QUEENSLAND ALCOHOL & OTHER DRUG TREATMENT & HARM REDUCTION OUTCOMES FRAMEWORK

Alcohol and other drug treatment and harm reduction services in Queensland provide effective, evidence informed responses in order to reduce alcohol and other drug related harm, and increase health and wellbeing.

Queensland Alcohol and other Drugs Sector Network (2019)

For more information contact one of the following authors:

Sean Popovich

Treatment Services Support Manager, Queensland Network of Alcohol and Other Drug Agencies (QNADA)

07 3023 5050 | sean.popovich@qnada.org.au

Rebecca Lang

Chief Executive Officer, Queensland Network of Alcohol and Other Drug Agencies (QNADA)

07 3023 5050 | rebecca.lang@qnada.org.au

Jeff Buckley

Director, Insight: Centre for AOD training and Workforce Development

Metro North Hospital and Health Service

07 3837 5655 | jeff.buckley@health.qld.gov.au

Linda Hipper

Director, Addiction Services Academic Clinical Unit (Addiction & Mental Health Service)

Metro South Health

07 3156 9813 | linda.hipper@health.qld.gov.au

Cameron Francis

Social Worker / Team Leader, Dovetail

Metro North Hospital and Health Service

07 3837 5621 | cameron.francis@health.qld.gov.au

Eddie Fewings

Manager AOD, Queensland Aboriginal and Islander Health Council (QAIHC)

07 3328 8500 | eddie.fewings@qaihc.com.au

Helen Taylor

Director, Alcohol and Other Drugs Strategy, Planning & Partnerships Unit, Mental Health Alcohol & Other Drugs Branch

Department of Health (Qld)

07 3328 9534 | helen.taylor@health.qld.gov.au

Kate Podevin

Principal Policy Officer, Alcohol and Other Drugs Strategy, Planning & Partnerships Unit, Mental Health Alcohol and Other Drugs Branch

Department of Health (Qld)

07 3328 9850 | kate.podevin@health.qld.gov.au

Stefan Preissler

Program Manager (Policy and Program Delivery)

Queensland Mental Health Commission

07 3033 0319 | stefan.preissler@qmhc.qld.gov.au

Leanne Hides

NHMRC Senior Research Fellow

Clinical Psychologist, Lives Lived Well

Professor of Alcohol, Drugs & Mental Health, School of Psychology, University of Queensland

Australasian Professional Society on Alcohol and other Drugs (Qld representative)

07 3365 1111 | l.hides@uq.edu.au

Suggested citation:

Queensland Alcohol and Other Drugs Sector Network. (2019). *Queensland Alcohol and other Drug Treatment and Harm Reduction Outcomes Framework*. Brisbane: Author.

CONTENTS

ABOUT THIS DOCUMENT

The Queensland Alcohol and other Drug Treatment and Harm Reduction Outcomes Framework (THROF) describes the way Queensland alcohol and other drugs (AOD) treatment and harm reduction services can measure their impact. It suggests a series of outcome indicators that, when measured and considered in the context of each other and specific treatment types, help to inform service quality.

The THROF has been developed by a partnership of statewide AOD policy, sector and workforce development organisations based on direct input, feedback and research from AOD treatment providers from across Queensland as well as clients from AOD services.

The THROF reflects the Queensland AOD sector's consensus about what can be reasonably expected of AOD treatment and harm reduction services and should be considered in combination with the Queensland Alcohol and other Drug Treatment Service Delivery Framework.

The THROF is intended for services to use as a guide to self-identify a range of client, organisational and system outcome indicators, which they consider most relevant to their service model for implementation.

The THROF is not intended to replace organisational policy or compel organisations or workers to measure outcomes in any particular way.

The Queensland AOD Sector Network will be supporting implementation of the THROF, including collaborating with commissioners of services to develop processes to measure system level indicators and promote the use of the THROF. The Queensland AOD Sector Network should be the first point of contact for practitioners, services, commissioners and system administrators who are considering its application. The authors of the THROF and their contact details are listed on page 2.

The potential benefits and applications of the Queensland Alcohol and other Drug Treatment and Harm Reduction Outcomes Framework include:

- developing a shared language and common approach to outcome measurement across AOD treatment and harm reduction services
- facilitating benchmarking across similar service types in Queensland
- communicating the aims of AOD treatment and harm reduction with other sectors
- using the THROF as a critical reflection tool for workers, services and system administrators to enhance their practice at client, organisational and system levels.

The Queensland Alcohol and other Drug Treatment and Harm Reduction Outcomes Framework was informed by:

- a Queensland AOD outcomes symposium held in April 2016 bringing together local and international speakers with experience in developing outcome measures related to AOD treatment and harm reduction
- a series of reference groups conducted with 48 representatives from 35 services (non-government, government and private) in February, March, April, and June 2017
- three client focus groups and one individual interview to ensure alignment of the indicators with what clients value in treatment
- data collected at the Queensland AOD Sector Convention 2018, which was held on Friday 22nd June 2018 at Brisbane City Hall. The Convention was attended by over 100 service managers, policy makers, and sector leaders from across the government and non-government AOD sector in Queensland (for details, please see the *Report on the Queensland AOD Sector Convention 2018)*
- an Aboriginal and Torres Strait Islander community controlled sector consultation held on 29th November 2018.

INTRODUCTION

The purpose of the Queensland Alcohol and other Drug Treatment and Harm Reduction Outcomes Framework (THROF) is to support alcohol and other drugs services to be able to measure their impact in a way that best suits their service type and context. Measuring the impact of AOD treatment and harm reduction in the lives of clients and communities is essential to ensuring that organisational practice standards continue to improve.

Outcomes-based thinking can drive clinical, organisational, and system improvement meaning better AOD treatment and harm reduction responses can be provided to individuals, families, and communities in Queensland.

Understanding our impact can support:

- continuous improvement of interventions delivered
- organisational improvements that make AOD services more accessible and / or effective
- system administrators to make effective investment decisions to reduce AOD related harm.

It is noted, while specialist AOD treatment services may respond to a range of issues throughout the course of support, providing responses to people who experience problems with substance use through a range of evidence informed interventions is the focus of AOD treatment.

In Queensland, the primary outcomes (which may be achieved in the short, medium, or longer term) of AOD treatment and harm reduction for clients include:

- reduced experiences of AOD-related harm
- reduced levels of substance use
- improved capacity to better understand and manage health and wellbeing.

These primary outcomes are the foundation of the THROF.

While treatment may have a range of secondary impacts on a person's life, these secondary impacts are varied, difficult to establish, and not the focus of the THROF. These are:

- ability to comply with legal or statutory directives
- changes in housing / accommodation
- changes to participation in education / training / work
- changes in criminal / offending behaviour.

INTERPRETING THE FRAMEWORK FOR SPECIFIC POPULATIONS

Every individual has particular needs, concerns and barriers that need to be addressed in order to provide fair, effective, and accessible AOD treatment.

Working with some population groups requires additional specialist skills and specific considerations of relevant and measurable outcomes. Examples of specific population groups include:

- Aboriginal and Torres Strait Islander peoples
- young people
- people who identify as lesbian, gay, bisexual, transgender, intersex, questioning and others (LGBTIQ+)
- people from culturally and linguistically diverse backgrounds
- people from refugee and asylum seeker backgrounds
- people with a disability
- families.

Through awareness and application of relevant population-specific frameworks, strategies and guidelines, ongoing training, and workforce and sector capacity building, practitioners and services can be supported to work better with these groups and facilitate improved AOD treatment outcomes.

It is noted some of the tools recommended in the THROF have not been validated for use with some or all of these populations. It is expected that services will make the necessary enquiries as to which tools are appropriate for their service context.

It is also acknowledged that there may be other sources of reference to guide consideration of meaningful outcomes at a client, organisation, and system level for these population groups, as well as the need to collaboratively develop supplements to the THROF to better meet this need.

Aboriginal and Torres Strait Islander peoples

Good AOD outcomes are more likely to be achieved when organisations involved in supporting Aboriginal and Torres Strait Islander peoples recognise and respond to the social and emotional wellbeing needs of clients, which include:

- culture, ancestry, and spirituality
- land and sea Country
- community, family, and kinship
- physical, mental, and spiritual health.

Social and emotional wellbeing needs will be different for each individual, family and community however they are inextricably linked to AOD treatment and harm reduction outcomes.

Organisations and practitioners should be aware Aboriginal and Torres Strait Islander peoples have many cultures with different cultural protocols. Establishing a culturally safe organisational environment and therapeutic relationship requires ongoing training, cultural supervision, and mentoring.

The cultural background of an individual influences health beliefs and behaviours as well as treatment expectations and experiences. Services should consider how to adapt methods of engagement, assessment, treatment provision, and aftercare to be responsive to these issues (eg traditional healing as an accompaniment to treatment, flexibility to support staff and clients who must attend to Sorry Business).

