Key Performance Indicators for NSW NGO AOD Treatment Services

Interim Report

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Introduction

This document outlines the procedural details for the collection of 14 Key Performance Indicators (KPIs) for non-government (NGO) alcohol and other drug (AOD) treatment providers in NSW.

The set of KPIs have been developed with extensive involvement of the Network of Alcohol and other Drug Agencies (NADA) members, and their funders and service users. The intent of the KPIs is to have a core set of KPIs that are standardised for use in contracts by funders of NGO AOD treatment services in NSW.

The use of one, some, or all, of the KPIs should be a process negotiated directly between an NGO and their funder/s. It may not be appropriate to use the KPIs for all services. These decisions would depend on the size of the service, the type of services being delivered, who services are being delivered to, and the amount of funding being provided.

These KPIs have been developed with an intentional focus on their use in the context of four main treatment types: psychosocial counselling, residential rehabilitation, case management and support, and day rehabilitation. It is expected that there will be a process of review and revision of these KPIs based on the data collected and experiences of services in that collection.

At this early stage the application to withdrawal services, outreach programmes, and other forms of treatment or settings is yet to be determined but agencies are welcome to pilot the KPIs across multiple treatment types and settings if they so wish.

These KPIs have also been developed with reference to client's own drug use and do not cover potential KPIs more suitable for people accessing treatment for someone else's drug use, nor for families/loved ones.

It should be noted that there are a range of complex factors that impact a person's AOD use that are outside of the treatment provided. They include broader social determinants of health such as unemployment, income, homelessness, poverty and family and community connectedness (AIHW, 2021), cultural, political and colonial contexts (Department of Health, 2021; Smallwood, Woods, Power et al., 2020) and a range of individual risk and protective factors (Australian Drug Foundation, 2020; UNODC & WHO, 2018). This should be taken into consideration when reviewing data collected for the indicators.

Background

The motivation behind developing standardised KPIs for the sector was driven by:

- The existence of multiple funders with differing expectations and measures resulting in a burden of reporting, and concerns about attributing performance and outcomes related to different funding sources and streams.
- Balancing the needs and expectations of community, service users, treatment providers, governing bodies, funders, and policy makers. This included a lack of clarity on what constitutes an effective treatment outcome, which may vary between stakeholders.
- The use of multiple data systems (including some paper based), issues with data quality and treatment providers fears about the interpretation of data and comparison with other providers that does not consider the complexity of people who access treatment.

Development of the KPIs have occurred in extensive collaboration with the sector including:

- An assessment of existing measures in contracts against best practice by three independent raters (that found 500 unique measures being used)
- Focus groups with service users, treatment providers and funders
- A Delphi process with a purposeful sample of service users, treatment providers and funders to prioritise a finite list of performance measures.

More information is available in NADA's position paper on performance measurement here - https://nada.org.au/news/nada/aod-performance-measurement.

This document provides specifications for the KPIs that resulted from the above processes. Specifications aim to provide a standardised definition and parameters for collecting quantifiable measures for each KPI. It is an interim document – with an expectation that the KPIs be reviewed after a period of data collection and then further refined.

In developing these specifications, extensive consultation with NADA members, key sector stakeholders and funders took place over two years (2022-2024). This included:

- A full day workshop with service providers and funders to work through implementation and reporting issues
- A sector-wide survey
- Online workshops and targeted consultations
- Three rounds of feedback on drafts.

Additionally, a comprehensive review was undertaken of existing frameworks and evidence on KPIs and outcomes measurements, in order to inform these specifications.

KPI 1 Quality of Life

Rationale

Quality of Life has been shown to be a useful global measure of wellbeing and positive treatment outcomes (Chenhall & Senior, 2012; Kelly, Robinson, Baker et al., 2018). As Quality of Life reflects the broader social, psychological and physical wellbeing of clients (beyond AOD use) it is seen as a holistic measure of treatment outcome.

Description

The number and proportion of people that report an improvement in overall Quality of Life.

Application

These KPIs have been developed with an intentional focus on their use in the context of four main treatment types: psychosocial counselling, residential rehabilitation, day rehabilitation and case management and support. At this early stage the application to withdrawal services, outreach programmes, and other forms of treatment or settings is yet to be determined but we welcome agencies piloting the KPIs across multiple treatment types and settings.

Timepoints for data collection

Timepoints for data collection	
Entry	**During Treatment**
Within 7 days	At agencies discretion

This KPI is measured at entry to treatment and during treatment. See table above.

At treatment entry: A Quality of Life measure should be administered within seven days of treatment starting.

During treatment: A measure of Quality of Life should be administered during treatment[1]. The service can decide what is the most appropriate during-treatment time point to use for the purposes of reporting for this KPI, in accordance with the measure used (e.g. it may be 4 weeks, or within the first 4 sessions). This is a within-treatment progress measure.

Measure of Quality of Life

The following provides a list of QoL tools that services may wish to use for the purposes of this KPI. It is not an exhaustive list and services can choose their preferred tool to measure Quality of Life among their clients for the purposes of this KPI as long as the tool is validated.

- Australian Treatment Outcomes Profile (ATOP) Quality of Life assessment question (ATOP_2K)

[1] The NSW Ministry of Health Clinical Care Standards (2020), Standard 5, requires that monitoring of treatment progress and outcomes occur at least every 3 months.

- European Health Interview Survey (EUROHOIS)QoL 8 (EQoL) (WHO 8-QoL 3.1 to WHO AQoL 3.8)
- The World Health Organisation Quality of Life (WHOQOL-BREF)
- Any of the Assessment of Quality of Life (AQoL) instruments, including AQoL-8D, AQoL-7D, AQoL-6D and AQoL-4D
- Substance Use Recovery Evaluator (SURE) (Section B)
- Personal Wellbeing Index (PWI).

Calculations

Scoring: each instrument is scored according to the instructions provided for that instrument. For example:

- For the single question (ATOP), the score is from 0-10 (with 0 being poor and 10 being good)
- The EQOL requires summing the scores on each of the 8 different items (each with a score of 1-5 (Not at all/very dissatisfied = 1 to Completely/very satisfied = 5)
- The WHOQOL-BREF requires summing the 26 different items all with a score of 1-5 (Not at all/very dissatisfied = 1 to Completely/very satisfied = 5)
- AQoL varies depending on the AQoL instrument chosen but is scored on a Likert scale for each item
- SURE ranks each answer on a score between 1 and 3
- PWI has seven domains, with questions in each domain scored on a Likert scale with a corresponding score from 0-10.

