brief measure of quality of life (Schmidt, Muhlan, & Power, 2005). It is a shortened version of the World Health Organisation Quality of Life-100 Scale. The EQoL has questions that examine psychological ("How satisfied are you with yourself?"), physical (e.g. "How satisfied are you with your health?"), social ("How satisfied are you with your personal relationships") and environmental (e.g. "How satisfied are you with the conditions of your living place?") aspects of quality of life. Each item is rated on a 5-point Likert scale. Summing each of the items produces an EQoL total score. In the NADAbase, the EQoL has been found to have high internal consistency (α = .86). The EQoL is a widely used measure. For example, it was recently used in a large US based national study examining the indicators of recovery form substance dependence (Kelly, Greene, & Bergman, 2018a).
The first item of the of the EQoL is almost identical to the single item measure used in the ATOP. The main difference is the rating scale used (see below). In the original ATOP validation study, these two items were found to be strongly correlated (r = .72), suggesting that they measure the same construct.

<u>The ATOP includes a single item measuring physical health status:</u>

- "Clients rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner, satisfied with living conditions). This item is rated on an 11-point scale from 0 (Poor) to 10 (Good).

<u>The NADAbase include the following item:</u>

- "How would you rate your quality of life?"
    - Very poor

- Poor
- Neither poor nor good
- Good
- Very good

3. Discussion: Inclusion of items from the ATOP within the NADAbase

As outlined by Ryan, et al. (2013), there are a number of possible applications for the use of the ATOP within alcohol and other drug treatment services. These broadly include:

- Improving clinical care (e.g. feedback to clients, assist in care plan, improve clinical communication),
- Assisting in service evaluations by measuring "clinical outcomes", and
- Enabling benchmarking across services with a standardized measure

The following section discusses these possible applications in relation to including the ATOP within the NADAbase.

3.1 Improving clinical care:

One advantage with using routine outcome assessment tools is that they can potentially be used to enhance client care. For example, there is a strong body of research suggesting that client outcomes are enhanced when clinicians regularly use outcome assessment tools, review the results, and discuss these results with their clients (Lambert & Lo Coco, 2013; Lambert et al., 2003). In collaboration with the client, this information can be used to develop or modify the persons care plan.

The NADAbase currently has a well-developed online platform to support the collection and reporting of assessment results within the NADAbase. As reported by the NADA team, training conducted by NADA reinforces the importance of service providers to review assessment results and to discuss these with clients. From a feedback perspective to clients and clinicians, there does not appear to be an advantage of including the ATOP within the NADAbase. As detailed in Section 2, the ATOP and NADAbase screen and assess the same clinical domains (i.e. substance use, injecting risk behaviour, education and employment, criminal behaviour, accommodation, psychological health, physical health, and quality of

life). There are some slight variations in the way that these domains are measured, however, from a clinical utility perspective they are essentially serving the same function. It is unlikely that including the ATOP within the NADAbase would result in any meaningful improvement in client care over and above the current item set. Likewise, as there is considerable overlap, it is unlikely that including the ATOP within the NADAbase would enhance clinical communication. Due to the overlap in the items and domains assessed, the ATOP and NADAbase already 'speak the same language'. A strength of the NADAbase is that it already incorporates well established scales (e.g. K10, EQoL) that are widely used across the broader health field (e.g. general practitioners, mental health sector). The use of these measures may help to promote clinical communication with the broader health sector.

3.2 Assisting in service evaluations by measuring "clinical outcomes"

To conduct rigorous service evaluations, it is important to collect sufficient descriptive data to accurately describe the population. It is also important to collect key process and outcome variables to effectively measure 'important' outcome domains. As outlined in Section 2, the NADAbase currently includes a broad range of well validated and widely used measures. The ATOP and the NADAbase measure the same domains and there is very high overlap in the types of items used. This includes the substance use frequency questions that are also used in the TOP and ATOP and have been used to conduct large scale evaluations of alcohol and other drug services in the UK (Eastwood, et al., 2018; Marsden, et al., 2009; Marsden, et al., 2012). Additionally, the NADAbase includes several very widely used and well validated measures (e.g. K10, SDS, EQoL). It is unlikely that including the ATOP within the NADAbase would improve the 'clinical outcomes' already being measured in the NADAbase.

An additional factor when considering the appropriateness of 'clinical outcomes' is ensuring that the most appropriate analyses can be used to inform rigorous service evaluation. Across the broad health and psychotherapy literature, there have been increasing calls to move beyond the calculation of statistically significant change to evaluate services. The use of reliable change indices is now widely recommended, as these approaches help to demonstrate the proportion of people who make reliable change (i.e. the proportion of people who either improve or deteriorate; Jacobson & Truax, 1991; Lambert & Ogles, 2009; Marsden et al., 2010). The substance use frequency items from the TOP have been used in several studies that have involved the calculation of reliable change indices (Dalton, et al., 2016; Marsden, et al., 2010). For example, using the substance use frequency items from the TOP (heroin, crack, cocaine powder, and alcohol), Marsden, et al. (2010) concluded that the Jacobson and Truax Reliable Change Index was the "optimal measure of change for evaluations of treatment for substance use disorder" (p. 294). Currently, reliable change can be calculated using the ATOP or the NADAbase. As reported by the ATOP Project Team, work is currently being conducted by their group to calculate rates of reliable change using the ATOP. Likewise, results have previously been presented demonstrating rates of reliable change using data from the NADAbase (Kelly, et al., 2018b; Kelly, et al., 2014).

An extension to the Jacobson and Truax Reliable Change Index is the calculation of clinically significant change (Jacobson & Truax, 1991). This involves determining the proportion of people who move from a position that is typical of a dysfunctional population (e.g. people attending substance dependence treatment), to a population that is more functional (e.g. people from the general population). Whilst clinical change can be calculated using sample specific parameters (see Jacobson & Truax, 1991), it is generally recommended that normative data is used to calculate clinical change indices (Lambert & Ogles, 2009). As the ATOP health and wellbeing items were developed specifically for the ATOP, there is not

currently population-based norms, and there is a lack of other comparative data to inform service evaluations or benchmarking activities. The availability of Australian and international normative data for both the K10 and EQoL is a significant strength of the NADAbase (e.g. ABS National Health Survey; Kelly, et al., 2018a; Schmidt, et al., 2005).

