Gone but not forgotten

The theory and practice of ***outcome monitoring****. Overleaf, two alcohol projects tell how they overcame the obstacles and tested their performance against the bottom line – what happens to clients when they leave. On this page, a commentary from* FINDINGS *concludes there is no substitute for post-treatment follow-up.*

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If service management is a cycle beginning with plans, moving through implementation to evaluation, which feeds back into planning, there is usually one major gap – knowledge of what happens to clients when they leave. On the next two pages Accept and WACS show that even for small services, this gap is not inevitable. They found what the research also indicates: there is no reliable substitute for long-term follow-up.

Client satisfaction is an important quality measure in its own right[1] and can relate to discharge status.[2] However, it is not a proxy for longer term outcomes, not even necessarily an indicator of who will stay the course.[3, 4] Good attendance at treatment sessions and completing the programme – aspects of treatment compliance – are more promising indicators of longer term success, but the links can be loose.[5, 6] How people do during treatment may be a guide to their later welfare, but the intensive therapies that most need justification – especially residential options – provide so much support that how people do while they are there is a poor guide to how they will manage on their own.

Surely we can simply replicate what we know works from previous evaluations? There are two problems. First, studies rarely describe the treatments and those found to benefit in sufficient detail for all the elements to be replicated. Second, the influence of the therapist and other factors[7] is such that what worked before may flop with new staff in a different setting.[8, 9]

A combination of implementing proven strategies, assuring staff deliver the intended inputs at high quality, and monitoring treatment completion rates, may stand in for outcome monitoring. As long as ❶ what works elsewhere also works at your service ❷ you have the right idea about what counts as 'quality' ❸ your clients stay the course because they really have turned away from drink. It might be as well to check.

There is some good news. Drinking outcomes in the first year after treatment have been found to predict outcomes in later years – not perfectly, but consistently.[10] So a single reasonably comprehensive follow-up effort around 12 months after treatment may be enough. If these outcomes can be micro-related to different inputs – such as which therapists worked with the client, how they related to them, what services were provided, and aftercare arrangements – then you have a powerful tool for improving the service.

Same aim, different methods

Even if the *desirability* of collecting outcome data is recognised, feasibility may be questioned. The difficulties have led some to counsel against the attempt unless provider arms are severely twisted by purchasers.[11] This may be too pessimistic. Though probably very much in the minority,[12] Accept and WACS have shown that follow-up can be managed, even by small agencies.

Their approaches share common features. Both avoid repeated contact attempts by assuming that non-responders are doing badly. This risks missing people not in stable accommodation, but it does make follow up more feasible. And the assumption has support from research which showed that ex-clients who had to be chased to get them to respond were doing worse than those who responded to the initial contact.[13]

Both services make it easy for ex-clients to respond and for the agency to analyse the data by stripping questions down to those most relevant to treatment goals. For both this dictated abstinence as the primary measure; services aiming for less harmful drinking would face the more difficult task of gathering data on the harms they were targeting and then deciding what counts as success if these reflect a mixed picture. Finally, both agencies see follow-up as an opportunity for ex-clients in need to receive further support.

Beyond these important parallels, their systems could hardly be more different. Accept's mailed questionnaire facilitates anonymity while at WACS a counsellor phones the ex-client. WACS cuts down workload by sampling while Accept contacts all clients but makes this manageable by the simplicity of a mailshot.

Clearly these options do not exhaust the possibilities, but they do demonstrate that such work is feasible and seen as valuable by agencies which undertake it. Their methods might not past muster in academia and the lack of standardisation is an obstacle to service planning based on comparative performance as well as raising question marks over the validity of the outcomes. Neither do they function perfectly as a safety net for ex-clients in trouble. However, they are practical – and a great deal better than trusting to luck.

References and further information sources page 25

Golden Bullets

Essential practice points from this article

- Even small services can manage a routine client follow-up system which they and their funders value.
- Benefits include ❶ assessing performance ❷ improving effectiveness ❸ enhancing staff morale ❹ bolstering purchaser support ❺ contacting former clients in need of help.
- If you want to influence stakeholders, develop the system with them. Added bonus – perhaps they will fund a system which delivers the data they want.
- To improve effectiveness you'll need to connect outcomes with inputs. That means also recording what was done with which clients.
- Keep it simple. Use occasional more thorough follow-ups to check your routine system.
- Be clear about your key treatment goal. Measure that, then see what else (if anything) you can do.
- Use standard outcome measures if they will do the job. Then you can compare your outcomes against established benchmarks and against other services.