Total score: for each episode of care, there will be a total score at each of the timepoints: entry and a progress measure.

Improved Quality of Life: the number of clients who had a higher total score at a timepoint after their "entry" Quality of Life measure.

KPI reporting

The KPI should measure and report on:

1. Number of clients with a closed episode of care who have a treatment entry measure of Quality of Life

2. Number of clients with a closed episode of care who have at least one Quality of Life progress measure during treatment

3. Number of clients (from 2) who have improved Quality of Life between entry and during treatment

4. Proportion of clients with improved Quality of Life between entry and during treatment (i.e. 4 divided by 2)

Reporting period: Annually.

Reporting entity: Where agencies offer multiple treatment types, they can choose whether reporting is against the agency as a whole or against different treatment types.

Definitions

- Improvement is taken to be any improvement on the chosen measure i.e. 1 point movement on any of the scales (see notes).
- *Entry:* this is defined to be the first day of treatment at the service or for those who have been previous clients, the first day of a new episode of treatment.

Related key performance indicators, frameworks and standards

NSW Clinical Care Standards 2020 (Standard 5: Monitoring treatment progress and outcomes)

Notes

- At time of writing there did not appear to be any validated culturally appropriate tools for capturing Quality of Life of Aboriginal and Torres Strait Islander peoples (Howard, Anderson, Cunningham et al., 2020). Howard et al (2020) are in the process of developing a wellbeing measure through the What Matters study WM2Adults and note:

  > "Any instrument to measure the wellbeing of Aboriginal and Torres Strait Islander people should be culturally appropriate and safe, include relevant dimensions, and be informed by their own values and preferences. Existing QOL instruments do not meet these standards."

- The ATOP has been validated across a range of treatment settings and substances and is a reliable instrument for assessing health and welfare (including Quality of Life) for people in AOD treatment (Deacon, Mammen, Bruno et al., 2021).
- The EQOL is a brief 8-item measure that has been used widely with people who use AOD in Australia (Kelly, Robinson, Baker et al., 2017; Kelly et al., 2018; Tait, McKetin, Kay-Lambkin et al., 2012).
- The WHOQOL-BREF is a tool developed by the World Health Organization to measure multidimensional aspects of Quality of Life. It is used internationally and has been validated among diverse populations, including people who use AOD (Feelemyer, Jarlais, Arasteh et al., 2014).
- The SURE is a patient reported outcome measure of drug and alcohol treatment that was developed with people in treatment in order to capture domains of 'recovery' most relevant and important for them (Neale, Vitoratou, Finch et al., 2016). It contains a range of domains related to Quality of Life (section B), and has been found to have good face and content validity, acceptability and usability for people in treatment (Neale et al., 2016).
- The PWI scale contains seven items of satisfaction, each one corresponding to a Quality of Life domain as: standard of living, health, achieving in life, relationships, safety, community-connectedness, and future security. The PWI is a highly reliable measure of subjective wellbeing that has been consistently validated in diverse population sub-groups in Australia and overseas (Gallardo-Peralta, Ángeles Molina Martinez, & Schettini del Moral, 2019; McGillivray, Lau, Cummins et al., 2009; Tomyn, Fuller Tyszkiewicz, & Cummins, 2013). Items in the PWI are simple and easy to understand and have been recommended for use by the OECD and WHO.
- To address potential recall bias, measures could include a Reliable Change Index Threshold. For instance, research shows that the Reliable Change Index Threshold for the ATOP QoL would be at least 2 points change (Deacon, Mills, Bruno et al., 2023). However, during consultations for the development of these KPIs, the majority preference was for no

consideration of a margin of error and all change to be reported. It is intended that the KPIs will be revisited based on reporting results and so may be open for change to improve accuracy or reporting.
- The time period for the during treatment measure used for reporting is at the discretion of services/agencies. For example, for residential rehabilitation it might at 3 months, whereas counselling and support services may wish to use a monthly measure. The NSW Ministry of Health Clinical Care Standards (2020), Standard 5, requires that monitoring of client treatment progress and outcomes occur at least every 3 months.

KPI 2: Severity of dependence

Rationale

Severity of dependence is a strong predictor of treatment outcome (Adamson, Sellman, & Frampton, 2009; Langenbucher, Sulesund, Chung et al., 1996; Morley, Teesson, Sannibale et al., 2010). This KPI measures reductions in severity of dependence, as a marker of good treatment outcome.

Description

The number and proportion of people that report a reduction in severity of dependence.

Application

These pilot KPIs have been developed with an intentional focus on their use in the context of four main treatment types: psychosocial counselling, residential rehabilitation, case management and support, and day rehabilitation. At this early stage the application to withdrawal services, outreach programmes, and other forms of treatment or settings is yet to be determined but we welcome agencies piloting the KPIs across multiple treatment types and settings.

Timepoints for data collection

Timepoints for data collection	
Entry	**During Treatment**
Within 7 days	At agencies discretion

This KPI is measured at entry to treatment and during treatment. See table above.

At treatment entry: A severity of dependence measure should be administered within seven days of treatment starting.

During treatment: A severity of dependence measure should be administered during treatment[2]. The service can decide what is the most appropriate during-treatment time point to use for the purposes of reporting for this KPI, in accordance with the measure used (e.g. it may be 4 weeks, or within the first 4 sessions). This is a within-treatment progress measure.

Measure of severity of dependence

The following provides a list of severity of dependence tools that services may wish to use for the purposes of this KPI. It is not an exhaustive list and services can choose their preferred tool to measure severity of dependence among their clients for the purposes of this KPI as long as the tool is validated:

- The Severity of Dependence Scale (SDS)
- Substance Use Recovery Evaluator (SURE)
- Drug-Taking Confidence Questionnaire-8D (DTCQ-8D)

[2] The NSW Ministry of Health Clinical Care Standards (2020), Standard 5, requires that monitoring of treatment progress and outcomes should occur at least every 3 months.

Calculations

Scoring: each instrument is scored according to the instructions provided for that instrument. For example:

- the SDS is scored by summing the scores across all five questions (with total range from 0 to 15).
- The SURE requires summing the scores on each of the different questions in sections A and B (a score of 1-3).

Total score: for each episode of care, there will be a total score at each of the timepoints: entry and progress.