3.3 Enabling Benchmarking across services with a standardized measure

Benchmarking is a structured approach to comparing processes or outcomes with the purpose of identifying areas for improvement, stimulating innovation, and ultimately aiming to improve overall client care. There are a number of different ways to conduct benchmarking. This might include 'internal' benchmarking, where a team or service might benchmark their activities against other similar teams or services. It could also involve teams, services, or organizations benchmarking their outcomes against 'external' teams, services or organizations. Within the academic literature there is an increasing number of benchmarking studies that compare results found in routine practice to results obtained in randomized controlled trials or against other normative data (also see 3.2; Oei & Boschen, 2009; Westbrook & Kirk, 2005). From a broader governance perspective, it may also be of interest to funding bodies to make comparisons between different service providers to compare the 'quality' of care.

To effectively conduct benchmarking, it is important that the metrics being collected are directly comparable. As outlined in Section 2, there is a large degree of overlap in the items being used in the NADAbase and the ATOP. Where these items are the same, benchmarking activities could easily be completed between a team using the ATOP and another team using the NADAbase (e.g. substance use frequency). However, where the items are worded differently or alternate time frames are used (e.g. 28-days compared to 3-months), benchmarking becomes more challenging. For example, it may be difficult to benchmark the

three ‘health and quality of life’ items in the ATOP with the NADAbase. Whilst these three items correlate moderately to strongly with the items or scales used in the NADAbase (see Section 2), scores on these items will not necessarily be directly comparable. To effectively conduct benchmarking, it is important that consistent measures are used. For example, as identified in Section 2, if ‘days of paid employment’ was considered an important outcome for the sector, NADA could consider including this item from the ATOP within the NADAbase.

Caution is recommended if the sector or funding bodies are considering using single item measures for comparison or benchmarking activities. Whilst single item measures have considerable clinical utility and they are efficient to use, caution is recommended when they are used to conduct formal evaluations. As described by Hoeppner, Kelly, Urbanoski, and Slaymaker (2011);

“single-items are more vulnerable to random measurement errors, which are more likely to be cancelled out with multiple items. Single items may also be more vulnerable to unknown biases in meaning and interpretation. Multiple-item scales are designed to sample a broader range of meanings to cover the full range of a construct, while with single items, the respondent is left with greater ambiguity to interpret the meaning of the item.”

Of concern with the single item measures used in the ATOP, is that the each of the wellbeing items are measuring quite broad domains. For example, the psychological health measure requires participants to rate their average “psychological health status” by considering their “anxiety, depression and problem emotions and feelings” over the past 28-days. This is a challenging task for clients and is likely to be influenced by a range of factors, including the level of training and the interviewing styles of the clinician delivering the item. It is likely that the scores reported in the NADAbase for the K10 will provide a more reliable measure of psychological distress. Likewise, the 8-item measure of quality of life used within

the NADAbase is likely to provide a more reliable measure of quality of life compared to the single item measure used in the ATOP.

4. Summary and Recommendations

Both the ATOP and the NADAbase are significant achievements for the alcohol and other drug treatment sector in Australia. It is impressive how the ATOP Project Team have conducted a systematic program of research that has focused on validating the ATOP scale within an Australian context and implementing it across services. The increasing use of the scale across different Australian research and clinical settings speaks to the value of the tool. Likewise, the development of the NADAbase has been an extremely important project for the non-government alcohol and other drug sector. Based on a comprehensive literature review, NADA have established a routine outcome assessment system that is now widely used across the sector. With over 20,000 initial NADA COMS assessments now completed, NADA have successfully established an extremely important resource for their members and the broader sector.

As highlighted throughout this report, the ATOP and NADAbase are very similar. They both measure the same broad domains and there is considerable overlap in the questions that are used. For example, the ATOP is 24-items in length and 9 of the items are directly comparable (substance use frequency items). From a clinical care perspective, there does not appear to be any advantage in including the ATOP within the NADAbase. It does not provide any additionally significant information that is not already collected within the NADAbase. Likewise, from a service evaluation perspective, there would not appear to be an advantage in including the ATOP within the NADAbase. The items and scales used in the NADAbase are taken from widely used and well validated scales that are directly comparable, and have substantially greater psychometric research validation data available, than the items used in the ATOP (i.e. K10, EQoL). In their current forms, both the ATOP and NADAbase can be used to calculate reliable change indices to determine the proportion of people who demonstrate reliable improvement or deterioration. Additionally, there is normative

population-based data and published research studies using the K10 and EQoL (and the SDS) that can be used by service providers to evaluate the clinical effectiveness of their services.

A limitation with the alcohol and other drug treatment services using different measures is that it limits the potential to compare services or conduct benchmarking between services who use the ATOP and services that use the NADAbase. If this is a priority for the sector, NADA could consider including specific items from the ATOP within the NADAbase. Alternatively, consideration could be given to including additional items or scales within the ATOP. However, this should be carefully considered. It would be important to determine how the data would be combined and what the purpose of combining this data would be. As demonstrated in Section 2, there is considerable overlap in the wording of the items used between the ATOP and NADAbase. Adding the same items, with slightly different rating scales, is likely to be frustrating for clients to complete (e.g. quality of life or physical health items within the EQoL). Likewise, changing the existing response scales within the NADAbase to match the ATOP would mean that EQoL total score could not be calculated. There would also be training and resource issues associated with including items from the ATOP within the NADAbase. The ATOP has been validated as a clinician delivered interview, whilst the NADAbase can be completed as a self-report measure. It is important that frontline workers are appropriately trained to administer any new items included in the NADAbase.

Establishing and maintaining a routine outcome monitoring database is a huge challenge. It is a credit to NADA that they have been able to engage the sector and promote the regular completion of outcome measures across a range of service providers. A major strength of the NADAbase is the amount of routine data that has been collected and continues to be collected. Should changes be made to the NADAbase it is strongly recommended that they are carefully considered. To maintain the integrity of the dataset, it is important that

service providers continue to collect a core range of measures. Any additional items or scales should add clear value to the NADAbase.