It's good to be jolted

by **Barbara Elliott**

At the time of writing, Director of Accept Services, a day centre in West London offering abstinence and controlled drinking services

Measuring what happens to clients while they are with you and when they leave is a crucial starting point for improving services. If we fail to do so, while advocating change in our clients, we avoid one of the main motivators of change for ourselves and our agencies – the jolt of finding out how clients *really* do when they leave. Commissioners too increasingly demand evidence of effectiveness, especially for intensive or long-term treatments.

So why is follow-up monitoring so rare? Get-out clauses include 'limited resources' and 'respecting client privacy'. Our experience is that neither hold water. Without noticeable client resistance, Accept has implemented routine follow-up with a small team of three clinical workers and three part-time volunteers.

Clients of Accept who opt for abstinence design their own day programme and work in the groups they choose for anything between six weeks and six months depending on how they feel they are doing. During this time the number of weekly sessions tapers until (ideally) they spend the last year or two attending a weekly evening aftercare group. In a typical week up to 24 clients attend the day programme and 30 or more the aftercare groups. The follow-up system applies only to these clients.[1]

Who to follow up?

Assessing how people are doing six or 12 months after leaving comes at the end of a series of data collection points. From our office register we identify those who *fail to engage* (leave during first two weeks) and *drop-outs* (unplanned leavers after the first two weeks). We also monitor *attendance* in the aftercare group.

From this data we know that about one in eight new clients fail to engage. Half of the remainder leave the day programme at between eight and 30 weeks after having completed their plan; most then move into an evening aftercare group. The other half generally drop out unplanned and do not resume contact in response to two letters inviting them back.

In estimating longer term outcomes we err on the side of caution by assuming that drop-outs are not doing well. By virtue of attending aftercare or for other purposes, many clients stay in regular contact after completing the day programme, so their drinking status is known. Only planned leavers no longer in regular contact need to be followed up using our postal system.

This consists of a simple tick box questionnaire with an addressed and stamped return envelope. Recipients can choose whether or not to return it anonymously. The SAE is more than a courtesy; I feel it is largely responsible for the high response rate. All clients are contacted between six and 12 months after they started the day programme; some who started earlier are also re-contacted. For the purposes of the statistics, we assume that non-responders are struggling with their drinking.

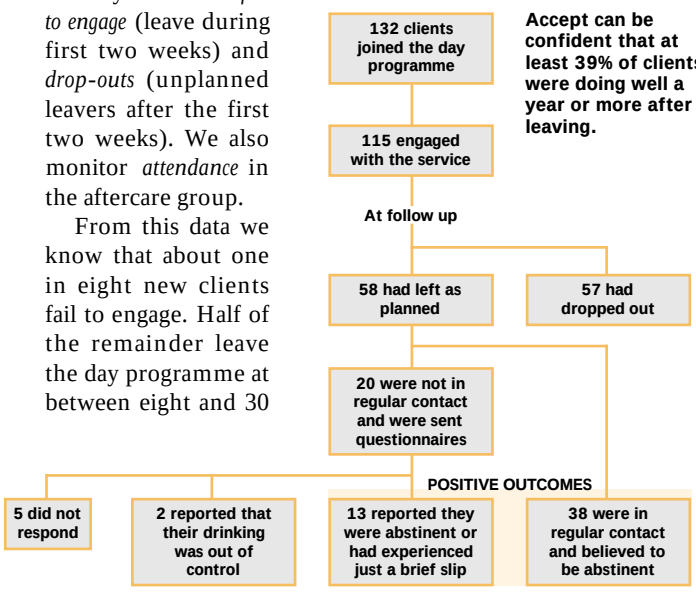
What to ask?

Our aim is simply and quickly to gain a snapshot of what happens to clients after they leave. Far from seeing it as an intrusion, most respondents seem pleased to tell us how they are doing, often adding notes and messages. Some who *don't* respond may be less pleased, but so far we have received no complaints. For both sides the procedure is extremely simple: a few hours work for Accept, a few minutes ticking boxes for the client.

