Using the
CLIENT OUTCOMES MANAGEMENT SYSTEM (COMS)
About NADA
The Network of Alcohol and Drug Agencies (NADA) is the peak organisation for the non government drug and alcohol sector in NSW, and is primarily funded through NSW Health. NADA has approximately 100 members providing drug and alcohol health promotion, early intervention, treatment, and after-care programs. These organisations are diverse in their philosophy and approach to drug and alcohol service delivery and structure.
NADA’s goal is ‘to support non government drug and alcohol organisations in NSW to reduce the alcohol and drug related harm to individuals, families and the community.’
The NADA program consists of sector representation and advocacy, workforce development, information/data management, governance and management support and a range of capacity development initiatives. NADA is governed by a Board of Directors primarily elected from the NADA membership and holds accreditation with the Australian Council on Health Care Standards (ACHS) until 2014.
Further information about NADA and its programs is available on the NADA website at www.nada.org.au.

Purpose of this Guide
The purpose of this user guide is to provide instruction and guidance in the use of the NADA Client Outcomes Management System (COMS) data collection and reporting functions in the NADA online database.

NADA
PO Box 2345
Strawberry Hills NSW 2012
Australia
Telephone: 02 9698 8669
Web: www.nada.org.au
ABN: 52 793 744 040
NADA is a not-for-profit organisation incorporated under the NSW Associations Incorporations Act (2009).
May 2012
© Network of Alcohol and other Drugs Agencies (trading as Network of Alcohol and Drug Agencies) 2012
This work is copyright. You may download, display, print and reproduce this material in unaltered form only (retaining this notice) for your personal, non-commercial use or use within your organisation. Requests for further authorisation should be directed to the CEO, NADA, PO Box 2345, Strawberry Hills, NSW 2012.

NADA gratefully acknowledges the NSW Ministry of Health for funding the production of this guide.
CONTENTS

1. INTRODUCTION ........................................................................................................... 1.1
Purpose of this guide ........................................................................................................... 1.1
The NGO Drug and Alcohol and Mental Health Information Management Project .......... 1.2
Background to the project ..................................................................................................... 1.2

2. COMS MEASURES ..................................................................................................... 2.1
Determining outcomes measures for COMS ........................................................................ 2.1
Final outcomes dataset ......................................................................................................... 2.2
– Drug and alcohol use ......................................................................................................... 2.2
  » Severity of Dependence Scale ...................................................................................... 2.2
  » Drug and alcohol use ..................................................................................................... 2.2
– Psychological health ......................................................................................................... 2.2
  » K10+ ............................................................................................................................ 2.2
– Health and social functioning ........................................................................................... 2.3
  » QoL-8 ........................................................................................................................ 2.3
  » MDS items .................................................................................................................. 2.3
  » Arrests ......................................................................................................................... 2.4
– BBV risk taking scale ........................................................................................................ 2.4

3. GUIDELINES FOR ADMINISTERING COMS .......................................................... 3.1
Guidelines for completing the questionnaire ...................................................................... 3.1
Clinical judgement .............................................................................................................. 3.1
Do’s and don’ts ................................................................................................................... 3.1
Timeframe for Completing the questionnaire ..................................................................... 3.2
Collecting information on Indigenous status ....................................................................... 3.2
Privacy and confidentiality ................................................................................................... 3.3

4. USING THE COMS ONLINE DATABASE .................................................................. 4.1
4.1 Logging in .................................................................................................................... 4.1
4.2 The main menu ............................................................................................................ 4.1
4.3 Adding or updating client information .......................................................................... 4.2
4.4 Client outcomes .......................................................................................................... 4.4
4.5 Generating reports ...................................................................................................... 4.5
  4.5 (1) Generating client reports ...................................................................................... 4.8
  4.5 (2) Exporting client outcomes reports ........................................................................ 4.11
  4.5 (3) Generating agency outcome reports ...................................................................... 4.11
  4.5 (4) Other agency reports .......................................................................................... 4.14

5. INTERPRETATION AND SCORING ......................................................................... 5.1
5.1 Outcomes measures .................................................................................................... 5.1
  5.1 (1) Drug and alcohol use domain ............................................................................... 5.1
  5.1 (2) Psychological health domain .............................................................................. 5.3
  5.1 (3) Health and social functioning domain ................................................................. 5.3
  5.1 (4) BBV exposure risk-taking domain ........................................................................ 5.4
5.2 Interpreting reports ...................................................................................................... 5.5
  5.2 (1) Client outcome report .......................................................................................... 5.5
    5.2 (1.1) Drug and alcohol use .................................................................................... 5.5
    5.2 (1.2) Psychological health ..................................................................................... 5.7
    5.2 (1.3) Health and social functioning ....................................................................... 5.7
    5.2 (1.4) BBV risk taking table ................................................................................... 5.8
  5.2 (2) Agency outcome report ....................................................................................... 5.9
    5.2 (2.1) Drug and alcohol use .................................................................................... 5.9
    5.2 (2.2) Psychological health ..................................................................................... 5.12
    5.2 (2.3) Health and social functioning ....................................................................... 5.13
    5.2 (2.4) BBV risk taking table ................................................................................... 5.15

6. AGENCY OPTIONS ..................................................................................................... 6.1
6.1 Agency stages ............................................................................................................... 6.1
6.2 Agency flagging options ............................................................................................... 6.1
6.3 Agency reporting options ............................................................................................. 6.2
6.4 User permissions ........................................................................................................... 6.5

7. APPENDIX .................................................................................................................. 7.1
Timeline follow-back calendar client instructions ............................................................... 7.1
Timeline follow-back calendar staff instructions ............................................................... 7.2
Timeline follow-back calendar example ............................................................................ 7.3
COMS user guide for client ............................................................................................... 7.4
Copy of COMS questionnaire ............................................................................................ 7.4
Standard drinks chart ........................................................................................................ 7.4
Privacy and consent hand out for clients ........................................................................... 7.4

Guidelines for completing the questionnaire ...................................................................... 3.1
Clinical judgement .............................................................................................................. 3.1
Do’s and don’ts ................................................................................................................... 3.1
Timeframe for Completing the questionnaire ..................................................................... 3.2
Collecting information on Indigenous status ....................................................................... 3.2
Privacy and confidentiality ................................................................................................... 3.3

4. USING THE COMS ONLINE DATABASE .................................................................. 4.1
4.1 Logging in .................................................................................................................... 4.1
4.2 The main menu ............................................................................................................ 4.1
4.3 Adding or updating client information .......................................................................... 4.2
4.4 Client outcomes .......................................................................................................... 4.4
4.5 Generating reports ...................................................................................................... 4.5
  4.5 (1) Generating client reports ...................................................................................... 4.8
  4.5 (2) Exporting client outcomes reports ........................................................................ 4.11
  4.5 (3) Generating agency outcome reports ...................................................................... 4.11
  4.5 (4) Other agency reports .......................................................................................... 4.14

5. INTERPRETATION AND SCORING ......................................................................... 5.1
5.1 Outcomes measures .................................................................................................... 5.1
  5.1 (1) Drug and alcohol use domain ............................................................................... 5.1
  5.1 (2) Psychological health domain .............................................................................. 5.3
  5.1 (3) Health and social functioning domain ................................................................. 5.3
  5.1 (4) BBV exposure risk-taking domain ........................................................................ 5.4
5.2 Interpreting reports ...................................................................................................... 5.5
  5.2 (1) Client outcome report .......................................................................................... 5.5
    5.2 (1.1) Drug and alcohol use .................................................................................... 5.5
    5.2 (1.2) Psychological health ..................................................................................... 5.7
    5.2 (1.3) Health and social functioning ....................................................................... 5.7
    5.2 (1.4) BBV risk taking table ................................................................................... 5.8
  5.2 (2) Agency outcome report ....................................................................................... 5.9
    5.2 (2.1) Drug and alcohol use .................................................................................... 5.9
    5.2 (2.2) Psychological health ..................................................................................... 5.12
    5.2 (2.3) Health and social functioning ....................................................................... 5.13
    5.2 (2.4) BBV risk taking table ................................................................................... 5.15

6. AGENCY OPTIONS ..................................................................................................... 6.1
6.1 Agency stages ............................................................................................................... 6.1
6.2 Agency flagging options ............................................................................................... 6.1
6.3 Agency reporting options ............................................................................................. 6.2
6.4 User permissions ........................................................................................................... 6.5

7. APPENDIX .................................................................................................................. 7.1
Timeline follow-back calendar client instructions ............................................................... 7.1
Timeline follow-back calendar staff instructions ............................................................... 7.2
Timeline follow-back calendar example ............................................................................ 7.3
COMS user guide for client ............................................................................................... 7.4
Copy of COMS questionnaire ............................................................................................ 7.4
Standard drinks chart ........................................................................................................ 7.4
Privacy and consent hand out for clients ........................................................................... 7.4
1. INTRODUCTION

Purpose of this guide

The purpose of this guide is to provide instruction in the use of the NADA Client Outcomes Management System (COMS). The COMS is an online system to record and report on client outcomes data.

The COMS user guide includes:

- A brief description and rationale for the items in the Client Outcomes Management System (COMS)
- General guidelines for administration of the questionnaire
- Instructions for entering information into the database and generating reports
- Instruction for interpreting and scoring questionnaire data
- Additional resources including: timeline follow-back calendar, standard drinks chart, client information sheet and a client privacy and consent form.

Not included

This guide does not provide:

- Clinical guidance to service providers when completing the COMS questionnaire (although some general guidelines and aids to interpretation are included);
- Guidance in the use of Minimum Data Set reporting functions in the NADA on-line database (this information is available in other NADA publications).

Audience

This COMS user guide is intended for non-government service providers working with clients with drug and alcohol or co-existing drug and alcohol and mental health issues and who use the COMS to collect and analyse outcomes measures for these clients.

Abbreviations

The following abbreviations are used in this guide.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AATOM</td>
<td>Australian Alcohol Treatment Outcome Measures</td>
</tr>
<tr>
<td>ADCA</td>
<td>Alcohol and other Drugs Council of Australia</td>
</tr>
<tr>
<td>AODTS</td>
<td>Alcohol and Other Drug Treatment Services</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood-Borne Virus</td>
</tr>
<tr>
<td>BTOM</td>
<td>Brief Treatment Outcome Measure</td>
</tr>
<tr>
<td>BTOM-C</td>
<td>Brief Treatment Outcome Measure - Concise</td>
</tr>
<tr>
<td>COMS</td>
<td>Client Outcome Management System</td>
</tr>
<tr>
<td>DATS</td>
<td>Drug and Alcohol Treatment services</td>
</tr>
<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>EUROHIS QoL-8</td>
<td>See WHO QoL-8, below</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>InforMH</td>
<td>Information and reporting branch of the Mental Health Drug and Alcohol Office NSW Health</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>K10</td>
<td>Kessler 10</td>
</tr>
<tr>
<td>K10+</td>
<td>Kessler 10 Plus</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>MDS</td>
<td>Minimum Data Set</td>
</tr>
<tr>
<td>MERIT</td>
<td>Magistrates Early Referral Into Treatment</td>
</tr>
<tr>
<td>MHCC</td>
<td>Mental Health Coordinating Council</td>
</tr>
<tr>
<td>MHDAO</td>
<td>Mental Health Drug and Alcohol Office</td>
</tr>
<tr>
<td>MH-OAT</td>
<td>Mental Health Outcomes &amp; Assessment Tools</td>
</tr>
<tr>
<td>NADA</td>
<td>Network of Alcohol and other Drug Agencies</td>
</tr>
<tr>
<td>NDARC</td>
<td>National Drug and Alcohol Research Centre (University of New South Wales)</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>NMDS</td>
<td>National Minimum Data Set</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>QoL</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>SAAP</td>
<td>Supported Accommodation Assistance Program</td>
</tr>
<tr>
<td>SDS</td>
<td>Severity of Dependence Scale</td>
</tr>
<tr>
<td>SF-36</td>
<td>Short Form Health Survey 36</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WHO QoL-8</td>
<td>World Health Organisation Quality of Life-8</td>
</tr>
<tr>
<td>WHO QoL-BREF</td>
<td>World Health Organisation Quality of Life-Brief</td>
</tr>
</tbody>
</table>
The NGO drug and alcohol and mental health information management project

As part of the then NSW Health (now Ministry of Health) strategy, *A New Direction in Mental Health*, NADA was funded in 2008 to undertake an information management project, to develop and implement a system for measuring client outcomes of care in non-government drug and alcohol organisations. The Client Outcomes Management System (COMS) data set consists of items from existing standardised tools used to measure outcomes in relation to drug and alcohol use, psychological health, health and social functioning and risk-taking behaviour.

In late 2009 NADA undertook to develop the COMS and incorporate it with the existing NADA online database. A pilot process to trial the outcomes data set and data collection system with a small group of NADA members commenced at the beginning of 2010. Organisations were selected to participate through an expression of interest process. Implementation training sessions were held with staff from each organisation. The training included an overview of outcome measurement and the outcomes data set, computer based training on use of the data collection system and a change management component to support organisations to successfully implement the outcome measurement system.

Pilot organisations were involved in an external evaluation of the pilot phase including a review of the data set, database, training and support provided by NADA. This evaluation has informed continued modification to the system and supporting resources.