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Treatment Outcomes Profile

Client ID | D.O.B. (dd/mm/yyyy) | Name of keyworker

TOP interview date (dd/mm/yyyy) | Gender: M ☐ F ☐ | Treatment stage: Start ☐ Review ☐ Exit ☐ Post-treatment exit ☐

Total for NDTMS return

Section 1: Substance use (Use NA only if information is not disclosed or not answered)

Record the average amount on a using day and number of days substances used in each of past four weeks

	Average		Week 4	Week 3	Week 2	Week 1	Total
a Alcohol		units/day	0–7	0–7	0–7	0–7	0–28
b Opiates/opioids (illicit)*		g/day	0–7	0–7	0–7	0–7	0–28
c Crack		g/day	0–7	0–7	0–7	0–7	0–28
d Cocaine		g/day	0–7	0–7	0–7	0–7	0–28
e Amphetamines		g/day	0–7	0–7	0–7	0–7	0–28
f Cannabis		spliff/day	0–7	0–7	0–7	0–7	0–28
g Other problem substance? (name.....)		g/day	0–7	0–7	0–7	0–7	0–28

*Includes street heroin and any non-prescribed opioid, such as methadone and buprenorphine

Section 2: Injecting risk behaviour (Use NA only if information is not disclosed or not answered)

Record number of days client injected non-prescribed drugs in past four weeks

(if no, enter zero and 'N', and go to section 3)

	Week 4	Week 3	Week 2	Week 1	Total
a Injected	0–7	0–7	0–7	0–7	0–28

			Total
b Inject with needle or syringe used by someone else?	Yes ☐	No ☐	Enter 'Y' if any yes, otherwise 'N'
c Inject using a spoon, water or filter used by someone else?	Yes ☐	No ☐	

Section 3: Crime (Use NA only if information is not disclosed or not answered)

Record days of shoplifting, drug selling and other categories committed in past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
a Shoplifting	0–7	0–7	0–7	0–7	0–28
b Drug selling	0–7	0–7	0–7	0–7	0–28

			Total
c Theft from or of a vehicle	Yes ☐	No ☐	Enter 'Y' if any yes, otherwise 'N'
d Other property theft or burglary	Yes ☐	No ☐	
e Fraud, forgery and handling stolen goods	Yes ☐	No ☐	
f Committing assault or violence	Yes ☐	No ☐	Enter 'Y' or 'N'

Section 4: Health & social functioning (Use NA only if information is not disclosed or not answered)

a Client's rating of psychological health (anxiety, depression, problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good — 0–20

Record days worked and at college or school for the past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
b Days paid work	0–7	0–7	0–7	0–7	0–28
c Days attended college or school	0–7	0–7	0–7	0–7	0–28

d Client's rating of physical health (extent of physical symptoms and bothered by illness)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good — 0–20

Record accommodation status for the past four weeks

e Acute housing problem	Yes ☐	No ☐	Enter 'Y' or 'N'
f At risk of eviction	Yes ☐	No ☐	Enter 'Y' or 'N'

g Client's rating of overall quality of life (able to enjoy life, gets on with family and partner, etc)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good — 0–20

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Treatment Outcomes Profile (TOP)

NHS
National Treatment Agency for Substance Misuse

About the TOP

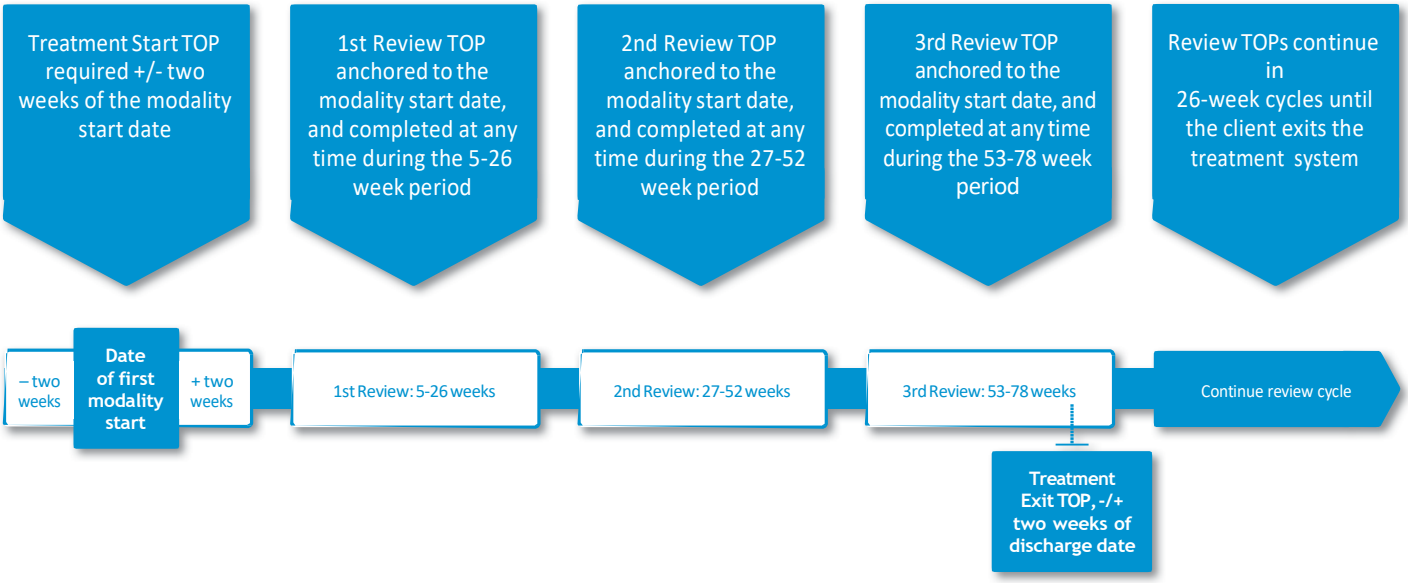
The TOP is a validated tool for monitoring the changes that occur during treatment for service users. It was developed by the NTA and implemented throughout the English drug treatment system in 2007 to provide service users, clinicians, service managers and commissioners with objective and comparable information about 'real' changes that occur in service users' lives, in order to inform and improve practice on both an individual and strategic level.