Creating close partnerships with community representatives, elders and community controlled organisations to guide treatment planning and delivery are important components of providing AOD treatment and harm reduction to Aboriginal and Torres Strait Islander peoples. It is expected that organisations continuously support staff to work in culturally appropriate and safe ways.

The outcome indicators included in the THROF should be viewed through the lens of social and emotional wellbeing when working with Aboriginal and Torres Strait Islander peoples. In this context, organisations should ensure indicators selected are congruent with workforce skill, particularly in relation to providing cultural activities and support.

Young people

There are a range of issues that youth AOD services must consider when working with young people such as developmental, environmental, and social factors.

Working with young people in AOD treatment settings can require services to facilitate non-treatment activities designed to keep young people engaged with the service. This process of engagement is not an outcome or treatment in and of itself but occurs alongside a range of evidence informed AOD treatment strategies.

While the outcome indicators do not go beyond AOD treatment, it is recognised that there are other components of youth AOD work which are not captured by the THROF that can be equally as valuable as treatment and just as necessary.

LGBTIQ+ people

People who identify as members of the LGBTIQ+ community who are experiencing problematic substance use may have additional needs that should be considered such as treatment accessibility and unique support needs during treatment.

Services working with LGBTIQ+ people are encouraged to consider the framework in this context and methods that may be used to improve service accessibility and workforce capability such as Rainbow Tick accreditation.

Culturally and linguistically diverse peoples

The provision of inclusive treatment in a multicultural society requires more than simply addressing language barriers. As noted previously, cultural background also influences health beliefs and behaviours as well as treatment expectations and experiences. Services should consider how to adapt methods of engagement, assessment, treatment provision, and aftercare to be responsive to these issues. Flexibility in approaches and creating close partnerships with community representatives and associations to guide treatment planning and delivery are important components of providing AOD treatment and harm reduction to people from culturally and linguistically diverse backgrounds.

People from refugee and asylum seeker backgrounds

People from refugee and asylum seeker backgrounds may have additional needs to those from non-refugee and asylum seeker backgrounds related to experiences of forced migration, exposure to traumatic events, and interrupted access to health care. Particular efforts may therefore be necessary to foster engagement, retention, and outcomes in treatment for refugee communities.

Treatment providers should seek additional training in responding to the needs of culturally diverse and refugee and asylum seeker background communities where required.

People with a disability

People may experience physical, cognitive, or intellectual disabilities either separately or in combination which can impact access, engagement, and overall treatment outcomes.

To support access, services need to consider physical access issues (eg for people who use mobility devices) as well as program delivery issues (eg adaptions to cognitive behaviour therapy based programs for people with identified cognitive impairment).

Families

Turning attention to the needs, coping skills, and resilience of the family unit can support clients to maintain the positive benefits of treatment and increase the chance of achieving successful AOD treatment outcomes.

Indicators within this framework should be applied and interpreted in the context of family sensitive and child aware approaches. While the framework does not include outcome indicators for families per se, it can and should be considered with children, families, and significant others in mind.

USING THE FRAMEWORK

Organisations tend to use a combination of outcome and output measures to monitor and continually improve their services. The THROF focuses on outcomes only (which may be short, medium, or longer term) and is designed to complement existing AOD treatment and harm reduction service program logics.

It is organised into three domains that provide scaffolding for the proposed outcome indicators:

- **Client** indicators that can be measured in clients, family, and friends receiving AOD treatment and harm reduction services
- **Organisational** indicators like governance, operational, and clinical practice arrangements, which affect service quality
- **System** indicators that influence the ability of clients to access services and services to respond to demand.

Indicators that can be applied to any intervention type can be found by referring to the section titled 'Universal indicators'. Indicators that are intervention specific can be found by referring to the relevant sections:

- Harm reduction
- Medication assisted treatment
- Psychosocial interventions
- Residential treatment
- Withdrawal management.

Intervention specific indicators should always be considered in conjunction with universal indicators.

Indicators included in the 'Harm reduction' specific section of this framework refer only to services funded by State or Commonwealth Department of Health (ie needle and syringe programs). Diversion services and other forms of harm reduction services have not yet been considered, although a range of indicators which may be relevant to these services can be found by referring to the universal indicators.

Due to the anonymous nature of some harm reduction interventions (eg needle and syringe programs), a restricted number of universal indicators will be applicable.

Because clients of AOD services often have multiple and complex needs, different sets or types of outcomes will be relevant depending on individual needs and service type. Therefore, the outcome indicators that services choose to use can be expected to vary depending on the organisation and interventions provided.

In order to ensure the THROF is adaptable to a wide range of contexts, the outcome indicators are not designed as questions but rather intended as descriptors to inform the function of the clinical tool, feedback, survey, or particular questions that may be used to measure them.

. . . DIFFERENT SETS OR TYPES OF OUTCOMES WILL BE RELEVANT DEPENDING ON INDIVIDUAL NEEDS AND SERVICE TYPE.

TREATMENT AND INTERVENTION SERVICE TYPES

SERVICE TYPE	DEFINITION
Harm reduction	Harm reduction services provide a range of support to people who use AOD. While all AOD services provide harm reduction as part of their client work (eg new equipment, advice on safer using), a harm reduction service is a specialist service whose core focus is to increase a person's safety and wellbeing. Examples include: • **primary needle and syringe programs** which provide a full range of new injecting equipment and sharps disposal containers alongside harm reduction interventions such as information and education, blood borne virus screening and treatment, vein care advice and referral information • **secondary needle and syringe programs** which provide basic new injecting equipment distributed by non-NSP staff or through vending machines • **diversionary centres and programs** which offer supervision and accommodation for people who are intoxicated as an alternative to police custody (eg night patrol)[1] • other harm reduction initiatives such as drug safety testing (also known as drug checking or pill testing).
Medication assisted treatment	Medication assisted treatment is clinically supervised replacement of a substance of dependence with a medicine that is administered to reduce or eliminate withdrawal symptoms and cravings. This includes alcohol pharmacotherapy and opioid treatment programs.
Psychosocial interventions	Psychosocial interventions involve employing a range of evidence informed treatment approaches (eg cognitive behaviour therapy, motivational interviewing), integrated with social support and can be delivered in various settings (eg outreach, clinic-based).
Residential treatment	Residential treatment is an intensive treatment program conducted in a residential setting typically offering a mixture of one on one, group work, peer support, and team / community building processes. This includes therapeutic communities which use the 'community as method' approach.
Withdrawal management	Withdrawal management (also known as detox) is the provision of support (that can include medically assisted care) for clients experiencing withdrawal symptoms and can be delivered in an inpatient (eg hospital) or outpatient (eg ambulatory, home-based, community based) setting.

1 Please note, indicators included in the harm reduction specific section of this Framework refer only to services funded by State or Commonwealth Department of Health (ie needle and syringe programs). Diversion services and other forms of harm reduction services have not yet been considered, although a range of indicators which may be relevant to these services can be found by referring to the universal indicators.

MEASURING OUTCOMES

Data to measure outcome indicators can be collected using a variety of methods including screening and assessment tools, client questionnaires, surveys, feedback mechanisms, clinician / practitioner record keeping tools (eg client management systems, case files, treatment plans), and regular auditing procedures.

Please note that some methods of measuring outcome indicators are more reliable than others. Wherever possible, a validated assessment tool is preferred as it has generally been shown to be effective in measuring the indicator in question.

At a client level, most methods will involve assessing change over time. For example, a service might conduct an initial screen and then follow up using the same instrument at regular intervals during treatment (eg every three months, month or every day depending on service type and instrument used). The service may then compare collated data from all screens and follow ups within a certain time period as an indicator of outcome progression.

Some screening or assessment tools that enquire about changes over longer periods (eg over the last year) tend to be less useful measures of progress for shorter term treatment types.

The THROF provides some guidance on commonly used tools in Queensland's AOD sector as they apply to measuring each of the indicators.

Organisational indicators (eg *Percentage of clients with an agreed treatment plan*) may require services to review information or reports from client management systems (eg treatment plans, case notes) or conduct internal audits.

System level indicators are indicators that AOD system administrators are encouraged to consider with regards to system design and function. Measuring these indicators can include review of high level data such as National Drug Strategy Household Survey data, Alcohol and Other Drug Treatment Services National Minimum Data Set, National Opioid Pharmacotherapy Statistics Annual Data, Australian Needle and Syringe Program Survey data, and AOD workforce needs assessments and surveys.

The methods used will depend on the nature of the indicator and the availability, practicality, and usability of instruments in the context of specific AOD treatment services.