Background to the project

National and NSW minimum data sets

In 1995 the Alcohol and other Drugs Council of Australia (ADCA), the national peak body for the drug and alcohol sector, hosted a forum to look at the barriers between research and service delivery. One of the recommendations of the forum was the development of a national minimum data set for alcohol and drug treatment services.

A feasibility study found that some data was already being collected by agencies, but that it was not recorded or reported consistently. This finding led to the development of the Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS NMDS) overseen by the then Commonwealth Department of Health and Aged Care. In this process, all states and territories agreed to the national collection of a defined set of treatment data elements.

The NMDS is a subset of the agreed NSW Minimum Data Set of Drug and Alcohol Treatment Services (NSW MDS DATS) which has a number of additional items.

The 1999 NSW Drug Summit endorsed the implementation of a minimum data set collection as part of a coordinated strategy to standardise and improve the consistency of client data collection in drug and alcohol services in NSW. Since July 2000, all service providers who receive drug and alcohol funding from NSW Ministry of Health or the Department of Health and Ageing (DoHA) are required to collect and report on the NSW MDS and NMDS.

The NADA Information Technology project commenced in July 2001 to focus on the development and maintenance of an online database which collects the NSW MDS and a number of additional items. Organisations enter their MDS/NMDS data into the online database which is then accessible to the organisation’s Local Health District (LHD), fulfilling the organisation’s obligation to report MDS data to the NSW government.

In 2003, the Brief Treatment Outcome Measure (BTOM) was implemented across NSW drug and alcohol services by the then NSW Health and the National Drug and Alcohol Research Centre (NDARC). NADA incorporated the BTOM into the NADA online database so NADA members could easily collect and utilise this data.

Health outcomes data collection in the drug and alcohol sector

Previous outcomes data collection systems used in the NSW non-government drug and alcohol sector include:

- **NADA Health Outcomes Data Set**: Collected for approximately two years in the late 1990’s, with 10 NGOs involved in pre and post treatment client data collection and reporting, the data set examined client risk behaviours, drug use, crime, accommodation, employment, education, income and personal relationships. The Short Form health survey 36 (SF-36) which measures health and well being was also included in the data set. The introduction of the BTOM saw the demise of the NADA Health Outcomes Data Set because, unlike the BTOM, it was not validated.

- **Magistrates Early Referral Into Treatment (MERIT) program health outcomes database**: The MERIT program, based in NSW Local Courts, provides adult defendants who have drug problems and who are eligible for bail with the opportunity to receive individualised drug treatment. The MERIT program aims to reduce drug related crime and illicit drug use and to improve health and social functioning.
The instruments in the MERIT health outcomes data set are reliable, validated, can be administered by all treatment staff and scores are readily available and easily interpreted.

Currently there are two drug and alcohol NGOs providing full MERIT program services and using the MERIT data base.

- **Brief Treatment Outcome Measure (BTOM):**
  
  The BTOM was developed by NDARC and (the then) NSW Health as a standard treatment sector outcome monitoring system. Originally designed only for people receiving opioid maintenance pharmacotherapy, additional treatment specific modules were subsequently added to the BTOM for a range of service types; counselling, residential rehabilitation and detoxification (withdrawal services). The NADA online database was updated to include facility for members to enter BTOM data.

  The uptake of the BTOM was not widespread in the drug and alcohol sector and the NSW Ministry of Health no longer requires NSW drug and alcohol services to collect or report BTOM data.

**Outcomes data collection in the mental health sector**

NSW public mental health services use a collection of measures for assessment and outcome monitoring called the Mental Health Clinical Documentation Suite (previously known as the MH-OAT – Mental Health Outcomes and Assessment Tools).

There is currently no standard data collection or outcome measures used across non-government mental health services. However, the NSW Mental Health Coordinating Council (MHCC) has undertaken a project on routine consumer outcome monitoring. This project involved a research stage and the development of a training program called *Mapping the Difference We Make*, which provides training on implementing consumer outcomes measuring. This project is now part of a broader *Outcomes through NGOs initiative*.

**Rationale for this project**

In recent years there has been an increasing focus on how best to identify and work with people with coexisting drug and alcohol and mental health issues (also referred to as co-occurring disorders, co-morbidity or dual diagnosis). The high prevalence of coexisting disorders within treatment settings is well established, and clients with coexisting mental health and drug and alcohol issues are more likely to have highly complex and complicated illness courses.

**Lack of consistency or cross-sectoral collaboration**

At present there is no consistency in the screening, assessment and outcomes data collected for drug and alcohol misuse and/or mental health issues between national and state governments, between government and non-government sectors, between drug and alcohol and mental health sectors, and among individual service providers.

**NGO sector**

It is challenging for many service providers to identify the screening, assessment and outcome measurement tools that are most suitable for them and for those persons utilising their service. Consultation with NGOs in the sector has made it clear that some collect only required data items (such as MDS), some collect data in addition to that required for compliance purposes but do not use it, while others use some of the data for their own planning purposes.

For the non-government drug and alcohol sector as a whole, apart from the MDS or NMDS, there is no standard data collected.

**Need for outcomes measures**

An outcome in this context is a change in an individual that is attributable to an intervention or series of interventions. Data on outcomes is generally obtained by collecting standard measures over a period of time, commonly at treatment entry, some midpoint, at exit and at a follow up point.

Outcome monitoring is concerned with establishing whether the treatment experience of the person is associated with change and establishes that improvement has occurred following treatment. Although outcome monitoring does not prove that the outcomes were caused by the treatment, it can demonstrate effectiveness of treatment as it is experienced by the client.

Outcome data can inform treatment interventions with individuals, and can also provide data for organisations and the sector as a whole, thereby improving reporting and enabling advocacy for appropriate resources.
2. COMS MEASURES

This section explains the rationale for the measures selected for COMS and provides a brief description of each.

Determining outcome measures for COMS

A project advisory committee was formed in late 2008, consisting of representatives from the NADA membership, NSW Ministry of Health (MHDAO and InforMH) and external experts in the areas of research, data management, mental health and drug and alcohol policy and service delivery.

To inform the selection of items and measures in the data set, NADA undertook two major activities.

1. A researcher was engaged to undertake a critical review of screening, assessment and outcome measures that may be used in drug and alcohol service delivery. This review resulted in a report entitled *A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings*. This report is available on the NADA website.

2. NADA conducted a baseline consultation questionnaire with members to gather information on the standard measures currently used in the non-government drug and alcohol sector, and determine how client data is collected and used by those services. The results of this consultation are also available on the NADA website.

The results of the baseline consultation indicated that:

- A variety of standardised measures were in use across the sector
- Most organisations were not regularly completing an outcomes measure, i.e. a standard measure that is taken at various points during treatment to measure progress and outcomes and to inform treatment planning.
- Most organisations would like to systematically collect more information on the impacts of drug and alcohol treatment on clients.
- There was broad agreement that enhancements to the current NADA on-line database and the implementation of standardised client outcome measures was the best way to improve client information management in the non-government sector.

Considerations for the outcomes data set

Some key considerations when deciding which measures were to be included in the COMS were:

<table>
<thead>
<tr>
<th>Purpose of the tool</th>
<th>What is the tool designed to measure?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicability of the measure</td>
<td>Is the measure appropriate for use in a range of service types, with a range of client groups and by a range of staff with varying levels of experience and expertise?</td>
</tr>
<tr>
<td>Availability of the measure</td>
<td>Does the tool require an initial cost or ongoing licence fee?</td>
</tr>
</tbody>
</table>

The COMS as a whole needed to be:

- Comprehensive enough to cover the range of client outcomes that can result from treatment
- Brief enough to be used without imposing a large, additional data collection burden
- Applicable across a range of services and program types (e.g. residential facilities, counselling and case management programs).

The measures included in the COMS could replace some existing measures used by NADA members and/or reduce the need to collect a number of other measures.

The project advisory committee made final recommendations on the items for the outcomes data set, incorporating existing standardised measures and items from tools that have undergone research to establish their validity and reliability.

The measures and items incorporated in the outcomes data set are summarised below.
**Final outcomes dataset**

The following four outcome domains form the COMS outcome measures.

- **Drug and alcohol use**
  - **Severity of Dependence Scale (SDS)**
    - The SDS is a brief five-item screening measure of psychological aspects of dependence\(^1\). This short (it contains only five items and takes less than one minute to complete) yet effective tool is easy to administer to evaluate the level of severity of substance dependence perceived by the client.
    - The items are specifically concerned with an individual’s feelings of impaired control over their drug taking and with their preoccupations and anxieties about drug taking.
    - It is widely validated across a range of drug using groups, including heroin, cannabis, cocaine, amphetamine and benzodiazepine users\(^2,3,4\). Studies among heroin, amphetamine and cocaine users have shown the SDS to be a reliable measure of psychological dependence.
    - The SDS has been validated in a range of translations\(^5,6,7,8\) and in both adolescent and elderly populations\(^9,10,11\). It has also been used with Aboriginal and Torres Strait Islander peoples in research studies\(^12\). The wording of the SDS is straightforward and the concepts appear to be understood by a variety of different groups of drug users.
    - SDS scores range from 0-15 with higher scores indicating a higher level of dependence.
  - **Drug and alcohol use**
    - Number of days used for illicit drugs and benzodiazepines, and
    - Number of days used and quantity used for alcohol and tobacco.
    - Two separate measurements for alcohol use were included: number of days the person drank alcohol and average number of drinks per day, and number of days of heavier drinking than usual and average number of drinks on those days.

- **Psychological health**
  - **Kessler 10+**
    - The Kessler 10 scale (K10) is a widely used, simple self-report measure of psychological distress, which can be used to identify those in need of further assessment for anxiety and depression\(^13\). It is based on questions about the individual’s level of nervousness, agitation, psychological fatigue and depression in the past 4 weeks. The Kessler 10+ (K10+) measure consists of the 10 questions from the K10 that are used to determine a K10 score and an additional 4 questions that do not contribute to the final score but add context for greater understanding of the meaning of the score. The K10+ is used in the COMS.
    - It is designed to span the range from few or minimal symptoms through to extreme levels of distress. This measure was designed for use in the general population to detect high-prevalence mental health disorders (e.g. anxiety and depression); however also serves as a useful clinical tool and scores may be an indicator of mental health disorders with lower population prevalence (e.g. schizophrenia and bipolar disorder\(^14\)). The K10+ can also be used as an outcome measure\(^15\). Changes in K10 score can be strongly indicative of both improving and worsening general psychological distress as well as a warning sign of deterioration of a clinical mental health condition.
    - The K10+ has been shown to be a very good screening tool for detecting levels of distress that are associated with an independently determined current DSM or ICD diagnosis of an anxiety disorder and/or depressive disorder\(^16\), and has been found to outperform other instruments in detecting anxiety and depressive disorders\(^17\).

- **Anecdotaly, researchers who have used the SDS have found that scores may stay elevated for a period of time even after an individual has stopped or decreased their drug use. This could be related to the fact that the SDS questions focus on concern/worry about drug use, rather than the actual amount used or whether the person used at all.**

---

**Drug and alcohol use**

**Psychological health**

**Kessler 10+**
• The K10+ has been used in a wide variety of surveys including the Australian National Survey of Mental Health and Wellbeing, surveys in New South Wales for Chief Health Officer and surveys of Aboriginal populations in Western Australia and the Northern Territory.

• The K10+ is commonly used and understood by non-mental health specialists such as General Practitioners.

• The K10+ has been successfully used in a range of populations, including a range of different Australian settings and specifically with drug and alcohol users in Australian settings. It has been used in and translated into a number of languages other than English and validated with a number of cultural groups.

• This measurement tool consists of ten core questions (1-10). Each item is scored from 1 to 5, from “none of the time” to “all of the time”. Scores are then totalled, resulting in a K10 score between 10 and 50, with higher scores on the K10 indicating greater distress. Missing items are excluded from the calculation of the total score.

• The K10+ includes an additional four questions (11-14) that aim to quantify the impact or degree of disability associated with the person’s identified degree of psychological distress. Note that items 11 to 14 are excluded from calculation of the total score.

• Although these additional items do not contribute to the total score, they assess variables that give an indication of the impact or degree of disability associated with the person’s level of psychological distress.
  – Question 11 asks clients to identify how many days in the last month they were TOTALLY UNABLE to function, while Question 12 asks of the remaining time in the last month, how many days did they have to CUT DOWN on activities of daily living as a result of their distress.
  – Question 13 asks clients to identify how many times they have had to consult a health professional in the last month. Note that the maximum number of consultations allowed is 89 or almost 3 a day.
  – Question 14 has clients indicate the amount of time their psychological distress was related to physical health problems rather than mental or emotional distress.

• Scoring, administering and interpreting the K10/ K10+ is considered simple with no special training or clinical expertise required.

### Health and social functioning

#### Quality of Life scale

The World Health Organisation Quality of Life 8 questions (WHO QoL-8, also known as the EUROHIS QoL-8) was designed for use as a very short and concise quality of life instrument. The WHO QOL 8-item index was developed as an adaptation of the WHOQOL-100 and the WHOQOLBREF and is therefore an international cross-culturally comparable quality of life assessment tool. It has been used and validated across a range of populations, including in drug and alcohol settings and with those with mental health disorders. It has been validated cross culturally and in the Australian context. It has been found to be reliable and valid in both older and younger people and has been extensively tested in both psychiatric and drug and alcohol contexts.