Reduced severity of dependence: the number of clients who had a lower total Severity of dependence score at a timepoint after their 'entry' severity of dependence.

KPI reporting

The KPI should measure and report on:

1. Number of clients with a closed episode of care who have an entry severity of dependence assessment

2. Number of clients with a closed episode of care who have at least one other severity of dependence measure during treatment

3. Number of clients (from 2) who have reduced severity of dependence between treatment entry and during treatment (see notes for details)

4. Proportion of clients with reduced severity of dependence between entry and during treatment (i.e. 4 divided by 2).

Reporting period: Annually.

Reporting entity: Where agencies offer multiple treatment types, they can choose whether reporting is against the agency as a whole or against different treatment types.

Definitions

- Improvement is taken to be any improvement on the chosen measure i.e. 1 point movement on any of the scales.
- 'Entry': this is defined to be the first day of treatment at the service. Or for those who have been previous clients, the first day of a new episode of treatment.

Related key performance indicators, frameworks and standards

NSW Clinical Care Standards 2020 (Standard 5: Monitoring treatment progress and outcomes)

Notes

- The SDS, SURE and DTCQ-8D are all validated instruments that have been used widely by AOD treatment services (Gossop, Darke, Griffiths et al., 1995; Neale et al., 2016; Sklar, Annis, & Turner, 1997).
- The time period for the during treatment measure is at the discretion of services/agencies. For example, for residential rehabilitation it might be at 3 months, whereas counselling and support services may wish to reassess clients monthly. The NSW Ministry of Health Clinical Care Standards (2020), Standard 5, requires that monitoring of client treatment progress and outcomes occur at least every 3 months.

KPI 3 AOD use

Rationale

Treating AOD use disorders is the primary role of AOD treatment services. Stabilising use or assisting clients to reduce use where that is their goal, is a critical outcome of AOD treatment services.

Changes in AOD consumption is a measure that clinicians, prospective clients, and the general public see as important outcomes from AOD treatment. For some clients abstinence will be an appropriate and sought after goal; for others reductions in the amount of AOD use per use occasion (quantity) is the goal, for others it may be reducing the number of days of use (frequency).

Description

The number and proportion of clients who report a decrease in AOD use.

This measure is concerned with principal drug of concern (PDOC) only.

Application

These pilot KPIs have been developed with an intentional focus on their use in the context of four main treatment types: psychosocial counselling, residential rehabilitation, case management and support, and day rehabilitation. At this early stage the application to withdrawal services, outreach programmes, and other forms of treatment or settings is yet to be determined but we welcome agencies piloting the KPIs across multiple treatment types and settings. This measure may not be valid where the period of treatment entry is preceded by a detox (see notes).

Timepoints for data collection

Timepoints for data collection	
Entry	**During Treatment**
Within 7 days	At agencies discretion

This KPI is measured at entry to treatment and during treatment. See table above.

At treatment entry: A measure of AOD use should be administered within seven days of treatment starting.

During treatment: AOD use measures should be administered during treatment[3]. The service can decide what is the most appropriate during-treatment time point to use for the purposes of reporting for this KPI,in accordance with the measure used (e.g. it may be 4 weeks, or within the first 4 sessions). This is a within-treatment progress measure.

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[3] The NSW Ministry of Health Clinical Care Standards (2020), Standard 5, requires that monitoring of treatment progress and outcomes should occur at least every 3 months.

Measure of AOD use

The following provides a list of AOD use measures that services may wish to use for the purposes of this KPI. It is not an exhaustive list and services can choose their preferred tool to measure AOD use among their clients for the purposes of this KPI as long as the tool is validated:

- The ATOP (Section 1: Substance Use)
- The Drug and Alcohol Use Survey
- The Timeline Followback

Determining PDOC

- Services should record PDOC as per requirements of the National Minimum Data Set (NMDS) and NSW MDS. For example, in the NADAbase Data Dictionary this is item 21: MDS PDOC

For alcohol PDOC
Where alcohol is recorded as the PDOC, measures should be taken for both frequency and quantity.

For all other drugs (excluding alcohol)
Where the PDOC is any other drug except alcohol, measures should be taken for frequency.

Calculations

Scoring:

For alcohol the total score for each time point is a Quantity/Frequency measure.

For all drugs except alcohol (and tobacco) the total score, for each timepoint is a Frequency measure.

Each instrument is scored according to the instructions provided for that instrument. For example:

- ATOP (for alcohol): PDOC use measure = quantity of use *times* frequency of use (Q/F measure)
- ATOP (for all other drugs): PDOC use measure = frequency of use (sum of days used over 4 weeks)

Total score: for each episode of care, there will either be a total Q/F score or total frequency score at each of possible timepoints: entry and progress.

Decreased AOD use: when the Q/F or Frequency amount is lower at the second timepoint compared to the first.

KPI reporting

The KPI should measure and report on:

1. Number of clients with a closed episode of care who have an entry AOD use measure for their PDOC

2. Number of clients with a closed episode of care who have at least one progress (within treatment) measure of AOD use for their PDOC

3. Number of clients (from 2) who have decreased AOD use between entry and during treatment for their PDOC (see notes for details)

4. Proportion of clients with decreased AOD use between entry and during treatment for their PDOC (4 divided by 2)

Reporting period: Annually.

Reporting entity: Where agencies offer multiple treatment types, they can choose whether reporting is against the agency as a whole or against different treatment types.

Definitions

- Improvement is taken to be any improvement on the chosen measure i.e. 1 point movement on any of the scales (see notes)
- *Entry:* this is defined to be the first day of treatment at the service or for those who have been previous clients, the first day of a new episode of treatment.