It is a simple set of questions that can aid improvements in clinical practice by enhancing assessment and care plan reviews, helping to ensure that the clients' needs are identified and addressed in the care plan and place them in the best position to help them meet their treatment goals.

The TOP should be completed with clients in all Tier 3 and 4 structured treatment modalities (as defined by Models of Care: 2006 update) at the start of treatment (Treatment Start TOP), periodically throughout the clients treatment journey (Treatment Review TOP) and when the client exits the treatment system (Treatment Exit TOP)

We recommend that the TOP is completed during the care planning process. It is good practice to review a client every 12 weeks. However, this may be more or less frequent depending on individual need. The TOP should be reported to NDTMS in accordance with the reporting protocol below.

The protocol for TOP reporting



How to complete the TOP

Start by entering:

- Client name and identifiers (date of birth and gender)
- Your name
- Date of assessment
- The stage at which you are completing the TOP – Treatment Start, Review, Treatment Exit, or post Treatment Exit.

Types of responses:

- Timeline – invite the client to recall the number of days in each of the past four weeks on which they did something, for example, the number of days they used heroin. You then add these to create a total for the past four weeks in the blue NDTMS box
- Yes and no – a simple tick for yes or no, then a 'Y' or 'N' in the blue NDTMS box
- Rating scale – a 21-point scale from poor to good. Together with the client, mark the scale in an appropriate place and then write the equivalent score in the blue NDTMS box.

A few things to remember

- The blue shaded boxes are the only information that gets sent to the NTA
- Week 4 is the most recent week; week 1 is the least recent
- The Treatment Start TOP should always capture pre-treatment drug use, so it is important that the recall period is the 28 days before the treatment start date. Not doing this will skew outcomes as there is likely to be a lower baseline.

Calculating alcohol units

$$\frac{\text{Volume (ml)} \times \%\text{ABV}}{1000}$$

Thank you for your contribution to NDTMS by using the TOP

ATOP v3

ATOP

Rollout
v3.1 Sept 2012

Surname: _____ MRN: _____

Given Names: _____

Date of Birth: ____/____/____ Sex: _____

Affix Patient Label here

ATOP DATE ___ /___ /_____ **CLINICIAN** _____

Treatment stage: ☐ Start of service episode ☐ Progress review ☐ Discharge ☐ Post Discharge

Main treatment type: ☐ Pharmacotherapy ☐ Withdrawal management ☐ Counselling ☐ Rehabilitation ☐ Information and education only ☐ Support and case management only ☐ Assessment only ☐ Other

Principal drug of concern for this treatment episode: ☐ Alcohol ☐ Cannabis ☐ Amphetamine ☐ Benzodiazepines ☐ Cocaine ☐ Methadone ☐ Heroin ☐ Other_____

Section 1: Substance use

Record number of days used in each of the past four weeks

		Ave qty per day	*Units*	**Week 4 (most recent)**	**Week 3**	**Week 2**	**Week 1**	**TOTAL**
a	Alcohol		Std drinks	0-7	0-7	0-7	0-7	0-28
b	Cannabis			0-7	0-7	0-7	0-7	0-28
c	Amphetamine type substances (eg. ice, MDMA etc.)			0-7	0-7	0-7	0-7	0-28
d	Benzodiazepines (prescribed & illicit)			0-7	0-7	0-7	0-7	0-28
e	Heroin			0-7	0-7	0-7	0-7	0-28
f	Other opioids (not prescribed methadone/buprenorphine)			0-7	0-7	0-7	0-7	0-28
g	Cocaine			0-7	0-7	0-7	0-7	0-28
h	Other problem substance			0-7	0-7	0-7	0-7	0-28
i	Daily tobacco use?					Yes ☐	No ☐	

Record number of days client injected drugs in the past four weeks (if no, enter zero and go to section 2)

		Week 4	**Week 3**	**Week 2**	**Week 1**	**TOTAL**
j	Injected	0-7	0-7	0-7	0-7	0-28
k	Inject with equipment used by someone else?			Yes ☐	No ☐	

Section 2: Health and Wellbeing

Record days worked and at college, school or vocational training for the past four weeks

		Week 4	**Week 3**	**Week 2**	**Week 1**	**TOTAL**
a	Days paid work (incl. all paid work; not voluntary work)	0-7	0-7	0-7	0-7	0-28
b	Days at school, tertiary education, vocational training	0-7	0-7	0-7	0-7	0-28

Record the following items for the past four weeks

c	Have you been homeless?		Yes ☐	No ☐
d	Have you been at risk of eviction?		Yes ☐	No ☐
e	Have you, at any time in the past four weeks, been a primary caregiver for or living with any child/children	(i) under 5yo?	Yes ☐	No ☐
		(ii) 5-15yo?	Yes ☐	No ☐
f	Have you been arrested?		Yes ☐	No ☐
g	Have you been violent (incl. domestic violence) towards someone?		Yes ☐	No ☐
h	Has anyone been violent (incl. domestic violence) towards you?		Yes ☐	No ☐

i Client's rating of **psychological health status** (anxiety, depression and problem emotions and feelings)

0 1 2 3 4 5 6 7 8 9 10
Poor **Good**

j Client's rating of **physical health status** (extent of physical symptoms and bothered by illness)

0 1 2 3 4 5 6 7 8 9 10
Poor **Good**

k Client's rating of **overall quality of life** (e.g. able to enjoy life, gets on well with family and partner, satisfied with living conditions)

0 1 2 3 4 5 6 7 8 9 10
Poor **Good**

CLIENT OUTCOMES MANAGEMENT SYSTEM QUESTIONNAIRE

Survey Administration Date:_____ Stage: _____

Client Code: _____

SECTION ONE: DRUG AND ALCOHOL USE

SEVERITY OF DEPENDENCE SCALE

Over the last three months, what drug was causing you greatest concern?