The WHO QoL-8 is a broad domain based measure that has applicability across the range of program types in the non-government drug and alcohol sector. It measures quality of life across the following domains:

- general or overall quality of life
- overall perception of health
- quality of physical life
- quality of psychological life
- quality of social relationships
- quality of living environment.

#### NSW MDS items

3 items from the NSW MDS have been included as a different and more objective measure of changes in these areas than the satisfaction ratings from the WHOQOL-8.

The items ask about a person’s living arrangements, who they live with and their main source of income. These items are collected by most NADA members as part of their NMDS or MDS data reporting requirements however they also form a useful outcome measure and can be taken at a number of occasions during a person’s engagement with a service.
**BTOM-C items on arrests**

The client’s number of police arrests is an important outcome measure, as crime may be instrumentally linked to the funding of drug use, and a reduction in criminal behaviour is an important societal and personal benefit of treatment\(^{42,43}\).

The questions are the crime questions that are part of the validated BTOM outcome measurement tool developed by NSW Ministry of Health. These two questions ask the number of times the client has been arrested in the last 3 months and how many arrests were for offences committed in the last 3 months\(^{44}\).

The 2 questions are regarded as the most appropriate outcome measure, due to the difficulty (including ethical and confidentiality difficulties) of collecting information on specific criminal activities through self-reporting.

**BBV exposure risk taking scale**

**BTOM-C items on risky drug using practices**

Sharing of equipment such as needles and syringes, spoons and filters increases the risk of transmitting blood borne viruses such as Hepatitis C, HIV\(^{45,46,47,48}\), and other injection-related infections\(^{49}\). Drug injection trends among participants in the Australian Needle and Syringe Program showed hepatitis C antibody prevalence to be consistently high among respondents that reported last injecting heroin, cocaine, and methadone or pharmaceutical opioids\(^{50}\). Other harms include fatal and non-fatal drug overdose\(^{51,52}\), which is linked to a range of negative outcomes such as brain damage\(^{53}\) and even death\(^{54}\).

A key finding of the 2011 Illicit Drug Reporting System (IDRS) surveys reported twenty-five percent of participants had shared injecting equipment (excluding needles)\(^{55}\). Among this national sample, one in ten participants who inject drugs (PWID) borrowed needles in the month preceding the interview.

The BBV exposure risk-taking domain comprises 4 items from the BTOM-C on injecting drug use and overdose. The questions are the risk taking questions that are part of the validated BTOM measurement tool developed by NSW Health. These items measure changes and outcomes in relation to injecting and other risky drug use practices.


GUIDELINES FOR ADMINISTERING COMS
3. GUIDELINES FOR ADMINISTERING COMS

This section contains:

• guidelines for the administration and completion of the questionnaire.
• circumstances for using clinical judgement before administering the questionnaire.
• do’s and don’ts – general activities and approaches to adopt and avoid when administering the questionnaire.
• recommendations for collecting information on the Indigenous status of clients when administering the questionnaire.
• privacy and confidentiality guide.

Guidelines for completing the questionnaire

• The COMS can be directly administered by a support worker or clinician, or can be completed by the client (with the support of a worker) on paper or directly into the COMS database.
• Ensure wherever possible the whole questionnaire is completed on one occasion. If this is not possible, record the date each section of the questionnaire is completed.
• If a person is self-completing all or part of the questionnaire, review the questionnaire to ensure that all questions are answered. If questions are unanswered, encourage the person to answer them.
• Ensure that all answers are based on the client’s response, not on the clinician’s guesses or assumptions.
• Assure clients that refusal to complete the questionnaire will not lead to their being treated differently.
• Ensure that the exact wording and format of the questionnaire (especially scored measures – the Kessler 10, SDS and WHOQoL-8) is adhered to, as the COMS is based on standardised measures.
• Assure the person that the questionnaire is subject to the same rules of confidentiality and privacy as all other information held in their client record.
• Inform the person that the information gathered will be used only for their individual treatment planning and will provide a useful tool to inform their progress; however that de-identified data may be used for organisation level planning and reporting, sector wide reporting or for research purposes.
• Explain to the person that identifiable information will be available only to those involved in their direct care.

Clinical judgement

Use clinical judgment as to whether or how to administer the questionnaire:

• If the person is distressed and completing the questionnaire may add to their distress.
• If the person is too unwell to complete the questionnaire.
• If the person is unable to understand the content and requirements for completing the questionnaire (e.g. due to a psychotic or mood disturbance).
• If there are cultural or language impediments that make self-reporting inappropriate.

The “do’s” – activities and approaches to adopt when administering the questionnaire

✔ Do be warm, friendly and helpful.
✔ Do request and encourage the person to fill out the questionnaire.
✔ Do let the person know that you will be there to support and assist them if required.
✔ Do emphasize that there is not right or wrong answer.
✔ Do tell the person to answer the question based on what THEY understand the question means. Provide definition of words if the person is unfamiliar with it.
✔ Do encourage the person to answer ALL the questions.

The “don’ts” – activities and approaches to avoid when administering the questionnaire

✖ Do not force or command people to fill out the questionnaire.
✖ Do not answer the questions for the person.
✖ Do not tell the person how you feel they should answer the questions.
✖ Do not allow other people (including family members) to help the person complete the questionnaire (except in cases where issues such as literacy or difficulty with English are a factor).
✖ Do not minimise the importance of completing the questionnaire.
Do not accept an incomplete questionnaire without first encouraging the person to fill out unanswered questions.
Do not paraphrase, rephrase, interpret or explain a question.

Timeframe for completing questionnaires

While some questions in the COMS relate to a period of 3 months, the majority relate to a period of 4 weeks. This difference reflects the use of existing standardised measures that use these timeframes.

NADA has not specified or even offered a suggested timeline for the administration due to the diversity of organisations who will be using it. The time points at which to administer the COMS questionnaire will depend on the length of an organisation’s treatment program; the particular organisation’s needs and resourcing. However, organisations and services are strongly encouraged to apply the COMS as frequently as possible during treatment as this will allow for the most useful information both clinically and organisationally.

For example, a 28-day residential program might administer COMS at intake and exit and then follow-up assessment as part of an aftercare program. Alternatively, a 12-month residential program might administer COMS at Intake, progress stages every 3 months and at Exit. The follow-up questionnaire(s) might be completed as part of an aftercare program.

Recommended guidelines for collecting information on Indigenous status

The Indigenous status question is asked through the MDS/NMDS of all persons who attend a service. It is important to collect data on Indigenous status as it enables the planning and delivery of suitable services, as well as to assess and monitor changes in Aboriginal and Torres Strait Islander health.

Due to prevailing inequalities in health status between Indigenous and non-Indigenous Australians, it is important that staff follow the recommended guidelines for collecting information on Indigenous status.

The recommendations below are based on The National best practice guidelines for collecting Indigenous status in health data sets (AIHW, 2010):

• Do not assume the person to be an Aboriginal person.
• Indigenous status should be asked of all persons irrespective of appearance, country of birth or whether the staff knows the person or their family background.
• Regard the Indigenous status question as no more or less sensitive or problematic than other items of personal data routinely collected from persons.
• All persons, whether Aboriginal, Torres Strait Islander or non-Indigenous, have the right to self-report their Indigenous status. Staff should not question or comment on the person’s response.
• Refrain from asking any person the Indigenous status question as an act of discrimination.
• Should a person want to change their Indigenous status, it should be received without comment and they should not be required to provide a reason for changing their status.
• If a person does not speak English, but is accompanied by someone who can interpret for them, it is recommended that the person accompanying them is asked to translate the question and their response.
• If there is no one with the person who can speak English, it is recommended that an interpreter or Aboriginal or Torres Strait Islander liaison officer (who can interpret the relevant Aboriginal or Torres Strait Islander language spoken by the person) be called to assist.

If a form is to be completed and the person cannot read or write, it is recommended that an appropriate staff member (e.g. an interpreter, social worker, Aboriginal or Torres Strait Islander liaison officer/health worker) go through the questions with the person.
Privacy and confidentiality

NADA members and users of the COMS will generally be required to comply with the National Privacy Act including the 10 National Privacy Principles (1988-revised 2011)\(^1\) and the NSW Health Records and Information Privacy (HRIP) Act (2002)\(^2\). These Acts outline the responsibilities the organisation has with regards to collection, use and security of data.

Before administering the COMS questionnaire, it is important to inform clients that steps will be taken to protect the privacy of their personal information. The following are appropriate steps to ensure this. A sample privacy and consent form is provided in the appendix:

- Inform the client why you are collecting this information
- Assure the person that their personal health information will be protected in accordance with the relevant Acts.
- Inform the person they are entitled to access their own records according to your organisation’s policies and are entitled to make a complaint about handling of personal information and privacy.
- Explain to the client that their personal information will be given to another person only if this is important for their health care or can be otherwise legally and ethically justified.
- Explain that de-identified information may be used in service and sector wide planning, reporting or research activities.

Note

De-identified information is information or opinion about a person whose identity cannot be ascertained from the information or opinion. For information to be classified as de-identified it must not contain identifiers which, if linked with other information, could lead to the identity of a person.

Hint: reasonable steps to de-identify the information

When de-identifying information, removing the name and address may not always be enough, particularly if there are unusual features, a small population, or there is a discussion of a rare clinical condition. Reasonable steps to de-identify might also include removing other features, such as date of birth and ethnic background that could otherwise allow an individual to be identified in certain circumstances.

---

USING THE COMS ONLINE DATABASE
Section 4 instructs users in logging in and entering and editing data in the outcomes measurement section of the NADA online database (the COMS). It does not provide instruction on entering data into the Minimum Data Set section of the NADA online database, except in that some fields are common (e.g. entering the client’s details, date of birth, sex, etc.).

4.1 Logging in

1. Enter the URL www.nada.org.au to access the NADA website
2. Click the ‘online database’ button on the home page
3. The log in page will appear
4. Enter your ‘username’ and ‘password’, then click ‘login’

Note

If you do not have a user name and password or have forgotten them please contact the Information System Development Manager at NADA. For the ISD’s contact details see the staff page on www.nada.org.au.

4.2 Main menu

5. If your organisation has more than one program or site or agency covered under the same log in, at the next screen you will have to choose which program or site or agency you want to work in.
6. When you have clicked it, you will proceed to the ‘main menu’. If you only have one program or site or agency under that log in you will proceed straight to the main menu.
4.3 Adding or updating client information

The ‘edit client/episode information’ option allows you to add a new client or enter information about an existing client. This part of the database contains both the Minimum Data Set (MDS) section and the Client Outcomes Management System (COMS) section.

1. To add a new client or edit an existing client click on the ‘edit client/episode information’ button.

4.3.1 Updating existing client information

You can search for an existing client (past or current) through their last or first name (if your agency enters those details) date of birth (compulsory information) or client code (compulsory information).

When searching for a client using a first name, last name or date of birth, all clients with that first name last name or date of birth will be listed, if you use more than one category to search with (e.g. last name and date of birth) only those clients with both those details matching will be listed. Click on that client to proceed to edit that record.

1. If there is no one in the database with those details no clients will be listed and you will need to create a new client code (see 4.3.2 below).

When searching for a client using client code which is a unique identifier, i.e. only one client can have a particular client code, and that client should retain the same code from episode to episode) enter the client code into the client code field and press search. Where that client already exists in the database you will proceed to their record.

2. Where that client does not exist you will be prompted to create a client with that client code.

3. Alternatively you can click on ‘show all clients’ which will produce a list of all clients for that service in client code order, or ‘show current clients’ which will produce a list of all current clients (i.e. clients with no date of cessation) in client code order.

4. Click on the client you want to edit.
4.3.2 Creating a new client

1. Enter the client code for the new client in the client code field

2. As this client code will not exist you will be prompted to create a client with the code you have entered.

3. This will take you to the client info screen where you will enter the client's data

4. After you have entered the client information click 'save'. You will now be able to enter Minimum Data Set/National Minimum Data Set data in the 'episodes' tab or outcomes data in the 'outcome measures' tab.

5. If you use the NADA online database for MDS/ NMDS you need to create an episode of treatment in the 'episodes' section of the data base first, this information will then be available to you through the 'outcomes' section. For more information see Using the NADA MDS System.

6. If you do not use the NADA online database for MDS/ NMDS or if you have already created an episode in this section of the database please click on the 'outcome measures' tab.

Please note that the questions in the top half (client code, date of birth, sex, indigenous status, country of birth and preferred language) are compulsory, while those in the bottom half are not and are protected against viewing by people outside your service.

For further information on how to answer these questions, please read Section 5 of this user guide Interpretation and scoring and/or the COMS data dictionary. If your service uses the NADA online database for their NMDS and/or MDS recording, refer to the Alcohol and other drug treatment services NMDS specifications 2008–09 and the Data dictionary & collection requirements – NSW Minimum Data Set – Drug/alcohol services 2005 – 2007 as the client information section here is also the client information data source for the MDS/NMDS.

Please also see the NADA publication Using the NADA MDS System.
4.4 Client outcomes

4.4.1 Treatment episode
For a client that has had no outcome measures entered the outcome measures screen will show no episodes.

For a client that has had outcomes measures entered, this screen will show the episodes and stages that have been entered so far.