The focus is on a concrete, self-reported behaviour – drinking alcohol. Life's other problems do not always improve when such drinking stops, but it's a fair assumption that most clients who aimed for abstinence and who later achieved it will have also improved across the board. This means the returns can be categorised simply by the degree to which drinking outcomes have fallen short of abstinence. The categories we use are:

- maintained abstinence since last seen;
- experienced 'learning curve slips' but now abstaining;
- experienced full-blown relapses;
- now drinking, either uncontrollably or in a controlled manner.

Outcomes at the end of 1998 for clients who had entered the day programme between January 1996 and June 1998 (chart) suggested that at least 44% who had engaged with the programme were abstinent or near abstinent. To this could be added an unknown number of drop-outs and non-responders who were nevertheless doing well, bringing the probable success rate to 1 in 2. Among those who engage with the service, abstinence rates over 30% make me think we must be moving in a positive direction.



Feedback affects practice

Our methodology may lack precision, but it is an easy, quick and inexpensive way to gain feedback on whether our intervention was useful. Fail-safe assumptions about drop-outs and non-responders leave the honesty of responders as the main question mark. However, there is plenty of evidence that people tell the truth about their drinking when they have nothing to gain from lying. In this case the responders are no longer our clients and can respond anonymously; probably most are truthful most of the time. Of course, *if they are equally suitable*, standardised instruments are preferable to custom solutions. But when we set up the system none *were* suitable. Measurement tools such as the Maudsley Addiction Profile have since become available.

What influence do the results have? Strangely, service commissioners do not seem to pay much attention. However, the results do have a great impact on the staff team and on its practices, helping us assess whether promising innovations really do translate into better outcomes.

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1 Another 15 to 20 clients a week work on controlled drinking goals. The high turnover in this programme precludes (with current resources) systematic follow-up.

Gone but not forgotten

Simplicity gets the job done

by **Fiona Dunwoodie** *and* **Jo Blackledge**
Business Manager and Senior Counsellor at the Waltham Forest Alcohol Counselling Service (WACS).

The Waltham Forest Alcohol Counselling Service (WACS) provides a full-time abstinence-based programme of group therapy and individual counselling for problem drinkers and their families. Clients commit to attend every weekday for at least two weeks. The programme is intensive, but it was not so much the expense as our methods which prompted us to assess long-term outcomes. Abstinence is often an unpopular basis for treatment; pressured by funders to provide alternatives, we sought to defend our programme by showing that – for our severely addicted clients – abstinence was appropriate, and that our programme effectively achieved and maintained it. The only convincing way to do this was to follow up clients no longer under the protection of the day programme.

The procedure we use was introduced by a consultant hired by the local health authority to assess the service. She sampled clients seen during a randomly selected month from the previous year; it happened to be September, the month we still sample to maintain comparability.

The system's beauty is its simplicity. Everything is done over the phone. Each September we collate the phone numbers of clients who attended during the previous September, whether or not they completed the minimum two weeks. In practice, very few leave early – 49 throughout the latest year. We exclude those who were assessed but did not join the programme, either because they dropped out or were referred elsewhere, roughly three a month.

Our senior counsellor makes the calls; sometimes several attempts are needed. Problems arise when numbers change, but in that case addresses too will normally be out of date, and our experience is that phone calls generate a higher response rate than postal questionnaires. Some agencies might prefer non-clinical staff to make the calls; we reason that the counsellor's personal relationship with clients means they are more likely to be open and responsive.

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Funders impressed

The calls are casual and friendly. We always ask if the client is drinking, but beyond that probe how they are doing in ways which make sense for that client at that time. The fact that one person makes most of the calls probably helps prevent significant inconsistencies.

Though abstinence is the treatment goal, 'success' for us embraces not just abstinence but any positive gains – a return to work, improved family relationships, alcohol no longer posing problems, or a relapse reversed. Those we are unable to contact are not counted among our successes; this may underestimate the success rate but does ensure that it is never over-optimistic.

Perhaps because of the relaxed approach, even drinking clients have not reacted aggressively to the calls; normally they are glad to hear from us and forthcoming about how they are progressing.

Follow-up is one way we pick up on clients in need of further support, and several have subsequently returned to the programme. But, of course, it only reaches those attending in September. All former clients are also contacted by post twice a year, providing further openings for those in trouble to return to the project.