☐ Alcohol	☐ Cannabis	☐ Other Opioid	☐ Tranquilisers (eg.benzos)
☐ Amphetamines	☐ Cocaine	☐ Tobacco	☐ Non-opioid Analgesics
☐ Another Drug	☐ Heroin	☐ Methadone	☐ Buprenorphine

The following questions ask about how you have been thinking/feeling about that drug over the last 3 months, **even if you have not been using** (please check one answer).

1. Did you ever think that your use of this drug was out of control?
Never or almost never ☐
Sometimes ☐
Often ☐
Always or nearly always ☐

2. Did the prospect of missing this drug make you very anxious or worried?
Never or almost never ☐
Sometimes ☐
Often ☐
Always or nearly always ☐

3. Did you worry about your use of this drug?
Not at all ☐
A little Quite ☐
a lot A ☐
great deal ☐

4. Do you wish you could stop?
Never or almost never ☐
Sometimes ☐
Often ☐
Always or nearly always ☐

5. How difficult would you/did you find it to stop or go without?
Not difficult ☐
Quite difficult ☐
Very difficult ☐
Impossible ☐

Is this the substance that was causing you the most concern at Intake?

☐ **Yes** Proceed to the **Drug and Alcohol Use Section Below**
☐ **No** Proceed to the next question

Over the last three months, what drug was causing you greatest concern?

☐ Alcohol	☐ Cannabis	☐ Other Opioid	☐ Tranquilisers (eg.benzos)
☐ Amphetamines	☐ Cocaine	☐ Tobacco	☐ Non-opioid Analgesics
☐ Another Drug	☐ Heroin	☐ Methadone	☐ Buprenorphine

The following questions ask about how you have been thinking/feeling about that drug over the last 3 months, **even if you have not been using** (please check one answer).

1. Did you ever think that your use of this drug was out of control?
Never or almost never ☐
Sometimes ☐
Often ☐
Always or nearly always ☐

2. Did the prospect of missing this drug make you very anxious or worried?
Never or almost never ☐
Sometimes ☐
Often ☐
Always or nearly always ☐

3. Did you worry about your use of this drug?
Not at all ☐
A little Quite ☐
a lot A ☐
great deal ☐

4. Do you wish you could stop?
Never or almost never ☐
Sometimes ☐
Often ☐
Always or nearly always ☐

5. How difficult would you/did you find it to stop or go without?
Not difficult ☐
Quite difficult ☐
Very difficult ☐
Impossible ☐

DRUG AND ALCOHOL USE

1. How many **days** in the last four weeks did you use:

Heroin	_____days
Other opioid-based drug	_____days
Cannabis	_____days
Cocaine	_____days
Amphetamines	_____days
Tranquillisers (benzos)	_____days
Another drug	_____days

2. How many days in the last four weeks did you drink alcohol? (beer, wine, spirits)
_____days

3. On average, how many standard drinks did you have on those days when you were drinking (refer to standard drinks chart)?_____number of drinks

4. On the days, in the last four weeks when you were drinking much more heavily than usual, how many drinks did you have?_____number of drinks?

5. How many days, in the last four weeks did you drink at this level?_____days

6. How many days in the last four weeks did you use tobacco (cigarettes, cigars, pipe tobacco)?_____days

7. How many cigarettes/cigars/pipes did you have on a typical day when you did use tobacco?
_____cigarettes/cigars/pipes.

SECTION TWO: PSYCHOLOGICAL HEALTH– KESSLER 10 PLUS

Select the appropriate answer:

1. In the last four weeks, about how often did you feel tired out for no good reason?

None of the time	☐
A little of the time	☐
Some of the time	☐
Most of the time	☐
All of the time	☐

2. In the last four weeks, about how often did you feel nervous?

None of the time	☐
A little of the time	☐
Some of the time	☐
Most of the time	☐
All of the time	☐

3. In the last four weeks, about how often did you feel so nervous that nothing could calm you down?

None of the time ☐
A little of the time ☐
Some of the time ☐
Most of the time ☐
All of the time ☐

4. In the last four weeks, about how often did you feel hopeless?

None of the time ☐
A little of the time ☐
Some of the time ☐
Most of the time ☐
All of the time ☐

5. In the last four weeks, about how often did you feel restless or fidgety?

None of the time ☐
A little of the time ☐
Some of the time ☐
Most of the time ☐
All of the time ☐

6. In the last four weeks, about how often did you feel so restless you could not sit still?

None of the time ☐
A little of the time ☐
Some of the time ☐
Most of the time ☐
All of the time ☐

7. In the last four weeks, about how often did you feel depressed?

None of the time ☐
A little of the time ☐
Some of the time ☐
Most of the time ☐
All of the time ☐

8. In the last four weeks, about how often did you feel that everything was an effort?

None of the time ☐
A little of the time ☐
Some of the time ☐
Most of the time ☐
All of the time ☐

9. In the last four weeks, about how often did you feel so sad that nothing could cheer you up?

None of the time ☐
A little of the time ☐
Some of the time ☐
Most of the time ☐
All of the time ☐

10. In the last four weeks, about how often did you feel worthless?
None of the time ☐
A little of the time ☐
Some of the time ☐
Most of the time ☐
All of the time ☐

11. In the last four weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings?_____(Number of days)

12. [Aside from those days], in the last four weeks, HOW MANY DAYS were you able to work or study or manage your day to day activities, but had to CUT DOWN on what you did because of these feelings? (Number of days)

13. In the last four weeks, how many times have you seen a doctor or any other health professional about these feelings?_____(Number of consultations)

14. In the last four weeks, how often have physical health problems been the main cause of these feelings?
None of the time ☐
A little of the time ☐
Some of the time ☐
Most of the time ☐
All of the time ☐

SECTION 3: HEALTH AND SOCIAL FUNCTIONING WHO–8: EUROHIS Quality of life scale

This set of questions asks how you feel about your quality of life, health or other areas of your life. Please think about your life in the last two weeks.