1. To add a stage to an existing episode of treatment click ‘select’ next to the episode and then add or edit a stage (see 4.4.3 below)
2. To add an episode of treatment, click ‘add episode’ You will be prompted
3. This is a link to the MDS episodes discussed above (4.3.2), if you use the NADA online database to record MDS/NMDS data you will select ‘yes’ here. A screen displaying all treatment episodes for that client will display.

4. Choose the episode of treatment you want to add data to and click.
5. If you do not use the NADA online database to enter MDS/NMDS data you will click ‘no’ here to create an episode.

6. Enter in the commencement date for the treatment episode and click ‘save’.
7. To change the commencement date (only for those episodes created directly in the Outcomes section, not those linked to an MDS episode, these cannot be changed), click ‘edit’ next to the appropriate episode in the ‘outcome measures’ screen and change the commencement date. You can also tick the checkbox for ‘does not consent to research’ if the client doesn’t not give consent for research (See 4.4.2).

4.4.2 Consent to research
As the information entered into the COMS could potentially be used as de-identified data for research either by the organisation or by the sector as a whole through NADA, the client needs to have to opportunity to not consent to this (see the privacy and consent statement available in the Appendix).

1. If the client chooses not to consent to having their data used click on ‘edit’ next to the episode of treatment you wish to edit.
2. This will take you to the client consent window where you will check the box ‘does not consent to research’. Then click ‘save’.
4.4.3 Adding outcomes stages to a treatment episode

1. Click ‘select’ next to the episode you wish to add a Stage to (this is unnecessary if there is only one episode). Select a stage from the ‘stage’ drop down list (e.g. ‘intake’, ‘progress one’) and click ‘start survey’.

2. First enter the survey date (the actual date this survey was administered) or click the calendar icon to open the calendar and select the date.

3. Then enter the data for the ‘Severity of Dependence Scale’ as reported by the client, clicking on the radio button next to the response chosen.

4. After the 5 Severity of Dependence questions are answered at any stage other than intake, an additional question will be available, asking whether the drug of concern chosen was the same as the initial drug of concern at intake.

4.4.4 Adding outcomes data

For more information regarding all of the questions in the COMS questionnaire see Section 5 of this guide and/or the COMS data dictionary.

All the domains below are optional, see Section 6: Agency options.

1. The Drug and alcohol use section is the first screen to appear once a stage is chosen. You will notice that the side menu bar has also changed to allow you to navigate within this stage record.

2. First enter the survey date (the actual date this survey was administered) or click the calendar icon to open the calendar and select the date.

3. Then enter the data for the ‘Severity of Dependence Scale’ as reported by the client, clicking on the radio button next to the response chosen.

Note

For more information on ‘stage’ see Section 5 of this user guide Interpretation and scoring and/or the COMS data dictionary.
5. If you chose ‘yes’ you will proceed to the ‘drug and alcohol use’ questions, if you chose ‘no’ you will need to complete another ‘Severity of Dependence Scale’ on the original drug of concern which will automatically fill. This enables the original substance to be tracked across the course of treatment even if the client changes what they consider to be their primary drug of concern.

6. After the Severity of Dependence questions enter the data for ‘drug and alcohol use’

Every box needs to have an answer entered even if the response is ‘0’.

**Hint:** the maximum number of occasions to have seen a health professional is 89

**Hint:** a standard drink chart and timeline follow back calendar are provided in the Appendix.

7. When the page is complete click ‘next’. If you have forgotten to enter any data you will be prompted to do so before moving on to the next screen.

8. Next complete the Psychological health section

9. Click the radio button next to the appropriate response for questions 1-10 and question 14, enter an appropriate number (including ‘0’) for questions 11-13. Then click ‘next’.

10. Next complete the Health and social functioning section

11. Click the radio button next to the appropriate response for questions 1-8

12. For questions 9-11 select an answer from the drop down box that best describes the client’s circumstances.

13. For questions 12-13 a number needs to be entered into the box, even if that number is ‘0’. Then click ‘next’.

14. Next complete the BBV exposure risk taking scale section

**Important:** for clients for whom an MDS/NMDS episode has been created, these details will auto fill. For stages later than intake, these responses need to be checked and potentially changed as the person’s circumstances may have changed. That’s what makes these three responses an outcome measure.
15. For question 1 click the radio button next to the answer as reported by the client. Questions 2-3 only need to be answered if the client answered ‘in the last three months’ to question 1, if they did not, questions 2-3 will be greyed out. If they answered ‘in the last three months’ then for questions 2-3 click on the radio button next to the answer as reported by the client.

16. For question 4 enter a number, even if that number is ‘0’. Then click ‘next’.

17. Click ‘submit’.

That survey for that stage has been submitted. If you log out of the database before the survey is submitted, the survey will be saved as unsubmitted.

18. To complete the survey:
   1. Log into the database and search for client.
   2. Click the ‘treatment outcomes’ tab.
   3. Click ‘finish’ to complete survey.

4.4.5 Closing a treatment episode

1. Where a client’s episodes are managed through the MDS/NMDS section of the NADA online database, then closing the episode will be done there (see Using the NADA Online MDS System).

2. If your agency does not use the NADA online database to enter MDS/NMDS data each episode in the Outcomes section that is still open will have an option next to it ‘close’.

Note
It is still possible to add stages to an episode after it is closed, for example follow up surveys after the client has left the service and the treatment episode is closed.

3. The system will prompt you to enter the reason for cessation and where the client was referred on to.
4.5 Generating reports

4.5.1 Generating client outcome reports
To determine which graphs and tables will always appear in any of the COMS reports these should be selected through agency options (for instructions in how to utilise the agency options see Section 6: Agency options).

1. To manually remove some graphs and tables from a particular report, the radio buttons at the top of the report should be used (this option is not available for client stage reports as they do not contain graphs or tables, also, it is not possible to add graphs or tables that have not been selected in the agency options section).

2. To generate client outcome reports, you should first search and then select the client. All client outcome reports (including all stage, episode and full client outcome reports), can be accessed under the ‘outcomes measures’ tab.

4.5.1.1 Full client outcome report across services
A full client outcome report across services is a report of client treatment outcomes for all episodes and stages recorded for that client across different services but same organisation.

1. To generate a full client outcome report, click the ‘client report (across services)’ button.

This will generate a full client outcome report. It is important the client code stays consistent across different services of the same organisation. Only then can a report be generated for the same client across services.
4.5.1.2 Full client outcome report

1. A full client outcome report is a report of client treatment outcomes for all episodes and stages recorded for that client. To generate a full client outcome report click the ‘client report’ button.

This will generate a full client outcome report.
### 4.5.1.3 Client episode report

A client episode report is a report of outcomes from all the stages associated with one particular episode of care.

1. To generate a client episode report for a particular episode of care, under the ‘outcomes measures’ tab, select the ‘print’ option from the ‘actions’ column next to that episode.

This will generate a client episode report.

### 4.5.1.4 Client stage report

A client stage report is a report of a client’s particular responses to the COMS questionnaire for one stage within one episode.

1. Under the ‘outcomes measures’ tab, choose the episode of treatment of interest and click ‘select’.

2. Select ‘print’ in the ‘actions’ column next to the stage you wish to generate a report for.

A report will then be generated.
4.5.2 Exporting client outcomes reports

Once a report has been generated, you are able to export it to a number of different programs.

1. To export a report, select the type of program from the ‘select a format’ drop-down list and then click ‘export’.

This will generate a report that includes all relevant graphs and tables in a separate document opened in programs such as Microsoft Excel or Microsoft Word. This applies for both client outcome reports and stage reports.

4.5.3 Generating agency outcomes reports

An agency outcomes report summarises the results of all outcome measures successfully submitted to the database by that service within the designated time period.

1. To generate an agency outcome report, go the main menu located on the top left corner, and click ‘agency treatment outcomes’.

The agency outcomes screen will be displayed.

2. Select the date range of interest for the agency treatment outcomes report and choose ‘show report’, ‘export to excel’ or ‘export to CSV’.
4.5.3.1 Show report

‘Show report’ creates a report displaying graphs and tables describing the aggregate outcomes for clients of that service during the designated dates.

Once a report has been generated, you are able to export it to a number of different programs.

To export a report, select the type of program from the ‘select a format’ drop-down list and then click ‘export’.

This will generate a report that includes all relevant graphs and tables in a separate document opened in programs such as Microsoft Excel or Microsoft Word.

For assistance in interpreting the agency outcomes reports see Section 5: Interpretation and scoring.
4.5.3.2 Export to excel

This report creates an Excel spreadsheet with multiple worksheets displaying every answer for every question for every client stage and episode within that time period, essentially the raw data for that time period.
Export to CSV creates an spreadsheet displaying every answer for every question for every client stage and episode across different services within that time period, essentially the raw data for that time period. Unlike the export to excel function, this is an untabbed, unorganised form with all data in number form. The primary purpose of this function is to organise the data in a way that can be easily exported to statistical software packages. It includes some MDS data for those services who also use the NADA online database to collect MDS data (client type (i.e. own drug use/ others drug use), treatment delivery setting, source of referral, main treatment type).

4.5.4 Other agency reports

4.5.4.1 Produce graphic reports

The COMS database produces other reports in addition to the client outcomes reports and the agency outcome reports. These are:

- Indigenous status by treatment outcomes report
- gender by treatment outcomes report
- drug of concern by treatment outcomes report.

4.5.4.1.1 Indigenous status by treatment outcomes report

The Indigenous status by treatment outcomes report differentiates the agency outcomes by Indigenous status, that is, for each outcome domain for each stage, the report shows the score for Indigenous clients (Aboriginal, Torres Strait Islander or those who identify as both Aboriginal and Torres Strait Islander) in comparison with the score for those who identify as not Indigenous.
To produce this report:
1. Click ‘produce graphic reports’

2. Click the radio button for ‘treatment outcomes report breakdown’

3. Enter the start and end date for the period you want the report for

4. Click ‘Indigenous status by treatment outcomes’.

4.5.4.1.2 Gender by treatment outcomes

The gender by treatment outcomes report differentiates the agency outcomes by gender, that is, for each outcome domain for each stage, the report shows the scores for men and women separately.

To produce this report:
1. Click ‘produce graphic reports’

2. Click the radio button for ‘treatment outcomes report breakdown’

3. Enter the start and end date for the period you want the report for
4. Click ‘gender by treatment outcome’.

2. Click the radio button for ‘treatment outcomes report breakdown’

3. Enter the start and end date for the period you want the report for

4. Click ‘drug of concern by treatment outcomes’

4.5.4.1.3 Drug of concern by treatment outcomes

The drug of concern by treatment outcomes report differentiates the agency outcomes by initial drug of concern, that is, for each outcome domain for each stage, the report shows the scores for each initial drug of concern separately.

To produce this report:
1. Click ‘produce graphic reports’
INTERPRETATION AND SCORING
5. OUTCOMES MEASURES

5.1 Drug and alcohol use domain

Severity of Dependence Scale (SDS)

The SDS was devised to provide a short, easily administered scale which can be used to measure the degree of dependence experienced by users of different types of drugs. The SDS contains five items, all of which are concerned with the psychological aspects of dependence, specifically—impaired control over drug taking and preoccupation and anxieties about drug use.

The SDS is an excellent measure of substance dependence as defined in the DSM-IV TR, with high specificity and sensitivity.

The SDS is validated across a range of drug groups, including heroin, cannabis, cocaine, amphetamine and benzodiazepines.

The SDS has been validated in a range of translations and used in both adolescent and elderly populations. The wording of the SDS is straightforward and the concepts appear to be understood by a variety of drug users. It has also been used among Aboriginal and Torres Strait Islanders in research studies.

The SDS has been found to retain high validity in populations with coexisting disorders.

The SDS scores range from 0-15 with higher scores indicating a higher level of dependence.

<table>
<thead>
<tr>
<th></th>
<th>NEVER/ALMOST NEVER</th>
<th>SOMETIMES</th>
<th>OFTEN</th>
<th>ALWAYS/NEARLY ALWAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you ever think that your use of this drug/alcohol was out of control?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Did the prospect of missing this drug/alcohol make you very anxious or worried?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Did you worry about your use of this drug/alcohol?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Do you wish you could stop?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. How difficult did you find it to stop or go without?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
In relation to question 4 “do you wish you could stop?”, if an individual has not used any drugs in the previous three months, they will generally answer “never/ almost never”, however even if the individual is in a treatment program that requires total abstinence, it is still important that every question, including question 4, is answered.

As the SDS is a measure of psychological dependence, preoccupations and impaired control, often SDS scores remain elevated even after a person has stopped using or significantly decreased their use. SDS scores often show a higher level of dependence than the person may initially self report (e.g. they think it’s “not that bad”) and potentially may initially rise with an increased awareness through the process of treatment of impaired control, preoccupations and anxieties.

The COMS allows for tracking of a primary substance of concern at each stage after intake as well as tracking the original drug of concern if that is different, to take into consideration those persons who may change their primary drug of concern.

Studies have shown that an SDS score of 3 (out of 15) is correlated with a DSM-IV TR diagnosis of current substance dependence with a high level of specificity and sensitivity17,18. Some studies have shown that a score of 4 may be a more appropriate cut off for younger cannabis users (14-18 years)19 or a score of 6 may be a more appropriate cut off for prescription drug abuse, particularly benzodiazepines20.

The screening aspects of the SDS are important in determining dependence on the substance; however the change in score over time in treatment is what makes the SDS an outcome measure. The COMS will graph and tabulate the change in score through the stages and this is a measure of change in substance dependence over time in treatment and at follow up.