Generally, each indicator is capable of providing a quantitative and a qualitative measure. For example, indicator 6, *Client is involved in goal setting* can be measured as individual self-reported involvement in goal setting, and more broadly as the proportion of clients involved in goal setting when compared to the total number of clients who were seen during the selected period.

The remainder of the framework is set out in the following structure:

- Quick reference guide to the indicators (p 12)
- Universal indicators with explanatory notes (p 16)
- Intervention / treatment specific indicators with explanatory notes (p 26)
- Screening and assessment tools commonly used by AOD services in Queensland (p 31)
- Example client survey questions (p 37)
- Example client records review tool (p 39).

It is likely that a combination of methods will be used by services to measure their impact. Additionally, each indicator should be viewed in the context of other indicators. For example, it may not make sense for services to look at *level of trust* without also considering other indicators such as whether a client felt *listened to and understood* or even the *rate of workforce retention*.

Superscript numbers appearing next to the recommended tools in the 'context and methods' section (see p 16) correspond to the indicators measured by that tool.

GENERALLY, EACH INDICATOR IS CAPABLE OF PROVIDING A QUANTITATIVE AND A QUALITATIVE MEASURE.

OUTCOME INDICATOR QUICK REFERENCE GUIDE (see p 16 onward for full context)

UNIVERSAL INDICATORS

CLIENT

Quality of client relationship with service

1. Feeling welcomed and respected
2. Feeling comfortable in the physical and cultural environment
3. Feeling listened to and understood
4. Feeling safe
5. Level of trust in worker / service

Quality of client engagement with service

6. Client is involved in goal setting
7. Client reported progress on goals
8. Worker reported progress on goals

Quality of AOD treatment / intervention

9. Understanding of harms and risks associated with substance use
10. Knowledge of harm reduction strategies
11. Confidence to implement harm reduction strategies
12. Client reported implementation of harm reduction strategies
13. Understanding strategies to improve one's level of health and wellbeing
14. Confidence to apply these health and wellbeing strategies
15. Client reported implementation of health and wellbeing strategies
16. Client reported satisfaction with services received
17. Client reports the treatment / intervention helped
18. Client reports they would recommend the service to others

ORGANISATION

Governance

19. Maintenance of accreditation to relevant standards, and / or compliance with legislative requirements

Staffing

20. Staff receive orientation specific to their role and service type
21. Staff receive regular operational supervision, and performance planning and development reviews
22. Staff receive routine clinical / practice supervision
23. Staff participate in regular relevant training and professional development
24. Staff are confident to deliver endorsed treatment / interventions

Service engagement with client

25. Percentage of clients with an agreed treatment plan
26. Percentage of treatment plans reviewed routinely (within the service)
27. Routine plan reviews occur with the client
28. Percentage of clients who come back after the first session where treatment is indicated

Access

29. Screening is undertaken to determine the appropriate treatment type
30. Time from first contact to intake (or screening) and assessment
31. Time from first contact to indicated treatment
32. Duration of support offered is matched to assessed client need
33. Information and education is provided in multiple formats
34. There are strategies in place for working responsively to meet the needs of identified priority population groups

UNIVERSAL INDICATORS

ORGANISATION

Treatment matching

35. Comprehensive assessment is completed where AOD treatment is indicated
36. Treatment type offered is congruent with assessment & client preference
37. Clients are actively supported to engage with services that meet their non AOD treatment needs and goals
38. Coordinated planning occurs (with consent) where there is more than one service involved

Service exit planning

39. Clients are actively supported to transition to services that meet their needs and goals
40. Follow up occurs after the client completes or leaves treatment
41. Percentage of clients that report they would return to treatment if they needed it

SYSTEM

42. Distance travelled to access treatment
43. Level of met versus unmet need
44. Cultural responsiveness of service
45. The impact of reporting requirements on service delivery (eg ratio of time, cost)
46. Referrals in are appropriate (translate to service offered)
47. Rate of workforce retention

. . . EACH INDICATOR SHOULD BE VIEWED IN THE CONTEXT OF OTHER INDICATORS.

ADDITIONAL INTERVENTION SPECIFIC INDICATORS

HARM REDUCTION INDICATORS

Client	Organisation	System
	48. Percentage of clients offered information on safe injecting	50. Client reported satisfaction with equipment provided
	49. Range of equipment offered is appropriate to the client's needs	51. Rates of HIV and Hep C

MEDICATION ASSISTED TREATMENT INDICATORS

Client	Organisation	System
52. Percentage of clients reporting minimal side effects / adverse events	58. Clients are screened for blood borne viruses, sexually transmitted infections, and other physical health issues	
53. Client reports a reduction in cravings	59. Practice is consistent with dosing / clinical guidelines	
54. Client reports satisfaction with medication	60. Clients are provided with appropriate doses of medication	
55. Client reports a reduction in the use of alcohol or other drugs	61. Proportion of missed doses	
56. Proportion of missed doses		
57. Client reports least possible complications associated with withdrawal		

INTERVENTION SPECIFIC INDICATORS SHOULD ALWAYS BE CONSIDERED IN CONJUNCTION WITH UNIVERSAL INDICATORS.

ADDITIONAL INTERVENTION SPECIFIC INDICATORS

PSYCHOSOCIAL INTERVENTION INDICATORS

Client	Organisation	System
62. Client reported engagement in activities they identify as important to them 63. Client reports improvement in social, cultural and / or community support where indicated 64. Client reports reduction in the use of alcohol or other drugs		65. Proportion of referrals from court and diversion programs versus other referral sources 66. Proportion of clients receiving services referred by court and diversion versus other referral sources

RESIDENTIAL TREATMENT INDICATORS

Client	Organisation	System
67. Level of withdrawal management (detox) completed where indicated 68. Client reports abstinence from alcohol and other drugs while participating in residential treatment		69. Availability of withdrawal management services in the region 70. Proportion of referrals from court and diversion programs versus other referral sources 71. Proportion of clients receiving services referred by court and diversion versus other referral sources 72. Availability of pre and post treatment support

WITHDRAWAL MANAGEMENT INDICATORS

Client	Organisation	System
73. Reduction of withdrawal symptoms 74. Client reports reduction/ cessation in the use of alcohol or other drugs while engaged in withdrawal care 75. Absence of adverse clinical incidents associated with withdrawal	76. Duration and type of withdrawal management support offered matches assessed client need	

INDICATORS, CONTEXT AND METHODS

Superscript numbers appearing next to the 'recommended tools / data source' in the 'context and methods' section correspond to the indicators measured by that tool. A description of recommended screening and assessment tools is located on page 31. Where the recommended tools / data source is review of record keeping tools (eg client management systems), please refer to the example client records review / audit tool located on page 39. Where client surveys are recommended, please refer to the example questions on page 37.

UNIVERSAL INDICATORS – CLIENT LEVEL

INDICATOR	CONTEXT & METHODS
QUALITY OF CLIENT RELATIONSHIP WITH SERVICE	
1. Feeling welcomed and respected	These indicators refer to how clients feel about the service. For example, looking for opportunities to complete structured assessments in natural settings outside of the clinical environment may help clients to feel more comfortable in the physical environment, and build a better relationship and ongoing engagement with the service. Services should also consider their cultural environment, including whether processes, forms, and other ways of working are accessible, welcoming, and appropriate for specific populations. Depending on cultural setting and context, concepts of respect, comfort, understanding, trust, and safety may take on different meanings for different people. Therefore, it is essential that these indicators are communicated, interpreted, and measured through a culturally appropriate lens if meaningful data is to be gained. Frequency and methods of measurement should be considered in the context of intervention provided. For example, harm reduction services may use waiting room surveys while psychosocial intervention services may undertake session by session feedback. Consider that these indicators may: • be influenced by issues around privacy, confidentiality and consent • depend on whether a client is voluntary or mandated • appear negative during early stages of treatment and improve on follow up after establishing rapport • require that clients are able to provide responses anonymously. **Recommended tools / data source:** Session Rating Scale[1, 3] | client surveys[1, 2, 3, 4, 5]
2. Feeling comfortable in the physical and cultural environment	
3. Feeling listened to and understood	
4. Feeling safe	
5. Level of trust in worker / service	