Related key performance indicators, frameworks and standards

- NSW Clinical Care Standards 2020 (Standard 5: Monitoring treatment progress and outcomes)

Notes

- The ATOP, Drug and Alcohol Survey and Timeline Followback are all validated instruments that have been used widely by AOD treatment services (Deacon et al., 2021; Fals-Stewart, O'Farrell, Freitas et al., 2000; Long & Hollin, 2009; Schinke, Schwinn, & Fang, 2010).
- The time period for the during treatment measure is at the discretion of services/agencies. For example, for residential rehabilitation it might be every 3 months, whereas counselling and support services may wish to reassess clients monthly. The NSW Ministry of Health Clinical Care Standards (2020), Standard 5, requires that monitoring of client treatment progress and outcomes occur at least every 3 months.
- To address potential recall bias, measures could include a Reliable Change Index Threshold. For instance, research shows that the Reliable Change Index Threshold for the ATOP for AOD use would be 30% (Deacon et al., 2023) and the ATOP manual suggests that for substance use, a change of 4 or more days in 28-day substance use is required to be a clinically meaningful change (Lintzeris, Deacon, Mills et al., 2020). However, during consultations for the development of these KPIs, the majority preference was for no consideration of a margin of error and all change to be reported. It is intended that the KPIs will be revisited based on reporting results and so may be open for change to improve accuracy or reporting.
- We note that the ATOP reporting guidelines suggest reporting on groupings of patients based on low and high frequency consumption (Lintzeris, Mammen, Holmes et al., 2020). For the purposes of simplicity, we have chosen to not include further groupings/calculations. As above, these KPIs may be revisited based on reporting results and so may be open for change to improve accuracy or reporting.
- Note that depending on the reference period for entry, this measure will not be valid where a client enters treatment immediately after a detox (e.g. for residential rehabilitation services), as their entry AOD use will be zero and this KPI reports on improvement only.

KPI 4: Mental health

Rationale

Many people who seek treatment for AOD use also experience co-occurring mental health issues (Lee & Allsop, 2020). Identifying mental health issues of clients and supporting clients to address those needs is critical to support clients in achieving successful treatment goals.

Description

The number and proportion of clients who report any improvement in mental health.

Application

These pilot KPIs have been developed with an intentional focus on their use in the context of four main treatment types: psychosocial counselling, residential rehabilitation, case management and support, and day rehabilitation. At this early stage the application to withdrawal services, outreach programmes, and other forms of treatment or settings is yet to be determined but we welcome agencies piloting the KPIs across multiple treatment types and settings.

Timepoints for data collection

Timepoints for data collection	
Entry	**During Treatment**
Within 7 days	At agencies discretion

This KPI is measured at entry to treatment and during treatment. See table above.

At treatment entry: A measure of mental health should be administered within seven days of treatment starting.

During treatment: A measure of mental health should be administered during treatment[4]. The service can decide what is the most appropriate during-treatment time point to use for the purposes of reporting for this KPI, in accordance with the measure used (e.g. it may be 4 weeks, or within the first 4 sessions). This is a within-treatment progress measure.

Measure of mental health

The following provides a list of measures of mental health that services may wish to use for the purposes of this KPI. It is not an exhaustive list and services can choose their preferred tool to measure of mental health among their clients for the purposes of this KPI as long as the tool is validated:

[4] The NSW Ministry of Health Clinical Care Standards (2020), Standard 5, requires that monitoring of treatment progress and outcomes should occur at least every 3 months.

- Single item question on psychological wellbeing (ATOP2I in NADAbase)
- Kessler 10 (K10)
- Kessler 5 (K5)
- Depression, Anxiety and Stress Scale – 21 Items (DASS-21)
- The Mayi Kuwayu Study adapted K5 Items (MK-K5)
- The Indigenous Risk Impact Screen (IRIS), Mental Health and Emotional Wellbeing Risk section (questions 8 to 13).

Calculations

Scoring: Scoring should adhere to the tools used.

e.g. the ATOP is a single score (0 to 10), The K10+ is a single score obtained by summing the 10 individual items. Total scores can range between 10 and 50.

Total score: for each closed episode of care, there will be a total MH score at each of two possible timepoints: entry and progress.

Improved mental health:

Improvement is taken to be any improvement on the chosen measure i.e. 1 point shift from baseline.

This will be determined by the tool used. For example:

ATOP: the number of clients who had a higher ATOP 2I score at a timepoint after their 'entry' ATOP 2I score

K10: the number of clients who had a lower total K10 score at a timepoint after their 'entry' total K10 score.

KPI reporting

The KPI should measure and report on:

1. Number of clients with a closed episode of care who have an entry mental health measure

2. Number of clients with a closed episode of care who have at least one progress measure for mental health

3. Number of clients (from 2) who have improved mental health between entry and during treatment

4. Proportion of clients with improved mental health between entry and during treatment (4 divided by 2)

Reporting period: Annually.

Reporting entity: Where agencies offer multiple treatment types, they can choose whether reporting is against the agency as a whole or against different treatment types.

Definitions

- Improvement is taken to be any improvement on the chosen measure i.e. 1 point movement on any of the scales (see notes).
- *Entry:* this is defined to be the first day of treatment at the service or for those who have been previous clients, the first day of a new episode of treatment.

Related key performance indicators, frameworks and standards

NSW Clinical Care Standards 2020 (Standard 5: Monitoring treatment progress and outcomes)

Notes

- The data recorded here is not a replacement for mental health assessments taking place in treatment services for clinical purposes. The data recorded here are for the purposes of recording service performance. Services should continue to use other standardised mental health tools being employed for clinical assessments as driven by the needs of the client (e.g. Suicide Risk Screening Tool).
- This KPI seeks to provide a simple measure for mental health that can be compared over time and is not intended to capture complex or detailed mental health needs. As above, services should continue to use additional tools for clinical purposes as required.
- The time period for the during treatment measure is at the discretion of services/agencies. For example, for residential rehabilitation it might be every 3 months, whereas counselling and support services may wish to reassess clients monthly. The NSW Ministry of Health Clinical Care Standards (2020), Standard 5, requires that monitoring of treatment progress and outcomes should occur at least every 3 months.
- The K10+ is a reliable, validated, 10 item instrument to measure mental health. Scores range between 1 and 5 for each question. It is available within the NADAbase.
- The K5 is a subset of questions taken from the K10. The five questions ask about how someone has been feeling over the previous four weeks. Answers are rated on a score of 1-5 and summed to give a total score. The K5 is designed for use in surveys of Aboriginal and Torres Strait Islander peoples.
- The MK-K5 has slight wording changes to the K5 and additional clarifying statements to increase conceptual understanding of items (where needed). The MK-K5 has been validated as a measure of psychological distress with Aboriginal and Torres Strait Islander peoples and has clinical utility (Brinckley, Calabria, Walker et al., 2021).
- The IRIS is a validated tool for screening for alcohol and drug and mental health risk for Aboriginal and Torres Strait Islander peoples (Schlesinger, Ober, McCarthy et al., 2007). Answers are rated between 1 and 3, and summed together over the six questions to provide an overall Mental Health and Emotional Wellbeing Score
- DASS-21 is validated in AOD settings and with Aboriginal and Torres Strait Islander peoples (Stephens, Bohanna, Graham et al., 2013).
- As per the other KPI measures, there is no Reliable Change Index Threshold applied and all change is measured. It is intended that the KPIs will be revisited based on reporting results and so may be open for change to improve accuracy or reporting.