**Drug and alcohol use**

This outcome measure measures the actual number of days spent using all substances over the previous 4 weeks, or 28 days. It is therefore in contrast to the Severity of Dependence Scale that is an outcome measure focused on the primary drug of concern with a time frame of three months.

The measure for illicit substances and tranquillisers (benzodiazepines) is number of days used in the previous 28 days. Illicit drugs can be highly variable in quality and potency and only number of days used is able to provide an objective outcome measure. Other measures such as number of injections, number of joints, number of lines tell little about the actual quantity of the drug taken and may be misleading or variable.

The measure for alcohol is number of days on which alcohol was consumed and number of standard drinks ingested on those days. The alcohol measure includes a further measure of how many of those days were spent drinking more heavily than normal and number of drinks consumed on those days. The amount of alcohol in a standard drink is an objective measure. The appendix of this user manual contains a standard drink chart.

The measures for tobacco are number of days the person has smoked tobacco and quantity of tobacco smoked (measured in cigarettes).

The drug and alcohol use measure tracks all drug and alcohol use including but not limited to the primary drug of concern. As a screening tool it can identify other drugs the person consumes. As an outcome tool this can assist in tracking changes in drug and alcohol use as a result of treatment. For example, reduction in use of primary drug of concern with a consequent increase in some other substance or a reduction in all substance use.

This tool is able to be used in goal setting and case management as well as in harm reduction, tracking changes against goals the person defines for themselves or against risky levels of use.

The tool screens, tracks and assists in goal setting for tobacco use also. Reduction in, or cessation of, tobacco use is a feature of some drug and alcohol treatment programs, and is an important health outcome in any program.

The outcomes in the drug and alcohol use domain may also be read in conjunction with outcomes from the BBV exposure risk taking domain such as frequency of sharing injecting equipment and frequency of overdose. This could provide information with regards to whether reduction of use has been associated with reduction in risky using behaviour for example.
5.1.3 Outcomes measures: health and social functioning domain

**WHO EUROHIS QoL-8 (QoL-8)**

A briefer adaptation of the WHO QOL-100 and the WHO QOL-BREF, it comprises 8 questions that measure physical health, psychological health, social relationships and the person’s environment. The WHO QOL-8 is a tool that assesses quality of life both as an assessment tool and as an outcome measure, and was designed to be used in a range of medical, treatment and research situations.

The WHO QOL instruments were developed across a range of centres worldwide and since the initial development have been translated and validated across a wide range of countries and cultures. The QOL tools have been used successfully in adolescent and older populations. These instruments have also been widely tested and validated in mental health and drug and alcohol populations.

Each of the 8 questions in the QOL-8 are scored from 1-5 with a poor quality of life response (e.g. not at all, very poor, very dissatisfied) scoring 1 and a good quality of life response (e.g. completely, very good, very satisfied) scoring 5. The QOL-8 therefore gives a score from 8-40 with 8 representing the very poorest perceived quality of life and 40 representing the very best perceived quality of life.

The QOL-8 is also domain score-able and the NADA COMS database provides graphing options for comparing outcomes across the domains. The 6 domains are:

1. overall perception of quality of life (q.1)
2. overall perception of health (q.2)
3. physical quality of life (q.3 + q.5)
4. psychological quality of life (q.6)
5. satisfaction with social relationships (q.7)
6. satisfaction with environment (q.4 + q.8).

Although there are no validated bands representing different levels of quality of life, when used as an outcome tool the intention is to measure the various rates of improvement or deterioration in the various domains.

---

**5.1.2 Psychological health domain**

**Kessler 10+ (K10+)**

The Kessler 10+ scale is a widely used, simple self report measure of psychological distress. This measure was designed for use in the general population to detect high prevalence mental health disorders (e.g. anxiety and depression). It can also detect mental health disorders with lower population prevalence (e.g. schizophrenia). It also can be used to simply measure an individual’s levels of nervousness, agitation and psychological fatigue.

The Kessler 10+ has good sensitivity and specificity from its lowest to its highest score. The K10+ is simple and easy to use and score and is appropriate for a wide range of clients and service types. It has been translated into a wide range of languages and has been validated with a number of different cultural groups. The K10+ has no significant biases for gender or education and has been successfully used in a range of Australian settings and populations including rural populations and drug and alcohol settings.

The K10+ is well understood outside drug and alcohol settings and is often used by GPs. The K10+ is used by the Australian National Survey of Mental Health and Well Being, surveys in New South Wales for the Chief Health Officer and surveys of Aboriginal populations in Western Australia and the Northern Territory.

Scoring:

The scoring of the K10+ only relates to scores for the first 10 questions, each question being scored from 1 (none of the time) to 5 (all of the time), with a total score thus being from 10-50.

- **Low risk (10-15):** one quarter of the population risk of meeting criteria for anxiety or depressive disorder and are unlikely to make a suicide attempt in their life time.
- **Moderate risk (16-21)/high risk (22-29):** three times the population risk of having a current anxiety or depressive disorder and three times the population risk of ever having made a suicide attempt.
- **Very high risk (30-50):** ten times the population risk of meeting criteria for anxiety and depression and twenty times the population risk of ever having made a suicide attempt.

The additional 4 questions (the ‘+’) do not contribute to the total score but are chosen as variables relevant to the distress that may be being experienced by the person and are available for staff and the person to use as additional information to assist in the interpretation of the K10 score.
3. The third question asks about the person’s usual accommodation. At intake for a residential service this would be usual accommodation just prior to entering the service, whereas progress points would reflect the fact that the person was residing in the treatment program. Usual accommodation reflects where the person spends most of their time, for further definition of ‘usual accommodation’ see the COMS data dictionary. The service needs to decide in cases where, for example, a client’s most recent residence was a psychiatric hospital or a gaol whether to record those details or the person’s ‘home’.

The next two questions come from the Brief Treatment Outcome Measure – Concise (BTOM-C). They are also non-scoring questions and not graphed and also measure social functioning through the outcome measure of increasing or decreasing criminal behaviour.

5.1.4 BBV exposure risk taking domain

**BBV exposure risk taking**

These four questions measure risk drug using behaviour, specifically injecting drugs, sharing needles and syringes in the last 3 months, sharing other injecting equipment in the last 3 months and number of occasions on which the person overdosed in the last 3 months. Where the person answers that they have not injected in the last three months, they will not be asked whether they have shared needle and syringe or other equipment in the last three months.

Overdose is not limited to heroin overdose; any acute toxic reaction to a drug may be classed as an overdose

These four questions are not scored and not graphed, however they provide a useful outcome measure, looking at changes in risky behaviour around drug and alcohol use.

---

**Additional questions**

The first 3 ‘additional questions’ are taken from the NSW Minimum Data Set (MDS) for Drug and Alcohol Services. Where the MDS questions in the NADA online database are already completed these will autofill in the COMS, if not they need to be entered by the organisation.

**Important:** as these answers auto fill for those organisations that use the MDS section of the NADA online database, they remain the same from stage to stage. These three factors are outcome measures and they need to be asked again at each stage as social functioning circumstances may change (for e.g. moving from temporary benefit to part time employment). Where there is a change from the initial response, the organisation needs to remember to choose the more appropriate answer from the drop down list.

These three questions are non-scoring questions and as such are not graphed, they are social functioning questions and the associated outcome measure is improved social functioning (for e.g. moving from a temporary benefit to part time employment or from less to more stable housing).

1. The first question asks what is the person’s principle source of income (the greatest proportion of all income received). For the purposes of the MDS, full time employment is considered as 20 or more hours per week, temporary benefit includes Newstart Allowance, Youth Training Allowance, and Sickness Allowance, permanent benefit includes Disability Pension, Aged Pension, and Carers Pension. For a more comprehensive definition of the various sources of income, refer to the COMS data dictionary.

2. The second question asks the person’s living arrangements, whether living alone, with family members or other living situations. Persons currently residing in a residential treatment facility should be recorded as ‘alone’. For a more comprehensive definition of Living Arrangements, refer to the COMS data dictionary.

Important: as these answers auto fill for those organisations that use the MDS section of the NADA online database, they remain the same from stage to stage. These three factors are outcome measures and they need to be asked again at each stage as social functioning circumstances may change (for e.g. moving from temporary benefit to part time employment). Where there is a change from the initial response, the organisation needs to remember to choose the more appropriate answer from the drop down list.

---

Additional questions

The first 3 ‘additional questions’ are taken from the NSW Minimum Data Set (MDS) for Drug and Alcohol Services. Where the MDS questions in the NADA online database are already completed these will autofill in the COMS, if not they need to be entered by the organisation.

Important: as these answers auto fill for those organisations that use the MDS section of the NADA online database, they remain the same from stage to stage. These three factors are outcome measures and they need to be asked again at each stage as social functioning circumstances may change (for e.g. moving from temporary benefit to part time employment). Where there is a change from the initial response, the organisation needs to remember to choose the more appropriate answer from the drop down list.

These three questions are non-scoring questions and as such are not graphed, they are social functioning questions and the associated outcome measure is improved social functioning (for e.g. moving from a temporary benefit to part time employment or from less to more stable housing).

1. The first question asks what is the person’s principle source of income (the greatest proportion of all income received). For the purposes of the MDS, full time employment is considered as 20 or more hours per week, temporary benefit includes Newstart Allowance, Youth Training Allowance, and Sickness Allowance, permanent benefit includes Disability Pension, Aged Pension, and Carers Pension. For a more comprehensive definition of the various sources of income, refer to the COMS data dictionary.

2. The second question asks the person’s living arrangements, whether living alone, with family members or other living situations. Persons currently residing in a residential treatment facility should be recorded as ‘alone’. For a more comprehensive definition of Living Arrangements, refer to the COMS data dictionary.

---

5.1.4 BBV exposure risk taking domain

**BBV exposure risk taking**

These four questions measure risk drug using behaviour, specifically injecting drugs, sharing needles and syringes in the last 3 months, sharing other injecting equipment in the last 3 months and number of occasions on which the person overdosed in the last 3 months. Where the person answers that they have not injected in the last three months, they will not be asked whether they have shared needle and syringe or other equipment in the last three months.

Overdose is not limited to heroin overdose; any acute toxic reaction to a drug may be classed as an overdose

These four questions are not scored and not graphed, however they provide a useful outcome measure, looking at changes in risky behaviour around drug and alcohol use.
5.2 Interpreting COMS reports

5.2.1 Client outcome report

All of the following reports for 5.2.1 – client outcome reports are illustrated using a client episode report (all outcomes for one treatment episode), however the interpretations and explanations hold true whether this report, a full client report across all episodes within one service, or a full client report across all episodes across all services within an individual organisation were to be produced.

5.2.1.1 Drug and alcohol use

5.2.1.1.1 Average SDS score (across all substances) by stage: graph and table

The average SDS score by stage graph and table show the client’s average SDS score at each stage. In the example, the graph shows at intake the SDS score is 11.0 which indicates a high level of substance dependence. During and after treatment however, the average SDS score is shown to decrease to 6.0. This is a reduction from the higher level of drug dependence this client was experiencing at intake.

Please note: that the COMS allows a client to choose which drug they are most concerned about at each stage, the COMS continues to track whichever drug they were most concerned about at intake and so from any point after intake the SDS score could be the average of the current substance of concern and the initial substance of concern and is therefore a measure of their general concern about their use of substances. This is broken down further in subsequent graphs and tables.

5.2.1.1.2 Initial substance SDS score by stage: graph and table

The initial substance SDS score by stage graph and table tracks the SDS score at each stage only for the substance that was of greatest concern at intake. In this example we can see that the initial substance of concern was amphetamines. The dependence on amphetamines decreased during treatment, increased a little at exit (although as we will see later the client was no longer using amphetamines) and then decreased to 3 at follow up. This graph and table will often be read in conjunction with the next graph and table, tracking the primary drug of concern at each stage.

5.2.1.1.3 Individual substance SDS by stage: graph and table

The individual substance SDS score by stage graph and table track the SDS score for each individual substance at each stage. This graph and table therefore breaks down the average SDS illustrated in the Average SDS graph and table enabling each primary drug of concern to be tracked individually.

In the example, the table shows that ‘Amphetamines’ is the primary drug of concern at intake with an SDS score of 11.0, this is considered highly dependent.

<table>
<thead>
<tr>
<th>Substance (SDS Score)</th>
<th>1/01/2011</th>
<th>1/04/2011</th>
<th>1/07/2011</th>
<th>1/08/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td>11</td>
<td>9</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note: that the COMS allows a client to choose which drug they are most concerned about at each stage, the COMS continues to track whichever drug they were most concerned about at intake and so from any point after intake the SDS score could be the average of the current substance of concern and the initial substance of concern and is therefore a measure of their general concern about their use of substances. This is broken down further in subsequent graphs and tables.
At progress one, the primary drug of concern remains Amphetamines and the SDS score is shown to decrease to 8.0. At exit however, the primary drug of concern has changed to Cannabis with an SDS score of 7.0. This indicates that the client now believes that Cannabis is the drug they are most concerned about. At follow-up one, the client is still most concerned about cannabis and the SDS has increased to 9.0. This client is still less dependent on their cannabis use than they were initially dependent on their amphetamine use when they began treatment. As was seen in the above graph and table the client’s SDS for amphetamines, the initial substance of most concern, at exit and follow up one were 9 and 3 respectively.