INDICATOR	CONTEXT & METHODS
QUALITY OF CLIENT ENGAGEMENT WITH SERVICE	
6. Client is involved in goal setting 7. Client reported progress on goals 8. Worker reported progress on goals	Progress on goals is recognised by clients and AOD practitioners as an important way to understand if treatment is on the right track, particularly the level of congruence between how clients rate their progress and how workers rate client progress. In order for this to be achieved, clients must be actively involved in treatment decisions and goal setting as the goals of clients may look different based on their needs and the range of issues they may be experiencing. These indicators should be contextualised depending on the pattern of substance use and treatment type, and may include considerations such as: • developmental • cultural, social, and spiritual • cognitive • physical • environmental. These indicators can be interpreted to include the goals of the primary client and their family where appropriate. For example: • Concepts of family can be broader than immediate relatives for Aboriginal and Torres Strait Islander peoples. For some Aboriginal and Torres Strait Islander clients it's particularly important that consultation with the family occurs (with consent) as part of the treatment process to ensure the service provided is culturally suitable and appropriate. • Goal setting with young people needs to be age appropriate and consideration should be given to the needs of families and carers and what they would like for their young person. Where there is incongruence between client and worker reported progress on goals, this presents an opportunity to consider why, explore this further with the client and adjust the approach accordingly. It is unlikely that harm reduction services (eg needle and syringe programs) will measure these indicators due to the anonymous and episodic nature of support provided in harm reduction programs. **Recommended tools / data source:** Australian Treatment Outcomes Profile (ATOP)[7] | Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)[7] | ASSIST – Y (Youth)[7] | Substances and Choices Scale (SACS - youth)[7] | Growth and Empowerment Measure (GEM)[7] | Indigenous Risk Impact Screen (IRIS)[8] | Menzies Stay Strong Plan[7, 8] | Westerman Aboriginal Symptom Checklist-Adult (WASC-A)[7] | WASC-Y (young people)[7] | Substance Use Sleep Scale (SUSS)[7] | Depression, Anxiety and Stress Scale 21 (DASS 21)[7] | DASS 10[7] | Kessler Psychological Distress Scale (K10)[7] | Health of the Nations Outcome Scales (HoNOS)[8] | HoNOSCA (Child and Adolescent)[8] | World Health Organisation Quality of Life Scale - abbreviated (WHOQOL-BREF)[7] | Session Rating Scale (SRS)[6] | Outcome Rating Scale (ORS)[7] | client surveys[6, 7] | review of record keeping tools for evidence that indicators have been met[6, 7, 8] | International Classification of Diseases 10 (ICD-10)[8] | Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5)[8]

INDICATOR	CONTEXT & METHODS
QUALITY OF AOD TREATMENT / INTERVENTION	
9. Understanding of harms and risks associated with substance use 10. Knowledge of harm reduction strategies 11. Confidence to implement harm reduction strategies 12. Client reported implementation of harm reduction strategies	Harm reduction strategies will vary depending on intervention type, be substance specific, and should be described clearly in plain language that is accessible and easy for clients to understand. For example, some clients may not understand particular concepts (eg 'tolerance'). Services may find it useful to establish a baseline measure of these indicators when clients first engage with the service so that change over time can be measured at intervals throughout treatment. Alternatively, a method which may be suited to services that provide one-off brief interventions, may be to use questions that simply ask clients to rate their level of change in understanding, knowledge, or confidence after speaking with the service. For harm reduction services (eg needle and syringe programs), a simple survey question which clients can anonymously answer is recommended for these indicators. Please note that indicators relating to reduction in substance use or abstinence are included within indicators for specific treatment types. For client reported implementation of harm reduction strategies, non-residential services are more likely to use this indicator than residential services due to the requirement for abstinence while in residential treatment. **Recommended tools / data source:** Client surveys[9, 10, 11, 12] | review of record keeping tools[9, 10, 12]

INDICATOR	CONTEXT & METHODS
QUALITY OF AOD TREATMENT / INTERVENTION	
13. Understanding strategies to improve one's level of health and wellbeing 14. Confidence to apply these health and wellbeing strategies 15. Client reported implementation of health and wellbeing strategies	Building clients' capacity to manage health and wellbeing is a primary objective of AOD interventions. The type of work that services undertake to improve client health and wellbeing varies depending on intervention type and duration. For example, many residential rehabilitation services integrate life skills programs into their treatment structure, and services that provide counselling may provide clients with strategies they can practice implementing between sessions. The World Health Organization defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Health and wellbeing are concepts which are interrelated and difficult to separate. Aboriginal and Torres Strait Islander peoples define health as 'not just the physical well-being of an individual but . . . the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being for their community.' (from: *National Aboriginal Health Strategy 1989* in *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019*). When measuring these indicators, a range of life domains should be considered depending on the clients' treatment plan and goals. These may include: • physical health (eg sleep, nutrition) • mental health (eg relaxation, mindfulness) • cultural connection (eg land and sea Country, connection to family) • social connection (eg art, music, cultural groups) • spiritual connection (eg meditation, prayer) • environmental factors. **Recommended tools / data source:** Growth and Empowerment Measure (GEM)[13, 14] | Menzies Stay Strong Plan[15] | client surveys[13, 14, 15] | review of record keeping tools[13, 15]
16. Client reported satisfaction with services received 17. Client reports the treatment / intervention helped 18. Client reports they would recommend the service to others	Requirements to obtain client feedback form part of accreditation and governance processes for AOD services and client satisfaction is recognised as significantly contributing to positive treatment outcomes. While there is currently no client satisfaction measure validated for the Australian AOD context, there are existing tools that services may find useful to measure these indicators. Where appropriate, services should also seek feedback from family members and significant others about whether they are satisfied with the service. **Recommended tools / data source:** Client Satisfaction Questionnaire (CSQ)[16, 17, 18] | Session Rating Scale[16] | client surveys[16, 17, 18] NB: A comparison of data gathered from other indicators may serve to logic check to indicator 17.

UNIVERSAL INDICATORS – ORGANISATIONAL LEVEL

INDICATOR	CONTEXT & TOOLS
GOVERNANCE	
19. Maintenance of accreditation to relevant standards, and / or compliance with legislative requirements	Non-government and government AOD services tend to be accredited to standards such as: • ISO 9001:2015 (Quality Management Systems) • QIC Health and Community Services Standards 7th ed. • WANADA Alcohol and Other Drug Human Service Standard (version 2, 2018)[2] • Standard for Therapeutic Communities and Residential Rehabilitation Services (STCRRS) • National Safety and Quality Health Care Standards • EQuIP 5th ed. **Recommended tools / data source:** Internal and external audits[19]
STAFFING	
20. Staff receive orientation specific to their role and service type 21. Staff receive regular operational supervision, and performance planning and development reviews	Staff orientation (also known as on-boarding or induction) should ensure new staff are familiar with: • the service with which they are employed (eg policies, procedures, ways of working) • the AOD sector (eg local services, treatment types, statewide frameworks) • AOD training requirements in order to perform the role (eg motivational interviewing, cognitive behavioural therapy, harm reduction) • local community and cultural protocols, which are likely to be different in each region. Orientation milestones should be achieved within a reasonable timeframe (eg by the completion of a probationary period) and supported through routine operational and clinical / practice supervision. Operational supervision is distinct from clinical / practice supervision in that operational supervision is typically delivered by a line manager, while clinical / practice supervision is delivered by a practitioner who is not line management. Ongoing operational supervision and performance planning support a shared understanding of endorsed practice approaches and areas for staff development (eg training) so they can provide high quality care to clients. Shadowing arrangements (both within and outside of the service) and staff mentoring programs can support good orientation to the AOD sector. There may also be opportunities to connect staff with external mentoring programs such as that delivered by Indigenous Allied Health Australia. **Recommended tools / data source:** Internal and external audits[20, 21] | review of staff files[20, 21] | regular staff surveys to look for evidence that staff feel their professional needs are being met and to identify any operational issues that need to be addressed at an organisational level[20, 21]

2 Formerly known as the Standard on Culturally Secure Practice (AOD sector)

INDICATOR	CONTEXT & TOOLS
STAFFING	
22. Staff receive routine clinical / practice supervision 23. Staff participate in regular relevant training and professional development 24. Staff are confident to deliver endorsed treatment / interventions	Clinical / practice supervision in AOD treatment settings is focused on achieving good client outcomes while also supporting professional development and worker wellbeing. Clinical / practice supervision relies on a distinct supervisory relationship that enables staff to engage in critical reflection and improve their practice. It is preferable and considered good practice that clinical / practice supervision is provided by a professional who is not the staff member's current line manager. Cultural supervision and mentoring arrangements should also be considered for all staff (Indigenous and non-Indigenous) to support culturally reflective practice. Where services don't have in-house capacity to deliver cultural supervision and mentoring, strategies such as partnering with other organisations skilled in this area can be explored. Staff confidence to deliver endorsed treatment / interventions is supported by supervision and mentoring, however this indicator is intended as a measure of overall staff confidence and not the confidence of specific individuals. Organisations should identify what treatment / interventions are endorsed as good practice and support staff confidence through the provision of relevant training and professional development in those areas along with regular supervision and mentoring. **Recommended tools / data source:** Internal and external audits[22, 23] | review of staff files[22, 23] | regular staff surveys to look for evidence that staff are confident to deliver the treatment / interventions[24]
SERVICE ENGAGEMENT WITH CLIENT	
25. Percentage of clients with an agreed treatment plan 26. Percentage of treatment plans reviewed routinely (within the service) 27. Routine plan reviews occur with the client	Treatment plans should be agreed and routinely reviewed with clients to ensure they continue to be relevant to their needs including individual, cultural, and spiritual. This process of review is ongoing and in addition to internal service mechanisms such as case review / case conferencing in teams. Frequency of reviews will be dependent on service type and context however more frequent rather than less frequent reviews are recommended as this can be a way to highlight client achievements and increase motivation in treatment. Please note, indicator 26 refers to internal review processes such as case reviews and indicator 27 refers to reviews that occur with the client. **Recommended tools / data source:** Internal and external audits[26, 27] | client surveys[25, 27] | review of record keeping tools[25, 26]
28. Percentage of clients who come back after the first session where treatment is indicated	While clients are less likely to return to a service if their initial help seeking experience is perceived as poor or stigmatising, there are also other reasons why clients do not return to a service (eg distance from home, severity of the problem, not comfortable in the physical and cultural environment). This indicator should be interpreted cautiously and in context but may provide services with an opportunity to investigate ways client needs can be met. **Recommended tools / data source:** Review of record keeping tools[28]