KPI 5: Treatment (care) plan

Rationale

Treatment planning, also referred to as care planning, forms a core part of AOD interventions. Not only do treatment plans structure the interventions in a tailored, individualised way and enhance positive outcomes, they also serve as an important collaborating tool between clinicians and clients.

Description

The number and proportion of clients with a treatment plan for whom an episode of care was closed during the reporting period.

Measure

All clients with a closed episode of care that had a treatment plan during the reporting period.

Numerator: Number of clients with a treatment plan

Denominator: Number of clients for whom an episode of care was closed during the reporting period

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KPI reporting

1. Number of episodes of care provided during the reporting period (e.g. 6 or 12 months)
2. Number of the above episodes of care with a treatment plan
3. Percentage of episodes of care with a treatment plan (2 divided by 1).

Reporting period: As required by services and/or funders, e.g. it could be six monthly or yearly.

Reporting entity: Where agencies offer multiple treatment types, they can choose whether reporting is against the agency as a whole or against different treatment types.

Definitions

The definition of a 'treatment plan' aligns with Care Planning as defined by Standard 3 under NSW Health Clinical Care Standards:

> "A care plan is a document where the client's short to medium-term goals regarding substance use, health and welfare are identified and recorded. A care plan should assist in improving the quality of treatment through enhanced communication by those involved in the delivery of care.
>
> It is used as a tool to engage clients in decision-making related to their substance use, health and welfare needs. The care plan can also be used to improve communication with the range of service providers and carers involved in client care. It outlines treatment goals,

actions to achieve the goals, the person(s) responsible for completing the planned actions and review dates" (NSW Health, 2020).

Treatment planning should:

- Be client-led with clients involved in all decisions regarding their treatment
- Identify the client's most important goals for treatment
- Be strengths-focused
- Include all the people involved in the client's care including the treating team, primary care physician, carers/support persons etc
- Be written in language that is easy to understand, with a copy provided to the client.

Related key performance indicators, frameworks and standards

NSW Clinical Care Standards 2020 (Standard 3: Care Planning)

National Safety and Quality Health Services (2021) Standards (5.13: Developing the comprehensive care plan)

Notes

- Clients with lengthy episodes of care may have multiple treatment plans. As long as there is a minimum of one care plan per episode of care, than the client is counted as having a care plan i.e. there is no double counting of clients with multiple care plans per episode of care.

KPI 6: Treatment goals achieved

Rationale

There are a number of different ways of measuring outcomes from AOD treatment. While changes in AOD use may be seen as a primary outcome, some clients have goals not concerned with amount consumed per se, for example to reduce harmfulness of use, to stay connected with family and friends and so on. This KPI measures whether clients perceive that they have achieved their treatment goals.

Description

The number and proportion of clients who report that they achieved their own treatment goals.

Timepoints for data collection

This KPI is measured at the end of or exit from treatment.

Measure of treatment goal achievement

Services can choose the best approach to measuring self-reported treatment goals achieved:

- Systematically including such a question at discharge planning, exit point from treatment
- Asking clients during a follow-up call (within 7 days of treatment end)
- Using the provided "exit survey" (see Appendix A)

A five-item exit survey can be used to capture data for KPIs 6, 7 and 8. This is a client self-reported item (see Appendix A for greater detail). These questions could also be integrated into existing surveys.

In the survey the following item is used to record clients' perceptions of treatment goal achievement at the end of treatment:

- How many of your treatment goals were achieved? (answer choices: 'All', 'most', 'some', 'few', 'none')

KPI reporting

1. The number of clients asked about achievement of treatment goals within 7 days of ending or exiting treatment

2. The number of clients with a positive response on the treatment goals question by grouping:
   a. all or most
   b. some or few
   c. none

3. The proportion of clients achieving all or most treatment goals (2a divided by 1)

Reporting period

As required by services and/or funders, it could be six-monthly, or yearly

Reporting entity: Where agencies offer multiple treatment types, they can choose whether reporting is against the agency as a whole or against different treatment types.

KPI 7: Linked up

Rationale

Ensuring people know where to go for further help if needed is important in supporting clients and addressing the chronic nature of harmful AOD use which is often characterised by periods of relapse or return to drug use (Lubman, Manning, Best et al., 2017). This indicator is about recording clients' perspectives of if and how well they were "linked-up" with other services upon leaving a program.

Description

The number and proportion of people that report they were linked-up with other services when they leave the program.

Timepoints for data collection

This KPI is measured at the end of or exit from treatment.

Measure of linked up

This KPI is a measure of client's experiences at the end of treatment.

The following two items should be used to record clients' perceptions of being linked with other services at the end of treatment:

1. 'I have been linked up with other services to support me when I leave this program' (answer choices 'strongly agree', 'agree', 'neither agree or disagree', 'disagree' and 'strongly disagree')
2. I am confident in where to go for further help if needed' (answer choices strongly agree', 'agree', 'neither agree or disagree', 'disagree' and 'strongly disagree').

Services can choose the best approach to measuring these two items. The five-item exit survey captures these two items (see Appendix A). This is a client self-reported item (see Appendix A for greater detail). These questions could also be integrated into existing surveys.

Numerator: Number of clients who agree or strongly agree (for each question)

Denominator: Number of clients who competed an exit survey

KPI reporting

The KPI should measure and report on:

1. Number of clients who were asked about being linked up

2. Number of clients reporting they agreed or strongly agreed that they were linked up with services

3. The proportion of clients reporting that they agreed or strongly agreed that they were linked up with services

4. Number of clients reporting they agreed or strongly agreed that they were confident in where to get help if needed

5. The proportion of clients reporting that they agreed or strongly agreed that they were confident in where to get help if needed

Reporting period: As determined by services and/or funders, e.g. it could be six-monthly, or annually

Reporting entity: Where agencies offer multiple treatment types, they can choose whether reporting is against the agency as a whole or against different treatment types.

Definitions

- Being "linked-up" with other services can comprise a number of different activities such as referral to other AOD treatment services or social support services, transfer of care to other organisations, aftercare planning, tangible supports to access other services and the provision of information of other services or supports.
- What is important here is that clients felt that they were provided with the information and/or support they needed to:
    - Access ongoing treatment where needed
    - Access different health and welfare systems where needed
    - Access community support (e.g. to peer groups)
    - Know how to re-engage with services and where to go for further support if needed.