At exit, the client’s primary concern was with their cannabis use, however their SDS score for amphetamines was still higher (9 compared with 7) indicating they were actually still more dependent on amphetamines. At follow-up one the client was most concerned with their cannabis use, and the SDS score for cannabis was higher than for amphetamines (9 compared with 3).

5.2.1.1.4 Drug and alcohol use graph and table

The drug and alcohol use graph and table show the average number of days spent using each substance over the previous 4 weeks (28 days). The second section of the drug and alcohol table show the average number of drinks consumed on days when alcohol was consumed, the number of days alcohol was consumed more heavily than normal and the number of drinks consumed on those days, and the number of cigarettes consumed on those days when the client smoked.

Drug and alcohol use is used in conjunction with the SDS to compare the client’s dependence with their actual use (actual use may decline while dependence remains high, for example in a program requiring total abstinence). These two measures show different things that combine to give a useful picture of the client’s drug and alcohol use. The drug and alcohol use table also provides a useful outcome measure in particular for alcohol and tobacco use, both of which use a standard measure. For example both the number of days used and number of drinks per day can both be compared. A client may drink the same number of days but half as many drinks per day for example. This is a useful outcome measurement tool in that it can track trends in all drug and alcohol use rather than just the primary drug of concern at each stage.

Clearly, as with all the domains and individual measures in the COMS, comparisons may be made, for example did psychological distress or quality of life increase or decrease in line with increases or decreases in use of drug and alcohol?

In the example, the graph shows at intake the client has frequently used Cannabis, Amphetamines, Tobacco and alcohol in the last four weeks. Throughout treatment, the use of drugs in the last 4 weeks decreases to 0 indicating that drug use patterns changed when provided treatment. This client resumed alcohol, tobacco and cannabis use post treatment but to a lesser extent in both number of days used in all three cases and amount used in the cases of alcohol and tobacco.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How many days in the last 4 weeks did you use:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>25</td>
<td>20</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Heroin</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Other opioids (e.g., methadone, oxymorphone)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Cannabis</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Tranquilizers (doxylamine, valium)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Tobacco (cigarettes, pipes, pipes)</td>
<td>20</td>
<td>16</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Another drug</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>On average, how many standard drinks did you have on these days when you were drinking?</td>
<td>10</td>
<td>6</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Number of drinks when drinking more heavily than usual</td>
<td>10</td>
<td>15</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Number of days in the last four weeks drinking at level heavier than usual</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>How many cigarettes did you have on a typical day when you used tobacco?</td>
<td>25</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
</tbody>
</table>
5.2.1.3 Health and social functioning

5.2.1.3.1 Overall Quality of life graph and table
The overall Quality of Life graph and table shows the client’s total quality of life score (out of a total score of 40) at each of the defined stages.

In this example, the client’s overall quality of life score is extremely low, at 6. This however improves throughout the program with scores shown to increase up to 25. By follow-up, the score does decrease slightly to 20 however this is still a significant improvement from their quality of life at intake.

5.2.1.2 Psychological health

5.2.1.2.1 K10+ graph and table
The K10+ table and graph show the average K10 score at each stage. The second section of the K10+ table shows the responses to the additional four questions of the K10+. In this example the graph shows the client is experiencing severe levels of distress with an average K10 score of 40. Throughout treatment (from intake through to exit) K10 scores progressively decrease to a score of 26 at progress one and then to 20 at exit which indicate the client is experiencing mild to moderate levels of distress. At follow-up average K10 scores have increased but is still within mild to moderate levels of distress, which is a significant improvement from the distress experienced at intake.

It is important to remember that the K10+ measures psychological distress and is particularly linked to anxiety and depression, although changes in K10+ score can also be linked to changes in illnesses such as schizophrenia and other psychoses. Although it is not unusual for a client’s psychological distress to worsen on commencement of treatment, with the removal or reduction of drug and alcohol use and the possible commencement of some therapeutic interaction, any worsening in the K10+ score needs to be addressed by the service.

5.2.1.3.2 Complete Quality of Life domain graph
The complete Quality of Life domain graphs show the client’s quality of life responses broken down into a number of domains. The first graph shows the general quality of life score at each stage (more specific than just the total quality of life in 5.2.1.3.1, above) and the second graph displays the ‘perception of the health’ score at each stage. The third graph shows the clients satisfaction across different domains: physical, psychological and social and environmental.

From the Quality of Life graphs, one can see that at intake the client’s scores are relatively low in all fields but all improve during treatment. This however improves throughout the program with scores shown to increase up to 25. By follow-up, the score does decrease slightly to 20 however this is still a significant improvement from their quality of life at intake.
5.2.1.3.3 Quality of Life full table

The Quality of Life full table shows the client’s responses related to their perceived quality of life at each of stage. This table is useful because it shows the actual answers given for each question at each stage rather than just total or average scores. It can highlight any changes or improvements the client may experience between their perceived health and satisfaction with their physical and social environment.

5.2.1.3.4 Additional questions table

The additional questions table shows the client’s response to the five questions of the ‘additional questions’ section at each stage. The questions track any change that has occurred to the client’s external circumstances, which can be read, for example, in conjunction with their levels of psychological distress. This table is also useful for identifying any changes in the occurrence of criminal behaviour.

In this example, the table shows that at intake the client has been arrested twice in the last three months. After treatment, this reduces to 0, which indicate a decrease in criminal behaviour. This may be correlated with a change in main source of income from being dependent on others to part-time employment.

5.2.1.4 BBV risk taking table

The BBV exposure risk taking table displays the number of times the client has participated in risky taking behaviour, including overdose, around drug and alcohol use.

In the example, the number times the client overdosed in the last three months has reduced from 5 to 0 indicating that there has been a reduction in risky behaviour around drug and alcohol use. This table also indicates that the client has ceased injecting drug use, which correlates with earlier graphs and tables showing that the client has ceased amphetamine use (presumably injected) and is now drinking alcohol and smoking cannabis.
5.2.2 Agency outcome report

5.2.2.1 Drug and alcohol use

5.2.2.1.1 Average SDS score by stage graph and table

The average SDS score by stage graph and table show the overall average SDS score for all clients at each stage.

For example, the graph shows at intake the average SDS score for all clients is 12.4, this indicated a high level of substance dependence. On average clients show less dependence severity during treatment as indicated by the exiting SDS score of 2.8, however become slightly more dependent after exiting the program, with an average SDS score of 4.6. This is still a significant improvement from the higher level of drug dependence clients were experiencing at intake. It should be remembered that this change in average severity of dependence may or may not be related to change in drug use, for example a program requiring total abstinence may still have clients with high levels of concern about their drug use.

5.2.2.1.2 Average SDS score for initial substance by stage graph and table

The average SDS score for initial substance by stage graph and table tracks the average SDS score of the drugs that were indicated as the primary drug of concern at intake.

For example, the graph and table show at intake the average SDS score for initial substances for all clients is 12.4, indicating a high level of substance dependence. Clients are generally less dependent on their initial drug of concern during treatment as indicated by the score of 4.3 at progress one and 1.0 on exit. At follow-up however, the average SDS score for those substances is seen to increase to 2.3 but the severity of dependence is still well below what clients were experiencing at intake.

![Average SDS Score (across all Initial substances)](image)

<table>
<thead>
<tr>
<th>Average SDS Score</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow-up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Total Score (15)</td>
<td>12.4</td>
<td>4.3</td>
<td>1.0</td>
<td>2.3</td>
</tr>
</tbody>
</table>
5.2.2.1.3 Individual substance SDS score by stage graph and table

The individual substance SDS score by stage graph and table show the average SDS score for all clients who stated that that substance was their primary substance of concern at that stage. The brief table shows the mean scores for all clients at each stage while the full table includes the median individual substance SDS scores and the total number of clients from whom the mean and median scores were taken. This graph is broken-down into individual substances and shows the average SDS scores at the defined stages. The example graph shows at intake the average SDS score for cocaine is high at 11.7 however is shown to decrease to 2.7 at exit. At follow-up the overall SDS score for cocaine increases to 6.0 which is less dependent than at intake. On the other hand, Tobacco (coded in yellow) use has become the primary drug of concern for some clients at exit and at follow-up shows an SDS score of 9.0. This follows a different pattern to that of cocaine.

![Individual Substance SDS by Stage Graph](image)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow-up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>12.7</td>
<td>7.5</td>
<td>1.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>12.8</td>
<td>8.3</td>
<td>3.0</td>
<td>4.8</td>
</tr>
<tr>
<td>Cannabis</td>
<td>7.0</td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Cocaine</td>
<td>11.7</td>
<td>7.7</td>
<td>2.7</td>
<td>6.0</td>
</tr>
<tr>
<td>Heroin</td>
<td>11.6</td>
<td>12.0</td>
<td>4.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Tobacco</td>
<td>9.0</td>
<td>9.0</td>
<td>9.0</td>
<td>9.0</td>
</tr>
<tr>
<td>Tranquilizers (e.g. benzodiazepines, valium)</td>
<td>11.6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.2.2.1.4 Individual substance SDS for initial substance of concern by stage graph and table

The individual substance SDS for initial substance of concern by stage graph and table show the average SDS score for each drug that was indicated as the primary drug of concern at intake at each outcome stage. This graph tracks individual substances and shows the average SDS scores of initial substances at the defined stages for all clients. The graph shows high SDS scores of the substances recognized as the primary drug of concern at intake but decrease significantly throughout treatment (intake to progress one to exit). The brief table shows the mean scores for all clients at each stage while the full table includes the median individual substance SDS of initial substance scores and the total number of clients from whom that mean score was taken. In this example, some clients have recognised either Amphetamines or Cocaine as their primary drug of concern with SDS scores of 12.8 and 11.7, respectively. Dependence on these substances dramatically reduce at progress one and further upon exit. Overall, the graph is useful for tracking the dependence on the substance clients initially list as their primary drug of concern. One can see from the graph that SDS scores decrease to a significant degree. The increase shown at follow-up may provide useful information for program planning.

![Individual Substance SDS by Stage (Initial Substance) Graph](image)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow-up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>12.7</td>
<td>7.5</td>
<td>1.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>12.6</td>
<td>4.0</td>
<td>1.3</td>
<td>4.0</td>
</tr>
<tr>
<td>Cocaine</td>
<td>11.7</td>
<td>3.0</td>
<td>1.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Heroin</td>
<td>11.6</td>
<td>10.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Tranquilizers (e.g. benzodiazepines, valium)</td>
<td>11.6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow-up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>12.7</td>
<td>7.5</td>
<td>1.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>12.8</td>
<td>4.0</td>
<td>1.3</td>
<td>4.0</td>
</tr>
<tr>
<td>Cocaine</td>
<td>11.7</td>
<td>3.0</td>
<td>1.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Heroin</td>
<td>11.8</td>
<td>10.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Tranquilizers (e.g. benzodiazepines, valium)</td>
<td>11.6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.2.2.1.5 Drug and alcohol use graph and table

The drug and alcohol use graph and table show the average number of days spent using each substance over the previous 4 weeks (28 days) for all clients. The second section of the Drug and alcohol table shows the average number of drinks consumed on days when alcohol was consumed, the number of days alcohol was consumed more heavily than normal and the number of drinks consumed on those days, and the number of cigarettes consumed on those days when the client smoked. The brief table shows the mean number of days for all clients at each stage and the full table also includes the median number of days clients have used each substance in the last 4 weeks at each stage. It also shows the total number of clients using a specific drug at each stage.

In the example, the average number of number of days used in the last four weeks is relatively high for each drug(s). Upon exit, a dramatic decrease is seen in the use of drugs in the last 4 weeks except for tobacco use which has remained relatively consistent throughout the treatment program. Overall there has been a dramatic decrease in drug usage even at follow-up suggesting that all drug use—rather than just use of the primary drug of concern—patterns change when provided treatment. This is a useful outcome measurement tool in that it can track trends in drug and alcohol use other than the primary drug of concern.

<table>
<thead>
<tr>
<th>Question (Mean days)</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow-up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many days in the last 4 weeks did you use?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>10.1</td>
<td>16.0</td>
<td>8.9</td>
<td>16.6</td>
</tr>
<tr>
<td>Heroin</td>
<td>21.4</td>
<td>0.0</td>
<td>0.0</td>
<td>2.6</td>
</tr>
<tr>
<td>Other opioid based drug</td>
<td>20.8</td>
<td>0.0</td>
<td>0.0</td>
<td>16.8</td>
</tr>
<tr>
<td>Cannabis</td>
<td>17.8</td>
<td>28.0</td>
<td>9.9</td>
<td>6.0</td>
</tr>
<tr>
<td>Cocaine</td>
<td>14.7</td>
<td>0.0</td>
<td>0.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>10.6</td>
<td>20.0</td>
<td>9.9</td>
<td>5.6</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>22.9</td>
<td>25.1</td>
<td>29.9</td>
<td>25.0</td>
</tr>
<tr>
<td>Another drug</td>
<td>4.6</td>
<td>0.0</td>
<td>0.0</td>
<td>6.0</td>
</tr>
<tr>
<td>On average, how many standard drinks did you have on those days when you were drinking?</td>
<td>12.3</td>
<td>12.2</td>
<td>19.3</td>
<td>15.3</td>
</tr>
<tr>
<td>Number of drinks when drinking more heavily than usual</td>
<td>19.4</td>
<td>19.4</td>
<td>19.3</td>
<td>13.3</td>
</tr>
<tr>
<td>Number of days in the last four weeks drinking at level heavier than usual</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>How many cigarettes did you have on a typical day when you used tobacco?</td>
<td>16.2</td>
<td>15.0</td>
<td>12.1</td>
<td>15.0</td>
</tr>
</tbody>
</table>

INTERPRETATION AND SCORING
5.2.2 Psychological health

5.2.2.1 K10+ graph and table

The K10+ table and graph show the average K10 score for all clients at the defined stages. The brief table shows the mean score for all clients at each stage, while the full table also includes the median K10 score and the number of clients from whom that average score was taken. The K10+ graph graphs the mean scores only.