INDICATOR	CONTEXT & TOOLS
ACCESS	
29. Screening is undertaken to determine the appropriate treatment type	Intake, screening, and assessment should be conducted in a way that enables services to successfully determine whether further engagement with an individual is appropriate based on their needs and the services available. It also enables clients to be triaged to appropriate treatment types where required. Clients should be provided with information on all treatment options available (including those offered by other nearby services) in an appropriate format to ensure they are able to make an informed treatment choice. **Recommended tools / data source:** *See screening and assessment tools commonly used by Queensland AOD services on page 31.* Internal and external audits[29] | review of record keeping tools[29]
30. Time from first contact to intake (or screening) and assessment 31. Time from first contact to indicated treatment 32. Duration of support offered is matched to assessed client need	Clients and workers highlight the importance of capitalising on motivation for treatment, which can shift quickly. It is important that time from first contact to intake, assessment, and indicated treatment is as short as possible. Offering some type of service while a person is on a waitlist for another service type will help to maintain treatment motivation and provide an opportunity to meet some needs while they wait. Time from first contact indicators may highlight opportunities for services to investigate the feasibility of strategies to increase responsiveness such as: • increasing flexibility of appointment times • group intake options • pre-treatment support options available to clients (both in and outside of the service). Please note, not all delays in access can be solved by individual services. For example, increases in treatment demand without increases in resources can lead to longer wait times and more time limited support for people seeking or accessing services, which is an issue that needs to be addressed at a system level. While treatment provided should be of sufficient duration to meet clients' assessed needs and be able to respond to often complex problems experienced, levels of resourcing and funding models can limit the duration of treatment a service can offer. Nevertheless, client needs should be periodically reassessed to inform any adjustments required to treatment duration and where services are unable to provide continuing care for reasons outside of their control, appropriate referrals should be made (with client consent). **Recommended tools / data source:** Internal and external audits[30, 31, 32] | client surveys[30, 31, 32] | review of record keeping tools[30, 31, 32]
33. Information and education is provided in multiple formats	Information and education provided to clients and families should be accessible. For example, clients with low literacy may require a combination of verbal and written explanation of their rights and responsibilities upon accessing a service. This information should be easy to understand and obtain (eg via a website, pamphlets in different languages and formats etc.). **Recommended tools / data source:** Internal and external audits[33] | client surveys[33]

INDICATOR	CONTEXT & TOOLS
34. There are strategies in place for working responsively to meet the needs of identified priority population groups	Examples of identified priority population groups include: • Aboriginal and Torres Strait Islander peoples • young people • people who identify as lesbian, gay, bisexual, transgender, intersex, questioning and others (LGBTIQ+) • culturally and linguistically diverse peoples • people from refugee and asylum seeker backgrounds. Strategies may include staff training (eg in the use of culturally appropriate screening and assessment tools), cultural supervision and mentoring, organisational strategic actions (eg development of a Reconciliation Action Plan), and accreditation (eg Rainbow Tick accreditation). Staff and client surveys may be used as a means of evaluating the effectiveness of the strategies implemented. Measures such as the percentage of clients from specific populations that were provided with a service should be used cautiously. For example, AOD issues disproportionately affect certain populations and geographic areas. Therefore, measuring percentage of clients accessing a service against general population ratios is an inaccurate representation of accessibility to those populations. Additionally, it is noted that client surveys are likely to omit people who may know of a service but choose not to make contact. Therefore, a combination of methods should be used to measure this indicator. **Recommended tools / data source:** Operational plans[34] | internal and external audits[34] | review of staff files[34] | staff surveys[34] | client surveys[34]
TREATMENT MATCHING	
35. Comprehensive assessment is completed where AOD treatment is indicated 36. Treatment type offered is congruent with assessment & client preference	There should be a clear link between the assessment result and the type of treatment offered (eg if a person is pre-contemplative they should not be offered residential rehabilitation, opioid replacement therapy should only be offered to people who are opioid dependent). Many people seeking AOD treatment also experience a range of co-occurring issues. Assessment should be comprehensive and cover the range of life domains (eg AOD, mental health, physical health, housing, safety) and may include an exploration of the needs of a person's family and community. Assessment may be formal (eg use established tools) or informal (eg a structured conversation with a client about their needs). Where a person's identified needs are outside of the service scope, referrals should be considered with the client.
37. Clients are actively supported to engage with services that meet their non AOD treatment needs and goals	Where it is determined that a referral to other service types is appropriate, the referral should be actively supported (eg by maintaining active communication with clients about the referral, providing assistance for clients to make contact with the service / warm referrals) and followed up with the client and / or the service to see how it is going along with providing ongoing coordinated care. **Recommended tools / data source:** See tools commonly used by Queensland AOD services on page 31[35] | internal and external audits[35, 36, 37] | client surveys[35, 36, 37] | review of record keeping tools[35, 36, 37]

INDICATOR	CONTEXT & TOOLS
38. Coordinated planning occurs (with consent) where there is more than one service involved	Effective case coordination, advocacy and planning is required so that clients experience continuity of care. Case coordination between agencies should be conducted with full client knowledge and consent, unless in exceptional circumstances when there is significant or urgent risk of harm to the client or someone else. Case coordination and planning activities should be congruent with the client's goals and treatment plan. **Recommended tools / data source:** Internal and external audits[38] | client surveys[38] | organisational surveys (eg feedback from other services)[38] | review of record keeping tools[38]
SERVICE EXIT PLANNING	
39. Clients are actively supported to transition to services that meet their needs and goals	Planning for post-treatment transitions and continuing care is essential to maximise client outcomes. Transition planning should begin in the earlier stages of treatment. Post treatment referrals should be actively supported by workers and followed up to determine if the referral was successful. Client follow up may also be particularly important when transitioning between AOD treatment types, which are delivered by separate organisations (eg withdrawal management to residential treatment). In some cases, there may be a gap between exiting one service and entering another, therefore continued service contact will assist to increase the likelihood of a successful transition. It is noted that transitioning clients to other services will depend on the availability / capacity of that service, which should be considered in the interpretation of this indicator. Services are also encouraged to follow up with clients after they complete or leave treatment. Please note that clients should be made aware of intentions to conduct post-treatment follow ups and following up clients after completing or leaving treatment may not always be feasible (eg where a client has requested to not be contacted by the service). Follow up with clients should also be time limited (eg within one month of completing treatment) and reasonable in terms of frequency of attempted contact. **Recommended tools / data source:** Internal and external audits[39, 40] | client surveys[39] | review of record keeping tools[39, 40]
40. Follow up occurs after the client completes or leaves treatment	
41. Percentage of clients who report they would return to treatment if they needed it	Positive experiences of service increase help seeking behaviour and the likelihood of achieving positive outcomes. Clients say that an indicator of the quality of overall service provided is whether they would return if needed. **Recommended tools / data source:** Client surveys[41]