1. How would you rate your quality of life?
Very poor ☐
Poor ☐
Neither poor nor good ☐
Good ☐
Very good ☐

2. How satisfied are you with your health?
Very dissatisfied ☐
Dissatisfied ☐
Neither satisfied nor dissatisfied ☐
Satisfied ☐
Very satisfied ☐

The following set of questions asks about how **completely** you experience or were able to do certain things in the last two weeks.

3. Do you have enough energy for everyday life?
Not at all ☐
A little ☐
Moderately ☐
Mostly ☐
Completely ☐

4. Have you enough money to meet your needs?
Not at all ☐
A little ☐
Moderately ☐
Mostly ☐
Completely ☐

The following questions ask you to say how **good or satisfied** you have felt about various aspects of your life over the last two weeks.

5. How satisfied are you with your ability to perform your daily living activities?
Very dissatisfied ☐
Dissatisfied ☐
Neither satisfied nor dissatisfied ☐
Satisfied ☐
Very satisfied ☐

6. How satisfied are you with yourself?
Very dissatisfied ☐
Dissatisfied ☐
Neither satisfied nor dissatisfied ☐
Satisfied ☐
Very satisfied ☐

7. How satisfied are you with your personal relationships?
Very dissatisfied ☐
Dissatisfied ☐
Neither satisfied nor dissatisfied ☐
Satisfied ☐
Very satisfied ☐

8. How satisfied are you with the conditions of your living place?
Very dissatisfied ☐
Dissatisfied ☐
Neither satisfied nor dissatisfied ☐
Satisfied ☐
Very satisfied ☐

Additional questions

9. What is your main source of income?
Full-time employment ☐
Part-time employment ☐
Temporary benefit (e.g. unemployment) ☐
Pension (e.g. aged, disability) ☐
Student allowance ☐
Dependent on others ☐
Retirement fund ☐
No income ☐
Other ☐
If other, please specify_____
Not known/not stated/inadequately described ☐

10. Living Arrangement - Who do you live with?
Alone ☐
Spouse/partner ☐
Alone with child(ren) ☐
Spouse/partner with child(ren) ☐
Parent(s) ☐
Other relative(s) ☐
Friend(s) ☐
Friend(s)/parent(s)/relative(s) and children ☐
Other ☐
If other, please specify _____
Not known/not stated/inadequately described ☐

11. Usual Accommodation
Rented house or flat (public or private) ☐
Privately owned house or flat ☐
Boarding house ☐
Hostel ☐
Psychiatric home/hospital ☐
Alcohol/other drug treatment residence ☐
Shelter/refuge ☐
Prison/detention centre ☐
Caravan on serviced site ☐
No usual residence/homeless ☐
Other ☐
If other, please specify_____
Not known/not stated/inadequately described ☐

The next two questions refer to activity in the last three months.

12. How many times in the last three months have you been arrested?_____times

13 How many of these arrests were for offences allegedly committed in the last three months?_____arrests

SECTION 4: BBV EXPOSURE RISK-TAKING SCALE

1. When did you last inject/hit up any drug?
In the last 3 months ☐
More than 3 but less than 12 months ago ☐
12 months ago or more ☐
Never injected ☐
Not stated/inadequately described ☐

If the answer to Question 1 in this section was 'in the last 3 months,' answer Questions 2 and 3. Otherwise, skip to Question 4.

2. How many times in the last 3 months did you use a needle or syringe after someone else had already used it (including your sex partner and even if it was cleaned)?
More than 10 times ☐
6 to 10 times ☐
3 to 5 times ☐
Twice Once ☐
Never ☐
☐

3. In the last 3 months did you share any spoons, filters, water, tourniquets, drug solution/mix, or swabs with anyone else?
Yes ☐
No ☐

4. How many times have you overdosed from any drug in the last 3 months?
_____times.

Blood-Borne Virus and Sexual Health Screener

Printable version (further information referred to is available on the website)

Rationale: NADA recognises the unique opportunity of AOD services to combine hepatitis A, B, C, HIV and sexual health education and information into their programs, and where appropriate assist in linking clients with testing and medical treatment providers. The integration of BBV screening questions into NADAbase will help ensure all people accessing AOD treatment will be screened as part of standard practice.

Process: All clients are to be screened for blood-borne viruses (BBV) and sexual health testing using the below questions and pre-amble. Clients are to be made aware that these questions are standard practice and they will not be excluded from the service based on their responses. **Clients will not be asked to complete these questions themselves.** For information on hepatitis A,B,C, HIV, STI's and safe sex. Messages for consideration are included in text boxes like this one.

Read the statement:

We know that people who report concern about their substance use are at risk for exposure to blood-borne viruses and sexually transmitted infections.

To better assist us in providing support and information to you, we ask all our clients a set of questions that tells us about their situation. We ask these questions a few times throughout the program to help people tell us about their experiences when they are ready. These questions may or may not apply to you and you don't have to answer if you don't want to. It is helpful to know whether people have been tested however you may decide that you do not wish to disclose the results of that test. No one is excluded from our service because of a positive test for BBV or STIs. We may share results with your medical treatment team in consultation with you and as part of a holistic care plan.

SECTION A

1. In the last 12 months, have you been tested for a blood-borne virus such as hepatitis A, B, C or HIV?
   - ☐ Yes
   - ☐ No
   - ☐ Don't wish to say

☐ Did not ask

2. In the last 12 months, have you had a sexual health check-up?
   ☐ Yes
   ☐ No
   ☐ Don't wish to say
   ☐ Did not ask

If no, don't wish to say or no response to either question 1 or 2, provide the client with some information on hepatitis A, B, C, HIV, STI's and safe sex. Remind them that they will be asked again at a later time about this and let them know they can talk to staff later if they want to.