The second section of both K10+ tables show the responses to the additional four questions of the K10+, the brief version shows the mean number of occasions for the first three questions and the percentage who gave each response for the fourth question, while the full table gives the above but includes the median response for the first three questions and the number of clients for all four questions.

These tables and graph represent the change in psychological distress at each stage, providing information for treatment care planning, program planning, reporting, and tendering. The graph and tables indicate, on average, how clients of the particular service are responding in the areas of depression, anxiety, and general psychological distress and can highlight relevant patterns, for example clients’ psychological distress worsening before a subsequent improvement, or worsening prior to discharge.

In figure 1, the graph shows at intake the average K10 score for all clients is 37.8, this indicates severe levels of distress. During treatment (from intake through to exit) K10 levels are shown to decrease to 27.3 at progress one, which while lower, still indicates that clients who have been in treatment 30 days (progress one for this example service) are experiencing severe psychological distress and then to 18.4 at exit which suggests that on average clients are experiencing mild to moderate levels of distress. At follow-up average K10 scores have increased somewhat but still within mild-moderate levels of distress, which is a significant improvement from the distress they were experiencing at program entry and during the early stages of engagement.
5.2.2.2 K10+ bar chart

The K10+ bar chart shows the proportion of clients who fall into each band of psychological distress at each outcome stage. The stages are Low (K10 of 10-15), Moderate (K10 of 16-21), High (K10 of 22-29) and Very high (K10 of 30-50).

In this example, at intake approximately 90% of clients of the service are very highly psychologically distressed and approximately 10% are highly distressed (and therefore 100% of clients are either high or very high in their K10 score). By progress one only about 35% remain very highly psychologically distressed, about 45% are highly psychologically distressed, about 15% are moderately distressed and about 55% show low levels of psychological distress. By exit no clients were showing very high psychological distress any longer, about 17% showed high distress, 63% showed moderate psychological distress and about 20% showed low distress. By follow-up one, the proportional distress levels had worsened a bit, about 15% were now very highly distressed, 30% were highly distressed, 20% were moderately distressed and approximately 255 showed low levels of psychological distress.

Note

Please refer to 5.1.2 for descriptions and indicators of each of these bands of psychological distress.

5.2.2.3 Health and social functioning

5.2.2.3.1 Overall Quality of Life graph and table

The overall Quality of Life graph and table shows the average total quality of life scores for all clients each stage. The overall Quality of Life table also shows the mean scores for each domain (Quality of Life, perception of health, physical, psychological, social etc.) for all clients at each stage.

In this example, the overall Quality of Life score at intake is 9.7 but significantly improves to 19.1 at progress one then to 23.9 at exit. By follow-up the overall quality of life scores worsen to 20.5 but is still a significant improvement from the quality of life they were experiencing prior to treatment.
5.2.2.3.2 Complete Quality of Life domain graphs
The **complete Quality of Life domain graphs** show the quality of life responses converted as a score for all clients. The first graph, **Quality of Life graph** shows the average quality of life scores at the defined stages. The second graph **perception of health graph** displays the average perception of the health scores at the defined stages. The last graph displays the scores related to satisfaction with life across the different domains: physical, psychological and social and environmental at the defined stages for all clients.

From the **complete Quality of Life domain graphs**, one can see the scores at intake are relatively low in all fields but progressively improve during treatment (progress one through to exit). This suggests that clients overall have become more satisfied with their quality of life in all fields. By follow-up scores have slightly decreased in all domains. Despite this, there has been a significant improvement the perception of health in all domains for clients in general.

5.2.2.3.3 Quality of Life full table
The **Quality of Life full table** shows the percentage and number of clients who gave each response to each question in the quality of life section of the health and social outcomes domain. For example of the 20 clients measured at intake 11 of them (or 55%) rated their quality of life as very poor, 4 of them (or 20%) rated their quality of life as poor, and so on. This full table enables the service to have a better breakdown of the various components of the average quality of life scores.

<table>
<thead>
<tr>
<th>Question</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction with quality of life</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very poor</td>
<td>59%</td>
<td>0%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>Poor</td>
<td>19%</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Neither poor nor good</td>
<td>21%</td>
<td>62%</td>
<td>14%</td>
<td>21%</td>
</tr>
<tr>
<td>Good</td>
<td>10%</td>
<td>9%</td>
<td>9%</td>
<td>73%</td>
</tr>
<tr>
<td>Very good</td>
<td>0%</td>
<td>9%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>(Total number of clients)</td>
<td>(20)</td>
<td>(19)</td>
<td>(18)</td>
<td>(11)</td>
</tr>
</tbody>
</table>

| Satisfaction with health | | | | |
| Very satisfied | 55% | 0% | 9% | 0% |
| Dissatisfied | 19% | 25% | 16% | 19% |
| Neither satisfied nor dissatisfied | 11% | 56% | 9% | 21% |
| Satisfied | 10% | 19% | 59% | 46% |
| Very satisfied | 0% | 9% | 9% | 9% |
| (Total number of clients) | (20) | (19) | (18) | (11) |

| Satisfaction with ability for everyday life | | | | |
| Not at all | 35% | 0% | 9% | 0% |
| A little | 20% | 6% | 7% | 9% |
| Moderately | 15% | 44% | 7% | 16% |
| Mostly | 20% | 59% | 79% | 64% |
| Completely | 0% | 9% | 7% | 9% |
| (Total number of clients) | (20) | (19) | (18) | (11) |

| Satisfaction with ability to perform your daily living activities | | | | |
| Very dissatisfied | 20% | 0% | 9% | 0% |
| Dissatisfied | 30% | 6% | 9% | 10% |
| Neither satisfied nor dissatisfied | 20% | 59% | 7% | 26% |
| (Total number of clients) | (4) | (9) | (11) | (1) |
5.2.2.3.4 Additional questions table
The additional questions table shows the percentage and total number of clients who gave each response to the first three questions of the 'additional questions' section at each stage. This table tracks any change involving a person's external circumstances such as living arrangement income or usual accommodation and can highlight any relevant patterns.

The table also displays the average number of times clients have been arrested in the three-month period prior to each stage, and the average number of crimes committed during that period. This table is useful for identifying any changes in the occurrence of criminal behaviour.

5.2.2.4 BBV risk taking table
The BBV exposure risk taking table displays the total number and percentage of clients who gave each response to the first three risk taking behaviour questions around drug and alcohol use. The table also shows the average number of times (median also included) clients have overdosed in the last three months at the defined stages.

This table is a useful indicator for detecting changes in risky behaviour around drug and alcohol use. In the example there is a reduction in the number of times clients on average have overdosed from 3.6 at intake to 1.2 at progress one and then to 0 by follow up one.

### Additional Questions

<table>
<thead>
<tr>
<th>Main source of income</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time employment</td>
<td>25%</td>
<td>6%</td>
<td>7%</td>
<td>0%</td>
</tr>
<tr>
<td>(5)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Part-time employment</td>
<td>5%</td>
<td>0%</td>
<td>7%</td>
<td>27%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Temporary benefit (e.g. sickness, unemployment)</td>
<td>20%</td>
<td>10%</td>
<td>21%</td>
<td>0%</td>
</tr>
<tr>
<td>Permanent (e.g. aged, disability)</td>
<td>15%</td>
<td>12%</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>Student allowance</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Dependent on others</td>
<td>30%</td>
<td>30%</td>
<td>26%</td>
<td>45%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Retirement/land</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>No income</td>
<td>5%</td>
<td>25%</td>
<td>36%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Total number of clients</strong></td>
<td>(20)</td>
<td>(16)</td>
<td>(14)</td>
<td>(11)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living with</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone</td>
<td>45%</td>
<td>34%</td>
<td>83%</td>
<td>65%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Spouse/partner</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Alone with children</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Spouse/partner with children</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Parent(s)</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Other related(s)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Friend(s)</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>27%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Friend(s)/parent(s)/relative(s) and child / children</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Total number of clients</strong></td>
<td>(20)</td>
<td>(16)</td>
<td>(14)</td>
<td>(11)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living in</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rented house on the outskirts of private</td>
<td>20%</td>
<td>6%</td>
<td>7%</td>
<td>35%</td>
</tr>
<tr>
<td>privately owned house or flat</td>
<td>40%</td>
<td>12%</td>
<td>7%</td>
<td>45%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Boarding house</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Hotel</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Psychiatric hospital</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
</tbody>
</table>

**Question**

1. Did you last inject NMU anytime during the last three months?

<table>
<thead>
<tr>
<th>Question</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last three months</td>
<td>66%</td>
<td>25%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>More than three but less than twelve months ago</td>
<td>6%</td>
<td>31%</td>
<td>43%</td>
<td>36%</td>
</tr>
<tr>
<td>Twelve months ago or more</td>
<td>20%</td>
<td>18%</td>
<td>21%</td>
<td>0%</td>
</tr>
<tr>
<td>(4)</td>
<td>(3)</td>
<td>(3)</td>
<td>(3)</td>
<td>(3)</td>
</tr>
<tr>
<td>Never injected</td>
<td>15%</td>
<td>18%</td>
<td>21%</td>
<td>18%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Net stated inadequate decreased</td>
<td>5%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
</tbody>
</table>

| **Total number of clients**         | (20)   | (16)         | (14) | (11)         |

2. How many times in the last 3 months did you use a needle or syringe after someone else had already used it?

<table>
<thead>
<tr>
<th>Question</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than ten times</td>
<td>36%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(7)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Six to ten times</td>
<td>6%</td>
<td>18%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Three to five times</td>
<td>16%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(3)</td>
<td>(3)</td>
<td>(3)</td>
<td>(3)</td>
<td>(3)</td>
</tr>
<tr>
<td>Twice</td>
<td>5%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Once</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Never</td>
<td>6%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
</tbody>
</table>

| **Total number of clients**         | (20)   | (16)         | (14) | (11)         |

3. In the last 3 months did you share any 'uppers' (hers, 'mush', 'shroom', 'pepsi hit', or 'Sniffer' with anyone else?.

<table>
<thead>
<tr>
<th>Question</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>56%</td>
<td>18%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>No</td>
<td>16%</td>
<td>8%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
</tbody>
</table>

| **Total number of clients**         | (20)   | (16)         | (14) | (11)         |

**Number of times overdosed in the last 3 months (Mean, Median and Total)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Intake</th>
<th>Progress One</th>
<th>Exit</th>
<th>Follow up One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of times injected in the last 3 months</td>
<td>3.6 (3.0)</td>
<td>1.2 (1.0)</td>
<td>0.0 (0.0)</td>
<td>0.0 (0.0)</td>
</tr>
<tr>
<td>(15)</td>
<td>(5)</td>
<td>(5)</td>
<td>(5)</td>
<td>(5)</td>
</tr>
</tbody>
</table>

**Interpretation and Scoring**


5.16 NADA network of alcohol & other drugs agencies
It is recommended that organisations use all the domains in the COMS. The COMS is designed in such a way that information from one domain informs and gives context to information from another domain, for example changes in drug and alcohol use and changes in psychological distress, changes in psychological distress and changes in quality of life or changes in living arrangements and changes in drug use. It is also important to have the fullest range of outcomes information possible when reporting to funders and for use in NADA’s sector advocacy work.

The COMS online database does however allow organisations to customise the questionnaire to best suit needs for measuring outcomes and for reporting outcomes. Section 6 instructs users of the COMS database on how to modify reporting functions, change user privileges and how to nominate which domains will be measured at each stage. A total abstinence service, for example may only measure drug and alcohol use at intake and at follow up.

6.1 Agency stages

Within the ‘agency stages’ section you can set the stages within an treatment episode that will be relevant to the service, i.e. those points at which you have decided that you will be collecting data (e.g. intake, progress one, progress two, exit, follow-up one etc.).

To modify the agency stages:
1. Click on the ‘agency options’ button from the main menu.
2. Under the tab labelled ‘agency stages’ tick the boxes next to those stages the service will be collecting data for.
3. Click ‘save’.

Note

Users of the data base will now only be able to enter data for those stages that have been checked.

6.2 Flagging options

The COMS database does not require agencies to complete all parts of the questionnaire and instead can be customised to best suit your agency.

To choose the domains (drug and alcohol use and/or severity of dependence scale, psychological health, health and social functioning and BBV exposure risk taking scale) for your questionnaire:
4. Click on ‘agency options’ in the main menu
5. Click on the ‘flagging options’ tab.
6. Check the boxes of the measures you wish to include for each stage and then click ‘save’.