UNIVERSAL INDICATORS – SYSTEM LEVEL

INDICATOR	CONTEXT & TOOLS
SYSTEM INPUTS	
42. Distance travelled to access treatment 43. Level of met versus unmet need 44. Cultural responsiveness of service 45. The impact of reporting requirements on service delivery (eg ratio of time, cost) 46. Referrals in are appropriate (translate to service offered) 47. Rate of workforce retention	There are additional system indicators with reference to specific treatment types on the below pages of this document, however the Queensland AOD sector views these indicators as relevant to all treatment types. Please note: • Service location can affect a person's access to treatment. For example, if withdrawal management is not locally available then a person may not be able to access residential rehabilitation at the right time. Additionally, dislocation from family and natural support networks can present significant challenges when people are required to travel away from their community to receive treatment. This affects both a person's ability and motivation to seek help or remain in treatment. Distance travelled to access treatment should be interpreted with the understanding that due to limited treatment options in some regions, people may be required to use resources or tools such as online or telephone counselling. Nevertheless, these may not be the primary indicated or most appropriate treatment for clients but only what is available. • Available services should be proportionate to local demand and need as this can impact on wait times and can be a disincentive to treatment. Consideration of unmet need should include specialist services required for specific populations (eg Aboriginal and Torres Strait Islander Community Controlled Health Organisations, LGBTIQ+ services). • Commissioners should consider ways to structure procurement processes to ensure appropriate community consultation is evident where services are tendering for Aboriginal and Torres Strait Islander specific service delivery. This may include: - applications demonstrating understanding of culturally appropriate approaches and are endorsed by community - valuing consortia / collaborative applications between Aboriginal and Torres Strait Islander Community Controlled Health Organisations (AICCHOs) and mainstream organisations - funding streams specific to AICCHOs. • Reporting requirements should be efficient, complement service delivery and maximise time spent working with clients. • Referrals into the AOD treatment system should be appropriate, which may require other sectors to invest in upskilling of their workforce around AOD (particularly stigma reduction). Level of met vs unmet need should be interpreted in the context of this indicator (eg a referral on its own does not indicate the need for a particular treatment). • System level retention strategies with respect to workforce satisfaction and wellbeing should be considered to maintain a skilled and healthy workforce. This indicator can be interpreted in the context of supervision and professional development indicators above, however it is not an organisation specific indicator but rather intended to provide a general whole of workforce perspective. Other issues such as funding stability should also be considered with reference to this indicator. **Recommended tools / data source:** Review of client postcode comparatively with service location data[42, 43] | National Drug Strategy Household Survey data[43] | Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS)[42, 43, 46] | Australian Needle and Syringe Program Survey data[42, 43, 46] | conducting specific AOD workforce needs assessments and surveys[45, 47] | review of procurement processes[44] | client surveys[42]

TREATMENT / INTERVENTION SPECIFIC INDICATORS

The following treatment / intervention specific indicators should be read as additional to the relevant universal indicators, which are considered applicable to all treatment types. It is also noted that many AOD treatment services deliver multiple specific interventions. For example, a residential treatment service may provide one or several treatment types despite their primary role as residential treatment. In such cases, it is appropriate to consider the other relevant intervention specific indicators relevant to the service.

Harm reduction indicators

INDICATOR	CONTEXT & TOOLS
Organisational level	While harm reduction services provide a range of support, the following indicators focus on needle and syringe programs. While diversion services and other forms of harm reduction services have not yet been considered, indicators which may be relevant to other harm reduction interventions can be adapted from the universal indicator set. Please note the full harm reduction treatment / intervention type definition on page 9. *Client reported satisfaction with equipment provided* is considered a system level indicator as individual harm reduction services do not have the ability to select or change suppliers. Where the quality of equipment is lacking, clients may not use services. This issue requires addressing at a system level. HIV and Hepatitis C rates should be monitored for any increases as an important early warning indicator. **Recommended tools / data source:** Review of national and statewide blood borne virus statistics[51] | needle and syringe program evaluations[48, 49] | review of record keeping tools[48, 49] | client surveys[48, 49, 50]
48. Percentage of clients offered information on safe injecting	
49. Range of equipment offered is appropriate to the client's needs	
System level	
50. Client reported satisfaction with equipment provided	
51. Rates of HIV and Hep C	

Medication assisted treatment indicators

INDICATOR	CONTEXT & TOOLS
Client level	Clients receiving medication assisted treatment should be stabilised on their medication as quickly and safely as possible with the least possible complications associated with withdrawal and / or medication management. Treatment should be consistent with dosing guidelines and appropriate doses of medication should be provided to clients appropriate to their needs. Please note proportion of missed doses as both a client and organisational level indicator. Proportion of missed doses may indicate service accessibility issues (eg lack of takeaway options may be hindering a person's ability to maintain their employment, lack of privacy when collecting doses). There may also be system level issues to consider such as the cost of doses in pharmacy settings, which may not be affordable for clients. **Recommended tools / data sources** Withdrawal scales[52, 53, 54] | ATOP [55] | ASSIST / ASSIST-Y [55] | internal and external audits[54, 56, 58, 59, 60, 61] | review of record keeping tools[54, 55, 56, 57, 58, 59, 60, 61]
52. Percentage of clients reporting minimal side effects / adverse events	
53. Client reports a reduction in cravings	
54. Client reports satisfaction with medication	
55. Client reports a reduction in the use of alcohol or other drugs	
56. Proportion of missed doses	
57. Client reports least possible complications associated with withdrawal	
Organisational level	
58. Clients are screened for blood borne viruses, sexually transmitted infections, and other physical health issues	
59. Practice is consistent with dosing / clinical guidelines	
60. Clients are provided with appropriate doses of medication	
61. Proportion of missed doses	

Psychosocial interventions indicators

INDICATOR	CONTEXT & TOOLS
Client level	In addition to specialist AOD interventions provided, psychosocial intervention services seek to build client resilience and improve social, cultural, and other supportive structures around clients (eg by linking with supportive family members, engaging with other services to address needs, facilitating connection to cultural and / or spiritual identity). This can include identifying activities that are important to clients as an alternative to using. It is noted cultural activities should be supported by practitioners who have the appropriate level of cultural skill and knowledge. Please note, while a range of support may be provided by psychosocial intervention services, particularly when working in outreach settings, psychosocial intervention services are primarily focused on AOD treatment. Additionally, psychosocial interventions may be delivered as part of other AOD treatment settings (eg residential treatment), therefore the psychosocial client indicators should be considered where appropriate in those settings as well. While reduction in alcohol and other drugs use is included here as a specific psychosocial intervention indicator, please note universal indicators above such as 'client reports implementation of harm reduction strategies' which also apply. Reduction, cessation, and safer use are all valid indicators and will depend on client goals. At a system level, court and diversion programs can impact on availability of places for voluntary clients in need of support. **Recommended tools / data source:** Menzies Stay Strong Plan[62, 63] | Growth and Empowerment Measure (GEM)[63] | Westerman Aboriginal Symptom Checklist (WASC-A / WASC-Y)[63, 64] | Strengths and Difficulties Questionnaire[62] | WHOQOL-BREF[63] | ATOP [64] | ASSIST / ASSIST-Y [64] | SACS [64] | client surveys[62, 63, 64] | review of record keeping tools[62, 63, 64] | AODTS NMDS[66]
62. Client reported engagement in activities they identify as important to them	
63. Client reports improvement in social, cultural and / or community support where indicated	
64. Client reports reduction in the use of alcohol or other drugs	
System level	
65. Proportion of referrals from court and diversion programs versus other referral sources	
66. Proportion of clients receiving services referred by court and diversion versus other referral sources	

Residential treatment indicators

INDICATOR	CONTEXT & TOOLS
Client level	*Level of withdrawal management completed* should be interpreted with caution and in context of availability of withdrawal management services in the region. Withdrawal management may not be indicated for all clients and will depend on a range of factors including the substance of concern. Where clinically indicated, withdrawal management should be completed before entering residential treatment, as these programs are generally designed with the assumption that people will be able to participate in community activities from the commencement of treatment. A lack of available withdrawal management services (particularly moderate to complex inpatient services) is a barrier to accessing residential treatment or can lead to residential treatment services accepting clients they are not resourced to manage which is a system issue. Abstinence is expected during participation in residential treatment, which is reflected by the inclusion of the abstinence indicator. Client abstinence does not include medications prescribed for the client by a medical practitioner. Please note that continued abstinence post-residential treatment is not considered a reasonable indicator of treatment outcome. At a system level, court and diversion programs can impact on availability of places for voluntary clients in need of support, which in turn can impact wait lists, and subsequently intake lag time between withdrawal management and residential treatment. Additionally, issues may arise between clients around perceptions of motivation to engage in the program. **Recommended tools / data source:** Withdrawal scales[66] | urine testing (when appropriate)[67] | health needs assessment data (eg from Primary Health Networks)[68] | AODTS NMDS[68, 69] | review of record keeping tools[66, 67]
67. Level of withdrawal management (detox) completed where indicated	
68. Client reports abstinence from alcohol and other drugs while participating in residential treatment	
System level	
69. Availability of withdrawal management services in the region	
70. Proportion of referrals from court and diversion programs versus other referral sources	
71. Proportion of clients receiving services referred by court and diversion versus other referral sources	
72. Availability of pre and post treatment support	