Related key performance indicators, frameworks and standards

NSW Health Clinical Care Standards for AOD Treatment (2020): Standard 6 Transfer of care

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Notes

- Prior work on developing patient-reported experience measures have similarly attempted to capture how well people have been 'linked-in' with other services through simple questions directed at clients post exit (Hinsley, Kelly, & Davis, 2019; Kelly, Hatton, Hinsley et al., 2021).
- Caution should be applied in interpreting results, especially for services in rural/remote locations or for targeted populations where the amount of available services to link people to may be limited.

KPI 8: Culturally safe and inclusive services

Rationale

Stigma, discrimination and racism create barriers to accessing health and treatment services and are a key driver of health inequities (Curtis, Jones, Tipene-Leach et al., 2019). To ensure safe, effective and high-quality treatment, services should be culturally safe and inclusive to all population groups and respect the knowledge and diversity of different communities and cultures.

While we acknowledge the specific meaning cultural safety can have for Aboriginal and Torres Strait Islander peoples (NACCHO, 2011), for the purpose of this KPI, it is applied across all identities, communities and cultures (see notes below).

Description

The number and proportion of people that report the service was culturally safe and inclusive.

Timepoints for data collection

This KPI is measured at the end of or exit from treatment.

Measure of culturally safe and inclusive services

This KPI is a measure of client's experiences at the end of treatment.

The following questions is used to measure cultural safety and inclusive services:

1. Did you find the service to be culturally safe and inclusive? (answer choices 'strongly agree', 'agree', 'neither agree or disagree', 'disagree' and 'strongly disagree')

Services can choose the most appropriate approach to measuring this item. One option is the five-item exit survey (see Appendix A for greater detail). This is a client self-reported item.

The exit survey also includes the following opportunity for feedback to the service:

2. If you did not experience it as culturally safe or inclusive, can you say a bit about that to help service improvement?

Calculations

Total number of people saying they found the service to safe and inclusive: Sum of those answering agree or strongly agree

Proportion of those finding the service safe and inclusive: Numerator (=Number of clients who responded strongly agree or agree) divided by denominator (=Number of clients who completed an exit survey)

KPI reporting

The KPI should measure and report on:

1. Number of clients with a response to this measure provided within 7 days of ending or exiting treatment
2. Number of clients reporting they agreed or strongly agreed that the service was culturally safe and inclusive

Reporting period: As determined by services and/or funders, e.g. it could be six-monthly, or annually

Reporting entity: Where agencies offer multiple treatment types, they can choose whether reporting is against the agency as a whole or against different treatment types.

Definitions

Culturally safe and inclusive services require that an entire organisation respect diverse cultures, beliefs, gender identities, sexualities and experiences of people (including clients and staff), to support an inclusive environment for the safety and security of people, their families and significant others, and create a positive, safe work environment that supports the rights, dignity and safety of all people (NSW Health, 2020). People can hold multiple identities and services need to be culturally safe and inclusive to all.

Culturally safe practice is one aspect of cultural safety and supports "the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism" (Ahpra, 2020, p. 9). Unsafe cultural practice is any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual (NATSIHWA, 2016).

As a term that has come from Indigenous (Māori) healthcare, cultural safety has a particular meaning and context for Aboriginal and Torres Strait Islander peoples that explicitly acknowledges ongoing colonisation and that "Aboriginal and Torres Strait Islander peoples have culturally different understandings of health and wellbeing compared with those of the dominant culture, as well as historically poor experiences with the healthcare system" (Hunter, Coombes, Ryder et al., 2022). It is widely accepted that for Aboriginal and Torres Strait Islander peoples cultural safety can only be defined by those who receive health care. "They will determine if their cultural identity and meanings are being respected, and they are not being subjected to discrimination."(NACCHO, 2011).

Related key performance indicators, frameworks and standards

- National Safety and Quality Health Services (NSQHS) Standards (1.21; 1.33)
- National Framework for AOD Treatment 2019-2029
- NSW Health Clinical Care Standards: Alcohol and Other Drug Treatment (5.3 Cultural Competence)
- Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health
- National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023[5]

[5] https://www.health.gov.au/sites/default/files/documents/2021/02/national-aboriginal-and-torres-strait-islander-health-plan-2013-2023.pdf

- The National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) Cultural Safety Framework[6]
- NSW LGBTQI+ Health Strategy 2022 – 2027
- NSW Plan for Health Culturally and Linguistically Diverse Communities 2019-2023

Notes

- While all the different AOD funding and monitoring bodies require services to address discrimination of Aboriginal and Torres Strait Islander peoples and to make services more accessible, welcome and appropriate, there are currently no suggested tools to capture the experience of different types of cultural responsiveness (i.e. there are no tools for mainstream AOD services to assess client perceptions of culturally safety, although hospitals are currently developing one). This KPI should be updated as new measures become available.
- During 2022 extensive consultation took place with the sector on who this KPI should apply to (i.e. only Aboriginal and Torres Strait Islander peoples or all marginalised and/or minority communities and populations). The majority opinion was that it should apply to all people noting that many people can hold multiple different identities, and services should be accessible to all irrespective of cultural background, race, language, religion or sexual orientation.
- Caution should be applied in interpreting results given that all clients can respond to the proposed survey item.
- Previous drafts used the term ‘culturally safe and appropriate’. After receiving feedback from the sector the KPI terminology was changed (to culturally safe and inclusive) to reflect the specific cultural meanings and application of both of those terms for Aboriginal and Torres Strait Islander peoples and to be indicative of the application of this KPI to other cultural groups.
- It is intended that the KPIs will be revisited based on reporting results and so may be open for change to improve accuracy or reporting or to ensure that the way data is collected is appropriate for all services.

[6] https://www.naatsihwp.org.au/sites/default/files/natsihwa-cultural_safety-framework_summary.pdf

KPI 9: Staff Trained in Aboriginal Cultural Competence

Rationale

Cultural competency training is but one initiative in a range of organisational and sector-wide strategies needed to improve the cultural safety of an organisation and the creation of an environment that is respectful of Aboriginal and Torres Strait Islander clients and workforce (ACSQHC, 2019; Bainbridge, McCalman, Clifford et al., 2015; Wylie, McConkey, & Corrado, 2021).

