Clinical utility of the Alcohol and Drug Outcome Measure (ADOM) in a community alcohol and other drug practice setting in Auckland, New Zealand

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The aim of this study was to assess the clinical utility of the Alcohol and Drug Outcome Measure (ADOM) in real-world practice at a community alcohol and drug (AOD) treatment service. The client cohort were referred to the treatment programme via the probation service. The ADOM was completed at treatment entry and at 3 and 6-months post-programme. Clinicians and researchers were asked about their views on using the ADOM to evaluate client outcomes in practice. The ADOM was completed with 278 clients at treatment entry, with 96 clients at 3 months and 53 clients at 6 month follow-up post-programme. The ADOM was found to be straightforward and brief to administer and it was an effective therapeutic tool facilitating clinical practice through recording change in client substance use and impact of use over time. In addition, aggregated ADOM data from the participating offender cohort enabled the treatment service to evaluate the effectiveness of their intervention programme.

The use of outcome measurement within clinical settings, assessing change across various domains, has become increasingly popular over the past few years (Andrews, Peters, & Teesson, 1994; Peters, 1994). There is increased recognition of the impact of multiple morbidities on well-being and a number of measures look to provide a holistic client-centred perspective to treatment and recovery. The use of outcome measures within treatment sectors aimed at provision of treatment modalities for chronic conditions, such as various mental health problems or alcohol and drug problems, highlights the purpose of integrated recovery-focused treatment approaches with impact not just on the individual, but also on significant others and the wider community.

Routine clinical outcomes measurement (RCOM) as a tool to inform clinical decision-making in the mental health sector has not always been well utilised (Andrews & Page, 2005). However, its potential to do so is well recognised (Andrews & Page, 2005; McLellan, Mckay, Forman, Cacciola, & Kemp, 2005), user benefits have been reported (MacDonald & Trauer, 2010; Stein, Kogan, Hutchison, Magee, & Sorbero, 2010), and new outcome measurement instruments continue to be developed for use in international jurisdictions (Marsden et al., 2008; Simpson, Lawrinson, Copeland, & Gates, 2009).

Recent interest in routine outcome monitoring in the New Zealand alcohol and other drug (AOD) treatment sector, gave rise to a number of initiatives aimed at developing a feasible way of measuring outcomes for clients accessing treatment for their drug and / or alcohol problems (Christie et al., 2007; Deering et al., 2004; Deering, Sellman, Adamson, Horn, & Frampton, 2008). The New Zealand Ministry of Health commissioned the development and testing of an outcome monitoring instrument, the Alcohol and Drug Outcome Measure (ADOM); a generic outcome monitoring instrument designed for use in the New Zealand AOD treatment sector (Deering et al., 2009). The ADOM assesses the nature and severity of AOD use and the impact on health and well-being, employment, relationships, and self-reported involvement in any illegal activity, at various points within the client treatment journey. It is an 18-item questionnaire split into two discrete sections: Part A, covering type and frequency of substance use (11 items) and Part B, covering associated psychosocial issues (7 items). The ADOM was developed and validated for use in a collaborative project between the National Addiction Centre (University of Otago) and the Clinical Research & Resource Centre (Waitemata District Health Board) as part of a Ministry of Health research intiative for inclusion in the national suite of outcome measures. A copy of the ADOM is presented as Appendix 1.

The ADOM was validated for use within the drug and alcohol population accessing treatment in New Zealand and the results are reported in an earlier edition of this journal (Pulford et al., 2010). The authors recommended that the ADOM was field tested in a small number of AOD treatment services and that the level of uptake and perceived clinical utility should be closely examined especially with regards to the questions in Part B about psychosocial issues (Pulford et al., 2010).

This brief report describes the clinical utility of the ADOM in the real-

world practice setting of a Community Alcohol and Drug Service (CADS) in Auckland, New Zealand.

Method

Study setting and data collection

The Community Alcohol and Drug Services in Auckland introduced an initiative to prospectively follow up a sample of clients recently engaged in offending behaviour, referred for assessment and treatment by their probation officer as part of a pilot Offender Programme. The programme is described in more detail in the companion paper. Ethical approval was obtained for this project from the Auckland Ministry of Health, Health and Disability ethics committee (NTX/09/150/EXP).