Withdrawal management indicators

INDICATOR	CONTEXT & TOOLS
Client level	Withdrawal management may be undertaken in a range of settings (eg residential, outpatient). It can form part of medication assisted treatment, residential treatment, and occur simultaneously with psychosocial interventions or as a standalone intervention with referral to other agencies for continuing care. Withdrawal management should be provided for an appropriate duration sufficient to support clients to withdraw safely with a reduction in symptoms and an absence of adverse clinical incidents associated with withdrawal. In outpatient settings, it may be possible for clients to participate in a withdrawal process through a gradual reduction in their use of alcohol or other drugs. Therefore, clients may report reduction or cessation in the use of alcohol or other drugs while engaged in withdrawal care. **Recommended tools / data source:** Withdrawal scales[73] | ATOP[74] | review of record keeping tools[73, 74, 75, 76]
73. Reduction of withdrawal symptoms	
74. Client reports reduction / cessation in the use of alcohol or other drugs while engaged in withdrawal care	
75. Absence of adverse clinical incidents associated with withdrawal	
Organisational level	
76. Duration and type of withdrawal management support offered matches assessed client need	

COMMONLY USED SCREENING AND ASSESSMENT TOOLS

The following table provides an overview of screening and assessment tools commonly used in Queensland AOD treatment settings. Some of these tools specifically measure AOD issues, however others have been included which are applicable in AOD treatment settings but measure other domains. Please note there are hundreds of screening and assessment tools available and services may find tools not listed below which are also applicable to their service context. The tools are listed in alphabetical order.

MEASURE	DETAILS	ADMIN.	PERIOD	TRAINING REQU'D.
Addiction Severity Index	Measures a range of domains in addition to substance use including demographics, medical status, employment / income, legal status, family and social relationships, psychiatric status.	Interview	Varies by domain	Training is required.
Alcohol Use Disorders Identification Test (AUDIT)	A brief measure of substance use (alcohol only).	Self-report	Year	No formal training is required. A manual is available and should be understood before administering.
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST / ASSIST-Y)	Measures recent substance use and associated risky behaviours. A youth version of the ASSIST is available called ASSIST-Y.	Interview	3 months / lifetime	No formal training is required. A manual is available and should be understood before administering.
Australian Treatment Outcomes Profile (ATOP)	A brief one page measure of substance use with additional domains (ie employment, education, housing, carer status, justice, violence, psychological health, physical health, and overall quality of life).	Interview	4 weeks	No formal training is required. A manual is available and should be understood before administering.
Client Satisfaction Questionnaire (CSQ)	A measure of general service satisfaction.	Self-report	Day	No training is required, however this tool requires a licence to use and has associated fees.
Depression, Anxiety and Stress Scale (DASS 21 / DASS 10)	A brief screening tool for depression, anxiety and stress. There are several versions available. The DASS 21 and DASS 10 are most commonly used in AOD settings.	Self-report	Week	Training is recommended for interpretation. A manual is available for a fee.

MEASURE	DETAILS	ADMIN.	PERIOD	TRAINING REQU'D.
Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5)	A diagnostic manual containing a range diagnosable mental health and alcohol and other drugs conditions.	Interview	N/A	Formal training is required to use the DSM. However, the diagnostic criteria can be a useful reference for non-diagnosing practitioners as a guide to determine longer term outcomes with relation to AOD.
Domestic Violence Safety Assessment Tool	A domestic and family violence risk assessment tool.	Interview	Lifetime, recent	No formal training is required.
Drug Use Disorders Identification Test (DUDIT)	A brief measure of substance use (drugs other than alcohol).	Self-report	Year	No formal training is required. A manual is available and should be understood before administering.
Growth and Empowerment Measure (GEM)	The GEM has been shown to be an effective measure of empowerment and wellbeing, was developed specifically for use when working with Aboriginal and Torres Strait Islander peoples, and has been used in a range of settings including residential and other AOD treatment. The GEM is also suitable for working with non-Indigenous populations.	Self-report	Current	No formal training is required. Online training and background information is available.
Health of the Nation Outcome Scales (HoNOS / HoNOSCA)	This is a practitioner reported tool that prompts workers use all information available to them from various sources (eg case files, family members, other workers). It does not require clients to be present, therefore workers must ensure client consent. The tools covers a range of domains including behaviour, cognition, social functioning, and alcohol and other drugs. There is a child and adolescent version of the HoNOS available which is the HoNOSCA.	Practitioner reported	2 weeks	Training is recommended and online training is available.

MEASURE	DETAILS	ADMIN.	PERIOD	TRAINING REQU'D.
Indigenous Risk Impact Screen	A brief measure of substance use and emotional wellbeing risk developed specifically for use with Aboriginal and Torres Strait Islander peoples.	Interview	Recent / lifetime	Training is recommended.
International Classification of Diseases 11 (ICD-11)	A diagnostic manual containing a range of diagnosable physical health, mental health and alcohol and other drugs conditions.	Interview	N/A	Formal training is required as the ICD-11 is a diagnostic tool. The criteria can still be useful for non-diagnosing clinicians / practitioners as a guide to determine longer term outcomes.
Kessler Psychological Distress scale (K10)	A brief screening tool for psychological distress based on symptoms of anxiety and depression. There are several versions available. The K10 is most commonly used in AOD settings.	Self-report	4 weeks	No formal training is required. Information for interpreting and scoring is available.
Menzies Stay Strong Plan	A brief measure specifically developed for use when working with Aboriginal and Torres Strait Islander peoples. The tool integrates commonly used mental health assessments (eg K10 and mental state examination) alongside safety and treatment planning. It investigates a range of domains including substance use but does not include AOD treatment specific assessments.	Self-report with the exception of the mental state examination which is practitioner reported	Current	No formal training is required.
Montreal Cognitive Assessment (MoCA)	A detailed assessment that requires clients to undertake a series of activities in relation to memory, attention, language, recall, orientation, abstraction.	Interview	Day	Training is recommended. The tool should be used by professionals with experience in delivering manualised cognitive assessments.

MEASURE	DETAILS	ADMIN.	PERIOD	TRAINING REQU'D.
Outcome Rating Scale (ORS)	A brief measure which requires clients to provide a rating of personal well-being, family and relationships, social well-being, and general sense of well-being. The scale can be used in conjunction with the Session Rating Scale (SRS).	Self-report	Week	No formal training is required and the tool is free for individual providers.
Outcomes Star (Drug and Alcohol Star)	A brief measure of substance use, physical health, social wellbeing, emotional health, accommodation, money, offending, family and relationships.	Interview	N/A	There are fees to use the tool and training is required as a condition of the licence.
Session Rating Scale	A brief measure designed for session by session use which requires clients to provide a rating of their experience in receiving support. The scale can be used in conjunction with the Outcomes Rating Scale (ORS).Domains covered include relationship with the practitioner, goals and topics discussed, approach or method, and overall satisfaction.	Self-report	Day	No formal training is required and the tool is free for individual providers.
Severity of Dependence Scale (SDS)	A measure of substance dependence which can be adapted to a variety of substances. There are different cut off scores for young people and adults.	Self-report	3 months	No formal training is required.
Smoking Cessation Clinical Pathway	A brief measure of smoking dependence and withdrawal. Provides guidance on nicotine replacement therapy pathways.	Interview	30 days	Training is recommended.
SOCRATES	A brief measure of substance use which seeks to measure a person's level of problem recognition, ambivalence and whether they are taking steps toward addressing the issue. This tool assumes a problem exists.	Self-report	Day	No formal training is required. Instructions for interpretation of scores are available.

MEASURE	DETAILS	ADMIN.	PERIOD	TRAINING REQU'D.
Standardised Folstein mini mental state examination	A detailed assessment that requires clients to undertake a series of activities in relation to orientation to time and place, short and long term memory, registration, recall, constructional ability, language and the ability to understand and follow commands.	Interview	Day	Training is recommended. The tool should be used by professionals with experience in delivering manualised cognitive assessments.
Strengths and Difficulties Questionnaire (SDQ)	A behavioural screening tool for young people which covers domains including emotions, conduct, hyperactivity/ inattention, peer relationships, and prosocial behaviour.	Self-report or interview	Current	No formal training is required. Scoring and norms are available from the SDQ website.
Subjective Happiness Scale	A very brief four item measure of general happiness.	Self-report	Current	No formal training required. Scoring and scale norms are available.
Substance Use Sleep Scale (SUSS)	A brief measure developed with people participating in residential AOD treatment. It considers 'mind and body sleep problems' and 'substance-related sleep problems'.	Self-report	Week	No formal training is required. Instructions for interpretation are included on the measure.
Substances and Choices Scale (SACS)	A brief one page measure of recent substance use and associated risky behaviours specifically developed for young people.	Interview	4 weeks	No formal training is required. A manual is available and should be understood before administering.
Suicide Assessment Kit (SAK)	A suicide risk assessment tool.	Interview	4 weeks / lifetime	No formal training is required to use the tool however it should be delivered by professionals with experience in responding to suicide risk.