Description

The number and proportion of staff trained in Aboriginal and Torres Strait Islander cultural competence.

Qualifiers

Staff who identify as Aboriginal and/or Torres Strait Islander are not required to undertake cultural competency training for the purposes of this KPI although they may choose to do so. Where Aboriginal and/or Torres Strait Islander staff wish to opt-out of training they will be discounted from the total staff count for the purposes of this KPI.

Calculations

This KPI utilises a point-in-time count to determine number of staff employed i.e. Services can choose a point in time during the reporting period when they count the number of staff.

Services then need to count how many of those staff have undertaken cultural competency training *at any time* during employment at the service.

Numerator: The number of staff who have undertaken cultural competency training while employed at the service

Denominator: The number of staff employed at the organisation minus any Aboriginal and Torres Strait Islander staff who opted out of cultural competency training.

KPI reporting:

The service reports on the following:

1. Number of staff who have undertaken cultural competency training while employed at the service
2. Proportion of those staff who have undertaken cultural competency training while employed at the service

Reporting period: As determined by services and/or funders, e.g. it could be six-monthly, or annually

Reporting entity: Where agencies offer multiple treatment types, they can choose whether reporting is against the agency as a whole or against different treatment types.

Definitions

Organisations can choose which cultural competency course to make available to staff although should be guided by the NACCHO Cultural Safety Training Standards (NACCHO, 2011) and/or recommendations from the Australian Commission on Safety and Quality in Healthcare (ACSQHC) review of cultural safety training (Hunter et al., 2022), including that courses involve:

- Reflective practice and exploration of pre-existing knowledge
- Interactive delivery
- Asking participants to consider how to implement their learnings in practice
- Information that is relevant to the local community
- Clearly naming racism and understanding the effect this has on health outcomes.

Any chosen course must also either be delivered by an Aboriginal and Torres Strait Islander organisation or have been developed and delivered in partnership with or by local Aboriginal or Torres Strait Islander people.

Related key performance indicators, frameworks and standards

- Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health (Domain 3)
- NSW Health Clinical Care Standards: Alcohol and Other Drug Treatment (5.3 Cultural Competence)
- National Safety and Quality Health Services (2021) Standards (1.21)
- NADA AOD Treatment Guidelines for working with Aboriginal and Torres Strait Islander People (6C: Training Provided).

Notes:

- There are no current standards or guidelines around how frequently/recent cultural competency training must be. The Australian Health Practitioner Regulation Agency (Ahpra) suggests that training should be provided on a rolling basis for all staff within the first year and then every three years (Ahpra, 2020). The NADA AOD Treatment Guidelines for Working with Aboriginal and Non-Aboriginal People in a Non-Aboriginal Setting notes that training should be actively promoted to all staff, not just service delivery staff, be embedded into learning and development plans, be compulsory and available on a regular basis (Wallace & Allan, 2019).
- This KPI has chosen to count staff at a point in time (rather than all staff employed over the reporting period) as the simplest method of recording and reporting for services.

KPI 10 Treatment capacity

Rationale

Measuring the capacity of treatment services and their efficiency is a standard metric for healthcare services. Treatment capacity is measured as bed occupancy rate for bed-based services. It is rare to measure treatment capacity for non-bed-based services, but would reflect the use of available counselling sessions.

This KPI focusses on bed occupancy rate.

Description – bed-based services

Bed occupancy rate

Qualifying services

Any bed-based services

Timepoints

Bed occupancy is calculated for a set period of time: most commonly over a period of one year, (although it can be more frequent in theory).

This KPI specifies an annual bed occupancy rate (given fluctuations over the course of a year, anything less than an annual figure is likely to be unreliable).

Measure and calculation

The formula for bed occupancy rate is:

> Total number of inpatient days for a given period x 100 / Available beds x Number of days in the period.

Where:

> inpatient days = is the number of occupied bed days, and is usually calculated by the number of clients times their length of stay.
>
> Available beds = the number of beds in the facility (see definitions below).

Worked example

In a detox unit with 10 beds; their bed occupancy rate for one month (30 days) is calculated by:

> Client 1 stays for 3 days = 3 occupied bed days
>
> Client 2 stays for 10 days = 10 occupied bed days

Client 3 stays for 5 days = 5 occupied bed days

Client 4 stays for 2 days = 2 occupied bed days

(and so on)

If there was a total of 280 occupied bed days for the month to total occupancy rate would be 93%: (280 x 100)/(10 x 30) = 93%

KPI reporting

1. Annual bed occupancy rate

KPI reporting period:

As determined by services and/or funders, e.g. it could be six-monthly, or annually.

Definitions

Available beds: These are beds that are vacant and includes those that are not occupied and not quarantined or reserved for pending or future clients. A client who is on leave is still considered to occupy a bed.

Children and babies: these beds are not included in the count.

KPI 11: Accreditation

Rationale

The National Quality Framework requires that all AOD services in receipt of government funding comply with the principles in the Framework and, in addition, obtain accreditation against an acceptable accreditation standard.

Accreditation provides independent verification that: "an organisation meets the requirements of defined criteria or standards. Accreditation standards and the accreditation cycle supports organisations to establish and maintain quality improvement processes, meet minimum requirements of operations and service delivery, and provide a level assurance to service users and funders about service safety and quality" (NSW Health, 2018).

Description

The organisation holds current and valid accreditation relevant to the AOD treatment types / services being provided against one of the following approved health and community service standards:

- The Australian Service Excellence Standards (ASES), (Sixth edition, 2018)
- The Evaluation and Quality Improvement Program (EQuIP5), (2013)
- Human Services Quality Framework Queensland (HSQF), (Version 5, 2019)
- International Standards Organisation (ISO) 9001: Quality Management Systems (2015)
- The National Safety and Quality Health Service (NSQHS), (second edition, 2017)
- Quality Improvement Council Health and Community Services Standards (QIC), (seventh edition, 2017)
- Royal Australian College of General Practitioners (RACGP) Standards for General Practices (fifth edition, 2017)
- Western Australian Network of Alcohol & Other Drug Agencies (WANADA) Alcohol and Other Drug Human Service Standard (version 3, 2019)

As per the National Quality Framework, four other accreditation standards cannot be used independently but can be used in conjunction with one of the accreditation standards listed above:

- Victorian Human Services Standards
- Australasian Therapeutic Communities Association (ATCA) (second edition, 2018)
- Tasmanian Quality and Safety Standards
- National Standards for Mental Health Services (NSMHS)

KPI reporting:

The service reports one of the following, mutually exclusive options:

- They have accreditation (and against which standard)
- They are working towards accreditation but do not currently have accreditation
- They do not have accreditation and are not currently working towards accreditation.