3. If so, do you know the results of that test?
   ☐ Results positive
   ☐ Results negative
   ☐ Don't know
   ☐ Don't wish to say
   ☐ Did not ask

Questions 4, 5 and 6 to be responded to if 'Results Positive' is selected

4. What did you test positive for? (*More than one box can be selected)*
   ☐ HIV
   ☐ Hepatitis A
   ☐ Hepatitis B
   ☐ Hepatitis C PCR Test
   ☐ STI
   ☐ Don't wish to say
   ☐ Did not ask

If hepatitis B is NOT selected at Question 4 the following question should be asked

a. Have you been vaccinated for hepatitis B?
   ☐ Yes
   ☐ No
   ☐ Not sure
   ☐ Don't wish to say

☐ Did not ask

5. If you tested positive, have you been offered regular check-ups and information about treatment options?

☐ Yes

☐ No

☐ Not sure/don't remember

6. Are you currently undertaking treatment?

☐ Yes

☐ No

☐ Don't wish to say

☐ Did not ask

7. Action/s taken as a result of the screener. (*More than one box can be selected)*

☐ Action added to client care plan
☐ Referral made to external service
☐ Referral made to internal service
☐ Consultation recorded in client progress notes
☐ No action taken
☐ Education information provided

Domestic and Family Violence Screener

Printable version (further information referred to is available on the website)

Rationale: NADA recognises the unique opportunity AOD services have to reduce the very serious risks posed by domestic and family violence (DFV). Evidence suggests the use of direct questions can help prevent violence and improve victim safety. The integration of DFV screening questions into the NADAbase will help ensure all women accessing AOD treatment will be screened as part of standard practice. NADA has also developed a policy template which can support you in this work.

Process: All women are to be screened for Domestic and Family Violence (DFV) using the below questions and pre-amble. Female clients are to be made aware that these questions are standard practice and they will not be excluded from the service based on their responses. **Clients will not be asked to complete these questions themselves.** Messages for consideration are included in text boxes like this one.

Read the statement:

Here at [*state your organisation*] we take domestic and family violence very seriously. We know that many women experience unsafe relationships and we have some set questions that we ask to help women tell us about their situation. This is so we can provide support and information. We ask these questions a few times throughout the program to help women tell us about their experiences when they are ready. These questions may or may not apply to you and you don't have to answer if you don't want to. No one is excluded from our service because of family or domestic violence. In some situations we may discuss with you the sharing of this information with other support services.

SECTION A

8. In the last 12 months, has someone in your family or someone you were in a relationship with pushed, hit, kicked, punched, grabbed you around the neck or otherwise hurt you?

- ☐ Yes
- ☐ No
- ☐ Don't wish to say
- ☐ Did not ask

Alert! If choking/grabbed around the neck, use of any weapons or harm to pets is mentioned more detailed screening and threat assessment using the DVSAT should be prioritised.

9. Are you afraid now or have you been afraid of anyone you've been in a relationship with or in your household/family?

- ☐ Yes
- ☐ No
- ☐ Don't wish to say
- ☐ Did not ask

Note: ensure your organisation's policy for assessing the safety of the client is followed. In the absence of specific policies access NADA's Identifying and responding to Domestic Violence policy template for guidance.

If no, don't wish to say or no response to either question 1 or 2 give the client some information on DFV (e.g. Charmed and dangerous resource), remind them that they will be asked again at a later time about this and let them know they can talk to staff later if they want to.

SECTION B

10. When you were hurt, did you get hit on the head, grabbed around the neck or lose consciousness?

- ☐ Yes
- ☐ No
- ☐ Not sure/don't remember

Alert! If yes, your client may need to be assessed and/or monitored for signs of a cognitive impairment. Any blow to the head or loss of oxygen to the brain can cause brain impairment. Refer to the NADA www.complexneedscapable.org.au resource.

11. Who hurt you and/or who are you afraid of? *(More than one box can be selected)*

- ☐ Partner
- ☐ Ex-partner

☐ Sibling

☐ Parent

☐ Child

☐ Other family member

☐ Other person

☐ Don't wish to say/no response

12. Is there anyone else in the family/household who is experiencing or witnessing these things?
(More than one box can be selected)

☐ Child/ren

☐ Sibling

☐ Parent

☐ Partner

☐ Ex-partner

☐ Other family member

☐ Other person

☐ Don't wish to say/no response

☐ No one else

Alert! Remember to follow the mandatory reporter guidelines where information relates to risk of harm of children/young people.

13. Are you worried about how the experiences we've been talking about may be affecting your children or anyone else in the family/household?
(More than one can be selected)

☐ Child/ren

☐ Sibling

☐ Parent

☐ Partner

☐ Ex-partner

☐ Other family member

☐ Other person

☐ Don't wish to say/no response

☐ No one else

Alert! Remember to follow the mandatory reporter guidelines where information relates to risk of harm of children/young people.

14. Action/s taken as a result of the screener. *More than one box can be selected*

☐ Action added to client care plan
☐ Referral made to external service
☐ Referral made to internal service
☐ Consultation recorded in client progress notes
☐ No action taken

Suicide Screener

Printable version (further information referred to is available on the website)

Rationale: NADA recognises the unique opportunity AOD services have to reduce the very serious risk of suicide, and where appropriate assist in linking clients with medical treatment providers. The integration of suicide screening questions into the NADAbase will help ensure all people accessing AOD treatment will be screened as part of standard practice. The Suicide Assessment Kit (SAK) has been developed to support you in this work.

Process: All clients are to be screened for risk of suicide using the below questions and pre-amble. Clients are to be made aware that these questions are standard practice and they will not be excluded from the service based on their responses. **Clients will not be asked to complete these questions themselves.** Messages for consideration are included in text boxes like this one.

Read the statement:

To better assist us in providing support and information to you, we ask all our clients a set of questions that tells us about their situation. We ask these questions a few times throughout the program to help people tell us about their experiences when they are ready. These questions may or may not apply to you and you don't have to answer if you don't want to. We may share results with your medical treatment team in consultation with you and as part of a holistic care plan. We also want you to know that support is always available to you via Lifeline on 13 11 14.