Clients who consented to being followed up post-programme were administered the ADOM at entry to the programme and then at two further time points (3 and 6-months post-programme). The initial ADOM assessment was completed face-to-face with the client and a CADS clinician and the 3 and 6-month post-programme follow-ups were completed by the research team by telephone.

Clinicians and researchers (n=14) who had used the ADOM with clients as part of the pilot Offender Programme were asked to provide feedback by email to seven structured questions on ease of use (in-person and by phone), clinical utility and advantages/disadvantages of using the ADOM in real-world practice. Any other comments were also requested as part of the feedback form.

Results

Between May and December 2009 a cohort of 278 clients participated in the self-reported outcome evaluation. At 3-month post-programme follow-up 96 were able to be contacted by phone (34.5% of baseline participants) and at 6-months post-programme 53 were able to be contacted (55.2% of 3-month participants and 19.1% of baseline participants). The companion paper describes the cohort demographics and the aggregated ADOM results at each of the three time-points. (see CADS Offender Evaluation Outcome pg118)

Feedback about administering ADOM in routine practice

Eight CADS clinicians and three researchers provided feedback about using the ADOM in practice (n=11/14). The ADOM received varied reviews from the clinicians who used it face-to-face. Most noted that it was easy to administer and could be completed quickly in 5-10 minutes, however they expressed concern about the wording of Part B items and reported they would "change the wording to fit the situation" with individual clients. Clinicians also reported that the ADOM assumed problematic AOD use and psychosocial problems and their preference was for a more positive or neutral style of questioning. Those who used the ADOM at follow-up (by phone) also found that it was quick to administer taking about five minutes. They reported that Part A was straightforward and that some of the questions in Part B needed further explanation and clarification.

Some advantages that were identified were the brevity of the tool *"it's short and to the point"* and that it gathered useful information that could help with treatment planning. For example Part B was reported to be helpful in quickly assessing whether clients were experiencing any psychosocial issues that were impacting their life, and needed to be addressed. This was particularly relevant to this client group where assessments were brief and completed within 40 minutes to one hour. It was also reported to be a useful tool for tracking changes in the client's AOD use and progress and, when used in conjunction with other screening tools, the ADOM offered a chance to explore any discrepancies in reported AOD use. Follow-up use of the ADOM by phone was reported to be easy and useful in comparing change. The Project Co-ordinator also found at follow-up that the tool stimulated conversation with the client about behaviour change and could be used collaboratively to affirm progress and highlight areas of difficulty as a therapeutic tool. Unfortunately because of time constraints in the pilot Offender Programme most clinicians only administered the tool at treatment inception (they did not administer the tool at later time points, thereby were not able to track client changes) and subsequently did not see the value of the tool as an outcome measure as.

The disadvantages of using the ADOM, as reported by clinicians, supported the need to provide additional explanations for questions in Part B as they were not clear. Particular mention was made of questions 13 and question 15. They also reported difficulty with the final question as they were concerned that client's may under report criminal activity. Some clinicians commented that there was inadequate space to record the "quantity" of substances used other than alcohol and therefore felt it was a "blunt tool" to identify change in use. The tool was commended for collecting information about tobacco use but many clients reported using hand-rolled tobacco and this was difficult to capture in the tool because they reported their use in terms of grams/week rather than number of cigarettes.

Much of the negative feedback about the ADOM from clinicians focussed on process issues – having to administer the ADOM in addition to other assessment tools which clinicians felt led to duplication of information. However, the clinicians did not believe that the ADOM could be used in place of other screening tools (such as the AUDIT, Leeds Dependency Questionnaire and Severity of Dependence scales) because it did not collect enough information about quantity and dependence.

Discussion

The aim of this brief report was to describe the clinical utility of the ADOM in real-world practice. The reported experiences with the ADOM are interesting. Results suggest it is useful as a follow-up measure, but perhaps limited as an assessment tool. It could therefore be recommended as one component of a suite of measures used for assessment, but alone as a primary outcome measure. However, clinicians felt that the number of assessment tools being used at AOD treatment entry needed to be minimised so this recommendation remains an issue. The suggestion that clinicians would 'change the wording' is also of some concern from an outcome measurement point of view where consistent application of the tool would be essential.