Convincing the purchasers was the major motivation for setting up the system and in this respect it has paid dividends. Our annual follow-ups have shown that the service really does work. A year later 35 of the 43 clients who attended in September 1997 had remained abstinent, three were back drinking, and five could not be contacted. Combined with user satisfaction surveys, follow-ups also form a solid basis for WACS to 'self assess', providing an overview of our success rates while the surveys highlight how the programme might be improved. We now have enough experience to convince us that such monitoring is an effective way of gauging what works and what doesn't – one which ought to be considered by every alcohol agency.

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SECOND SIGHT Reactions from two of our expert advisers

Assure quality and outcomes will follow

by **Mike Blank**
Director, Surrey Alcohol and Drug Advisory Service

These agencies have done well to identify and follow up people to find out if they responded to interventions, but the reluctance of others to do so is in some ways understandable. Evidence suggests that people who complete programmes or respond to brief interventions show positive outcomes in terms of abstinence or controlled drinking. This means that an agency which can show it is using tried and tested interventions can also be confident that a significant number of clients who complete their programmes will do well. The issues to be addressed by purchasers are therefore quality standards and quality assurance, not necessarily follow up.

Resources devoted to following up programme completers might be better deployed in assertive outreach for those who disengaged or failed to engage. They are more likely to be in trouble with their substance use and to have mental health or other problems and should be chased up and helped to re-engage.

Walk before you run

by **Dima Abdulrahim**
Substance Misuse Advisory Service (SMAS)

Providers and commissioners would be well advised to consider their monitoring and evaluation needs as a whole before rushing into post-treatment outcome monitoring. Few monitor treatment outcomes in any meaningful way – many do not even monitor what they do – so commissioners often have little knowledge of who the clients are and which groups are under-represented. Before taking on advanced monitoring, providers need to develop basic activity monitoring and familiarise themselves with the differences between outcome monitoring, activity monitoring, client satisfaction surveys, and other feedback mechanisms.

The other reason for caution is that SMAS has seen cases across the country of instruments developed to measure outcomes, which in reality measured something else, or nothing at all. Standard instruments are preferable – but collecting such data is of little use unless you also have the skills to make sense of it.

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1 Metrebian N., *et al*. "A model of consumer audit for substance misuse services." *Journal of Substance Misuse*: 1997, 2, p. 222–227.

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5 Stark M.J. "Dropping out of substance abuse treatment. A clinically oriented review." *Clinical Psychology Review*: 1992, 12, p. 93–116.

6 Mattson M.E., *et al*. "Compliance with treatment and follow-up protocols in Project MATCH: predictors and relationship to outcome." *Alcoholism. Clinical and Experimental Research*: 1998, 22(6), p. 1328–1339. A year after treatment in Project MATCH, whether clients achieved abstinence was at best only weakly related to treatment compliance.

7 Tucker J.A, *et al*. "Resolving alcohol and drug problems: influences on addictive behavior change and help-seeking processes." In: Tucker J.A., *et al, eds. Changing addictive behavior*. Guilford Press, 1999, p. 99.

8 Project MATCH Research Group. "Matching patients with alcohol disorders to treatments: clinical implications from Project MATCH." *Journal of Mental Health*: 1998, 7(6), p. 596. Project MATCH was unable to prevent a few of its highly trained and supervised therapists delivering outcomes "significantly worse" than their colleagues.

9 Connors G.J., *et al*. "The therapeutic alliance and its relationship to alcoholism treatment participation and outcome." *Journal of Consulting and Clinical Psychology*: 1997, 65(4), p. 597. "Even in the context of the same treatment protocol", results seen at one project might not be replicated at others.

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13 Stinchfield R., *et al*. "Hazelden's model of treatment and its outcome." *Addictive Behaviors*: 1998, 23(5), p. 669–683.

For more information on outcome monitoring

How to show treatment works by Don Lavoie in FINDINGS issue 1, p. 25–26. A commissioner's view on performance monitoring.

A DIY guide to implementing outcome monitoring by Sara Burns, Alcohol Concern, 1997. Advice on outcome monitoring tailored to alcohol service providers.

Outcome-based evaluation of alcohol misuse services. A paper for purchasing authorities. Advice from Alcohol Concern for alcohol service commissioners.

Copies: for all apply Alcohol Concern, 020 7928 7377.