SECTION A

15. I need to ask you a few questions on how you have been feeling, is that ok?

- ☐ Yes
- ☐ No
- ☐ Did not ask

16. In the past 4 weeks did you feel so sad that nothing could cheer you up?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time
- ☐ Don't wish to say
- ☐ Did not ask

17. In the past 4 weeks, how often did you feel no hope for the future?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time
- ☐ Don't wish to say
- ☐ Did not ask

18. In the past 4 weeks, how often did you feel intense shame or guilt?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time
- ☐ Don't wish to say
- ☐ Did not ask

19. In the past 4 weeks, how often did you feel worthless?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time
- ☐ Don't wish to say
- ☐ Did not ask

Note: Response boxes marked in red indicates a high or moderate risk answer. If yes is selected, ensure your organisation's policy for assessing the safety of the client is followed. If your organisation does not have a policy relating to managing suicide risk, please refer to the Suicide & Self Harm Prevention Section taken from the Client Clinical Management Policy, NADA Policy Toolkit. The Suicide Assessment Kit (SAK) has also been developed to support you in this assessment.

20. Have you ever tried to kill yourself?

- ☐ Yes*
- ☐ No
- ☐ Don't wish to say
- ☐ Did not ask

If YES is selected at Question 6 the below shadowed questions are to be responded to.

a. How many times have you tried to kill yourself?

☐ Once

☐ Twice
☐ Three times or more
☐ Don't wish to say
☐ Did not ask

b. How long ago was the last attempt?
☐ In the last 2 months
☐ 2–6 months ago
☐ 6-12 months ago
☐ 1-2 years ago
☐ More than 2 years ago
☐ Don't wish to say
☐ Did not ask

c. Have things changed since?
☐ Yes
☐ No
☐ Don't wish to say
☐ Did not ask

21. Have you gone through any upsetting events recently? (*tick all that apply*)
- ☐ Family breakdown
- ☐ Relationship problem
- ☐ Loss of loved one
- ☐ Conflict relating to sexual identity
- ☐ Impending legal prosecution
- ☐ Child custody issues
- ☐ Chronic pain/illness
- ☐ Trauma
- ☐ Don't wish to say
- ☐ Did not ask

22. Have things been so bad lately that you have thought about killing yourself?
- ☐ Yes
- ☐ No
- ☐ Don't wish to say
- ☐ Did not ask

If YES is selected at Question 8 the below shadowed questions are to be responded to.

a. How often do you have thoughts of suicide?
☐ Daily
☐ Weekly

☐ Monthly
☐ Don't wish to say
☐ Did not ask

b. How long have you been having these thoughts?
☐ In the last 2 months
☐ 2–6 months ago
☐ 6-12 months ago
☐ 1-2 years ago
☐ More than 2 years ago
☐ Don't wish to say
☐ Did not ask

c. How intense are these thoughts when they are most severe?
☐ Very intense
☐ Intense
☐ Somewhat intense
☐ Not at all intense
☐ Don't wish to say
☐ Did not ask

d. How intense have these thoughts been in the last week?
☐ Very intense
☐ Intense
☐ Somewhat intense
☐ Not at all intense
☐ Don't wish to say
☐ Did not ask

e. Do you have a current plan for how you would attempt suicide?
☐ Yes
☐ No
☐ Don't wish to say
☐ Did not ask

If YES is selected at Question 8e the below shadowed questions are to be responded to.

f. Do you have access to means?
☐ Yes
☐ No
☐ Don't wish to say
☐ Did not ask

g. Have all necessary preparations been made?
☐ Yes
☐ No
☐ Don't wish to say
☐ Did not ask

h. How likely are you to act on this plan in the near future?
☐ Very likely
☐ Likely
☐ Unlikely
☐ Very Unlikely
☐ Don't wish to say
☐ Did not ask

23. Do you have any friends/family members you can confide in if you have a serious problem?
☐ Yes
☐ No
☐ Don't wish to say
☐ Did not ask

If YES is selected at Question 9 the below shadowed questions are to be responded to.

a. Who is/are this/these person/people? (*tick all that apply*)
☐ Friend
☐ Partner
☐ Carer/counsellor
☐ Parent
☐ Peer
☐ Sibling
☐ Child
☐ Other family member
☐ Don't wish to say/no response

b. How often are you in contact with this/these person/people?
☐ Daily
☐ A few days a week
☐ Weekly
☐ Monthly
☐ Less than once a month
☐ Don't wish to say
☐ Did not ask

24. Client presentation/statements (*tick all that apply*)
☐ Agitated
☐ Disorientated/confused

☐ Delusional/hallucinating
☐ Intoxicated
☐ Self-Harm

Alert: If client presents as any of the above and is expressing thoughts of suicide, risk level is automatically **HIGH**. Ensure your organisation's policy for assessing the safety of the client is followed. The Suicide Assessment Kit (SAK) has also been developed to support you in this assessment with guidance on how to respond to each level of risk. The clinician is to complete the below risk level of the client based on responses to questions and using the SAK as guidance in the final assessment.

Clinician rated risk level of client

☐ Low
☐ Moderate
☐ High

Level of risk	Suggested Response
Low: • No plans or intent • No prior attempt/s • Few risk factors • Identifiable 'protective' factors	• Monitor and review risk frequently • Identify potential supports/contacts and provide contact details • Consult with a colleague or supervisor for guidance and support • Refer client to safety plan and keep safe strategies should they start to feel suicidal
Moderate: • Suicidal thoughts of limited frequency, intensity and duration • No plans or intent • Some risk factors present • Some 'protective' factors	• Request permission to organise a specialist mental health service assessment as soon as possible • Refer client to safety plan and keep safe strategies as above • Consult with colleague or supervisor for guidance and support • Remove means where possible • Review daily
High* • Frequent, intense, enduring suicidal thoughts • Clear intent, specific/well thought out plans • Prior attempt/s • Many risk factors • Few/no 'protective' factors	• If the client has an immediate intention to act, contact the mental health crisis team immediately and ensure that the client is not left alone • Remove means where possible • Call an ambulance/police if the client will not accept a specialist assessment, or the crisis team is not available • Consult with a colleague or supervisor for guidance and support

25. Action/s taken as a result of the screener. (*at least one box must be selected)*

- ☐ Action added to client care plan
- ☐ Referral made to external service
- ☐ Referral made to internal service
- ☐ Consultation recorded in client progress notes
- ☐ No action taken