Note

Only the stages that you select under the ‘agency stages’ tab (see 6.1) will appear in this window, so in this image, the organisation has chosen to only take the outcomes measures from clients at intake, at progress point, at exit and at a follow up point.

Note

It is possible to select different measures for different stages, so for example if you only want to measure drug and alcohol use at intake and follow up, you only tick those options for those stages.
6.3 Reporting options

6.3.1 General report settings
To select which graphs and tables will always appear in the any of the COMS reports,

1. Click on ‘agency options’
2. Click on the ‘reporting options’ tab
3. Then select ‘yes’ next to the graph/table you wish to include in the report (the converse also applies select ‘no’ next to the graph/table you do not wish to include in the report).
4. Do this for each report (client stage report, client episode report, full client report and the agency aggregate report) and then click ‘save’.

Client stage report: This creates a report for a specific client for a specific stage within one episode; it contains no graphs as only individual scores are available

SDS score: The Severity of Dependence score for the substance or substances of concern, where the substance of concern has changed from intake, both the original and the new substance of concern are shown in separate tables.

Drug and alcohol use table: a table showing the number of days the client reported using each of the listed substances in the previous 4 weeks, and the number of drinks ingested and cigarettes smoked on those days when the client drank alcohol or smoked cigarettes

Psychological health table: a table showing the average K10 score out of 50 and the actual response for the additional four questions

Quality of Life table: a table showing the actual responses to the 8 Quality of Life questions

Additional questions: a table showing the actual responses to the five additional questions outlined in the health and social functioning section of the COMS.

Brief QoL score: table showing the total Quality of Life score out of 40

QoL scores by domain: a fuller table showing the Quality of Life scores in each of the 6 more specific domains (perception of health, satisfaction with physical environment, satisfaction with relationships etc.)

BBV exposure risk taking table: a table outlining the actual responses to each of the BBV risk taking questions
**Client episode report**: A report outlining outcomes for all stages within one defined treatment episode.

**Average SDS score by stage graph**: graph showing the average SDS score for this client at each stage, this includes an average of the current substance of concern and original substance of concern (if they are different)

**Note**

As noted in *Section 5: Interpretation and scoring*, the average score may not accurately reflect the person’s current dependence on substances, if, for example a client had become quite dependent on alcohol (SDS=10) but was no longer dependent at all on their originally reported substance of most concern, for example amphetamines (SDS now= 0) their average SDS would be 5 which may be misleading if not interpreted correctly.

**Average SDS score by stage table**: table showing the actual average SDS score for each stage (as also graphically displayed in the average SDS score by stage graph)

**Individual substance SDS by stage graph**: graph showing the SDS scores for all substances for which SDS scores were taken. This graph tracks the original substance of concern, as well as the substance of concern raised at each subsequent stage, if that is different from the original.

**Individual substance SDS by stage table**: table showing the actual SDS scores for all substances for which SDS scores were taken (as also graphically represented in the individual substance SDS by stage graph).

**Drug and alcohol use graph**: graph showing the number of days the client used each substance at each stage

**Drug and alcohol use table**: table showing the actual number of days the client used each substance at each stage

**K10+ graph**: graph showing the total K10 score at each stage for the client, includes a brief text box to aid in interpretation

**K10+ table**: table showing the actual total K10 score for each stage (as graphically represented in the K10 score graph) and showing the responses for the 4 additional ‘+’ questions

**Overall Quality of Life graph**: graph showing total overall quality of life score for that client at each stage

**Overall Quality of Life table**: table showing the actual total overall quality of life score for the client at each stage (as graphically represented in the overall quality of life graph)

**Complete Quality of Life domain graphs**: 3 graphs showing:
- score for general quality of life domain
- score for general perception of health domain
- scores for physical quality of life, psychological quality of life, social quality of life and quality of living environment domains for the client at each stage

**Quality of Life full table**: table showing actual responses to each question at each stage (without scoring)

**Additional questions table**: table showing actual responses to each ‘additional questions’ question in the health and social functioning domain at each stage

**BBV risk taking table**: table showing actual responses to each ‘BBV Risk taking’ question.

**Full client report**: a report outlining outcomes for all stages of all episodes of treatment for an individual client. The options are identical to those outlined for Client Episode Report, above.

**Agency aggregate report**: a report outlining outcomes for all clients at all stages within the defined time period

**SDS all substances brief table**: table showing average (mean) SDS score across all clients in that time period for each substance for each stage

**SDS all substances full table**: table showing the mean and median SDS scores across all clients in that time period for each substance for each stage as well as the number of clients who reported that substance as their primary concern at that stage

**Note**

Remember that at any point after intake a client may have more than one substance of concern, the current one and the initial one

**Average SDS score by stage line graph**: graph and table showing the average SDS score for all substances for all clients at that stage

**Individual substance SDS by stage line graph**: line graph showing the average SDS score at each stage broken down into individual substances, i.e. the average SDS score for all clients who stated alcohol was the substance they were most concerned about at each stage.

**Note**

Remember that at any point after intake a client may have more than one substance of concern, the current one and the initial one
Average SDS score by initial substance of concern graph: A graph showing the average SDS score only for the initial substance of most concern tracked across each stage, averaged across all substances, across all clients.

Average SDS score by initial substance of concern table: A table showing the actual average SDS scores represented graphically in the average SDS score by initial substance of concern graph.

SDS score by initial substance of concern by substance graph: A graph showing the average SDS score for each initial substance of most concern at each stage.

SDS score by initial substance of concern by substance table: A table showing the actual SDS scores represented in the SDS score by initial substance of concern by substance graph.

Drug and alcohol use line graph: A graph showing the average number of days clients used each particular substance at each stage (average across only those clients who actually used that substance in that period).

Drug and alcohol use brief table: A table showing the average (mean) number of days clients used each substance at each stage (average across only those clients who actually used that substance in that period).

Drug and alcohol use full table: A table showing the mean and median number of days clients used each substance at each stage (across only those clients who actually used that substance in that period) as well as the number of clients who reported using that substance in that period.

K10 bar chart: A bar chart showing the proportion of clients experiencing low, moderate, high and very high levels of psychological distress at each stage of the program.

K10 average line graph: A graph showing the average total K10 score for all clients at each stage and including a text box to aid in interpretation of scores.

K10+ brief table: A table showing the actual average (mean) K10 score at each stage of the program that is graphically represented in the K10 average line graph and showing the responses for the 4 additional (+) questions including averages for the first 3 questions and the proportions who gave each response for the final question.

K10+ full table: A table showing the mean and median K10 scores at each stage of the program, as well as the number of clients who were surveyed at that stage of the program and showing the responses for the 4 additional (+) questions including mean and median for the first 3 questions and the proportions who gave each response for the final question, as well as the number of clients who were surveyed at each stage.

Quality of Life brief table: A table showing the average quality of life scores (including overall total quality of life, and the six quality of life domain scores) at each stage.

Quality of Life full table: A table showing the actual proportions who gave each response to each question, the number of clients that represented and the total number of clients surveyed at that stage.

Additional questions table: A table showing the proportion of clients who gave each response to each of the additional questions’ questions, the number of clients that represented and the total number of clients surveyed at that stage.

QoL overall by stage graph: A line graph showing the overall average total quality of life score at each stage.

QoL domain breakdown by stage graph: 3 graphs showing:
  - score for general quality of life domain
  - score for general perception of health domain
  - scores for physical quality of life, psychological quality of life, social quality of life and quality of living environment domains for the client at each stage.

BBV risk taking table: A table showing the proportion of clients who gave each response to each of the ‘BBV risk taking’ questions, the number of clients that represented and the total number of clients surveyed at that stage.
6.3.2 Specific report settings

While the above options are generally set in the agency options screen for the client episode report, the client full report and the agency outcomes report (agency aggregate report) and reflect how the service normally wants their reports to look, it is also possible to ‘fine tune’ a report by removing tables or graphs that are not needed for a specific report being produced. The options bar above where the report is being produced gives the user this option. Only options chosen in the agency options screen can be removed to simplify a report, it is not possible to add options that were not originally chosen.

To fine tune a report:

1. Create the report (see 4.5 in section 4)
2. Change any items you do not want to appear in this specific report from ‘true’ to ‘false’
3. Click ‘view report’

Only those items for which you have clicked ‘true’ will appear.

6.4 User permissions

The COMS database allows the service to assign different levels of permission to different log-ins. The levels are:

**Read only:** Can only generate and view reports, cannot enter or edit any data.

**General user:** Can generate and view reports and can enter and edit client data, however cannot alter agency options

**Administrator:** Can generate and view reports, enter and edit client data and alter agency options. Only the administrator can alter the permission levels of lower level log-ins.

If your organisation only has one log-in, it will automatically be set as administrator.

1. To change the privilege level of a user click on ‘edit’ under the actions column next to user you wish change.
2. Select the user privilege level from the ‘permission level’ drop-down list and then click ‘save’.

**Note**

If you are unable to make changes, please contact the Information System Development Manager at NADA. For the ISD’s contact details see the staff page on www.nada.org.au.
COMPLETING THE COMS QUESTIONNAIRE

Timeline follow-back calendar – client instructions

To help us evaluate your drug use, we need to get an idea of what your drug use was like in the past. The timeline follow-back calendar is a memory tool that will help you recall your daily alcohol, cigarette and/or drug use in the last four weeks.

Instructions

1. Fill in the start date and end date of the last four weeks. For example, the day you complete the calendar, is the end date. Count back four weeks from the end date, and that will be your start date.

2. On days when you did not use alcohol/cigarettes/drugs, you should tick ☑ in the box.

3. On days when you did use alcohol/cigarettes/drugs, you should indicate what was taken, including the type of drug. It is up to you how you specify it on the calendar. For example, ‘Co’ = Cocaine.

4. DOUBLE CHECK THAT ALL DAYS ARE FILLED.

Remember: try to be as accurate as possible. We realize that it is not easy to recall perfectly and that is okay. If you are unsure whether you used drugs or on which day you did use, give it your best guess. The aim of this calendar is to help you get a sense of how frequently you use drugs and your patterns of drug use.

Hint: jot down any special occasions to help you recall your drug use such as Christmas Day or a birthday event.

If you have a regular pattern of drug use, you can use it to help you recall your drug use. For example, drinking alcohol while watching Saturday night football.

Please do not hesitate to ask for assistance if you have any questions.
COMPLETING THE COMS QUESTIONNAIRE

Timeline follow-back calendar – staff instructions

The timeline follow-back calendar (TLFB) is a method to assess recent alcohol, cigarette and/or drug use in clients. It involves asking clients to retrospectively estimate their drug, alcohol or tobacco use in the last four weeks. This temporal framework allows clients to best accurately complete the drug and alcohol section of the Outcomes Measurement Database.

Instructions

In order to help recall their alcohol/cigarettes/drug use, clients are encouraged to jot down key dates and/or discrete events to help identify periods of use or abstinence. For example, use of birthdays and other personal events that are meaningful to people can assist recall of alcohol/cigarettes/drug use. Also, anchor points can be used to identify use that occurs during, before and after events (e.g., job loss, marital breakup) or notable drinking episodes (e.g., started using after the death of a close relative).

On the days when the client has used alcohol/cigarettes/drugs, it is important to that he/she indicates what was taken, including the type of drug. How they decide to specify it on the calendar is entirely dependent on the client. Of course, staff members may help ‘code’ the type of alcohol/cigarettes/drug used, e.g. ‘Co’ = Cocaine; ‘A’ = Alcohol, ‘T’ = Tobacco and etc.

* Please see below for example.

**Important:** It is important to ensure that all staff double check that something is written for every day, regardless of whether alcohol/cigarettes/drugs were used or not used.

---

**TIMELINE FOLLOWBACK CALENDAR**

**JANUARY 2011**

**START DATE** (Day 1): 1/1/2011

**END DATE:** 2/12/2011

<table>
<thead>
<tr>
<th>SUNDAY</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
<th>SATURDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NEW YEAR'S</td>
</tr>
<tr>
<td>2</td>
<td>START</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>DETOX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>16</td>
<td>FINISHED</td>
<td>17</td>
<td>18</td>
<td>T</td>
<td>T, Ca</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DETOX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21</td>
<td>22</td>
<td>T, Co, A</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>T, A, Co</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>T, Co, AD</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Co, AD</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>29</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*T = Tobacco, 'A' = Alcohol, 'Ca' = Cannabis, 'Co' = Cocaine, 'AD' = Another Drug

---

# TIMELINE FOLLOWBACK CALENDAR

## 2012

**START DATE** (Day 1): ____________  
**END DATE**: ____________

<table>
<thead>
<tr>
<th>SUNDAY</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
<th>SATURDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HOW TO ANSWER THE COMS QUESTIONNAIRE

Please read before completing the questionnaire

The COMS questionnaire is a simple set of questions aimed to help track your progress during and after treatment.

How to best answer the questions

• Select the answer that best describes your situation
• Only one answer can be chosen
• Some questions in the questionnaire may require you enter in a number in the box provided- enter the number.

Some of the questions may ask you to remember what your drug and alcohol use has been like. We understand that it is difficult to recall perfectly. This is okay. Staff will have ‘memory’ tools that can help you can answer the questions.

Tips for completing the COMS

• Do not feel pressured to answer these questions a certain way
• Remember that all the answers you give are confidential
• Try to be as accurate and honest as possible
• If at any stage you are confused or do not understand what is being asked, please do not hesitate to ask for help

Good luck!