MEASURE	DETAILS	ADMIN.	PERIOD	TRAINING REQU'D.
Westerman Aboriginal Symptom Checklist (WASC-A / WASC – Y)	The Westerman Aboriginal Symptom Checklist is available in two versions, one for adults and one for young people. It covers a range of domains including alcohol and other drug use, depression, anxiety, and cultural resilience.	Self-report	Current	Training is required as a condition of licence to use the WASC-A and WASC-Y. There are fees associated with using and refilling both tools.
Withdrawal assessment scales	The Queensland Alcohol and other Drug Withdrawal practice guidelines contain a range of withdrawal scales (alcohol, opioids, benzodiazepines, amphetamine, and cannabis). These scales are designed for use by health practitioners providing withdrawal management support.	Interview and observations	Day	Training is recommended.
World Health Organisation Quality of Life –BREF (WHOQOL-BREF)	This is an abbreviated version of the 100 item WHOQOL. The WHOQOL-BREF is 26 items plus demographic questions and covers domains of overall quality of life, general health, physical health, psychological, social relationships, and environment.	Self-report	2 weeks	No formal training required. A manual is available and should be understood before administering.

EXAMPLE CLIENT SURVEY QUESTIONS

Services may like to adapt the questions below to fit the service context or develop their own. These questions are not intended to replace validated tools but rather serve as an example of how services might gain more qualitative information from clients for outcome indicators which validated tools do not measure. These may be delivered to clients verbally and then noted by the practitioner or via paper or web based surveys. Questions can also be adapted to be open, yes / no, or rating scale. Some questions may require an option for people to describe why they have answered in the way they did. The superscript numbers correspond to indicators in the framework. Refer to the outcome indicator quick reference guide on page 12 to see how the questions correspond.

EXAMPLE QUESTIONS / PROMPTS

- Did the staff treat you with respect and dignity?[1]
- I felt the staff treated me in a professional manner.[1]
- On my visit to this service I was made to feel comfortable.[2]
- When you arrived at your appointment, did staff make you feel welcome?[1]
- Were staff helpful with your questions?[3]
- Did your worker listen carefully to you?[3]
- I trust that the information I share will be kept confidential[5]
- Did staff understand your needs and issues?[3]
- My worker/s are trustworthy.[5]
- The service is trustworthy.[5]
- Do you think your views were taken into account when deciding on your treatment / intervention goals?[6]
- The worker I saw focussed on the things that are important to me.[6]
- Do you feel safe when you work with us?[4]
- I felt I did not get anywhere with my problems.[7]
- Do you feel like you know more about the way alcohol and other drugs affect lifestyle and health?[9]
- Did you find that you learned things about safer alcohol / other drug issues while working with us?[10]
- How confident are you that you could use the harm reduction strategies (eg using a wheel filter) provided to you by your worker if you wanted to?[11]
- I have used the strategies I learned to keep me safer when using alcohol or other drugs (eg not sharing equipment)[12]
- Do you know more about how you can improve your health and wellbeing?[13]
- Was the service helpful in learning coping skills?[17]
- Was the service helpful in learning life skills (eg budgeting, paying bills)?[17]
- I would recommend this service to someone I know with similar problems.[18]
- A treatment plan is a document that should be developed consultation with you and the alcohol and other drugs service. The plan should reflect your goals and needs. Do you agree with what is in your treatment plan?[6, 25]
- My plan (eg treatment / care plan) was reviewed with me regularly[27]
- How long did it take for our service to start working with you after you first made contact with us?[30]
- I got to see a worker in a reasonable amount of time.[31]
- My worker asked for my permission before talking with other people / services about me.[38]
- When I was referred to another service, my worker helped to make sure that the transition was as smooth as possible.[39]
- I would return to this service if I needed help again.[41]
- It was easy for me to get somewhere where I could meet a worker.[42]
- How long does it usually take you to travel to see your worker?[42]
- When I collected my sterile equipment, I was offered information on safe injecting.[48]
- Please describe how satisfied you are with the equipment provided.[50]

EXAMPLE QUESTIONS / PROMPTS

- Did you work with staff to form a treatment plan so your needs could be met?[6]
- You had a say in how our service supported you.[6, 27]
- Did the service help direct you towards feeling able to deal with your problems?[7]
- Do you feel like you dealt with some alcohol / other drug issues while working with us?[7]
- How confident are you that you could use the strategies to improve your health and wellbeing provided to you by your worker if you wanted to?[14]
- Were there any aspects of the services that could be improved?[16]
- What worked well for you?[16]
- What could we improve?[16]
- Overall I am satisfied with the quality o f service I received.[16]
- Overall, how happy are you with the services you received?[16]
- Were you satisfied with the services you received?[16]
- I felt the reason why I attended this service was fully assessed.[17]
- I found the information provided useful and applicable to my situation.[17]
- Was the service helpful in learning about and dealing with substance use problems?[17]
- The worker stuck with me as long as I needed them to.[32]
- My options for subsequent treatment were fully and clearly explained to me in a way that I could understand.[33]
- Did you feel that the service was able to help with your cultural & spiritual needs?[34]
- Were your cultural values respected and incorporated in our work with you? [1, 34]
- The worker I saw was interested in the whole range of issues I am dealing with.[35]
- Do you feel like you were provided with what you needed?[36, 49]
- Since working with this service, I have been able to participate more in activities that I like doing.[62]
- Since working with this service, I feel more supported from other people and services too.[63]
- How good was the service when it came to linking you up with other people and services that could help you?[37]
- The worker I saw could recommend other useful services or places to get support if I needed it.[37]
- Were you connected with the other supports that you felt you needed while working with us?[37]

EXAMPLE CLIENT RECORDS REVIEW

The prompts below can be adapted to meet the needs of the program / intervention type. They are organised into information that may be gathered through a review of individual records or general review of data available in most client management systems. The superscript numbers correspond to the indicators measured. This example includes prompts for the universal indicators only.

Individual records

- There is evidence that the client's goals have been set and agreed with them.[6] **YES/NO**
- There is evidence that the client has been able to make progress on or achieve their goals, or that the goals were adjusted in response to changes in the client's needs.[7, 8] **YES/NO**
- Substance use harms and risks have been discussed with the client in the context of their patterns of use and substance of concern.[9] **YES/NO**
- Relevant harm reduction strategies have been provided to the client.[10] **YES/NO**
- There is evidence on follow up that clients have implemented the strategies.[12] **YES/NO**
- Strategies to improve health and wellbeing have been discussed with the client in the context of their needs.[13] **YES/NO**
- What percentage of treatment plans reviewed have been signed off or verbally agreed with clients.[25]
- Treatment plan reviews are dated and reviewed with the client regularly in line with organisational policy.[26] **YES/NO**
- The duration of support offered to the client makes sense considering their needs.[32] **YES/NO**
- What percentage of clients with a current treatment plan have completed a comprehensive assessment?[35]
- There is evidence that the treatment being provided is congruent with the assessment and what the client wants.[36] **YES/NO**
- There is evidence that the client's key worker has provided active support when making referrals (eg being with the client while calling, introducing the client to the service).[37] **YES/NO**
- There is evidence of coordination of care and the appropriate consents are in place (eg signed consent forms are in place for services currently being communicated with).[38] **YES/NO**
- The client's treatment plan includes a strategy for unplanned and planned exit from the service, which is actively maintained.[39] **YES/NO**
- Where consent has been provided, the client has been followed up after leaving treatment.[40]

General review

- When reviewing intake data, what percentage of clients come back when it is recommended by the service?[28]
- What is the average time it takes from when a client first contacts the service to participate in intake, screening or assessment?[30]
- What is the average time it takes from when a client first contacts the service to get into the treatment recommended for them?[31]

THE QUEENSLAND ALCOHOL AND OTHER DRUGS SECTOR NETWORK IS COMMITTED TO SUPPORTING THE THROF IMPLEMENTATION AND SHOULD BE THE FIRST POINT OF CONTACT FOR PRACTITIONERS, SERVICES, AND SYSTEM ADMINISTRATORS WHO ARE CONSIDERING ITS APPLICATION. THE AUTHORS OF THE THROF AND THEIR CONTACT DETAILS ARE LISTED ON PAGE 2.

qnada
Queensland Network of Alcohol and Other Drug Agencies Ltd

Dovetail
supporting the youth alcohol and drug sector in Queensland

insight
Centre for alcohol and other drug training and workforce development

Queensland Mental Health Commission

QAIHC

QISMC

APSAD
The Australasian Professional Society on Alcohol and other Drugs

Queensland Government