Reporting period: Annually

Related key performance indicators and standards

- NSW NGO AOD Performance Indicator Specifications (2018): AOD-Core 2 Organisation accreditation and clinical governance
- NSW NGO AOD Treatment Service Specifications (2017): 4. Accreditation
- National Quality Framework for AOD Treatment Services (2018)

Notes

- For the purposes of this KPI services can choose which standards to attain accreditation against from the listed standards.

KPI 12: Professional development

Rationale

Professional development opportunities allow staff to gain or improve skills, competencies and knowledge. Relevant professional development assists staff in responding appropriately to clients, in their provision of treatment and support and in improving worker confidence, performance and skill base. The provision of continuing professional development opportunities supports quality services and improved service delivery.

Description

The number and proportion of staff who have undertaken relevant continuing professional development.

Calculations

This KPI utilises a point-in-time count to determine number of staff employed i.e. services can choose a point in time during the reporting period when they count the number of staff.

Services then need to count how many of those staff have undertaken professional development activities *at any time* during the previous year.

Numerator: The number of staff who have undertaken professional development over the previous year

Denominator: The number of staff employed at the organisation.

KPI reporting

The service reports on the following:

1. The number of staff who have undertaken professional development over the past year

2. The proportion of staff who have undertaken professional development over the past year

Reporting Period: Annually

Definitions:

- Professional development for the purposes of this KPI includes that undertaken for the following purposes:
    - Practice certification and professional association purposes
    - Other (non-certification) occupational requirements (e.g. learning about new approaches such as trauma-informed care)

    - To keep informed of new research, evidence and developments appropriate to role, occupation and area of speciality
    - To gain vocational or higher education tertiary qualifications that can or will be used in a role within AOD treatment services (including diplomas or certificates provided through a registered training organisation and any undergraduate or postgraduate qualifications including Bachelors, Honours or Masters degrees, PhDs or graduate certificates).

- The following types of professional development are included:
    - Relevant vocational or higher education qualifications that can be used in a role within AOD treatment services
    - Short courses, workshops and trainings
    - Webinars, seminars, talks, presentations (including instructional videos)
    - Clinical or cultural supervision
    - Mentoring, workplace exchanges and site visits.
- All modes of delivery are considered for the purposes of this KPI. i.e. both online and face-to-face professional development should be counted
- All workers of the AOD service are counted for the purposes of this KPI
- It is suggested that the following not be counted as professional development for the purposes of this KPI:
    - Cultural competency/awareness training – this is counted independently under KPI 10
    - Tertiary qualifications NOT relevant to AOD services cannot be counted for the purposes of this KPI. E.g. someone is employed as a social worker but who is undertaking study to become a teacher.

Related key performance indicators and standards

- NADA Workforce Capability Framework (2020): 5.3 Engage in continuing professional development
- NSW Non-Government Alcohol and other drugs Workforce Development Plan 2016-2022
- National Quality Framework for QOD Treatment Services (2018)
- National Framework for AOD Treatment 2019-2029: Workforce development
- National Safety and Quality Health Service Standards (2021): Safety and quality training action 1.20
- NSW Clinical Care Standards (2020): Principle 7 ‘Services are delivered by a qualified workforce’

Notes

- This KPI has chosen to count staff at a point in time (rather than all staff employed over the reporting period) as the simplest method of recording and reporting for services.

KPI 13: AODTS-NMDS

Rationale

All government funded AOD services are required to provide an electronic extract of the AOD Treatment Services National Minimum Data Set (AODTS-NMDS).

Information from the AODTS-NMDS is used to better understand the clients accessing services and the services being provided, as well as for broader system planning and policy development in order to reduce AOD-related harm and improve the quality of AOD treatment service provision.

Services funded by the NSW Health are also required to provide an electronic extract of the NSW Minimum Data Set for Drug and Alcohol Treatment Services (NSW MDS DATS).

Description

Provision of an electronic extract of the AODTS-NMDS and NSW MDS DATS.

Related key performance indicators and standards

- Australian Institute of Health and Welfare (AIHW) Meteor
- National Health Data Dictionary Version 12 (AIHW)
- NSW NGO AOD Performance Indicator Specifications (2018): AOD-Core 1 (NSW MDS DATS)
- Data Dictionary & Collection Requirements for the NSW MDS DATS, NSW Health Policy Directive (Ministry of Health, 2015)

KPI reporting

The organisation or service reports on the following:

- Yes/No they have reported data to AODTS-NMDS
- Yes/No they have reported data to NSW MDS DATS

KPI reporting period: Annually

Data sources As reported to the AODTS-NMDS and the NSW MDS

KPI 14: Audited Financial statement

Rationale

AOD non-government services are required to provide audited financial statements to their Boards, funders, and to the Australian Charities and Not-for-profits Commission (ACNC) (or other registration bodies). All services should maintain financial statements in accordance with Australian Accounting Standards and maintain accounts and records so that they can be audited in accordance with Australian Auditing Standards.

Description

Provision of an annual independently audited financial statement for each funded program or contract.

Related key performance indicators, frameworks and standards

- NSW Ministry of Health (2023), Financial Requirements and Conditions of Subsidy (Government Grants)

KPI reporting

The organisation or service reports on the following:

- Yes/No they have provided audited financial statements

Frequency of data source(s) collection: Annually

Data sources Audited financial statement

Appendix A: Exit survey

It is proposed that a short exit survey is put together for the following KPIs – this should ideally be integrated into any existing surveys that services use with clients at exit:

- KPI 7: Treatment goals achieved
- KPI 8: Linked up
- KPI 9: Culturally safe

This exit survey should be anonymous wherever possible (i.e. not linked to other client data), and completed by every client on exit (whether a planned or unplanned exit).

Proposed exit survey questions are below:

1. How many of your treatment goals were achieved?

All goals	Most goals	Some goals	Few goals	None

Please rate how much you agree with the following statements:

2. I have been linked up with other services to support me when I leave this program.

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

3. I am confident in where to go for further help if needed.

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

4. Did you find the service to be culturally safe and inclusive?

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

5. If you did not experience the service as culturally safe or inclusive, can you say a bit about that to help service improvement?

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