This pilot evaluation has furthered the validation of the ADOM (especially examining the value of Part B) within a specific cohort of offending individuals with problematic substance use. Ideally, further field testing of the ADOM in a wide range of AOD treatment settings is required to assess clinical utility and level of uptake as part of routine practice.

In summary, the ADOM was found to be easy, straightforward and brief to administer and was effective as a therapeutic tool in recording change in client substance use and impact of use over time in real world practice. In addition, aggregated ADOM data from the participating offender cohort enabled the treatment service to evaluate the effectiveness of their intervention programme. These findings align with MacDonald and Trauer's large observational study of the routine use of clinical outcomes measurement in mental health services (MacDonald & Trauer, 2010). They reported that despite initial criticism "RCOM seems valid and practical in mental health services"; for example supporting trial data, allowing service effectiveness information to be collected routinely, identifying interventions that are successful/or unsuccessful at a service and individual client level (especially where a number of practitioners or teams are involved), comparing perspectives and input from range of people (practitioner, client, carer etc) and tracking change over time (MacDonald & Trauer, 2010).

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Appendix 1: The Alcohol and Drug Outcome Measure (ADOM): Part A

All questions relate to the past four weeks
The questions do not apply to prescribed medication; however, any misuse of prescription medication should be included e.g. taking more than prescribed/injecting of medications not intended to be injected
If the client has been an inpatient or in custody for more than 22 days during the last four weeks, do not complete the questionnaire.

IN THE PAST FOUR WEEKS:	Days used (0-28)	
1. On how many days did you drink alcohol?		
2. How many standard drinks did you consume on a typical drinking day? (*1 Standard Drink = 1 can of beer, 100ml wine, or1 double of spirits, where bottle of wine = 7 or jug of beer = 3 or 750ml spirits = 23)*		

IN THE PAST FOUR WEEKS, ON HOW MANY DAYS DID YOU USE:

	Days used (0-28)	
3. Cannabis		
4. Amphetamine-type stimulants e.g. methamphetamine, speed, methylphenidate (Rubifen)		
5. Opioids		
6. Sedatives/tranquilisers E.g. diazepam (Valium), temazepam		
7. Any other drugs. e.g. ecstasy, hallucinogens, solvents, GHB etc Specify what drugs: _____ *(interviewer: if "other drugs" contains substances covered in the above questions please return to the appropriate question and recode)*	_____ _____ _____	_ _ _
8. How many cigarettes have you smoked per day, on average (if non-smoker, enter zero):		

9. Please put a tick in the right hand column to identify main substance of concern (for some clients there may be more than one).

IN THE PAST FOUR WEEKS:

10. On how many days have you injected drugs? *(if none, enter zero and go to question 12)*	Days injected (0-28)	
11. Have you shared any injecting equipment? (*sharing means using someone else's equipment which has already been used or someone using yours regardless of whether you were both present at the time or not; equipment includes needles, syringes, water, dregs, tourniquets, spoons, filters)*	Yes	No

Please turn over

The Alcohol and Drug Outcome Measure (ADOM): Part B

IN THE PAST FOUR WEEKS:

12. How often has your physical health interfered with your day-to-day functioning?

Never	Less than weekly	Once or twice a week	Three or four times a week	Daily or almost daily

13. How often has your psychological or mental health interfered with your day-to-day functioning?

Never	Less than weekly	Once or twice a week	Three or four times a week	Daily or almost daily

14. How often has your alcohol or drug use led to conflict with friends or family members?

Never	Less than weekly	Once or twice a week	Three or four times a week	Daily or almost daily

15. How often has your alcohol or drug use interfered with your work or other activities (include social, recreational, parenting/caregiving, study or other personal activities)?

Never	Less than weekly	Once or twice a week	Three or four times a week	Daily or almost daily

16. How often have you engaged in paid employment, voluntary work, study, parenting or other care giving activities?

Never	Less than weekly	Once or twice a week	Three or four times a week	Daily or almost daily

17. How often have you had difficulties with housing or finding somewhere stable to live?

Never	Less than weekly	Once or twice a week	Three or four times a week	Daily or almost daily

18. Apart from using illicit substances, how often have you been involved in any criminal or illegal activity (e.g. driving a motor vehicle under the influence of alcohol or drugs or supplying an illicit substance to another person)?

Never	Less than weekly	Once or twice a week	Three or four times a week	Daily or almost daily